

Committee and Date
Joint Health Overview and
Scrutiny Committee

Item No

Public

MINUTES OF THE JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE MEETING HELD ON 11 APRIL 2012

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Present

Shropshire Council:

Karen Calder and Tracey Huffer

Telford and Wrekin Council:

Derek White (Chairman), John Minor and Co-opted Members Jean Gulliver and Richard Shaw.

In Attendance

Adam Cairnes, Chief Executive, Shrewsbury and Telford Hospital NHS Trust
 Kate Shaw, Programme Manager, Shrewsbury and Telford Hospital NHS Trust
 Chris Benham, Assistant Director of Finance, Shrewsbury and Telford Hospital NHS Trust
 Chris Needham, Associate Director of Estates, Shrewsbury and Telford Hospital NHS Trust
 David Taylor, Corporate Director People, Shropshire Council
 Fiona Howe, Committee Officer, Shropshire Council
 Stephanie Jones, Scrutiny Officer, Telford and Wrekin Council

1. APOLOGIES FOR ABSENCE

- 1.1 Apologies were received from Councillors Gerald Dakin (SC) and Veronica Fletcher (TWC), and co-opted Member David Beechey, Pamela Paradise, Mandy Thorn (SC), and Dilys Davies (TWC).

2. DECLARATIONS OF INTEREST

- 2.1 No declarations of interest were noted.

3. MINUTES OF THE LAST MEETING

3.1 RESOLVED:

That the Minutes of the meeting held on 15 March 2012 be approved and signed by the Chairman as a correct record.

4. THE FUTURE CONFIGURATION OF HOSPITAL SERVICES: FULL BUSINESS CASE

- 4.1 Consideration was given to a presentation of the Full Business Case Executive Summary, with amendments. Adam Cairns, Chief Executive, Kate Shaw, Programme Manager, Chris Needham, Director of Estates, Chris Benham, Assistant Director of Finance, from the Shrewsbury and Telford Hospital NHS Trust (SaTH) were in attendance for this item.
- 4.2 Members were updated on timescales for the approval of the Full Business Case and associated works, and were advised that planning permission had been granted for a new Women and Children's Unit at Princess Royal Hospital site, and the Trust was awaiting approval for the small extension at the Royal Shrewsbury Hospital site, expected around 16 April 2012. The Full Business Case was due to be considered for approval by the Trust Board on 16 April, followed by the PCT Cluster, with a final decision by the Strategic Health Authority being made on 24 May 2012. During this period SaTH would continue to work with, and receive feedback from, focus groups and clinical teams, as well as continued engagement with the public and stakeholders to ensure any concerns were identified and allayed.
- 4.3 Since approval of the Outline Business Case, the Trust had undertaken work to develop several areas, including the transport plan, workforce plan, estates and facilities, as well as developing a robust communication and engagement process, and assurance and governance through an on-going review of progress and delivery recommendations.
- 4.4 Members were advised that the Trust had removed the Integrated Assessment Unit (IAU) from configuration plans, and were currently in discussion with the Clinical Commissioning Group over health provision for the County, stating that progressing the provision of an IAU would be the preferred option, but indicated that they had not reached that stage in discussions.
- 4.5 The Trust had focused on productivity, and over the past year had recorded 100 fewer events than over the same prior the previous year, which had resulted in existing space in clinical areas being made available at both acute hospitals. During the development of the FBC the Trust had found a proven need to move Paediatric Outpatients at the Royal Shrewsbury Hospital adjacent to A & E, which had not been identified in the OBC.
- 4.6 One of the most important changes since the OBC was the pursuance of an alternative funding source, from the Department of Health, and it was noted that the Public Dividend Capital of £35 million had been confirmed to fund the Scheme. In financial terms, with revenue costs being finalised and the Guaranteed Maximum

Price to be agreed for all construction work prior to the commencement of main works, the Scheme remained affordable and within budget.

- 4.7 Mr Cairns, Chief Executive, reported that although the Public Dividend Capital did not attract interest, as it was an investment, the Trust would continue to pay a dividend of £1.118m for the asset in perpetuity, which was consistent with financial protocols for the existing buildings. The dividend would be paid for the life of the building, which was common place practice for hospital developments.
- 4.8 The Trust had continued to seek assurances for the proposed reconfiguration. A Gateway 3 Review took place in March, which used the Treasury Principles to review the plan, and delivery, and the scheme was given a clean bill of health. The Clinical Assurance Group held periodic meetings to review proposals, and at the last meeting was reassured over the degree, and emphasis made by Paediatric Consultants in promoting the changes to service.
- 4.9 Assurances had been given to the Joint Health Overview Scrutiny Committee over the reconfiguration process.

Paediatric Services: Identified benefits of bringing the Paediatric Assessment Unit adjacent to A & E at Royal Shrewsbury Hospital, and ensuring that clinical staff were heavily involved in service design and development.

Neonatology Services: Proposals to provide an additional isolation cot on the neonatal unit. The benefits of joint working, training and development with neonatologists at the Royal Wolverhampton Hospital, with the potential for shared posts, had been expressed by staff.

