The Shrewsbury and Telford Hospital NHS Trust

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

Thursday 10 February 2022 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
Mr N Lee	Chief Operating Officer
Prof T Purt	Non-Executive Director
Mrs H Troalen	Director of Finance
IN ATTENDANCE	
Ms A Milanec	Director of Governance & Communications
Mr R Steyn	Co-Medical Director
Ms C West	Improvement Director
Mr T Baker	Deputy Director of Operations, W&C Division *In attendance for Agenda Item 017/22*
Mr M Wright	Programme Director, Maternity Assurance *In attendance for Maternity Agenda Items*
Ms B Barnes	Board Secretariat (Minutes)
APOLOGIES	
Dr D Lee	Non-Executive Director
Ms R Boyode (non voting)	Director of People & Organisational Development

No.	ITEM	ACTION
PROCEDURAL ITEMS		
001/22	**Welcome, Introductions and Apologies** The Chair welcomed all those present, and observing members of the public attending the meeting via the live stream.	

002/22	**Patient Story** The Director of Nursing introduced a story, which followed on from the Staff Story shared at the Board of Directors meeting in December 2021. The Board was reminded that the story in December had described how the Paediatric Team worked collaboratively to meet the needs of a patient within their care. This subsequent story described the experience from the perspective of the patient's mother following the admission of her son in April 2021. The patient's mother shared her initial concerns for her son's physical and psychological needs, however her anxieties were allayed when she was able to be with her son, leaving her reassured. She appreciated how people from different services came together to support her son, also advising her how she could help to participate in his physical recovery. The patient was in an anxious state, however, his mother appreciated that the staff recognised this, and she took reassurance from the approach taken by all members of the team to ensure her son felt nurtured and safe within the hospital environment. Her son had now made a good recovery and he was in college studying towards his A Levels. Reflecting on the experience, his mother shared how she had learnt from the staff what was important in life, and this had positively changed her relationship with her son. The Board of Directors noted the story from the mother's perspective, and took assurance from the work being undertaken to listen and be responsive to feedback from people accessing services within the Trust to improve patient outcomes and experience of care.	
003/22	**Quorum** The Chair declared the meeting quorate.	
004/22	**Declarations of Conflicts of Interest** The Chair advised that from 1 February 2022 Mr Bristlin had been appointed as a Non-Executive Director of a Trust outside of the local system. Dr McMahon confirmed that Mr Bristlin would continue in his role as Non-Executive Director and Vice Chair of the SaTH Board of Directors for the next few months whilst replacement recruitment was underway. Mrs Barnett declared that her husband had recently been appointed as Chair of North West Anglia NHS Foundation Trust and that he would shortly be leaving the previously declared role of Chair of QEH Kings Lynn NHS Foundation Trust.	

	It was confirmed that the Register of Directors' Interests would be updated accordingly. No further 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.	
005/22	**Minutes of the previous meeting** The minutes of the meeting held on 9 December 2021 were approved by the Board of Directors as an accurate record.	
006/22	**Action Log** The Board of Directors reviewed the action log, and agreed the closure of Action 3. No further actions were listed for review.	
007/22	**Matters Arising from the previous minutes** The Chair referred to her intention, as detailed in the previous minutes, to convene a single item Board meeting in public in January 2022, to receive a final report relating to an issue which was being worked through. Dr McMahon explained that the expected report had not yet been received by the Trust in its final form, and the meeting had therefore needed to be postponed. She clarified that the meeting would take place as promptly as possible once the final report had been received, and members of the public would be informed of the revised date via the Trust website. No further matters were raised which were not already covered in the action log or agenda.	
STRATEGIC AND POLICY MATTERS		
008/22	**Report from the Chair** The Board of Directors received a verbal report from the Chair, which covered the following points: • Dr McMahon acknowledged with thanks the work undertaken throughout the latest phase of the COVID-19 pandemic by all staff, in addition to the considerable challenges from the Winter period and elective recovery pressures; • The contribution made by partners of the Trust was also acknowledged with appreciation, noting the effectiveness of all system partners working together to address the needs of patients requiring support; • The importance of support provided to staff by their families was also recognised with thanks, as was the contribution of the	

