Enclosure 1

The Shrewsbury and Telford Hospital NHS Trust

TRUST BOARD MEETING

Held on Thursday 27 June 2013 at 9.30 am
Lecture Theatre, Education Centre,
Princess Royal Hospital

PUBLIC SESSION MINUTES

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

2013.1/199 **WELCOME :** The Acting Chair welcomed everyone to the meeting. The Acting Chair said that there will be opportunity to ask questions from the floor about any matters discussed during the meeting, and reminded everyone that this is a Trust Board meeting held in public and not a public meeting.

2013.1/200 **DECLARATION OF INTEREST** by members in relation to any matters on the agenda : None.

2013.1/201 **MINUTES OF THE MEETINGS HELD IN PUBLIC** on 30 May and 6 June 2013 were **APPROVED.**

	MATTERS ARISING FROM THE FORMAL BOARD MEETING HELD ON 30 MAY 2013
2013.1/158	**Question from the floor re. JSC members visit**. The DQS said that the issue raised previously related to Ward 10 and this ward is currently under a Quality Improvement Framework and progress is being monitored weekly. Item **complete.**
2013.1/181	**Q&S Committee meeting held 23 May 2013 – 1st bullet point – update on bathroom facilities –** The FD confirmed that the Director of Estates had agreed to make the necessary changes before September 2013. Item **complete**.
2013.1/182	▪ IPR Quality – re. avoidable pressure ulcers and the process : the DQS said a timetable is not required by the CCG. ▪ Risk Summit – to be followed up at the July or September 2013. **Action: CEO**. ▪ Medical Appraisals – to be discussed at the July Board. **Action: MD.**
2013.1/183.2	**BAF** – (423) Staff Engagement – a document will be brought to the July Board. **Action : WD.**
2013.1/184	**Final Quality Account –** Item is on the agenda. Item **complete**.
2013.1/185	**The Trust's Response to the Francis Report –** Members signed off the agreed Statement of Common Purpose. Item **complete.**

.....
Acting Chairman
25 July 2013

	MATTERS ARISING (Continued)
2013.1/191.3	**Questions from the floor –** The DQS said she had arranged a meeting between Mr Jones and the new Head of Complaints & PALS when she starts the post. Item **complete.**
	3-MONTH FORWARD PLAN for the period June to September 2013 was **AGREED.**

2013.1/202 CHAIR'S AWARD

The Chair's Award was awarded to Dr Probal Moulik and Sister Erica Richardson who were two deserving individuals with clear commitment to Putting Patients First. The Director of Quality & Safety (DQS) said the Award was made to them following recommendations from colleagues in recognition of their passion and commitment for the improvement of Diabetes Care and the impact of this work on experience, safety and outcomes for our patients. Erica wished to recognise the help and effort she received from Tom George and Nick Holding.

2013.1/203 CHAIR'S UPDATE

Members **NOTED** the following verbal report :

Update on current Board vacancies

- **Chair** – two drop-in sessions have been advertised in the local Press and wider afield. Interviews will be held on 9 July by the Trust Development Authority (TDA).
- **Non Executive Director vacancies on the Board –** Closing date is 25 July 2013 in order for the new Chair to be involved in the interviews. The response so far has been encouraging.

Local Meetings:

- **Tripartite Meeting** (between SaTH and the 2 Clinical Commissioning Groups(CCGs) has been arranged for 1 July 2013.

Celebration of the 65th Birthday of the NHS is taking place next week;
NHS Heroes – the Trust is following this with enthusiasm. It is an ongoing exercise and to date 48 individuals and teams have been nominated by colleagues, patients and relatives.
FT Network – The Acting Chair on behalf of the Board congratulated Peter Herring on his election to the Board of the Foundation Trust Network.

2013.1/204 CHIEF EXECUTIVE'S REPORT

Members **NOTED** the following verbal report :

- **Emergency and Urgent Care -** BBC Radio Shropshire had a week focussing on Urgent Care in the NHS. During this time interviews were held with the Medical Director (MD), Care Group MD, Deputy Chief Nurse and Caron Morton – Accountable Officer - Shropshire CCG. The week concluded with an interview involving himself and Julia Bridgewater – Interim CEO – Shropshire Community Trust. The CEO said this was a very positive chance to share the progress being made but also that a lot of progress still needs to be made in relation to launching the refreshed Unscheduled Care Strategy.
- **Temporary Changes to the Stroke Service –** to be discussed under the Integrated Performance Report agenda item.
- **Health & Wellbeing –** The CEO congratulated those staff who participated in a number of activities including half a Marathon and full Marathon raising money in memory of Dr Mike Dean and also raising funds for the Lingen Davies Cancer Centre. Also Health Roadshows were held during the month to improve the health of our staff.

.....
Acting Chair
25 July 2013

2013.1/205 KEY SUMMARY UPDATES FROM TRUST COMMITTEE MEETINGS were RECEIVED and NOTED.

Audit Committee meeting held on 6 June 2013
Dr Hooper (NED) referred to the paragraph on External Audit issued ISA260 which was also that referred to in the Special Trust Board meeting. He said that when External Auditors carry out their Audits they do not always add detail about the reported position and sometimes this could enhance the understanding for the reader. The Auditors accepted these comments. It was confirmed that the action relating to the Workforce Committee receiving appraisal reports identifying the best and worst performing areas would be actioned. **Action completed.**

Finance Committee meeting held on 25 June 2013 - Mr Jones confirmed that the Committee:

- Reviewed the Future Configuration of Hospital Services (FCHS) project which was largely on track and within budget and programme including strategies to address capacity. The Committee wished for the Board to note that £3 million to preserve bed capacity cost will come from the Capital Programme during the next 2-3 years. The suggestions raised by Mr Sandbach at the last Board meeting in public had been considered but were not seen as the best way forward.
- Finance Report Month 02 – Income was acceptable but contained an element of risk and uncertainty that may not be clarified until the second half of the year and a close review of contract claims will be required. Pay remains a significant challenge. In terms of Quality Impact Assessments (QIAs) in relation to the Cost Improvement Programme (CIP) – the Committee recognised that the need to ensure quality and safety is not undermined by CIP proposals but equally financial targets are important therefore the Committee recommended that QIAs are completed as soon as possible and if there are quality issue they will need to reconsider.
- Patient Property – there were concerns around working practices which impacts on patient experience when valuables are mislaid.
- Terms of Reference (ToR) of the Finance Committee – to make better use of Executive Directors time, it was agreed that changes to the ToR are made to include Dennis Jones, Simon Walford and the Finance Director as members and then attendance of other EDs when relevant and upon request. The Board **AGREED** to this change.

Hospital Executive Committee meeting held on 25 June 2013
The Finance item will be covered further in the IPR agenda item. The CEO said the Committee received an update on Pathology Service reconfiguration across the two sites which is currently at the consultation stage with staff. The biggest issue relates to whether Commissioners will participate in the Region-wide tendering process which could mean the loss of our full direct access from GPs which equates to around £5 million of income. Following negotiation with the Commissioners there is a possibility that an agreement could be reached that they will not participate in this tender exercise. The Board will receive an update report next month. **Action: CEO – July 2013.**

Quality & Safety Committee meeting held on 20 June 2013 – Dr Walford (NED) said that the Committee had a very good meeting and discussed key operational challenges with the COO. Some core agreements were made about how to monitor some additional quality indicators which would support measuring the impact of different escalation levels on the quality of care (e.g. having sight of medical outliers, cancelled operations and 4 hour waits). The Committee also discussed its Term of Reference and possible changes.

