The Shrewsbury and Telford Hospital NHS Trust

TRUST BOARD MEETING
Held 1.00pm, Thursday 30th May 2019
Seminar Rooms 1&2, Shropshire Education & Conference Centre (SECC), Royal Shrewsbury Hospital
PUBLIC SESSION MINUTES

Present:	Mr B Reid	Chair
	Mr T Allen	Non-Executive Director (NED)
	Mr A Bristlin	Non-Executive Director (NED)
	Mr C Deadman	Non-Executive Director (NED)
	Dr D Lee	Non-Executive Director (NED)
	Mr B Newman	Non-Executive Director (NED)
	Mr A Carroll	Associate Non-Executive Director (A. NED)
	Mrs B Beal	Interim Head of Nursing & Midwifery (IDNMQ)
	Dr E Borman	Medical Director (MD)
	Mr N Lee	Chief Operating Officer (COO)
	Mr M Hall	Senior Finance Officer (Acting for FD)
	Mr S Wright	Chief Executive Officer (CEO)
In Attendance	Mrs V Rankin	Workforce Director (WD)
	Mrs J Clarke	Director of Corporate Governance / Company Secretary (DCG)
Meeting Secretary	Mrs L Perkins	Assurance Team Administrator
Apologies:	Mr N Nisbet	Finance Director

2019.2/63 WELCOME & APOLOGIES:

The Chair welcomed all to the Trust Board meeting.
It was noted that Mr M Hall was representing Mr N Nisbet

The Chair also advised that Ms A Edwards (NED) and Mr H Darbhanga (A.NED) had stepped down with immediate effect from their respective roles with the Trust, thanking them both in absentia for their support and hard work.

2019.2/64 PATIENT STORY

The Board received a Patient Story by way of a short film to coincide with International Clinical Trials Day which fell on 20th May 2019. The video played interviews from a number of patients involved in clinical research trials, expressing their views and feedback.

The team, represented by Sister Helen Moore, are trying to raise the profile of the work carried out by the Trust's Research and Innovation/Clinical Trials Department.

It was noted that:

- Over 110 open studies are underway involving 16 specialties within the Trust.
- SaTH is one of the top 8 recruiters across 128 hospitals in the UK.
- 2018/19 saw over 2,050 patients participate in clinical studies within SaTH, making this an increase of 15% compared to 2017/18.
- There is an opportunity to significantly increase our pharmaceutical trials which generate income for Trusts and enable access to novel therapies for patients with debilitating or life-limiting conditions.
- The NHS Constitution states that access to clinical research should be core business.
- There is evidence that organisations which actively support research have better patient outcomes and there is clear evidence of overall reduced mortality rates, not just for those on a clinical trial.

…….. Chair
1 August 2019

- There is also a body of evidence which points to a positive patient experience with 72% of patients strongly agreeing they would take part in another study.

The MD said there was a desire to increase the take up of such trials especially the *70@70* project involving midwives and nurses. The *100,000 Genome Project* involved 250 patients with rare diseases or cancer establishing an individual genome map resulting in the ability to provide tailored treatment.

The Chair thanked Mrs Moore for attending and the Board praised the work of the Department. The Interim DNMQ also commented on how powerful the video was through hearing directly from participating patients.

2019.2/65 BOARD MEMBERS' DECLARATION OF INTERESTS

The Chair declared he is now a non-paid Director for HF Holidays Ltd.

Mr Allen (A.NED) declared he is also a NED for Dudley CCG.

The Board RECEIVED and NOTED the Declarations of Interest.

2019.2/66 DRAFT MINUTES OF MEETING HELD IN PUBLIC ON 4 APRIL 2019

The Minutes were APPROVED as a true record.

2019.2/67 ACTIONS / MATTERS ARISING OF MEETINGS HELD 4 APRIL 2019

It was noted that the Non-Executive Directors' Statutory Training has been arranged for 29th August 2019 during the Board Development session. **Completed.**

2019.2/68 CHIEF EXECUTIVE OVERVIEW

Strategy

<u>£32m Investment</u>
The Chief Executive detailed the recent announcement on the additional investment in both clinical staff and equipment. He advised the Board that some of the clinical staff that will be recruited included a Sepsis Nurse and additional substantive A&E nursing roles, to provide safer care of the highest standard. Some of the capital investment included additional fire safety works across the sites in order to meet the increased Building Control requirements to ensure the highest levels of safety following the Grenfell Tower disaster

At PRH there a second CT scanner will be purchased. At present there is only one ageing CT scanner at PRH which is frequently out of action resulting in patients having to be transferred to RSH for investigations and then back to PRH for treatment which is completely unsatisfactory for the patients and for our staff.

Other improvements include the automation of drug dispensing, in particular within Opthalmology, being rolled out to improve efficiency and effectiveness. There will also be significant improvements to the Endoscopy service through investment in state of the art equipment.

People

The CEO advised that a recurring theme from our staff was the perceived lack of engagement and communications in some areas. This has been a theme in the staff survey for many years and focussed efforts were being made to improve this.

The CEO advised that there are now 17 Freedom to Speak Up Advocates, three Freedom to Speak Up Guardians, over 100 Engagement champions and 140 Lean for Leaders across the Trust. There are also 20 'Think On' Master coaches

in the organisation. All of these are intended to improve engagement and communication with a focus on continuous improvement and shared learning.

Think On Master coaches support positive and purposeful conversations to encourage a safer environment and increased learning.

Community Engagement

In an effort to hear the voices of in our community, especially in rural areas, the CEO advised that he and the DCG had led a number of listening events around the county. These had proven very powerful and work was being developed to strengthen and build on the approach that had been welcomed by local communities.

It was noted that SaTH had won the national Membership & Engagement Services (MES) Engagement Champion 2019 award for its work around community engagement and particularly The People's Academy programme. It was noted that many of the graduates from the People's Academy go on to support our Transforming Care work, patient focus groups and volunteering.

Values in Practice Awards

The CEO advised that these had been presented to:

- Rachel Lee for her physiotherapy treatment that enabled a patient to regain the ability to walk.
- Dave Thomas from Estates for improving the patient environment, often in very difficult circumstances.
- The Critical Care Outreach Team (Sepsis) for their hard work on embedding the sepsis 'bundle' which was in addition to their normal work. There has been an overall improvement in activity and results in this area.

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Mr Carroll (NED) questioned how we change the culture in relation to Staff Engagement and how to ensure our senior leaders are actively involved in Lean for Leaders and communicating with their teams.

The CEO responded that the visibility of the executive team to staff has been and will continue to be increased and that modelling expected behaviours was a key component for leading change.

The Board RECEIVED and NOTED the update.

2019.2/69 STP SYSTEM OPERATIONAL PLAN

The paper was received by the Board.

The Chair queried as to the extent of NED involvement in the current governance framework supporting the STP.

The CEO advised that engagement with Chairs and NEDs across all STPs needed improvement. It was noted that Shropshire, Telford & Wrekin STP had worked collaboratively to bring a single aligned narrative that captures:

- System priorities and deliverables
- Understanding of activity assumptions
- Understanding of capacity planning
- Understanding of strategic workforce planning
- System financial understanding and agreed approach to risk management
- Understanding of efficiencies and the collective responsibility to deliver them

It was noted that there were two key programmes to support strategic development in system leadership and capability:

- System Commissioning Capability Programme
- Integrated Care System Development Programme

Mr Bristlin (NED) asked how the STP would support the Digital Agenda at SaTH.

The CEO said a Digitisation workstream was one of the key STP workstreams, and moving forward SaTH will be looking to the STP to support SaTH's agenda and any bids for potential funding.

Dr Lee (NED) asked what authority the STP had at Trust level.

The CEO explained that there was no common approach:

- Some Trusts use the STPs for joint decision-making purposes as this can aid collective agreements.
- However, some STPs work with 8 or 9 Boards so making collective decisions is difficult on occasion. Furthermore the sequencing of decisions is not always timely.

The Board RECEIVED the update and NOTED the STP System Operational Plan.

2019.2/70 TRANSFORMING CARE INSTITUTE (TCI) UPDATE

The CEO presented a paper which provided an update on the Transforming Care Production System (TCPS) continuing to support improving the experience of our patients, their families and our staff. He also made reference to the Development session prior to this meeting with the TCI, and described how the TCPS continues to support the implementation of the organisational strategy.

It was noted that moving forward there will be a review of the current TCPS training programme through:

- PDSA of the current training provided and an update of the content by the KPO Team
- Integration of *ThinkOn* principles within Lean for Leaders and improvement events

This will ensure that TCPS training will meet organisational needs and will support the delivery of the organisational strategy and objectives. This will be achieved by:

- Training SaTH Leaders in Lean for Leaders
- Creating bitesize training/ refresher topics to support value stream work
- Developing kaizen events training so that our Leaders have knowledge and skills to run improvement events
- Collaborating with Undergraduate training, Foundation training, the SaTH People's Academy and the Princes Trust

The CEO confirmed that SaTH's partnership with the Virginia Mason Institute is approaching its fifth and final year. During the last 4 years the KPO Team have supported the embedding of the TCPS as a single improvement methodology for SaTH. Over 80 leaders at SaTH have completed Lean for Leaders training and this is creating a ground swell of people who are using TCPS and daily management tools to improve their work.