Paediatric Oncology: The Trust had been working with parents and families on the design and feel of the new unit. The design would enabled day treatment facilities, and access to high dependency beds, to be separated off from children's outpatients. Concern had been raised previously over the loss of the Rainbow Unit, and Members were assured that the Trust was working with all parties who took part in initial fundraising for the unit to decide on its legacy.

Maternity Services: 'Skill Drills', which provided MLU practice runs/rehearsals, had been broadened, and a senior staff member was working with Powys Teaching Health Board to review the policies and processes to assess levels of risk, and implement best practice.

Acute Surgery: An Abdominal Aortic Aneurysm (AAA) Screening programme was due to be rolled out, and had only been made possible through the reconfiguration process. It was hoped that the consolidation of surgery at the Royal Shrewsbury Hospital and transfer of inpatient Head and Neck Services to Princess Royal Hospital would take place in 2012.

Travel and Transport: The Trust had secured a cross-border agreement with WMAS and WAS, with consideration of the Travel and Transport Plan due to take place in summer 2012. The Chief Executive stressed the need for input by the Local

Authority in the development of the plan, indicating that focus groups for staff and patients on travel plans would also feed into the plan.

Public & Staff Engagement: The Trust had set up staff, patient and public focus groups, along with producing regular newsletters, and updates at the Town Council, LJC and community meetings.

- 4.10 Members were advised that since the OBC was approved, there had been a small reduction in the number of posts, but these could be managed through the removal of vacant posts from the current staffing structure, which would reduce the risk of redundancies. Key elements to changes to staffing structures include additional hours against Consultants and Nursing provision, and the need to reduce provision in areas where services had been combined.
- 4.11 Mr Cairns advised the meeting that the FBC's impact on income and expenditure indicated that net costs would reduce over time, and additional decanting costs had been built in for 2013/14 to allow for the transition of services from one site to another, while maintaining a constant provision for patients. He stressed that if the Trust had not taken any action, the cost for maintaining both sites would increase significantly. The long term financial position for the next 5 years suggested that the Trust would achieve a surplus of £2 million, which was in line with the Monitor Financial Risk Rating of 3.
- 4.11 The next steps for progressing the configuration of SaTH included the commencement of building work and refurbishment of existing buildings in August and September 2012, respectively, commence the implementation programme from summer 2012 onwards, including moving some services, training staff and putting new clinical pathways in place. The Trust intend to start publicising the changes later in 2013 in order that the public had a good understanding of where they should go for care and treatment. The Women and Children's Unit was expected to open at Princess Royal Hospital in July 2014, with all other service reconfigurations expected to be in place by this date.
- 4.12 Mr Cairns then responded to a number of questions, which had been submitted by the Committee prior to the meeting, along with questions raised at the meeting:
- Can you give clear details about how the impact of the £8m shortfall in funding from the PCT for 2012/13 has affected the FBC, and what impact will the reduction of funding have on services?
Response: The Trust had been in discussions with Commissioners over the changes to service delivery across the health economy, and that the shortfall in funding would be offset by these changes. Members should note that the shortfall did not relate in its entirety to the reduction in funding, but also to changes in the way health care was to be provided in the future. The Trust were expecting to save £1.7m, which had not been factored into the long term financial plan, and would give them additional security in the future.
 - When exactly will the Finnermore report be available? The Joint HOSC would like to see a copy.

Response: Members were advised that there was no published timetable for the completion of the working being undertaken by Finnermore, but SaTH expected it to be complete by June 2012. Work was ongoing and the size quantum for Shropshire health economy needed to be handled, and shared with the wider health community.

- Can you give assurance that the reconfiguration will ensure A & E will be sustained on 2 sites?

Response: There would be no changes to A & E provision at either site, and the reconfiguration process did not change the scope, need or scale of A & E provision for the county.

- Assurance Grid 1.1 – How long does it take for the on-call paediatric consultant/s to travel to RSH out of hours?

Response: Contracts for consultants require them to live within 30 minutes or a 10 mile radius of base, but most lived nearer. Those who didn't, made arrangements to stay in temporary accommodation while they were on call. This practice would continue, which would ensure that an on-call paediatric consultant would be a matter of minutes away from base.

- Assurance Grid 2.1 – Can you provide more information about how the skills/techniques of clinicians delivering services in rural areas are being enhanced? Can you explain what the 'Skills Drills' in the MLUs are, and how the Skills Drill has been broadened out?

Response: Skills Drills involved undertaking practice runs for events, or 'rehearsing', to ensure that Midwives were prepared if, and when, events occurred. A senior member of the nursing team had been working with MLUs in Scotland and Powys to identify best practice and implement them at SaTH.

- Assurance Grid 3.6 – Can you give assurance that if patients at PRH cannot be stabilised and transferred to RSH that the consultant will travel to PRH?

Response: The Chief Executive confirmed that if a patient was unable to be stabilised and transferred to the RSH that a consultant would travel to PRH as patient safety was a priority.

- The Joint HOSC would like to see a copy of the Risk Register, and to receive regular updated copies.

Response: The Programme Manager tabled a copy of the current Risk Register for Members information, and confirmed that regular updates would be made available at future meetings.

- Can you confirm the timetable for "going live" with Telemedicine across service areas. What opportunities will this present for the repatriation of angioplasty (and other) services to the county?

