Minutes of a meeting of the
QUALITY & SAFETY COMMITTEE
Held on 21st June 2018 at 9:30am
K2, William Farr House, Mytton Oak Road, Shrewsbury, Shropshire, SY3 8XL

Present: Nuala O'Kane Non-Executive Director (NOK) **Chair**
Steve Gregory, Director of Nursing and Operations (SG)
Mike Ridley, Chairman (MR)
Julie Thornby, Director of Corporate Affairs (JT)
Dr M Ganesh, Medical Director (MG)
Alison Trumper, Associate Director of Quality (ATr)
Jo Gregory, Head of Nursing & Quality – Children (JG)
Andrew Thomas, Head of Nursing & Quality – Adults (AT)
Rita O'Brien, Chief Pharmacist (ROB)
Susan Watkins, Lead Pharmacist for Community Services (SW)
Angela Cook, Head of Nursing – Adults (AC)
Jan Ditheridge, Chief Executive
Yvonne Gough, Deputy Director of Operations

Apologies: Steve Jones, Non-Executive Director

Minute taker: Diane Davenport, PA to Director of Nursing & Operations (DD)

Guests: Dr Louise Warburton, TeMS Medical Lead (LW)
Sarah Rock, Children Young People & Families SDG Manager (SR)
Karen Taylor, SDG Manager TeMS & Outpatient Services – Item 10 (KT)
Sarah Yewberry, Practice Education Facilitator (SY) – Item 11

Minute number:	***Agenda Item title***	
	The Chair, NOK, welcomed Dr Louise Warburton, TeMS Medical Lead and Sarah Rock, Children Young People and Families SDG Manager to the meeting.	
2018/06/01	**Declarations of Interest** (Agenda Item 3) No declarations of interest.	
2018/06/02	**Minutes of the Previous Meeting held on 24th May 2018** (Agenda Item 4) The minutes of the meeting held on 24th May 2018 were approved and accepted.	
2018/06/03	**Matters arising not covered by the rest of the Agenda** (Agenda Item 5) **Action Log Monitoring** Action log discussed and updated. **Minute No. 2018/05/04 - End PJ Paralysis** – a discussion took place with regard to people still in their pyjamas at lunch time and what is the solution. NOK queried if there are enough staff available to assist with dressing patients and there are other factors to be taken into consideration. SG suggested discuss when reviewing Establishment paper. Should also take into consideration the purpose for admission and people clear about that and proportion of patients less able. It was decided to include for discussion at a	

	future Quality & Safety Committee and the Action Log updated accordingly. **Minute No. 2018/05/09 Timescale for reconditioning of manual wheelchairs for issue to users** – AT advised the Committee that they had revisited the audit proposal and the system has changed and the original proposal is no longer relevant. The project has been postponed and a new proposal will be submitted for inclusion on 2018/19 forward plan.	
2018/06/04	**Quality Performance Report** (Agenda Item 6) The purpose of this report is to provide the Quality and Safety Committee with an overview of our quality and performance for 2017/18 as at the end of May 2018. The report provides a summary of the main performance report for Quality which is enclosed for information. ATr explained that the exception report aims to provide assurance to the Quality and Safety committee on the Trust Quality Key Performance metrics and other intelligence on quality, safety and patient experience. There are currently three areas requiring focus at the moment, Stoke Heath Prison, Safer Staffing – MIU Services and Trends related to patient transfers from Shrewsbury and Telford NHS Trust (SaTH). MR queried in relation to SaTH and the issues relating to patient transfers, what was their reaction. SG and MG had a meeting with Directors from SaTH and provided the Committee with an update. MR asked if there is a clear protocol with regard to admission. There is a protocol which is very comprehensive and includes criteria for accepting patients. MR questioned if SaTH have a protocol and they do and includes criteria with regards to admittance time, dress, transport etc. ATr has also discussed the issue with her equivalent at SaTH and a review of the process needs to take place. A discussion took place about what is and isn't acceptable and to ensure staff are briefed. JD referred to the issue at the prison and the terminology and could this be reviewed and amended for Board next week. Also what is the risk and mitigation at the prison and an understanding of what is happening and what is being done. ATr provided an update with regard to a number of triangulated trends and issues (sickness, high vacancy, medication errors, reported SI related to medicines in June, and more resuscitation 'grab bag' being seriously unfit for purpose) at the prison that have had an impact. Actions are being taken to support and solve the problem. YG informed the Committee that staff are currently heavily involved in the prison tender which is being finalised this week and additional staffing is required at the prison and a recruitment event is planned and YG will take forward and will inform JD. A new Pharmacy technician has just been appointed which will assist with sight of the medicines on the wings. Sickness absence is to be monitored and JT to investigate what is being done and to keep an eye on that and bring it back to the Committee. SG noted that Medicines Management, Dental and MIU have not reported and why is it acceptable that they don't submit and what is being done about information not being submitted. ROB explained that SW will be visiting the services and ROB has spoken to Phil Atkins at MIU. The Prison has now submitted and support is being provided to Dental services. **Falls** – there was a sharp increase in the number of falls overall: 25 compared to 7 the previous month. The Head of Nursing for Adults is leading on a range of actions being taken to strengthen processes to reduce falls overall. MG raised	**ATr** **YG** **JT**

	concern about the huge increase in falls and is a deep dive planned and has anything changed to create an increase. ATr explained the correlation about when the patient falls and correlation of staff, increased falls and staffing levels were high and if staff was sub optimal and process on Datix and can include if staff was sub optimal. SG queried if a falls risk assessment was included and could be an increase in injury due to fall. NOK asked what the reporting mechanism was and AT pointed out that if put into context, whilst 25 is high, then 7 is very low and looks more stark. AC said in terms of falls risk assessment this has been included in the Datix so reporting should be better. **Complaints process** – the approach to receiving and responding to complaints has been reviewed and revised to enable all receiving complaints to be reviewed by the relevant HoN with the time of supporting and strengthening the process of signposting to the appropriate staff member for involvement and for response. JD shared with the Committee that the Complaints team do a good job and it is about creating a better ownership about handling the complaint, it is to enhance and to ensure that services get involved and treat people differently. MR referred to the data breach which was fairly serious and does the person need support and why was this one complaint selected. ATr reflected that this complaint was identified as it has caused distress to the complainant who is being supported by the relevant HoN. The reason for the breach is now understood and steps have been taken to ensure this will not occur again. JG is providing support to the complainant and shared with the Committee the issue. **IDT's – improving holistic approach to care, reducing task orientated approach** – JD asked for clarification with regard to the inclusion of the Exception Item. ATr explained it is how work is allocated to the District Nurse and themes from RCAs have identified a cultural change toward a task orientated approach to care delivery, rather than a patient centred holistic approach. There are several possible reasons for this; vacancy situation (12.wte across the areas) this will add pressure on staff in post possibly compounding a "getting through the list" approach to care. A staff workshop has been arranged for July to address and complete a rapid improvement cycle in relation to improving holistic orientated care. YG commented that this is being looked at and is a broader issue than detailed in the report. **Basic Life Support Training** – Children's Immunisation and Vaccination team are at 62% and a deep dive will be undertaken. JG and SR have reviewed the team and identified the staff to undertake training and explained the risk to service users has been mitigated as the service is delivered through a team approach with 4 team members being present at the time of services delivery, thus there is no risk to service users. **Appraisals** – appraisal rates continue to improve with 7% of staff now overdue. **ATr to make slight amendments to the report prior to the Board meeting in June 2018.**	**ATr**
	CARING & RESPONSIVE	
2018/06/05	**RCA, Complaints and Coroners – Lessons Learned** (Agenda Item 7) The purpose of this report is to: Provide assurance to the CQRM in relation to the processes around reporting, investigation and learning from clinical incidents requiring a Root Cause Analysis and actions or learning from Coroner's Inquests and Claims.	

	AT provided a summary of the key points in the report and provided further explanation of the different sections of the report. **Section 1.0** – highlights the processes for an incident to be reportable as a Serious Incident (SI), whether DATIX reported clinical incident is reportable as an SI or if any Root Cause Analysis Investigation (RCA) is required. **Section 2.0 – Serious Incidents January – May 2018 subject to internal and external RCA review** – Pressure Ulcers are still high and details are included in the report of where incidents are occurring. The Action tracker is used at Adult and Children's Q&S meetings to monitor progress and provide assurance and used as an aide memoire when undertaking quality visits. Reference was made to Table 2.2 and could the dates be checked.	**AT**
	Medication RCAs – with regard to high risk medication incidents is there any potential for serious harm. The incidents are included on Datix and monitor the actions at meetings and see if any improvements. ROB advised the committee that as an Organisation required to have a nominated medication manager and that is Jo Gregory and CQC have attended a meeting and congratulate SCHT on our processes. Meetings are held monthly and a very supportive environment and come up with lots of solutions and seen a big reduction in Medication incidents **Lessons Learned** – AT referred to Lessons Learned and this is reflected in the Quality & Performance Report. Main lessons are: • Communication between team members (e.g.) handover and AC has undertaken a lot of work in this area. • Pressure ulcers • Recognising the deteriorating or very frail patient, which would allow for longer visits • A task based, rather than holistic care approach was taken JD commented that it was helpful to see range of actions and learning difficult to theme with SIs as low numbers, and who sense checks that the actions are timely. However, how will Committee members know when SI is closed off, which are completed or did the action work. AT informed the Committee that an immediate appraisal is undertaken when reported as an SI, receive all the Datix and any immediate action is carried out and reviewed. There is a "completed by" date and SI is closed by the CCG and included as part of quality visits. JD asked if some consideration could be given as to how the Committee will know that the SI is closed. JD referred to Liverpool report and may be worth revisiting. MR referred to the **Claims against the Community Trust** and the incident at Stoke Heath Prison and the outcome as yet undecided and is this all sorted now and has treatment been undertaken. AT will enquire and report back to MR.	**AT**
	With reference to North West IDT this would suggest going to pay costs as a result of pressure ulcer and does the cost come from a central pot and received any claims previously for pressure ulcers. JT advised that one had been received previously. MR questioned if the CAMHs claim was with our Insurance Policy and this will be actioned by SSSFT.	

	JD queried where the claims are agreed and who makes the decision to pay. JT informed the Committee that they are discussed at Audit Committee and our Insurers agree the value of the claim and NHS Solutions make decision. JD asked if we have an opportunity to contest and does the detail of the cost of the Claim go to R&P Committee. It was not clear if cost details go to R&P and this is to be considered. **The report was discussed and noted.**	
	EFFECTIVE	
2018/06/06	**Service Delivery Group Dashboards and Risk Registers** (Agenda 8) **Adult SDG – Quality & Performance Dashboard June 2018** JD commented that she liked the new format and queried what action was being taken with regard to vacancies. YG explained there is a lot of activity taking place with regard to recruitment and the numbers in the report are not a true reflection of the current situation. Our challenging area is In Patients and working hard to recruit to this area and recently had successful recruitment events at Ludlow and Bishop's Castle Community Hospitals. Staffing review is to be undertaken to help recruit to vacancies and looking at new packages of recruitment including retention. YG recently attended the Confed Conference and took the opportunity at look at recruitment initiatives and how to attract people to Shropcom and the USP. JD suggested including narrative into the main report and good to hear in terms of mitigation and would be useful to know if using regular bank staff. As a Committee understand what we have in terms of risk, what we are doing to mitigate. It was a big message from Confed about looking after new employees and recruitment is a national issue. NOK asked if staffing has an impact on our ability to admit patients. YG commented that this may occur very occasionally and would be an isolated incident. ATr said the most recent incident was at Whitchurch Community Hospital due to GP issue but not aware of any incidents of not admitting patients due to staffing. Our priority is to address this issue. MR queried the agency usage and does not look brilliant from some of the figures. SG advised that there was a slight increase and closer than we were hoping and SG and YG have discussed with regard to our own processes and not just utilising Agency but could staff work in those areas. Need to do better otherwise won't meet our obligations. Reference was made to the Carter review which includes an article on small wards and maybe worth reviewing. MR asked if a range of providers was used for Agency staff. SG commented that is an ID Medical master vendor and then other agencies available. Initiatives to reduce reliance on agency staff are being constantly considered by the SDG. JD made reference to the inclusion on the Risk Register the spend on Agency and the impact on quality and lower risk. If you times with vacancy with sickness etc. do we still believe it is 12. There is on-going monitoring and when you times with sickness is it a bigger risk. The Risk needs to be reviewed and in our mitigation review what we are doing.	

