UN-CONFIRMED MINUTES of a Public meeting of the Board of Directors held at 09:00 on Thursday 29th March 2018 in the Boardroom, King's Mill Hospital

Present:	John MacDonald	Chairman	JM
	Ray Dawson	Non – Executive Director	RD
	Neal Gossage	Non – Executive Director	NG
	Tim Reddish	Non – Executive Director	TR
	Claire Ward	Non – Executive Director	CW
	Richard Mitchell	Chief Executive	RM
	Paul Robinson	Chief Financial Officer	PR
	Simon Barton	Chief Operating Officer	SiB
	Dr Andy Haynes	Medical Director & Deputy Chief Executive	AH
	Julie Bacon	Executive Director of HR & OD	JB
	Shirley Higginbotham	Head of Corporate Affairs & Company Secretary	SH
	Peter Wozencroft	Director of Strategic Planning & Commercial Development	PW
	Paul Moore	Director of Governance & Quality Improvement	PM
	Suzanne Banks	Chief Nurse	SuB
	Barbara Brady	Specialist Advisor to the Board	BB
In Attendance:	Joanne Smith	Minutes	
	Sue Bradshaw	Minutes	
	Robin Smith	Deputy Head of Communications	RS
	Elaine Jeffers	Deputy Director of Governance & Quality Improvement	EJ
	Alison Steel	Research Lead	AS
	Sue Smith	Research Nurse	SS
	Roger Whyles	Research participant and patient	RW
	Dominic Nash	Research Team	
Observers:	Michelle Dunna	CQC Relationship Manager	
	Yin Naing	CQC Regional Inspection Manager	
	Keith Wallace	Governor	
Apologies:	Graham Ward	Non – Executive Director	
	Kerry Beadling-Barron	Head of Communications	

Item No.	Item	Action	Date
16/745	**WELCOME**		
	The meeting being quorate, JM declared the meeting open at 09.00 and confirmed that the meeting had been convened in accordance with the Trust's Constitution and Standing Orders.		
16/746	**DECLARATIONS OF INTEREST**		
	There were no declarations of interest		
16/747	**APOLOGIES FOR ABSENCE**		
	Apologies were received from Graham Ward, Non-Executive Director and Kerry Beadling-Barron, Head of Communications		
16/748	**MINUTES OF THE PREVIOUS MEETING**		
	Following a review of the minutes of the Board of Directors in Public held on 22nd February 2018, the Board of Directors APPROVED the minutes as a true and accurate record.		
16/749	**MATTERS ARISING/ACTION LOG**		
2 mins	The Board of Directors AGREED that actions 16/635.3, 16/690.2, 16/726.1 and 16/726.2 were complete and could be removed from the action tracker.		
16/750	**CHAIR'S REPORT**		
2 mins	The Chair's report was taken as read. JM advised NHSE and NHSI have recently announced closer working relationships. The understanding is there will be seven regions with a single Regional Director and there will be a single lead for national initiatives. JM felt this is a good step forward and should lead to a greater level of consistency and clarity in working with the regulators. The Board of Directors were ASSURED by the report		
16/751	**CHIEF EXECUTIVE'S REPORT**		
12 mins	RM presented the report, advising the Trust remains under pressure from Winter, recognising there have been 18-19 weeks of consecutive challenges. RM expressed gratitude to staff and partner organisations for their continued hard work and support. RAG ratings remain the same as last month, although the progress made in relation to the 62 day cancer standard was recognised. RM advised the 3 principle risks on the Board Assurance Framework (BAF) remain the same, these being Financial Sustainability, Managing Emergency Demand and Staffing Levels. Work is ongoing in relation to the risks associated with the 52 week waiters. This is due for discussion at the next meeting of the Risk Committee to ensure the risk		

	is captured correctly. Steps are being taken to mitigate this risk and RM confirmed the Trust is compliant with the Duty of Candour guidance and no patients have come to harm, but did recognise the patient experience is poor. RM advised the staff survey results are good, showing an improvement for the second consecutive year. SFHFT compares well to other organisations but areas for improvement have been identified and plans are in place to address these. It was recognised that engaged, well supported staff deliver safe care and this is evidenced in the Trust's results. SFHFT continues to provide safe personalised care, despite winter pressures, and the quality indicators continue to improve. As part of the continuous improvement in relation to the Trust's governance structure, RM highlighted the appendix to the CEO's report which provides information which feeds into the Divisional Performance Meetings on a monthly basis to provide the Board of Directors with oversight and assurance on issues discussed at those meetings. RM felt the upcoming CQC visit is a good opportunity for the organisation. The standard of care SFHFT is providing currently is better than it was 12-24 months ago. It was recognised there are risks to the organisation but the Trust is sighted to those. RM felt that the Trust will further improve over the next 12-24 months. The Trust has been working with partners in health and social care in relation to a range of items, in particular financial performance. RM acknowledged the work of PR and his team for financial delivery for 2017/2018 and for developing the plan that is in place for 2018/2019. There is a good contract in place. SFHFT will deliver the control total, Cost Improvement Plan and agency cap for 2017/2018. Patients on cancer and diagnostic pathways continue to receive timely care but it was noted emergency and elective care has deteriorated over the last 12 months. This is an area the Trust is focusing on; the challenges and reasons for those are known. Further improvement is expected over the coming months. JM felt it would be useful for the Trust to refresh the 3 year financial plan and for this to be presented to the Board of Directors. JM noted the risk identified in relation to the provision of sterile medical equipment and queried the governance process for this. PM explained there had been a discussion in relation to this risk at the Risk Committee to ensure the issue was given the correct risk rating. PM confirmed the governance for Sterile Services sits within Estates and Facilities and the Division of Surgery and is dealt with through the Risk Committee. It was agreed feedback should go through the Quality Committee. ***Actions:***		
	• ***3 year financial plan to be refreshed and be presented to the Board of Directors***	**PR**	**26/04/18**
	• ***Risk Committee to provide feedback to Quality Committee in relation to provision of sterile medical equipment***	**PM**	**26/04/18**