Workforce Committee meeting held on 13 June 2013 - The Workforce Director said that the Committee discussed the following :

- People Strategy (previously known as the Workforce Strategy) – this will come back to the Board in July. **Action: WD.**
- Sickness Absence which was covered under the IPR agenda item.
- Statutory and Mandatory Training – this is currently a standard item on the Committee agenda. The Committee is very clear that responsibilities fall on the Managers to ensure individuals undertake this training.
- Response to the Francis Report – The Workforce team had assessed the recommendations against current and proposed work to develop an analysis of any areas that are not currently being addressed.

.....
Acting Chair
25 July 2013

The following points were noted following questions from the NEDs :

- Response to Francis Report - SaTH is on track in terms of improving the leadership team. Each team has a detailed information pack of their results. Centres have come up with their own key areas and it is hoped that these actions will lead to improvements.
- Additional HR Resources being used – this includes 2 additional HR individuals to support Sickness Absence at a cost of £90k for this financial year. The impact on this is equivalent to £100k per month cost avoidance and directly contributes to patient experience. Dr Hooper (NED) said this was an important point as evidence for the Auditors.
- The DCG said she would bring a full pack of amended Committee Terms of Reference to the September Board meeting. **Action: DCG – September 2013.**

The Acting Chair thanked all Committee Chairs for their efforts in providing a vital scrutiny role.

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

The Board **RECEIVED** the Integrated Performance Report in respect of the month of May 2013.

QUALITY : Patient Safety, Effectiveness and Patient Experience

The DQS introduced the report which referred to the overview and key information in May and was pleased to note that there were a lot more "green" areas on Table 1 of this Quality report. The following points were noted :

- **Serious Incidents (SIs)** (3.2) there were 8 SIs in May, and this is the first time this had fallen below the trajectory of 12 since Qtr 2 of 2012/13. Of the 8 SIs, 6 related to clinical effectiveness and 2 were operational in nature relating to booking and scheduling errors.
- **Pressure Ulcers** (3.3) - There were no grade 3 or 4 Trust acquired pressure ulcers reported for May and May also saw the lowest Trust acquired Grade 1 & 2 pressure ulcers. The DQS said that Section 3.3 should be amended to 101 days since a Grade 4 had been reported, and 57 days since a Grade 3 had been reported. Three pressure ulcers had been reviewed today with staff and were considered to be unavoidable and outlined good documentation and practice, future Board reports would clearly report the avoidable pressure ulcers. The DQS outlined that she had informed the CCG about the internal validation process and would have further discussions with them. The Pressure Ulcer Task Group is providing robust peer review and challenge to any Grade 2 or 3 pressure ulcers and there is a clear focus from senior nurses and ward staff.
- **Falls** There was 1 RIDDOR reportable fall in May relating to a patient fall on a ward. The patient suffered harm and a full Root Cause Analysis is being undertaken lessons learnt reviewed against other falls outcomes. The Falls Task Group is continuing to closely review and reduce falls within the Trust.
- **Infection Control** - The **C difficile target** will be challenging to achieve this year. Although April and May performance indicator was Green, the Infection Prevention & Control (IPC) Committee had reviewed the Local Health Economy (LHE) and Trust-wide action plans and as a result a campaign will be developed. The **MSSA bacteraemia** graph shows a steady increase in the last 3 months. In May there were 9 cases of which 5 were apportioned to SaTH. The agreed target for 2013/14 is 21. The indicator is currently Red and this will be carefully monitored.
- **MRSA screening in both elective and emergency admissions** remains below 95%, at 93.7% and 94.3% respectively, with the indicator is on Amber. This has been discussed at the Q&S Committee and the Director of IPC is committed to reducing this through Ward Managers, as it is considered to be critically important in preventing MRSA bacteraemias.
- **Friends and Family test** includes a new methodology, nationally determined, where there is a 5-star system and this will be tracked through Q&S Committee.

.....
Acting Chair
25 July 2013

2013.1/206 INTEGRATED PERFORMANCE REPORT, BOARD GOVERNANCE AND MONITOR LICENCE CONDITIONS SELF-CERTIFICATIONS (Continued)

QUALITY : Patient Safety, Effectiveness and Patient Experience (Continued)

The following points were noted following questions from the NEDs:

- Actions being taken to avoid the continued Information Governance breaches where patients are receiving information on other patients. The MD said there were two specific instances which involved a combination of user error and machine malfunction which permitted the mistake. To mitigate these errors the machine settings have been reviewed and engineers have performed additional checks to ensure the bundles of letters intended for GPs are not mistakenly sent to patients. The MD said this matter had been taken very seriously.

The Medical Director (MD) covered the following two issues :

- **Mortality (3.6)** – SaTH is now a member of CHKS which uses a different methodology for reporting mortality called Risk Adjusted Mortality Indicator (RAMI). Table 4 in the report shows average annual figures from April 2012 to Feb 2013 and shows that SaTH is broadly tracking the national average with a slight rise during the winter period. SaTH's current full-year figure is 94 against a national benchmark of 100. The MD said he was reviewing specific HSMR categories and particular attention was being paid to deaths due to Urinary Tract Infections (UTI). The review concluded that coding is an issue and work is also underway with colleagues in emergency care to escalate those potential UTI cases in a more proactive way.
- **VTE assessments** (3.7) – the VitalPAC assessment rate trend for May was 89.3% against a VTE assessment target of 95%. As a result of a number of actions, the VitalPAC assessment trend for May shows an improvement of 4% on April's performance. The MD said he had written to all doctors, including trainees, about the importance of VTE training and using the Patient Status at a Glance (PSAG) boards and the VTE icon to ensure sustained improvement.
- **Maternity Dashboard** – the Board noted two updates on Amber areas of the dashboard including Midwifery supervision and Birth to Midwife rations. Both ratios are now being achieved and are being reviewed by the LSA who are content.
- **Patient Metrics** (3.9) – Tables 5 and 6 showed that we are back on green for nutrition score increased by 6% and patient observations showed an increase of 7%. Dr Vernon (NED) said there is a need to improve communication with discharge as it is still one key issue showing a low score on the metrics. It was noted that Discharge is now recorded in Table 5. The DQS said there is a lot of focus on discharge and a composite bundle has been agreed between the DQS and COO which had been introduced to make improvements.
- **External Feedback and Assurance (3.10)** – The Trust received an unannounced visit in May to Wards 22(0) and 27. The Trust has responded on accuracy to the draft report and a final report is awaited.
- **Wards 10, 12 and 22(0) were subject to a Quality Improvement Framework (3.11**) and are being supported. It was clarified that the process is to review in 4 weeks and realistically it is at least 2 months. Wards 10 and 12 will need to be maintained for at least another 2 months. Senior nurses are driving this through.

OPERATIONAL PERFORMANCE - The COO introduced Section 4 of the report :

- The Trust achieved the 95% A&E 4-hour target in May with 95.51%, giving a year to date position of 91.60% and is on track to achieve the target for June. The COO congratulated all staff involved in delivering improvements and maintaining them. However the status is still very fragile. The solution is to be able to discharge the patients who are fit to transfer out of acute beds. This issue was discussed with TDA yesterday and there are looking into this. Ultimately the Trust is aiming to deliver 98% compliance, to allow some headroom within the hospital.
- 18 week Referral To Treatment (RTT) admitted showed an improvement. There are now weekly meetings taking place. There is a plan to clear the backlog but the position is initially expected to worsen until November 2013 whilst the backlog is cleared.

