QUESTION NO.	MEETING DATE	QUESTIONER	QUESTION	ANSWER
001/2020	28/05/20	Gill George	**Cancer Care** Relating to the period 1st January 2020 to the present: How many cancer patients have had their treatment delayed during this period? Who took decisions on this? What criteria were in place to determine who would be treated and who would not? I understand a decision was also taken to withhold diagnostic information from some patients (i.e. they were not told of a newly diagnosed cancer). Their treatment was therefore also delayed. How many patients were affected? Again, who took decisions on this, and based on what criteria? Were the Medical Director, Chief Executive and Board aware of the decisions to delay diagnostic information and treatment to some cancer patients?	An extract from the minutes of the Board of Directors' meeting on 28/05/20. At the beginning of the pandemic (March 2020) there was a clear national steer to cancel as many inpatient, ambulatory appointments and procedures as possible, in order to protect vulnerable people and create the capacity to deal with any potential surge due to the pandemic. Whilst SaTH maintained a number of urgent surgical procedures and a full programme of radiotherapy and chemotherapy, in responding to the pandemic, the Trust recognised there have been a number of cancer patients whose diagnostics and treatment have been delayed. The Trust is not aware of any patients where the outcome of their cancer diagnosis was deliberately withheld. If you have evidence of such information being withheld, the Trust would ask you to forward it to David Holden, Interim Director of Governance (David.holden7@nhs.net). It will be investigated and the appropriate action taken.

002/2020	30/07/202	Gill George	**CQC Report** The April 2020 report (from a 2019 inspection) is quite damning. It shows a failure to improve in very many areas, and a deterioration in some. The 'well led' domain continues to be rated as inadequate. The report notes that the Trust breached its CQC registration with regard to 11 regulations. These included 'Regulation 5: Fit and Proper Persons- directors'; 'Regulation: 17: Good Governance' and 'Regulation 20: Duty of Candour'. These areas are fundamental. Without strong and principled leadership, the Trust will of course struggle to provide high quality clinical care. Major weaknesses in leadership were identified by the CQC in November 2018. Many of those concerns evidently remained a year later. What were the 'Fit and Proper Persons' breaches in November 2018? What steps were taken to resolve these? What were the 'Fit and Proper Persons' breaches a year later, in November 2019? Do these breaches still exist? A lack of understanding of Duty of Candour has caused great distress in the past, not least in the Trust's handling of avoidable deaths and harm in the maternity service. What is the evidence that the current leadership team has meaningful commitment to the Duty of Candour, including a willingness to fight for a culture of openness and transparency across the organisation? Does the current Board recognise there have been damaging failures around candour in the recent past?	At the time referred to, effective governance systems were not in place to ensure all director files were complied with the 'fit and proper persons' regulation. The Trust could not therefore be assured that all directors were 'fit and proper' to carry out their responsibility for the quality and safety of care. The Trust has since improved governance including the review of the Fit and Proper policy. The Trust commissioned its newly appointed auditors to ensure systems and processes are up to speed and good practice is being followed and maintained.

			Public board meetings since November 2018 have failed to identify ongoing weaknesses around leadership. Why? Has the Board been unaware? Or did the Board choose to withhold concerns around leadership from the public? Is the Board confident that leaders with the skills to achieve fundamental transformation at SaTH are now in place? Assuming the answer is 'Yes', what is the basis for that confidence?	

003/2020	30/07/20	Gill George	**Former Chief Executive** What external support has SaTH received from Virginia Mason in the last year? Has this included any input from former SaTH Chief Executive Simon Wright?	Simon Wright has not had any input into SaTH through his Virginia Mason work.

004/2020	30/07/20	Gill George	**Staff Survey** The 2019 staff survey showed particular weaknesses around 'themes' of Health and Wellbeing and Staff Engagement. What steps is the Board taking to ensure that staff feel valued, listened to and supported through a difficult period? Will the Trust seek to ensure the involvement of **all** staff in current and future service changes, encouraging staff to see themselves as the champions of patient care and safety, and placing staff at the heart of change? The history has perhaps been one of over-reliance on a small group of senior medical staff.	The Trust has recognised and now focused on the issues that impact staff. These include ensuring staff feel valued, listened to and supported. The health and wellbeing of the staff remains a critical priority – and never more so than during this Covid period. Actions taken include: • Investment in a comprehensive support package for staff at all levels of the organization including online and face to face advice and guidance. • Tailored psychological support has been provided by MPFT and another external provider for key areas (especially Covid wards and W&C) and the Trust is currently exploring additional areas (such as renal and radiology) • Additional support has included the provision of wellbeing rooms, staff apps, fast-track physio, online mental health awareness and mindfulness sessions alongside regular consultations with staff groups on other health and wellbeing needs. The Trust recognises there is more to be done and we will continue to identify staff needs and respond to them.

				With a new leadership team in place, the Trust has already taken steps to put staff alongside patients at the heart of service changes. As an example, the Hospital Transformation Programme has been consulting with staff groups and clinical teams across the organisation about the future configuration of services. This will continue throughout the autumn to ensure their views are fully reflected in the Outline Business Case. Staff at all levels are being consulted, including Facilities, Estates, Administration and other support services, not simply senior medical and nursing staff. A new monthly information Cascade designed to reach all staff, has been well received which includes an opportunity for staff to give feedback and ask questions which are channelled back to the senior team.

005/2020	30/07/20	Gill George	**Maternity Dashboard** The report of the Maternity Assurance Committee notes 'A maternity dashboard was presented to the meeting'. The maternity dashboard used to be published and in the public domain as a matter of course. It was withdrawn by SaTH at a time of mounting concern about the maternity service. I have asked for publication of the maternity dashboard to be reinstated at least twice in the past. Maternity is an area of significant public interest, and it is in the interests of transparency for SaTH to share this information. Will SaTH publish the current maternity dashboard? Will SaTH make this maternity dashboard, along with previous and future maternity dashboards, available on its website?	The Maternity Dashboard has been under review for several months and remains under review to ensure it meets national standards and follows good practice. The Trust will be reviewing publication of the dashboard, the context of the data and the Statistical Process (SPC) charts.

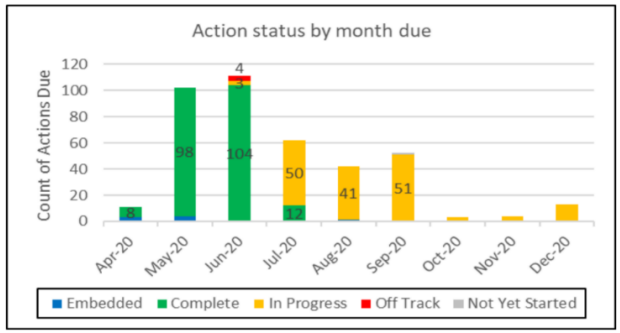
006/2020	30/07/20	Gill George	**Births Before Arrival (BBAs); MLUs** 1. How many BBAs have taken place so far in 2020/21? 2. How many BBAs took place in 2019/20? 3. How many BBAs took place in 2018/19? 4. What proportion of births took place in MLUs in 2019/20? 5. What proportion of births took place in MLUs in 2018/19? 6. What proportion of births took place in MLUs in 2017/18? (This data will be recorded by SaTH as a matter of routine and should take a few minutes to look up).	 1. 9 in total = 0.9% 2. 41 in total = 1% (method of data collection changed) 3. 8 in total = 0.2% Based on the new criteria this number would be 36 = 0.8% 4. 5.4% Closure of RSH MLU in 2019 for refurbishment 5. 8.1% 6. 11.3% BBA data is not a direct reflection on closure of the MLUs. This would only be significant if the number of BBAs were specifically Midwifery led women, as it is these women who should be booked for care and birth at an MLU.
007/2020	30/07/20	Gill George	**Cancer follow up care** This question is asked at the request of K, a SaTH patient: I'm 35, with young children. I have a serious gynaecological cancer.	 During Covid-19, cancer services continued as a priority. All appointments were triaged by a consultant to ensure that an appropriate appointment option was offered. Where appropriate, telephone follow ups were offered rather than face to face, and some follow up appointments

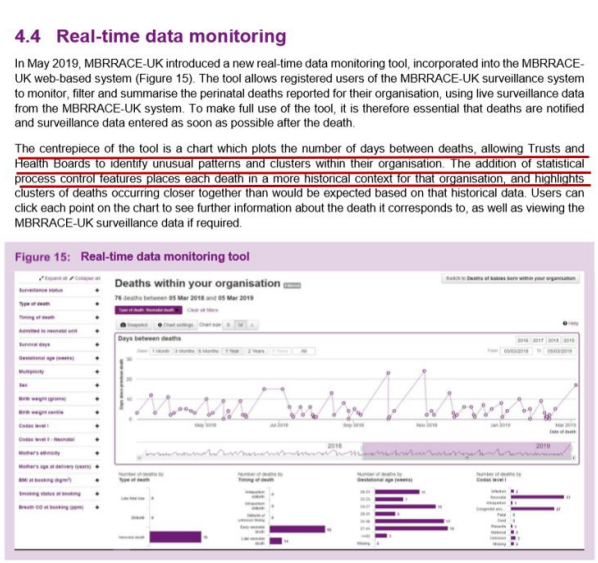
			My initial treatment of major surgery was successful, but I continue to need regular review appts because the consequences of recurrence could be very serious indeed. My SaTH consultant has stressed the critical importance of these reviews and of these happening on time. My last booked review would have been 8 weeks overdue – but it was then cancelled, with one day's notice. I had to make a fuss to get another appointment arranged, earlier this month. My consultant highlighted again – not just to me but to the wider service – the importance of scheduled follow up happening on time. I am due for a vault smear in early October. I received a letter from SaTH seeking to replace my appointment for a smear with a telephone appointment! This is meaningless. Again, I have had to take the responsibility for sorting out my own care. I'm tired and unwell. Cancer has changed my life. I don't want to have to take on the job of arranging my own care, and I think many others in my situation would be unable to do this. What's happening? Has your system for offering follow up to cancer patients broken down in the last few months? Why? What steps will SaTH take to audit existing cancer patients to ensure that people who have not been offered appropriate care will now receive high priority appointments?	were converted into telephone or consultations via other means. It would not be usual for a smear appointment to be replaced with a telephone call, but this may have been a result of consultant triage as above. Waiting time targets continue to be achieved in gynaecology, and all patients on a follow up list are reviewed.

