The Shrewsbury and Telford Hospital NHS Trust

TRUST BOARD MEETING
Held 1pm Thursday 29 June 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 C Ovington	Maternity Services Lead Reviewer
Meeting Secretary	Mrs S Mattey	Committee Secretary (CS)
Apologies:	None	

2017.2/95 WELCOME:

The Chair welcomed the Board members and members of the public. He also welcomed Deirdre Fowler, Director of Nursing, Midwifery & Quality, to her first official Board meeting.

The Chair reminded the public that it is a business meeting being held in public. The agenda had been structured to hold discussions around Maternity Services earlier and it was planned to adjourn the meeting to take questions from the floor. He requested no cameras or recordings be made, and the importance of the Trust Values at all times. The Chair thanked the public for their continued support.

2017.2/96 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.

May 2017 Winner:
The Board welcomed May's winners, the IT Team, who were nominated by three separate teams across the organisation in response to the cyber-attack on Friday 12 May 2017. The team worked extremely hard through the night and over the weekend to ensure minimal disruption to patients; only 37 patients were affected and the IT Group went above and beyond their duties.
The Board thanked the IT Team and the Chair reported that it was a really impressive job. The IT Team said they felt very privileged to have been nominated to receive the Chair's Award.

…….. Chair
27 July 2017

2017.2/97 PATIENT STORY

The DNMQ presented a video entitled 'What Matters to Me' which outlines the challenge of when an individual is admitted to hospital and what matters to them.

When a person is admitted to hospital, they will have their vital signs measured. Vital signs are the most important signs that tell clinical teams about a patient's life-sustaining function and are taken to help assess the health of a person and give clues to possible illnesses. However, one of the biggest challenges facing local and global healthcare delivery is an absence of compassion. The continual focus on improved technical cures and the next new machine or drug has been at the expense of simple care, empathy and understanding.

At SaTH's recent Dementia Conference emphasis was placed on working in partnership with our patients, families and carers. As an organisation, we have started to weave the principles of "What matters to you" into our work especially with care of people living with dementia; as well as sharing good practice and co-design and production with and joint work with external partners and stakeholders.

Mr Cronin (NED) would like the message to also be applied to the people important to the patient, their family and carers. The members acknowledged this and the need for personalised care.

The Chair thanked the DNQ for sharing the important, powerful message.

2017.2/98 BOARD MEMBER'S DECLARATIONS OF INTEREST

The Board RECEIVED and NOTED the Declarations of Interest

2017.2/99 DRAFT MINUTES OF MEETING HELD IN PUBLIC on 27 APRIL 2017

The following slight updates to the minutes were requested and agreed:

2017.2/82 – Emergency Department Update
The Chair *requested* that as Emergency Services is one of the Trust's challenged services, an update will be provided to the Board on a monthly basis. **Action: CS to update**

2017.2/86 – Transforming Care Institute Update
Mr Newman (NED) asked 'imposed' be removed from "SaTH is underway with this solution". **Action: CS to update**

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

2017.2/100 DRAFT MINUTES OF SPECIAL MEETING HELD IN PUBLIC on 30 MAY 2017

The minutes of the Special Board meeting to receive and approve the 2016/17 Annual Report and Annual Accounts were APPROVED as a true record.

2017.2/101 ACTIONS / MATTERS ARISING FROM MEETING HELD 27 APRIL 2017

2016.2/15 – Patient Experience Strategy – Inclusion of Equality & Diversity
The DNMQ confirmed that the Patient Experience Strategy includes additional detail in relation to Equality & Diversity, as requested by the WD during the February 2017 Trust Board meeting.
The updated version will be presented to the July Trust Board meeting.
Action: DNMQ Due: July 2017

2017.2/73 – Declarations of Interest
CS to update the Register of Interests following changes from Dr Lee & Mr Deadman.
Completed. Action closed.

…….. Chair
27 July 2017

2017.2/74 – Draft Minutes of Meeting held 30 March 2017
CS to make agreed amendments to minutes.
Completed. Action closed.

2017.2/75 - 2016.2/173 – Recommendations from Trust commissioned Independent Midwifery Review 2016 – Birthrate Plus
DNMQ to present update to the June Trust Board regarding external assessment Birthrate Plus
This aspect was included in the review to be presented to the Board. **Action closed.**

2017.2/75 – 2017.2/16 – Complaints & PALS Q3 Update
DCG to look at section 6 of the report regarding 'Formal complaints by location' and look at measuring the metrics differently; and provide further assurance in the next quarterly Complaints & PALS report
See minute 2017.2/113

2017.2/75 – 2017.2/27 – People Strategy Update
WD to present to June 2017 Trust Board
See minute 2017.2/108

2017.2/75 – 2017.2/45 – Temporary suspension of Neurology Outpatient Service for New Referrals
COO to provide update to September Trust Board
Action: COO Due: September 2017

2017.2/75 – 2017.2/54 – Annual Operating Plan – Part One
FD to present Part Two and Part Three to June 2017 Trust Board; this will be presented to the July 2017 Trust Board.
Action: FD Due: July 2017 POST MEETING NOTE: To be reported through Sustainability Committee

2017.2/89 – Summary of Audit Committee held 21 April 2017
The DCG to present an updated version of the Board Assurance Framework to the June 2017 Trust Board
Completed. Action closed. See Minute 2017.2/122

2017.2/102 3-MONTH FORWARD PLAN

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

2017.2/103 CHIEF EXECUTIVE OVERVIEW

The CEO informed the Board of the following items that have progressed or raised media attention over recent weeks:

2017.2/103.1 Ophthalmology Service
The CEO reported that the Ophthalmology Service has encountered a number of challenges for over a decade; however, with the involvement of the Trust's patients, a new environment has been designed and created in the Copthorne Building which opened to the public from 26 June 2017.

2017.2/103.2 Virginia Mason Institute (VMI)
The Trust has approached the 18-month point since commencing the partnership with the Virginia Mason Institute. Since this work commenced, approximately 1,800 members of staff have experienced training in Transforming Care which has resulted in over 57,000 safer patient journeys. A number of staff from across the organisation are also receiving training as part of 'Lean for Leaders'.

2017.2/103.3 Junior Doctor Training
The CEO has received feedback from the Deanery in relation to training. If the Trust invests in high-quality training for its junior doctors, it is more likely that they will return to work for the organisation when they complete their training. The CEO thanked the MD and all the teams for their continued commitment and hard work in this area.

…….. Chair
27 July 2017

2017.2/103.4 Leadership Academy

The Trust's Leadership Academy was launched on 28 June 2017 following a year-long consultation with staff throughout the Trust in terms of leadership requirements.

The Academy is an opportunity for people who are managing people to be supported in learning and to support them through training to become great leaders. It was noted that there are a range of development opportunities. The CEO highly commended this piece of work.

Mr Darbhanga (NED) enquired how this learning is being offered to the wider organisation. He was informed that it has been launched across both sites; an advertising campaign has been held, as well as one to one sessions being offered to staff. It is also being offered to medical staff and a formal evaluation will take place.

The Chair thanked the WD and her team for this excellent piece of work. The WD agreed to review this regularly, with the Chair of the Workforce Committee. **Action: WD**

MATERNITY SERVICES

2017.2/104 IMPROVING AND DEVELOPING MATERNITY SERVICES ACTION PLAN

The DNMQ presented a paper to inform and update the Board of actions completed and ongoing in relation to improving and developing maternity services, following the extraordinary Board meeting held during April 2016.

Background

Following concerns raised about maternity services and the historical pattern of perinatal mortality, which had been an issue since before his appointment, the Chair of the Trust asked for the maternity services to be independently reviewed in relation to the death of a baby in 2009. This review resulted in the development of an action plan with 70 action points to rectify service shortcomings. The action plan has been reviewed at each meeting of the Board and the Quality and Safety Committee. There are two further reviews being undertaken; the first commissioned by the Secretary of State for Health to review the investigations completed on a number of perinatal and maternal deaths dating back to 2000. The second will be undertaken by the Royal Colleges of Obstetrics and Gynaecology and Royal College of Midwives to assess the service currently being provided against recognised standards of expected practice. These reviews are expected to conclude later in the year and will be reported to the public Board.

Introduction

The report focused on work undertaken within the Care Group to support and develop staff to deliver care which is woman-centred, provided by high performing teams and well-led in a culture that promotes innovation and continuous learning.

Leadership changes

Key to the work undertaken in the last year and on-going work to embed improvements are the changes made to both clinical midwifery leadership and managerial support to the Care Group**.** This has enabled a fresh internal view of progress and to provide leadership, focus and pace, where necessary. Their energy to ensure that standards of practice and care has been welcomed; what this has done within the Care Group is to bring a tighter grip on governance processes, fresh insight into the safety of the service and improved team working across the midwifery services.

Maternity Incident Action Plan - Update

The Care Group Director and Head of Midwifery have reviewed and updated the implementation of actions and their delivery. Of the original 70 actions; three remain in evolvement:

1. Management review in line with Trust HR policy – Amber (outstanding)
2. A complete revision and implementation of SI/RCA training – Green (this review and roll-out is in progress)

…….. Chair
27 July 2017

3. A review of the Women & Children's Risk Management Strategy - Green (in progress). This is has been incorporated into the wider Trust Risk Management Strategy so will be completed if the Board approve the Strategy which is on this agenda.