Response: The Chief Executive was unable to confirm a timetable for plans to go live with Telemedicine. The Trust was working with external partners to provide a more rapid implementation of a scheme, and it was hoped that they would have more information on progress over the next 12 weeks. It was important to note that the Trust was working on a private/public funding option, as it would be difficult for the Trust alone to identify capital to take the plan forward.

Individual groups had been appointed to review repatriation of services to SaTH, including angioplasty, but the Trust needed to show that they had adequate staffing and procedures in place before they could move the plan forward. It was noted that if the Trust was successful in repatriating services, they would likely be based at a single site. Mr Cairns indicated that it would take the groups 6 months to complete the work, and 12 months before the Trust would be able to show all referral pathways were in place to support services.

- Is staff moral low, and if so, how is this being addressed?

Response: The responses to SaTH's staff survey in October 2011 was not as favourable as the Trust would have hoped. Mr Cairns indicated that the survey was undertaken at a time when the Trust was restructuring management structures and there was also considerable uncertainty over the reconfiguration process.

The Trust was now focusing on promoting the Trust as a good place to receive treatment as well as work, which would in itself improve staff moral in the future. It was noted that staff were keen to move the process forward, although there were still a few people uncertain over how the reconfiguration process effected them, and those uncertainties needed working through, and provide those members of staff an opportunity to get involved in the process.

- Can SaTH confirm what assurance/audit process the FBC financial case has gone through?

Response: The Trust had utilised technical design, build and transport planning specialists when preparing the scheme, and independent cost advisors were appointed to test and validate the finances.

- Who is on the Clinical Assurance Group? Were there any concerns raised at the meeting and if so what were they?

Response: The Clinical Assurance Group was made up of clinicians, GPs and managers. The Group held periodic meetings to review proposals, and at the last meeting had been reassured over the degree, and emphasis made by Paediatric Consultants in promoting the changes to service.

- What were the risks flagged up by the Gateway 3 Review?

Response: There were no material risks flagged up by the Gateway 3 Review.

- What is the material effect of the removal of the Integrated Assessment Unit from the plans at RSH? Is this being delayed, or abandoned?

Response: Members were advised that the delayed implementation of the IAU was being considered by Commissioners and SaTH, and discussions were progressing to combine services in the long term. Clinicians indicated that in the next 3 – 5 years, medical, surgical and paediatric assessment units which would circle A & E would provide the required integrated provision.

- What are the options for the alternative accommodation for Shropdoc out of hours service?

Response: Discussions were ongoing as to how to deliver Out of Hours and urgent care, and a number of options were being considered. It was hoped that Shropdoc could be relocated within the existing facilities next to A&E. Once discussions had concluded the Trust would be in a position to identify where Shropdoc fits in to the development.

- In what ways has the building design deviate from applicable standards?
Response: Mr Cairns confirmed that that the new build achieved development standards. The refurbishment would be slightly more challenging as they were having to work within the physical restraints of an existing building which meant that not all standards could be met, but the plans had met the requirements of all regulators.
- Workforce plans – the FBC states that all medical workforce plans, job plans and rosters will be reviewed again at the end of April 2012 in the light of recent changes in the availability of middle grades from the Deanery. What does this mean?
Response: The Trust had a commitment to review medical workforce plans, job plans and rosters for senior doctors on an annual basis to reflect changes in demand, need and service. Workforce plans needed to keep pace with changes in training and services.
- What progress has been made on training the APNPs and how much more is to be done? Are there long-term plans for the PAU to be a completely nurse-led services?
Response: Training was ongoing, and broadening, for APNPs as discussed previously in the meeting, and there were no plans for the PAUs to be nurse-led services. A medical presence would be maintained as it would not be considered clinically safe to run without them.
- What overall reduction of beds will there be in the surgical inpatient wards and surgical assessment unit compared with existing capacity? Even with new ways of working, will there be enough capacity?
Response: Members were advised that there would be a reduction of 22 beds in the surgical inpatient wards and surgical assessment unit compared with existing capacity. It was noted that many of the surgical beds were occupied by medical patients, but that the new plans and ways of working would resolve this situation, for example the separate surgical assessment unit would identify patients who could receive day treatment. Clinicians were confident that the plans would provide adequate capacity.
- How will re-grading of medical staff in all surgery and anaesthetic specialities affect staff? Is it likely to affect moral or retention?
Response: The Trust would not be changing banding for nursing staff, and the re-grading of medical staff referred to national improvements to terms and grading for junior doctors.
- There is £3.5m plus budgeted for fees, what does this include?
Response: Mr Needham confirmed that the budgeted fees were in line with fees expected for this size of capital project. They included professional fees related

to the physical works such as architects, engineers, surveyors (e.g. ground works, ecological surveys), BREAM assessments, building inspectors, transport, and planning fees, and professional fees for developing the business case such as cost advisors. The scheme would be delivered to a high standard and a team would be in place to oversee the process.

- Is the Optimism Bias in line with the required level?

Response: Mr Cairns confirmed that the Optimism Bias was in line with required levels.

- Are there any contingencies other than the Optimism Bias and Planning Contingencies built into the budget?