.....
Acting Chair
25 July 2013

INTEGRATED PERFORMANCE REPORT (Continued)

OPERATIONAL PERFORMANCE (Continued)

- 62 day cancer target saw no real improvement. There are four specialties that are challenged but there is a Cancer action plan is in place which aims to achieve the 62 day target by end of July 2013 with performance being reported in August. The high number of emergency admissions earlier in the year did impact on performance in this area. It is recognised that there is a need for a Cancer Board and a Cancer Strategy to be developed with the CCGs.
- **Stroke Services** – The CEO referred to the Annex of the report and explained that due to a Stroke Physician vacancy, the inability to recruit a locum and annual leave during Summer 2013 it is necessary to move the Stroke Services temporarily on to one site to PRH i.e. during July and August, and this plan will enable the safe and effective delivery of Stroke Services. The Consultant post will be filled on a permanent basis in September 2013 and the service returned to RSH. This action has been discussed and agreed with our Commissioners but it was stressed that it is a temporary move, although permanent discussions regarding the location of stroke services will be part of our wider clinical services strategy. The COO gave assurances that the standard in the Stroke Services was achieved up to March in RSH and the failure to achieve the stroke target in April and May was due to bed pressures in those months.
- **Booking & Scheduling** – Following significant challenges the Trust has started to see improvements following the development of a focused action plan. The COO said a meeting involving Commissioners and GPs is due to take place in July to look at how to improve compliance with Choose & Book. The COO agreed to bring the full report to the July Board. **Action: COO.**

Following questions from NEDs the following points were noted :

- The CEO confirmed that five joint working streams have been agreed with the CCGs and these will proceed over the next couple of months, these were : Admission avoidance - led by Commissioning Group, System-wide capacity - led by CCG; Patient Flow within emergency departments - led by SaTH; Discharge pressures - led by SaTH and, in conjunction with our colleagues led by Julia Bridgewater; creating or finding capacity to manage the patients who are safe to transfer outside of the acute Trust differently. The CEO said the pace of change needs to be very rapid as there is only a small window of two months before winter sets in. Discussion took place on government funding when the CEO agreed to raise through FT Network the changes around social care and its impact. Dr Vernon (NED) said that whilst it was regrettable to move Stroke Services temporarily on to one site it showed a level of maturity around risk and quality awareness and to the importance placed on providing safe services.

FINANCE The Finance Director (FD) introduced this section :

At the end of May the Trust had recorded a cumulative deficit amount of £2.94 million compared to a planned deficit of £2.805 million. At present the forecast year-end position is £2.428m deficit.

Pay – The Pay spend is a major concern. In May pay costs overspent by £447k. Achievement of the Trust forecast Outturn is dependant upon the Trust reducing pay spending to budgeted levels and also delivering upon the Pay elements of the Cost Improvement Programme (CIP). At the end of May the net level of over establishment after allowing for vacancies amounted to 127.55 posts. Over establishment of posts are predominantly located across nursing budgets within the Unscheduled Care Group. The FD referred to the profile of spending tabled on Page 21 which indicated that spending had increased significantly from November 2012 to May 2013 from £16.8 million to £17.4 million. In order to ensure recovery, there is a need to reduce the pay spend to £16.7 million monthly. The CEO added that the COO and her team have already put a lot of initiatives in place but there is a meeting planned after the Board to look at some significant proposals to reduce pay costs. He said it is absolutely vital to get the pay bill down without affecting quality of service provision. There are many areas of inefficiency and cited a lack of control in agency and overtime in particular. It is important to reduce these excess costs quickly so that we do not precipitate the need for greater action later in the year.

Non Pay – The level of spending in May is broadly consistent with previous years and within our budget.. The available monthly Non Pay budget for the remaining months in 2013/14 after allowing for achievement of a non-pay CIP amounts to £7.469 million; presently the Trust is spending at an average rate of £7.307 million each month.

.....
Acting Chair
25 July 2013

INTEGRATED PERFORMANCE REPORT (Continued)
FINANCE (Continued)

Cash Flow was described in the Table on Page 23. The cash position will need to be re-modelled based on actions to take to bring about pay costs reductions. Following discussions with NTDA they have indicated that it is likely that SaTH could draw some funds to support its cash position in 2013/14 before September but pay costs have to reduce.

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

- Sickness Absence – Absence rates for May fell to 3.99% which was the first time in two years that the absence rate fell below 4%. This was a major achievement. Focusing additional HR resources is improving the confidence in Line Manager to ensure we sustain this reduction.
- Appraisals :
  - Non Medical Appraisal coverage – the rate during May increased by 1% and whilst small it is the first time in over 5 months that an increase has occurred. This metric will be monitored by the COO through the Operational Performance Group and it is expected to see further improvements.
  - Medical Appraisals – the rate remained at 69% and as described in the MDs report last month, he has set clear guidance on increasing coverage which is anticipated over the coming months.

Dr Hooper (NED) expressed serious concern over the appraisal rate and said that every organisation should have 100% appraisal rates. He said that the staff survey response rates could be a reflection that staff have not received appraisals. The CEO agreed that it should be 100% of eligible staff but new starters would not be included.

The MD referred to the appraisal educational programme and confirmed that the 4th session will be delivered next month and this will cover 200 of the 300 senior doctors and at least one more session will be held to accommodate the remaining 100. The MD said he has made it known that he is taking this very seriously and a process is in place to match doctors with appraisers. The CEO said it is an absolute requirement to have an annual appraisal.

Page 26 - Section 7 - Monthly Self Certifications – NTDA Mandatory Requirement:

Section 7.1 Quality, Safety and National targets – it was noted that SaTH fell short of the monthly targets in three areas :

- 18 weeks RTT target (Admitted) – 1 penalty point
- 18 weeks RTT Target (Open Clocks) – 1 penalty point
- 62 day wait for first treatment – 1 penalty point

The Trust is rated Amber/Red with 3 penalty points but there is an additional 4 points from the A&E override therefore a total of 7 penalty points and an overall Governance Risk Rating of Red. In relation to a question on when the A&E overlap phases out, the DCG said she understood that the Trust had to achieve a full quarter of the target however it was noted that the PMR is gradually being replaced by the self certification process.

The Trust followed the formal process and has submitted templates in June covering the month of May relating to :

1. Monitor Licensing Requirements - a summary of each relevant licence condition. It was noted that all conditions were marked compliant.
2. Trust Board Statements covering clinical quality, finance and governance was included in the report at Appendix 2. Only one area was identified as non-compliant that is No. 5 Governance – the Trust had reported a deficit position of £1.8 million in April. RTT in May was 78.74% for Admitted. Trajectories have been agreed with the NTDA to deliver the relevant targets at a speciality level between July and November 2013. RTT for non-admitted was achieved at 95.51%. Cancer under-achieved against the 62 day pathway in month with 78.66%. Unvalidated VTE compliance in May was below 95% target, action plans are in place to recover all the above targets. A&E performance improved in the month of May and was achieved at 95.51% with improved performance during June to date. The Board will ensure that the Trust remains at all times compliant with the NTDA accountability framework and shows regard to the NHS Constitution at all times.

.....
Acting Chair
25 July 2013

INTEGRATED PERFORMANCE REPORT (Continued)

The Board **AGREED** to the above retrospectively and **AGREED** delegated authority for the CEO and FD to sign for June.

The Board **NOTED** the Integrated Performance Report for June 2013.

2013.1/207 ANNUAL REPORT 2012/13

The Finance Director (FD) introduced the Annual Report for 2012/13 and said that all NHS Trusts are required to produce an Annual Report in accordance with guidance set out in the NHS Finance Manual : Manual for Accounts". The Annual Report 2012/13 was included in the Information Pack for Board members and subject to approval the Annual Report will be signed, and printed for presentation at the Trust's AGM on 12 September 2013. The Finance Director (FD) thanked Adrian Osborne, Communications Director, and his Team for the construction of this document.

