SPECIAL TRUST BOARD MEETING
Held on Friday 25 May 2018
Shropshire Conference Centre, Royal Shrewsbury Hospital

PUBLIC SESSION MINUTES

Present:	Mr B Reid	Chair
	Mr C Deadman	Non-Executive Director (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 Fowler	Director of Nursing and Quality (DNQ)
	Mr N Lee	Chief Operating Officer (COO)
	Mrs J Price	Representing Finance Director (FD)
	Mrs J Clarke	Director of Corporate Governance/Company Secretary (DCG)
	Ms V Maher	Workforce Director
Apologies:	Mr H Darbhanga	Non-Executive Director (NED)
	Dr D Lee	Non-Executive Director (NED)
	Mr N Nisbet	Finance Director

2018.2/95 WELCOME AND APOLOGIES

The Chair welcomed the Board members to the meeting which was held to approve the draft Annual Accounts for 2017/8 before their submission to NHSI and the Trust's Auditors.

It was noted these had been previously received, discussed and recommended for approval by the Audit Committee.

2018.2/96 DECLARATIONS OF INTEREST

There were no declarations of interest from members of the Board relating to matters on the agenda.

2018.2/97 ADOPTION OF ANNUAL ACCOUNTS AND APPROVAL OF THE MANAGEMENT REPRESENTATION LETTER

The Deputy FD presented the following for approval; these were concluded upon at the Audit Committee meeting held prior to the Trust Board meeting:

- Annual Accounts 2017/18
- Management Representation Letter
- Statement of Chief Executive's Responsibilities as the Accountable Officer of the Trust
- Financial Monitoring and Accounts Forms
- Statement of Financial Position as at 31 March 2018

It was noted that the Auditors gave an Unqualified opinion on the Annual Accounts 2017/18. There was a minor adjustment needed which was not materially significant. A number of presentational changes were recommended and were agreed.

It was noted that the Auditors would be issuing a Value for Money 'Except For' opinion which indicates that adequate processes are in place, but reflects the Trust's end of year and cumulative financial position.

……Chair
5 July 2018

	The CEO thanked the Deputy FD for covering the FD and delivering the end of year position on the annual accounts. The Board **APPROVED** the Annual Accounts 2017/18, **APPROVED** the Management Representation Letter; **APPROVED** the Statement of Chief Executive's Responsibilities as the Accountable Officer of the Trust, **APPROVED** the Financial Monitoring and Accounts Forms and **APPROVED** the Statement of Financial Position as at 31 March 2018.
2018.2/98	**ANNUAL REPORT 2017/18** The CEO presented the 2017/18 Annual Report and advised this had been discussed at Audit Committee, Executive Directors and approved by External Audit. This is a key feature of the Trust's governance and accountability structures, reporting on progress and challenges of the Trust during the year and setting out the priorities for the year ahead and providing key mandatory information in support of governance, compliance and accountability. The DCG reported that a shorter reader-friendly version would be produced for the public. The Annual Report had been approved by Audit Committee however it was noted that p38 – Information Governance breaches should read 2017/18 and 3, not 4 breaches. It was also noted that the correct A&E attendance figure was shown on p12 re: trend in A&E Attendances (123,999) and p8 would be amended to reflect this Following discussion, the Board **APPROVED** the Annual Report which will be published on the Trust website.
2018.2/99	**ANNUAL GOVERNANCE STATEMENT** The CEO introduced the Annual Governance Statement which had been considered by the External Auditors at the Audit Committee. Three significant control issues have been identified for the year 2017/18: • Cash flow • Emergency Department staffing • Patient flow The final version will be submitted with the Annual Accounts on 29 May 2018. The Board **APPROVED** the SaTH Annual Governance Statement 2017/18.
2018.2/100	**HEAD OF INTERNAL AUDIT OPINION** The Head of Internal Audit Opinion provides assurance for the statements in the Annual Report and Financial Statements and is reflective of the work undertaken by Internal Audit throughout the year. The overall Head of Internal Audit Opinion was presented to the Audit Committee. <u>Core Internal Audits – Overall Assurance</u> During 2017/18, Deloitte issued the following six formal core internal audit reports, designed to improve the system of internal control: • Cash management – Moderate • Income and debtors – Moderate • Payments and creditors – Substantial • Budgetary control – Limited • Payroll - Substantial; and • Computer based IT controls – Moderate

	Substantial assurance was given in two reports, Moderate assurance with respect to three of the core internal audit reports and Limited Assurance with respect to one core internal audit report. <u>Risk Management and Board Assurance Framework – Overall Assurance</u> Deloitte issued one internal audit report relating to Risk Management and Board Assurance Framework. A **Substantial** assurance rating was issued in respect of this report. <u>Performance Internal Audits</u> Deloitte completed the following three performance reviews across 2017/18: • Outpatients appointments process – Limited • Temporary staffing review – Limited; and • Business continuity and IT disaster recovery planning – Limited No additional areas of control weakness relating to governance, risk management or internal controls were identified. A **Moderate** assurance rating was issued in respect of this. The Trust Board **RECEIVED** the Head of Internal Audit Opinion 2017/18 report.
2018.2/101	**AUDIT COMMITTEE ANNUAL REPORT 2017/18** The Audit Committee Annual Report reviews the role and operation of the Committee including attendance rates, reporting to and from the Committee and summarises the reports received from the Internal and External Auditors. The Chair of the Audit Committee complimented the Executives for focusing on areas for development to demonstrate learning for organisations. He also felt the Executives and Audit Committee work very closely and effectively. The Board **RECEIVED** the Audit Committee Annual Report 2017/18 and **ACKNOWLEDGED** the following recommendations: • With the exception of the internal control issues, the Trust has a generally sound system of internal control that supports the achievement of its policies, aims and objectives and those control issues have been or are being addressed • It has a system in place that identifies any actions that need to be taken to remedy either gaps in control/assurance but this needs to be constantly reviewed • Continue the processes for recommendation tracking to ensure timely completion of action plans following audit. The Chair thanked Mr Deadman for standing in as the Chair of the Committee.
2018.2/102	**DRAFT QUALITY ACCOUNT 2017/18** The DNMQ presented the draft Trust Quality Account for 2017/18. Points to note: • SaTH has complied with the most recent amendment to the NHS regulation that requires the organisation to include statutory statements relating to Learning from Deaths and an update about Seven Day Services. • SaTH has been visited by external auditors who have reviewed C difficile reporting and the Friends and Family Test data and will provide a report on receipt of the final draft • Some data is still outstanding but most is included • The report will be shared as required with external stakeholders including the Hospital Overview Scrutiny Committee (HOSC), CCG and Healthwatch. This was discussed at length at the Quality Committee and the need for information to be finalised in a timely way which was problematic due SUS data which isn't available until mid-June. **Action: Delegated final approval to Chair's action to meet deadlines**

	The Board **RECEIVED** the draft Quality Account 2017/18 which will be uploaded to NHS Choices on or before 30 June 2018.
2018.2/103	**ANY OTHER BUSINESS** No further business raised
2018.2/104	**THE MEETING CLOSED AND THE BOARD TOOK QUESTIONS FROM THE FLOOR**
Q1	Sylvia Jones asked for details of savings that related to Future Fit
A1	The CEO agreed to provide this information but it was recognised that in any event, the Trust has to deliver 3-4% efficiencies going forward and this will be reflected in the final Business Case. **Action: CEO to provide information to Sylvia Jones**
Q2	David Sandbach asked for information relating to income by provider and to separate out daycases and inpatients
A2	It was agreed to include this information in the Annual Report summary
2018.2/105	**DATE & TIME OF NEXT FORMAL MEETING** Thursday 31 May 2018, 1.30pm, Lecture Theatre, Education Centre, Princess Royal Hospital

……Chair
5 July 2018

ACTIONS / MATTERS ARISING FROM THE SPECIAL TRUST BOARD ON 25 MAY 2018

Item	Issue	Action Owner	Due Date
2018.2/102	**Draft Quality Account 2017/18** Delegated final approval to Chair's action to meet deadlines	Chair of Q&S Cttee	**Ongoing**
2018.2/104	**Questions from the Floor – Q1** To obtain details of savings that relates to Future Fit and provide information to Sylvia Jones	CEO	**June 2018**

……Chair
5 July 2018

The Shrewsbury and Telford Hospital NHS Trust

TRUST BOARD MEETING
Held 1.30pm, Thursday 31 May 2018
Lecture Theatre, Education Centre, PRH

PUBLIC SESSION MINUTES

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

2018.2/106 WELCOME & APOLOGIES:

The Chair welcomed all to the Trust Board meeting. He informed the public that Paper 4 - Maternity Services Update in relation to the MLUs was being deferred following additional information which had been received the previous evening which could affect the options. He assured the public that an update will be presented to a future Trust Board once the options are clearer.

Apologies were noted for Non-Executive Director Dr Weiner, Associate Non-Executive Director Mr Darbhanga and Finance Director, Mr Nisbet.

2018.2/107 VALUES IN PRACTICE (VIP) AWARD

The WD welcomed and introduced the General Medicine Booking & Scheduling Team to the meeting who had been nominated to receive the VIP Award for the month of April 2018:

RSH Booking and Scheduling Team - April 2018

The General Medicine Booking Team won the April Values in Practice Award for their continued contribution to the Shrewsbury and Telford Hospital. The team were specifically being congratulated and thanked for their recent support to the Ops team and clinical nurse specialists. Due to winter pressures, NHS England requested clinics be cancelled to create capacity; for some clinics this was very short notice. The team contacted every patient to inform them of the cancellation and dealt with patient disappointment sensitively and professionally. They worked hard and quickly to rebook appointments, always having the patient's best interest at the centre of their work.