Response: The Trust had no further contingencies in place for the project as the biggest risk mitigator was covered by the provision of Guaranteed Maximum Price for all construction work prior to main works commencing.

- How was the 2.1% reduction in income representing the reduced income given to the Trust by local QIPP schemes arrived at?

Response: The Trust had been in discussion with Commissioners over changes to the delivery of services for the health economy, and the figure of 2.1% had reflected those changes.

- 4.13 The Chairman thanked Mr Cairns and his staff their attendance, and assisting Members in their deliberations. The Committee also thanked Mr Cairns for his drive and dedication whilst being in post at SaTH, and wished him well in his new position.

RESOLVED:

That the Joint Health Overview and Scrutiny Committee support the proposals laid down in the Full Business Case, subject to approval by the PCT Cluster and Strategic Health Authority, and the assurance that the financial business case, submitted by Shrewsbury and Telford Hospital NHS Trust (SaTH), is robust, and that the Trust has taken account of reductions in funding provision in future years.

The Committee thanked Adam Cairns and his staff for their dedication in driving the reconfiguration forward. Members felt the plans were the best possible option for protecting, and enhancing, hospital services in the county, and that the changes would be very positive for the people of Shropshire.

5. CHAIRMAN'S UPDATE

- 5.1 The Chairman reported that correspondence had been received from the Midlands and East Specialised Commissioning Group, inviting Members to contribute their views on the current proposals for developing Children's Neuroscience Network to coordinate care for children with health conditions requiring neurosurgery and related care.
- 5.2 The Chairman indicated that if Members wished to receive a copy of the correspondence, they should contact the Committee Officer in the first instance, and respond to the consultation by 5 p.m. on 16th May 2012.

5.3 It was noted that the new regional Trauma Network had been launched on 26th March 2012, which saw Royal Shrewsbury Hospital playing a vital role as a Trauma Unit, and working closely with Major Trauma Centres in Stoke and Birmingham.

6. FUTURE AGENDA ITEMS

6.1 Members agreed to include the following items on the work programme:

West Midlands Ambulance Services

- Engagement with development of clinical pathways and Travel & Transport Plan
- Update on implementation of 'Make Ready'
- Workforce development needs – recruitment and training of paramedics, advanced paramedics, coverage and training of community first responders
- 111 Update

Shrewsbury and Telford Hospital NHS Trust

- Ophthalmology Services
- Configuration Process:
 - Implementation Plan
 - Travel and Transport Plan
 - Workforce development/transformational change programme
 - Update on training and support for GPs and midwives
 - Risk register
 - Hospital at Home

6.2 The Committee stressed the need to review all aspects of Transport, and ensure that they were satisfied that the travel plan was robust. It was noted that a Transport Task and Finish Group was carrying out a review on transport provision across the county, and that information considered through the Joint Healthy Communities Scrutiny Committee should be fed back to this Group, and vice versa.

6.3 Members indicated the importance of a Hospital at Home service, ensuring that there was a clear understanding of how services were going to be provided, and ensure savings were realistic. Hospital at Home services implemented in other areas, had seen varying degrees of success, but there was no evidence presently to show that any of the schemes worked well.

10.00 a.m. – 11.27 a.m.

Chairman:.....

Date:.....

Update on Cataract Surgery at the Royal Shrewsbury Hospital and the Wrekin Community Clinic in Telford

Cataract surgery at the Royal Shrewsbury Hospital and the Wrekin Community Clinic in Telford resumed on 3 May 2012.

This service had been temporarily suspended following a number of incidents where patients did not receive the high standards of care that we aspire to offer every time for every patient. Specifically, these patients received lenses that were of a slightly different power to that which was planned for their procedure.

We deeply regret that these events occurred. We stopped the service so that we could identify the reasons and make changes in order to prevent any further incidences. A thorough review has since been undertaken and at the beginning of May we were in a position to be able to reassure patients that the service was ready to resume with new protocols in place.

Hospital care is by definition complex. We have procedures in place in our operating theatres that are based on international best practice and that aim to deliver the best possible outcome for these patients. However, these incidents demonstrated very clearly that our procedures were not meeting our expectations every time for every patient. We decided that the best possible approach to safeguard care for patients was to temporarily suspend cataract surgery so that a thorough review could take place, with involvement from hospital clinicians, local GPs and external experts from the Royal College of Ophthalmologists.

Importantly, patients who had received a slightly different power of lens from that which was intended were also invited to participate in the review and I am delighted that some did choose to take part. We thank them for their insight and for sharing their experiences throughout the process.

We are committed to meeting the high standards of patient experience, patient safety and clinical effectiveness that our patients and our communities expect and deserve. We deeply regret these standards were not met and we have taken a range of robust steps to improve procedures in response to this. We are confident that these will address the problems identified.

As earlier mentioned, in order to enable the Trust to build on the significant steps already taken to ensure a safe system within this specific aspect of the service, cataract surgery at the ICAT and also at the Royal Shrewsbury Hospital was temporarily suspended.

The service resumed on 3 May and we are working hard to re-book patients who have faced delays.

All other eye services continued unaffected as this issue specifically related to the cataract surgery service.

As well as those patients directly affected by the incidents that led to this review, we also extend our most sincere apologies to any patients who have faced a longer wait for local treatment as a result of the suspension to the service.