The Board **APPROVED** the Annual Report 2012/13.

2013.1/208 QUALITY ACCOUNT 2012/13 – FOR SIGN OFF

The Director of Quality & Safety (DQS) introduced the Draft Quality Account 2012/13 which is a mandatory document prepared in accordance with the Department of Health guidance. All Trusts have to publish their Quality Account (QA) by 30 June 2013 and provide a copy to the Secretary of State for Health. The Q&S Committee had reviewed the document and the draft had been received at the last formal Board meeting when the Deputy DQS, who had lead on this and undertaken significant stakeholder engagement, had given a PowerPoint presentation. This version has been shared with statutory stakeholders in order to gain their formal commentary which is included in the final draft Quality Account. The DQS also **tabled** a replacement Page 36 which included a response received after papers were issued from Shropshire Healthwatch to make it complete. Annex 2 provided a Statement of Directors' responsibilities in respect of the Quality Account (QA) to meet the following criteria :

- Presents a balanced picture of the Trust's performance over the period covered;
- Performance information reported is reliable and accurate;
- Proper internal controls over the collection and reporting of the measures of performance included in the QA and these controls are subject to review to confirm that they are working effectively in practice;
- The data underpinning the measures of performance reported in the QA is robust and reliable, conforms to specified data quality standards and prescribed definitions, and is subject to appropriate scrutiny and review;
- The QA has been prepared in accordance with the DoH guidance.

The Board **APPROVED** this Quality Account 2012/13 giving the Acting Chair and Chief Executive delegation to sign off the Quality Account. The Acting Chair said it was particularly good to see two External Stakeholders present (Montgomery CHC and Shropshire OSC) in the audience. The Acting Chair thanked and acknowledged the stakeholders for their work in reviewing priorities for last year and this year. He also thanked the Deputy DQS for her hard work in the production of this document. It was noted that a 4-page succinct summary would also be made available.

.....
Acting Chair
25 July 2013

2013.1/209 TO RECEIVE AND REVIEW GOVERNANCE AND COMPLIANCE UPDATES :

209.1 CQC REVIEW OF COMPLIANCE AT PRH – FINAL

The Director of Quality & Safety (DQS) introduced the report which confirmed the findings of an unannounced Inspection to PRH by the CQC on 25 April 2013. The inspection was based on concerns raised by patients and other agencies relating to care provision. On the day of the Inspection, the CQC team fed back to the Executive team and this was shared with Board members in the May private session, prior to the formal report being received. The findings were very disappointing and regretful for the patients whose experiences on one ward were less than the standards we would expect and require. This was balanced with some very positive reflections of the care provided in another ward on the same site.

Immediate actions were taken where required and arrangements made to ensure that a Quality Improvement Framework was put in place to provide additional senior support to the ward team and to drive and ensure rapid improvements. Daily reviews are in place through the Matron and senior nurse team to undertake Quality checks and weekly reports provided to track the range of improvements required. Ward 12 is make good progress.

The report was sent to the Trust in draft form for comments on factual accuracy in May and in its final format on Tuesday 18th June which has now been published on the CQC web site.

The Inspection reviewed CQC outcome 1 and 4 and as a result of the Inspection placed a "moderate concern" for both outcomes on the Princess Royal Hospital. The detail of these outcome measures were contained within the full report.

The CQC require the Trust to identify the actions being taken to address the concerns raised and this was being collated at the time of this report being generated.

Dr Vernon (NED) said that the report will be reviewed by the Q&S Committee.

It was noted that Monitor did not consider a Moderate Concern to necessarily preclude authorisation, but if CQC were not satisfied with the Trust's action plan and issued a Warning Notice, this would act a red flag.

Dr Vernon (NED) said that the Q&S Committee had asked the DQS and MD to present 5 bullet point paper for the next Q&S meeting to describe what is being done to make sure patient dignity is maintained on the wards. In terms of medical staff the MD said that he had taken this to the Senior Staff Committee and medical leaders to point out that this was unacceptable and it is part of their responsibility to make sure these matters are quickly addressed.

The Board was very disappointed at the findings. The Board :

i) Acknowledged that some work has been done since the inspection, and the draft report has been made available;
ii) Acknowledged that the CQC is going to look into this in more detail; seek reassurance from a nursing perspective;
iii) Acknowledged that the Q&S Committee will report back to the Board at the next meeting. **Action: DQS – July 2013.**

The Board **RECEIVED** and **NOTED** the CQC Report.

.....
Acting Chair
25 July 2013

209.2 **AMENDMENT TO CQC REGISTRATION – FINAL REPORT**

The Director of Corporate Governance (DCG) introduced the paper and advised that the Trust is registered with the CQC to provide a number of different regulated activities at a number of different locations. Following clarification of the guidance from the CQC, it has been necessary to add the regulated activity of 'Treatment of Disease, Disorder or Injury' to the activities carried out at Ludlow. This covers the work of the satellite renal unit. This application has been approved by the CQC.

From the end of August 2013, the Trust is planning to carry out minor procedures at Bridgnorth Community Hospital. This will be in addition to the maternity services already provided by the Trust as this location. In order to do this, the Trust must have the following regulated activities added to the CQC registration certificate for Bridgnorth: Treatment of Disease, Disorder of Injury, Screening and Diagnostics; and Surgery

The Trust considers that it is compliant with the essential standards for this location.

In addition, the CQC has been asked to amend the name of these peripheral locations on the registration certificate from Ludlow Maternity Unit to Ludlow Community Hospital, and from Bridgnorth Maternity Unit to Bridgnorth Community Hospital.

The Board **APPROVED** the application to add additional regulated activities to the services provided at Ludlow Community Hospital to the certificate of registration.

2013.1/210 **TO RECEIVE THE FOLLOWING ANNUAL REPORTS :**

210.1 **INFECTION CONTROL ANNUAL REPORT 2012/13**

Dr Graham Harvey attended on behalf of Dr Patricia O'Neill, DIPC, who was on annual leave. The DQS carried out a presentation (copy of slides **attached**).

The report described the Infection Prevention and Control position for the Trust during 2012/13. The year has been another successful period in the reduction of Health Care Acquired Infection (HCAI) at the Trust. This is against a year where there has been high activity, rapid turnover of patients through inpatient beds; also a year in which bed reconfiguration took place and a reduction in available side wards – all of which had to be closely monitored. Staff were congratulated for maintaining high standards despite the rapid turnover of patients.

The MRSA bacteraemia numbers dropped again to one case. This is 93% reduction since the peak in 2003/04. C difficile numbers dropped to 45 cases, a 93% drop since the peak in 2003/04 and achieved our reduction trajectory for 2012/13. MSSA bacteraemia infections and E Coli bacteraemia infections continued to be tracked through the year.

In 2013/14 the Trust has agreed to have zero hospital associated MRSA bloodstream infections and no more than 27 cases of C difficile cases, both will be extremely challenging particularly C difficile target which requires a 40% reduction. The Trust is working with community partners to achieve them without putting patients at risk by unbalancing care.

The following points were raised :

- On a question regarding how to benchmark surgical site infection surveillance, Dr Harvey advised that our infections are broken down and compared to the national rates. SaTH is generally better or the same as other Trusts.

