

The Shrewsbury and Telford Hospital NHS Trust

TRUST BOARD MEETING
Held on Thursday 28 November 2013 at 9.30 am
Seminar Rooms 1 & 2, Shropshire Education & Conference Centre,
Royal Shrewsbury Hospital

PUBLIC SESSION MINUTES

Present:	Mr P Latchford Mr H Darbhanga Dr R Hooper Mr D Jones Mrs D Leeding Dr S Walford Mr P Herring Mrs S Bloomfield Dr E Borman Mrs D Kadum Mr N Nisbet	Chair Non Executive Director (NED) Non Executive Director (NED) Non Executive Director (NED) Non Executive Director (NED) - part meeting Non Executive Director (NED) Chief Executive (CEO) Acting Director of Nursing and Quality (ADNQ) Medical Director (MD) Chief Operating Officer (COO) Finance Director (FD)
	Mrs J Clarke	Director of Corporate Governance/Company Secretary (DCG)
In attendance	Miss V Maher Mrs D Vogler	Workforce Director (WD) Director of Business & Enterprise (DBE) – part meeting
Meeting Secretary	Mrs B Graham	Committee Secretary
Apologies:	None	

2013.1/272 **WELCOME** : The Chair welcomed everyone to his first meeting. He recognised that the Trust is in a challenging time and there are big issues to deal with which would need careful consideration.

2013.1/273 **DECLARATION OF INTEREST** by members in relation to any matters on the agenda. There were none.

2013.1/274 **CHAIR'S AWARD**

The Chair's Award went to Ceri Adamson who was nominated by the Chief Operating Officer and Acting Director of Nursing & Quality. Both spoke highly of Ceri who was awarded Highly Commended Leader of the Year in 2011. Since then she had demonstrated true leadership in a high pressured environment during one of the worst winters on record, working tirelessly for the benefit of the patients. She has a positive manner which inspires everyone around her. The Chair congratulated Ceri who took the opportunity to say that she receives different forms of appreciation on a daily basis from her colleagues, patients and relatives which gives her huge job satisfaction.

2013.1/275

PATIENT STORY

The Acting Director of Nursing & Quality (ADNQ) introduced Mrs Wendy Booth who presented her late mother's experience in A&E at PRH a year ago, following a fall. Mrs Booth described her mum's journey from the time she arrived at PRH through to her admission to a ward at 5.30 pm. Mrs Booth explained that her mum was 91 years of age, suffered from dementia and was very confused. Her mum had had to wait in a corridor until a consultant could examine her and the examination was carried out in the closest vacant room which happened to be the Plaster Room. Although they had been given cups of tea, her mum had had no food except for a banana that Mrs Booth had brought in. Mrs Booth described the difficulties on the ward in coping with a very confused and agitated patient. Her mum eventually had the operation and this was a total success. She received physiotherapy and everyone was kind to her, however, Mrs Booth said that she had to keep explaining to them that her mum had dementia but they appeared to fail to acknowledge this. Mrs Booth asked the Board to recognise that if carers are available they should use them to help feed and care for patients. She understood that a Butterfly scheme is going to be introduced to indicate that a patient has dementia.

Helen Coleman, Dementia Project Lead Nurse, had accompanied Mrs Booth to the meeting to support her. She said she would be happy to update the Board on a regular basis on improvements to the care of patients with dementia. Mrs Booth said she was pleased to be a member of the Patient Representative Group looking at care for dementia patients.

The Board was enormously grateful to Mrs Booth and thanked her for sharing her experiences.

2013.1/276

MINUTES OF THE MEETING HELD IN PUBLIC on 31 October 2013 were APPROVED.

	MATTERS ARISING FROM THE FORMAL BOARD MEETING HELD ON 31 OCTOBER 2013
2013.1/245	Integrated Performance Report (IPR) - Operational Performance Cancer Referral to Treatment (RTT) action plan would be presented to the Board meeting. Action: COO – Jan 2014.
2013.1/249.2	Integrated Education Annual Report 2012/13 – the Workforce Director (WD) said it was decided that it would be more appropriate for the full Training update to be taken to the Workforce Committee in November and then reported to the Board in the Workforce Committee summary in January 2014. It was noted that Donna Leeding is the NED member of the Workforce Committee along with the current NED vacancy. Action: Workforce Director – Jan 2014.
2013.1/263	Integrated Performance Report (IPR) – Quality : Infection Control – The feedback on typing would be fed back to Quality & Safety Committee in January. Action complete.
2013.1/263	Integrated Performance Report (IPR) Operational <ul style="list-style-type: none"> ▪ Capacity/Demand Dashboard demonstration will be presented at a Board Development Session ▪ Medical Records – the request on percentage of people seen in clinic without notes had been included in this month's IPR. Action complete.
2013.1/264	Financial Recovery Plan – Nursing Review – Item on the Agenda. Action complete.
2013.1/266	<ul style="list-style-type: none"> ▪ Stroke Services Programme – The COO explained that the recommendation for the provision of services for the medium term had been delayed as the Commissioners are still considering a request for additional funding from the West Midlands Ambulance Services. The public have been kept informed through the local Press with the issue discussed over many months and an understanding that the service will stay on PRH site until a decision has been made. It will be discussed at the next Joint Overview & Scrutiny Committee (Joint OSC) public meeting. The Clinical Lead, Dr Srinivasan, would report the recommendation to the Board when the decision re Ambulance funding had been made by the Commissioners. ▪ Stroke Review – An update would be circulated to Parish Councils which would include the wider service reconfiguration issues in due course. Action complete.
2013.1/270	Appreciation – Mr Jones' comments had been passed on to Mr Craig. Item complete.