	CQC Medicines management – MR requested an update on what is the position on this and can we have year-end target. ROB responded that unfortunately data has not been submitted by the Prison, Dental and MIU service leading to an overall poor position. The target is 100% and want to show an improvement and SW has undertaken visits and assurance that the services are not failing and support is being provided. The 3 areas are struggling to provide KPIs and the Committee would like a report back at the next meeting. **Children & Families – Quality & Performance Report June 2018** JG referred to one area of concern with regard to New birth visits within 14 days (M), our current compliance at the moment is at 88.5% and new target is 95% and not 90%. There is some ambiguity with regard to "day 1" and have now agreed what "day 1" is and hopefully that will reflect in our compliance. Informatics meeting with Service leads to understand reporting challenge on RiO. Assurance was given that mums are receiving a visit and couple of missed visits due to notification from maternity services. JD asked what members of staff would say if they are not up to 95%. JG advised that at a recent C&F Performance meeting consensus suggests that this is attributable to data recording and parental/carer choice. Team to be notified of accurate reporting timeframe for consistency. Data has been shared at team meetings and AT to include on visit sheets. YG commented that parents get visits up until day 10 and face to face visits or telephone contact does take place. NOK said that she is assured in other meetings that the visit does take place and it does. **Safeguarding Training Compliance Level 2 & 3** – discussion took place about Safeguarding compliance not "Green". Top Hotspot areas have been identified and service managers are following up with individual staff members in their teams to reach compliance. SR supporting managers to do this and outside of the meeting SR and JG to review. JG to review the figures and data to ensure it is correct prior to the report going to the Board meeting. **Appraisal Rates** - SG asked with regard to appraisals and training how do you share what you are doing. ATr had a meeting this morning and theme discussed was sharing of information and the learning identified and how we can learn from that. Improving the quality of appraisal is a priority action on the C&F SDG staff survey action plan. Appraisal training pilot scheduled for Shropshire 0-19 Public Health Nursing Team in October 2018. **The report was noted and discussed**.	**JG**
2018/06/07	**Quality Account 2018/19** (Agenda Item 9) The purpose of the report is to provide the Q&S Delivery Group and subsequently the Q&S Committee and Trust Board opportunity to comment on and approve this year's Quality Account for 2018/19. AT shared with the Committee that the Quality Account is now 99% final and have received further feedback from Shropshire Clinical Commissioning Group and the factual accuracy on page 66 has been corrected. NOK commented that the Committee has already seen the report, for our	

	approval and to Board. MR asked if no feedback is received what happens. AT explained that the Quality Account will be processed if no feedback is received and that Healthwatch, CCGs, Local Authorities have all been invited to comment. Healthwatch were also involved in assisting with setting the priorities. JD commented that is a good reflection looking back at 2017-2018 and a good aide memoire and include in the CQC pack for Board members. ATr commented that strengthen as Quality team and aspects of the Report have been shared with staff on the ground and what it means for them and what we are doing and good to see reference to *'take a break'*. **The Quality & Safety Committee Approved the Quality Account and go forward to Board.**	
2018/06/08	**TEMS Update** (Agenda Item 10) The aim of the report is to make the Committee aware of the current status of the TeMS Services. This will include highlighting key activities currently underway to improve the operational and financial performance of the Service and following the presentation of the TeMS viability paper at Board in March 2018, this report will also capture actions relating to the Boards directives. JD queried why the TeMs Report was on the Quality & Safety Committee agenda. AT explained that following quality concerns it was scheduled to come to the Committee every 6 months. KT shared with the Committee that from a quality perspective, TeMS have made good progress on 30 week waiters and the RTT position is currently at 92.02% (open clocks) and compares favourably with the position 6 months ago. KT provided a general update on the TeMS service and outlined the actions that are being taken to support delivery improvements. LW commented that the TeMS Service has made good progress and there is still an issue with Rheumatology and governance and everywhere else is running well. LW attended the GP Forum on Tuesday and reinforced access to the service and GPs said doing really well. MR made reference to introduction of RiO which has tripled the time requirements for appointing patients. KT said this is an issue and it has been highlighted to ATr for consideration of actions to be taken. JD noted that staff experience did not do well in Staff Survey and include in the report. KT commented that actions relating to the Staff Survey results are well underway and have included improvements to 1:1 scheduling and appraisals are now standing at 78%. Other staff directed improvements relate to work systems and estates. NOK noted that it is good to hear about improving picture and KT done a good job.	

	WELL LED	
2018/06/09	**Pre-Registration Education Annual Report** (Agenda Item 11) The report is to provide a summary of Trust placement activity in support of pre-registration students and provide assurance regarding placement quality and compliance with Health Education England and Professional body requirements. To provide insight into future opportunities and challenges in education. SY referred to report and provided a summary of the key points. It has been a busy year and Staffordshire University are main provider and in the last 12 months have developed stronger relationships with Glyndwr University, Open University, apprentices community experience, acute trust and working with other local partners. Still more work to be done and well supported by NHS AHPs lead to engage with AHPs. In May the NMC published radical changes to mentorships and the new standards must be adopted by all HEIs by September 2020; on adoption of the new standards, the NMC will no longer regulate mentorship of students and there will be no NMC approved mentorship qualification. The NMC have devolved responsibility to HEIs and practice partners to determine how Supervisors and assessors of students will be prepared for their future roles. JD commented that it was a good report with an informative front sheet and got to the crux of the matter. SG commented that SY work's tirelessly away at Education and it is under the radar and good feedback is received about SY's leadership. JD referred to the SaTH arrangement and guaranteed a job after training and could Shropcom offer something similar and this will be looked into and given consideration. YG suggested that should ensure that students who have not done a placement, know we exist and JD explained there are far more students in the services and all report good experience. JG asked about new standards from NMC and removal of 40% mentor. SY have monitored and in new standards it is up to Universities and partner organisations how they use mentors and are working together to decide on principles so hopefully mentor qualification be replaced by assessment qualification. The Committee acknowledged it was a good report.	
2018/06/10	**Establishment Paper** (Agenda Item 12) ATr presented the paper and it outlines a summary of the formal review of SCHT current staffing establishment proposal within our Community Hospital In-patient service and Minor Injuries Units (MIU). The Committee is requested to receive this report for consideration to take forward for Trust Board Approval. ATr provided a summary of the key points in the report and provided more detail with regard to staffing, financial impact, In-patient service, staff wellbeing and further background. The Finances are due to be discussed at RPC and initially there will be an increase in base line budgets with an overall cost reduction annually. SG provided further detail with regard to the MIU proposal and the financial	

	impact. In-patient review concluded sustaining safe staffing levels could be achieved through different ways of working and development of different workforce models. This strategy would not adversely impact on nurse patient ratios and average care hours each patient receives, and, supports our ambition to strengthen our substantive in-patient clinical workforce thus reduce reliance on agency staff. NOK welcomed the review and important to say that we have to do this due to staffing but acknowledge skills that are available and important to retain the skills wish you well with implementation whilst still operating within a safe environment. ATr informed the Committee that the model builds in that there will be a band 6 on duty on each ward at weekends and bank holidays to undertake assessment with the Capacity Manager. In addition, a new Capacity Manager role is proposed 7 days per week. NOK queried if this will be a registered health professional with a clinical background. JD commented that the vacancy has already been approved and need to do banding and the post will be advertised next week and will assist with visibility and an interesting role. NOK queried implementation. SG advised that need agreement at the Q&S Committee to take forward and then need sign off from RPC and once obtained would go ahead. MR referred back to the safety aspect and it is a good paper and looks positive but how are the Committee assured with regard to reducing the number of clinicians that patient safety will be achieved. JD commented that not reducing the numbers of staff in MIUs but increasing and looking at skills mix and are staff and skills in the correct team/service. NOK noted that it will require careful management and monitoring and acknowledgement of the skills of the workforce. The Committee thanked ATr for the Report and look forward to receiving an update on implementation. **The Quality & Safety Committee considered the report and it is value for money and looked at risks impact and recommend that it goes to RPC and then to Board to take a view.**	
	SAFE	
2018/06/11	**CQC Progress Report** (Agenda Item 13) ATr advised the Committee that a comprehensive report will be presented at the July 2018 meeting and will include all the activity that has taken place.	
2018/06/12	**Medicines Management Report** (Agenda Item 14) The purpose of the report is to provide the Quality & Safety Committee with an overview of medicines management and governance within SCHT. Summary of key points in report: • Clinical pharmacy support (medicines optimisation) • Status of medicines policy documents • Status of patient group directions documents	

- Controlled drugs governance
- CQC Standards for medicines management
- Team structure
- Team risk register

ROB provided a brief summary of the report and explained that the report is intended to give an oversight into medicines governance arrangements in SCHT. ROB is due to retire at the end of June and Susan Watkins will start on 1st July 2018 and has been promoted from within the existing team. With regard to Controlled Drugs Governance, SW as Chief Pharmacist will be the appointed Accountable Officer for Controlled Drugs (CDAO). The CQC Controlled Drugs National Group Condensed Minutes were attached to the report for information.

CQC Standards for Medicines Management – regular peer review against these standards has been undertaken by several pharmacists in the team and where required, remedial plans agreed with the service managers for local implementation. Staff are fully briefed about the importance of basic checks such as ensuring the drug fridges are monitored properly to maintain the drugs within the manufacturer's licences and aide memoires have been developed.

Medicines Management Team Risk Register – there is only one risk scoring 12 with regard to the high use of agency nursing staff and locum doctors that puts the pharmacy at risk. Controls have been put in place and various guidance documents available on ward desktop.

NOK thanked ROB for her years of service, the good practice that has been introduced and wished her well in her retirement. NOK welcomed Susan Watkins to the Committee who will be the Chief Pharmacist for the Trust from 1st July 2018. NOK queried if her position would be back filled and ROB explained that are looking at career development opportunities for the team and will review.

JD referred to CQC visit and fridges were front and centre of that CQC inspection and what are the real hot issues. ROB explained that there has been a huge improvement with regard to drug fridges and will continue to monitor.

ATr commented that the Quality team work well with Medicines Management and will look at the non-medical prescribers to be included in the Quality & Safety Performance report.

MR thanked Rita for the report and for her commitment to the organisation.

The Committee noted the Report.

2018/06/13	**Themed Review this month** The Themed Review was a presentation on the Shropshire Public Health Nursing Service - Telford and Wrekin 0-19 teams. Lorraine Vine, Specialist Public Health Nurse Community Practice Teacher Tracy Jones, Healthy Child Programme Support Worker Gail Desouza, Health Visitor Coordinator in Telford. The presentation was to highlight the work that is being undertaken by the service and to share with the Quality & Safety Committee. The presentation will also be shared at a staff meeting later today. Handouts were provided detailing the service and reference to the 456 model and provided an explanation of the journey to date. The service has received good feedback and comments from the FFF tests were circulated. The Team shared with the Committee that the recent co-location of staff has increased positive communication and working patterns had enhanced working together and recent innovations had been introduced. NOK thanked the team for their presentation and is impressed by the enthusiasm of the staff and congratulate the team on embracing the new working arrangements and was an excellent and improved service. MR asked the team if they were pleased with the co-location. The team explained that the co-location was working well with regard to meeting staff, networking, cross the board service and integration of the teams. If anyone is interested there is a hot desking facility available at Telford.	
2018/06/14	**Policies for noting: N**one **For Approval:** None **Items for Information:** Quality & Performance Report	
2018/06/15	**Risks: Risks identified at the meeting** Safeguarding Training Compliance Level 2 & 3 – incorrect detail and will be corrected before the report goes to Board. Staffing issue at the Prison and actions are being taken to mitigate VTE still an area of concern and to be included on the Risk Register. Use of Agency Staff and quality impact on service. **Assurances: Assurances given at the meeting of internal control/risk mitigation effectiveness, either positive or negative.** Update from ROB about Medicines Management.	
2018/06/16	**Any Other Business (Agenda Item 21)** None	

	Date of Next Meeting Thursday 23rd August 2018, 09:30 – 12:30, K2, William Farr House, Mytton Oak Road, Shrewsbury, Shropshire SY3 8XL **Forthcoming Themed Reviews:** • **August 2018 –** Covert Medicines and Mental Capacity	

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QUALITY & SAFETY COMMITTEE
Held on 19th July 2018 at 9:30am
K2, William Farr House, Mytton Oak Road, Shrewsbury, Shropshire SY3 8XL

Present:

Nuala O'Kane, Non-Executive Director - **Chair** (NO'K)
Steve Gregory, Director of Nursing & Operations (SG)
Jan Ditheridge, Chief Executive (JD)
Mike Ridley, Non-Executive Director (MR)
Angela Cook, Head of Nursing - Adults (AC)
Jo Gregory, Head of Nursing & Quality - Children (JG)
Liz Watkins, Infection Prevention Control Manager (LW)
Andrew Thomas, Head of Nursing & Quality (AT)
Dr Ganesh , Medical Director (MG)
Susan Watkins, Chief Pharmacist (SW)
Julie Thornby, Director of Corporate Affairs (JT)

Apologies: Alison Trumper, Deputy Director of Quality (ATr)
Yvonne Gough, Deputy Director of Operations (YG)
Steve Jones, Non-Executive Director

Minute taker: Diane Davenport, PA to Director of Nursing & Operations (DD)

Guests: Mark Crisp, Complaints & PALS Manager and Natalie Hughes, PALS/FOI Manager - Item 7
Cath Molineux, Nurse Consultant, Item 8
Sara Hayes, Head of HR & Workforce and John Snell, Head of Workforce Planning, Systems and Information - Item 13

Minute number:	***Agenda Item title***	
	NOK welcomed Susan Watkins to her first Quality & Safety Committee in her new role as Chief Pharmacist.	
2018/07/01	**Declarations of Interest** JD queried why there was no operational representation at the meeting. SG responded that this was due to annual leave and sickness. No declarations of interest.	
2018/07/02	**Minutes of meeting held on 21st June 2018** (Agenda Item 4) **Minute No. 2018/06/12 Medicines Management Report** – the start date for the new Chief Pharmacist is incorrect and should be 2018 and not 2019 as stated in the minutes. The minutes to be amended. The minutes of the meeting held on 21st June 2018 were approved and accepted with the amendment to **Minute No 2018/06/12** to be incorporated.	
2018/07/03	**Matters Arising not covered by the rest of the Agenda** (Agenda Item 5) **Action Log Monitoring** Action Log discussed and updated.	

	Minute Number 2018/05/04 – End PJ Paralysis – AC provided an update and shared with the Committee action that has been taken. There is still further work to do with regard to implementation and the tool has been revised and will be relaunched and educate staff about importance. JD referred to a recent visit to different areas and there were still quite a lot of patients in bed at 3pm in their PJs and did try to work out why and from a leadership point of view understand importance and why should focus on. AC is attending Ward Manager's meetings and will discuss. JD commented that it is important to triangulate with VTE protocol and risk of blood clots if patient remains in bed. NOK thanked AC for the update and also JD for her comments and reminder about the link to VTE. **Minute No 2018/06/04 CQC Medicines Management** - SW shared with the Committee that there had been a significant improvement with regard to reporting. However there are still a few gaps and expecting full compliance by next month. NOK queried if need an update next month and JD commented that figures are included in Performance Scorecard and SG informed the Committee that the next Medicines Management quarterly report is due in September. **Minute No. 2018/06/05 Claims against the Trust** – AT informed the Committee that the patient has received appropriate dental treatment. The claim was undecided because we were at fault due to a delay in referral for treatment to the dental team and for that we are going to offer a small compensation package. However the claim was for his long standing dental decay which we weren't accountable for and that is why the decision was delayed. The figure has now been agreed and MR queried who decides on the figure. AT responded that it is decided in-conjunction with the Litigation Authority. **Minute No 2018/06/05 Dental Never Event** – AT has shared the Liverpool CQC report with the dental team highlighting the relevant elements for learning and action as required. JG has visited the dental team and some of the actions have been undertaken and confident that the learning has been taken on board. An Audit will be undertaken and JG will be involved and will be looking at culture rather than the process. JD queried if staff understood why JG was there. JG advised the Committee that the staff understood her presence and JG has just got to meet with PZ to complete assurance. SG added there are a number of vacancies in the dental team and he has met with colleagues to discuss and look at a different proposition about leadership going forward so we can plan prior to the Clinical Director retiring.	
2018/07/04	**Quality & Performance Report** (Agenda Item 6) JG presented the Report on behalf of ATr. The purpose of the report is to provide the Quality & Safety Committee with an overview of our quality and performance for 2017/18 as at the end of June 2018. JG referred to 3 key areas of the report: **Medicines Management** – SW provided an update earlier with regard to medicines management and CQC Standards.	

Patient falls resulting in harm – a SI was raised as a result of a patient falling and an RCA undertaken.

NHS 70 Birthday – very successful and well attended NHS 70 celebrations held at William Farr House on 3rd July 2018. NOK commented that she did pop in and it was a good event and there was a sense of pride and achievement and a good morale booster and congratulations to the team on organising the event. JD referred to the other activities that were also undertaken that week and staff who attended York Minster and Westminster really enjoyed the events; staff also attended a Royal garden party and invited to join the PM for lunch.

JG referred to the LAC assessments and a recovery plan is in place and proceeding well and more narrative is available in the SDG Dashboard & Risk Register for Children & Families.

0-19 Public Health Nursing Service - MR queried the reference to the SMART action plan and what is the current situation. JG shared with the Committee that concerns had been raised about the service in Shropshire and that some of the team have raised concerns. JG and SR are taking on a role of joint professional lead role with 0-19 Service managers for Telford and Shropshire which includes an action plan and weekly meetings. NOK asked if the team have any idea about what action they can take. JG commented that the team and leads have shared how they feel, areas for improvement have been identified and that there were regular meetings to review progress.

JD shared with the committee that she has received a couple of anonymous letters and referred to a letter that she received about 2-3 years ago regarding similar issues. The Exec team visited the service recently and JD did mention in her Weekly brief how positive things were.

NOK feels it is very important to hear and understand if teams feel pressure and what is the impact on that service and still delivering a good service or is it suffering as a result of this. JG commented that the passion of the team and managers was still evident but extra support is required to maintain the great service great service.

NOK looks forward to hearing more about developments in the service.

SAFE domain - SG asked why the figures change when we are always looking at the same number and could the figures be checked.

Safer Staffing – MIU services – update from June 2018 – MR referred to the MIU and at Oswestry in particular and what comes first the highest risk area with the ENP vacancies or the successful appointments and once appointed will that no longer be a high risk area. AC responded that yes that is her understanding.

MR requested clarification with regard to radiology high volumes occur i.e. long queues and what is a departmental safety pause. JD referred to the recent recruitment issue at Oswestry MIU to the senior leadership position that was really important for CQC and the service and will the recent temporary secondment to a locality post for 3 months create further risk in this area.

	SG responded it is a temporary appointment and he did pose his concerns. The CSM post will still be leading on the MIU, the CSM role includes Community Teams who are being support but another CSM and PA will be concentrating on MIUs. JD commented it is important that staff do understand that they should consider a secondment opportunity carefully for both themselves and the organisation. JD requested reassurance that it was thought through with regard to the risk in that area, not related to the individual. NOK queried if discussions about leadership issue did take place. SG acknowledged that discussions have taken place and the issue is have we created a risk in an area that CQC picked. In answer to both questions, an urgent performance review to look at performance against CQC standards has been arranged and will be doing the same with the End of Life Care which was also identified in the CQC Report. The meeting will include AT, AC, SG and the teams and it was requested that the presentation is shared with the Quality & Safety Committee. SG explained in terms of staff numbers at Oswestry MIU, which is included in the Establishment paper, we are confident about addressing together with the culture issue and leadership. SG clarified that permission to pause is LEAN and for health and safety reasons only so many people can be accommodate in the waiting area to ensure efficient management of patients and to support the wellbeing of the current small number of substantive team at Oswestry MIU. JD explained that during certain times of the day they are under pressure in particular when the radiology dept. is open between 10.00 a.m. – 2.00 p.m. and therefore high demand. The Leader on that day takes stock and considers alternative ways of managing the process, prioritise differently and look at work load. MR referred back to overflow and is that a particular issue. SG advised at certain times of the day can be an issue and is monitoring the situation. MR requested details on how many times the "safety to pause" has been implemented. SG advised that will be reported back. MG commented that it is similar to issue at A&E and advise patients of waiting time. MR asked if CQC look at this particular issue since it was raised last time and would we get a big tick at present. MR referred back to previous questions and once we have made appointments are we no longer a high risk area. SG commented that not necessarily a high risk area anyway and shifts are all covered but in the Establishment review which came to the last meeting shifted some of our thinking. **The Quality & Safety Committee discussed and accepted the content of the three SDG Dashboards and noted the actions and key risks.**	
	CARING AND RESPONSIVE	
2018/07/05	**Complaints and PALS Annual Report 2017/18** (Agenda Item 7) Mark Crisp (MC) and Natalie Hughes (NH) presented the report which details complaints/PALS enquiries for the last year. It meets the requirements of the NHS Complaints Regulations for a Complaints Annual report, and also provides additional information related to correlation with patient experience data. MC provided a summary of the report and highlighted the main points. • The number of complaints has decreased by 39% compared to the previous year.	

- The two services with most complaints are HMPYOI Stoke Heath and Community Orthopaedics.
- The areas with the greatest number of complaints are quality of care, followed by communication and waiting times.
- The Ombudsman did not investigate any Trust complaints. *MC informed the Committee that people are always advised that they have the option to contact the Ombudsman if appropriate.*
- Compliments have decreased by 29% on the previous year. Service leads have been asked to remind their services of the importance of recording their compliments using the data capture form in Datix as this helps to provide context alongside complaints and PALS data. MC drew the attention of the Committee to the Compliments Chart and noted that the figures on Page 8 of the report are incorrect and will be amended and MC apologised for the inaccuracy.

The overall decrease in complaints is largely due to the reduction in complaints about CAMHS who transferred to SSSFT as of May 2017 and Stoke Heath Prison healthcare.

JG asked with regard to the compliments and decrease is there any element that people are using FFTs to provide compliments instead. MC commented that these are unsolicited compliments. JD queried if there is an easier way of sending complaints/compliments. MC advised could look at Web page as there is already an online complaints form and possibly introduce a compliments form. AC queried if compliments can only be written or can verbal be included. JD thought that we already take verbal complaints and MC commented that most complaints start as verbal.

NOK noted that when visiting services there are a lot of thank you cards and MC acknowledged these are acceptable.

SG commented about connectivity with other reports and annual report on Complaints/PALs and not totality and connected and what is quite interesting if you look at the data in 2016/17 there was quite an increase and is this due to people being more aware of complaints.

MC advised undertaking a review of policies with the intention of possibly merging together. MC does attend the FIG meetings, which provides an opportunity to discuss complaints and compliments. JD commented that her understanding is that we have to produce an Annual Complaints/PALS Report and MC confirmed that we do.

JD requested clarification with regard to the number of complaints from TEMs and the Prison and TEMs is usually waiting times and prison is normally related to prescriptions and therefore what does Quality of Care refer to. MC to check and review.

MR asked what the *Incident in Learning group* is. MC advised the Group is Chaired by ATr and PF, AT, Heads of Nursing and relevant Clinicians attend, to review Serious Incidents and RCAs. SG noted that the Group was established following the CQC visit as it was identified, we did not have the ability to identify and share learning and themes. MR asked where does it report to. SG advised the Group reports to Quality Delivery Group first and Quality & Safety Committee quarterly.

