The Shrewsbury and Telford Hospital NHS Trust

TRUST BOARD MEETING
Held 12noon Thursday 28 September 2017
Seminar Rooms 1&2, Shropshire Conference Centre, RSH

PUBLIC SESSION MINUTES

Present:	Mr P Latchford	Chair
	Mr P Cronin	Non-Executive Director (NED)
	Mr H Darbhanga	Non-Executive Director (NED)
	Mr C Deadman	Non-Executive Director (NED)
	Dr D Lee	Non-Executive Director (NED)
	Mrs T Mingay	Designate Non-Executive Director (D.NED)
	Mr B Newman	Non-Executive Director (NED)
	Dr C Weiner	Non-Executive Director (NED)
	Mr S Wright	Chief Executive Officer (CEO)
	Dr E Borman	Medical Director (MD)
	Mrs D Kadum	Chief Operating Officer (COO)
	Mr N Nisbet	Finance Director (FD)
	Mrs D Fowler	Director of Nursing, Midwifery & Quality (DNMQ)
	Mrs J Clarke	Director of Corporate Governance / Company Secretary
In Attendance	Miss V Maher	Workforce Director (WD)
	Mr P Evans	Programme Director, Sustainability and Transformation Programme & Future Fit
Meeting Secretary	Mrs S Mattey	Committee Secretary (CS)
Apologies:	None	

2017.2/157 WELCOME:

The Chair welcomed the Board members and members of the public and reminded the public that it is a Board meeting being held in public.
The Chair also welcomed Sue Holden and Fiona Burton from NHSI who were in attendance to observe and provide support in helping the Trust in its journey towards becoming an exemplary organisation.

The Chair suggested trialling a public question and answer session; breaking at each section of the agenda to provide the public with the opportunity of asking a question if they have attended to raise a particular item.

2017.2/158 VIP AWARDS

The Chair reported that the Values In Practice (VIP) Awards is celebrated every month to recognise the amazing work of the Trust's staff and volunteers to support patients and their families each day.

July 2017 Winner:
Lisa Butler – to be presented during the November Trust Board meeting.

August 2017 Winner:
The Board were informed that the Post-graduate Medical Education Team had won the August VIP Award for the work undertaken for the annual doctor change over in August.

…….. Chair
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"The caring aspect of the department is always commented on as they are often the first port of call if things are going professionally or personally wrong for doctors. The team go the extra mile to help and have a gentle kindness and empathy with the trainees.
The team respect everyone's role in the Trust as they deal with every level of staff when engaging with them for supervision, training and assessment.
Excellence is standard with the team achieving high standards in their detailed organisation of events, interaction with staff within the Trust and at the Deanery.
The team make it happen by all pulling together, this ability is not an easy one and is testament to their resilience and common goal of improving the culture and achievements of education within the Trust".

Unfortunately not all of the Postgraduate Medical Education Team could be present; those that were thanked the Board for the recognition of the hard work undertaken.

September 2017 Winner:
To be presented during November Trust Board meeting.

2017.2/159 PATIENT STORY

The MD welcomed Kelly Jones to the meeting who was supported by Mr Andrew Tapp. Kelly attended to provide a video relating to the loss of her twin girls, Ella and Lola, at the Trust three years ago.

Kelly informed the meeting that she was admitted at 37 weeks and was informed of the need to deliver the babies, however she was later discharged. A scan later revealed that they could not detect a heartbeat for the twins.

Kelly reported that she felt she was not listened to and this personal tragedy could have been avoided.

Kelly identified areas of her care that could have been improved. She was pleased that the Trust has introduced new antenatal CTG monitors to monitor both mother and baby's heartbeats; along with enhanced training for midwives and doctors in CTG interpretation.

SaTH is also using an extended version of the video for training clinicians in the importance of compassion, good communication and competence for the delivery of kind and safe care.

Kelly sees this work as her mission and feels that by working with the Trust to achieve improvements in care, she will attain greater meaning from the tragic events.

Kelly highlighted and thanked a number of key members of staff who have helped and assisted her. Kelly also highlighted the need for a Bereavement Line as well as a Remembrance Garden at the Trust.

The Chair and Board members thanked Kelly for her courage in attending to share her very sad story and following discussion, the CEO assured her that we will work with Kelly to deliver a garden haven for patients and public, as well as better support for bereaved patients.

2017.2/160 BOARD MEMBER'S DECLARATIONS OF INTEREST

Dr Weiner (NED) reported that he is no longer Clinical Director at Wiltshire Health & Care. He also confirmed that he is a Member of NHS England in West Midlands.
Action: CS to update Declarations

The Board RECEIVED and NOTED the remainder of the Declarations of Interest.

2017.2/161 DRAFT MINUTES OF MEETING HELD IN PUBLIC on 27 JULY 2017

Mr Newman highlighted the following slight amends:

2017.2/141.4 – Performance Report – Finance
Mr Newman highlighted that he has previously requested the data be broken down into *actual,* variance and month-to-date. The FD agreed to provide that level of information.
Action: FD to break down data as requested

The remainder of the minutes were APPROVED as a true record.

2017.2/162 ACTIONS / MATTERS ARISING FROM MEETING HELD 27 JULY 2017

2017.2/32 – Patient Story – Dementia
DCG to arrange Alzheimer's Society Dementia Friends awareness sessions for all Board members to attend
The DCG reported that she circulated an email to the Board members to attend awareness sessions which are offered to volunteers of the Trust.
Completed. Action closed.

2017.2/134.3 – Draft Minutes of meeting held 29 June 2017
CS to update minutes 2017.2/114.1 & 2017.2/116.
Completed. Action closed.

2017.2/135 – Actions/Matters Arising from Previous Minutes
2017.2/45 – COO to provide update to September 2017 Trust Board re: Temporary suspension of Neurology outpatient service for new referrals
As per minute 2017.2/169.1 Action closed

2017.2/105 – Midwifery Led Unit Proposal
DNMQ to undertake a mid-term review (at three months) and provide update to September Board
As per minute 2017.2/169.2 Action closed

2017.2/136 – 3-Month Forward Plan
Winter Planning – COO to provide update to September Trust Board
As per minute 2017.2/168 Action closed

Maternity Services Review – CS to remove from Forward Plan as Mr Deadman is content with detail received from Mr Ovington
Completed. Action closed.

2017.2/138 – Summary of Sustainability Committee held July 2017
Exec Team/CEO to discuss shaping agendas using all aspects of deep dive stool
Completed. Action closed.

2017.2/139 – Endoscopy Business Case
Exec Team/CEO to explore patient flow through the hospital / increase in capacity
Completed. Action closed

2017.2/140.1 – ED – Service Continuity Plan
COO to present Service Continuity Plan to September Board
As per minute 2017.2/169.3. Action closed.

2017.2/140.6 – Services under the spotlight – Midwifery Led Unit
WD to investigate the data around the recent interest in midwifery applications/recruitment and report through Workforce Committee which provides assurance to the Board
The WD reported that the line of enquiry related to why SaTH were able to recruit midwives when they have been unable to before; the WD reported that there has been a change of approach in midwifery recruitment with Band 5 (with support) positions being advertised. There had also been a number of temporary contracts due to maternity leave which have been unable to be filled due to staff returning to post. The volume of recruitment has been

substantive. The Trust has learned from this; supporting people into roles and the team has also spent a great deal of time looking at job adverts to improve upon this in future.
Completed. Action closed.

2017.2/141.2 – Workforce Programme – Appraisal Training
DNMQ to investigate the Q&S department SSU compliance which currently sits at 50.88%
The DNMQ re4ported that on further investigation this was due to the pause in training last year, however the low level appraisal rate has now increased to 77% and the trajectory is 95% compliance by November.
Completed. Action closed.

2017.2/141.4 – Finance Performance
FD to produce data broken down into actual, variance and month to date
The FD assured the Board that this has been completed but the revised version has been omitted from the Board papers. The updated version will be included in the November Board papers.
Action: FD Due: November 2017 Trust Board

2017.2/142 – Summary of Q&S Committee held 19 July 2017
DNMQ to provide update in relation to SI/RCA process
As per minute 2017.2/170.4. Action closed.

The DNMQ also reported that circa 50 staff members will attend a one-day RCA/SI course during November. A two-day course is also available focusing on a deeper dive/root causes. Members of the Board have agreed to attend.
Completed. Action closed.

2017.2/144 – Community Engagement Approach
DCG to provide update on a quarterly basis.
Action: DCG Due: 1 Feb 2018 Trust Board & Added to Board Schedule of Business

2017.2/148 – TCI Update
NEDs to attend future Report Outs
Dr Lee informed the members that a Report Out would be held the following day at 12 noon at PRH and urged members to attend
Action closed.

2017.2/152 – Annual Reports – Research & Innovation
MD to add SaTH's ability to innovate to future edition of R&I Annual Report to Trust Board
Action: MD Due: July 2018 Trust Board – Added to Board Schedule of Business. Action closed.

2017.2/163 3-MONTH FORWARD PLAN

The members RECEIVED and APPROVED the remainder of the three-month forward plan.

2017.2/164 CHIEF EXECUTIVE OVERVIEW

2017.2/164.1 The CEO reported that a number of guests have visited the Trust; Professor Ted Baker, Chief Officer of CQC spent a day and has expressed a wish to return to spend further time within the hospitals.
Professor Dolan also visited to talk about the Red to Green initiative in a bid to safely discharge patients earlier; and Ruth May also spent time at the Trust and met with a number of senior nurses.

2017.2/164.2 Positive discussions were held during a Board to Board with Telford & Wrekin CCG regarding how to work closer to improve patients' health.

2017.2/164.3 Future Fit is moving closer towards public consultation with a continued investment in public engagement. The CEO welcomed the Trust's recently appointed Kate Ballinger in her role as Community Engagement Facilitator who was present to observe and provide support moving forward.

…….. Chair
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2017.2/164.4 The CEO highlighted the challenges of the Emergency Department as we move closer towards winter. He reported that the Board members had received their flu jabs and the Trust is working hard with local authorities for a robust plan for the population.

SUSTAINABILITY (PATIENT & FAMILY)

2017.2/165 SUMMARY OF SUSTAINABILITY COMMITTEE MEETING HELD 26 SEPTEMBER 2017

Mr Deadman (NED), Chair of the Sustainability Committee, presented the following key summary points from the meeting held on 26 September 2017.

