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

Unconfirmed **MINUTES** of a Public meeting of the Board of Directors held at 9:30 am on Thursday 5th November 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
	Ruby Beech	Non Executive Director	RB
	Graham Ward	Non Executive Director	GW
	Karen Fisher	Acting Chief Executive	KF
	Paul Robinson	Chief Financial Officer	PR
	Susan Barnett	Interim Chief Operating Officer	SBa
	Graham Briggs	Interim Director of Human Resources	GB
	Peter Wozencroft	Director of Strategic Planning and Commercial Development	PW
	Suzanne Banks	Interim Chief Nursing Officer	SBan
In attendance:	Shirley Clarke	Deputy Director of Corporate Services	SC
	Joy Heathcote	Minute Secretary	JH
	Catherine Armshaw	Interim Head of Communications	CA
	Victoria Bagshaw	Deputy Director of Nursing & Quality	VB
	Nicola Boulding	Medical Director's Office Manager	NB
	Liz Williamson	Divisional Matron, PC&S	LW
	Sharon Baxter	Head of Nursing, Theatres & ITU	SBax
	Heidi McMillan	Specialist Nurse, Tissue Viability	HM
	Jo Richardson	Patient Safety Fellow	JR
	Helen Beecham	Chad	HB
	Maryam aiser	Newark Advertiser	MQ

		Action	Date
	CHAIRS WELCOME AND INTRODUCTION		
15/211	The meeting being quorate, SL declared the meeting open at 9.30 am and confirmed that the meeting had been convened in accordance with the Trust's Constitution and Standing Orders. SL welcomed Ruby Beech and Graham Ward, Non Executive Directors to the meeting, confirming that Mark Chivers would be leaving the Trust following today's meeting. Further details regarding the new Non Executive Directors had been included in the Chairman's Report. SL also welcomed Suzanne Banks, Interim Chief Nursing Officer and Catherine Armshaw, Interim Head of Communication to the meeting.		
	DECLARATIONS OF INTEREST		
15/212	It was CONFIRMED that there were no declarations of interest		

	relating to items on the agenda.		
	APOLOGIES FOR ABSENCE		
15/213	It was CONFIRMED that apologies for absence had been received from Susan Bowler, Executive Director of Nursing & Quality, Andrew Haynes, Executive Medical Director, Eric Morton, Improvement Director and Helen Flear, Turnaround Director.		
	PATIENT STORY		
15/214	SL welcomed LW, SB and HM to the meeting to provide a patient story which related to pressure ulcers. Following investigation of the grade 4 pressure ulcer from June 2015, the findings highlighted concerns in the care of a patient with complex care needs. Additionally that the Waterlow risk assessment tool was not specific enough to capture the personal care and equipment needs and the nursing staff did not use their professional judgement in ensuring the patient had the appropriate dynamic pressure relieving mattress in place when transferred from intensive care to the surgical ward. Post operatively there was also an assumption made that this fit young man would mobilise and eat quickly post operatively, and so therefore did not require pressure relieving equipment or a high protein/calorie diet. The care and incident review identified the young man had nutritional requirement above what was identified and he was malnourished and had an undiagnosed neuropathic illness that severely hindered his recovery. This patient story was being shared at the Trust Board Meeting, and the Nursing and Midwifery Board meeting on 23rd October 2015. Nursing 'Proud to Care' study days scheduled throughout the following year would include this patient story to ensure trust wide learning and support nurses to think widely about their responsibilities to deliver personalised care. Mitigation plans along with actions to date and future planning included: • Individual ward reviews have occurred during the week commencing 12th October, by named Tissue Viability Nurses to identify specific training and support needs within the entire nursing and allied health professionals team. The Tissue Viability Nurse Consultant will lead the programme of learning and development for the Trust. • The Tissue Viability key performance indicators will also be clearly communicated and monitored with the Matrons and Ward Leaders with the support of the Divisional Matrons. • Purpose T trial – a new evidenced pressure ulcer risk assessment tool to be piloted on four wards across the Trust from 26th October 2015. • A new wound care pathway to be piloted by the Tissue		

