The Shrewsbury and Telford Hospital NHS Trust

TRUST BOARD MEETING
Held 1.00pm, Thursday 6 February 2020
Seminar Room 1&2, SECC, Royal Shrewsbury Hospital

PUBLIC SESSION MINUTES

Present:	Mr B Reid	Chair
	Mrs B Beal	Director of Nursing & Quality (DNQ)
	Ms T Boughey	Non-Executive Director (NED)
	Mr A Bristlin	Non-Executive Director (NED)
	Mrs P Clark	Chief Executive Officer (CEO)
	Prof C Deadman	Non-Executive Director (NED)
	Mr J Drury	Finance Director (FD)
	Dr D Lee	Non-Executive Director (NED)
	Mr N Lee	Chief Operating Officer (COO)
	Mr B Newman	Non-Executive Director (NED)
	Prof T Purt	Non-Executive Director (NED)
	Dr A Rose	Medical Director (MD)
In Attendance:	Mr T Allen	Associate Non-Executive Director (A.NED)
	Mr S Balderstone	Associate Director, Workforce – representing AWD
	Ms L Barnett	CEO Designate (CEO.D)
	Dr E Borman	Director for Clinical Effectiveness (DCE)
	Mr D Brown	Associate Non-Executive Director (A.NED)
	Mrs J Clarke	Director of Corporate Services / Company Secretary (DCS)
	Mr D Holden	Interim Director of Governance (IDG)
	Ms B Tabernacle-Pennington	Director of Transformation & Strategy (DTS)
	Ms A Vicary	Improvement Director, NSHI
Apologies:	Ms R Boyode	Acting Workforce Director (AWD)
	Ms E Burrowes	Associate Non-Executive Director (A.NED)
Meeting Secretary:	Mrs B Barnes	Trust Board Secretary

2020.1/01 **WELCOME & APOLOGIES**

The Chair welcomed all to the Trust Board meeting, and highlighted the following new appointments, departures and changes in responsibilities:

- Louise Barnett, attending the meeting as CEO Designate, joins the Trust as Chief Executive Officer from 10 February 2020
- This will therefore be Paula Clark's last Board meeting as Interim CEO, and the Chair thanked Paula for her contribution to the Trust during her tenure
- David Holden, also attending today's meeting, has recently joined the Trust as Interim Director of Governance / Company Secretary
- The transfer of the above responsibilities to David will allow Julia Clarke an opportunity for dedicated focus on her extensive portfolio of responsibilities as Director of Corporate Services, across Estates, Facilities, Legal Services, Security, Health and Safety, Communications, Environmental Sustainability, Charities Liaison and Community Engagement

2020.1/02 **PATIENT STORY – LIVING WELL WITH CANCER**

The Board received a Patient Story by way of a presentation and short extract from the newly launched Living Well with Cancer video which features Colin, a cancer survivor. Colin explains in the video what living well with

cancer means to him, and his story is one of four films in which people with cancer talk about their advice and tips for living well. The patient stories are designed to help others and are incredibly powerful.

Jessica Greenwood, Lead Cancer Nurse, attended the meeting together with Colin. She advised that the development of the video was led by SaTH, and has been produced in partnership with Macmillan and colleagues from other Trusts within the West Midlands.

The Living Well video is part of the Living With and Beyond Cancer (LWBC) programme, which has been funded by Macmillan for three years and is aimed at enabling and empowering patients to live as well as possible during treatment and beyond. The focus is on addressing what matters most to the patient using a person-centred approach and supporting people to safely self-manage.

For nearly five years, SaTH has put on Health & Wellbeing sessions, which are aimed at helping support cancer patients to live well. Over the years these have evolved into Living Well Sessions. The informal and interactive sessions are free for people to attend and open to anyone affected by cancer, whether patients, friends, family, carers or supporters at any stage of their pathway. The events take place once a month at venues throughout Shropshire, Telford & Wrekin, and during the sessions patients are signposted to local services, eg The Macmillan Cancer Support Centre, Macmillan Welfare Rights & Benefits Service, the Lingen Davies Get Active Feel Good Team and many more. Evaluation on the day and at three-month follow up has been excellent.

The Living Well with Cancer video is due to go live by the end of February 2020, and will be accessible via the Trust's website. There is also a short feedback form, which users can submit, to allow the Trust to gain further feedback and assess the impact of this patient initiative. The web based publication format also allows relatives who are unable to attend appointments to access information which might be useful to the person affected by cancer.

The Trust's Cancer Services team are also developing a patient 'Passport' to support cancer patients from diagnosis to living well. This is currently in the design phase and has had patient input in the development stage.

The Board NOTED the excellent work being undertaken, and the Chair thanked Colin and Jessica for their informative and inspiring presentation.

2020.1/03 **BOARD GENBA WALK FEEDBACK**

The Chair provided a verbal summary of observations from the 'Genba Walks' (a term used to describe personal observation of work, where the work is happening) that had been made by Board members earlier in the day to the following three areas:

Pre-Operative Assessment Unit

- Positive - use of the Transforming Care Production System (TCPS) methodology to make improvement for patients was evident
- Could do better – Lack of clarity around communication with Bookings staff on patient pathways

Radiology

- Very positive feedback from nurse around the "one stop shop" process for lung cancer patients requiring CT guided biopsy
- Great use of huddles daily to allocate radiologist for complex reporting, thereby helping to eradicate interruptions
- Risks/ Recommendation – it was noted that standardisation is not considered when compiling business cases for new equipment. This has an impact on cross-site working and requires additional training

Stores

- Positive - clear evidence of improvements using the TCPS methodology
- Could do better – an electronic stock control system and bar codes on each item would be beneficial

The Board NOTED that the feedback captured during the visits will be centrally recorded and evaluated, and used to inform improvements in line with Care Quality Commission (CQC) Well-Led recommendations and guidance.

………………………….. Chair
26 March 2020

2020.1/04 **BOARD MEMBERS' DECLARATIONS OF INTERESTS**

The Board RECEIVED and NOTED the Declarations of Interest.

2020.1/05 **DRAFT MINUTES OF MEETING HELD IN PUBLIC – 28 NOVEMBER 2019**

The minutes were APPROVED as a true record.

2020.1/06 **ACTIONS/MATTERS ARISING FROM MEETING HELD 28 NOVEMBER 2019**

2019.1/180 – Quality Governance Report
Consideration to be given to making pressure ulcers chart more informative by showing a comparison with the previous month/year.
The DNQ advised that data analyst support is being secured to address this point. Action closed.

2019/1/181 – Transforming Care/Improvement Plan Update
Update to be provided at next meeting on link between staff development and culture change
6 February agenda item. Action closed.

2019.1/183 – Maternity Oversight Group Meeting Report
DNQ to meet with Chair of Quality & Safety Committee to discuss maternity dashboard
The DNQ confirmed as actioned and complete. Action closed.

2019.1/184 – Emergency Department Oversight Group Meeting Report
Chair requested inclusion of ED System in future reports, and Group ToR to state that it is a Task & Finish Group, which sits 'at the side of' standard governance
Committee Chair confirmed both actions noted/complete. Action closed.

2019.1/185 – Complaints and PALS Report
Customer care staff development requirement to be discussed with AD of Organisational Development
The DCS confirmed that discussion has taken place. Action closed.

2019.1/191 – Audit and Risk Committee Annual Report
List of audits carried out over the last three years to be provided to Executive, to inform decisions on which audits should be re-run
The DCS confirmed as actioned and complete. Action closed.

2019.1/192 – Board Assurance Framework (BAF)
Wording to be worked up for sepsis strategic risk
Included in 6 February BAF agenda item. Action closed.

MONTHLY OVERVIEW

2020.1/07 **CHIEF EXECUTIVE OVERVIEW**

Before presenting her Overview Report, the CEO made reference to the current threat of Coronavirus. She reported that the Trust is receiving information from the centre daily and submitting all returns as required. She provided assurance that the Trust is well prepared should the situation escalate.

2020.1.07.1 **Feedback from the Care Quality Commission (CQC) Well-Led Inspection**

The CEO reported that the CQC has written to SaTH following their recent Well-Led inspection, with some initial feedback, so that the Trust can start considering what actions are required to continue to make improvements in this area of the organisation. It is important to note that the feedback shown below does not replace the draft inspection report, which will be sent by the CQC in early March for factual accuracy review.

Leadership

- The Trust has a Leadership Team that has experienced significant change over the last nine months, with three interim Executive posts, including the Chief Executive. The interim post holders have held Executive positions before, and bring experience of how an Executive Team and Board should function. The Executive Team was working as a cohesive group.
- Some Middle Managers lack the skills and knowledge in how to lead and manage effectively. The Trust recognised the training needs of Managers and was working to provide leadership and development opportunities, however this was at an early stage.
- The Trust's Leadership Team had knowledge of current priorities and challenges and was taking action to address these, however there was a history of action and improvements not being sustained.
- Senior Leaders made sure they visited all parts of the Trust however the staff perception of the visibility of the Board was not positive. There was a lack of systematic feedback to the Board from these visits to discuss challenges faced by staff and the services.

Vision and Strategy

- The Trust's strategy and vision were developed in 2016 and required review, which the Trust were aware of. Some Senior Leaders advised that the values remained current, however strong feelings were expressed by some who felt they were not lived by all staff and also required review.

Culture

- We heard of Executive Leaders who had addressed poor practice, but other Managers were not consistently taking actions.
- The Trust was not consistently taking action as a result of concerns raised. Some staff felt nothing was done until a grievance was raised.
- Staff, including those with protected characteristics under the Equality Act, do not always feel they are treated equitably. However we did hear about volunteers from different communities who were having positive effects on breaking down barriers.

Governance

- The governance arrangements were becoming clearer, but levels of assurance and confidence in the assurance processes were not mature.
- The Board was clear about its roles and accountabilities, but this was not the case throughout the organisation. Leadership development was not yet in place throughout the different levels of the organisation and this was apparent in a lack of knowledge and experience in holding difficult conversations, such as middle management level.

Management of risk, issues and performance

- Risks were not always dealt with appropriately or quickly enough. Systems did not support robust and corroborated information.
- Complaint management lacked detailed learning, nor was there sign off that learning had been achieved.
- There was inconsistent completion of serious incident investigation forms, with a lack of robust learning from some serious incident investigations. A new process was in place for Executive oversight of serious incidents. We asked the Trust to re-look at the actions from a specific serious incident as we did not feel these covered all the issues identified.
- The Trust did not have assurance that low and no harm incidents were recorded appropriately and it was difficult to map trends and themes.
- We have asked for up to date information on backlog of incidents forms as the number had been high and we had conflicting verbal information on if it had reduced and by how much.
- The Trust has had a deteriorating financial performance and has not met its control total in previous years. This trend has continued in this financial year.
- The Trust recognised its challenged financial position and has identified some of the reasons for this performance. Interventions were in place, however no financial improvements were expected in this financial year.

Information Management

- There was a heavy reliance on manual systems to provide information, with a lack of trust in the data available. This was recognised by the Trust, with a digital strategy in development.

Engagement

- A good and diverse range of people's views was heard and acted upon, and we heard of examples of this.
- People with diverse backgrounds were used to engage with staff and promote the understanding of the different needs of people.
- There was a large volunteer workforce who were recruited against the Values of the Trust.
- There were improving relationships with partners, but a need to develop shared vision with supporting actions in order for the Trust to deliver its improvements to patient care.

Learning, continuous improvement and innovation

- Systems lack maturity and senior leaders recognise this. Mortality review process in place but learning to promote safety less clear.

2020.1/07.2 **CEO's highlight report**

CQC Maternity Survey published

The CEO reported that she was pleased to read the findings of the 2019 CQC Maternity Survey (published on 28 January 2020) which showed that women cared for by SaTH had confidence and trust in the staff caring for them during their labour and the birth of their baby.

The CQC survey highlights women's views on all aspects of their maternity care, from the first time they see a clinician or midwife, through to the care provided at home in the weeks following the arrival of their baby.

With that in mind, it is pleasing that the Trust scored 8/10 or higher in 73% of the questions asked. Of the 35 questions in which SaTH achieved this score, 21 (60%) scored 9/10 or higher.

Findings of the survey include:

- Women having confidence and trust in the staff caring for them during labour and birth
- Women being treated with dignity and respect
- Concerns being taken seriously
- Midwives listening to women during their antenatal check-ups
- Women getting the help they needed, when they needed it
- Women being spoken to in a way they could understand
- Women being involved in decisions about their care

In response to queries from Prof Deadman (NED) regarding survey duration and how SaTH's performance compared with other Trusts, the CEO confirmed that the data had been collected during February 2019, and we compared favourably with other Trusts. She added that information is being gathered monthly as part of 'Maternity Safety Monitor Day' rather than waiting for CQC feedback.

Opening of two new wards

Two new wards are being created to increase capacity at both hospital sites.

A 25-bed therapy-led ward/discharge lounge will open at RSH over the coming weeks, while a 16-bed ward will open at PRH.

The therapy-led ward/discharge lounge will open in the Copthorne Building at RSH and has been designed to shorten the length of stay for patients, while freeing up acute beds.

The new ward at PRH will be created as a result of Wrekin MLU moving into a purpose-built modular building next to the Consultant-led Unit. The building, which will house a new state of the art MLU at PRH, was lifted into place

over Christmas and will include a birthing pool and en-suite bathrooms. It has been designed with the leadership team from the Women and Children's Care Group.

Equality, Diversity and Inclusivity Improvements

The Trust held its second annual Equality, Diversity and Inclusivity Stakeholder event on 23 January, where staff from across SaTH presented information about a range of services.

Each 10-minute presentation was followed by group discussions on what the service is doing well and what improvements could be made to meet the needs of the local community.

In February, the Trust will be holding two LGBT+ awareness workshops to support LGBT+ History Month. The Trust also recently introduced the Rainbow Badge scheme, in which staff can apply for a badge to champion and demonstrate awareness of the issues that LGBT+ people can face when accessing healthcare.

In March, Kal Parkash will join the Trust to take up a brand new role of Equality, Diversity & Inclusion Lead. Kal joins the Trust from West Mercia Police where she was shortlisted for the National Excellence in Diversity Awards, in recognition of increasing BME representation.

Two more Exemplar Wards

The Delivery Suite at PRH has become the fourth department at SaTH to be awarded Diamond status as part of the organisation's Exemplar improvement programme, while the Children's Ward recently achieved Gold status.

Patient experience is at the heart of Exemplar, which awards Silver, Gold and Diamond status to participating wards. Wards must show strong leadership to inspire their entire team to make changes in areas including care and compassion, infection control, documentation and communication, in order to improve a patient's journey through their ward.

Improving care of patients presenting with mental health conditions

Using Transforming Care Production System (TCPS) methodology the Trust has been exploring ways to improve the care of patients presenting with mental health conditions in our Emergency Departments (EDs).

During a week-long event, where staff were joined by Lynda Jones, an independent mental health activist, a number of new processes were designed and are now being trialled in our EDs. Improvements made during the week include:

- A Mental Health Triage Tool is to be introduced alongside the Physical Health Tool that is currently used in our EDs. The tool will be used to decide the next course of action for the patient
- A step-by-step guide has been created to ensure all staff are fully aware of the correct pathway for 16 and 17 year olds presenting in ED with a mental health condition
- Information folders are to be created containing important information, including the flowchart and the Mental Health Triage Tool, and contact details of external organisations that may be able to assist in the delivery of great patient care of those presenting with a mental health condition

Recognition and treatment of Sepsis

The Trust welcomed Dr Ron Daniels, CEO of the UK Sepsis Trust, to both PRH and RSH on 28 January. Ron delivered a fascinating lecture on the changing face of Sepsis and held a Q&A session at both sites, providing staff with the opportunity to make suggestions, raise concerns and have open and robust discussions about the condition.

SaTH has been working hard to understand the wider issues contributing to our current position and, as well as the visit of Dr Daniels, the Trust has made a number of significant improvements in recent months. These include the introduction of more Sepsis Trolleys, updating the staff app so staff can locate clinical information quickly, and increased education.

Successful Flu Campaign

The Trust's #WeWillRockFlu campaign has been a huge success, with over 80% - the national target – of frontline staff having their jab. There are less than 200 vaccinations left and anyone who has not yet had the jab has been urged to arrange it by calling the Trust's Flu Line.

The Trust's Infection Prevention and Control (IPC), Workforce and Communications teams have worked closely together to make this our most successful flu campaign ever.

Indian Nurses welcomed to SaTH

Following the announcement in October that the Trust had recruited 176 nurses from India, the CEO was pleased to report that the first cohort arrived in December and the second cohort in January.

This is extremely good news for the Trust's patients and staff, and the new nurses are settling in well to life at SaTH. Their arrival in cohorts means the Trust can ensure that the standards of proficiency, education and training meet our high standards.

The Trust has looked to overseas recruitment, through Health Education England's (HEE) Global Learners Programme, to help fill gaps in its substantive nursing and midwifery workforce. The HEE Programme was implemented to meet the shortfall of over 270 band five nursing and midwifery vacancies in the Trust and these appointments will help to improve the care we give to our patients.

New CT Scanner now live

The Trust now has four CT scanners in operation following the introduction of a new state-of-the-art scanner at PRH before Christmas.

The additional scanner will ensure the sustainable and reliable delivery of emergency and urgent CT scanning, particularly for stroke and paediatric patients. Its superior technology will also allow for improved image quality and advanced imaging, such as cardiac. Alongside the scanner is a newly created three-bedded bay which will be used for patients waiting for a CT scan, allowing them more privacy.

The scanner and bed bay are part of a £7 million investment in our Radiology Department, which aims to improve patient care and experience. It means that, should one of the scanners need essential maintenance or be out of use, patients will no longer have to be transferred to RSH for their scan.

Careers Event

The Trust is hosting a careers event in partnership with Shrewsbury Colleges Group (SCG) on 12 February from 4pm-7pm at the Shropshire Conference and Education Centre (SECC), RSH.

The event will be an opportunity to meet NHS staff working across our hospitals, find out about their roles, have a tour of hospital facilities, learn about the routes into diverse job roles including work experience and apprenticeships, and discuss the many qualifications and course packages offered by Shrewsbury College.

