

The Shrewsbury and Telford Hospital NHS Trust

TRUST BOARD MEETING
Held on Thursday 25 April 2013 at 9.30 am
Lecture Theatre, Education Centre,
Princess Royal Hospital

PUBLIC SESSION MINUTES

Present:	Mr M Beardwell Mr D Jones Dr P Vernon Dr S Walford Dr R Hooper Mr P Herring Mrs V Morris Dr E Borman Mr N Nisbet Mrs D Kadum	Acting Chair Non Executive Director (NED) Non Executive Director (NED) Non Executive Director (NED) Non Executive Director (NED) Chief Executive (CEO) Director of Quality & Safety (DQS)/Chief Nurse (DQS) Medical Director (MD) Finance Director (FD) Chief Operating Officer (COO)
	Mrs J Clarke	Director of Corporate Governance/Company Secretary (DCG)
In attendance	Mr A Osborne Miss V Maher	Communications Director (CD) Workforce Director (WD)
Meeting Secretary	Mrs B Graham	Committee Secretary
Apologies:	None	

2013.1/160 WELCOME

The Acting Chair welcomed everyone to the meeting, and officially welcomed Dr Edwin Borman, Medical Director, to his first Board meeting. The Acting Chair advised that the CQC team were currently on site carrying out an unannounced visit.

2013.1/161 DECLARATION OF INTEREST by members in relation to any matters on the agenda : None.

2013.1/162 MINUTES OF THE MEETING HELD IN PUBLIC on 28 March 2013 were **APPROVED** subject to the following:

- **Page 3, 2013.1/143 Chair's Report 1st heading should have read: Resignation of Non Executive Director Mr Barry Simms and Transformation Director Mr Steve Peak,, Retirement of Medical Director Dr Ashley Fraser**
- **Page 16, Questions from the Floor, Q4 to be amended to read : Mr Sandbach proposed to the Board that the Ambulance Service should be asked to sign up to a joint "Compact" agreement in the Shropshire Health Economy.**

.....
Acting Chairman
30 May 2013

	MATTERS ARISING FROM THE FORMAL BOARD MEETING HELD ON 28 MARCH 2013
2013.1/142	3-month Forward Plan – two items were amended. Item complete.
2013.1/148	Local Health Economy “Compact” – document amended. Item complete.
2013.1/150	Finance – Expenditure – The DQS confirmed that a meeting had taken place with regard to combining Quality Impact Assessments with the Cost Improvement Plan. There is a comprehensive plan which will be reviewed and progressed. The FD said that there are a number of CIP schemes which have major quality concerns and the process has not yet been completely formalised
2013.1/158	Questions from the floor – Decreasing Stock Levels in the Rehabitat Shop The DQS confirmed that she had met with Therapy Centre Chief and discussed with Mr Jones following last month’s Board meeting. The sustainability of the shop will be reviewed in the next quarter.
2013.1/158	Question from the floor – JOSOC findings in relation poor treatment of two patients DQS advised that further details were required to investigate the concerns raised last month. Dr Walford (NED) asked if there was a procedure for external people to follow when they carry out reviews to ensure immediate issues concerning quality and safety are reported to the Board. The DQS outlined that there are clear processes for statutory visits (CQC, LiNKS, CHC) to feedback any immediate quality or safety concerns. COO said there is professional obligation to report concerns and confirmed that the reviewers would raise concerns on the day.
	3-MONTH FORWARD PLAN for the period May to July 2013 was AGREED .

2013.1/163 CHAIR’S AWARD

The Chair’s Award was awarded to Andrea Phillips, Supply Technician from the Endoscopy Department. Andrea had been in the role for 4 years and had documented every piece of equipment that her department uses at RSH and PRH and refined the list so that she knows exactly what the department needs on a weekly basis so avoiding wastage. Her efforts show how quality and efficiency go hand-in-hand focusing on providing a great service for our patients. She also ensures she gets the most competitive price from suppliers for the best quality items that her team needs. Her actions have helped bring savings for her team, and ultimately the Trust as a whole, and in her first two years in post she has saved the Trust over £20,000. Andrea was awarded a Chairman’s Award Lapel Badge, a framed Chair’s Award certificate and a £50 Chair’s Award voucher on behalf of the Trust Board.