2013.1/277 FORWARD PLAN for the period November 2013 to February 2014 was NOTED.

2013.1/278 CHIEF EXECUTIVE'S OVERVIEW included three critical issues :

(i) Excellent and Sustainable Acute & Community Hospital Services Review

The Medical Director was due to present the outcomes from Call to Action following this overview but the CEO said the important feature of the process had been the national drive to consult on the future shape of the whole NHS. At a local Conference on 25 November 2013, the Clinical Commissioning Groups (CCGs) officially launched a review of the Excellent and Sustainable Acute and Community Hospital Services programme. It is a critical opportunity to create our vision for the future and to consider all available options to configure services across sites. Our clinical teams are involved in the shaping of the options. There was concern expressed that the prospect of a General Election might push the process back to 2015. The Trust is also exploring what can be done in the interim, particularly in relation to contingencies and operational efficiencies and sustainability. Dr Hooper (NED) echoed concerns about potential delays caused by the General Election.

(ii) Winter Planning

The greatest concern is that we have already moved into winter mode and whilst SaTH achieved the 95% A&E target in October, the month of November had been very challenging. We have a clear case of substantial bed deficit at RSH and we will not be able to cope with the additional demands without the Health Economy winter plan working effectively. This is a real concern in terms of our reliance on external factors. We are reliant on 69 additional beds in Community Hospitals and Nursing Homes being well utilised, but currently only a small proportion are in place. The Trust needs contingency plans in place to protect planned activity whilst meeting additional emergency demands. The position will be compounded by financial cuts in social care e.g. Telford & Wrekin who had a really good social care model but this is being compromised due to their need to make financial savings.

(iii) Cash Position

The current cash position continues to be a key concern. Whilst a small surplus was achieved in October, our financial position remains critical. There are negotiations being held with the NHS Trust Development Authority (NTDA) and our Commissioners in terms of recovery plans and exploring other possible savings and options.

Mrs Leeding (NED) also shared the CEO's concern around the finances and said she would like to see more action that is within our gift. She said there needs to be tough discussions and decisions made on where we can consolidate services as opposed to duplicating services, without breaching legislative consultation requirements.

Members **NOTED** the verbal report.

2013.1/279 PRESENTATION ON OUTCOMES FROM THE CALL TO ACTION PROGRAMME

The Medical Director (MD) gave a PowerPoint presentation (*copy of slides attached to the minutes*). The MD explained that the "Call to Action" is part of a national initiative launched by NHS England in July 2013. It calls for the public, NHS staff and politicians to have an open and honest debate about the future shape of the NHS. It recognises that the NHS must meet rising demand, introduce new technology and meet the expectations of its patients. It also acknowledges a backdrop of flat funding which, if services continue to be delivered in the same way as now, will result in a funding gap, therefore this is a "call for change". The next steps are to review clinical services, agree principles first and then consider the options. There are very tight timescales for the consultation, for developing models of care and considering the options for the future. He said we must get this right because we will be at risk of losing services and the General Election timescale is going to be a very major challenge. SaTH was using the national imperative to shape the local clinical service review – Excellent and Sustainable Acute and Community Hospitals (ESACH).

PRESENTATION ON OUTCOMES FROM THE CALL TO ACTION PROGRAMME (Continued)

Dr Hooper (NED) made reference to A&E having to significantly change in the future to ensure sustainability. The CEO advised that Bruce Keogh, Medical Director of the NHS, is leading work on how to consolidate proposed changes i.e. to move to 50-70 Major Emergency Centres, and SaTH needs to take action to see to what extent we can influence our own solutions and options going forward.