2020.1/07.3 **NHSI/E Weekly Bulletin Updates**

Each week the Trust receives a bulletin from our regulators at NHSI/E, which provides an overview of national policy developments, key events and details of actions that the Trust is required to take forward. Some key recent highlights include:

- It is the International Year of the Nurse and Midwife. This is the year we recognise and celebrate the enormous contribution that nurses and midwives make to all of us, our health services and our patients. It is our chance to shine a light on the skills and expertise it takes to be a nurse or midwife, and to encourage new recruits into the professions.
- A change in the law means two new groups have a legal right to a personal health budget. This includes people eligible for after-care services under Section 117 of the Mental Health Act and people eligible for an NHS wheelchair (who have a right to a personal wheelchair budget). This guidance is available to support clinical commissioning groups and other bodies to meet their duties in line with the new rights.
- The National Medical Examiner team is beginning reimbursement of approved costs for 2019/20. Any trusts who are recruiting for or running a medical examiner system in 2019/20 and have not yet received the initial data collection template, are asked to contact funding.nme@nhs.net urgently.
- NHSI/E are inviting expressions of interest in NHS stroke rehabilitation pilot sites. Further to the NHS Long Term Plan commitment, the sites will implement and evaluate evidence for stroke rehabilitation services and

inform future national stroke service developments, to help people recover after their stroke and remain as independent as possible.

- NHSI/E has launched a consultation on the suitability of the dementia assessment and referral (DAR0 data return used by acute trusts, and whether it should remain open or be closed
- The 'Pharmacy Advice' phase of the Help Us, Help You winter campaign has launched. Pharmacists can treat minor concerns like coughs, colds, sore throats, itchy eyes and earaches, helping to reduce pressure on busy GPs and A&Es. The campaign asks the public to 'take the drama out of minor illnesses' and go to their local pharmacist first. It includes a TV advert, social media and bus shelter adverts to help change behaviour.
- The last information and guidance on the Wuhan novel coronavirus is available from Public Health England.

2020.1/07.4 **Maternity Update**

Background

In 2017 the Secretary of State for Health asked NHS Improvement to commission a review of 23 cases where babies and mothers had died or potentially suffered significant harm whilst receiving care at the Trust. Donna Ockenden, expert in midwifery and maternity care, was appointed as chair to gather a clinical team. Donna produced an internal status update report at the end of January 2019. The Trust became aware of the status report in November 2019 when it was leaked to the media and it was then discussed at the November Public Trust Board meeting. Whilst the report was interim, the Trust Board felt it was important to address the key themes as part of the ambition to achieve best practice standards of care, and the Interim Chief Executive undertook to return with an update at 6 February 2020 Board meeting.

Status Report and Emerging Themes for Learning

Since the review was launched and following subsequent media coverage, the number of cases has risen and stands at over 900 as at January 2020. It was therefore imperative that the emerging themes were mapped against actions taking place within the Trust currently to establish any gaps and then to address these at pace for the families who have suffered loss and the confidence of the wider population.

There are 10 key emerging themes with some overlap, so where this is the case the Trust actions and response have been grouped into the seven areas below:

Theme for Action 1: All women should be able to make a fully informed choice and consent around maternity care and choice of place of birth in particular based on their own unique risk profile.

Response: The Trust recognises that further improvements are needed in this area. Conversations about choice and relative risks take place with women throughout their care but these are not always fully documented. The decision about choice is guided by the professionals, based on the risk profile of the woman. Although women can access additional information themselves the Trust still believes we could be better at directing and explaining (https://www.nhs.uk/conditions/pregnancy-and-baby/where-can-i-give-birth/)

An information leaflet is being developed with the Maternity Team and this will be in place by the end of March 2020 using best practice from other Trusts and the link above.

Theme for Action 2: Duty of candour and transparency/categorisation of Serious Incidents must be appropriate and evidenced. Openness and transparency through involvement of families from the outset in Serious Incident reviews including acknowledgement or explanation of the factors that have led to the death of a baby or to a poorly handled birth leading to long term consequences for the mother / and baby.

Response: A huge amount of work has been done in this area in response to the Royal College of Obstetricians and Gynaecologists (RCOG) Report and improvements in the Duty of Candour adherence throughout the Trust.

A Clinical Incident Management Policy has been in place since 2018 which has been reviewed and checked. Families are also informed by letter around the process being undertaken. Healthcare Safety Investigation Branch (HSIB) is in contact with families as part of a review of incidents meeting Each Baby Counts criteria.

Being Open and a Duty of Candour Policy is in place. There is clear process for Duty of Candour in the Care Group and reviews are undertaken to ensure compliance, and a review in line with psychological harm.

All Datix incident reports are now seen by the Executive Team and ESIRG (Executive Serious Incident Review Group) has been running since November 2019 on a weekly basis, at which all SIs are reviewed and checks made on Duty of Candour and patient/family involvement.

A monthly maternity agenda item will now be tabled at every Public Board meeting from February 2020.

Theme for Action 3: Kindness and respect for parents and families.

Response: There is recognition that in the past kindness and empathy were lacking for some patients, particularly when families and mothers needed this to be central to their care in difficult and sad circumstances.

The entire Trust is undergoing a Culture Survey to better understand the culture within the organisation as a whole which underpins the way staff interact with and care for patients and families. The recent Staff Survey has shown some improvement, the results of which are being used to roll out organisational development actions.

The recent CQC review of Maternity and the forthcoming survey of new mothers evidenced a positive culture of kindness and care, as did their recently published Maternity survey.

In addition to our informal avenues for feedback and the Friends and Family test (which is showing 100% recommendations of service to others), a formal 'contact us' card is being produced so that every new mother can come back to us with their views as they leave our service. We are actively engaging with women to gather feedback.

Theme for Action 4: Respect accorded to the deceased baby and lack of kindness to the families. Time must be allowed for families to be with their baby and viewing facilities to be to a high standard and appropriate to the situation.

Response: The Trust recognises that the facilities for families for viewing and spending time with their deceased baby was inadequate.

Since the CQC visit in October 2019 work has been underway to improve the facilities for families who suffer the loss of a baby or child. Mortuary staff have been involved in this work along with the Care Group team, Chaplain and Estates.

A full review of Bereavement Services is planned involving SANDS (Stillbirth and Neonatal Death Society), with SANDS training also to be undertaken within the Trust.

Implementation of Nursing Business Continuity Plan.

Theme for Action 5: Providing maternity bereavement support and a structured system of support for families who have suffered loss or harm.

Response: As Theme 4, Full review of Bereavement Services within the Care Group involving SANDS implementation of NBCP and Maternity Experience Bereavement measure to gain feedback from women.

A business case has been signed off for a SANDS support proposal.

A business case has been approved for a second Bereavement Midwife.

Theme for Action 6: Essence of learning 'missing' – incident, governance, investigation processes and Root Cause Analysis reports brief and fail to identify key issues.

Response: We recognise learning and the embedding of changed practice is a work in progress for the whole Trust and is not consistently applied. This was flagged at the recent CQC inspection. As part of their ongoing surveillance we are working with them to demonstrate improvements which will be tested when they return later in the year.

Maternity services are more mature in this area. In the Maternity service, focus has been given to RCA management, learning from incidents and applying this consistently.

Maternity team take part in multi-disciplinary training (over 90%) compliance, with particular focus on managing emergency situations.

A full Trust wide governance review has taken place in the Care Groups generally to ensure that the appropriate governance processes are in place. Recommendations have been made to ensure consistency and appropriate escalation to higher tier Board Committees and the Board. In the Women and Children's Care Group this is well advanced.

Governance structures at Board level have also been reviewed and changes are being implemented.

Theme for Action 7: Maternity services and links go into the 'wider NHS world' for bringing in best practice learning. Implications of RCOG, MBRRACE etc and other external and internal reviews are adopted and monitored, to ensure learning and embedded improvements in practice.

Response: Since 2017 the team in Maternity Services have taken a proactive approach to looking outwards and bringing in new staff from other NHS Trusts with their own experience.

We have new senior appointments in place including our Director of Midwifery, who has recently joined from another Trust, having led them from Inadequate to Good. Our management leadership team has also been strengthened and we are currently seeking a new Clinical Director for the Obstetric and Gynaecology Service.

Our Director of Midwifery is the Vice Chair for the West Midlands Heads of Midwifery Advisory Group, which has membership of Heads of Midwifery for the whole region.

In terms of the Medical team, they routinely take study leave outside the Trust nationally and internationally, and learning forms an important part of their appraisal and revalidation.

Implementation and monitoring of national recommendations via appropriate governance channels also takes place.

We have a newly implemented process whereby all external review reports are taken to the Executive Team meetings and then onto Board, each month as they arrive.

MIST e-learning programme

SaTH, in partnership with Health Education England and The Newcastle upon Tyne Hospitals NHS Foundation Trust, has developed the Midwifery, Identification, Stabilisation and Transfer of the Sick Newborn (MIST) e-learning programme to support maternity and emergency teams treating unexpectedly unwell newborn babies in community settings.

MIST is aimed at midwifery and ambulance colleagues to support the treatment plan for newborn babies who are, or have the potential to become, unwell following delivery in a community setting.

The Board RECEIVED and NOTED the Overview Report.

QUALITY & LEARNING (SAFEST & KINDEST

2020.1/08 **MATERNITY UPDATE**

2020.1/08.1 **MATERNITY OVERSIGHT GROUP SUMMARY**

The Chair presented the following summary of the key points/issues from the meeting held on 13 January 2020:

CNST Maternity Incentive Scheme 2019/20

The Committee received and discussed a report presented by the Director of Midwifery relating to CNST 2019/20 declaration and submission to NHSR, and next steps.

Level of assurance provided: Moderate
Direction of travel: Worsening

Ockenden Review

The Committee noted that the Trust is working closely with NHSI and the Ockenden Review Team. Ongoing and to be a standing agenda item.

Level of assurance provided: Moderate
Direction of travel: Worsening

The Chair reported verbally at this point that the Trust has been in discussion with University Hospitals of Morecambe Bay NHS Foundation Trust (UHMB), who have experienced similar issues previously, so that we can receive their advice and learn from their experiences. He summarised two key actions points from those discussions, as follows:

- The Trust recognises the need for adequate resource to deal with the scale and findings of the Ockenden Review, and a dedicated team is therefore being established in this respect
- The Trust will be setting up an external panel of national independent figures/expertise to monitor and review our action plans and endorse our response to the Ockenden Report when published. It is hoped that this will give the public confidence in our communicated responses and improvement actions plans.

Medical Leadership

Gaps in Care Group, and individual situations regarding medical leadership changes were highlighted to the Committee. Update to be provided by MD.

Level of assurance provided: Low
Direction of travel: Worsening

Maternity Risk Register

The Committee noted the review of Maternity Risk Register by the Director of Midwifery and triumvirate through Care Group Governance and Trust Risk Management Framework. Detailed presentation at next meeting

Level of assurance provided: Low
Direction of travel: Worsening

The Board RECEIVED and NOTED the report.

2020.1/08.2 **CONTINUITY OF CARER REPORT**

The Director of Midwifery attended the meeting to present a Continuity of Carer Report, following the Better Births report of the National Maternity Review (the five year forward view for NHS maternity services in England) which sets out a vision for maternity services in England which are safe and personalised.

This vision puts the needs of the woman, her baby and family at the heart of care, with staff who are supported to deliver high quality, continuously improving, care. At the heart of the vision is the ambition that women should have continuity of the person looking after them during their maternity journey, before, during and after the birth. This continuity of care and relationship between care giver and receiver has been shown to lead to better outcomes and safety for the woman and baby, as well as offering a more positive and personal experience.

The Maternity Transformation Programme was established to deliver the vision set out in Better Births, working through Local Maternity Systems (LMS) to deliver change locally. In March 2017 NHSE published Implementing Better Births; A Resource Pack for Local Maternity Systems, which set out an expectation on LMS to include details of how they will meet the ambition that 'most women receive continuity of the person caring for them during pregnancy, birth and postnatally by the end of 2020/21'.

The latest Maternity Incentive Scheme also includes an element of Continuity of Carer (CofC), and an action plan to demonstrate how the service will progress towards achieving 51% of women booked onto a CofC pathway by 31 March 2021.

There is a risk that this will not be achieved within the required timeframe due to multiple factors. The implementation of continuity models has been a challenge nationally due to the level of service transformation that is required. A model for implementation has now been developed and shared nationally. This model, named the Monte Carlo model, details a staffing model which can be applied in order to achieve the target level of 51% CofC. It should be noted that the present requirement is to have women booked onto the pathway, however it is

anticipated that future requirements will be to evidence that women are achieving CofC as measured at the end of their journey within maternity care.

Currently the service does not have any designated teams which are running CofC models as described in the Better Births recommendations. However, it is committed to ensuring that CofC is implemented in such a way as to ensure that it includes in particular those women who will achieve the highest benefit, such as those who are vulnerable or who have known pre-existing co-morbidities/risk factors, which may have a negative impact on the outcome of their pregnancy. Therefore, a generic model will be applied alongside some bespoke models (such as Rainbow pathway for those women who have experienced a previous pregnancy loss) rather than solely focusing on, for example, women suitable for midwifery led care.

The CofC will provide a range of care options to women with varying risk factors and the midwives will be skilled to be able to provide care to what would be considered an appropriate level. Core midwifery staff will be available within Delivery Suite to provide additional levels of care for the small number of women who have significant risk factors. The implementation of the model will be supported by appropriate guidance and discussion with women regarding place of birth recommendation, which will be supported by national evidence based guidance. Women will be encouraged to develop and document a personalised care plan based on their choices using the best available evidence to guide and support them, and women will be supported in their decisions.

In order to provide focus to this requirement the LMS has supported a project midwife for a period of four months to drive this forward.

A project plan for the Trust is in place, approved by the Director of Midwifery and shared with the senior Midwifery Leadership Team, to detail the actions required and also to monitor progress against the actions.

The service has also applied for additional training and support from Health Education England following a national offer made to all Trusts detailing a new training programme to support the implementation of CofC.

Mr Brown (A.NED) raised the following points and queries:

- The project plan provided as an appendix to the CofC paper, shows both the project start and end dates as 6 January 2020. This was noted by the Director of Midwifery and will be corrected.
- The Director of Midwifery clarified that the plan is not currently available in PERT format (ie to show interdependencies of actions)
- In terms of any link with the Midwifery Led Unit public consultation run by the CCG, the Director of Midwifery clarified that CofC is a national requirement, and she is not in a position to clarify. The DNQ added, however, that whatever the resulting model from the CCG consultation is, it will still involve Continuity of Carer.

In response to queries from Mr Bristlin (NED) on ratios and staffing levels contained within the Monte Carlo table presented in the Director of Midwifery's written report, she confirmed the following:

- The ratios are based on national guidelines
- The first two teams will be pilot teams so there is no requirement to alter staffing ratios elsewhere in the service
- A training needs analysis is being undertaken to ensure staff have the required skills. There will be an opportunity for buddying and support.

The Board NOTED the content of the report, and acknowledged that a monthly progress report will be provided to Board as part of the forthcoming new Maternity Dashboard.

2020.1/08.3 MIDWIFERY STAFFING REPORT – JULY-DECEMBER 2019

The Director of Midwifery presented a report to provide the Board with detail of the minimum evidential requirements to meet the CNST Maternity Incentive Scheme standard relating to demonstration of an effective system of midwifery workforce planning.

By way of background, the Director of Midwifery advised that the National Institute for Health and Care Excellence (NICE) published the report 'Safe Midwifery Staffing for Maternity Settings' in 2015, updated in 2019. This guideline aims to improve maternity care by giving advice on monitoring staffing levels and actions to take if there are not enough midwives to meet the needs of women and babies in the service. The guidance was produced in

response to previous reports such as the Francis Report in 2013. A gap analysis was completed against this, which is currently being reviewed by the Director of Midwifery.

The required CNST Maternity Incentive Scheme safety action standard is as follows:

- A systematic, evidence-based process to calculate midwifery staffing establishment is complete
- The midwifery coordinator in charge of labour ward must have supernumerary status (defined as having no caseload of their own during their shift) to ensure there is an oversight of all birth activity within the service
- All women in active labour receive one-to-one midwifery care
- Submit a bi-annual midwifery staffing oversight report that covers staffing/safety issues to the Board

The minimal evidential requirements for this standard are:

The bi-annual report submitted to the Board should include:

- A clear breakdown of BirthRate+ or equivalent calculations to demonstrate how the required establishment has been calculated
- Details of planned versus actual midwifery staffing levels. To include evidence of mitigation/escalation for managing a shortfall in staffing
- An action plan to address the findings from the full audit or table-top exercise of BirthRate+ or equivalent undertaken, where deficits in staffing levels have been identified
- Maternity services should detail progress against the action plan to demonstrate an increase in staffing levels and any mitigation to cover any shortfalls
- The midwife to birth ratio
- The percentage of specialist midwives employed and mitigation to cover any inconsistencies. BirthRate+ accounts for 8-10% of the establishment, which are not included in clinical numbers. This includes those in management positions and specialist midwives
- Evidence from an acuity tool (may be locally developed), local audit, and/or local dashboard figures demonstrating 100% compliance with supernumerary labour ward coordinator status and the provision of one-to-one care in active labour. Must include plan for mitigation/escalation to cover any shortallfs.

The Year 2 standard also included information regarding red flags which have been omitted from Year 3 but, due to the importance of noting and acting upon these, they have been reported in the paper.

Actions against the above were advised as follows:

- BirthRate+ assessment – A full assessment was completed by the service in April 2017. Agreement was reached in April 2019 to recruit to the recommended level of midwives as detailed in the report and the current number of vacancies against this is less than five, with plans to recruit to these posts. Services which do not have the recommended number of midwives as detailed in a BirthRate+ assessment have an increased risk of a high number of midwifery staffing red flags and times when the Delivery Suite coordinator cannot be supernumerary. The service has requested that the BirthRate+ assessment is repeated this year as it is now due for reassessment. *Action: Complete BirthRate+ assessment*

- Midwife to Birth ratio – The ratio is currently calculated using the number of Whole Time equivalent midwives employed and the total number of births in month. This is the contracted Midwife to Birth ratio. A more accurate Midwife to Birth ratio is given when using the actual worked ratio which is in use across the West Midlands network for the calculation of monthly Midwife to Birth ratio. This takes into account those midwives who are not available for work due to sickness or maternity leave whilst adding in the WTE bank shifts completed in each month. This 'worked' calculation will show greater fluctuations in the ratio but provides a realistic measure of the number of available midwives measured against actual births each month. The reporting of the contracted ratio is a useful measure to assess the recruitment and retention of midwives to the service although will show small fluctuations due to this as well as changes in birth numbers each month. *Action: Provide worked midwife to birth ratio each month alongside contracted ratio*

- Planned versus actual staffing levels – Each month the planned versus actual staffing levels are submitted to the national database using the information provided from the Allocate rostering system. The template for the

areas was incorrect during this reporting period having not been updated to reflect staffing changes. This has resulted in the data not being accurate in terms of percentage fill rates, plus there are some areas which appear to have a very high fill rate as well as other with a very low rate. The templates have now been changed but not yet reviewed by the Director of Midwifery. *Actions: Monitoring and reporting of fill rates each month, Staffing review, Review of staffing template*

- Intrapartum Acuity – The maternity service implemented the use of the Birthrate intrapartum acuity tool in 2017. This was initially using an excel based programme. From September 2018 the service introduced the web based App. The data is inputted into the system every four hours by the Delivery Suite coordinator and measures the acuity and the number of midwives on shift to determine an acuity score. Birthrate defines acuity as 'the volume of need for midwifery care at any one time based upon the number of women in labour and their degree of dependency'.