The Board thanked the RSH General Medicine Booking Team and the Chair presented them with a voucher, certificate and award.

…….. Chair
5 July 2018

2018.2/108 PATIENT STORY

The DNMQ introduced this month's patient story which related to a patient who underwent a laryngectomy at SaTH approx. 8 months ago; and how the patient felt her experience could have been improved. The following important points were highlighted:

- Patient was alone when she was informed that she would require a laryngectomy which she found hard to cope with
- Patient felt alone and isolated during her stay in hospital
- There was limited support in place following discharge home which again led to a feeling of isolation as the patient lives in a rural area with little support
- There was no single point of contact available resulting in patients having to make a number of calls to each site to seek support.
- In essence, the main learning is the importance of effective communication to meet the individual needs of a patient and ensuring that patients are aware of how to access support following discharge.

The Head & Neck Clinical Nurse Specialists were in attendance and, following this patient's experience, processes have been put in place to help support laryngectomy patients whilst inpatients, and following discharge.
Ward 17 has introduced a laryngectomy checklist to ensure patients receive all information, advice and contact details they need; also members of the team visit stoma / speaking valve patients in their own home.
A Standard Operating Procedure has been developed for Ward 17 for laryngectomy patients, also for Emergency out-of-hours, and processes have been put in place for patients requiring valve changes and speech and language therapy.

The CNSs informed the Board of the lack of side rooms available following the move from Ward 8 to Ward 17 as it only has two side rooms; resulting in a lack of privacy and dignity for patients.

Dr Lee (NED) highlighted that the absence of a treatment room on Ward 17 had been escalated to the Trust Board previously via the Quality & Safety Committee following a Ward visit some months ago; it is therefore on the Q&S Committee's radar. Dr Lee also reported that there is a very high risk of readmission to hospital when the transitional arrangements are not adequate – it is therefore vital to ensure the system has the correct discharge processes in place to support the patients.

The DNMQ reported that plans are in place to re-instate a room on Ward 17 to facilitate Head & Neck patients, which is a positive step forward. The CEO also reported on the launch of the Future Fit consultation; highlighting that one of the great advantages will be an increase in side rooms on all wards.

The MD thanked the members of the team for attending and recognised that the patient's surgeon, Mr Farhan, was also in attendance. The MD reported that there was a Royal College of Physicians/NCEPOD document named 'On the right trach' relating to tracheostomy patients. This has been followed through the Clinical Governance Executive. The H&N Team has done an impressive job of ensuring we fulfil as many of the requirements as possible; although work is ongoing and will continue to be tracked through the CGE. If required, this would be escalated through the Quality & Safety Committee.

The Chair welcomed Mr Farhan and his comments about this patients' care. Mr Farhan reported that he works very closely with his patients and has seen this particular patient every month.

The Chair acknowledged the positive steps that have been made. The CEO commented on the braveness of this patient for sharing her experience. In general, the CEO reported that loneliness is increasingly prevalent both inside and outside of our hospital and enquired if SaTH has a visitor process in place to help support patients if they feel lonely.

The DNMQ reported that the organisation doesn't currently run a visitor/patient support scheme, but we do have volunteers who befriend patients who may feel vulnerable/isolated.

…….. Chair
5 July 2018

The Chair thanked the team for attending the meeting to explore all of the issues, and thanked them for their continued work.

2018.2/109 BOARD MEMBERS' DECLARATION OF INTERESTS

The Board RECEIVED and NOTED the Declarations of Interest

2018.2/110 DRAFT MINUTES OF MEETING HELD IN PUBLIC on 3 MAY 2018

Mr Deadman (NED) requested minute 2018.2/67 be slightly amended to reflect Mrs Terry Mingay's correct name.
Action: CS to update minutes

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

2018.2/111 ACTIONS / MATTERS ARISING OF MEETING HELD 3 MAY 2018

2018.2/71 – Minutes of Trust Board held on 29 March 2018
CS to update 2018.2/45.1 to reflect 'the overspend of agency costs'.
Completed. Action closed.

2018.2/71 – Minutes of Trust Board held on 29 March 2018
CS to update minute 2018.2/49 to reflect the 12 serious incidents relating to 30 12-hour trolley breaches caused no harm to patients
Completed. Action closed.

2018.2/72 – Actions/Matters Arising
2018.2/72 – Organisational Development Plan
WD to present to 31 May 2018 Trust Board **- Deferred to October Trust Board.**
Action: WD Due: 25 October 2018

2018.2/72 – Actions/Matters Arising
2018.2/41 – Winter Planning – Early Lessons Learned
COO to provide additional update at end of winter pressures at 5 July Trust Board
Action: COO Due: 5 July 2018

2018.2/72 – Actions/Matters Arising
2018.2/43 - Maternity Engagement Plan
DNMQ to present recommendation to 31 May 2018 Trust Board - **Deferred to future Trust Board.**
Action: DNMQ Due: 30 August 2018

2018.2/72 – Actions/Matters Arising
2018.2/58 – Non Consultant Grade Medical Workforce Plan
Workforce Committee to support the work and progress and provide assurance to August Trust Board
Action: WD Due: 30 August 2018

2018.2/72 – Actions/Matters Arising
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 September 2018

2018.2/79 – Maternity Clinical Improvement Metrics
DNMQ to present NHS Resolution paper to 31 May Trust Board for sign off **– Deferred to future Trust Board**
Action: DNMQ

…….. Chair
5 July 2018

2018.2/86 – Board Assurance Framework & Risk Register
D.FD to identify costs of risks requiring capital funding to move highest risks down and provide update to 31 May Trust Board
Completed. As per minute 2018.2/126 - further information and costs included in Risk Register paper

2018.2/93 – Questions from the Floor
COO to provide feedback to Board via Operational Performance report on at least a quarterly basis regarding the sustainability of the 'Lets Crack It' initiative.
Action: COO Due: 5 July 2018

2018.2/93 – Questions from the Floor
CEO to hold conversations with the local authority regarding alternative accommodation for i) Phlebotomy Service and ii) Midwifery Service in Whitchurch
The CEO reported that Karen Calder, Chair of Shropshire HOSC, had put him in contact with colleagues from the local authority to explore alternative accommodation options for the Phlebotomy Service. Three options - Princess House, the Darwin Centre or the acute hospital site will be explored and we should be able to clarify within the next month which of these solutions will be put in place, whilst engaging with our patients who are using the service.
Completed. Action closed.

2018.2/112 MATERNITY SERVICES UPDATE – MLU POSITION

The CEO reported that a meeting had been held with the Shropshire CCG and Telford & Wrekin CCG the previous day as some additional information had been received which was the reason for deferring the paper.

It is expected this work will be concluded within the next week, so that we would be in a better position to discuss it completely, thoroughly and candidly at a future Board meeting, following engagement with the public.

2018.2/113 Q4 COMPLAINTS & PALS REPORT

The DCG presented the Q4 complaints and PALS report, drawing particular attention to the improvement in the response times: 74% of complaints are acknowledged in the timescales agreed initially, and where these are required to be extended, they are agreed with the patient. This is a great improvement from 48% response time just 18 months ago. The DCG congratulated the Complaints and PALS team for the work undertaken to achieve this.

The DCG also highlighted that whilst it is important to be timely, it is also important that the responses given are meeting the queries that patients have risen. SaTH is one of the few Trusts that send a survey out to all complainants two weeks after a complaint has been closed which 89% would be happy to use the complaint service again which is a strong endorsement that the complaints process is very thorough and robust.

Following the Q4 complaints, work is being undertaken with Workforce colleagues to look at issues around communication which have been raised as a theme; also the team were carrying out a deep dive into outpatients and appointments as this also had been raised as a theme.

PALS are now very involved in the Bereavement Team work; and SaTH has a very positive working relationship with the Registrar of Deaths, Births and Marriages. The DCG reported that over 160 families were able to report deaths at RSH rather than having to travel to the Shirehall which is a very positive step forward. NHSI have also recognised that this service is a great benefit to patients.

The Chair agreed this was a significant improvement.

2018.2/114 CHIEF EXECUTIVE OVERVIEW

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

Future Fit Consultation

The CEO reported that as of 30 May 2018, as a community we have now moved into formal consultation on the Future Fit proposal. This is the largest capital investment in the 70 years of the NHS in our country. It is an exciting opportunity and the consultation will be undertaken thoroughly and openly and with candour with all interested parties.

Continuous engagement and consultation will be undertaken with consideration of all components that are emerging to ensure the changes are a success for everyone.

Ophthalmology Service

The CEO paid tribute to Julie Southcombe, one of SaTH's patients who has been working with the Ophthalmology Service as a patient volunteer, who was recently asked to present at the national conference for NHS Improvement leading the work that SaTH is undertaking on patient engagement and improvement; this was very well received by the delegates. The CEO thanked Julie for her continued support.

Partners in Care Conference

This was linked to International Nurses Day. It was a fantastic day and reinforced what is best about the NHS in our county. There was great support from all of the agencies there which was a good indication/celebration of the quality and the learning that is taking place across all organisations.

The CEO concluded that it was really important to remind ourselves of the great work that is being undertaken by our teams across the Trust each and every day.

Performance

Pauline Philip Visit to the Trust

The Trust recently received a visit from Pauline Philip (National Urgent & Emergency Care Director). She noted the very fragile workforce and the need for SaTH to improve discharge processes in order to reduce bed occupancy levels, working with our partners so that we are able to see patients move swiftly through the ED when they need an emergency admission, and not create queues in that environment.

Streamlining of SaTH Objectives

Letters have recently been circulated to all staff highlighting the three main priorities the organisation has this year; these are i) to reduce the number of vacancies we have by 25%, ii) to create empty beds so there will be no more boarding; and iii) ensure we continue to be sustainable through the good stewardship of the money we have.

