

## The Shrewsbury and Telford Hospital NHS Trust

**TRUST BOARD MEETING**  
**Held on Thursday 27 March 2014 at 9.30 am**  
**Seminar Rooms 1 & 2, Shropshire Education & Conference Centre,**  
**Royal Shrewsbury Hospital**

**PUBLIC SESSION MINUTES**

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

2014.1/034 **WELCOME:** The Chair welcomed everyone to the meeting. The agenda had been re-structured into four headings - purpose, performance, process and people to ensure all areas were covered.

2014.1/035 **PATIENT STORY**

The Acting Director of Nursing & Quality (ADNQ) introduced Mrs Barbara Kurg, wife of the late Peter Kurg, and his twin brother Teorin Kurg. Peter had been a patient on Ward 21 at RSH, he was 61 years old and Mrs Kurg said he would have been delighted if his story could be of benefit to other patients. Peter had been diagnosed with Stage 4 lung cancer and given 12 months to live. He had three cycles of chemotherapy and received radiotherapy in June which left him very weak. He was hospitalised to Ward 21 in April and July and his care was second to none. By 17 August his condition worsened and he was suffering from respiratory distress. After many phone calls and assessments Peter was eventually admitted at 4 am after waiting for several hours, despite there being a bed available on Ward 21 when Mrs Kurg had phoned earlier that day.

Mrs Kurg had provided a list of Peter's drugs to the Ambulance staff however this had not been correctly transcribed on the ward which resulted in a delay in him receiving some of his medicines. That evening Peter was struggling to get out of bed to urinate. When Mrs Kurg queried the use of a catheter she was told that they did not like to use catheters as it could introduce infection and there was no one on the ward able to catheterise. It later transpired that Peter had been using the urine bottles upside down as he had never used them before and so did not understand what to do. Peter was catheterised the following day which he found much easier to manage and was able to get a good night's sleep.

A CT scan which was requested by the medical team was delayed and when carried out, Dr Wood confirmed that Peter had a 5 cm brain tumour and his life expectancy was weeks rather than months. Mrs Kurg said Dr Wood was fantastic and tried to get Peter's symptoms under control with steroids in order to give him some quality of life. That night, Peter had a bad night, unfortunately he had not responded to the steroids which meant that his life expectancy had reduced to days. Palliative care was discussed along with transfer to the Hospice. Again there was a procedure to go through to determine Peter's suitability for referral to the Hospice and Mrs Kurg questioned why this was necessary. Mrs Kurg asked the ward staff to bleep Jan, the Lung Cancer Nurse who had been supporting Peter since his diagnosis. She then decided to pop into the Lingen Davies Centre on her way to the restaurant to see if Jan was there. She was and had not been contacted by the ward at that time. Mrs Kurg felt that Jan was very supportive and fantastic in ensuring that hospice care was arranged as quickly as possible for Peter. Also on that day there was no sign of lunch for Peter and when she checked with the staff Mrs Kurg was told that her husband was too drowsy to be given any. On challenging this further with one of the nurses, a yoghurt was given with the message "that's all he can have", she showed no care or compassion.

On the night shift however, a very caring Sister was on duty and all the night staff were fantastic. In the morning a recently promoted Charge Nurse arrived to look at the syringe driver, he was very uncaring and rough when handling Peter and refused the use of Vaseline to put on Peter's dry lips as the Charge Nurse mistakenly thought it was combustible because of the oxygen present. Mrs Kurg said the whole experience with the Charge Nurse was very distressing for the family, however she understands that he has now had some retraining and received positive feedback from other patients.

Peter was transferred to the Hospice later that day and sadly died at 9.30 that evening.

Mrs Kurg said there were points to learn from this experience :

- i) Admission procedure could be streamlined, particularly when a patient is terminally ill – there was 10 hours between the initial phone call and Peter's admission to the Ward;
- ii) Communication skills particularly with junior staff who continuously quoted "we are not allowed". There has to be a balance between the needs of the individual, staff and the organisation. The organisation seemed to be "systems driven" by some of the staff rather than the job of looking after patients as individuals
- iii) Timing of the CT scan and delays - whilst there was recognition that it would not have changed the outcome, staff never explained why there was a delay in receiving the CT scan and the family still feel cheated and upset at the lack of opportunity to be with Peter whilst he remained conscious.

The ADNQ said that she and the Matron of Oncology had met with Mrs Kurg and a number of changes had been made.

The Chair thanked Mrs Kurg and Mr Kurg for attending the meeting to tell the story. On behalf of the Board he apologised for the care Peter had received. The issues worried him and were very broad. He said SaTH has a considerable way to travel on the cultural behavioural front.

Mrs Kurg said that she had received a letter from the Trust and it was very positive and non defensive. She thanked everyone for listening to her story

2014.1/036

## CHAIR'S AWARD

The ADNQ said that this month's Chair's Award went to Andrea Kershaw, Sister on Ward 24E at RSH partly related to end of life care. Reference was made to a patient story from 31 October 2013 which had been shared by Mr Ian Barnes in respect of his late mother's care whilst on Ward 24E. He said that the care his mother received from the onset was outstanding in relation to communication, care, staff attitude and leadership and he felt that Andrea was at the centre of that care. Mr Barnes felt he was fully supported throughout, and his mum was able to die with dignity. The Chair presented Andrea with the Award and congratulated her and her Team for living the Trust Values. Andrea said that she was very humbled by Mrs Kurg's story and said that Mr Barnes' experience was normal from her point of view and should be the same for all patients.