	JM queried if there was any cause for concern in relation to the surgery outstanding DATIX incidents over 60 days. PM explained this was an improving situation and over the last 6 months extra focus has been put on this through Divisional Performance Review meetings. In every division the incidents that remain open are being tracked and the numbers are reducing. RM highlighted two documents which will be presented in the CEO update to the Board of Directors in April. There will be an update on the Mid-Nottinghamshire Alliance and the quarterly meetings with Nottingham University Hospitals (NUH) about joint services and strategic working, which were cancelled in Q4, will be re-instated. The Board of Directors were ASSURED by the report		
16/752	**STRATEGIC PRIORITY 1 - TO PROVIDE OUTSTANDING CARE TO OUR PATIENTS, OPERATIONAL AND ACCESS IMPROVEMENT**		
27 mins	JM explained there will be three communication 'levels' for each of the strategies. The first will be an easily understood narrative for patients, public, etc. The second will be a 2-3 page summary for the Board of Directors showing the plan for the next 3 years and highlighting KPIs for monitoring purposes. The third level will be the full strategy, the governance of which will be at committee level. Progress reports will be provided to the Board of Directors every 6 months on Key Strategic Priorities. NG requested that critical success factors be identified and reported back to board on a quarterly or 6 monthly basis. **Dementia Strategy** SuB presented the Dementia Strategy, advising it is a 3 year strategy which sets out the guiding principles for delivering care to the most vulnerable group of patients. It is based on NHSI's Dementia Assessment Framework which has seven key principles, as highlighted within the strategy document. The Strategy has been considered at the Quality Committee and KPIs will be monitored through the Dementia Steering Group and the Advancing Quality Programme, which will feed into the Quality Committee. TR confirmed the Strategy had been reviewed in depth by the Quality Committee. TR acknowledged the Trust is thinking about what it wants to achieve, rather than reacting to what is being asked of the organisation. BB noted the focus in the strategy is patients aged over 75. However, given the community the Trust serves it is likely dementia will be prevalent in the lower age group. Therefore, the Strategy should not be age specific but focus on the issues and needs of patients. CW advised the Quality Committee discussed training for the Board of Directors so Board members were qualified to the level of Dementia Friend and ideally to have a Dementia Lead among the Non-Executive Directors.		

	Action		
	• ***Training of Board of Directors members to Dementia Friend level and identification of Non-executive Director as dementia lead***	**SB JM**	**26/04/18**
	AH felt there were opportunities in relation to the Alliance work to embed the strategy in the wider health service, noting the Health Optimisation Group was looking into pre-operative care for patients with dementia. SuB advised Learning Disabilities and Dementia are now within the same team and Band 5 support to cover both portfolios is being sought, recognising the crossover with these patient groups. The Board of Directors RATIFIED the Dementia Strategy. **Quality Strategy** PM presented the Quality Strategy, highlighting the four key strands. The first strand is 'Positive Patient Experience'. The aim of this strand is to place the patient at the heart of the decision making process and for them to be able to influence and direct how their care is managed. The second strand is 'Care is Safer'. This is a progressive goal, aimed at minimising risks. The aim is for SFHFT to have the lowest number of serious incidents of any acute provider in the East Midlands and to achieve 12 consecutive months without a never event. The third strand is 'Care is Clinically Effective' with the aim of adding value to the patients the Trust serves, achieving the best outcomes and enhancing quality of life. The fourth strand is 'We Stand Out'. The aim is for patients, service users, regulators and inspectors to highly rate the organisation. PM advised the measures are set out in the document presented to the Board of Directors and a dashboard is being built around the KPIs to monitor performance. TR advised the Strategy had been reviewed as part of a Board of Directors development session and also by the Quality Committee, who will be responsible for the effectiveness and monitoring of the Strategy. It was noted that the AQP underpins the Quality Strategy. RM advised both clinical and non-clinical staff have contributed to the Quality Strategy and it is central to everything the Trust is seeking to achieve. Care provided by the Trust is currently safer than it was in the past but the aim is for safer care in the future. BB felt a challenge for the organisation is to consider the difference between clinical effectiveness and clinical efficiency. Another point to consider is how to use patient reported outcome measures and patient activation measures. RD sought clarification regarding how the Trust is currently performing.		

	PM advised this information will be included in the dashboard, noting some of the measures will be achievable, others will stretch the organisation. JM asked if each service will be asked to develop a similar set of key measures and if services will be asked for any specific indicators they want to include. PM advised the measures will be trialled in certain areas of the organisation initially and specialisms will soon be in a position to generate their own improvement trajectories and the areas they want to focus on. PW advised of work previously completed where a synopsis was produced for each service against a set of financial and non-financial indicators and services were asked to identify issues relating to their own area. It was felt it would be useful to refresh this work in 2018/2019. The Board of Directors RATIFIED the Quality Strategy **Interim Engagement and Involvement Strategy** EJ presented the Interim Engagement and Involvement Strategy, noting the development of the strategy underpins the Dementia Strategy, Quality Strategy and Cultural Work. The aim of this strategy is to link patient experience and patient involvement, these two areas having previously stood in isolation. The Trust seeks to involve patients in how services are developed and moved forward. This strategy is closely aligned to the first strand of the Quality Strategy, 'A Positive Patient Experience'. JM advised of work taking place at system level in relation to developing system processes. There are opportunities to combine resources, look at wider pathways and link patient engagement into the Organisational Development (OD) for the system. In addition, the Trust Governors are changing their way of working and some are members of their local Patient and Public Groups (PPGs). These two ongoing areas of work provide an opportunity to look at how SFHFT can take the lead across the health community. RM advised as part of the improvement journey across all domains, SFHFT is learning from other organisations. As part of the Engagement and Involvement Strategy discussions and visits have taken place to other acute hospitals and mental health trusts. Further improvement is required over next the next 6 months, particularly in relation to greater working across the Alliance from both a health and social care perspective. EJ acknowledged consideration should be given to making better use of feedback and intelligence and how to truly involve patients and services users. It was AGREED the Strategy needs to be further developed and reviewed by the Quality Committee, with the full strategy to be presented to the Board of Directors in 6 months' time.		