Financial Position Month 5

The Committee discussed the financial position at month 5 noting that before the receipt of STF, the Trust recorded a deficit of £10.862 million; £4.974 million worse than plan. The consequences of not receiving STF funding in Quarter 2 and the impact this would have on cash was concerning. Given the current overspend the expected position at the end of 2017/18 is now £18.004 million deficit. The delivery of actions identified as part of a Recovery Plan could result in a revised outturn position of £10.497 however £4.030 million of the schemes identified were rag rated red risk.

As highlighted last month, the number of contract queries being received from the CCG continues to not only cause concern in terms of the financial scale of challenge (four times greater than the Trust is reserving for), but in terms of the time spent by staff responding to these queries (estimated to be consuming the full time of 4 members of staff).

The Sustainability Committee acknowledged that addressing the Agency problem was key to improving the financial position and maintain credibility with NHSI and other stakeholders. The Trust needed to find a way to focus more on this important matter and for more pace to be injected into decision making and in delivering the actions identified, e.g. decision re: weekly pay and ensuring staff rostering three months in advance. It was noted that at a time the majority of Trusts had made good progress, we, at SaTH, had seen a serious deterioration in performance which threatened to undermine quality of care and financial performance.

Trust Performance Report
A review of the Trust's performance at month 5 took place. The Sustainability Committee congratulated the Scheduled Care Group on the delivery of the 92% RTT target. This is a tremendous effort to bring this position back in line. The A&E position remains a concern.

Operational Plan 2017/18
An update on performance against the plan was provided. It was noted that a huge amount of work had taken place since the end of August, including the excellent PRH component of the bed realignment project (objective 8).
There was recognition that the delivery of a small number of important objectives were critical and would 'unlock' other issues. The Committee requested that these key objectives are highlighted in table (Appendix 1) for the next meeting and that this would be shared with Board as part of the Committee Summary. At present we believe the following objectives are the business and care critical items:

- Objective 3 - Capacity review to be completed by Meridian Consultancy by September
- Objective 4 - Stream patients effectively, finalise the Urgent Care Centre at PRH and address the Urgent Care Centre deficiencies at RSH by June
- Objective 5 - Complete workforce review or PRH/RSH A&E department and address 6pm-12am capacity shortfall by June
- Objective 6 - Plan to address capacity deficiencies occurring at the weekend addressing insufficient discharges by June
- Objective 8 - Realign SC & USC beds from April - October
- Objective 14 - Agree and implement the new bed profile in relation to the new nursing structure from April - October
- Objective 15 - Conclude arrangements to transfer 70 patients to community provision from April - October

…….. Chair
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- Objective 21 - Develop a trajectory for agency usage improvement by April

The table also illustrates the metrics Sustainability Committee is using to get assurance that real plans with detail and ownership are in place. As can be seen full assurance has not yet been received.

Other issues discussed:

Carter Review Update - Model Hospital – Informative presentation delivered by Keith Roberts, Senior PMO, which highlighted that in 2016/17 SaTH appeared in the lower quartile in a number of benchmarked areas indicating a good level of productivity and efficiency. By two strategic measures SaTH was an outstandingly efficient Trust, with the exception of the increase in agency tier 5 performance.

Sustainable Services Programme Update – received and noted. Overall status RAG rated Amber/Green. In seeking to understand the rigour of the community model, NHS England have requested further information from the CCG. This could lead to a potential impact on commencement of consultation process.

Mr Newman (NED) highlighted that previous deviations from budget have related to payroll, however it now relates to non-pay spend. Although there is some deviation, the FD assured him that he expects it to come in line by year end.

An assurance matrix was attached to the paper relating to business and care improvement objectives with a lead officer for each of the 36 objectives; Mr Deadman reported that this has been completed with a good level of rigour. The top 5/6 objectives are those of most importance and these will be regularly reviewed by the Exec Directors.

Mr Cronin (NED) highlighted the need to align capacity and prioritisation around the top 5/6 objectives.

The Chair suggested looking at the top 5/6 objectives through all legs of the four legged stool and reframe them for next year to ensure we are providing a level of scrutiny. The COO reported that NEDs have previously raised the importance of the four legged stool and she stressed the need of delivering the top 5/6 this year and also to look at for next year.

The DNMQ suggested the Board also have sight of an Quality Impact Assessment for the top 5/6.

Following discussion, the NEDs agreed to support the Exec Directors in grappling with these tough issues. FD to review the top 5/6 improvement actions for further discussion at the November Trust Board.
Action: FD Due: November 2017 Trust Board

2017.2/166 SUSTAINABILITY COMMITTEE ANNUAL REPORT 2016/17

The Sustainability Committee Annual Report was presented to highlight:

1. Assurance: The committee has received assurance that financial issues are well managed on a transactional basis and leadership from the finance function is strong and effective. Deviations are dealt with at Audit Committee.

2. Business cases: There is a need to get greater rigour over business cases. This will not only reduce the work load for people preparing these proposals but will also allow more efficient and effective approval and oversight.

3. Performance & Delivery: During the year the business managed to deliver, under the most difficult environment, the financial targets and core quality and safety objectives. This is a great achievement. However, in some areas we have seen a minor deterioration in some quality and safety issues. This is of severe concern to us. We need to find ways of financing and inspiring better performance. This will be achieved through the various business improvement proposals which the Executive team have developed.

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4. Ownership of Business improvement, business change and CIP programmes: While the Virginia Mason work is exceptionally successful we must be better at delivering agreed change programmes if we are to deliver our commitments to our communities. The committee is also keen to find ways of supporting people at all levels of seniority with the courage and leadership who are owning and driving our business improvement projects. Typically we have only delivered half of the quality, safety and financial benefits targeted. It may be plans are excessively 'heroic', and/or it may be we can be more effective at delivery of approved plans. To this end we are now looking for assurance that plans which have been approved are defined and owned. To do this we are using the following metric:
    - Have we defined the task?
    - Is there a plan?
    - Is there ownership of plan delivery?
    - Are we delivering?

5. With the support of the Executive the Committee is Green/Red profiling all business change and CIP programmes.

6. Reconfiguration of our Services: We need to reconfigure our services using the principles our clinicians and care staff recommend: We are content to deliver any solution which is practical and safe but we are dependent on political leaders finding some type of geographical compromise. Until that time the slow migration of specialist services out of the county will and should continue to organisations which are better able to run those services.

The Board specifically picked up the need for greater rigour over business cases. Mr Cronin (NED) suggested linking it to the Bereavement Line request, as highlighted in the Patient Story. He suggested the need to agenda items relating to innovation, creativity, etc.
Action: DCG

Following discussion, the Board RECEIVED and APPROVED the 2016/17 Sustainability Committee Annual Report.

2017.2/167 EMERGENCY PREPAREDNESS RESILIENCE & RESPONSE CORE STANDARDS

The COO presented a paper relating to NHS Emergency Preparedness, Resilience and Response (EPRR) Core Standards Assurance for 2017/18 which reported that provider organisations are required to undertake an annual self-assessment against the national EPRR core standards and rate their compliance. Individual ratings then inform the overall organisational rating of compliance and preparedness.

Once this process has taken place organisations are expected to take a statement of compliance to their Boards. This, along with the Core Standards assurance ratings and rectification plan should then form the submission to the Clinical Commissioning Group (CCG) and Local Health Resilience Partnership (LHRP).
The CCG will facilitate a formal calibration and formal compliance process via a Confirm and Challenge meeting on 19 October where the Deputy COO will present SaTH's assurance report findings.

SaTH compliance is rated as 'Partial' at this stage prior to NHS England and CCG scrutiny.

Following discussion, the Board:
- ACKNOWLEDGED the assurance submission and compliance level with associated work plan for approval
- Duly reflected the submission as having been sighted by the Trust Board in the published minutes of the Trust Board meeting for assurance to the CCG officers
- Ensured that the Core Standard level of compliance is acknowledged and published with the Trusts Annual Report, as per requirement.

Improvement

2017.2/168 WINTER PLANNING UPDATE

…….. Chair
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The COO provided an update and overview on the schemes within the 2017/18 Operational Plan that will contribute to safety and resilience over the winter period, as well as maintaining service delivery performance in line with the trajectory.

As winter approaches, it is necessary to ensure SaTH has enough bed capacity on both hospital sites to deliver the anticipated level of emergency activity, and keep both patients and staff safe.

Reconfiguration of the bed base
The present allocation of beds between Scheduled and Unscheduled Care does not meet demand - 22 Scheduled Care beds have therefore become part of Unscheduled Care; staff have already completed this realignment of beds to make that important change. The Operational Planning process identified a cohort of patients who did not need acute care but were unable to transfer home or to their existing care package arrangement. A programme of work is underway to implement the transfer of capacity equivalent to 50 beds. The beds closed, as part of the "SaTHatHome" service, will also re-open for winter capacity.
In making this change, the Trust can expect to realise a series of operational efficiencies as a consequence of there being reduced levels of outlying patients scattered across wards within the two hospital sites. This will improve length of stay for patients and therefore improve operational performance and flow.

Implementation of the SAFER (Red2Green) standard
Clinicians locally and nationally are agreed that there is a significant group of patients in hospital longer than they should be. The management of patient flow is an on-going and consistent challenge for the Trust, and the majority of acute Trusts in England.
A dedicated team solely focussed on the delivery of the SAFER Patient Flow Bundle, including the Red to Green process, are working with clinicians and managers to reduce non-value added time for patients and work to get them home sooner. By improving patient flow through the hospital, the Trust's EDs and emergency assessment areas will also flow more easily. This is being clinically led by the MD and DNMQ.

Increased community support provision/SATH2Home type service
Analysis of the length of stay of patients within the Unscheduled Care Group has shown that on average 65% of the Unscheduled Care bed base is occupied by patients with a length of stay of 11 days or longer. 86% of patients return to their usual place of residence following an inpatient stay. Therefore to support these patients to return to their home sooner and also create capacity to support increased demand over the winter period SATH will commission up to 50 packages of care. Discussions between SaTH and the Local Authority are ongoing and the final solution is to be agreed. In addition to the care packages, Shropshire Council will commission an additional 20 pathway 3 beds (nursing and residential homes), and 10 additional admission avoidance beds. Telford and Wrekin Council are to increase the number of enablement packages from November 2017.

Clinical Decision Unit (CDU) - PRH
Flow within the ED at PRH is compromised by the lack of a Clinical Decision Unit (CDU) which already exists on the RSH site. Each day there are up to 8 patients who would benefit from there being a CDU on site. Space has been identified and work is currently on going to provide a CDU at PRH.

