The Shrewsbury and Telford Hospital NHS Trust

The Shrewsbury and Telford Hospital NHS Trust
Board of Directors' meeting in PUBLIC

Thursday 9 December 2021 via MS Teams (and live streamed to a public audience)

MINUTES

Name	Title
MEMBERS	
Dr C McMahon	Chair
Mrs L Barnett	Chief Executive
Mrs T Boughey	Non-Executive Director
Mr A Bristlin	Non-Executive Director
Mr D Brown	Non-Executive Director
Prof C Deadman	Non-Executive Director
Mrs H Flavell	Director of Nursing
Dr J Jones	Acting Medical Director
Dr D Lee	Non-Executive Director
Mr N Lee	Chief Operating Officer
Prof T Purt	Non-Executive Director
IN ATTENDANCE	
Ms A Milanec	Director of Governance & Communications
Mr C Preston	Interim Deputy Chief Executive
Mr R Steyn	Co-Medical Director
Ms C West	Improvement Director
Mr P Corless	Deputy Director of Finance *In attendance for Agenda Item 296/21*
Ms R Gallimore	Director of Digital Transformation *In attendance for Agenda Item 298/21*
Ms E Wilkins	Deputy Director of People & Organisational Development *In attendance for Agenda Item 298/21*
Dr B Barrowclough	Guardian of Safe Working *In attendance for Agenda Item 305/21*
Ms S Jones	Interim Head of Midwifery *In attendance for Agenda Items 300/21-302/21*
Mr T Baker	Deputy Director of Operations, W&C Division *In attendance for Agenda Items 300/21-302/21*
Ms B Barnes	Board Secretariat (Minutes)
APOLOGIES	
Mrs H Troalen	Director of Finance
Ms R Boyode (non voting)	Director of People & Organisational Development

No.	ITEM	ACTION
PROCEDURAL ITEMS		
286/21	**Welcome, Introductions and Apologies** The Chair welcomed all those present, and observing members of the public attending the meeting via the live stream.	
287/21	**Staff Story** The Director of Nursing introduced a story shared by the Paediatric Matron, describing how the Paediatric Team worked collaboratively to meet the needs of a patient within their care. The young person attended the Emergency Department for treatment following a collapse at home. A head injury was ruled out and a referral was made to the Mental Health Liaison Team to seek specialist input. Due to the patient's catatonic state, appropriate treatment was commenced and they were transferred to Midlands Partnership Foundation Trust (MPFT). Following contact from MPFT a few days following admission, with regard to the patient requiring additional basic care needs to support recovery, it was agreed that the patient's care would be taken over and they would transfer to the Paediatric Ward within the Trust. To meet the young person's needs, specialty leads worked together to identify the best approach, moving treatment delivered in MPFT to SaTH twice a week to improve access and support recovery. The mother's needs were also considered, to ensure that support was in place to address her concerns and to enable her to visit the hospital at any time to be with her child, providing family centred care. Progress built gradually and small improvements were made, progressing to larger achievements. Steadily the young person regained more functional ability, developing methods of communication, starting to eat, and eventually taking steps. When at the right stage of recovery, the patient was supported in their transfer back to MPFT. The Board of Directors noted the compelling story, and acknowledged the collaborative work being undertaken across multidisciplinary teams and services to be responsive to individual patient needs, to improve patient outcome and experience of care.	
288/21	**Quorum** The Chair declared the meeting quorate.	
289/21	**Declarations of Conflicts of Interest**	

	No conflicts of interest were declared that were not already declared on the Register. The Chair reminded the Board of Directors of the need to highlight any interests which may arise during the meeting. The Director of Governance and Communications referred to the bi-annual review of the Register of Directors' Interests, under agenda item 307/21. Ms Milanec highlighted the following corrections and clarifications to the details provided in Appendix 1 of the paper: • Mr Steyn had provided a declaration of his interests, which had been duly recorded on the Register (shown in Appendix 1 as tbc); • Mrs Flavell was currently on secondment from the Trust's Improvement Partner, University Hospitals Birmingham (UHB), which had now been recorded on the Register.	
290/21	**Minutes of the previous meeting** The minutes of the meeting held on 11 November 2021 were approved by the Board of Directors as an accurate record, subject to the following corrections: Item 267/21: Sentence 1 of Paragraph 2 to be amended to read "….and the operational challenges faced due to a significant number of delays to discharges, ~~primarily as a result of community staff~~ ~~shortages~~ as a result of challenges faced by community partners, leading to delays in care packages for patients". Item 281/21: Final sentence of Paragraph 2 to be amended to read "… He (Dr Lee) highlighted in particular that the Mortuary at RSH and the Body Store at PRH were largely compliant against the requirements set out in a recent national letter from NHSE, and were compliant with the HTA standards".	
291/21	**Action Log** The Board of Directors reviewed the action log, and agreed the following: • Action 1 to be closed: The Director of Finance confirmed that a paper on the Capital Replacement of Medical Devices was presented to Finance & Performance Assurance Committee (FPAC) on 30 November 2021; • Action 2 to be closed: The Chief Executive confirmed that arrangements were underway for a Board to Board to take place with Shropshire Community Health Trust, with a proposed date of February 2022. No further actions were listed for review.	
292/21	**Matters Arising** No further matters were raised which were not already covered in the action log or agenda.	