Dr Walford (NED) said in his experience it would be advantageous to put actions into a strategic timescale. The CEO said there are national policy implications and it is frustrating for SaTH that the original timescale to go out to public consultation in March 2014 had slipped; however the Trust will continue to press the Clinical Commissioning Groups (CCGs) about expediting the timescales. In the interim there is a real need to focus on contingency plans and short-term plans.

The Medical Director said that the Call to Action provides an opportunity to address many quality problems that we are currently facing; many of the issues being discussed by the Board meeting today are illustrations of the problems caused by duplication and lack of optimum configuration of our services in financial, quality and operational terms.

The Board **RECEIVED** the update and **AGREED** the need to develop contingency plans and to expedite the clinical service review process. The CEO pointed out that any options will need to be taken to the Joint Overview & Scrutiny Committee (Joint OSC) as legally SaTH cannot reconfigure services without its approval and support.

2013.1/280

NURSING STAFFING REVIEW

The Acting Director of Nursing & Quality (ADNQ) introduced the paper and advised that following the publication of the Francis, Keogh and Berwick reports there had been considerable debate over safe nursing staffing levels and how assurance can be gained that these are being set and maintained appropriately. A review of nurse staffing levels across SaTH's adult inpatient wards was conducted using an evidence based methodology in order to ensure scrutiny, evaluation and challenge. As a result of this review a significant increase in nursing establishments was recommended plus improvement to assurance arrangements relating to nurse staffing. The ADNQ also referred to a publication released by the National Quality Board on 20 November 2013 entitled "How to ensure the right people, with the right skills are in the right place at the right time – A guide to nursing, midwifery and care staffing capacity and capability" which sets out 10 clear expectations and contains explicit information regarding the roles and responsibilities of Boards in ensuring firstly that safe staffing levels are set and consequently that appropriate staff are in place to meet these levels. These 10 expectations will feature as part of the contract discussions with Commissioners for next year. The paper proposed an increase in 95 substantive whole time equivalent posts, with the expectation that there would be a reduction in agency and bank costs currently running at 110 whole time equivalents.

Mr Jones (NED) said he broadly agreed with the principles in the paper but asked a number of questions relating to minimum staffing levels and affordability. Would existing resources spent on temporary staff be used to fund contracted staffing to improve quality and reduce temporary staffing costs. In essence it was not clear whether it is an increase to nursing pay budget uplift or further contracted posts offset by reduced temporary staffing costs.

The ADNQ said that the proposed increase is not mandated, but in her professional view it sets a minimum safe nursing staffing level. The CEO said that whilst it is not mandatory, there are significant expectations from the Care Quality Commission (CQC) and others in the context of potential risks. The Workforce Director said there is a shortage of adult nurses but SaTH is working on a number of options around recruitment practices taking place in the next couple of weeks. We are currently out to national adverts for nurses.

Mr Darbhanga (NED) asked if there was some assurance from the Finance Director in terms of managing the overspend. The Chair expressed concern that there was no clear picture of the financial implications.

NURSING STAFFING REVIEW (Continued)

The Chair stressed the importance of Board papers needing to identify clearly all available options, along with their financial implications, risks and mitigations and any other potential impacts, in order for an informed decision to be reached by the Board. The FD said the concern for the Trust and others across the country is being able to control the level of spending on nurse staffing. The FD referred to the Financial Recovery Plan and said that from now until the end of this financial year we still expect to deliver £5.7 million deficit going forward, but this included this proposed nursing uplift. In terms of future planning the CEO said it did not necessarily mean ring fencing all the nursing budget as there are other areas of nursing costs to explore. Dr Walford (NED) said this reflected a recalibration of the health service by NHS England. There is a view that there is recognition of a national pressure and, as a consequence, the tariff may be adjusted. We will have to have those discussions with the Commissioners.

The Chair acknowledged the professional opinion that this is the direction to take but struggled because there are no other options in the report, no explanation of the risks and no clear description of the financial implications within the report.

The Board **AGREED** that further information was required from ADNQ in the form of an effective control framework being put in place and monitoring arrangements with regard to :

1. Pay controls
2. Flexible staffing models
3. Reduction in sickness and improvements in appraisal.

The Board reserved its decision on the proposal until detailed discussion of Financial Performance (2013.1/282) in the Integrated Performance Report had taken place. Following significant discussion of the financial position and the safety implications, **Delegated Authority** was given to the Chair and CEO to approve the nurse staffing proposal with Dr Walford as Chair of Q&S Committee and Mr Jones, Chair of the Finance Committee, subject to a satisfactory Control Framework being drawn up by the ADNQ, WD and COO. **Action: Acting Director of Nursing & Quality, Workforce Director and Chief Operating Officer.**

