The Shrewsbury and Telford Hospital NHS Trust

Draft meeting notes from PaCE Panel meeting
15th August, 9.30am
Seminar Room 5, SECC, RSH

Attendees:

Chair: Ruth Smith, Lead for Patient Experience, SaTH (RS)
Greg Smith, Panel Member (GS)
Robert Ruane, Panel Member (RR)
Judith Barnes, Personal Assistant to Corporate Nursing Team (JB)
Dawn Thorns, Panel Member (DT)
Lynn Pickervance, Panel Member (LP)
Sarah Thomas, Panel Member (ST)
Ann Lewis, Panel Member (AL)
Natalie Parkinson, Panel Member (NP)

Apologies:
Rose Goodwin, Associate Director of Nursing (Interim) (RG)
Janet O'Loughlin, Panel Member (JO'L)
Colin Stockton, Panel Member (CS)
Julie Southcombe, Panel Member (JS)
Jackie Jones, Panel Member (JJ)

Item		Action
1.0	Opening remarks from the Chair and note of apologies	
	This meeting was changed to patient panel members only. Introductions made to Ellie Gunner, the new Patient Experience Assistant.	
2.0	**Patient and Carer members feedback (meetings held 27th June and 6th August)**	
	GS asked if a conference facility was available for meetings which would be helpful. At this stage conference facility is not available as attendance at the meeting is recommended. GS commented an agenda was set for the latest meeting held on the 6th August which helped streamline conversation. All the panel members are in agreement they want to be involved, feedback and support SaTH. The panel asked for further detail as below following discussion at the previous Patient Representative meeting only • An expression of interest for the panel to be involved in the Observe and Act process. To date GS and AL have attended the first part of the training, Colin, Bob and Lynn have taken an interest. Dawn has received training and taken part in a number of sessions, and Janet has taken part in the training through the Shropshire Community Trust. Discussion took place on how the results are followed up via action plans. RS confirmed the Care Groups own the actions, to be followed up, will look with the Care Group representatives.	

	• It was picked up about publicity around staff morale and recruitment, in particular comments in the media about interim Executives. The panel asked for an update and RS explained about the two Interim Associate Directors of Nursing that have replaced Helen Jenkinson since the end of May 2019. Two new substantive Deputy Directors will be starting 2nd September 2019 – Kara Blackwell and Clair Hobbs. The split of the roles is yet to be determined. RS confirmed the CEO post is currently being advertised, and in the longer term, the Director of Nursing, Midwifery and Quality (DoN) post will be staggered. The current DoN will be in place until at least April 2020. DT asked from a patient point of view, how does the staff feel about interims. RS explained an interim post would not affect the majority of staff. It helps provide a level of assurance for staff and patients. • Recruitment - 200 vacancies currently, and agency staff are being used to fill this. RS confirmed it is a challenge across both sites. Skype interviews for nursing staff are in the process of being carried out in India. An update on banding and structure is still to be given to the meeting. The Panel would like to know how successful bank placements are. It was commented as an example, New Cross do not employ agency staff. RS responded to this, and would suggest that this would have been a decision made by the relevant Hospital Trust to not employ agency staff. **Action – invite Paul Dabbs to the next meeting** • The panel would like to know what can they do to help. GS suggested a focussed approach to focus on a small number of topics, with a Trust representative nominated to work alongside. 2 or 3 topics should be chosen and reported to the main PaCE meetings and arrange for a Care Group Representative to help produce the Action Plan to focus attention, eg A&E action plan to follow up on an Observe and Act, record findings and pass to RS and follow up with the relevant Team. • Suggestion of quarterly meetings for all Care Groups and in between each a smaller group to attend the PaCE meeting with designated and assigned Care Groups to areas being focussed on. DT felt the meeting with 20 to 30 people is not a good use of officers and clinicians time and clinicians who attend have other time pressures to respond to. A quarterly meeting is recommended, and during the meetings an action plan formulated and output where required to be highlighted, the panel would like the Care Groups on board enabling positive steps to be made. RS felt the meetings have been good so far as previously there has been no engagement. DT on reflection of being on the PaCE panel after the 3 year tenure, she would like to feel and look back and say she has made a difference to SaTH. • Focus on Action Plans already available and look for areas picking up on Patient Experience and report to the PaCE which can then be reported to the Quality and Safety Committee, then to the Board. It is considered that this is how powerful this meeting group can be. ST considers this meeting group very passive. • The PaCE patient representatives would like to be seen as critical friends, they do not want to hear things are always great and satisfactory, but would like to be critical and work on the basis of lean management and look at ways to help the Trust to improve, such as Observe and Act, while having a balanced outlook. The panel are aware that patients have highlighted criticisms in the past but have not had any response, they have	