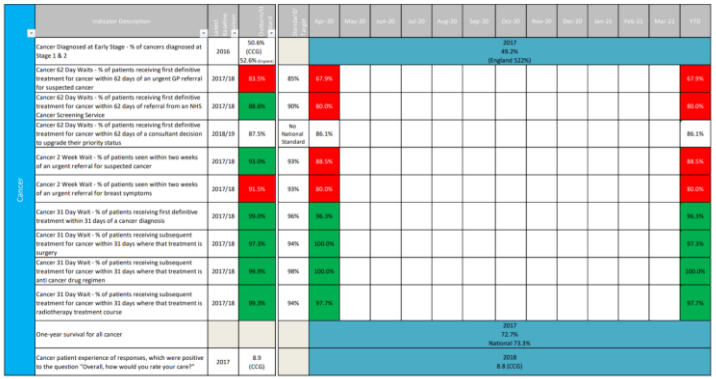
008/2020	30/07/20	Claire Howard, Parkinsons UK	**Parkinson's Nurse Specialist (PNS) post** In December 2019, following a number of conversations and meetings over the previous eighteen months, SaTH's Chief Operating Officer and Assistant Chief Operating Officer informed Parkinson's UK that the Trust had committed to recruiting to the vacant Parkinson's Nurse Specialist (PNS) post. However this post is still vacant and has not been advertised. Parkinson's UK understands the constrictions Covid placed on trusts' capacity for recruitment but we are also keenly aware that, for more than two years, people with Parkinson's have had limited access to a specialist nurse service in Shropshire. We are also aware that a number of other trusts have successfully recruited to these posts in recent months. Please can the board advise when the post will be advertised?" If there are any problems with this then please let me know. **29/07/20** It's great to hear that there is a plan to recruit and would be grateful to be kept updated on this process. I would also just like to confirm that this question will still be presented to and answered by the board this afternoon so that there is public acknowledgement of this? I hope that this would also then provide some reassurance to the Parkinson's community in Shropshire.	SaTH has a Parkinson's Specialist Nurse in post based at PRH in Neurology Services and is in the process of recruiting a second one.

009/2020	30/07/20	Diane Peacock	**Various Questions** *The questions below are intended to provide the public with information relating to the local outcomes of national directives and guidance on hospital admissions and discharges, from and into care homes in Shropshire and in Telford & Wrekin during Covid-19.* *In the interest of accessibility and transparency, the Governing Body is politely requested to supply actual numbers and dates when responding to questions 1-5.* 1. Since 2 March 2020, how many care home residents from a) Shropshire and b) Telford & Wrekin were admitted to hospital with suspected or confirmed Covid-19, and died in hospital with Covid-19 on their death certificates? 2. Since 2 March 2020, how many care home residents (if any) from a) Shropshire and b) Telford & Wrekin were admitted to hospital for another condition, then contracted Covid-19 and died in hospital with Covid-19 on their death certificate? 3. How many patients in total were discharged from hospital into care homes in a) Shropshire and b) Telford & Wrekin in the sixteen weeks from 16 March 2020 - 29 June 2020? 4. From Monday 2 March to the present which weeks saw the largest numbers of hospital discharges into care homes in a) Shropshire and b) Telford & Wrekin?	1. SaTH Information system is not able to derive this data. 2. SaTH Information system is not able to derive this data. 3. SaTH Information Team cannot provide this data. They are not able to differentiate between 'places of residences' - these could be home, or care/residential home. 4. SaTH Information Team cannot provide this data. They are not able to differentiate between 'places of residences' - these could be home, or care/residential home. 5. Guidance issued Friday 17th April 2020, Process designed Monday 20th April, Implemented Tuesday 21st April. Reporting started Friday 24th April.

			5. From what date were all hospital patients awaiting discharge into care homes tested for Covid-19? 6. Data from commissioners and providers captured by various national agencies (e.g. NHSE, NHS Capacity Tracker, ONS, PHE, DH&SC and CQC) when combined with intelligence from Local Resilience Partnerships and local Gold and Silver Command structures will have enabled the pattern of Covid-19 outbreaks in care homes to be analysed at granular level locally. Relating to this: What has been learned from data analysis when gauging the impact (if any) of hospital discharge patterns on <u>all</u> Covid-19 outbreaks* in Shropshire and in Telford & Wrekin care homes in March, April, May and June 2020? a. What impact (if any) did the mandatory testing of all patients before discharge from hospital into a care home have on the pattern of subsequent outbreaks? *As the Board will be aware, PHE outbreak data only include the first Covid-19 outbreak in a care home. It is likely there will have been some care homes with further outbreaks. If this is the case, this will have been recorded locally to inform analysis.	a. SaTH has followed Government guidance regarding testing and discharge and this will have had a positive impact on managing potential outbreaks in care homes but we would be speculating on what levels might have been like had we not done this. The learning from other areas is that rates might have been higher if we hadn't had these stringent measures in place. This is a multifactorial issue and outbreaks cannot solely be linked to discharge arrangements. There is also evidence nationally that visiting arrangements and staff flow in and out of homes has impacted on outbreak levels for instance. Generally care home outbreak levels have been low in STW when compared with the regional and national picture. Further detail can be sort from ONS. b. The impact of discharge arrangements is outside of SaTH so it should be for the Local Authorities and Shropshire Partners in Care to answer

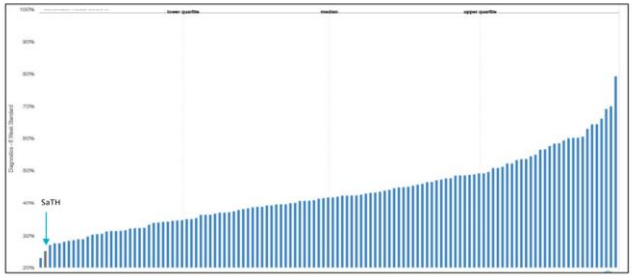
010/2020	30/07/20	David Sand-bach	**Various Questions** Replacement wording 'Prof Deadman (NED) high-lighted that the same serious WLI implementation policy issues appear to have been identified and re-portedly resolved by successive audit committee re-views in the last 9 years. We therefore need to check that when WLI audit actions are reported as com-pleted they result in lasting improvements. Yet another example of bad management at SaTH this comment looks like others whereby NED's com-plain about management inability to make plans stick on a permanent basis. See also – "Mr Allen (**A.NED**) made the point with re-gard to action plans that the Trust is good at finding solutions but these are not sustainable." **What does "embedded" mean?** Improvement Plan Trajectory:  "the Trust's Maternity Assurance Committee is also adding ***performance assurance rigour*** into the Care Group" In February this year I pointed out this facility:	The Trust has reviewed these audits and found no evidence of fraud. The Trust has reviewed job plans with individual consultants and identified explanations for audit findings relating to job planning and flexible working. It has provided clearer guidance for doctors. The Trust has amended relevant policies and intro-duced improved more accountable pro-cesses. In the CQC improvement plan, embed-ded means, sufficient time has been al-lowed to ensure systems, process and change have occurred to ensure the ac-tion is completed. For example: Following the development of a new pol-icy, embedding would mean actions are applied consistently with tangible and measurable benefits for patient out-comes. Cancer forecast included in Operational Plan (copy enclosed – slide 5 & 6) Updated FINAL - SaTH Op Plan - 20 08

			 Source: https://www.npeu.ox.ac.uk/downloads/files/mbrrace-uk/reports/MBRRACE-UK%20Perinatal%20Mortality%20Surveillance%20Report%20for%20Births%20in%202017%20-%20FINAL%20Revised.pdf page 38. Given the real time nature of this reporting system I would expect the Executive led Maternity Quality Committee and the MAC would find it a very rigorous assurance measurement tool. “Prof Deadman (NED) stated that he was pleased to note that the Trust has implemented an outpatient virtual consultation solution as part of the response to Covid-19.” SEE: https://www.sath.nhs.uk/patients-visitors/video-clinics/	Detail included in August IPR will be presented at Board of Directors Meeting on 17.09.20. Recovery Plan included on agenda for discussion at Finance & Performance (August 2020). Performance Report (copy enclosed) Performance Jul 2020v2.pptx The Trust is exploring the “Think 111 first” model and has requested data from other Trusts using it. Recognising the availability of other options, the Trust is being mindful not to increase ED attendances and is working with partners to expand the urgent treatment centre models. The activity taking place at MIUs continues to allow some patients to access care at the 2 MIU sites rather than attend the 2 Emergency departments – this reduces risk for staff and patients. The graph (attached) relates to the national diagnostic standard (DM01) – the aim is for 99% of planned diagnostic tests to take place within 6 weeks of the referral. The standard includes not only CT/MRI/Ultrasound, but also Endoscopy and Physiological Measurements such as ECGs and Audiology.