2014.1/037 DECLARATION OF INTEREST

An up-to-date list of interests was presented of members declarations. Dr Hooper subsequently added a further interest to his declarations : Director of Oak Street Properties Limited.

There were no interests declared in relation to any matters on the agenda.

2014.1/038 MINUTES OF THE MEETING HELD IN PUBLIC on 27 February 2014 were APPROVED.

MATTERS ARISING FROM THE FORMAL BOARD MEETING HELD ON 27 FEBRUARY 2014	
2014.1/010	IPR : Operational - Cancer Performance update was included within the IPR report. Item complete.
2014.1/024	<p><b>Winter Planning for Emergency Services:</b></p> <ul style="list-style-type: none"> <li>▪ Winter Planning for Emergency Services Formal Review of Health Economy was not due until end of April therefore the Board will receive the report in June. <b>Action: COO – 26 Jun 2014.</b></li> <li>▪ To arrange a health economy-wide Board session to improve the understanding of challenges being faced by all parties. Item complete.</li> </ul> <p><b>Contract Negotiations 2014/15</b></p> <ul style="list-style-type: none"> <li>▪ Strategic Debate had been added to the Forward Plan late Autumn. Item complete.</li> <li>▪ Outcome to be reported under CEO's briefing.</li> </ul>
2014.1/028	<p><b>IPR – Workforce</b></p> <p>Suggestion to be taken forward to adopt a more robust position in relation to sickness absence and appraisal rates; the WD advised that this will be discussed at the next Workforce Committee meeting on 10 April 2014 and the outcome reported back to the Board within the Workforce update. <b>Action: WD – 1 May 2014.</b></p>
2014.1/029	<b>Quality Complaints Report – Quarter 2</b> on the agenda. Item complete.
2014.1/031	<b>HR Policies – Guidance for NEDs expenses from TDA</b> to be brought back to the Board. <b>Action: WD – 29 May 2014.</b>

2014.1/039 FORWARD PLAN for the period March to June 2014 was RECEIVED.

2014.1/040 CHIEF EXECUTIVE'S OVERVIEW of the following three issues :

**Future Fit Programme**

The Clinical Commissioning Groups issued the outcome of the Clinical Advisory Groups' discussions on 13 March 2014 regarding the high-level vision for Acute and Community services. It clearly recommended, in line with the Trust's vision, that the best possible service for patients requiring urgent care can be delivered from a Single Major Emergency Hospital Centre coupled with more distributed Urgent Care Centres across the county. Whilst there has been some adverse reaction to this announcement, there has also been significant support from some key stakeholders, patient groups, and the public. During a Joint Overview & Scrutiny Committee (OSC) meeting of Shropshire and Telford & Wrekin held on 26 March 2014, the meeting agreed there was a case for change and were very supportive of the need to progress the programme. The JOSOC agreed timescales and agreed that the public consultation should take place before the general election i.e. during the course of the next 12 months. The CEO said this was very positive news.

**2014/15 Contract discussions**

Whilst a satisfactory contract has been agreed with Shropshire County CCG, the Trust has not reached agreement with Telford & Wrekin CCG around technical matters relating to rehabilitation services. SaTH has formally entered the arbitration process and the Arbitration Panel will consider the issues if discussions between SaTH and the T&W CCG were unable to reconcile the different positions with regard to the 2014/15 Contract.

The Chair referred to an action from the Matters Arising (2014.1/024) relating to holding a meeting with the CCG Chairs and CEOs. The meeting was very positive and the Chair was hopeful that there is recognition amongst all parties of the need to work together. The CEO added that work is underway to establish a Workshop in May for all the key organisations to try to look at the main issues facing the health economy. Dr Walford (NED) expressed his concern that there is no information around risk sharing; he said there needs to be more openness and transparency. The CEO said the point of the Workshop is to recognise the scale of the problem and try to agree a recognised position and create solutions.

Dr Walford (NED) said that he felt although SaTH had raised its game, he saw no evidence that other organisations were doing the same. The COO said that in her verbal report on Health Economy-wide flow improvements later on in the meeting, she would be able to give a flavour of some of the schemes that the local health economy are working on e.g. the strategy of urgent care that all partners have signed up to.

#### **Impact of key staffing shortages**

The CEO said he was becoming increasingly concerned with the day to day difficulties being experienced in medically staffing some key areas and whilst we manage to cover gaps in most instances, this is becoming an increasing struggle. This has been identified as a new risk in the Board Assurance Framework (BAF). He has asked Care Groups to quantify the level of risk and potential mitigating actions and advised that it would be helpful to have an independent review of the degree of clinical risk that is being carried by SaTH at this time to gain a clearer understanding. **Action: CEO – May 2014.** The Medical Director agreed with the CEO and said there were three specialties facing particular challenges ahead of conclusion of the Future Fit Programme and an additional issue relating to 7 day working. There is an urgency to progress Future Fit rapidly, but it will be some years and until then these risks have to be managed in the most effective way. Dr Hooper (NED) made the suggestion for NEDs attendance at CCG Board meetings and vice versa for mutual understanding of informed discussion. The Chair said he would take this suggestion forward. **ACTION: Chair to discuss representation at respective Boards**

Members **NOTED** the CEO's report.

#### **2014.1/041 FUTUREFIT PROGRAMME UPDATE**

The Director of Business & Enterprise (DBE) introduced the paper which updated the Board on progress with developing the key products of Phase 1 of the Future Fit Programme and to confirm the journey for the next 12 months. Key outputs included :

- Clinical Design workstream – Chaired by SaTH Medical Director;
- Community Hospital Utilisation workstream;
- Acute Hospital activity and capacity modelling workstream.