Governance

Additional Board sub-Committee

The CEO reported that an additional sub-Committee of the Board will be introduced, named Sustainability Committee which will provide oversight of the Future Fit reconfiguration of the two hospitals, and the work we are doing with the Virginia Mason Institute, and will recognise the importance of placing more of a focus on innovation.

Government Improvement Plan – Well Led

The CEO reported that a review of the CQC 'Well Led' framework will be undertaken to assess our governance processes and support the moves to improve the quality of our services in advance of the next CQC visit.

Workforce

A&E Consultant Appointments

SaTH has recently successfully appointed into one A&E Consultant vacancy and further interviews will be held within the next two weeks where we are hopeful that further appointments will be made. The CEO highlighted that this significant shift has happened since the commitment to invest £312m into our system.

Middle Grade Tier – Emergency Medicine

This is currently a significant risk. Steps are being taken to safeguard this risk in the short and medium term.

…….. Chair
5 July 2018

Senior Leaders in the organisation
The CEO reported that Board members had visited various Wards/Departments and non-clinical areas to talk with staff and patients, prior to the Board meeting. He highlighted the importance of not losing sight of spending time with frontline staff within the organisation.

Learning

Transparency – Maternity Incentive Scheme
The CEO reported on the ten incentive schemes that SaTH had signed up to ensure the safest standards are in place for our Maternity Service.

CHKS Top 40 Hospitals Award
SaTH received the CHKS Top 40 Hospitals Award once again; this is a good indication that we are making progress on our journey.

2018.2/115 FUTURE FIT UPDATE

The CEO reported that he had covered all development in the above CEO Overview.

QUALITY & LEARNING (SAFEST & KINDEST)

2018.2/116 QUALITY & SAFETY COMMITTEE SUMMARY – 23 MAY 2018

Dr Lee, NED and Chair of the Quality & Safety Committee, presented the following summary of the Quality & Safety Committee meeting held on 23 May 2018:

The meeting reflected recommendations with respect to strengthening governance arrangements, arising from NHS Improvement's review. The relative timing of the Q&S meeting and the Clinical Governance Executive (CGE) meeting have been adjusted to strengthen arrangements. The MD had presented a summary of the CGE meeting; it was also evident that some of the items considered at "Confirm and Challenge" meetings also need consideration by the CGE to ensure that the Q&S meeting can be appropriately assured.

Accident and Emergency Services (BAF 1134)

The current staffing levels across the two A&E Departments were discussed. There are positives in the recruitment of a new substantive consultant and interviews planned for further candidates during early June. There has also been success in developing a cohort of advanced practitioners. The viability of the current service model is highly dependent upon the presence of locum consultants. There are also concerns about vacancies in the middle grade medical staff.

The Q&S Committee recommended the monitoring of the service with a dashboard that pulled together key elements of service performance. This would include complaints, incidents, waiting times, admission rates and other key elements. This would help the Q&S Committee and indeed clinicians and managers to identify any adverse trends.

Mr Newman raised the doctors staffing of the A&E Departments. He requested assurance that when one of the Directors on-call was not clinically qualified, who would make a decision as to whether the department was safe. Mr Newman highlighted that SaTH is still at tipping point, and whilst new appointments are on the horizon, they will not be in post until the autumn.
The MD reported that this has been discussed during previous Board sessions, and has been appropriately challenged from the specialty with regard to the point at which further intervention may be necessary. The Business Continuity Plan makes this process clear.

The MD reported that there has been greater difficulty recently with regard to junior doctor and middle grade staffing and it has been more difficult to obtain locum doctors. SaTH's model of care has been reviewed and the MD felt the level of cover was currently safe. However, whilst consultant staffing has been addressed in the medium term, we do still have a challenge at middle grade level.

Maternity Incentive Scheme (BAF 1204)
The Q&S Committee received assurance from the Women & Children's Care Group that ten key requirements of the national Maternity Incentive Scheme can be achieved and evidenced. The Q&S Committee recommend that the Board should approve the submission.
The Chair questioned if the Board were happy to endorse this. The CEO reported that part of the outcome of completing these ten incentivised schemes is that it has a significant benefit in terms of the safety of mothers and babies; elements have been linked to a national piece of work.
Following discussion, the Board APPROVED the submission.

Maternity Services (BAF 1204)
There was discussion with respect to the current suspension of services at SaTH's Midwifery Led Units. The fundamental requirement is to ensure that the service is safe and this was emphasised by the sub-committee.
Prior to the Q&S Committee meeting, the NEDs, DNMQ and MD visited the Neonatal Unit and Obstetric Delivery Unit. On this visit, the calm atmosphere and outstanding cleanliness of the wards was noted. The team were also shown the computerised foetal heart rate monitoring equipment and have the 'fresh eyes' approach explained where the coordinator checked the foetal heart rate tracing on a regular basis.

Never Event
The Q&S Committee were briefed about a recent 'Never Event' where 'wrong site' surgery was undertaken. In accordance with the Significant Incident (SI) Policy a 'rapid review' has been held and a comprehensive investigation has been launched. The affected patient is recovering and clinicians have candidly explained the circumstances to the patient and family members.
Dr Lee assured the Board that the Q&S Committee will receive further reports as the investigation process proceeds.

Scheduled Care (Links to BAF 1185)
The Q&S Committee received a presentation from the Scheduled Care Group. They reported excellent performance against referral to treatment (RTT) targets linked to cancer care. SaTH are amongst the very top performers in England for receiving referrals electronically with a very tiny percentage of referrals arriving in paper format.
The Care Group reported that the services that they provide are still pressurised by the use of day surgery beds for medical patients during escalation periods. The Q&S Committee were impressed by the quality of the presentation and with the commitment of senior nursing and management to continuous improvement.

Mr Newman (NED) reported that he was extremely impressed by the confident and competent presentation by the Chief Nurse of the Scheduled Care Group and asked the DNMQ to relay that message to her.
Action: DNMQ

Dr Lee reported that some months ago the Q&S Committee visited the CT scanner and MRI scanners at the PRH site as part of their clinical site visit and raised concerns with respect to the point of failure in the stroke pathway represented by the single CT scanner on the PRH site. On visiting Ward 15 as part of the pre-Board Ward/Department visit, Dr Lee reported that he was disappointed to learn that the CT scanner was currently out of action, which emphasises the fact that having a single CT scanner is an issue.
The Chair recognised that the PRH CT scanner currently sits on the Trust's corporate risk register at priority 3 of the highest red risks at a cost of approx. £1.4m to action; and enquired, given the capital constraints going forward, if that is a realistic option. He requested a review of the options/proposals for a positive outcome.
The MD reported that he chaired the latest Capital Planning Group meeting; unfortunately the funds required to replace the PRH CT scanner cannot be covered in this year's capital funding. The Chair therefore suggested this be supported through revenue, which was one of the plans described in the operational risk register.

…….. Chair
5 July 2018

As Chair of the Performance Committee, Mr Deadman (NED) agreed to add this to the agenda of the next Performance Committee to investigate lease solutions, with recommendations being provided to a future Board meeting.
Action: Chair of Performance Committee Due: 30 August 2018 Trust Board

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.

2018.2/117 QUALITY & SAFETY PERFORMANCE REPORT – MONTH 1

The MD presented the following sections of performance report for Month 1:

Never Event
The MD informed the members that the key quality measures in the pack incorrectly identifies a Never Event in March 2018; however it correctly reports a Never Event which took place in October 2017 in Ophthalmology and a Never Event in February 2018 involving wrong administration of a drug.
The MD raised concerns that the organisation has now had three Never Events in three different specialties/areas. He assured the Board that he and the DNMQ will work very closely together to identify why after making a number of significant interventions we have had these individual Never Events, and accelerate the interventions to ensure patient safety is safeguarded.

Mortality
The MD reported that the Mortality detail was presented by way of graphs and, as previously reported, the members were informed that the organisation does have a seasonal variation where regrettably more people do die during the winter months. However, for our population we have had a lower mortality as compared with our peers. A review has also been undertaken in regard to patients with respiratory conditions where there was an early indicator where there may be an increase in the number of deaths, and that has not identified any specific factors that showed we would be an outlier in that regard.

VTE
The MD reported that SaTH's performance as a Trust continues to be very good at 95.9% against the national VTE target of 95% for this potentially avoidable risk in either harm or death for patients.
The MD reported that he recently received an email from NHSI/NHSE regarding particular concern that VTE assessments around the country had deteriorated; he was pleased to report that SaTH has continued to achieve this for two years.
Following discussion, the members RECEIVED and APPROVED the Quality & Safety Performance Report (M12) and actions being taken.

2018.2/118 QUALITY GOVERNANCE REPORT – MAY 2018

Progress throughout the month of May 2018:

MRSA Bacteraemia The DNMQ reported that unfortunately the Trust has reported one MRSA Bacteraemia; this is particularly disappointing as the last attributable case occurred in August 2016.
The output of the Root Cause Analysis (RCA) will be reported to the Infection Prevention Control Committee and will be tested at the Quality & Safety Committee and brought back to the July Trust Board. It looks like a particularly complex extraordinary case whereby the patient was admitted from a nursing home with lots of interventions (drips/drains).

Serious Incidents
Three SIs were reported during April, including the MRSA Bacteraemia.

NHS Safety Thermometer
The Trust no longer reports on the NHS Safety Thermometer; it has been removed from the contract with agreement by the CCG as it was a very complicated process, and only provided a snapshot of a moment in time.

…….. Chair
5 July 2018

However, SaTH will continue to monitor the prevalence of harm incidents through other routes and report them via the Q&S Committee up to the Board.