2013.1/281

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

- **Finance Committee meeting held on 26 November 2013** – the Key Summary was tabled due to the proximity of the meeting to the Board meeting. Mr Jones (NED) Chair of the Finance Committee referred to the Future Configuration of Hospital Services and said that the project at PRH was largely on track both operationally and financially, however, the project on RSH site was seeing a delayed commitment of capital which is being reviewed in light of the current Clinical Services Review. The Committee also discussed car parking changes and operational and public relations issues and the actions in place to improve the situation. The Chair added that car parking is a big issue and will be added to his list of areas to consider.
- **Hospital Executive Committee (HEC) meeting held on 26 November 2013** – the Key Summary was tabled due to the proximity of the meeting to the Board meeting. The Committee had received an update on the use of Medical Physician Associates which had saved a considerable amount of costs. One major component of the Winter Plan is the Discharge Standard Operating Procedure and this was approved to ensure patients are speedily worked up through the system. The Committee also discussed how to improve the effectiveness of the implementation of NICE guidance.
- **Quality & Safety (Q&S) Committee meeting held on 21 November 2013** - the Key Summary was presented by Dr Walford (NED), Chair of Q&S Committee, and specifically Item 3 where it reflected that there is now patient representation on the Q&S Committee. A report from the NHS Trust Development Authority (NTDA) relating to a recent visit had raised issues and led the Committee to ask the Director of Nursing to explore ways to enhance accountability for ward support services such as cleanliness and hygiene processes. It was noted that the Surgical Ward now managed their domestic team and it was felt other wards could consider doing the same. Members were advised that Board walkabouts are to be arranged through the offices of the ADNQ. It was noted that the next organised visit is due to take place on 12 December before the Audit Committee meeting.

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

The Board **RECEIVED** the Integrated Performance Report (IPR) in respect of the month of October 2013 which summarised the Trust's performance against all the key quality, finance, compliance and workforce targets and indicators for 2013/14.

QUALITY : Patient Safety, Effectiveness and Patient Experience –

The Acting Director of Nursing & Quality (ADNQ) briefed the Board of the following key areas :

RED RAG - RIDDOR Reportable Falls & Pressure Ulcers - There were five reportable falls in the month of October and two avoidable Grade 3 pressure ulcers. These are particular areas of concern. The key is record keeping by nursing staff and improvements have been made over the last year. The 50% reduction in falls had been as a result of an enormous amount of scrutiny and training which has paid dividends. There are some excellent Ward Managers in post and all will go through a Trust Leadership programme with new appointees completing the NHS Leadership Academy Edward Jenner on-line programme initially. Standardisation is being driven through this and the development of the Trust leadership programme so that all Ward Managers receive the same development as a baseline. There is a phased approach to deal with the backlog of action plans to get them to zero by the end of the financial year and the aim is to share learning from these action plans. The Medical Director added that these will also be reported to the Clinical Governance Executive to make sure the actions are taken, lessons are learnt and are cascaded.

The Chair said there were four key areas to focus on : record keeping, metrics management, nurse leadership and standards of procedure.

OPERATIONAL PERFORMANCE – The Chief Operating Officer (COO) briefed the Board on this section of the report :

A&E 4 hour wait target – the monthly target was achieved in October but the year to date target is under-performing; however four of the last seven months had seen an improvement.

Local Health Economy Winter Plan is a major concern. Weekly meetings have started. It is one of our greatest risk and at this point SaTH cannot respond to all surges. There are a number of contingencies being considered which include meeting with Healthcare at Home, an organisation that could help with discharging patients. Other areas being explored are: a drop-in mobile day surgery/ward, to be fully utilised in January for day case capacity. Exploring inpatient Gynaecology at the Nuffield Hospital; also discussing 69 community beds available for admission avoidance. The NHS Trust Development Authority (NTDA) visited recently and were impressed with plans to date. There are a number of key issues to work on including the Trust escalation and accountability response, improving discharges, models of care for the whole system; difficulties to resolve around GP out of hours (Shropdoc), and an IT system is needed in Emergency Departments to track patients in real time. With regard to system management, the NHS Trust Development Authority (NTDA) recognise our ability to achieve 4 hour target is largely dependent on external capacity. They have requested a single action plan for recovery which will be sent to them next week. The Commissioners (CCGs) have agreed from next week we should deliver 95% on a weekly basis which we believe is a significant challenge particularly as our current bed capacity is 99%.

Dr Hooper (NED) said that if everyone played their part SaTH would comply however he asked where the gaps were and what the options were. The Chair felt that the meeting with Healthcare at Home should take place immediately. Mrs Leeding (NED) said that this year is predicted to be the worst winter on record, she said there is clearly a gap and asked how else we plan to approach this. There are discussions around admission avoidance. The COO said that monthly Urgent Care Group Network meetings are taking place with Area Team representation who oversees progress and the risks and actions to be taken. The COO confirmed that there is a Health Economy communications plan.