An oral update will be provided to the meeting by Vicky Morris, Chief Nurse and Director of Quality and Safety, The Shrewsbury and Telford Hospital NHS Trust.

Last Updated: 23 May 2012

Update on NHS Foundation Trust Authorisation for The Shrewsbury and Telford Hospital NHS Trust



1. Introduction

The Government has made clear that all NHS providers must become authorised as NHS Foundation Trusts by 2014. In future NHS Trusts will not be able to exist in their current form, and will either need to become NHS Foundation Trusts in their own right or see the management of their services merged with another organisation or disaggregated between several other organisations.

We are ambitious about improving health services for the better. We passionately believe in the concept of local services for local people, and that we should become a Foundation Trust that is more accountable to the communities we serve. The freedoms that FT status brings us will enable us to further engage with our local community and develop our services in the best interests of the populations we serve.

Given that NHS Foundation Trust status creates new accountabilities to local communities, it is vital that plans for establishing these Trusts have been influenced by those communities. Authorisation as an NHS Foundation Trust therefore requires Trusts to demonstrate that they have consulted on their strategy and their governance arrangements.

Our plan is to become an NHS Foundation Trust by 2014. We undertook a major public consultation on our plans for NHS Foundation Trust status in 2008. Since then we have continued to engage our patients and stakeholders on an ongoing basis in the development of our plans. This has included regular public briefings, members newsletters, workshops and events, focus groups, the “Keeping It In The County” consultation, attendance at local council and community groups, local joint committees, annual general meetings, our Patient Experience and Involvement Panel, patient workshops to develop our Quality Improvement Strategy, Listening Into Action staff conversations involving over 400 staff and a range of other activities.

Through this ongoing engagement we have continued to seek views and feedback that have influenced our plans and priorities and the way in which the NHS Foundation Trust will be run. Given the period of time since our initial consultation there is an argument that we should undertake a further period of formal public consultation. However, we are confident that this ongoing engagement means that our plans for Foundation Trust status remain valid and grounded, and we are seeking to invest our resources in continuing to build and develop this ongoing conversation rather than undertaking a further period of formal public consultation.

Through this paper and a presentation to the meeting on 1 June 2012 we are seeking feedback and support from the Joint Health Overview and Scrutiny Committee for this approach.

2. An overview of the FT application process

All NHS Trusts must pass rigorous tests of their “fitness for purpose” before becoming an NHS Foundation Trust. Through these tests, Monitor (the independent regulator of NHS Foundation Trusts) must be confident and able to provide assurance to Parliament that we are legally constituted, financially sustainable, well-governed and locally representative.

This gives assurance that the Trust can be given the additional freedoms of NHS Foundation Trust status whilst continuing to deliver national NHS priorities to NHS standards and to respond to local needs.

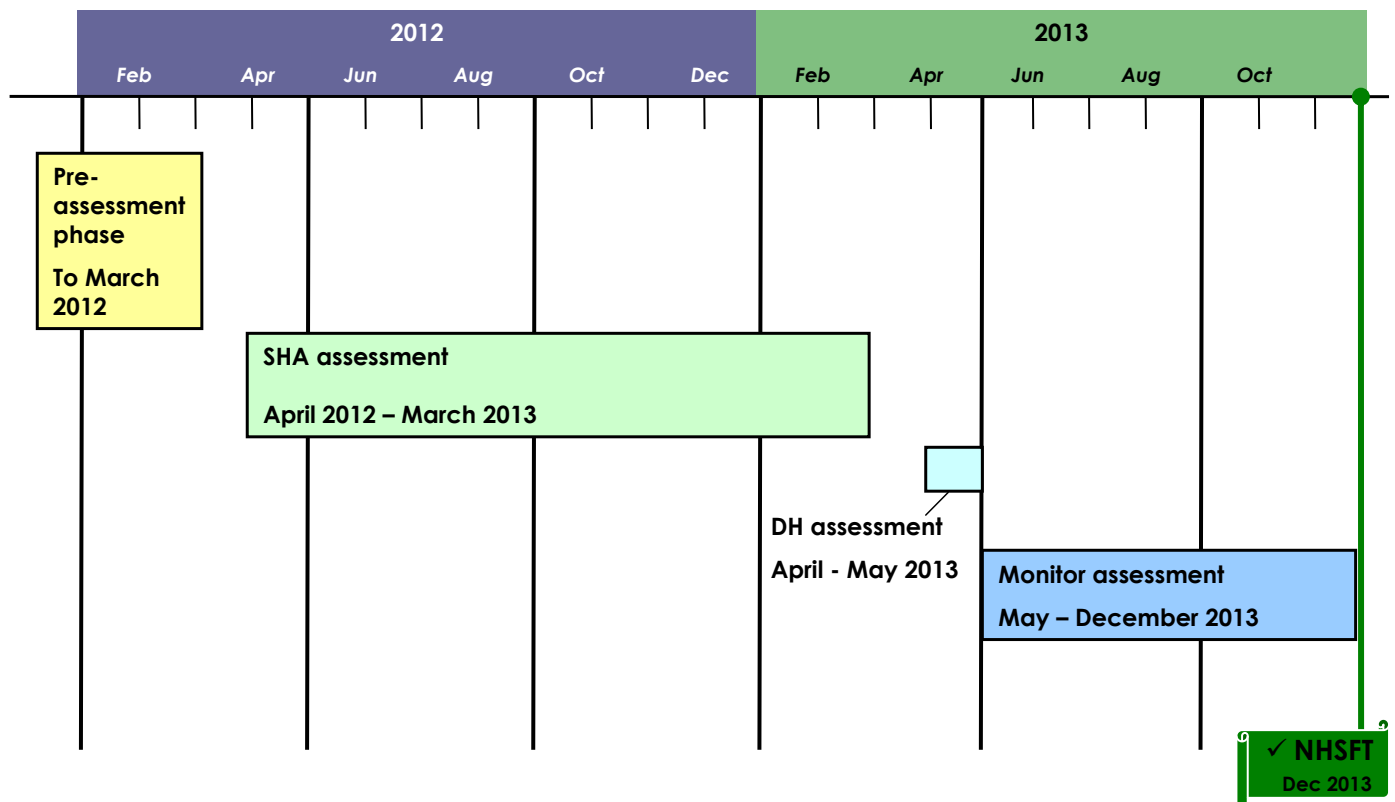
Before we can be authorised we must move through three distinct phases of an application and assessment process:

- **Strategic Health Authority (SHA)-led Trust Development Phase** – to prepare the Trust for the application process and Secretary of State support
- **Secretary of State Support Phase** – to determine whether the Trust is eligible to apply to Monitor for assessment
- **Monitor Phase** – to assess and potentially authorise us as an NHS Foundation Trust

Monitor’s involvement in the process starts once we have received approval from the Secretary of State for Health to apply for FT status.

Our timetable for moving through these phases is set out below:

Figure 1: SaTH FT trajectory



This timetable was agreed with the Strategic Health Authority and the Department of Health as part of a “Tripartite Formal Agreement” in 2011.

3. Key Requirements

As part of this application process the Trust will continue to develop our strategy (i.e. our plans for the future) and our governance arrangements (i.e. how we will be run). This development process has been influenced and shaped by the feedback we have continued to seek from our patients, communities and partner organisations

Whilst we undertook a formal public consultation ending in 2008, we viewed this as the start of an ongoing conversation with our communities rather than a standalone activity. Since then we have sought to build and develop our approach to engaging with our communities through a range of approaches.

This has included:

- regular public briefings
- members newsletters
- workshops and events
- focus groups
- the “Keeping It In The County” consultation
- attendance by directors and senior clinicians at local council and community groups
- roadshows and presentation for local joint committees
- the Trust’s annual general meetings (which will in future become our Annual Members Meeting when we are a Foundation Trust)
- our Patient Experience and Involvement Panel
- patient workshops to develop our Quality Improvement Strategy
- Listening Into Action staff conversations involving over 400 staff
- Newspaper advertisements
- Surveys to gather patient opinion (including the Inpatient Survey, Outpatient Survey, Friends and Family Test)
- Surveys to gather staff opinion (including the Annual Staff Survey and the Organisational Culture Assessment)

Overall we believe that we have significantly strengthened our ongoing engagement so that we can be increasingly confident that our plans are built on the feedback we receive in future. We look forward to strengthening this in future through a new Council of Governors with a majority of elected Public Governors (see Section 4).

As we move closer to our NHS Foundation Trust application, one option to demonstrate our engagement would be through a further period of public consultation. However, we would prefer to invest NHS time and resources in continuing to build and strengthen our wider network of engagement so that we have capacity and capability for the future. We believe that the programmes that we now have in place bring much richer and more grounded feedback than a further consultation specifically relating to NHS Foundation Trust status.

We welcome feedback from the Joint Health Overview and Scrutiny Committee on this proposed approach.

3. Stakeholder engagement

We plan to be **an engaged and engaging NHS Foundation Trust**. This includes having at the heart of our Constitution a new Council of Governors including Public Governors (elected from our patients and communities), Staff Governors (elected from our employees) and Partner Governors (nominated from partner organisations).

We have previously discussed and consulted widely to determine the geographical coverage of our public membership constituencies, our staff membership and the “classes” (or sub-constituencies” within this, and which organisations should nominate appointed Governors to the Council of Governors.

Our consultation ending in 2008 provided valuable feedback, and since then we have continued to review, refine and refresh these plans using various forums to shape the constitutional arrangements including Board Development Days, Hospital Executive Committee, Patient Experience Group, Trust Negotiating & Consultative Committee, Stakeholder Steering Group, Operational Delivery Group and Directors meetings. External meetings have also taken place with key stakeholders including Local Overview & Scrutiny Committees, Cabinet meetings of principal authorities, Local Involvement Networks, Shropshire Chamber of Commerce, Shropshire Partners in Care, Shropshire Enterprise patient/user groups and voluntary groups.

3.1 *The Foundation Trust Constitution*

The Constitution of every NHS Foundation must be based on Monitor’s ‘*Core Model Constitution*’, but adapted to suit local requirements. It defines composition of the Foundation Trust including the name of the Trust, its principal purpose, powers, membership and constituencies, the composition of the Council of Governors, and the model rules for the election of governors from the public membership.