Hypoxic Ischaemic Encephalopathy (HIE)
During April, the Trust reported zero neonatal HIEs (brain injuries).

Category 2 Caesarean Sections
April saw a very slight increase in trend; the local expected range would be from 0-8%, however April's rate was 8.3% which is slightly over the parameter. This will be monitored through the Clinical Governance Executive and Quality & Safety.

Friends & Family Test
The DNMQ reported a much improved response rate for the Friends and Family test in the Emergency Department which is to be commended.

The Chair queried where the Friends and Family Test results are reported. The DNMQ reported that the ward managers and clinical area managers have access to that qualitative data but it is a manual system which is difficult to analyse themes and trends, however the Trust has a new secondee into a post working alongside Clinical Audit and detail will be included in the Quality & Safety report.

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

2018.2/119 SAFEST & KINDEST QUALITY STRATEGY

The DNMQ presented the Quality Strategy which is an overarching document that describes the organisation's journey to improve standards of care for patients. It brings together themes of culture and leadership, quality governance, improving safety and positive experience for patient's carers, and our staff.

It is designed to be a living document which is intermittently updated as the organisation moves forward on its journey. It will be reported upon through the Quality & Safety Committee on a quarterly basis and is very much to compliment the composite Trust Improvement Plan, as well as the priorities in the Quality Account.

The Chair highlighted that a number of sub-committees report up through the Clinical Governance Executive, and requested sight of the Terms of Reference of the CGE alongside the Terms of Reference for the Quality & Safety Committee. Dr Lee (NED) confirmed that the two Committees have been designed to establish a much closer link, and he felt confident that the MD will submit a report with respect of clinical governance.
Action: MD/DNMQ to forward CGE and Q&S Terms of Reference to SaTH Chair

The CEO raised the detail of the report on page 17 regarding the percentages relating to improvement in the 4 hour target in ED and the number of 12 hour trolley breaches reported and requested the detail of the markers to be more specific.
Action: DNMQ

Following discussion, the Board RECEIVED and APPROVED the Safest and Kindest Every Day Quality Strategy.

PERFORMANCE (SUSTAINABILITY)

2018.2/120 PERFORMANCE COMMITTEE REPORT

NED and Chair of the Performance Committee, Mr Deadman, presented the Performance Committee summary of the meeting held on 25 May 2018 of which the Trust Chair, Mr Reid, attended:

Financial Performance Month 1
In the first month of the new financial year the Trust reported an in month pre-Provider Sustainability Fund (PSF) deficit of £2.995 million, £0.048 million better than plan. Inclusion of the PSF reduced the in-month deficit to £2.504

million. Future reports will focus on performance against the £18.439 million control total pre PSF.

Income was under by £0.44 million as a result of reduced capacity in Theatres. Pay was broadly balanced. This was made up of both adverse and favourable variances. In month the Trust has introduced weekly bank, which has had an adverse impact on the Trust of c£0.200 million offset by a favourable variance against pay waste reduction schemes of c£0.180 million. There was an underspend on Non Pay of £0.057 million linked to income.

The total agency spend planned for the 2018/19 financial year is £16.660 million inclusive of waste reduction schemes (£6.101 million higher than the agency cap). In month 1, the Trust had planned agency expenditure of £1.631 million, the actual in month position was £1.211 million an underspend £0.420 million. The underspend was linked to a reduction in nursing associated with the earlier than anticipated closure of escalation spaces and a switch to substantive workforce within medics. It is important to note that given the fragility of the ED workforce, an underspend in medical agency is not expected to continue at the same level.

A review of the Waste Reduction trajectory and status took place. There was an in-month over performance against plan of £0.165 million due to earlier than anticipated closure of escalation spaces. There was also some encouraging news on increased flow of patients though the hospital. Despite this over performance, there was recognition of significantly higher targets from Q2 onwards. The Committee discussed confidence in delivering the programme. As at month 1 the Trust was mostly confident in its delivery of those schemes that are badged as green and amber. However 98% delivery of all Green/Amber/Red schemes is needed if we are to hit the current NHSI agreed profile. Work is ongoing to further develop those schemes identified to be high risk with either a red or grey rating, with one to one meetings taking place between the Care Groups and COO early June 2018. The committee was not assured of the Trust's ability to deliver the target of £8.198 million and asked for an updated view of the position particularly from Q2 in order for the Board to be advised. The committee suggested that the Board may wish to consider re-profiling its CIP trajectory/target. It also recommended that all steps should be taken to support the Executive in accelerating delivery of the 2018/19 waste reduction programme. In particular the Executive was invited to be bold in looking for efficiency and effectiveness improvements and, where there are difficult decisions to be made, invited the Executive Team to bring those issues to the Board for resolution.
Overall, Mr Deadman felt the organisation had a reasonably good month against plan which is encouraging.
He congratulated the Executives for the progress in patient flow, and reductions in stranded patients which is core to the quality of care and our efficiency in effectiveness.

<u>Waste Removal Plans</u>
Following a great deal of discussion, the Performance Committee didn't gain assurance that SaTH's waste removal plans appear to be deliverable.
Mr Deadman referenced the graph on page 2 of the Performance Committee summary which reports that the Trust is targeting approx. £8m of savings which represents 2% of the Trust's cost base; however the Performance Committee members felt 50% of the savings appear to be deliverable. This may be recoverable by year-end, although Mr Deadman felt there is a need for the Executive to move this on at pace, supported by the Non-Executive members of the Board.
The COO reported that he chairs the Waste Reduction Group, working closely with the Deputy FD, MD and DNMQ who fully recognise the challenge and the delivery of that remains their commitment.
The COO informed the Board that he has received further updates following the recent Performance Committee; the level of high risk has reduced by a further £800k, and he believed other schemes have a good level of confidence.
The COO reported that work will be undertaken where there has been a change in activity; and also in terms of reducing the volume of escalation capacity to a level of both occupancy and bed capacity which we are able to maintain without agency. There is a significant amount of work to push that forward.
The members were informed that the Executive Team has looked at strengthening the site leadership for both sites in terms of senior management support to help the clinical teams maintain focus.
The D.FD assured that Board that there is a plan and focus will be placed on achieving the outcomes to provide the Performance Committee with assurance next month.

The Chair posed the challenge to move the risk on the BAF from not achieving our control total from Red to at least Amber.

…….. Chair
5 July 2018

Trust Performance Report
An update on the Trust's performance against RTT, A&E, Cancer and Diagnostic targets was provided. Care Groups were commended on their achievement of the RTT target and stranded patient work. Workforce constraints in the ED continue to be an issue. All nine cancer targets were achieved at the end of the year.

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).	**Red - No Change**
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).	**Red - No Change**
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).	**Red – No change**

In addition to the above risks, the Committee's attention was drawn to a risk relating to A&E workforce, particularly middle grade and consultants. This had been highlighted at other Committees.

Meridian Post Project Evaluation
Post Project Evaluation document received and noted. It was important that the Trust takes forward the findings of this work. A group has been convened to realise the efficiencies and improvements identified by Meridian in Theatres, Outpatients and Radiology.
Mr Newman (NED) raised concerns in that 'a group has been convened to realise the efficiencies' as he was under the impression that this had been undertaken months ago and we would now be in a position of implementing this. The COO reported that a range of work has been undertaken, especially in Theatres, where savings have been realised, i.e. reduced the numbers of operating sessions where efficiency has allowed. The COO reported that Transforming Care have undertaken a lot of work in outpatients which has looked to generate capacity, also reducing both DNA and cancellations of patients which has in effect also created additional slots.

Operational Plan 2017/18
The Operational Plan 2018/19, as submitted to NHSI on 30 April 2018, was received and noted. An update on progress at Month 1 was provided. The top five key schemes and how these link to the Waste Reduction Programme will be highlighted in future reports.
Deep Dive presentations were delivered on Nurse Agency Premium and Unavailability and Bed Reduction.

The Committee ratified:
- Cost Process 2017/18
- Charity Fundraising Policy

Other Items discussed:
- Services under the spotlight – Breast services (imaging) and Urology now considered fragile due to workforce constraints
- EPR/IT System Solution – Draft proposal to develop Outline Business Care by October 2018 and Full Business Case by May 2019 received for consideration
- Sustainable Services Programme update – Consultation commences 30 May 2018 for a period of 14 weeks
- Presentation/Update on Model Hospital

Following his attendance at the Committee meeting, the Chair felt there was a clear focus on what is required to be achieved alongside the control total which must be delivered.

…….. Chair
5 July 2018

2018.2/121 TRUST PERFORMANCE REPORT – M1

2018.2/121.1 OPERATIONAL PERFORMANCE

RTT Performance
April's RTT performance was 92.4% against a trajectory of 90.5%. The COO paid credit to the teams involved following the challenging Q4 period and also Easter. It is expected that this will continued to be delivered.
The COO reported that the team would like to take the opportunity to reduce any backlog and build a good sustainable position before entering the winter period. The D.FD assured the Board that the income around backlog is covered.

Ophthalmology
The COO reported that the work undertaken in Ophthalmology has been raised at previous Board meetings. It is planned that the Ophthalmology Team will attend the July Board meeting to provide an update.
Action: COO to invite Ophthalmology Team to attend 5 July Trust Board

Urgent Care Update – A&E
The COO reported that the Trust continues to be below the national target at 78.87% during April 2018. Focus will be placed on those areas where we can make a difference more readily; non-admitted pathways, flow and the work in discharge, especially with partners.
The CEO reported that the tasks and evidence from national work is being undertaken by all partners across our system to great effect. He highlighted that this is showing through in the Trust's A&E performance until 8pm; however we aren't seeing the maintenance of performance overnight due to workforce issues.