2013.1/164.1 CHAIR’S UPDATE

Update on current Board vacancies

- **Chair** – There has been a sense of frustration at the lack of speed in the process to appoint a new Chair but the Acting Chair was pleased to report that the NHS TDA had appointed an independent chair for the appointments process to proceed at speed.
- **Vice Chair** - The Audit Committee raised the issue that there was currently no Vice Chair of the organisation. Mr Dennis Jones (NED) was nominated and has agreed to act as Vice Chair.
- **Non Executive Director vacancy on the Board and others expected later in the year** - the Acting Chair said that the Trust would like to see a wider representation of the communities it serves and asked everyone to pass this message on to all contacts that there is an advert and expression of interests are being sought. He also proposed to hold an open session to talk about the role of a Non Executive Director.
- Since the last meeting there have seen major changes in the NHS both locally and nationally, PCTs have been replaced by new Clinical Commissioning Groups across the country, and the outgoing chair of the West Mercia PCT Cluster Jo Newton wrote thanking the Trust for its contribution and co-operation.
- Responsibility for the performance management of NHS Trusts has transferred from Strategic Health Authorities to the new NHS Trust Development Authority (NTDA), and the Authority’s Chair Sir Peter Carr has also written introducing himself, explaining his new role and wishing the Trust well for the future.

2013.1/164.2 CHAIR'S REPORT included the following :

- On 19 April 2013, the Hamar Centre was presented with the Quality Environment Mark by Macmillan Cancer Relief in recognition of the high standard of environment that they provide for people with cancer and their loved ones. The Centre received the highest possible rating with 5 stars out of 5. The Acting Chair was delighted to be part of this event where he was joined by the Mayor of Shrewsbury and Tudor Humphreys from Macmillan, with staff from the Hamar Centre.
- In other Cancer service developments, a new linear accelerator was delivered on 13 April, the new £2.8 million equipment provides the latest standards of image-guided radiotherapy treatment for people with cancer.
- By the next Board meeting over 300 people will have walked from Shrewsbury to Telford to raise funds for the new Children's Unit at this hospital. All the Board wished them all the best for the day.

2013.1/165 CHIEF EXECUTIVE'S REPORT

Members **NOTED** the following verbal report :

- On 15 April Monitor appointed the Special Administrator for Mid Staffordshire NHS Foundation Trust. Joint Administrators are Professor Hugo Mascie-Taylor, and Ernst & Young LLP. As a neighbouring NHS provider the Trust has had a preliminary discussion to discuss the process of the future of Mid Staffs Hospital and dependent on the outcome there may be changes in patient flow. They have 145 days timescale to complete this administration. The CEO said he would share further information with the Board as it becomes available.
- Linked to Mid Staffs, detailed work is underway in the Trust and with our patients and stakeholder to reflect on the findings of the Francis Report to identify areas where improvement is needed and set out a plan of action. An update on this work will be brought to the next meeting of the Trust Board. **Action: DQS – May 2013.**
- On 9 April 2013, due to exceptionally high levels of emergency activity, SaTH together with the Clinical Commissioning Groups made a decision to institute a Major Incident. The CEO said he was incredibly impressed with the staff response in very difficult circumstances. Lessons will be learnt from this experience.
- The NTDA Accountability Framework has been published and this will specify new arrangements and lines of accountability to work through.
- A major milestone for our Fertility services was celebrated this month, marking 10 years since the Shropshire and Mid Wales Fertility Centre opened at the Trust. The Fertility Services has some of the best outcomes in the country and has helped many couples. The service is regarded as a "gem" for us but it is in very poor accommodation and it is one area to look to develop going forward.
- It has been over a year – 386 days - since the last MRSA blood stream infection acquired in our hospitals. This very good achievement is credit to the high standards of Infection Prevention and Control maintained by staff across our hospitals.

2013.1/166 KEY SUMMARY UPDATES FROM TRUST COMMITTEE MEETINGS were RECEIVED and NOTED.

Audit Committee meeting held on 18 April 2013

Dr Hooper (NED) thanked the DCG for her support there were a number of issues raised by the Committee for the attention of the Board:

- Construction Industry Scheme requirements – the Finance Director confirmed that arrangements were now in place to comply and that any prior liability was likely to be small
- The Workforce Director would be preparing a paper for the next Remuneration Committee on engagements of over six months if greater than £220 per day. **Action: Workforce Director - Sep 2013**
- Dennis Jones (NED) was appointed Vice-Chair, pending appointment of permanent Chair
- The Board agreed there was some merit in investigating the appointment of associate NEDs (non-voting) after the present vacancies were filled. The Workforce Director will liaise with NTDA and update the Board on process. **Action: Workforce Director - May 2013.**