  A positive acuity score means that the midwifery staffing is adequate for the level of acuity of the women being cared for on Delivery Suite at that time. A negative score means that there may not be an adequate number of midwives to provide safe care to all women on Delivery Suite at the time. In addition, the tool collects data such as red flags which are defined as a 'warning sign that something may be wrong with midwifery staffing' (NICE 2015). SaTH has adopted the red flags detailed in the NICE report plus added some local indicators.

  The Royal College of Midwives, in discussion with Heads of Midwifery, has suggested that a target of 85% staffing meeting acuity should be set but that this can be reviewed and set locally depending upon the type of maternity service. In addition there should be a compliance with data recording of at least 85% in order to have confidence in the results.

  During the reporting period the service did not achieve 85% positive acuity in any month. The majority of negative acuity is amber with up to two midwives short, with a much smaller percentage of occasions being red, which equates to two or more midwives short.

  Current compliance with the data recording is poor for the scheduled times of reporting (3am, 7am, 11am, 3pm, 7pm and 11pm). However, data is also recorded ad hoc with, together with the scheduled recordings, has been used to provide the information below. In addition, the actions taken by the coordinator when there is negative acuity are not always recorded, meaning that they may take action to redeploy staff during times of high acuity but it is not possible to always evidence that happening.

  Actions: Meeting planned with coordinators to review use of acuity tool, Review of staffing to ensure correct numbers of midwives are available to work in Delivery Suite matched to acuity levels, Review of the escalation policy to ensure that it adequately supports the movement of staff around the unit during period of high acuity.

- Red Flags – In total there were 166 red flags recorded during this six month reporting period. The majority of these related to delays in the induction of labour process (66%). All delays will be incident reported via the Datix system and care reviewed to assess impact.
  Action: Review of the induction of labour pathway especially the process for prioritisation at times of high activity

- 1:1 Care in Established Labour – 1:1 care is defined as 'care provided for the woman throughout labour exclusively by a midwife solely dedicated to her care (not necessarily the same midwife for the whole of labour)' (NICE 2015). During this reporting period there were 11 occasions when 1:1 care was recorded as not being provided.
  Action: All cases where 1:1 care in labour has not been provided will be reviewed to assess impact and outcome including the 11 occasions noted in this report. This will be triangulated with the acuity and implementation of the escalation policy,

- Supernumerary status of the coordinator – the status is defined as the coordinator not having a caseload. The acuity tool has time built in for the coordinator to be supernumerary when it is recorded. The data identifies that the coordinator was not supernumerary on 25 occasions during the reporting period.
  Action: Review of the escalation policy to ensure that it supports the supernumerary status of the coordinator and clearly defines the actions to take to mitigate in times of high activity/acuity.

- Specialist midwives – the Board noted also that the service has a wide range of specialist midwifery posts as detailed below (to be reviewed by the Director of Midwifery):
  - Digital
  - Bereavement
  - Infant Feeding
  - Risk / governance
  - Education
  - Safeguarding
  - Antenatal and Newborn Screening
  - Guidelines

Prof Deadman (NED) thanked the Director of Midwifery for her comprehensive report, and asked if the Board could also receive a sense of our performance compared to other Trusts in future updates. **Action: DNQ/Director of Midwifery**

In response to a query from Prof Deadman on the Trust's success in being able to secure high calibre staff, the Director of Midwifery reported on the strong pool of candidates for a recent Professional Midwifery Advocate (PMA) recruitment round, resulting in the appointment of a Qualified PMA and very experienced midwife.

With regard to the Red Flags covered above, the DNQ provided assurance that there are also additional checks in the system. The Director of Midwifery gave examples of a daily huddle which takes place with the Senior Midwifery Team and a 'Look Forward' view is carried out.

Mr Newman (NED) asked for the Director of Midwifery's view on whether the Trust is now operating a safe service, particularly against the positive results from the CQC's Maternity Survey. Whilst noting that there is undoubtedly more that needs to be done, the Director of Midwifery provided assurance that we are operating a safe service at base level.

The Board NOTED the findings of the report, and the action plan that has been developed to address the issues raised. Given the issues identified, the Board APPROVED the recommendation that a quarterly update (rather than bi-annual) be provided. Board further NOTED that the metrics will be included on the forthcoming maternity dashboard, which will also provide additional monthly overview at the Maternity Oversight Group.

2020.1/08.4 **PERINATAL MORTALITY REVIEW TOOL REPORT**

The Director of Midwifery presented a report to provide the Board with assurance that all stillbirths and neonatal deaths are reviewed consistently using the national electronic online tool, The Perinatal Mortality Review Tool (PMRT). This is in line with the recommendations outlined in the NHS Resolution Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme to continue to support the delivery of safer maternity care.

The report confirms that the service is using the tool to the standard required by the Incentive Scheme and also identifies learning to improve.

The PMRT, launched in 2018, aims to support objective, robust and standardised reviews to provide answers for bereaves parents about why their baby died. It also aims to ensure local and national learning to improve care and ultimately prevent future deaths. The PMRT has been designed to support review of the following perinatal deaths:

- Late miscarriages (also referred to as late fetal losses) where the baby is born between 22+0 and 23+6 weeks of pregnancy showing no signs of life
- All stillbirths where the baby is born from 24+0 gestational weeks showing no signs of life

- All neonatal deaths where the baby is born alive from 22+0 weeks and dies up to 28 days after birth
- Post-neonatal deaths where the baby is born alive from 22+0 weeks and does after 28 days of birth following neonatal care; the baby may have died in hospital, or may have died in a hospice or at home following palliative care

The PMRT does not support the review of perinatal deaths where the death meets the criteria above but:

- The death follows a legal termination of pregnancy
- The baby was discharged home, had not received neonatal care but died up to 28 days after birth
- The baby was discharged home well, had not received neonatal care but died up to 28 days after birth

Assessment/Status against the required standard elements was reported as follows:

- A review of 95% of all deaths of babies suitable for review using the PMRT occurring from 20 December 2019 has been started within four months of each death – Overall compliance 100%
- At least 50% of all deaths of babies who were born and died at the Trust (including home births that died) from 20 December 2019 have been reviewed by a multi-disciplinary team, with each review completed to the point that a draft report has been generated within four months of each death – Overall compliance 100%
- In 95% of all deaths of babies who were born and died at the Trust the parents were told that a review of their baby's death will take place, and that their perspective and any concerns about their care and that of their baby have been sought – Overall compliance 100%
- Quarterly reports have been submitted to the Trust Board that include details of all deaths reviewed and consequent action plans. The quarterly reports should be discussed with the Trust Maternity Safety Champion – This will be the first report submitted to Trust Board for Q3 2019/20. The Board level Safety Champion is present at Trust Board meeting.

Actions were reported as follows:

- All cases will be reviewed at the multi-disciplinary Perinatal Mortality meeting:

    - Issue raised – The progress of the mother's labour was not recorded on a partogram in two cases
    - Actions – A review of the bereavement pathway is being undertaken; Delivery Suite Coordinators will lead and support the midwives caring for bereaved parents, ensuring that documentation is filled in appropriately

    - Issue raised – The process for referring women for ultrasound scans from a community satellite clinic is not robust
    - Action – An immediate change to the process has been instigated, women are referred directly to the Consultant Unit for a face to face meeting with the on call Consultant Obstetrician where all paper and electronic records can be viewed

Prof Deadman (NED) sought clarification on how data has been collected and information is owned, to provide assurance to the Board on the 100% compliance status being reported above. The Director of Midwifery confirmed that the data can be externally reviewed/validated.

The Board NOTED the contents of the report, and acknowledged that they will receive quarterly reports going forward.

The Chair paused the meeting at this point to take questions on the maternity service from members of the public. A summary of the points are below:

Q1 Taking into account the current situation, and volume of media reporting during 2019, what action is the Board taking to quell the growing demoralisation of Maternity Services staff, partly evidenced by the dozens of comments on 'I support SaTH' Facebook page in November and December?

A1 The CEO responded that whilst it is important that the Trust has publicly acknowledged failings of the service provided as an organisation, we are very mindful of the need to support our staff during this very

difficult period. NHSI have offered funding for counselling/support, and we are also ensuring we celebrate positive milestones with staff, such as the recent CQC report. The fact that the Trust continues to be able to recruit high calibre staff also gives confidence for the future, as had been evidenced by the Director of Midwifery earlier in the meeting.

Other actions being taken are:

- A series of focus groups to establish what support needs to look like
- A communications strategy is being developed with regard to improving morale and culture
- The DNQ, MD and other Executive Directors have visited Maternity on a daily basis
- The Director of Midwifery recently came into work on a Sunday and invited staff into her office for an informal chat. This was very successful and she will continue to be available 'at a time they would not normally expect' once a month
- A regular communications update has been introduced on the Workforce Committee agenda

The Chair highlighted the positive impact following the arrival of the new Director of Midwifery, and advised that he has also asked for the Freedom to Speak Up Guardians to spend regular periods in Maternity.

Q2 **Has the Board any thoughts on revisiting the Debbie Graham Review and Action Plan, reported to the Special Board meeting on 4 April 2016; in particular the inadequacy of the Action Plan to make recommendations to resolve the failings of the Trust Board, the Executive, Directors and others, clearly cited in Debbie Graham's Review? (Note: of the Board's 38 Action Points, only one loosely relates to corporate failings, despite Debbie Graham reporting over a dozen corporate failings in her Review)**

A2 The Chair responded that the Review and Action Plan dates to before his time as Chair of the Trust, and unfortunately nothing was passed onto him from the previous Chair. He gave a commitment that he was happy to pick this up, particularly if there are outstanding actions, if the report could be made available to him following the meeting.

The CEO added that the Trust will shortly be running the NHS Culture Tool, that allows organisations to 'test the temperature' of the culture within their organisation, as it was felt this would be a helpful baseline for the new CEO.

Q3 **With regard to the Chair's earlier reference to the creation of an independent oversight group to endorse the Trust's response to the Ockenden Report when published, can the Trust consider the inclusion on the panel of bereaved parents, expert midwives and ensure truly independent obstetricians?**

A3 The Chair responded that discussion has already taken place between himself and the CEO, and it has been agreed that families will be given a voice. He also has in mind a senior experienced midwife from UHMB, and he provided assurance that the group composition will be a credible, eclectic and expert mix.

Q4 **In light of data for 2018/19 showing there is a continuing historical pattern of high induction rates and very low caesarean section rates at the Trust, does the MD/Board consider it time to challenge such practices and review whether the reasons are clinically justifiable?**

A4 The Chair and MD responded that the situation is under review. The Director of Midwifery added that other clinical indicators are also being reviewed, eg vaginal births, third and fourth degree tears, and psychological aspects, and discussions are already taking place to gain assurance that women are having the birth of their choice.

Q5 **Can the Trust comment on the recent change in clinical leadership within Maternity, with particular regard to how the vacancy has arisen, and whether this is an internal or external move?**

A5 The Chair clarified that this is an internal move, to the Hospital Transformation Programme (HTP), and is from personal choice. He respectfully reminded the public that it is not appropriate to discuss individuals by name in a public forum.

Q6 There was an issue identified some time ago with a lack of anaesthetic cover in the Trust's Maternity Service. Is this still the case?

A6 The Director of Midwifery confirmed that the Trust is now at an appropriate level of resourcing in this respect.

Q7 Why is the Trust not doing more promotion of the recent improvements in its Maternity service, as evidenced from recent CQC visits?

A7 The Chair responded that it does not feel appropriate to do so at the current time, in light of the ongoing review into the Trust's Maternity Service.

The meeting resumed at this point.

2020.1/09.1 **QUALITY AND SAFETY COMMITTEE SUMMARY – DECEMBER 2019**

The Chair of the Quality and Safety Committee, Dr Lee (NED), presented the following summary of the Committee meeting held on 18 December 2019:

Board Assurance Framework (BAF)

The Committee reviewed the BAF for assurance on the following risks:

BAF 1134 – If we do not work successfully in partnership with the local health system to establish effective patient flow through well-staffed beds, then our current traditional service models will be insufficient to meet escalating demand

Previously the Committee reported on good progress with respect to more integrated acute and community services linked to stroke care. This does not seem to be replicated more widely. At a time of extreme pressure on hospital services, there is little evidence of community schemes developing that are credible, timely and impactful. The relationship with West Midlands Ambulance Service at a strategic and operational management level appears dysfunctional, although front line paramedics continue to offer an outstanding level of commitment to patients. This commitment is often delivered under pressure from ambulance operations to deliver patients to A&E and move off. *Assurance: Low*

BAF 1533 – We need to implement all of the 'integrated improvement plan' which responds to CQC concerns so that we can evidence provision of outstanding care to our patients

There is evidence of good progress against CQC improvements. Plans are being revisited in light of recent CQC visits and requirements. *Assurance: Moderate*

BAF 1204 – Our maternity services need to evidence learning and improvements to enable the public to be confident that the service is safe

The Women and Children's Care Group presented at this meeting. This gave the Committee opportunities to review the 2017 EMBRRACE data published earlier in the year. Whilst it is not possible to project EMBRRACE's adjusted statistics to the Trust's maternity data for 2018 and 2019, the crude non-adjusted figures are encouraging, with reductions in neonatal deaths and stillbirths. Recent CQC visits have observed significant improvements in services and service governance, and the Care Group has an impressive menu of successful improvements secured over the last 18 months.

A review of CNST declaration processes is being undertaken assisted by the Trust's Internal Audit function. *Assurance: Low*

Paediatric Ward Visit

Committee members and the Chair of the Workforce Committee visited the Paediatric Unit at PRH. Our visit followed a very busy few days for the unit. The unit is impressively run, and staff spoke proudly about the service. Key concerns are:

- Whilst retention rates for nursing staff are excellent, recruitment is a challenge and it is particularly difficult to cover maternity leave. Senior nurse leaders are seeking to introduce more varied roles with role rotation to try and attract additional staff.
- The nurse staffing applied to the ward rotas is reduced by a requirement to provide nurse hours to support specialist roles. This is an historic anomaly and needs to be addressed to ensure that there are sufficient nursing staff to deploy to the rota.
- The on-site senior medical cover is provided by a registrar, who covers the ward, admissions and neonatal requirements. Where senior presence is required simultaneously, a consultant is called in from home. This arrangement does not appear to provide ideal levels of on-site cover.
- Senior nurses feel that nursing could do more with additional clinical development support, which might include better support to other areas of the hospital and more confidence in supporting children and adolescents with mental health issues.
- There are significant challenges created by the Children and Adolescent Mental Health Service support to the unit. This means that children and young people are often on the ward for longer than is medically necessary, awaiting a CAMHS assessment.

The MD and DNQ are working closely with the Paediatric Team and wider Care Group to take forward the strategic direction of the service and to strengthen it further. This will include actions to address recent CQC findings as well as issues relating to child and adolescent mental health. *Assurance: Moderate*

Clinical Governance Executive (CGE)

The Committee received a comprehensive report of the proceedings of the recent CGE meeting. There is evidence that the committee is beginning to meet the aspirations of the Trust Board with respect to its governance and assurance role. The CGE raised concerns about the current commissioned arrangements to deliver ophthalmic surgery outside the Trust from an independent sector provider, including access, lack of specificity of pathways, the appropriateness of interventions and administration processes. These concerns are being addressed directly with the CCG by the Specialty and the Care Group, and were raised at CGE in order to ensure appropriate escalation and further action if the initial approaches are unsuccessful
Assurance with respect of CGE: Moderate
Assurance with respect to ophthalmology services: Low

Accident and Emergency

The Committee noted ongoing concerns about:

- The consultant workforce
- The extreme pressure on the service with resultant challenges to achieve acceptable performance
- Addressing CQC concerns with respect to sepsis and the deteriorating patient

Assurance: Low

Sepsis and the Deteriorating Patient

The repeated issues raised by CQC with respect to approaches in terms of recognising patients who are deteriorating, for example with sepsis, warrants the elevation of this risk. Risk wording has been suggested by the Committee. The MD has been charged with ensuring that the necessary controls are articulated, documented and appropriately reported.

2020.1/09.2 **QUALITY AND SAFETY COMMITTEE SUMMARY – JANUARY 2020**

The Acting Chair of the Quality and Safety Committee, Mr Newman (NED), presented the following summary of the Committee meeting held on 21 January 2020:

Renal Serious Incident

The internal investigation into the very tragic death of a patient whilst receiving renal dialysis at RSH in October 2019 has been completed by the DCE.

The Committee was informed of the additional safety measures that had immediately been implemented. In addition, external reviews of nursing documentation and standards of practice have been commissioned by the DNQ and DCE, the outcomes of which are awaited.

This Serious Incident has been reported to the appropriate authorities and the family members have been kept fully informed about the progress of the investigation, as have staff and clinicians. There is to be a Coroner's Pre-Inquest Review at the end of January, with a Coroner's Inquest at a later date.
Level of Assurance: Moderate. Direction of Travel: Same

System Demand

The Clinical Governance Executive (CGE) reported concerns of harm to some patients, in part because of prolonged waiting times in the ED departments. The meeting Chair requested details of the quantum of the problem of waiting in ED. The following data has subsequently been provided for the increases in the period April to December 2019/2- compared to 2018/19: A&E attendances +10%, Ambulance arrivals +16%, Emergency Admissions +9%. Month by month this equates to between 1000 and 2000 additional patients.
Level of Assurance: Low. Direction of Travel: Worsening

Maxillo-Facial Surgery

This is an NHSE commissioned service. The budget number of consultants is six. From February 2020 SaTH will have only four, of which head and neck, and skin cancer, surgeons reduces from two to one, putting this service at significant risk. From August 2020, the number of consultants will reduce further to three, 50% only of the budgeted strength. This is yet another specialty with a national shortage of consultants and thus far recruitment of either agency or permanent consultants has proved unsuccessful. With only three consultants there will be great difficulty in providing emergency on-call, and all performance KPIs (all waiting times, including cancer, 18 week referrals etc) will fail to be achieved.