	MR referred to Breach of Confidentiality and does appear to be down to basic fundamentals and has there been any reverberations right across Safeguarding teams and is everything now OK. JG advised it is the same issue as referred to at a previous Quality & Safety Committee. The lessons have been learnt and better processes have been put in place and confident it will not happen again and are also undertaking a RCA. AT asked in the more complex or emotional complaints, relating to quality of care do the complaints team work closely with the Clinician to try and meet the patient rather than provide a written response. MC commented that could probably do more visits and JD considers it should be our first consideration and it has been a real challenge to get us routinely to do and it should be a joint conversation as soon as that complaint is received. AT referred to section on Sharing lessons learned and meetings where they are shared. In order to see if lessons have been learnt as part of the joined up approach certain themes could be identified and put into an Audit programme so we can see if the learning has been embedded. SG advised that he considers it is part of the HON role. **The Quality & Safety Committee approved the report**.	
2018/07/06	**EOL Review and update** (Agenda Item 8) The purpose of the report is to provide a 6 monthly review of implementation of EOL strategy for Adults, whole system EOL care priorities and Gosport Inquiry awareness and potential implications. CM advised that information is included about where we are now with regard to the Strategy implementation and also the Gosport enquiry because of the implications, the media and public perception of syringe drivers. AC referred to EOL Champion and debate about Dying Well vs EOL Champion title and queried if staff had been consulted with regard to the title. CM commented that the title had been suggested by staff and a discussion had taken place about the title and was still up for debate and will discuss with the team. NOK suggested checking with other Trusts. JD referred to a recent visit by the Executive team to the Community Equipment Services and quite clear they respond quickly to EOL requests for equipment. Do we have a clear pathway so everyone concerned knows what is expected? CM commented that there isn't a pathway and usually it all takes place within the last few weeks of life and probably something that needs to be looked at and included in the EOL Plan. CM commented that it depends where they are on the EOL trajectory and probably when they are close to EOL. MG commented that it is difficult to determine as the patient's circumstances could have changed and challenging to consider what is required. CM to consider requirement for a Pathway and will discuss with EOL Operational Group and come back to the Quality & Safety Committee. MR asked if Shropshire Community Health NHS Trust will be responding to the Gosport enquiry. NOK explained that her understanding is there will be a Government response and something the Committee needs to look at in detail when the full report is available and the full lessons are learnt. MR queried if we have been approached for a request. CM commented	

	that no request has been received as yet and the Government's response is due in the Autumn. SCHT do use syringe drivers and some questions may be raised around the use and CM has spoken to Professor Willis at the Hospice and CM considers the Committee need awareness of the Inquiry. NOK considers there are a lot of lessons learnt and in particular around the culture of the organisation and should wait until the full outcome is available. MR requested clarification on the reference to *clear process is in place on commencing patients on opioids and for those on opioid*. CM shared with the Committee that one of the things that came out of the Gosport Inquiry is that some patients may require opioids and if you start them off on a high dosage they cannot tolerate and commence on a low dosage. NOK commented it is related to pain management and very important to get it right. **The Quality & Safety Committee discussed and noted the contents of the Report.**	
	EFFECTIVE	
2018/07/07	**Service Delivery Group Dashboards and Risk Registers (Agenda Item 9)** All dashboards are structured around the five CQC key lines of enquiry; caring, responsive, effective, well-led and safe. The aim is to provide visual assurance in relation to our quality and safety compliance measures, with additional detail by exception, to the Committee. AC provided a summary on the Adults SDG and Risk Register. MR asked if the Grade 4 pressure ulcer was in service or not. AC confirmed, yes it was in service and RCA on the way. MR referred to the Queen's Nurse Award and should this be announced at Board or give due recognition. AC has asked CH to include in Comms and SG will raise at Board. MG referred to VTE and when we will see improvement. AC advised the training programme has commenced and TA is leading. JD asked how we are holding Doctors to account. AC informed the Committee that TA in her report identifies reason for omission and taking back to GP. JD referred to vacancies and summarise risk we are actually carrying and hot spots and could the figure relating to Domestics off sick be checked for accuracy. JD commented the Executive Summary could be reviewed and information relating to vacancies could be captured in there. NOK commented that detail of the bottom line would be useful and is it mitigated by agency staff. SG commented with regard to more general question about total percentage we did request JS if he could produce the information and bring to SDG domain and could not advise what the level of percentage vacancy overall. MR referred to Ludlow In Patient ward has 16 staff not undertaken BLS training. AC commented this is how report has come out of ESR and having a tidy up and the Data is inaccurate and will check.	

	NOK commented need to have confidence in the reports and provide accurate information **Children and Young Families** JD referred to earlier conversation relating to Children's services and report does not reflect earlier discussion. NOK asked if it was just a snap shot and JG advised it was a snap shot of last month JG noted that Mandatory training, sickness and Appraisal rates are not as good as they previously were. JG noted that the vacancy rate for Shropshire 0-19 PH Nursing Team is still showing red and was hoping it would be amber/green by now. MR queried reference to Local Authority Review Health Assessments does that mean a report will come to the next meeting. JG advised a report will be presented at the September meeting and are undertaking a big review of our Out of County LAC Assessments as the LAC team are not receiving the health assessments in a timely way. **The Quality & Safety Committee reviewed and discussed the report and dashboards.**	
2018/07/08	**Annual Clinical Audit Report (Agenda Item 10)** The purpose of this annual report is to provide the Quality and Safety Committee with information and assurance regarding the work of the Clinical Audit team within Shropshire Community Health NHS Trust since April 2017. This paper appraises the Committee of actions to date listed as an appendix in order that the Committee may gain assurance that our clinical audit processes are effective. The paper is additional to the quarterly update provide and is a requirement of our assurance plan in line with good practice. The report seeks to demonstrate the plans for 2018/19 to develop the Clinical Audit service and further strengthen the contribution of the team to the achievement of Trust's objectives. The report has been through Audit Committee and requirement that it comes to Quality & Safety Committee and the report provides information regarding work of the Clinical Audit team within SHCT and Clinical Audit programme. AT queried if Board will require the full Audit report or a summary of the Quality & Safety Committee minutes will suffice and escalation of any risks to Board. AT was going to discuss with JT. MR asked what are the implications of us not taking part in the Central/National Audit. AT advised that there are no penalties it is just that our strategy and policy requires us to undertake as many national audits as we are able to do. This is a problem at the national audit end in terms of their data collection tool and not allowing us to take part at the moment. **Staff training and engagement** – MR queried the absence of a formal programme of training for clinical staff and the implications. AT advised we do not have formal training as a small team and do provide opportunities for learning but it is not mandatory when developing an audit proposal we are offering support and links there for on-line training. JD referred back to MR's question and what are the implications and not good enough to say	

	that we do not have enough people to do the training and there are other ways to deliver training. AT advised do provide on line training. JD consideration should be given to how the paragraph is written and if clinical staff undertake training will it remove risk. AT considers if training is undertaken then it will remove risk. **The Quality & Safety Committee noted the contents of the report.**	
2017/07/09	**Infection Prevention and Control Annual Report for 2017/2018** (Agenda Item 8) The purpose of the report is to provide Quality & Safety Committee with a summary of the activities undertaken by Shropshire Community Health NHS Trust to complete with the Health and Social Care Act 2008: Code of Practice on the control and prevention of infections and reduce the risk of healthcare associated infection for the year from April 2017 to March 2018. **The Quality and Safety Committee noted and approved the content of the report and agreed for the report to be placed on the SCHT website.** **Infection Prevention Control Report** - (Agenda Item 8a) The purpose of the report is to provide the committee with a summary of the activities undertaken by Shropshire Community Health NHS Trust to comply with the Health and Social Care Act 2008: Code of Practice on the prevention and control of infections and related guidance (Revised July 2015) in the period 1 April – 30 June 2018. MR referred to the *Legionella spp.* identified in the water supply at Whitchurch Hospital and the second sample taken on 29th June 2018 and have the results been received yet. LW shared with the Committee that the results were received yesterday and there are three positive areas identified and MPFT are going to assess. JD queried if the filters are still in place and LW advised that Whitchurch still has the filters in place and where the remedial work was carried out and samples without the filters have not been taken yet. At Ludlow Community Hospital, the filters have been removed is still being monitored and a programme of remedial work identified and meetings are being held. MR questioned if the space between the beds at Whitchurch Community Hospital will remain on the Trust's Risk Register. LW acknowledged it is still on the register and likely to remain. SG queried what the level of risk is. LW provided an update and it is a managed risk. MR noted that could this increase the risk of infection between beds. MR queried reference to cleaning by OCS at Oswestry Health Centre continues to be below standards. LW informed the Committee that have just received the audit and have revisited Oswestry and improvements have been undertaken. A separate cleaning audit was undertaken by Estates and scores are improving and a meeting will be held with OCS and NHS. **The Quality & Safety Committee received and accepted the report.**	

	WELL LED	
2018/07/10	**Safer Staffing Report** (Agenda Item 12) The purpose of the report sets out our expectations defined within the NHSE National Quality Board (NQB) sets our expectations defined within 2013 NQB paper; *How to ensure the right people, with the right skills, are in the right place at the right time (a guide to nursing and care staffing capacity and capability)*. AC provided a summary of the report and the key points. **The report was received and discussed by the Quality & Safety Committee.**	
2018/07/11	**HR & Workforce Report** (Agenda Item 13) JS provided a summary of the key points of the report and focus on a couple of areas. **Workforce Race Equality Standard (WRES)** – WRES reporting statistics are due for submission on Friday 10 August 2018 and details of our submission is at Appendix 3 to the report. More detail and an action plan will be presented to the Committee in September ready for publication on 28 September 2018. **Recruitment** – in response to the revised Establishment Paper and MIU, recruitment events are planned in early September and events have been held in Ludlow, Bishops Castle and further recruitment events are planned in Telford and at HMP Stoke Heath for Staff Nurses on 27th July 2018. A talent pool is being set up and a job rotational programme is one initiative that is being introduced to encourage newly qualified staff nurses to join the Trust. The ***Time to Recruit*** still requires some improvement and has identified areas where this can be undertaken. MR commented that he understands that a quarter of new starters will leave in the first year and is that an issue. JS informed the Committee the employees who leave within the first year is quite high and it is connected to expectation setting. To improve our understanding of turnover, changes are being made to the leavers' policy. Recruitment is a national issue particularly at Band 5 and we are working as a system to retain staff and SH advised that it is part of the STP Agenda and the recent changes to Agenda for Change will help with retention. SH advised there is a national recruitment drive and have looked more generally how we can put things in place for support and any other assistance. JD suggested could the interviews be held at the location of the vacancy and SH said that this does happen but sometimes people travel a distance. **Annual leave** - JD queried about annual leave and how it is rostered and the accumulation of annual leave in January/February and is a massive issue operationally and financially. SG commented there is a policy and Ward Managers know the rules for rostering. NOK queried if rostering is	

	done electronically. JD commented it is not but something looking into. SG advised that rostering is part of the Establishment paper and all rotas are generic and are clear and includes annual leave and apportioned out evenly over the 12 months and rota is done 6 weeks in advance and annual leave is agreed beginning of year. NOK thanked SH and JS for the report**.** **The Quality & Safety Committee considered, noted and approved proposed actions.**	
2018/07/12	**Medical Re-Validation (Agenda Item 14)** The purpose of the report is to provide assurance to the Trust Board of the Trust's progress in implementing the Responsible Officer Regulations. MG provided an outline for the requirement of the report and a copy of this report and its appendices will be sent to the higher level Responsible Officer at NHS England as part of the new Framework of Quality Assurance requirements. As at 30th April 2018, 9 doctors had a prescribed connection to the Shropshire Community Health NHS Trust, which means that the Trust is their designated body for the purposes of revalidation. During 2017/18, 8 doctors were appraised, 7 doctors have been revalidated and one doctor has so far been deferred – due to long term illness. MG drew the attention of the Committee to **Point 11 – Corrective Actions, Improvement Plan and Next steps** – confident that we have a well-designed system and governance process for appraisal and all doctors engage with the process and have to report to GMC. A survey was conducted on implementing medical revalidation: findings from a national survey of Responsible Officers in England. MG shared with the Committee the main findings of the survey were: • The quality of appraisals were variable • Communication between the appraiser and appraise was not consistent • Locum working and private practice and difficult to monitor. NOK referred to Locums and who is responsible for appraisal. MG noted that Locums have their own appraisal and MG requests a copy of the appraisal. NOK asked if there is any concern with regard to Locums not being appraised. MG advised that he does keep an eye on the process and will bring the learning into our processes and discussed with the team going forward and will review the plan and should be a clear Induction and Appraisal process along with CRB and they should declare if they are in private practice. MR queried if every GP is appraised and MG said they are and he receives confirmation of the appraisal. MR referred to **Annual report Template Appendix B – Quality assurance of appraisal inputs and outputs** and is there any significance in relation to *Review of significant events/clinical incidents* column and the figures. MG confirmed this is an error and will arrange for it to be amended.	