This was evident during a recent visit by NHS Providers Chief Executive, Chris Hopson who visited the Princess Royal Hospital and spent time on the Genba. He praised Shropshire's acute hospitals for their leadership, progress and 'desire to learn and improve'.

The Board NOTED and APPROVED the continuing development and improvement of the TCPS training and commended the 'Report Out' from around 40 staff at the Board Development session earlier in the day.

2019.2/71 COMMUNITY ENGAGEMENT UPDATE

The DCG gave a presentation which conveyed the message that as an NHS organisation, the Trust is committed to hearing the views of our local communities through engagement with them. It is also a legal requirement in Section 242 of the National Health Service Act 2006 that users of services are involved in provision planning, considered in proposals and decisions public bodies make affecting local services.

It was noted that in Q4 the team had provided support to:

- **Ophthalmology**
  - Support for engagement plan and patient survey
- **GI services**
  - Support for engagement plan
- **MLU pre-consultation support**
  - Attending community groups and gaining feedback
- **Macmillan Information Centre, RSH**
  - EQIA support and Patient survey

It was noted there were currently 948 volunteers at SaTH, plus a further 60 young volunteers, all of who have role descriptions, induction and DBS checks with ongoing support from the team during their time with us.

During Quarter 4 there had also been a number of engagement activities across the county and Mid-Wales including:

- Community Connectors, Oswestry, Market Drayton, Whitchurch and Bridgnorth
- Shropshire Disability Network
- VCSA Board
- Powys Community Health Council
- *A Life Outside Caring* Group
- Telford College

The DCG advised that further plans for 2019/20 included:

- Developing a SaTH's People's Forum - chaired by a NED
- Developing a People's Academy for individuals with learning difficulties
- Continuing to hold quarterly meetings Community Meetings in Telford and Shrewsbury to engage and hear the views of our local communities
- Regular attendance at external community meetings
- Support the involvement of local communities with service delivery and changes

Dr Lee (NED) commended the development of a People's Academy for adults with learning disabilities as it was important to be inclusive and ensure all members of the community were afforded the same opportunities.

The Interim DNMQ congratulated all those involved in Community Engagement work on their approach, which she felt was wide-reaching and innovative.

The Board thanked the DCG and Community Engagement team for their continued good work in this important area.

2019.2/72 WORKFORCE COMMITTEE SUMMARY

Mr Carroll (NED) presented the summary of the Workforce Committee meeting convened on 20 May 2019. The meeting received an update regarding the OD Plan and actions taken since the last meeting. The meeting recognised and supported the steps taken to progress the delivery plan since the previous meeting. The NEDs expressed their concerns relating to the ownership of the plan and emphasised the importance of this being owned trust wide and not just by the Workforce team. In order to improve the assurance level, it was agreed that an extraordinary Workforce Committee would be scheduled for early in the summer. The senior leadership team for each Care Group will be invited to attend this meeting and provide clarity to the Workforce Committee on how they are positively influencing the culture in their areas. This will

be followed by a further extraordinary meeting in Autumn time when the NEDs will be seeking clear examples of change being delivered in practice. Assurance for the OD Plan was Low.

The Staff Survey also received low assurance. The Workforce Committee had received an update on the staff survey action plan and was informed that over 30 expressions of interest have been received from staff interested in becoming *Freedom to Speak Up* Advocates. The meeting discussed triangulating data from HR, PALS, Complaints and including Datix reports to provide a fuller view of the organisational position. The Committee will receive a themed summary of the free text from the Staff Survey at the next meeting.

Assurance levels for Recruitment and Retention were also rated as low. The meeting discussed the Recruitment & Retention report and recognised that the starters and leaver's numbers were very similar and agreed that retention needs greater focus in order to maximise the organisational benefit of recruitment interventions. The meeting asked for more emphasis to be given to encourage bank workers to consider substantive positions.

The Chair advised the Board that a Tier 2 Recruitment & Retention Committee is being established with Mr Allen (NED) as chair to provide greater scrutiny in this area.

Board Assurance Framework (BAF)

The Board discussed the risks, noting the implications for the Board or Trust. This included:

BAF Risk 859 ***We need a recruitment strategy for key clinical staff to ensure the sustainability of services***
It was acknowledged that the Trust requires a suitable recruitment strategy for key clinical staff to reduce risk in respect to the sustainability of services. The WD was charged with actioning a Recruitment and Retention strategy to address this overseen by Mr Allen (A. NED). The Interim DNMQ informed the Board that she may be able to provide some support to achieve this and will liaise directly with the WD and Mr Allen (NED).

BAF Risk 423 ***We need positive staff engagement to create a culture of continuous improvement***
This was rated moderate and related to the organisational efforts to engage positively with staff to create a continuous level of improvement.

Mr Caroll (NED) requested more 'real time' results of staff views in order to would give more assurance to the risk rating. The WD responded that the Staff Survey is performed annually by a national organisation and it is therefore not within the Trust's gift to provide more frequent data from this source. However, the Pulse survey which is a much shorter survey is being carried out bi-monthly so should be much more responsive.

The Chair advised that Mr Carroll (NED) will take up the Chair of the Workforce Committee following Ms A Edwards' resignation.

The Board NOTED the Workforce Committee summary.

2019.2/73 WORKFORCE PERFORMANCE REPORT

The WD presented the Month 1, 2019/20 Workforce Performance report in relation to:

- Sickness / Absence / Unavailability – 4.15%
  The WD reported that she is concentrating on the areas with significant sickness levels to understand and potentially aid them. She felt that there may be an element that is due to seasonal variation but it is important to understand this better.
- Staff Turnover (exc. Junior doctors) – The WD advised that the recruitment rate is 10.11% of the turnover of the full workforce, Retention rate 89.04%. She advised that there is poor intelligence contained in the exit questionnaires. The Board acknowledged that a triangulation of the Exit Questionnaires and the Staff Survey may prove to be more helpful.
  ACTION. WD to compare Staff survey results with exit questionnaires and high turnover areas – to be reported back to the Board Sep-19

…….. Chair
1 August 2019

- Statutory and Mandatory Training
  This sits at 97% for the Trust. It was confirmed that he Board will receive their mandatory staff training on 29th August 2019.

The Board NOTED the report.

2019.2/74 FREEDOM TO SPEAK UP (FTSU) REPORT

Kate Adney (Freedom to Speak Up Guardian- FTSUG) presented the paper to the Board. It was noted that in response to concerns about culture in the NHS, the Secretary of State for Health and Social Care commissioned Sir Robert Francis to carry out an independent review: Freedom to Speak Up (www.cqc.org.uk/content/national-guardians-office). The review recommended that every NHS organisation should understand the value of speaking up which complies with national standards and enables organisations to support workers to speak up, respond appropriately and take necessary action as recommended by the report.

The FTSUG advised the Board that the FTSU activity also explained developments and actions that have been taken to further embed the FTSU role and to encourage a culture of speaking up to be 'business as usual'.

At SaTH the FTSU Guardians have been in place for twenty-seven months. It is clear that the visibility of the role has increased and this has resulted in increasing numbers of staff accessing the support FTSU Guardian, which is seen as a positive development.

There have been 37 FTSU cases since 1 December 2018 (compared to 33 cases in the previous six months) which have fallen into the following categories:

- Behaviours, Bullying and Harassment
- Concerns relating to Managers
- Patient Safety
- Other

One additional FTSU Guardian had recently taken up her post whilst another was due to start in July.

The CEO asked what impression the FTSUG had regarding staffs willingness to speak up.

The FTSUG felt there was definitely increased awareness of the role and generally staff were very comfortable about approaching her. She did advise that there was a need to have a better method of recording and being able to evidence changes that had been implemented in response to concerns raised It was considered that recording safety issues through the Trust's Datix incident reporting system could be a possible route to do this. The MD congratulated the FTSU team. He noted that Junior Doctors had been more forthcoming in expressing concerns particularly on the subject of safe working hours or workload.

The Interim DNMQ asked what improvements had resulted from this work and asked how FTSUGs could have a greater impact on patient safety.

The FTSUG said that she had very good links with all of the Executive Team so any resultant learning could be fed back there or to the Workforce Committee. It was acknowledged that the FTSU Guardian roles have existed for around two years but the FTSU Advocates have only been in place for a few weeks. Mr Bristlin (NED) reiterated that FTSU cases needed to be clearly recorded to enable a clear audit, a view further endorsed by Dr Lee (NED).

The Board RECEIVED and NOTED the report.

2019.2/75 ACCIDENT & EMERGENCY NURSING WORKFORCE BUSINESS CASE

The Chief Operating Officer presented the paper to the Board. It was noted that there were several key objectives that had been considered in the development of the business case. The key issue was the fundamental requirement to deliver adequate nurse staffing as per the regulatory compliance requirements that the Trust has received relating to the Accident & Emergency Departments. In summary this includes the necessity to:

- Increase the number of whole time equivalent (wte) trained nursing staff in post and on duty across all shifts in order to deliver safe care
- Provide additional trained nursing staff to service additional clinical service areas such as Streaming and the Clinical Decision Units (CDU)
- Significantly enhance nurse leadership in the departments in line with other systems by introducing a new tier of nursing (Band 7 pay scale) and increasing the volume of senior nurses (Band 6 pay scale) across all geographical departmental areas. It was noted that the current model is senior nurse (Band 6) as co-ordinator with junior nurses (Band 5) servicing all other areas often leading to poor skill mix and staff reporting that they feel unsupported.
- Improve the department's recruitment and retention profile by increasing both the volume and seniority of staff in the departments.