			Why have some of the surgical specialties e.g. vascular and colorectal not signed up to offering virtual clinics? **Has an evaluation methodology / evaluation team been established?** also not taken place. The maternity transformation work has been paused and therefore the work towards continuity of carer has been paused and monthly feedback to the Board has not occurred since March 2020. The DoM confirmed "Mr Newman asked if the Trust has a date by which it will be back on plan for cancer performance and diagnostics. He noted that the IPR is reporting the historical position, and provides no evidence of service recovery proposals. The COO responded that as part of the immediate restoration work the Trust has introduced some urgent services, and that extensive discussion is currently underway on how restoration is further developed as part of the Operational Plan." May 28th 2020 Board members may like to see this report from the SCCG Board papers dated 8th July 2020 to get a feel for the situation in the Shropshire CCG area: **3 CANCER** 3.1 As at June 2020, performance for the cancer indicators is as follows: 	In May, in line with national guidance, routine diagnostics were paused. SaTH was, and still is, unable to carry out the same number of tests per hour as pre-Covid. Referrals to all diagnostic modalities are prioritised based on clinical urgency. Pre Covid, SATH had one of the highest usage rates per scanner for CT and MRI in the region, and reductions in throughput due to social distancing and infection control measures does mean that the Trust requires more scanner capacity. In July, August and September, NHSI have supported SATH with mobile CT, and in October we will have both mobile CT and mobile MRI capacity to support increased imaging.

			https://www.shropshireccg.nhs.uk/media/2818/08072020-combined-part-1-sccg-governing-body-papers.pdf MONTHLY INTEGRATED PERFORMANCE REPORT **The Board of Directors noted the report, and the Chair requested that future reports incorporate a more forward looking focus. Need to check this is in the Board papers.** “The committee received a high level Draft Maternity Transformation Plan to bring the maternity services to where we need to be in the future. This is largely based on themes identified from the leaked DO report and aligns to Morecombe Bay report.” **Should the people of Shropshire, especially women of childbearing age, raise a glass of campaign to whoever leaked the DO report?** **Emergency Department Assurance Committee Key Issues Report**  The fundamental risk to Emergency Department performance is the mad cap, NHS establishment denial of reality by the SaTH Board, CCG’s and NHSE/I. (Recovery Plan included on agenda for discussion at Finance & Performance (August 2020)	

			Unless and until there is a centralised A&E department along the lines of the FF plan SaTH performance will remain abysmal for the next 5 – 6 years. These words will appear in the audit reports year on year: ***"KPMG was not satisfied that the Trust made proper arrangements to secure economy, efficiency and effectiveness in its use of resources. This was due to its financial position, high agency spend, inadequate CQC rating, failure to deliver a number of operational targets and the independent review into maternity care."*** I truly wish the SaTH Board did not believe that the earth is flat and that fundamental forces of clinical demand spread over two half-baked departments cannot be managed by re-arranging the corporate policy furniture and so called "help" from people who do not have any real skin in this game. The backlog of patients waiting for Diagnostics and Treatment has risen significantly during Q1 and additional capacity will be required to address this during the remainder of 2020/21". No Board paper explaining what the plan is to deal with the issue. A winter pressure plan is promised for the Board in September a few weeks before winter starts in the NHS. "We are planning carefully for the months ahead including winter." CEO report NEDs need more detail – as do the public. This comment is not good enough at this point in the winter planning cycle:	

			I refer you to my plan to open a Covid safe facility in Telford – at least it is a plan. NEDs should open these links and ask if SaTH has plans to introduce this technology “Call before you Attend service.” https://www.england.nhs.uk/wp-content/uploads/2020/07/Agenda-item-5-Future-of-UEC-services.pdf and this https://www.theguardian.com/society/2019/may/23/birmingham-to-begin-accident-and-emergency-online-chat-service-in-tech-revolution-for-nhs-care SATH UTC Activity and care at the MIUs continues to provide patients with a beneficial alternative to ED” **This is not what the SCCG is saying in their Board papers.** In May 2020, the Trust ranked 122nd out of 123 Trusts for the diagnostic 6 week standard, with a performance of 25.09%. The target is 99%, the highest performance was 79% and the lowest was 22%.  **Is this performance because SaTH is short of MRI’s and CT scanners?**	

011/2020	08/10/2020	Diane Peacock	How can it be acceptable that the SaTH information system is not able to 'derive' data on the numbers of hospital inpatient deaths that relate to *care home residents* based in Shropshire and in Telford & Wrekin (STW)?	Currently the Trust does not have systems in place to produce this information. The local CCG has also confirmed, that currently they also do not have systems in place to produce this information. The CEO advised it would be appropriate to the Trust to be able to provide this information in the future and this will be worked on for the future.
012/2020	08/10/2020	Diane Peacock	Can the Board please assure the public that written questions and Trust responses for July 2020 will be published retrospectively and, in future public questions with Trust responses are reported in full?	Response/s have been published previously. The Trust welcomes questions from the public, as they offer a different perspective on the issues discussed and additional insights into the challenges patients, staff and communities face. The Trust requires questions to be submitted 48 hours prior to the public meeting, so the Board of Directors have time to prepare the answers. This is important as many questions require some research. The Trust will aim to answer as many questions on the day of the Board meeting as possible. Those for which an immediate response could not be prepared will be acknowledged on the day. The Trust will post the answer to outstanding questions on the website by the

				next meeting (or sooner where possible). If the Trust is unable to post a response within this window, the question will be acknowledged on the website, with a timeline for response.
013/2020	08/10/2020	Diane Peacock	The fact that outbreaks affecting care home residents in STW have been relatively low compared to other areas means local intelligence on possible causal factors could be exceptionally informative when planning to safeguard local care home residents in the event of a future surge. Given the claim that a system-wide, multi-agency partnership approach was adopted locally to deal with the first Covid-19 outbreak, why is it that a multi-agency evidence base - to evaluate locally specific multifactorial elements impacting on care home residents – is apparently not available for public scrutiny?	Local health and social care have been integrated in the safe management of patients being discharged to all care settings (including domestic homes) during Covid-19. An integrated discharge team and hub manned by hospital, social care and community staff, has been put in place, providing an invaluable function. Local Authorities, as regional lead agencies, supported by the CCG, commission care homes and the Shropshire Partners in Care (SPIC) coordinate activities across the sector. Unfortunately the Trust does not have access to care home plans and activity. Whilst the Trust continues to monitor patients discharged to a community health and social care setting, it does not have access to the detailed Local Authorities' lessons learnt from the first wave of Covid-19, and benefits to residents and staff.

014/2020	08/10/2020	Diane Peacock	The Trust is claiming they are unable to differentiate between those patients discharged to their own home or to a residential care home at the beginning of the Covid-19 outbreak. Why is this information not available either via Capacity Tracker or as part of the various multi agency teams overseeing these processes?	The Trust's information systems will not enable an answer to this question and the integrated discharge team hub does not hold this information either. The Trust's new information system, tentatively scheduled to be installed in the Autumn of 2021 will solve this problem
015/2020	08/10/2020	Dulcie Howell	Have the Hip Operations at Telford Hospital resumed yet.	This surgical area has been prioritised although some operations have not commenced as quickly as the Trust would like. The Trust's surgical team has been asked to investigate the individual case and a clinician will be asked to contact Ms Howell.
016/2020	07/12/2020	Diane Peacock	With regard to the July Board questions relating to data, the response was that the 'SaTH Information system is not able to derive this data'. 1. While welcoming the new CEO's determination in that detailed data be available in future, does the CEO think it was acceptable that basic data on the admissions, discharges and deaths in hospital relating to care home residents could not be 'derived' when much of it was in fact available within national repositories such as the NHSE, the ONS and via local intelligence. 2. The CO-CIN reports for SAGE suggest that nosocomial transmission of Covid-19 in the sample started to rise again in October. Has the Trust collated data on cases of Covid-19 occurring up to 14 days after admission to hospital? If so what do the figures indicate, over time, about infection control?	

			In response to an October question about multi-agency working, the Trust stated that: 'Whilst the Trust continues to monitor patients discharged to a community health and social care setting, it does not have access to the detailed Local Authorities' lessons learnt from the first wave of Covid-19, and benefits to residents and staff'. 3. How can a local authority be expected to learn lessons from the first wave of Covid-19 unless local intelligence provided by all active agencies is pooled? 4. Does the CEO consider that the pooling of local intelligence including patterns of hospital admissions, discharges and inpatient deaths, relating for example to care home residents, at the height of the pandemic could have helped reduced further loss of life in the second wave to Covid-19? 5. With regard to CQC's inspection concerns (14.08.20), what is the evidence (qualitative and quantitative) to suggest that all aspects of end of life care at RSH are now meeting the standards all patients deserve? **Footnote:** Example: COVID-19 Hospital Activity https://www.england.nhs.uk/statistics/statistical-work-areas/covid-19-hospital-activity/ Example: Weekly provisional figures on deaths occurring and registered in England and Wales by Local Authority that includes of deaths designated to care home/ elsewhere/ home/hospice/ hospital/and other communal establishment Example: CO-CIN report https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/935139/dynamic-co-cin-report-sage-nervtag-all-cases-s0854-281011.pdf	
017/2020	07/12/2020	Gill George	**<u>Asbestos Management</u>** On 1st August 2019, Chair Ben Reid ordered an independent QC-led inquiry into the circumstances around the unfair dismissal of whistle blower Les	The independent report by Fiona Scolding QC was concluded and presented at the Board of Director's meeting in Public in July 2020 (Item 2020/099) - Chair's

			Small and the successful 2019 HSE prosecution of SaTH for unsafe management of asbestos on the Shrewsbury site. Did the inquiry ever conclude? Or even begin? If it was abandoned, who took the decision and why? If it reached interim or final findings, will SaTH now publish these? If not, why not? The history of the review is here: https://www.shropshirestar.com/news/health/2019/08/03/qc-to-oversee-independent-review-into-shropshire-hospital-trust-asbestos-concerns/ **Maternity** Questions around the maternity dashboard and around birthing locations were asked of the July 2020 Board meeting but were not answered. They remain relevant, and I request that the questions below are picked up. (SaTH's maternity dashboard disappeared from the public domain as the scale of its maternity crisis became increasingly clear. This has been queried on several occasions, and assurances have been given that this will be published as a routine part of Board papers going forward. Sadly, this has not happened.) **Maternity Dashboard** The report of the Maternity Assurance Committee notes 'A maternity dashboard was presented to the meeting'. The maternity dashboard used to be published and in the public domain as a matter of course. It was withdrawn by SaTH at a time of mounting concern about the maternity service. I have	Report incl. Investigation into the complaints made to the Care Quality Commission reported on this matter. The full report can be found here https://www.sath.nhs.uk/wp-content/uploads/2020/07/Chairmans-Report1.pdf Maternity - response/s published previously. Maternity Dashboard - response/s published previously. As stated at ORAC 25/3 we are committed to supporting women to make choices about their care in pregnancy, labour and birth. We have introduced personalised care plans in order to facilitate this. In Oct 2020 we introduced a monthly MDT meeting to discuss requests for care that falls outside of national guidance in order to mitigate as many risks as possible and to be sure that we have provided the woman with all available information and options. It is also an opportunity to identify any opportunities for training.