Planning for winter 2017/18
SaTH consistently works above the nationally recommended bed occupancy levels and is currently at 97%, so therefore needs to be able to create some flexible capacity over the winter months. If the activity predictions are correct and length of stay remains unchanged then for the winter period, 1st November 2017 to 31st March 2018 we will require an additional 99 medical beds. The COO highlighted the importance of avoiding patients waiting in ED or 'boarding' on the wards; SaTH cannot be in that place again this winter.
This number of beds required has been ratified using the bed modelling tool that we are using for Sustainable Services and the Outline Business Case (OBC). Activity is based on actual discharged spells from November 2016 to March 2017, using current length of stay and occupancy levels. There is no activity growth assumed within this model.

…….. Chair
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Bed Gap for 2017/18
Following delivery of the Operational Plan bed changes during the winter period, capacity associated with those bed closures is utilised. This allows Day Surgery capacity to remain operational for elective care.

Patient Flow and additional Discharge Enablers
The paper reported that in addition to the schemes identified within the Operational Plan to support patient flow and winter resilience, there are other schemes that have been identified that will release bed capacity by reducing length of stay, facilitate timely discharge and support delivery of the ED trajectory. In order to implement these schemes, additional resource would be required, as outlined below:
The MD highlighted the challenges relating to patient flow and the need to ensure discharge processes are as good as they can be.
The DNMQ also raised the importance of putting patients at the centre of their care, empowering them to ask key questions and suggested this be introduced at the start of the patient journey.

Discharge Lounge - RSH
There is a requirement to improve the time of discharge on both sites to enable flow from the Emergency Department before 10am each day. Discharge from hospital requires the coordination of a number of disciplines which can lead to delays in a patient being discharged. Patients within acute beds can be delayed whilst awaiting transport, discharge summaries to be written, medication to be dispensed and external care to commence. Significant work is required to coordinate a timely discharge and therefore the creation of a Discharge Lounge on the RSH site would support this process. The objective is to improve patient flow by timely access to inpatient beds, with the aim to reduce trolley waits within the Emergency Department and Acute Medical Unit, improving patient experience, quality and reduced clinical risk.

Ambulance Handover
Achieving ambulance handover standards and ensuring patient safety becomes challenging during times of peak escalation. Additional nurse staffing has been funded by both Clinical Commissioning Groups to support timely and safe handovers. Also, the Emergency Department team are working with West Midlands Ambulance Service (WMAS) to implement a new model of how patients are handed over. This will be implemented from 9th October 2017 and has been piloted in other acute Trusts.

Weekend Discharge Team
The purpose of this scheme would be to support and enhance weekend discharge provision and planning by ensuring access to senior decision makers. This would contribute to patient flow across the medical bed base over 7 days by increasing discharges.

Financial implications
The cost of the winter plan is estimated at £2.4m which is in line with the expenditure in 2016/17. We have received £1m against the £2.4m, and the remaining £1.4m is within the financial recovery plan but still subject to discussions with Commissioners.

The CEO reported that the organisation monitors the situation daily with focus placed on issues which cause delays/bottlenecks such as scanners being out of action, etc,. Focus is being placed on ensuring patients who do not need to be in hospital are able to leave; the Trust is working hard with partners in the wider system to introduce solutions.
Action: COO to provide update of actions at November 2017 Trust Board

In the four years that the Chair has served the Trust, he felt this is the most prepared the Trust has been going into the winter period. The MD agreed with the Trust's preparedness but recognised the work ahead.
The WD highlighted that the Trust must ensure both patients and staff do not encounter a winter as in previous years and suggested that the plans in place provide some confidence.

Mr Newman (NED) highlighted that D&V is hitting the population; the DNMQ reported that some work has been undertaken with regard to D&V however her concerns lie with Flu.

…….. Chair
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Following discussion, the Trust Board NOTED the contents of the winter plan update which provided an overview of the schemes within the Operational Plan that will contribute to increased resilience over the 2017/18 winter period.

Services in the Spotlight

2017.2/169.1 TEMPORARY SUSPENSION OF NEUROLOGY OUTPATIENT SERVICE FOR NEW REFERRALS

Further to previous discussions of services in the spotlight, the COO provided an update relating to the temporary suspension of the Neurology outpatient service for new referrals.

The Neurology Service at SaTH has for many years been challenged in terms of delivery due primarily to workforce limitations which led to patients waiting on average 30 weeks for a first out-patient appointment at the start of 2017. This position was further exacerbated due to the departure of two specialist nurses who provided additional clinical support in out-patient follow up capacity. Following discussions with Commissioners the service closed to new referrals from 28 March 2017 for a period of six months to ensure patient safety by allowing SaTH to prioritise addressing the backlog position, specifically new patients in the first instance, and then those past their maximum follow up wait time. During this time, Commissioners agreed to work jointly with SaTH to identify and implement a sustainable model for the future delivery of Neurology services.

There are currently two substantive general Neurology consultants in post against a budgeted position of 3.80 wte, leaving a shortfall of 1.8 wte. The national average position is one Neurologist per 80,000 people which would equate to 6 wte for SaTH's population. Despite numerous efforts to secure additional consultant staff this has not proved successful. One locum Doctor was employed to provide additional support to the service from April whom left the Trust on 10 August. A further locum was secured from 4 September 2017 and is now supporting the service.

Additionally, the Trust successfully recruited two specialist nurses to support the Multiple Sclerosis (MS) service. However, in July 2017 the more experienced of the two MS nurses resigned from post, subsequently leaving the service at the end of August 2017. The Trust is currently advertising for a replacement post.

The following points are the key risk areas:

- Patients currently waiting at 15 weeks for a first outpatient appointment, having originally waited at over 30 weeks prior to the suspension of new referrals;
- Securing substantive consultants given the national shortage;
- Securing a locum consultant within capped rates;
- Managing the levels of demand once the service reopens the front door to new referrals;
- Retaining and recruiting Specialist Nurse provision;
- Patient safety risk for those patients waiting excessively to be seen and/or reviewed. A series of actions have been undertaken to mitigate any risk

To mitigate the clinical risk associated with the delays in time to be seen, it was agreed to close the service to all new Neurology referrals. Referrals stopped being received by SATH on 27th March 2017 for a period of six months. Following recent discussions, it has been agreed between SaTH and Commissioners to continue with the closure to new referrals for a further three to six months to enable commissioners to complete their work to address the shortfall in capacity for Neurology services above the levels that can be provided by SaTH. This may include purchasing capacity from alternative providers and/or the implementation of alternative clinical pathways which will be developed in partnership with SaTH and other local providers.

A Task and Finish Group, consisting of commissioners from Shropshire, Telford & Wrekin and Powys was established to identify options for the development of a sustainable Neurology service for the local population.

A full review of all viable options was considered by the Task & Finish Group. The preferred option by all was to explore the potential for the development of a 'hub and spoke' model with nearby Tertiary Centres. Discussions were held between SaTH and these service providers however, despite some initial engagement, this proposal has not been supported. Further to this, local commissioners requested the submission of a proposal from SaTH about the

preferred option for delivery and the level of capacity that could be provided by the current Neurology service. Commissioners have requested similar information from other neighbouring Trusts. We have submitted a proposal that states our preferred option for delivery would be a hub and spoke model which the Trust has not been successful in securing with a request to commissioners that they explore this option with providers directly. If this model is not achievable, then the Trust's only option is to provide a service with capped levels of activity whereby our demand is reduced to match our capacity. The proposal also included a request to work in partnership with local commissioners to define the service model required from the specialist nursing teams for neurology over the next few months to ensure their sustainable delivery.

To support this process, an internal review is being undertaken of the current MS caseload and working practices to determine what elements of service absolutely must be delivered, what elements can be stopped and what elements could be delivered via alternative pathways. The MS nurse in post is also meeting with her colleagues across the West Midlands to understand working practices in other Trusts.

A joint statement from all commissioners and the Trust has been developed for patients, the public and GPs to inform them of the current service status and the extended closure. This is currently with commissioners and expected to be released on Friday 22 October 2017.

At the Telford and Wrekin Commissioning Board in September 2017, the preferred option for future delivery of neurology services was identified as services being delivered from one provider. Scoping of this option will now take place by the commissioning body. Shropshire Commissioning Group and Powys Local Health Board have indicated support to SaTH's proposal that they continue to deliver neurology to the capacity they have available.

The next steps as agreed with Commissioners are as follows:

- To actively monitor activity and report weekly the patient waiting list position both internally and to commissioners. The Board members were assured that patients are not sitting on a waiting list; the commissioners offer them the first available appointment.
- To await the outcome of the commissioner response to the proposal submitted by SaTH as outlined above, further to their internal discussions;
- To work with commissioners to develop and implement alternative clinical pathways in an effort to reduce demand on acute services;
- To complete the MS service caseload and workload review by mid October 2017;
- To recruit into the vacant MS nurse post;
- To publish a joint public statement regarding the current status of the service;
- Further to receipt of commissioner feedback on the submitted proposal in September a report will be provided to Board outlining the future plan for Neurology Services.

Dr Weiner (NED) enquired if the Trust has a responsibility for new referrals as he was concerned that they may be slipping through the net. The CEO assured him that if a new referral has been referred to an alternative provider the patient becomes their responsibility, although SaTH would offer to see them as a follow-up.

Mr Cronin (NED) questioned the options of both the hub and spoke model and capped activity and what these would mean in practice. The COO reported that the capped model relates to a set number of referrals that could be received against the organisations workforce profile; the key is for patients to be seen as early as possible. The CEO reported that the Trust would not want a capped service and would look to Tertiary Centres to assist.

Following discussion the Board was informed that the Neurology Service will remain closed to new referrals for a further three to six months. SaTH have advised Commissioners of the capacity they can deliver with regards to Neurology Services and advised they would wish to continue the service to the level of demand that the capacity can support.
SaTH are committed to working with commissioners to identify alternative pathways of care and new ways of working to support the demand on Neurology Services.

The Board NOTED the updated provided on Neurology Services.