Dr Walford (NED) said that hospitals should plan for a 15% increase for 6 weeks so he felt optimism might be slightly diminished and given the position with Social Services in both communities we are going to face a greater difficulty. We will continue to create contingency plans one of which will be additional spot purchasing but the Commissioners (CCGs) will have to respond to that.

Dr Walford (NED) added that external evidence would suggest that SaTH is one of the top 40 Trusts in the Efficiency Index and therefore our operational options for greater efficiency are very limited.

The Chair said that given this is one of the Trust's top three priorities, although actions are in place, if we have a severe winter things will go quickly off track and patients may suffer. He wanted to be kept informed of the scale of this problem.

(Mrs Leeding (NED) left at this point).

The CEO confirmed that contingency plans are being explored by the COO to include our greatest risks and all available options. It was agreed that NEDs can be assured through Dr Hooper (NED), as Chair of Audit Committee. **Action: CEO – Dec 2013.**

The Director of Corporate Governance (DCG) referred to CQC Intelligent Monitoring and advised that initially SaTH had been placed in Band 2 but the status had now been downgraded to the highest risk group Band 1, although an issue relating to methodology had been raised with the Care Quality Commission (CQC).

Referral to Treatment (RTT) position was as follows :

- 18 weeks RTT-Admitted (English) achieved 75.82% against a target of 78%. The Trust will continue to fail at this standard until the backlog is cleared.
- 18 week RTT-incomplete pathway (English only) Part 2 achieved 91.02% against a target of 92%.
- 18 week RTT-over 52 weeks (English) – 8 breaches

The Chief Operating Officer (COO) advised that the backlogs in RTT-Admitted in Maxillo-facial and Orthopaedic are so challenging that the Commissioners are considering the next steps to the solution. SaTH's actions have been to appoint three additional locums and outsourcing where possible. The COO is receiving weekly status reports and all options are being considered. Patients are offered a choice and GPs are trying to manage this issue, but patients generally do not want to travel outside their catchment area. It was noted that Orthopaedic numbers are so big that the backlog is unlikely to be cleared next year. To date no patients have to come to harm and the Quality & Safety (Q&S) Committee will be kept updated with regard to this.

Cancer Standards (RTT) position – September Performance Validated :

- 62 days urgent referral to treatment eleven patients breached. A meeting is scheduled for December to agree the Cancer action plan with a three month window to deliver the plan thereafter.
- 62 days referral to treatment from screening - two patients breached in Gynaecology and Colorectal areas due to patient choice.

The COO said this is another area of concern to her as performance is inconsistent. She had taken various actions to make improvements in this area including reviewing roles and responsibilities. In August both CCGs had served two contract query notices. A Joint Investigation had taken place in the two specialties and the report and action plan will be presented to the Board in January. **Action: COO in January 2014.**

The Chair asked that further Integrated Performance Reports be adjusted to reflect the areas of greatest concern. **Action: EDs in January 2014.**

FINANCIAL PERFORMANCE

The Finance Director (FD) introduced this section of the report and said that the Trust recorded a deficit at the end of October 2013 amounting to £5.76 million. This compares with an expected level of deficit at the end of October of £1.15 million based upon a recovery plan projected to produce a year end deficit of £16k. The forecast outturn after corrective actions is now estimated as a deficit of £6.2 million. Headlines to the end of October included income seeing the highest level all year at £26.817 million; Expenditure increased by circa £1 million per month to £26.803 million contributing towards a small surplus of £14k. Pay spend appeared to stabilise at £17.3 million per month. A big challenge going forward is :

- (i) Without corrective action we face a potential £9.9 million deficit;
- (ii) With corrective action we face a potential £6.2 million deficit

Discussions are being held with Commissioners in relation to penalties in particular A&E and RTT. He expected significant discussion and debate but he was confident that he could see a way through the penalty position with our Commissioners.

The corrective plan will include a combination of carrying out extra work and negotiating with our Commissioners to take away uncertainty around income. The FD will meet the Area Team and the NHS Trust Development Authority (NTDA) next week to agree income numbers to achieve our financial position.

Cash Flow – The FD said this is the main area of concern. The cash balance of £2.55 million was held on the Balance Sheet at the end of October and this balance included £3 million of temporary borrowing. The key observations were listed in the report and included an overpayment of income received from the NHS Commissioning Board which will be recovered in November 2013. To avoid a further cash problem there was a need to secure a further £3 million loan bringing the total to £6 million of temporary borrowing which would be repayable in full in March 2014. The FD said at that point he anticipated money starting to flow in as the end of year cash position assumes the receipt of cash from the two local Commissioners (CCGs) at a level consistent with the income position for the year.

