

The Shrewsbury and Telford Hospital NHS Trust

**TRUST BOARD MEETING**  
**Held 1.30pm, Thursday 3 May 2018**  
**Seminar Rooms 1&2, Shropshire Conference Centre, RSH**

**PUBLIC SESSION MINUTES**

|                          |  |   |
|--------------------------|--|---|
| <b>Present:</b>          | Mr B Reid<br>Mr C Deadman<br>Dr D Lee<br>Mr B Newman<br>Dr C Weiner<br>Mr S Wright<br>Dr E Borman<br>Mrs D Fowler<br>Mr N Lee<br>Mrs J Price | Chair<br>Non-Executive Director (NED)<br>Non-Executive Director (NED)<br>Non-Executive Director (NED)<br>Non-Executive Director (NED)<br>Chief Executive Officer (CEO)<br>Medical Director (MD)<br>Director of Nursing, Midwifery & Quality (DNMQ)<br>Chief Operating Officer (COO)<br>Deputy Finance Director (D.FD) |
|                          | Mrs J Clarke   | Director of Corporate Governance / Company Secretary  |
| <b>In Attendance</b>     | Miss V Maher   | Workforce Director (WD)   |
| <b>Meeting Secretary</b> | Mrs S Matthey  | Committee Secretary (CS)  |
| <b>Apologies:</b>        | Mr H Darbhanga<br>Mr N Nisbet  | Non-Executive Director (NED)<br>Finance Director  |

**2018.2/67 WELCOME & APOLOGIES:**

The Chair welcomed all to the Trust Board meeting.

Apologies were noted for Non-Executive Director Mr Darbhanga, and Finance Director, Mr Nisbet. The Board welcomed Deputy Finance Director, Mrs Jill Price, to the meeting to represent Mr Nisbet.

It was reported that Mrs Terry has resigned from her position as Designate NED; the Board formally recorded their appreciation of the work undertaken by Mrs Mingay during her tenure.

The Chair reported that a recruitment process is currently underway to appoint to the two vacant Non-Executive Director positions on the Board, as well as an additional two Associate Non-Executive Director positions.

**2018.2/68 VIP AWARDS**

The Board received videos of the following staff members who had been nominated to receive VIP Awards for the months of November 2017 & February 2018:

November 2017 - Hayley Pearson, Pharmacy Team

Hayley Pearson received the November 2017 VIP Award for showing great drive and commitment in her involvement with a recent task and finish project. The project has enabled Ophthalmology to begin the 'one-stop' model of administering patient care. This work will enable SaTH to pilot the new model which will not only benefit patients to receive their treatment in a more timely manner, but also in the safest possible way. The Trust will be able to seek re-imburement of costs from the CCG using Pharmacy reporting and the introduction of the Blueteq approval system.

..... Chair  
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### February 2018 – SaTH A&E Department Staff

The February VIP Award was awarded to both A&E departments of the Shrewsbury and Telford Hospital NHS Trust for their continued dedication to patient care while working under extreme pressure over the past months.

The staff have remained positive with a 'yes we can do approach' and have closely worked with the End of Life Care Team to improve the care given to those at the end of life.

Both teams have continued to make improvements in this area of care and have recently partnered with the Harry Johnson Trust by providing pyjamas for seriously ill children and children who die in our care.

End of Life Care specialist Jules Lewis said "I am very proud of the work with such dedicated and hardworking staff – the teams deserve a massive thank you for their tireless contribution to patient care."

The Chair congratulated each of the teams and presented them with a voucher, certificate and award.

2018.2/69

### **PATIENT STORY**

The DNMQ presented a video of a patient who is required to access health care on a regular basis and how she and her mother (also her carer) felt their experiences could have been improved during the patient's stay at SaTH. The following points were drawn from the video which could be developed and improved for all involved:

- Barrier to communication – not speaking directly to the patient, but talking in third person to her carer/mother. This caused the patient distress and lack of autonomy.
- What was important to her which was to bring her own comforter (toy) with her, and the use of personal contact such as holding her hand to comfort and reassure her
- To keep the patient and her carers informed at all times of her care and the need to involve them
- To convey the above information during handover to other providers of care, e.g. other hospitals / professionals

The DNMQ highlighted that the main learning is the importance of verbal and non-verbal communication for patients who are in hospital as they have a degree of vulnerability; the following additional improvements have since been introduced:

- Revised the Trust's Learning Disability Communications handbook to help communicate better with patients with learning disabilities
- Placed an Adult Learning Disability Support Nurse on each site to support patients, carers and staff in meeting the needs of patients with learning disabilities
- Promoted the use of the Patient Passport and included this in the Trust's revised nursing assessment documentation. The Patient Passport helps staff to understand more about a patient and better meet their needs in hospital
- Incorporated an electronic alert on patient notes to make staff aware that a patient has a learning disability
- Introduction of the Blue Ribbon Scheme which will mean vulnerable patients are not transferred from ward to ward, which can have a negative impact on their experience
- Created a poster to help staff understand better how to care for patients with learning disabilities.
- Carried out a Carer's Survey on a regular basis to help understand what carer's needs are
- Placed a Carer Support Worker on each site to support patient's carers.

The members discussed what would be acceptable or non-acceptable behaviour with regards to the use of personal contact. The DNMQ suggested staff should obtain permission to use personal touch/contact; and the MD highlighted the importance of engaging with the patient rather than making assumptions.

2018.2/70

### **BOARD MEMBERS' DECLARATION OF INTERESTS**

The Board RECEIVED and NOTED the Declarations of Interest

..... Chair  
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**2018.2/71 DRAFT MINUTES OF MEETING HELD IN PUBLIC on 29 MARCH 2018**

Mr Deadman (NED) requested minute 2018.2/45.1 be slightly amended to reflect 'the overspend on agency costs'. He agreed to forward a form of words to the CS to update the minutes.

**Action: C Deadman**

The DNMQ requested minute 2018.2/49 be updated to reflect that the 12 serious incidents relating to 30 12-hour trolley breaches caused no harm to patients.

**Action: CS to update minutes**

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

**2018.2/72 ACTIONS / MATTERS ARISING**

2018.2/36 – Minutes of Trust Board held on 8 February 2018

*CS to update 2018.2/08 to reflect that the hospital referred to is the Virginia Mason Medical Centre in America.*

**Completed. Action closed.**

2018.2/37 – Actions/Matters Arising

2017.2/192 – Key themes from exit surveys/interviews

*WD to include in Workforce Committee summary for 3 May 2018 Trust Board*

**See minute 2018.2/87 Action closed.**

2018.2/37 – Actions/Matters Arising

2017.2/217 – Organisational Development Plan

*WD to present to 31 May 2018 Trust Board*

**Action: WD Due: 31 May 2018**

2018.2/38 – CEO Overview – Future Fit Capital Funding

*CEO to forward letter of recognition to the former Director of Transformation and her team for the work undertaken*

**Completed. Action closed.**

2018.2/39 – Services in the Spotlight

*Chair of Performance Committee to keep this under review.*

**Update paper presented to Board - Minute 2018.2/83 Action closed.**

2018.2/41 – Winter Planning – Early lessons learned

*COO to provide additional update at end of winter pressures*

**Action: COO Due: 31 May 2018**

2018.2/43 – Maternity Engagement Plan

*DNMQ to present recommendation to 31 May 2018 Trust Board*

**Action: DNMQ Due: 31 May 2018**

2018.2/45.2 – Performance Committee Summary of 27 March 2018 – Financial Performance M11

*Chair of Performance Committee to review 2017/18 year and lessons learnt*

**Completed. Action closed.**

2018.2/46 – Annual Operating Plan

*Chair of Performance Committee to monitor, going forward*

**On-going.**

2018.2/58 – Non-Consultant Grade Medical Workforce Plan

*MD/WD to discuss the financial implications/benefits etc with Mr Deadman*

**Completed. Action closed.**

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*Workforce Committee to support the work and progress and provide assurance to August 2018 Trust Board.*  
**Action: WD Due: 30 Aug 2018**

2018.2/59 – Staff Survey Results 2017/18

*Workforce Committee to monitor results and assurance to be provided to September 2018 Trust Board*  
**Action: WD Due: 27 Sept 2018**

2018.2/65 – Questions from the Floor

*DCG to discuss with individual the request for figures over the last five years of babies born at home*  
**Completed. Action closed.**

*MD to obtain figures and forward detail on to the individual in respect of gender pay gap.*  
**Completed. Action closed.**

2018.2/73

## CHIEF EXECUTIVE OVERVIEW

The CEO provided an overview of the following which have occurred over the month:

### Workforce:

- Consultant Appointments – the Trust has been successful in appointing the first A&E Consultant in a number of years; and a process is underway to make further staffing appointments
- A meeting has been held with Health Education England regarding training
- In discussions with Wolverhampton University regarding the Telford campus
- £200k has been awarded to SaTH for a Skills Lab

### Quality & Safety:

- SaTH has been nominated as National Patient Safety Finalists for Stroke & Cancer
- Seeing good evidence of 'Stranded' and 'Super Stranded' patients going home. The regional average for Stranded patients is 47.1% and SaTH's average is 43.4%, whilst Super Stranded is 17.3% regionally whilst SaTH's average for Super Stranded patients is 11.8%
- SaTH is in the final stages of the Ophthalmology service refurbishment. Mr Newman (NED) reflected on the Ophthalmology Value Stream as two years ago the Ophthalmology service was in a challenged position, however this is now a service to be proud of. The Board acknowledged the work which has been undertaken by Mr Tony Fox and the staff involved in the Value Stream.
- Work has been undertaken by SaTH's operational and clinical teams to create space for a decant facility whilst essential fire work is undertaken at RSH, in the Ward Block in the first instance.
- The Secretary of State for Health & Social Care has made an announcement in relation to Breast Screening; this is being investigated by SaTH and patients will be contacted if they have received a delay in screening. The Board will receive assurance in relation to actions/mitigations, following discussions by sub-Committees of the Board.

### Performance:

- The A&E Department remains a challenge, although there has been improvement in performance
- During Easter, an initiative named 'Lets Crack It' was introduced to improve internal flow which worked well
- Governance processes have been tightened and a further sub-Committee of the Board will be introduced around Future Fit
- The Phlebotomy Service at Princess House in the Shrewsbury Town Centre has relocated to the RSH site for a period of three months. Patients will receive a letter regarding their views of the location to identify where they feel is more accessible; and the CEO reported that SaTH will abide by the patient's views.

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## 2018.2/74 SUSTAINABLE TRANSFORMATION PLAN UPDATE

The CEO presented a paper and highlighted the following updates over the month:

- Work is going forward with the Frailty Service
- Working is ongoing with Health Education England
- Extra funding has been extended to enable increase of Mental Health Service
- Continued improvement in diagnosis for Dementia – the rate for Shropshire is presently at 69.9% against that national benchmark of 66.7%
- A lot of work is being undertaken in relation to the SAFER initiative – working with Alex Knight and seen a two day reduction in length of stay
- SaTH is undertaking a Demand and Capacity Review
- Undertaken a digital maturity assessment across the whole system – identified a need to improve mobile phone signal across the county
- Work is ongoing with the Councils
- A Community Workshop is needed in February 2019
- Seeking ratification from the CCGs regarding the next level of consultation for Future Fit

## 2018.2/75 FUTURE FIT UPDATE

The CEO reported that one of the main strands is moving to the next level of public consultation. The CEO had nothing further to add at this point.

### QUALITY & LEARNING (SAFEST & KINDEST)

## 2018.2/76 QUALITY & SAFETY COMMITTEE REPORT

NED and Chair of the Quality & Safety Committee, Dr Lee, presented the following summary of the Quality & Safety Committee meeting held on 16 April 2018:

- **NHS Improvement Governance Review**
  - The Quality and Safety committee has worked closely with NHS Improvement to ensure that best practice has been implemented with respect to the sub-committee's work. The recent NHS Improvement Governance review has challenged SATH further with respect to governance arrangements. In relation to the recommendations from the report the Q&S Committee has been considering the recommendations. In particular, we are seeking better integration with the Clinical Governance Executive and Dr Lee reported that the MD is re-arranging the timings of the CGE meeting to better coordinate working.
- **Safe Staffing**
  - Whilst the staffing for both registered nurses and care staff across the hospital appears encouraging there is a high vacancy factor with unscheduled care (86.9 wte) being more adversely affected than scheduled care (44.82 wte). Dr Lee reported that the DNMQ and her team have been challenged to evidence any links between incidents and poorer staffing levels; as yet there is no evidence that that is the case, but it is an area that is being looked at very closely.
- **Fire Safety**
  - The Committee were briefed about arrangements to undertake essential fire safety work on the Ward Block at RSH in the first instance. Dr Lee highlighted the very productive work that has been undertaken with the local Fire Service to ensure the work is undertaken with sufficient haste and organisation to ensure patients are cared for appropriately whilst necessary moves are undertaken in an effective and efficient way. Plans to do this have been developed, starting with Ward 27 on 8th May.

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- **Women and Children's Services**
  - The reputation of SATH's maternity services has been identified as a key Board Assurance Framework risk. The Q&S Committee met again with the W&C Care Group to assess progress against some key actions; including arrangements for providing oversight on the monitoring of baby's heart tracing during labour are progressing well with a second staff member reviewing traces as a fresh pair of eyes on the maternity unit. The implementation of a technical solution will augment this approach. Staff have also received training with respect to the investigation of serious incidents; this training has been well received. And, the Committee received an initial briefing regarding a number of recent stillbirths that were reported. More formal investigations are in place. One potential theme is the need to encourage pregnant women to attend units promptly if they feel that their babies are moving less.
- **Testing A&E Plan**
  - Dr Lee reported on the increasing appointments of A&E Consultants and there is a degree of optimism with respect to running that recruitment process. He also reported on previous discussions held around the Trust's commitment to keeping the two A&E Departments running at the present time, however the Operations staff held a desktop exercise to test the A&E Escalation Plan to assure the Executives and Senior Managers that arrangements are robust in the event of failing to keep both departments running.

The Board RECEIVED and NOTED the Quality & Safety Committee meeting summary, and the Chair acknowledged the amount of work being undertaken behind the above summarised points.

2018.2/77

#### **QUALITY & SAFETY PERFORMANCE REPORT – MONTH 12**

The DNMQ presented the Operational performance report for Month 12:

##### VTE

The national VTE target of 95% was achieved for 2018. The MD reported that five years ago the Trust was performing at around 90%; however following a lot of work by all of the teams the increased target of 95% has been achieved for two successive NHS years. It was reported that the teams managed to maintain this national target throughout the challenged winter period.

Mr Newman (NED) highlighted that although the overall VTE performance is 95%, there are some specialties which find themselves at a lower percentage, and if these outliers were addressed we could find ourselves achieving 99%. The MD reported that these specialties do vary, but the individuals are contacted on a weekly and even daily basis, to ensure appropriate assessments are completed.

Dr Weiner (NED) highlighted that whilst it is excellent news that the Trust is achieving the national target each month; some of the specialties that are not achieving are high risk specialties for VTE, i.e. trauma and orthopaedics and general surgery, and highlighted that these issues should be addressed to maintain the safety of our patients. The MD agreed entirely and reported that reminders are continuing to ensure it is consistent across all areas.

Following discussion, the members RECEIVED and APPROVED the Quality & Safety Performance Report (M12) and actions being taken.

2018.2/78

#### **QUALITY GOVERNANCE REPORT – Q4 2017/18**

The DNMQ presented the Q4 Quality Governance Report to provide the Board with assurance relating to the Trust's compliance with quality performance measures against contractual and regulatory metrics for quality and safety.

- It is positive to note that the Trust has had zero Grade 3 pressure ulcers for four months
- 70% of complaints were closed within agreed timescale compared to 40% in February 2017
- More falls reported in Q4 compared to last year, although overall falls incidence and falls with harm remain lower than national benchmark

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- Although the Trust Friends and Family Test (FFT) satisfaction scores remain high, the response rate remains challenged with an overall response rate of 16.1%. The most challenged response rates are from maternity at 5.1% and Emergency Department at 12.8% for the quarter.
- The Trust remains non-compliant with Mixed Sex Accommodation (MSA) requirements due to the number of patients that wait for more than 12 hours to be transferred from our Critical Care Units. In March 2018, 41 patients across both sites waited for more than 12 hours to be transferred.
- A total of 4309 patient safety incidents were reported in Q4 2017/18 from 2991 in the same period during 2016/17; an increase of 1318 overall. The number of incidents graded as near miss/no harm in Q4 2017/18 were 2970 (69% of total incidents in the quarter), whilst this was 62% in Q4 of 2016/17. The DNMQ reported this is a good indicator of a positive reporting culture.
- Whilst the Trust has made an improvement in training compliance for Prevent, 41.7% have not achieved the 85% compliance rate by end March 2018. The 85% compliance was an NHS England three year trajectory which SaTH has been pursuing only since Q1 2017.
- The Trust declared 35 serious incidents (SI) and one never event (NE) in Q4 of which 28 were the no harm Emergency Department 12 hour trolley breaches. More recently the Trust's commissioners and NHS England have requested that 12 hour breaches are reported through the STEIS system as SIs.
- In the March the Trust reported a higher than expected number of intrauterine deaths at 1.8% (seven IUD) against an expected range of 0-1%. Five of the seven IUD were related to reduced foetal movements, and smoking was a common indicator across those five also. The overall figure for the year is 0.5%
- No obvious themes or trends identified in analysis of 104+ cancer waits but learning shared and monitored via Cancer Board and CQRM.
- Between December 2017 – March 2018, Maternity has seen zero HIEs (Hypoxic Ischaemic Encephalopathy) which is really positive, and is highlighted as being Green on the Maternity dashboard. The DNMQ reported that the Q&S Committee have been particularly diligent in the monitoring of this.