			asked for publication of the maternity dashboard to be reinstated at least twice in the past. Maternity is an area of significant public interest, and it is in the interests of transparency for SaTH to share this information. Will SaTH publish the current maternity dashboard? Will SaTH make this maternity dashboard, along with previous and future maternity dashboards, available on its website? **Numbers: Births Before Arrival (BBAs); MLUs; CLU** How many BBAs have taken place so far in 2020/21? How many BBAs took place in 2019/20? How many BBAs took place in 2018/19? How many births have taken place so far in MLUs in 2020/21? How many births took place in MLUs in 2019/20? How many births took place in MLUs in 2018/19? How many births took place in MLUs in 2017/18? (This data will be recorded by SaTH as a matter of routine and should take a few minutes to look up). Additionally, how many home births took place for the years listed above, and how many births took	In December 2019, the definition for Born Before Arrival (BBA) for the Maternity Services Dashboard was changed. Prior to the change, a birth was considered a BBA where the Place of Birth was selected as 'In Transit' or 'Other'. This was changed to the new criteria where the field "Name of Non Professional Person Delivering" contained a name. This was irrespective of the given Place of Birth. The change was due to the number of babies born with Place of Birth given as "Home" and delivered by a Non-Professional. The figures on the dashboard were backdated to the beginning of the 2019/20 Financial Year. The Dashboard figures per FY for BBAs are: • FY2017/18 = 3 • FY2018/19 = 8 • FY2019/20 = 41 (Altered criteria active from 01/04/2019) • FY2020/21 = 52 There is no national data on BBA's to enable a comparison. NMPA and GIRFT do not include this metric.

			place in the Consultant-Led Unit at PRH (broken down by year for both)? In its response to the first Ockenden report, will the Board reflect on the need for women to have choice and control during pregnancy and labour (emphasised in Better Births as important components of safe care)? And when is Shrewsbury MLU scheduled to re-open? What are the reasons behind the current prolonged closure of Shrewsbury MLU? (It closed – for the second time - in June 2019 for an estimated maximum period of 6 months). The rural MLUs were closed to maintain staffing levels at the PRH Consultant-Led Unit, with indefinite closure taking place without consultation in June 2018 following repeated short-term and short-notice closures throughout 2017. When is the legally necessary public consultation likely to take place? **Future Fit/ Hospital Transformation Programme** This immensely troubled and unpopular programme has been limping along since November 2013 now. In the autumn of 2015, the original 'whole system' approach was abandoned when NHS England deemed it unaffordable, and it was replaced with an acute-focused programme. Public consultation on this took place over the summer of 2018, at a time when the capital cost of Future Fit was estimated at £312m. Subsequently, Future Fit has been rebranded as the Hospital Transformation Programme. The estimated capital cost of Future Fit has slid about: rising to	

			£498m in a report leaked in December 2019, reported to local MPs by SaTH to have risen to £580m in January 2020 (when the then SaTH Chair Ben Reid also described the project as 'botched'), but the cost was then said by STP Chair Sir Neil McKay as £533m in July 2020. Any information available to the public has been via leaks. The level of secrecy around the project is unprecedented. What is the current estimated capital cost of implementing Future Fit/ Hospital Transformation Programme? If this is unknown, what is the *range* of capital costs under consideration? What level of capital funding has been authorised to date by NHS England and/or the Treasury? Is this still £312m? Is there an agreed (or even likely) funding source now identified? Can the Trust Board guarantee that the OBC now under development – reportedly via a £6m 'draw down' - will include *every* major component – at both sites – that went to public consultation in the summer of 2018? Can the Trust Board guarantee that any funding shortfall will not result in a phased implementation of the Future Fit/ Hospital Transformation Programme? If the Trust cannot guarantee these things, will you share with the public – the people you serve – the fullest possible information on which elements of Future Fit may be dropped entirely and which may be delayed, and by how long? Local people are the most important stakeholders you have.	

001/2021	07/01/2021	David Sandbach	How do you rate your performance in respect of the objectives noted below: "We want to be open and transparent about the way we do business. We want to ensure local people and groups have the opportunity to ask questions about our work." Source: https://www.sath.nhs.uk/about-us/trust-information/questions/	The Board of Directors acknowledge that there have been occasions when the Trust could have been more transparent or open about the way it transacts its business. However, there are many opportunities for local people and groups to engage with the Trust by asking questions about the Trust's work. We have criteria for what will constitute a 'public question' on the website. The Trust's website provides several links to various ways in which local people can engage with the Trust or with local groups and institutions where stakeholders have the opportunity to ask questions or raise issues In December 2020 attendees at Community Engagement Group meeting, met staff from the Trust, including the Director of Nursing. The Trust currently has circa 10,000 public / patient 'members' who engage with the organisation. The Trust's website provides contact details for patients to provide feedback, raise a concern or complaint, or simply share a story or comment. The website includes examples of how that feedback has improved patient experience at the Trust. The Trust's website includes details of a Publication Scheme, directing stakeholders to various pieces of information, such

				as responses provided to those who have asked for information under the Freedom of Information Act 2000. The Trust regularly publishes Trust documents, including the Annual Report and Accounts, the Quality Report, and reports from external agencies and third parties, all Trust expenditure over £25,000, a log of organisations that the Trust shares data with, declarations of interest from senior colleagues, registers, policies, and more. The Trust is committed to being transparent and open as it can be.
002/2021	07/01/2021	David Sandbach	Why is the Integrated Performance Report being hidden from the public?	It had been decided by the Trust that the agenda for the meeting held on 7 January 2021 would, under the circumstances, focus on the Trust's response to the Ockenden Report published on 10 December 2020. For this reason it was agreed that the IPR report would be published on the website as an information pack.
003/2021	07/01/2021	Gill George	Have you had any questions from families? Also, no one has discussed HOW this happened. How COULD this happen, not just briefly but for decades? And if you don't know, how can you stop it happening again? I would of course welcome a reply to my letter to the Chair and Non-Executive Directors (attached again here in case it has been mislaid).	Any details concerning correspondence between families affected by the events covered in Donna Ockenden's First Report, would remain confidential between the Trust and those involved. Hence the Trust is unable to respond to this question. The letter addressed to the Chair and Non-Executive Directors was responded to on 13th January 2021.

			Finally, the answers to my July questions – only recently discovered – indicate a change of methodology in the collection of data on 'Births Before Arrival' (BBAs). This seems to have the effect of approximately **quadrupling** the number of BBAs, which is a little bit surprising. Could you explain both the old and new methodologies? Does the change in methodology preclude a year by year comparison? If so, how does SaTH monitor its performance in this rather crucial area? If a comparison has been done, I would welcome this being shared.	In December 2019, the definition for Born Before Arrival (BBA) for the Maternity Services Dashboard was changed. Prior to the change, a birth was considered a BBA where the Place of Birth was selected as 'In Transit' or 'Other'. This was changed to the new criteria where the field "Name of Non Professional Person Delivering" contained a name. This was irrespective of the given Place of Birth. The reason behind the change was due to the number of babies born with Place of Birth given as "Home" – but were delivered by a Non Professional. When making this alteration to the Dashboard, the figures were backdated to the beginning of the 2019/20 Financial Year. The Dashboard figures per FY for BBAs are; ○ FY2017/18 = 3 ○ FY2018/19 = 8 ○ FY2019/20 = 41 (altered criteria active from 01/04/2019) ○ FY2020/21 = 52 There does not appear to be any national data on BBA's to enable a comparison to be made – NMPA and GIRFT do not include this as a metric.

004/2021	11/02/2021	David Sandbach	**Hospital Transformation Plan.** What does the term “reset” refer to? When will the Board be in a position to publish the Statement of Case supporting the Hospital Transformation Plan? Can you please confirm the model of hospital service provided by SaTH, as per the consultation document and subsequent decisions to have RSH as the emergency hospital and PRH as the planned & diagnostic remain as per the consultation document? £ 6,000,000 has been agreed in principle by NHSE/I to support the initial phase of the HTP planning process. Has this money been released to the Trust? **Maternity** There are circa six committees which have some oversight responsibilities for Maternity service. This looks like a complex command, control, coordination and communications system. Is any individual on all of these committees as a mechanism for continuity of input and detailed understanding of what is going on and integrity of the whole process? There appears to be two dates for the implementation of BadgerNet March 2021 and October 2021 when will BadgerNet be implemented? Would the Maternity plan be enhanced and more comprehensive if it had details of the IT facilities needed to support it were made explicit in the plan.	The term ‘reset’ relates to updating forward plans and milestones, incorporating required actions to improve programme delivery performance and ensuring full alignment with the ICS long term plans. Timelines for approval (and publication) of the SOC will be determined as part of the programme reset. The model of hospital service remains as per the consultation document. The funds have not been released to the Trust. Hayley Flavell DoN is the Responsible Executive and Chair of Maternity Quality Oversight Committee (MQOC), the extraordinary oversight committee reporting to QSAC, which Ms Flavell attends. BadgerNet implementation was originally set for May 2021, however, it is now proposed to implement the system from March 2021. October 2021 refers to the proposed EPR implementation date. The implementation of BadgerNet Maternity and Neonatal EPR is the system required to support the delivery of the plan.