**Overall Model of Care** – the Clinical Design workstream considered the health and social economy with a view to establishing models of care which fully integrate all services within it to achieve whole system transformational change. The Clinical Reference Group met on a number of occasions and agreed to the three main areas of health care delivery that needed to be defined and subgroups were formed to consider these :

- **Acute and Episodic Care outcome:** The Clinical Advisory Groups fully supported a single, fully equipped and staffed high acuity emergency centre with consolidated technical and professional resources delivering high quality emergency medical care 24 hours, 7 days a week. To serve as a trauma centre with a co-located critical care unit.
- **Long-term Conditions/Frailty Management** –early intervention, preventing/avoiding admissions in acute settings and step up from primary care into high acute and step down.
- **Planned Care outcome** –separating planned care from urgent care and also reducing work in a high acute setting

The DBE said there is a lot more work to do over the next 3-4 months with regard to the clinical design and it is hoped by August to be able to model it in terms of numbers and financial aspect.

**Community Hospital Utilisation** focuses on future use of community hospitals and tries to use them in a more effective way. It reduces Length of Stay from an average of 20 days to 12.5 days and factors in age-specific changes which overall showed a marginal change in the total community beds. It would be a better model for GPs for access to step up community beds (preventing admission into acute setting) and step down bed days in community hospitals (to reduce acute bed days in acute setting).

Dr Walford (NED) raised the issue that there is national guidance and requirements for day case surgery and he would need reassurance around these. The Chair said that this paper is clearly a work in progress and more clarity was needed around the role of Urgent Care Centres and Community Hospitals.

The MD said there were three key themes:

- There is a need for a model of delivery that is sustainable for change;
- To determine what the projected need is (he personally challenged some of the assumptions); it needs to be more rigorous before going out to consultation and more information will be required;
- More information is required relating to the balance between the Emergency Centre and Urgent Care Centres. As SaTH is getting in readiness to change we are not receiving the same message from primary care.

The CEO said from a Future Fit perspective, the initial stages are about agreeing the principles and the vision. There is going to be every opportunity to improve these principles. The programme needs to be fully evaluated through the months to come.

Mr Jones (NED) said he had concerns around the Trust's Five year strategy plan, the financial strategy with short-term deficits, turnaround etc. He questioned whether these changes can be achieved within timescales. The CEO said there is a great deal of scepticism on how quickly this can be achieved. If there is a determination to move ahead you can make it happen and this is what we have to do. The COO referred to a recent monthly meeting with the TDA to talk about the strategic issues that Shropshire faces. The TDA Executives want to hold a Shropshire meeting in May/June to focus on Shropshire with representatives from CCGs and SaTH in attendance and she felt this will be a great opportunity. The CEO said the TDA understands the level of risk and need for urgency so this will be a very important meeting.

Dr Walford/Dr Borman to be assured that assumptions and plans will deliver requirements.  
**Action: MD/Dr Walford (NED).**

The Board **NOTED** the outputs from the Clinical Design Workstream; the Community Hospitals Utilisation Workstream and the Activity and Capacity Modelling Workstream.

2014.1/042

## FINANCIAL STRATEGY 2014/15

The Finance Director (FD) introduced the draft paper which provided a description of the 2014/15 Budget and described the construction of the Income Budgets, Pay Expenditure, Non pay Expenditure and Cost Improvement Programme to deliver cost reductions in the year. He said the paper had initially been written in preparation for discussions with the other Executive Directors to gain agreement but due to his absence through illness these discussions had not taken place and therefore it was important to read it in this context. The key messages included the following :

- SaTH is forecasting a deficit for 2014/15 amounting to £6.2 million and there are still significant risks around the results of the arbitration process with Telford & Wrekin CCG described earlier. If unsuccessful this would mean £2.5 million less income and implications in relation to dis-establishing the Rehabilitation service.
- Within the overall income plan the Trust is still assuming £3 million Transitional support. There is agreement of £1 million from Shropshire CCG in 2014/15 but no agreement from Telford & Wrekin CCG. There is therefore £2 million transitional support at risk. Discussions around this will take place after the outcome of arbitration.
- Pay spend - the pay figure described on Page 7 of £216 million is based on current spending and is equivalent to £17.5 million per month, and does not include the 1% pay increase or any Cost Improvement Programme savings.
- Non Pay provides a monthly spend of £7.5 million as part of £94 million budget and before achievement of Cost Improvement Plan.
- Cost Improvement Programme (CIP) is identified to deliver savings in year of £15.2 million (representing 4.6% which is constrained by two-site working) through (i) Cash releasing expenditure savings of £9 million and (ii) activity efficiencies of £6.2 million. Revised management arrangements are being established to deliver the CIP overseen by the Financial Recovery Board.
- The TDA are expecting a five year plan from the Trust by July.

Mr Jones (NED) said the Finance Committee on 25 March 2014 considered the paper and agreed it reflected the position in terms of pay and non pay. The CIP achieved in 2013/14 was significant but 2014/15 CIP was considered substantial and despite this the Trust is left with a £6 million deficit. The Committee felt that it will be essential for the Board to secure an agreement as to how the position is financed prior to turnaround into surplus later in the 5 year projection. Also the deficit position will compound the current challenge over cash liquidity from early in the new financial year.

Dr Hooper (NED) referred to the Audit Committee held on 5 March 2014 when reference was made to the fact that SaTH had failed to deliver CIPs in earlier years and he therefore felt as NEDs there is a need for specific assurance that this year's CIP can be achieved. Mrs Leeding (NED) added that she was nervous because the plan omitted to specify the steps being taken to reduce the costs.