Dr Hooper (NED) was concerned about the continuing pay spend and lack of robust assurances and also referred to the previous paper about the nursing proposal where he accepted that the proposal was the right thing to do but putting that on to a budget that was already overshooting made it difficult to feel assured. Mr Jones (NED) referred to the financial recovery plan and questioned how real and robust the assumptions on efficiency targets were. He said there was a need to manage a way forward and assure the Board from next year onwards that SaTH can get out of the deficit position. In answer to the NEDs concerns, the FD said that in relation to signing off as a “going concern” SaTH is able to do this because it is not yet a Foundation Trust and this fact has been confirmed by the Auditors.

The FD said SaTH is looking to work through Cost Improvement Programmes, also guidance for tariffs next year indicates there is now the option to have discussions about local modifications to national tariff so SaTH is collating a set of information to present to our Commissioners which may provoke discussions around service changes needing to be underpinned by some form of additional resource but he could not give an absolute assurance around the ability to receive a sum of money from the CCGs.

The CEO said as a Board we have to balance maintaining patient safety and finances in a sustained organisation.

Mr Darbhanga (NED) said that the Finance Committee noted grave concerns regarding the cash flow problem and potential I&E deficit of £10.2 million. Following further discussion and concern the CEO said a decision was needed as to whether the Board supported the negotiation to get temporary borrowing.

The Board **AGREED** to request from NHS Trust Development Authority (NTDA) a further £3 million temporary borrowing and for discussions to continue regarding permanent borrowing.

WORKFORCE

The Workforce Director (WD) briefed the Board on this section of the report as follows :

- **Sickness Absence** – sickness absence had reduced in October however it remains above 4%. There are opportunities to improve controls with changes to nurse staffing. There is additional HR support in areas with high absence rates, line management to support the wider health and wellbeing initiative and tailored support around stress and musculoskeletal (MSK) conditions. A new absence policy is being finalised and will come to the Board in January 2014. **Action: Workforce Director – Jan 2014.**
- **Appraisals** – The appraisal rate has consistently been a concern for NEDs. The aim is to hit the appraisal target by March 2014. The Chair said that corporate values and the appraisal process are fundamental to the organisation. Appraisals should be a two-way flow of information.

MONITOR LICENCE CONDITIONS SELF-CERTIFICATIONS

Section 7 - Appendix 1 and 2 - Monthly Self Certifications – NTDA Requirement

The Trust followed the formal process and was submitting the monthly self-certification templates for October:

1. **Monitor Licensing Requirements** – summary of each relevant licence condition. A summary of the submission was included at Appendix 1 of the report. All conditions were marked compliant.
2. **Trust Board Self Certification Board Statements covering clinical quality, finance and governance** was included in the report at Appendix 2. The Trust is reporting a Financial Risk Rating of 2 for the month of October 2013 and non-compliance around performance issues already discussed. Action plans are in place to recover all the target. The CEO assured the Board that processes are in place.

The Chair referred to the Self Certification and asked the DCG to outline the process of assurance. **Action: Director of Corporate Governance.**

The Board **NOTED** the Integrated Performance Report for October 2013 and **APPROVED** the self certification submissions to the NHS Trust Development Authority (NTDA).

2013.1/283

QUALITY IMPACT ASSESSMENTS STATUS AGAINST COST IMPROVEMENT PROGRAMME 2013/14

The Acting Director of Nursing and Quality (ADNQ) presented the paper and said this followed the verbal update at last month's Board meeting; it contained evidence of the Quality Impact Assessments (QIAs) and the outcomes following the Executive scrutiny process. Commissioner colleagues had also discussed the QIAs and are happy with the approach taken. Attempts are being made to make QIAs easier for staff to complete.

The Board **RECEIVED** and **APPROVED** the status of Quality Impact Assessments against the identified Cost Improvement Programme.

2013.1/284 TO RECEIVE AND REVIEW GOVERNANCE AND COMPLIANCE UPDATES :

2013.1/284.1 TO RECEIVE COMMITTEE TERMS OF REFERENCE AND DATES OF TRUST BOARD MEETINGS FOR 2014

The Director of Corporate Governance (DCG) introduced the item and advised that Committees in Tier 2 have reviewed their Terms of Reference and the detail had been included in the Board Members Information Pack. The chart showed the Board Committee Structure at Attachment 1 and Membership at Attachment 2.

Board meetings for 2014/15 were detailed in the report as follows :

30 January 2014	27 February	27 March	1 May
29 May	5 June (Special)	26 June	31 July
28 August	11 September (AGM)	25 September	30 October
27 November	29 January 2015	26 February	26 March

Board Development sessions currently planned to take place after each Board meeting may need to be reviewed.

