Sherwood Forest Hospitals NHS Foundation Trust
('SFH', 'the Trust' or 'the Board')

Owing to matters of commercial sensitivity these Minutes are considered exempt under the Freedom of Information Act 2000.

Unconfirmed **MINUTES** of a Public meeting of the Board of Directors held at 10.00 hrs on Thursday 24th September 2015 in the Board Room, Level 1, King's Mill Hospital

Present:	Sean Lyons	Chairman	SL
	Claire Ward	Non-Executive Director	CW
	Ray Dawson	Non-Executive Director	RD
	Dr Peter Marks	Non-Executive Director	PM
	Tim Reddish	Non-Executive Director	TR
	Mark Chivers	Non Executive Director	MC
	Neal Gossage	Non Executive Director	NG
	Karen Fisher	Acting Chief Executive	KF
	Paul Robinson	Chief Financial Officer	PR
	Susan Barnett	Chief Operating Officer	SBa
	Dr Andrew Haynes	Executive Medical Director	AH
	Graham Briggs	Interim Director of Human Resources	GB
	Peter Wozencroft	Director of Strategic Planning and Commercial Development	PW
In attendance:	Joy Heathcote	Minute Secretary	JH
	Yolanda Martin	Head of Communications	YM
	John Kerry	Member of the public	JK
	Victoria Bagshaw	Deputy Director of Nursing & Quality (deputising for Susan Bowler)	VB
	Gillian Hooper	Improvement Director	GH
	Helen Flear	Turnaround Director	HF

		Action	Date
	CHAIRS WELCOME AND INTRODUCTION		
015/184	The meeting being quorate, SL declared the meeting open at 10.00am and confirmed that the meeting had been convened in accordance with the Trust's Constitution and Standing Orders. SL welcomed Victoria Bagshaw, Helen Flear and Gillian Hooper to the meeting. KF confirmed that discussion had taken place with Monitor and at the Trust and it had been agreed that it would be beneficial for HF and GH to attend both public and private Board of Directors meetings and to be involved in Executive Team activities. The Board welcomed this decision.		
	DECLARATIONS OF INTEREST		
015/185	It was CONFIRMED that there were no declarations of interest relating to items on the agenda.		
	APOLOGIES FOR ABSENCE		
015/186	It was CONFIRMED that apologies for absence had been received		

	from Susan Bowler, Executive Director of Nursing & Quality and Shirley Clarke, Deputy Director of Corporate Services.		
	PATIENT STORY		
015/187	SL confirmed that patient stories would be presented by two of the Trust's Non-Executive Directors regarding their experiences of care and treatment at the Trust. Dr Peter Marks (PM) provided details of his own treatment at the Trust during the summer of 2015. PM had been travelling with his wife and had experienced severe pain, resulting in his wife having to drive and bring him to the Emergency Department (ED) at King's Mill Hospital. PM suspected a kidney stone. He arrived at ED at 1.15pm on a Monday and was booked in and triaged which was carried out in a timely manner. The department had appeared to be relatively quiet until he was called through to a cubicle. The department then appeared to be full and there were a significant number of ambulance staff around, the Trust was also on black alert. PM was examined by a doctor and sent for a scan and was then admitted to SAU, before being transferred to a ward. Generally the care and treatment received was good and staff were caring and professional. The single room on the ward was clean and comfortable and the standard of food was very good (with the exception of the toast)! Staff had not been aware of his connection with the Trust until senior members of staff started to visit. PM then highlighted what had not been so good with his treatment. **ED** – the curtains were not sound proof and he had heard conversations within the department that he should not have done. **Ward** – PM's ward board had only been updated once in 3 days. **Radiology reporting** – on the radiology report it was recorded that the size of the kidney stone was 14mm which could not be passed on its own. The doctor had been surprised that PM was as comfortable as he was with the size of the stone. It was then discovered that the stone was 4mm, rather than 14mm which had been a typing error. **Medication issues/errors** - whilst in ED, PM was told that he would be written up for pain relief which he had to wait a further 3 hours to receive, as it had not been written up in the notes. PM had been asked on 5 separate occasions what medication he was taking, yet this had not been written up on the notes. A doctor		