The CEO clarified the following :

- The Board should note at this stage the draft Financial Strategy 2014/15; but should not approve the budget until the position with regard to arbitration is resolved.
- To note that very substantial savings had been made over the last two years and discussions had been held at Executive Directors meeting about more robust steps to drive down costs.
- Cost Improvement Programme for 2014/15 is in the early stages and there had been little opportunity to hold rigorous discussions. The COO added that a process is currently in place for Care Groups to develop their Cost Improvement Programmes from the bottom up. The ADNQ stressed that there is a robust Quality Impact Assessment process in place with regard to CIPs to ensure that quality is not compromised and that the proposed CIP schemes for 2014/15 would be subject to this process.

Mr Jones (NED) said it is always frustrating having budget discussions 24 hours before the new financial year starts and interim budgets stretching into June. On a quality and safety aspect the COO advised that all the risks had been validated and prioritised by the Operational Risk Group and for the first time all capital risks scoring 15 and above would be funded. The Board asked the Finance Committee to help with the challenge of CIPs by Centre going forward. **ACTION: COO to forward Centre's CIPs to Finance Committee.**

Dr Hooper raised several concerns: the QIPP process should have been agreed in advance of 31 March; issues around duplication of services and the fact that impact of these issues on quality of care is a major component. On the issue of duplication, the Finance Director said that as long as the Trust is operating duplicate services across the two sites there will continue to be serious underfunding. The challenge is to try to resolve this issue as quickly as possible (i.e. within 2-3 years).

The Finance Director confirmed that SaTH has a statutory duty to achieve breakeven, however, having been in regular conversation with the TDA he understood that a deficit of £6 million is a level which TDA is able to support, if supported by an improving position over the next 2-3 years.

The Board **DEFERRED THE DECISION** to agree the 2014/15 Budget until the outcome of the arbitration was resolved and bottom up work through the Centres. The Budget will be returned to the Board. **Action: FD – 1 May 2014.**

2014.1/043

## **FUTURE CONFIGURATION OF HOSPITAL SERVICES (FCHS) UPDATE**

The Director of Business & Enterprise (DBE) introduced the update which advised that with just 6 months until the transfer of inpatient consultant-led Women & Children's Services from RSH to PRH, the FCHS programme continues to meet all key target dates. The overall project remains affordable within the capital budget, subject to agreement of the scope and timing of the works at RSH and the cost pressures associated with the energy source.

The DBE said a decision was required by the Board with regard to interim arrangements that were necessary to the proposed Women and Children's Service Zones at RSH. She explained that the Trust remained committed to delivery of non-inpatient paediatric services at RSH as set out in the Full Business Case however the establishment of the Future Fit Programme had resulted in the need to rephase any new developments or builds at RSH pending the outcome of the Future Fit Programme. Interim proposals had also been worked up by the Maternity and Gynaecology Clinical Teams for the delivery of a Women's Zone at RSH.

The original provision for all the associated sub-projects was £5m, the new proposal was costed at £200k.

The Board **NOTED** the continued progression of the implementation of the FCHS programme and **APPROVED** the interim plans for Women and Children's Services at RSH and specifically the :

- Re-phasing of the creation of the new Children's and Women's Zones at RSH with the temporary location of these services
  - The children's outpatient service at RSH will be provided within children's oncology unit (Rainbow Unit) and the Child Assessment Unit from the vacated Shropdoc building adjacent to A&E;
  - Relocating Early Pregnancy Assessment Service (EPAS) and Antenatal clinic into vacated Ward 19 in Maternity Unit, relocating Pregnancy Antenatal Day Assessment (PANDA) into Ward 18 and also extending the Midwifery-led Unit into Ward 18.
- Postponement of the creation of: new offices within the existing Maternity Building; a Clinical Training Centre within the Rainbow Unit; and the relocation of DAART at RSH

The Board **NOTED** the required communication and engagement on the amended plan internally with all staff and externally with stakeholders, patients and the public.

2014.1/044

## **SUSTAINABLE DEVELOPMENT MANAGEMENT STRATEGY/PLAN**

The Director of Corporate Governance (DCG) introduced this item and the following latest points were noted :

- NHS Sustainable Day was taking place today and the Trust was participating in a national initiative to plant two trees at 2pm – these will be planted outside the main Ward Block at RSH and four cherry trees worth over £2k provided by Dingle Nursery would be planted outside the School of Health in April. The Nursery would also work with SaTH on a wider project to reclaim a natural wild life area on the site, utilising volunteers who might also wish to be involved. There were also events being organised on both sites to raise staff and public awareness and to encourage sustainability pledges. The Board were invited to complete the pledge tickets in front of them.
- The Trust has won a national bid, supported by the Department of Health, around creating sustaining landscape gardens in the NHS. This will provide landscape gardeners to design two sensory gardens for dementia patients in quadrangles at PRH. Again support from volunteers has already been pledged.
- The Trust had been shortlisted for a national sustainability award for its work with volunteers and community engagement. We now quadrupled the number of volunteers over the past four years and now have nearly 400 Trust volunteers who all receive training and support and also support induction and training of over 600 partners' volunteers e.g. League of Friends, RVS. In addition we are piloting a staff volunteer scheme for launch in the summer and also work with local schools and colleges to offer volunteer placements for 50 young people each year, many of whom use the experience as a pre cursor to pursue medical careers. This provided a splendid opportunity to further raise awareness and engagement.