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On a related note, Mrs Mingay (D.NED) asked if exit interviews were provided to the staff members that left employment at the Trust. The WD confirmed that this is offered to staff, along with a survey, but completion is relatively poor. Mr Newman (NED) suggested the Trust should make this mandatory. The WD agreed to investigate further.
Action: WD

2017.2/169.2 MID-TERM REVIEW OF MIDWIFERY LED UNITS

The DNMQ advised that the Women & Children's Care Group's strategic aim is to comply with Better Births requirements so we don't have unwarranted variation and can fully support patient choice. The W&C Care Group is completely supportive of maintaining the MLUs but it has to be done in a safe and sustainable way - we cannot compromise patient safety. She advised that the Trust has appointed 20.20wte into 20.67wte vacancies and most of the new starters will commence during late October so that currently there are still 17.6 WTE vacancies until staff take up their posts. This does not include the additional staff required to meet the requirements of Birthrate Plus (around a further 36wtes)

It is important to note that all the MLUs are still open and functioning but Bridgnorth, Ludlow and Oswestry are not currently providing inpatient services, although an on-call system for home births is in place. Both Shrewsbury and Telford MLUs are still providing these services. There have been approximately three additional births per week in the Consultant Led Unit at PRH.

The MLU engagement to date is described in the paper with an outline of engagement events and attempts to reach out to mothers. During the first three months of the suspension of some services one formal complaint has been received although this was prior to the period of the suspension. There have been no complaints from the West Midlands Ambulance Service (WMAS) and there has been no increase in the number of babies born before arrival. The paper also described the ongoing CCG Review looking at the longer-term future of maternity services and the DNMQ confirmed that the transitional model put in place by SaTH did not pre-empt the CCG Review which was engaging with the public for their views on future options. This should be completed by early October. Dr David Lee (NED) noted that the service could re-open with a newly approved configuration following this review and as we become aware of the preferred options, we will need to look to ensure that safety is a key consideration

There was discussion about the disappointing findings about communication from the survey sent out to almost 600 mothers or mothers-to-be. Paul Cronin (NED) raised the issue of mothers finding out about the change via the press. The DNMQ confirmed that the Care Group have learned many lessons from this experience and would be drawing up an action plan to improve its communication when all the feedback was received. It was noted that the response rate was low - only 14% but it was noted that the survey had not yet closed.

The CEO reported that he had travelled to Oswestry, Bridgnorth and Ludlow to answer questions and provide assurance to those communities about promoting rural solutions/care.

Brian Newman (NED) noted that the Board had a clear intention to re-open services at the end December and asked if it would be possible to bring that date forward? The DNMQ said that she would not recommend this as we are not in a position to understand all the variables.

The Chair noted that when the Board discussed this proposal in June it was principally about patient safety; however this paper suggests communication wasn't good enough and the service needs to ensure it has a clear engagement strategy in place although it is recognised this will take a while to be in. So although the patient safety issue has been progressed, the engagement approach has not been as good as it should be and will need to improve.

It was noted that the Head of Midwifery had issued an open invitation to meet with anyone with concerns and although three members of the public and two staff had responded; the three members of the public declined or did not attend offered meetings. The two members of staff did attend and simply wanted to be involved in the process moving forwards.

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Based on this evaluation, the Board APPROVED the continuation of the suspension for a further three months whilst awaiting the outcome of the CCG MLU Review, subject to a clear action plan arising from the feedback received to date, with a view to re-opening the Units on 1 January 2018 in order to allow for
(i) the Trust Board to consider the outcome of the CCG MLU review at the earliest opportunity (planned October 2017)
(ii) New staff to join the maternity service-late October
(iii) Consideration of the Birthrate Plus Business case to support investment in staffing resources

2017.2/169.3 SERVICE CONTINUITY PLAN FOR URGENT & EMERGENCY CARE SERVICES

The medium and long term vision for the health service within the county is being developed through the NHS Future Fit programme. This programme envisages a new model of sustainable safe care including a network of Urgent Care Centres (UCC) supported by a single Emergency Centre.

The COO provided the Trust Board with a progress update which reported that the Trust has been engaging with its stakeholders to develop the service continuity model in the event that it cannot sustain two Emergency Departments (ED) due to reaching the tipping point in either its Consultant or Middle Grade workforce.

Two stakeholder sessions were held on 16th June 2017 and 11th August 2017. The stakeholder group was joined by NHS Improvement and CQC representatives in August.

Stakeholder Workshop 16th June 2017:
At this workshop stakeholders were reminded of, and supported, the contingency plan to:

- Implement an Urgent Care service co-located with the existing ED department at PRH;
- Close the PRH A&E to ED classified patients during the night (20.00 – 08.00);
- Use the Sustainable Services Programme (SSP) principles of ED and UCC services as the basis for planning activity;
- Increase capacity at RSH to manage the additional 'ED' patients and those needing admission from PRH during the night;
- Address pathway challenges at PRH overnight e.g. Women and Children, Stroke, Head and Neck.

Following this workshop further activity analysis was undertaken with the specialty teams to enable them to model the impact on an overnight closure on the following services:

- Stroke;
- Head & Neck;
- Cardiology;
- Women & Children (mainly paediatrics);
- Acute Medicine.

Stakeholder Workshop 11th August 2017:
At this workshop each of the specialty teams presented the impact of an overnight closure on their respective service pathways, with options to maintain service delivery including risks and opportunities.
There are no easy solutions to mitigate the impact on specialty service delivery and West Midlands Ambulance Service (WMAS) through a reduction in opening hours of the ED at PRH. Reducing the workforce risks in ED will potentially adversely impact on specialities that have previously consolidated their workforce. Also, patient experience and access is likely to be compromised.

The stakeholder group identified the main risks to delivery of the service continuity plan as:

- Ability to deliver this solution within the 3 month timeframe set by the Board;
- Cost;
- Workforce availability; particularly for the Urgent Care Centre and the Paediatrics Emergency (non-trauma) team.

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On this basis it was agreed to establish Task & Finish Groups to further develop the preferred contingency options in the following areas:

- Urgent Care Centre – key staffing skill set to be identified;
- Paediatrics Emergency (non-trauma) team – focus on workforce risks;
- PRH ED staffing – risks and opportunities
- Communications and engagement – to develop the ideas presented during the workshop.

Work on the areas described above has commenced and early work has confirmed that this contingency plan could not be delivered within a 3 month timeframe due to the lead-in time to recruit to the UCC service and Paediatric Emergency (non-trauma) team. There are also significant concerns that this workforce is available.

As this remains the preferred option and is aligned with the future direction of urgent care services as part of sustainable services, an interim solution which can be delivered within 3 months will be discussed with the stakeholder group at its next session on 13 October 2017.

Mrs Mingay (D.NED) queried the likelihood of identifying a solution within 3 months. The COO reported that there are potential solutions but they would not be the preference of the public.

The best solution is to keep both EDs open and it is in the gift of the system to support SaTH; for everyone outside of this county to support those within it.

Following discussion, the Board RECEIVED and NOTED the progress with the development of the service continuity plan. There is an expectation that an interim plan to meet the Board's timeframe for implementation of 3 months can be met. This will come back to November Board for approval along with the preferred option.
Action: COO Due: November 2017 Trust Board

2017.2/169.4 QUESTIONS FROM FLOOR

The Chair opened the floor to questions particularly relating to the above themes.

The meeting re-convened at 3.00pm

Performance

2017.2/170 TRUST PERFORMANCE REPORT

The FD presented the Trust performance against all key quality, finance, compliance and workforce targets at M5 2017/18 (August 2017).

2017.2/170.1 MORTALITY

The MD reported that the Trust tracks a number of measures of mortality. The Hospital Standard Mortality Ratio (HSMR) performance has been consistently below the Hospital Episode Statistics (HES) peer since January 2016. There was a spike over the winter period (January) but this reduced down by July 2017. Also, since December 2015, the In-hospital Summary Hospital-level Mortality Indicator (SHMI) has been consistently below the HES peer.

The MD drew focus to the spikes which tend to fall during the winter months; he therefore highlighted the importance of prevention of flu as respiratory conditions, including pneumonia and septicaemia, are causes of death.

Mr Cronin (NED) questioned if the peer comparator is a fair comparison and suggested the inclusion of a narrative under the graphs.
Action: MD

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2017.2/170.2 OPERATIONAL PERFORMANCE

The COO provided an update, with particular focus to:

RTT performance - The Trust actual incomplete performance for August was above trajectory at 91% and the 92% target was also achieved at end September 2017.

Cancer and Diagnostics –
- 2 week wait – 93.3%
- 31 day – 99.6%
- 62 day – 88.0%

Urgent Care Update (A&E Trajectory) – August's actual performance was 76.6% against a target of 84.6%. The COO reported there had been a different level of demand for patients being brought to hospital by ambulance. It appears the 111 call-out has resulted in a higher conversion rate; commissioners are investigating capacity as the hospitals purely do not have sufficient physical space. Dr Lee (NED) suggested requesting feedback from the 111 provider to understand this more carefully. **Action: COO**

The Chair enquired what A&E under-performance means to patients. The COO reported that overall patient experience is compromised as patients are being cared for for far too long which contributes to patients staying in hospital for longer. Mrs Mingay (D.NED) highlighted that whilst the target and patient experience are both being monitored, she suggested 'staff experience' also be monitored. The Board agreed this approach.

The DNMQ assured the members that quality assurance processes are in place for patients waiting 4 hours or more, such as pain relief, correct mattresses, etc.

The CEO informed the members of the following delivery of improvement:
- Introduction of a Clinical Decisions Unit (CDU) at PRH from 1 October 2017 so patients can continue to receive treatment through the ambulatory model;
- GP streaming will also be in place from 1 October 2017;
- Ambulance handover programme to be launched on 9 October 2017;
- Fit to sit implemented on both sites from September – impact on 4-hour standard to be monitored
- Operational teams on shop floor to assist with delays
- Day before discharge planning to be monitored with Heads of Nursing

2017.2/170.3 WORKFORCE

Sickness / Absence – The WD reported a slight decrease in the sickness absence score at 4.12% for August 2017. She reported that some areas have significant absences; this affects all four legs of the stool.

Appraisal / Training – The WD reported a slight decrease in the completion of staff appraisals for August 2017 at 87.68%, and a slight decrease in statutory training compliance at 73.54%.
A recovery plan has been developed relating to the previous year's appraisal and statutory training totals with a view to improvement in future targets and stretch-targets.

2017.2/170.4 QUALITY & SAFETY

The DNMQ presented a separate Quality performance report to provide the Board with assurance relating to the Trust's compliance with quality performance measures during August 2017 (Month 4 of 2017/18).