	came to see him at 3am to write up his medication. PM was told that the Trust did not use diclofenac which was written up for pain relief so this was not given during his stay. This was only resolved at discharge when a pharmacist changed it to naproxen. PM confirmed that medication errors were regularly considered at the Quality Committee and suggested that this type of error should be flagged up as he wasn't clear if these would be captured. **Discharge planning** – on the first day, PM had been told that he would be seen by a Urologist and would more than likely be discharged home. He actually remained in hospital for 3 days whilst the Trust was on black alert which may not have been necessary. It had appeared that nobody wanted to discharge him and the length of stay had not been necessary as he could have come back for a blood test rather than staying in a bed. Claire Ward (CW) provided details of the treatment received by her husband at the Trust very recently. Her husband had severe stomach pain and visited his GP, who referred him immediately and asked him to go straight to SAU at King's Mill Hospital. He arrived at 1pm on a Friday. CW then visited him around 5.30pm. She had gone to SAU to find that nothing had yet happened to treat her husband, although he was nil by mouth due to a CT scan being required. At around 6.30pm the doctor attended and told him that he would be able to eat so a sandwich was provided, shortly afterwards, he was stopped from eating as he was required for a CT scan. The pain had got worse and following the scan, his diagnosis was diverticulitis. He was to be admitted. The porters were called at 9pm to transfer him to ward 31 and it was 2 hours later when a porter arrived, which meant that he did not arrive on the ward until 11pm, resulting in disruption to the ward. The drug chart was not in the patients notes so they had to chase SAU. When CW visited the following day, her husband was on intravenous antibiotics and fluids. The GP had sent a list of his usual medication in with the patient. CW had brought his own drugs to the hospital but the nurse had explained that she could not administer them as they were not written up in his notes. CW referred to the GP letter in the patient notes, which she again referred to when the doctor visited later on. After several references to medication, a doctor finally agreed to write up the medication in the drug chart. The patient was asked several times during his stay what medication he was on and CW referred doctors and pharmacists to the patient notes again. CW also highlighted privacy as an issue as on occasions the doctor had spoken very loudly when visiting people on the bay. All the staff were caring and kind. The biggest issue had been the		

	lack of pace, e.g. drugs being provided quickly and there was also a lack of information regarding what to expect. The doctor was very nice but had not read the patient notes therefore telling her husband that he should go to his GP in future rather than presenting straight to SAU - which he had done. The discharge process had been very challenging and the patient was told on Tuesday at 9.30am that he could be discharged but it was several hours before the necessary paperwork was completed, with staff admitting that required signatures had not been given. Whilst in hospital her husband had been taking his usual medication only to discover prior to discharge that staff had also been giving him this medication. It raised the issue of how patient self medication was monitored and recorded. Staff were concerned about whether to allow him to leave until they were confident that there were no ill effects from the double dose. When they did arrive home, they were unsure from the documentation what medication he had been given from the information provided. The food had been very good. SBa noted that in both cases this had not been safe, personalised care, which the hospital aspired to provide. PM we are able to articulate the issues where others might not be able to and highlighted the vulnerability of being a patient and of raising concerns, where if it was someone else you would say something. SBa highlighted that there were some significant issues which had been described and some of these types of issues had been recognised and a series of "breaking the cycle" events had been scheduled as part of a national programme. The first event would be held on 1st October with further events being held over the following 6 weeks. The first session would focus on improving medication to take out, patient discharge by 10am and discharge to ambulatory care. The events would be led by clinicians and each event would have a different theme leading to change and organisational learning. PM I had a delay; the day before I went home they said I needed blood test. I did not see a Consultant all the time I was on the ward. GH welcomed the "breaking the cycle" events and the topics that they would cover. The issues that had been highlighted by PM and CW presented high risk. Policies and protocol around self-medication. Second was data quality and the need to understand how the error occurred in recording a 14mm stone, rather than 4mm. The third issue was clinical supervision of junior doctors, as these people might have only been working at the Trust for a month. The clinical diagnosis should always start by looking at the		

	patient notes, which was fundamental. CW also said that she felt really sorry for the nursing staff due to the drip stands and monitoring equipment as it never seemed to function properly and an inordinate amount of time was spent dealing with the equipment and the alarms which sounded. VB highlighted that it was key to ensure the equipment was set up correctly in the first instance. TR highlighted that this again went back to brilliant basics. VB confirmed that there was awareness of the issues that had been highlighted and work was taking place with nurses to consider the fundamentals, quality of care and what 'good' looked like. There was a requirement to reflect on what was stopping staff providing good care. In response to VB, PM confirmed that someone did come back to him to check that the analgesia was working. VB highlighted the importance of checking with patients that the treatment given had worked. In response to SL, it was confirmed that the themes of clinical supervision, data quality and medication errors had been captured and would be addressed by SBa and VB. In response to KF, CW confirmed that the staff were caring and had been both embarrassed and frustrated and had apologised to them regarding the issues that had arisen regarding discharge. PM agreed with these comments and highlighted that it was the nurses who had to deal with these issues constantly whereas the doctors would visit patients but then leave the ward. VB noted that it was the nurses that monitored the care of the patients. SL emphasised the power of hearing these stories and thanked PM and CW. GH noted that this was about expertise in delivering care. MC endorsed the thoughts regarding the care and and his observation would be that doctors and HCAs should be included whilst patient stories were being delivered. In response to SL, HF confirmed that from a turnaround efficiency view, such issues as efficiency and length of stay greatly affected turnaround.	SBa/VB	Nov 2015