STRATEGIC MATTERS		
293/21	**Report from the Chair** The Board of Directors received a verbal report from the Chair, which covered the following points: • Dr McMahon drew the Board of Directors' attention to the current pre-election period of purdah, and reminded colleagues that no discussion that could be regarded as of a political nature should take place during this meeting; • Observing members of the public were encouraged to view the latest Care Quality Commission (CQC) Inspection Report of the Trust, available via the Trust's website. Dr McMahon was pleased to acknowledge that meaningful progress had been made across a number of key areas, in incredibly difficult circumstances, however the report also reinforced the amount there was still to do on the Trust's improvement journey. She acknowledged the extensive action planning work that was underway to improve services and care for patients and families; • The Trust had been advised of a delay to the publication of the second/final Ockenden Report, which was now expected in March 2022; • As the next Ockenden Report Assurance Committee meeting had been deferred until January 2022, to allow external reports to be finalised, it was noted that the usual monthly Committee Report was not included in the Board papers on this occasion; • Dr McMahon spoke about the ongoing COVID-19 situation, the new Omicron variant, and in particular the continued requirement for colleagues, patients and visitors to wear masks, respect social distancing, and follow the rules with regard to visiting. She noted with thanks that the vast majority of those who came to both hospital sites respected these requests, but highlighted a recent unfortunate increase in the number of incidents of colleagues receiving verbal abuse over these requirements. Dr McMahon stressed that any abuse was wholly unacceptable, would not be tolerated by the Trust, and all necessary action would be taken in such circumstances, to ensure colleagues were able to work without fear; • Finally, the attention of the Board of Directors was drawn to a recent joint letter from the local health and care leaders, setting out the need for the community to work together to help manage the pressures across the challenging winter period. This included individuals ensuring they were fully vaccinated, or members of the community thinking about the alternative care options available before attending A&E. Dr McMahon thanked colleagues and observing members of the public for everything being done to help to slow or stop the spread of COVID-19 to date, and for their continued support through the coming months. The Board of Directors noted the report.	
294/21	**Report from the Chief Executive**	

	The Board of Directors received a verbal report from the Chief Executive, and noted that Mrs Barnett had no additional items to raise at this meeting which were not already covered in subsequent reports.	
295/21	**Cardiology Proposal** The Board of Directors received the report from the Chief Operating Officer. Mr Lee provided an update on the current risk being held by the Cardiology Service. He clarified that the plan developed to centralise Inpatient Cardiology at PRH was to improve patient flow and journey, by addressing the current challenge of staffing the service on two sites in terms of expertise, allowing a focus on skill mix, and providing opportunities to develop cross skilling across both lab and ward. Following extensive engagement with patient groups and partners, and support by the Joint Health Overview and Scrutiny Committee (HOSC), approval 'in principle' had been received on 8 December 2021 from the Clinical Commissioning Group (CCG) Governing Body pending their formal confirmation letter. The Board of Directors noted the report, and was pleased to acknowledge the approval 'in principle' received from the CCG.	
QUALITY AND PERFORMANCE MATTERS		
296/21	**Integrated Performance Report (IPR)** The Board of Directors received the report from the Chief Executive. Mrs Barnett referred to the following key points from her Executive Summary: • There continued to be a high prevalence of COVID-19 in the local community, with an increase in the number of patients admitted to hospital with COVID-19; • The Trust remained under significant pressure, particularly relating to some lengthy delays for patients accessing emergency departments, and challenges around overall health system (and regional) capacity for urgent and emergency care services. The Trust was working hard to address these challenges with system and regional partners. The winter admission avoidance schemes which started in November 2021 were also aimed at providing additional capacity outside of the acute hospital setting, to ensure appropriate alternatives were in place for patients who might otherwise present at the hospital's emergency departments; • Whilst the Trust remained with an overall rating of Inadequate following the CQC Inspection Report published in November, Mrs Barnett endorsed the comments made by Dr McMahon in her report, highlighting that the Inspection Report recognised the significant improvements that had been made across many areas,	

with a number moving from Inadequate to Requires Improvement or Good. Despite the current operational pressures, focus continued on improvement planning and implementation, and extensive communication had taken place with colleagues and wider stakeholders in this regard. Mrs Barnett thanked all those involved for their support and feedback.