Stranded Patients – Current Position/Trajectory
The MD reported that there has been considerable focus on what are being defined nationally as 'Stranded' patients. SaTH's Scheduled Care team have undertaken considerable work on a day by day basis, checking with wards and ensuring the management plans for patients are appropriate. That process will be expanded to all areas across both sites.
The MD reported the sustained improvement in line with trajectory; and on average the Trust has 50 fewer stranded patients than this time last year.

Cancer
The COO reported that the Trust achieved the full year target for 62 days at 89.3% against a target of 85.9%; this is being monitored for the months of April and May.
The COO also assured the Board that the department is responding fully to the national breast screening incident.

Diagnostics
The COO reported that diagnostics remains above the 1% threshold at 99.64%; he paid tribute to the Diagnostic team for the amount of work being undertaken by the team.

2018.2/121.2 FINANCIAL PERFORMANCE

Income & Expenditure – M1
The D.FD reported that the organisation has a deficit of £18.4m as a control total before we receive Provider Sustainability Fund (PSF); therefore SaTH will be managed against a control total of £8.6m.

In the first month of the new financial year the Trust is reporting an in-month pre-provider sustainability fund (PSF) deficit of £2.995m which is £0.048m better than plan. Inclusion of the PSF reduces the in-month deficit to £2.504m. Income is under by £0.44m due to reduced capacity within Theatres.

Pay
To date the pay spend amounted to £20.839m against a plan of £20.843m resulting in an underspend of £0.004m. 15% of the Trust's pay costs in Month 1 are attributable to temporary staffing.

…….. Chair
5 July 2018

Agency
The Trust continues to rely heavily on temporary staffing to support its fragile workforce and as a consequence remains above the agency ceiling as set by NHSI.
The Month 1 run rate is down by £0.346m compared to the average run rate seen in 2017/18.

Non Pay
To date the non-pay spend amounted to £9.260m against a plan of £9.317m resulting in an underspend of £0.057m.

Waste Reduction Performance
In Month 1 there is an over performance against plan of £0.165m due to the earlier than anticipated closure of escalation spaces. All other schemes delivered to plan with the exception of procurement where additional schemes are being explored to address this shortfall.
The D.FD highlighted that although there is an over performance in Month 1, the Trust is aware of the significantly higher targets in Q2-Q4. A monthly multi-disciplinary waste reduction group has been established to monitor each of the schemes and identify any additional schemes to ensure delivery of the £8.198m part year effect target.

Trust Cash Position
The cashflow meets the required minimum cash balance of £1.700m to be held on the balance sheet.
The Trust will require support of Department of Health and Social Care loan in order to underpin the Trust's control total of deficit £8.615m post PSF. This loan is included in order to meet our £1.700m cash balance.
The Trust will also require a loan of £1.531m in June to support the Trust's Q1 forecast deficit and to cover PSF for Q1 which is not received until after Q1. Going forward, the D.FD informed the Board that she will include the detail of debtors and creditors.

Following discussion, the members RECEIVED and APPROVED the Month 1 Trust Performance Report.

2018.2/122 WINTER PLANNING – LESSONS LEARNT

The COO reported that last year's winter brought extremely significant challenges and impacts for our patients and staff which resulted in the Trust escalating above its initial plan.

The key actions to maintain high quality and safe care and support winter resilience from November 2017 – March 2018 included:

- Reconfiguration of the Trust's bed base
- Implementation of SAFER (Red2Green)
- Implementation of SaTH2Home
- Clinical Decisions Unit at PRH

In addition to the above schemes other key enablers had been established to release bed capacity and facilitate timely discharge:

- Discharge Lounge established at RSH – this worked well although the location was not appropriate. Further options are being scoped to look at alternative settings in preparation for winter 2018/19.
- Ambulance handover nursing support
- Weekend discharge teams
- Frailty front door service

As part of the system wide plan, external schemes were put in place to avoid admission to an acute bed base and support patients in their own homes:

- GP Primary Care Streaming at PRH
- 10 admission avoidance beds
- 20 discharge to assess beds
- 7 day brokerage service
- 4 extra care beds in Shrewsbury

…….. Chair
5 July 2018

- Hospital Activity Liaisons Officer (HALO) to avoid unnecessary handover delays

The COO raised the importance of addressing the lessons of last winter not only as an acute Trust but also as a whole health system; discussions have been held internally and also at the end of April with our partners in the local system. Work has also been undertaken with colleagues across the community regarding capacity and demand to ensure we have plans and a system of escalation.

The Chair questioned when the Trust is required to sign up to the Winter Plan and asked the COO to include detail at a strategic level regarding changes/improvements. The COO agreed to work with colleagues and include in the Winter Plan which is required to be signed off at end July 2018.
Action: COO Due: 30 August 2018 Trust Board

Mr Newman (NED) commended the Deputy Chief Operating Officer for capturing the detail in a short Board report and suggested she be congratulated. The Board agreed.
Action: COO

2018.2/123 OPERATIONAL PLAN 2018/19

Further to the presentation on progress which went to the 29 March 2018 Trust Board, the D.FD provided the two year 2018/19 Operational Plan which is a continuation of the Plan which was signed off last year. The Operational Plan has three elements:

- Element One – addresses the state of readiness. How the Trust and Care Groups will respond to the 'here and now'; maintaining high quality and kind and safe care within the context of:
    - National targets and standards
    - Workforce constraints
    - The financial control total; and
    - Infrastructure challenges
- Element Two – the service appraisals undertaken with the Care Groups to determine the service strengths and attractiveness using an adapted GE/McKinsey Matrix have been reviewed. This will be built upon by the Scheduled Care Group in particular for this coming year, forming the foundation to the discussions of the 'what business are we in'
- Element Three – the design solution for the Trust's services in the future draws on the adapted McKinseys Matrices and the Trust's five year plan using the principles of the four Ps – Place, Product, Price and Promotion.

The D.FD highlighted three ambitions around i) Reducing the boarding of patients/creating empty beds, ii) Reducing the reliance on temporary staff and iii) Achieving waste reduction targets which are key against all of the issues that sit within the Plan. It includes details of the 30 required objectives for 2018/19 which link to the Financial Strategy and the operational ambitions. It will be measured by the Performance Committee on a monthly basis. The Chair felt it was a very coherent Plan, and should sit at Board level.

The CEO commended the Head of Contracts and Performance for producing the Plan alongside the Care Groups. It is evidence based and looks to the above three issues raised by staff.

Mr Newman (NED) referenced the grid on P22 of the Operational Plan which relates to Competitive Strength and Market Attractiveness and whilst further work is required, he urged team to get it right as it should drive the development of our services.

Following discussion, the Board ADOPTED the 2018/19 Operational Plan.

2018.2/124 SERVICES IN THE SPOTLIGHT UPDATE

The COO presented a further updated position regarding key services that have particular workforce challenges.

…….. Chair
5 July 2018

Emergency Departments

The COO reported that this continues to be a main area of focus. It is encouraging that since the announcement of £312m capital funding the organisation has started to recruit Emergency Department consultants, which is key. It is also important to note that SaTH now has a number of Emergency Care Practitioners; and an Advanced Care Practitioner was appointed during May 2018. A number of actions are in place in relation to the middle-grade staffing situation.

The WD reported on the substantive appointments but highlighted that the impact of those appointments will come towards the end of the year; she therefore highlighted the fragility that we have in the departments between now and that point in time. The Trust is therefore working closely with Health Education England (HEE) and NHS Improvement to secure further support for the department.

The WD highlighted the impact this is having on existing staff who are working in an extremely pressurised environment with a lack of cover.

Neurology Outpatient Service

Further to previous updates to the Trust Board, the COO reported that the main area of focus has been to obtain an agreement with the Walton Centre in Liverpool. The COO reported that he has received confirmation that the location for the service will be in the Oswestry Health Centre.

Other routes are continuing to be pursued to achieve additional capacity; however, this is a great step forward.

Dermatology Outpatient Service

Although SaTH continues to work with the Shropshire Skin Clinic, we do want to go out to formally tender for additional clinical work. We are therefore working with the Skin Clinic to manage relationships whilst going through that process.

Mr Newman (NED) enquired how the Skin Clinic are able to recruit at consultant level and at junior doctor level and SaTH can't, and suggested HR should look into this.

The COO confirmed that a lot of work is going on to attract substantive consultants; however the WD agreed that this was a fair challenge and agreed to take it as an action.

Action: WD Due: 5 July 2018 Trust Board

Breast Service

The COO reported that a weekly meeting is now held with Breast Radiology and Breast Services; the challenge relates to breast radiology capacity as SaTH has only one breast radiologist and one consultant radiographer. This is an issue nationally. We have received two CVs for locum radiologists, and these are being looked at pace.

This is one of the Trust's top risks on the Trust risk register.

Urology

This service continues to be under pressure. Whilst focusing on the interim, the COO highlighted that the Trust must also look at the strategic opportunity as surgeons in this specialty now use robotic surgery. The Team are looking to develop a business case to attract candidates for the future, but this will require good financial scrutiny as well as the quality of the service.

Ophthalmology

The CEO celebrated that Ophthalmology is no longer an area under the spotlight, as it has been a specialty that has been challenged for over a decade. It has transformed itself over two years, alongside the work of the Virginia Mason Institute and by the design of its patients. The CEO reported that staffing problems were at almost 50% vacancies and these are now almost at full quota which is a significant improvement.

The Board RECEIVED the Services in the Spotlight update.