	OUTCOMES RE LAST MONTH'S PATIENT STORY		
15/188	No follow up action was required from the volunteers story at the last meeting, however SL gave recognition that one of the Trust's volunteers, Barbara Read had just passed 50 years of service at the Trust and it had also been her 90th birthday.		
	MINUTES OF THE MEETING HELD ON 30th JULY 2015		
15/189	Following review of the minutes of the public meeting held on 30th July 2015 the following amendments and updates were provided: • Page 7, para 1 – GH confirmed that further work had been undertaken to re-format and strengthen the Quality Improvement Plan (QIP) and that there was some good work in progress. • Page 8 – tracked changes to be removed from document. • Page 9, para 9 – JH to clarify statement "day of death rather than date of admission" with AH.		
	MATTERS ARISING/ ACTION LOG		
15/190	The Matters Arising/Action Log from the meeting held on 30th July 2015 was considered and the following updates were provided: • **Item 3** – KF outlined wider discussion regarding staff engagement as a strategy had been presented previously which was really a process. Further discussion to take place at the private Board meeting on 24th September as there were further actions. • **Item 44** – SBa confirmed that a meeting regarding Urology would take place the following day and she would ask Nick and John to provide an update at a future Board meeting. • **Item 47** – VB confirmed that the Patient Experience Report had been strengthened and would report to the October Board meeting. National themes had been considered and the reformatted report would provide assurance. It was agreed that NG would review the report for appropriateness ahead of presentation at the next meeting and at the request of VB, GH would also review the report. PM clarified that the aim was to combine learning between complaints and incidents as there were some common themes. • **Item 49** – GB had spoken to the relevant Business Partner to ensure that the increase in bed complement was correct. The Board accepted the updates provided.		
	CHAIRMAN'S REPORT		
15/191	SL presented the Chairman's report which provided details on		

	progress, plans and regulatory developments for the Trust. Directors noted updates regarding Monitor Activity, CQC Inspection, Membership Activities, Governor Activities, Board Appointments, AGM, CCG AGM's, Staff Excellence Awards, Fundraising & Donations and Patient/Family Interaction. SL reported that the AGM had been a successful event. TR noted that the video had been excellent in highlighting the good work being carried out and suggested that there could be improvements in the Trust communications and the use of digital boards around the Trust to highlight successes. VB confirmed that it had been a great success but noted that not many staff had been in attendance. With regard to patient/family interaction, SL had two experiences to report. Firstly, he had met a gentleman who had been an inpatient on ward 24. The patient had been told that he was going to be discharged on the Friday and he was concerned that his flat was locked and he couldn't get the keys. The patient had drug related issues and as the Trust had passed him as fit to go home he didn't know what to do about it. SL had contacted the discharge team who had been very helpful. The following day, SL had seen the patient in the WH Smith outlet at the Trust and the patient was explaining to the staff there that a locksmith had been arranged to change the locks and a care package was in place for him to go home. SL then spoke to the patient again and it was very uplifting to hear this story and wished to share this with the Board, noting that staff had taken appropriate action to support this vulnerable patient. Secondly, SL had met a family on site and had asked about the care they had received. The patient was in his mid-eighties and was receiving treatment for bowel cancer and they said that the care and treatment had been fantastic. The family had experienced some difficulties regarding communication when they had contacted the Welcome Treatment Centre, as they required advice on what they could do to assist. The family were anxious about their mother and they could not get the information they required. SL had reported this issue through the appropriate channels but noted that although the care was good, there were issues with administration and communication that had caused anxiety to the family. The Chairman's Report was noted.		
	CHIEF EXECUTIVE'S REPORT		
15/192	KF introduced discussion of the Chief Executive's report which		

	highlighted recent events and developments. With regard to the new rules for nursing agency spend, KF confirmed that a response was awaited regarding the new procurement arrangements from 19 October. PR confirmed that there would be further discussion the following day to ensure this was driven forward. KF confirmed that the Trust had put forward six entries in this year's prestigious HSJ Awards and was delighted to report that Samantha Musson, Team Leader in the Women's Health and Continence Physiotherapy service, had been shortlisted for the 'Rising Star' category at this year's HSJ Awards. This was fantastic news. SL suggested that Samantha should be invited to join the Board so that her success could be recognised. The Star of the Month award for July had been presented to Brent Gillicker, ODP, Theatres, and Lee Scothern, Theatre Support Worker who were nominated by Dale Travis and Liz Williamson for their excellent work on improving patient experience through theatres. PM noted that this was a particularly good story, with really good work taking place and he felt that this learning should be shared with other areas. He also felt that the write up was very short and could have been extended. A Horizon Scanning Schedule had been included as an appendix to the report which provided an update on key reports relating to the NHS and in response to SL, KF confirmed that the Executive Team would consider the most appropriate way to keep the Board informed. The Chief Executive's Report was noted.		
	QUALITY AND SAFETY MONTHLY REPORT		
15/193	VB introduced discussion of the Quality and Safety Monthly Report highlighting that the latest data confirmed that the Trust's HSMR was now less than 100. Work also continued to improve the management of sepsis and reduce sepsis related mortality. The CQUIN for Sepsis was aligned with the piece of work being undertaken for the CQC. Significant work had been carried out relating to inpatient falls and at a recent meeting, it had been agreed to change the reporting of falls causing harm as part of the CQUIN targets. Patients falling with a resulting fractured neck of femur would now be captured on the risk register as severe or catastrophic harm and downgraded		