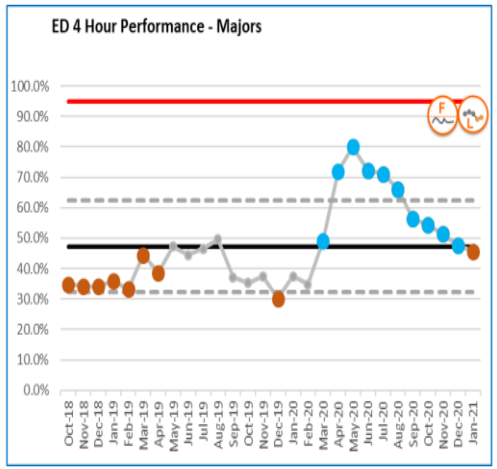
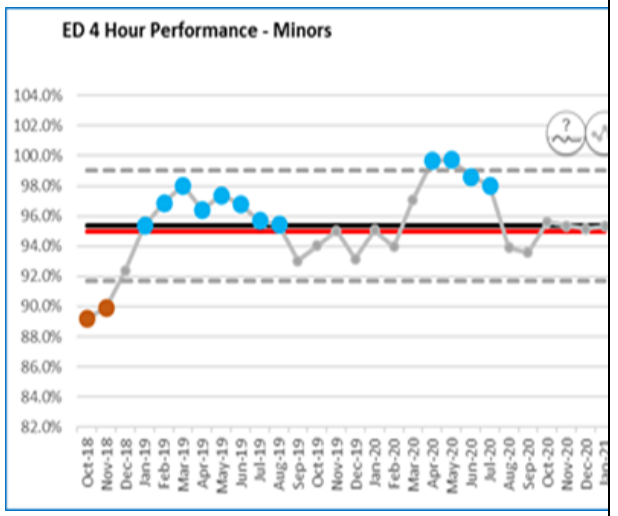
			Does the SaTH Board expect their EMBBRACE data to improve as a result of the actions being taken post feedback in the Ockenden report?	The service continues to implement and monitor the impact of national initiatives designed to reduce the rate of avoidable stillbirth and neonatal deaths. There was a reduction in extended perinatal death rate (EPDR) in 2018. And whilst the Trust has continued to observe a downward trend in the crude EPDR it does not have comparative unit data to enable comparison in line with MBRRACE.
005/2021	11/02/2021	Dag Saunders	Is the Trust satisfied with the accuracy level of the lateral flow test for staff?	Lateral Flow Tests (LFT) are an additional tool for identifying a small cohort of asymptomatic staff. They have a high specificity (over 95%) with few false-positive results. Covid-19 tests cannot be 100% accurate. https://www.ox.ac.uk/news/2020-11-11-oxford-university-and-phe-confirm-lateral-flow-tests-show-high-specificity-and-are#
006/2021	11/03/2021	Linda Senior	**Questions around maternity** 1. One of SaTH's 'Immediate and Essential Actions' arising from the Ockenden Review is 'listening to women and families'. A central strand of achieving this is working with the Maternity Voices Partnership (MVP). Does the Board have assurance that the MVP is representative? For example, does it include women/families who have lost a baby or who have had a baby harmed in SaTH's care? Or who have been harmed themselves? Does it include rural women who have been directly affected by the	The Shropshire Telford and Wrekin Maternity Voices Partnership is independent to the Trust, but includes colleagues working for the Trust to support its aim to improve maternity care across the region. Individuals (independent women and their families) are able to get involved with the MVP on a voluntary basis – contact details appear on the MVP website – but the Trust has no responsibility to ensure that the MVP is representative of local communities.

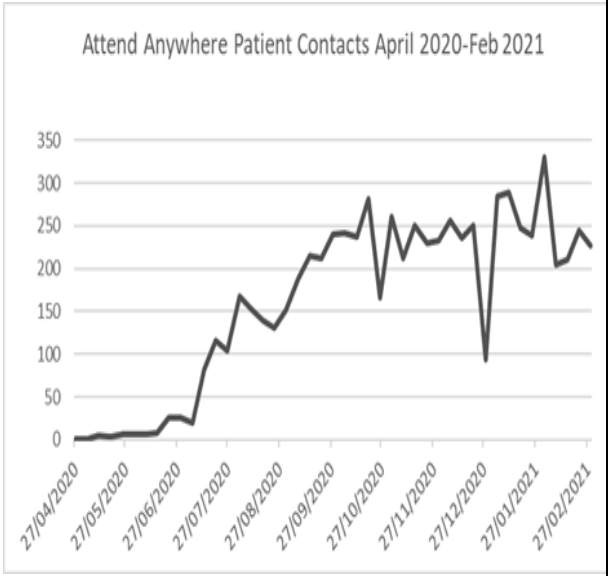
			continued closure of rural MLUs? If not, how will you ensure these voices are heard? 2. What is SaTH's legal justification for the continued closure of the three rural MLUs? Please explain in particular how you have adhered to Section 242 of the NHS Act 2006 (the Duty to Involve). A pretence that the closures are temporary is not compelling four years on. How did SaTH take into account the outcome of public engagement on MLU closure that took place in the summer of 2018? (This showed very strong community support for community MLUs to re-open). 3. The paper on SaTH's response to the Ockenden Review includes many, many actions that are 'on track', but not yet delivered. The 'not yet delivered' actions include many strands around safety and risk assessment, listening to women and ensuring informed consent, consultant/specialist involvement in complex cases, adherence to national guidelines etc. These are core components of safe maternity care. What does this tell the Board about the maternity service that has existed until a few months ago and perhaps continues to exist? What does this tell the Board as a whole about its own lack of oversight and its failure over many years to challenge both its Executive and its clinical leaders within Maternity and Women and Children's? There is strong reason to believe that 'attitudinal' problems contributed very substantially to avoidable deaths and harm in maternity over a period of decades. In particular, there seems to have been	The Board has stated at meetings in public that the decision to suspend the MLU birthing service was on safety grounds due to staffing and the safest use of the available workforce; that suspension will continue until the CCG Review is complete. Safety issues remain paramount. The Board considered the findings from the engagement exercise but the safety of the services was and remains the key priority. July 2018 https://www.sath.nhs.uk/wp-content/uploads/2018/07/13-MLU-Update.pdf October 2018 https://www.sath.nhs.uk/wp-content/uploads/2018/10/Maternity-PPT-engagement-responses-Sept-18.pdf November 2018 https://www.sath.nhs.uk/wp-content/uploads/2018/11/09-MLU-Update-Nov-2018.pdf November 2018 https://www.sath.nhs.uk/wp-content/uploads/2019/02/02-Minutes-of-29-November-2018-Trust-Board.pdf At this stage, the Trust is unable to confirm or deny whether members of staff have been referred to either the GMC or NMC over the last decade.

			an active failure to learn from very senior members of staff in Maternity and Women and Children's. 4. 5. Is the Board entirely comfortable that senior staff members continue to hold influential positions within SaTH and continue to shape the future of patient care (and patient safety) delivered by the Trust? 6. How many staff members have been referred to the GMC as a result of patient safety issues in the maternity service over the last decade? And how many have been referred to the NMC (for the same reason, and the same period)?	
007/2021	11/03/2021	Gill George	**Future Fit/ HTP** We know that a draft Strategic Outline Case for Future Fit/ Hospital Transformation Programme was submitted to NHS England in November 2019. Will SaTH make this publicly available, and also share the NHS England response?	This was a draft document that was submitted for comment but not approved, so we are not planning to share it in the public domain – at the time, my understanding is that no formal feedback was received from NHSEI.

008/2021	11/03/2021	Sue Campbell	**Future Fit/Hospital Transformation Programme** 1. Is SaTH confident that robust community services, preventive work and social care are in place to support the Future Fit/ HTP model and its implementation? If so, what is the basis for your belief? 2. What new modelling has taken place since public consultation? (Most modelling work took place in 2014 and 2015, with a hasty update prior to public consultation in 2018. This will now of course be substantially out of date; even more so given the likely impact of 'long Covid' on local services). Will SaTH make its recent modelling work publicly available? 3. Why is there an apparent policy of secrecy around Future Fit/ HTP? If there is not, then simply make information on Future Fit/ HTP available to the public on your website. If you are committed to secrecy, please explain your rationale and how you justify this (referencing the Nolan Principles in your response)? 4. Is it the current intention that the Future Fit model will be implemented in full?	There is a lot of work still to do in this area – and this is one of the key components that we need to focus our collective efforts towards as we move forward, working closely with our health and social care system partners.