The DCG then introduced the five year Sustainability Strategy which outlined a vision and three NHS Sustainability goals based on the challenges that factor in the environmental impact of the health and care system and the potential health co-benefits of minimising this impact. SaTH is committed to improving its sustainability performance for environmental, social and economic reasons and has reviewed its five year Sustainability Strategy in the light of the latest national and legal requirements and to align to its longer-term vision and objectives. For the first time in the capital budget SaTH has also seen a link to modest investment in sustainable initiatives – invest to save schemes. The detailed action plan in the information pack incorporated the National Good Corporate Citizen objectives, as well as locally derived ones, aligned to SaTH's own priorities and the full strategy listed the scope 1 CO<sub>2</sub> emissions by category and the plan to reduce these over the next five years. Attachment 2 was an information leaflet issued to our 9000 FT Members and to staff via a payslip drop to raise awareness of individual impact and to ensure greater engagement.

The Board **APPROVED** the Strategy and Action Plan and asked that greater focus be placed on healthier eating options. It was agreed that Mrs Leeding (NED) would act as NED sustainability champion as she had experience in this area.

## 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 February 2014 which summarised the Trust's performance against all the key quality, finance, compliance and workforce targets and indicators for 2013/14. The report confirmed that SaTH is currently at Escalation Level 4 (of 5) in the NHS Trust Development Authority's Accountability Framework. This is classified as a "material issue" requiring interaction led by the Director of Delivery & Development. Regular meetings are being held with the TDA to update them on SaTH's improvement trajectories. Key areas have been highlighted in the report.

### QUALITY : Patient Safety, Effectiveness and Patient Experience

The Acting Director of Nursing & Quality (ADNQ) provided an overview of the activity in February 2014 when a number of improvements within quality and safety were noted including :

- WHO checklist (safer surgery) – showed continuous compliance within the Trust theatres of 99.5%.
- Infection Prevention & Control – showed positive performance across all areas.
- Ward to Board metrics continues to show measured improvements. A continued area of focus for improvement relates to communicating discharge arrangements with patients, relatives and carers. Patient representatives are being more involved in this and matrons have accepted this new role.
- SaTH heard earlier in the week that it had achieved CNST Level 3 in Maternity and was one of only 30 Trusts in the country. The staff had worked exceedingly hard and scored 48 out of 50 areas. The external assessors fed back that the team was focused on quality and transparency. Financially it means £0.5 million savings. The Board expressed its thanks to the Team.

OPERATIONAL PERFORMANCE – The Chief Operating Officer (COO) gave an overview of the operational performance for February 2014.

**RED RAG : Overview of Performance Standards by Exception** included :

**A&E 4 Hour Access Standard** : In February 2014, 93.88% patients were admitted or discharged within the 4 hour quality target against a target of 95%, this was against a background of increasing emergencies. The year to date performance is currently at 93.46%. Work is on-going to develop plans to avoid patients spending longer than required within the Emergency Department.

**Cancer Performance** : Unvalidated performance for February showed an improvement in the 2 week GP to 1<sup>st</sup> outpatient appointment breast symptomatic standard, achieving 93.83% against the target of 93% but the validated January data shows failure of the 31 day subsequent surgery and 62 day urgent referral to treatment standards. SaTH is actively working to a Remedial Action Plan (RAP) in the four challenged tumour sites (Colorectal, Lung, Upper GI and Urology) which are contributing to the non-performance of the 62 day standard. The Intensive Support Team (IST) have undertaken a review of cancer services and a draft report is being completed on 28 March 2014. Once the report is received the recommendations will be incorporated into the RAP and will be monitored at the Cancer Board. IST will then work with the Clinical Centres to review patient pathways so that cancer standards are delivered from Quarter 2 in 2014/15.

The ADNQ said that SaTH had not performed well in the Cancer Patient Experience Survey from 2013 with a number of questions being ranked within the worst bracket of Trusts in the country. A themed review of quality and performance of Cancer Services has been presented at the CQRM and Commissioners will receive quarterly updates on improvements. Dr Walford (NED) said that the Quality & Safety Committee was also concerned and the COO agreed that it was unacceptable.

**Referral to Treatment Performance** : We are on track against our plan. The non-admitted standard was achieved. Ophthalmology remains a concern and the CCGs are now commissioning additional activity from 'The Practice' (an independent provider). There was one 52 week breach due to a technical error, the patient was assessed as quickly as possible and no harm identified.



## FINANCIAL PERFORMANCE

The Finance Director (FD) introduced the item and advised that the Trust deficit position at the end of February 2014 was £1.135 million, after allowing for NHS Trust Development Authority (NTDA) transitional support of £3.667 million and the position is on target to breakeven. This is a requirement by the NTDA and for which the Trust received £4m transitional support and therefore March needs to replicate January in respect of volume. A cash balance of £11.329 million was held on the Balance Sheet at the end of February. This balance includes £7.5 million temporary borrowing and is required to be repaid in full in March 2014. The Finance Director confirmed that cash models for the next 12 months had been presented to the NTDA and SaTH will need to secure temporary borrowing rising to £6.2 million by March 2015.

## WORKFORCE

The Workforce Director (WD) introduced this section of the paper, the following points were **NOTED** :

- **NHS Pay Award for the next two years** was different from other years where staff employed in NHS will be eligible for an annual increase of at least 1%, either through contractual pay progression or, for staff at the top of their pay bands, through a non consolidated payment. For SaTH 66% of employees are at the top of their pay band therefore will receive a 1% increase. It was noted that there were discussions nationally about this.
- **Sickness Absence** reduced by 0.22% in February to 4.72% but represented a £60k cost avoidance. The Chair said he wanted the organisation to aim for a target of 3% in sickness absence.
- **Appraisal rate** is improving and the WD was confident that SaTH will achieve 80%. Year to date performance is currently 78%. The WD said that following staff survey results, one of the objectives is to change the appraisal process and this is being actioned.