In relation to the outstanding Management Review the WD advised:
"The Trust has undertaken a series of investigations. The Trust has been asked to comment on these processes and appreciates the public interest in them. The confidence of the public it serves is a key consideration for the Trust. However the Trust is not in a position to divulge detailed information identifying individuals – it appreciates and is advised that to do so may jeopardise the effectiveness of the processes. However the Trust would like to share the following:

- None of the individuals investigated have been in front line patient care roles since the investigations commenced
- The Trust commissioned independent investigators to conduct all the investigations
- The completed cases have resulted in a variety of disciplinary action including termination and one member no longer being on the professional Register. [Correction note - Subsequent to the Board meeting on 4 July it was confirmed with the Nursing & Midwifery Council (NMC) that **no** removals from the Register could take place until their investigations were complete. The Board apologises unreservedly for the misleading statement about the professional Register in this final bullet point of the original statement].
- Only one investigation is outstanding but expected to conclude shortly"

The Board and Quality and Safety Committee will continue receive and review any improvement plans and progress within maternity services for assurance that the care of women and their babies is as safe as it can be.

The members discussed the MBRRACE-UK Perinatal Mortality Surveillance Report and the need to build on learning from the report. It was highlighted that one of the best indicators is the view of the women we serve and whilst 98.8% of mothers answering the Friends and Family Test (FFT) would recommend the service, 1.2% were not happy with the service they received. Mr Darbhanga (NED) enquired what actions have been taken around this; the DNMQ informed the Board that she will work with the Care Group to investigate the qualitative data from the Friends and Family Test and work up a robust plan. **Action: DNMQ**

Dr Weiner (NED) acknowledged the amount of work that has been undertaken across the organisation over the past 12 months, but enquired how long it will take to achieve a culture we are happy with going forward. The MD felt the work with VMI is a good indication of progress. The WD reported that the cultural indicators will be reviewed across the organisation, and the Trust is taking positive steps towards delivering the culture we wish to achieve.

Mrs Mingay (D.NED) highlighted that the staff must have the energy to continue to be part of a learning culture and suggested the Board be more visible and hold individuals to account.

It was reported that the action plan was required to be approved in the knowledge of the actions being tracked at every Quality & Safety meeting and the completion of the remaining actions throughout the year; as well as continued maintenance of what has been achieved, and the continuation of staff willingness to report, which is a key metric on the cultural piece.

Following discussion, the action plan was APPROVED by the Trust Board.

2017.2/105 MIDWIFERY LED UNIT PLAN

The DNMQ informed the members of the meaningful and successful stakeholder event which had been held earlier in the week with patient representatives and other health economy stakeholders. She also presented a paper of the current risks being balanced and managed within SaTH's Maternity Services. The paper provided a summary of the risks impacting on the service and the proposed 'transitional' model developed by the clinicians to mitigate risks.

…….. Chair
27 July 2017

The Clinical Commissioning Group (CCG) Midwife-Led Unit (MLU) Review is on-going and seeks to provide a medium to long-term plan for maternity services, in addition to strategic planning work by the local maternity system (LMS). It was re-iterated that the proposed changes in this paper are temporary and do not pre-empt the outcome of either review. The paper described an immediate plan to mitigate risks and maintain patient safety.

Current challenges

Activity - The activity aligned to the Consultant Unit (CU) in relation to 'high risk women' and women choosing to deliver within the CU reflect the national picture of changes in demographics, epidemiology and choice; whereby activity remains high with an increasing demand at the Consultant Unit(CU), MLU births on the whole have declined in number.

Birth rate (total births) by location – (2016/17)

- Consultant Unit = 4194 (85%)
- Shrewsbury MLU = 142 (2.9%)
- PRH Wrekin MLU = 337 (6.8%)
- Ludlow MLU = 36 (0.7%)
- Oswestry MLU = 52 (1.1%)
- Bridgnorth MLU = 77 (1.6%)

Service Model

The current midwifery staffing model does not reflect or address the service demands which result in women migrating from community/MLU births to the CU due to choice or increase in their pregnancy risk status. Birthrate Plus ® supports this analysis of staffing deficit based on risk status of women and birth numbers. The most recent Birthrate Plus ® assessment was commissioned by the Care Group and completed in April 2017. Results have demonstrated that the current service model does not support the activity, which is predominantly within the Consultant Unit; furthermore, the Birthrate Plus ® report advises that staffing levels are higher within the three smaller MLU's – Oswestry, Ludlow and Bridgnorth, than the activity requires and that the service should seek to redistribute staff in addition to recruiting more staff.

Additionally, recent adverse media and continued external scrutiny has resulted in greater staffing challenges on the maternity service i.e. less midwives are willing or able to undertake additional shifts (bank and overtime) and an unprecedented challenge to recruit midwives.

Due to time pressures to address the challenge there are several options available to the Care Group in order to address this; these have been risk assessed and include:

1. Option - Do nothing – risk score 20
2. Option - Complete closure of the 3 smaller MLU's – Oswestry, Bridgnorth and Ludlow - to fulfil the staff ratio required to meet the needs of the women on the Consultant Unit at PRH and in the two larger MLU's – RSH and PRH risk score 20
3. Option - Preferred - Based on a holistic risk assessment, the preferred option temporarily redistributes staff from units where birth activity and acuity (level of care required based on severity) is lowest – MLUs, to the area of highest birth activity and acuity – The Consultant Unit and provides alternative options for women who chose to have a midwife led birth i.e. home birth or birth in Wrekin (PRH) or Shrewsbury (RSH) Midwife Led Units and maintains all other essential services within the community settings i.e. antenatal and postnatal (outpatient) care.
   As a point of note, SaTH has nearly 5,000 births per year with only 140 births in MLUs. It is with this in mind that the preferred proposal is to temporarily suspend inpatient services (intrapartum and postnatal) at the rural MLUs to redistribute staff to the Consultant Unit and the two larger MLU's at RSH and PRH. Work will continue towards reinstating services in the smaller MLUs, possibly, with a midwifery on-call model. It is planned that this approach will commence from 1 July 2017 for a period of up to 24 weeks.

…….. Chair
27 July 2017

It was confirmed that there is no intention or suggestion that this temporary suspension will lead to permanent closures. The Trust is committed to working towards the recommendations of Better Births and therefore re-iterated that this suspension is temporary, to maintain a safe service whilst other plans and reviews are considered, in addition to securing additional workforce.

The members were informed of the increase in the number of high risk expectant mothers with complex needs requiring one to one midwifery care, which explained the increase in consultant-led deliveries i.e. older women, higher BMIs, diabetes, induction rates and whilst it was reiterated that the Trust continues to promote midwifery led births, focus remains on the importance of keeping patients safe.

The MD reported that Baroness Julia Cumberledge has identified what is perceived to be the safer option and lower risk in the *National Maternity Review looking at a five year forward plan for Maternity Care*; however, patient choice is changing as well as changes to guidelines, changes in patient complexities and challenges with staffing.

The Chair requested assurance regarding balancing safety and kindness. The DNMQ reported on the following proposals to mitigate risks, provide safe care to our mothers-to-be and support staff during this time:

- The inpatient and overnight provision is suspended in three of our smaller MLU's with the least birth activity (Ludlow, Bridgnorth and Oswestry) beginning 1st July 2017 for up to 24 weeks.
- The MLU buildings will function as a day community based service rather than an over-night inpatient service. This will mean that all community antenatal and postnatal care will continue to be provided either within the unit during the day or in the community, however, women will not (during this period) be able to give birth in these units or be transferred to them for their postnatal care. For care in labour (intrapartum) all women will be offered birth in either RSH or PRH MLU's or the Consultant Unit. In some areas, women may wish to give birth outside of our County, for example, either at Wrexham, Hereford or another unit of their choosing. Women, will however, still be able to receive all of their community postnatal care from their local unit, either at the unit (during the day) or at their home. Additionally women can still choose to have a home birth and this will continue to be facilitated in line with their current choices
- This will release 3 midwives and 3 support workers per night to be redistributed in a planned (rather than reactive) way to areas of high demand on the consultant unit and possibly the other MLU's (dependent upon activity) including the Antenatal Ward, Delivery Suite and the Postnatal Ward. This action supports the recommendations and evidence; of the choices that women are making and will maintain safe midwifery services within local rural areas. Furthermore, where activity is very low or zero, a further midwife in the area can be flexed to provide day attendance support and community support within the area.
- The Care Group will prioritise the work required to develop a plan working with users , which may include a robust on-call system to allow safe staffing levels and a modern service delivery plan.
- Support to develop a recruitment and retention initiative for midwives so that gaps are filled and there is a positive energy surrounding the prospect of working and staying at SaTH.
- The Care Group will continue on-going work to develop the current workforce plan in line with Birthrate Plus ® recommendations and in partnership with their Executive Team will implement the agreed workforce plan.
- This action will introduce certainty for mothers-to-be and Midwifery Services in the coming 6 months, whereas currently there is uncertainty over exactly which MLUs will be open.
- The Trust will use this time with our commissioners to help develop a new model of care, fully staffed, to avoid further anxiety for our population and to allow our people to return to a positive place in delivering the 'Safest, Kindest' care possible for mums, babies and families.
- SaTH will be working with service users and stakeholders to ensure they are fully engaged in the process to shape the service. Head of Midwifery, Sarah Jamieson, is keen to hear your views. If you would like to be involved please contact her via her PA by calling 01952 565996 or email nick.robinson@sath.nhs.uk
- Regular meetings are planned to consider options and future models but this work will not pre-empt the outcome of the Midwife-Led Unit review that our clinical commissioners are carrying out.