The Chief Executive referred to her executive colleagues, in order to provide more detailed information for the Board.

Quality Summary
The Director of Nursing, and Acting/Co Medical Directors, referred the Board of Directors to the full detail contained within the Quality Section of the IPR, and provided a summary of some of the key points:

- The number of falls remained an area of concern and was consistently higher than the improvement target, although a reduction was being seen in repeat falls. Ongoing work continued on actions to improve performance through the Trust's falls programme. Comparative work with the region had shown that the Trust was not an outlier in this area, however a deep dive would be carried out by the Quality & Safety Assurance Committee (QSAC) in this regard;
- Performance on all Hospital Care Acquired Infections (HCAIs) remained better than the national standard set and, with the exception of E.coli, the Trust was close to achieving the more ambitious locally set improvement trajectory for the year;
- An increase in higher grade pressure ulcers had resulted in additional actions being taken within the Medicine and Emergency Care Division and investigation of the three Grade 3 ulcers reported on their wards. The year to date performance suggested the improvement trajectory set internally for the year was on course to be delivered;
- The data quality was currently being clinically reviewed and validated following new key performance indicators on Caesarian Sections being reported against the Robson classification:
- Current performance against the national Smoking Rate at Time of Delivery (SATOD) metric was showing improvement almost in line with national rates, noting that this was a system wide action;
- Significant improvements had been seen in complaints management performance, however there was still further work to do in this area, and the process remained under review.

Workforce Summary
The Deputy Director of People & OD, Ms Wilkins, reported on the following key points:

- The latest staff COVID-19 booster vaccination uptake stood at 54%, and 67% for the flu vaccination. Vaccination clinics would be operating throughout December and January, with a particular focus on areas of low uptake. Support was also being provided to colleagues who had not yet received the vaccinations;

	• Although the number of staff leavers in October 2019 of 62 WTE was in line with the average number of leavers per month, work life balance was stated as the top leaving reason for 17% of those individuals. To support retention, a flexible working campaign had now been launched, with information and support to be published across the Trust over the next month; • Working with NHSEI and the Integrated Care System (ICS), validation continued on the Trust's underlying position in respect of vacancies. Including significant quality investments, the vacancy position had increased to 613 WTE. It was noted that this had been done to support the Trust to recruit to vacancies despite posts being phased in at points in the future aligned to business cases. It was further noted that a number of staff remained in supernumery roles whilst training. Review continued of maternity and secondment adjustments which may also be affecting the vacancy position. Forecasts would continue to be refined; • Vacancies and short-term sickness were the main reason for requests for temporary staffing together with the continued need for 1:1 care requiring additional Health Care Assistants (HCAs) at short notice. The Trust had recently recruited an additional 60 HCAs to supplement its bank staffing, which would help to reduce the need to request agency HCAs. Ms Wilkins undertook to clarify the year to date figure for agency expenditure, and respond to Mr Brown with that information following the meeting. **Operational Summary** The Chief Operating Officer, Mr Lee, provided a summary of the following key points, referring the Board of Directors to the fuller detail contained in the IPR: • The pressures seen at both Emergency Departments remained significant, with demand as well as acuity remaining high. The Trust continued to look at all possible options to provide swifter ambulance offload and capacity internally. In parallel, work with ambulance services on pre-hospital pathways, as well as with the developing capacity for 'Rapid Response' from community services was continuing, to support alternative pathways for patients wherever possible; • Demand also remained high for elective and cancer services, and as many schemes as possible were being progressed to address the service backlog; • The addition of a mobile CT scanner based at PRH, to the existing mobile MRI, was adding much needed capacity in diagnostics, which remained a vital step in a patient pathway. The diagnostic waiting list was however significant and, as with patients requiring surgery, patients on a diagnostic waiting list were clinically prioritised, with the most urgent cases as well as cancer pathways the highest priority; • In response to a query from the Chair on the Operational Performance Benchmarking chart within the report, Mr Lee clarified that the Trust was being ranked out of 122, ie in comparison to other English Trusts reporting the same indicator.	