It was noted that the Emergency Department nursing workforce had not been formally reviewed at Executive level since approximately 2014. Since then activity within both departments has increased and the clinical footprint has also grown including changes in practice. As a matter of fact, it was acknowledged that the Trust has regularly been one of the worst performing Trusts in the country in terms of achieving the 4 hour wait target.

While additional staff above the budget are being utilised in an effort to address the consistent shortfall in nurse staffing to meet demand/ provide some additional services, in 2018/19 on average 37% of the band 5/6 nursing workforce were bank or agency. The variation in total temporary staffing week to week can be much greater than this average. This level of agency is not only unsustainable but also puts significant pressure on substantive staff to ensure all of the key areas were covered but with poor skill mix at times. There are also significant negative financial implications of managing the workforce in this way.

In addition to the changes in activity from the time of the last nursing workforce review, the A&E footprint and services offered has changed to help improve and manage flow of patients through the department incorporating recommendations of best practice from our regulators. The improvement and staffing implications are:

Service Improvement	**WTE**
The development and implementation of ambulance 'Pit stop' services on both sites to address corridor waits for ambulance handovers	8.8
The provision of 'Fit2Sit' services on both sites whereby one cubicle space is used to seat up to 6 ambulatory patients at a time	11.2
Clinical Decision Unit (CDU) services on both sites (12/7)*option B	5.4
Ambulance Handover Nurses on both sites (Band 6)	10.8
Streaming to triage role on both sites within 15 minutes of arrival (Band 6)	10.8
Total	**47.0**

In November 2018 the CQC published their formal report following their inspection of SaTH last summer which rated Urgent & Emergency Care as Inadequate for safety and the Trust was also issued with 2 CQC notices (Section 29 & 31) which mandated urgent improvements. Within the summary of findings the Trust were informed to '*ensure nurse staffing is adequate to keep all patients safe, including paediatric patients, ensure appropriate mandatory training is undertaken to ensure staff can carry out their roles in a safe and effective way and ensure that staff constantly manage and review deteriorating patients in line with national guidance'.*

A 3 year implementation plan has been developed alongside the service model to inform financial planning. Due to the current fragility of the ED nursing workforce and the requirement to significantly improve our position to deliver the service improvements noted in the CQC report and notices, agency usage to deliver key roles was factored into the planning. It was noted that a nominal figure was included in the Trusts prioritisation process of £0.9m as a 'holding position' prior to the development of the preferred clinical model. The proposed plan to provide sufficient cover for key roles in the departments (including 24/7 CDU's on both sites and 24/7 streaming) and to deliver the improvements noted by CQC is therefore greater than what was originally estimated.

…….. Chair
1 August 2019

The cost (including agency premiums) of the ED nursing was £5.1m in 2018/19 (excluding the double bank payment in February 2019). The financial strategy in 2018/19 was £4.8m. The proposal is to grow the level of staffing (option 2 – full investment if all shifts are covered) in year 1 (2019/20) to £6.5m, an increase in cost of £1.4m. As part of operational planning for 2019/20 the prioritisation process identified an increase in cost of £0.9m (including growth in agency premiums) based on the original plan presented to the Executive Team in January 2019. Implementing this option could therefore introduce a cost pressure of £0.5m into 2019/20. However, as described above in the outline summary of the options, the limited access to workforce is very likely to balance the risk of this cost pressure.

Further investment above the year 1 level is required to cover year 2 cost of £7.6m (+£1.0m), before reducing to £7.3m in year 3 (-£0.3m).

It was noted that the benefits would include:

- Delivery of CQC improvement requirements
- Improved staff morale and retention
- Ability to deliver regulator and ECIST recommended service improvements
- Template in place for safe staffing levels as per ECIST recommended model
- Improved performance against the 95% patient safety standard

The Board discussed the recommendations and the preferred option and noted the increase in costs from the original prioritisation figure. There was overwhelming support for the investment to ensure that safety was improved through improved substantive staffing levels. Mr Bristlin (NED) commended the paper for its comprehensive explanation and descriptions of issues, consequences and options.

The Board APPROVED Option 2 for implementation over the three year plan.

2019.2/76 STAFF SURVEY REPONSE PLAN

The WD presented this paper.

She advised that overall the results of the 2018 Staff Survey identify a number of areas that require improvement. Three of the 10 overall themes are significantly worse than the sector and national average scores, these themes being:

- Health and Wellbeing
- Safety Culture (scored the worst nationally)
- Staff Engagement

Through consultation with staff, discussion at Senior Leadership Team and agreement through Workforce Committee, our Organisational priorities focus on Safety Culture and Staff Engagement. The WD pointed out that the high level priorities have been translated through at Care Group level and each Care Group has in addition identified further key priorities. The Workforce Committee will seek assurance on the impact of this work through two specific Care Group focused sessions.

The WD advised that this year's staff survey response plan has been incorporated into the 6-month OD delivery plan agreed at Workforce Committee. The OD plan details four key areas of focus; Behaviours & Respect, Leadership Development, Psychological Safety *and* Innovation & Change with a cross-cutting theme of Staff Engagement. The plan detailed the first 6-month delivery to support our cultural improvement. It was agreed that this response cannot be viewed in isolation as it is cross cutting with priorities within the 6 month OD delivery plan.

The CEO asked for ongoing assurance that this would address the issues that staff have raised consistently for a number of years.

…….. Chair
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Mr Carroll (NED) advised that he will require the Care Groups to present their findings and action plans to the Workforce Committee to ensure that the overarching plan is owned at all levels.

The Board RECEIVED and NOTED the action plan update and noted that where actions are off track there is a recovery plan in place.

2019.2/77 QUALITY & SAFETY COMMITTEE SUMMARY

The Chair of the Quality & Safety Committee, Dr D Lee (NED), presented the following summary of the meeting held in 22 May 2019:

Quality and Safety
The Committee wished to emphasise that the most significant risk to Quality and Safety within SaTH is around the current workforce and the need to improve the recruitment and retention of sufficient, substantive staff to ensure a safe service provision. Staff need recognition of their efforts in the face of often overwhelming difficulty, but also cannot be expected to sustain such efforts indefinitely without a risk to quality and safety. This is especially the case in Urgent Care. It is recognised that the situation is not wholly within our gift to manage as there is a national staffing shortage of in some specialties.

BAF
Although the BAF risks have been re-examined, reworded and revised earlier in the year, there are risks in Scheduled Care regarding the flow around the organisation and from incoming organisations. It was agreed that Dr Lee (NED) would meet with the DCG to ensure the BAF captured and reflected the current situation.

Day Surgery
Committee members visited this area and discovered the ward was dealing with a number of pressures including:

- Adult day surgery;
- Paediatric day surgery;
- Medical patients in escalation beds;
- Trauma patients in escalation beds; *and*
- Providing staff to the Vanguard Unit.

Whilst SaTH has clearly listened and learned with respect to improving the management of patients, for example by providing a dedicated medical team and identifying pharmacy support for the unit, it is clear that there is still much to do to improve the quality of patient and staff experience. The Q&S members who visited the ward strongly supported the suggestions by staff to create a more appropriate paediatric bay which reduces the contact between children and adult patients. The complexity and multiple pressures were articulated by the workforce. Committee members valued the input and understood the issues raised.

Quality Impact Assessments (QIAs)
It was acknowledged that QIAs for all potential CIP schemes (Cost Improvement Programme) must be seen by the Quality & Safety Committee to appreciate the potential impact of cost improvement proposals. At present the Q&S Committee felt there was little assurance that QIAs were being meaningfully developed.

The Chair requested an update on QIA development for CIPs from the COO who explained that the process had been delayed by the recent PMO restructure. However the COO will work with the MD and Interim DNMQ to gain sign-off of current QIAs and then submit them to the Quality & Safety Committee for assurance.

The Board NOTED the Quality & Safety Committee summary.

2019.2/78 MATERNITY TASKFORCE OVERSIGHT COMMITTEE SUMMARY

The Chair presented the report which covered an the following updates:

Local Maternity System (LMS)

Committee members discussed the finance that the LMS has received this year from NHSE and were informed of a workshop that is being undertaken to effectively utilise the investment. The Committee was informed of the outstanding actions from the LMS report, and members discussed the Transforming Midwifery Care options and the process involved for the agreed option to be implemented.

Workforce Plan

The Committee was informed that the trust has a total of 50.6WTE midwife vacancies and received an update on the recruitment plan for Band 5 and Band 6 Midwives, informing members of the recent success in recruiting 27WTE Band 5 preceptorship Midwives as well as 18.6WTE Band 6 Midwives. There was further discussion regarding the newly created Maternity Support Worker role and the progress of the recruitment to the post. Obstetric workforce issues were also discussed, particularly the difficulties in implementing a 7 day service.