For the purpose of the CCG Review, the Chair suggested forwarding a letter of support to our commissioners to confirm that the proposed changes will in no way influence the outcome of the review.

…….. Chair
27 July 2017

It was noted that the proposals set out in the Board paper are deemed necessary to ensure the safe and sustainable delivery of these services in the short term. The Board paper makes clear that the measures proposed are temporary measures whilst further work and reviews in relation to maternity services at the Trust are undertaken. There is no suggestion or intention that such measures represent permanent closures.

It is fully accepted that the proposals trigger section 242 of the NHS Act 2006. The proposals have been the subject of public involvement in that there have been meetings with patient representatives and other stakeholders. There has also been much information in the press about the continuing problems with the MLU services and pressure on the Consultant Unit. S 242 requires the Trust to ensure that users of the services, whether directly or through representatives, are involved (whether by being consulted or provided with information, or in other ways) in decisions to be made affecting services. Such involvement has taken place. Whilst it is acknowledged that a full public consultation is not planned, there is no such requirement under section 242 or otherwise to do so. The nature and extent of any such involvement in accordance with section 242 will necessarily be dictated by the proposals under consideration and the circumstances pertaining at the time. In view of the context within which these proposals are being put forward (including the current significant amount of scrutiny that the Trust's maternity services are under), there is an immediate need to take action to address patient safety concerns and, as the Board paper clearly points out, these proposals serve to do just that. Against this background, in view of the public involvement that has taken place and the temporary nature of the proposals, the Trust believes it has complied with its section 242 duty.

Dr Lee (NED) discussed the commitment of engaging with staff and the population. The DCG reported that there has been a degree of involvement, including the stakeholder event, discussion during the Board meeting, and contact details have also been made available to contact the Head of Midwifery.

Following discussion, the Board supported and APPROVED the temporary suspension of services at Bridgnorth, Ludlow and Oswestry Midwife-Led Units for a period of between three and six months (or 12-24 weeks) subject to:

- The MD requested a mid-term review at three months. **Action: DNMQ**
- Writing to our clinical commissioners to ensure this temporary closure doesn't pre-empt the outcome of the Midwife-Led Unit review that the commissioners are carrying out. **Action: DNMQ**
- Ensure meaningful engagement with service users, stakeholders and staff to help shape the service pending the outcome of the review being led by commissioners. **Action: DNMQ**

2017.2/106 MATERNITY SERVICES REVIEW AND RECOMMENDATIONS (*Presentation attached to Minutes*)

The Chair welcomed Mr Colin Ovington to the meeting. At the beginning of May 2017, Mr Ovington was requested to undertake a review of Maternity services at SaTH between 2007 –2017. The review relates to maternity services and its culture, governance and processes and does not replicate any other work/reviews (Secretary of State review and Royal College of Obstetricians and Gynaecology [RCOG]) being undertaken. It did NOT look at any individual cases

The members were informed that there has been a number of reviews of the service by:

- NHS England
- Healthwatch
- Care Quality Commission
- Independent midwives
- Clinical Commissioning Groups

A presentation was provided to inform:

<u>How SaTH compares to other NHS providers</u>

- Learning from events at Barking Havering & Redbridge, Morecambe Bay – SaTH has already gone beyond the action plans described on Cardiotocography (CTG)
- For most indicators, SaTH is middle of the pack (good Friends & Family response rates)
- SaTH has two patient survey questions that are amongst the best performers nationally and two further indicators where the results show statistically significant improvement

…….. Chair
27 July 2017

- 98.8% of mothers would recommend the service
- SaTH has a lower caesarean section rate (13 - 21.8%) to the average (25%) which is generally seen as better practice
- Monthly range of data about the service is measured against a variety of targets and are predominantly RAG rated green

What is SaTH doing now about patient safety?

- SaTH has signed up to 'Sign up to Safety' in terms of
    - Leadership
    - Learning
    - Team working
    - Improve data
    - Innovation
- Incident action plans
- It requires a co-ordinated and focused approach to gain commitment across the multidisciplinary team
- Mitigation for staffing high risk areas

In summary:

- There isn't a single marker which alone can be used in isolation to define safety
- Multiple markers of safety used across the NHS have been explored to understand the safety and risks associated with the maternity service at SaTH
- There is no substantial evidence to demonstrate that the maternity service is unsafe in totality, however there are areas which require a continued focus
- Deepen learning – through peer review and deeper RCA. The members were informed that 22 midwives and 5 doctors have received RCA training and whilst RCAs are being completed, their coverage and depth needs improvement. This will be actioned by the W&C service.
- There needs to be better engagement with a range of stakeholders with future and experienced users of the service – moving towards a coproduction model
- Need to co-ordinate efforts to improve safety in a single plan
- Need to further develop the leadership of the service as the team requires coaching and mentorship as they take the service forward on its journey of improvement.
- Whilst there has been improvement in perinatal mortality specifically, over the time frame of this review, it is still too high, as demonstrated in the latest MBRRACE report and there should be no avoidable baby deaths.
- The continued efforts of the maternity team to focus on individual risk factors for all newly pregnant women entering the service, with sign posting to relevant areas of choice for women and dedicated attention to fetal monitoring, and improved neonatal stabilisation knowledge and skills will be the key elements that will make a difference.

The members thanked Mr Ovington for the detailed report over a short period of time, which has been achieved independently and reflected the position of the service.

Dr Lee (NED) reported that the Trust is on a 'safest & kindest' journey and highlighted that every baby and every mother counts; focus will continue against the actions and recommendations to also see kindness coming through.

Mr Deadman (NED) reported that he would like to see the data behind the report and, following discussion, agreed to meet separately with Mr Ovington.
Action: C Deadman

Mr Cronin (NED) raised concerns regarding perinatal mortality which he feels remains too high; he welcomed a conversation with Mr Ovington to explore this.
Action: C Ovington / P Cronin

…….. Chair
27 July 2017

The DNMQ discussed the improvements relating to perinatal mortality which nationally is required to reduce by 20% by 2020. Work is therefore required to achieve better than the national average.

Mrs Mingay (D.NED) reported that 'the learning' and 'the journey' had been referenced throughout the discussion and enquired of the Root Cause Analysis (RCA) tool; the DNMQ reported that the Trust has an RCA tool although she felt it needs to grow further to develop a deeper analysis, which she is currently reviewing.

Mr Newman (NED) raised that the Trust has a tired workforce and questioned their willingness to learn; he also highlighted the need for keeping in touch with parents. The Board were assured that work will continue in both areas.

The Chair highlighted that the presentation reported that 'SaTH is middle of the pack'; he informed the members that he has three daughters of childbearing age, and 'middle of the pack' is not good enough. For every mother we need work to continue to ensure SaTH has zero avoidable baby deaths and every baby should have a successful outcome.

The Board agreed that the Trust has excellent and committed but tired staff; it needs to move away from a blame culture and support must continue to be provided to staff to achieve a safest and kindest service.
Following discussions, the Board RECEIVED and APPROVED the Review of Maternity Services at SaTH 2007-2017 and its recommendations and agreed for it to be uploaded to the Trust website.

THE MEETING ADJOURNED TO TAKE QUESTIONS FROM THE FLOOR

It was highlighted that a member of the public who had attended with her baby had to leave without having the opportunity to ask her questions, although the WD did speak to her.
Following discussion, Sylvia Jones kindly agreed to contact the lady. The DNMQ has since been in contact and agreed to meet with her. **Action: DNMQ**

A number of questions were received and answered. The Chair reported that the Trust continues to be held to account by the population it serves and thanked the members of the public for their questions.

The meeting then re-convened at 4.50pm

WORKFORCE

2017.2/107 SUMMARY TO WORKFORCE COMMITTEE MEETING HELD 15 MAY & 19 JUNE 2017

Mr Cronin (NED), Chair of the Workforce Committee, presented the following key summary points from the Workforce Committee meetings:

2017.2/107.1 Workforce Committee meeting held on 15 May 2017:

Board Assurance Framework
The Committee received the Board Assurance Framework report. It was agreed to include the work carried out in relation to the staff survey for risk 423 but that this would remain amber. However due to ongoing discussions regarding Emergency Medicine staffing Risk 859 remains red.

DBS
The Committee received the DBS report and discussed this in detail. The Committee agreed that the report needed to include more detail around completion dates, commentary regarding non-compliance and the HR process for managing this along with a trajectory of how many forms need to be completed and the timescales involved. This information will be included in the Workforce Assurance paper in future.

…….. Chair
27 July 2017

Workforce Sustainability

The Committee received an update from the Agency Task and Finish Group who had agreed to take holistic view to nursing workforce and sustainability including development and training package for nurses. Other issues being reviewed include flexible working times and shifts to make the employment offer more attractive. A strategy linking in with workforce is being developed with the hope of completion in June. .

Response to Staff Survey / Employment Experience

The Committee received an update and assurance that action has been taken following the staff survey results. The Workforce Business Partners have been proactive in their Care Groups speaking to members of staff through a variety of forums including walkabouts, staff meetings and focus groups. The Committee agreed that the Trust must demonstrate that it is delivering on the survey results via a "you said we are doing" approach.

2017.2/107.2

Workforce Committee meeting held on 19 June 2017:

Workforce Committee new structure

The Workforce Committee trialed a new format for the meeting structure in June which split the meeting into two parts. The first part involved one of the care groups providing a deep dive regarding their people agenda and the second part covered the normal committee agenda items. The feedback on this new format was positive and it was agreed to continue with a different care group presenting each month. It was felt both meetings provided a level of assurance.