VTE Performance – The Trust continues to report over 95% of patients admitted to the Trust who receive a VTE risk assessment (95.2% achieved during July 2017). This is monitored at Care Group level at Governance Boards and through the Confirm and Challenge meetings.

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Clostridium Difficile Incidence – Three C diff cases were reported during July and one case during August bringing the year to date total to 12 against an annual target of 25.

Avoidable Pressure Ulcers – One Grade 2 and one Grade 3 avoidable pressure ulcer were reported during August – these have been investigated and actions plans developed and monitored. Significant patient safety incidents that do not meet the revised SI framework are managed as High Risk Case Reviews (HRCR) therefore some Grade three and four pressure ulcers and some Falls resulting in fractures will not be reported as SIs but will be reviewed to ensure any learning is recognised and shared in order to observe trends and potential actions which may reduce risk going forward.
Mr Cronin (NED) highlighted the persistence of reds around avoidable Grade 2 / Grace 3 pressure ulcers; and enquired if there are any reflections on what is not being done and what can be done to turn the reds back to green.
Dr Lee (NED) reported this may be due to the increase of temporary staff on wards which are already over-bedded, etc. The DNMQ and Dr Lee agreed to investigate further and add a 'Deep Dive' to the Quality & Safety Committee.
Action: DNMQ

MRSA Screening (non-elective) - The Trust achieved the MRSA (non-elective) screening target during August with 95.6% against the performance indicator over 95%.

Patient Falls - The Trust reporting is below the national benchmark and generally has a reducing trend. During August there was one fall reported as a Serious Incident

Serious Incidents – The Trust reported 5 SIs during August 2017. All are in the process of being reviewed.
Following discussion at the July Trust Board meeting, the DNMQ assured the Board that an update relating to 'Learning from Moderate and Serious Incidents' was included in the Quality Performance update.

Safeguarding Children, Young People and Adults – In August there were nine safeguarding adults concerns raised involving the Trust; five raised by the Trust and four against our services. All are being investigated.
The Chair reported that he would be interested to hear of the learning. **Action: DNMQ to feedback to Chair**

Mixed Sex Accommodation (MSA) Breaches - The Trust is not compliant with MSA requirements due to the number of patients that wait for more than 12 hours (local target) to be transferred from our Critical Care Units. There were 31 patients who waited more than four hours to leave our intensive care areas once deemed well enough to do so. This issue is being monitored by the Quality & Safety Committee.

Additional Patients -– Due to the increasing number of patients being admitted to a hospital bed and the increasing numbers of patients using the Emergency Department, there are occasions when there are insufficient beds available for new admissions which results in additional patients needing to be placed on wards. The frequency of this has increased and is happening on a regular basis. There have been 114 patient episodes which is intolerable. A number of steps are in place to control this including:

- Realignment of wards
- Hospital Full Protocol outlines plans for escalation and steps which need to be taken to ensure safety of patients using a balance of risk.
- Discharge Policy
- Clinical Site Managers regular reviews and de-escalation plans
- Regular quality checks by matrons, and Datix submitted for every incident
- Risk assessments and Impact Assessments for every patient to ensure areas are safe for patient use and actions put in place to promote patient safety

Complaints & PALS – Fifty formal complaints were received in August 2017; Unscheduled Care continues to receive the most complaints which is in line with levels and nature of activity. Clinical treatment and communications remain the top subjects with complaints that cover a range of issues and specialties. Inadequate discharge planning continues to be an issue raised in a number of complaints.
The DCG agreed that the recurring theme relates to the amount of times patients are cancelled due to capacity being unable to meet demand.

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Complaints in Women & Children's Care has decreased slightly from previous months.

2017.2/170.5 FINANCE

The FD reported on the Trust's current financial position, as per Sustainability Committee summary at minute 2017.2/165.
At the end of Month 5 the Trust recorded a deficit of £10.862 million; £4.974 million worse than plan, before the receipt of STF. The consequences of not receiving STF funding in Quarter 2 and the impact this would have on cash is concerning. Given the current overspend the expected position at the end of 2017/18 is now £18.004 million deficit. The delivery of actions identified as part of a Recovery Plan could result in a revised outturn position of £10.497 however £4.030 million of the schemes identified were rag rated red risk.
The FD reported that he was due to meet with the Regional Director of Finance to talk through actions to recover the position.

Expenditure
Pay
To date the pay spend amounted to £101.340 million against a plan of £99.025 million resulting in an overspend of £2.315 million, predominately due to the continued use of agency and non-delivery of key CIP schemes.

A significant element of the pay overspend relates to the continuing use of agency above those levels planned and continue to spend well in excess of the Agency Ceiling set by NHSI. Total agency spend for April – August 2017 amounted to £7.718 million; £2.888 million above the Agency Ceiling set by NHSI. There are actions being taken and NHSI are focusing on reasons for the increase.

Non Pay
To date the non-pay spend amounted to £46.807 million against a plan of £44.779 million resulting in an overspend of £2.028 million.

Following previous requests, the FD informed Mr Newman that the finance data had been broken down into action, variance and month-to-date, but the updated version had unfortunately been omitted from the papers. He assured the members that it would be included from November onwards.

Following discussion, the members RECEIVED and APPROVED the Trust Performance Report.

2017.2/.171 Q1 COMPLAINTS & PALS REPORT

The DCG provided an overview of the formal complaints and PALS concerns received by the Trust during Q1 (April to June 2017). A total of 144 formal complaints and 392 PALS contacts were received during Q1.

Key themes
Each complaint may be multi-faceted, particularly where the complaint relates to inpatient care that involve the multidisciplinary team or events over an extended period of time. Each issue identified in the complaint is recorded which means that the total number of issues will exceed the number of formal complaints received.

Actions and Learning from Complaints
The Trust recognises the importance of learning from complaints and using the valuable feedback obtained to reflect on the care we provide and take steps to improve services for future patients. When service improvements are identified following investigation of a complaint, staff develop action plans that are monitored until complete. Some of the significant changes made as a result of complaints received are as follows:

- Use of treatment room for boarding to be reported on Datix
- Risk relating to use of treatment room for boarding to be reviewed
- Staff to ensure they provide up to date waiting times
- Complaint to be used as case study in junior doctor training
- Staff to ensure they document all communication with relatives

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- Housekeeper numbers to be increased in A&E
- Regular audit of hand hygiene in Ophthalmology
- All consent forms to be available in each clinic room
- Booking times for patients to be reviewed
- Weekly checks to be carried out by bookings team to review all patients not yet on lists
- Individual training requirements for staff to be addressed
- Complaints shared with relevant staff for wider reflection

50% of complaints closed in quarter one had an action plan completed. From quarter two, the complaints team are sending out monthly reports to each of the care groups to let them know which responses still require action plans and to seek confirmation of completed action plans

Patient Advice and Liaison Service (PALS)
PALS is the first point of contact for patients and relatives wishing to raise concerns about their care and with prompt help these can often be resolved quickly. The majority of contacts are by telephone or in person. During quarter one the PALS team handled 392 contacts. The DCG reported that she would like to see the number of complaints decrease and the number of PALS contacts increase, going forward.

Main themes arising from the concerns raised via PALS
The majority of PALS contacts relate to concerns about appointment issues (primarily appointment availability, waiting times and cancelled appointments), and communication (primarily with the patient).

Bereavement Service
The DCG reported that the Bereavement Service has continued to work closely with the End of Life (EoL) Care team during quarter one to enhance the care and support given to grieving families. During quarter one the Registrar of Deaths has increased her presence on site to three days a week. The feedback from relatives continues to be very positive in relation to this. Discussions have been held recently about extending the service to include registering births as well and the Bereavement Service is working with the Maternity Service to facilitate this.
In addition, the team have been working with the End of Life Care team to develop and pilot a sympathy card to be included in the pack issued to the family.

The DCG reported that agreement has recently been reached with the EoL team for the PALS team to make phone calls to relatives who have expressed a wish for further discussion after the death of a family member in hospital. PALS staff have been trained to make these calls to allow the EoL team more direct time with patients and families.
Following discussion the Board REVIEWED the report and NOTED how feedback received is being used to improve services and encourage shared learning to provide a better patient experience.

QUALITY – SAFEST & KINDEST (OUR VISION)

Dr David Lee (NED), Chair of the Sustainability Committee, presented the following key summary points from the Quality & Safety Committee meetings held on 24 August and 20 September 2017.

He reported that clinical site visits are held prior to each meeting and reported that he has already seen an impact from the VMI and Lean processes.

2017.2/172.1 SUMMARY OF QUALITY & SAFETY COMMITTEE MEETING HELD 24 AUGUST 2017

1. Whilst recognising the pressures on the hospitals, the Committee remains concerned with the use of "additional beds" on wards at times of high demand. Recent research has again highlighted the impact of lower staffing levels, linking "care undone" to readmission, morbidity and mortality. This operational approach must not become accepted as the norm within Shrewsbury and Telford Hospitals

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2. The Committee received a very positive report from the Women's and Children's Care Group and were pleased to hear that recruitment to midwifery posts has been very successful. Obstetricians reported that MBRace have accepted representations regarding the inaccuracy of the total numbers of births per year within SaTH. This significantly affects some of the comparisons made within the report. If corrected they would present a much more favourable comparative picture.

3. The August meeting represented the Committee's first "deep dive" with a Care Group, in this case Scheduled Care. The formal meeting was preceded by a visit to ward 22 (Trauma and Orthopaedic), the ward manager's development plans for the ward were strongly based upon her "Lean for Leaders" training

4. The publication of the "Getting it Right First Time" report for General Surgery offers opportunities for patient safety improvements, the removal of waste and reduced costs. It sets out 20 recommendations from Mr John Abercrombie, a leading colorectal surgeon and author of the GIRFT national report into general surgery in England. Mr Abercrombie has made recommendations that would particularly benefit patients by helping to shorten the time they spend in hospital and to reduce complications that can lead to readmissions. Implementation of such recommendations would generate savings for hospitals by freeing up beds for other patients. Nationally, this could deliver efficiencies of over £160m each year. The recommendations were developed by reviewing data from all acute hospitals in England and visiting 50 general surgery departments. The recommendations have also been fully endorsed by the Royal College of Surgeons.