	Actions: • ***Engagement and Involvement Strategy to be developed by Quality Committee and presented to Board*** The Board of Directors RATFIED the Interim Engagement and Involvement Strategy	**PM**	**27/09/18**
16/753	**STRATEGIC PRIORITY 2 - TO SUPPORT EACH OTHER TO DO A GOOD JOB**		
11 mins	**Nursing and Midwifery Strategy** SuB presented the Nursing and Midwifery Strategy, advising this has been developed as a 2 year strategy as the Allied Health Professionals (AHP) strategy is due to for update in 2020, at which point the strategies will be combined. The Strategy has been built around the 5 strategic priorities and shows the nursing and midwifery commitment to deliver against each of those. Staff have been consulted on the Strategy through engagement events, presentations and team briefings. The Strategy will be monitored through the Nursing and Midwifery and AHP board, reporting to the Quality Committee. JM sought clarification on progress of the development of a system level workforce strategy, recognising nursing and midwifery staff make up a large portion of the overall workforce. JB advised there is a workstream looking at this. The initial work is to determine the baseline position and then link to plans. One of the aims is to flag-up to the Sustainability and Transformation Partnerships (STP) board where the key gaps are. All partner organisations contribute to this workstream. JM felt it would be useful for a discussion to take place between Richard Mitchell and Amanda Sullivan (CCG) as joint Senior Responsible Officers (SROs) to agree how the Nursing and Midwifery Strategy can be incorporated into wider system working. JB advised there is a formal programme which sits within the STP workstream. In addition, supplementary workstreams are looking at different models of employment, for example, how to employ people rotating across different organisations, different roles, etc. JM felt this would be a useful topic for a future Board of Directors workshop. ***Actions:*** • ***Discussion to be facilitated between Richard Mitchell and Amanda Sullivan (CCG) to agree how Nursing and Midwifery Strategy can be incorporated into wider system working*** • ***Discussion on STP Workforce Programme to be topic for Board Workshop*** The Board of Directors RATFIED the Nursing and Midwifery Strategy	**RM** **JB**	**26/04/18** **TBC**

	Workforce Strategy JB presented the Workforce Strategy, noting this had been approved last year. Therefore, this Strategy is the refresh for 2018/2019 and 2019/2020. This Strategy underpins Strategic Priority 2 but, as the overarching workforce strategy, it also underpins the workforce element of the other priorities. An integrated approach has been taken in developing this Strategy, which is built around the six key elements of attract, engage, develop, nurture, perform and retain. The Strategy is underpinned with a detailed action plan which will be RAG reported quarterly to the Board of Directors during 2018/2019. The Board of Directors RATFIED the Workforce Strategy		
16/754	**PATIENT STORY - STAMPEDE:** **PARTICIPATING IN A CLINICAL TRIAL**		
35 mins	SS presented information on the STAMPEDE clinical trial. RW, patient, then told his story about being involved in this trial. TR enquired what psychological support RW was provided with during the period from diagnosis to starting on the trial and if there was anything that could be improved. RW felt everything went smoothly and nothing could have been done better. RW explained a contact number for the team was provided so there was always someone at end of phone to answer any questions. CW enquired if there had been any opportunities for RW to provide suggestions about how the service could be improved, for him to share experiences or discuss concerns with other patients going through the same process. RW advised this meeting was the first opportunity to share his story but would be only too pleased to share his experience with patients if those opportunities exist. AH felt this was a compelling story and acknowledged the time between biopsy and diagnosis and diagnosis to treatment needs to be as short as possible. Research can help with this as it is a structured process. AH enquired if being involved in the STAMPEDE trial made understanding the diagnosis easier for RW. RW advised there is a wealth of background information about the STAMPEDE trial on Cancer Research UK and Medical Research Council websites. In addition, updates about the trial were received from the team at SFHFT. RW felt the initial diagnosis left him stunned but he couldn't recall delays being a problem as everything ran smoothly and happened quicker than he thought it would. RW hopes to see the day when the drug Abiraterone can be rolled out. AH advised NICE are awaiting the results of trials like STAMPEDE.		

16/755	**CQC PREPARATIONS**		
23 mins	EJ presented an update on the preparations for the CQC visit, re-iterating the work undertaken since 2015/2016 has not been aimed just at getting a different CQC outcome but is how the Trust wants to work. Through the core service self-assessment process, areas for improvement have been identified which are not just areas which are not doing so well, but also areas which are doing well but can be improved, highlighting the continuous improvement programme. A trial run Provider Information Request (PIR) was completed in July 2017 which proved to be a useful process. This work will be refreshed in November 2018 as it is likely the Trust will be asked for this information annually. EJ noted that the quality of the information the Trust has been able to provide has significantly improved which is testament to everyone across the organisation. The Trust has eleven core services and while not all will be inspected as part of the CQC visit, all services will be prepared. It was noted that the core service self-assessment programme had been slightly delayed due to Winter pressures. Regular CQC Engagement meetings have been held. The three key risks identified in the BAF are in relation to workforce, emergency demand and financial. The challenge for the organisation is getting the right person, with the right skills, in the right place to deliver care to patients within the constraints of managing patient flow and within financial controls. RM advised these key risks sit across the NHS. SFHFT is trying to reach a position where the Trust has greater control and influence over them, within the organisation and across the health system. TR enquired what lessons can be learned from this process and how pressure on staff in relation to the CQC visit can be minimised. EJ explained this is a programme of the Trust continually questioning itself. This is part of the way of working in the future. The Trust should meet the requirements of the regulator, patients and service users as a consequence of doing the right thing in the best way possible all of the time. Staff are not anxious about the CQC visit but are proud of the work they do and are looking forward to the opportunity to share this with the CQC. JM felt it would be useful for the Executive Team to review the preparatory work after the CQC visit to establish if there is anything which should be ‘business as normal’. RM advised April and May will be normal months for the Trust. SFHFT is aiming to represent the level of care that takes place across the organisation. Staff are positive and excited about the opportunity to explain what they have been doing to deliver safe care over the last two years and what they will be doing over the coming two years. Staff have not been coached on what to say, but have been encouraged to talk about their role in the Trust.		