	Viability Team from week commencing 19th October 2015. • Dynamic mattresses: a programme of work is being developed to improve effectiveness and ensure the appropriate equipment (dynamic mattresses) are delivered to patients in a timely manner and are safe to use. In response to a number of observations from the Board, it was confirmed that there was nothing obvious in the notes regarding learning disabilities. The lessons learned, links to CQC themes, consideration of personalised care, metrics, better decision making at MDT's and the other learning from the care of this patient would be shared cross divisionally so that there would be organisational learning. SL gave thanks for the honest story provided.		
	OUTCOMES RE LAST MONTH'S PATIENT STORY		
15/215	SL reminded Directors of the patient stories presented the previous month from PM and CW and VB confirmed that the issues raised had been included within the workstreams in the Quality Improvement Plan.		
	MINUTES OF THE MEETING HELD ON 24th SEPTEMBER 2015		
15/216	Following review of the minutes of the public meeting held on 24th September 2015 the following amendments and updates were provided: • Page 1 – PM noted the header which referred to the minutes being subject to the Freedom of Information Act 2000 and SC agreed to check whether this was required. • Page 6 Chairman's Report - AGM - it was agreed that for 2016, more staff would be encouraged to attend the AGM. • Page 17 – With regard to the No Smoking Policy, PM confirmed that the word challenge should be avoided but it was still expected that staff would have conversations with smokers to advise of the smoke free site and to use the hand out cards. TR also suggested that this was about supportive engagement rather than challenge and KF confirmed that conversations were expected to take place but not where risk to staff might be possible. PW to ensure that hand out cards were available for staff to hand out to smokers on site. GB to check whether reference could be made to no smoking and brief intervention training at the Trust's Orientation Day. • Page 18 Duty of Candour – The policy required approval and it was agreed that SC would check that this was included at the next Quality Committee meeting. .	SC PW GB SC	

	MATTERS ARISING/ ACTION LOG		
15/217	The Matters Arising/Action Log from the meeting held on 24th September July 2015 was considered. A number of timescales had slipped on the action tracker and SL stated this would not be acceptable in the future. SL would agree the timescales in the action tracker immediately following the Board meeting. It was highlighted that actions would need to be realistic with appropriate timescales. **Action 47** - VB confirmed that a revised Patient Experience Report was included in the Board pack. The action went back to the workstream in the Quality Improvement Plan and the action was complete. **Action 50** – Diversity & Inclusivity - KF sought assurance that all completed forms had been received and as this was not the case, it was agreed that a blank form would be provided at the meeting to be returned by 06/11/15. The website would then be checked to ensure that it reflected ethnic minority of the Board appropriately. **Action 51** – Patient Experience - VB confirmed that the issues highlighted by the patient stories would be included in the Quality Improvement Plan and the action changed from red to yellow. **Action 52** – Nurse Revalidation - It was confirmed that Nurse Revalidation would be introduced from April 2016. VB was liaising with K Lorenti regarding process and policy. The OD & Workforce Committee would provide assurance going forward that this was on track. **Action 54** – Mandatory Training – GB confirmed that this action was complete and that mandatory training at the Trust was compliant with nationally recommended standards. The Board accepted the updates provided.	GB	06/11/15
	CHAIRMAN'S REPORT		
15/218	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, Governor Activities, Board Appointments, Membership Activities, AGM, Volunteer Recognition, Staff Excellence Awards and Patient/Family Interaction. KF highlighted the Volunteer Recognition section and the special mention of Barbara Read who had celebrated 50 years as a volunteer, which was a fabulous achievement. SL confirmed that Barbara could be seen on the posters in the KTC and had also		

	just celebrated her 90th birthday. TR confirmed that the net value contribution of the Trust's volunteers was estimated at circa £0.5m per year. With regard to patient/family interaction, SL highlighted that he had witnessed two members of staff wearing their blue uniforms including hats in the Daffodil Café and that this behaviour should be challenged. SL had also witnessed a patient in a wheelchair who was propelling himself along using crutches and had escorted him back to the ward. It expired that the patient had gone for a cigarette on his crutches, but when he wanted to return to the ward he felt unwell and had requested a wheelchair. SL asked the Board to consider what was accepted and what was not challenged during day to day experiences. SL highlighted that it had been a time of achievement and that the Staff Excellence Awards had been a night of celebration. The Chairman's Report was noted.		
	CHIEF EXECUTIVE'S REPORT		
15/219	KF introduced discussion of the Chief Executive's report which highlighted recent events and developments. The Quality Summit had taken place on 30th October and a significant number of staff engagement sessions had taken place since. There had been some difficult conversations at these sessions and further drop in sessions had been scheduled to listen to staff and to update them on the CQC Report and the Quality Summit. Further conversations would take place with Senior Managers the following week to ensure that the outcome of the CQC Report had been shared with their service lines and that action plans would be developed for inclusion in the Quality Improvement Plan. Relevant communications would also be circulated to Trust staff. The Staff Excellence Awards night had been a great celebration and recognition of the Trust's staff. The horizon scanning schedule had been included as an appendix and the Executive Team would continue to review this and provide updates. TR confirmed that the CQC follow up sessions related to accountability and that actions would need to be followed up. It had been agreed that the issues arising from each session would be recorded and CA confirmed that these were available on the intranet and that key themes were emerging which would be		