.....
Acting Chair
25 July 2013

INFECTION CONTROL ANNUAL REPORT 2012/13 (Continued)

- Although it was highlighted that there was concern over the low percentage rate of portering and domestic staff receiving training, Dr Vernon (NED) observed that out of 470 medical staff (including Consultants, Associate Specialists, Speciality Doctors and Staff Grades) only 36% had completed the training. Dr Harvey admitted that this was a difficult group to target. The Acting Chair said that there must be a concerted effort within the organisation to get into a culture where if staff are in the front line service it is absolutely crucial that they receive this training to provide safe services. The Workforce Director said that there is a strong theme about inadequate training coverage and this had been discussed at the Workforce Committee. Through implementing an e-learning tool it is hoped to capture more take up and will also give the ability to send out reminders when training is due. Dr Borman (MD) added that he and the Workforce Director are working together and discussing this issue with the LNC. The Training Department are also undertaking an analysis and will publicly provide a spreadsheet that lists individual doctors training detail. Dr Vernon (NED) said he would like to see a full review of training towards the end of the year. **Action: WD to bring a Training paper to Board – November 2013.**
- Dr Walford (NED) said that it is a relief to see access to training being modernised and to track training is the right direction of travel.

The Board **APPROVED** the Infection Prevention Control Annual Report 2012/13 and sent the Board's thanks to Dr Patricia O'Neill on the quality of the report.

210.2 **SAFEGUARDING ANNUAL REPORT 2012/13**

This report describes the developments within the Trust's Safeguarding Team, and highlights the achievements over the last 12 months. The Annual Report for 2011/12 was presented to the Board in October 2012, this report covers the time period of 1 September 2012 to 31 March 2013 and is supported by additional training information and activity data. Future presentation of the Safeguarding Annual Report will be submitted to the Trust Board in May and will cover the previous financial year from 1 April to 31 March. The report outlines how the Trust has responded to local and national developments, both internally, and as a member agency of the Local Safeguarding Children Boards (LSCB) and the Local Adult Safeguarding Boards.

The DQS said that it was disappointing to note the low percentage of compliance in training during the period however additional resources have been put in place to support the Adult Protection Lead Nurse. The DQS welcomed the contribution of lead clinician, Dr Elin Roddy, as Named Doctor for Adults at Risk. It was noted that the report outlines all governance processes internally and links with the Shropshire and Telford & Wrekin Vulnerable Adults Safeguarding Board. It was noted that :

- Within Paediatrics a Serious Case Review has recently been undertaken on the death of a young child, the findings have yet to be published.
- Within Adult Safeguarding there have been discussions with regard to a peak in referrals in March but April and May referrals were significantly lower.

The following questions were raised :

Page 7, Section 3.9.3 – The Acting Chair said that in March 2013 there were 17 Adult protection referrals against the Trust, the majority of which had been included as delayed discharges but he said there were different levels of discharge and safety of discharge and means any discharge process. The DQS said the document published in April by the Safeguarding Board provides clarity but as referenced there is now a Task & Finish Group reviewing some of the trends and themes to ensure lessons are learnt. The report is going back to the Adult Safeguarding Board in July and will be taken back to the Q&S Committee.

.....
Acting Chair
25 July 2013

SAFEGUARDING ANNUAL REPORT 2012/13 (Continued)

Page 11, Section 6 Training – Dr Walford (NED) raised the issue of lack of capacity by the Adult Protection Lead to provide training to the volume of staff required and asked whether the Trust should be considering on-line training.

Mr Jones (NED) asked if SaTH was any nearer resolving the issue with the Mental Health Trust regarding support with practitioners in A&E which poses safeguarding and security risks. The DQS said that more support was needed although RAID had started which was a very timely intervention.

The Board **APPROVED** the Safeguarding Annual Report (Adults and Children) 2012/13 and would look to the Q&S Committee to see that progress moves in the right direction.

210.3 SECURITY ANNUAL REPORT 2012/13

The Director of Corporate Governance (DCG) introduced the Security Annual Report and took the opportunity to thank Mr Dennis Jones for his input as Non Executive Director although a recent communication from the Department of Health states that a NED lead for security is no longer required but she hoped he would continue to maintain an interest in this area. The report highlighted :

- a 44% decrease in reported incidents of intentional aggression and violence against staff which is partly due to the introduction of Body Worn Video surveillance camera equipment when security is called. This video recording is accepted as prima facie evidence by the Police and CPS.
- Significant progress in terms of CCTV has been made by the opening of a CCTV security camera control and monitoring room at the PRH. Work is underway to do the same at the RSH during 2013-14 after funding support was gained from charitable and University funds.
- Page 22 listed the priorities for 2013/14. Staff attendance at Conflict Resolution Training has been disappointing but reflects the operational pressures throughout the organisation. A training needs analysis is being carried out and e-learning access is being explored. There is also a plan to reinforce the positive message to staff through improved communications..
- A pilot to increase security guarding provision was being introduced i.e. 2 on each site for 18 hours a day as opposed to 12 hours a day currently. The increased provision will reinforce the zero tolerance approach adopted by the Board and allow a more proactive approach to problems.
- The DCG paid tribute to John Simpson, Security Manager, as he has led improvements across the Trust and been involved in ensuring hi-tech security systems for the Lingen Davies Centre and the new Womens and Children's site.

The Board **NOTED** the progress during 2012/13 in relation to security across the Trust and provided final ratification before submission to NHS Protect. The Board also expressed thanks to the Security Manager.

2013.1/211 QUALITY IMPROVEMENT STRATEGY

The DQS said the five-year Strategy for Quality Improvement was approved by the Board in March 2012. The Quality Improvement Strategy had been reviewed by lead Executives, clinicians and staff to ensure it continues to be an iterative document, supporting continuous Quality Improvement, and to be constantly reviewed and aligned with the Quality Account. Reflecting on last year, the DQS said each Centre developed their own quality development plan to drive through improvements such as Diabetes mentioned under the Chair's Award. . Changes made to the Strategy related to the new operational structure, new executive and national requirements. Also the Francis Inquiry sits at the heart of quality issues as well as a combination of care.

Board Members were extremely disappointed to note that Ophthalmology alone had not produced a Quality Development Plan. The CEO assured the Board that under the new organisational operational arrangements this will be addressed.

.....
Acting Chair
25 July 2013

QUALITY IMPROVEMENT STRATEGY (Continued)

The Board **NOTED** that the updated Quality Improvement Strategy will be circulated out to wards and Departments to inform team and care groups of discusson for 2013/14. The revised operational structure and the enhanced Governance Committee arrangements will monitor the Quality Improvements closely and ensure that Board level Committees are able to gain regular assurance on the progress of the Quality improvements required.

2013.1/212 QUALITY IMPACT ASSESSMENTS RELATING TO THE COST IMPROVEMENT PROGRAMME

The Director of Quality & Safety (DQS) ***TABLED*** documentation and said that the Board had been updated on the Cost Improvement Schemes (CIP) through the monthly Finance report. The CIP schemes have a clinical or operational lead who are required to complete the Project Initiation Document (PID). The PID outlines how each CIP scheme will achieve the required total savings. The CIP lead will complete a Quality Impact Assessment (QIA) document to outline the potential impact on patient safety, clinical effectiveness/clinical outcomes and patient experience. These will then be signed off by the MD, DQS and COO. There have been delays in completing the PIDs which have led to delays in the QIAs being brought forward for consideration by the Executives. The formal sign off for each PID in the Cost Improvement Board can only take place once the QIA has been completed.

Appendix 1 outlined the main CIP schemes as listed in the Board Finance reports and identified whether a PID is in place and where a QIA has been received. It was noted that 65% of schemes have had an initial QIA and some had been returned for further information. Two schemes were on the main CIP list. Appendix 2 provided a total list of QIAs for reference.