	NG enquired if there was a danger of being over confident and is there evidence to support the claims being made. EJ confirmed the evidence is there. The Trust recognises it is not perfect. However, what is done well and where we are not getting it right all the time is known. The areas of focus are known. RM felt the Trust has improved against many indicators over the last two years; there are risks but the organisation is sighted to those risks. ***Actions:*** • ***Following CQC visit conduct review of preparations for visit*** The Board of Directors were ASSURED by the report	**RM**	**31/05/18**
16/756	**SINGLE OVERSIGHT FRAMEWORK PERFORMANCE REPORT**		
60 mins	**QUALITY** SuB reported there were six cases of e-coli in February, taking the YTD total to forty-eight. There is a national drive for a 10% reduction within the health economy in cases of e-coli. In 2017/2018 there were fifty cases within the Trust. Therefore, SFHFT is not in that position. In each case, a Root Cause Analysis (RCA) is completed. Two of the six cases in February were catheter related. The focus for the infection control team is how catheter care can be supported and associated infections prevented. AH advised the Trust's current rate is 19 per 1000 occupied bed days, which is the third lowest of East Midlands trusts. The number of non-trust apportioned cases is five times higher than the number of cases within SFHFT each month. The big burden is catheter related, which is where the Trust is focusing. The number of catheter related UTIs has reduced. SuB advised the falls rate is 5.6 per 1000 occupied bed days, which is below the national average of 6.3. However, the internal target is 5.5. A deep dive in relation to falls has been completed and considered by the Quality Committee, who were assured regarding the ongoing positive work in relation to the reduction of falls. After each fall, the Falls Lead looks at the staffing position to establish if there is any direct link to staffing levels; no direct correlation has been found. An RCA is also completed. TR confirmed there was nothing which gave the Quality Committee cause for concern and no single factor was identified to account for the peak in November. The coding on severity of falls has been changed, bringing SFHFT into line with standards elsewhere in the NHS. SuB advised a deep dive in relation to dementia had been completed and presented to the Quality Committee. Dementia is reported in three areas, Find, Assess and Refer, and each area should achieve 90%. The issues in relation to dementia were reported to the February meeting of the Board of Directors. The latest figures (January data) has seen an improvement for Find which has increased from 29% to 60%, Assess has increased to 100% and Refer has also improved but is still		

	only 52%. All patients still within the Trust were referred. All patients who have been discharged would naturally have been referred to their GP. All GPs for patients previously missed for screening were contacted and the response received was they would complete the assessment and screening. Therefore, they have not been re-contacted asking them to complete this. Actions taken include contacting neighbouring trusts to establish monitoring processes, spot checks on documentation used in the Emergency Department (ED) have been completed, the flow of documentation has been adapted, approval has been given to recruit a Band 5 nurse for a period of 6 months, prior to the dementia question being added to Nervecentre, to support the unified and qualitative aspect of referring and supporting patients and a mental health nurse has been seconded for 2 days per week for 6 months to help drive forward some of the dementia work. NG sought clarification on the reasons for the drop in performance. SuB advised there were two main issues. The documentation used in ED had been re-printed with the dementia question omitted. This documentation has now been amended. There was also an issue with reporting as this was an administrative process and patients were not followed through. This is now looked at from a clinical perspective. TR acknowledged there were some mitigating circumstances for the drop in performance. The Quality Committee has requested a trajectory for when performance should return to 90% across all three areas. There will be less opportunity for screening to be missed with the next release of Nervecentre. JM sought clarification regarding the issue of GP referrals. SuB confirmed patients are being referred to their GP. The issue related to patients who had been discharged when the audit was completed and it had been identified they had been missed for screening. It was noted some assurance was required that these patients were being followed up. SuB advised there was one avoidable Grade 2 pressure ulcer in February, but no Grade 3 or Grade 4s. In relation to the staffing position, there is one amber rating in the unified return but there is no direct correlation to any harm. Two tipping points were breached in relation to staffing safeguards. However, there were more than sufficient staff on duty in each case, with a minimum of four registered nurses on duty. There was no adverse harm. PM advised in February the Trust achieved 99% satisfaction on the inpatient friends and family test; this has not been achieved previously. The response rate for the Friends and Family test in ED is low. Text messages and volunteers with iPads have been trialled but this has not yielded a response rate the Trust is satisfied with. However, despite the		

	pressures within ED, satisfaction is quite high. The Friends and Family recommendations for Maternity Services have been on a downward trend for some time. The team are sighted to the issues. It is felt the issues people are concerned about are 'treatable'. The Friends and Family recommendations for Outpatients Services is also an area of concern. The decline in rating has been halted but an improvement has not yet been seen. As with Maternity Services, the issues highlighted (with the exception of car parking) are treatable. CW noted other trusts are achieving higher return rates for the Friends and Family test than SFHFT. Ways to improve the return rate should be investigated, but in a way that doesn't compromise patient care. ***Actions:*** • ***Ways to improve return rate for Friends and Family Test to be considered and compared to other similar trusts*** **OPERATIONAL** SiB reported the Trust achieved 89% against the target of 95% for the 4 hour standard in February. This ranked SFHFT 25th of 137 trusts. 18.7% of ambulance handovers waited over 30 mins, representing a 6.5% improvement on January. The key issue identified is the mismatch in demand and capacity. The usual trend is for the number of admissions to fall over the weekend, but this has not been the case. This creates issues with patient flow as the Trust does not discharge the same level of patients at the weekend. There are three workstreams, each led by a clinician, looking at these issues. Steps being taken include looking at what pathways can be created to safely stream patients round the Emergency Admissions Unit (EAU) and increasing ambulatory care. A contingency plan is being developed to look at how the Trust manages external decommissioning of capacity. The Trust is trying to improve the ambulatory care model at weekends. In addition, a weekend discharge team is being trialled who will visit wards and identify patients who can safely be discharged at the weekend. AH advised the Trust has recruited substantively to established middle grades within ED. Interviews will take place week commencing 2nd April 2018, with the expectation this will lead to a substantive team of consultants in ED, which will strengthen the Trust in terms of safety. AH reported through the mortality surveillance group it is known that all deaths which occurred within ED, EAU and geriatrics were reviewed using the mortality review tool and 80% of deaths in medicine were reviewed. This has highlighted that none of the deaths were avoidable. NG noted the 95% 4 hour wait target has not been achieved since July 2017 and, as a result, the Trust has lost £3m Sustainability and Transformation Funding (STF). Given not all beds in EAU were available due to staffing issues, and the Trust has kept within the agency cap, NG queried if STF funding could be protected by breaching the agency cap, thus providing more staffing to EAU and getting a	**PM**	**26/04/18**