GOVERNANCE (LEADERSHIP)

2018.2/125 AUDIT COMMITTEE CHAIR'S REPORT

…….. Chair
5 July 2018

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

Counter Fraud
The Committee approved the Counter Fraud Work Plan based on risk assessment and meetings with Executive Directors. The Plan (attachment 1) is attached, but will be subject to any proactive work. The Committee supported the continuous monitoring element of the plan, which it was felt provided additional assurance.

Internal Audits
Four audits were resubmitted with revised management responses and clarification of outstanding / partially implemented recommendations. It was also agreed that the CIP was a key priority and should be undertaken in Q2 with presentation to the Audit Committee on 14th September with the relevant Executive Directors in attendance to comment; with subsequent monitoring at Performance Committee. This is an absolute priority for 2018/19. It was noted that the Care Group Governance audit was being finalised. A SOP was agreed between Deloitte and SaTH later in the meeting to prevent this recurring.

Budgetary Control and Financial Reporting Audit

Audit	Opinion	No. Recommendations	Committee
Budgetary control and financial reporting	Limited	2 high; 5 medium; 1 low	Performance

There was a difference in relation to this report with one recommendation not agreed initially. There was a difference in relation to financial reporting at Care Group Level, which highlighted weaknesses in the Confirm and Challenge process, but this needed to be balanced against the need to focus on more strategic issues. After discussion it was agreed that a trackable quantitative financial analysis at Care Group level accompanies the current summary.

External Audit
- Noted that the accounts were completed an unqualified opinion will be issued.
- Noted that the financial statements included the Annual Report and Annual Governance Statement
- There were no material adjustments and all the presentational adjustments were implemented. External Audit advised that the accounts and co-operation from the Finance Team had been exemplary, and was much appreciated.
- Will be issuing an 'except for' Value for Money opinion (which looks and processes and arrangements in place). This concludes that there are adequate arrangements in place except for the underlying financial position (17.4m deficit), and A&E performance of the Trust. This will require a Section 30 referral to the Secretary of State as there is a breach of the Trust's statutory duty. This is purely a factual letter setting out the in-year and cumulative position of the Trust. The Auditors also considered the Trust's judgement to be balanced in the areas of Provisions, Accruals, Deferred Income and Debtor's Provisions.

Year-end Reporting
Received and recommended approval to the Board before submission to Parliament
- Annual Report
- Annual Accounts
- Audit Committee Annual Report

Mr Deadman reported that some of the issues are connected with the delivery of the organisation's waste removal scheme.

Security Annual Report
The Committee sincerely thanked Jon Simpson and the Security Team for the continued support and professional approach provided to safeguard staff and visitors to site.

…….. Chair
5 July 2018

Board Assurance Framework
The Committee:

- Considered and agreed that the strategic risks have remained the same. Considered that the impact in relation to the I&E risk had probably increased although not sufficiently to change the position.
- Discussed the Trust Risk Register and was pleased to note that almost half the register in April 2017 had been closed or reduced, and removed, although new risks had been added with the residual risks relating to either workforce shortages or capital requirements. The Operational Plan also focuses on reducing the key strategic risks

Recommendation Tracking
The Committee was pleased to note that there were no outstanding recommendations. It was agreed to extend the implementation date of two recommendations.

Committee self-assessment
A collective self-assessment was undertaken of the performance of the Committee; which was much more useful than doing it individually by email. It was based on NHS guidance and it was agreed to circulate to Tier 2 Committee Chairs as a possible template for other committees.

The Board RECEIVED the Audit Committee summary.

2018.2/126 BOARD ASSURANCE FRAMEWORK & TRUST OPERATIONAL RISK REGISTER

The CEO re-emphasised the importance that this is a live document and is tracking what we are doing in the management of organisational risks; the RAG ratings should therefore improve over time.

The DCG felt encouraged that the Tier 2 Committees are using the Board Assurance Framework (BAF) in an active way which is an effective way of providing assurance for the Board.

The DCG informed the Chair that the operational risk register report includes the capital action costs as well as additional information relating to assurances, as requested at the 3 May Trust Board.

The Board were also informed that a paper was presented to the Audit Committee looking at the risk profile April 2017-April 2018 and although the number of risks on the risk register remain broadly the same, over half had either been closed or removed in that 12 month period. The DCG therefore reported that as well as the BAF being a live document, the Operational Risk Register was also live and was hotly debated by the Operational Risk Group on a monthly basis.

Following discussion, the Board REVIEWED and APPROVED the Board Assurance Framework and agreed that the risks status currently remained unchanged.

2018.2/127 SECURITY ANNUAL REPORT – 2017/18

The DCG presented the 2017/18 Annual Security Report which had been presented to the Audit Committee. She drew particular attention to section 1.4 which highlights the proactive nature of the work, looking at risk assessments of the environments.

The DCG also asked the Board to note the two of the highest scoring staff survey results were in relation to the reduction in violence and aggression against staff by members of the public; that is due to our proactive approach to responding and controlling acts of aggression.

The DCG informed the Board of a recent incident which had occurred, and wished to commend the two security guards in the Emergency Department after dealing with a very difficult and dangerous situation. The DCG reported that she had forwarded a letter to them to thank them on behalf of the Emergency Department staff as well as the Trust Board.

…….. Chair
5 July 2018

The Trust Board RECEIVED and APPROVED the 2017/18 Security Annual Report.

WORKFORCE (PEOPLE)

2018.2/128 WORKFORCE COMMITTEE REPORT

The WD presented the summary of the Workforce Committee meeting held on 21 May 2018:

Board Assurance Framework including Breast Radiology
The Committee reviewed the BAF and concluded that whilst no changes to overall ratings applied, the movement of Risk 859 'Sustainability of clinical services due to potential shortages of clinical staff' has a deteriorating trend.

The Committee received a briefing regarding Breast Radiology and an increased workforce risk following a retirement. The role is recognised nationally as a difficult to recruit role, to date the service has undertaken a number of actions to mitigate this risk however the retirement will change this. Interim actions have been agreed to support the clinical pathways however additional Breast Radiologists are required. Breast services have been escalated to the Board Assurance Framework and will be added to the Services under the Spotlight. All efforts are being made to recruit to the service and the marketing campaign is being designed. The Committee was assured that all actions are being taken to support the service and were advised that weekly team meetings are being held, chaired by the Deputy COO.

Evaluation of weekly pay in July
Through Workforce Assurance report the Committee received an update regarding the reintroduction of weekly pay which took place from 1st April 2018. Following feedback from staff, Bank employees have been offered the choice of either monthly or weekly pay options and staff are still making final decisions regarding which payment process suits them. A review of the impact of weekly pay will be presented to the July Committee to allow a complete introduction period. The Committee also asked that bank pay rates were included in this evaluation.
Mr Newman (NED) highlighted that the issue of 'pace' had been raised on a number of occasions throughout the Board meeting, and noted that 'weekly pay to Bank nursing staff ' had been raised at least two years ago and questioned if the impediment to change from monthly to weekly mid-year has been removed.
The CEO confirmed that the WD and her team have been trying to address this for some time. He reported that to move to weekly pay generates a £750k cash pressure for the Trust in terms of the payment structures in the course of the year; there is therefore a significant financial impact and the organisation had to ensure it was in a position to be able to introduce this so as not to compound its cash position further.

DBS
The Committee received the monthly DBS Check Assurance Statement and congratulated the team on completing over 900 checks over the past eighteen months. The only outstanding checks (5) are due to maternity or sick leave and will be completed as soon as the members of staff return to work.
The Committee also received a proposed work programme for 2018 / 2019 which was approved and agreed, along with a bi-monthly reporting to Committee.

Changes to SSU reporting
The Committee received a proposal to change the method of reporting statutory and mandatory training compliance with effect from June 2018. Members of staff are required to complete all components of the training to be reported as compliant. The new method will capture the components staff have completed. It will increase the compliance from 70% to 86% and allow departments to focus on the areas with the lowest compliance rates. The Committee challenged that there would still be a lack of compliance in some areas but were assured that this would provide the Care Groups with better intelligence and a reflective position. Trajectories are being monitored through Confirm and Challenge. The Committee approved this new reporting method and supported a greater use of e-learning.

People Priorities
Following discussion at last month's committee regarding the People Priorities, the committee received a draft chart of the actions that are required to be delivered over the next twelve months.
The Committee were positive about this new presentation and felt that the visual format was helpful. The Chair felt

that this new approach would lead to a different agenda and potentially a more efficient meeting due to the presentation. The Committee asked for this to be analysed and presented to the June Public Board. It will also be used as a document to monitor and track progress.

Audit Reports
The Committee received the Deloitte internal audit report on the Temporary Staffing review. The Committee considered the report focusing on the recommendations. The report had found a number of areas requiring improvement. The management action plan has been developed and agreed and work is ongoing to progress these actions. The Chair expressed his thanks to the Committee for their positive response to this audit.

GDPR
The Committee received an update regarding the new General Data Protection Regulation (GDPR) which will supersede the current Data Protection Act from 1998, effective from 25 May 2018. The Committee received assurance on progress made to date and the proposal for work streams moving forward. The clear plan was pleasing however it would be essential for the Committee to receive further updates. The Committee noted that there are significant fines for non-compliance and agreed that this should be added to the risk register.

Dr Lee (NED) reported that a joint Workforce and Q&S Committee had been held two weeks previously, ensuring the alignment of the Board sub-Committees.

Mr Deadman (NED) requested confirmation that the Workforce Committee is focusing on sickness. The WD confirmed that sickness performance is reviewed in detail every month at Workforce Committee, broken down into areas which enables the Committee to identify through a range of metrics if there is any areas of concern.

The Board RECEIVED the Workforce Committee summary and the Chair highlighted that as Chair of the Workforce Committee, Dr Weiner is aware of the importance of the Committee driving forward the completion of statutory training for all staff members.