Finance Committee meeting held on 23 April 2013

Paper was **TABLED** due to proximity of meetings. The Board was advised that the Finance Committee had received an update on FCHS project, which was largely proceeding as planned, although the increased demand on emergency beds has led to a review of the schedule of works being undertaken. Mr Jones (NED) noted that for the year end 2012/13 the Trust ended up where we expected to be and there is a more healthy cash balance, however, there is still pressure on maintaining that going forward. The Finance Committee was concerned that SaTH had not yet signed the 2013/14 contract and was pleased to note that a release of over-performance monies from the CCGs and cash released by Shropshire and Staffordshire Local Area Team had helped clear the previous creditor suppression position.

Quality & Safety Committee meeting held on 18 April 2013

Dr Vernon (NED) said that the Committee took the opportunity to look at the Francis Report and its implications on SaTH. This will be discussed at the next Board meeting as confirmed in the CEO's report. Dr Hooper (NED) raised a question from the Audit Committee around whether the Board understands where the challenged Wards are. The Acting Chair said it is a statement of fact that the Board has had reports in the past concerning challenged wards and actions and changes have occurred and this is the normal process followed. The CEO took the opportunity to advise the Board that the CEO of the TDA indicated that the implications of the Francis Report had pushed the whole Foundation Trust process back two years. The Board **NOTED** this.

Workforce Committee meeting held on 12 April 2013

The WD advised that the Committee discussed :

- Statutory and Mandatory Training and compliance. Numbers have increased but it is still below the target. This will be a focus for the year ahead.
- Staff Survey is a standing agenda item and will be discussed at the TLT meeting on 26 April 2013.
- Partnership with the Prince's Trust – 15 young people had joined the programme undertaking placements and will finish the programme on 10 May 2013. This reflects positive community engagement.

2013.1/167 **INTEGRATED PERFORMANCE REPORT**

The Board **RECEIVED** the Integrated Performance Report.

QUALITY : Patient Safety, Effectiveness and Patient Experience

The DQS introduced this section:

- **Pressure Ulcers** – showed a high level of Grade 3 and 4. This issue has been discussed by the Board and a detailed action plan has been drawn up. The DQS said it is now necessary to look over and above that and she will undertake a formal review of all pressure ulcers reported.
- **C difficile** – target of 45 was achieved. The new target is 27 is a significant reduction and will be an ongoing challenge to achieve. A detailed action plan will be prepared and will be shared with the Board at next month's meeting. **Action: DQS – May 2013.**
- **MRSA** – SaTH is in an extremely good position with no cases since April 2012.
- **MSSA and EColi screening** – SaTH failed to hit the target for screening elective and non elective patients. There are ongoing discussions with Ward Managers to ensure all patients that come through the emergency entrance of the Trust are screened. This will be closely monitored by the Q&S Committee.
- **Serious Incidents** – there were 28 incidents in the month which is the highest number recorded of which 14 were 12 hour trolley waits. An outline plan to improve patient flow will be discussed later by the COO. The DQS said she and the Medical Director chaired an RCA into long trolley waits to review the safety and quality provided and there was a good demonstration of how the team worked to ensure safety was not compromised.

Dr Walford (NED) advised that nationally reporting of SI's is going to change and there might be a need to change the way SaTH reports these to reflect the same approach as external organisations. Dr Vernon (NED) said that Q&S Committee will look at this but he considered the key issue is to find out where SaTH sits in relation to similar Trusts.

INTEGRATED PERFORMANCE REPORT (Continued)

QUALITY : Patient Safety, Effectiveness and Patient Experience

- **Board to Board Patient Experience Metrics (Table 9)** – The Board felt that comparing these results with the recent poor results of the Inpatient Survey was disappointing. The areas that have deteriorated will be looked into and discussed and discharge planning in the Board paper remained a concern. Dr Vernon (NED) asked if the DQS was confident that this process is giving a realistic representation of patient experience. The DQS said she felt there was consistency e.g. Table 8 indicated more “green” and Table 9 showed more “amber” but recognised results had to be looked at in the context of the pressure facing the Trust; however in terms of the method used for the in-house survey she had absolute confidence for the patient experience metrics. The CEO also said that the hospital is under extreme pressure and communication becomes more difficult and this is when downward trends occur. The Acting Chair said patient experience is one of the key measures and will be discussed in detail under the National Patient Survey item on the agenda and later at the Board Development session.
- **Mortality – Section 3.7:** The MD requested an amendment to two figures on Table 1, HSMR Feb 2013 should read 104.7 and March 2013 should read 97.2. The MD said that he is aware of public uncertainty around mortality rates. He explained that crude deaths are deaths that occur in hospital but this measure does not account for the clinical condition of the patient. HSMR looked at 56 main diagnoses which covers three-quarters of the total number of presentations within the hospital. The new measure “SHMI” model (Summary Hospital Model-level Indicator) has now replaced the HSMR model. Both HSMR and SHMI look at standardised mortality – expected deaths taking into account the patient’s clinical condition, against actual deaths. SHMI covers all conditions and deaths in the community within 30 days of discharge. Our target fell in mortality and we recognise that there has been a small increase of patients discharging from hospital and dying within 30 days after discharge. The reason for this may be that the hospital treatment is complete or due to the decision of families or other reasons. Table 5 (SHMI scores) updated figures were :