2017.2/172.2 SUMMARY OF QUALITY & SAFETY COMMITTEE MEETING HELD 20 SEPTEMBER 2017

End of Life Care

The Committee received a report looking at progress with respect to the management of patients at the end of their lives. Positive progress has been made since an audit in 2014 but the Committee felt that:

- Delivering exemplary end of life care is the business of all staff;
- They need to be supported in this through the availability of service information and best practice guidance;
- This should be enabled by a clinically led team that includes physicians with an interest in palliative care; and
- There should be strong integration with primary care, community services and hospice services within a system wide approach that works for patients and their families.

Enabling Discharge

One of the key Board Assurance Framework risks monitored by Quality and Safety includes the risk of failing to manage simple discharges effectively.

The SaTH Board has previously supported the implementation of more effective, clinically safe, discharge processes to improve patient flow. The Quality and Safety Committee received a paper relating to improving weekend discharge. This incorporated a section on the implementation of criteria led discharge.

At present, there is a strong understanding of the scope of the issue and the obstacles that need to be overcome to achieve improved approaches to discharge. Solutions to overcome these obstacles are less evident. This was emphasised on our clinical site visit to ward 32 (short stay medical unit) where we heard that:

- Working with a supportive consultant criteria led discharge is possible;
- There are requirements to issue a discharge note to the GP and to request discharge medications from the pharmacy. This causes problems as the pharmacy will not process "next day" orders; and the prescription request to the pharmacy must be sanctioned by a Dr as the prescriber. This process of sanctioning or effectively "pushing the button" on the system also creates the discharge note.
- Work is urgently required to develop and trial solutions in advance of winter pressures

Tier 5 Agency Use

The Committee received a briefing on current nursing staff levels and a proposal to stop using expensive agencies (Tier 5 agencies) to provide temporary staff. As presented, whilst reducing agency spending is a fiscal requirement, further work is required to mitigate the risk of embargoing those more expensive agencies. The Committee again highlighted the desirability of using bank staff who are familiar with the hospitals and SaTH ways of working as opposed to agency staff who are less likely to be. This may require the movement to weekly pay for bank staff already identified as a means of attracting more staff to work on the bank.

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Learning from Death

In keeping with the national requirements, SaTH is implementing a programme of mortality reviews across its care groups. This programme needs to meet national expectations, provide high quality learning and make best use of clinical time. The proposed SaTH approach uses a slightly different assessment methodology than the nationally suggested one. This is currently acceptable but there is an expectation that, over the next few years, a national approach may be mandated. The Quality and Safety Committee will oversee the process and seek assurances with respect to its implementation and outcomes. The Medical Director's proposals for the scheme were approved.

The Chair enquired if Dr Lee (NED) felt reassured of i) the Trust's RCA processes and ii) kindness processes. Dr Lee highlighted the importance of having a methodology to learn from adverse incidents. Although he feels SaTH has the training at the right level, sometimes it does not feel that the RCAs are drilled down enough. He assured the Board that the Quality & Safety Committee will monitor this. Dr Lee also agreed that the Q&S Committee would do a sweep through to ensure all functions are 'being kind'.

The CEO requested reassurance around Falls for the frail and elderly which was picked up following a Coroner's case as a risk assessment was incomplete. The members agreed the process of assessing risks is required, along with ensuring trained staff are on the wards.

The Chair thanked Dr Lee for his leadership and, following discussion the Board RECEIVED and APPROVED the Quality & Safety Committee summaries.

2017.2/173 CQC NATIONAL ADULT INPATIENT SURVEY 2016 (*Presentation attached to Minutes*)

The DNMQ informed the members that the adult inpatient survey is the most important survey of the year; it is circulated during September/October each year to capture a cohort of patients from July.

A paper was presented which reported that the Trust surveyed 1250 patients during the month of July 2016. For this survey SaTH achieved a response rate of 53% which is 9% higher than the national average.

Key facts:

- The 2016 results demonstrate that SaTH showed a statistically significant improvement since 2015 for 3 questions (noise at night, cleanliness of ward/room and cleanliness of toilets and bathrooms); these were all areas the Trust has worked hard to improve over the last year.
- Two questions showed a statistically significant decline since 2015 (length of time on waiting list and during hospital stay and was patient asked to give views on quality of care); these areas will be included in the focus for the Trust's action plan this year. It will also be included as a question in the on-going local quarterly inpatient survey.
- SaTH performed 'worse' than other Trusts in one question relating "Did you get enough support from health or social care professionals to help you recover and manage your condition"
- All other individual questions indicated that SaTH performed 'about the same' as other Trusts

In summary the results for the 2016 National Inpatient Survey are very positive. All eleven areas surveyed indicate that SaTH is "About the Same" as most other Trusts in England this year, which remains consistent with the 2015 results.

The 2015 survey results saw 19 areas with statistically significant improvements compared to 2014. With so many improvements it was positive to see even more in 2016.

The Chair queried what improvements should we see next year against the inpatient survey and the staff survey. The DNMQ suggested 'improving the wellbeing of staff' as one of the areas of improvement.

The CEO enquired how feedback from patients is captured; and Dr Weiner (NED) questioned the understanding of what our communities are seeing. The DCG reported that workshops are being held and the Trust's vision is to become exemplary with regard to engagement which is currently work in progress. The members agreed it is

fundamental to becoming the safest and kindest organisation.

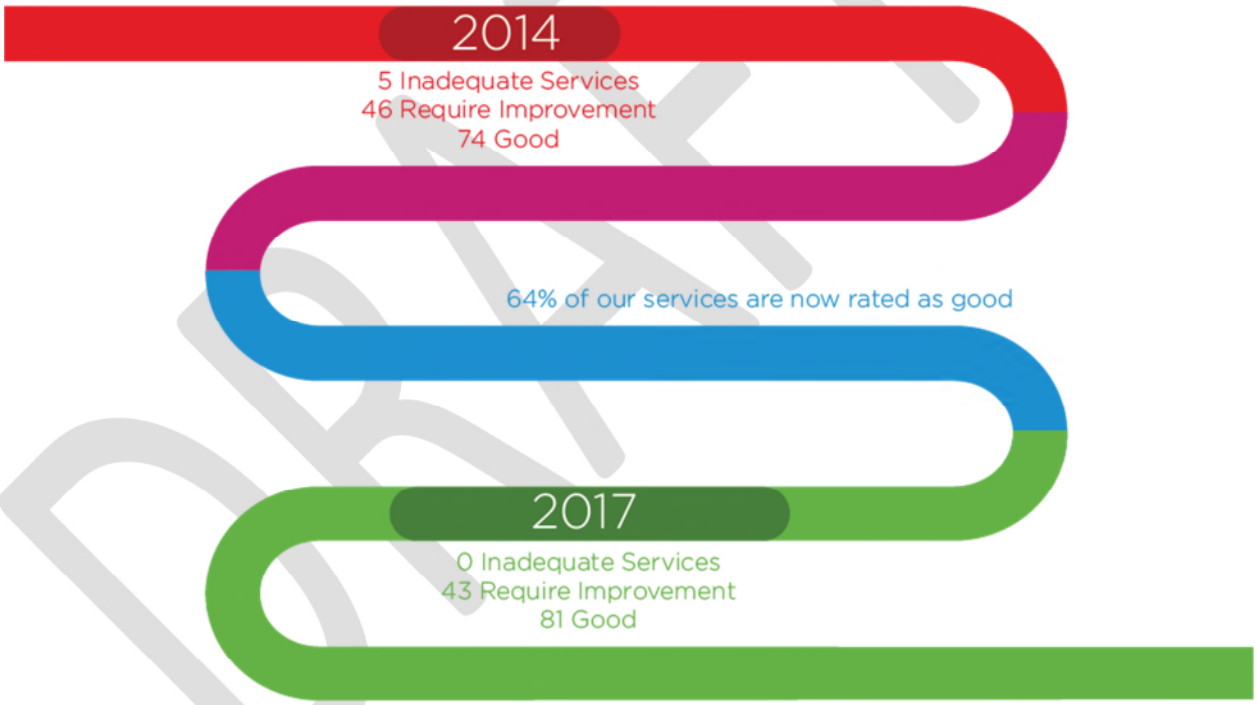
Mr Cronin (NED) highlighted the measure where SaTH performed worse than other Trusts relating to "Did you get enough support from health or social care professionals to help you recover and manage your condition"; he enquired if the Trust has an understanding of the contributory factors relating to this.
The DNMQ agreed to look into this and bring league table back to Board.
Action: DNMQ Due: November 2017 Trust Board

The DNMQ reported that a composite Trust Improvement Plan is being developed which will progress through the Quality & Safety Committee; she agreed to present it to the November Trust Board.
Action: DNMQ Due: November 2017 Trust Board

Following discussion, the Board APPROVED the findings of the Adult Inpatient Survey.

2017.2/174 CQC INSPECTION REPORT 2016 (*Presentation attached to Minutes)*

The CEO provided a presentation relating to the CQC Inspection undertaken at SaTH during December 2016. Although SaTH received an overall "requires improvement" rating, the CEO highlighted the following since the 2014 inspection:



Areas of Outstanding Practice highlighted by Inspectors:

- We have rolled out the End of Life Care "Swan Scheme" across the Trust which included a Swan Bereavement Suite, Swan Rooms, boxes, bags and resource files for staff.
- The Palliative Care Team has developed a fast track checklist to provide guidance to ward staff on what to consider when discharging an end of life patient.
- The Virginia Mason Institute (VMI) designed and developed its systems to become widely regarded as one of the safest hospitals in the world. The Trust has embraced these methodologies and in partnership with VMI, they have developed new initiatives within the hospital. They used the model to create the Transforming Care Institute (TCI). TCI wants an effective approach to transforming healthcare by coaching teams and facilitating continuous improvement. However, there were also areas of poor practice where the trust needs to make improvements.