#### Mortality

The MD reported that he has previously drawn attention to the seasonal variation in mortality and we find, as our peer comparators do, that during the winter months sadly more patients and members of the population die. He reported that SaTH have specifically been looking at a particular cohort in terms of diagnostic groups, relating to respiratory conditions.

The MD and CEO were pleased to report that SaTH's performance on mortality is significantly better than the peer groups that SaTH is marked against, and has been for a significant period of time.

#### Grade 2 Pressure Ulcers

The DNMQ reported that the Trust is undertaking a lot of work in terms of education and training in the management and prevention of pressure ulcers, although there needs to be a system approach as a lot of patients are admitted to hospital with Grade 2 pressure ulcers. SaTH is therefore putting together 'Harm Free Shropshire' to work with care providers, residential homes, nursing homes, district nurses, etc, to improve identification at the early stages and prevent formation of Grade 2 pressure ulcers.

#### Reduced Foetal Movements

The CEO highlighted that the DNMQ had previously raised the impact of smoking in terms of reduced foetal movements and asked what aspects of work SaTH is undertaking with partners in getting health messages across to our population.

The DNMQ reported that there is good evidence that we have a significant impact on health and wellbeing when we work with our local partners; an example being smoking the in Telford & Wrekin commissioning area. With the introduction of a Smoking Cessation Midwife we have seen the smoking statistics in T&W reduce from approx. 22% to 15.1% which demonstrates we can see tangible benefits.

The DNMQ also reported that reduced foetal movements is a key issue to tackle as an organisation, and as a health system. The Women & Children's Care Group have robust plans to spread the message regarding reduced foetal movements, and raise awareness and education, specifically in the cohort of young women.

Dr Weiner (NED) raised smoking in pregnancy and is aware that smoking cessation services are now commissioned through the local authority; however he enquired how the Board could be assured that we are effectively engaging with those individuals who are commissioning the smoking cessation services for our communities in order to protect our patients.

The DNMQ confirmed that SaTH engages with commissioners through the Quality Forum (CQRM) on a monthly basis. She reported that she believes the smoking cessation service will be withdrawn from 2020; work is therefore ongoing with commissioners on how we can influence a change in that intention as it is a significant public health issue. The CEO reported there are a series of forums such as the STP Board, joint overview and scrutiny committee, etc, where we could raise our concerns and explore areas of challenge or risk.

The Trust Board RECEIVED the performance report in relation to key quality indicators at end March 2018.

2018.2/79

## **MATERNITY CLINICAL IMPROVEMENT METRICS**

The DNMQ presented an overview of data within the new maternity metrics for April 2018, highlighting:

- Ten clinical quality maternity metrics
- Clinical Quality Improvement Metrics (CQIM)
- National Maternity Indicators (NMI)
- Other Maternity metrics

### Key Messages:

- The new maternity dashboard is in line with nationally recommended indicators derived from the work of the maternity transformation programme
- The new dashboard also takes in to account the findings of wave one of the National Maternity Neonatal Health Safety Collaborative (SaTH is in wave 2)
- All new metrics are measured against nationally available data
- SaTH Maternity has a higher normal birth rate, a lower caesarean section rate and lower episiotomy rate than national data
- SaTH Maternity has a lower rate of 3<sup>rd</sup>/4<sup>th</sup> degree tears, a lower rate of assisted (operative) births and a lower rate of postpartum haemorrhage than national data
- SaTH Maternity has exceptionally high rates of skin to skin contact following birth – 100% and in cases where babies require admission to neonatology, parents have a consultation with a senior member of the team in 100% of cases

The new dashboard will be reported to both Quality and Safety Committee and externally to CQRM.

### Top ten clinical quality maternity metrics:

1. Normal birth rate
2. Caesarean section rate
3. 3<sup>rd</sup>/4<sup>th</sup> degree tears
4. Postpartum haemorrhage
5. Episiotomy
6. Assisted birth (primips)
7. Stillbirth
8. Neonatal death
9. Consultation with parents
10. Skin to skin contact following birth

### Clinical Quality Improvement Metrics (CQIM)

1. Smoking rate at booking
2. Normal birth rate
3. Caesarean section delivery rate in Robson group 1 women
4. Caesarean section delivery rate in Robson group 2 women



5. Caesarean section delivery rate in Robson group 5 women
6. 3rd and 4th degree tear rate among women delivering vaginally
7. Rate of postpartum haemorrhage of 1500ml or greater
8. Rate of successful vaginal birth after a single previous caesarean section
9. Smoking rate at delivery
10. Proportion of babies born at term with an Apgar score <7 at 5 minutes
11. Proportion of babies born at term admitted to the neonatal intensive care unit
12. Proportion of babies readmitted to hospital at <30 days of age
13. Breastfeeding initiation rate
14. Breastfeeding rate at 6-8 weeks

National Maternity Indicators (NMI):

1. Mortality and morbidity
2. Clinical care and health promotion
3. Choice and continuity
4. Experience
5. Organisational culture

The Chair queried SaTH's CNST score. The DNMQ reported that the Trust was CNST Level 3 however it no longer applies as it is now outcome based. The organisation will now be judged on the above metrics.

An NHS Resolution paper will be presented to 31 May Trust Board for sign off relating to ten key standards that the Trust is required to comply with.

**Action: DNMQ Due: 31 May 2018**

The Board RECEIVED the new Maternity metrics for April 2018 and NOTED the positive indicators that SaTH has an improving and strong maternity service.

2018.2/80

**CCG LOCAL MATERNITY STRATEGY** (*Presentation attached to minutes*)

The DNMQ introduced Ms Christine Morris, Executive Nurse & Deputy Chief Officer for Telford & Wrekin Clinical Commissioning Group, who attended to present the Local Maternity System Transformation Plan.

Ms Morris reported that Better Births was published in February 2016. The document sets out a five year vision for the transformation of maternity services to promote safer and more person centred care delivery across England.

In order to implement the recommendations within Better Births, NHS England (NHSE) has instigated a National Maternity Transformation Programme and is monitoring delivery at an STP level through the Local Maternity Systems (LMS).

The multi-agency LMS across Shropshire have worked collectively to develop a transformation plan for delivery over the next 3-5 years in accordance with NHSE timelines. The plan implementation will be a dynamic and evolving process that is co-produced with women and their families to ensure services commissioned and delivered are equitable, the safest they can be and delivered within the financial envelope available to commissioners.

The LMS plan was submitted as a draft in October 2017 with positive feedback received. A second version to respond to the key lines of enquiry was submitted on 12th February 2018. The plan is at a moment in time as there is a strong governance process behind it which is monitoring delivery and impact.

It is recognised that further detailed work on the financial costings is required and this has commenced, aligned to the Midwifery Led Unit review. Furthermore, there is recognition that additional funding would be required for the system to deliver all the stated milestones within the timeframe and bids have been submitted to NHS England for pump-priming funds.

..... Chair  
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Ms Morris reported that there is a real commitment to make this happen; it is a real opportunity to make a lasting difference to the population in terms of their maternal health, and there is a real keenness and support from women and families to achieve this.

Mr Newman (NED) reported that the organisation's ambition is to be the healthiest half million and the Board had previously held conversations during the meeting relating to smoking in pregnancy and the dangers that that can lead to increased risk of stillbirth. He also raised that the initiation rate for breastfeeding is 75%, however after 6-8 weeks that reduces to only a half in Shropshire and a quarter in Telford & Wrekin. He therefore enquired what education programmes are in place to improve that.

Ms Morris informed the Board that working with the population is key to finding out what they want and what they feel will help them to improve those rates. The Maternity Voices Partnership needs to be working with the cohort of women to understand what is going to make it a success for them, rather than imposing further leaflets and documentation onto them.

The CEO highlighted that some of the anxiety that exists around the LMS model is around the shape of that model for the future; and suggested the teams provide some independent evidence of how the health of mums and babies have/will improve. Ms Morris reported that the purpose of the LMS Plan is to establish that baseline; there is a wealth of national evidence around the benefits of doing the work that the LMS are proposing to do. The Plan has been very well received at a national level, and they do recognise that the milestones are realistic and deliverable.