	NOK queried if a GP is under investigation at practice would we receive notification and what is the requirements. MG understands that they are supposed to advice the Medical Director and JD understands there is a clause in contract/SLA that they have to advise the Trust. **The Quality & Safety Committee noted and approved the report**.	
	SAFE	
2018/07/13	**CQC Progress Report** (Agenda Item 15) AT shared with the Committee the CQC Update presentation and highlighted the main points. AT to circulate the presentation to Committee members for reference. JD queried if the reference to staff morale has been shared with the team. AC clarified that support is being provided to the team and discussions have taken place and team aware of impact. JD considers that team should be made aware and given an opportunity to respond. SG has had conversations about culture. NOK asked who the presentation is intended for as some of the information is very useful for staff teams. JD would like the presentation to Board in Well-led slot. JD recently discussed with SG that another Trust has included a link under the rating to show where work has been undertaken and helpful for both staff and CQC and something that we could consider. AT to take presentation to Clinical Forum and to Board. NOK thanked AT for the presentation and good to see and progress that has been made and how we improve our service to patients.	AT
2018/07/14	**Medicines Safety Officer MSO report** (Agenda Item 16) The purpose of the report is to provide a brief update on the key work streams of the Medication Safety Officer (MSO). To provide assurance that the Medicines Incidents Lessons Learnt Review group is learning lessons and identifying best practice to ensure we can continue to deliver high quality, safe and compassionate care. JG provided a summary of the report and highlighted the key point in the report relating to: • The human factor of communication has been a contributory factor in many incidents reporting during the last six months. Actions are being taken to improve handover in all services whilst ensuring that they are patient specific. This has been identified as a priority action at Q&S Delivery Group. MR requested clarification with regard to the RCA document being updated. JG informed the Committee that following feedback received from nursing staff, the RCA document leads staff to duplicate detail and the incident detail can be ambiguous and the form will be updated. SW commented that the form did not document clearly what was needed.	

	MR referred to the incidents involving insulin omissions continue to be an issue. JG advised there is still a problem and AC has done a lot of work with regard to work undertaken and handover and a lot of the incidents this quarter were due to bad weather. NOK commented on how much time District Nurses spend on administering insulin and is it a big problem and can anything be done to reduce the time such as self-administer. AC acknowledged that it is a bit of an issue and to train patients to self-administer takes a lot of investment initially. A Diabetes Task and Finish group has been set up which included reviewing the number of patients living with diabetes per caseload and exploring confusion regarding insulin documentation. Training packs for District Nurses to use are to be launched and considering requirement for an educator role and not a trainer. NOK would like to review at future Quality & Safety meetings and how it is being managed. MR requested clarification with regard to the Community Hospitals table and could any examples be provided for incidents included in "Other Medication Incident". JG commented that this could be medication dropped on the floor, running out of stock, staff not aware where medication is stored, patients were asking relatives to bring in medication and taking medication that had not be prescribed. **The Quality & Safety Committee discussed the contents of the report and the Chair would like an update at a future Quality & Safety Committee meeting.**	
	THEMED REVIEW – No Review	
2018/07/15	Policies for Noting: **Community Hospital Cleaning Policy** – this policy details direction in maintaining and improving cleanliness standards across all community hospital sites. The Report has been to the IPC Governance meeting on 27 June 2018 and was approved. **For Approval:** None **Items for Information:** Quality & Performance Report	
2018/07/16	**Risks: Risks identified at the meeting** MIUs - mitigate risk of staffing issue and secondment. **Assurances: Assurances given at the meeting of internal control/risk mitigation effectiveness, either positive or negative**	
2018/07/17	**Any Other Business** None	
	Date of Next Meeting Thursday 20th September 2018 – 9.30 a.m. – 12.30 p.m. – K2, William Farr House, Mytton Oak Road, Shrewsbury, Shropshire SY3 8XL	

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Minutes of a meeting of
PART I - RESOURCE & PERFORMANCE COMMITTEE
Held on 29th May 2018 at 1:00pm
Room B, William Farr House

Present: Steve Jones, Non-Executive Director (Chair) (SJ)
Ros Preen, Director of Finance (RP)
Peter Phillips, Non-Executive Director (PP)
Yvonne Gough, Deputy Director of Operations (YG)
Steve Gregory, Director of Nursing and Operations (SG)
Mike Ridley, Chairman (MR)
Julie Southcombe, Patient Representative (JS)
Sarah Lloyd, Deputy Director of Finance (SL)
Robert Graves, Director of Facilities and Estates (RG)

In Attendance: Alice Horton, PA to the Director of Finance (Secretary) (AH)
Gina Billington, HR Manager (GB)
Sara Hayes, Head of HR & Workforce (SH)
Mark Mawdsley, Head of Costing and & Contracting (MM)
Andrew Crookes, Head of Informatics (AC)

Apologies: Phil Stringer, Patient Representative (PS)
Jan Ditheridge, Chief Executive (JD)
Julie Thornby, Director of Corporate Affairs (JT)
Rolf Levesley, Non-Executive Director (RL)

Minute number:	***Agenda Item title***	***Action***
2018/5/367	**Declarations of Interest** (Agenda Item 3) No declarations of interest were noted. It was noted that RL had sent his apologies as he had resigned from the trust with immediate effect. The committee wished to thank him for the major contribution that he had made to the work of the committee.	
2018/5/368	**Minutes of the Previous Meeting held on 23rd April 2018** (Agenda Item 4) Part I Minutes of the meeting held on 23rd April 2018 were agreed as a true record of what had been discussed.	
2018/5/369	**Monitoring of Action Log from the previous meeting** (Agenda Item 5.1) Action 2 - *To consider the contents of the Performance Report to enable the Committee to receive a high level view* – It was noted that this had been kept open for a while. RP noted that Steve Price has been meeting with Quality to look at improvements and that over the next couple of meetings there will be some incremental changes on how the metrics are measured. **It was agreed that the action should be kept open and with the view to closing next month.** Action 3 - *To target as a matter of urgency outstanding appraisals at Oswestry & Ludlow and provide assurance at the February Committee.* – It was noted that there had been an improvement as the appraisal rate is currently over 90%, and that there had been a marked	**RP**

	improvement in Oswestry. YG explained that every area has had a rapid improvement notice and HR colleagues have confirmed that there has been increased activity to record appraisals. YG noted that they are now focusing on areas that are still falling short and this will be performance managed. **It was noted that SG/YG would update next month where further improvement is expected.**	**SG/YG**
	Action 9 - *The Controls for the use of agency staff to be brought to R&P to get assurance.* – SG noted that there are a few main reasons why agency staff is being used, and that there are different controls in place for each. While all the gaps haven't been closed they have improved, and the fluctuation of patient need would always present an issue. SG noted that it was talked about in the establishment review. **Establishment paper to be brought at the next meeting.**	**SG**
	Action 10 - *TeMS to be measured against the 3 areas of priority and YG to measure how well TeMS performs against them and provide an update next month* – this is included in the TeMS paper discussed later in the meeting. Action closed.	
	Action 11 - *YG to calculate final numbers for how many clinics TeMS requires at SaTH and update at the meeting* – YG explained that a different approach had been agreed with RP and SG. A letter was being sent to Commissioners to give them some options; for them to give approval to cease using SaTH entirely, to have a small number of SaTH clinics, or for the Trust to continue paying SaTH and for funding to be provided by the commissioners. **To be updated at the next meeting.**	**YG**
	Action 12 - *RP to look into a revised approach to the CIP plan by next meeting. R&P meeting to review and challenge the CIP plan* - this was included in the Finance paper discussed later in the meeting. Action closed.	
	Action 13 and 14 – Estates actions – these were discussed as part of the Estates update discussed later in the meeting. Action closed.	
	Action 15 - *YG to look into the possible impact of SaTH Phlebotomy services withdrawing from Princess House on community services.* – YG noted that there was no evidence yet of any increased impact on community services, but staff have been asked to be vigilant and report if they see increased number of referrals and if they come from any particular area. Action closed.	
	RP noted that there were various lines of inquiry running around accommodation around Princess House, but that a response had been sent to SaTH. It was also noted that SaTH had taken the decision retrospectively to their board and were going to consult with patients for 3 months, so there may be further updates around this.	
2018/5/370	**Work Plan** (Agenda item 5.2) The work plan was agreed at the meeting.	

2018/5/371	**Finance Report Month 1 and CIP Report** (Agenda Item 6.1) SL presented the Finance report for Month 1. SL noted that currently the Trust is reporting a small deficit, although this is a favourable position compared to the plan, and that the biggest risk is the cost improvement plan. It was noted that this has reduced, but there is still unidentified CIP savings of £1.6 million. It was noted that a number of programmes of work are ongoing, including a review of governance arrangements for CIP and Transformation Group that should be confirmed by the end of June. SL explained that the Trust is targeting a fairly low level of CIP across the first quarter, but from July the savings would increase to 320k per month, so either CIP's will have been developed and be being delivering or alternative mitigations will have been identified. MR asked for further information regarding the review of the governance arrangements and SL confirmed that this would change the way the groups operate as there are various monitoring/delivery groups and by streamlining these meetings, time could be invested differently. SL noted that 3 operational workshops were being run through June where teams are be tasked to bring ideas for efficiencies in their teams. Some teams are being targeted to save more, but a minimum of 2% saving was set as the target. It was noted that this had not done in this way before and that the new initiative had been welcomed by teams. SL noted that previous CIPs had targeted back office areas quite hard and the Trust is still trying to target corporate and non-clinical areas rather than clinical services. It was noted that internal possibilities are being considered, like partnership opportunities for the IT helpdesk and EPR system. SL observed that other strands are under review including; efficient procurement, energy savings and agency costs. It was noted that there would be more clarity at the June committee, but that the challenge would be to hold the current position and that if plans were not in place by July, there would be a visible deterioration in financial outlook. It was noted that there were plans in place until the end of June, with 3 schemes expected to deliver in that time frame. PP noted that while the overall percentage of CIP is quite similar to last year it gets more difficult each year. PP noted that while the Trust is used to having unidentified schemes, it does assume that other CIPs will deliver, and some parts of the developed schemes are high risk. It was noted that the committee will need to be mindful about this and see how this progresses over the next month. It was agreed that the **Finance Report should include whether the CIP target had been met for each month.** MR queried why the report showed ¼ million on Estates for CAMHs. SL noted that this figure is a non-recurrent assumption that CAMHS will continue to use our bases. SL noted that the service would need to give 6 months' notice of change, and that this is an annual estimate for money that the Trust would receive as rent.	**SL**
2018/5/372	**Apprenticeship Levy** (Agenda Item 6.1) SH and GB attended to present the report. It was confirmed that the trust was going to spend the entire levy for this year and that there are	

	32 starters planned. It was noted that the public sector target is 35, so we are on track to meet the target. GB noted that there was a number of awareness sessions set up, one in all of the community hospitals. GB confirmed that there are posts that are open to members of the public and confirmed that apprenticeships are no longer age limited. It was noted that the recruitment doesn't target school leavers specifically, but that GB and SH have attended careers events where schools have attended. It was noted that the Trust was in a much better position than before and SJ congratulated the team on their work. RG noted that there were only 8 apprentices aimed at healthcare posts. It was noted that there needed to be a balance where funding is going and where the Trust have vacancies. YG noted that the Trust have assistant practitioner posts, but that services can only support so many of these posts as the apprenticeship levy will only fund the cost of the course, not the cost of backfilling the post.	
2018/5/373	**Monthly Performance Report** (Agenda Item 7.1) RP presented the performance paper. It was noted that due to the start of the new financial year the metrics had resetr. The new style of zero tolerance metrics would flag up these of metrics in the month it happens, but, if in the subsequent month the metric wasn't tripped, it would go back to green to allow the Committee to react at the point that the metric changed. RP noted that in areas where trends are important the trend analysis won't change. It was noted quite a lot of indicators are on an upward trajectory. MR picked up admission avoidance and SG noted that while admission avoidance was a challenge, the early discharge had exceeded expectations. It was noted that there needed to be some discussion and review with partners around ICS and the way that some of this information is captured. The therapies project and IV's in community should contribute to admission avoidance, but the way the data is captured is not helpful. A new RiO report has been developed to support this. The other thing that impacts these figures is that the Trust is relying on other services to refer to us for admission avoidance, so it is a whole system issue. It was noted that this had been raised at Health and Wellbeing board and that commissioners are being challenged to put more money into better care fund and to fund more schemes for admission avoidance. SG picked up the Delayed Transfer Of Care (DTOC) and noted that this was likely to go up due to bed occupancy. It was noted that the occupancy rate during May hovered around 80 patients out of the 97 beds, but that the length of stay for patients is good and SG noted it was 7 days less than SSOTP's length of stay.	
2018/5/374	**Monthly TeMS Update Report** (Agenda Item 7.2) YG ran through the report. YG noted that there is still double running with the SATH consultant clinic, but there is improved capacity of current staff, and they are holding sub-contractors to account for their productivity and capacity, and reducing low clinical value activities. YG	