July 2011 to June 2012 = 106.8;

October 2011 to September 2012 = 105.3.

Following concerns in 2010-11 about death rates at the Trust an initiative commenced to reduce crude deaths by 350 in two years. The initiative was very impressive and achieved the following crude deaths figure 2010-11 = 1,770; 2011-12 = 1,591 and 2012-13 = 1,647. SaTH had maintained a reduction over two years but disappointingly due to the difficult winter last year, with an increase in frail and elderly patients and more emergency admissions, there was a small rise in the last quarter. The MD said he has identified four clinical groupings and initiated a review into individual deaths and will also look at comparative Trusts against the four areas. The MD said although statistics are helpful, interpretation is key but it must be remembered that each individual patient who has died is a patient and not a statistic. The CEO said that the Trust needs to be careful in setting crude death targets because activity had gone up significantly with far more elderly patients presenting.

Dr Vernon (NED) acknowledged the amount of work already undertaken but expressed his concern there is a need to ensure that we are counting correctly and move forward with initiatives to implement with clinical staff. He added that SaTH is still worse than average and quarterly figures have drifted up again but need to explore link with increased clinical activity. The MD was confident that the Trust was counting correctly and recognised that there is a need to make a difference and learn from individual patient deaths. The MD will keep the Board informed of progress and will bring initial findings to the June Board meeting and will also take diagnostic area information to the Q&S Committee. **Action: MD – June 2013.**

INTEGRATED PERFORMANCE REPORT (Continued)

OPERATIONAL PERFORMANCE - The COO introduced this section of the report :

- **Emergency Access:** The COO reported that the Trust ended the year with 90.62% against the emergency access target of 95%. She said the paper following this item should improve performance in this area.
- **ED attendances:** Activity during January to March 2013 had increased each month and the additional patients have caused additional pressures and high bed occupancy levels. On a positive note over the last four weeks the Trust has seen an improvement. With the operational changes about to be made, the COO felt that the Trust would be back on trajectory. It was noted that high volumes remain a national problem and that SaTH has brought this continuing position to the attention of the CCGs, the Trust Development Authority (TDA) and the Local Area Team (LAT).
- **Whole System Review of Urgent Care in Shropshire and Telford & Wrekin** was completed by ATOS. The feedback session on 12 April and yesterday's Director level session complemented SaTH's internal plan to improve performance. Schemes with whole economy responsibility were being progressed. Ward reconfiguration starts on 26 April 2013 and this should help improve plan by ensuring beds are available where they are most needed and physically adjacent to key areas.
- **Scheduled Care** – the RTT target for Admitted patients failed with 77.99% against the 90% target, as a direct consequence of emergency patients whereby surgical beds were used. Action plans are in place to deliver the target. RTT Non Admitted target was achieved with 95.08%. Urology has appointed two Consultants to start in June 2013 to enable 18 week RTT performance to improve. Validation of 18 weeks is being worked on as part of Booking and Scheduling.
- **Cancer** targets were achieved year end but in March we failed to achieve four standards and this reflected the pressure the Trust was under. The COO said it was important for the Board to be aware that the challenges experienced in March will impact upon the achievement of Cancer targets.
- **Cancelled Operations** – The COO advised that there were 277 cancelled operations in March 2013 which was far too high and as a direct consequence there is an action plan to improve the position. It was disappointing that six patients were not readmitted within the 28 day standard.