A joint action plan has been created with commissioners, but without recruitment it will yield little or no improvement. Collaborative working for head and neck cancer is being discussed with other providers to allow the services to remain at SaTH. Moreover, the Trust is also expending this urgently with NHSI/E to ensure that no patients are placed at risk.
Level of Assurance: Low. Direction of Travel: Worsening

Ophthalmology

The Committee received a report from the CGE of a patient who had suffered irreversible harm. The CGE produced a detailed schedule of the serious shortcomings of a separately commissioned provider, and in particular the unsatisfactory interface between them and SaTH. Further support of, and urgent action by, the CCG is being sought to resolve this problem, which is putting patients' safety at risk.
Level of Assurance: Low. Direction of Travel: Worsening

The DCE, as Chair of the CGE, added that it may be necessary for the Trust Board to raise this issue with the CCG Board if a rapid resolution is not achieved.

Infection Prevention and Control

The Committee noted that to December 2019 (9 months) there had been 44 cases of C Difficile against an annual target of no more than 43. The likely year's total could therefore significantly exceed the target. Investigation of recent cases, as to whether there were linkages, has so far proved to be inconclusive. An action plan is in place, with a follow up meeting planned for those concerned. The Committee will keep this matter on its agenda. In addition to C Difficile, MSSA, E-coli and MRSA statistics, from April 2020 the Trust is mandated to report on cases of Klebsiella BC and Pseudomonas Aeruginosa. Reporting has already commenced on both to the Committee.
Level of Assurance: Moderate. Direction of Travel: Same

Scheduled Care

The Committee received the triennial visit from the Scheduled Care Group. Work will commence shortly to improve the Endoscopy service at both sites. RTT is challenged by giving up beds, eg in day surgery for Winter and indeed current all-year round pressures. Constraint on capital is becoming critical in some areas, for example theatre lighting from the 1970's. Lack of consultant capacity (anaesthetists, intensivists, general surgeons and MaxFac – see above) remains challenging.

Board Assurance Framework (BAF)

The Committee reviewed the BAF for assurance on the following risks:

BAF 1134 – If we do not work successfully in partnership, THEN our current traditional service models for both unscheduled and scheduled care will be insufficient to meet escalating demand.
Level of assurance provided: Moderate

BAF 1533 – If we do not implement all of the 'integrated improvement plan' which responds to CQC cncerns THEN we cannot evidence provision of improving care to our patients.
Level of assurance provided: Moderate

BAF 1204 – If our maternity services do not evidence learning and improvement THEN the public will not be confident that the service is safe.
Level of assurance provided: Moderate

In considering the above risks, the Committee can confirm that the BAF risks are up to date, the direction of travel stated is current and correct, the current risk rating is correct, and there is no additional/updated content or new risk(s) that need to be added.

The Board RECEIVED and NOTED the December and January reports.

2020.1/10 **CARE QUALITY COMMISSION (CQC) SECTION 31 UPDATE REPORT**

Following the CQC inspection of the Trust in November 2019, the CQC varied the conditions already imposed, on 13 September 2018, 2 October 2019 and 18 April 2019, and imposed new conditions in respect of the Trust's regulated activities, specifically in relation to the care in the Trust.

The DNQ presented a report to provide an update in relation to the CQC Section 31 varied and new conditions imposed in relation to the two Emergency Departments, the Inpatient Wards and to all clinical areas. The report also provided an update in relation to the existing Section 31 conditions in place following the CQC inspection in September 2018 and April 2019 for the Emergency Departments and the Maternity Unit.

The Maternity Unit has consistently demonstrated improvements in relation to the weekly reporting against these conditions. For the Emergency Departments, Inpatient Wards and conditions applied to all clinical areas, the data analysis in the report outlines that although systems, processes, monitoring and actions are in place in relation to the improvement required, there is significant work to be done to ensure these actions are embedded and consistently applied.

2020.1/10.1 **Update on current actions**

The current status of actions in the Inpatient Action Plan stands at:

- 0 not yet started
- 1 in progress
- 5 delivered
- 10 delivered and ongoing monitoring
- 0 overdue

The current status of actions in the ED Action Plan stands at:

- 2 not yet started
- 7 in progress
- 23 delivered

- 47 delivered and ongoing monitoring
- 0 overdue

Many of the actions completed/delivered relate to the implementation of processes. The status of a majority of the actions is that they have been implemented but that there is ongoing monitoring as the performance against these actions is not always achieving the required levels, or is fully embedded, and therefore assurance in relation to these is more limited.

2020.1/10.2 **Extended Conditions**

In addition to the Section 31 conditions already in place, the extended conditions included:

Emergency Department

10.2.1 The registered provider must ensure that there is an effective system in place to identify, escalate and manage all service users in line with the relevant national clinical guidelines who present with possible sepsis or a deteriorating medical condition
10.2.2 Effective management of service users under the age of 18 through the emergency care pathway
10.2.3 The registered provider must ensure that there is an effective system in place to ensure mental health risk assessments are completed in line with relevant national guidance

The Trust is required to report separately for the RSH and PRH Emergency Departments.

Throughout all clinical areas in the Trust

10.2.4 The registered provider must ensure that there is an effective system in place to ensure de-escalation management and intervention holds are completed in line with relevant national guidance. This includes, but not limited to, the use of rapid tranquilisation.

Inpatient Medical Wards

10.2.5 The registered provider to ensure the system is in place for effective management of deteriorating patients and sepsis at RSH and PRH.

2020.1/10.3 **Reporting Requirements and Actions – Emergency Department**

10.2.1 - The Trust is required to report weekly on:

- Confirmation of actions taken to ensure that the system is implemented and is effective
- Details of action taken to ensure the system is being audited, monitored and continues to be followed
- Results of monitoring data and audits undertaken that provide assurance that action is taken to improve the quality and safety of services

In addition to the sepsis audit results undertaken by the ED staff for the last six months, performance for the last five weeks for both PRH and RSH EDs is compared with the additional peer audits which are now in place and are undertaken on a sample of 10 patients weekly for each site, to provide fresh eyes and assurance

The Sepsis Specialist Nurse continues to work closely with the two EDs to improve awareness and understanding. A weekly Deteriorating Patient Group is in place to progress actions to improve performance and compliance against the critical quality measure in relation to safety. Actions include:

- Review of policies, training, sepsis processes and compliance
- ED compliance heat map to be shared and used as a visual tool at huddles to identify aspects of good compliance and areas for improvement
- Peer assessor undertaking the weekly audit of 10 patient CAS cards address issues directly with the shift co-ordinator at the time of the audits

Audit results relating to the proportion of patients receiving a full set of observations on arrival at the ED show there is variable compliance with undertaking a Patient Full Set of Observations on arrival to the EDs. They also show variability by site, with the results for PRH showing lower compliance than RSH. Performance against this quality measure is impacted in part by there not being a pain score documented as part of this assessment and

in line with national guidance. The peer audits, on a smaller sample, show poorer results than those collected in the audit undertaken by the Emergency staff in the Department.

10.2.2 – The Trust is required to report weekly on:

- The number of service users under the age of 18 not triaged within 15 minutes of arrival to the ED or seen by the Paediatric medical team within the hour, and details of any harm arising as a result of the delay
- Results of monitoring data and audits undertaken that provide assurance that a process is in place for the management of children requiring emergency care and treatment
- Details of all children who left the Department without being seen
- Details of any follow-up and details of any harm arising through the result of the child leaving the Department without being seen

The Trust is required to report weekly individually for the RSH and PRH sites.

A majority of the Paediatric patients have not had a time recorded for when they were triaged, meaning it is difficult to report if they were triaged within 15 minutes. For those patients where a triage time was recorded, the audit results show that at present only a small percentage of Paediatric patients are triaged within 15 minutes, only 15% at PRH and 19% at RSH. Actions to including compliance:

- Registered nurses reminded to document the triage time
- The teams are considering options to have a dedicated Paediatric Triage Nurse
- In addition, at the PRH site (where there are more Paediatric patients) the team are considering having a ring-fenced area for all Paediatric patients to be treated by a separate team. These discussions are in the early stages but need to move forward at pace to improve access to assessment for these patients.

The audits show that the number of children who left the Department without being seen has reduced since 22 December 2019. The records of all children who leave the Department before being seen are reviewed and followed up by an ED Consultant, and no harm has been reported following these reviews.

10.2.3 – This is a new condition which applies to both the PRH and RSH EDs.

In response to the conditions applied, the EDs commenced twice daily audits of three sets of patients presenting with mental health issues, to provide assurance that patients are being triaged and escalated appropriately. Due to the number of mental health attendances to the EDs, often the number of patients audited is much lower than this. Overall, more patients are audited for the PRH site, reflective of more attendances for mental health issues.

The proportion of patients with mental health issues who have had a mental health triage tool completed remains variable. For the week commencing 13 January 2020 79% of patients had an assessment completed compared to 100% at RSH. In comparison, escalation following completion of the tool was 100% at PRH and only 67% at RSH. The results continue to show that the use of the mental health tool is still not fully embedded. Actions being taken to improve compliance include:

- Mental Health Act training initiated in September 2019 extended to medical and AHP colleagues. Further sessions in February 2020
- Staff continue to be reminded at daily huddles about completion of the mental health tool
- Ongoing education to all ED staff in relation to completion of the tool
- The Mental Health Liaison Team have been providing support to the EDs in promoting awareness of compliance with national guidance

<u>Existing Section 31 Conditions for the Emergency Department</u>

An update on the conditions previously imposed in September 2018 and April 2019 which remain in place are outlined below:

- *The registered provider must ensure there is a system in place to ensure effective environmental risk assessment and management across the Emergency Department.*

This condition includes:

- The results of any monitoring data and audits undertaken that provide assurance that the system of risk assessment and risk management in place is effective

Environmental checks continue in the EDs and in addition to this the Matron/Lead Nurses are undertaking three additional audits per site. These audits include some environmental checks, for example the security in the department. Every effort is being made to ensure doors remain closed and discussions have commenced with security and facilities to agree a plan for a secure unit.

- *The registered provider must ensure all adults who present to the Emergency Department are assessed within 15 minutes of arrival in accordance with the relevant national clinical guidelines.*

The time to initial assessment is reported weekly to the CQC. The data shows variability in the triage time, with the most recent week (20 January 2020) showing that patients were assessed at both EDs within 15 minutes.

- *The registered provider must ensure that the systems in place across the Emergency Departments account for patient acuity, and the location of patients at all times.*

Patient acuity is assessed on admission and displayed on the whiteboard alongside the patient's 'NEWS' score, alerts, time in the Department, breach time and treatment updates. Patients are prioritised and oversight is obtained through a 2-hourly huddle between the co-ordinator and a senior doctor. The ED spot check audits provide assurance that the patient's observations and frequency of these are being monitored and actioned.

- *The registered provider must ensure that the staff required to implement the system as set out in the previous condition are suitably qualified and competent to carry out their roles in that system, and in particular to undertake triage, to understand the system being used, to identify and to escalate clinical risks appropriately.*

There are now substantive Clinical Nurse Educators in post, all training is co-ordinated and records are updated regularly. All new staff are given a four week supernumerary time to ensure their training is embedded and they are aware of department standing operating procedures and protocols. The Departments continue to implement the training plans, against trajectory, for the Manchester Triage Training.

2020.1/10.4 **<u>Reporting Requirements and Actions – Throughout all Clinical Areas in the Trust</u>**

10.2.4 - This is a new condition added to the Section 31, applying to all Wards and Departments, and includes

- Details of de-escalation management and intervention holds including type and length of hold and post hold action
- Results of monitoring data and audits undertaken that provide assurance that a process is in place for the management of physical intervention

The immediate action taken in response to regulation included:

- One minute brief sent to all staff, which summarised the key points of the Policy for Clinical/Safe Holding of Adults and Children Receiving Care in the Trust (2021)
- Development of SOP and checklist for the restraint of patients in line with current policy
- A system was put in place to correlate the security database / reports with the number of Datix reports
- Establishment of monthly safe holding review meeting
- Weekly audit of all patients who have been restrained whilst cared for at the Trust

In total 38 patients have been restrained across the Trust since the restraint audits commenced on 16 January 2019; the number of patients restrained in the prone position has been small (5%). Most of these patients were restrained in the EDs or on the Acute Medical Units.

In line with the bespoke training received by security staff, the prone position for restraint is only used as a means of gaining control and staff are required to release the patient as soon as possible so he/she can begin to rise from the floor of their own accord. If further control of the patient is needed, restraint can then be re-instated using an alternative position eg seated or standing. In this sense, and based on the training security staff have received, prone is only really used as part of a combination of holds to control a patient. The use of the prone position in isolation is discouraged.

In line with the training given, when using the prone position both staff carrying out the restraint are required to lie next to or get down either side of the patient, so they can observe the patient's breathing. The patient's own arms and hands are positioned beneath the front of the patient's own shoulders so as to provide a space for the chest to expand and breath.

A majority of the patients who were restrained were patients with alcohol related issues who were agitated, aggressive and requiring treatment. Initially for some of the patients restrained, the rationale was not documented but this has improved over the last two weeks with a rationale documented.

Restraint training for security teams is provided by accredited NHS training staff from the Midlands Partnership NHS FT. The training consists of a 5-day foundation course and annual refresher days thereafter. The regular security team have attended their one day annual refresher training in January 2020.

A total of 19 (50%) of patients received chemical restraint. For patients who have been restrained and those who may also have received chemical tranquilisation, results indicate that the process is not embedded across the Trust and further work is required to consolidate staff knowledge of the process and restraints pathway, as this alerts staff to the action they are required to complete.

2020.1/10.5 **Reporting Requirements and Actions – Inpatient Wards**

10.2.5 - This condition was previously applied to the EDs but has been varied to include all Inpatient areas and outlines:

- Confirmation of actions taken to ensure that the system is implemented and is effective
- Details of action taken to ensure the system is being audited, monitored and continues to be followed
- Results of monitoring data and audits undertaken that provide assurance that action is taken to improve the quality and safety of services

Immediate actions were taken in response to these conditions. These include:

- All patients' 'NEWS' scores to be handed over as part of the shift handover on all other adult Medical and Surgical Wards
- Daily check of 'NEWS' observations via Vitalpac at individual ward level by nursing staff, Ward Manager and Matrons
- Patients with 'NEWS' higher than 5 are handed over to Hospital at Night Team and the oncoming Critical Care Outreach Team on the day shift
- Matron weekly spot check of patients with 'NEWS' > 5
- Commenced Corporate Nursing monthly peer audit review
- Commenced weekly deteriorating patient nursing group (task and finish group) whose remit is to ensure action progress on the deteriorating patient action plan. This group will report to the monthly Trust-wide deteriorating patient meeting

The daily spot checks of the observations on Vitalpac by the Ward Manager identify any patient that has triggered a 'NEWS' > 5 and prompts a review to ensure that the deterioration has been escalated and actioned. The Ward Managers have also been challenged to ensure that patients' observations are recorded on time and a daily performance report is circulated to all Wards, Matrons and Heads of Nursing.

A peer audit undertaken of patients has also commenced. The data is entered manually onto the audit proforma and analysed by the Clinical Audit Department. These peer audit results will be presented in future CQC update reports.

2020.1/10.6 **Maternity Update Section 31**

The Section 31 conditions for Maternity Services have been in place since September 2018. None of these were varied and no new conditions were added to Maternity Services following the inspection in November 2019.

The registered provider must ensure that there is an effective system in place to ensure effective and continued clinical management for low and high-risk patients who present to the midwifery services in line with national clinical guidelines. This includes Cardiotocography (CTG), Modified Early Obstetric Warning System (MEOWS), reduced fetal movement and triage guidelines. The provider must ensure that Trust guidelines include a clear escalation plan to secure timely review from medical staff.

The previous conditions which remain in place and are reported on weekly include

- The actions taken to ensure that the system is implemented and effective
- The actions taken to ensure the system is being audited and monitored and continues to be followed
- The report should include results of any monitoring data and audits undertaken that provide assurance that an effective clinical management system is in place, and patients are escalated appropriately for medical support and review in line with national clinical guidelines

The elements in the Section 31 are included in the clinical incidents case reviews which take place in the Weekly Obstetric Neonatal Risk Meeting. Approximately 10 cases are reviewed from notification of pregnancy to the time of the incident. This includes evidence of accurate completion of MEOWS charts and appropriate interpretation and escalation of CTGs. Good practice and learning is identified and disseminated via the 3 minute brief and case study to staff huddles. Clinical incident reviews are submitted to the CQC on a weekly basis via minutes of meetings, a case study and evidence of dissemination of learning.

There were a number of self-discharges from Triage whilst awaiting doctor review. The process for following up self-discharges is being reviewed by the Director of Midwifery.

Results of December 2019 analysis outline that:

- All triage attendances were appropriately managed according to guidelines
- Earliest possible follow on appointments were arranged in all instances as required
- MEOWS were completed in all triage assessments, however there are some instances of incorrect transcription
- 100% of women who were reviewed were either discharged or admitted with a clear plan of care

The twice daily Handover of Care on Delivery Suite continues to be monitored. Compliance has consistently been achieved at 100% with the exception of Week 68 (9 December 2019). This was the first time in seven months that complete documentation had not been submitted. The missing information was escalated to the Clinical Director, Care Group Medical Director and Delivery Suite Ward Manages to reaffirm the importance of maintaining the standards achieved. The Delivery Suite Handovers are quality checked by using a 'fresh eyes' approach.

2020.1/10.7 **<u>Conclusion</u>**

The report outlines that although systems, processes, monitoring and actions are in place in relation to the improvements required to comply with the new and varied conditions imposed for the ED and Inpatient areas, there is significant work to be done to ensure these actions are embedded and consistently applied. This is also relevant to some of the existing conditions previously imposed in the Emergency Department. The data shows variation in the performance against these improvements and that the improvement work needs to be embedded at some pace given the significant concerns relating to the quality and safety of care.

In response to a query from Mr Newman (NED) on the triage and care provided to teenage patients, the DNQ reported that the Trust is working with local providers to consider how response times can be improved.

Dr Lee (NED) raised concerns around the responsiveness of partner organisations with regard to ED, which are exacerbating many of the reported issues.

The Board RECEIVED the report, and NOTED the significant improvement work still to be done in ensuring actions are embedded and consistently applied.

2020.1/11 **TRANSFORMING CARE/IMPROVEMENT PLAN UPDATE**

The DTS presented an update on the work being undertaken to refresh the Trust's approach to Quality Improvement and the activity that has been supported by the Trust's Transforming Care Production System (TCPS) since November 2019.