	shared by KF the following week. PM offered support if the Non Executive Directors could assist with drop in sessions. With regard to Junior Doctors Industrial Action and in response to PM, KF confirmed that GB would be leading on this. GB confirmed that he had seen the ballot which asked members to vote on strike action or action short of a strike. In response to SL it was agreed that GB would ensure that contingency plans and communications around any proposed action were in place. It was agreed that a note would be provided for assurance if there was an update ahead of the next Board meeting. With regard to the cap on agency staff costs and in response to NG, GB confirmed that there was a degree of flexibility and in the long term if capacity was not available, this would need to be matched to demand. GB would work with SBan and this would be considered at the Executive Team meeting. SL highlighted the important themes within the Quality Improvement Plan and the 10 workstreams which had been developed. Further consideration would be given to this during the private Board session and how Non Executive Directors could provide support. The Chief Executive's Report was noted.	GB GB	
	QUALITY AND SAFETY QUARTERLY REPORT		
15/220	VB introduced discussion of the Quality and Safety Quarter 2 Report, confirming that within the 2015/16 Quality Account, the Trust had agreed a number of key Quality and Safety targets and these were identified within the Trust's Patient Quality and Safety Strategy. This report provided an assessment and future plans against those priorities. SL introduced Jo Richardson to the meeting who was deputising in the absence of Andy Haynes. VB confirmed that the report had been reviewed in line with comments from Board members regarding content and she highlighted the graph on page 7 of the report as an example. As reported at the previous meeting, VB confirmed that all falls were now reported as level 4 and downgraded as necessary. This action had been undertaken following liaison with colleagues both locally and nationally and the datasets had been revised to reflect this change. Non Executive Directors noted that the monthly number of falls was required rather than cumulative numbers and that perhaps falls should be recorded as near misses.		

	In response to NG, VB confirmed that part of the work currently being undertaken would include benchmarking against other Trusts. PM noted that the number of falls hadn't reduced since August and SBanks confirmed that there were national rates and the Trust would be able to build a picture and in response to TR confirmed that recording was by bed day and did not reflect population. In response to PM regarding the reporting of the early warning system at the Quality Committee, VB confirmed that reporting was being improved and would be more consistent in future. It was noted that there was a discrepancy in the number of falls reported on page 7 and page 8. SL asked that the Linking the Thinking event scheduled in December be publicised. VB highlighted the mitigation plan and actions to date and future planning relating to falls. PM noted that work relating to falls seemed to have reached a plateau and VB confirmed that some of this related to networking with other Trusts to share learning and best practice. PM also highlighted that there was facility on the PAS to flag patients at high risk of falls. In response to SL regarding PAS, PW confirmed that he had liaised with IT and there should be resolution soon. SL requested PW to circulate a note by the end of the week to update on the position. SBar confirmed that there was a requirement to understand how falls happened, identify themes, e.g. time of day, location and VB confirmed that Lead Nurses had been requested to undertake analysis and identify any themes. In response to SL, VB confirmed that there was a particular group of patients on Ward 52 that were high risk. PM asked if Ward 52 was being monitored and whether themes from Bradford would be used and VB highlighted the requirement for personalised care and identifying those patients at greater risk. SL confirmed that if equipment was required, such as the anti-slip mats to reduce the risk of slipping when moving off pressure mattresses, then these should be purchased immediately and recharged retrospectively, not to wait for charitable funds to be allocated. TR highlighted current issues relating to charitable funds in that a	SC PW	Nov 2015 6/11/15