The DNMQ reported on recent key evidence of better birth outcomes which relates to the levels of maternity staff and midwives in relation to the number of women. As partners in the system, we should look to ensure that the quality impact of the levels of midwifery staff going forward is sustainable.

The Chair thanked Ms Morris for attending to provide the LMS Plan presentation.

## PERFORMANCE (SUSTAINABILITY)

2018.2/81

### PERFORMANCE COMMITTEE REPORT

NED and Chair of the Performance Committee, Mr Deadman, presented the Performance Committee summary of the meeting held on 1 May 2018:

#### Financial Performance Month 12

The Trust ended the financial year 2017/18 where it expected to with a deficit (before STF) of £21.332 million. This was £5.964 million worse than plan. Taking account of STF income received the deficit reduced to £17.400 million.

#### Financial Strategy 2018/19 Update

A non-recurring revision to SaTH's control total for 2018/19 has been agreed by NHSI. The revised control total is a deficit of £8.615 million. The reduction in control total is accompanied by a reduction in the Provider Sustainability Fund (PSF) (formerly STF). As a result of the reduction in the PSF and in order to deliver the revised control total, the Trust will now need to increase its level of waste reduction schemes to deliver £8.1 million.

**Board Assurance Framework** - The committee reviewed the following risks:

|   |                        |
|---|------------------------|
| If we do not achieve safe and efficient patient flow and improve our processes and capacity and demand planning then we will fail the national quality and performance standards (CRR 561).                                       | <b>Red - No Change</b> |
| If we are unable to resolve the structural imbalance in the Trust's Income & Expenditure position then we will not be able to fulfil our financial duties and address the modernisation of our ageing estate and equipment (670). | <b>Red - No Change</b> |

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| 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 (1187). | <b>Red – No change</b> |
|---|------------------------|

At the end of the meeting the committee confirmed that the three BAF risks had been considered in the discussions which had taken place at the meeting.

### **Trust Performance Report**

An update on the Trust's performance against RTT, A&E, Cancer and Diagnostic targets was provided. Despite significant efforts, RTT, A&E and 62 day Cancer targets were not achieved during March. The Trust continues to achieve the Diagnostic target.

### **Operational Plan 2017/18**

Progress report for performance at month 12 against the Trust's delivery of Part 1 of the 2017/18 Operational Plan was received and noted by the Committee.

Mr Deadman referred to the assurance matrix for business and care improvement objectives and the highlighted the following items of importance:

- 3) Capacity review to be completed by Meridian consultancy by September
- 4) Stream patients effectively, finalise the Urgent Care Centre at PRH and address the Urgent Care Centre deficiencies at RSH by June
- 5) Complete workforce review of PRH/RSH A&E department and address 6pm-12am capacity shortfall by June
- 6) Plan to address capacity deficiencies occurring at the weekend addressing insufficient discharge by June
- 7) Implement Red to Green and SAFER programme from April – June
- 8) Realign Scheduled Care and Unscheduled Care beds from April – October
- 14) Agree and implement the new bed profile in relation to the new nursing structure from April – October
- 15) Conclude arrangements to transfer 70 patients to community provision from April – October
- 21) Develop a trajectory for agency usage improvement by April
- 22) Full analysis of job plans to be put in place aligned to operational needs by September

Mr Deadman reported that a great amount of work has been undertaken over the last year; some relating to initiatives to improve quality and care and some relating to making SaTH more efficient and effective; however there are still a large amount of Amber and Red ratings at the end of the year. He therefore suggested applying the learning from last year to the year ahead.

### **Operational Plan 2018/19**

As requested at the last meeting, the committee was provided with further detail behind the Operational Plan 2018 / 2019, including trajectories. Six key areas of focus had been identified and each one assigned with a key senior lead from either SaTH, the CCGs or the Local Authorities.

The committee noted the A&E trajectory to achieve a target of 86.45% at the end of March 2019. The workforce, system wide support and continued performance management would be critical to delivering this. Plans to reduce winter beds and the number of escalation beds by 1<sup>st</sup> July 2018 were shared. This would not only allow the Trust to deliver bed occupancy of 92% but would be a key enabler to the waste reduction schemes associated with agency usage. The Trust's focus on workforce in 2018/19 was explained to the committee and would include improving agency bookings through the preferred supplier, removal of tier 4 and 5 agency and recruiting 30 wte registered nurse.

The committee is to continue to seek assurance on improved agency performance as part of the committee's discussions and monitoring of the Waste Reduction schemes. Details of the schemes were shared and their current status noted (majority red). Potential waste reduction schemes amounting to £8.890 million have been identified. However in the light of the revised control total and now the need to deliver £8.198 million CIP (2.2%), this leaves

..... Chair  
31 May 2018

little room for slippage/non-delivery. A monthly Waste Removal Group has been established and a robust governance structure put in place. The committee will continue its monitoring of the programme through its 'deep dive' of the schemes. Nurse agency and bed reduction will be the subject of the 'deep dive' at the next meeting.

Despite the hard work underway, the personal ownership exhibited and welcomed from the COO and some signs of greater clinical and nursing leadership and ownership, Mr Deadman (NED) stated he did not currently feel assured the organisation would be able to deliver the scale of savings and improvements targeted. Most of the Performance Committee agenda was committed to seeking further assurance and this issue would be extensively discussed at their next meeting.

### **Services under the Spotlight**

The committee was updated on services currently provided by the Trust that are considered fragile due to workforce constraints which impact on service delivery. These are the Emergency Department, Neurology Outpatient Service and Dermatology Outpatient Service. The key risks, actions taken to date and next steps were outlined to the committee.

The committee was encouraged by the recent successes in the recruitment of consultant staff which positively impacts on the ability to attract middle-grade staff, although acknowledged that this would not solve the short term challenges the Trust is facing, particularly with regard to the Emergency Department. The committee requested that these services remain under intense spotlight to ensure the safety of all concerned.

### **Sustainable Services Update**

The Sustainable Services Programme update was received and noted.

### **Any Other Business**

The committee was invited to comment on the Northumbria Technical Report circulated to members.

Overall, Mr Deadman reported to the Board that there are a series of plans to achieve this year's target of approx. £8m however there is a significant number of Red and Amber ratings in the current year's financial plans. At the moment we need to deliver 92% of the plan in the current year. Given where we have been, Mr Deadman suggested 92% feels heroic, but we need to provide plenty of support to those leading the initiatives and ways of addressing this.

The Chair reported that it is a relief that we have the £8.1m financial target for 2018/19 and it has produced a settlement of 2.2% which is generous in NHS terms, and in terms of what other Trusts have been asked to achieve (4% and above). The Centre has looked at all of the circumstances around the Trust and has taken a more lenient view than taken with others. The Centre has reached out to help SaTH given the unique circumstances that we have. Although it is a large figure to achieve, the CEO reported that we are seeing the schemes align in terms of our patients going home early, therefore we are not staffing wards that we don't need or escalation areas that we shouldn't have open, and not relying on bank and agency staff that we can't afford, to ensure our patients are in the right environments receiving better care, outcomes and experience. The work that the operational teams, alongside the MD and the DNMQ's support, show a good indication of progress which is encouraging.

Also, unlike previous operational plans, SaTH has three specific themes of improvement for 2018/19 which makes for a significant improvement, alongside work with Virginia Mason to reduce waste.

2018.2/82

## **TRUST PERFORMANCE REPORT – M12**

2018.2/82.1

### **FINANCIAL PERFORMANCE**

The D.FD presented the key issues of the Month 12 report, informing the Board that in January 2018 the Trust made the decision that it could no longer achieve the original control total of £15.3m before we had received any STF money. That target was revised to £21.3m; therefore £5.96m away and that is genuinely what was delivered at the end of the year. There were some adjustments for the STF funding, and we received £2.7m more than originally envisaged at the end of the year, so ended with a deficit total, after taking account of the STF funding, of £17.4m.

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The significant recurrent deficit of in excess of £20m is being considered in the 2018/19 position.

The D.FD assured the Board that from January 2018, actions were delivered, particularly around the Tier 5 staffing. Rectification plans put in place from December onwards have been delivered, hence bringing broadcasts to where they were expected, therefore a reasonably comfortable Month 12 position which is beginning to show control of where SaTH needs to be.

Discussions have been held through the Performance Committee, especially relating to issues around the CIP plan and the processes put in place for that. The D.FD highlighted that a number of issues are RAG rated Red; they will not be converted to Amber or Green ratings until there is absolute rigour and assurance around them. A lot of the schemes relate to capacity and flow issues which need to be focused upon, although processes appear to be in place, and some key issues are being delivered.