	community who had supported the Trust by abiding with social distancing measures and regulations on the wearing of masks. • Publication of the second and final Ockenden Report was expected in March 2022, and considerable preparatory work was being undertaken to ensure the provision of external psychological support to families and staff; • An invitation was extended to Non-Executive Directors, and observing members of the public, to join the Ockenden Report Assurance Committee (ORAC) meeting to be held in public on 15 March 2022. The meeting would focus on the complete plan which was put in place following the first Ockenden Report, with a comprehensive review of the completion status of all actions against the plan; • The Trust's first Public Assurance Forum was held on 24 January 2022 and was well attended by both public members and Divisional representatives. In addition to Cardiology and Renal Service change engagement updates, there was a Trust Strategy Briefing. There was also discussion on the Hospitals Transformation Programme (HTP) and it was agreed that progress updates would be provided once the draft Strategic Outline Case (SOC) had been approved. The Forum received a draft of the quarterly report on the work of the Public Participation team, which it was noted could be found in the Board Information Pack for today's meeting; • The Chair reported on her recent visit to the Trust's Pathology Labs, during which she heard of the innovative practices being carried out which it had been very pleasing to hear were 'ahead of the curve' from a national perspective. It was, however, clear that Microbiology colleagues would benefit from improved facilities when compared to other areas, and a business case would be prepared aimed at delivering improvements for that team. The Board of Directors noted the report.	
009/22	**Report from the Chief Executive** The Chief Executive advised that she had no additional items to raise at this meeting which were not already covered in subsequent reports.	
010/22	**Policy Approval – Anti-Fraud, Bribery amd Corruption** The Board of Directors received the report from the Director of Governance and Communications. The Board was referred to the detail contained in the report and accompanying appendices, and the following key points were noted: • The findings from an anti-bribery review, undertaken by the Trust's internal auditors, in conjunction with counter fraud, resulted in an action plan, which was aimed at supporting the Trust to strengthen the controls and arrangements already in place regarding fraud, bribery and corruption;	

	• The Audit and Risk Assurance Committee (ARAC) had been monitoring progress of the plan on a regular basis throughout the financial year, and colleagues across the Trust had been receiving regular newsletters and national fraud warnings through the Trust's email portal, reminding colleagues of their responsibilities regarding fraud; • As part of this work, the Board of Directors received Anti-Fraud, Bribery and Corruption training at a Board seminar in January 2022; • In response to a concern raised by the internal auditors on improvements required to the Trust's Gifts and Hospitality Reporting system, Ms Milanec acknowledged that the system operated by the Trust was not following best practice and there was scope for improvement. Assurance was provided to the Board that additional resource was planned in this regard with the aim of building a robust system. The Board considered and noted the Briefing Note (Appendix 1 of the report), prepared by the Trust's Anti-Fraud Specialists to support the Director of Governance and Communications, as Fraud Champion for the Trust. The Board considered and noted the Chief Executive's Statement (Appendix 2 of the report), which would be uploaded to the Trust's website, acknowledging that the statement provided a public declaration of the Trust's position on fraud, corruption and anti-bribery, and the implications of non-compliance. Finally, the Board approved the updated Anti-Fraud, Bribery and Corruption Policy (Appendix 3 of the report), which had been produced in conjunction with the Trust's counter fraud specialists and had been recommended by ARAC for Board approval.	
QUALITY AND PERFORMANCE MATTERS		
011/22	**Integrated Performance Report (IPR)** The Board of Directors received the report from the Chief Executive. Mrs Barnett clarified that the IPR was presented in the context of the Trust's Getting to Good plan, through which the Trust was seeking to deliver high quality care. The Board was referred to the detail contained in the Chief Executive's Summary, recognising the significant pressure the Trust, and NHS as a whole has been experiencing. The continued prevalence of COVID-19 and continuing challenges of the Winter period had been compounded by increased absences and staffing issues, but colleagues continued to work tirelessly to meet the additional challenges. 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 the following key points were covered:

- With regard to mortality and recent Summary Hospital-level Mortality Indicator (SHMI) rebasing, Dr Jones advised that audits in relation to the conditions with the highest number of excess deaths were presented to the Learning from Deaths Group. It was noted that septicaemia had been added to the conditions with the highest number of excess deaths, and was the cause of the second highest number of excess deaths. Assurance was provided that audits would take place on this condition going forward which would be included in those presented to the Learning from Deaths Group;
- The number of falls continued to remain an area of concern, and was consistently higher than the improvement target. In response to an observation from the Chair on the increasing level of falls also seen across other Trusts, and a potential link to muscle deconditioning following lockdown measures as a result of the COVID-19 pandemic, Mrs Flavell confirmed that there was focus on this issue across the system;
- The Trust was broadly on course to deliver the year end improvement trajectory on pressure ulcers, and Mrs Flavell provided assurance on the extensive work taking place between the central Tissue Viability Team and clinical teams, including a robust investigation process, thematic reviews, deep dive, and regular weekly meetings;
- Recruitment in Midwifery was improving and was having a positive impact on the Delivery Suite acuity level reported, which had improved to 65%. However, COVID-19 short term absences and the level of maternity leave amongst the staff had necessitated the temporary closure of the Wrekin Unit to support safe staffing levels and ensure 1-1 care in labour continued, with over 98.4% being achieved.

Workforce Summary
The Workforce Summary was taken as read in the absence of the Director of Workforce & OD. The Board of Directors was invited to contact Ms Boyode following the meeting should members have any questions on this section of the IPR.

Operational Summary
The Chief Operating Officer provided a summary of the following key points, referring the Board of Directors to the fuller detail contained in the IPR:

- COVID-19 continued to impact on both patient admissions as well as on staff absence, which had in turn affected elective capacity and activity. It had, however, been pleasing to see a reduction in COVID-19 admissions during the last few days;
- Clinical pressures in both Emergency Departments (EDs) and in the community, caused by crowding in the EDs and ambulance

handover delays, continued to be the highest priority for all senior leaders across the Trust and partner organisations. Assurance was provided to the Board that the Trust continued to work very closely with the ambulance services, with on-site solutions including cohorting of patients with an ambulance crew to release other crews to community calls, and the use where possible of alternatives to hospital conveyance;

- Within the elective programme, cancer pathways were the Trust's priority alongside the most urgent surgery. Cancer demand remained high, and activity for outpatients under the 2-week wait pathway was also high, with a combination of demand and workforce challenges in a number of areas resulting in waiting times longer than 2 weeks. Where workforce vacancies were a factor, the Divisions were actively recruiting as well as looking at agency and locum options, however it was noted that services such as Oncology were a pressured specialty across England;
- The cohort of patients who potentially could be waiting over 104 weeks from referral to treatment was continuing to reduce each week, although the rate of reduction reduced during December, in part due to lost bed capacity, staffing challenges and the bank holiday period. Teams were doing all they could to meet and if possible exceed the objectives set for 104 week waits at the end of the financial year. The latest guidance was a target of zero by the end of July 2022;
- Assurance was provided to the Board by the Acting Medical Director that the Trust had a clear categorisation of surgery prioritisation in line with the national scheme.