	Finance Summary The Deputy Director of Finance, Mr Corlass, highlighted the following key points, referring the Board of Directors to the fuller detail contained in the IPR: • The Board of Directors was reminded that the Trust continued to operate under a temporary financial regime, in compliance with national guidelines; • The forecast was to deliver a deficit of £9.590m for the full 12 month period, which had been accepted by the system and regulators, and would therefore form the basis of the Trust's internal plan for the remainder of the year; • £3.448m of efficiency savings had been delivered year to date, which was broadly in line with plan, although c43% had been delivered non-recurrently. The overall recurrent annual efficiency requirement was for £7.550m (1.6%) and the Trust was currently forecasing to deliver £7.438m. It was clarified, in response to a query with regard to achievability due to agency staff expenditure, that the forecast had been risk assessed and that focus was on the recurrent nature of the programme, with some recurrent benefits available for use; • The capital allocation for the Trust had increased, mainly due to the inclusion of funding for the Community Diagnostic Centre of £4.581m. Total capital spend year to date was £7.135m against a planned spend of £14.880m. It was noted that the Trust was still forecasting to deliver the total capital programme for 2021/22 of £39.159m. **Transformation Summary** The Board of Directors was referred to the detail contained in the IPR in the absence of Mrs Troalen, and the summary report was taken as read. Mrs Barnett advised that the Getting to Good programme was being revised to include actions as a result of the CQC Inspection Report, and plans would be shared with the Board of Directors as they progress. The Board of Directors noted the Integrated Performance Report.	
297/21	**Incident Management Overview Report** The Board of Directors received the report presented by the Acting Medical Director and Director of Nursing. Dr Jones clarified that the incident reporting supporting this paper had been reviewed to assure that systems of control were robust, effective and reliable, thus underlining the Trust's commitment to the continuous improvement of incident and harm minimisation. The Chair acknowledged, with thanks, the transition in the design of the report, noting the focus on the whole breadth of evidence in terms of patient safety and care. Dr McMahon provided assurance to observing	

	members of the public, as the detail within the report had to be kept unidentifiable, that all Serious Incidents (SIs) were reviewed in depth at QSAC, and Non-Executive Directors also had the opportunity to raise any queries with the Executive and other colleagues. The Board of Directors was referred to the report for further detail and analysis of themes and learning, and noted the contents of the report.	
298/21	**Digital Report** The Board of Directors received the report from the Interim Deputy Chief Executive, supported by Ms Gallimore, Director of Digital Transformation. Mr Preston reminded the Board of Directors of the importance of increasing the organisation's digital maturity to: • Provide effective and engaging experiences for patients; • Deliver high quality personalised care; • Improve operational effectiveness by embedding and standardising best practice in an automated way; • Address staffing challenges, with the delivery of an effective digital infrasture making the Trust a more attractive place to work; • Provide a Shared Care Record, enabling partner organisations to cross share appropriate information, through alignment to the digital strategy of the Shropshire Telford and Wrekin Integrated Care System (ICS) and Hospitals Transformation Programme (HTP). Ms Gallimore reported on progress to date and future deliverables across clinical systems, core and enabling technologies, and system alignment and partnership working, referring the Board of Directors to the fuller detail contained in the report Discussion took place on the most significant risks to the delivery of the remainder of the digital programme in 2021/22, and the following assurance was provided in response to queries from Non-Executive Directors: • A robust quality management approach had been developed to implementations, to ensure that lessons learned were built into the programme and that future implementations were adapted as necessary; • Supplier capacity issues and resource constraints were being addressed through agile working, and relationship building with partner organisations, to provide consistency of staffing through movement between projects. Discussion also continued with suppliers on how some elements of the programme could be de-risked; • Engagement was recognised as key to ensuring the enduring success of clinical systems, and clinical champions continued to be identified for all projects, together with the provision of ongoing support through dedicated sessions with clinical staff, and the appointment of digital lead roles within Nursing and Therapies;	

	• With regard to depreciation of short assets, the Deputy Director of Finance provided assurance that Finance were fully aware of the revenue implications of capital investment, which had been factored into the system recurrent sustainability plan. The Chair acknowledged the lead role the Trust was taking across the system on the digital programme, and expressed the Board's appreciation to all those involved. The Board of Directors noted the report.	
299/21	**Bi-Annual Staffing Review** The Board of Directors received the report from the Director of Nursing. Mrs Flavell highlighted the following key points, noting that a paper in full had been presented to QSAC, where a summary of the data collected in July 2021 relating to substantive availability and red flags was triangulated and discussed. • The Trust had met national guidance on required nurse to patient ratios; • Data had indicated that most wards did not meet the required threshold of at least 65% Registered Nurses (RN) compared to unregistered posts, with an average overall percentage of 53%. Work continued with the Director of People & OD on recruitment activities to deliver improvements in this regard; • Care Hours per Patient Day (CHPPD), when reviewed on Model Hospital and benchmarked, suggested the Trust was above peer and national average; • The Trust was partially compliant with the national Developing Workforce Safeguards policy. A gap analysis had been completed and an improvement plan implemented, monitored via QSAC quarterly for progress against targets; • Data from the Safer Nursing Care Tool (SNCT) suggested the number of RNs currently budgeted was insufficient and the number of Health Care Assistants (HCAs) was too high. It was stressed, however, that this should be regarded with caution currently due to the increased assurance required on data capture, and the continued inability to be able to utilise two consistent data captures due to ward areas continung to flex and change to meet the operational demands of COVID-19 and non-elective emergency activity. The Board of Directors noted the report.	
300/21	**Clinical Negligence Scheme for Trusts (CNST) Quarterly Report** *Ms Jones and Mr Baker joined the meeting.* The Board of Directors received the report from the Director of Nursing.	