	better result from a financial point of view as well as dealing with more patients. RM explained STF money can't be used by the organisation to employ more staff or invest in capital. PR explained, from a purely financial perspective, NG's suggestion would breach the Trust's pre-STF control total, meaning the Trust wouldn't receive the STF funding applied to financial which is 3 times greater than the ED access STF determined amount. Cash received in respect of STF reduces reliance on loans and saves interest on loans but it is not money the Trust can invest in patient care. CW sought clarification regarding the money lost through postponing elective surgery. RM acknowledged postponing inpatient surgery was far from ideal from a patient experience perspective. The Trust has identified the longest waiting patients, cancer patients, day surgery, clinically urgent cases, etc. and those patients have continued to have surgery. Despite cancelling elective inpatient and orthopaedic cases, the Trust has maintained overall financial performance. There is a case for investing money to protect elective work but the challenge is staff recruitment as more substantive nurses are required to open up the bed base and at present there is not the huge increase in nurses to enable SFHFT to open up those beds safely. SuB advised part of the reason the Trust has stayed within the control total is the work done negotiating rates with agencies. Staffing safeguards have been developed which have clear tipping points, one of which is the ratio of substantive staff to agency staff. There have been times when the ratio of agency staff has been higher than substantive staff but the mitigation is the agency staff have been working at SFHFT for a number of months. The high usage of agency staff to allow more beds to be opened would have an adverse effect on the tipping point and put the Trust in an unsafe position. AH advised the number of patients brought by ambulance and discharged with no treatment has increased. East Midlands Ambulance Service (EMAS) has recognised this and the Trust is working with them to understand who these patients are. Various systems are in place in the community to avoid conveyance. SiB advised the 62 day standard for cancer patients had been achieved for the second consecutive month, with 90% in January. The forecast for February is 84% and 90% for March. Referral to Treatment (RTT) continued to decline in February. The identified reasons for this are imbalances in demand and capacity in cardiology and neurology. There is an improvement plan in place in cardiology. The neurology service is linked to NUH and has recently not been operational; this will restart in May. Postponed inpatient elective care over Winter has impacted on the RTT backlog and backlogs are being created by the ongoing validation work in relation to the overdue review list. Bulk closures are being considered and an audit to assess the risk of bulk closures is underway. It has been		

	agreed by the Trust Management Team (TMT) any patient identified as waiting over 52 weeks through this process will be seen within 2 weeks, with monitoring and reporting on that standard. AH advised bulk closures are being monitored through the data oversight quality group. The expectation is a recommendation of what can be safely closed will be presented to the Board of Directors in April. NG sought clarification regarding the 62 day referral to treatment from screening standard for cancer patients, noting this had not been achieved but the overall 62 day standard had been met. SiB explained it was part of the same overall standard. As the total volume of treatments apportioned to SFHFT per month is relatively small it is possible to deliver the overall standard but fail the screening standard and vice versa. ***Actions:*** • ***Data Quality Group to make recommendation to Board regarding categories for bulk closure*** **ORGANISATIONAL HEALTH** JB reported sickness absence has decreased to 4.2% in February, from 4.7% in January, although this is still above the target of 3.5%. The increased levels can be attributed to flu. Sickness absence is managed robustly. There has been positive sickness absence management over the last year so the expectation is absence levels will reduce. Given the pressures the division has been under, it was noted Urgent and Emergency Care have done well to achieve an absence rate of 3.41%. Eleven more people joined SFHFT than left in February. Medical vacancies are below the 10% threshold. There is a concern in relation to the granting of Certificates of Sponsorship for clinical fellows by the Home Office as of the seven applied for this month, only two were granted. This is due to the number the Home Office permit to go through. While the Trust will re-apply next month, this causes delays in start dates which in turn adds more pressure to rotas and increases agency spend. NHS Employers are lobbying the Home Office in respect of this. RGN vacancy rate is 12%, but the Band 5 vacancy rate is increasing which is attributable to internal promotion. Whilst acknowledging this leaves shortages on the wards, JB felt this was a positive as it shows people are choosing to have their career with SFHFT. An assessment centre was held in March and seven new nurses were appointed. Currently a lot of recruitment is from the student out-turn so they won't start work for the Trust until September 2018. JB advised appraisal performance is now achieving the 95% target and mandatory training is at 94%. CW enquired if a survey of staff had taken place to establish the reasons for people not having the flu vaccination.	**AH**	**26/04/18**