The Transforming Care Partnership Board agreed in December 2019 that a number of value streams would transition into business as usual and that the Patient Safety, ED/Flow, Deteriorating Patient/Sepsis, Surgical and Standard Work value streams will be re-scoped and new Kaizen plans established to support delivery of the improvements required. Initially, priority will be given to those improvements linked to the conditions set within the CQC Section 29 and Section 31 notices.

The ThinkOn methodology adopted by the Trust 18 months ago has also been aligned to the improvement work, to ensure there is engagement in the improvement process. Each value stream will have a ThinkOn master coach aligned to them and the lead master coaches have developed a ThinkOn action plan with a specific focus on supporting ED, Paediatric Pathway and Mental Health improvements.

A new Transformation and Strategy structure that aligns the work being undertaken by the PMO and KPO teams, and will provide additional capacity to deliver quality and cost improvement programmes, has been approved. The Transformation and Strategy team currently has a number of vacancies and acting up arrangements, so work is underway to ensure that a substantive structure is in place by the first quarter of 2020/21.

The Board NOTED the progress made to date in the development of Phase 2 of the Quality Improvement Plan, the planned activity that will take place to support improvements required as a result of the CQC findings, and progress with establishment of a new Transformation and Strategy structure.

2020.1/12 **6 MONTH REVIEW OF MONTHLY STAFFING REPORT AND CARE HOURS PER PATIENT DAY**

The DNQ presented a paper to provide an overview for assurance to the Board in relation to nurse staffing on In-Patient wards. The paper headlined the reviews performed monthly on Care Hours per Patient Day (CHPPD) information, quality metrics and exception reports from the Care Groups over the last six months.

The key issues were summarised as follows:

- Fill rates or Registered Nurses (RNs) have improved overall since June 2019
- August saw lower fill rates, which is believed to be due to the main school summer holidays
- Telford site fill rates are lower than Shrewsbury
- Healthcare Assistants (HCAs) are regularly filled above agreed establishments in a number of ward areas
- Areas that have improved their fill rates have not always reflected an improvement in quality indicators
- HCA fill rates have not dropped as RN rates have increased
- Those wards with the fewest substantive staff have worse quality and safety metrics, likely due to the numbers of temporary staff and their transient workforce

The Deputy Director of Nursing is conducting establishment reviews for all In-Patient adult ward areas during the month of January 2020 to assess current budgeted establishments whilst triangulating with quality and safety data and acuity data. This will provide an understanding of the workforce requirements for individual ward areas and help determine if the over filling of shifts is a necessity. Oversight is being provided by the NHSI National Lead for Safer Staffing.

There is then a plan to conduct an establishment review for emergency portal areas such as ED and SAU, the Paediatric ward area and the Clinical Nurse Specialists.

In response to a query from the Chair, the DNQ confirmed that exit interviews are conducted with HCAs, and feedback is primarily around a lack of flexible working, and staffing issues resulting in the HCAs being left to do a lot of the work.

Mr Newman (NED) asked if the Trust has an indication of the number of positions it might be necessary to fill over the next 12 months, in view of data previously presented to Board relating to the current nursing cohort age demographic. The DNQ responded that the situation at the Trust links with the national picture, and the AD for Workforce reported there will be over 150 nurses eligible to take retirement at the Trust over the next two years. The DNQ added that the Trust participates in the national return to practice programme, which should hopefully

help to mitigate this situation to a degree. She also highlighted the Trust's positive relationship with the higher education institutions as an ongoing recruitment avenue.

Prof Deadman (NED) highlighted the subject of nurse shift pattern flexibility and his understanding that the Trust has had a policy on this which allowed local nurse/ward leaders to change this to suit local workforce requests and needs for some time. However he had observed on some wards these options were not being taken advantage of. He questioned whether this was an example of a cultural issue within the Trust, ie people having authority to take decisions but not feeling comfortable in doing so. The DNQ responded that she feels the level of leadership across the organisation is variable, which has been recognised by the Trust and development actions are being taken to address this.

The Board NOTED the issues covered in the report and the actions that are being taken.

2020.1/13 **QUALITY GOVERNANCE REPORT**

The DNQ presented this report to provide the Board with assurance relating to compliance with the Trust's quality performance measures during December 2019, and to outline areas where further assurance may be required. Key points to note by exception were as follows:

Infection Prevention and Control

- There were six cases of C Difficile attributed to the Trust in December 2019. The Trust has now reported 44 cases year to date, breaching the target of 43 for 2019/20
- Although the performance has remained above the 95% target for six months since June 2019, non-elective MRSA screening is showing special cause for concern due to a run of 8 data points below the mean. This measure is being monitored closely

Serious Incidents (SIs)

There were eight SIs reported in December 2019. Overall reporting numbers are higher at this point in 2019/20 when compared to the same reporting period for 2018/19.

Patient Falls

Although patient falls demonstrate common cause variation (and for falls per 1000 bed days/falls resulting in moderate harm measures remain below benchmark levels) Ward 9 has seen an unusual increase in reported falls during December 2019 which will require monitoring.

The DNQ advised that in addition to working with the DCE and his team on this issue, the National Lead for Falls is conducting a review at the Trust in March, and findings will be brought back to the Board.

ITU Delayed Discharges

From January 2020 reporting of delayed discharges from ITU will now focus on > 4 hours delayed discharges (previously by local agreement with commissioners reporting focused on > 12 hour delays). The > 4 hours measure shows special cause for concern with a number of data points above the mean since December 2018 and in October 2019 above the upper control limit. This measure highlights challenges related to wider issues of demand, capacity and patient flow, and requires close monitoring.

Mr Brown (A.NED) raised the following two points:

- C Difficile - it would be useful if the figures in the full report could revert to the way they were previously displayed and show a comparison with the previous year. **Action: DNQ to raise with IPC Committee.**
- Pressure ulcers – request that future reports show a comparison with previous year's data. **Action: DNQ**

Discussion took place on the recent increase in SIs, the key points of which were as follows:

- The DCE felt that the reported increase was likely to be due to the way that SIs are now been explored and investigated. Specifically, a recent review of the SI reporting pathway had concluded that if there was any doubt as to whether a case fulfils the criteria for SI reporting, it should be reported and investigated as an SI, then subsequently downgraded if investigations prove otherwise.

- Mr Bristlin (NED), from an assurance perspective, requested that information on the timeliness of reviews is covered in future reports. He also asked if the charts in the full report could be in Statistical Process Control (SPC) format going forward. **Action: DCE to explore**
- Dr Lee (NED) queried how Duty of Candour has been discharged, how staff are being supported when something goes wrong and what are the immediate actions that have been instigated. The DCE advised of the recent completion of an audit of compliance against the statutory Duty of Candour, which is covered in his report below. With regard to the other points raised by Dr Lee, the DCE will report back to the Quality and Safety Committee. **Action: DCE**
- The Chair felt that greater engagement should be evidenced with the family as part of an SI. **Action: DCE to action an amendment to the documentation in this respect.**

The Chair queried the 'red' status of one of the entries in the mortality metrics section of the full report (% mortality in hospital within 30 days of emergency admission with a heart attack aged 35-74), and asked if the Quality and Safety Committee have explored the background to this. The DCE clarified that the status represents a shift from the Trust being 'very good' to 'slightly good', ie the way in which the data is displayed is slightly misleading. The Chair asked for quantification on this by the Quality and Safety Committee, however, as it is not clear in the report. **Action: DCE**

The Board RECEIVED and NOTED the report.

2020.1/14 **REPORT FROM THE DIRECTOR FOR CLINICAL EFFECTIVENESS**

The DCE presented the following report to provide the Board with an overview of progress from the Directorate of Clinical Effectiveness:

Research and Innovation

The Research and Innovation team is working hard to address a difficult combination of reduced regional funding, falling research activity and staffing challenges. Currently, performance is at 63% of the yearly target for the main Key Performance Indicator (number of patients recruited into trials), and at 100% for second KIP, which is Recruitment to Time and Target. The team is consolidating its existing portfolio of research, for which it has a good reputation for delivery, whilst exploring new options for research activity.

Some recent positive results include:

- The Trust's results from the national 100,000 genome project have been received. These are in the process of being shared with the oncology patients who took part in this major trial
- The Trust's Radiotherapy and Physics Team won Clinical Research Network West Midlands 'Team of the Year' for their significant contribution to clinical research

Patient Safety (including Learning from Mortality)

Serious Incident Pathway / learning from incidents: The team has continued to support the embedding of the Executive Serious Incident Review Group (ESIRG) as a key step in the SI pathway. This has provided the means for all cases that may meet the national criteria to be reviewed, on a regular basis, by the relevant members of the Executive team. Key learning points from SIs, in terms of quality and investigation, and clinical and operational learning, are identified to reduce risk and improve quality and safety of care. This is now summarised monthly as a key output from ESIRG and reported to CGE.

A quarterly summary of systems learning (pathway, department and Care Group) is also being taken to CGE. The report identified if action is already being taken to address the issue identified, or if additional action needs to be taken. In addition, a bi-monthly cross Care Group safety learning forum has been agreed. The Terms of Reference, and the process for this forum are being drafted, with a view to the first meeting being held in March 2020.

Audit of compliance against the statutory Duty of Candour: The Patient Safety Team has co-ordinated and supported the completion of an audit of two years' worth of SIs and high-risk case reviews (HRCRs) to determine the extent of completeness of the Trust's compliance against the Duty of Candour regulations. The audit of SIs was completed in December 2019 and presented to the CGE. The audit of HRCRs has now been completed and

is in the process of being reviewed. The safety team will be working with colleagues in the Care Groups to consider the results of the audit outcomes and to ensure that recommendations and actions can be taken to the CGE in February 2020.

Learning from Mortality: The Board is aware of the Trust's existing mortality review system, that is well-developed, functions well in most specialties, and provides regular reports to the Board. The governance pathway for this follows the route from the Mortality Committee, to the Clinical Governance Executive, to the Quality and Safety Committee, the Trust's commissioners and regulators. In addition, the Trust is working with partners on a system-wide review, commissioned by the CCGs, being performed by Niche Consulting.

Support for completion of SI investigations: Following a review of the threshold for investigation, there has been an increase in the number of cases being reviewed by the Patient Safety Team. This, combined with staff shortages within the team, has resulted in significant on-going challenges regarding assigning appropriate investigating officers to support timely completion of SI investigations.

In addition, a number of complex cases have required particularly detailed investigation, with external expert engagement, further challenging the current resources of the team. A business case is being developed, to ensure that the team is appropriately resourced and the Trust is able to focus on learning more fully from clinical incidents.

Complaints and PALS

The Complaints team is continuing its efforts to improve the timeliness and quality of responses to concerns and complaints. This is being conducted using Transforming Care Institute methodology, and has already identified that a significant rate-limiting step is the time taken to get a response from the relevant clinician(s). The current increase in emergency workload is also having an effect, with a significant drop in timely responses being received for complaints received in November, only 25% of which were received on time. Further work is under way to explore supportive ways of working with clinical colleagues.

The Medical Examiner Service continues to function well at RSH, with the focus now on ensuring timely implementation at PRH, through recruitment of sufficient numbers of Medical Examiners in order to achieve this. A lesson learned from implementation at RSH is the importance of having designated office space for this confidential service and potential areas are being explored. The trust has been successful in appointing Medical Examiner Officers, who support the work of the Medical Examiners. All are required to complete face to face accreditation with the Royal College of Pathologists.

Much work has been done by the team to ensure that the many forms of guidance and standards provided by NICE, the Royal Colleges and other standard-setting bodies, are reviewed and implemented as appropriate.

The historical backlog of outstanding NICE guidance that had not been benchmarked, has been further reduced, from 111 guidelines to 21. This was achieved by changes to the process that has been applied, enabled by time saved from not carrying out national patient surveys in-house. Members of the clinical audit team now meet with the relevant specialty lead for NICE guidelines to facilitate completion of the benchmark template, rather than doing this by email. In addition, this improved process has been presented at specialty Clinical Governance meetings, so that colleagues are more informed of the importance of reviewing NICE guidance.

In addition, out of date clinical guidelines and policies, that had been live on the Trust's intranet site, have been reduced from 468 to 45. This has been achieved by providing greater clarity on the requirements, and implementing a more directive review process, and the Board asked for their thanks to be relayed to the team on the achievement of this huge task. **Action: DCE**

Chaplaincy

Like most departments across the Trust, but for rather different reasons, the Chaplaincy service has been more busy than usual towards the end of the calendar year and the start of the new one. Carol services were held at both hospitals, and there were 'singing visits' from the Salvation Army at RSH and the group Tempronilla at PRH.

Whilst the end of one year and the start of another is a festive time for many people, for patients in hospitals, and their families, it can be a particularly challenging time. For bereaves families, they may feel, even more powerfully, the loss of their loved one. This is particularly so for families who have suffered the loss of a child or baby during this time. The Chaplaincy service provides support for all who wish to receive this, from pastoral care, to support

for patients and families, to providing a special service for families who have lost a baby, to spiritual support for members of staff.

The Chaplaincy service has also been busy, in anticipation of improvements, with plans for refurbishment of the chapels, and a peer-review visit by the Head of Spiritual and Pastoral Care, and Freedom to Speak Up Ambassador for South London and Maudsley NHS Foundation Trust.

The Board RECEIVED and NOTED the report.

2020.1/15.1 **EMERGENCY DEPARTMENT OVERSIGHT GROUP SUMMARY – DECEMBER 2019**

The Chair of the Emergency Department Oversight Group, Prof Purt (NED), presented the following summary of the meeting held on 19 December 2019:

CQC Compliance

Five additional key new points from the 29/11/19 letter were added to the key action list/action plan.

An action plan review is to be brought to the next meeting for assurance on:

- Sepsis – documentation/escalation/compliance
- Paediatrics – escalation
- Mental Health – protocol/escalation

It had been agreed that a new medical emergency team be assembled with Nursing strengthening the Sepsis team, and a task and finish group being pulled together with 'Deteriorating Patient Group', with a requirement agreed for a similar group for Paediatrics and Mental Health.

ED Leadership

Agreed that there is a requirement to review senior leadership and decision making across the four sub departments of ED to enable a clearer flow to be established.

Level of assurance: Moderate. Direction of Travel: Improving

Workforce

Significant gaps still exist with Nursing (32 WTE Band 6s) with HCA now off trajectory. Consultant cover remains a major challenge.

EDOG has requested sight of a clear action plan with timelines, markets to explore and recruitment/retention packages to alleviate the issues above.

Level of assurance: Low. Direction of Travel: Same

Positives

System C implementation going well. Any operational issues and risks to be brought to the next meeting.

Level of assurance: High. Direction of Travel: Improving

The COO highlighted verbally to Board members at the meeting that the ongoing successful implementation of the System C project was a credit to the team involved.

Board Assurance Framework (BAF)

The Committee reviewed the BAF for assurance on the following risk –

BAF 668 – If we do not deliver our Hospitals Transformation Programme (HTP) THEN we cannot ensure our patients get the best care.

Level of assurance: Moderate

2020.1/15.2 **EMERGENCY DEPARTMENT OVERSIGHT GROUP SUMMARY – JANUARY 2020**

Prof Purt (NED) presented the following summary of the meeting held on 23 January 2020:

Paediatric Discharge/Streaming to ED

Picked up by the CQC during their visit in November, this is still causing some concern. Paediatric patients are required to be triaged within 15 minutes of arrival in the department, however the timings are not always being recorded. Individuals have been identified and are being supported with documentation issues and this should now see an improvement.

Level of assurance: Moderate. Direction of travel: Improving

Managing and Improving Flow

There are four front doors to the department which is having an impact on flow. Management of flow is currently clinically led, and when this is led by a locum there does not appear to be the same drive as when led by a substantive Consultant. Work is ongoing with Criteria Led Discharge, which should see an improvement, however the department needs to ensure it is using the correct leadership model.

Level of assurance: Moderate. Direction of travel: Same

Workforce – recruitment and retention

The Trust is actively recruiting through agencies along with international recruitment and 'head hunting'. Four new consultants will be in post by August 2020, 24 of the 32 required middle grades have been recruited, 11 of whom will require support. Five long term agency consultants are close to becoming substantive.

A retention strategy is in development which will support existing staff as well as those newly recruited.

Level of assurance: Moderate. Direction of travel: Improving

Board Assurance Framework (BAF)

The level of assurance on BAF 668 was agreed as unchanged from the December meeting, ie *Moderate.*

The Board RECEIVED and NOTED the December and January reports.

PATIENT & FAMILY

2020.1/16 **COMMUNITY ENGAGEMENT UPDATE Q3**

The DCS provided an update on the Trust's community engagement activities during Quarter 3 by way of a presentation.

She reminded the Board that the Trust has a legal duty to involve the users of our services, whether directly or through representatives, in the planning and provision of those services, the development and consideration of proposals for changes in the way those services are provided, and decisions to be made by the Trust affecting the operation of those services. In summary, 'we engage with our communities because listening to people helps us to deliver the best care we can'.

The key Quarter 3 activities covered in the presentation are summarised as follows:

The People's Academy – which included Young People's Academies and Learning Disability Academies had been well attended and supported

Pilot Learning Disability Academy

The Pre-Operative Assessment Clinic at PRH hosted six attendees from 'My Options' Telford. With support from the Pre-Op Assessment Clinic, Patient Experience, Medical Engineering Stores, Learning Disability Liaison Nurses (MPFT) and Catering, the attendees watched a video of clinic and possible tests to be carried out. Equipment was also made available for attendees to familiarise themselves with, all aimed at providing reassurance of what to expect if they ever have to visit or stay in hospital.

Next steps relating to the Learning Disability Academy will be to ask the service users what matters to them, create an appropriate video for Academy sessions and YouTube/Website, and set up an Academy schedule for 2020/21.

Working Together

Between October and December 2019, the Trust received four requests for public representatives to support work within our Trust, and seven Academy graduates have come forward to work with us. Opportunities were planning of radiographer in theatres, hospital transformation workshop, theatres lockdown and Equality and Diversity Lead interviews.

The Engagement Team have also supported Corporate Nursing and Education in the planning and delivery of the Equality, Diversity and Inclusivity Stakeholder event.

Engagement across the region

Between October and December 2019 the Engagement Team attended 14 events, with many in Wales, to maintain our engagement with service users from all geographical areas serviced by the Trust.

The team also hosted two SaTH Community meetings, and topics covered included:

- Frailty
- CQC and Special Measures
- Developing a People's Forum

Improvements in Quarter 3

The Team has 'borrowed' an idea from the CHC and created a feedback leaflet that enables them to collect information while they are out in the community. The leaflet has recently been revised to include a return address so that copies can be taken by community groups and returned to the Engagement team when completed. Statistics will be reported in the next update to Board.