Finance Summary

The Director of Finance highlighted the following key points, referring the Board of Directors to the fuller detail contained in the IPR:

- The Trust's year to date reported position was a deficit of £7.929m, £3.055m adverse to plan. The adverse position was a result of an overspend on the Elective Recovery Programme during the first six months of the financial year, and additional costs associated with the operational and workforce pressures experienced during Quarter 3;
- The forecast was to deliver a deficit of £9.590m at the end of the 2021/22 financial period. However, given the ongoing costs associated with the operational and workforce pressures, it was likely that costs would increase and negatively impact the forecast outturn. The forecast was a deficit of £10.9m which was £1.5m adverse to the plan. This had been discussed with the Integrated Care System (ICS) and it was likely that the system as a whole would still deliver the overall financial plan.

Transformation Summary

The Director of Finance referred the Board of Directors to the detail contained in the IPR, and the following additional points were covered:

	• Clarification was sought by the Board on the decline in month on the Quality and Safety programme. The Acting Medical Director confirmed that this referred to the timeline with regard to the framework that described all standards of quality of care, the introduction of which had been slower than originally anticipated. Progress was underway, with a slight change of scope to include nursing as well as medical metrics. Specialties would also have their standards mapped into the framework; • The Chief Executive observed that since more comprehensive information was now available on the Getting to Good Plan, the last section of the Transformation Summary would benefit from amendment. The Director of Finance undertook to review the format of this section, with a suggestion that a version of the Getting to Good Plan was included in the data pack of the IPR. The Board of Directors noted the Integrated Performance Report.	**DoF**
012/22	**Incident Management Report** The Board of Directors received the report presented by the Acting Medical Director and Director of Nursing, to provide assurance to the Board of the efficacy of the incident management and Duty of Candour compliance processes. The following key points were highlighted: • There was an ongoing particular focus on incidents around admissions, which had increased significantly since Spring 2021. Acknowledging the risks presented as a result of ambulance handover delays, the Trust continued to focus on mitigating actions through the provision of different pathways of care, including making greater use of the Same Day Emergency Care Centre; • Noting that Appendix 2 of the report identified learnings from closed incidents, assurance was requested by the Board that the learnings were being acted upon and delivered. The Director of Nursing provided assurance that the new Quality Governance Framework and structure enabled a standardised approach, with the process including assurance that all actions were embedded. • The inclusion of reporting of no harm near miss incidents was welcomed by the Board, noting that it would be useful to see learning from such incidents. The Executive provided assurance that any significant near miss incidents would be investigated like any other case. 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.	
013/22	**Report from the Director of Infection Prevention and Control (IPC)** The Board of Directors received the report from the Director of Nursing, providing an overview of the IPC key metrics for Quarter 3 2021. The Board was referred to the full detail contained in the report, and the following key points were noted:	

	• The Trust continued to perform well in relation to the national targets for Healthcare Acquired Infections, and against a majority of locally agreed improvement targets, with the exception of E.Coli which was higher than the local target; • There had been no IPC Serious Incidents in Quarter 3; • There had been an increase in COVID-19 outbreaks in Quarter 3, with the emergence of the more transmissible Omicron variant. The Board was advised of the Trust's robust assurance system around COVID-19, with two outbreak meetings held weekly, one of which included external partners. Assurance was further provided that lessons learned during outbreaks had been actioned and shared across organisations; • The Trust had maintained its green RAG status following an IPC sustainability visit from NHSE/I in January 2022, and the Director of Nursing has requested a 6 month peer review; • Discussion took place on the degree of IPC engagement levels across the organisation. Assurance was provided on key actions which had taken place, including the integration of the Facilities/Cleanliness team into the Nursing Directorate. There was acknowledgement of challenges with some medical colleagues, but the Board was assured that the Acting Medical Director was heavily supporting in this regard; • NHS guidance was awaited on anticipated isolation period changes and it was not yet known whether this would be different to public guidance. Assurance was provided to the Board that Trust and system level meetings take place when there are any changes to national guidance and legislation. The Board of Directors noted and took assurance from the report.	
014/22	**Public Participation Report** The Board of Directors was referred to content contained within the Report from the Chair under Agenda Item 008/22. The Co-Medical Director also directed the Board to the full Public Participation Team Quarterly Report included in the Board Information Pack for today's meeting. The Chair clarified that Mrs Julia Clarke, as Director of Public Participation, continued to lead on community engagement, volunteering and SaTH Charity activities, however she now reported into the Co-Medical Director in this regard, and has stepped back from reporting directly to Board. Dr McMahon relayed her thanks to Mrs Clarke and her teams, on behalf of the Board of Directors, for the excellent work being carried out in this important area for the Trust. The Board discussed the valuable contribution that volunteers were making within the Trust, noting in particular the considerable number of	