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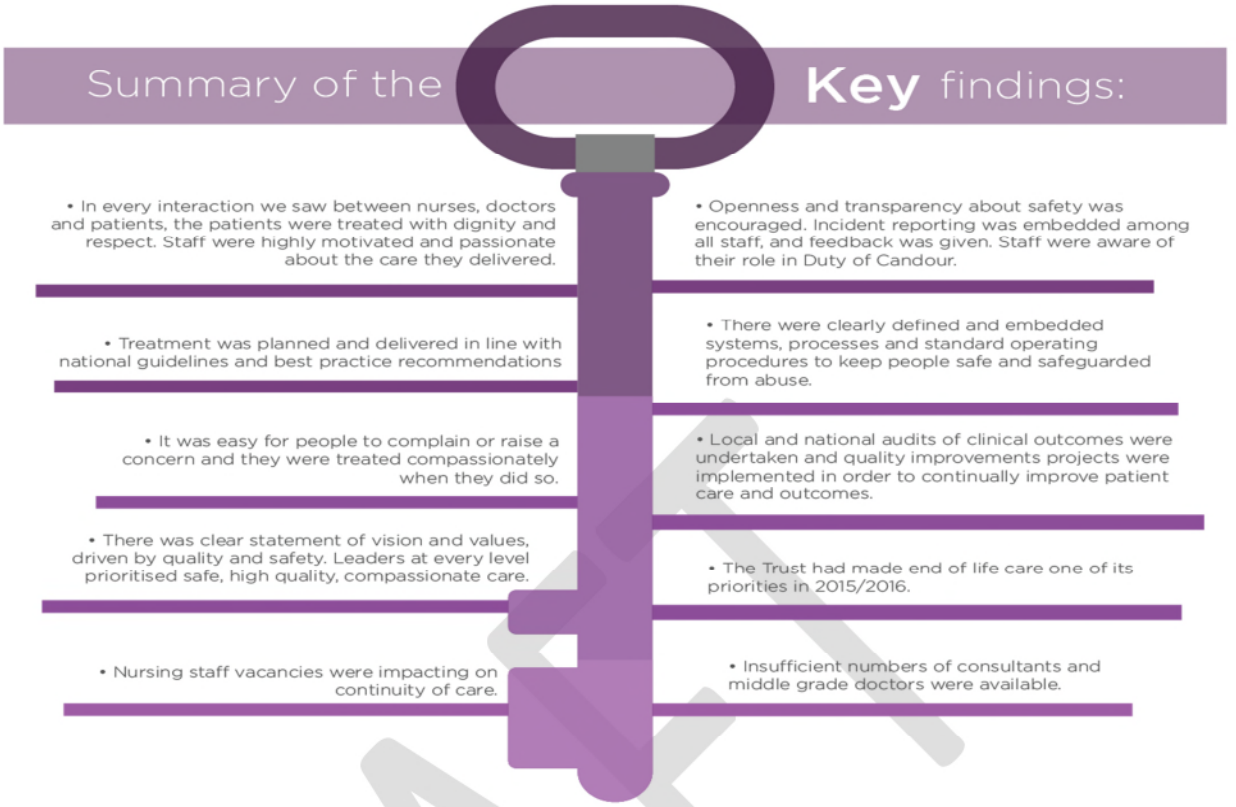

Priorities for improvement arising from the report are:

- Ensure our Emergency Department meets the Department of Health's target of discharging, admitting or transferring 95% of its patients with four hours of their arrival in the department.
- Ensure all patients brought in by ambulance are promptly assessed and triaged by a registered nurse.
- Ensure a suitably qualified member of staff triages all patients, face to face, on their arrival in the Emergency Department by ambulance.
- Ensure the Trust meets the Referral to Treatment Time (RTT) for admitted pathways for surgery
- Ensure all staff received an annual appraisal.
- Ensure there are sufficient nursing staff on duty to provide safe care for patients. A patient acuity tool should be used to assess the staffing numbers required for the dependency of the patients.
- Review medical staffing to ensure sufficient cover is provided to keep patients safe at all times.
- Ensure that all staff are up-to-date with mandatory training.
- Ensure all staff have an understanding of how to assess mental capacity under the Mental Capacity Act 2005 and that assessments are completed, when required.
- Ensure the application of the World Health Organisation's (WHO) 'five steps to safer surgery' checklist is improved in theatres.
- Make sure an up-to-date safety thermometer information is displayed on all wards
- The trust must ensure they are preventing, detecting and controlling the spread of infections, associated in the mortuary department by ensuring surgical instruments are decontaminated to a high level and there are arrangements in place for regular deep cleaning.
- The trust should consider using the maternity specific safety thermometer to measure compliance with safe quality care

The Board were informed that the CQC have changed their processes and will undertake visits on a quarterly basis; the Board will therefore receive updates on a regular basis which the Board members welcomed.

Dr Lee (NED) pointed out the improvements in palliative care and End of Life care and suggested this should continue to be challenged. Mr Darbhanga (NED) enquired how the Trust converses with the Severn Hospice in relation to palliative care and EoL care. The DNMQ assured the Board that EoL care is a continuum and is based on a pathways-based approach which includes the Severn Hospice.

…….. Chair
30 November 2017

Mr Cronin (NED) suggested keeping this on the Q&S agenda to ensure performance is sustained in the longer term.

Following discussion, the members agreed that the Trust is on a journey of improvement and should aspire to beyond 'Outstanding'.

The Board NOTED the December 2016 CQC Inspection Report and the CEO agreed to liaise with the CQC Inspectors to formally thank them.
Action: CEO

HEALTHIEST HALF MILLION (OUR MISSION)

2017.2/175 SOCIAL RESPONSIBILITY / GOOD CORPORATE CITIZEN UPDATE (*Presentation attached to Minutes*)

The DCG provided a presentation which outlined the progress being made in the area of Social Responsibility, including:

- Sustainable Development Management Plan (SDMP) – 287 actions from 447 have been fully implemented and closed (64% to date)
- NHS Sustainability Awards – shortlisted as a finalist for the fourth successive year. The Trust received its first win at the Awards for Travel and Transport and either highly commended or within the top three for other categories of Leadership, Digital, Procurement and Water.
- Waste – The Trust is looking at ways to improve the amount of waste being recycled and will shortly be tendering a new domestic waste contract.
- Carbon Reduction – The Trust's CRC emissions and payments has reduced this year, compared with last year, due to a reduction in energy consumption.
- Travel & Transport – The Trust has been acknowledged as an exemplar for sustainable Travel and Transport initiatives
- Community Engagement – The Trust has approximately 800 volunteers; the highest number outside of London. The Trust was shortlisted for the 2017 Engagement Champion Award for work around sustainability and the local community and was also highlighted in Health Education England's Volunteer Strategy Consultation document as an area of good practice for SaTH's Young Volunteer scheme and induction programme and handbook.
- Social Media & Partnering Working – SaTH's website and social media pages are continuing to do well; the Facebook page has over 2,300 followers. The Web Development Team are working on developing a webpage around SaTH's partnership working with Shropshire Wildlife Trust and the gardening projects.

Mr Cronin (NED) felt the above is having a significant positive impact and suggested it be considered for an annual VIP Award category.
ACTION: WD to consider Sustainability as category for 2018 awards

Mr Newman (NED) suggested the Trust should aim to become a 'Fairtrade' Trust. The members agreed.

The Board RECEIVED and NOTED the update from the Social Responsibility Group.

TRANSFORMATION – INNOVATIVE & INSPIRATIONAL (LEADERSHIP)

System-wide Transformation

2017.2/176 SUSTAINABLE TRANSFORMATION PLAN UPDATE

The Chair welcomed the Sustainable Transformation Plan Programme Director, Mr Phil Evans, to the meeting who provided the following update since the report to the July Trust Board:

1. Further development of the system 'one plan' for all programmes within the STP, including:
    - Telford, Shropshire and Powys neighbourhoods –
        - Unscheduled care
        - Planned care

    - Community resilience and prevention
    - Neighbourhood teams
    - Primary care development and GP five year forward view
    - Population health management
    - Secondary care admission avoidance
  - Musculoskeletal (MSK)
  - Frailty (System)
2. System-wide governance review
3. STP PMO process flow development with system-wide collaboration
4. Workforce projects – STP/Workforce planning and resource tool
5. Digital Programme Manager resource on board
6. Increase STP Capital & Expenditure presence and output
7. Frailty rapid evaluation pilot started
8. Out of hospital offer has been submitted to Public Consultation Business Case (PCBC) and Outline Business Case (OBC)

Moving forward, the CEO asked Mr Evans to provide an update which is easily understood by all members/public.
Action: STP Programme Director to provide presentation to November Trust Board

The Board RECEIVED and NOTED the update.

Transformation at SaTH

2017.2/177 FUTURE FIT UPDATE & CONSULTATION ENGAGEMENT PLAN

The Future Fit Programme Director, Mr Phil Evans, presented the draft Future Fit Consultation Plan (August 2017) and informed the members that he had attended several public Board meetings over the past 10 days regarding the Public Consultation Business Case (PCBC).

Mr Evans reported that the next phases include:

- Delivery of a formal public consultation – Proposed timeline October 2017 for 12/13 weeks
- Deliberation and analysis of findings – Proposed timeline January 2018 for 6 weeks
- CCGs Governing Body meetings (decision making) – Proposed timeline February/March 2018
- Full Business Case by end 2018

The members were informed that the Consultation Plan belongs to the CCGs; SaTH can comment on it but cannot sign it off.

The Chair highlighted the importance of the engagement strategy and the consultation process; he suggested it should be offered as a hypothesis that has been tested by the public. The CEO also suggested engagement be advertised openly to ensure public concerns are addressed; he highlighted a commitment so nobody is left behind.

The DNMQ suggested it may be useful and beneficial to include case studies within the document; she also highlighted that an Equality Impact Assessment was not included.

The WD suggested holding staff events, alongside pubic consultation, to address the significant changes and alleviate anxieties.

Mr Newman (NED) enquired why the process is going to take so long; Mr Evans reported that the full Business Case had not yet been completed.

It was highlighted that the Board had been issued with the Consultation Plan rather than the Consultation Document – Mr Evans agreed to forward the Consultation Document to the DCG to circulate to Board members.
Action: Future Fit Programme Manager / DCG

…….. Chair
30 November 2017

Following discussion, the Chair thanked the STP / Future Fit Programme Director for providing a clear understanding. The members RECEIVED and NOTED the Future Fit Consultation Plan update.

2017.2/178 TRANSFORMING CARE INSTITUTE (TCI) UPDATE

The members were informed of the following achievements since the report to Trust Board during July:

As the end of the second year of SaTH's partnership with Virginia Mason approaches, steady progress was reported on all four established Value Streams:

- Respiratory Discharge
- Sepsis
- Recruitment and Outpatient Department (Ophthalmology)

Underpinning all of the transformational work is the continued training and coaching of Trust staff and leaders, and the Transforming Care Production System.