	case for funding needed to be presented to the Commercial Development Group for approval ahead of submission for funding and had to meet the charitable criteria. In response to SL, TR confirmed that there was not a list of equipment currently for charitable funding and he had asked the divisions to identify what their requirements were for the coming year. JR presented the HSMR section confirming that this reflected the reduced crude mortality during the summer months and the data reflected the improvements made in terms of pathways of care, record keeping and coding. The Trust's indexes were now above others nationally and work had taken place to continuously monitor recording and coding data so that there would be sustained improvement. In response to SBar, JR confirmed that there had been some delays in uploading data so predicted figures for July/August were not yet available. It was recognised that we were going into the time of year where it was expected that mortality would increase. PM welcomed the improvements and suggested that comparison to the previous year would be helpful. GW noted that mortality rates at another local Trust was increasing and there should be caution as to whether this might affect the Trust. SBar referred to other items later within the report relating to demand, length of stay and flow and asked if any wider comparisons had been made to staff having more time to look after the patients, or other soft intelligence. JR confirmed that this would be something else to consider within the reporting. SL noted that staff had commented that they were able to do more and he asked what the current position was regarding admission on a week day versus the weekend. JR confirmed that this was difficult to assess as it related to a small number of patients but that the Trust had really good cover arrangements in place at the weekends and care received was as good as during the week. SL asked if there were any other measures that could be used to better understand this data and PM suggested that SUIs could be considered. KF highlighted that this was something that should be considered at Quality Committee meetings and JR agreed to forward a proposal to PM. With regard to Sepsis and in response to SL, JR confirmed that there were weekly meetings and that improvements had been made. The focus was now being extended to wards and a Trust wide point prevalence audit had just been undertaken to consider	JR	Nov 2015

	the management of Sepsis and there was now greater awareness and this was part of business as usual. Performance against the CQUIN target of 60% was currently at 75% and weekly performance had recently been consistently above 90%. TR highlighted that the CQC had confirmed that they had seen progression with Sepsis and KF noted that this was now about sustaining the improvements. PM suggested that the ward figures should be included in future reports. SL outlined a discussion he had with a Healthcare Assistant who wanted to know more about Sepsis and suggested that this should be considered going forward. JR confirmed that the initial focus had been on front line staff but could be considered for other staff groups. With regard to infection control, VB confirmed that there had been one case attributable to the Trust during August, which related to contamination in how the sample was taken. Discussion was still ongoing to confirm whether this was the case. The Trust had not met its CDiff performance targets, they had been exceeded in Q1 and although there had been improvement in Q2, the maximum number was still exceeded. PM asked about lapses of care and VB confirmed that this was another area which required consideration. In response to NG, KF explained that there had been a benchmark during a certain year and then year on year reductions were set going forward for CDiff. PM noted that the findings of the RCA related to simple things and thought that there should be less issues due to the single rooms. VB confirmed that she had discussed the outcome of the commode audit with ward matrons as this was unacceptable. Consideration would be given to improving how data was reflected within the report. Despite work with the Infection Prevention Control Committee and work on the wards, compliance on hand hygiene training had fallen and a month on month improvement was required. CW expressed concern regarding hand hygiene compliance rates and asked what the recourse was and the consequences of this. VB confirmed that consideration should be given to what the consequence should be. With regard to the linen services at Newark Hospital and in response to CW, VB confirmed that clear expectations should be	VB	Nov 2015

	set out with the contractors and it would be necessary for all issues to be logged so that they could be held to account. PM noted that sharps incidents had increased and this was basic awareness. VB confirmed that consideration would need to be given to the action required, both in the short and long term. Discussion took place regarding certain behaviours and there was inconsistency in leadership and managing accountability. It was suggested that there should be less tolerance regarding slippage and appropriate issues such as appraisal and mandatory training should take place, with supportive engagement of staff to give them confidence. VB highlighted the significant environmental changes that would take place on Ward 52 to support patients with dementia and the opening date of 17 December which was very challenging. SL requested PW to ensure that the opening would take place on 17 December and asked all to include this in their diaries. With regard to safeguarding there were 57 areas that required a Vulnerable Adults Champion and a number of areas that needed to be moved forward, particularly regarding safeguarding children as there was some non-compliance against national standards. Following receipt of the external report in October, consideration was being given to a restructure, which was also a theme from the CQC report. PM asked what the position was relating to the level 3 safeguarding and mental capacity act training as the CQC had highlighted that some staff had indicated a lack of understanding. VB confirmed that some issues of mental capacity training related to doctors intervention and there had been increased attendance at training sessions. There was an issue that the training was not always leading to a changed behaviour and SBanks suggested that this was about looking at the evaluation following training. SL asked when the identified actions would be complete and SBanks confirmed that discussion was currently taking place regarding the issues that needed to be addressed and an action plan would be developed. With regard to learning disabilities, PM suggested that some of the less positive aspects should be captured and KF confirmed that there would be a detailed Quality Improvement Plan at the next Board meeting and it would be agreed how issues would be reported, with agreed actions. VB referred to the narrative on page 28 relating to CQUINs and confirmed that the dementia CQUIN had been ragged as amber due to Q4 uncertainty regarding improvements in IT systems. Significant work was also being undertaken with mental health colleagues and conversations as part of Better Together, as when the CQUIN had been set in April, there was no clarity on what	PW	17/12/15