Mrs Flavell confirmed that NHS Resolution (NHSR) was operating year four of the CNST maternity incentive scheme, launched in August 2021, to continue to support the delivery of safer maternity care. As in year three, the scheme incentivised 10 maternity safety actions (SAs).

It was noted that there were a number of reports that the Board of Directors must be provided with by certain deadlines throughout the CNST period, prior to submission of the completed Board declaration form to NHSR at the end of June 2022. Those with a deadline of November 2021 were covered within this report, as follows:

- Perinatal Mortality Review Tool Quarter 2 Report (relating to Safety Action 1 – "Are you using the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard?"):

  One of the evidence requirements for this action was that 'a report had been received by the Trust Board each quarter from 8 August 2021 onwards that included details of the deaths reviewed and the consequent action plans'.

  The Board of Directors took assurance that the Trust was compliant with PMRT reporting for the period July-September 2021.

- ATAIN Action Plan 2021/22 (relating to Safety Action 3 – "Can you demonstrate that you have transitional care services in place to minimise separation of mothers and their babies and to support the recommendations made in the Avoiding Term Admissions into Neonatal Units Programme?"):

  One of the evidence requirements for this action was 'an action plan (to address points b)[1] and e)[2] being agreed with the Maternity and Neonatal Champions and Board level Champion and signed off by the Board no later than 30 November 2021'.

  The ATAIN plan for 2021 was received by the Maternity and Neonatal Safety Champions Group and approved by the Board of Directors as part of CNST year 3. However, for the avoidance of doubt, the Board of Directors was requested to approve the plan for 2021/22. Additionally, the Board of Directors was requested to note that the relevant quarterly review and audit findings would be reviewed and discussed by the Safety Champions and appropriate assurance would be provided to the Board of Directors at their February 2022 meeting and quarterly thereafter.

  The Board of Directors approved the ATAIN plan for 2021, and noted the proposal for future quarterly assurance to be provided in this regard.

- Qtr 2 Small for Gestational Age and Fetal Growth Restriction Report and Review of Pre-Term Births (relating to Safety Action 6 – "Can you demonstrate compliance with all five elements of the Saving Babies Lives Care Bundle version two?"):

CNST requires evidence of "Trust Board level consideration of how its organisation is complying with the Saving Babies Lives Care Bundle (SBCL) version 2, published in April 2019". Furthermore, the SBL Care Bundle stipulates that certain data pertaining to Elements 2 and 5 must be shared with the Board of Directors (and the Local Maternity and Neonatal System) for information on a quarterly basis.

Regarding Element 2, it was noted a data review of babies born in the Trust Small for Gestational Age in Quarter 2 2021/22, and accumulative graphical data commencing from the October 2020 report, was included within the meeting papers. The Board of Directors was requested to note, as per the SBL requirement for Element 2 that "maternity providers will share evidence of these improvements with their Trust Board and the LMS and demonstrate continuous improvement in relation to process and outcome measures".

The Board of Directors noted that babies <10th centile delivered on or after 40+0 weeks and babies <3rd centile delivered on or after 38+0 weeks was lower than the Perinatal Institute's national GAP average, which were standards within Element 2. The Board of Directors noted, therefore, that the Trust was maintaining a good standard of detection and management.

Regarding Element 5 (Reducing Preterm birth), the Board of Directors was requested to note, as per the SBL requirement for Element 5, that "maternity providers will share evidence of these improvements with their Trust Board and LMS and demonstrate continuous improvement in relation to process and outcome measures".

The Board of Directors noted that a linear trend line demonstrated a continuing positive decrease in singleton preterm births, and that the Trust was below (exceeding) the Government target of 6% by 2025.