009/2021	11/03/2021	Marilyn Gaunt	**Birth-rate Plus** 1. Will SaTH share the terms of reference of its most recent Birthrate Plus staffing review? Did the review look at staffing of two MLUs or five? Will you also share the review report? **Culture and Behaviours** 2. What are the 'new values' and what is the 'Behavioural Framework'? **Infection Control** 3. The report on infection control makes reference to a significant number of Covid outbreaks at both hospitals. This is of course concerning. Recent press reports have highlighted something slightly different: the discharge home of patients who are Covid-positive who have then infected other family members. In one case, a relative was casually advised at the point of discharge, 'Oh by the way, he's Covid-positive' (i.e. this was known to SaTH in advance of discharge). What steps is SaTH taking to deal with both problems? Is it considered acceptable practice to discharge Covid-positive patients to destinations where the chance of them infecting others is high?	The Birthrate Plus staffing review to be presented to the Board in June 2021. The Trust's 'new values' were published in 2020, and are: Partnering, Ambitious, Caring, Trusted, providing the acronym PACT. An outbreak is two cases or more cases. Each case is classified through a robust process including NHSEI/CCG/PHE, chaired by DIPC with assurance provided via IPAC and reported to the Trust Board BoardWe were unable to provide a response at the March board meeting, as results were, as noted, published on the same day as the board meeting. However, a much fuller report was presented to the Board at its April meeting, and appears on the Trust website.
010/2021	11/03/2021	David Sandbach	A 95.3% performance would give a very different graph. Is the figure of 95.3% correct?	The data in the IPR dashboard is correct – shows 4 hour (67.5%) and split of 4 hour into majors (45.6%) and minors (95.3%). In the exception report the

			ED Majors Performance  **January 2021 actual performance** 95.3% **Variance Type** Common Cause Variation **National Target** 95% **Target/ Plan achievement** Delivered for last 3 months NB According to this graph just over 50% of majors are stuck in A&E for longer than four hours. The quality implications of this are very serious. **Use of MBBRACE data.** Can you please explain your position as stated at last month's meeting with your current position noted in the new Quality Improvement Strategy: <u>Question from last month:</u> Does the SaTH Board expect their EMBBRACE data to improve as a result of the actions being taken post feedback in the Ockenden report? Answer: "The service continues to implement and monitor the impact of many national initiatives which will lead to a reduction in the rates of avoidable stillbirth and neonatal deaths. The 2018report showed a reduction in extended perinatal death rate (EPDR) and we have	overall 4 hours and narrative is correct – 67.5%. This graph however is 'majors' , whereas the table is 'minors' performance –so both correct but shouldn't have been next to each other.  The scheduled closing time of the meetings is 4pm. The meeting last month overran. Our Director of Finance Designate attended her first board meeting on 11 March 2021. She will take up the substantive role as from 1 April 2021. This is an internal management document containing some sensitive and commercial information, so we are not planning to share the full report in the public domain at this time.

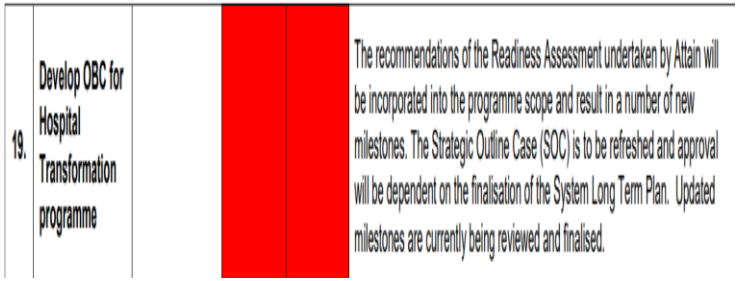
			observed a continued downward trend in the crude EPDR **but the service does not have comparative unit data to enable definitive comparison with MBRRACE."** Quality Improvement Strategy: 05.1 BoD PUBLIC Quality Improvement Strategy incl. COVERSHEET a (sath.nhs.uk) "How will we know if we have succeeded? Reduction in the number of stillbirths, neonatal deaths and maternal deaths measured by **MBRRACE** **FACT** MBRACE puts comparative data into the public domain e.g. size of units by type and numbers of births etc.; also there is a Perinatal Review Tool available. If you have not already done so please fill this form in and you will reap benefits from a quality assurance point of view - PMRT registration form Jan 2018.pdf (ox.ac.uk) Did the meeting close at 16.00 hrs? The Chair thanked the public for attending the meeting. **MEETING CLOSED** **1600** Prof. C Deadman (CD) | Non-Executive Director (NED) | Left c.16:00 I attended all of this meeting and seem to remember that it went on until past 17.00 hrs. Why has the SaTH Board not managed to hire a substantive Finance Director?	In terms of AttendAnywhere 7230 from mid-April 2020 to end February 2021, since Sept average 235 per week – graph below (which includes Audiology which isn't in SUS data) 

A) Why has the Board not hired a substantive HR Director? Asking someone to act up over long period of time is wrong from an ethical point of view i.e. it looks like exploitation of a loyal employee. Culture – culture don't you know.

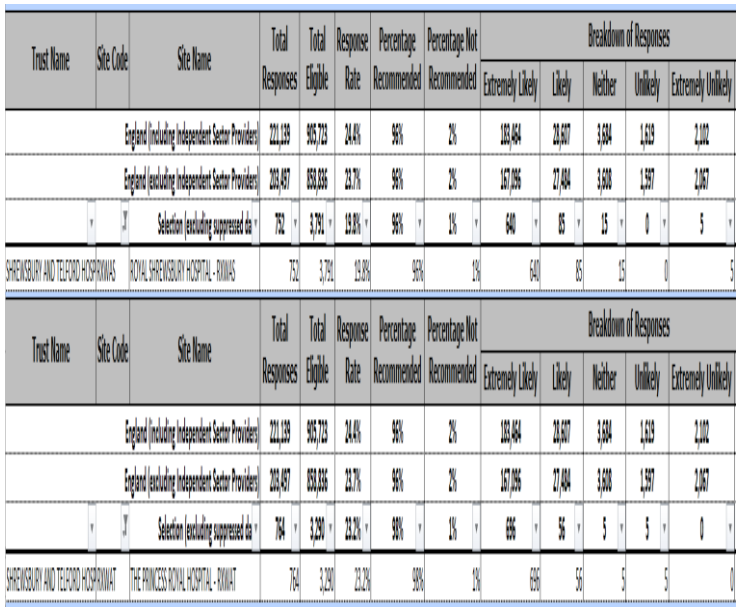
Given the frustration with poor progress concerning the Future Fit / Hospital Transformation Programme, which has recently expressed by three of our beloved local MPs, is the SaTH Board willing to put the Readiness Assessment report into the public domain.

MPs ask health boss for Future Fit plan review | Shropshire Star
MP calls for investigation into Future Fit delays | Shropshire Star
MP asks parliamentary watchdog to investigate Future Fit delays | Shropshire Star

Also is the SaTH Board prepared to make a full and clear statement as to the cause of the hold up on this very vital project? It is well known God (and the tax paying public) loves repentant sinners 😉



Would it be possible for the SaTH Board to numerate and explain the known milestones referred to above?

			How will we know if we have succeeded? Increase in staff and patients recommending services as a place to receive care including through Friends and Family scores and National Inpatient, Emergency Department, CYP Surveys" Will the SaTH Board publish this kind of data in future? SaTH response rate Feb 2020 In patient feedback  A&E Feedback	

Trust Name	Site Code	Site Name	Total Responses	Total Eligible	Response Rate	Percentage Recommended	Percentage Not Recommended	Breakdown of Responses				
								Extremely Likely	Likely	Neither	Unlikely	Extremely Unlikely
		England (including Independent Sector Providers)	221,139	905,723	24.4%	96%	2%	135,454	28,937	3,834	1,619	2,102
		England (excluding Independent Sector Providers)	203,497	859,936	23.7%	96%	2%	127,096	27,494	3,608	1,527	2,067
	RW	Selection (excluding suppressed data)	752	3,791	19.8%	96%	1%	640	85	15	0	5
SHREWSBURY AND TELFORD HOSP NHS	RWA	ROYAL SHREWSBURY HOSPITAL - RWAS	752	3,791	19.8%	96%	1%	640	85	15	0	5

Trust Name	Site Code	Site Name	Total Responses	Total Eligible	Response Rate	Percentage Recommended	Percentage Not Recommended	Breakdown of Responses				
								Extremely Likely	Likely	Neither	Unlikely	Extremely Unlikely
		England (including Independent Sector Providers)	221,139	905,723	24.4%	96%	2%	135,454	28,937	3,834	1,619	2,102
		England (excluding Independent Sector Providers)	203,497	859,936	23.7%	96%	2%	127,096	27,494	3,608	1,527	2,067
	RW	Selection (excluding suppressed data)	764	3,299	23.2%	98%	1%	695	56	5	5	0
SHREWSBURY AND TELFORD HOSP NHS	RWAT	THE PRINCESS ROYAL HOSPITAL - RWAT	764	3,299	23.2%	98%	1%	695	56	5	5	0

Site Name	Total Responses	Total Eligible	Response Rate	Percentage Recommended	Percentage Not Recommended	Breakdown of Responses					
						Extremely Likely	Likely	Neither	Unlikely	Extremely Unlikely	Don't Know
England	132,173	1,088,974	12.1%	85%	9%	86,549	25,792	5,981	4,441	7,526	1,884
Selection (excluding suppressed dat	350	3,353	10.8%	95%	1%	266	66	11	3	2	2
Royal Shrewsbury Hospital - RKWAS	350	3,353	10.8%	95%	1%	266	66	11	3	2	2

Site Name	Total Responses	Total Eligible	Response Rate	Percentage Recommended	Percentage Not Recommended	Breakdown of Responses					
						Extremely Likely	Likely	Neither	Unlikely	Extremely Unlikely	Don't Know
England	132,173	1,088,974	12.1%	85%	9%	86,549	25,792	5,981	4,441	7,526	1,884
Selection (excluding suppressed dat	140	3,726	3.8%	90%	3%	77	49	9	1	3	1
The Princess Royal Hospital - RKWAT	140	3,726	3.8%	90%	3%	77	49	9	1	3	1

NB Data submission and publication for the Friends and Family Test (FFT) restarted for acute and community providers from December 2020, following the pause during the response to COVID-19. The first three months of data will be published in April 2021. For full details see FFT frequently asked questions or email england.friendsandfamilytest@nhs.net

See also:

Dementia assessment:

Overall Summary	Number to whom case finding is applied	Number of emergency admissions	Percentage to whom case finding is applied	Number who had a diagnostic assessment	Number with positive case finding question	Percentage with a diagnostic assessment	Number of cases referred	Number with a positive or inconclusive diagnostic assessment	Percentage of cases referred
	49,644	60,776	81.7%	9,136	9,046	91.9%	4,369	4,567	95.4%
SHREWSBURY AND TELFORD HOSPITAL NHS TRUST	267	269	99%	2	2	100%	1	1	100%

			https://www.england.nhs.uk/statistics/wp-content/uploads/sites/2/2020/05/Dementia-Data-Collection-February-2020-XLS-29KB.xlsx How many out-patient episodes have been provided using the Attend Anywhere facility SaTH has invested in? NHS video clinics - SaTH	
011/2021	08/04/2021	Andrew Metcalf	I have recently discovered that the response of SATH staff to a nationwide survey of NHS trusts rates SATH management literally at the bottom of NHS trusts on such issues as the ease and encouragement of staff to raise concerns about any aspect of clinical or administrative and those same staff's confidence that they will be listened to, and that issues raised will be rigorously investigated and appropriate actions taken by management to improve identified problems. This is unquestionably a key indicator of significant problems within the managerial culture of SATH compared with other NHS trusts, who are themselves not highly rated on such questions compared with other industries. There can be little doubt in the mind of any unbiased, open-minded observers or analysts that this major managerial cultural problem is a significant contributor to SATHS widely reported and catastrophic management failings over many years, particularly in maternity care - with little or no evidence of SATH management, acknowledging these problems, taking them seriously or improving their appalling record.	It is assumed by the Trust that the question referred to appears below at log numbers 2021/012 and 2021/013 The April board meeting provided an overview of the results of the staff survey and details of some of the work that is ongoing to support staff, the role of culture in creating high quality of care and the work being undertaken in this regard, and details of the 'Clever Together' initiative.