	RM advised there had been some ad-hoc feedback but agreed this would be a useful exercise. ***Actions:*** • ***Anonymised survey to be conducted to establish reasons why staff do not take up offer of flu vaccination and which staff group they belong to*** **FINANCE** PR advised that with the exclusion of STF the February position was £300k better than plan and is in line with forecast. The YTD position is £42.25m deficit, which is £450k behind plan. When STF is factored in, the position is £2.4m worse than plan YTD which reflects the non-delivery of the 4 hour ED target since July 2017. The pre-STF forecast for year end is to deliver a £45.53m deficit, which is £900k better than plan due to the receipt of Tranche 1 Winter monies from NHSI. Factoring in STF the forecast is £440k worse than plan which reflects the expected failure to achieve the ED target for month 12. However, there is now an expectation the Trust will be in receipt of incentive STF monies in respect of the £900k Tranche 1 Winter monies. The plan that was set at the start of year will be achieved. PR advised as of the end of February the Cost Improvement Plan was ahead of plan and the forecast is this will be achieved for the year. In relation to the agency ceiling, as of the end of February the position was £1.2m below the ceiling, which had been set at £10m less than last year's expenditure. It is expected this position will remain the same to year end. The expectation is to deliver the Capital Programme to forecast. The cash holding remains above plan at Month 11 and will remain so through Month 12. NG felt although there was a £45.5m loss, this has been very well controlled. JM felt with a month to go 2017/2018 had mainly been a good year, with the exception of ED performance which whilst still performing well compared to other trusts has experienced a decline in performance. This reflected activity, workforce and capacity issues across the urgent and emergency care pathways and need to be a focus over the coming months. The Board of Directors were ASSURED by the report	**JB**	**TBC**
16/757	**WINTER PRESSURES REPORT**		
15 mins	SiB advised there has been a 6% growth in admissions of patients over 75 onto the medical pathway compared to last year. Capacity has been identified as an issue this Winter as the Emergency Admissions Unit (EAU) has 12 less beds than last year. Additionally, the Trust has been unable to staff a medical ward which was available last year and there is less capacity in the community. An interim winter debrief has been completed. This identified staffing constraints as being a big risk. However, safe staffing levels have been		

	maintained. There have been two periods of adverse weather. It is acknowledged the first of these could have been better managed and improvements can be made in relation to reacting to elective care at times of adverse weather. A local cold weather plan is being developed. The Easter is plan in place. Winter capacity remains open and will remain so until the end of April. The aim is to make Good Friday and Easter Monday as near to a normal working day as possible. Extra medical cover has been made available to certain areas over the Easter weekend. Some inpatient elective care has been postponed and the Trust is working with external partners to get patients to the care they need in the community where this is appropriate. It was highlighted the Trust is in a fragile position going into the Easter period as this week has seen the highest admission level of medical patients aged over 75 than has been seen for years. SuB advised some surgical capacity has been re-designated as medical capacity over Winter. A staffing safeguard SOP is used to ensure safe staffing for nurses is maintained. An area for improvement which has been identified is to use a 'buddy' system when surgical beds are changed over to medical beds as lack of expertise has been a concern for staff. AH advised extra shifts have been put in place, particularly in middle grades, in ED and EAU. These will remain in place until the pressures start to ease. The lessons learned from this Winter will be taken into account when planning for next year. Capacity has not been flexible this Winter. There is a need for better system escalation and strong internal plans. In addition, system wide capacity needs to be better understood. RM advised an update review on Winter will be presented to the Board of Directors in April. The four main issues are staffing levels and concerns that substantively surgical wards have been used as medical wards, there were a number of days linked to snow where elective work was postponed, at times of pressure the Trust needs to ensure it doesn't overly focus on flow as opposed to individual patient's needs and the recognition that at times of pressure difficult conversations can take place between staff. The Board of Directors were ASSURED by the report		
16/758	**ASSURANCE FROM SUB-COMMITTEES**		
33 mins	**Audit and Assurance Committee** RD presented the report, advising the Annual Counter Fraud plan had been agreed. It was noted 4,400 staff have completed the Counter Fraud e-learning package. The Internal Audit plan for 2018/2019 has been agreed, with some emphasis on cyber security. The new external auditors, PwC, will be taking a more active role in some areas which were previously internal audit's responsibility. A progress report for internal audit was received which confirmed the Head of Internal Audit Opinion would be available by year end; a positive response is expected from this.		

	An internal audit report with limited assurance in relation to Delayed Transfers of Care was accepted on the basis of the improvement plan which is in place. A report in relation to the IG toolkit was presented with limited assurance. A lot of work has been completed in response to the report and the Audit Committee were assured the reasons for the result was timing issues. However, some lessons have been learned from this. The reporting for the 4 hour wait target is now based on SystmOne only. This should greatly reduce the issues identified by 360 Assurance. A further review will take place in 2 months' time. The Trust is on track to meet the deadline of 25th May 2018 for compliance with General Data Protection Regulation (GDPR). A risk analysis has been completed in relation to the Trust's FM providers following the Carillion situation. This has not highlighted any concerns. Conflicts of interest declarations is an area of concern as 291 staff are non-compliant. SH confirmed emails have been sent to the relevant staff and their line managers have been contacted. From 1st April 2018 the declaration is required annually. Therefore, on 1st April 2018 everyone will be non-compliant. RD enquired if this could be considered as part of the appraisal process. JB advised the appraisal paperwork is due to be relaunched. There will be a set of paperwork for Bands 8a and above. Therefore, a checkbox for this could be included. RD advised the Single Tender Waivers report was approved, noting a significant reduction in value compared to the previous 2 years. The Audit Committee Terms of Reference were reviewed and a Committee Effectiveness Self-Assessment was completed. **Finance Committee** NG presented the report, advising the Finance Committee had considered the BAF principle risk 4 (Financial Sustainability) and doesn't propose any change to the overall score at the moment, recognising the risks remain. However, it is hoped the rating can be lowered during 2018/2019. The first draft of the 2018/2019 plan was submitted. However, it was identified more work is required to finalise the plan, particularly in relation to Financial Improvement Programme (FIP) and divisional plans. There are over 170 initiatives in place for 2018/2019 but very few of these have firm plans against them. Further work has since been undertaken and the opportunity of £11m to £19m for FIP for 2018/2019 has been identified. The Finance Committee are not yet assured on the plan, recognising more work is required. The Finance Committee were asked to consider the renewal of the Medway PAS system. NG felt it inappropriate to present this item to the Finance Committee without any prior notice, given approval was sought		