Section 3 related to some significant Workforce issues, and although these had been considered by the Executive Directors there were concerns about signing off the Workforce QIAs. It requires urgent collective Executive discussion within the next 2 weeks to consider whether to proceed and consider the impact of amending previously agreed schemes to mitigate the risks. The Board was asked to agree that the conclusions of the executive discussions on Workforce CIP schemes go back to the July Q&S Committee and Finance Committee for detailed discussion on the outcome of those discussions and formal consideration of the impact on the workforce CIP schemes. It was proposed that a summary of these discussions be presented to the Board in July. The Acting Chair said that as the paper was only tabled this morning and as it is very important issue it was doubtful whether Board members would be able to give it sufficient weight of discussion. He asked if the EDs could take it away and Q&S to consider this or, alternatively, it comes back to the July Board together with additional comments. The CEO said that some of the QIAs had been signed off but others have not been received. He considers the process to be ineffective and it would need to be replaced with a smarter way of progressing it going forward to satisfy ourselves on the degree of risk. Given there is more work to be done he recommended that the Board receive it formally at the end of July.

Mr Jones (NED) said that he endorsed the view that financial and quality effect have to go together but his reading was that there is a backlog issue falling behind schedule of the CIP programme and it is a problem for the Trust. The FD gave reassurance that schemes are not slipping as there were a couple of areas with pay costs which will be discussed later but there are a number of schemes that are in place and are progressing and are the right thing to do such as catering where it had gone through a tendering process and it is up and running but the QIA has not been written up. Dr Vernon (NED) said there are two red boxes which represents one-third of staffing, Q&S Committee therefore needs to look at this next month as well as Finance Committee. The DCG said that the issues are important and will therefore need to come back to the Board to be fully aware of the risks.

The Board invited the Executive Directors to discuss how best to deal with this and report back to the July Board, Q&S Committee and Finance Committee. **Action: DQS.**

.....
Acting Chair
25 July 2013

2013.1/213 HR POLICY UPDATE

The Workforce Director (WD) introduced the paper and advised that the Policy Approval Group established to review policies prior to ratification. The following policy had recently been updated and approved :

- HR28 Flexible Working Policy which outlined arrangements in place to support staff in requesting flexible working arrangements. It was noted that there is a legal requirement to consider all flexible working requests and consequently there are tight timelines which must be adhered to when reaching a decision on a request.

The Board **RATIFIED** the policy for dissemination through the Centres.

2013.1/214 QUESTIONS FROM THE FLOOR RELATING TO ITEMS ON THE AGENDA

Q1 Mr Dakin referred to the minutes of the previous meeting and specifically the Business Case for the creation of inpatient capacity. He said he was confused as he had recently spoke to the CCG who advised that there was no shortage of beds within the Shropshire economy. The COO clarified that the paper related to replacing lost capacity (one ward) because of the new Womens & Children's Unit, not creating additional beds. This is replacing existing capacity and aims to address the surge of activity in winter and deal with infection control outbreaks. The CEO stressed that there are an inadequate number of beds in the health economy. Mr Dakin requested a copy of the paper which had been published on the website. **Action: Secretary**.

Q2 Montgomery CHC representative :

Q2.1 What is current bed occupancy at the two hospital sites? It was confirmed that occupancy was running at over 97%.

Q2.2 Does the Quality Account and Operational Performance figures include Welsh patients? The DQS said her understanding was that they included Welsh patients. Also Welsh Ambulance Service? The DQS agreed to check this out.

Q2.3 Stroke Service temporarily moving from Shrewsbury to Telford for 2 months is an important factor for the Welsh in particular the time to get thrombolysis. When are you thinking that this will start and when will it transfer back to Shrewsbury? The COO said that it will transfer from July and transfer back at the end of August 2013. The CD said that Montgomery CHC have been briefed on this along with the Welsh Ambulance Service.

Q2.4 Serious compromise of dignity of care on Ward 12. Also a lapse of care. DQS agreed to discuss both matters outside the meeting.

Q3 A lady said she had recently been in day surgery and there seems to be a different attitude of staff in there compared to the main wards. She asked if there were any opportunities to make comment. The DQS said that providing feedback through talking to staff giving direct feedback is very helpful. Ward Managers are considering this direct engagement. The Acting Chair asked the DQS to speak to the lady after the meeting.

Q4 Mr Sandbach supported the CEO's words which he felt were quite inspirational.

Q4.1 Quality Account – Bed Occupancy rate should be 80% and it is no surprise that SaTH is running at 97% which is dangerous although he recognised the solution lay with the CCGs not SaTH.

Q4.2 Stroke Service Temporary Transfer to PRH - His father and brother both died of strokes and he asked if there was any way of getting this service moved to one site on a permanent basis. The COO said there is a long-term review to be undertaken as part of the Clinical Service Strategy.

.....
Acting Chair
25 July 2013

Q4.3 Finance Committee key summary from 25 June 2013 – Mr Sandbach noted that his comments had been discussed at the meeting however he was willing to meet with the Chairman of the Finance Committee to explain his thoughts and observations.

Q4.4 At 8.30 am this morning SaTH was declaring on its website 721 adult acute beds. How many beds and how many have been mothballed. Can you formally respond and ensure your website is up to date? The CEO said he would take another look at the figures but confirmed that there is no physical capacity to open and that is a serious risk.

Q4.5 Urgent Care Network is a new Board, the first meeting was held last week run by the CCG. Has a plan been produced and where is that document? The COO said that it would need to be requested from CCGs. The Winter Plan deadline is at the end of July and is currently being formulated.

Q4.6 Clinical Service Strategy – when will you be able to produce this? The CEO said that discussions are taking place with the CCGs about the process with stakeholders. We expect to start in the next couple of months. There is no definitive consultation date but it could be around the autumn period.

2013.1/215 DATE OF NEXT MEETING :

Formal Board Meeting – Thursday 25 July 2013 at 9.30 am Seminar Rooms 1 & 2, Shropshire Education & Conference Centre, Royal Shrewsbury Hospital.

The meeting then closed.

.....
Acting Chair
25 July 2013

UNRESOLVED ITEMS FROM PUBLIC TRUST BOARD MEETING ON 27 JUNE 2013

Item	Issue	ACTION LIST	PRIORITY
209	**CQC Review of Compliance at PRH** The Board acknowledged that the Q&S Committee will report back to the Board at the next meeting.	DQS	July 2013
214	**Questions from the floor** Mr Dakin requested a copy of the previous month's paper on Business Case for the Creation of Inpatient Capacity.	Secretary	ASAP