2018.2/129 WORKFORCE PERFORMANCE REPORT

The WD presented the Month 1 performance report in relation to:

Sickness / Absence / Unavailability
The WD reported that the Trust is seeing a positive trajectory in relation to sickness at 3.93%

Mr Deadman (NED) asked the WD to keep a watchful eye on unavailability as a whole issue. The WD agreed.
Action: WD

Appraisals – Overall compliance rate 87.06%
The WD reported positive movements in Appraisal rates; however work is on-going with some areas.
Trajectories are reported to the Confirm and Challenge meeting on a monthly basis in relation to statutory training as well as appraisals.

Statutory Safety Update (SSU) Training – Overall compliance rate 69.71%
As detailed in the Workforce Committee summary, the WD highlighted the changes to the reporting mechanism for statutory training compliance. This will therefore be presented in a slightly different way going forward.

Mr Newman (NED) raised his concern regarding the importance of staff completing their annual training and highlighted that it is 'statutory' for a reason. The WD reported that this was discussed at the Workforce Committee in a level of detail and agreed its importance. She asked the Board to be mindful that the report is providing detail on the number of staff who are behind with their training; it doesn't reflect that we have a level of incompetence in the workforce.

…….. Chair
5 July 2018

The WD reported that the Trust has a real challenge in releasing its staff to attend classroom based training (the DNA rate is 16% for statutory training); she agreed that there is more that the Trust has to do, such as the provision of e-learning / provision at Ward/Department level, as it is a basic of the employment relationship.
The CEO confirmed that the Executive Team have dates for one-to-one appraisals in the coming months, and the Executive meetings will be utilised to ensure the Exec Team fully comply with statutory training, to lead by example.

Staff Turnover (exc. Junior doctors) – Recruitment rate 9.94%, Retention rate 91.76%
The WD reported that this remains static, however as discussed at the joint Workforce and Q&S Committee there are a number of areas where targeted pieces of work are being undertaken as they have higher levels of turnover and retention.
Work has been undertaken in relation to 'leavers' in the first 12 months and there is no real cause for concern.

The Trust Board RECEIVED the Workforce Committee update.

2018.2/130 FREEDOM TO SPEAK UP GUARDIAN ANNUAL REPORT

The WD welcomed the Freedom to Speak Up Guardians, Kate Adney and Teresa Love to the meeting to provide an overview of their role, information on the last 12 months statistics, analysis of cultural change within the Trust and next steps.

Summary of Findings:
From February 2017 to March 2018, the Freedom to Speak Up Guardians handled 40 cases; these have fallen into the following categories which echoes the Staff Survey results:

- Bullying and Harassment – 24%
- Concerns relating to Managers – 32%
- Process issues – 8%
- Environmental and Infrastructure – 10%
- Behavioural and Relationship issues – 16%
- Communication issues – 2%
- Patient Safety – 4%
- Other (Payroll/Pensions) – 4%

Conclusions and Next Steps
From the data and cases that the Freedom to Speak Up Guardians have collated, the main cause for concern is staffing issues with their managers, and forms of bullying and/or harassment.

The next steps would see the Freedom to Speak Up Guardians:

- Continuing to listen to colleagues and feedback and/or escalate as required
- Continue to engage and communicate with as many staff as possible across all three sites
- Engage more closely with the Senior Leadership Team, including attending and feeding back at Workforce Committee on a quarterly basis
- Encourage Board members to promote and encourage the Freedom to Speak Up
- Host the Regional FTSU Networking event to further embed relationships with colleagues in other Trusts
- Increase communication activity to further reach out to staff, produce a video to be shown at all inductions
- It would be appropriate for the Freedom to Speak Up Guardians to have more time in order to fully deliver the role in accordance with the National Guardian Office and the requirements of the CQC. At present the FTSU Guardians are not able to fully support 6,000 Trust staff in a timely manner in just 10 hours a week each.

The Chair informed the Freedom to Speak Up Guardians that he was fully supportive of their roles; it is another mechanism for staff to raise concerns. He encouraged them to attend the sub-Committees of the Board as required; and to inform him of any concerns that they may have.

…….. Chair
5 July 2018

The CEO thanked the Guardians for their hard work and referred to their request to have more time to fully deliver their roles to the 6,000 staff members. He agreed to take this seriously and discuss with the WD in terms of supporting the ongoing need to expand exposure.

The CEO encouraged the Guardians to continue to challenge both him and the Trust Chair to create the right climate in the organisation where staff feel free and able to raise concerns, as it is a significant priority.

Mr Deadman (NED) enquired if the FTSU Guardians liaise with Guardians in other organisations, and if there is any sense of how SaTH is performing. The Guardians reported that the National Guardians website provides a benchmark of how SaTH is performing against other Trusts. From a regional point of view, others work differently and at different levels, although the FTSU Guardians felt they are proactive in engaging with staff through the 'round the table' events held, which other Trusts don't hold. It is a positive concept that has been rolled out to help with staff engagement.

Mr Newman (NED) enquired if the FTSU Guardians have been approached by staff members in relation to bullying/harassment where they haven't taken it up with their line managers, who may be the issue. The FTSU Guardians felt staff members may feel unable to report it up to their line managers; in which case they could be called to sit in on conversations.

Following discussion, the Trust Board RECEIVED and NOTED the Freedom to Speak Up Guardians Annual Report and agreed for an update to be provided to the Board on a six-monthly basis.
Action: Update to November 2018 Trust Board

2018.2/131 STAFF SURVEY RESPONSE PLAN

The WD reported that the Staff Survey results were disappointing. To truly understand them, a staff engagement exercise was undertaken to understand what mattered to the staff and to agree the focus for this year.

A draft Organisational Development Plan has been completed but felt a little light in addressing staff feedback. The Staff Survey paper presented to Board was therefore a six month focus, and the WD reported that the Organisational Development Plan will be further developed and presented to the Board during the autumn.

Within the paper, it highlighted the following key messages received from staff:

- We are not consistently living our values; at times of pressure behaviours can become inappropriate.
- We need to do more to engage our staff and to ensure they are up to date with what is happening in the organisation.
- We need to support our staff to take breaks and have the appropriate uniform and tools to do the job.
- We need to significantly reduce/eliminate boarding. The WD reported that this message came through every conversation held with all members of staff
- We need to recognise that every role counts.
- We need to support staff to undertake training/develop skills and give them time to do this.

The two Organisational priorities for improvement and the area of celebration were agreed and a draft action plan completed by the Senior Leadership Team (SLT):

<u>The celebratory priorities:</u>

- Key Finding 1 -Staff recommending the organisation as a place to work or receive care
- Key Finding 16- Reducing staff experiencing bullying, harassment and abuse by other staff
- Key Finding 22- Celebrating success of top 20% nationally for staff experiencing low levels of physical violence from patients

Project Plan

A high-level plan has been drawn up which includes a structured programme of work up until December 2018, at which point the 2018/19 Staff Survey will close.

It is suggested that a more detailed Project Plan will be drawn up to identify local level actions (as a sub plan within the organisational Project Plan) which will be monitored through Workforce Committee on a monthly basis and an update provided to Board during September 2018.

In addition, the Workforce team have mapped the current Organisational Development activities against the Best Companies 8 Factors of Workplace Engagement to review if the current offer supports levels of high engagement and improvement in employment experience. This assessment is informing a refreshed Organisational Development plan which will also be heavily influenced by the Staff Survey and Cultural Assessment Tool (CAT) and will be presented to the October Trust Board.

Action: WD Due: October 2018 Trust Board

The Chair reflected that we have previously relied on the NHS Staff Survey which is a lengthy process; and enquired if we have considered targeting the areas in most distress with a far shorter sharper process.

The WD reported that the organisation is required to undertake a quarterly shorter Friends and Family Test which currently asks two questions around i) would you recommend the Trust as a place to work and ii) would you recommend the Trust as a place to receive care. She reported that an additional five questions will be included in the test, and through the analysis from the Staff Survey, areas that require the greatest support will be targeted.

The completion of this will be encouraged through the staff engagement activities and conversations with staff.

The CEO highlighted the importance of continuing the interaction with staff and listening to what they are saying and recognising their concerns.

2018.2/132 PILOT WARD STAFFING MODEL

This paper, produced by the WD, was presented by the DNMQ regarding the need to provide more timely and safe care to our patients in a different way which promotes improved outcomes for patients and supports the morale of the nursing workforce.

For the last two-three years the Trust has been carrying significant gaps for Registered Nurses; however approximately 80 will be recruited by September 2018. The alternative way of supporting the nursing work has a quality and safety imperative, a workforce imperative in supporting morale, operational delivery and performance, as well as a financial imperative.

The approach being used to look at an alternative staffing model to compliment the nursing gaps will use a single change methodology using our Transforming Care Production System (TCPS). The DNMQ highlighted that engagement is vital to the sustainability and effectiveness of this model, from our people. Some pilot wards will be used.

Equally important is the engagement with external stakeholders; namely we have received commitment from Health Education England to support this endeavour, as well as NHS Improvement, Higher Education Institutes, and once we have a worked up plan we will engage heavily with stakeholders, commissioning bodies, CQC and other regulators.

Going forward, the DNMQ presented the New Ward Project Plan reporting that the ambition is to roll out to 7 wards by the end of March 2019. The DNMQ reported that an RPIW week is planned for 30 July and we will then have a clearer idea of the future state.

This will be reported through both Quality & Safety and Workforce Committees and a robust QIA and EQIA will be developed to ensure our patients and staff are kept safe.

The Chair requested assurance that this be progressed at pace. The DNMQ agreed, and reported that the Workforce Team are supporting her team to achieve this.