Communication Vision

The Committee received the new Communication Strategy which has previously been considered by the Executive and Senior Leadership Teams and the strategy aligns. The Committee discussed good communication at all levels and the importance of links with our communities. Feedback included the need to target improvements in communication with individual patients / families in view of the fact that this was the second largest category of complaints. The strategy could say more on this. The Workforce Committee supported the Communication Strategy which will now be implemented.

People Strategy and Organisational Development (OD) Plan (Belong to Something)

The Committee have discussed both items for a number of months. A decision has been taken that the OD Plan will be called the 'Belong to Something' Plan and will be further developed. The Committee were advised of the planned focus and supported the direction of travel.

The People Strategy has been refreshed to align to the organisation strategy and annual plan. The Committee felt the focus was right and were pleased to see the continued focus on recruitment, engagement and leadership. A five year Workforce Transformation Plan further supports this strategy.

Recognition Agreement

The Workforce Director and Staff Side Chair presented the Recognition Agreement and Disciplinary Sanctions to the Committee. The Workforce Director confirmed with the exception of British and Irish Orthoptic Society (BIOS) and Unison (originally agreed to the document but have since asked for further changes), all other unions and professional bodies had agreed. The Staff Side Chair confirmed that all unions are in agreement with the policy except Unison and the Workforce Committee agreed to recommend these to the Board.

The Committee recognised the agreement as a positive step forward in the Employee Relations Agenda. The Committee thanked the Staff Side Chair and her colleagues for their support.

Discussion with Workforce Business Partners

The Committee received an update from Unscheduled Care from the Workforce Business Partner highlighting some fragile areas in particular ED and assuring the Committee that an action plan and OD plan are in place to support the staff in this area. The sickness for Unscheduled Care in May was 3.7% which is the lowest for a significant period. Nurse vacancies are a particular challenge in Unscheduled Care. The Committee agreed that it was important to recognise the positive achievements in the care group and agreed that a member of the Committee would attend some of the care group meetings in person to acknowledge these achievements. The Committee celebrated Scheduled Care Group recent achievement of JAG Accreditation and will be nominating the team for a VIP Award.

…….. Chair
27 July 2017

DBS

The Committee received an update on the DBS project. The Committee were assured that processes are in place for non-compliance and risk assessments are carried out where appropriate. A one page update will be presented at each Workforce Committee providing assurance of progress to date.

Following discussion, the Trust Board RECEIVED and APPROVED the Workforce Committee summaries.

Learning

2017.2/108 PEOPLE STRATEGY

The WD presented a paper which reported that the Trust re-launched its Organisational Strategy last year which will take us forward into the future. It outlines SaTH's ambition for change and to be the safest and kindest organisation in the NHS. In light of this, the People Strategy has been refreshed, which is a key enabler to taking the Trust forward on this journey.

The Trust continues to recognise the contribution of our people and the significant difference that all their roles make to our patients. It is also clear that we need to improve the employment experience that our staff have. The People Strategy sets out a vision **to make our organisation a great place to work.**

The CEO reported that he was pleased to see this alignment and following discussion, the Trust Board RECEIVED and APPROVED the People Strategy.

Safety

2017.2/109 SENIOR DOCTORS REVALIDATION STATEMENT

As a responsible Officer for all senior doctors employed by SaTH and by the Severn Hospice, the MD presented a paper regarding the implementation of Revalidation.

Over the last four years the structure and framework required to provide assurance and governance around the requirements for Revalidation have been implemented. The key requirements being annual appraisal, review of complaints and concerns, confirmation of engagement in clinical governance system and multi-source feedback. Clear direction has been given to the senior medical staff as to the requirements for Revalidation and robust processes are now in place to ensure all elements required. These include:

- Personal emails from the Medical Director to each doctor due for revalidation on the requirements needed for revalidation
- Monthly reports to the Clinical Directors, Care Group Medical Directors and HR Business Partners of the appraisal status of all Trust-appraised medical staff
- Updates provided for all senior doctors on appraisal and revalidation as part of the on-going Doctor's Essential Education Programmes (DEEP)
- Validation and improvement of the Trust's appraisal systems in order to ensure reliable delivery
- Improvement and development of the electronic appraisal and revalidation system (Equiniti) and the reports provided from this
- Support to doctors in the use of the electronic appraisal and revalidation (Equiniti) system
- Support to doctors on how to complete multi-source feedback in a timely manner
- Trust guidance on skill mix requirements for colleague raters for multi-source feedback
- A robust process with the Complaints Department to check complaints and concerns for senior medical staff
- The maintenance and validation of a reliable database of all senior doctors at SaTH
- An agreed dataset of achievements of the key requirements for revalidation
- Ensuring the full implementation of pre-employment checks of doctors, including their compliance to date with revalidation requirements
- The standardisation of appraisals based on the Equiniti System
- The training of a further five medical appraisers, bringing these to a total of 70

…….. Chair
27 July 2017

- Continuing professional development for appraisers with education events being delivered
- Ensuring that a governance framework is in place for continued development and support for medical appraisers
- Embedding of exception reporting for all overdue appraisals.
- The development of the role of the Appraisal Lead for Consultants and SAS doctors
- Providing doctors with information about their clinical performance via the Information Department

Revalidation Outcomes:
There have been fewer doctors requiring revalidation in this financial year – 18 to revalidate and 10 deferred (total of 28) during 2016/17 compared to 119 to revalidate and 21 deferred (total of 140) during 2015/16.

Additional points of note:
There has been a continued trend of an increase in doctors who are not in Senior Doctor posts and who also not in training, i.e. not in Deanery posts, who now fall within the Trust's appraisal system. There has also been a further increase in international doctors in the past year who have not previously completed appraisals. These doctors are set an appraisal month which takes into account their registration date, future revalidation date and start and end dates of their post.

Severn Hospice doctors are employed through a service level agreement with their contract being held at SaTH. They have been allocated to SaTH as their designated body and they are the responsibility of the Trust's Responsible Officer.

The Trust Board RECEIVED the report and APPROVED the Statement of Compliance

Mr Newman (NED) enquired if a similar report is required for Trust nursing staff revalidation. The DNMQ agreed to provide a paper to the July Trust Board.
Action: DNMQ Due: July 2017 Trust Board

2017.2/110 RECOGNITION AGREEMENT & DISCIPLINARY SANCTIONS PROCESS

The WD presented a paper regarding the Recognition Agreement and Disciplinary Sanctions Process.

Recognition Agreement
Working in partnership with Staff Side colleagues, considerable time has been spent developing a new Recognition Agreement in the best interests of both patients and staff on matters that are of concern to the Trust and particularly to our staff.

The Agreement has been signed by all Staff Side bodies except BIOS (Rep not available) and Unison. However the remaining Staff Side colleagues agreed on 14th June 2017 that the Agreement would be progressed to Trust Board for approval without these signatures. Unison representatives have been present at all discussions regarding this agreement.

Disciplinary Sanctions Process – Addendum to the Disciplinary Policy and Procedure
The Trust current Disciplinary Policy was first agreed in 2008 and has been reviewed since to maintain suitability and effectiveness. During 2016, with Staff Side colleagues, a pilot for issuing sanctions was piloted on a few disciplinary cases. The pilot has proven successful and during the last few months, work has been undertaken with Staff Side colleagues to formalise the process into an addendum to the current Disciplinary Policy.

The Trust Board RECEIVED and APPROVED the Recognition Agreement and Disciplinary Sanctions Process (Addendum to the Disciplinary Policy and Procedure)

…….. Chair
27 July 2017

QUALITY

2017.2/111 SUMMARY OF QUALITY & SAFETY COMMITTEE MEETING HELD 17 MAY & 21 JUNE 2017

Dr Lee (NED), Chair of the Quality and Safety Committee, presented the following key summary points from the Q&S Committee meetings:

2017.2/111.1 Q&S meeting held on 17 May 2017:

Prior to the formal Q&S meeting, the Committee visited Ward 27, the Respiratory Ward at RSH, where Committee members talked at length to senior nursing staff.

- It was evident that staffing the ward is heavily dependent upon recruiting agency staff as the ward is unable to recruit a full complement of permanent staff. Staff have some clear proposals as to how this situation could be improved, indeed the addition of a single additional role to the night shift would unlock recruitment and reduce costs to the Trust by reducing agency premium costs. The committee are keen to understand how senior clinical staff can feel empowered to make decisions with respect to staffing and how they can access business support to "unpack" and develop ideas;
- Pressure on staffing expenditure has led to identified coordinator roles across shifts not having the opportunity to effect a handover. Staff feel that this is problematic with respect to patient care.
- The ward itself is a very large ward that must be difficult to nurse. The committee were persuaded that the addition of extra beds into the current bays is not a feasible option as it will impact on the quality of care that can be delivered by clinical staff as well as having an adverse effect on patient's dignity; also, the ward's floor is in a poor condition with many dints in its surface.

The Committee meeting had further discussions with the Women's and Children's Care Group; reviewed the Deloitte Report into governance processes and also looked at the root cause analysis (RCA) for a Theatre 'Never Event'. Over the course of these discussions, the Committee formed a view that there was still scope for significant improvement in the way in which significant events are investigated and reports presented. The Trust should seek to train a core group of skilled investigators who can support the use of standard best practice tools and ensure that reports are aligned to best practice. This should accompany the wider on-going development of RCA awareness across the Trust.