	as necessary, rather than the other way round. With regard to falls, PM welcomed the work undertaken but did not have a sense of where the Trust should be and what was "good" and it would be helpful for this to be reflected on the scorecard. He said that there needed to be an understanding of what the impact of being in hospital and having a fall had for the patient. It was highlighted that the current contract with the external provider for the Friends and Family Test (FFT) would terminate in January 2016 and alternative options were being explored. One of the options was a refreshed package relating to Saviance where FFT and patient experience would be incorporated into this system and a pilot was currently being undertaken in Clinic 6. Directors noted that Nurse Revalidation would be introduced by the Nursing and Midwifery Council (NMC) in April 2016 and the Trust was well organised to meet this challenge. Changes to the rules had now been implemented for lapses in NMC registration and it was noted that this could take between 2 – 6 weeks for revalidation and readmission to the register. The Trust's approach to this would need to be strengthened to ensure that revalidation took place and VB would discuss whether changes were required to the policy with GB. Significant work was being undertaken with nurses and midwives. KF confirmed that there was a clear policy in place which set out the requirements for registration. In terms of numbers the Divisional Matrons would monitor this in line with representative bodies. The minutes of the Nursing & Midwifery Board would be considered at the OD and Workforce Committee. GH outlined the assurance processes and confirmed that the NHSE/CCGs and Monitor had established an Oversight Group, with the first meeting taking place on 25th September. This was a positive and constructive way forward. With regard to feedback on falls, PW noted that the Quality Account included quite a lot of narrative on falls and would describe the new processes. In response to PM, KF confirmed that the Sepsis Action Plan would be considered by the Executive Team. MC referred to the Friends and Family Test (FFT) and noted that this was undertaken to understand our customers and patients much better and to ensure improvements in patient experience in the organisation. It now appeared that there was an IT issue in approving the bolt on to Saviance and there had not been a paper presented at the Finance Committee the previous day.	VB	Nov 2015

	VB explained that as the financial implications were below £50k, a Business Case would be presented to the Commercial Development Group ahead of approval at the Trust Management Board. **Nurse Staffing Report** VB presented the Nurse Staffing Report confirming that the most challenging areas had been ED and Ward 43, due to the level of care required. A further recruitment event would be held on 26th September and the Trust was considering all options to ensure that Registered Nurses were recruited to fill the gaps. PM requested an explanation of what 100% meant as on some occasions there had been a 120% fill rate on the wards and he questioned whether this was required. There had been increasing incidence of less than 100% and EAU was a concern as this was a high risk area. VB confirmed that there would be a different report the following month as consideration had been given to the style of reporting. This would include monitoring of the acuity and dependency of patients which had not been reported previously. With regard to the percentages, 100% was what was on the roster 6 weeks previously and consideration was given to acuity and dependency and the staffing levels required to address this. Where deficiencies were identified, consideration was given to where staff could be moved around the wards to ensure safe care. SL recognised the significant work being undertaken relating to acuity and dependency and the level of information provided and sought further assurance on whether this resulted in the Trust providing safe care. VB agreed that further triangulation was required across all areas and asked colleagues to provide detailed feedback regarding the changes to reporting which would be presented the following month. TR welcomed the confirmation that a 90% fill rate was the norm and felt that it would be useful to have a 1 – 2 page highlight report that confirmed what the percentage was, the acuity and dependency of patients and that it was safe. PM asked for clarification of which committee was best placed to consider this detail as it was not presented at Quality Committee meetings. KF confirmed that a discussion would take place at Executive Team as to whether this should be considered by the OD and Workforce or Quality Committee. In response to NG regarding monitoring of nurse staffing levels, VB confirmed that this should be completed throughout the day and at 10pm to ensure safe staffing at night times.	KF	Nov 2015

	SBa noted the significant work that had been undertaken over the past 6 weeks which was perhaps not reflected in the report and it would be important going forward that the Board received appropriate information.		
	INTEGRATED PERFORMANCE REPORT		
15/194	SBa discussed the detailed report of the Trust's performance confirming that there were 2 Monitor compliance points which related to underachievement against the RTT incomplete pathway standard and the 62 Day Cancer standard. As a consequence of the Trust's financial and performance risk ratings the Trust remained in breach of its authorisation with automatic over-ride applying a red governance risk rating. SBa confirmed that additional detail had been provided by specialty this month and the report would become more integrated. For August, the incomplete pathway RTT standard was achieved at 92.35% against the 92% standard. Areas of non compliance had been identified and within max fax, this was due to unplanned sickness and in vascular, this was reliant on the joint provision of services with Nottingham. The Trust was working in collaboration with relevant partners and weekly meetings were taking place with the CCG to address the issues, sometimes using the private sector. There had been three 52 week breaches and RCA had been undertaken for each case. From October 2015, the method of reporting would change and the 'clock' could no longer be stopped whether the patient was on holiday or for other reasons, which by definition would result in an increase in numbers breaching. ED performance had been good and Q1 had been achieved (with the exception of June) and Q2 performance was at 96%. A total of 86 beds had been closed since January 2015. Work had commenced with the National Ambulatory Care Network on how to move patients to ambulatory care and SBa had attended an Urgent and Emergency Care national event with the CCG that week which highlighted that they anticipated this winter as being worse than last winter. The SRGs had been requested to submit returns to their regulators by 12th October and there would be increased intensity on reviewing current plans. In response to RD regarding the number of beds closed since January and expected winter pressures, SBa confirmed that this would need to be considered as part of the whole health economy, taking into account any risks related to opening additional capacity.		