	for expenditure of approximately £2m over 7 years, which the Board of Directors would in turn need to ratify. In addition, a possible issue in terms of a single tender waiver was identified. The Finance Committee requested the Head of Procurement go back to the supplier and seek a better deal. The Surgery Division appeared before the Finance Committee for the fourth time as the forecast outturn had changed by £0.75m since last month. However, the reasons for this were noted as cancellation of elective work and poor weather. It was acknowledged these factors were out of the Division's control. There is more confidence the Division can deliver their plans for 2018/2019. The Finance Committee were assured by the performance of NHIS. The issue of cyber security was discussed. Assurance was received that a lot of the old operating systems will be phased out by the end of Q1 of 2018/2019 and the servers will be upgraded. It was noted SFHFT is ranked 108th in relation to procurement performance. However, factors were identified which meant SFHFT were being compared unfairly to other trusts. The initial report suggested a gap of £1.2m in our buying as against the average for the sector. However, when the identified factors were taken into account the 'real' gap is £0.6m. The procurement team is now working on this gap using a pareto approach to identify where further savings can be made. The audit fee in respect of the appointment of PwC as external auditors was approved, noting this is slightly higher than the previous auditors. The Finance Committee's Terms of Reference were approved and a Committee Effectiveness self-assessment completed. JM noted cyber security had been highlighted in the report of both the Audit and Assurance and Finance Committees. Clarification regarding the governance process is required to avoid duplication. In relation to the Medway issues, the Audit Committee should confirm the Standing Financial Instructions (SFI) were followed. Additionally, guidance should be developed for the Executive Team to ensure major issues are presented in a timely manner. ***Actions:***		
	• ***Clarification required regarding governance process for cyber security***	**SH**	**26/04/18**
	• ***Audit committee to establish if Standing Financial Instructions (SFI) process was followed in relation to renewal of contract for Medway PAS System***	**PR**	**26/04/18**
	• ***Guidance to be developed for Executive Team regarding major issues being presented to sub committees in a timely manner***	**PR**	**26/04/18**

	Quality Committee TR presented the report noting the work undertaken by the Patient Safety and Quality Group (PSQG) and the way the group has developed over the last year. The significant progress in terms of recruitment within ED was noted which will put the Trust in an improved position. The CQC insight tool has been used as a proactive approach to identify areas of progress. A Committee Effectiveness self-assessment has been completed and the Terms of Reference reviewed, with some adjustment to reflect the responsibilities of the Quality Committee in relation to workforce. The PSQG requested additional assurance in relation to the security and storage of controlled drugs. It was identified further work is required to better understand the current position and to determine whether this is a declining or improving situation. The Advancing Quality Programme was noted as being an integral part of underpinning the quality strategy. The BAF was reviewed and while noting the current risk ratings remain, more focus and work is required in the future to consider where the risk may be more than the current rating. The Board of Directors were ASSURED by the report		
16/759	**UPDATE SERIOUS INCIDENTS AND NEVER EVENTS**		
9 mins	PM advised YTD 28 incidents have been reported as Serious Incidents in accordance with the current framework. It was noted the current framework is being reviewed by NHSI. The outturn for 2017/2018 is the same as 2016/2017. There have been two Never Events in 2017/2018 and the Board of Directors was briefed on those in December 2017. 50% of the Serious Incidents this year can be accounted for by two issues, falls involving serious harm and delays in diagnosis or treatment. The other issues are one offs. In relation to falls, any fall resulting in a long bone, sternum, skull or pelvic fracture is regarded as serious harm. In these cases, if a defect in care was identified through the investigation, the fall would be classified as a serious incident, bringing SFHFT into line with other organisations. This has increased the number of falls designated as serious. A causal factor analysis has been completed to identify any underlying issues. Human factor has a significant role in causation of serious incidents as staff do not always follow policy and procedure at critical points in the patient's journey, which is compounded by poor communication, leading to errors or erroneous decision making. Other issues identified are poor design of the control framework and policies are not as clear as they could be or are too voluminous for staff to work with. The nature and complexity of the patient's clinical condition is another factor as increasingly SFHFT is treating more complex cases. Work is ongoing to address these causal factors by strengthening and clarifying policies and procedures, putting emphasis on training, education and support as people learn those procedures, strengthening the process of personal reflection and raising awareness when seeing		

	patients. In relation to the Never Events, the conventions for marking in dermatology have been reviewed to ensure the operation is in the correct anatomical area and a culture of check and challenge is being instilled. The Trust is meeting its Duty of Candour obligations. It was noted there was one incident where duty of candour was not completed on the advice of the Police as to do so would have compromised their investigation. It was noted two serious incidents in February may be stood down in due course when the review into these is completed. The Board of Directors were ASSURED by the report		
16/760	**STAFFING GAP ANALYSIS**		
1 min	SuB reported a gap analysis had been completed against three national documents in relation to nursing workforce. The gap analysis shows five areas the Trust needs to focus on. For each area of shortfall, SFHFT has systems in place and these will be reported through the Nursing Taskforce Steering Group. The Board of Directors were ASSURED by the report		
16/761	**STAFF SURVEY REPORT**		
10 mins	JB reported SFHFT had committed to surveying all staff on the last staff survey, which was completed in 2017. Over 2500 staff responded, which is a 57% response rate and places SFHFT 7th highest of acute trusts in England. It was felt the results of this survey were more valid than previous surveys due to the higher response rate. SFHFT is placed in the top 10 of acute trusts in England in a number of result areas and there are only 5 of the 32 key result areas where the Trust is below the average for an acute trust. While the results are pleasing, areas for improvement have been identified. One area which has been highlighted is staff are feeling under pressure to attend work if they are unwell. Whilst maintaining rigour in this area, the sickness absence policy and approach will be reviewed. There has been an increase in the number of staff who witnessed potential harmful errors or incidents. Whilst it appears this score is worse than the previous survey, feedback suggests this could be due to staff being aware of better practice. There has been a sustained improvement in results. In the 2015 survey only 48% of staff would recommend SFHFT as a place to work, this has increased to 70% in 2017 against the national average of 61%. Additionally, in 2015 57% of staff would recommend the Trust as a place to receive care. This has increased to 78% in 2017 against the national average of 71%.		