## MONITOR LICENCE CONDITIONS SELF-CERTIFICATIONS

### **Appendix 1 and 2 - Monthly Self Certifications – NTDA Requirement**

The Trust followed the formal process and was submitting the monthly self-certification templates for February 2014 :

- **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.
- **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 3 for the month of February 2014 and non-compliance around performance issues. Action plans are in place to recover all the targets.

The Board **NOTED** the Integrated Performance Report for February 2014 and **APPROVED** the self-certification submissions to the NHS Trust Development Authority (NTDA). It was noted that this is for February 2014 and whilst there are risks going on next year SaTH is still a going concern. The Board **AGREED** that a qualifying note should accompany the Self Certification to the NTDA approving finance but on the understanding that NTDA is underwriting a known deficit. **Action: FD.**

2014.1/046

## **CARE QUALITY COMMISSION (CQC) INTELLIGENT MONITORING REPORT (IMR)**

The Director of Corporate Governance (DCG) introduced this item and advised that the CQC had published the second edition of its Intelligent Monitoring Report (IMR) on 13 March 2014. SaTH was identified as having two elevated risks (compared to four in the October edition) and five other risks which places SaTH in Band 3 (of 6 Bands where Band 1 indicates the Trusts considered highest risk and Band 6 low risk). The full IMR had been circulated to members and was available on the website.

Significant improvements had been made in Venous Thromboembolism (VTE) over the last year and this had contributed to the improved banding. Also the Trust had introduced a more robust process for responding to any issues highlighted through Patient reported outcomes measures (PROMs). The Chair congratulated all those involved in this improvement.

The Board **NOTED** the latest Intelligent Monitoring Report from the Care Quality Commission.

## 2014.1/047 QUALITY COMPLAINTS REPORT

The Acting Director of Nursing & Quality (ADNQ) introduced the second Quality Complaints report which provided an overview of formal complaints received by the Trust during Quarter 3 (October to December 2013). The report outlined the Trust's performance and included trends and themes arising from complaints.

The following points were noted :

- The number of complaints to the Trust continued to reduce and was partly due to improvements in process.
- There was improved performance in responding to complaints within the agreed timescale with the complainant (100% in December and 93% for the quarter).
- Key themes - the ADNQ was pleased to report that medical and nursing care issues had reduced but there was a slight increase in complaints relating to communication and attitude (e.g. referenced within the patient story told earlier).
- Triangulation with patient safety is important and relates to health concerns, complaints, and Serious Incidents/Claims/Legal cases - it makes sure that nothing is missed including any concerns relating to safeguarding adults and children.
- PALS contacts have reduced, largely due to changing processes and responding more directly to patients e.g. car parking problems.

Work is underway to make it easier for patients to provide feedback – both compliments and complaints - and 50 notice boards in wards around our hospitals are being provided to give a variety of feedback opportunities. The Head of Complaints and PALS will present an Annual Complaints Report in the summer.

The Board considered the report and **NOTED** its findings.

## 2014.1/048 BOARD ASSURANCE FRAMEWORK (BAF)

The Chief Executive introduced the Board Assurance Framework (BAF) update which included work undertaken on strategic objectives and challenges since January 2014, along with comments received at Risk Committee meeting held in 3 March 2014. Some additional assurances had also been added. It was noted that since the last presentation to the Trust Board one risk had been added i.e. "Risk to sustainability of clinical services due to potential shortages of key clinical staff". Attachment 3 was a compilation of BAF Associated Action Plans. The CEO reported on the following risks :

- Pressure ulcers and infection – improving situation but still work to do – Amber/Green
- Falls – improving situation but still work to do – Amber
- New risk - sustainability of clinical services due to potential shortages of key clinical staff – RED.  
Although there is a national shortage it was felt to be specific to our configuration of split site working which is not attracting the right calibre of staff. It was noted that this was an important component for a case for change.
- High Performance – whilst our service has improved over the last 12 months, there is a need to improve patient flow (process, capacity and demand planning) – RED.
- Staff Engagement – confident that actions have been put in place to improve the culture – AMBER.
- Clinical Service Vision – positive reaction around the Future Fit programme - AMBER/RED.
- Financial strength – as discussed earlier – RED.

The CEO proposed that the suggested development for the coming year in relation to the Clinical Service Vision be presented to the Board in May. **Action: CEO – 29 May 2014.**

The Board **REVIEWED** and **CONSIDERED** if any additional assurances were necessary to assure the Board that the risks to the strategic objectives were being properly managed; and **APPROVED** the Board Assurance Framework.

**HEALTHCARE ECONOMY-WIDE FLOW IMPROVEMENTS**

The Chief Operating Officer (COO) presented a slide which focused on the Healthcare economy-wide flow improvements including Winter Plan 2014/15 developments and included :

1. Joint therapies pathways between SaTH and Shropshire Community :
  - Stroke/Neuro-Rehabilitation
  - MacMillan Therapy Pathways
  - Fragility Rehabilitation
2. Integrated Care Service rollout in Shropshire
3. Development of Emergency Ambulatory Care at RSH;
4. Development of Urgent Care Centre at RSH;
5. Telford & Wrekin Better Care Fund initiatives – integrated community enablement model;
6. Implementation of SaTH Medicine Strategy;
7. Development of Clinical Decision Unit at PRH (to replicate current RSH CDU).