Staff engagement

The Committee viewed two infographics to support staff engagement within the Maternity service. The weekly Focus Friday infographic updates maternity staff on items such as birth statistics, safety message and good news stories. The Midwifery Voice - Ward to Board infographic gives Midwives and Service Assistants information on the meeting structure within the Trust. Mr Newman (NED) reported that staff were passionate about changing opinions and creating a positive culture. He felt this positive change and approach was something that could be disseminated across the Trust.

The Chair noted that the Maternity Oversight Task and Finish Group was overseeing successful improvements, i.e. the *Friday Focus*, and the lead could be soon passed back to the Care Group.

The Board NOTED the Maternity Oversight Committee summary.

2019.2/79 QUALITY GOVERNANCE REPORT

The MD presented the paper and highlighted that there were three Serious Incidents reported in April:

- One related to the death of a patient where opportunities may have been missed to diagnose an aortic abdominal aneurysm of which the coroner has been informed;
- One surgical incident;
- One fall resulting in a head injury (which will be subject to inquest).

There were no cases of MRSA bacteremia reported in April but two cases of C-Diff were attributed to the Trust during this period.

There was an increase in the number of patients waiting for more than 12 hours to be discharged from ITU in April 2019 (37) compared to March 2019 (26). This related to bed capacity challenges linked to high levels of emergency demand.

The Adult Safeguarding team flagged an issue relating to discharges and incorrect discharge summaries/incorrect medication on discharge. An initial mitigation of a discharge check list was put in place which appears to have reduced the number of issues occurring so far (in May). A paper will be taken to Clinical Governance Executive (CGE) in June outlining the issue and asking CGE to oversee longer term actions to maintain safety and quality.

The MD pointed out that page 155 cites a Never Event which was reported in March. However the RCA investigated this with the CCG and both agree that it will be downgraded as it did not meet the criteria of a Never Event. The MD expressed his disappointment regarding non-achievement of the VTE target, as referenced on page 156. Teams are being tasked to chase down these cases and IT systems will be aiding the clinicians.

The Board RECEIVED and NOTED the update and the assurance provided.

2019.2/80 TRUST MORTALITY DASHBOARD

The MD introduced the paper which explained that as part of the National Quality Framework 'Learning from Deaths', Trusts are required to publish data on the number of Mortality reviews conducted into patient deaths within the Trust. The number of in-patient deaths recorded at SaTH for 2018-19 is 1,816 which is over 200 less than the previous year. This may be partially due to a better summer and milder winter. There were also 100 less deaths in Quarter 4 this year compared to last.

There has been one death graded as CESDI 3 this quarter relating to a patient who had a delayed diagnosis and treatment of bowel obstruction. This was reported as a Serious Incident in March 2019. It was highlighted that the clinical team are learning from the experience, as a Learning Disability is thought to have been a contributory factor in the treatment administered to this patient.

The total number of deaths graded as potentially avoidable for 2018-19 is 4, compared to 5 for 2017-18. All these deaths have been reported to the Coroner as Serious Incidents and the families notified.
The percentage of completed reviews has fallen, but efforts have commenced in an attempt to clear the backlog within the next few months. The Dashboard is updated with late completed reviews.

Discussions are underway to examine how the new Medical Examiner process will complement the Mortality case-note review process. At the current time, it is envisaged that the two systems will continue to run separately. There has been positive feedback on the Medical Examiner system implemented at RSH and it is planned for this to be rolled out at PRH in the near future.

The Chair asked for clarification on the role of the Medical Examiner.

The MD explained that the Shipman Inquiry had highlighted the need for independent case reviews of all deaths. The Medical Examiner is a qualified doctor with additional specialist training, who reviews cases with other clinicians. If they are not satisfied with findings they will raise their concerns with the local coroners. The Medical Examiner also speaks to the families concerned.

Mr Allen (NED) asked where the actions were located in this report.

The MD explained that due to a formatting error they had been missed off. He agreed to reinstate these and ensure that all actions would be included in future reports.

Mr Deadman (NED) asked how clinicians could be encouraged to be more actively involved in discharging patients in a more timely way.

The MD said that he has been looking to the Trust's peers for ideas on championing discharges and the resultant reduction in Length of Stay levels. He has also asked the Virginia Mason Institute for advice. The Interim DNMQ offered to liaise with the MD to explore other approaches and options.

The issue of Urology cancer patients was raised and the COO advised that patients are being referred to UHNM, where the robotic surgery is available. However he advised that the whole pathway is to be reviewed as there is a view that robotic surgery could be provided at SaTH, with discussions are underway with UHNM. It was noted that this is also a national issue.

The Board RECEIVED the update..

2019.2/81 QUALITY IMPROVEMENT PLAN UPDATE

The CEO introduced the paper and advised that in response to the "Must Do" and "Should Do" findings set out by the Care Quality Commission (CQC) in their November 2018 inspection report, the Trust has developed a Quality Improvement Plan (QIP). Progress is being made across all five Improvement Steering Groups (ISGs). All besides the Well-led ISG are reporting in two-weekly cycles ('sprints'). Owing to the nature of actions included in the Well- led improvement plan this is reporting on a monthly basis.

A substantive programme management office (PMO) has been put in place to manage the QIP, taking over from external support. Preparation for the next CQC inspection will also be undertaken to ensure that improvements, as well as future plans, can be clearly articulated. The impact and embeddedness of the QIP is measured through Key Performance Indicators (KPIs). These have been developed for all Must Do and Should Do Root Causes. High-level KPIs aligned across the five CQC domains for each ISG (Safe, Effective, Caring, Responsive and Well-led) have also been developed to measure overall improvement.

It was noted that at the end of April, the latest full month for which reporting is available, 93 "Must Do" Root Causes and eight "Should Do" Root Causes were completed. This is over 75% of the forecast completion trajectory, a slight reduction from the 80% of trajectory completion achieved at the end of March. All actions that are off track are routinely escalated to a weekly Executive Continuous Improvement Board meeting, with supporting recovery plans. Any proposed changes to the plan are also reviewed and approved at this meeting.

The PMO facilities the provision of evidence to the approving authorities and to avoid duplication or misinformation.

Some of the improvements achieved as a result of the QIP were discussed, including changes to children's streaming in the Emergency Department. Additional nurses were recruited and children are now streamed within 15 minutes of arrival. All shifts now have an EPALS (European Paediatric Advanced Life Support) trained nurse on duty and all staff have received education on paediatric pathways.

The full Well-led improvement plan was signed off by the ISG at the end of April. This plan differs from other QIPs and is structured around the CQC's eight KLOEs (Key Lines of Enquiry). The CQC uses these KLOEs and their constituent 'prompts' as a guide within the assessment process to determine the Well-led rating.

The recommendations and findings from prior reviews (including the most recent by the CQC) are reflected throughout the plan. A number of key common themes have emerged from the reviews previously undertaken. These themes underpin the approach to well-led improvement:

- Organisational culture
- Governance of the organisation
- Engagement
- Developing capability
- Leadership capacity

Organisational performance is impacted by all five themes. The themes also cut across the eight KLOEs within the Well-led assessment framework. The Well-led ISG maintains oversight of progress against the plan, and in common with other ISGs is accountable, via the Accountable Executive, to the Executive Continuous Improvement Board.

It was noted that some actions were not yet closed but the CEO felt confident he could evidence activity and their timelines would not slip.

Mr Bristlin (NED) asked what the main issues were within the *Must Do* and the *Should Do* recommendations, the methodology of assuring Board and how we were acting on the CQC recommendations.

The CEO advised that he felt that the CQC will re-examine the Trust as a fresh new review but it was important that we could evidence all the learning from the November 2018 report.

The COO responded by explaining that Unscheduled Care's issues were split over several areas including, ED, Medicine and Hospital at Night. All of these matters were complex and interlinked with wider areas of the organisation. Evidence was being gathered and the recovery plan was being tracked and actioned.

Dr Lee (NED) articulated his wish to see posters, fliers, Health Messaging screens around the Trust so that patients (as well as local/national regulatory bodies) can visually see the improvements implemented. The DCG confirmed that she was already actioning this approach.

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The MD added that the staff were also helping to increase the positive view and this verbal evidence was feeding back to the CQC.

The Board RECEIVED the update and NOTED the progress of the QIP.

2019.2/82 GUARDIAN OF SAFE WORKING

The MD presented this paper. He explained that the 2016 Junior Doctor Contract was implemented in October 2016 and all trainees in the Trust are now employed under its Terms and Conditions. The Exception Reporting process gives trainees the opportunity to highlight variations from their contractually agreed service requirements and educational activities. The Guardian of Safe Working (GoSW) has oversight of all Exception Reports and is responsible for monitoring compliance with the process. Safety issues identified in these reports are escalated to the responsible Care Group Director and the Medical Director. The GoSW reports to the Medical Director monthly, and the LNC and Workforce Committee quarterly.