The Board currently has a Non Executive Director (NED) vacancy which created some difficulty for Committee quoracy. Following discussion it was **AGREED** to combine the Finance Committee with the Charitable Funds Committee. **Action: Director of Corporate Governance.**

The Board **NOTED** and **APPROVED** the Tier 2 Committee structure and Terms of Reference subject to the change above and **RATIFIED** dates for Board meetings for 2014/15 listed above.

2013.1/284.2 TO RECEIVE AND REVIEW DECLARATION OF INTEREST UPDATE AND CORPORATE SEAL UPDATE

Declarations of Interest : The Board **CONFIRMED** that the Interests listed in the paper were correct apart from those relating to Dr Hooper (NED). Subsequently, Dr Hooper (NED) declared that changes had been made to his interests and his interests were now :

- Governor of Carlisle College;
- Director of Planning Group Limited
- Chief Executive of Eden District Council
- Director of Verity House Limited
- Director of Enterprise Prospects Limited
- Director of Global Enterprise Solutions Limited
- Director of Hooper Burrowes Legal
- Director of Sports Booker Limited
- Director of Acton Mill Care Farm Limited

The Chair asked that an updated List of Board Members' Declarations is made available at every Board meeting. **Action: Secretary.**

Use of Corporate Seal : The Board also **NOTED** the use of the Common Sealing on Documents as listed in the report.

2013.1/284.3 **TO RECEIVE THE EMERGENCY PREPAREDNESS, RESILIENCE AND RESPONSE SELF ASSESSMENT ACTION PLAN**

The Chief Operating Officer (COO) introduced this item and advised that following receipt of a letter from NHS England she was required in October 2013 as the Trust's Accountable Emergency Planning Officer to submit a compliance statement to the Commissioning Board, using the Red, Amber, Green risk assessment process.

There were 120 core standards. There were no Red-rated standards and of the Amber standards the one she wished to bring to the Board's attention was the requirement to have sustainable plans that set out how the Trust will maintain business continuity. She advised that plans exist at a high level but more work is needed at a local departmental level.

This is an area for development for all NHS organisations. In addition to the above compliance submission, an implementation plan for achievement against non-compliant standards was also required and submitted.

A baseline assessment of all non-compliant standards will be completed by the end of January 2014 and an action plan put in place for the delivery for each quarter of 2014. A position statement will be submitted to the Hospital Executive Committee (HEC) for information at the end of each quarter. A Training Programme has been written by the Emergency Planning & Resilience Manager and will be delivered in 2014/15.

The Board **APPROVED** the Trust's assessment of its current status of compliance against the core standards.

2013.1/285 **QUESTIONS FROM THE FLOOR RELATING TO ITEMS ON THE AGENDA.**

Written observations from a member of Healthwatch were circulated to the Board following the meeting.

2013.1/286 **DATE OF NEXT MEETING**

Formal Board Meeting – 30 January 2014 at 9.30 am in the Lecture Theatre, Education Centre, Princess Royal Hospital.

The meeting then closed.

MATTERS ARISING FROM THE PUBLIC TRUST BOARD MEETING ON 28 NOVEMBER 2013

Item	Issue	ACTION OWNER	DUE DATE
245	Matters Arising : IPR Operational Performance Cancer RTT action plan would be presented to the Board	COO	Jan 2014 Item on Agenda
249.2	Integrated Education Annual Report 2012/13 Full training update will go to the Workforce Committee in Nov 2013 and reported to the Board through Workforce Committee Key Summary in Jan 2014.	WD	Jan 2014
263	Integrated Performance Report - QUALITY : RIDDOR Reportable Falls – the Board will receive details on whether falls are avoidable/unavoidable within the IPR.	ADNQ	Jan 2014
266	Stroke Services Programme Recommendation for the provision of these services had been delayed as Commissioners consider a funding request from the West Midlands Ambulance Services. Dr Srinivasan will update the Board when the CCGs decision is received.	CD	
280	Nursing Staffing Review To provide Control Framework to implement nurse staffing review to Chair, CEO and NEDs.	ADNQ/WD/ COO	Dec 2013
282	Integrated Performance Report - Operational Performance – Winter Plan An update on contingency plans will be drawn up to include our greatest risks and assured through Dr Hooper (NED) as Chair of Audit Committee.	CEO	Dec 2013
282	Integrated Performance Report - Operational Performance – Cancer Standards RTT position A Joint Investigation had taken place in two specialties and the report and action plan will be presented to the next Board.	COO	Jan 2014 Item on Agenda
282	Integrated Performance Report – Workforce Sickness Absence – A new Absence Policy will be presented to the Board in January 2014.	WD	Jan 2014 Item on the Agenda
282	Integrated Performance Report The Chair asked that Integrated Performance Reports be adjusted to reflect the areas of greatest concern.	EDs	Jan 2014
282	Monitor Licence Conditions Self Certifications Point 14 – Assurance on Self Certification process.	DCG	Dec 2013
284	Committee ToR and Dates of Board meetings 2014 <ul style="list-style-type: none"> ▪ Agreement reached to combine Finance Committee with Charitable Funds Committee. ▪ Board dates ratified – members to note. ▪ List of declarations to be included with every agenda. 	DCG Members Secretary	ASAP ASAP Jan 2014 Item on Agenda