	SBa highlighted that the majority of patients presenting at the Trust were frail elderly, respiratory or mental health patients and in response to PM, confirmed that there was between 22% to 31% conversion rate of attendances to admission. The confidence in support from the community and improvements in processes was reliant on breaking the cycle. Consideration would need to be given to the degree of the impact of this and evaluation and the empirical evidence that suggested that where possible, it would be better if the ambulance did not bring the patient to hospital in the first place. SBa confirmed that advice from the National Team was to be prepared and that further guidance would be available in the near future. PW highlighted that Care Navigator had just been approved for implementation of the first phase in November, along with single front door and that a degree of system alignment was required. Consideration was being given to where any interventions could be accelerated. With regard to 6 week waiting times for diagnostics, SBa confirmed that the largest area related to Endoscopy, although there had been technical issues with the mobile MRI scanner at King's Mill Hospital resulting in lost capacity. In response to PM, SBa confirmed that a plan had been submitted to JAG and no concerns had been received. Updates would be provided to the Quality Committee. The 62 day Standard Improvement Plan was submitted to Monitor at the end of August 2015. This set out a detailed plan for improvement, in line with the 8 key priorities identified by the Cancer Waiting Times Taskforce (CWTT), in order for the Trust to meet and sustain the 62 day standard from February 2016. The 3 national issues related to Urology, Lung and GI and the Trust had put itself forward for the National Diagnostic Programme and looking at more direct ways through to diagnostics In response to SL regarding DNA rates, SBa confirmed that the situation had worsened and work was being undertaken to ensure improvements were made. With regard to new to follow up ratios and in response to PM, SBa confirmed that the number of follow ups coming through from the original plan was greater than the previous year. Discussion was taking place with the CCG as the local population had a different ratio to the national picture. CW noted that theatre utilisation was demonstrated as a trust wide figure rather than being broken down and SBa confirmed that this was affected by beds, outpatients and theatres. Four Eyes had communicated that there could be significant improvements in how		

	patients arrived in theatres and then once they were in theatres. There was a focus on Orthopaedic patients as these were high in numbers and all theatres had high utilisation, but there was a possibility that a theatre could be closed. HF confirmed that closing 1 theatre could save approximately £1m per year. SBa confirmed that all areas would need to be considered as there were many strands to these workstreams and this was about efficiency. In response to RD, PW confirmed that Service Line Reporting would not be completed by the end of September and that PwC had been requested to support this piece of work. Data packs had been shared with service lines and some documentation had been received on clinical performance metrics. There was a requirement to ensure that this work was undertaken appropriately with the full engagement of service managers. The process would need to be authentic and accurate and it was felt that this would extend until the end of the year and would be taken through Divisional Leadership Board meetings throughout autumn and winter. It was confirmed that Mr Irfan Akbar was now the Cancer Lead, replacing Dr Shafiq Gill. With regard to the financial position, PR confirmed that the Trust's August 2015 financial position was a deficit of £21.30m, against a year to date plan deficit of £19.06m. This represented a deterioration of £0.78m against plan in August and £2.24m cumulative year to date. The year to date position included items totalling £1.22m which were not included within the year to date plan and included £0.63m of clinical income which was under negotiation with commissioners. There had been wide debate at the Finance Committee meeting with the largest concern being medical pay. Divisions were undertaking significant work to resolve this position. Income and expenditure had presented some challenges and creditors were being pushed out during August to counteract this. In response to SL regarding medical staffing costs, HF confirmed that there had been a reforecast, although costs both pay and non pay continued to rise. KF confirmed that there would be further discussion that afternoon and deep dives would take place to identify particular areas. Directors NOTED the Integrated Performance Report.		