Maternity and Neonatal Safety Champions Locally Agreed Safety Intelligence Dashboard and updated Pathway Document (relating to Safety Action 6 – "Can you demonstrate that there are robust processes in place to provide assurance to the Board on maternity and neonatal safety and quality issues?"):

One of the evidence requirements for this action was that "Board level Safety Champions present a locally agreed dashboard to the Board on a quarterly basis. To include, as a minimum, the measures set out in Appendix 2 of the Perinatal Quality Surveillance Model, drawing on locally collected intelligence to monitor maternity and neonatal safety at Board meetings".

The Board of Directors noted the following:

- **the latest version of the dashboard, which was first provided to the Board in September 2021 as required by CNST, now included data from October 2021, and the dashboard was reviewed and discussed by the Board;**
- **The Healthcare Safety Investigation Branch (HSIB) escalation letter of 20 September 2021 relating to a case referenced in the September entry for the line titled 'HSIB/NHSR/CQC or other organisation with a concern or request for action made directly with the Trust'** *(The Board of Directors was asked to bear in mind when preparing its CNST declaration, that CNST guidance states on page 5 of the 'Conditions of the Scheme' document for year 4 that "the Trust must also declare on the Board declaration form whether there are any external reports which may contradict their maternity incentive scheme submission and that the MIS evidence has been discussed with commissioners").*
- **Although the action states that the dashboard should be submitted to the Board of Directors on a quarterly basis, the advice from the Trust's NHSEI midwifery adviser and the preference of the Board level Executive and Non-Executive Champions is that the frequency should be monthly.**

A further requirement was 'evidence of a revised written pathway, in line with the perinatal quality surveillance model, that is visible to staff and meets the requirements detailed in part a) and b) of the action is in place no later than 30 September 2021'.

The Board of Directors noted that the revised pathway, included within the appendices to this report, was implemented in September 2021 in compliance with the stated deadline, and was affixed to the Safety Champions noticeboard in the same month. The Board of Directors further noted that the pathway had been approved by the Safety Champions Group, and maternity and divisional committees, to be followed by formal review (with a request for approval) on behalf of the LMNS at the December 2021 Board and Perinatal Quality Surveillance Group meeting. The Board of Directors therefore took assurance that this part of the Safety Action had been met.

- <u>Safety Action 5 – "Can you demonstrate an effective system of midwifery workforce planning to the required standard?":</u>

The Board of Directors noted that a midwifery staffing oversight report (titled 'Director of Midwifery Report') would be provided to them under a separate cover, as an addendum to the December 2021 meeting papers, which would contain the evidence required to demonstrate the above standard. It was further noted that a second such report would be provided at the Board of Directors' meeting in June 2022, to comply with

the requirement for the reports to be provided every six months.

- Safety Action 4 – "Can you demonstrate an effective system of clinical workforce planning to the required standard?"

  The Board of Directors was advised that the obstetric workforce document, as required in standard a) part 1 of this action, would be provided at the Board meeting in February 2022, rather than December 2021, as initially aimed for. The additional time was required because in order to 'monitor compliance of consultant attendance for the clinical situations listed in this document when a consultant is required to attend in person', a specific audit was required and the findings would not be available until January 2022.

  The Board of Directors was assured that this still met CNST requirements at Trust Board level, as it had already been agreed that CNST deadlines that were met by the Board of Directors in their meeting of the following month were acceptable, as time was needed for reports to be adequately reviewed by divisional committees and Board Assurance Committees.

  It was noted that, as required by the Safety Action, a further audit and report of the standard would be conducted within six months and the findings submitted to the Board of Directors in time for the CNST deadline of 30 June 2022.

  The Board of Directors noted the revised February 2022 deadline at Trust Board level, acknowledging engagement with the RCOG document along with an action plan to review any non-attendance to the clinical situations listed in the document; and took assurance that the revised deadline still met the January 2022 sign off requirements of CNST at Trust Board level.

- Safety Action 8 – "Can you evidence that a local training plan is in place to ensure that all six core modules of the Core Competency Framework will be included in your unit training programme over the next three years, starting from the launch of MIS year 4? In addition, can you evidence that at least 90% of each relevant maternity unit staff group has attended an 'in house', one-day, multi-professional training day which includes a selection of maternity emergencies, antenatal and intrapartum fetal surveillance and newborn life support, starting from the launch of MIS year 4?":

  The Board of Directors took assurance from the following:
  - **a local training plan had been drafted by the Clinical Education Midwife and Consultant Lead for Clinical Education, to ensure that all six core modules of the Core Competency Framework would be included in the unit training programme over the next three years;**
  - **With regard to the multi-professional training, as of September 2021, the Trust was meeting or exceeding the**