.....
Acting Chair
25 July 2013

Annual Infection, prevention and Control Report

Vicky Morris & Dr Graham Harvey

27th June 2013

IPCC

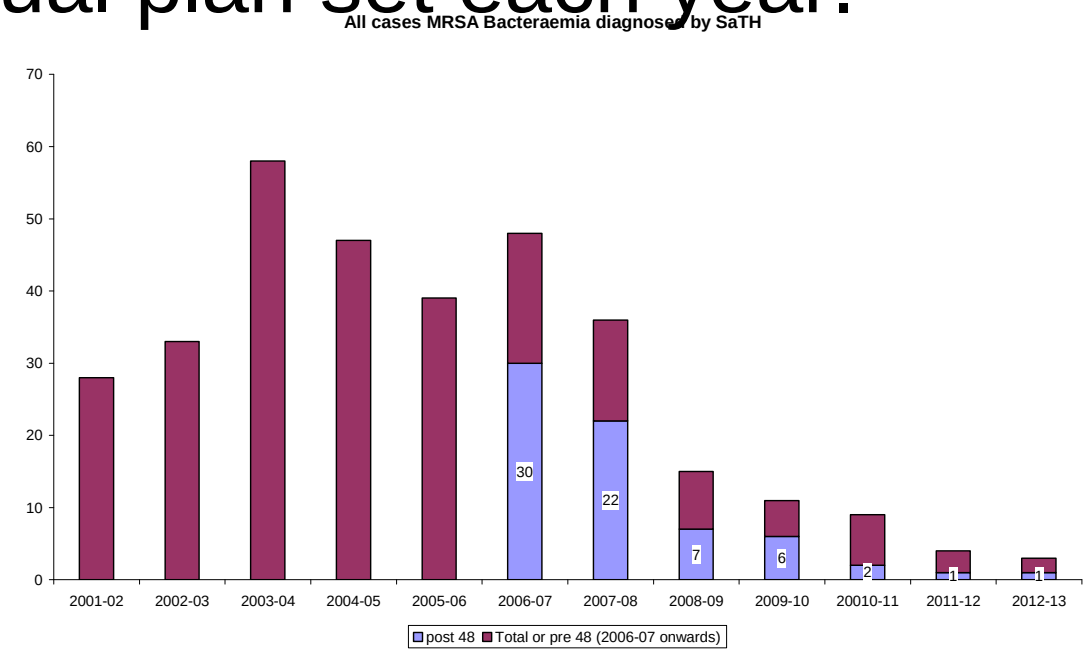
- HCAI – Trust Board focus on Key performance Indicators.
- Monthly IPCC reporting to CGE & Q&S
- 1 MRSA
- C Diff- 93% reduction since the peak in 2003/4 and achieved our reduction trajectory for 12/13.
- Continue to track MSSA &E-Coli

Annual report- 12/13

- Context – high activity, rapid turnover of patients through Inpatient beds.
- Also a year in which :
  - bed reconfiguration
  - we had a reduction in available side wards
  - which DIPC and team have been closely monitoring
- Monitor clinical Infection prevention and control standards –
  - congratulations to staff for maintaining high standards.

The team and the results

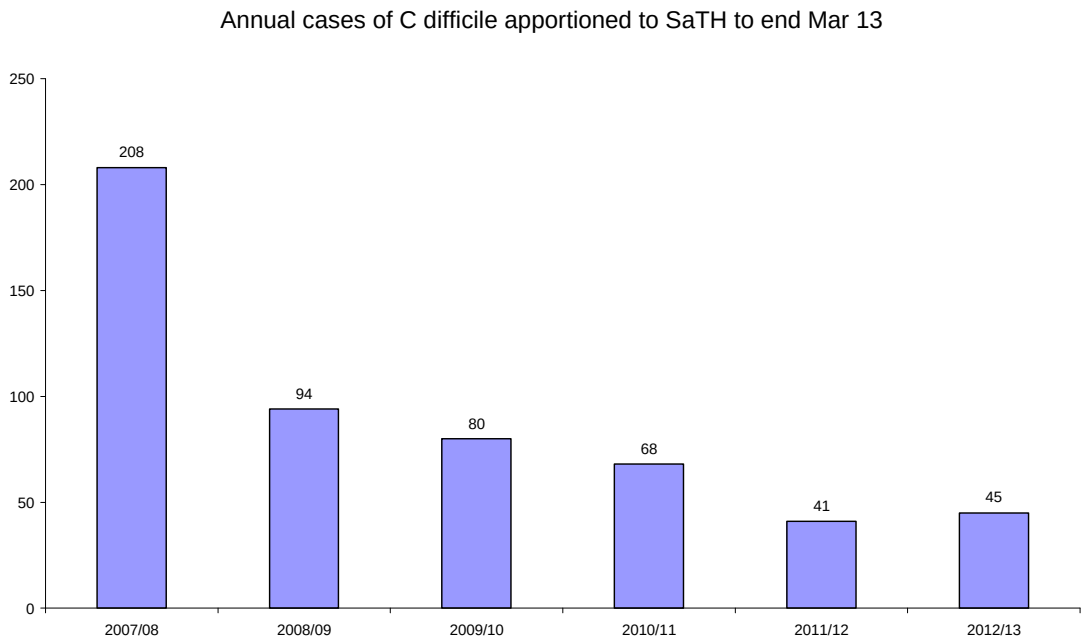
- Report format- IPCC and cleanliness
- IPCC team in total & their focus on the annual plan set each year.



Putting Patients First | Honesty And Integrity | Being a Clinically-Led Organisation | Working and Collaborating Together | Encouraging Individual Ability and Creativity | Taking Pride in our Work and our Organisation

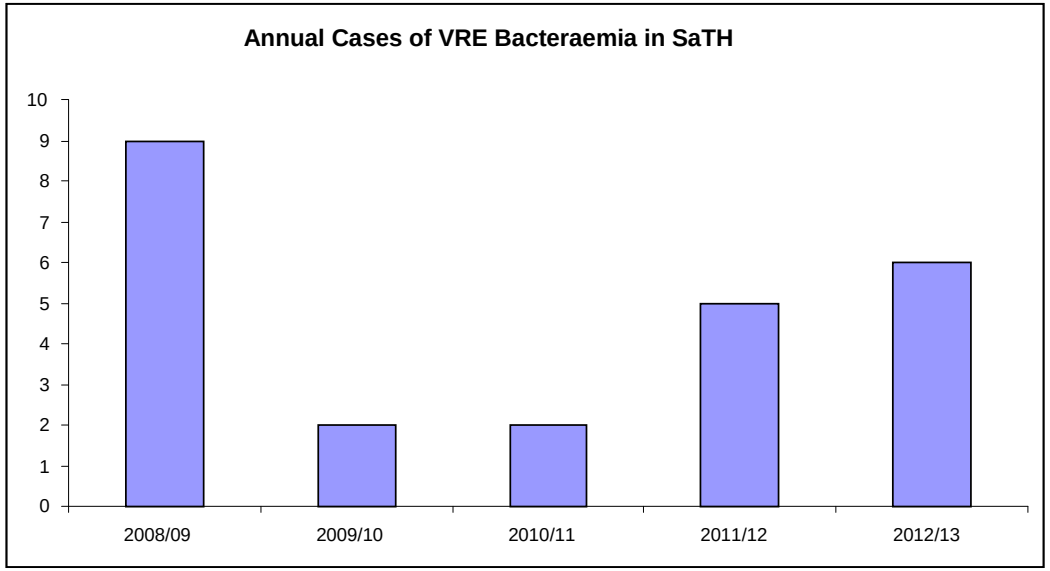
Infection Control Annual Report 2012/13

- IPCC Committee focus has been on ensuring that appropriate & timely samples taken



Infection Control Annual Report 2012/13

- All Trusts are required to report Vancomycin resistant Enterococcus-
  - Highly resistant to antibiotics
  - Can cause infections in vulnerable patients
  - 6 cases in total (haematology and oncology)- focus on care of central lines to prevent these infections