#### Income & Expenditure

At the end of the 2017/18 financial year, the Trust had planned to receive income amounting to £348.205m and had generated income amounting to £354.093m; an over performance of £5.888m.

#### Pay

To date the pay spend amounted to £225.049m against a plan of £239.299m resulting in an overspend of £5.75m, predominantly due to the continued use of agency and non delivery of key CIP schemes.

A significant element of the pay overspend relates to the continued use of agency above those levels planned which is well in excess of the Agency Ceiling set by NHSI. Total agency spend for April 2017 – March 2018 amounted to £18.689m, £8.130m above the Agency Ceiling set by NHSI.

Mr Newman (NED) referred to the Non-Pay line of the 2017/18 Month 12 position which has deviated by approx £4m and reported that the FD had previously assured the Board at the half-year report that it would come back on budget by Month 12; the D.FD reported that this is due to expenditure in non-pay and drugs payments, however the D.FD assured the Board that run-rate/spend has been broadly consistent month by month. The areas where there has been some concerns relate to clinical supplies, particularly in Theatres and drugs as there has been an increase, but a piece of work will be undertaken through the CIP scheme to look into this further.

#### Non Pay

To date the non-pay spend amounted to £116.207m against a plan of £109.835m resulting in an overspend of £6.372m.

#### Trust Capital Programme

The Capital Resource Limit (CRL) for 2017/18 has been increased to £11.834m representing internally generated CRL of £10.068m and Public Dividend Capital (PDC) allocation of £1.600m for PRH A&E Streaming Capital Project (£1.000m Urgent Care Centre and £0.600m Clinical Decisions Unit) and an additional PDC allocation of £0.166m in respect of Cyber Security.

At Month 12, £11.834m has been expensed with the Trust achieving its Capital Resource Limit.

#### Trust Cash Position

The Trust is required to hold £1.700m on the Balance Sheet at the end of the financial year which was achieved, with £1.649m cash held in the Trust's bank account.

Due to delays in expenditure in the Trust's Capital Programme, there is over £4.000m of payments to 'capital creditors' which will be due during the first quarter of 2018. This has been factored into the cash model; it is therefore pivotal for the Trust to control its expenditure to ensure that cash is available to pay the creditors.

For 2018/19 the Trust is forecasting a deficit of £19.380m and in the cash model it is assumed revenue financing will be made available from the Department of Health. However, the Trust has been informed that this financing will be subject to increased challenge and scrutiny.

The CEO reminded the Board of the decision that was made to invest in 30 additional junior doctors; those costs are clearly within the financial overview so some of the reason the financial position has worsened is due to the decision to invest in the organisation's workforce; directly attributable to the experiences of winter.

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Summary

Against the combined CIP and rectification plan of £13.574m, £10.355m was achieved at the end of April 2018, reflecting £4.236m original CIP schemes and £6.119m rectification plans.

There was an over performance in Procurement and CSS schemes against plan, with shortfalls in month seen in Meridian against Month 11.

Overall, the shortfalls are due to the non-delivery of PAY CIP schemes, Scheduled Care, and the failure to release savings from Bed reconfiguration.

**2018.82.2****OPERATIONAL PERFORMANCE**

The COO referenced the Waste Reduction Scheme and the CIP and cost savings and reported that the team is firm on it being a waste reduction focus rather than simply taking cash out; and it is about improving what we do and how we do it.

To reassure and confirm, the process of ensuring that we have the right documentation which has been quality assured, linked with the clinical leaders, is really important. Some of the other markers mean that we are able to track different parts of the process to the documentation. The robustness is essential; and it is encouraging to see that we're already seeing some of this work correctly.

The COO highlighted that one of the key critical paths of focus in Q1 is to reduce the escalation space that we were holding, some of which was boarding. This was not only a pressure on the staff but also a financial implication to the Trust. Already in April a number of those escalation spaces have been closed, including the winter wards as well as the space to allow the fire work to take place on the Ward Block at RSH. This has also meant a reduction in the agency requests for both registered nursing and others, which is in line with our plans.

The other element of 'Lets Crack It' was a mechanism to reinvigorate six key workstreams under the Urgent Care programme; three of which are led by SaTH Execs and three of which are led by other Execs across the system; and to really learn lessons and encourage what is going right, and other lessons to push back in to the workstreams. SaTH is already seeing a reduction in Stranded patients.

RTT Performance

The Trust actual combined (admitted and non-admitted) incomplete performance of 91.3% for 2017/18 did not achieve the target of 92%.

Urgent Care Update

The COO reported that whilst in a couple of events the weather did play a part for both staff and patients, urgent care pressures were significant and disruption to the daycase areas was one of those. One of the priorities was to come out of the day surgery environments as quickly as possible to allow them to function, which was one of the first results and outcomes of the Easter 'Let's crack it' focus.

A&E Performance

Performance was lower than required and whilst this has improved during April, further work is still required.

The COO reported encouraging signs around the Emergency Care workforce, including the appointments of Emergency Care Practitioners who will be able to work in the Minors/Non-admitted, and add clinical expertise alongside medical staff.

Cancer

The COO highlighted a slight correction regarding the figure for cancer performance where we narrowly missed the 85% - this was for February 2018.

The COO assured that Board that a lot of work has and continues to be undertaken, and the figure for April was well above the 85% target. Indication is that the organisation will be Green in all of the different measures for the full year.

### Diagnostics

The COO reported that diagnostics is a really important part of a patient's pathway. The Trust has been well over the 99% target and maintained that, and this has been carried through to April 2018.

Dr Weiner (NED) reported that the NEDs visited a number of clinical areas prior to the Trust Board meeting and he enquired how frontline staff are receiving feedback regarding performance, as he did not physically see a great deal of information as to how the organisation is performing every day.

The COO reported that the main mechanisms are around the Executives being as visible as possible; he also reported that he holds a weekly meeting with his senior team, and the MD and DNMQ also hold meetings with their medical and nursing teams. The Emergency Department have live trackers and sheets that the emergency co-ordinators and medical staff record after every 12 hour shift to show the numbers and performance and that is fed back through nursing, medical and managerial lines.

Daily work is also undertaken at the operational level for elective work, and a weekly review meeting held for both cancer MDTs as well as RTT.

The Chair enquired how performance is cascaded to key workers (porters, domestics etc). The CEO reported that there are a number of tools that are used, e.g. the business intelligence tool which is available on the Intranet which features live data and metrics; the Patient Status at a Glance (PSAG) Board is also available to show the status of the hospital.

The CEO and DNMQ felt this was a good challenge and suggested refreshing with the staff that these tools are available. The CEO reported that electronic technology is used rather than a paper approach as it is live data which would otherwise be out of date. The DNMQ suggested using the methodology of the Transforming Care Institute link boards/production boards, in a far more effective way to make it standard work across the organisation.

The WD reported that whilst there are a number of mechanisms used across the organisation, they are mainly technology based. She highlighted that from the Staff Survey results, communication is an area for improvement. The importance of conversations will form part of the work with the Leadership Academy and how managers are supported to hold every day conversations to keep their teams informed.

Dr Lee (NED) reflected on his visit to the Wards prior to the Trust Board meeting; and he left the staff with a challenge to redesign the quality board with a way which was more meaningful for them, and reflect the quality of service that they are delivering.

The DCG reported that the Senior Leadership Team (SLT) held discussions about the power of face to face conversations. She highlighted the importance of holding face to face conversations and engaging with teams, with three key messages that have come from the Trust Board on a monthly basis.

Following discussion, the members RECEIVED and APPROVED the Trust Performance Report (M12) and actions being taken to address performance.

2018.2/83

### **SERVICES IN THE SPOTLIGHT UPDATE**

Further to the update provided to the 29 March 2018 Trust Board, the COO presented a further updated position regarding key services that have particular workforce challenges.

### Emergency Departments

The COO reported that it is encouraging that we have recruitment taking place with substantive Emergency Department consultants. The COO also reported that there are a number of middle grade applicants and interviews are imminent. It is therefore an increasingly improving picture going forward.

The COO reported that daily reviews take place to keep a firm eye on the challenges in the meantime.

### Business Continuity Plan

Dr Weiner raised the Business Continuity Plan for the Emergency Department and reported that the Board discussed the table-top exercise at meetings held on 8 February and 29 March 2018 where it was noted that SaTH

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did not have engagement from all partners across the system, and dialogue had commenced with the Ambulance Service. Dr Weiner enquired if the organisation is now receiving improved engagement from external bodies, and if they are working to help develop the business continuity plan so that it could deliver more effectively, if required. The COO confirmed that SaTH is receiving improved engagement and there has been a significant amount of dialogue with the Ambulance Service over the past month.