Dr Hooper (NED) made reference to the increase in demand and the fact capacity is not adequate to meet demand – he asked if this is a national issue and whether the Board should draw it to the attention of other organisations, and in the light of the Francis Report. The CEO confirmed that SaTH had drawn it to the attention of the Commissioners, Area Team and TDA as part of the action plan. The CEO said that the Patient Flow Sustainability Action Plan will provide an opportunity for debate and help the Trust in reducing levels of occupancy and create extra capacity.

Dr Vernon (NED) said that he was assured two months ago that an IT solution to the VTE assessment would be implemented on all Wards by the IT staff, however it was evident from a visit to Ward 4 that this has not happened. The MD confirmed that the system had gone "live" on some pilot wards but had not been fully rolled out. The COO said there are some underlying issues around holding people to account and the culture of people. With the new structure with Clinical Directors and new professional performance group she was sure that there will be more control around performance managing some of these targets.

FINANCE

- The Finance Director (FD) and Dr Hooper (NED) paid tribute to the Finance Team for producing the Annual Accounts within the deadline of 21 April 2013. The FD explained that Pay and Non-Pay expenditure in March is traditionally higher as a lot of year-end transactions take place.

INTEGRATED PERFORMANCE REPORT (Continued)

FINANCE (Continued)

In terms of income there are differences between SaTH and Commissioners regarding the following key elements and a meeting is due to take place later today to take the discussion forward. The FD clarified the position :

- The amount of money Commissioners spend will be lower than SaTH believes it needs. SaTH costed the contract for A&E based on actual casemix this year, but the Commissioners view is that it should be based on average price for A&E activity.
 - There is an ongoing dispute on whether the patient level of activity is accurate. SaTH is confident that it is and has agreed for them to investigate.
 - QIPP is the major issue where both Commissioners believe £6.3 million can be saved (i.e. £3.8 million from Shropshire and £2.5 million from Telford & Wrekin). SaTH has agreed to work with them but not until it receives a detail plan to enable us to confidently expect that level of activity to reduce. SaTH cannot agree reductions in income until CCGs have robust plans to deliver QIPP.
- Mr Jones (NED) expressed his deep concern that the Board had found itself in this position for a number of years, having to have plans and income assumptions based on activity levels that were unreal. He said he was not prepared to go into the year in this situation and to agree plans that are so unrealistic. The FD agreed that the issue of QIPP has to be resolved, plus access to any transitional funding.
- Dr Walford (NED) said that he was not reassured and the clinical quality regime requires that we have the right staff in place to deliver the right care and that £10 million of income at risk was too great.
- Dr Hooper (NED) referred to the TDA advice to not sign up to a contract you do not believe in.

The CEO said he did not think it appropriate or sensible to go to formal arbitration over the QIPP plans as there would be an expectation of an agreed QIPP target. SaTH needed to work with its health partners to have greater assurance of the QIPP plans. He said that although not comfortable we have to accept that this year, whilst building up stronger relations, we have to make a risk judgement. Both he and the FD had confidence that the contract would be signed. The meeting later today would be to try to resolve issues around transitional support and avoid going to arbitration by agreeing to sign the contract on or before 30 April 2013.

The Acting Chair said that the views of the NEDs and whole Board had been noted and would be communicated to Commissioners by the CEO and FD. Members **fully supported the decision to give delegated authority to the CEO and FD** to make sure the contract does not place our patients at risk because of a contract that does not take account of activity. The possibility of a three-month break clause was also discussed as an alternative approach.

WORKFORCE – The Workforce Director (WD) introduced this section of the report :

- Sickness Absence – saw a continued reduction in March and in long-term sickness. Reasons for sickness absence included stress and anxiety and this is being targeted by the Health & Wellbeing programme.
- Appraisals – the Trust achieved 72% against the 80% target. This will be managed going forward through operational teams. Medical Appraisals fell by 2% to 76% with consultant appraisals at 78%. The MD will focus on this through LMC and clinical colleagues.

The WD said that high absence rates is a real issue and is being looked at in a pro active way e.g. focusing an HR advisor into one ward had already significantly reduced absence rates. SaTH has also recruited one HR individual to support sickness management which should pay for themselves as absence rates reduce.

INTEGRATED PERFORMANCE REPORT (Continued)

Section 7.1 of the Report : The CEO confirmed that the following Penalty Point would be corrected :

- 18 week RTT Target (non admitted) achieved therefore no penalty point;

However 6.5 penalty points were applied in relation to one point for each of :

- A&E 4 hour wait standard
- 18 weeks RTT (admitted)
- 18 weeks RTT (open clock)
- 62 days wait for first treatment
- 31 day second or subsequent treatment
- Clostridium Difficile (in-month)

0.5 Penalty point was applied for:

- 31 day diagnosis

In addition there was a 4 point penalty for the A&E override performance.