			I believe that a question from the public highlighting this problem has been tabled for inclusion on the upcoming SATH Board Agenda. In my mind, and based on my discussions with other people served by SATH, addressing this continuing clear and significant management failings, explicitly, urgently and openly, should be right at the top of SATH management's agenda. This letter, copied to the Shropshire Star, is a formal request to you to ensure that this question of critical importance is included on the agenda for the upcoming SATH Board Meeting.	
012/2021	08/04/2021	Gemma Offand/ Jean Macdonald/ Joy Stocks/ Julia Evans/ Kath Perry/ Kayleigh Griffiths/ Laura Fletcher/ Linda Senior/ Penny Dunachie/ Rhiannon Davies/ Sophie Dick/ Steve Dunachie/ Sue Overton/ Walt Zak/ William Edmondson/	Please take this question at your Board meeting on 8th April. I know that most questions from the public are currently being 'lost'. The 2020 Staff Survey results for SaTH are truly terrible. One that stands out is that your own staff give SaTH the worst rating of any acute trust in the country on 'Safety Culture' – that cluster of questions around staff being able to report unsafe care and the organisation acting to put things right. Patients have a right to know about the safety of their care – but these major safety concerns were not reported to your Board on 11th March and are well hidden in the written report to the 8th April Board meeting. A culture of dishonesty and concealment contributed to the scandal of avoidable deaths in your maternity service. Have you learned the lessons?	Public questions arising from Board Meetings are not ignored, and responses are provided where possible. The April board meeting provided an overview of the results of the staff survey and details of some of the work that is ongoing to support staff, the role of culture in creating high quality of care and the work being undertaken in this regard, and details of the 'Clever Together' initiative.

		Marilyn Gaunt/ Lizzie Fletcher/ David Fletcher	On 8th April, will your Board make a necessary collective commitment to honesty and accountability to the public you serve?"	
013/2021	08/04/2021	David Sandbach	At the last SaTH Board meeting it was announced to the WORLD (and all the malicious hackers therein) that SaTH cyber security was wanting. *"Ms Milanec confirmed that implementation of the actions on the plan for the Toolkit, continued, but **that lack of** oversight in the area of information governance and **cyber security had, for some years, been minimal** and that the Trust was now having to 'catch up'."* What action has been taken to inform SaTH partners i.e. the NHS ICS members and THE Local Authorities who are members of the ICS? **NB** *"not being able to demonstrate compliance with the toolkit was potentially problematic."* Catastrophic more like – who wants to hang-out with the weakest link in the ICS? The Board ignores data on compliments. This is a really dumb thing to do because it is not conducive to improving esprit de corps and staff wellbeing. I would like to suggest that the Wellbeing Guardian supports the introduction of direct patient feedback in the form of a web based feedback system. The endorsement / compliment can be fed directly to individual members of staff. How many items are on the risk register? By the looks of things there seem to be at least 2065.	Ms Milanec further clarified her response, with additional comments, at the April meeting, also confirming that all members of the Board of Directors (save one) had now completed independent Cyber Security Training aimed specifically at Boards. The Trust does indeed, receive compliments concerning the care that it provides. It has recognised that such compliments should be more publicised, and ways in which to do so, are currently being explored. A response to this question was provided at the April board meeting – circa 500 risks appear on the Trust's risk register.

			Can members of the public have access to the SaTH Risk Register? NB SaTH has a duty of transparency and candid behaviour. *"In response the Trust undertook an immediate and complete review of all patients to ensure that appropriate actions/assessments were in place or completed and that the patients were safeguarded from any potential harm and that mitigations to risks were actioned. These actions were undertaken and completed in response to this condition on the 1st. March 2021."* Will these actions be "embedded" permanently in the SaTH SOP? *"but following this overnight stay the child/young person must be transferred to an alternative care setting to meet their mental health care needs if they are not well enough to be discharged."* Is there any evidence the SaTH Board will receive in due course? *"The registered provider must adopt an effective system to enable them to identify where all patients under 18 are located within the hospital. Appropriate oversight of the care of these patients must be provided by suitably competent staff. This must include continuous oversight by a registered mental health nurse and regular oversight from a child and adolescent psychiatrist for patients under 18 who are admitted with acute mental health needs, learning disabilities and behaviours that challenge."*	A summary of the high level risk register will be published on a quarterly basis from May 2021. There is a robust risk assessment. Cascaded across the appropriate areas. Mentally unwell, i.e. not physical - we cannot admit isolated mental health patients. There will be compliance monitoring. System KPI Action plan is tracked via groups that feed into QSAC and board A SOP is in place for oversight Joint working with MPFT re oversight Nurses and medic Placement Challenges have occurred both in ED and wards once medically. Escalation in place. A system wide response is required. Additional Mental Health Matron will be joining the Trust in May 2021 focusing on C&YP. This role has been funded by NHSE/I

			Has this happened and has this caused any placement problems? *"Ongoing system wide work is required to further develop responsive, timely, robust quality specialist mental health services to the Trust and address current gaps in service provision, for example the lack of acute psychiatric liaison services at PRH site between 1am and 8am, and the lack of a Child and Adolescent Mental Health Consultant out of hours to support the Trust. Mental Health services are commissioned by the CCG and provided to the Trust from MPFT so the system will be working to ensure these are in place moving forward."* Bearing in mind SaTH only has access to one MH Matron is the SaTH Board content that it has enough resources to comply with this condition? Did the SaTH management ever raise the issues regarding service gaps with the CCGs or with the sub-contractor i.e. MPFT. Has the MPFT demonstrated to SaTH management a sincere and unequivocal determination to resolve the problems noted by the CQC? Ditto the new Shropshire & T&W CCG and ICS committee? Bearing in mind the much publicised poor performance in respect of SaTH Maternity Services and the recent CQC report about MH services for children and young people, do the SaTH Board have a corporate bias **against** youngsters and are youngsters i.e. people 0 – 18 years **low priority** at SaTH? Does SaTH have a Director of Workforce?	SaTH management did raise the issues regarding service gaps with the CCGs and/or with the sub-contractor i.e. MPFT. The Trust Board of Directors do not have a corporate bias against children and young people.

			The Acting Director of Workforce has been attending SaTH Board meetings since Mrs V Rankin stopped attending SaTH Board meetings in October 2019. 17 going on 18 months is a very long time to have a person in an acting position. When does the SaTH Board expect to employ a substantive Director of Workforce? When will the SaTH Board be in a position to make public the SOC and OBC relating to the Hospital Transformation Plan? *"The overall programme is progressing well against the plan. The MoU has now been received for £9.3m in 2021/22 for the **RSH ED reconfiguration** and the approval process is in motion. This should allow the enabling and main works to start as planned. A firm completion date will be agreed when the contract award process is completed in March 2021."* What plan, when was this plan discussed at the Board meeting? MoU (Memorandum of Understanding) from which organisation e.g. CCG / ICS / NHSE/I / private financiers has SaTH received the MoU? Can members of the public have copies of the MoU document? What is meant by the term 'reconfiguration' - is this some reference to building work which is temporary i.e. money which will be spent on propping up the existing A&E at RSH until the Future Fit / HTP building work is complete and SaTH acquires a state of the	The Trust has an Acting Director of Workforce. The Trust will employ a substantive Director of Workforce in due course.

			art ED facility as promised to the public in the FF consultation . In which publication and when was the contract advertised and has it been signed yet? What disruption to patients (i.e. emergency, out patients and in patients) and visitors will the enabling and main works cause and for how long? Why has this project not been mentioned and **FULLY** explained during an earlier Board meeting? Are the words honesty, transparency, candour and openness embedded (deeply rooted) in the culture of the SaTH Trust Board or like many other things on the Boards last agenda is the embedded bit just too hard for the Board to achieve?	
014/2021	08/04/2021	Diane Peacock	The questions below were submitted to the Board for the December 2020 meeting and remain unanswered and unpublished. Diane Peacock 5.4.21. With regard to the July Board questions relating to data, the response was that the 'SaTH Information system is not able to derive this data'. While welcoming the new CEO's determination in that detailed data be available in future, does the CEO think it was acceptable that basic data on the admissions, discharges and deaths in hospital relating to care home residents could not be 'derived'	Response/s published previously.

			when much of it was in fact available within national repositories such as the NHSE,1 the ONS2 and via local intelligence. The CO-CIN3 reports for SAGE suggest that nosocomial transmission of Covid-19 in the sample started to rise again in October. Has the Trust collated data on cases of Covid-19 occurring up to 14 days after admission to hospital? If so what do the figures indicate, over time, about infection control? *In response to an October question about multi-agency working, the Trust stated that:* *'Whilst the Trust continues to monitor patients discharged to a community health and social care setting, it does not have access to the detailed Local Authorities' lessons learnt from the first wave of Covid-19, and benefits to residents and staff'.* How can a local authority be expected to learn lessons from the first wave of Covid-19 unless local intelligence provided by all active agencies is pooled? Does the CEO consider that the pooling of local intelligence including patterns of hospital admissions, discharges and inpatient deaths, relating for example to care home residents, at the height of the pandemic could have helped reduced further loss of life in the second wave to Covid-19? With regard to CQC's inspection concerns (14.08.20), what is the evidence (qualitative and quantitative) to suggest that all aspects of end of life care at RSH are now meeting the standards all patients deserve?	