	young volunteers. Volunteering was also recognised as an opportunity for young people who wished to pursue a career in healthcare to gain work experience, and assurance was provided that this was built into the volunteer programme through the Trust's links with St Johns Ambulance, Cadets and other organisations. The Board of Directors noted the report, and acknowledged the valuable work taking place.	
Assurance Framework		
015/22	**Board Assurance Framework (BAF)** The Board of Directors received the report from the Director of Governance and Communications, which brought together details of the newly formatted BAF document for the quarter ending September 2021. The Board was referred to approvals requested on risk scores, and new risk proposals. The Board noted the report and and approved the following: • The risk scores for BAF1 – BAF9 for the period ending 30 September 2021; • The addition of risk BAF10 – "The Trust is unable to meet the required national urgent and emergency standards"; • The 'current' score for BAF10 of 5 x 5 = 25, recognising the high score given but noting the narrative above; • The addition of risk BAF11 – "The current configuration of and layout of acute services in Shrewsbury and Telford will not support future population needs and will present an increasing risk to the quality and continuity of services"; • The addition of risk BAF12, relating to the non-delivery of integrated pathways, driven by the ICS and ICP; and • The addition of risk BAF13, relating to maternity services.	
016/22	**Risk Management Report** The Board of Directors received the report from the Director of Governance and Communications, providing an oversight of the Trust's current risk framework. The Board was referred to the detail contained within the report, and the following points were noted: • The Trust's interim Head of Risk Management had made excellent progress with the new risk management structure, engaging with many colleagues and stakeholders requiring the framework; • Assurance was provided to the Board that the move from the 4Risk system to Datix would provide the Trust with greater functionality, and it was noted that the transfer was an opportunity to review all risks;	

	• With regard to a query on what would be seen as good practice in terms of percentage of risk closures, Ms Milanec responded that there so many different attributes as to why risks would be added or removed, however she undertook to investigate if any benchmarking information was available The Board of Directors noted and took assurance from the report.	
017/22	**NHS Resolution Clinical Negligence Scheme for Trusts (CNST) Year 4 Quarterly Report** The Board of Directors received the report from the Director of Nursing, who was joined for this item by Mr Baker, Deputy Director of Operations, Women & Children's Division. Mr Baker provided a reminder that there was a requirement for the Board to receive regular updates and items for sign off throughout the CNST period, culminating in final sign off by the Board of Directors, and submission of the completed Board declaration form to NHSR, at the end of June 2022. The information presented at this meeting was to: • Provide the Board with reports associated with Safety Actions 2 and 6 for review and discussion (appendices 1 and 2 of the report); • Provide an update on specific elements of Safety Actions 1, 3 and 4, for information and assurance and, where relevant, for approval. • <u>Appendix 1 – Safety Champions Locally Agreed Dashboard (December 2021)</u> It was confirmed that the Board had reviewed and discussed the Safety Champions Locally Agreed Dashboard, which evidenced compliance with Safety Action 9 (standard b). The Board of Directors took assurance from the fact the Trust was compliant with PMRT and HSIB reporting standards, and that meaningful engagement with service users and staff was being achieved via the Maternity Voices Partnership and Maternity and Neonatal Safety Champions respectively. • <u>Appendix 2 – Saving Babies Lives Elements 2 and 5 Audits Quarter 3 2021</u> This information was provided for information and assurance relating to Safety Action 6. The Board of Directors took assurance (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 measure) that babies <10th centile delivered on or after 40+ weeks and babies <3rd centile delivered on or after 38+ weeks remained lower than the Perinatal Institute's national GAP average. The Board noted that these were standards within Element 2, which suggested that the Trust was maintaining a good standard of detection and management.	