2017.2/111.2 Q&S meeting held on 21 June 2017:

The Committee visited the ITU Unit at PRH. It was impressed with the level of professionalism exhibited by the staff. Of particular note was the cross-site use of staff to manage variations in activity. Issues relating to moving people from the ITU to Wards were desisted but plans for addressing this were also being developed.

The Committee received the annual Complaints & PALS report. The Committee discussed the whole report but made particular note of complaints in which "communication" was an identified element. Actions to address this will need to be developed and assurance provided.

Building upon last months' meeting, further discussion resulted from the presentation of the Root Cause Analysis (RCA) for a historic Never Event. Quality and Safety members are pleased that staff training on RCA's is being implemented

The Committee was advised of escalating pressures on the number of midwives available for shifts. This will place pressure on the Trust's ability to offer services at community MLU's. There is an urgent need to present alternative service models to offer a sustainable service

The Chair enquired how Dr Lee, as Chair of the Q&S Committee, plans to take forward the above items of concern; whilst the COO and FD highlighted the importance of the Care Groups managing the issues themselves.

Mrs Mingay (D.NED) highlighted that it relates to leadership at every level and staff being able to lead and be empowered.

Following discussion, the Board RECEIVED and APPROVED the Committee summary.

…….. Chair
27 July 2017

Patient Experience

2017.2/112 QUALITY ACCOUNT 2016/17

The DNMQ presented a paper which reported that the Trust is obliged to publish a Quality Account by 30 June every year. The document is made up of statutory statements and information and the Trust's ambitions in a number of Quality Priorities for the coming year.

The document was reviewed at the 30 May Special Trust Board meeting, following which amendments and additions were made.

The Quality and Safety Committee reviewed and approved that the Quality Account at the meeting of 21 June 2017 with some minor amendments which have been incorporated.

Following discussion, the Board RECEIVED and APPROVED the Quality Account 2016/17.

2017.2/113 QUARTERLY COMPLAINTS & PALS REPORT

The DCG provided the Board with an overview of the formal complaints and PALS concerns received by the Trust during quarter four, and assurance that the Trust is handling complaints in accordance with the regulations.

Complaints
In quarter four, the Trust received a total of 142 formal complaints which equates to less than one in every 1000 patients complaining (0.62 complaints per 1000 patients). There has been an increase in the number of complaints from the same period last year; however it should be noted that there has been a recent change in process to ensure that all complaints are accurately triaged and captured which accounts for this increase. The new process provides greater transparency and assurance, as all complaints are now correctly captured and seen by the CEO. The number of complaints will continue to be closely monitored.
Also, all complaints are reviewed at monthly governance meetings as well as regular staff meetings to review specific issues and to identify trends and themes and look at learning.

Patient Advice 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. The majority of contacts are by telephone or in person. During quarter four, the PALS team handled 562 contacts, mainly from Orthopaedics, Ophthalmology, Accident & Emergency, Urology and Respiratory.

Freedom of Information (FOI)
The number of FOI requests received by the Trust is steadily increasing. Until recently, the average number of requests received was around 45 per month but this has risen to almost 60 per month. March 2017 saw the highest number of requests received with 90, and the first week of April 2017 saw 30 requests. Many of the requests are complex which is causing the Trust difficulty in responding within the timeframes allowed; there is a limit of 20 working days to provide a response. The Trust FOI policy has been disseminated to senior managers and heads of service, and a reminder 'One Minute Brief' has been issued to all staff.

The Trust Board RECEIVED the Q4 Complaints & PALS Report

Spotlighted Services

2017.2/114 SERVICES UNDER THE SPOTLIGHT

The COO presented an update on fragile clinical services following the paper that was presented to Trust Board on 30th March 2017 and subsequent verbal updates.

There are a number of services currently provided by the Trust that are considered fragile due to workforce constraints which impact on service delivery. Shropshire and Telford & Wrekin Clinical Commissioning Groups (CCG's) have been aware of these longstanding capacity and workforce issues and have been working closely with

the Trust to find suitable and safe alternative capacity, where appropriate. All these specialties are challenged nationally and SaTH's current service configuration increases the challenge of finding sustainable solutions to these fragile services. Each service risk has been reviewed to see if there has been any change since the last formal report to Trust Board in March 2017. The services affected:

2017.2/114.1 Emergency Departments – Increased risk in Middle Grades

- Inability to staff both sites consistently with substantive workforce
- Inability to recruit into posts
- Retention of staff due to regular gaps on the rota
- Reliance on Consultants acting down
- Impact on ED performance due to high level of locum usage
- Financial impact of very expensive locums

The service continuity plan was further developed involving all stakeholders at a workshop held on 16 June 2017 (including commissioners) to progress the development of the plan, should it be required. The COO reported that the general consensus of the stakeholder meeting was the requirement for a 24/7 Urgent Care Centre at PRH.
It is the aspiration to have a UCC at PRH; the COO reported that this cannot be guaranteed at the moment. The CEO reported that the STP and the A&E Board will have a view on this. A further stakeholder meeting has been scheduled to follow up on the agreed actions at end July 2017.

The MD reported that he has been engaging with the Consultants. The COO confirmed that the level of risk has **increased;** the Trust should have 16 Consultants to run the ED service, and it is currently running at 4/5 which impacts on both patient and staff experience. The ED is under constant pressure and the workforce are exhausted with consultant staff working an onerous on-call rota and no senior cover on site at PRH for some evenings and weekends.

2017.2/114.2 Ophthalmology – Increased risk

- Substandard and fragmented accommodation - this risk has reduced as the Ophthalmology service is now accommodated in the Copthorne Building at RSH which opened to patients on 26 June 2017.
- On-going Serious Untoward Incidents (SUIs) – the Department has realigned its governance structures and a Consultant Ophthalmologist was appointed as the department's Consultant Governance Lead. Bi-weekly department patient safety meetings are held to review incidents and relevant trends and outcomes of investigations are reported at the monthly governance meetings.
- Workforce gaps and team dynamics - recruitment plans have commenced to reduce the reliance on premium rate locum workforce. The Paediatric Consultant position, which has been vacant since March 2016, will be re-advertised as previous interviews held during September 2016 and March 2017 were unsuccessful.
- The inability to see patients within the past maximum wait standard, and demand exceeding capacity – SaTH is working with other provider Trusts to source additional capacity

The members were assured that discussions continue to be held through the monthly Quality & Safety Committee meetings.

2017.2/114.3

Neurology Outpatient Service – No change/slight improvement

- Failure to deliver across waiting time target
- 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

Following discussions at the March 2017 Trust Board, the members were reminded that it was agreed to close the service to all new Neurology referrals to mitigate the clinical risk associated with the delays in time to be seen. Referrals stopped being received by SaTH on 27 March 2017 and will continue for 6 months.

Two specialist nurses have been recruited and have been established from 1 May 2017, releasing 12 consultant

slots per week. All urgent referrals have been cleared and focus is now being placed on routine patients.

A meeting took place on 18 May 2017 with commissioners to further discuss the options for sustainable delivery; a Task & Finish Group has been established and a short list of options has been identified and actions assigned to appropriate leads to progress. One option includes working with commissioners to 'triage' referrals prior to referral to neurology services for some pathways (i.e. headache) and potentially establishing a 'Hub and Spoke' model with neighbouring Trusts (this model is available around the country but not in the Midlands).

2017.2/114.4 Dermatology Outpatient Service – Reducing risk

The Trust has been operating with a single handed consultant for many years despite numerous attempts to recruit to a substantive Consultant Dermatologist post. The Consultant led service is not viable due to the need for all cancer 2-week referrals and new patient activity to be supervised by a Consultant Dermatologist. During periods of annual leave/sickness, the service would have to be cancelled and SaTH would not be able to deliver against its contract.

A meeting with commissioners has been held to discuss the options for sustainable service delivery. A discussion with the Countess of Chester NHS Trust has been held regarding the potential of their doctors providing support to our service; although they currently have 3wte substantive consultant dermatologists in post with a plan for a fourth in October, they are struggling to deliver the 92% standard for RTT and don't believe they have capacity to support SaTH on a regular basis. Further discussions have been held with Wolverhampton, Walsall and Dudley NHS Trusts and whilst there is not a direct offer of assistance available to SaTH, there is commitment from all to provide aid on a short term basis, should it be required.

2017.2/114.5 Spinal Service – No change

SaTH has been unable to provide a full spinal service within the organisation due to the unexpected sudden illness of the single-handed spinal surgeon during February 2017. SaTH therefore worked in partnership with The Robert Jones & Agnes Hunt Orthopaedic Hospital NHS Foundation Trust (RJAH) to manage this on a temporary basis. All patients were contacted and advised and those who did not want to attend RJAH were offered alternative providers.

The SaTH spinal surgeon returned to work on 16 June 2017 indicating that he no longer wishes to continue to operate, offering to only undertake Outpatients and teaching sessions. Agreement has therefore been reached between both CEOs of SaTH and RJAH regarding the long term provision of spinal services in Shropshire, with a proposal to provide a 'Hub and Spoke' model of care. A case for change is being prepared jointly for discussion with the commissioners, Hospital Overview Scrutiny Committee (HOSC) and the Trust Board.

Following discussion, the Trust Board RECEIVED and NOTED the update in relation to fragile services.

TRANSFORMATION

2017.2/115 SUSTAINABLE TRANSFORMATION PLAN (STP) UPDATE

The Chair welcomed the Sustainable Transformation Plan Programme Director, Mr Phil Evans, to the meeting who provided a brief update report.