The Board had **considered** performance for March 2013. Due to ongoing concerns around delivery of a number of key performance targets and financial performance the Board **AUTHORISED** the Chair and Chief Executive to sign Declaration 2: There is insufficient assurance available to ensure continuing compliance with all existing targets.

The Vice Chair reminded members of the following responsibilities of the Board :

- To ensure adequate systems of governance for all aspects of the Trust;
- Responsibility of NEDs to adequately challenge, so EDs feel appropriately challenged.

The Board is very conscious that EDs have been incredibly busy and the Acting Chair asked the EDs to pass the Board's thanks to all staff who have coped with the demands in the organisation over the course of the last three months. **Action: EDs.**

2013.1/168 PATIENT FLOW SUSTAINABLE ACTION PLAN

The Chief Operating Officer (COO) introduced the paper which explained that the Trust had failed to deliver the 4 hour A&E target since July 2011 and this needed to be quickly and sustainably addressed. Whilst working with the Local Health Economy (LHE) on new models of care there are improvements that SaTH can make internally to improve patient flow and improve performance. There was a brief explanation as to why current/projected performance was not on target and a remedial action plan which outlines short-term (within next three months), medium-term (3-6 months) and longer-term (six-months plus) actions that needed to be taken to improve performance. The COO briefed the Board on key points as follows:

The main issue relates to the shortfall of bed capacity by around 70 beds. The use of flex beds has supported medical demand and these are now permanently staffed and funded but there is still no surge capacity available. Reconfiguration of Wards in RSH will happen on 26 April 2013 and has the aim of placing the right patient in the right place at the right time. This change is driven by clinicians and the need to establish a Clinical Decision Unit. The outcome should be to reduce waits, improve patient experience and in turn reduce length of stays.

2013.1/168 PATIENT FLOW SUSTAINABLE ACTION PLAN (Continued)

It is important that service areas i.e. emergency department and acute medicine have robust professional standards in place and that Wards have better discharge planning arrangements. Underpinning this is having the right operational management structure in place and holding people to account so roles and responsibilities need to be clearly understood.

The COO was pleased to report that the Community Trust, Local Authority and CCGs have agreed to provide additional capacity outside the hospital giving access to 22 beds or bed equivalent from 29 April 2013. There has also been a recent offer to use beds at Whitchurch which would be discussed in more detail to identify staffing options. The additional capacity and ward reconfiguration should support significant improvement in A&E waits and less cancelled operations. The CEO said that the plan has been submitted to the NTDA and they have been very supportive of the process.

He said that certain aspects of delivery rely on partners' co-operation but there is greater confidence that these schemes will improve the situation and relieve the pressure. The CEO stressed that the scheme will not resolve all the capacity issues which are long term but it will provide some alleviation of pressure. He advised of a Risk Summit which will be held in May which is a formal quality risk review process led by Commissioners and the NTDA with all key partners in the health economy involved to look at a collective strategic approach to quality issues.

Mr Jones (NED) referred to Page 9 "Predicted Performance Trajectory" and asked for an explanation with regard to the drop from 97% in August to 95% in September. From experience the COO said that there is always a shift in case mix – some minor injuries - in September and then during the winter when patients are sicker.

The Board **NOTED** the Patient Flow Sustainable Action Plan and looked forward to a progress report **ACTION: COO to update Board on progress July 2013.**

2013.1/169 INPATIENT SURVEY 2012

The Director of Quality & Safety (DQS) introduced the report and advised that the recently published Inpatient Survey provided very disappointing results for the organisation. It reflected a snapshot taken from August 2012 and sampled 850 patients, of which 60.7% (516 patients) responded. The survey covered 70 questions grouped into sections. Four of the sections were in the worst performing Trusts, with all other scores being about the same as most other Trusts. The worst areas were the Emergency Department, Doctors, Leaving Hospital and Overall experience. Page 5 highlighted significant changes from SaTH's 2011 results – A&E, waiting to get a bed on a ward, were you offered a choice of food, were you bothered by noise at night and did doctors talk in front of you as if you weren't there. One area had improved – how clean was the hospital ward or room you stayed in?

The DQS said that the results of the survey need to be disseminated to the clinical centres and discussed with our patient representatives to ensure that we capture the full scope of our improvements and our priorities for the coming year. The DQS also outlined the importance of considering the findings with the results from the Staff survey.