	Regarding Element 5 (Reducing Preterm Birth), the Board of Directors noted (as per the SBL requirement for Element 5) that a linear trend line demonstrated a slight increase in singleton preterm births between 24 and 36+5 weeks. This now placed the Trust slightly above (falling short of) the Government target of 6% by 2025, and was an increase compared with the previous quarter. The Board noted that the Trust was still achieving better results than the national average. Additionally, and in accordance with Safety Action 6 'technical guidance', the Board of Directors: ○ took assurance from the evidenced compliance rate of 99% (exceeding target of 90%) of women who give birth in an appropriate care setting for gestation (in accordance with local ODN guidance); and ○ took assurance that the Trust had undertaken a quarterly review of a minimum of 10 cases of babies that were born <3rd centile <37.6 weeks' gestation. It was noted that the review sought to identify themes that could contribute to FGR not being detected (eg components of Element 2 pathway and/or scanning related issues). The Trust had a rate of 2.9% which was better than the national average of 4.7% for the period. The Board therefore took assurance from evidenced compliance with reporting requirement 7 of standard 2 of Element 2 of Safety Action 6. • <u>Appendix 3 - Perinatal Mortality Review Tool (PMRT) Quarter 3 Report</u> This report was shared with the Board in its entirety, in compliance with Safety Action 1 "Are you using the National PMRT to review perinatal deaths to the required standard". The Board of Directors reviewed the report and took assurance that the Trust had achieved 100% compliance with PMRT reporting in quarter 3 2021/22, noting that the information had also been provided to the Maternity Safety Champions. The Trust was therefore noted as fully compliant with Safety Action 1 to date. The Chair requested that a high level summary of the report was provided for the Board of Directors meeting in public going forward to ensure that data protection requirements were not breached. • <u>Update on progress on Safety Action 4 Standard a) Part 1 (as at January 2022</u> It was noted that a detailed paper outlining the Trust's current level of compliance with this standard was produced by the Clinical Director of Obstetrics and had been received by the Quality and Safety Assurance Committee (QSAC), who were assured by the findings and confirmed that they were satisifed with compliance as highlighted below.	**DoN**

Taking assurance from QSAC's confirmation, the Board of Directors (via the minutes of this meeting) recorded that it signed off Part 1 to standard a) of Safety Action 4 to the effect that:

- The Board of Directors acknowledged the engagement and compliance of obstetric services with the RCOG document titled 'Roles and responsibilities of the consultant providing acute care in obstetrics and gynaecology';
- The Board of Directors acknowledged that the Ockenden Report Action Plan Case Notes Pilot audit indicated compliance with attendance of the clinical situations listed in the said document, but stated that it required to see the findings of the follow-up audit and, dependent upon these findings, an action plan to address any findings of non-compliance.

It was noted that the Board of Directors would also be provided, no later than April 2022, with evidence of an agreed plan to satisfy Part 2 of standard a) of Safety Action 4.

- <u>ATAIN Report for Quarter 3 2021</u>
  It was noted that a report was received and approved by QSAC at their January meeting, which evidenced compliance with several standards within Safety Action 3.

  The Board of Directors took assurance from the fact that term admissions had exceeded the performance target of below 5% for the last seven consecutive months.

- <u>Appendix 4 – Transitional Care Report July-September 2021</u>
  Also linked to Safety Action 3, it was noted that CNST required Trusts to report on transitional care. The Trust had conducted a quarterly 'Transitional Care Audit' and the report covering July to September 2021 was provided to QSAC at its January 2022 meeting to provide assurance. The October and November report had subsequently been provided and would be shared with QSAC at its March meeting.