	acknowledgements for compliments, however not receiving feedback on concerns. **Action: RS confirmed that all written complaints should have feedback and will follow this up with the PALS team**. DT gave an example of her daughter's complaint and nothing has been actioned despite chasing up. RS confirmed as an example PALS could be an area to focus on. Examples given of different types of complaints eg verbal, should all be considered as a complaint and would expect to be responded to in the same way as written. RS explained since Julia, Complaints and PALS Manager has been in post (past couple of years) new processes have been introduced. • A&E is mentioned considerably in the media, LP would like a focus group developed and enable an understanding of what is causing the issues. GS commented about the comparative information heard in the PaCE group Vs negative media (A&E, recruitment, CQC). BR stated he has had 3 admissions in A&E over the past 7 months, and has never waited less than 10 hours. DT reflected on facebook update where A&E is classed as good compared with negative external comments in the newspaper. The information is conflicting. The PaCE group are here to support SaTH. Action – A&E suggested as a focus group, look at Action Plan with patient experience comments or can pick up own concerns. RS reconfirmed that the vision is for the Care Groups to be involved. LP suggested the panel can keep their own log and tick off when done and work with the action plan. DT would like to see the patient experience being good in A&E, eg staff keeping an eye on people such as making sure water available, ask how people are, and helping to make a more positive relationship. ST agreed a better experience and then when seen by medical staff , they generally feeling better about themselves. • RS explained the various areas of patient feedback – FFT, RaTE, complaints, national inpatient survey, national paediatrics, national outpatients, national maternity, carers survey. RS explained the role of the patient group with clinical audit. Action – obtain feedback from patient group from Sally Allen. • Patient communications were discussed, eg letters, texts. RS commented there is a group who look at letters. LP added that the CCG review communication, from a patient point of view, and will ask the patient for comment and feedback. **Action – RS will ask further about the group and what linkages can be developed with PaCE**. Signage is another method of communication, even when visiting the consultant there can be a different name on the door. DT comments on occasions she can come from an appointment and she is not sure who she has seen. LP suggested that fracture clinic is a good example of being told who you are seeing and could be reflected across the hospital. • Further discussion carried out for agreement to focus on workstreams : A&E, PALS, Maternity, patient feedback process (FFT, survey, response rates), environment GS commented that providing that there is full capacity on three groups these workstreams can be achieved, however aware that meetings not fully attended by all patient representatives, and suggested that a review of attendance should take place in November. • There is general disappointment that the panel may be losing momentum however RS explained as she has been the only person covering patient experience, she has had limited resource, however can now plan ahead and will continue for example with the Carers meetings as pointed out by	

	J'OL has not happened since the first meeting (as fed back via GS). RS also pointed out that the patient strategy will need to be submitted to the Board by December 2019. RS has organised 4 consultation meetings in September and will be asking for themes from these meetings to inform the strategy, once the patient strategy has been completed, the carers strategy will be worked on. RS will be consulting with groups in the wider health economy. BR asked for an explanation on the purpose of these other groups such as Healthwatch, carers partnerships, and suggested the hospital is under enough pressure without having extra groups to attend. RS confirmed that she attends the carers partnerships which invites reps from the Trust along with Social Services, Community Health Trust, etc. RS explained the purpose of Healthwatch which visits hospitals and nursing homes, and publishes reports on their findings available in the public domain, along with informing the CQC of feedback. • Environment – RS has set up groups to review PLACE, which has an annual assessment (comprising of 10 weeks duration). PLACE has been changed and piloted nationally, and likely to take place end of Sept/Oct 2019. GS and J'OL have already shown interest in this. The outcome will be shared with the main PaCE panel and then feedback nationally. GS would like to see results of this coming back to PaCE. **Action; RS to set up groups** • GS acknowledged that the CQC work is happening currently, and asked how can the panel get access to the report. As a second phase of the PaCE workstream, the CQC report could be looked at. RS explained the report is on the CQC website. GS asked if the CQC talk to patients? LP commented about the inspection experiences she has had with the CQC based on the patient groups (external to SaTH) she has been involved with, and felt the approach for the inspection by the two inspection teams has been different each time and feels the CQC need to know the inconsistencies. BR agreed that the CQC need to know how different the inspection process can be when compared with different organisations and gave his experiences of the inspection process in private sector organisations such as the MHRA where there is no inconsistencies during the process to ensure all inspected with the same protocol. RS confirmed that the next CQC inspection may potentially happen in November this year. GS would like to see the CQC Action plan scoped with PaCE – and would like to see how the Care Groups are looking at the patient experience. BR would like to ask if a patient representative can be on the inspection. RS commented that the inspection will be unannounced.	
3.0	**What does the future PaCE Panel look like**	
	The next meeting is planned for the 26th September and following the above discussion a new type of agenda will be devised. GS asked RS who she saw as attending the next meeting. Interim meetings will be set up with focus initially on A&E, Outpatients and the Environment. LP asked what does an Action Plan look like and asked for documentation. GS would like to have this reported back at the next PaCE meeting. ST agreed that this appears logical and tangible following on from the CQC Action Plan. **Action – RS to ask Care Groups what are their priorities for patient experience.**	,

	Action – JB and RS to look at group co-ordination BR would like involvement with Future Fit and what involvement opportunities there are.	
12.0	Close	

Date of next meeting – 26th September 9.30 to 11.30am, SECC, RSH