Following a challenge from Dr Vernon (NED) about the incompatibility of the Survey results with the Ward to Board Patient metrics (Table 9 IPR) the CEO said there are significant cultural issues to address and this was discussed in some detail at the last Executive Directors meeting. The Workforce Director has been tasked with developing a cultural organisational development programme which she will bring back to the Board in June 2013. **Action: WD.**

INPATIENT SURVEY 2012 (Continued)

The COO said she and the Deputy DQS had recently met with the Matrons and talked about leadership, and specific nurse leadership roles have been identified to develop during May 2013. The MD also added he had met with Medical Leaders to indicate that the organisation will be going through transformative challenges and their role in effecting this. The agreed agenda will focus on operational pressures and is absolutely critical for safe and timely patient care.

The Board **NOTED** the disappointing results and the key areas for improvement and **SUPPORTED** the detailed review of these survey results in conjunctions with the staff survey and operational performance to agree the best approach for improvement. This item will be discussed this afternoon at the Board Development session.

2013.1/170 INFORMATION GOVERNANCE TOOLKIT (ASSESSMENT) UPDATE 2012/13

The Finance Director (FD) introduced the update. The Information Governance Toolkit (Assessment) is an annual mandatory requirement required across all NHS organisations. The Trust scored 78% (Satisfactory) attaining a Level 2 score in all 45 requirements to achieve a statement of compliance. The Information Governance (IG) Manager will work with the Information Security Group on an action plan for improvement.

The Medical Director (MD) as Caldicott Guardian for the Trust advised that he had met with the IG Manager to talk through ways of working through IG training in a more innovative way to make sure staff refresh their knowledge and have a high regard and recognition of patient confidentiality and their responsibilities.

Mr Jones (NED) referred to the Outpatient backlog and Finnamore's involvement to a series of inadequacies, the FD clarified that this was a different issue. IG relates to holding data and level of training and understanding whereas the issue concerning Outpatient inadequacies was expected to improve through the new Booking system, which is being scrutinised through Audit Committee.

The DCG added that Information Governance is also a standard requirement for Foundation Trust in terms of authorisation requirements and if breached can attract heavy fines from the Information Commissioner's Office.

The Board **NOTED** the IG Toolkit Assessment at Level 2 compliance.

2013.1/171 RISK MANAGEMENT STRATEGY

The Director of Corporate Governance (DCG) introduced the strategy which has been substantially revised to take account of internal organisational changes. The revisions are also in line with the latest national guidance including the Audit Committee Handbook (2012). It also reflected the changes to the Trust's objectives. A significant amount of operational detail has been removed and this will be included in a Risk Management Handbook to be completed by the end of April which will provide support and guidance to managers and staff. The strategy has been reviewed by Internal Auditors who have given the Risk Management process and the Board Assurance framework a substantial assurance opinion, as reported to the February Audit Committee.

Dr Hooper (NED) referred to the list of Membership of the Risk Committee and asked that the MD's name be corrected; also asked if there might be value to having a staff member on the membership. As Chair of the meeting the CEO said he would give some thought to this.

The Board **REVIEWED** and **APPROVED** the Risk Management Strategy.

2013.1/172.1 GOVERNANCE AND COMPLIANCE UPDATE provided a suite of documents as follows :

- **Use of Corporate Seal**
- **Declaration of Interests**
- **CQC Compliance**

The Board **NOTED** the list of Sealings as detailed in the Register for the period 17 April 2012 to 31 March 2013; **CONFIRMED** that the Declarations listed in the report were correct and **NOTED** that members were asked to advise the Committee Secretary within six weeks, of any changes. The Board also **NOTED** the CQC Registration and Trust compliance assessment. Following a query from Dr Walford (NED) about other services provided at Bridgnorth, and by extrapolation other Community Hospitals, the DCG said she would check the registration details. **Action: DCG.**

2013.1/172.2 ▪ **Annual Losses and Compensation, and write offs**

The FD confirmed that the Trust had used an organisation to recover the bad debts but it had failed. Dr Hooper (NED) referred to the Pharmacy expiry write offs which had risen in the last two years. He was assured that this matter had been discussed at some length by the Audit Committee who received an explanation from Bruce McElroy, Chief Pharmacist, which confirmed that they had robust controls and interaction with other hospitals. The spike came from a very small number of expensive drugs regime which needed to be written off because they were ordered for individual patients. The COO agreed to discuss further outside the meeting.