It was noted that 24 exception reports had been received in Q4. Where Exception Reports identify excess time worked, time off in lieu remains the preferred option to enable Junior doctors to remain within their safe working hours. When this is not possible because of service demands, financial reimbursement is authorised. The MD advised that there is a need to further strengthen exception reporting and as a result engagement with the FTSU Guardians has taken place to encourage this.

The MD confirmed that senior doctors have been reminded to resolve the issues raised by the junior doctors.

The Board RECEIVED and NOTED the update.

2019.2/83 COMPLAINTS & PALS REPORT

The DCG presented the report and noted the service would pass to the MD in his new role as Director of Clinical Effectiveness (DCE) from 17 June.

The Board were advised Complaints and PALS contacts continue to be managed in line with Trust policy, with reviews held at a variety of levels, including the weekly Rapid Review meetings, Care Group Board meetings and Specialty Governance meetings. 167 complaints and 465 PALS contacts were received during the fourth quarter of 18/19, with the main themes and locations remaining similar to previous quarters.

Data on protected characteristics is now being captured where available.

There are ongoing improvements to the processes for issuing bereaved families with a Medical Certificate of Cause of Death, and work is ongoing in introducing the new Medical Examiner role and associated processes with the system being rolled out at RSH during Quarter 1 of 2019/20, following the appointment of eight Medical Examiners.

Increases were noted in complaints relating to Ward 27, AMU at RSH, and within Paediatrics and Gynaecology. These have been highlighted within the relevant Care Groups and will continue to be monitored for any trends. There have been slight decreases noted in complaints relating to staff attitude and appointments.

PALS contacts relating to appointments have increased significantly from the previous quarter, and it is encouraging to see the service being promoted and used to support patients and their families.

Work continues to ensure that learning and actions to implement learning are considered for all complaints, with 89% of complaints closed in Q4 having evidence that this was considered. Training has been given in investigating complaints to a number of sisters in both EDs and on wards, with further sessions planned to help improve the quality of investigations and learning. 70% of complainants responding to the complaints survey felt that the Trust had used their complaint to learn, which is a significant increase on previous quarters.

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The Board were reminded that where increases are noted in particular areas, or in relation to specific individuals, this is highlighted to the relevant managers and support given to identify reasons for increases and what can be done to address this. As outlined above and in the main report, there have been some areas with increases noted in quarter four, which are being addressed. There have been no significant areas of concern identified in quarter four, but there are a number of areas that continued to be monitored.

The Trust recognises the importance of learning from complaints and using the valuable feedback obtained to reflect on the care we provide and take steps to improve services for future patients. The DCG advised that 89% of complaints closed in quarter four had an action plan completed or confirmation that no actions were required. When service improvements are identified following investigation of a complaint, an action plans is developed and monitored until complete. Some of the significant changes made as a result of complaints received with respect to the way consent is taken are as follows:

- Management of patient having panic attack in MRI scanner -staff to ensure future incidents reported on Datix
- Failure to communicate results as agreed - ensure responsibilities for communicating agreed in MDT
- Patient kept as NBM on three occasions then told procedure would not go ahead - NBM status to be included as part of post ward round de-brief to ensure decisions made and acted upon promptly

The DCG paid tribute to the sensitive and compassionate PALS team in processing bereavement certificates.

The Board members NOTED the content of the Q4 Report..

2019.2/84 HEALTH & SAFETY EXECUTIVE (HSE) ASBESTOS PROSECUTION

The DCG presented the paper reported that there had been an HSE prosecution at Telford Magistrates Court on 8th May 2019 relating to an incident in 2012. The Board has received regular updates; both on the related Employment Tribunal matter and the Investigation itself, including disciplinary hearings and changes introduced to the management of asbestos following this incident.

On 8 May 2019 the Trust attended a hearing at Telford Magistrates Court. The judge awarded a fine of £16,000 plus £18,009.80 costs and a Victim Surcharge of £120.

These events led to an Employment Tribunal case and a linked whistleblowing disclosure to the Director of Corporate Governance in early 2014, internal disciplinary investigations in 2014/15, and an HSE investigation from 2014 to 2018.

The following remedial action has been taken to prevent a recurrence.

- In 2015/16, letters were written to staff and contractors involved in the 2012 incident.
- The MICAD software suite was purchased in 2015, with the express intention of using the Asbestos Module to inform the future management of asbestos in Trust buildings.
- The Trust's asbestos management policy and asbestos management plan were reviewed, updated and reissued, in 2015 and 2016 respectively.
- A review of asbestos management training led to Senior Estates Managers attending the British Occupational Hygiene Society's P405 'Management of Asbestos in Buildings' qualification. Estates managers issuing work to Operational staff, and overseeing the works of both Operational and Capital contractors, undertook UKATA-approved Asbestos Duty to Manage training. All other Estates staff continue to undertake UKATA-approved Asbestos Awareness training, as before.
- Estates secured the services of an Asbestos Management Consultant working in-house from July 2016 on, currently provided by White Young Green (WYG). The services of an independent "Authorising Engineer" (AE) for asbestos have been secured, and annual external audits are undertaken.
- Estates management convened an Asbestos Task and Finish Group to oversee remedial works, and the ongoing development of the Trust's management of asbestos in Trust premises.

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Extensive asbestos removal works have been completed at RSH on a risk basis. Wherever possible asbestos removal is undertaken during Capital refurbishment works in order to reduce the total amount of asbestos-containing materials on Trust premises.

At the hearing the Trust pleaded guilty to the following two offences:

1. Breach of Regulation 4(3) of the Control of Asbestos Regulations 2012: "*In order to manage the risks from asbestos in non-domestic premises, the duty holder must ensure that a suitable and sufficient assessment is carried out as to whether asbestos is or is liable to be present in the premises."*
2. Breach of Regulation 16 of the Control of Asbestos Regulations 2012: *"Every employer must prevent or, where this is not reasonably practicable, reduce to the lowest level reasonably practicable the spread of asbestos from any place work under the employer's control is carried out."*

The Trust's basis of plea addressed the following issues:

- Both offences arose out of a single, isolated incident in 2012.
- No one was physically harmed and subsequent independent testing confirmed that the asbestos control limit would not have been breached and was well below (the control limit is 0.1 asbestos fibres per cubic centimetre of air (0.1f/cm^3) averaged over a 4 hour period. In this case the 2013 environmental monitoring revealed that for the board around the soil stack the results were twenty times lower than the Control Limit (0.005 f/cm^3) and for the cupboard it was 50 times lower (0.002f/cm^3). The reality is that there are minute particles of the material continually present as a minor pollutant in the atmosphere and it is documented that we all receive an annual exposure of 0.001f/cm^3, which can be several times more in urban city environments.
- Prior to the incident the Trust had commissioned external consultants to provide it with policies and procedures for dealing with asbestos, and expert advice, external audits and support regarding the management of asbestos.
- The Trust had invested, and continues to invest in asbestos remediation and removal works annually, running to several hundred thousand pounds per year.
- In 2011 (the year before the incident) the Trust had commissioned fresh asbestos management surveys, external audits and an asbestos management plan document, and was subject to an HSE management inspection which resulted in no enforcement action.
- At the time of the incident the Trust had in place policies, procedures and arrangements which, had they been followed, would have dealt with all the issues that lay at the centre of the breaches. These arrangements included UKATA-accredited Asbestos Awareness training for Estates staff.

However the Trust fully accepts that the matter should have been properly dealt with and accepts its duty to reduce worker asbestos exposure to as far below the control limit as possible, and there were disciplinary proceedings against a number of individuals.

The DCG advised that the case had been reported to HSE as part of the investigations. There had also been high level of cooperation by the Trust with the HSE investigation and the Trust had been commended by the Court for being open and transparent throughout the HSE investigation.

The Trust has taken very seriously what happened and put measures in place to prevent it from happening again. It has also shared all of its information with the HSE.

It was also confirmed that the investigation had been thorough and internal disciplinary action to the managers concerned had resulted. Also relevant staff had been contacted and the whole process has now been updated and it recognised that the matter should have been dealt with properly at the time.

The Board members NOTED the content of the Report.

2019.2/85 SUSTAINAIBILITY COMMITTEE SUMMARY

The Chair presented the summary of the meeting held 23 May, 2019

Digital Strategy

…….. Chair
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- A&E Options Appraisal – The Committee endorsed the progress for the A&E Options appraisal and requested that this was undertaken at pace.
- Data Warehouse – Servers had been delivered. Invitations to submit tender responses and shortlisting had taken place. It was agreed that KMACH Limited would be approved as the chosen supplier.
- The meeting discussed electronic prescribing. The Chair was aware that there was central funding available from NHSE for Trusts to fully implement EPMA but that SaTH had been unable to submit for the first two rounds due to lack of senior support which is a pre-requisite. The 3rd and final round for bids is expected to be in late autumn. The Board approved support for submission of a bid for national EPMA funding and recognised this would require senior support from executives and commitment to ongoing support for EPMA in terms of staffing for IT systems support and clinical support to ensure effective training, implementation, rollout, developing and troubleshooting rule based pathways within EPMA.