Volunteering

There are currently 982 active volunteers working across both hospital sites. In addition, there are 34 volunteers in progress on the 18+ scheme, and 31 volunteers in progress on the 16-18 scheme.

Helpforce Response Volunteer Bid

The Trust has successfully received a £25k grant from NHSE/I to implement a Response volunteer scheme to support the hospital during winter pressures. Response volunteers provide support to areas/wards experiencing pressures such as delayed discharge or delayed transfer of care, and they could have a significant impact on Winter pressures, as well as improving patient and staff experience. Trusts who have already implemented this volunteer scheme have reported very positive results.

SaTH Charity Update

- Wrekin Golf Club will be supporting SaTH Charity throughout 2020. All the money the club raises throughout the year will go to our Neonatal Department, by request of their club captain
- The Priory School raised more than £3,700 during their charity year, which was donated to SaTH Charity's Swan Fund. The donation enabled improvements to be made in the Trust's end of life care
- More than 100 bikers dressed in festive outfits from 'Midlands Riders' visited the RSH to drop off a van brimming with donated gifts for young patients

The Hamar Centre Redesign Project

The Trust and Macmillan Cancer Support are working in partnership with other local charities to build new and improved Macmillan Cancer Support services and extend existing Trust services.

The Trust provides counselling and well-being services at the Hamar Centre to individuals with life threatening and life limiting conditions, and Macmillan Cancer Support provide an information and benefit welfare advice service. Following the redesign, the Trust will have two new multi-purpose rooms to provide therapy and support groups to clients and community groups, and Macmillan will have a larger information service, which will include a quiet room for patients and relatives.

Coming Up in Quarter 4

- Equality, Diversity and Inclusivity Stakeholder event
- SaTH Community Engagement meetings
- Hamar Centre Stakeholder Forum

………………………….. Chair
26 March 2020

- Developing the Response Volunteer scheme
- Support for Stroke Services engagement plan and EQIA
- SaTH Charity Fun Day planning
- People's Academy, Young People's Academy and a bespoke academy for Telford Job Centre

The Board NOTED the community engagement activities undertaken during the quarter, and Chair thanked the DCS for her informative presentation.

PERFORMANCE (SUSTAINABILITY)

2020.1/17.1 **SUSTAINABILITY COMMITTEE SUMMARY – DECEMBER 2019**

The Chair presented the following summary of the meeting held on 19 December 2019:

Hospitals Transformation Programme (HTP)

Design options are being worked through and costed. *The Chair reported verbally at this 6 February meeting that the costed proposals of the preferred option have now been submitted to NHSI, and the Trust is awaiting a response.*

A structural survey of the ward block will be completed within the next month and the HTP are working through options taking into account benefits and costings.

Assurance: Moderate

Energy Centre

Carbon Energy Fund has met with the Trust and presented possible solutions for the delivery of energy across the whole site. There would be a meeting scheduled with the FD to discuss whether the solutions were on or off balance sheet and an options appraisal would also be completed in terms of suppliers.

Assurance: Moderate

Digital Agenda

Windows 10 – There was currently a lack of funding identified to facilitate the full roll out of Windows 10 across the Trust.

Draft digital pipeline is being produced and will be discussed at Executive Directors meeting in January 2020.

ED System resources and funding required to deliver the project within the timescales were ongoing and update will be provided at the next meeting.

Assurance: Moderate

Capital Programme

Care Group has identified £651k for the relocation of Medical Records to Atcham Business Park. The DCS will present a report at the next Executive meeting for agreement. Sustainability Committee supported the revised proposal.

Assurance: Moderate

Board Assurance Framework (BAF)

The Committee reviewed the BAF for assurance on the following risk:

- Risk 668 – We need to deliver our £312m hospital reconfiguration to ensure our patients get the best care. *Assurance: Moderate*

Mr Newman (NED) raised the funding issue relating to the roll out of Windows 10, against a background of the imminent ceasing of support for Windows 7. The Chair confirmed that this is part of the Trust's digital strategy, and the FD has subsequently confirmed that funding is available within the capital budget to facilitate the Windows 10 roll out.

2020.1/17.2 **SUSTAINABILITY COMMITTEE SUMMARY – JANUARY 2020**

The Chair presented the following summary of the meeting held on 23 January 2020:

Hospitals Transformation Programme – NHSI feedback on Strategic Outline Case (SOC)

As stated above, a formal response is awaited to the SOC. There is no real definition of how to move forward in the meantime.

Level of Assurance: Moderate. Direction of Travel: Same

Hospitals Transformation Programme – Progress of Outline Business Case (OBC)

The HTP team has, supported by the Transformation Unit, reviewed the requirements as laid out within the NHSI Business Case Checklist and the HM Treasury Green Book Guidance, and has produced a draft OBC plan detailing the path to the completion of the OBC. This plan has been validated with the Finance, Workforce, Estates and Clinical Leads.

Level of Assurance: Moderate. Direction of Travel: Same

System-wide QIPP position

The most recent expectation, as contained within the system plan, is to deliver a QIPP saving of £50m over the next five years. Previously, the Trust has been notified of the figure, amounting to £18m. The £18m figure has been used in the development of the SOC.

Level of Assurance: Moderate. Direction of Travel: Same

Board Assurance Framework (BAF)

The Committee reviewed the BAF for assurance on the following risks:

- BAF 668 – IF we do not deliver our Hospitals Transformation Programme, THEN we cannot ensure our patients get the best care. *Level of Assurance: Moderate*
- BAF 1584 – IF we do not invest in our ageing estate nor replace old equipment THEN we cannot provide a safe environment. *Level of Assurance: Moderate*
- BAF 1492 – IF we do not have an agreed Digital Strategy THEN we cannot effectively underpin service improvement. *Level of Assurance: Moderate*
- BAF 1558 – IF we do not have sufficient, competent and capable Directors THEN we cannot deliver the Trust's agenda. *Level of Assurance: High*

In considering the above risks, the Committee confirmed the risks were up to date, the current risk rating is correct and there is no additional/updated content or new risk(s) that need to be added.

The Board RECEIVED and NOTED the December and January reports.

2020.1/18 **PERFORMANCE COMMITTEE SUMMARY**

The Chair of the Performance Committee, Prof Deadman (NED), presented the following summary of the meeting held on 4 February 2020:

Performance Committee Assurance meetings

Meetings were held on 15 January and 4 February to focus on progress to drive efficiencies in Theatres, Endoscopy, Outpatients and Agency. Assurance was sought on four key areas in order to assess the maturity of improvement objectives – Has the task been defined? Is there a plan? Is there ownership? Are we delivering? All areas were assessed as amber or green, with the exception of Nursing Agency and Medical Agency which were assessed as red for task definition, and Outpatients and Endoscopy for delivery.

At future meetings, project staff will be better able to propose assurance levels for review. Levels of ownership by front line leaders were, in many cases, good, and in some cases excellent. However, the Committee concluded that there is still a lot of work required.

Level of Assurance: Moderate. Direction of Travel: Improving

In-Year Finance, including Financial Improvement Programme

An update on the 2019/20 financial position was received, noting a deficit of £7.8m adverse to plan for the period April – December pre-provider support. Key drivers are CIP delivery, including agency expenditure.

A detailed review of the financial position including expenditure run rates and forecast CIP delivery and forecast for income had taken place, which included the end of year settlement reached with the Trust's two main commissioners. In light of this, and taking into account an issue regarding 2018/19 rebates, the most likely outturn position is now a deficit of £35.4m. This reflects a £1m deterioration in financial performance predicted in December 2019.

With regard to CIP, Core CIPs have delivered £3.47m YTD against the NHSI submitted plan of £9.43m (36%). In month delivery of £0.94m. The Trust is forecasting Core CIP delivery of £5.47m. Prof Deadman (NED) observed that in the current and previous two financial years we have consistently only been able to deliver between a third and half of the budgeted CIP programme. Accordingly when planning for delivery of CIP in the 2020/21 year SaTH needed to recognise realistic levels of plan delivery in our plans and that proposals are credible and robust. This will also require the setting of a CIP target higher than the budgeted requirement to manage the risk of deferral and slippage.

Financial Planning 2020/21

Initial financial modelling has been undertaken to assess the Trust's forecast position for 2020/21 against indicative control totals from HSE/I and STP. Three scenarios for income were presented together with draft positions for I&E. Some of those scenarios appeared exceptionally stretching and possibly aspirational. The Committee recognised that the baseline position was fundamental. It was agreed that further substantial and extensive discussion would take place at the next meeting.

An update on the development of the 2020/21 CIP programme was provided. A series of workshops are taking place to further generate efficiency ideas. The current rollover positions from 2019/20 into 2020/21 estimate savings of £2.40m based on the projects already in delivery.

Performance

An update on operational performance was provided. Key points to note include:

- RTT performance continues to be impacted by Urgent Care pressures. A detailed update on RTT and forward look to 2020/21 was received. Acknowledged that capacity and demand are key.
- Diagnostics performance is slightly below target. Cardiorespiratory is a challenge. Plan of action to recover this by March 2020.
- Cancer – two week wait performance remains close to the 93% target. 62 day performance remains below the threshold with challenges in key specialties.
- A&E 4 hour performance – continues to be excessive level of demand and a significant number of 12 hour breaches reported.

Level of Assurance: Low. Direction of Travel: Worsening

Board Assurance Framework (BAF)

The Committed reviewed the VAF for assurance on the following risks:

- BAF 561 – IF we do not have system-wide effective processes in place THEN we will not achieve national performance standards for key planned activity
- BAF 670 – IF we do not deliver our control total and meet the trajectory to live within our financial means THEN we cannot meet our financial duties nor invest in service development and innovation

The Committee confirmed that they considered the risks were up to date, the current risk rating is correct and there is no additional/updated content or new risk(s) that need to be added.

The Board RECEIVED and noted the report.

2020.1/19 **OPERATIONAL PERFORMANCE REPORT – MONTH 9**

2020.1/19.1 **Operational Performance**

Elective Activity – RTT 2019/20 Trajectory

The Trust achieved 82.76% in December 2019 against a trajectory of 92.25%, a -9.49% variance. Key actions and risks will be:

Actions

- Review of urgent and long waiters
- Management of list to minimise short notice cancellations
- Capacity options Quarter 4 to continue to ensure no 52 week breaches

Risks

- Bed gap will impact on DSU usage if emergency demand continues
- March 2020 waiting list size to be same as March 2019
- Staffing gaps within theatre teams and consultant anaesthetists
- 52 week waits if DSU escalation continues in Quarter 4

The RTT Waiting List size in December 2019 was 19759 against the operational plan trajectory at this point of 17939. The requirement is to bring the March 2020 position back in line with the March 2019 level (18064).

The number of 40 week waits has risen to 134 in December 2019.

Diagnostics

The December 2019 national diagnostic waiting times of 99% (for patients who have waited less than 6 weeks) was achieved for Imaging and Endoscopy but was impacted by a 92.03% rate in Physiological Measurement, resulting in an overall result of 98.59%. Key actions and risks will be:

Actions

- Reduce cardiorespiratory backlog by undertaking additional sessions in February and March

Risks

- Increase in CT scan requests on delivery of overall DM01 trajectory
- 60 hours of scanning and reporting required to manage demand

Cancer

2 Week Wait Trajectory: The Trust achieved 91.2% against the national target of 93%. Key actions and risks will be:

Actions

- Continue to review two week wait performance, booking within 7 days, at weekly Cancer Performance and Assurance meeting
- Monitoring of capacity for two week wait referrals in respiratory clinics

Risks

- Reduction in capacity linked to WLI clinics

31 Day Wait Summary: The Trust achieved 96.6% against the national standard of 96%.

62 Day GP Referral: The Trust achieved 75.8% against the national standard of 85%. Key actions and risks will be:

Actions

- COO to COO communication to improve processes between organisations
- Additional UGI clinics (Sundays) introduced to cope with increasing demand (it is believed this is as a reulst of changes to testing which have made for a more ‘user friendly’ investigation that patients are accepting)

- Harm reviews to be completed for urology patients waiting for robotic surgery at UHNM
- Shadow monitoring of 28 day faster diagnostic target

Risks

- Urology capacity due to workforce gaps
- Impact of 2 week wait lunch capacity on 62 day performance
- Pathway redesign work is delayed due to winter pressures
- Diagnostic capacity within Radiology

Urgent Care Update

A&E Performance (excluding MIU): The Trust achieved 60.6% against the national standard of 95%.

A&E Attendances (excluding MIU): Attendances were 12434 against a trajectory of 11434, representing a variance of 1010

A&E Breaches: Breaches were 4901 against a trajectory of 2482, representing a variance of 2419

Continued pressures in A&E are reflected in the 12 hour delays from decision to admit, with the Trust experiencing a significant number of breaches. The elderly patient admissions and attendances has seen a rise, a factory in the increase in the breaches (A&E attendances and emergency admissions have both risen by 11% when comparing December 2018 to December 2019)

A&E Ambulance Arrivals:

- Attendance % comparison December 2019 vs December 2018 was 9.2%
- Attendance No. comparison December 2019 vs December 2018 was 345
- YTD Attendance % comparison stands at 15.7%

2020.1/19.2 **Financial Performance**

In month the Trust has an adverse variance to plan, and therefore control total, of £5.4m. Key points of note include:

- **Income - £2.6m below plan, inclusive of support funding**
- Generally, income continues to over-deliver against plan predominantly within non-electives, with under-performance in Outpatients and Other Services
- Provider support has been adjusted on light of the Trust's current forecast outturn, and is the main driver for the adverse variance to income
- **Pay - £1.0m above plan**
- Non-delivery of CIP, £0.3m
- Agency usage, £0.6m above plan
- **Non Pay - £2m above plan**
- Non-delivery of CIP, £0.1m
- Diagnostic reporting and send away tests, £0,2m
- Clinical supplies, £0.3m
- Consultancy fees, £0.4m
- Maintenance contracts, £0.1m
- Overseas Nursing Recruitment Fees, £0.2m

Income & Expenditure Position

The Trust has a planned deficit, pre support funding, of £14.1m for the period April – December 2019. The actual deficit reported for the same period is £21.9m, being £7.8m adverse to plan (Full-year Plan £17.4m deficit, pre support funding).

Income - £7.4m favourable variance, inclusive of support funding:

- Non elective activity £3.1m (3%) above plan
- A&E activity £0.9m (6%) above plan
- Non Elective Other (Maternity) £1.0m
- Additional £0.3m for posts funded externally including Health Education England
- Deferred Income and Education income release £0.4m
- Assumed Readmission income of £1.5m
- FIT Monies of £0.6m

The overall income position includes a £3.8m reduction in provider support, £1.3m for month 9 and £2.5m relating to months 7 and 8, in light of the Trust's forecast outturn position.

Pay - £7.4m adverse variance, as a result of an overspend on agency costs of £5.5m and non delivery of CIP of £2.0m

Non Pay (excluding pass through) £12.7m adverse variance. Main drivers:

- Additional senior appointments and organisational change payments £1.0m
- Diagnostic reporting £1.4m
- Non delivery of CIP of 4m
- Additional costs of clinical waste, estate costs and facilities costs £2.0m
- Clinical supplies £1.1m
- RN recruitment £0.4m

Balance Sheet review £1.2m – release of Balance Sheet items transacted in the Month 3 financial position

Forecast Outturn – as previously reported, following a detailed review of the Trust's financial position, run rates and CIP delivery at Month 8, the most likely end of year position was forecast to be a £34.4m deficit. At Month 9 there has been no change to this forecast.

The forecast position recognises the maximum amount of central support funding that can be received.

NEDs raised the following points and queries:

- Mr Brown asked what percentage of CIP is recurrent. The FD clarified this to be the majority but offered to confirm the exact figure offline if required
- Dr Lee queried the background to the senior appointments driver listed under Non Pay, and the FD confirmed that this links to the significant strengthening of teams beneath Director level, which are shown in Non Pay as they are on/off payroll
- Dr Lee highlighted the central pressure to increase our bed base but, from a financial perspective, the Trust will struggle to resource any increase, resulting in potential quality and safety risks. The FD clarified that Operational Plan guidance refers to maintaining peak level of beds, and he noted that the meaning of that will need to be considered and addressed as the planning process progresses.
- Prof Deadman agreed with Dr Lee's point, however highlighted that the Trust's overseas nursing recruitment would hopefully help to mitigate the situation. The COO added that reviews are underway on ways of working, eg considering different ways of staffing wards, most effective use of Advanced Clinical Practitioners, with a view to these providing further mitigation.
- Mr Newman requested an update on progress with 2020/21 Cost Improvement plans. The COO provided a summary of some of the activity in this respect, eg work within the Care Groups, work with Deloitte on the transformation element, and review of Pathways undertaken by the MD.

The Board RECEIVED and NOTED the Trust Operational Performance Report.

2020.1/20 **WINTER PLANNING**

The COO provided an interim update to the Board on the success of the Trust's winter schemes, key enablers as part of the system Winter Plan 2019/20, the impact that the schemes realised, and the plan for Winter 2020/21.