	WORKFORCE MONTHLY REPORT		
15/195	A detailed Workforce Report was considered. SL highlighted some areas of mandatory training, e.g manual handling and suggested that he and some other staff did not require this training, particularly as resource was an issue. GB agreed to give this further consideration. PM noted that there still remained 20% of staff that had not completed all their mandatory training and felt that this was not a satisfactory position. He wanted to know that clinical staff were up to date, particularly in terms of training such as life support. GB explained that staff may have completed 4 out of 5 of their mandatory training requirements and that there was continuing demand to add more items to mandatory training. This was kept under regular review and would continue to be reported to the Board. In response to CW, GB confirmed that there were different levels of mandatory training and a report was provided on a monthly basis for all members of staff. VB highlighted the link in terms of attending mandatory training and pressures and releasing staff to attend the training. SL asked GB to consider how further detail could be given to provide the Board with assurance and what sanctions there were for non-compliance. KF confirmed that this would be reported to the OD and Workforce Committee ahead of being presented to the Board. PM noted that there appeared to be some misalignment on this and whether mandatory training needed to be completed ahead of appraisal taking place. With regard to overseas nurse recruitment and in response to TR, GB explained that more than one offer had been made in Italy and that there was a minimum number required. In particular areas, the candidates were not of the quality expected and this comment was supported by VB. In response to PM regarding sickness absence, GB confirmed that the cumulative position was a rolling average and was 0.01% change. NG confirmed that his largest concern related to medical staffing and consideration of where the Trust should be focussing and GB confirmed that there were difficulties nationally in specific areas. Some positions were attracting increased salaries, although this would not be a long term solution and consideration should be	GB	Nov 2015

	given to using doctors in a different way, models of care and the use of ANPs, etc. In response to SL, HF confirmed that there were some inefficiencies relating to administration processes in the organisation which were currently being considered along with other projects, including the Outpatient Improvement Programme. TR reminded Directors of ensuring brilliant basics to bring about efficiencies. Directors NOTED the Workforce Monthly Report.		
	STRATEGIC NARRATIVE		
15/196	PW confirmed that the narrative complemented some parallel work to produce an analysis of service line performance and sustainability. The outputs of the two pieces of work would provide the context (external and internal) for long term strategic decisions to be made for each service. Progress has been made in recent weeks on both fronts, with the Clinical Senate (held on 10th September) providing an opportunity to share the strategic narrative more widely and gather feedback on the development of the service line analysis. Divisional Management Board meetings had also been used to encourage further dissemination of the strategic narrative and to engage clinical leaders in the service line review work. Directors NOTED the update on the Strategic Narrative.		
	MONITOR COMPLIANCE REPORT		
15/197	KF introduced discussion of the Monitor Compliance Report Board members APPROVED the submission, having carefully considered the sources of assurance presented in the paper, and their own understanding.		
	LAMPARD REVIEW ACTION PLAN		
15/198	VB introduced discussion of the Lampard Review Action Plan which had been developed following analysis of the findings and recommendations of the investigation report. An organisational wide gap analysis had been undertaken in order to identify examples of compliance and areas that required further development. SL noted that some of the actions within the plan had fallen behind the proposed completion dates. TR confirmed that the Charitable Funds Committee had adopted the policies and principles and these were currently on track.		

	PM reminded Directors of the importance of ensuring that DBS checks were up to date and SL confirmed that the Board should be kept up to date.		
	BOARD ASSURANCE FRAMEWORK		
15/199	KF explained that the BAF document was populated with a summary of the detail provided in the Board Assurance Reports (BARs). Each of the BAR's were owned by an Executive Lead and allocated to a lead committee who provided the scrutiny required to evidence assurance. RD highlighted that the Audit & Assurance Committee had not been assured by the BARs and the BAF and although these had now been updated, he had been asked to highlight this to the Board. PM confirmed that the Quality Committee had not seen the relevant BARs and that the clinical ones did not appear to reflect the current risks. In response to SL, KF confirmed that an update would be provided to the Board of Directors next month.	SC	Oct 2015
	FIT AND PROPER PERSON PROCESS		
15/200	KF confirmed that in order to ensure full implementation and compliance with the FPP requirements the following improvements had been made: • Review and revision of the policy to address concerns raised, e.g. outlining the risk assessment process, supported by clear documentation when information such as a DBS is awaited; • Full review of all personal files to ensure the required processes had been completed and the relevant documentation was in place; • Implementation of robust processes for the recruitment of new Board members, e.g. Chief Executive and Non-Executive Director. GB also confirmed that 360 Assurance had been requested to undertake a review of the whole Trust and this would be used to provide assurance to the Board. KF noted that an update should be provided annually to the Board of Directors. The Board APPROVED the proposal for 360 Assurance to undertake a Trust review of the FPP Regulations and NOTED the update provided.		

	NO SMOKING POLICY		
15/201	Directors were reminded that agreement had been reached at the Board meeting held on 31st July 2014 to sign the Nottinghamshire Declaration on Tobacco Control. Following that meeting, a Smoke Free Group was convened at the Trust and this group had continued to meet and develop the Trust's Smoke Free Policy in line with the NICE guidance NICE PH 48 (Nov 2013) Smoking cessation – acute , maternity and mental health services. The proposed Smoke Free Policy was presented and SL highlighted concerns that had been raised by Newark Hospital staff. PM confirmed that there was not an expectation that staff would challenge smokers or put themselves at risk. There would be new posters throughout the Trust, along with a communications plan and this would be a supportive move to help staff to stop smoking. It had also been agreed that use of the word challenge should be removed from the policy. YM confirmed that the posters had been completed and hand-out cards were currently being printed with details of the support available for those wishing to stop smoking. Discussion took place with regard to home visits and staff going into homes where there were smokers and the policy recommended that this was reported to the Line Manager. It was agreed that there was evidence based risk where this occurred, although there was a professional responsibility to treat patients in their homes. The policy should be amended appropriately. SL highlighted that the Board were being asked to approve the Smoke Free Policy subject to amendment regarding the issues raised. In response to CW, KF highlighted that smoking on site would require cultural change and a consistent message being given on an ongoing basis. TR welcomed the fact that the policy had been updated and suggested that the message would get through gradually and that the Trust should continue to use national initiatives to promote non smoking. SL supported the concerns raised by staff, patients and visitors that it was not appropriate for staff and patients in pyjamas and those with drip stands, etc to be outside the main entrance smoking and every effort should be made to stop this occurring. The Board of Directors APPROVED the Smoke Free Policy with the amendments discussed.		