ACTION: Medical Director to advise Chief Pharmacist of Board support for bid submission via Sustainability Committee

Sustainable Services Programme

- SSP Structure to deliver the Outline Business Case (OBC) – recruitment process had started. The lack of senior positions being filled is impacting upon decision making and overall project strategy. Current team capacity constraints have resulted in key Task and Finish Groups prioritising clinical design and key adjacencies over detailed patient pathways and workforce detail.
- Affordability due to inflation costs – this remains an issue. The Technical Team are working up options to evaluate how the scheme could be delivered to get the best value for money.
- Energy Centre and Multi-Storey Car Park – plans are being progressed, it is acknowledged that these are additional to the £312m scheme but remain enablers for SSP.

Capital Programme

- Financial Review as at Month 1 (April 2019) - within the Financial Strategy agreed by the Trust Board the internally generated Capital Resource Limit (CRL) for 19/20 was agreed at £10.450m. The CRL for 2018/2019 increased to £14.143m.
- Mattress contract expires in October 2019. The bed frame stock is c.10 years old and will need to be replaced shortly. CPG agreed that it was imperative that this project, together with Ultrasound Scanner Replacement, needs to be prioritised and resourced correctly. Operating lease options were being explored.

The Board RECEIVED the paper and APPROVED the recommendation to submit the EPMA bid, which would need to be received at Sustainability Committee first.

2019.2/86 PERFORMANCE COMMITTEE SUMMARY

Mr Deadman (NED) presented the summary of the meeting held 28 May 2019.

Operational Performance

It was noted that recovery plans are in place and although some slippage apparent, there is also evidence in many areas of some performance improvement.

- RTT – we have been unable to maintain the 92% target and do not expect to achieve the trajectory until Quarter 2. There are some unresolved issues relating to capacity planning that could affect performance in winter.
- Cancer Action Plans were reviewed. Areas of acute pressure remain, particularly in Breast Radiology, Skin and Urology. Challenge to deliver 2 week waits and 62 day performance. Some slippage in the recovery trajectory was noted. It was acknowledged that the importance of improving the experience for our patients was essential.
- ED performance continues to present a challenge, with performance in April at 68% (excluding Minors). A recovery plan was in place to improve the position; however, the timely discharge of patients was still and influencing factor on this.
- The committee commended the Trust on its Stranded and Super Stranded patient performance. SaTH remains in the top 5 Trusts in England.

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Assurance: Medium

Due to unforeseen circumstances the financial update was not available for this meeting.

The Chair expressed his disappointment regarding the Month 1 costs and requested assurance from Mr Hall that there will be financial and CIP information before the next meeting.

Mr Hall advised that the Pay and Non-Pay levels were broadly where one would expect at period one. He was unable to comment on income.

The COO gave a verbal update on CIP in the absence of a written report. He advised that Mr Obi Hasan has been appointed as the Cost Improvement Director (CID). There are various CIP schemes both internally and externally, with plan savings amounting to £10.7 million. There will be joint work with the Care Groups. The CIP has a potential for a further £8 million but there are significant risks to this and the schemes will require further scoping. Much of GIRFT (Get It Right First Time) related opportunities have been scoped and the CID has been tasked to explore these with the clinical teams.

The Chair queried the confidence level for full delivery of the planned CIP. The COO confirmed there were areas of risk but in his view, waste reduction was under control. The Chair requested a report for the next meeting and the COO committed to producing this. The Chair also asked for monthly rather than quarterly reporting to be implemented.

Mr Deadman (NED) urged deep caution as our waste removal/CIP plans were incomplete, and Performance Committee had not been able to secure assurance that they would deliver the hoped for benefits.

The COO stated that BAF 561 **We need to have system-wide effective processes in place to ensure we achieve national performance standards for key planned activity** should be medium risk not low. Mr Deadman (NED) agreed.

Approval of High Value Diagnostic Equipment

It was noted that a plan to accelerate and approve proposals was discussed. It was imperative the Radiology equipment was approved, ordered, commissioned and installed at the very earliest time. The Chair and Tony Allen (NED) have offered to make themselves available at short notice to approve the final proposals, which the Board have already approved should proceed.

The Board NOTED the paper.

2019.2/87 PERFORMANCE REPORT

The COO presented the paper but it was noted that most of the issues had already been discussed.

RTT- Going forward for 2019/20 the Trust is working towards the following to help improve the RTT performance:

- Ward moves have taken place to ring fence beds for orthopaedic elective activity.
- In Quarter 1 of 2019/20 a Vanguard unit will be located at PRH, clearing 600 off the activity backlog.
- The Trust is looking to recover its 92% performance by Quarter 2, along with reducing the overall waiting list.

Key risks: June Bed gap (-54) will impact on DSU usage if demand continues as planned.

Cancer - During February and March, the Trust has aimed to reduce the backlog of patients waiting over 62 days. However this increases treatments in month and affects performance. Detailed action plans in place to recover performance in Quarter 3

Urgent Care – Discharges - Super Stranded position April 2019 was 80 despite compared to 130 at corresponding time last year, so despite an intervening outbreak of Noro Virus this still provided a 38% improvement. The position continues to improve currently at 51 Supers (w/c 15/04), consistently maintaining 44% improvement overall against the 23% improvement target set by NHSI April 2018

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The Board NOTED the report.

2019.2/88 SERVICE DEEP DIVE

This paper was presented by the COO, explaining that there are a number of services currently provided by the Trust that are considered fragile due to workforce constraints which impact on service delivery. Shropshire and Telford & Wrekin Clinical Commissioning Groups (CCG's) have been aware of these longstanding capacity and workforce issues and have been working closely with the Trust to find suitable and safe alternative capacity, where appropriate. All of these specialties are challenged nationally and SaTH's current service configuration increases the challenge of finding sustainable solutions to these fragile services. Each service risk is reviewed on an ongoing basis to see if there has been any change since the last formal report to Trust Board, on a monthly basis.

ED Risks: CRR1122, CRR626, CRR817
The Trust has sent a team to Dubai and India (March 2019) to recruit middle grade medical staffing with some success.

Dermatology Outpatient Service Risk CRR1216
The Trust had been operating as a single consultant-led service for a number of years and had been unable to recruit despite numerous attempts. In order to ensure sufficient capacity the service relied on locum support over this time and a sub-contract with a private provider.

Over the Autumn of 2018 a procurement process was undertaken to secure additional capacity. Alongside this, the service was contacted by two consultants who expressed an interest in working at SaTH, one of whom was available to commence soon and the other towards the autumn of 2019. A recruitment campaign was therefore undertaken.

A successful bidder to the Procurement exercise commenced at SaTH in November 2018 (Health Harmonie).

Commissioners have advised SaTH that additional activity may be sent to SaTH following findings of incidental cancer at St Michael's Clinic via their General Dermatology Service. The level of activity is currently being quantified and data will be shared with SaTH at the earliest opportunity. Discussions have taken place with colleagues in Head and Neck in order to manage the capacity required to any increase in demand.

Neurology Outpatient Service: CRR1154
The long-standing capacity and workforce issues in this area remain. The situation is similar to regional and national consultant workforce issues in this specialty. Following discussions with commissioners the service was closed to all new referrals from March 2017. Commissioners sourced and secured additional capacity from The Royal Wolverhampton Hospital Trust during this period. SaTH currently employs one full-time and one part-time consultant neurologist.

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SaTH had sourced additional capacity from The Walton Centre however further work was required to reach a more mutually beneficial agreement. The Walton Centre also agreed to work up proposals for both short and longer term working with SaTH. Whilst the longer term plans are progressed, The Walton Centre has offered to undertake one full day of clinics per fortnight. As SaTH's backlog is now at manageable levels, in order to support the capacity from The Walton Centre, SaTH would require a partial opening of the service. The longer term plans were not submitted to The Walton Centre's Executive Board and will now be presented at the end of April as long as the short term plans are supported by local commissioners. As part of the next steps a business case will be completed, a short and long-term model will be created and agreement will be sought from commissioners to open on a phased approach.

Urology Service: CRR1468

The impact of the rising demand within Urology has been included in this paper and has been presented at a number of Tier 2 Committees. Additionally the growth, particularly in cancer referrals means the service continues to face significant workforce challenges. The two week wait demand continues to show an increase of 40% year on year and a combination of consultants on phased return from sickness, departing the Trust and securing the timely replacement of locums has compounded the issue. The RTT 62 days standard was not achieved in March with 22 patients breaching.

The Board NOTED the paper.

2019.2/89 TRUST OPERATIONAL PLAN

The Chief Operating Officer introduced the Operational Plan which had been discussed at length by the Board at draft stage in addition to Performance Committee. It was noted that it is based upon planning with each Care Group along with data analysis undertaken to support our areas of focus for 2019/20.

The coming year's strategy is to focus on developing strong foundations and ensuring we have the building blocks for success as we move towards making Future Fit a reality for the people of Shropshire, Telford and Wrekin and Mid Wales.

Through Board and Senior Leadership Team discussions, three main priorities have agreed as the organisational focus for 2019/20:

- Move out of Special measures
- Achieve our agreed performance trajectories for ED/RTT/Cancer/Diagnostics
- Achieve our agreed control total

The Performance Committee has asked for the Plan to be disseminated to the relevant committees for their review against the dashboard KPIs and with the Performance Committee keeping the overview of the Plan it its entirety.