#### Neurology Outpatient Service

This is a challenge nationally. SaTH has worked with a number of specialist centres to ensure we have care for our inpatients and support for outpatients. A number of sessions will be secured from the Walton Centre by the end of May 2018; although it is not the total amount of sessions required. Conversations are therefore being held with other centres (UJNM).

#### Dermatology Outpatient Service

This is also a national issue. SaTH continues to be supported by a long-term locum. We are also looking to understand how we would secure and procure a service. We have looked at GPs with specialist interest etc. Whilst this is not immediately a risk, we are looking at how we continue to support the service.

#### Ophthalmology Service

The COO reported that whilst Ophthalmology in continuing to open to further services, the next six months will see the final capital investment create a fit for purpose unit for the department.

The Board RECEIVED the Services in the Spotlight update.

## GOVERNANCE (LEADERSHIP)

2018.2/84

### AUDIT COMMITTEE CHAIR'S REPORT

NED and Chair of the Audit Committee, Mr Deadman, presented the summary of the Audit Committee meeting held on 13 April 2018:

#### Internal Audit

- (i) Gus Miah (Deloitte) advised that management identify areas of concern for the performance reviews as these are the areas for greatest gain and learning, although this may result in a limited opinion.
- (ii) IA plan – The Committee discussed the IA plan for 2018/19.
- (iii) The following Audits were presented:

| Audit                                | Opinion     | No. Recommendations     | Committee                   |
|--------------------------------------|-------------|-------------------------|-----------------------------|
| <b>Core Audits</b>                   |             |                         |                             |
| Risk Management and BAF              | Substantial | 1 med; 3 low            | Audit                       |
| General IT controls                  | Moderate    | 3 high; 2 medium        | Resources Directorate Board |
| <b>Performance Reviews</b>           |             |                         |                             |
| Draft Outpatient appointment process | Limited     | 3 high; 6 medium        | Q&S                         |
| Draft temporary staffing review      | Limited     | 5 high, 1 medium; 1 low | Workforce                   |
| Draft Business continuity planning   | Limited     | 3 high; 3 medium; 1 low | Performance                 |

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Concern was expressed that in a number of audits two issues were arising on occasions in certain audits, it appeared that minimal scope recommendations were being proposed to the Audit Committee on the basis that the residual risk was acceptable. However it was not clear if Executive leadership had reviewed the acceptability of this situation. In addition there did not always appear to be a clear link to risk management. There was also some uncertainty around the number of restated recommendations in the report and it was agreed that a post-meeting review would be undertaken.

It was agreed that:

- The Director of Corporate Governance would contact Lead Directors to review responses and consider raising the issues as organisational risks.
- Audit Committee asked for a system to ensure assurance from the lead Director that the management responses on the Moderate and Limited Assurance Audits were proportionate and appropriate. In future Lead Directors should also be given the opportunity to sign off the management response before submissions to Internal Audit.
- It was also agreed that all recommendations, when being closed, should be reviewed at Executive Directors as some recommendations appeared to have been closed inappropriately.
- Going forward it was agreed that the DCG would consider a process to Quality Assure all management responses before submitting to Deloitte. Deloitte will need to ensure responses have been signed off before finalising reports. The DCG confirmed that a Standard Operating Procedure (SOP) has been drawn up, following concerns expressed at the last meeting, to ensure a stronger QA process and robust system before recommendations are closed, where all of the Executives will agree that the actions are closed off.

#### Head of Internal Audit Opinion

The Committee discussed the core elements - Moderate Opinion; Assurance Framework – significant assurance; and Performance Reviews – moderate opinion but note that “these are focussed on areas identified as offering greatest scope for improvement to maximise the benefit and learning of the Trust”. The overall opinion will be Moderate.

#### Counter Fraud Annual Report

The Committee was pleased to note that SaTH had again achieved an overall rating of full compliance against each of the NHS Counter Fraud standards for Strategic Governance:

- Inform and Involve
- Prevent and Deter
- Hold to Account

#### Board Assurance Framework and Operational Risk Register

The Audit Committee discussed the revised BAF aligned to the new strategic objectives agreed with SLT and the Board. Also discussed the risk appetite for delivery of the objectives and recommended approval to the Trust Board. The Committee also discussed the new risks added to the Operational Risk Register.

Mr Deadman reported that Deloitte are very complimentary about the Executives appetite to focus their work on areas where they are worried. He congratulated the Executive on being very open and welcomed that approach.

Mr Newman (NED) enquired if there is a statutory requirement to go out to tender for the Internal and External Auditors. The DCG reported that the External Auditor used to be appointed by the Audit Commission however that arrangement ceased two years ago and KPMG were appointed from going out to the market.

The Trust is required to go out to the market for Internal Auditors; and Deloitte were awarded a three year contract, with the possibility of extending it by two years. The DCG reported that the Trust is currently in Year 2 of having Deloitte at its Internal Auditors.

The Board RECEIVED the Audit Committee summary.

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2018.2/85

**INTERNAL AUDIT PLAN**

Mr Deadman (NED), presented the Internal Audit Plan for 2018/19 which the Audit Committee had discussed during the 13 April meeting where they agreed that Future Fit governance should be removed and replaced by the following performance reviews:

- Model Hospital Programme
- Complex Discharges Management

Remaining on the plan will be the following performance reviews:

- Business cases
- Quality indicators
- Staff travel
- Follow up of previous recommendations

Mr Deadman requested the Board to let him know if issues arise or if they would like the Audit Committee to look at other areas as there will be scope to flex part of the Plan.

The Trust Board APPROVED the Internal Audit Plan subject to the above amendments.

2018.2/86

**BOARD ASSURANCE FRAMEWORK & TRUST OPERATIONAL RISK REGISTER**

The CEO reported that the Senior Leadership Team (SLT) agreed the revised objectives for 2018/19 and beyond, and the revised Board Assurance Framework with the draft risk appetite for each of the objectives. It is an active document which the Executive review on a regular basis to determine that the underlying risks are being addressed and are progressing.

The Chair questioned the operational risk register and the highest risks (scoring 20) as many require capital funding to reduce the risk; he therefore asked the D.FD to identify the costs to move the risk ratings down.

**Action: D.FD Update Due: 31 May 2018**

The D.FD assured the Chair that she is comfortable with the process from a capital point of view; the Capital Planning Group is highly linked to the risk register, and risks scoring 20 are immediately presented to the Capital Planning Group. However there are other risks on the risk register, e.g. workforce risks where the Trust has the budget but is unable to recruit to the positions.

The Chair asked what it would take to turn the risks to Green at Board level. He felt comfortable that there is full sight of the risk register at an organisational level but felt uncertain of the Board being asked to accept such high level risks. The Chair therefore suggested additional detail be included in the update being presented to Board e.g. inclusion of capital costs, if document awaiting approval, etc.

**Action: DCG**

The DCG assured the Chair that the paper was a summary document, and behind each of the risks there is a web-based system which identifies the costs, controls and action plans to mitigate to the lowest available risk score. The BAF is discussed in detail at every Audit Committee, and is also reviewed by each of the sub-Committees of the Board.

Mr Newman (NED) raised the risk relating to the Cardiac Catheter Lab replacement (CRR1105) as he pays particular interest in getting a lot of cardiology work repatriated to the county; and requested further information following it being presented to the Capital Planning Group (CPG) during January 2018. The MD reported that he sits on the CPG and there was the recognition that it is an important area that would need to be resourced, but given other areas that also need to be resourced, the risk would need to return to the CPG in the new financial year. The MD assured the Board that it is a high priority and there is recognition that there is an impact on the ability to care for our patients.

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Mr Deadman agreed that the Trust is carrying a high level of risk, and feels the Trust needs to improve its business case processes. He highlighted that some risks have been seeking funding, some for many years; this therefore needs to be addressed as the organisation is not currently in a comfortable place.

The CEO reported that a detailed review of the Estate was undertaken and identified that the organisation's backlog maintenance is £140m; this is part of the reason why the Department of Health have agreed to give the organisation half of the national capital allocation to be able to re-build our hospitals in recognition of that risk; however that is a number of years away and we therefore need to ensure risks are managed well in the intervening time.

Following discussion, the Board REVIEWED and APPROVED the Board Assurance Framework.

## WORKFORCE (PEOPLE)

2018.2/87

### WORKFORCE COMMITTEE REPORT

NED and Chair of the Workforce Committee, Dr Weiner, presented the summary of the Workforce Committee meeting held on 23 April 2018:

#### Board Assurance Framework

The Committee received the Board Assurance Framework report and held a full discussion regarding this. The Committee agreed that the ratings would remain the same. The Committee will undertake a Deep Dive in May focused on the Emergency Department.