	noted that the team have made significant strides around demand and capacity although it was noted that it's proven difficult to quantify around financial benefits as it is a developing situation. RP picked up that the committee will need to wait until next month to see how the review will impact on the service. A Terms Of Reference has been drafted for the review and scoped internally and has been shared with commissioners, but the review's commencement has been delayed. It was noted that a figure had been suggested by commissioners to underpin the service for the 1st 6 months of the year. It will need to be looked at in light of the financial recovery actions of the team. It was noted that it looks like TEMS activity is roughly on plan which was agreed to be very good news. RP noted that she is waiting for further analysis, and so hasn't accepted the figure until it is confirmed precisely what the amount required to underpin the service is. **RP to raise with the committee if there is a difference between what is being offered and what is required.** There was a discussion around the notice period, and it was noted that the commissioners were receptive, and that **RP is seeking to formalise this**.	**RP** **RP**
2018/5/375	**Estates Update** (Agenda Item 8.1) RG gave a verbal update around Estates and the ongoing schemes including; Dorrington and Wellington, Bridgnorth Hospital's generator, the cottage hospital car park and a macerator for Ludlow sluice. RG also noted that fire risk assessments were well underway. The actions from the previous meeting were picked up and discussed. RG noted that the electronic asset management system for estates (ERIC) includes finance costs and utilisation and this was being used for the NHSI returns which were due to be submitted on the 24th June. RG noted that he was going to complete a piece of work around the top 20 most expensive buildings to better give a view of where savings can be made, how things can be rationalised back and how best to how to share/co-align spaces. RG noted that he had recently had a conversation with JT around being more assertive around the CIP and where SSSFT and Shropcom estate can support each other. RG noted that the CIP should be crystallised over the course of June and that the data is a lot cleaner this year. There was discussion around efficient patient pathways and the evidence is that, where mental health/physical health are co-located, patients receive better care. It was also noted that this would also feed into the STP by potentially releasing land. RP noted that there was more scrutiny and that this would feed into Model Hospital metrics. This information should then start be played out through the Carter review and give greater benchmarking, which is a positive for the Trust. SG queried with RG what savings would be possible in estates. RG noted that it would depend how brave the Trust was prepared to be, but with a change of culture and getting the most efficient patient pathways, RG suggested that 20% of the estates could become savings, but that initially half of this saving would have to be directed into IT. It was noted that if the patient pathways were clarified, it would help patients stay well and get home faster and there could be potential synergies as part of a 2 year plan.	

	JS queried if they were referring to just the patient pathways in the community, or how they intersect with other trusts and how community pathways mesh into acute care pathways. It was noted that initially the focus would be on community pathways where the Trust has greatest influence and then it would look at linking with acute pathways.	
2018/5/376	**Capital Bid Recommendations From Capital & Estates Group** (Agenda Item 8.2) It was noted that the finance report made reference to two capital bids, but due to the scale of the bids, they have to be brought to RPC for approval. These bids have been scrutinised at the Capital and Estates meeting prior to being brought to RPC. **The committee reviewed and approved these bids.**	
2018/5/377	**Quarterly Contract Monitoring Report** (Agenda Item 9.1) MM attended to present the report. He noted that financial values for contracts had been agreed with the commissioners. MM noted that there had been negotiations around the Prison contract, as well as Vaccinations and Immunisations service. MM had some specific negotiations regarding the Immunisation Service as this has been agreed, but the caveat is that they only want to do it for a year. MM noted that this gives the Trust an opportunity to get the service working well. MM noted that there had been some variances for 17/18, due to out of county contracts, but that he wouldn't expect those variances to continue into the long term. SJ picked up the point about unsigned contracts and SLA's as, if the trust is delivering a service and there isn't a legally binding contract, this put the Trust at risk. It was noted that there are a number of trading relationships that aren't formalised properly, but that in the majority of cases the risk is low, but this does need to be tightened up. A training session is being run around SLA's, but this needs to be updated to include the new regulations around GDPR. **More detail around this to be brought back to next meeting as part of the Finance Report as this is scheduled to come to the next meeting** RG queried about the CQUIN, it was noted that the Trust hasn't met some of the targets and that this is unrecoverable and non-recurrent, and there will be a new set of targets this year.	**MM/SL**
2018/5/378	**EPR Project Board Update** (Agenda Item 10.1) AC presented papers and noted that the Trust was on track with its implementation plans. The only current issue is around TeMS and a report is going to Project Board to consider further the risks of deployment of EPR in this service. AC noted that there had been an NHSI mandate around E-referrals and that connectivity continues to be problematic. AC noted that tactical solutions had been put in place around connectivity and capacity and that the Trust is going to sign up to the aggregate procurement for network solutions (HSCN), which is a regional contract for buying supplies.	

	AC noted that Benefits Realisation meetings had taken place on 29/05/18 and that they are working on a tracker to help get some traction going forwards. AC also noted that he was in discussion with Steve Price and that there is a very firm framework around patient safety, efficiency, finances. AC also raised that due to the Chief Pharmacist leaving the trust, David Young is currently leading on the EMPA process. AC confirmed that an initial meeting had been planned. There was a discussion around some service user resistance to EPR and AC confirmed that EPR training is technical training and how much is supplied to each service depends on the nature of the service; they could have a week or 3 months of training. AC noted that there is a helpdesk and support around the use of EPR and that there is infrastructure around the development process. AC noted that the team have had advice during the process from Jon Davis and have been pre-empting difficulties.	
2018/5/379	**EPR Project Board Minutes** (Agenda Item 10.2) The minutes were reviewed. It was noted that SG has taken over clinical officer role so if there was anything that needed escalating for a clinical sign off SG would adopt that role, but due to time pressures, this would have to be reviewed if anything serious started to develop. **The Committee accepted the EPR project board minutes**	
2018/5/380	**Transformation Programme Group Minutes** (Agenda Item 11.1) SJ noted that he and RP had reviewed the minutes prior to the meeting and due to the nature of the meeting felt that they were best placed to be reviewed in the second part of the meeting.	
2018/5/381	**Information Management & Technology Strategy** (Agenda Item 11.2) AC presented the Information Management & Technology Strategy, and summarised the key points; • Patient Wi-Fi is being subsidised by the Department Of Health, and it has to be operational by the end of December 2018. • IT are working with the Local Health Economy STP Digital Enabling Group on a number of areas like GDPR . • There is increased risk around cyber security and this is a theme running across any new deployment. • A particular product set has been chosen for unified communications that is cloud based and will be hosted remotely. It was noted that this would be deployed gradually and would present a host of additional benefits.. • Sharepoint will be moving to a cloud based service. • The Trust will be involved in a nationally-agreed enterprise agreement by NHS Digital to purchase Microsoft Windows and advanced threat support and that this also tied into cyber security. It was noted that there needed to be a balanced view on where to deploy resources and RP queried if the right level of investment was going into IT. AC agreed that there was generally, but there are some pressure areas which needed further consideration.	

	PP picked up point 6.2 around mobile phone reception issues and AC explained that most clinical staff have a laptop with a SIM-card in them, which should be able to connect to mobile signal depending on location, but that there was also an option for clinical staff to use "Store & Forwards", a programme that would collect data while disconnected, then would automatically upload the date when staff get back into signal range. It was noted that by the nature of where the trust is based, sometimes it can be very difficult to get connectivity. SG asked where the cloud for storing data would be based, and AC confirmed that it would be a Microsoft secure cloud in UK.	
2018/5/382	**BAF Risks** (Agenda Item 12.1) The rating for Finance was discussed, as this has come down to 16. The BAF ratings are not static and fluctuate as the risk changes, so this will be reviewed again at the end of the June. PP noted that RP is showing as both the lead and also the non-exec lead for transformation, when SJ should be the non-executive lead. **Database to be amended.**	**RP**
2018/5/383	**Risks/Assurances:** (Agenda Item 13) **Risks Identified at the Meeting** (Agenda Item 13.1) • CIP was identified as a risk. • TeMS – it was noted that that risk for TeMS has reduced, but hasn't reduced to an extent where the committee is assured of the medium-term financial viability of the contract. • Aren't any significant newly emerging risks. **Assurances given at the meeting of internal control/risk mitigation effectiveness, either positive or negative** (Agenda Item 13.2) • Positive assurance around the Levy was received. • More assurance was required around CIP **Any Comments on the Committee's effectiveness** (Agenda Item 13.3) • None	
2018/5/384	**Any Other Business:** (Agenda Item 14) There was no other business recorded at the meeting.	
Date and time of next Meeting: Monday 25th June 2018, Room B, William Farr House from 1pm – 4pm.		

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Chair – Steve Jones

…….
Date

Minutes of a meeting of
PART I - RESOURCE & PERFORMANCE COMMITTEE
Held on 25 June 2018 at 1:00pm
Seminar Room 1, Shropshire Conference Centre

Present: Peter Philips, Non-Executive Director, (Chair) (PP)
Mike Ridley, Chairman, (MR)
Steve Gregory, Director Of Nursing and Operations (SG)
Jan Ditheridge, Chief Executive (JD)
Ros Preen, Director of Finance (RP) – Part meeting

In Attendance: Alice Horton, PA to the Director of Finance (Secretary) (AH)
Sarah Lloyd, Deputy Director Of Finance (SL)
Robert Graves, Director of Facilities and Estates (RGr)
Yvonne Gough, Deputy Director of Operations (YG)
Rob Goodrich, Procurement Lead (RGo) – Part meeting

Apologies: Steve Jones, Non-Executive Director (SG)
Julie Southcombe, Patient Representative (JS)

Minute number:	***Agenda Item title***	***Action***
2018/6/385	**Declarations of Interest** (Agenda Item 3) No declarations of interest were noted. PP chaired the meeting on behalf of Steve Jones. At the time of the meeting it was thought that the meeting was not quorate and that any decisions made at this committee would need to be approved at the next meeting, however on review of the terms of reference, the meeting was in fact quorate.	
2018/6/386	**Minutes of the Previous Meeting held on 29th May 2018** (Agenda Item 4) Part I Minutes of the meeting held on 29th May 2018 were agreed as a true record of what had been discussed.	
2018/6/387	**Monitoring of Action Log from the previous meeting** (Agenda Item 5.1) Open Action 1 - *To consider the contents of the Performance Report to enable the Committee to receive a high level view.* Software has been implemented and is working well as expected. A meeting has been held with Performance around reporting and to assess whether the report is in line with performance framework. It was also noted that there had been a meeting last week between Steve Price, Alison Trumper and YG to look at the performance metrics and they are confident that the reporting to this committee is in line with the framework. JD noted that the action was initially around the committee receiving too much too much detail within the reports and asked if the committee was assured that they were receiving the right amount of information and understand key risks. SL noted that the report had moved towards exception reporting and MR agreed that this was moving in the right direction and that the report had improved enormously. **JD to raise at**	

	the next Executive Team meeting to discuss and agree next steps to ensure the report is reporting on an exception basis only and key risks are highlighted. Open Action 2 – *To target as a matter of urgency outstanding appraisals at Oswestry & Ludlow and provide assurance at the February Committee* - SG noted that there was now a better percentage of appraisal completion overall, but where individuals are not compliant then the appropriate measures have been taken. It was noted that Ludlow hospital are still below the 90% target. **AH to update action log and the action to be; to continue checking Ludlow/Oswestry appraisal rates and YG to provide an update to the next meeting.** Open Action 3 – *The Controls for the use of agency staff to be brought to R&P to get assurance* - The Establishment Review Paper has been brought to the meeting. JD noted the need for all of the Directors to understand existing agency controls, including NEDs. **Action is now closed**. Open Action 4 - *YG to calculate final numbers for how many clinics TeMS requires at SaTH and update at the meeting* – YG confirmed that the required number was 12. **Action Closed.** YG noted that a letter has been sent to Telford and Wrekin CCG and she is awaiting a response from commissioners. **SL and YG to chase up**. Open Action 5 - *RP to further analyse the underpinning amount offered by the commissioners and raise with the committee if there is a material difference between what is being offered and what is required* – SL noted that the assessment has been completed and it has been confirmed that the offered sum will be sufficient to underpin the TeMS service and RP had confirmed this with the CCG. SL noted that this is currently going through CCG governance and that the trust expects to receive a contract variation for the non-recurrent funding. Any future issues will be picked up in the TeMS report. **Action is closed.** Open Action 6 – *Notice period for TeMS to be formalised* – It was noted that the Trust may want a shorter notice period if it was decided that the TeMS service wasn't viable at the end of the review period. It was noted that RP is picking this up as part of the service review. It was noted that draft scope had been shared with the CCG and that a meeting is being arranged to finalise this. SG noted that the CCG had been receptive about this, and JD picked up that the Trust should stay mindful of the existing 12 month notice period. **Action remains open**.	
2018/6/388	**Work Plan** (Agenda item 5.2) The work plan was agreed at the meeting.	
2018/6/389	**Finance Report Month 2** (Agenda Item 6.1) SL ran through the report reporting a deficit at end of May which was slightly favourable position compared to the predicted trajectory and the forecast position currently meets the control total. SL picked up that the significant risk at the moment is CIP and that this would be discussed under the CIP paper. It was noted that the capital resource limit has been agreed by NHSI and is larger than expected. SL noted that the capital and estates group	

are considering asking for an increase to this value and it will feedback to RPC if it is agreed that an increase is required. SL noted that NHSi have shared the proforma for extending the capital resource limit with us and that the Capital and Estates Group is clear on what needs to be done once it has come back with a final recommendation.