The COO briefed the Board on the proposed developments. She said there was a lot of activity but her concern remained that there is no overarching urgent care strategy, and concentrated more on small schemes rather than an overarching approach. The CEO added that at the Urgent Care meeting on 24 March this point about the lack of a coherent strategy and the lack of strategic direction had been made. There are three aspirations - admission avoidance; attendance avoidance and early supportive discharge. The COO said that she would continue to report on progress. **Action: COO.**

The Board **NOTED** the verbal report.

**SYSTEMS STRATEGY UPDATE**

The Chief Executive said this is the first year the Trust has tried to focus on putting fundamentals in place to strengthen the organisational structure (e.g. management capability, introducing management framework and starting engaging in cultural change in the organisation). He listed four important areas to consider but recognised that SaTH is on a journey of change and these need to be handled within the Trust's management capacity and constraints :

- A strategy for investment needs to be clearly developed – there is a very reactive and risk based approach, we fail to think revenue and resources to drive towards business objectives.
- A coherent strategy around Information Technology needs to be developed - to improve efficiency and reduce cost.
- Lean - A comprehensive strategy for Re-Design needs to be developed – identify as part of cultural programme to create a culture of continuous improvement.
- Improvements required to analyse our market and understand profitability/business intelligence. This will be discussed at the Board Development session after Trust Board.

The Chair said the priorities this year were to be very clear around communications and more focus on compassion.

The Board **NOTED** the verbal briefing and recognised that not all areas can be achieved at once and prioritising progress was a key issue.

**Audit Committee meeting held on 5 March 2014** – The key summary was **NOTED**. Dr Walford (NED) briefed the Board in the absence of Dr Hooper (NED) Chair of Audit Committee who had left early. He said the Internal Auditors had issued a letter separately to the Chair of Audit Committee (letter and response had been circulated to Board) regarding concerns about the current and forecast position of the Trust. Although their audits did not identify significant control issues there were concerns about the Trust's outcome position, if no mitigating action were taken and recommended liaison with Commissioners regarding levels of income available to the Trust. Dr Walford (NED) said that it was a useful prompt and Dr Hooper (NED) had responded to confirm that the Trust was taking it very seriously.

The Board **RECEIVED** and **APPROVED** the Internal Audit Forward Plan.

**Finance Committee meeting held on 25 March 2014** – The key summary was **NOTED**. Mr Jones (NED) Chair of the Committee briefed the Board as follows :

- Financial Strategy 2014/15 was considered when it was noted that reference was made to the Telford & Wrekin CCG unresolved position on income levels which is a key risk that could materially impact if not effectively controlled or mitigated.
- The Finance Committee approved a procurement recommendation to establish a "Master Vendor" for nursing staff agency supply similar to that already in place for medical agency supply. It was anticipated that this will improve quality, reduce management and administration and save money. The Board **NOTED** this approval.
- Booking and Scheduling - the Committee noted that there was a continued need to improve the "cashing up" of clinics to reduce the inherent risk to patients. There was a need to ensure revised Standard Operating Procedures (SOP) are adopted across the Trust and the Committee asked that a "source of leadership" be agreed to secure SOP compliance. The COO said she would take steps to address this. **Action: COO.**
- Losses/Special Payments – the Committee received and reviewed these items.

**Clinical Quality & Safety (Q&S) Committee meeting held on 17 March 2014** – Key summary was **NOTED**. Dr Walford (NED) Chair of the Committee briefed the Board on the following :

- Visit - The Committee visited Theatres and discovered very capable people running this area. They pointed out the very substantial donations of equipment made by the League of Friends which was in constant use.
- QIPP Programme - The Committee had ongoing concerns about this programme across the wider health economy and how SaTH can address the quality impact on hospital services of any more concrete proposals that may come forward. The Chair said that this issue would be discussed at the Workshop scheduled for May.
- Learning from Root Cause Analyses – the Committee queried whether a general summary of the changes to operational systems and clinical care derived from this learning should be summarized in its Board public sessions. The Chair agreed that this would be a mark of transparency. **Action: ADNQ.**

**Risk Committee meeting held on 3 March 2014** – the key summary was **NOTED** which had been reflected in the Board discussion on the Board Assurance Framework.

## BOARD CYCLE OF BUSINESS 2014/15

The Director of Corporate Governance (DCG) presented the governance schedule for 2014/15 which informed the Board of the governance-related planned items it could expect to receive during the year which enables the Board to obtain assurances in relation to its governance. Additional items will be added to the presentation of the three-monthly schedule at each Board meeting as they arise.

The Board **REVIEWED** the Business Cycle for 2014/5 and noted that this will be updated as required.

2014.1/053 PEOPLE STRATEGY PROGRESS

The Workforce Director (WD) gave a verbal update. It was noted that the People Strategy is intended to support and develop the people in our organisation to provide and support high quality frontline care however the WD recognised that it will take time. The staff survey results have been fed into the plan and key actions to embed the "values", agreeing behaviours and staff development. Trust values have been included in the recruitment processes for Nursing staff, Health Care Assistants, Phlebotomists and Domestics and as a result of this better recruitment results are being seen. Also based on feedback from the Chair and CEO we are intending to make changes to consultants recruitment, weaving true values throughout the process. There is a need to understand the workforce challenges across the organisation e.g. there is a struggle to employ domestics at RSH. A Leadership Development programme will be extended throughout the organisation and will start in May. The focus will be on leadership capacity and behaviours; setting the tone, culture and role models so as to hopefully avoid patient stories like the one presented earlier today. Discussions are also taking place around food and healthy options; and aspects of health and wellbeing and NICE guidance around obesity through the new absence policy will help manage business and robustness going forward.