The Board NOTED the paper and ADOPTED the Operational Plan.

2019.2/90 FINANCIAL STRATEGY 2019/20 (INCLUDING CAPITAL PLAN)

The CEO presented the Financial strategy which had been revised following feedback from NHSI/E on the 16 April 2019 whereby the Trust was requested to review its finance plan for the year with the expectation that the Trust should be able to meet its initial breakeven control total target.

Work has been undertaken internally since, including a presentation to the Senior Leadership Team illustrating the challenges the Trust faces and the level of savings required. This has included a number of suggestions to reduce the scale of the gap including; income backed schemes, capital expenditure, balance sheet review, phasing of developments, the skill mix and phasing of additional capacity and STP wide efficiencies.

The combined effects of increased levels of activity, workforce difficulties and the need to respond appropriately to the requirements placed upon the Trust by the CQC following inspection have understandably heavily influenced the shape

of the Trust's budget for the 2019/120 financial year. This paper described the construction of the 2019/20 budget. Specifically:

- It begins by describing how the recurrent position of the Trust worsened during the year, *and*
- Progresses to describe a volume of spending commitments that are necessary to enable the Trust to respond to increased levels of activity and better manage its quality and safety risks.

In doing so, the paper also describes the Trust's waste reduction programme and also how its plans compare with the financial performance expectations that have been placed upon the Trust by NHSI.

2018/19 financial year

The Trust began the 2018/19 financial year with a recurrent deficit amounting to £20.7 million, during the course of the year the scale of the recurrent deficit has risen; the effect of this has meant that the Trust enters the 2019/20 financial year with a recurrent deficit amounting to £29.0 million.

In developing the 2019/20 budget, consideration is made of:

- Additional funding requests, and
- Inflationary pressures and cost improvement delivery

The scale of the recurrent deficit was shared with the Trust's Senior Leadership Team alongside the proposed investments through a series of prioritisation workshops. The workshops were also aligned to the Operational Plan objectives. This resulted in the series investments described previously, alongside the scale of savings required.

The cost improvement target for the 2019/20 year requires the Trust to deliver savings to cover the expected level of expenditure inflation after allowing for the funding provided through Tariff. The level of cost improvement that is required therefore amounts to £4.2 million; expressed as a percentage of turnover (used by NHSI to determine appropriateness of scale of ambition) this produces a CIP target percentage of 1.1%.

In setting the Trust's control total for the year the Trust as a challenged financial organisation is required to supplement its internally generated target with a further sum of £1.7 million. Consolidating the additional sum then results in the Trust being required to deliver cost efficiency savings in the year amounting to £6.0 million or 1.5%.

In order to achieve the Control Total, the scale of savings required amounts to £18.9m. The Cost Improvement Programme has been developed via the Waste Reduction Group and the Senior Leadership Team. This represents a challenging scale of cost improvement for the Trust. Progress on delivery will be monitored via the Waste Reduction Group.

In the 2019/20 financial year, the Trust will be required to work towards reducing the level of agency spending so as to be consistent with the agency ceiling target issued by NHSI, currently the Trust is presenting an adverse variance of £5.5 million above the prescribed annual agency spend ceiling. During the 2018/19 year, workforce pressures, particularly related to ED, resulted in the level of agency spending increasing and is estimated to amount to £17.1 million. Further spending commitments identified for 2019/20 lead to a further increase in agency spending and it is now anticipated that agency spending in year will amount to £19.1 million.

In order for the Trust to achieve a balanced financial position, the scale of the Cost Improvement Programme amounts to £18.9m. In addition the Trust will receive Central Funding amounting to £17.4m upon delivery of the plan, enabling an Income and Expenditure balanced position to be achieved. These elements are notably marginal rate emergency threshold (MRET), provider sustainability funding (PSF) and financial recovery funding (FRF) which provide a combined value of £17.4 million.

Capital Programme 2019/20

The condition of the Trust's existing Infrastructure defined as Estate, Medical Equipment and IT equipment continues to be of concern. Within the Trust's SSP Strategic Outline Case there are plans to address the backlog issues relating the Trust's Estate. However, with the continued delay in receiving approval for the Business Case, the condition of the Estate continues to deteriorate.

…….. Chair
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The table below illustrates the risks that are described as Priority 1 by the departmental heads:

Departmental Priority 1 Schemes	2019/20	2020/21	2021/22	2022/23	2023/24	Total
	£000s	£000s	£000s	£000s	£000s	£000s
Estates Risks Priority 1 (on-going assumed same as 2019/20 - dependant upon SSP)	2,485	2,485	2,485	2,485	2,485	12,425
Medical Equipment Replacement Priority 1 (current P2/4 years)	1,364	1,405	1,405	1,405	1,405	6,984
IT Replacement Priority 1	266	138	241	241	241	1,127
Radiology Replacement Priority 1 (not included - revenue solution)						
Total Priority 1 Schemes	**4,115**	**4,028**	**4,131**	**4,131**	**4,131**	**20,536**

As can be seen, there are £4.1 million of schemes which require funding in 2019/20, with a total of £20.5 million over the five year period. The level of funding available to the Trust is limited to the Trust's Capital Resource Limit (CRL). In 2019/20 this has been set initially to £10.5 million. In line with previous years, and given the scale of infrastructure risk, the Trust has continued to adopt an approach where:

- Priority is given to spending in areas where there is deemed to be high clinical/operational risk, *and*
- A level of contingency is held due to the scale of backlog issues. Holding contingency funds enable the Trust to respond to unpredictable capital problems. These contingencies have been allocated based on historic values and have been increased to include three new contingencies for 2019/20:
    a. Radiotherapy (as agreed at CPG/PC) for in-house maintenance of Linear Accelerators £0.1 million,
    b. Gemba Walk Contingency of £0.1 million, *and*
    c. Estates Compliance Reports to inform the Capital Programme £0.1 million.

The summary capital programme for 2019/20 is as follows:

Selected High Risk Areas	2019/20
	£000s
Estates Priority 1 – Continuation of Fire Safety Programme (as per Estates Condition Survey)	291
Estates Priority 1 – Continuation of Subway Duct works (including works required for Road Adoption by Council)	950
IT – Priority 1 Continuation of Storage Solution	450
Contingencies	3,550
Pre-committed Capital Schemes	1,550
Endoscopy Suites Reconfiguration	1,300
Uncommitted	2,359
Total	**10,450**

The above table shows an uncommitted value of £2.4 million. This uncommitted value is being held to cover those items listed below and in addition is anticipated to cover additional resource associated with the SSP. However, it is important to note the capitalisation of any costs associated with the SSP project will need to adhere to NHS capital criteria as specified within the NHS manual of accounts.

It should be noted that there are many issues that are known, but for which there is no allocation currently included.

The Trust has been set a Control Total target by NHSI to achieve a deficit in the 2019/20 year (excluding PSF, FRF and MRET funding) of £17.4 million. The Trust has submitted to NHSI a financial plan that demonstrates it can deliver to this control total.

The Trust financial difficulties in the 2019/20 year arise because:

- in the 2018/19 financial year, approved spending commitments increased the recurrent deficit by £8.3 million.

- new spending commitments are planned for the 2019/20 year amounting to £19.3 million however, £5.6 million is offset by increased income associated with demographic change, resulting in new year pressures of a net £13.7 million.

The Trust's medium term financial plan has been overhauled to reflect a revision of National Tariffs and a more recent understanding of Commissioner QIPP savings requirements. The plan has also been adjusted to reflect recent calculations in respect of workforce savings and the work undertaken by PA Consulting (Management Consultants) that describes the cost of introducing an EPR solution.

The medium term plan continues to chart a path to greater sustainability for the Trust through the reconfiguration of its clinical services. Doing so enables the serious capital backlog estate difficulties to be addressed and returns the Trust to an income and expenditure surplus financial position (£2.7 million).

An examination of the Trust's estate and equipment issues confirms that the level of backlog risk cannot be addressed through the use of Internally Generated Capital funds and that instead alternative financing solutions will need to be found in order to support the replacement particularly of high cost diagnostic equipment. In the 2019/20 year the Trust will once again need to establish sizeable contingency resources in order to be able to respond to the anticipated regular albeit unplanned need throughout the year for capital work to be completed and equipment replaced.

The Trust's in-year cash position is secure providing it delivers its operational and financial plan. Should the Trust not achieve its targets, then there is likely to be an adverse impact on the Trust's cash position, which could result in a cash shortfall of £30.3m. In such circumstances, there would be a need to secure authorisation from NHSI to underpin the deficit with an equivalent level of cash support.

The Board NOTED the paper

2019.2/91 AUDIT COMMITTEE SUMMARY

The Chair of the Audit Committee, Mr Bristlin (NED) presented the summary of the meeting held 24 May 2019.