	CAR PARKING PROPOSAL		
15/202	KF confirmed that staff car parking charge increases were transacted on the 1st April 2015 and agreement was made with the Joint Staff Partnership Forum that staff parking charges would increase by RPI each April. Patient/visitor charges had not been increased since 2011. Following review of comparable Trust benchmarks, this paper recommended a new pricing structure for Patient and Visitor parking and was recommended as a CIP opportunity. The paper took into account feedback from the Executive Team and Board of Directors Strategy Sessions during September 2015 and a further option 1a had been included which proposed a modest rise and annual RPI increase. SL confirmed that this option had been presented to the Council of Governors on 23rd September. In response to TR, PW confirmed that the revised charges would be implemented from 1st November. The Board APPROVED the increases set out in Option 1a.		
	DUTY OF CANDOUR POLICY FOR RATIFICATION		
15/203	KF introduced discussion of the update on the Trust's Duty of Candour Policy confirming that the policy was being updated to reflect current legislation and to refine the Trust's process in order to mitigate the risks to the Trust. The policy had been reviewed by Browne Jacobson, the Trust's external legal advisers to ensure that it was robust and considered all the requirements necessary to ensure compliance. These recommendations would be included in the updated policy and SL reminded Directors that once the new policy was implemented, this would need to go through the Board assurance process.		
	GOVERNOR MATTERS		
15/204	SL confirmed that there had been a Non-Executive Director and Governors event the previous year and that this had been scheduled for 1st October this year. Unfortunately, due to annual leave and other commitments, this event was likely to be rescheduled. Consideration was being given to changes to the Council of Governor committees and this item would be discussed at the event.		

	ESCALATION OF ISSUES FROM TMB		
15/205	KF introduced discussion of the items discussed at the Trust Management Board (TMB) meeting held on 24th September. The Overseas Visitors Policy was presented and approved by TMB with a request for a full implementation and communication plan to be submitted to the next meeting. The Hospitality Policy was presented and approved with a minor change to the wording regarding declarations on the hospitality register. The Head of Strategic Procurement presented an updated on how the trust was performing against the Carter recommendations. The Trust was already reviewing a number of the areas suggested in the report and were working with procurement colleagues across the region to ensure the Trust was achieving best value from its contracts and NHS supplies. The Head of Estates and Facilities presented a proposal to increase visitor car parking charges and directed members of the committee to the different options. The proposal has been discussed informally at a Board Development Session and had been distributed to the Governors for consultation. A brief Council of Governors was being held prior to the AGM on Wednesday 23rd September in order for the Governors to approve or not the proposal. The proposal was scheduled for discussion at the public meeting of the Board of Directors on Thursday 24th September. The Car Parking Policy was presented and approved subject to the inclusion of annual RPI increases to visitor parking charges being included. The annual increase of staff car parking charges was already identified in the policy. The outcome of the external review of Diabetic Podiatry was presented, further work was required to populate all of the actions identified from the recommendations and a working group had been established to complete this by the end of the month. There was discussion regarding how this group would report through the governance process and it was agreed it would be via the Divisional Management Board with escalations to TMB. There were further discussions regarding how this work 'fitted' externally as there were clear links with community provision and the overarching Better Together Programme. The Divisional General Manager for Diagnostics and Rehabilitation, on behalf of the Chief Operating Officer presented a report regarding the NHS England Assurance process for Emergency Preparedness Resilience. The Trust had self-assessed against the compliance criteria at Substantial, 'the plans and work programme in place did not appropriately address one or		