	90% threshold for Practical Obstetric Multi-Professional Training for all in-scope groups except for non-Obstetric Consultants, and a proactive training plan was in place to reach targets where they were not yet met, and maintain targets already reached; ○ **The new Learning Management System (LMS) project had taken over from the plan for Maternity Training, to be included within the staff compliance report, which would make monitoring of completion levels more efficient.** The Board of Directors was advised that NHSR had subsequently confirmed that, whilst face to face training was preferable, eLearning was acceptable. **In line with the requirement to inform the Board of Directors whether any eLearning may be necessary, the Board took assurance that whilst this may be required for 5-10% of the workforce, it would be targeted at the least clinically facing roles.** • Safety Action 10 – "Have you reported 100% of qualifying cases to HSIB and to NHSR's Early Notification (EN) scheme for 2021/22?": **The Board of Directors took assurance that ongoing compliance with this action was monitored in a monthly meeting between the Trust's Assistant Director of Nursing Quality Governance and the Divisional Quality Governance Lead.** **The Board of Directors noted the governance and reporting actions remaining between this point and the CNST deadline of 30 June 2022, in order to achieve full compliance, and took assurance that at this point the Trust was on track in terms of compliance with requirements of the scheme to date. The Chair of the Audit & Risk Assurance Committee (ARAC), Prof Purt, also advised that ARAC had commissioned a piece of work to review key parts of the process, to provide additional assurance to the Board of Directors.**	
ASSURANCE FRAMEWORK		
301/21	**Bi-Annual Maternity Staffing Report** The Board of Directors received the report from the Director of Nursing. Mrs Flavell highlighted the following key points, referring the Board of Directors to the fuller detail contained in the report: • Whilst recognising that, based on October 2021 data, a 90/10% (RN/Maternity Support Worker) skill mix, in accordance with the Birthrate Plus report model, was not yet implemented, it was envisaged that there could be a potential over establishment of the	

	midwifery clinical workforce of 4.08 WTE. If an over establishment materialised it would provide the workforce with a degree of resilience over the next few months whilst the skill mix was implemented in full and new roles were embedded; • The number of maternity red flag events (a warning sign that something may be wrong with midwifery staffing) reported on the maternity dashboard had increased significantly over the previous three months, which was reflective of staffing changes. Following review of the critical red flags to gain a greater understanding of data highlighted on the maternity dashboard, it was clear that multiple reports, due to four hourly reporting, had been submitted for individual women. It was clarified, in mitigation, that as the women were inpatients during the delay, there was ongoing monitoring of maternal and fetal wellbeing, and care would be reprioritised in the event of any issues. Assurance was provided to the Board of Directors that, as decision making and prioritisation of care involved the multidisciplinary team, any delay had not put them at additional risk of harm. Assurance was also provided of the robust review and governance processes with regard to quality and safety issues, including a monthly review meeting chaired by the Director of Nursing, and a review of nursing templates on wards. Assurance was also provided to the Board of Directors on the focus in ensuring Nursing Associates were being used appropriately across the organisation, continuing with the pipeline of international recruits, and proposals to engage with community colleges to offer a robust work experience package and development opportunities, with a view to developing people to stay within the organisation. Mrs Flavell concluded her report by assuring the Board of Directors that despite a challenging year, the service now had improved oversight of staffing vacancies, and oversight of safety metrics, with a clear plan in place to address these. It also had a clear workforce plan that utilised a more diverse skill mix, to enhance care provision and strengthen the clinical workforce The Board of Directors took assurance from the report.	
302/21	**The Ockenden Report - Progress Report** The Board of Directors received the report from the Director of Nursing. Mrs Flavell highlighted the following points, referring the Board of Directors to the fuller detail contained in the report: • Since the last update to the Board of Directors, two further Immediate and Essential Actions (IEAs) had progressed through robust divisional governance processes, culminating in acceptance by the Maternity Transformation Assurance Committee (MTAC) as 'Evidenced and Assured' • Delivery of the 52 actions in the Trust's Ockenden Report Action Plan was progressing well, although there were three Local Actions for Learning (LAFLs) that were off track. Two of the actions had	