It was reported that 90 day plans for all programmes under the STP are being developed:

- Telford, Shropshire and Powys Neighbourhoods –
  - Unscheduled Care
  - Planned Care
  - Community Resilience and Prevention
  - Neighbourhood Teams
  - Systematic speciality review & transfer of service to community
  - Primary Care Development and GP Five Year Forward View
  - Population Health Management
  - Secondary Care Admission Avoidance
  - Community Services Review

- Musculo-skeletal
- Community services
- Frailty (System)
- Future Fit
- Enablers -
    - Workforce
    - Digital
    - Estates
    - Finance

Mr Evans reported that the governance structure and membership has been updated; additional staff (substantive Head of PMO, Communications & Engagement Programme Manager and Digital Programme Manager) have been recruited, and assured the Board that the Programme is moving along at pace.

The DNMQ enquired if there is a Clinical Design Group and volunteered herself to sit on the Group.
The CEO reported that he has seen strong evidence of team working with primary care, alongside community services, seeing a reduction in elderly placements into residential/nursing homes. He reported that he is beginning to see pilots of work and although there is a great deal of work to be undertaken, he feels progress is being made.

The FD provided an update in relation to the Outline Business Case (OBC); reporting that Shropshire CCG have agreed to make available assumptions relating to the community option, and the Telford & Wrekin CCG have received some information. The OBC is to be reviewed and further detail will be received in the Trust in the next 3-4 weeks.

The Board RECEIVED and NOTED the update.

2017.2/116 FUTURE FIT UPDATE

The members welcomed the Future Fit Programme Director to the meeting who reported that work progresses on the independent review, the supplementary IIA and clarifying the Joint Committee arrangements. Independent members of the Joint Committee have been sought with the support of NHSE. These were received for endorsement by Boards in their June Governing Body meetings.

The programme timeline is being reviewed by Chief Officers due to the delay in appointing the firm to perform the independent review of the option appraisal process. A delay in the decision making and consultation process is assumed. Any revised timeline will be potentially subject to change dependent on the outcome of the independent review which is expected to be known in mid July 2017.

The Future Fit Programme Director reported that the pre-consultation business case is required to be received by the CCG Boards and NHSE. In terms of the timeline; it will go to the Programme Board by end July 2017; the Programme Board will then make a recommendation to the Joint Committee and a meeting will take place during end July/early August 2017. The timeline for the local process and regional process is end August 2017 and consultation early September 2017.

Mr. Newman (NED) observed that in David Mowat, the Health Minister's statement in the Commons 11th January 2017, he laid out the timetable for (a) completion of a review of the Future Fit process by independent consultants and, assuming this was found to be satisfactory, (b) the reconvening of the joint CCG Boards with an independent, but voting, chairman (this latter subsequently changed to an independent, voting chairman plus two independent, voting additional panel members). The timetable was to be 8-12 weeks, meaning that this should all have been completed latest by mid-April; here we were over two months later and neither action had been completed, demonstrating once more a lack of pace. Mr. Evans, Accountable Officer from T&W CCG responded that there had been delays in appointing independent auditors for the process but that KPMG were now underway with the work.

…….. Chair
27 July 2017

The Chair highlighted the Boards concerns of carrying the risk of increasing fragility. Mr Evans, from T&W CCG, confirmed that the fragility of the services in the Trust is understood and shared by CCGs and stakeholders and whilst there is a process to follow, they are keen and committed to deliver to timescales.

Dr Lee (NED) reported that he and Dr Weiner (NED) have reviewed the critical path for Shropshire, with their public health and primary care backgrounds.

Following discussion, the members RECEIVED and NOTED the Future Fit update.

2017.2/117 TRANSFORMING CARE INSTITUTE (TCI) UPDATE

The members were informed that the Trust has reached the 18-month point since commencing the partnership with the Virginia Mason Institute.

The Board were informed that the Trust has achieved several new milestones during the month including the successful achievement of Advance Lean Training (ALT) by the new KPO specialist; the delivery of Session 3 of Lean for Leaders for the 2017/18 Cohort, the delivery of 2 Rapid Process Improvements (RPIW) in one week and hosting a very successful Regional Sharing Event.

The Transforming Care programme of work is demonstrating tangible improvements in our test genbas:

- Over 57,000 patient experiences (per annum) are safer and kinder.
- Patients involved in the Rapid process improvement weeks are helping to achieve significant improvements in patient experience.
- Non value adding time is released from poor processes back to direct care
- Recruitment time is reduced
- Set up time for rehabilitation is reduced and patients are better prepared
- Board rounds are focus on the patients priorities of 'help me get better & help me get home'
- One letter template has now replaced the 17 previously used for ophthalmology clinic appointments

Quality improvements are demonstrating an associated financial benefit in the following areas:

- Reduction in temporary staffing usage
- Absorption of additional work
- Redistribution of excess stock
- Reduction in stock par levels
- Reduction in cost per case for patients being treated for sepsis
- Reduction in unnecessary hospital transport journeys

Mr Newman (NED) reported that the familiarity with the Lean methodology has reached a new level and every member of staff involved is excited in the difference the changes are making to the organisation.

It was reported that the NEDs visited the Transforming Care Institute during the May Board Development session to receive an update of the work undertaken throughout the Trust and also to receive training.

Following discussion, the Trust Board NOTED the overall improvements being made:

- Over 57,000 patient journeys (pa) are safer and kinder thanks to our staff engaging with the Transforming Care Production System (TCPS) and the 4 value streams.
- Patients giving generously a week of their time to participate in improvement weeks.
- 1900+ staff are now educated in the Transforming Care Production System.
- 450+ staff are using this approach in their work to remove waste from their processes and improve patient experience and release more time to care.
- Open invitation to attend the RPIW report outs, the Transforming Care (CEO) stand ups, and the offer for individual introduction to the work by the KPO Team.
- Sustained improvements achieved through the RPIW work.
- Success of the Regional Sharing Event held on 2 June 2017 where our work was showcased.

…….. Chair
27 July 2017

- Another KPO Specialist has achieved their ALT training.
- SaTH undertook two RPIWs in the same week, a first within the 5 Trusts in partnership with VMI.

SUSTAINABILITY

2017.2/118 SUMMARY OF SUSTAINABILITY COMMITTEE MEETING HELD 23 MAY & 17 JUNE 2017

Key summary points from the meeting held on 23 May 2017:

Month 1 Finance Position

At the end of month 1 the Trust had planned to deliver an in year deficit before CIP delivery of £2.384 million and actually recorded a deficit of £2.834 million, £0.450 million away from plan, or £1.017 million away including the CIP. Income was lower than expected with some areas underperforming against plan and this would be monitored over the next few months. Pay and Non pay expenditure were consistent with previous spend. Delivery of the full CIP would again be a challenge for the Trust.

Review of Standing Financial Instructions, Standing Orders and Reservation of Powers to the Board

Following a review of the above documents and subject to some additional very minor amendments, the committee recommended approval of the documents to Trust Board.

Meeting Current and Future Endoscopy Demand

A business case to address the challenges of meeting the current and future endoscopy demand was presented to the committee. Acknowledging the increasing demand of endoscopy services and the recent loss of the Trust's Joint Advisory Group accreditation, the committee considered three options. After reflection, the committee recommended approval of the preferred option 3 to Trust Board, subject to a re-examination of the expenditure in 2017/18. Details of this to be presented to the committee meeting on 27th June 2017.

Operational Plan 2017/19 – Progress Report Month 1

The committee noted the performance as at Month 01 and the particular progress being made in relation to each of the 36 objectives. The committee requested a monthly progress update at future meetings from Meridian on the Productivity Improvement project relating to Theatres, Radiology and Outpatients. More detailed updates on objectives 23 (Paediatric Service Model), 29 (roll out of Exemplar Ward Programme), 30 (Results and Recommendations following CQC assessment in December 2016) and 31 (Reporting process of serious incidents) were also requested.

The two objectives selected for presentations this month were:

- Dischargology (Objective 19) which aims to support the Trust's proposal to reduce length of stay, better align therapy resources and quantify the value of therapy activity, and
- Red to Green (Objective 7), a national improvement initiative introduced as a result of the significant number of patients in hospital longer than they should be with the aim to reduce non-value added time for patients and work to get them home sooner.

The committee commended the work being undertaken in relation to these two initiatives.

Other issues discussed

- Approval of Costing Process 2016/17.
- Board Assurance Frame risks were reviewed and rag rating status re-confirmed.

Key summary points from the meeting held on 27th June 2017:

Meeting current and future endoscopy demand

As requested at the previous meeting, the committee received and was satisfied with the phasing of the finances of the endoscopy business case, particularly in relation to year and re-confirmed their support and approval of this. Agreed that the business case should be re-visited in 18-months time with a view to establishing whether what was expected was delivered.

…….. Chair
27 July 2017

Update on the relocation of Fertility Services
Received and progress noted. Move date April/May 2018. Committee to receive a post project review 6 months after move has taken place, i.e. September 2018.

Month 2 Finance Position
Informative presentation highlighting key financial issues. Of particular concern was the dramatic increase in Tier 5 expenditure without any clear understanding of the reasons for this. Comparing April/May 2017 usage with that of the previous year, indicates an increase of 115% (29.25 wte), which has not been budgeted for. Furthermore, the Trust has already spent 27% of the Agency Ceiling value of £10.559 million set by NHSI. Expected that this will be the focus of discussion at forthcoming meetings with NHSI. The committee requested the Executive Team work through the actions identified to reduce Tier 5 usage. Important quality and safety factors should also be considered when using this volume of Tier 5 agency staff.