  The Board of Directors took assurance that:
  - evidence requirements for standard b) had been complied with and that the audit showed 100% compliance with the Transitional Care Policy;
  - As validated by QSAC, the quarterly audit findings had been shared with the Maternity and Neonatal Safety Champions Group, Local Maternity and Neonatal System Board, and the Perinatal Clinical Quality Surveillance Group.

- <u>Risks and Issues to Highlight</u>
  The Board was advised that the risks set out in Table 1 of the report were flagged to the Maternity Transformation Assurance Committee in December 2021 (1 and 2 only) and to the Divisional Risk Meeting in January 2022, and were in the process of being formally uploaded into the Divisional and Corporate Risk Logs.

	The Board of Directors was therefore asked to note that compliance with CNST by June 2022 could not be guaranteed due to the risks outlined in the table. The Board was, however, provided with assurance that proactive mitigation was already underway and was a major priority for the Women and Children's Division. The Board was also provided with assurance that triangulation was taking place with the Ockenden Report Action Plan and multi-disciplinary teams, with all 52 actions cross-referenced with the Maternity Transformation Programme and governance within the Division.	
018/22	**The Ockenden Report - Progress Report** The Board of Directors received the report from the Director of Nursing. The Board was referred to the detail contained in the report, and took assurance that good progress continued to be made against the required actions from the first Ockenden Report (2020), with work continuing at pace. It was noted that many of the outstanding actions had some external dependency, were large or complex to deliver, or required significant audit and review activities to test compliance. Nonetheless, the plan remained on track for its latest agreed final delivery date of August 2022, although this was contingent to some extent upon the content of the final Ockenden Report. The Board of Directors noted and took assurance from the report.	
019/22	**Ockenden Report Assurance Committee (ORAC) Report** The Board of Directors received the Co-Chairs' summary report from the live-streamed ORAC meeting in public which had taken place on 18 January 2022. It was noted that the following topics had been covered: • An update on Obstetric Anaesthesia; • Implementation of the National Bereavement Care Pathway; and • Harnessing the User Experience (UX) System, an engagement tool that had been co-produced with the Maternity Voices Partnership, with the aim of capturing service user experiences using UX cards based on a specific theme to guide maternity service improvements. The next ORAC meetings were scheduled for 15 February and 15 March 2022, commencing at 2.30pm and would be live-streamed in public. The Board of Directors noted and took assurance from the report.	
020/22	**Audit and Risk Assurance Committee Report**	

	The Board of Directors received the report from the Committee Chair, Prof Purt. The Board was alerted to the following key issues: • The three completed internal audit reports brought before the meeting each had an assurance rating of only 'limited'. It had been agreed that these audits would be tracked for progress through the Internal Audit Recommendations Tracker, and Executive Directors would be invited to attend future meetings to provide appropriate explanations if actions were not delivered on track; • The Committee heard that little progress had been made regarding the implementation of Criteria Led Discharge, with Committee members reminding the Executive that this matter had been ongoing for some years. It was agreed that this item would be brought back to each ARAC meeting until clear progress was made; • The Committee was provided with a detailed account of issues affecting slow progress with the implementation of Waiting List Initiatives. It was noted that a key meeting was to be held imminently on this subject, with an appropriate policy to be drawn up thereafter. It was agreed that this item would be brought back to future meetings to monitor progress; • The Committee was concerned to learn, with regard to outstanding internal audit recommendations relating to cyber/digital, that the issue of cloud based back-ups had still not been resolved, and this item would continue to be monitored by ARAC. The Committee recommended to the Board a minor change to the Trust's delegation approval limits, increasing the revenue expenditure approval limit from £50,000 to £100,000 for Executive Directors, and other directors as designated by the Chief Executive. The Board of Directors approved the above increased approval limit, and took assurance from the monitoring proposals detailed in the report.	
021/22	**Finance and Performance Assurance Committee Monthly Report** The Board of Directors received the report from Mr Brown on behalf of the Committee Chair, Prof Deadman, who had unavoidably had to leave the meeting. The Board was alerted to the following key issues: • Bed capacity and space remained a significant challenge. This was acknowledged as a continuing regional and system-wide issue, with system partners focused on supporting all pathways; • Despite recruitment and temporary staff, the Trust had a 7% shortfall in WTE establishment, which had been further exacerbated by the monthly leavers rate of approx. 65 per month. It was noted that the Director of Workforce & OD was investigating the reasons for the shortfall;	