	Divisions have presented their results and action plans which will be monitored at monthly performance meetings. 200 individual comments were received from staff and these have been provided to the divisions. Other actions being taken include staff drop-in sessions and undertaking a Pulse survey as follow-up. JM noted there appears to be a theme of bullying, harassment and violence from patients, members of the public and other members of staff in the bottom five result areas. More work is required to establish the reasons for this. TR noted no issues had been raised through the 'Speak-up Guardians'. CW queried if any feedback had been provided through discussions with the trade unions. JB advised no particular information had been received. The only theme identified from the comments is some teams can be cliquey, rather than any major issues being highlighted but when considering the survey result for teamwork, SFHFT was placed the fourth best acute trust in country, so the results don't correlate with the comments. RM advised only small numbers of staff at SFHFT and in other organisations have highlighted this as an issue. ***Action:*** • ***Actions to address the areas where concerns were highlighted in the Survey and the conclusions from the focus groups should be brought to the Board of Directors*** The Board of Directors were ASSURED by the report	**JB**	**26/07/18**
16/762	**GENDER PAY GAP REPORT**		
7 mins	JB advised publication of gender pay gap information is a new legislative requirement. The published information is based on six calculations and will be published annually, using data from the previous year. The first deadline is March 2018 and the published information is based on data from March 2017. The mean and median averages are published to identify the proportionate difference between average male and female pay. Both basic pay and bonus difference are reported. Most trusts are suggesting the median average for basic pay is the most useful figure to consider. Given the different numbers of males and females in the workforce it is better to use the median rather than mean figures. SFHFT's median average is 16.62%, which is about average for trusts. The significant factor affecting this figure is medics' pay. If medics' pay is not included in the calculations, the median gap is in the region of 1.5%. Medics' pay also affects the figures for bonuses as medics' discretionary points and Clinical Excellence Awards (CEA) form part of these calculations.		

	CEAs are cumulative and the amount received is affected by length of service and length of time as a consultant. SFHFT has a higher proportion of male consultants who are getting towards the end of their careers. Therefore, they will have received more through CEAs. New arrangements for CEAs are being introduced and in future they won't be cumulative and will be non-pensionable so the gap will start to change. This issue is not specific to SFHFT as it applies equally to other trusts. The aim is to encourage more female applications to these roles. Other actions being taken are in relation to Leadership Talent Mapping and Succession Planning Work and this will include gender and diversity matrix. The Board of Directors were ASSURED by the report		
16/763	**DIVERSITY REPORT**		
6 mins	JB presented an update on the work of the Gender and Inclusivity Group, which is led by HR and includes a range of attendees. The Group sets objectives for the year which covers services and employment. In relation to workforce, the focus has been on encouraging networks and undertaking analysis. A diversity dashboard is produced and one area this identifies is recruitment trends. From this it has been identified there is slightly less chance for someone who declared a disability to be shortlisted and appointed and there is a slight preference for appointing men. However, the numbers are low so it is difficult to establish if this is a specific trend. SFHFT is working in partnership with Remploy to introduce an Access to Employment Scheme to the Trust. A number of charters are subscribed to and work is ongoing to encourage more staff to report under diversity arrangements through ESR. Various initiatives will continue, for example, Black History Weeks, open days and sessions. TR acknowledged people don't have to register a disability and there is a challenge to encourage that demographic, and any other less represented groups, to get involved. TR queried if apprenticeship schemes could be used to encourage recruitment and for positons to be ring fenced initially. JB advised the Remploy scheme covers some of these elements, but it is something to consider further. CW queried the figures for 'Trust Board from BME background' and why 11.54% is showing as not stated as the figures suggest more diversity at Board than is the reality. JB advised guidance can be issued to staff on how to amend their record. The Board of Directors were ASSURED by the report		

16/764	**IG TOOLKIT SUBMISSION**		
2 mins	PR reported the current score, and what will be submitted, is 92% satisfactory. No standards are reported at Level 1 and the number at Level 3 has increased by 11 compared to last year. A limited assurance report had been received from 360 Assurance in relation to the Trust's preparation for IG Toolkit submission. This week 360 Assurance have undertaken further scrutiny on evidence, submission and the Trust's self-assessment, the outcome of which is they consider their opinion to be consistent with the submission. The Board of Directors were APPROVED the submission		
16/765	**CONFLICTS OF INTEREST REGISTER**		
1 min	SH presented the report and confirmed the Conflicts of Interest Register is published on the Trust website. The Board of Directors were ASSURED by the report		
16/766	**COMMUNICATIONS TO WIDER ORGANISATION**		
1 min	The Board of Directors agreed the following items would be distributed to the wider organisation:- • Strategies • Balance on performance - acknowledging it has been a good year but areas of focus are known • Patient story • Staff survey • Gender pay gap • Diversity		
16/767	**ANY OTHER BUSINESS**		
1 min	RM expressed public thanks to charitable funds for their support in providing staff and volunteers with hot cross buns and hot drinks as a gesture of gratitude for their support over Winter.		
16/768	**DATE AND TIME OF NEXT MEETING**		
	It was CONFIRMED that the next Board of Directors meeting in Public would be held on 26th April 2018 in the Boardroom at King's Mill Hospital at 09:00. There being no further business the Chair declared the meeting closed at 13:30.		

16/769	**CHAIR DECLARED THE MEETING CLOSED**		
	Signed by the Chair as a true record of the meeting, subject to any amendments duly minuted. John MacDonald **Chair** **Date**		

16/770	**QUESTIONS FROM MEMBERS OF THE PUBLIC PRESENT**		
	No questions were raised.		