The CEO added that the Workforce Director and Head of Organisational Development attended the last EDs meeting and described some of the work around workforce transformation. He said he had asked them to present this excellent work to the Board in the near future. **Action: WD - June/July 2014.**

2014.1/054 STAKEHOLDER COMMUNICATIONS

The Communications Director provided an update on engagement and communications. The following points were noted :

**Joint Overview & Scrutiny Committee :** The Committee was a very positive, discussed future configuration and were very supportive of progress. The Committee was also supportive of the Stroke Services.

**Montgomery CHC :** the meeting was very supportive of the Stroke Services and want to be engaged in this.

**Health Watch in England :** Meets regularly. Understands the strategy and works together in partnership. Last week they discussed catering.

**Charities Board :** agreed that there are tremendous fund raising opportunities to be had from working together.

**News Media :**

- **Positive** - Health Care Science - a credit to the Communications Team and staff across the organisation. Also Sam Bunn went on BBC Radio Shropshire to talk about Maxillo Facial along with a patient and that patient story was syndicated to all BBC Radio stations around the country.
- **Negative** : Food – question around how to level up the quality of food on both sites.
- **Digital Media** – how its changing and how to use it in wards and departments e.g. there had been a positive comment about a patient on Ward 4 at PRH who had Alzheimers, where his dignity was maintained and staff were caring. This reinforces how to engage with our community – this will be developed.

The Board welcomed the introduction of this update. The Chair said he would like to bring "Twitter" into play in the future. In relation to performance, the Chair said he would like to keep quality, performance, finance and workforce for the moment but keep engagement separate at this time.

2014.1/055 REVIEW OF MEETING

**Observational Review** was undertaken by the Communications Director (from a member of the public point of view) when the following points were noted :

- Members need to speak up at all meetings.
- Reassurance throughout in terms of quality and safety outcomes of patients – this is a dominant theme and what it means to support our staff. Aspirations within the four headings is becoming more visible in discussions and is really powerful.

- At times there is the risk of focusing in on personal interests rather than interests of patients and our role to deliver them.
- Openness has to be the norm.

**Members Review :**

- Mrs Leeding (NED) liked the new agenda structure and felt none of the substance was lost.
- The COO referred to the TDA requirements about the Board being reassured that they understand all issues. The CEO said that this concerns operational issues and there needs to be a balance.
- Dr Walford (NED) referred to the time spent on patient stories and referring to this month's in particular, he felt that it is important to also scrutinise the medical body.

2014.1/056

**DATE OF NEXT MEETING**

Public Board Meeting – 1 May 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 27 MARCH 2014**

<b>Item</b>	<b>Issue</b>	<b>ACTION OWNER</b>	<b>DUE DATE</b>
2014/010	<b>Integrated Performance Report</b> To develop Board reporting so all papers include performance, quality, finance and workforce issues in a more integrated approach and to routinely include Centre-specific performance against all these measures in IPR.	CEO	Jun 2014
2014.1/024	<b>Winter Planning for Emergency Services</b> Formal Review of Health Economy report not due until April.	COO	26 Jun 2014
2014.1/028	<b>Integrated Performance Report – Workforce</b> Trust adopted a more robust position re. sickness absence and appraisal rates. The WD to take this forward and return with recommendations.	WD	1 May 2014
2014.1/031	<b>HR13 Reimbursement of Travel, Accommodation &amp; Subsistence Expenses</b> Guidance for NEDs expenses from TDA around change of the scope. To be brought back to the Board.	WD	29 May 2014
2014.1/040	<b>CEO's Briefing – Impact of key staffing shortages</b> <ul style="list-style-type: none"> <li>▪ Care Groups to quantify the level of risk and potential mitigating actions – to be brought back to the Board.</li> <li>▪ NEDs attendance at CCG Boards and vice versa. Chair to discuss representation at respective Boards.</li> </ul>	CEO  Chair	May 2014  ASAP
2014.1/041	<b>Future Fit Programme</b> Dr Walford and MD to be assured that assumptions and plans will deliver requirements.	MD/SW	ASAP
2014.1/042	<b>Financial Strategy 2014/15</b> <ul style="list-style-type: none"> <li>▪ The Board asked the Finance Committee to help with the challenge of CIPs by Centre going forward. COO to forward Centre CIPs to Finance Committee.</li> <li>▪ The Board <b>DEFERRED DECISION</b> to agree 2014/15 budget until the outcome of the arbitration was resolved and bottom up work through the Centres. Budget to return in May.</li> </ul>	COO  FD	ASAP  1 May 2014
2014.1/045	<b>IPR Self Certification</b> – a qualifying note should accompany self-certification to the NTDA approving finance but understanding that NTDA is underwriting a known deficit.	FD	Immediate
2014.1/048	<b>Board Assurance Framework</b> Clinical Service Vision to be presented to the Board.	CEO	29 May 2014
2014.1/049	<b>Healthcare Economy-wide flow improvements</b> COO to continue to report on progress.	COO	Ongoing
2014.1/051	<b>Trust Committee Meetings Update</b> <ul style="list-style-type: none"> <li>▪ <b>Finance Committee</b> : Booking &amp; Scheduling – source of leadership be agreed to ensure SOP compliance.</li> <li>▪ <b>Learning from RCA</b> General summary of the changes to operational systems and clinical care derived from learning to be summarized at public Boards.</li> </ul>	COO  ADNQ	ASAP  ASAP
22014.1/053	<b>People Strategy</b> WD/Head of OD to present on workforce transformation.	WD	Jun/Jul 2014