…….. Chair

5 July 2018

LEARNING

2018.2/133 TRANSFORMING CARE INSTITUTE (TCI) UPDATE

The CEO presented an update in a slightly different format from those previously received, which is in part following the principles of Lean as it is being used in other forums to make it more accessible for staff and patients.

The CEO informed the members of the following steps:

- This is the first month that Kaizen events are being undertaken with external partners; working with Shropshire local authority which has been really positive, also work is being undertaken with WMAS to reduce further ambulance delays and handover.
- Transformation is targeted in areas of high risk which include Radiology and the Emergency Service, and we look forward to seeing the progress that will be delivered in these areas.
- In terms of the Stroke service; the organisation's Lean for Leaders undertook a piece of work in relation to the swallowing technique for patients which is a finalist in the National Patient Safety Awards; the CEO felt proud of the team's achievement.
- The CEO reported that work will continue with the 700 staff who have already received training and with those trained in 5S; he highlighted that the savings that this work has generated should be articulated.
- The CEO reported that the burden of meetings is reducing – now moving towards far more huddles in which attendees stand up which encourages the discussion to be brief, as well as the use of Production Boards where teams gather around the boards to discuss the day's work.
- A number of significant improvements are being made – these are reported at the weekly Stand Ups/Report Outs.

Mr Newman (NED) reported that the Steering Group had an agreement that all members of staff would receive basic training in 5S by end December 2018. This was agreed.

The Board RECEIVED the Transforming Care Institute monthly update.

2018.2/134 ANY OTHER BUSINESS - No further business raised.

2018.2/135 THE MEETING CLOSED AND THE BOARD TOOK QUESTIONS FROM THE FLOOR :

Q1 In the Complaints/PALS report there seems to be a sharp increase in reports between December-February – which Care Groups does this relate to?

A1 The DCG reported that the detail is in the full Complaints/PALS report. The figures do smooth out throughout the year, but appear high during December-February due to the increase in activity during those months. There does not appear to be a trend.

Q2 Also, it also shows 20 complaints regarding Obstetrics/Maternity - How does this compare with last year and how many people are complaining about MLU closures?

A2 The Trust has seen an increase in regard to complaints regarding the MLU closures following a post on social media which asked patients to write a letter of complaint – it was encouraged as part of a wider campaign and a number of 'template' letters had been received.
There has been zero 'non-template' letters received in relation to the issue, although all 'template' letters had been responded to.

Q3 An update was requested in relation to the national Breast Screening issue reported at the last Board meeting.

A3 The COO reported that we have approx. 2000 patients identified; the team has looked at the screening with the potential that some are positive. It will take until early autumn to review all of those patients but that is being managed in accordance with national guidelines.

Q4 Does the £20.5m annual recurrent deficit impact on hospital reconfiguration costings?

A4 The CEO reported that the costings have been a part of the Outline Business Case for some time. It forms part of

that which was approved by the NHS England and NHS Improvement assessment process that got us to the point where the funding was released and the approvals were made to go into public consultation.
The Chair reported that each year the organisation is required to sign up to a control total – which is part of the whole NHS process. It has no effect on the Capital funding; it is part of our planning.

Q5 **Two years ago the Board decided to scale down the Maternity Led Units to save £1.5m – has the Board noticed a reduction in income from the consequence of this? And, given the plans to move the Women & Children's Unit from PRH, would it be better to offer MLUs to the patients of Shropshire?**

A5 The CEO reported that he did not recognise the statement that a conscious decision was made to scale down the MLUs; SaTH has acknowledged there has been safety concerns which on occasions has been a reason. There was also a period of suspension of birthing due to workforce gaps, and also acknowledged that in recent years there has been a change in the decisions of mums which has seen them choosing to have their babies in the consultant unit – this is a national trend, and not unique to Shropshire.
In terms of income – there has been approx. a £2m drop in income in the maternity services but can't see any correlation, i.e. mums choosing to have elsewhere (Stoke, B'ham etc). Nationally there has been a reduction in births.
In terms of promoting the MLUs – we need to move into dialogue as soon as we can. We will continue to be strong advocates for providing services in the community for mums, although it must be measured against the safety component.
The DNMQ reported that it is right to promote choice, but it has to be set in a perspective of safety first. The Birthrate Plus acuity tool shows that women's pregnancies are increasing in complexity; the opportunity to birth in MLUs is reducing locally and nationally.
The DNMQ highlighted that SaTH is looking forward to complying with Better Births and the opportunity following the LMS Review that we will have a sustainable model that will offer choice, safety and continuity of care.

Q6 **A request was made for the provision of printed Board papers to the public**

A6 The Chair informed the public that the Board papers are available on the Trust website, and WiFi is available in the Trust meeting rooms making the papers accessible via a tablet. Logistically it would be difficult to provide the public with paper copies, although iPads could be loaned to the public during the meetings.

Q7 **A member of the public reported that last month the Board referred to the importance of communication with staff and there would be three points of reference to come out of each Board meeting; the member of the public requested the three items from this month's Board meeting.**

A7 The Chair reported the following messages:

- A good start to the year; a lot of lessons have been learnt from the previous year and we have a plan going forward
- Relaying positive messages to the staff regarding performance - SaTH is achieving targets in relation to RTT which other Trusts are not achieving, as well as positive messages for the finances in Month 1
- SaTH has a significant plan to eliminate patient boarding

Q8 **The provision of the Phlebotomy Service was raised and its timescale. It was also reported that it is still not clear why this decision was taken. The member of the public invited the CEO to attend the Shropshire Scrutiny Board on 16 July to provide reassurance on the type of engagement and consultation planned.**

A8 Unfortunately the CEO reported that he would be unable to attend as he is on annual leave; but would be more than happy to attend an alternative forum.
The CEO reported that Shrewsbury's Darwin Centre is an option however it is being driven by the rental charges as they are significantly greater than Princess House; it would need to realistically align with other costs and once resolved could move quickly, taking into consideration the views of the patients using the service.

2018.2/136 **DATE OF NEXT PUBLIC TRUST BOARD MEETING -** Thursday 5 July 2018

- 1.30pm - Opening of the White Garden at RSH
- 2.00pm - Public Board meeting, Seminar Rooms 1&2, SECC at RSH

The meeting closed at 4.55pm

…….. Chair
5 July 2018

ACTIONS / MATTERS ARISING FROM THE PUBLIC TRUST BOARD ON 31 MAY 2018

Item	Issue	Action Owner	Due Date
2018.2/110	Draft Minutes held on 3 May 2018 *To update minutes to reflect Mrs Terry Mingay's correct name*	CS	**June 2018 COMPLETED**
2018.2/111	Actions/Matters Arising 2018.2/72 – Organisational Development Plan *To present to 25 October 2018 Trust Board* 2018.2/41 – Winter Planning *To provide Winter Plan Update to 30 Aug Trust Board* 2018.2/43 – Maternity Engagement Plan *To present recommendations to 30 Aug Trust Board* 2018.2/58 - Non-Consultant Grade Medical Workforce Plan *Workforce Committee to support the work and progress and provide assurance to 30 Aug Trust Board* 2018.2/59 – Staff Survey Results 2017/18 *Workforce Committee to monitor results and assurance to be provided to 27 Sept Trust Board* 2018.2/79 – Maternity Clinical Improvement Metrics *To present NHS Resolution paper to future Trust Board* 2018.2/93 – Questions from the Floor *To provide feedback to Board via Ops Performance Report re: 'Lets Crack It' Initiative*	WD COO DNMQ WD/Workforce Cttee WD/Workforce Cttee DNMQ COO	**25 Oct 2018 ADDED TO SCHEDULE** **30 Aug 2018 ADDED TO SCHEDULE** **30 Aug 2018 ADDED TO SCHEDULE** **30 Aug 2018 ADDED TO SCHEDULE** **27 Sept 2018 ADDED TO SCHEDULE** **ADDED TO SCHEDULE** **5 July 2018 AGENDA ITEM**
2018.2/116	Q&S Committee Summary <u>Scheduled Care Group Presentation</u> *To feedback positive comments to Scheduled Care Group Chief Nurse* *To investigate lease options for PRH CT scanner and report back to 30 Aug Trust Board*	 DNMQ Chair of Perf. Cttee	 **June 2018 COMPLETED** **30 Aug 2018 ADDED TO SCHEDULE**
2018.2/119	Safest & Kindest Quality Strategy *To forward Terms of Reference for Q&S and CGE Committees to SaTH Chair* *To add further detail to the markers on page 17 of report in relation to percentages*	MD/DNMQ DNMQ	**5 July 2018 COMPLETED** **July 2018**
2018.2/121.1	Operational Performance – Ophthalmology *To invite Ophthalmology Team to 5 July Trust Board*	COO	**5 July 2018 AGENDA ITEM**

…….. Chair
5 July 2018

2018.2/122	Winter Planning – Lessons Learnt *To present 2018/19 Winter Plan to 30 Aug 2018 Trust Board*	COO	**30 Aug 2018 ADDED TO SCHEDULE**
2018.2/124	Services in the Spotlight Update – Dermatology OP Service *To focus on consultant/junior doctor appointments, as per Skin Clinic processes*	WD	**Aug 2018**
2018.2/129	Workforce Performance Report – Sickness / Absence / Unavailability *To keep watchful eye on unavailability as a whole issue*	WD	**Ongoing**
2018.2/130	Freedom to Speak Up Guardians *To provide update to Board on six-monthly basis*	WD / FTSU Guardians	**29 Nov 2018 ADDED TO SCHEDULE**
2018.2/131	Staff Survey Response Plan – Project Plan *To refresh Organisational Development Plan and present to 25 Oct Trust Board*	WD	**25 Oct 2018 ADDED TO SCHEDULE**

…….. Chair
5 July 2018