SL noted that the agency expenditure has increased materially during the month and that the trust is now above the internal plan by £146000. It was noted that this is still below the national agency ceiling, but is a significant increase between April and May. It was noted that Ludlow, Whitchurch and Stoke Heath were all key areas of spend and that this had been discussed at the Agency Working Group. SL noted that an agency reduction plan has been put in place and that this is being updated. YG noted that a number of actions have been taken following discussions at Q&S to make it easier to recruit and retain staff, but that it would take time for the actions to have an impact.

YG listed the Main controls;

- Only bring in agency in if they are needed
- Use other clinical staff if they are trained to do so
- Challenge whether agency is required.

It was noted that the key focuses were on recruitment, retention and e-rostering, as well as getting the right management in and out of hours. YG noted that they were waiting for the revised establishment paper to see the impact. It was noted that there may be ways of working and deploying staff better. It was noted that a company is coming in to discuss e-rostering and see what impact this may have.

It was noted that there were some AHP vacancies in south-east Shropshire and that they were working hard to recruit there. The locum GP at Whitchurch was also discussed, and while a number of options have been explored they have been unable to find any suitable alternatives at the moment. It was noted that nationally this is a problem and that they are re-exploring alternatives. Progress on this will be flagged up in the finance report. The locum dental consultant was also discussed and it was noted that this was due to extreme difficulties in recruitment, and vacancies due to maternity leave and sickness. It was noted that this has gone back out to recruitment.

MR noted that the figure for Community Equipment Stores was high at £123,000. It was noted that the demand for community equipment has significantly increased for supportive discharge from hospital. In order to have more robust understanding of this new software is being put in to enable requests to be reviewed more successfully. It was noted that it will have a record of all orders to give greater clarity of who is ordering what equipment and highlight outliers. It was also noted that the service is meeting requests from across health economy, not just from within the trust, so there wasn't the same level of clarity on all requests.

MR queried why the Trust was paying for Whitchurch Claypit Medical Practice. It was noted that the Trust is currently invoicing NHSPS, but they are refusing to pay until a number of unrelated things are resolved which RGr is following up.

SL noted that, as asked last month, the SLAs has been brought to the

	committee as appendix 7 of report, which shows all trading relationships. It was noted that the Committee were concerned as the Contracting Report highlighted unsigned agreements and wanted assurance around levels of risk. It was noted that each SLA had been given a RAG rating and 2 are high risk and 6 are medium risk. It was noted that the 2 high risk tie back NHSPS and the service charge for Claypit Medical Centre, as discussed earlier. The committee noted this position.	
2018/6/390	**CIP Report** (Agenda Item 6.1) SL ran through report. It was noted that there had been a low target for CIP in the first quarter, but that this would increase from July. It was noted that this hadn't delivered and that there is an adverse variance of £27,000 after 2 months. At month 2, £1.6 million CIPs had yet to be identified and much of the identified CIP's are high risk. SL noted that there is a challenge out to improve Estates CIP delivery and that there are 2 operational workshops planned this week which are expected to identify opportunities. It was noted that Lord Carter's report was appended to the report, and that these areas are being explored. JD noted that there are suggestions within the Carter review that are applicable to the Trust and could generate efficiencies, and that these needed to be implemented rapidly. SL noted that a workshop is being set up to go through the Carter Report. **SL to bring the gap analysis to the next RPC meeting as part of the CIP report.** SL noted that the CIP paper proposes that in addition to working to identify additional CIPS, other layers of control should be added, and the committee was asked to approve these. SL explained the 5 layers and, under worst case scenario, the last 2 stages would have impact on non-pay, and the last stage would impact on pay. There was further discussion around this and it was observed that the stages don't fit with the QEIA approach and that there is already good governance in place. It was noted that CIP needed to be identified now and that budget setting should be playing a big part of this. Leaders should be looking at budgets and Finance and HR should be supporting them by providing the right information. It was noted that the committee had not seen as much transformation in the CIP plan as expected. It was also noted that RP had received a proposal from the CSU to see how corporate areas could be made more efficient through the STP back office work stream and that this is currently being explored. The Committee did not agree to the additional controls at this time.	
2018/6/391	**Monthly Performance Report** (Agenda Item 7.1) The Performance report was discussed and it was noted that there were 18 red indicators, 2 of which were new. These were around claims for compensation and another around the underlying financial position It was noted that the 18 week RRT non-admitted shows the April position on the report and that there has been slight improvement in May which is referenced in the exception report, but the Trust is still not meeting the 95% target. It was noted that the non-framework agency does not have a recovery plan, and that there should be one to include all the controls and actions. **Action: Steve Price to work with Operations to ensure an agency recovery plan is put in place as**	

	soon as possible.	
2018/6/392	**Performance Framework** (Agenda Item 7.2) The Performance Management Framework was discussed and it was noted that the document has been updated to reflect the NSHI Single Oversight Framework and also updates the trust's approach on performance review meetings. It was noted that there hasn't been large scale refresh of the document, and that the front sheet details areas that have been updated. The committee approved the new framework, but agreed that it should be circulated to members for approval given the meeting is not quorate. **AH to circulate the framework and ask for approval vote outside of the meeting and report back to next meeting.**	
2018/6/393	**TeMS Monthly Update Report** (Agenda Item 7.3) It was noted that the TeMS service is making a loss of £32000 at the end of May and SG noted that this is an improvement from last year. The main points of the report were summarised; 1. Currently, the service is forecasting break even. 2. The service still haven't got clarity around double running, but this will be followed up, 3. Pending the contribution from the CCG 4. The service is still working on increasing productivity. It was noted that overall performance is improving, with increasing numbers of new patients and decreasing numbers of returning patients. It was noted that the service is concentrating on patients who have waited more than 30 weeks, and these have reduced to 16, and there are no patients waiting longer than this. It was also noted that there was less income than expected from Trauma and orthopaedics, but more had been spent. It was also noted that the current figures anticipate a halt in the double-running, so a delay in this will impact upon the forecast position.	
2018/6/394	**Establishment Review Paper (Agenda Item 7.4)** It was noted that this paper had also been reviewed at Q&S Committee and was predicated on change based upon safe quality input; for example, changing establishments to be reliant on different types of worker. It was noted that if the paper was agreed, it would reduce the centrally held budgets buffer and would present a risk as the trust could overspend significantly if controls weren't put in place. It was noted that agency spend would have to go to a very minimal level. SG observed that the Trust would have to look at and update on how successful we are on recruitment as a specific metric. There was a discussion around the methodology of recruitment, and the consistent struggle had in certain areas. It was noted that the trust start with a deficit and so needed to put more effort into retaining staff. SL recognised the benefits of the paper, but noted that the financial proposal doesn't allow for any use of agency and only for a low use of bank. It was noted that it wouldn't take much agency cost to mean that costs exceed current run rate. In addition to this the report talks about	

	impact on inpatient nursing by band, and it shows we would have 4.26 band 6 in excess of requirement, which would be an additional cost pressure of approximately £40,000 a year assuming these staff are in place instead of Band 5 staff, and the same is also true of MIU for band 2's and 3's. It was noted that from a financial perspective there is significant risk. It was suggested that the approach could be moved through incrementally, with reviews at various stages to check that the plan is still on track. It was noted that it was proposed to create a new post to co-ordinate capacity, along with greater visibility of more senior staff. It was noted that it was very aspirational at this stage. JD raised her concerns around controls and wanted assurance on this and management of staff, as well as staff buy in. RP noted that while she tentatively supported the paper the controls she would like to see in place would be, for example, a set time frame as well as some red-line parameters/limits around agency/bank use and a mechanism that would flag risks up. There was consideration around the time-frame and controls and that operationally there would be an expectation for people to be paying attention to the metrics daily/weekly and to have a tight grip on sickness absence, as well as a quarterly report back to the RPC meeting. MR noted that the paper was ambitious, but that it felt like something the Trust should be progressing. The paper was approved subject to setting out the controls and parameters which will be put in place in advance of any recruitment. **SG/YG to bring back progress on the Establishment Paper with a detailed project/implementation plan with milestones to be reviewed at the September RPC meeting.**	
2018/6/395	**Estates Update** (Agenda Item 8.1) RGr noted that he was pushing hard on CIP priority at the moment, and working on how best to co-align and share with other organisations to reduce space and cost. RGr noted that he had stopped at co-alignment rather than integration, but it was noted that integration and transformation would be good. RGr also noted that he was starting to look at longer term plans for other sites and JD encouraged RGr to stimulate conversations and flag potential integration areas. YG noted one of the medical practices we occupy is an expensive venue, but we have to be mindful of joint working with GPs. RGr suggested that service leads were nominated for each area so he can liaise with them. It was also noted that if the partnership with Shropdoc went ahead, it would be worth thinking about how to make best use of space.	
2018/6/396	**Quarterly Procurement Report** (Agenda Item 9.1) Rob Goodrich presented the report. It was noted that, operationally there were some issues around the X-ray machines due to NHSPS arrangements. It was queried how this could be accelerated, and it was noted that the current conversation has escalated to CEO to CEO discussion, with letters drafted to resolve this in the next week. It was noted that the safety of patients needed to be our priority. **JD to discuss with RGr/RGo outside of the meeting.**	

2018/6/397	**EPR Project Board Update** (Agenda Item 10.1) RP presented the report. It was noted that there was a fairly significant degree of assurance that project is on track, although it was noted that TeMS have asked if they defer receiving full EPR to recover their position which was considered at project board. It was noted that deferring would have a significant impact and it was agreed that the full rationale would be brought to RPC if required. The Committee accepted the report.	
2018/6/398	**EPR Project Board Minutes** (Agenda Item 10.2) The Committee accepted the EPR project board minutes	
2018/6/399	**Information Management and Technology Steering Group Minutes** (Agenda Item 11.1) The Committee accepted the minutes	
2018/6/400	**BAF Risks** (Agenda Item 12.1) The BAF risks were reviewed by the committee.	
2018/6/401	**Risks/Assurances:** (Agenda Item 13) **Risks Identified at the Meeting** (Agenda Item 13.1) • SLA RAG rated red; NHS Properties Services relating to the Service Charge for Claypit Medical Centre • X-Ray issues as mentioned in the procurement report - already on corporate risk register. **Assurances given at the meeting of internal control/risk mitigation effectiveness, either positive or negative** (Agenda Item 13.2) • **Any Comments on the Committee's effectiveness** (Agenda Item 13.3) •	
2018/6/402	**Any Other Business:** (Agenda Item 14)	
Date and time of next Meeting: Monday 23rd July 2018, Room B, William Farr House from 1pm – 4pm.		