So far this Winter, A&E attendances and emergency admissions have increased by 11% year on year, and exceeded the plan. The demand has impacted on available bed capacity and waiting times within both of the

emergency departments, as well as affecting elective activity. Therefore, in addition to the schemes identified as part of the system plan, there have been further actions taken to keep patients safe and ensure patient flow, as follows:

- Use of fracture clinic cubicles for Ed patients (some peak days)
- Additional clinical site managers to support the admission portals and ward flow
- Patient transfer team to support wards
- Elective orthopaedic ward used for increase in trauma activity (January 2020)
- Extra emergency theatre lists to manage demand

What went well

- Dedicated discharge team on both sites working well, however could be further enhanced by rolling out criteria led discharge
- Extended hours for acute medicine has enabled SDEC to remain open for twilight sessions (not 7 days during 19/20)
- Pharmacy extended hours, able to facilitate more discharges – 6 days as of January 2020
- Demand and capacity bed modelling – updated monthly to show capacity shortfall and is accurate
- Maintained super stranded patient metric despite increase in admissions
- Recruitment to key posts to support winter happened earlier in the year, eg Therapy
- Extra beds on both sites to relieve pressure in ED
- Vanguard Unit in place releasing escalation capacity from December 2019 – started on schedule
- Weekend planning and Multi-disciplinary working
- 12 Surgical short stay beds on DSU
- Prioritisation and investment of ED and Acute Medical workforce as part of 19/20 plan

What has not gone so well

- Acute Medical admissions area used for escalation, therefore unable to optimise SDEC
- Lack of bedded discharge lounge due to Ward 35 not being available as expected
- Impact on elective activity and some patients being cancelled more than once
- Planning for use of fracture clinic/communication channels
- Staffing challenges for the Frailty team (Community, Social Care and SaTH)
- Some rise in complex discharge delays (Powys during December)
- Pre 12 discharges continue to be below the national standard of 30% (circa 17%)
- System schemes not well publicised within SaTH, therefore staff unaware of alternative pathways to admission
- Increase in ambulance attendances has resulted in increased corridor care and ambulance handover delays
- Ward 35 delays
- Delay in MLU move on PRH site
- Unable to quantify the impact of some of the system schemes
- Variable success of differential pay rates

Key challenges/issues

A number of other challenges and issues are worthy of note:

- Due to increased activity and ambulance conveyances across the two sites there has been an increase in the number of 12 hour trolley waits within both EDs and therefore corridor care was in place
- Locum/agency numbers for medical and nursing staff. This has added to pressures in EDs and some wards, as well as reducing efficiency
- The personal and professional demands on teams and individuals has been significant, across departments (for clinical and operational management staff) and for on call staff

Proposals for 20/21

Planning for 2020/21, the SaTH Winter Plan needs to be incorporated within the Operational Plan and therefore allow schemes and key enablers to be put in place and tested before Winter. The first draft of the demand and capacity bed model for 2020/21 has been completed and has identified the bed gap across the two sites, which is sizeable. There is more work to be undertaken over the next month to understand the impact and opportunity of the SCED model, which is an important STP and national objective for 2020/21. Key SaTH areas to focus on for 2020/21 are:

- Address bed/capacity shortfall
- Options for Frailty Unit at RSH
- Dedicated SDEC and AMA facilities on both sites to avoid bedding of units for escalation
- Adequate bedded discharge lounge facilities on both sites
- Increase clinical site staffing levels to support admission portals, including SDEC
- Robust plan for maintaining elective activity during peaks in demand; Vanguard Unit or outsourcing
- On call capacity
- Review of transfer team pilot

Across the health and social care system, there are a number of important work streams to work on together with system/STP partners, including WMAS.

In response to a query from Dr Lee (NED) on what actions could be taken to improve the pre 12 discharge situation, the COO responded that this is being picked up under current 'sustaining change' work, involving the KPO Team, with information being taken into weekly Urgent Care meetings.

The Board NOTED the update provided, and the further actions that are being taken in preparation for 2020/21.

2020.1/21 **SHROPSHIRE AND TELFORD SUSTAINABILITY AND TRANSFORMATION PARTNERSHIP (STP) UPDATE**

The DTS provided an update to Board on the work being undertaken within the STP over the last month, including an update on Partnership working progressed in relation to Pathology, Urology and MSK.

Work is continuing within the STP and the Senior Leadership Group (SLG) in relation to the finalisation of the Long Term Plan (LTP) and also the initiation of the shadow ICS Board (paper received by Board in November 2019).

Work has been undertaken to outline the priority areas for the next year through a clinical workshop supported by the STP.

The AO and Chief Executives now have a fortnightly meeting in place and the development of a Provider Board is underway. Meetings of the Chairs have also taken place.

STP/LTP

The STP is currently undertaking a prioritisation process for agreeing the year one priorities for the LTP. It is essential that both the SaTH planning phase and the LTP development align.

On 23 January 2020 the STP supported a clinical workshop to agree and consult on the priorities outlined in the LTP. This was attended by numerous clinical staff from SaTH, members of the Executive team and members of the HTP team.

The outputs from the session will be agreed by the next SLG on 5 February 2020.

The Trust has continued to work closely with UHNM in relation to the Urology and Pathology Services. Clinical support in relation to these areas has been excellent, and the Urology pathway is continuing to be developed.

Urology

The scope of the Urology work is the establishment of a urology alliance between UHN and SaTH for Urological Services, enabling the implementation of the GIRFT (Getting It Right First Time) and Cancer Alliance recommendations, and the development of a Urology Alliance business case for the provision of an additional robot and latterly a review of benign services.

NHSI have, however, also outlined their direction for Urology services and outlined their model and approach at an event in November. This requires further testing, but envisages an over-arching West Midlands provider collaborative for Urology surgery (general urology and cancer), which then creates (probably four) provider alliances to serve the patients in the West Midlands (Birmingham & Solihull, Black Country, Herefordshire & Worcestershire, Coventry & Warwickshire, Shropshire and Staffordshire). A programme director for this work is currently being identified.

Pathology

The Trust continues to pursue the networking opportunities with UHNM in relation to Pathology. An update of the situation so far was received by the Executive Team on 21 January 2020. The clinical teams are working to ensure that there is a full understanding of our service in order to drive the right partnership agreement in the future and define the joint operating model.

A project structure is under development which will outline the key milestones for the business case development and also the supporting elements including the LIMS upgrade. The Board will continue to be sighted on these developments through future monthly updates, and also through reporting at the Performance and Sustainability Committees.

MSK

As agreed at the November Board meeting, exploration has continued of partnership arrangements in the county in relation to MSK. There is now an MOU in place supporting the Trust to work towards an alliance with RJAH and Shropshire Community Services. A Transformation Board has been initiated supported by the Operations group with members from all organisations participating.

The first element of this work will be looking at the triage process through the TEMS and SOOS services. Again, we will continue to provide future monthly updates, with the necessary detail being produced for the relevant Tier 2 Committee as work progresses.

Conclusion

Work continues to progress in relation to the STP development, and also partnership working. The Trust also continues to explore further opportunities with our service pathways through utilisation of GIRFT data and Model Hospital information.

A monthly update paper will be provided to Board in relation to all of these elements to ensure the Board is sighted on how these continue to progress.

The Board NOTED the update provided.

2020.1/22 **AWARD OF PUBLIC DIVIDEND CAPITAL (PDC) FOR ENDOSCOPY**

The FD presented a paper providing details of £100,000k of PDC that has been approved by the Department of Health & Social Care for Endoscopy.

The funding will be used to deliver increased capacity for gastrointestinal endoscopy procedures through the transition to more up to date technology, increasing patient throughput. It will increase efficiency through the procurement of new devices and facilitate appointment reminder implementation beyond Outpatients to reduce DNAs and visibility of list booking and free slots.

The scheme will deliver:

- Replacement of ageing, poorly performing devices with faster, Windows 10 devices within the Trust's two Endoscopy Departments, to provide improved security and increased efficiency
- Improved user experience through increased responsiveness, integration and usability of IT devices
- Improved visibility and utilisation of capacity through DNA reduction and providing increased patient choice across the symptomatic and screening services, maximising the number of 'points per list'.

The Board NOTED the allocation and APPROVED the use of this funding.

WORKFORCE (PEOPLE)

2020.1/23 **WORKFORCE COMMITTEE SUMMARY**

The Chair of the Workforce Committee, Ms Boughey (NED), presented the following summary of the meeting held on 20 January 2020:

Visit to Ward 25

The Committee have introduced a Ward visit prior to each full Committee meeting. Committee members visited Ward 25 (RSH) and met with staff and the Ward Manager. The Committee heard about some of the workforce challenges they face particularly in relation to substantive staffing levels. Notwithstanding this, the Committee heard strong levels of passion and commitment to the Trust and patient safety. The Committee were shown the dedicated secure 'Sepsis Tray' and use of technology was observed to aid patient management and expedient discharge. The Ward Manager feedback following the visit indicated that they found it beneficial and it was a pleasure to accommodate the Committee members.

The Committee agreed to widen the scope of the visits to include non-ward areas, such as Estates and IT.

Level of Assurance: Moderate. Direction of Travel: Same

Staff Survey and OD Plan

The Committee received a verbal update based on the embargoed initial raw data following the 2019 National Staff Survey.

The initial data shows that whilst response rates remain low, there is a marginal improvement in some (but not all) areas. Working groups will be set up to focus on key areas that need addressing, in particular patient safety and quality of care, leadership and cultural issues within the Trust. The initial data does not provide any comparison indicators with other Trusts at this stage and more information will be available in due course.

The Committee also reflected on the Extraordinary Workforce Committee held in early January 2020 and agreed that this session was extremely informative in gaining an insight into the work which has been carried out in the Care Groups following the 2018 National Survey. It was agreed that a follow-on Extraordinary Workforce Committee will be scheduled for mid-2020 to enable continued review and oversight to take place.

Level of Assurance: Low. Direction of Travel: Improving

Workforce Reports

The Committee received the Workforce Assurance Report and Workforce Plan 19/20 monthly update. The key points were highlighted including:

- Appraisals were reported as being at 90%, which is the Trust target
- Statutory Safety Update training is at 88% for the fourth month running, which is the highest the Trust has seen against a target of 90%
- Staff absence is currently at 4.94% against a Trust target of 4% and a national target of 3.99%. It was noted that mental health as a reason for staff absence remains high and support is being given in this area
- The Committee received a nationally required update on our organisational self-assessment against provider Flu Campaign best practice template. This was a requirement from NHSE/I to help reduce the variability of provider uptake (average 70.3% rising to >90%) by sharing best practice. The Committee noted that this best practice framework was utilised in planning and delivering our campaign through 2019/20
- The Committee discussed the importance of the data accuracy and agreed that it should be presented in a clear, concise and consistent format that can be understood by all.
- The Committee discussed the implementation of Medic on Duty system and noted a delay. The Committee heard that a revised date for implementation is now expected to be 1 April 2020 following working groups and consultation with clinicians.
- The Workforce Plan update shows that the Trust is using a great number of substantive and agency staff than planned, and monitoring is ongoing of all the strategies which impact on staff numbers in each Care Group.

- The Committee also discussed and agreed that a clearer format for the Workforce Plan would be helpful, rather than just a spreadsheet and the presentation will be refreshed to ensure the data is more meaningful.
- The FD reiterated that there has been a significant increase in substantive staff and agency staff, and expressed concerns around establishment control.

Level of Assurance: Low. Direction of Travel: Same

OSCE Nurses

The Committee received a paper from the DNQ in relation to OSCE ready nurses, which would be supplied to the Trust through a private company in India who have been introduced to the Trust by the Trust Chair. The Committee heard that these nurses also have ED and Paediatric experience. The Committee also heard that additional benefits include reduced supernumerary time (a potential reduction from 12 to 4 weeks). It is proposed that a pilot is undertaken with 30 nurses joining in March 2020.

The Committee acknowledged the potential benefits of using the private Indian company. The Committee also recognised the Trust's need to increase staffing levels particularly in areas where workforce fragility persists, such as ED, in order to add the CQC Section 31 notice. However, the Committee discussed governance and financial implications. The Committee noted that they were conflicted and it was agreed that this matter should be discussed at Performance Committee and Trust Board.

Level of Assurance: Low. Direction of Travel: Same

Board Assurance Framework (BAF)

The Committee reviewed the BAF for assurance on the following risks:

BAF 423 – IF we do not have positive staff engagement THEN we cannot support a culture of safety and continuous improvement. *Level of Assurance: Moderate*

BAF 859 – IF we do not have a recruitment and retention strategy along with demand-based rostering for key clinical staff THEN we cannot ensure the sustainability of services. *Level of Assurance: Low*

Following consideration of the risks, the Committee agreed that the ratings would remain the same. The Committee acknowledged that the Risk Register had not been updated since November 2019 and asked that Committee members review their risks and report back in February 2020 on the actions taken against each risk.

The Board RECEIVED and NOTED the report.

2020.1/24 **PEOPLE & ORGANISATIONAL DEVELOPMENT STRATEGY UPDATE**

The AD for Workforce (representing the (AWD), and DTS, provided the Board with a verbal update on progress with the development of the Trust's People & Organisational Development Strategy.

It was reported that the document comprises of seven key themes, many of which are there to help influence culture.

Next steps are for the Workforce Leadership Team to work up the operational elements of the plan. The AWD will also take the Trust's new CEO through the plan so far, and incorporate the Trust's Staff Survey action plan.

The Chair suggested that the AD of Workforce has a discussion with Ms Vicary of NHSI to seek input and advice. He wished it to be recorded that the Board will be expecting to see a high quality document, which is very different to what has previously been submitted.

Following a query from Brian Newman (NED) on whether benchmarking has taken place against other Trusts, the CEO suggested use of the Model Hospital in this regard.

The Board NOTED the update provided.

2020.1.25 **WORKFORCE ASSURANCE REPORT**

The AD for Workforce (representing the AWD) presented this report, to provide the Board with oversight of the organisation's workforce and metrics for December 2019.

Sickness Absence

Sickness continues to track at anticipated levels, with a rate of 4.94% for December (against a Trust target of 4% and a national target of 3.99%).

Mental health remains high as a reason for absence, and support is being provided through development for managers and the Employee Assistance Programme.

Appraisals and Statutory Safety Update (SSU)Training

The appraisal completion rate stands at 90%, in line with the Trust target. Departments are encouraged to ensure protected time is planned for appraisals due or outstanding, and lowest completion areas are targeted, to ask them to ensure completion.

The SSU training completion rate stands at 88% for the fourth month running. This is the highest ever compliance achieved by the Trust, but is still 2% below target. Non-attendance has risen to 30%, despite increased completion on eLearning. The HRBP team are supporting the Care Groups to ensure this reduces during the month.

Staff in Post and FTE Budgeted Establishment

Staff in post levels have remained at a consistent level since October 2019. Although budgeted establishment has also remained broadly unchanged, an increase in escalation outside of budgeted establishment has presented an increase in demand on workforce resources. It is, however, envisaged that this will start to ease over the coming months as the international nurses integrate into the workforce.

Turnover and Retention

Following a reduction in turnover in October, turnover rates have risen again through November and December to a more consistent rate. The turnover rate stands at 1.2% in December 2019, which is above the monthly target of 0.75%.

The Board RECEIVED and NOTED the report.

2020.1/26 **OVERVIEW OF INTERNATIONAL NURSE RECRUITMENT AND PILOT FOR OSCE READY NURSES**

The DNQ and AD for Workforce presented a paper providing an overview of international nurse recruitment to date and highlighting the potential to recruit OSCE ready nurses from India into the organisation via a new pipeline, to reduce the overall vacancy gap.

International Nurse Recruitment

The Trust needs to ensure that the pipeline of staff is sustainable to meet ongoing requirements and in line with the increase in bed base as outlined in the Operational Plan.

A collaborative working relationship with HEE Global commenced in 2019 and has resulted in 172 WTE of the original planned 176 WTE Indian nurses currently being organised to join SaTH. The first 26 candidates are already in the UK, with the first six nurses who arrived in December 2019 due to take their OSCE on 31 January.

A plan is now in place to accept 30 per month, and the plan of 100 nurses before 31 March remains on track. Several nurses have dropped out of the pipeline due to various personal reasons such as pregnancy, and to ensure we continue to meet the agreed plan of 176 WTE nurses, further Skype interviews will take place. These additional interviews are likely to be in April or May when there is a clearer indication of definite numbers of urses still on track to join, as it is assumed there will be further drop out at various stages.

So far the overseas nurses who have joined us are of a high calibre, with very good English and clinical skills. The phased approach of 30 per month was agreed to ensure that the clinical and OSCE Team can support the international recruitment, both in the short and medium term. These nurses require circa 12 weeks supernumerary period on arrival within the UK in order to be trained and prepared to take the OSCE exam before they will be issued with the PIN number from the NMC. From the first two cohorts that are in the UK, it has become apparent that due to the high standard of the nurses, several of the candidates will require a shorter supernumerary period.

With the Trust's turnover at 9%, and with successfully employing the originally agreed 176 WTE via HEE Global, it is forecast that the registered nurse vacancy gap is likely to be at 50-60 WTE by September 2020. Currently the project is on track for 172 nurses but, as highlighted above, the likelihood is there will be few that will not come or will be sent home if they fail their OSCE, meaning that the vacancy figure predicted for September could be slightly higher. All efforts will be made to ensure 176 WTE remain on track to be recruited. In order to make the Trust a more attractive place to work, with a sustainable workforce model and with an aim to work at an 80:20 substantive to bank/agency ratio, further recruitment is now required early in 2020 to secure this plan for September 2020 onwards.

OSCE Ready Nurse Recruitment

A private Indian company has been introduced to SaTH. This company are offering OSCE ready nurses with 80 potential employees currently ready to be deployed to the UK. They are offering to support SaTH and are already actively working in Maidstone and Tunbridge Wells NHS Trust, who have employed 40 nurses.

SaTH intends to conduct a pilot with this company, and the current proposal that has been accepted in principle by the Executive Team is to accept up to 36 OSCE ready nurses in April (earliest possible time) with a focus on ED vacancies and Unscheduled Care vacancies, where there are still critical gaps in workforce.

This increased recruitment will also meet the requirement of the MUST take action identified in the CQC inspection report published on 29 November 2018.

Skype interviews were held during the week of 6 January 2020 and the calibre of nurses has been encouraging. Of the 37 nurses interviewed, 36 are suitable to be offered. Whilst the nurses will be OSCE ready, and could complete and hopefully pass their OSCE within a week of landing in the UK, there will then be a wait for the NMC to issue the PIN number (average turnaround time is circa two weeks presently but this could change). Early indications are suggestive that these nurses will require four weeks (maximum of eight) supernumerary period after joining SaTH in order to complete the OSCE, receive their PIN number, complete induction and become acclimatised to the clinical areas and practices prior to becoming an independent practitioner within the chosen area.

There is a current risk with regard to OSCE as slots for exams are becoming difficult to book, with some candidates being required to travel as far as Ulster to obtain an earlier date. The agreed plan will be to try to book all OSCE slots for April, for those nurses that accept their offer.

The company have stated that given the extensive network of their own hospitals in India they are constantly recruiting nurses. They are able to support their nurses who have an interest in working in UK hospitals to become IELTS, CBT and OSCE trained in advance of leaving India.

The company also has additional benefits outlined below:

- Accent trainer from the UK have been hired so the nurses being trained are equipped with a proper understanding of the spoken English language. This will hopefully help them to pass IELTS more easily. It will also help in better communication with patients and colleagues already working in the NHS.
- Extensive use of computer based training (CBT) as its core method of training and testing. The company has developed its own web-based portal for NMC CBT training.
- They have recruited Nurse OSCE trainers from the UK and relocated them to India. There are two dedicated OSCE training facilities in the North and South of India, and a comprehensive OSCE training programme is available, with refresher courses and mock tests. All training and mock tests are simulated to UK NMC OSCE standards.
- The training performed can include bespoke topics as requested by SaTH, such as Sepsis and Deteriorating Patient.
- With regard to support to retain the RNs at SaTH, there is an extensive programme in relation to community integration which provides social and psychological support and includes issues such as providing jobs to spouses and provision of child care. Support is also offered to help further integrate them into the community and includes events of significance around their religion and social events that are carefully planned and organised to help with integration and prevent isolation.
- Pastoral support on landing in the UK including transport to Shropshire and their place of residence.