	was required. VB confirmed that end of life care had its own workstream and SL noted that national guidance recommended that a Non Executive Director was involved in this work and he agreed to speak to RB and GW. VB offered her support in sharing the work that was being undertaken. With regard to maternity, the national survey had just been received and this was being worked through. There appeared to be some similar themes as the CQC report and the Maternity Improvement Group were focusing on these areas and actions would feed through to the Quality Improvement Plan. VB highlighted the patient story with regard to pressure ulcers, confirming that the focus of work was on the new wound care pathway currently being piloted and the review of dynamic mattresses and how equipment was moved around the organisation. This would have both quality and financial impact. With regard to Venous Thromboembolism (VTE), VB highlighted current performance and SL confirmed that discussion would need to take place imminently regarding the clinical leadership. With regard to serious incidents and in response to MC, VB confirmed that a piece of work was being undertaken to ensure that incidents were reported correctly and at the time of occurrence. KF confirmed that external expertise had been sought and a first draft report had been received. In response to PM relating to STEIS, VB confirmed that work was being undertaken to close the loop and to ensure that this was consistent across the organisation regarding changes in practice and behaviour. JR also confirmed that SI sign off group meetings were in place and although she could not provide timescales at present, within the next 6 – 8 weeks these should be returned to a reasonable timeframe, with targets set. In response to SL, KF confirmed that she had recorded the concerns raised regarding the Quality and Safety Report and the actions required.	SL	Nov 2015
15/221	**SAFER STAFFING REPORT** VB introduced discussion of the Safer Staffing Report confirming that the paper presented the six-monthly review of nursing and care staffing across inpatient wards and ED. This information triangulated professional judgement, a review of patient incidents pulled from nurse sensitive indicators with the data analysis from the nationally recognised evidence based Safer Staffing tools		

	used by the Trust: Safer Nursing Care Tool for inpatient wards. Following discussion with nursing teams in September 2015, all ward areas were now undertaking a twice daily collection of patient acuity and dependency. The review was also underpinned by monthly safer staffing reports which had previously been presented to the Board, detailed staffing on a shift-by-shift basis at ward, divisional and Trust level to the Board. In response to RD and SL regarding assurance and safety, VB confirmed that the report was being revised to provide assurance and reporting on the e-rostering system that was due to be completed by March 2016. There would be assurance available and further work was currently being undertaken to ensure that the additional staff requested was appropriate. Staffing numbers were considered 4 times per day at the bed meetings and consideration was being given to how to include this within the report. Ward by ward data would be available along with tipping points to identify where action was required to ensure safe staffing levels which would be built into the e-rostering system. PM referred to the 50:50 registered nurse:HCA skill mix and VB confirmed that work was being undertaken with divisions to consider establishments and their safety and requirements. Whilst immediate actions had been taken following the Keogh Review some 2 years ago there was now a focus on safer staffing levels to manage acuity and dependency and to evidence the decisions being made.		
	PATIENT EXPERIENCE QUARTERLY REPORT		
15/222	Directors noted the Patient Experience Quarterly Report which detailed the concerns, complaints and compliments received by the Trust from 1 July – 30 September 2015 (Quarter 2). The Patient Experience Team provided a single point of access of all patient feedback, including concerns, complaints, compliments, Friends and Family Test and NHS Choices and also demonstrated the openness in the culture of the organisation. The report also detailed the number of concerns against the number of complaints and all concerns raised were provided with the opportunity to escalate these to formal complaints. In response to TR, VB confirmed that as part of the process of responding to and learning from the complaint, everyone involved with the complaint was involved. In response to PM regarding the number of complaints received regarding Outpatients and cancellations, SBa confirmed that the technology was not yet available to identify the numbers. In response to SL, PW confirmed that new systems should be implemented by the end of November 2015.		