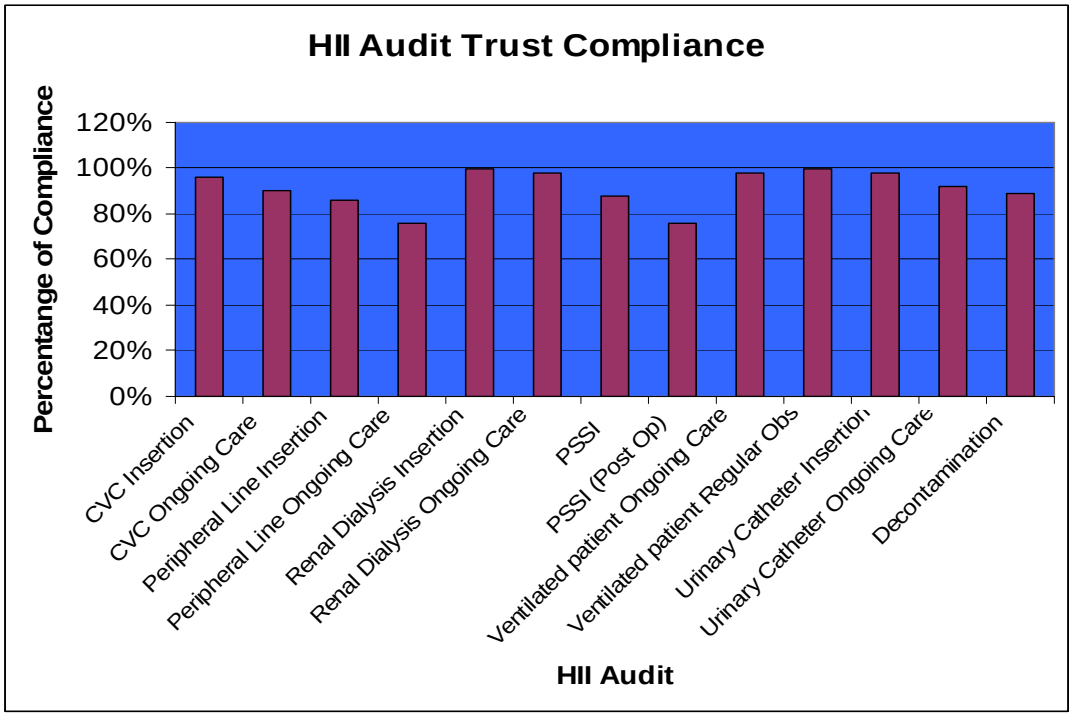
Infection Control Annual Report 2012/13

3f Surgical Site Infection Surveillance Scheme (SSISS)

Type of surgery	Number of Months	Number of cases	Number of In-patient/re-admission Infections (%)	Post Discharge Infections
Abdominal Hysterectomy	3	49	0	6 (12.2%)
Large Bowel	3	96	4 (4.2%)	4 (4.2%)
Breast	3	176	1(0.6%)	5(2.8%)
Vascular	3	67	1 (1.5%)	3 (4.5%)
Total Hip Replacement	12	243	2(0.8%)	3(1.2%)
Total Knee Replacement	12	252	1 (0.4%)	4 (1.6%)

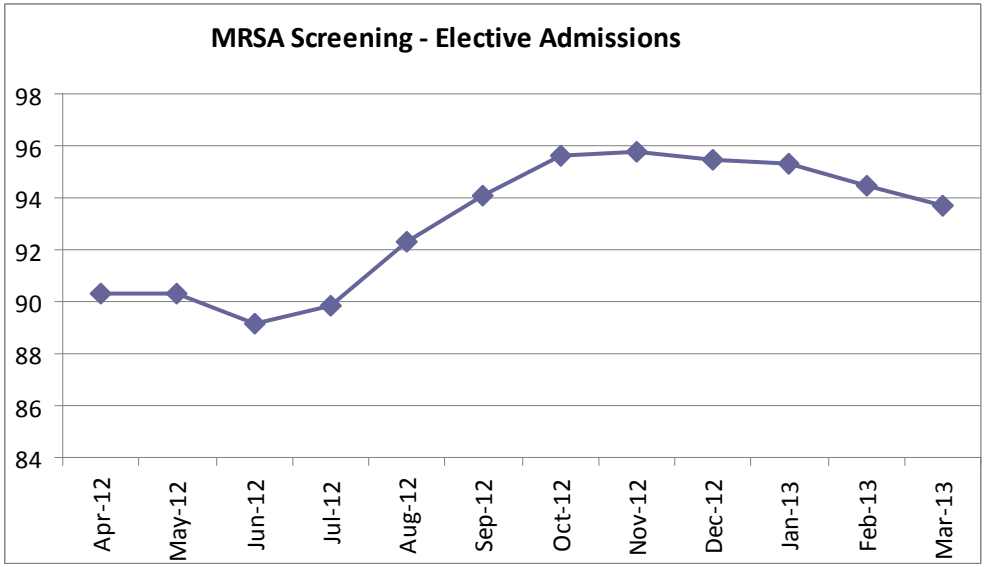
Infection Control Annual Report 2012/13

- Focus on High Impact Interventions is key to reducing Infections.



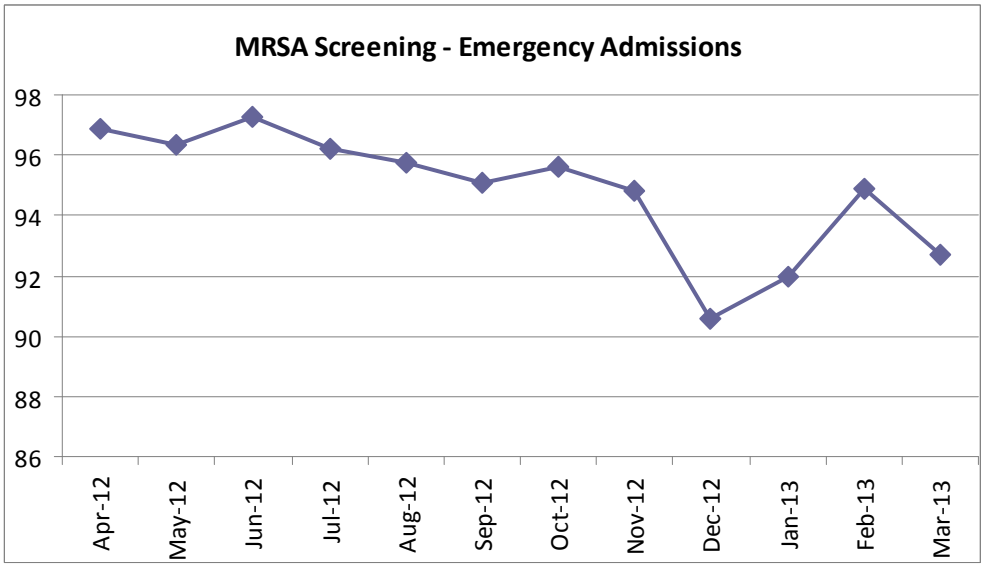
Infection Control Annual Report 2012/13

- Range of actions to sustain screening but 3-4 months at the end of 2012/13 where not achieved. Continue discussions with team to improve compliance.



Infection Control Annual Report 2012/13

- Emergency as well as elective



Infection Control Annual Report 2012/13

- Annual work programme for each year and for 2012/13 determined by requirements of the Health Act.
- The duty on the Trust is to protect the welfare of staff and patients
- 9 criteria laid down in the Health Act upon which we would be judged
  - Teaching, audit, policy development, mandatory reporting, working with OH on a vaccination programme- uptake was 46.7%
  - **Education**- page 16 eg. Portering and Domestics
  - 4th Annual IPC Conference
  - Road shows for hand hygiene
  - Validation of self assessment against health Act requirements
- Cleanliness – Monitoring standards of cleanliness- PEAT
- PLACE- patient led assessments of the Care environment (May &June)

Infection Control Annual Report 2012/13

Looking forward into 13/14

KPI's-

- 0 MRSA
- No more than 27 C-Diff cases-
- Meaning a 40% reduction over an already historically low figure- LHE work plan
- IPCC Reporting through to CGE
- Assurance at Quality and Safety Committee

ANY QUESTIONS