Our first draft Constitution was developed following a formal public consultation which ended in early 2008 and then refreshed again over a ten week period in 2009 with a further refresh between March and May 2012. During our formal consultation there was 99% support from respondents for our application. The main opposition related to concerns about the concept of NHS Foundation Trusts, which is a matter of national policy rather than local discretion. Indeed, since that original consultation the Government has made clear that all NHS Trusts must become NHS Foundation Trust.

Issues raised during that consultation, in our subsequent refreshes and through our ongoing engagement with patients and other stakeholders and informed the continued evolution of our Constitution. For example:

- Since the original consultation there has been the change to unitary authority status in Shropshire, and we have continued to review our public sub-constituencies within Shropshire to reflect the local joint working arrangements within the authority
- The Powys sub-constituency was amended to additionally include Beguildy, Knighton and Llangunllo wards. As a result our overall public constituency now includes Telford & Wrekin, Shropshire, the Montgomeryshire wards within the county of Powys and additional Beguildy, Knighton and Llangunllo wards.

In 2012 we have also established a new **Stakeholder Conference** as a quarterly forum to bring together a broad range representation of local stakeholder groups to influence our plans and priorities. This will continue to influence our strategy and governance going forward, with this role becoming formalised through the new Council of Governors once we are authorised as an FT.

Through all of these channels of communication, we have again invited views on:

- **Our strategy and vision for the future:** Our current strategic plan is based on the central organising principle of "Putting Patients First". This simple phrase makes us think about what really matters so that we can focus our time, our skills and our resources where it will make the best possible impact for our patients. We continue to welcome ideas and suggestions for what should feature in our future plans. Our latest Annual Plan is due to be considered by our Trust Board on 31 May 2012 and an oral update will be presented to the Committee. More information is also available from our website at www.sath.nhs.uk/about-us/mission.aspx
- **Our governance arrangements and constitution:** Our Constitution sets out how the NHS Foundation Trust would be run, and includes a Council of Governors with a majority of public governors elected from the communities we serve in Shropshire, Telford & Wrekin and mid Wales. More information about our proposed Council of Governors can be found in Section 3.3. The current draft constitution is available from our website at www.sath.nhs.uk/about-us/nhsft/constitution.aspx

Over the three distinct periods of public consultation, and through our ongoing engagement, we have welcomed ideas and suggestions for any changes and amendments for our proposals about how the NHS Foundation Trust is run. We established a dedicated FT Membership Office and email address (consultation@sath.nhs.uk) to provide a direct and convenient point of contact to enable the Trust quickly and effectively deal with all enquiries relating to the FT application. Most recently, we have also been consulting with our stakeholders on views for a suitable name for us as a Foundation Trust. (ensuring that Monitor guidance and contractual obligations have been considered).

3.2 Foundation Trust Membership

The total FT membership currently stands at 12,761 members (7306 public and 5455* staff members). Public membership exceeds our current target (which is 1% of the eligible population within our catchment area). Staff membership currently represents 96.7% of the total substantive workforce.

The Trust aspires to an engaged, active and representative membership from both the general public and staff in terms of geography, age, gender, disability, ethnicity, faith, sexual orientation and socio-economic groups. A comprehensive register of the NHS Foundation Trust membership has been developed to support us to achieve this. The establishment of an FT Membership Office not only ensures good support and communication with members but will also support the future Council of Governors.

Public membership

Membership of the Trust is open to those members of the public and patients residing in our public constituency who are over 14 years of age (members must be 16 years of age to stand for election to become a Governor). Some NHS Foundation Trusts have tertiary or specialist services covering a much wider catchment, but given that over 99% of the Trust's patient referrals come from our public constituency we feel that a separate patient constituency is not required.

We also recognise that different members may require different levels of engagement. As a member, individuals can choose to have as little or as much involvement as they wish; although these tend to fall into three main groups – members who wish to be kept informed, be engaged or be active.

The benefits and rights of all members include:

- Taking the opportunity to declare their support for the work of the Trust and receiving regular newsletters about the hospital and other services its provides
- Being consulted on future development of our services

- Participation in surveys, events, health lectures, special interest groups, workshops, focus groups and behind the scenes tours.
- Having access to their Public Governor who represents their local area and will bring views from the area to the Trust.
- Vote or stand for election as a governor

The Foundation Trust membership office has over the past 6 months continued to develop ways for members to become involved with the Trust. The Trust now has an ongoing programme of engagement activities for Foundation Trust members, but it is also important that we continue to recruit new members, particularly in under-represented areas.