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Chair – Peter Phillips

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Date

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Minutes of a meeting of
PART I - RESOURCE & PERFORMANCE COMMITTEE
Held on 23 July 2018 at 1:00pm
Meeting Room B, Shropshire Conference Centre

Present: Mike Ridley, Chairman, (Chair) (MR)
Steve Gregory, Director Of Nursing and Operations (SG)
Jan Ditheridge, Chief Executive (JD)
Ros Preen, Director of Finance (RP)
Julie Southcombe, Patient Representative (JS)

In Attendance: Alice Horton, PA to the Director of Finance (Secretary) (AH)
Sarah Lloyd, Deputy Director Of Finance (SL)
Robert Graves, Director of Facilities and Estates (RG)
Yvonne Gough, Deputy Director of Operations (YG)
Julie Thornby, Director of Corporate Affairs (JT)

Apologies: Steve Jones, Non-Executive Director (SJ)
Peter Phillips, Non-Executive Director (PP)
Phil Stringer, Patient Representative (PS)

Minute number:	***Agenda Item title***	***Action***
2018/7/403	**Declarations of Interest** (Agenda Item 3) PP and SJ sent their apologies to the meeting. It was noted that the meeting was not quorate; therefore all decisions will be taken to be approved at the Board on Thursday 26th July 2018.	
2018/7/404	**Minutes of the Previous Meeting held on 25th June 2018** (Agenda Item 4) Minutes were agreed and accepted as a true record.	
2018/7/405	**Monitoring of Action Log from the previous meeting** (Agenda Item 5.1) Action 1 – *'To consider the contents of the Performance Report to enable the Committee to receive a high level view.*' – RP noted that the Executive Team haven't had a discussion about the performance report since the last committee. The report has been amended to include less detail and fewer appendices. JD and RP have discussed the report and agreed a statement of ambition and required actions. **The statement of ambition and related actions regarding the presentation of performance information are to be brought to the next committee.** Action 2 – *To target as a matter of urgency outstanding appraisals at Oswestry & Ludlow and provide assurance* - YG noted that it had continued to be a struggle with appraisals and mandatory training in the two areas. YG also noted there are on-going issues with ESR not reflecting an accurate position. SG noted that he has called an urgent meeting to talk about leadership issues in the Adult services. It was agreed that this would continue to be monitored. **Action remains open.** Action 5 – *'YG to update the meeting in regards to the commissioner's response to the letter sent to the commissioners laying out the options in regards to SaTH clinics'* – SL and YG confirmed that this has been followed up, but that there has been no reply. **RP to raise at the**	**RP**

	meeting with the commissioners on 24/07/18. Action open. Action 7 – *'The formal notice period for TeMS to be formalised as 6 months rather than 12 months.'* **It was noted that this action would also be raised at the meeting with commissioners on 24/07/18.** Action 8 – *'SL to bring a gap analysis in relation to the Carter report to the next RPC meeting.'* SL noted that the gap analysis had been included in the CIP report as appendix 2. **Action closed.** Action 9 – *'Steve Price to work with Operations to ensure an agency recovery plan is put in place as soon as possible.'* It was noted that the agency recovery plan is in place, but has not been appended as part of the performance papers. **YG to circulate the plan to the committee.** Action 10 – '*Establishment Paper progress to be reviewed at the September RPC meeting, to include a detailed project and implementation plan with milestones.'* **Action remains open to be reviewed in September 2018.**	**RP** **YG**
2018/7/406	**Work Plan** (Agenda item 5.2) The work plan was reviewed and agreed.	
2018/7/407	**Finance Report Month 3** (Agenda Item 6.1) SL presented the Finance Report. SL noted that there were no significant changes and that CIP remained the trust's biggest financial risk. SL extracted some key areas for the committee to note; agency spend, costing requirements and the pay award. <u>Agency Spend</u> It was noted that the agency spend has increased again in June after a big increase between April and May. SL noted that there was an agency reduction plan in place, but that the most significant action that could be taken would be the staffing changes linked to the Inpatient and MIU establishment paper. YG noted that she has started to implement the changes. SL noted that the Trust is currently exceeding the internal agency plan for expenditure and is also exceeding the NHSI agency ceiling by £41,000. The Trust is forecast to spend less than the NHSI ceiling at the end of the year. SL noted that the team had completed analysis on the areas that have increased their agency spend and it was noted that shift numbers have gone up due to a combination of factors, including; vacancies, increased sickness and enhanced supervision. SG queried what the benefit of the Specialist Nurse had been and it was noted that it doesn't appear to be making a difference. JD noted that close attention needed to be paid following leadership changes. SL noted that new NHSI agency rules have been put in place and that the Trust's Standard Operating Procedure is being updated to be in line with this. JD noted that when the forecasting report is completed she would expect the committee will start to see the impact and potential risk in relation to agency spend and other cost pressures and what can be done to cease or reduce these risks.	

	Costing Requirements SL noted that the mandatory Reference Cost return needs to be submitted by 30th August, and that the team is currently on plan to submit this using the new costing system. SL noted that the approach taken is entirely consistent with the advice from the manual published by NHSI. Pay awards SL noted that since writing the report, the finance team have received information from NHSI to clarify the position around Pay Awards. SL noted that current estimate is a cost increase to the Trust of just over 4% to include living increase and incremental changes although this is still under review. NHSI has issued their assessment that our costs will increase 3.1% and have also assumed a small saving around unsocial hours and sickness and have applied a scaling factor. SL noted that at this point the trust has a maximum risk of £150,000 in-year, based on staff in post, although it is expected that it could be lower than this. SL noted that the Finance Team is currently reworking the financial numbers and waiting for NHSI to provide further information around how the estimates were drawn up. It was noted that staff will be paid at the new rate in July. SL also noted that the NHSI estimates are based on information from the ESR system, which is staff currently in post, so there could be more exposure if vacancy levels drop. RP noted that this key risk will be included in forecast for the year, and the impact will be seen next month. Capital Expenditure was discussed and it was noted that the Trust Capital and Estates Group is considering potential schemes. JD queried why a longer term plan hadn't been done back in autumn using predictions for the available money. RG noted that there had been financial changes over the year and that they have been doing a lot of work around feasibility options appraisal, and that they do now have items on the list for next year. RG noted that Estates are working towards a 3 year rolling programme. It was also noted that the demand is increasing on Community Equipment Stores and it was queried if more investment would be available. RP noted that the Commissioners have not provided any additional funding. It was noted that this had been referenced as part of the scope for the Care Closer To Home Group and there was a possibility of progressing it further through that route. YG noted that new community equipment services software goes live in November and that this would allow the trust to have more of an understanding of spend. SG noted that any impact on CES spend needs to be included in the winter plan and **YG agreed to include this**. RP noted that from an alternative perspective, this is an indicator of success as it is getting patients home and keeping them there through support of that service. JS noted that it would be useful to have more work done around collecting equipment once the patients have no more need of it as patients get frustrated at having equipment at home. YG noted that there would be more focussed attention with the new system. **YG to ensure that there is increased awareness of Single Use pieces of equipment supplied by Community Equipment Services, and also greater awareness of where they can be recycled.**	**YG** **YG**

2018/7/408	**CIP Report** (Agenda Item 6.2) SL presented the report and noted that while there has been progress in the month delivery of the CIP target is still a significant financial risk and that the risk is increasing as the financial year progresses. SL noted that the Trust has assessed the level of any non-recurrent mitigation available but more action is required. SL noted that a number of schemes had been developed following Operational workshops in June and that the full-year estimate is that these could deliver £750,000. The schemes are to be developed and quality impact assessed and may deliver £250,000 in-year. It was also noted that any benefits arising from the operational workshops were not yet included in the figures and that this should reduce the current planning gap as would any additional estates savings. It was noted that with 6 months left in the year, the trust is looking for over £2 million in CIP savings, reduced to £1.6 million by the mitigations. The importance of forecasting work was noted. MR queried the EPR benefits figure in table 2 and RP noted that initially there had been an assumption that there would be efficiencies around EPR, but that no benefits are projected from EPR this year due to the elongation of rollout and learning curve for staff. It was noted that the efficiency programme for EPR was set 2 years ago and the expectation had been carried forwards despite a change in approach. JD noted that there needed to be a clear plan and the committee needed to be able to see clearly the actions taken and trajectory. JD noted that she would expect at this point to understand what was coming out of this and have the equivalent of a recovery plan. It was noted that Operations, Finance and Transformation are all working together to address the issue, but more work is required. SG noted that the EPR, Transformation and CIP meetings are being combined to provide one meeting with a single focus. **SL to present next month's CIP report to include bullet points for the core content and a forecast with clear actions with timescales. Any small scale efficiencies should be wrapped together.**	**SL**
2018/7/409	**Quarterly Estates Report** (Agenda Item 7.1) RG presented the Estates reports, it was noted that it was an improving picture and a water safety plan is in place with staff completing appropriate training. RG noted that the Water Safety Group has not yet been set up and this would be discussed outside the meeting. There was a discussion around Whitchurch Hospital's water supply and RG agreed to review this. It was noted that the Ludlow X-Ray project will be completed in 5 weeks. It was noted that a valuable lesson had been learned around escalating issues earlier. RG noted that the estates rationalisation work had identified a huge amount of work that could be done. RG noted that he would suggest that an additional unit is not hired for CES, as the space the Trust already has could be used more intensively. **It was agreed that this would be discussed outside of meeting and any relevant points fed back.** It was noted that the Trust needed to challenge when renewing leases and have a strong clinical drive to rationalise space with a forward view strategy. RG noted that he needed to discuss capital with JT and start looking at	**RG**

	3 year programme rather than 1 year. JT noted that there was a list that addressed different types of schemes that they are trying to prioritise, which some schemes that could be followed through into next year. **List of Schemes to be reviewed at Capital And Estates Group.** RG noted that in the Midlands Partnership Foundation Trust (MPFT) they are starting to look at room booking to reducing amount of external bookings and to better utilise clinical consultant spaces. It was noted that the Council is trialling a room-booking system as well. It was thought that this might not be a large cost saving for the Trust, but it was also noted that room space could be rented out. JS noted that local groups like charities/disabled groups would also be grateful to use hospital spaces for meetings. MR raised a query around section 5 of the report and observed that the Trust shouldn't be delaying decisions due to Future Fit. JD noted that the Carter Review had identified a number of areas of potential efficiency and RP stated that overlays into Transformation. It was noted that the gap analysis had been led by Finance with input from various relevant people. It was noted that the 2 key areas were: productivity of clinical staff; and back office use and that this should be picked up as part of the CIP development and transformation work.	**JT/RG**
2018/7/410	**Monthly Performance Report** (Agenda Item 8.1) RP presented the report and explained that the report is highlighting additional KPI's. Out of those 5, only 1 is of material interest to RPC committee. The changes to the report were discussed; including a graph looking at ICS admission avoidance. It was noted that different ways of measuring performance would allow the committee to focus on areas of improvement. It was noted that there hasn't been much improvement on the Well-Lead indicators. It was agreed that refreshing the methodology and looking at things differently would lead to better performance. RP observed that she was looking at different methodology to see which to take forwards. YG noted that the clinical model needed to be challenged and different approaches to performance management needed to be developed.	
2018/7/411	**TeMS Monthly Update Report** (Agenda Item 8.2) SG noted that TeMS headline performance will mean that the service will not make a contribution to the trust, but will break even. It was noted that the service is now in a much better financial and quality position. The waiting time has improved and there is now no-one over 40 weeks. YG noted that there is a weekly review of every-one waiting more than 18 weeks, and all have a narrative explaining why they are waiting. There was discussion around the First Contact Physiotherapy Model pilot and the opportunities and risks this presented. **To be picked up in the meeting with commissioners 24/07/2018 and fed back.**	**RP/YG**
2018/7/412	**EPR Project Board Update** (Agenda Item 9.1) It was noted that the progress with the EPR rollout is as planned and key milestones are being hit. It was noted that the project team have been asked to absorb some additional work, and that this is being monitored by the Programme Board. It was noted that the substantial piece of work was the upgrade to software as this is significant in various ways and introduces some additional functions. RP noted that	

	the IT team worked around the clock to implement this and commended the high level of commitment in the team, as this had been an example of very good collaborative working and embedding learning. RP also noted that the Out Of Hours audit had just been conducted and that very month there were 10,000 instances of people logging in outside of working hours. This is being looked at further. The implications of the deferral of the TeMS Service moving onto EPR were queried and the effects of this would continue to be reviewed.	
2018/7/413	**EPR Project Board Minutes** (Agenda Item 9.2) The minutes were reviewed and agreed	
2018/7/414	**BAF Risks** (Agenda Item 10.1) It was noted that no BAF changes were reported. The Financial targets BAF entry will be reviewed following the August RPC meeting to assess the scale of risk and look at the rating. It was noted that the target is to reduce the rating from 16 to 9. The Transformation risk was discussed and it was noted that this would be picked up as part of Transformation Programme Group. The Transformation - System risk was also discussed, but it was noted that there were no proposed changes.	
2018/7/415	**Risks/Assurances:** (Agenda Item 11) **Risks Identified at the Meeting** (Agenda Item 11.1) • Agency costs • No new risks – some have escalated **Assurances given at the meeting of internal control/risk mitigation effectiveness, either positive or negative** (Agenda Item 11.2) • **Any Comments on the Committee's effectiveness** (Agenda Item 11.3) •	
2018/7/416	**Any Other Business:** (Agenda Item 14)	
Date and time of next Meeting: Tuesday 28th August 2018, Room B, William Farr House from 1pm – 4pm.		

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Chair – Mike Ridley

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Date