#### DBS

The Committee received the DBS Check Assurance Statement and congratulated the team on the progress to date. The expectation of the Committee is that the update work will be completed by the end of April 2018, apart from those small numbers of cases with exceptional personal circumstances (e.g. extended sickness absence). The Committee discussed some of the areas in the Trust that do not have DBS checks carried out and asked for sight of the risk assessment carried out on all roles in the Trust to provide assurance to the Committee that the appropriate staffing groups are being checked.

#### Staff leavers, Staff Survey, Values Guardians updates

The Committee received updates on 'exit surveys', the Staff Survey and the Values Guardians. These three updates indicate common themes that impact the employment experience of staff. Work will be completed by May with the intention of addressing these themes. The common themes include aspects of behaviour and people management.

#### Peoples priorities

The Committee received a proposal for the future focus of work. An initial draft of high level priorities linked to outputs for 2018 / 2019 was presented. The two highest level priorities identified for the Workforce Committee are (a) growing and developing Team SaTH and (b) ensuring people feel supported. The Committee agreed:

- Support for the high level priorities
- That the overall structure and plan requires more detailed work and this will be presented to the Committee in May 2018
- That outputs expected of the work should be Comprehensive, Specific, Measureable, Realistic and Timely
- A desire to see outcomes that can be tracked on a monthly or quarterly basis rather than relying on infrequent measures that do not lend themselves to driving improvement
- That the active management of risks within the Board Assurance Framework should be included within the high level priorities and all work should clearly be linked to preventing, reducing or mitigating risk within our system
- A clear framework, with performance indicators that allows effective management and governance around the priorities to be in place and fully operational by July 2018
- This work will be a standing item on the Committee's agenda and given a high focus of attention.

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### 8 High impact for junior doctors

The Committee received a report on improving the working environment for Junior Doctors presented by the Deputy MD. The Committee ran through the 8 key areas that require improvements and held a focused discussion around the provision of food for junior doctors, especially hot food at night. The Committee agreed that a full proposal was needed and it was agreed that this would be presented to the Workforce Committee in August, following agreement at the Executive Directors. It was highlighted that this aspect of work could and should benefit all staff.

### NHS70

The Committee received an update on the NHS70 celebrations throughout 2018 by the DCG. The Committee were asked to support the recommendation that the two HSJ finalists attend the AGM Spotlight Session which is Cancer App and the Stroke Team which was agreed.

Dr Weiner highlighted the People's Priorities of the written summary which reports that the Workforce Committee intends to refocus the work of the Committee over the next two – three months to be more effective at addressing the underlying risks and improve the quality of life for the workforce, and also for our services as a result of that.

The Board RECEIVED the Workforce Committee summary.

2018.2/88

### WORKFORCE PERFORMANCE REPORT

The WD presented the Month 12 performance report in relation to:

#### Sickness / Absence

The WD reported that the Trust is seeing a downward trend in workforce sickness/absence at 4.10% which is heading in the right direction; however as a Committee and the conversations held around the Peoples Priorities, the highest reasons for absence remain to be MSK and Mental Health. Whilst there are a range of initiatives for staff (fast-track physio for staff, 24/7 counselling available for staff, etc), we are not seeing the kind of improvements that we would like. Further work has therefore been carried out for further understanding.

The DNMQ highlighted that the Facilities Directorate sickness/absence seemed disproportionately high; the WD informed the Board that the rate remains high and a significant number of the workforce sit within that function, but they have reduced it quite significantly. They presented to the Workforce Committee and reported that the sickness level has reduced by 4% over the last 6 months, so a lot of work is going on.

#### Appraisals – Overall compliance rate 76.31%

The WD reported that the Workforce Directorate appraisals rate was 67%, not 16.42% as documented. The Chair did not feel comfortable to accept the overall level of compliance; and reported that the organisation will not achieve the People objective unless a full appraisal system is in place; he therefore remitted this to the work of the Workforce Committee.

#### Statutory Safety Update (SSU) Training – Overall compliance rate 64.95%

The WD reported that the Workforce Directorate SSU compliance was 84%, not 37.10% as documented. The Chair highlighted that the SSU figures are poor and therefore asked the Workforce Committee to pick this up as all workforce professionals should keep themselves up to date with their training.

The WD suggested the Trust is still catching up following the Trust's decision to pause training for a period of time which has impacted on that.

Dr Weiner agreed that compliance for Appraisals and SSU is not acceptable; and referred to one of the Peoples Priorities which relates to having a clear framework with performance indicators that allows effective management and governance to be in place and fully operational by July 2018, which he would like to see covered in these systems.

#### Staff Turnover (exc. Junior doctors) – Recruitment rate 9.73%, Retention rate 92.24%

The WD reported that the Board had talked about the increase in recruitment which is having a positive impact.

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The Trust Board RECEIVED the Workforce Committee update.

## 2018.2/89 TRUST DRESS CODE AND APPEARANCE POLICY

The WD presented the revised Dress Code and Appearance Policy which sets out the expectations of the Trust in relation to personal appearance, uniform and work wear, which applies to all Trust staff.

The Trust will take a sensitive approach when matters affect personal appearance, dress and uniform requirements, however there will be circumstances in which there are genuine occupational reasons (e.g. the need to minimise the risk of cross-infection) as to why the wearing of certain articles and/or clothing is not permissible. Priority will be given in relation to:

- Minimising the risk of cross infection
- Minimising the risk of injury to patients
- Complying with Health and Safety regulations
- Providing a positive and professional image
- Providing a consistent approach to uniforms to support easy patient recognition of staff
- Enhancing Trust security arrangements
- Complying with Food Safety Legislation

Following discussion, the Trust Board RECEIVED and APPROVED the updated Trust Dress Code and Appearance Policy.

## 2018.2/90 REMUNERATION COMMITTEE

The members were informed that a Remuneration Committee had been held as the CEO would like to take some annual leave, and in the absence of the FD & Deputy CEO, the Remuneration Committee members asked the WD to act up as Deputy CEO until the end of June 2018. This was agreed.

## LEARNING

### 2018.2/91 TRANSFORMING CARE INSTITUTE (TCI) UPDATE

The CEO presented an update which reported that several more significant steps have been achieved in relation to:

- Over 2600 staff have been educated in the methodology
- Over 100 leaders in the organisation have completed/commenced Lean training
- SaTH will support the NHSI KPO
- Over 70 wards/departments have introduced 5S as a methodology to improve safety
- Patient safety huddles have been successfully tested within Maternity Services, with further areas for roll out identified
- Active values streams with the launch of Value Stream#7 Radiology (Colorectal Cancer) in April 2018
  - Respiratory discharge has been repatriated back into the Unscheduled Care Group
  - Sepsis pathway – the sepsis bundle is being delivered within 30 minutes and a multitude of vehicles are being used to do that
  - Recruitment process – 97 days have been taken off the recruitment process which is a huge improvement
  - Outpatient Ophthalmology service – starting to see a 57% improvement in cancellations
  - Patient safety (initially focused in W&C services) – the next Rapid Improvement Week will look at low/no harm and the evidence around that
  - Two new Value Streams – i) Emergency Care – our teams have gone through the most difficult winter but continue to attend the sessions around the improvement work to invest in making changes in their departments and the experience for their patients; also ii) Radiology commencing April/May 2018.

..... Chair  
31 May 2018

The CEO reported that 24 Rapid Improvement Weeks will be carried out throughout the year where clinical staff will be taken out of their departments and given time to look at their services in detail and make changes.

All Executives, apart from the recently appointed COO, have completed the Lean for Leaders training; and staff trained in the methodology are gaining a deep understanding of how we can use this methodology to improve patient safety. 50% of Trust staff have been trained in this method in two years which is the most significant outcome of any of the Trust's involved in this work.

The CEO informed the Board that staff who have been accredited must be re-accredited to ensure they are practising the skills each year, to ensure they do not lose the skills.

The COO reported that the methodology has been offered to CCGs, the Community Trust and local authorities and the two local authorities have accepted; this methodology will therefore be used with a multi-agency approach with a number of different partners involved.

Following discussion, the Board RECEIVED the Transforming Care Institute monthly update.

2018.2/92

**ANY OTHER BUSINESS**

No further business raised.

2018.2/93

**THE MEETING CLOSED AT 4.25pm AND THE BOARD TOOK QUESTIONS FROM THE FLOOR :**

Q1

**How does the Future Fit process and public consultation affect the services for the rest of the county?**

A1

The consultation relates to the reconfiguration of the hospitals rather than what the community services should look like. It shouldn't imply or suggest that this is going to have an impact on the rural services – that would be done separately.

Q2

**How can the public consultation take place without informing the public how much of the £312m funding will be Public Dividend Capital?**

A2

The Board confirmed that they have not yet been informed how the £312m will be funded; and re-iterated that it is the CCG's public consultation.