September also celebrated:

- A very successful Sponsor Development Day launching the Patient Safety Value Stream where 26 highly motivated individuals, staff and partners, identified seven areas for a Rapid Process Improvement Week (RPIW) and described a future state for the reporting of patient incidences with the removal of delays, greater patient involvement, enhanced feedback to patients, families and staff, and involvement and co-design of this new process with our patients.
- The first Advanced Lean Training (ALT) course to be held at SaTH.
- Report from Brian Bennett, PEIP, in gathering patient feedback prior to the RPIW, which is looking at day of discharge.

The CEO extended an open invitation to the Report Out sessions to hear of the achievements that the staff have identified during the RPIW; the Reports Outs are held at 12 noon each Friday following the RPIW. Staff would value the support.

Mr Newman (NED) informed the members of the one-day training session available and urged the NEDs to attend. **Action: NEDs**

The Board RECEIVED the Transforming Care Institute monthly update.

ASSURANCE

2017.2/179 SUMMARY OF AUDIT COMMITTEE MEETING HELD 15 SEPTEMBER 2017

Mr Darbhanga (NED), Chair of the Audit Committee, presented the following key summary points from the meeting held on 15 September 2017:

Internal Audit

(i) Internal Audit Plan 2017/18 - The Internal Audit plan for 2017/18 was agreed by the Audit Committee. The Internal Audit Plan was attached for perusal/Board approval.
(ii) Completion of 2016/17 Plan – it was noted that moderate assurance was given to the Information Governance Toolkit Audit with two medium priority recommendations. The Committee was disappointed to note that the Budgetary Control 2016/17 report has not yet been finalised and will be presented to the December meeting.
(iii) Capital Improvement Programme Terms of Reference – The ToR for the audit of CIP will be developed with the Finance Director and Chair of Sustainability Committee to include wider aspects relating to quality, and ownership. Mr Deadman, Chair of Sustainability Committee, invited Deloitte to attend the Sustainability Committee to make an independent judgement on the effectiveness of the meeting.

…….. Chair
30 November 2017

Action Targets
The Audit Committee stressed the importance of setting realistic targets in management responses to audits.

Medical Job Planning
The Audit Committee expressed great concern that the Trust appears to be an outlier in terms of not having an electronic job planning system for senior medical staff; and strongly recommended that this is considered as a matter of urgency. The cost of a system is c. £30,000 pa with £12,000 implementation costs.

The MD was pleased to report that the Executive Directors have approved and will go ahead with the electronic job planning system.

Maternity Services
The Women & Children's Care Group Director attended to provide the Audit Committee with an update on progress in Maternity Services. Deloitte commended the Care Group and the Complaints Department for the changes introduced.

External Audit
The Audit Committee welcomed KPMG as the Trust's new External Auditors

Recommendation Tracking
The Audit Committee agreed to extend the deadline for a recommendation from the payment and creditors report. The report recommended that a Board approved policy / procedure document is created which stipulates a recommended formal approach to the prioritisation of payments to suppliers, and considers a more data driven alignment of payment timing to the cashflow position of the Trust. The deadline was extended until December to allow a procedure to be developed and approved by November Trust Board.
Action: FD to introduce procedure for prioritisation of payments to suppliers Due: November 2017 Trust Board

Following discussion, the Board RECEIVED and APPROVED:
1. the September 2017 Audit Committee summary
2. the 2017/18 Internal Audit Plan

2017.2/180 CONFLICTS OF INTEREST POLICY

The DCG presented an updated Conflicts of Interest Policy following the review of guidelines by NHS England to strengthen the management of conflicts of interest.

The guidance provides clear and simple advice to staff and organisations about what to do in common situations; and supports good judgement about how interests should be approached and managed. The guidance sets out minimum standards but organisations are free to adopt stricter guidance. The guidance includes a template policy which has been adapted; it is straightforward as the Trust policy (HR52) 'Standards of Business Conduct' (HR52) was due for review and the existing Trust policy is stricter than the new guidance in most respects.

The guidance permits staff to receive small tokens of gratitude from patients but will require them to decline anything that could be seen to affect their professional judgement. Gifts with a value over £50, accepted on behalf of organisations, will need to be declared. It is also required that any member of staff – clinical or non-clinical –declare outside employment and the details of where and when this takes place.

The Trust will be required to publish registers of interests annually for 'decision making staff'. Decision making staff are defined as Executive and Non-Executive Directors, staff at Agenda for Change Band 8d or above; members of advisory groups such as Drugs and Therapeutics Committee, and Devices. Products, and Gases Committee; administrative and clinical staff who have the power to enter into contracts or purchase goods on behalf of their organisation.

…….. Chair
30 November 2017

The existing Trust guidance already covered these matters with declarations are made on the Trust web-based Insight4GRC system. This has been updated in light of the revised requirements.

A 'Frequently Asked Questions' has been developed to assist staff in understanding the requirements.

The DCG urged the members to read the updated Conflicts of Interest policy and to answer the related questions.
Action: Board members

Following discussion, the Board RECEIVED and APPROVED the Conflicts of Interest Policy.

2017.2/181 BOARD ASSURANCE FRAMEWORK

The DCG presented the quarterly Board Assurance Framework which identifies the Trust's objectives and principal risks, along with an associated action plan.

The DCG reported that this was discussed in great detail by the September Audit Committee.

The Chair reported that the Trust's BAF is the best he has seen of any organisation.

Following discussion, the Board REVIEWED and APPROVED the BAF and AGREED the RAG ratings and direction of travel for each risk.

2017.2/182 ANNUAL REPORTS

2017.2/182.1 Safeguarding Annual Report 2016/17:

The DNMQ presented the 2016/17 Safeguarding Annual Report which was RECEIVED and APPROVED .

2017.2/182.2 Infection Prevention Control Annual Report 2016/17:

The DNMQ presented the 2016/17 IPC Annual Report. It was highlighted that Doctors Hand Hygiene compliance was at 43%. The MD assured the Board that this is being pursued with junior doctors. The MD agreed to provide an update to the November Board.
Action: MD

2017.2/183 ANY OTHER BUSINESS

No further business raised.

2017.2/184 LEARNING / REFLECTION OF THE MEETING

- The DCG felt the breaking to take questions from the floor after key themes was an improvement. The Chair felt they were probing and challenging questions and were performed respectfully; he therefore agreed to take this practice forward for future Board meetings.
- The CEO highlighted the constant grapple with the lengthy agenda. The EDs agreed to frame the process prior to Board to ensure time is given to items for discussion and those presented for information only. **Action: EDs to discuss**

2017.2/185 THE MEETING THEN CLOSED AND THE BOARD TOOK QUESTIONS FROM THE FLOOR

2017.2/186 DATE OF NEXT PUBLIC TRUST BOARD MEETING
Thursday 30 November, Seminar Rooms 1&2, Shropshire Conference Centre, Royal Shrewsbury Hospital

The meeting closed at 5.15pm

…….. Chair
30 November 2017

ACTIONS / MATTERS ARISING FROM THE PUBLIC TRUST BOARD ON 28 SEPTEMBER 2017

Item	Issue	Action Owner	Due Date
2017.2/160	Board Members Declarations of Interest *To update Dr C Weiner's Declarations*	CS	**COMPLETED**
2017.2/162	Actions/Matters Arising from meeting held 27 July 2017 2017.141.4 – Finance Performance *To break down data into actual, variance, month-to-date* 2017.2/144 – Community Engagement Approach *To provide update on quarterly basis*	FD DCG	**30 Nov 2017 AGENDA ITEM** **AGENDA ITEM**
2017.2/165	Sustainability Committee Summary *To review the top 5/6 improvement actions for further discussion at the November Trust Board*	FD	**30 Nov 2017 AGENDA ITEM**
2017.2/166	Sustainability Committee Annual Report *To look at including items relating to innovation, creativity, etc, to agenda*	DCG	**On-going**
2017.2/168	Winter Planning Update *To provide update of actions at November Trust Board*	COO	**30 Nov 2017 AGENDA ITEM**
2017.2/169.1	Temporary Suspension of Neurology O/P Service for New Referrals *To look into making exit interviews/surveys mandatory for staff leavers*	WD	**30 Nov 2017 MATTERS ARISING**
2017.2/169.3	Service Continuity Plan for Urgent & Emergency Care Services *To present interim plan to November Trust Board*	COO	**30 Nov 2017 AGENDA ITEM**
2017.2/170.1	Performance Report – Mortality *To add narrative under the graphs*	MD	**30 Nov 2017 AGENDA ITEM**
2017.2/170.2	Performance Report – Operational Performance *To request feedback from 111 provider to understand the call outs / capacity*	COO	**30 Nov 2017 MATTERS ARISING**
2017.2/170.6	Performance Report – Quality & Safety *To add a 'Deep Dive' to the Quality & Safety Committee of Grade 2 / 3 pressure ulcers* *To feed back to Chair regarding the safeguarding adults concerns, involving the Trust*	 DNMQ DNMQ	 **30 Nov 2017** **30 Nov 2017**
2017.2/173	CQC National Adult Inpatient Survey 2016 *To investigate the measure where SaTH performed worse than other Trusts, and bring league table back to Board*	DNMQ	**30 Nov 2017**

…….. Chair
30 November 2017

	To present Trust Improvement Plan to November Trust Board	DNMQ	**30 Nov 2017 AGENDA ITEM**
2017.2/175	Social Responsibility / Good Corporate Citizen Update *To consider Sustainability / Social Responsibility for an annual VIP Award (2018 awards)*	WD	**July 2018**
2017.2/176	Sustainable Transformation Plan Update *To provide presentation to November Trust Board*	STP Prog Director	**30 Nov 2017 AGENDA ITEM**
2017.2/177	Future Fit Consultation *To forward Consultation Document to DCG to circulate to Board members*	FF Prog Director / DCG	**COMPLETED**
2017.2/179	Audit Committee Summary – Recommendation Tracking *To introduce procedure for prioritisation of payments to suppliers – provide update to November Trust Board*	FD	**30 Nov 2017 AGENDA ITEM**
2017.2/180	Conflicts of Interest Policy *Board members to read the Conflicts of Interest Policy and answer related questions*	Board members	**30 Nov 2017**
2017.2/182.2	Infection Prevention Control Annual Report 2016/17 – Doctors Hand Hygiene compliance *To provide update to November Trust Board*	MD	**30 Nov 2017 MATTERS ARISING**
2017.2/184	Learning / Reflection of the Meeting *To frame the agenda to ensure time is given to items for discussion and those presented for information only*	EDs	**On-going**

…….. Chair
30 November 2017