	With regard to the Parliamentary Health Service Ombudsman (PHSO) and in response to TR, VB confirmed that 3 cases had been partly upheld by the PHSO. SL also noted that at Tameside Hospital NHS Foundation Trust, the Governance Support Unit was heavily involved in complaints. In response to KF regarding the speed of acting on complaints, VB confirmed that although prompt action was taken to investigate and respond to complaints, the process currently in place could be improved. Directors were asked to note that the current F&FT was a labour intensive process and work was being undertaken to ensure quality improvements and the patient and relative experience captured appropriately. An alternative external provider was being sought to ensure that improved data was captured and that the provider could be held to account. A dedicated CQUIN Support Worker had been allocated to FFT in order to increase overall response rates.		
	INTEGRATED PERFORMANCE REPORT		
15/223	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 ED continued to achieve performance standards in Quarter 2 and work would continue on flow and systems and increasing the use of ambulatory care to ensure patients were treated within timescales. Work also continued in EAU and Respiratory care, particularly with patients with long term conditions and working with GPs to focus on preventative care and being rigorous regarding transfer to care though the SRG. SBa highlighted the increasing pressures on EMAS in the Midlands and East and October had been particularly difficult with a 12% increase. There had also been changes in patient flow from Derby and recruitment difficulties. There were also issues with Social Services and the availability of facilities to discharge patients to which had been a particular issue at Newark Hospital and patients that required little support. In response to NG regarding increases in demand for ambulances, SBa confirmed that the outcome was not certain. There had also been a 30% increase in calls to the NHS 111 service, although the conversion rates remained the same.		

	With regard to RTT, the incomplete standard had been achieved and monitoring would continue on the other two standards. There were specific issues regarding vascular and max fax being smaller specialties and consideration was being given to joint and specialist centres. In outpatients, specific work was being undertaken to ensure there was visibility of all patients and additional staff were required to complete this work, although had not yet commenced. The Access Policy was currently undergoing consultation and the Annual Leave Policy was being strengthened along with a consistent focus on demand and capacity plans. In response to SL, SBa confirmed that a focus remained in outpatients to ensure that there was visibility and that best practice was being followed. SBa reminded Directors that the Trust received approximately 100,000 per quarter and that work was being undertaken regarding DNA's and to increase the availability in Endoscopy which would need to be compliant by the end of December to ensure that accreditation was retained. In response to SL regarding the letter received from the CCG in October, SBa confirmed that all information flowed through the SRG meeting and it had been agreed that a root and branch diagnostic would be undertaken. The Trust was currently non-compliant against 62 day cancer waiting time standards and a focus continued that all patients over the standard were managed appropriately. There were usually around 1000 high risk cancer patients at any one time and the Trust was on track to deliver compliance ahead of the February 2016 target. A further letter had been received which stated that any patients over 104 days should be considered as potential harm. PR presented a high level exception summary on financial performance. Directors NOTED the Integrated Performance Report.		
	WORKFORCE MONTHLY REPORT		
15/224	A detailed Workforce Report was considered. With regard to sickness absence, the position continued to slip and there had been 3 consecutive months of small but cumulative increases. Whilst the overall headline figure of 3.79% rolling average was very respectable, in comparator terms it was expected that this would increase moving into winter. The HR Business Partners had been requested to set recovery targets as		

	a minimum to stabilise matters over winter with an accelerated recovery for the end of the year. The effort into managing sickness remains intense. In July, August and September of 2015 the OH department dealt with a 45% increase in manager referrals compared to the same position last year and there was awareness that mental health issues remained one of the key reported reasons for absence. The OH function had delivered extensive training of managers in mental health awareness and staff training in mental health resilience. These sessions were evaluating very positively and further sessions would be commissioned. With regard to appraisal, completion rates comparative to last year, month on month performance in 2015/16 was noticeably better than 2014/15 but a step change was required to deliver the 98% overall target. The HR Business Partners were actively working with managers to agree compliance plans for the remainder of the year. Establishment, the overall vacancy rate fell to 8.27% and the Trust was able to reduce its nurse vacancies by a net 25 wte. A real and genuine focus on filling these posts continued. Of particular note was the Government's decision to add nurses to the occupational shortage list which would bode well for the ability to secure the contingent of Philippine nurses due at the start of 2016/17. The real benefit compared to European recruitment was that the visas would be site specific, reducing the risk of the nurses seeking jobs elsewhere in the UK. Included within the report was a skeleton financial case to recruit further in the Philippines. A full case would be considered through the Executive Team. In terms of medical staff, a task group had been set up to ensure there were individual recruitment plans for each vacancy. With regard to recruitment and in response to NG, GB confirmed that an assessment was undertaken for each vacancy as some of these were shortage specialties. SL asked when details would be available and GB agreed to provide a response as soon as possible. CW asked if medical recruitment could be considered at the same time as nursing recruitment and KF confirmed that the Trust had been out to tender internationally for nursing staff and also for medical staff. Bank and Agency spend continued particularly in medical staffing. The Trust had commenced the process of putting in place the systems necessary to comply with the Governments caps for Agency staffing. It remains to be seen if these Government arrangements were sufficiently robust with winter pressures	GB	Nov 2015