	received a deadline extension for both delivery and evidencing dates to March 2022. The third, complex action, remained off track as some of the actions fell within the Trust to deliver whilst other components were dependent upon national action being taken to establish specialist maternal medicine centres, which was out of the Trust's control. A delivery and evidence date of April 2022 was due to be proposed to MTAC, based on likely timelines for the establishment of the regional Maternity Medicine Centre (MMC) upon which this action was contingent. Mrs Barnett acknowledged that a number of actions required clinical governance support, and the divisional colleagues present for this item clarified that they were receiving the support they required, which included from the Patient Safety Team, Sherwood Forest Hospitals Foundation Trust (the Trust's maternity improvement partner), and two NHSEI funded midwifery governance posts. The Board of Directors took assurance from the report. *Ms Jones and Mr Baker left the meeting.*	
303/21	**Finance and Performance Assurance Committee Monthly Report** The Board of Directors received the report from the Committee Chair, Mr Deadman. The Director of Governance and Communications raised a point of governance with regard to the wording of two items within the 'Alert' section of the report. The current wording incorrectly stated that the Committee had approved the H2 financial budget and Phase 1 of the Renal Dialysis Business Case, however in both instances this should have read that 'The Committee had reviewed and recommended approval to the Board'. The Board of Directors noted the point of governance above, and took assurance from the report.	
304/21	**Quality and Safety Assurance Committee Monthly Report** The Board of Directors received the report from the Committee Chair, Dr Lee. The Director of Governance and Communications referred to the review of risks detailed within section 2d of the report, and confirmed that a Board Assurance Framework (BAF) report would be brought to the Board of Directors meeting in February 2022. The Board of Directors took assurance from the report.	
REGULATORY AND STATUTORY REPORTING		
305/21	**Guardian of Safe Working (GoSW) Annual Report 2020/21 and Q1 Report 2021/22**	

	The Board of Directors received the reports from the Acting Medical Director, co-presented by Dr Barrowclough, the Guardian of Safe Working Hours. The Board of Directors was referred to the detail contained in both reports, and discussion took place on the following points: • Workload intensity and moves away from parent wards, resulting in over work, was reflected in reports throughout the year. Assurance was provided that the Division was committed to working with their Junior Doctors via Exception Reporting, Junior Doctor Forums and LNC meetings to ensure concerns were addressed; • It was noted that the GoSW continued to maintain close working relationships with the Divisional Directors but had to rely on the fact that the absence of further exception reports suggested a matter had been addressed. Assurance was provided by the GoSW that themes were reviewed and investigated to ensure that any outstanding matters were resolved. On a wider point, the Chair sought assurance from the Director of Nursing that monitoring was taking place of the working hours of other patient facing staff. Mrs Flavell undertook to raise this matter with the Director of Workforce & OD following the meeting, and advise accordingly. The Chair expressed her thanks to Dr Barrowclough on behalf of the Board for all she was doing to ensure that issues of compliance with safe working hours were addressed in accordance with the Junior Doctors Terms and Conditions of Service. The Board of Directors took assurance from the report.	**ACTION**
BOARD GOVERNANCE		
306/21	**Risk Summary Report** The Board of Directors received the report from the Director of Governance and Communications. Ms Milanec summarised the following key points, referring the Board of Directors to the fuller detail within the report for the period ending 30 November 2021: • The total number of risks on the risk register was 429 (446 previous month); • The total number of risks closed was 37 (30 previous month); • The total number of new risks added was 37 (17 previous month) • The risk registers would continue to be reviewed and updated whilst work was embarked upon to improve the Trust's risk management framework and to seek a more robust and effective risk management process. This would include moving from the current software package, to Datix, a widely-used system within the NHS.	

	The Board of Directors noted the report.	
307/21	**Register of Directors' Interests Bi-Annual Review** The Board of Directors received the report from the Director of Governance and Communications. Ms Milanec referred the Board of Directors to the clarifications and corrections which had now been recorded on the Register, as covered under agenda item 289/21 earlier in the meeting. The Board of Directors reviewed the Declarations of Conflicts of Interest 2021/22 and confirmed that no further amendments were required at this time.	
PROCEDURAL ITEMS		
308/21	**Any Other Business** The Chair advised the Board of Directors and observing members of the public that a final report relating to an issue which was being worked through would need to be brought to the Board. For that reason, she intended to convene a single item Board meeting in public in January 2022, prior to the next scheduled meeting in February. Dr McMahon clarified that the Trust needed to receive the final report before a date for the meeting could be finalised, however she intended to provide at least 7 days notice to the Board, and members of the public would be informed via the Trust website. *(January 2022 Post-meeting addendum: Unfortunately the proposed meeting needed to be postponed and would not now take place in January 2022, as the expected report had not been received by the Trust in its final form. The Board of Directors would be advised, and details would be published on the Trust website in due course, as to when the meeting would take place).*	
309/21	**Date and Time of Next Meeting** The next meeting of the Board of Directors was scheduled for Thursday 10 February 2022, commencing at 13.00hrs. The meeting would be live streamed to the public.	
STAKEHOLDER ENGAGEMENT		
310/21	**Questions from the public** The Chair reminded observing members of the public that questions were welcome on any items covered in today's meeting, which could be submitted via the Trust's website.	

	Dr McMahon confirmed that the questions which had been submitted following the Board meeting on 11 November had been answered by appropriate members of the Executive Team, and had now been published on the website.	
The meeting was declared closed.		