	more of the core standard themes standards that the organisation is expected to achieve'. The additional work identified was – a need to fully embed Business Continuity Plans, update some procedures and training e.g. Trusts Evacuation Plans and CBRN plans to reflect updated NHSE guidance. The Trust had invested in the role of Emergency Planning & Business Continuity Officer and this was being recruited to. TMB approved the content of the self-assessment and noted the actions identified on the action plan. **Emergency Care and Medicine** The division presented an update on the Single Front Door and informed TMB that the second phase would commence w/c 21st September. The Quality Assurance Team from the Bowel Cancer Screening Programme was scheduled to visit the Nottinghamshire Bowel Cancer Screening Centre on 7th October, although the main focus of the visit would be at Nottingham City Hospital, it was expected a small team would visit KMH prior to the main visit to review patient notes for a documentation audit. There were no known outstanding issues. An area of risk identified may be the Endoscopy admin support; the Trust was already in discussion with NUH regarding managing admin processes across both sites to mitigate this risk. A review of progress against the annual plan resulted in a discussion regarding how the risks identified on the annual plan related to the issue previously discussed. The division raised the issue of lack of capacity within the Business Support Unit to develop the robust business cases required to drive service improvements forward. **Planned Care and Surgery** On-going issues within outpatients with ASI and incomplete PTL and how this impacted on the Trust's performance against the RTT target were being unpicked. 410 patients had been identified and 67 urgent patients had been booked onto clinics. The full action plan was being led by the Divisional General Manager for Diagnostics and Rehabilitation. There had been problems recently regarding letters to patients on the Syntec system, however this had been resolved and all letters had been re-issued. This incident had been placed on the risk register, a briefing would be provided to the CCG tomorrow, 22nd September and the COO would be consulted regarding how to update the CQC. Assurance route for the outpatient programme confirmed as the Risk Committee. Risk identified regarding Theatre upgrades and Theatre 5 had to		

	close due to issues identified, the impact of this would be more weekend working as the work had been absorbed into other theatres. Community Paediatric review starting in October would require support from the Strategic Planning and Commercial Development department and finance colleagues. Vascular pathway – NUH had appointed a Programme Manager to drive this. **Diagnostics and Rehabilitation** An update on the annual plan was given. EMRAD the new PACs programme was due to be implemented December 2015 and was on target however, it had been identified that £90K of revenue had not been included in reserves. Capacity was becoming an increasing issue with the need to hire the mobile MRI up to 5 days a week from 3, the impact on this was reporting which was now a challenge and the division were considering outsourcing CT scanner reports. There were no escalations for the Board to consider.		
	REPORTS FROM SUB COMMITTEES		
15/206	**Finance Committee** – NG confirmed that the worsening financial position along with the shortfall relating to CIPs against the original plan had been considered and assurance was required on the management actions. PwC had undertaken work on the financial plan for the remainder of 2015/16. There had not been time to consider all the items on the agenda and there was a proposal to increase the committee to 5 hours. There had been questions relating to the performance report and which committees this should be reported to. The Financial Governance Action Plan had been considered and it was noted that some of the actions had slipped. **Quality Committee** – PM reported that there had not been enough time to consider all the items on the agenda and the committee would be moving to monthly meetings in future. The paper regarding the Sepsis Action Plan had been withdrawn and as this was required for submission to the CQC on Monday, delegated authority was given to KF/AH/PM to sign this off. Two papers relating to Endoscopy had been withdrawn, although actions relating to JAG accreditation had been completed. There was no paper relating to the Maternity Action Plan.		

	Discussion had taken place regarding performance data in the Complaints Annual Report as this did not seem to correlate and the committee had been asked to sign off the Infection Control Annual Report for 2015/16, although time had run out and the committee did not feel they had the relevant knowledge to sign off. There was concern regarding delays within the Serious Incidents Report and although the Outpatients Report provided some assurance, there remained a significant number of patients to be reviewed. The Safeguarding Adults and Learning Disabilities Annual Reports were noted. TR recognised that there was a significant amount of work being undertaken. GH noted that there were action plans available for Sepsis and Maternity which were focussed on RCA. She had proposed to the Oversight Group that there should be a specific focus on these two areas of importance. **Charitable Funds Committee** – there were no escalations to report. **Audit & Assurance Committee** – RD escalated the BAF and BARs which had not been presented for some time. There were some administration issues regarding circulation of papers for the meeting.		
	QUESTIONS FROM MEMBERS OF THE PUBLIC		
15/207	With regard to the no smoking policy and in response to JK, it was confirmed that the local authority and police had not been informed as there was no requirement for consultation. JK was concerned regarding the issues raised as part of the patient stories and asked whether the Trust would come out of Special Measures. SL confirmed that this was not yet known and that the Trust had completed the factual accuracy response, but was awaiting the final report, which was expected during October.		
	COMMUNICATIONS TO WIDER ORGANISATION		
15/208	It was agreed that the following items should be communicated to the wider organisation: • Reminder regarding responses to the Strategic Narrative • Financial position and CIPs • No Smoking Policy • Car Parking Charges		

	• Leadership communications to the organisation • Key CQC messages		
	ANY OTHER BUSINESS		
15/209	There were no further matters arising.		
	DATE AND TIME OF NEXT MEETING		
15/210	It was CONFIRMED that the next meeting of the Board of Directors would be held on Thursday 29th October 2015 at 9.00am in the Board Room, Level 1, King's Mill Hospital. There being no further business the Chairman declared the meeting closed at 13.54pm.		
	Signed by the Chairman as a true record of the meeting, subject to any amendments duly minuted. **Sean Lyons** **Chairman** **Date**		