The DNMQ reported that the Quality & Safety Committee also raised concerns regarding Tier 5 expenditure, which she feels is unacceptable. Following discussion, the DNMQ, COO and WD agreed to undertake a piece of work relating to the reliance of Tier 5 staffing.
Action: DNMQ/COO/WD

The Sustainability Committee discussed the impact of the above and the underachievement of CIP on the outturn position which was now predicted to be a deficit of £14.7 million, against a control total agreed with NHSI of £6.063 million, with the potential for this to rise even further.

Operational Plan 2017/19 – Progress Report Month 1
The committee discussed and noted the performance against the Operational Plan as at Month 02. Additional information in terms of project lead, date objective reviewed and prioritisation of objectives in terms of important process issues, to be added to the paper for future meetings.
The presentation this month on Arrangements to transfer 70 patients to community provision (Objective 15) was deferred until the next meeting.

Other issues discussed:

- Progress report received from Meridian on the Productivity improvement across outpatients, theatres and radiology project. The committee acknowledged the important and significant investment in the project and was pleased to hear that it was progressing well in the early stages. The challenge to engage with senior clinical staff was noted. The diagnosis stage was nearing completion, the project would then move to a period of change. Details of the when the Trust will start to see improvements/efficiencies was requested for the next meeting.
- Services under the spotlight – an update on the Trust's fragile clinical services was received and the additional risks emerging since the issue of the paper, noted. The committee discussed whether a different approach/model should be taken and consideration given to a more proactive rather than reactive approach with discussions and decisions regarding sustainable services and the provider of these taking place. Paper to be prepared for discussion at a future Board Development Session, where this can be discussed further.
- Managed Print Service Printing Policy – approved.
- Sustainable Services Programme Update – received and noted. RAG rated red/amber to reflect the risks associated with primary and community service solution, interdependency within IT development and future clinical model and the detail of the workforce plans. The estimated deadlines for completion of these pieces of work were advised, at which time the committee requested more detailed updates on these.

The Board RECEIVED and APPROVED the Committee summaries.

2017.2/119 PRODUCTIVITY IMPROVEMENT ACROSS OUTPATIENTS, THEATRES & RADIOLOGY

Following discussions at previous Trust Board meetings, the FD presented a paper regarding the three week scoping review by Meridian in March 2017 (at no cost to the Trust).

…….. Chair
27 July 2017

The review concluded that potential exists through revised working practices to improve productivity across the Trust in Outpatients, Theatres and Radiology activities. The improvement potential from the analysis identified an estimated level of achievable cost reduction amounting to £2.5milliion in a full year, reducing additional costs through better resource management and improving KPIs.

In recognition that the Trust does not have the resources internally to progress the actions required, at their meeting on 28 March 2017, the Sustainability Committee approved, subject to approval by NHS Improvement, the implementation of the 32 week project at a fixed rate of £561,789 including expenses, conditional upon the level of savings generated. If annualised savings during the programme do not reach a rate equal to or greater than the total programme fee then the supplier will refund the difference, thus guaranteeing the costs. The full implementation programme must be completed for this guarantee to be valid.

Meridian brings a number of benefits to our existing organisational capacity and will work directly with all management levels to ensure that the defined benefits become embedded.

The Trust Board APPROVED the business case to improve productivity across the Trust's Outpatient, Theatres and Radiology activities.

2017.2/120 REVIEW OF STANDING ORDERS / STANDING FINANCIAL INSTRUCTIONS / RESERVATION OF POWERS TO THE BOARD

A review of the following has taken place:

Standing Orders:
Reviewed but no amendments from the September 2016 version

Reservation of Powers to the Board and Delegation of Powers
Reviewed but no amendments from the September 2016 version

Standing Financial Instructions changes:

- Changes to general references to NHS Improvement where previously referenced to NHS Trust Development Authority (TDA).
- Internal Audit Standards 2013 updated to Internal Audit Standards 2017
- Reference to Better Payment Practice Code (previously Public Sector Payment Policy
- Reference to Electronic Expenses System, previously paper forms
- Section 8 – Terms of Service, Allowances and Payment of Members of the Board and Executive Committee and Employees and Section 8.3 – Staff Appointments – both updated to reflect the process for approval of expenditure in times of exceptional circumstances such as high escalation levels.

The Trust Board NOTED and APPROVED the key changes.

2017.2/121 TRUST PERFORMANCE REPORT

The FD presented the Trust performance against all key quality, finance, compliance and workforce targets at M2 2017/18 (May 2017).

2017.2/121.1 OPERATIONAL PERFORMANCE

Performance against the monthly trajectories agreed with NHSI:

- Mortality – The Hospital Standardised Mortality Ratio (HSMR) has been consistently below the HES peer since January 2016. There was a spike during January 2017 which was reduced down in February and sustained into March 2017. The In-Hospital Summary Hospital-level Mortality Indicator (SHMI) has also been consistently below the HES Peer.

…….. Chair
27 July 2017

- VTE performance – The Trust continues to report over 95% of patients admitted to the Trust receive a VTE risk assessment (95.6% achieved during April). This is monitored at Care Group level at Governance Boards and through the Confirm and Challenge meetings.
- Cancer Targets:
    - 2 week wait – 94.1%
    - 62 day – 87.2%
    - Both performance targets (62 day and 2 week wait) achieved in April and are projected to continue to achieve.

- Cancer 104+ days – Two patients received their first definitive treatment for cancer after 104 days (the target for referral to treatment being 62 days); one Haematology patient (118 days) with a complex pathway, and one Lung patient (104 days) with a complex diagnostic pathway/medical delay. The patient's will be reviewed by the cancer performance team and the Cancer Board and action will be taken to reduce the number of 104+ waits further.
- RTT performance – May's performance was 87.8% against the submitted Operational Plan target of 85%. The admitted performance was 64.9% and the non-admitted performance was 94.2%
- 4 hour Accident and Emergency waiting time access target – Mays actual performance was 77.5% against a target of 83.1%. The COO requested specific focus be placed on A&E for full discussion at the July 2017 Trust Board. **Action: COO Due: July 2017**

The WD highlighted that the Endoscopy Team has achieved Joint Advisory Group on Gastrointestinal Endoscopy (JAG) Accreditation which is a phenomenal achievement. The Board congratulated the team on the work undertaken to achieve this.

2017.2/121.2 **WORKFORCE**

Sickness / Absence - The WD reported an increase in the sickness absence score as 4.19% for May 2017. The Workforce team are looking into this to identify trends, i.e. hayfever during the summer months. She highlighted that colds/coughs are planned for during the autumn/winter months, but not seasonal allergies during spring/summer months.

Appraisal / Training - The WD reported that the completion of appraisals for May 2017 was 89.12%, and Statutory training compliance was 72.48%.

Recruitment/Retention - Staff turn-over during May saw a recruitment rate of 9.91% and a retention rate of 92.26%

2017.2/121.3 **QUALITY & SAFETY**

Clostridium Difficile Incidence - During May, three cases were reported which were above the target of no more than two per month. RCA investigations continue to be carried out on all cases.

Hand Hygiene - Audits have been carried out during May as per Trust Policy; overall compliance with standards for the Trust is 97%.

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

In Service Pressure Ulcers (all grades) - This year, the Trust has reset the targets for avoidable pressure ulcers (grades two, three and four) to zero. During May, the Trust reported no avoidable in service grades three and four pressure ulcers but did report an avoidable grade two, bringing the in-year to date total to one compared with five at this point in 2016/17.

Patient Falls - The Trust reporting is below the national benchmark and generally has a reducing trend. During May, there were two falls which resulted in a patient sustaining a fracture; this was not reported as a serious incident

following initial review.

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 to be transferred from the Critical Care Units. Actions are taken to address any breaches and the issue of non-compliance is on the risk register. To date there have not been any complaints or contacts with the Patient Advice and Liaison Service (PALS) and the service continues to monitor this closely. This will be reported through the Quality & Safety Committee.

Nursing, Midwifery and Care Staff data - The monthly Nursing, Midwifery and Care Staff data was RECEIVED for information.

2017.2/121.4

FINANCE

Income - Two months into the new financial year, the Trust had planned to receive income amounting to £57.083m and had generated income amounting to £56.945m; an over performance of £0.139m.

Pay - To date the pay spend amounted to £40.326m against a plan of £39.635m resulting in an overspend of £0.691m

Tier 5 Agency WTE Usage - Tier 5 agency usage April 2016 – May 2016 as compared to April 2017 – May 2017 has increased by 115% (29.25 WTE)

Delivery of the Agency Ceiling - Total agency spend for the first two months of the year amounted to £2.835m; £775k above the agency ceiling level set by NHSI. In these two months, 27% of the £10.559m total agency ceiling value has been spent.

Non-Pay - To date the non-pay spend amounted to £18.249m against a plan of £17.732m resulting in an overspend of £0.517m.

Forecast Outturn - Given the overspend that exists to date; the expected position at the end of the 2017/18 financial year is a £13.880m deficit, assuming the current trends continue and no corrective action is taken. This takes the Trust to £7.800m (detailed below) above the agreed control total with NHSI.