	• There was currently a £15-30m gap in the 2022/23 financial plan, and further details were awaited from the Director of Finance in this regard. . The Board of Directors noted the report and took assurance from the ongoing monitoring activity by the Committee.	
022/22	**Quality and Safety Assurance Committee Monthly Report** The Board of Directors received the report from Ms Boughey, in the absence of the Committee Chair, Dr Lee. The Board was alerted to the following key issues: • Paediatric triage within 15 minutes performance remained poor due to lack of space to triage children and lack of alternative pathways. It was noted that there was no current evidence of harm but achieving this metric was proving very challenging; • Medically Fit for Discharge continued to be a key issue impacting on patient flow, due to pressures across the entire system, although constructive work had been taking place with partners in this regard. The Board of Directors noted the report and took assurance from the ongoing monitoring activity by the Committee.	
023/22	**Appointment of Caldicott Guardian** The Board of Directors received the report from the Director of Governance and Communications in the role of Senior Information Risk Owner. The Board was reminded that the Trust had been without a formally appointed Caldicott Guardian since the departure of Dr Rose, however both the Acting Medical Director and Co-Medical Director had now completed Caldicott Guardian training. Following discussion, Mr Richard Steyn had agreed to take up the role in the first instance. The Board was assured that there was no barrier to a non-substantive member of staff taking up the role, with the only stipulation being that the Caldicott Guardian had to be a senior Director with access to the Board. The Board of Directors approved the formal appointment of Mr Richard Steyn as Caldicott Guardian, and noted that arrangements would be made for the details to be published to the national Caldicott Guardian Register, held by NHS Digital.	
024/22	**How we learn from deaths Report** The Board of Directors received the report from the Acting and Co-Medical Directors.	

	The Board was referred to the full detail contained in the report, which was taken as read. The Chair observed that one of the purposes of independent Medical Examiner scrutiny was to provide assurance around elements of care, however this detail did not feature within the report. The AMD acknowledged this point and confirmed that the information would be included going forward. The Board of Directors took assurance from the report.	**AMD / CMD**
PROCEDURAL ITEMS		
025/22	**Any Other Business** **025.1 CQC Maternity Survey** The Director of Nursing was pleased to advise the Board of Directors of the publication that day of the CQC's 2021 Maternity Survey results, which showed that the Trust was one out of only seven of the 122 Trusts surveyed across the country to receive a rating of 'Better than Expected' (noting that no Trusts had achieved the highest rating of 'Much better than expected'). The Board of Directors provided its congratulations on this achievement, noting in particular that the survey reflected the direct experience of those we care for. **025.2 CQC Conditions** The Director of Nursing advised that the CQC had recently reviewed the significant amount of conditions which had been placed on the Trust's licence since 2018, across a variety of areas. Mrs Flavell was delighted to report that the review had resulted in a significant reduction, leaving two remaining conditions, with three having been varied and consolidated. The Board of Directors was pleased to note this excellent news, and expressed its appreciation to all teams for the extensive ongoing improvement work taking place across the Trust.	
026/22	**Date and Time of Next Meeting** The next meeting of the Board of Directors was scheduled for Thursday 10 March 2022, commencing at 13.00hrs. The meeting would be live streamed to the public.	
STAKEHOLDER ENGAGEMENT		
027/22	**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 any questions which had been submitted following the Board meeting on 9 December had been answered by appropriate members of the Executive Team, and had now been published on the website.	
The meeting was declared closed.		