	across the whole NHS system. In response to NG regarding bank and agency, SBan confirmed that the figures referred to registered and unregistered nurses and with regard to unfilled rates, VB confirmed that a number of requests would have been submitted before the rotas had been published and a decision would be taken as to whether the post should remain unfilled as necessary. Mandatory training had remained unchanged at 80% for the month. This important issue had now been incorporated into a specific QIP workstream and significant progress was expected, with personalised compliance plans for staff emerging over the next couple of months. With regard to the F&F Test, Directors attention was drawn to the key improvements and deteriorations in the F&F test report. Encouragingly staff were reporting better engagement and appraisals, which was a positive basis for the QIP engagement workstream. Less positively, staff remained anxious regarding Trust wide issues and formal and informal feedback on their work. These were issues that would also be built into the QIP workstreams. With regard to Freedom to speak Up Guardians and in response to SL, GB confirmed that a specification had been designed for these individuals. SL suggested that the champions should have a line of sight to TR, which was agreed that GB confirmed that Kate Lorenti was the mentor. In response to PM regarding HEEM, GB confirmed that all the points in the HEEM action plan had been addressed. There wuld be a further HEEM visit on 23rd November. Directors NOTED the Workforce Monthly Report.		
	REVALIDATION AND APPRAISAL UPDATE		
15/225	This Report updates the Board of Directors on the April-June 15 position in relation to appraisal and revalidation. The Appraisal and Revalidation team had submitted Quarter 2 data to NHS England which demonstrated that 10 were outstanding and current compliance was at 67%. Overall compliance was over 90%. Following the software upgrade of the new Medical Educators module within the MYL2P system, presentations had been provided to the Educational Supervisors Forum and each Educational Supervisor had been provided with a summary of the evidence required to meet each of the 7 domains. There were some concerns raised as to the availability of some of the evidence and the Medical Education Department are raising this		

	with the Deanery. It had been reiterated to the Educational Supervisors that the expectation was to see a greater degree of evidence in the appraisal portfolio such as feedback from trainees and evidence of supporting and monitoring educational progress. With regard to GMC Connect and revalidation, as of 30th June 2015, there were currently 252 doctors under the designated responsibility of the Trust. Any doctor that had a deferral recommendation made to the GMC would be monitored through the Appraisal and Revalidation Workforce Group. A revalidation action plan was part of the wider Quality Assurance Framework in ensuring that there was a plan in place for any deferrals, monitoring the progress and requirements of the doctor to achieve a positive outcome. The reason for the 3 deferrals was due to the doctors commencing with the Trust with insufficient evidence to make a positive recommendation to the GMC. In accordance with the Framework of Quality Assurance (FQA) and the Independent Verification process, the Regional Medical Directorate would be visiting the Trust on the 21st January 2016 to review systems and processes for revalidation which were based on the core standards. The visiting team would also interview 2 appraisees and 2 appraisers which would be randomly selected. NB had contacted other Trusts where visits had already taken place and considered areas of good practice. TR welcomed the helpful and succinct report and asked if there were any doctors who were being managed through a process at the moment. NB confirmed that there were none at present and that PM was the Non-Executive lead who would be consulted in such cases. Directors NOTED the update on appraisal and revalidation.		
	USE OF TRUST SEAL		
15/226	Directors noted that in accordance with Standing Order 19, the Sherwood Forest Hospitals (NHS) Trust Official Seal had been affixed to the following document by the Acting Chief Executive and Chief Financial Officer. Deed of variation to the Project Agreement (Waste Services) between Sherwood Forest Hospitals NHS Foundation Trust and Central Nottinghamshire Hospitals PLC Directors noted the application of the Trust Official Seal.		