A membership recruitment action plan is being developed as part of our Membership Strategy for 2012-2015. This sets out our targets for the future, for example to expand our public membership base to 10,000 people with a particular focus on recruiting from sectors of our communities that are currently under-represented

A summary of the main phases of our public membership strategy are set out below:

- **Establishing Membership Arrangements and Commencing Recruitment:** The first phase of membership recruitment focused on establishing membership arrangements and beginning to recruit members as part of the consultation process. This led to over 3700 members who were broadly representative of the area we serve in terms of age, gender, geography and ethnicity. Under-represented areas at the end of phase 1 include Bridgnorth, Oswestry, Powys and members under the age of 50. These areas have been targeted as part of our membership recruitment.
- **Building membership to 1% of catchment and increasing representativeness:** This phase of membership recruitment sought to build a public membership of at least 1% of our total catchment (5000 public members) that was broadly representative of the communities we serve (in terms of age, geography and ethnicity). Over the summer of 2009, a Foundation Trust consultation review and refresh was held where members and stakeholders were contacted to comment on the Trust's proposed governance arrangements in the light of any changes since the original consultation.
- **Building and sustaining membership:** The current phase of membership recruitment builds on our existing membership. A Foundation Trust Membership and Engagement Manager was appointed in January 2011 to further develop this phase of the process, supported by a Membership Officer. Members have been contacted quarterly through newsletters for their views and involvement. In order that our membership feels informed and involved, it is essential that we ensure that our communication with them is timely and relevant. A further public consultation 'refresh' undertaken between March and May 2012. We fully acknowledge that strong communications with our membership is essential to the success of engaging and involving staff and public members in the activities of the Trust. Currently the Trust uses and is further developing a wide range of methods to ensure that its membership is kept informed.

Both the Trust website and intranet have a dedicated section for all developments relating to our Foundation Trust application. We will use this and other methods of communication to inform our membership of up and coming events, ways that members can become more actively involved with the Trust (e.g. Volunteering, being a representative) and how individuals can feedback about the Trust services. There is also clear signposting to the electronic FT membership application form.

Ahead of NHS Foundation Trust authorisation we are seeking to move from a traditional Annual General Meeting to an engaging Annual Members Meeting. Our next meeting in September will be open to all members of the Trust and will be widely advertised via the Trust's Communications Team. Alongside displays, events and activities for members the event will incorporate the formal AGM at which the Board of Directors will present the Annual Report and Annual Accounts.

3.3 NHS Foundation Trust Council of Governors

A central mechanism for ensuring that NHS Foundation Trusts are more accountable to local communities is through the Council of Governors. The Council of Governors brings patients and staff to the heart of decision making in their local NHS, giving them important statutory powers to oversee and shape the delivery of local healthcare. Whilst the Board of Directors will continue to be accountable for the day-to-day running of the services provided by the Trust, the Council of Governors will have a vital role in holding them to account to ensure that the decisions they make are in the best interest of the communities they serve within the resources available to them.

The development of the Council of Governors must meet a few core rules set out by Monitor and in legislation:

- The Chairman of the Trust chairs both the Board of Directors and the Council of Governors
- There must be a majority of elected public or patient governors
- There must be staff governors
- There must be at least one Governor nominated by the appropriate local authority
- There must be at least one Governor nominated by the relevant university (where appropriate, e.g. where the Trust has teaching status in partnership with a University Medical School)

Based on feedback from our communities and this guidance we have proposed a Council of Governors comprising:

- 16 public governors elected from 5 public sub-constituencies
- 5 elected staff governors elected from 5 employment classes
- 5 appointed governors including one governor from each of our three main local authorities, a governor from Keele University and a governor from Staffordshire University

Elected Public Governors will represent their communities and will be drawn from five sub-constituencies, with the number of governors proportional to the population both now and in the future:

- central Shropshire – 3 public governors
- Montgomeryshire and north east Radnorshire – 2 public governors
- northern Shropshire – 3 public governors
- southern Shropshire – 3 public governors
- Telford & Wrekin – 5 public governors

Public members will be eligible to stand for election as a Governor from age 16.

Staff governors elected from five employment classes based on professional groups (e.g. nurses and midwives).

Partner governors nominated from key partners including local authorities and universities.

Subject to continued achievement of milestones on our journey to authorisation as an NHS Foundation Trust, our first Governor elections would take place during 2013.

4. Conclusions

The Trust serves a wide range of stakeholders across a large geographic area. We feel we can ensure, through our membership and in future, Council of Governors, that the interests of our stakeholders are represented.

We have consulted widely regarding the constitutional issues associated with Foundation Trust status. We have an active and engaged membership which has been involved with all aspects of the Trust's proposals for the reconfiguration of hospital services. We participate in patient engagement meetings and openly invite members of the public to participate in activities such as health lectures and hospital tours.

Our Foundation Trust Constitution aims to achieve a balance between the Council of Governors and the Board of Directors, enabling both to work together to realise the new opportunities that Foundation Trust status will bring, while allowing the executive leadership the freedom it needs to act quickly on key decisions. In order to achieve this we have ensured that our governance arrangements are appropriate and robust for a Foundation Trust.

As a Foundation Trust, we will not be directed by Government but will be accountable to our local communities through the establishment of a membership body and Council of Governors; our commissioners through contracts; the Care Quality Commission through the legal requirement to register and meet the associated standards for the quality of care provided; and Monitor, as our regulator. We must also lay an annual report and accounts before Parliament.

This will be complemented by the vital role of local bodies such as Health Overview and Scrutiny Committees, Community Health Councils (in Wales), Local Involvement Networks and, in future, Local HealthWatch.

We aspire to continue to develop and build our engagement with our communities and seek support from the Joint Health Overview and Scrutiny Committee to continue this process rather than undertaking a further period of formal public consultation on plans for FT status.

Last updated 23 May 2012.