The successful candidates would require the same levels of package, including three months of accommodation, which will be a challenge and is currently being investigated by the Workforce Team to ensure SaTH can meet this demand from April 2020 onwards.

References have been obtained from the Director of Workforce at Tunbridge Wells NHS Trust. Feedback overall has been positive although the OSCE pass rate was slightly lower than other international nurses employed by their Trust from other routes. With this in mind, the contract that is currently being drafted will include a payback fee to SaTH for those nurses who do not pass.

The business case to support is currently being finalised alongside the required contract. The financial impact will assume 36 nurses on a four week supernumerary period and a recouping of £1,600 per nurse over 12 months in line with the HEE GLP overseas nurses package. Costs may rise if certain individuals need a longer supernumerary period. The payback period would be 12 months.

The Board NOTED the oversight provided in this comprehensive report.

2020.1/27 **FREEDOM TO SPEAK UP GUARDIAN (FTSU) Q3 UPDATE**

Kate Adney, Lead FTSU Guardian, attended the meeting to present a quarterly summary of activity, feedback and themes of concern raised to the FTSU Guardians during Q3. Also included were 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'.

Themes emerging from concerns raised

1. Staffing levels of nurses on the wards – Nursing staff and other clinical staff have expressed concerns about staffing levels. There are high numbers of bank and agency staff, and Winter pressures and escalation levels can lead to uncertainty and anxiety around ensuring patients are well cared for and kept safe.
2. Behaviours and treating each other with respect – This is not just in relation to the behaviours of Managers and Leaders but all staff treating each other with respect, keeping in line with our Trust Values. Managers should be able to challenge poor behaviours and performance manage if required without the fear of repercussions when doing so.
3. Communication – Ensure that there is clear communication to all staff, keeping them up to date with changes to processes. For staff to communicate to each other with respect regardless of Bank or Job Title

Learning and Sharing (linked to above)

1. DNQ and Senior Leaders have put in place measures to encourage staff to take up bank shifts on wards. Matrons and Leaders are aware of the feedback, and are ensuring that they keep their staff up to date with recruitment and retention plans, supported by the Communications Team. FTSU Guardians feed back to Ward Managers when concerns around patient safety/dignity are made. Guardian endeavour to raise any patient concerns on the same day and ensure that we escalate if required within seven days. The need to submit Datix reports is emphasised.
2. Senior Leaders are visible on site to hear concerns directly from staff.
3. Feedback has been shared with colleagues and through the Improving Together newsletter. Positive feedback has also been shared from staff members who have raised concerns.

Summary of FTSU activity during Q3

- FTSU Guardians spend time on a weekly basis in as many areas of the Trust as possible to ensure visibility. Guardians have spent time walking the wards as well as visiting other clinical and non clinical areas.
- The National Guardian Office Speak Month was held in October, and October was made the official launch of the Trust's FTSU Advocates. There are now 43 Advocates in total.
- All the feedback received during October Speak Up Month was acted upon accordingly, and fed back to relevant Line Managers/Leaders. Several communication engagement sessions have been held to talk about speaking up and facilitated team sessions through practical workshops.
- Drop in sessions and feedback/comment boxes have been left around all sites. FTSU Guardians were supported by the Communications Team to raise the profile of FTSU through a series of events and

promotional materials. FTSU Guardians have featured in the local press and were interviewed by Radio Shropshire.

- FTSU Guardians have continued to hold 'Round the Kitchen Table' events, at both RSH and PRH, where staff have a safe space to raise concerns. Feedback meetings have been held with line managers and other relevant colleagues.
- 1:1 meetings have been held with colleagues who have concerns they wish to raise. Support interventions have included facilitating meetings within departments to improve communication and working relationships in teams.
- FTSU Guardians have continued to support the Junior Doctor Drop In Sessions and attend Junior Dr Forums.
- Guardians have attended Workforce Committee to provide an update, and continue to support the Well Led ISG.
- FTSU now also has regular representation at Engagement and Enablement meetings, and Equality & Diversity meetings.

The Board was pleased to NOTE the positive update provided.

2020.1/28 **FREEDOM TO SPEAK UP GUARDIAN ACTION PLAN**

Kate Adney, Lead FTSU Guardian, also presented a FTSU Action Plan, drawn from themes taken from the FTSU Self Review Tool, Comparison Paper from the Royal Cornwall Case Review, and Board Development Session in August 2018.

The Action Plan identifies areas for action for the Trust over the next 12 months, and provides important information that will be used to devise and implement the FTSU Vision and Strategy, Objectives and Communication Plan for the next 12-24 months.

Eight key objectives have been identified, with relevant actions for stakeholders, together with expected outcomes. These are summarised as follows:

- Senior Leaders to articulate the Trust's FTSU Vision and ley learning from issues that staff have spoken up about (Completed October 2018)
- Executive Lead for FTSU (the MD) to review the FTSU Vision and Strategy (Overdue – due by July 2019. Complete by January 2020)
- Increase reach and Speak Up cover across all sites (All elements complete)
- Senior Leaders to play a part in the development of the FTSU Vision and Strategy and explore what FTSU means to leaders in the Trust (Board Development Session completed May 2019, Self Review tool completed October 2019)
- FTSU cases to be compliant and quality assured (Due by end of March 2020)
- Senior Leaders to model speaking up by acknowledging mistakes and making improvements (Trust Board November 2019 and quarterly thereafter. Quarterly feedback at SLT)
- The Board to be able to state with confidence that staff know how to speak up and do so with confidence (FTSU Policy updated April 2019, next review due April 2020. Communications Plan implemented June 2019, to be reviewed in May 2020)
- Senior Leaders to demonstrate an understanding of FTSU and the impact this has on staff who have spoken up (Ongoing)

In response to a query from Mr Brown (NED) on whether issues are being linked across to the Care Groups, Kate confirmed that this is the case, and the FTSU Guardians have good relationships with all Care Groups.

Mr Newman (NED) referred to leadership training within the Trust, and asked if there are any themes coming through which could be reported to and considered by the Board. The MD, as FTSU Executive Lead, offered to provide a report around these themes for the next Public Board meeting. **Action: MD/FTSU Lead Guardian**

Ms Boughey (NED) advised the Board that she now meets with Kate on a 1-1 basis every month, in her role as Chair of Workforce Committee, to ensure that themes are picked up and fed through to Workforce as appropriate.

The Board NOTED the Action Plan and progress against the key objectives.

………………………….. Chair
26 March 2020

2020.1/29 **GUARDIAN OF SAFE WORKING (GoSW) Q2 REPORT**

The MD presented the Q3 Guardian of Safe Working Report to the Board. The GoSW continues to champion safe working hours in the Trust and ensure compliance with the Exception Reporting system. Junior trainees can use this process to report hours worked over, missed rest breaks, and differences in service commitments and variations in educational opportunities.

Key points for Q3 were covered as follows:

- 23 Exception reports have been received in the quarter. The majority of reports were raised from trainees in the Unscheduled Care Group
- One Immediate Safety Concern (ISC) was raised within Paediatrics due to extenuating circumstances of sudden sickness during shift resulting in staff shortages
- No breach fines were raised in this period

The GoSW recommends::

- That the Trust supports initiatives to ensure that doctors not only receive adequate rest as contractually agreed together, but also increase awareness that missed rest impacts patient safety.
- The Trust reviews its annual and study leave process in the USCG with respect to ensuring that adequate staff are available at all times to enable trainees to work within their safe limits and reiterates previous recommendations to implement the e-leave and e-rostering systems
- To continue to respond to concerns regarding Junior Doctor staffing levels in the USCG especially at weekends and support initiatives to enable further recruitment

The Board NOTED the report, and APPROVED the GoSW recommendations.

2020.1/30 **FLU VACCINATION ANNUAL SELF-ASSESSMENT REPORT**

The AD for Workforce, representing the AWD, presented a report to Board to confirm through self-assessment detail how the Trust is fully compliant with the NHSE/I healthcare worker flu vaccination best practice management checklist.

The Trust has met every national target set for flu vaccinations of frontline healthcare workers for the previous three years and has received full CQUIN income.

With a view to continuous improvement, the Trust has continued to look for ways to increase vaccination uptake and considered all available evidence that may support delivery. The multi-disciplinary flu action group welcomed the framework from NHSE/I and used it to guide further developments within the Trust's campaign.

The organisational approach to the 2019/20 campaign was developed further by consideration of the recognised best practice framework. The campaign this year (still underway at the time of reporting) has achieved over 80% uptake for frontline healthcare support workers, improving the Trust's performance from last year of 75.8%.

The Board was pleased to NOTE the content of the Self-Assessment Report, and congratulated all those involved in a highly successful result.

2020.1/31 **WORKFORCE POLICIES TO NOTE**

The following Policy Updates were presented for ratification by the Board:

- Leave Policies – Adoption Leave, Maternity Leave, New Parent Support, Shared Parental Leave, Special Leave, and Leave Policy Framework
- NHS Pension Scheme Policy

The Board RECEIVED and RATIFIED all of the above Policy Updates.

GOVERNANCE (LEADERSHIP)

2020.1.32 **AUDIT & RISK COMMITTEE SUMMARY**

The Chair of the Audit and Risk Committee, Mr Bristlin (NED), presented the following summary of the meeting held on 6 December 2019:

Cash and Treasury Management Internal Audit Report

The report has been issued with limited assurance, the same as the previous year. This is based primarily on two high and two medium priority recommendations. Management are focused on addressing the points raised. One of the recommendations in respect of the forecast loan drawdown in year and the future repayment of debt is more long term and strategic in nature. To the extent that this risk is not entirely within the control of the Trust, work will be undertaken with NHSE/I. Actions are in hand to address those matters within the recommendation that are within the control of the Trust. The limited assurance opinion ongoing may impact on the annual Head of Internal Audit Opinion (HoIA), however the FD and Deloitte will agree the approach prior to finalising the HoIA. The FD will ensure the strategic risk (BAF 670) accurately reflects this.

Level of Assurance: Low. Direction of Travel: Same

Medical Waiting List Initiatives (WLI) and Annual Leave Audits

The MD updated the Committee on Medical Leave. The key issue is to book annual leave through an electronic system (Allocate). This requires an additional module to be added to the current system. The MD will raise the priority of this with the Executive and other required governance in the Trust.

WLI is more complex and not standardised across the Trust. The MD reported that he will be reviewing policy to 'tighten up' the process and harmonise the payment range – a similar issue with locum consultant rates. All changes will need to be renegotiated with LNC.

Level of Assurance: Low. Direction of Travel: Same

Tracking Recommendations of Open/Overdue Internal Audit points

The Committee was pleased to note an improved position on closed recommendations. The COO updated the Committee on closed recommendations within Operations, mostly around Pharmacy where a new policy went to the Quality and Safety Committee in November and there is an ongoing audit plan to ensure embeddedness.

There were three overdue high priority recommendations. One was requested to be superseded and two further requests for extensions until 28 February 2020, which were agreed. There were no overdue medium or low priority recommendations.

Level of Assurance: Moderate. Direction of Travel: Improving

Internal Audit

There are four risk based performance reviews currently either in progress or planned for Q4. These are Workforce recruitment processes, Ward to Board reporting, Datix Clinical Management and Freedom to Speak Up.

It was also noted that the Internal Audit and Local Counter Fraud Services currently provided by Deloitte are due for renewal from 31 March 2020 and a tender process has been initiated in Q4.

Level of Assurance: Moderate. Direction of Travel: Same

External Audit

KPMG provided an update on their plan for the 2019/20 'external' audit which included how the audit is conducted, materiality levels, the significant risks considered and areas of audit focus:

- Financial statements
- Value for money
- Quality Account opinion

In addition, KPMG provided an update on the following:

- New accounting standard (IFR16 – accounting for leases) and our readiness for its implementation from 1 April 2020. The Committee was satisfied with progress to date.

- A KPMG external benchmarking report (forwarded to Performance Committee).

It was also noted that the External Audit Services currently provided by KPMG are due for renewal from 31 March 2020 and a tender process has been initiated for Q4.

Level of Assurance: High. Direction of Travel: Same

Risk Assurance

Recommendations for development of the Board Assurance Framework have been drafted and were considered by the Committee. The revised version is referred to the Trust Board for approval.

The DTS addressed the Committee to outline the function of the newly formed Performance Review meetings and how they will address operational risks classified as high or very high.

Level of Assurance: Moderate. Direction of Travel: Same

In response to a query from Mr Newman (NED), the Committee Chair confirmed that KPMG will be obliged to complete the 2019/20 audit, despite their services being due for renewal from 31 March 2020.

The Board RECEIVED and NOTED the report.

2020.1/33 **BOARD ASSURANCE FRAMEWORK (BAF)**

The DCS presented this paper, and the following key points were covered:

The Board Assurance Framework (BAF)

The BAF brings together in one place all of the relevant information on the risks to the Board's strategic objectives. It is an essential tool for Boards, and provides a structure and process that enables focus on those risks that might compromise its principal objectives.

All Tier 2 Committees review and update the BAF at each meeting.

New Risk

The DCS drew the Board's attention to a new key strategic risk relating to sepsis. The wording below is the current iteration in draft for consideration by the Board:

BAF 1746 – IF we do not have effective systems in place to consistently identify and escalate and manage patients with sepsis or other deteriorating medical conditions, THEN patients will not have the best outcomes possible.

The Board ACCEPTED the above recommendation.

Highest scoring operational risks

Operational risks scoring >15 are reviewed monthly at Operational Risk Group (ORG) and form the Corporate Risk Register (CRR). The highest scoring risks (>20) are scrutinised through the monthly Performance Review meeting, led by the DTS. Information taken from the 4risk system is validated by each Care Group/Service area's governance meeting and their senior management teams then describe their approach to risk mitigation to Executive Directors, committing to target dates whereby their operational risks are reduced or closed.

The Board RECEIVED and NOTED the BAF.

2020.1/34 **COMMON SEALING OF DOCUMENTS**

The DCS provided an update on the use of the Trust's Common Seal since the last update to the Board, pursuant to s9 Standing Orders 'Custody of Seal and Sealing of Documents'.

All sealed transactions are numbered consecutively in a book provided for that purpose, and signed by the persons who have approved and authorised the document and those who attested the seal.

The Board NOTED the Common Sealings of Documents – Seal Numbers 80-97, as provided in a list accompanying the report.

2020.1/35 ANY OTHER BUSINESS

No further business was raised.

2020.1/36 QUESTIONS FROM THE FLOOR

Q1 **Reflecting on the direction of travel for SaTH, can the Board comment on the impact on the Trust as an organisation?**

A1 The Chair drew the questioner's attention to the HTP strategic plan, the publication of which will determine the direction of travel. The Trust is unable to comment further at this time.

Q2 **A member of the public drew the Board's attention to a statement made by the current Chair's predecessor in March 2016 that Future Fit would not go ahead if adequate community capacity was not in place. As there is little evidence of community schemes developing that are impactful, in addition to a large increase in demand, how will the Trust cope with this scenario?**

A2 The Chair acknowledged that within the Future Fit document there is a commitment to providing improved community support, however the system is yet to demonstrate how this will be achieved. The Trust does not yet have any assurance in this respect, above the fact this will form part of the 5-year vision for STP.

Q3 **Why did the £312m Future Fit capital cost figure remain the same over a 4 year period, when it was way adrift from the true figure, ie not reflective of the public sector cost index upward trajectory during that period?**

A3 The Chair clarified that it is only when the Trust took control of the project that a review identified an increase in cost, as the system had put a lock down on numbers. He clarified that it is not within the gift of the Trust to publish the SOC, as this sits with NHSI.

Q4 **Are the 176 international nurse numbers in addition to or replacements for agency staff**

A4 The Chair confirmed they are replacing agency nurses.

2020.1/37 DATE OF NEXT PUBLIC TRUST BOARD MEETING

Thursday 26 March 2020,1.00pm, Lecture Theatre, Education Centre, Princess Royal Hospital

The meeting closed at 5.00pm.

………………………….. Chair
26 March 2020

ACTIONS / MATTERS ARISING FROM THE PUBLIC TRUST BOARD ON 6 FEBRUARY 2020

Item	Issue	Action Owner	Due Date
2020.1/08.3	Midwifery Staffing Report Request from Prof Deadman (NED) for the Board to receive a sense of our performance compared to other Trusts in future updates.	DNQ/ Director of Midwifery	March 2020 To be reported to next Workforce Committee meeting. **Action closed**
2020.1/13	Quality Governance Report Request from Mr Brown (NED) for C Difficile figures to show a comparison with the previous year.	DNQ to raise with IPC Committee	March 2020 The DNQ confirmed that this is in hand. **Action closed**
2020.1/13	Quality Governance Report Pressure ulcers – request from Mr Brown (NED) that future reports show a comparison with previous year's data	DNQ	March 2020 The DNQ confirmed that this is in hand. **Action closed**
2020.1/13	Quality Governance Report – Serious Incidents • Request from Mr Bristlin (NED) for information of timeliness of review to be covered in future reports • Request from Mr Bristlin for the charts to be in SPC format going forward • Report via Q&S Committee on how staff are being supported when something goes wrong, and the immediate actions that have been instigated • Request from Chair for evidencing of greater engagement with the family as part of an SI – documentation to be amended to facilitate this	DCE DCE to explore DCE DCE	March 2020 Dr Lee, Chairman of the Quality & Safety Committee, acknowledged the improvements that had been made recently in Q&S reporting. **Action closed**
2020.1/13	Quality Governance Report – Mortality Metrics Q&S Committee to quantify situation on red status of one of the entries (% mortality in hospital within 30 days of emergency admission with a heart attack aged 35-74)	DCE/ Q&S Committee Chair	March 2020 Query resolved. **Action closed**
2020.1/14	DCE Report Relay thanks from Board to Complaints and PALS Team on the huge achievement of a reduction from 468 to 45 of out of date clinical guidelines and policies on the Trust's intranet site	DCE	February 2020 Complete. **Action closed**
2020.1/28	FTSU Guardian Action Plan Request from Mr Newman (NED) for a report to be provided to Board on themes coming through from leadership training across the Trust	MD / FTSU Lead Guardian	March 2020 The CEO confirmed that a clear plan exists to address any gaps and development themes, and the Executive will continue to focus on ensuring these are addressed. **Action closed**

………………………….. Chair
26 March 2020