Q3

**A query was raised in relation to the criteria of transporting patients' relatives to hospital (if they are required to escort the patient); and it was suggested this issue be fully examined as part of the Future Fit proposal as it there are serious consequences around transportation.**

A3

The CEO reported that he would obtain the information and report back via the minutes for the 31 May public Board meeting

POST-MEETING NOTE: The Deputy COO advised that there is no set criteria and each case is assessed on the need of the patient. Patients who normally require an escort (if registered blind, dementia, learning disabilities) would be allowed to travel with an escort. The Deputy COO agreed to investigate further with the Shropshire CCG who hold the contract.

Q4

**It was questioned if staff are being praised for their continued hard work, as this boosts morale.**

A4

The CEO reported that every opportunity is taken to remind staff in every way possible that they do a remarkable job; and the Trust is very fortunate to have such dedicated staff.

The Board members had visited the Wards prior to the Board meeting and chatted with the staff. The CEO also reported that a Report Out is held each month where staff are invited to attend to celebrate the work they have been undertaking.

Q5

**A member of the audience highlighted that she had requested at a previous Board meeting data relating to the patient profile of those classified as frail and elderly. She confirmed that she had received and studied the data and feels there are serious questions around i) the geriatric workforce; ii) ambulatory care sensitive patients (respiratory in the older population); iii) the younger population, and how many of these are hitting A&E with chronic conditions.**

- A5** The Chair reported that the Trust's aspirations are to work with the community service so that we can plan the whole process; he recognised the points being made and the improvements that can be achieved.
- The CEO reported that it is a very complex issue. A huge amount of work being undertaken, which can be seen from the context within the STP and the various schemes.
- Q6** **How many people in the 'stranded' patient group are also in the 'delayed transfer of care' group?**
- A6** The COO reported that the 'stranded' patient terminology has been used to describe patients who have been in hospital for over 7 days, although there will be patients in that group who are poorly. He confirmed that the two groups do overlap.
- He COO assured the meeting that the organisation is working to improve pathways and the preparation for patient discharge.
- Q7** **The 'Let's Crack It' initiative was referred to and it was questioned how are we going to check if the initiative is sustainable in three months' time, as in previous years the organisation held a week of 'Breaking the Cycle' where the staff saw huge improvements but felt demoralised when this was not taken forward.**
- A7** The COO reported the collective approach being undertaken by the MD and DNMQ, supported by the WD, regarding embedding changes. He agreed to provide feedback on quarterly, if not monthly, basis via the Operational performance report to Board.
- Action: COO**
- Q8** **Concern was raised regarding the Phlebotomy Service, previously provided at Princess House in the Shrewsbury town centre, as a relative of a regular attendee reported that the accommodation provided for this service at the Royal Shrewsbury Hospital won't be sufficient for the amount of patients attending, and will therefore not be safe (patients required to queue, stand if chairs unavailable, etc).**
- A8** The CEO agreed to investigate this further; and also reported that it is intended to gauge the view of the patients using the service over a three month period.
- A Counsellor from Shropshire Council suggested the CEO holds a conversation with the local authority regarding the location and premises of the Phlebotomy Service; also to hold conversations in relation to alternative venues for the midwifery service in Whitchurch. The CEO welcomed this approach.
- Action: CEO**
- Q9** **A further member of the public raised concerns regarding the relocation of the Phlebotomy service and asked the CEO to commit to reopening the service in Princess House with immediate effect.**
- A9** The CEO reported that he would be unable to commit to this; but did commit to liaising with the local authority in terms of alternative accommodation as SaTH would not want to compromise the safety of patients using the service at the RSH site.
- The CEO also gave assurance that he would obtain the level of detail around the equality impact assessments.
- Q10** **A reorganisation of the 'early years' and 'family hubs' is taking place – from a maternity perspective in the outlying MLUs, could these been joined up?**
- A10** The DNMQ agreed and reported that the NHSE report around 'Better Births: Improving outcomes of maternity services in England – A Five Year Forward View for maternity care' talks of integrating community hubs.
- Q11** **Queries were raised regarding the target of cost savings to be achieved through Future Fit? What figure is SaTH seeking to achieve through reconfiguration? Can the figure and financial plan be shared with the public before consultation?**
- A11** The CEO reported that the consultation relates to the model of care rather than the finances. The position on finances will be available in the Outline Business Case which will provide all of the detail and context. It will also be available in the Full Business Case which will be available to the public.

**Q12**            **A member of the public raised the issue relating to Breast Screening which had been raised nationally and enquired how long the review will take and how likely is it that people will be recalled?**

**A12**            The CEO envisaged that the Trust should be able to achieve a view within the next 7 days to identify the impact of anyone who feels they may have been impacted by this; the individuals will be contacted and additional support put in. Actions will be put in place quickly, and the organisation will be transparent about the outcome.

**Q13**            **The Board were asked if they were aware of the interest rates for the £312m funding**

**A13**            The CEO reported that the Board are awaiting clarity; it will be dependent on the way that the funding is structured as the interest rates will vary depending on the source.

**2018.2/94**            **DATE OF NEXT PUBLIC TRUST BOARD MEETING**

Thursday 25 May 2018, 1.00pm, Seminar Room 1, Shropshire Conference Centre, RSH (Special Board to approve annual Accounts)

Thursday 31 May 2018, 1.30pm, Lecture Theatre, Education Centre, Princess Royal Hospital

**The meeting closed at 5.20pm**

DRAFT



## ACTIONS / MATTERS ARISING FROM THE PUBLIC TRUST BOARD ON 3 MAY 2018

| Item      | Issue  | Action Owner      | Due Date                          |
|-----------|--|-------------------|-----------------------------------|
| 2018.2/71 | Draft Minutes of 29 March 2018<br><i>To forward form of words to Committee Secretary to update minute 2018.2/45.1 to reflect 'the overspend of agency costs'</i>                                     | C Deadman /<br>CS | May 2018<br>COMPLETED             |
| 2018.2/71 | Draft Minutes of 29 March 2018<br><i>To update minute 2018.2/49 to reflect the 12 serious incidents relating to 30 12-hour trolley breaches caused no harm to patients</i>                           | CS                | May 2018<br>COMPLETED             |
| 2018.2/72 | Actions/Matters Arising –<br>2018.2/37 - Organisational Development Plan<br><i>To present to 31 May 2018 Trust Board</i>   | WD                | 31 May 2018<br>AGENDA ITEM        |
| 2018.2/72 | Actions/Matters Arising –<br>2018.2/41 - Winter Planning – Early lessons learned<br><i>To provide additional update at end of winter pressures</i>   | COO               | 31 May 2018<br>AGENDA ITEM        |
| 2018.2/72 | Actions/Matters Arising –<br>2018.2/43 - Maternity Engagement Plan<br><i>To present recommendation to 31 May 2018 Trust Board</i>  | DNMQ              | 31 May 2018<br>AGENDA ITEM        |
| 2018.2/72 | Actions/Matters Arising -<br>2018.2/58 - Non-Consultant Grade Medical Workforce Plan<br><i>Workforce Committee to support the work and progress and provide assurance to August 2018 Trust Board</i> | WD                | Aug 2018<br>ADDED TO<br>SCHEDULE  |
| 2018.2/72 | Actions/Matters Arising –<br>2018.2/59 - Staff Survey Results 2017/18<br><i>Workforce Committee to monitor results and assurance to be provided to September 2018 Trust Board</i>                    | WD                | Sept 2018<br>ADDED TO<br>SCHEDULE |
| 2018.2/79 | Maternity Clinical Improvement Metrics<br><i>To present NHS Resolution paper to 31 May Trust Board for sign off</i>  | DNMQ              | 31 May 2018<br>AGENDA ITEM        |
| 2018.2/86 | Board Assurance Framework & Risk Register<br><i>To identify costs of risks requiring capital funding to move highest risks down, and provide to 31 May 2018 Trust Board</i>                          | D.FD              | 31 May 2018<br>AGENDA ITEM        |
| 2018.2/86 | Board Assurance Framework & Risk Register<br><i>To include additional level of detail in future risk updates to Board</i>  | DCG               | 31 May 2018<br>AGENDA ITEM        |
| 2018.2/93 | Questions from the Floor<br><i>To provide feedback to Board via Operational Performance report on at least a quarterly basis regarding the sustainability of the 'Lets Crack It' initiative</i>      | COO               | 5 July 2018                       |
|           | <i>To hold conversations with the local authority regarding alternative accommodation for i) Phlebotomy Service, and ii) Midwifery Service in Whitchurch</i>   | CEO               | 31 May 2018                       |