Internal Audit Progress Report and Plan 2019/20

The Head of Internal Audit (HoIA) presented the report which provided a summary of progress with respect to the Trust's Internal Audit Plan for 2018/19 (see Appendix A) and also the draft audit plan for 2019/20. The proposed forward plan included the schedule for mandated core audits (WRP / Budgetary, BAF, Cash Management, Income and Debtors, Payments and Creditors, Fixed Assets and IT controls) over 100 days and a number performance reviews:

- Workforce – recruitment process
- Ward to Board Reporting assurance
- Datix Risk Management
- Complex Discharge Management – Follow-up
- Never events – Follow-up

In discussion, it was agreed that a Freedom To Speak Up (FTSU) review should also be included within the plan. The Audit Committee concluded that it made sense to include FTSU as a priority and push back the two follow-up reviews. This approach would also ensure the plan remained within the agreed performance audit budget (100 days) for the year.

Head of Internal Audit Opinion

Based on the plan of work undertaken in year, the HoIA confirmed and formally stated the following opinions of the Trust for 2018/19:

- Overall – Limited assurance based on the core audits in 18/19 and the financial position of the trust (17/18 - Moderate)
- Assurance Framework is sufficient to meet the requirements of the 2018/19 AGS – Moderate assurance (17/18 Substantial)
- Adequate and effective system of internal control – Moderate assurance (17/18 Moderate)

…….. Chair
1 August 2019

It was reported that the remit of the Audit Committee will be expanded to include risk assurance and the first meeting of the renamed Audit and Risk Assurance Committee will be held at the next planned meeting in September.

External Audit update/ISA 260 report

KPMG presented the audit of the Trust's Financial Statements and the Value for Money (VFM) of the Trust for the year ended 31 March 2019. They stated that there was an unqualified opinion for the Financial Statements. There was a qualified VFM opinion based on the inadequate rating by the CQC, the deficit position of the Trust in the year and cumulatively and the failure to meet a number of operational targets, in particular the accident and emergency and 62 day cancer target.

The proposal to extend the contract with KPMG as the Trusts External Auditor for a further 12 months was approved by the Audit Committee.

The Board expressed the continued need to have an honest and open approach to this work, and focused Executive sign-off was necessary to encourage their further engagement. As such it should be share with the SLT at their monthly meeting.

The Board NOTED the Audit Committee summary.

…….. Chair
1 August 2019

2019.2/92 CHARITABLE FUNDS COMMITTEE REPORT & CHARITIABLE FUNDS QUARTERLY ACIVITY REPORT

Chair of the Charitable Funds Committee, Mr Allen (NED) presented the summary of the meeting held 10 May 2019.

Investment and Funds Activity 18/19
The committee received an update of the Trust's charitable income and expenditure .The charity had received donations and legacies of £373,000 whilst it had spent £654,000 on charitable activities.

Accessing Charitable Funds Publicity
The committee approved a proposal to make staff aware of the 100 charitable funds available and how these can be accessed and to increase the number of staff raising funds for the SaTH Charity. Plans of how to do this were shared and include features in Chatterbox and Safest and Kindest newsletters and details of the funds and their fund managers, increasing the recognition the internal fundraisers receive, having a "Fundraiser of the month" and linking fundraising to volunteering. The committee wished to encourage donations to general funds and for funds to be spent in a timely manner, thereby significantly reducing the fund balances.

The DCG introduced the Quarterly update report and it was noted that donations for February were £41,495 and March were £34,089. Key developments raising awareness of SaTH Charity through the media and internal communications to encourage greater support. The SaTH staff lottery is scheduled for its first draw in July. The new SaTH Charity policy has been presented to staff side and has been approved by PAG (Policy Approval Group) and clarifies the process both for raising funds and for bidding for them.

The Board NOTED the Charitable Funds Committee report and the Activity Report.

2019.2/93 POLICY FOR APPROVAL – CHARITABLE FUNDS

The Board RECEIVED and NOTED the policy.

2019/2/94 ANNUAL REPORT – SECURITY

The DCG introduced the Annual Report and noted that under the provisions of the NHS Standard Contract, Providers are required to have in place and maintain security arrangements in their organisations.

A safe environment for staff and patients continues to develop through our policy and stance on tackling violence and aggression. The DCG and CEO issue warning letters to perpetrators advising of the risk of withdrawal of non-emergency treatment to ensure meaningful sanction and redress has taken place in response to incidents. This has limited re-offending- last year 66 warning letters and/or letters of concern were issued. Only four of those receiving our initial warning letter during the period have since been reported as being involved in any further incident. None of the 66 letters were challenged by the recipients as being false or unwarranted. This reporting year the Courts have handed out prison sentences amounting to over 3 years to individuals found guilty of more serious and inexcusable aggression towards staff.

All staff involved in acts of abuse or aggression are contacted by the DCG advising them of the steps taken and reminding them they can seek help from Occupational health if they have any further concerns following the incident

It was noted that Mr Allen (NED) is the NED Link for Security

Of the reported 114 intentional violence and aggression incidents in 2018-19, 56 occurred at the RSH, 57 occurred at PRH and one off-site, but involved staff. 38 involved physical contact (however minor or inconsequential). 23 were on staff (22 of these were carried out by patients, 1 involved staff on staff). 15 were by patients or relatives (public) on the same.

One of the intentional physical assault incidents involving Trust staff during 2018-19 resulted in serious injury or triggered RIDDOR reporting to the Health & Safety Executive (HSE)

There were 76 intentional non-physical incidents i.e. incidents of verbal abuse, threatening or other anti-social behaviour by patients, relatives or public, 72 of these were made towards staff and the other 3 towards other patients, relatives or public.

…….. Chair
1 August 2019

The DCG pointed out that Security Officers attend the majority of all reported security incidents. With any aggression incident they are called to help provide reassurance and assistance in seeing the safe closure of the incident or prevent further escalation, as well as providing pre-arranged preventative support to staff to stop a foreseeable incident occurring or escalating. They also further support clinical staff by completing the Datix reports, therefore allowing them to return to their clinical duties more rapidly.

The DCG thanked Jon Simpson, the Trust's Security Manager for his work and the fact that the Security teams are highly valued by the areas they support

The Chair commended the security work as excellent and commented on how robust this Trust is in comparison to others. The COO seconded these thoughts and verbalised how visible the security team is and their desire to 'do the right thing'.

The Board RECEIVED and NOTED the report and passed on their thanks to the Security team.

2019.2/95 BOARD ASSURANCE FRAMEWORK

The CEO presented the Board Assurance Framework to the Board. It was noted that the BAF provides a structure and process that enables focus on those risks that might compromise the achievement of the Trust's principal objectives. The CEO noted that each of the Tier 2 Committees had considered and commented on their allocated BAF risks and some of the higher operational risks. It was noted that in May 2019 there are 110 risks on the register in total, which is 61 more than May 2018. Over the year, 24 risks have been closed. 49 new risks have been identified over the year; and 16 further risks have increased in score (≥15).

The Board RECEIVED the paper and APPROVED its contents.

2019.2/96 PROVIDER LICENCE SELF CERTIFICATION

The CEO presented the paper which explained that NHS Trusts are required to self-certify that they can meet the obligations set out in the NHS provider licence (which itself includes requirements to comply with the National Health Service Act 2006, the Health and Social Care Act 2008, the Health Act 2009 and the Health and Social Care Act 2012, and to have regard to the NHS Constitution) and that they have complied with governance requirements.

Although NHS Trusts are exempt from needing a Provider Licence, directions from the Secretary of State require NHS Improvement (NHSI) to ensure that NHS Trusts comply with conditions equivalent to the licence as it deems appropriate.

Consequently, all provider NHS Trusts must self-certify the following after the financial year-end:

- Condition G6(3) - the provider has taken all precautions necessary to comply with the licence, NHS Acts and NHS Constitution
- Condition FT4(8) - the provider has complied with required governance arrangements

The Trust Board is required to approve the self-certification statements for 2018/19 before 31 May 2019 (Condition G6) and 30 June 2019 (Condition FT4).

Mr Bristlin (NED) asked about the signing these when the Letter of Undertaking from NHSI outlined non-compliance. It was explained that the letter related to different Licence Conditions (FT4(5), FT4(6) and FT4(7) whereas the Conditions in the self-certification relate to Licence Conditions G6(3) and FT4(8).

The Board RECEIVED the paper and APPROVED its contents.

…….. Chair
1 August 2019

2019.2/97 ANY OTHER BUSINESS / QUESTIONS FROM THE FLOOR

Q1 Why isn't the Operational Plan on the website?
A1 The DCG confirmed that it was on the website

Q2 Had the Board received the questions from Gill George?
A2 It was confirmed the Board had received the questions and answers would be sent following the meeting

No further business was raised.

2019.2/98 DATE OF NEXT PUBLIC TRUST BOARD MEETING –

Thursday 1 August 2019, 1.00 pm, Princess Royal Hospital

The meeting closed at 5pm

…….. Chair
1 August 2019

ACTIONS / MATTERS ARISING FROM THE PUBLIC TRUST BOARD ON 30 MAY 2019

Item	Issue	Action Owner	Due Date
2019.2/73 Workforce Performance Report	WD to compare Staff survey results with exit questionnaires and high turnover areas – to be reported back to the Board	WD	13 Sep-19
2019.2/85 Sustainability Committee Summary	Medical Director to advise Chief Pharmacist of Board support for bid submission via Sustainability Committee	MD	22 Aug-19

…….. Chair
1 August 2019