- CIP underachievement - £4,700.000
- Tier 5 agency usage - £2,400.000
- Escalation - £100,000
- Income shortfall - £600,000

Cash Position

- The Trust pays creditors outside NHS Terms and Conditions of 30 days
- The cash to underpin the additional £7.800m can only be released by further delaying payments to creditors
- Creditor payments would have to be further extended by 22 days
- Extended terms would need to be implemented imminently to enable the Trust to manage its cash during 2017/18
- By extending payment days, creditors will refuse to supply the Trust with goods and services which was experienced at the end of 2016

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

ASSURANCE

2017.2/122 SUMMARY OF AUDIT COMMITTEE HELD 30 MAY 2017

…….. Chair
27 July 2017

Key summary points from the meeting held on Tuesday 30 May 2017:

Internal Audit

- Head of Internal Audit Opinion Internal Audit concluded their opinion was of Substantial Assurance that the Assurance Framework is sufficient to meet the requirements of the 2016/17 Annual Governance Statement and provide a reasonable assurance that there is an adequate and effective system of internal control to manage the significant risks identified by the Trust. Internal Audit confirmed that as a result of carrying out our 2016/17 Performance Internal Audit reviews, they had not identified any areas of control weakness relating to governance, risk management or internal controls that further impact upon the overall HoIA opinion of moderate assurance.
- IT Controls Audit – it was noted that moderate assurance was given with two high priority recommendations relating to access control (Oracle and Windows Active Directory).
- Counter Fraud – The annual plan was agreed which includes a number of proactive exercises, particularly in relation to testing controls for waiting list initiatives and clinical utilisation. The Committee were pleased to note that a 10 minute online training package will be rolled out over the year.

External Audit

- External Audit reported that they were issuing an unqualified opinion on the financial statements; and a qualified opinion on Value for Money, due to the Trust's financial challenges. External Audit have issued a referral to the Secretary of State Under Section 30 (1)(a) of the Local Audit and Accountability Act 2014 due to the breach of the Trusts statutory responsibility to achieve a breakeven financial position at 31 March 2017, with the Trust reporting a deficit of £5.6M and a cumulative deficit of £54M
- 'WannaCry' Ransomware Attack - A briefing note on the recent global ransomware attack was discussed. The Trust was not badly affected by the attack. The Chief Executive stressed that this was due to good management in two key aspects: the Trust had taken a strategic decision to upgrade software from Windows XP and had invested in this; and, on the evening of the attack, took an operational decision to isolate systems, which greatly limited any impact.

Annual Report, Annual Accounts and Annual Governance Statement

The Audit Committee recommended the Annual Report, Annual Accounts and Annual Governance Statement for approval. These were approved by the Trust Board on 30 May 2017.

Managing Conflicts of Interest in the NHS

New guidance has been issued by NHS England; this will be incorporated into a revised Trust policy. However, the existing Trust policy is compliant with the national guidance and more strictly applied.

Following discussion, the Board members RECEIVED and APPROVED the Audit Committee summary.

2017.2/123 RISK MANAGEMENT STRATEGY

The DCG reported that the Trust's risk management processes are reviewed annually by Internal Audit as part of their review of the Board Assurance Framework. The last review, carried out in March 2017, gave an opinion of substantial assurance on the processes in place in the Trust for the fifth consecutive year.

Some changes have been made to the Risk Management Strategy, mainly to define the risks, the addition of Statement of Intent to include reference to Duty of Candour, the addition of a 'strategy on a page', updated information on risk profiles to map to the Operational Risk Group Terms of Reference, and updated appendices.

The members were assured that the strategic risks form part of the Board Assurance Framework.

Following discussion, the members APPROVED the Risk Management Strategy.

…….. Chair
27 July 2017

2017.2/124 BOARD ASSURANCE FRAMEWORK

The DCG presented the draft Board Assurance Framework which has been revised to reflect draft strategic objectives and proposed risks. Four new risks have been proposed:

- If we do not have the patients in the right place, by removing medical outliers, patient experience will be affected (Risk Reference 1185)
- If we do not develop real engagement with our staff and our community we will fail to support an improvement in health outcomes and deliver our service vision (Risk Reference 1186)
- If we do not deliver our CIPs and budgetary control totals then we will be unable to invest in services to meet the needs of our patients (Risk Reference 1187)
- If the maternity service does not evidence a robust approach to learning and quality improvement, there will be a lack of public confidence and reputational damage (Risk Reference 1188)

In addition, one risk has been reworded:

- If we are unable to implement our clinical service vision in a timely way then we will not deliver the best services to patients (Risk Reference 668)

The Trust Board REVIEWED and APPROVED the revised Board Assurance Framework and AGREED the RAG ratings and direction of travel for each risk.

2017.2/125 ANNUAL REPORTS

The Board NOTED the following Annual Reports and formally thanked the staff for the enormous amount of work undertaken:

- Health, Safety, Fire & Security – 2016/17
- Security – 2016/17
- Complaints – 2016/17

Following the recent events of the Grenfell Tower tragedy, Mrs Mingay (D.NED) enquired if the Trust has any cladding/fire risks. The Board were informed that the same cladding material is present within three areas of the organisation; it is not cladding on walls and is not deemed a fire risk. The Board were assured that all fire alarms and fire doors throughout the Trust have been enhanced/replaced.

The need for a decant facility was discussed; this features on the Capital Programme and discussions are being held with Care Groups.

2017.2/126 ANY OTHER BUSINESS

Mr Deadman (NED) highlighted the large number of Board papers which the members are required to read for each Board meeting; the DCG reported that the papers which feature in the supplementary Information Pack are for information/assurance as they have already been escalated through the Tier 2 Committees.

No further business raised.

2017.2/127 LEARNING / REFLECTION OF THE MEETING

- The WD highlighted that the Board had touched on 'engagement' throughout the meeting. Following discussion, the DCG agreed to provide a 'Community Engagement' piece for discussion at the July 2017 Trust Board. **Action: DCG**
- The members noted that the agenda items had overrun, although it was felt that the right discussions were held for the required amount of time. Dr Weiner (NED) suggested identifying the correct timings for future Board meetings to show respect to the members of public in attendance. Dr Lee (NED) agreed that the timings on the agenda should be realistic. The DCG suggested holding the Public session one hour earlier. **Action: DCG to discuss shape of future meetings with the Chair**

…….. Chair
27 July 2017

2017.2/128 THE MEETING THEN CLOSED AND THE BOARD TOOK QUESTIONS FROM THE FLOOR

2017.2/129 DATE OF NEXT PUBLIC TRUST BOARD MEETING
Thursday 29 June 2017, Seminar Rooms 1&2, Shropshire Conference Centre, Royal Shrewsbury Hospital

The meeting closed at 6.35pm

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27 July 2017

ACTIONS / MATTERS ARISING FROM THE PUBLIC TRUST BOARD ON 29 JUNE 2017

Item	Issue	Action Owner	Due Date
2017.2/99	*Draft Minutes of 27 April 2017* To make agreed amends to 2017.2/82 & 2017.2/86	CS	**July 2017** **COMPLETED**
2017.2/101	*Actions/Matters Arising from 27 April 2017* *2016.2/15 – Patient Experience Strategy* To present updated version to July 2017 Trust Board *2017.2/45 – Temporary Suspension of Neurology Outpatient Service for New Referrals* To provide update to September 2017 Trust Board *2017.2/54 – Annual Operating Plan* To present Part Two and Part Three to July 2017 Board (To be reported through Sustainability Committee	 DNMQ COO FD	 **27 July 2017** **AGENDA ITEM** **28 Sept 2017** **FORWARD PLAN** **July 2017** **COMPLETED**
2017.2/103.4	*Leadership Academy* To review this piece of work on a regular basis	WD	**On-going**
2017.2/104	*Maternity Services Action Plan* To work with W&C Care Group to investigate the qualitative data from the Friends & Family Test and work up a robust plan	DNMQ	**27 July 2017** **MATTERS ARISING**
2017.2/105	*Midwifery Led Unit Proposal* • To undertake a mid-term review at three months • To write to clinical commissioners to ensure proposal doesn't pre-empt the outcome of the commissioners MLU review • To hold engagement with service users, stakeholders and staff to help shape the service pending the outcome of the review	DNMQ DNMQ DNMQ	**28 Sept 2017** **FORWARD PLAN** **July 2017** **July 2017**
2017.2/106	*Maternity Services Review and Recommendations* • To meet with C Ovington to discuss data behind report • To discuss perinatal mortality in further depth with C Ovington • To liaise with member of the public who left the meeting without having opportunity to ask question	C Deadman/ C Ovington P Cronin/ C Ovington DNMQ	**COMPLETED** **July 2017** **July 2017**
2017.2/109	*Senior Doctors Revalidation Statement* To provide paper of nursing staff validation to July 2017 Trust Board	DNMQ	**July 2017** **AGENDA ITEM**
2017.2/118	*Summary of Sustainability Committee held 27 June 2017* To undertake a piece of work relating to the reliance of Tier 5 staffing	DNMQ/COO/ WD	**27 July 2017** **MATTERS ARISING**

…….. Chair
27 July 2017

2017.2/121.1	*Trust Performance Report - Operational Performance* To provide a paper in relation to A&E to July 2017 Trust Board	COO	**27 July 2017 AGENDA ITEM**
2017.2/127	*Learning / Reflection of the Meeting* To provide a 'Community Engagement' piece for discussion at the July 2017 Trust Board To discuss the shape of future meetings with the Trust Board Chair	DCG DCG	**27 July 2017 AGENDA ITEM** **July 2017**

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27 July 2017