The Board **NOTED and APPROVED** the annual write-off schedule for bad debts.

2013.1/173 HR POLICY – HR27 PARENTAL LEAVE

The Workforce Director (WD) introduced HR27 Parental Leave policy which noted that from April 2013 the legal entitlement to parental leave was increased from 13 to 18 weeks and standardised across groups.

Dr Hooper (NED) pointed out that there were cost implications to this policy and suggested that the Trust should write to the Secretary of State to draw this to his attention. The Board **did not accept** this view as this was legislation and it would have received a period of consultation. Dr Hooper (NED) said he may recall this in the future.

The Board **NOTED** the policy for full implementation.

2013.1/174 ANY OTHER BUSINESS – None.

2013.1/175 QUESTIONS FROM THE FLOOR RELATING TO ITEMS ON THE AGENDA

- Q1** A gentleman from the audience raised a very pressing personal health concern around his experience at the lack of communication from his Consultant at RSH.
- A1** The Acting Chair thanked the gentleman for raising his issue and asked Dr Edwin Borman, Medical Director to discuss this with the gentleman outside of the meeting to try to resolve the issue.
- Q2** (i) 2013/14 Budget - signing the contract : Mr Sandbach suggested that from experience he knew that the Trust could consider including a break clause after three months in the contract.
(ii) 2013.1/158 - Mr Sandbach had spoken to the patient he mentioned at the last Board meeting and no-one had been in touch from SaTH about an issue raised at the last Board meeting and therefore the item had not been finished. Details were provided and the DQS said she would follow it up. **Action: DQS.**
(iii) Is it the Board's view to abandon the policy to close 120 beds, as last year the beds were closed and staff were reduced, there is confusion in the community over this.
- A2** The CEO said the Board had discussed the situation many times. There is no intention to close any further beds from this point on in the current circumstances, in fact we have not got enough beds even though permanent beds had been reinstated. Until there are some changes – e.g. emergencies start to fall significantly, patients discharged more safely and internal changes take place to improve patient flow, it is the Board's policy that there will be no further bed closures.
- Q3** Mr Sandbach said he intended to complain to the CCG regarding the current occupancy rate running at 97.9%, they have a duty of care to ensure safe practices are available, and this level of occupancy puts everyone at risk.
- A3** The CEO said there is a realisation amongst all health partners that there is a capacity issue. Mr Sandbach was free to complain but he assured him the CCG are very supportive going forward to try to resolve the capacity problems.
- Q4** Mr T Jones, PALS Volunteer, said he was delighted to see Barbara Graham back from sick leave.
- Mr Jones said he was very concerned about the low staffing levels of the PALS service at PRH and RSH sites, particularly when one staff member is on leave it means one hospital has no PALS representative and therefore no one to attend to people's complaints and their issue can then escalate to a full complaint.
- A4** The DQS informed Mr Jones that a new manager of Complaints and PALS has been appointed and it will be a good opportunity for her to review the issue raised. There will also be some benchmarking to look at different processes.
- Q4** Mr Jones said that he found the Board meeting very interesting and it is very sad that more people do not attend these meetings. He added that some people from Market Drayton do not know when the meetings are held. The DCG said that Notices are displayed on both sites and posted on the SaTH website. People can also contact the Committee Secretary if they want copies of agenda papers.

2013.1/176 DATE OF NEXT MEETING :

Formal Board Meeting – Thursday 30 May 2013 at 9.30 am Seminar Room 1 & 2, Shropshire Education & Conference Centre, Royal Shrewsbury Hospital.

The meeting then closed.

UNRESOLVED ITEMS FROM PUBLIC TRUST BOARD MEETING ON 25 APRIL 2013

Item	Issue	ACTION LIST	PRIORITY
158	Question from the floor re. JSC members visit Item carried forward from last meeting raised by Mr Sandbach. DQS agreed to look into this.	DQS	ASAP
166	Key Summary Updates <ul style="list-style-type: none"> ▪ Paper to be prepared for next Remuneration Committee meeting on contracts over six months earning more than £220 per day. ▪ Appointment of Assoc NEDs -WD to liaise with NTDA and update the Board on process. 	WD WD	Sep 2013 May 2013
167	Integrated Performance Report <ul style="list-style-type: none"> ▪ Board's thanks to be passed on to staff who coped with the demands in the organisation over the course of the last 3 months. 	EDs	ASAP
172.1	Governance & Compliance Report – CQC Compliance Bridgnorth Licence to be checked.	DCG	ASAP