	BOARD ASSURANCE FRAMEWORK		
15/227	SC presented the Board Assurance Framework (BAF) which evidenced the work of the Board in reviewing the effectiveness of internal controls, to gain assurance and to test governance processes that had been established in the organisation. The document reflected the organisations risk profile and contained the principal risks identified by the Trust, the controls in place, and gave the strength and quality of assurance available on how well risks were being managed. The QIP, Governance workstream would review and further develop the BAF in order to ensure the Board were able to gain robust assurance with regard to the risk profile of the Trust and to the achievement of its strategic objectives. The Board were asked to consider how the work of their Committees might better support assurance of the effectiveness of internal controls and ensure they drive the agendas accordingly and agree to the Confirm and Challenge Session scheduled for 16th December 2015. SL highlighted that it would be essential to ensure that the risks highlighted within the BAF were correct. The Board agreed that the Confirm and Challenge Session scheduled for 16th December 2015 should be used to review and update the principal risks for reporting to Board on 22nd December 2015 for approval as part of the QIP – Governance workstream.		
	TERMS OF REFERENCE FOR QUALITY & SAFETY IMPROVEMENT BOARD		
15/228	KF introduced discussion of the Terms of Reference (ToR) for the Quality & Safety Improvement Board confirming that there were 10 workstreams with identified leads. In response to NG, KF confirmed that a Non-Executive Chair would not be required, particularly as PM would be included in the membership. The Board APPROVED the ToR for the Quality & Safety Improvement Board.		
	TERMS OF REFERENCE FOR OD & WORKFORCE BOARD		
15/229	GB introduced discussion of the Terms of Reference (ToR) for the OD & Workforce Board confirming the purpose of the Committee to provide the Board with assurance concerning all aspects of strategic and operational workforce and organisational development relating to the provision of care and services in support of getting the best clinical outcomes and experience for patients and staff.		

	To assure the Board through consultation with the Quality Committee that the structures, systems and processes were in place and functioning to support the workforce in the provision and delivery of high quality, safe patient care. To assure the Board that, where there were workforce or organisational development risks and issues that may jeopardise the Trust's ability to deliver its objectives, that these were being managed in a controlled way through the Trust Executive Team and Trust Management Board. In fulfilling its obligations the Committee would be mindful of the need to improve the diversity of the workforce so that it better reflected the population which the Trust served. A number of observations were highlighted by Non-Executive Directors including the wide ranging responsibilities of this committee, a requirement to be focussed on the risks and CQC actions, financial representation which was required to ensure connect with relevant areas, absolute clarification of the role of the committee. The Board AGREED that further consideration was required and a revised ToR presented to the next Board of Directors meeting.		
	GOVERNOR MATTERS		
15/230	SL confirmed that a full Council of Governors meeting was scheduled for 18th November and that discussion would take place regarding their involvement with the Trust. A session would also be arranged for the Council of Governors to meet with Non-Executive Directors to consider how Non-Executive Directors were challenging the Executive Team.		
	ESCALATION OF ISSUES FROM TMB		
15/231	An update from the Trust Management Board (TMB) meeting held on 26th October 2015 was proved and noted by the Board of Directors. There were no escalations for the Board to consider.		
	REPORTS FROM SUB COMMITTEES		
15/232	**Finance Committee** – NG confirmed that the financial position was currently forecast at a £53.4m deficit. Assurance had been provided that appropriate action was being taken as necessary. Budget planning for the 2016/17 year was underway. A revised business planning process had been agreed to the Commercial Development Group for onward submission.		

	Quality Committee – PM reported that the Quality Committee meeting had been postponed to allow preparation for the Quality Summit. **Audit & Assurance Committee** – RD confirmed that the dates for the A&AC for 2016 had been arranged. He did not feel that these had been scheduled appropriately as these had been based on the previous year's dates. **Charitable Funds Committee** – TR confirmed that an update paper was being drafted relating to the last 3 months activities. It was hoped that charitable funds of £0.5m per year could be raised and £0.5m per year could be utilised. A strategic plan would be developed to look forward, which would also be linked into Better Together. TR wished to develop meetings with General Managers so that they could identify areas where fundraising could support them.		
	QUESTIONS FROM MEMBERS OF THE PUBLIC		
15/233	There were no questions from members of the public.		
	COMMUNICATIONS TO WIDER ORGANISATION		
15/234	KF confirmed that communications to the wider organisation would need to reflect how things would be taken forward in the future. SL confirmed that it was MC's last attendance at the Board of Directors meeting and thanked him for his commitment and input to the Trust. SL also gave thanks to SBar for the significant work she had undertaken and have moved the Trust forward. Best wishes were given.		
	ANY OTHER BUSINESS		
15/235	There were no further matters arising.		
	DATE AND TIME OF NEXT MEETING		
15/236	It was CONFIRMED that the next meeting of the Board of Directors would be held on Thursday 26th November 2015 at 11.30am in the Board Room, Level 1, King's Mill Hospital. There being no further business the Chairman declared the meeting closed at 15.02pm.		
	Signed by the Chairman as a true record of the meeting, subject to any amendments duly minuted.		

	Sean Lyons **Chairman** **Date**		