			Example: COVID-19 Hospital Activity https://www.england.nhs.uk/statistics/statistical-work-areas/covid-19-hospitalactivity/ **Example:** Weekly provisional figures on deaths occurring and registered in England and Wales by Local Authority that includes of deaths designated to care home/ elsewhere/ home/hospice/ hospital/and other communal establishment 3Example: CO-CIN report https://assets.publishing.service.gov.uk/government/uploads/	
015/2021	08/04/2021	Gill George	**Future Fit/ HTP** What is the estimated cost now of Future Fit/ HTP? Has the expenditure been authorised by the Treasury? How much of this capital has been secured, and from what sources? What is the likely revenue impact annually of the capital required for Future Fit/ HTP? What is the current implementation plan for Future Fit/ HTP (i.e. in what order will stages be implemented and what are your estimated or target dates both for beginning and ending these stages)? We know that a draft Strategic Outline Case for Future Fit/ Hospital Transformation Programme was submitted to NHS England in November 2019. Will	The cost for this reconfiguration at pre-consultation business case (PCBC) stage in 2016 was £312m. In the revised 2019 draft SOC, the funding requirements had increased to £533m, predominantly due to increases in published government inflation rates and changes to technical classifications (which in total add £162 million to the predicted capital cost). Many of the variables will continue to change as we progress through the programme and updated estimates of the capital cost will be summarised as the scheme moves through the business case approval cycle. Other capital schemes of this nature nationally, where development is taking place over a number of years, are also

			SaTH make this publicly available, and also share the NHS England response?	being impacted in similar ways. The projected increase in costs would have applied to all of the options that were considered prior to consultation. In March 2018, the Department of Health and Social Care approved £312 million of funding. The sources of funding are being reviewed as part of the finalisation of the SOC The annual capital charges (based on the latest capital costs) are estimated to increase by circa £30m (based on the estimates included in the 2019 draft SOC). However, in taking forward the scheme the Trust expects to generate significant annual revenue savings that will be used to offset. We fully expect the programme to deliver the service changes outlined in the public consultation. System partners and stakeholders, including people impacted by the reconfiguration such as patients, families and the wider population of the health system will be kept informed and involved as the programme progresses. The Trust uses an internationally recognised organisation to undertake demand and capacity modelling for the HTP. The demand and capacity models allow for

				regular adjustment to reflect the most up-to-date circumstances. An updated version of the demand and capacity modelling will be included in the finalised SOC. There is a lot of further development required in this area and this is one of the key components that we need to focus our collective efforts towards, working closely with our health and social care system partners. Linked to the recommendations of that review, a number of key focus areas were identified and are being progressed at pace: • Updating of a number of specific areas of content to finalise the Strategic Outline Case (SOC); • Resetting of programme timelines and strengthening governance arrangements; • Accelerating the implementation of acute reconfiguration clinical models; • Addressing the affordability challenge. The delivery of the timelines for the finalisation of the SOC and the development of the OBC are also dependent upon the timely release of the required funding from NHSE/I. The Trust recently undertook a review of the HTP to assess current status and reset future plans (as the impact of the

			“Please take this question at your Board meeting on 8th April. I know that most questions from the public are currently being ‘lost’. *The 2020 Staff Survey results for SaTH are truly terrible. One that stands out is that your own staff give SaTH the worst rating of any acute trust in the country on ‘Safety Culture’ – that cluster of questions around staff being able to report unsafe care and the organisation acting to put things right.* *Patients have a right to know about the safety of their care – but these major safety concerns were not reported to your Board on 11th March and are well hidden in the written report to the 8th April Board meeting.* *A culture of dishonesty and concealment contributed to the scandal of avoidable deaths in your maternity service. Have you learned the lessons? On 8th April, will your Board make a necessary collective commitment to honesty and accountability to the public you serve?”* The opening two paragraphs simply provide the context for our questions to the Board. To avoid any possibility of confusion, the questions to the Board are these:	COVID-19 pandemic reduces). the capital charge increase. Since the last board meeting, a review of questions received from the public over the last few months, has been reviewed. Where questions are able to be answered factually, they have been. All questions are considered, none are ignored.

			Importantly, will you now respond to the public questions previously submitted to you in 2021? Will you also update the 'Public Questions Log' – frozen in time at 7th January 2021 – to show all submitted questions, enabling the public to keep track of which questions are answered and which questions are ignored. Is the Board familiar with the NHS constitution, and its commitment that 'The NHS is accountable to the public, communities and patients that it serves'? Is the Board familiar with the Nolan Principles of Public Life? These include accountability, openness and honesty. Has the Board had recent training in the Principles of Public Life? Will the Trust Chair circulate the NHS Constitution and Nolan Principles to every Board member? Will she commit to reminding all Board members of the importance of the Principles of Public Life at the start of every Board meeting, public and private A like? The Ockenden report has been revealing. Does the Board agree with us that a greater degree of accountability, openness and honesty from predecessor SaTH Boards might well have saved lives? Has the Board discussed if, arising from events in maternity, there are lessons to be learned around its own culture and way of working?	The April board meeting provided an overview of the results of the staff survey and details of some of the work that is ongoing to support staff, the role of culture in creating high quality of care and the work being undertaken in this regard, and details of the 'Clever Together' initiative. Yes, the board is familiar with the NHS Constitution, and the more recently refreshed Handbook to the NHS Constitution. Yes, the board is familiar with the Nolan Principles of Public Life. Each board member, as part of their induction, receives a copy of the Principles, and NHS Constitution, together with other information. See above See above

			In Future Fit (or its current Hospital Transformation Programme brand name), SaTH is implementing the greatest changes in local health care that have taken place for many decades. You and the CCG together are doing this in near-total secrecy. Inevitably this suggests you have something to hide. In the interests of accountability, openness and honesty, will you now publish the fullest possible information on Future Fit, including your current plans, the proposed timetable for implementation, and the best information available to you on funding arrangements (including capital cost, the likely source of this capital funding, and its potential revenue impact)? A comment in passing, but the Covid pandemic has stretched the local NHS to its limits. If SaTH had successfully implemented Future Fit in 2015, you would have had many fewer beds and nurses available to you over the last year. If public opposition had not stopped the 2016/17 Shropshire CCG assault on community hospitals, there would have been many fewer community beds too, and little or no chance of moving urgent care to Bridgnorth. And a related question: how has Future Fit/ Transformation Programme modelling been updated to reflect the experiences of the Covid pandemic and the likely impact of 'long Covid' on population health? What maternity issues or concerns have been identified through the current involvement of	May public board agenda, item 101/21 provides an update on the HTP. Further information will be published when it is available. The Board is aware of inaccurate media reports of maternity concerns having 'been identified' by Sherwood Forest Hospitals NHS Foundation Trust. No measures were recommended or actions taken. Opinion sought Opinion sought The Board is aware of an inaccurate media report which suggested that concerns

			Sherwood Forest NHS Trust? What measures have been recommended by Sherwood Forest, and what steps have been taken by SaTH in response? Will you ensure that public Board papers will, as a matter of course, include the appendices made available to Board members?	had been raised by Sherwood Forest NHS Foundation Trust. No recommendations were made, or steps taken. Yes.
016/2021	08/04/2021	Linda Senior	One of SaTH's 'Immediate and Essential Actions' arising from the Ockenden Review is 'listening to women and families'. A central strand of achieving this is working with the Maternity Voices Partnership (MVP). Does the Board have assurance that the MVP is representative? For example, does it include women/families who have lost a baby or who have had a baby harmed in SaTH's care? Or who have been harmed themselves? Does it include rural women who have been directly affected by the continued closure of rural MLUs? If not, how will you ensure these voices are heard? What is SaTH's <u>legal</u> justification for the continued closure of the three rural MLUs? Please explain in particular how you have adhered to Section 242 of the NHS Act 2006 (the Duty to Involve). A pretence that the closures are temporary is not compelling four years on. How did SaTH take into account the outcome of public engagement on MLU closure that took place in the summer of 2018? (This showed very strong community support for community MLUs to re-open).	Response/s published previously.

			The paper on SaTH's response to the Ockenden Review includes many, many actions that are 'on track', but not yet delivered. The 'not yet delivered' actions include many strands around safety and risk assessment, listening to women and ensuring informed consent, consultant/specialist involvement in complex cases, adherence to national guidelines etc. These are core components of safe maternity care. What does this tell the Board about the maternity service that has existed until a few months ago and perhaps continues to exist? What does this tell the Board as a whole about its own lack of oversight and its failure over many years to challenge both its Executive and its clinical leaders within Maternity and Women's and Children's? There is strong reason to believe that 'attitudinal' problems contributed very substantially to avoidable deaths and harm in maternity over a period of decades. In particular, there seems to have been an active failure to learn from very senior members of staff in Maternity and Women's and Children's. Is the Board entirely comfortable that senior staff members continue to hold influential positions within SaTH and continue to shape the future of patient care (and patient safety) delivered by the Trust? How many staff members have been referred to the GMC as a result of patient safety issues in the maternity service over the last decade? And how many have been referred to the NMC (for the same reason, and the same period)?	