An update for SaTH Board on the Call to Action

Edwin Borman
Medical Director



Proud To **Care**
Make It **Happen**
We Value **Respect**
Together We **Achieve**

What is the Call to Action?

- The “Call to Action” is part of a national initiative
 - launched by NHS England in July 2013
 - “The NHS belongs to the people: a call to action”
- This calls for “the public, NHS staff and politicians to have an open and honest debate about the future shape of the NHS”
- It recognises that the NHS must “meet rising demand, introduce new technology and meet the expectations of its patients”
- And acknowledges “a backdrop of flat funding which, if services continue to be delivered in the same way as now, will result in a funding gap”

It is a call for change

Who is addressing the Call to Action here?

- In accordance with NHS England's requirements, the two CCGs are responsible for this initiative
- As a first step, a survey has been conducted of:
 - the Public
 - Clinicians, from SaTH, SCCG, T&WCCG, SCHAT
- The questions asked were:
 1. In terms of healthcare, what is most important to you and your family and why?
 2. What might be the options for change?
 3. What do you think are the main difficulties and opportunities for the NHS over the next 5 years?

In terms of healthcare, what is most important to you and your family & why?

- 59% prioritised **access to services**
 - not specified 40%, GP 36%, Hospital 19%
 - issues related to
 - proximity, travel time, availability of service, equity of access
- 22% prioritised **quality**
 - not specified 69%, GP 17%, Hospital 11%
 - issues related to
 - GP continuity of care, Hospital compassionate care

What might be the options for change?

- 28% want **improved local services**
 - reducing reliance on hospitals
 - improved access to GPs and GP out of hour services
- 16% want **improved hospitals**
- 14% want **increased resources**
 - by increased funding, and/or
 - by reducing the number of managers

What do you think are the main difficulties and opportunities for the NHS over the next 5 years?

- **Difficulties**

- 44% are concerned by **limited resources**
 - ageing population, population growth
- 28% are worried about **increasing demand**
 - economic climate, staff shortages
- 9% are frustrated by **politics**
 - increasing privatisation, re-organisation, interference

- **Opportunities**

- 40% feel we should **do more**
 - train more HCPs, improve education for patients, use technology better
- 25% want to **change the pattern of care**
 - move care closer to home, improve co-ordination of care
- 15% want **improved management**
 - reduce bureaucracy

What were the results?

Free text responses included...

- 41% had concerns regarding **the management and the organisation of local services**
 - quality of care, care closer to home
- 30% highlighted **availability and quality of local services**
 - and expressed a wish for better services
- 13% were concerned about **acute hospital configuration**
 - fear of losing services and worries about the process

The negatives

Public (first 500)

- Resources feel tight
- Concerns about attracting / retaining staff
- Rising tide of demand (expectations/aging)

- Previous management and political interference and unsatisfactory change

- Poor morale

✓

✓

✓

✓

[Has there been too much or too little change?]



1 [The NHS belongs to the people: a call to action](#) NHS England, July 2013

2

What the Clinicians think

- Home is normal
- Match level of care to need
- Safety and Quality are fundamental
- Right care, right time, right place, delivered by the correct practitioner
- Treat, in the most appropriate setting, using the least resources required
- Integration, co-ordination, whole system thinking and working
- Seven day services across the entire health and care system
- Parity of esteem and focus for mental health services
- Use the data we have to model change before implementation
- Build for long term viability and for sustainability of services
- Resources will be required to support these changes

Yes, we can!

What next?

- This is the start of the journey...
 - and really is a consultation
- The review of clinical services
- Parallel work strands
- We need to plan for the future...
 - and not be held up by the past
- Agree principles first, then consider the options

The need for momentum

Some personal reflections

- There is a difference in emphasis between the survey results and some public statements
- The priority for most people is primary care
- There is greater consensus amongst clinicians than ever before, and they are willing to build on this
- We have a very tight timescale for... the consultation, developing models of care, and considering the options
- We must get this right
 - the forces affecting the NHS will be unforgiving of delay, disagreement and lack of delivery

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