Dedicated to Outstanding care

NHS
Sherwood Forest Hospitals
NHS Foundation Trust

UN-CONFIRMED MINUTES of a Public meeting of the Board of Directors held at 09:00 on Thursday 28th June 2018 in the Boardroom, King's Mill Hospital

Present:	John MacDonald	Chairman	JM
	Neal Gossage	Non – Executive Director	NG
	Graham Ward	Non – Executive Director	GW
	Tim Reddish	Non – Executive Director	TR
	Claire Ward	Non – Executive Director	CW
	Barbara Brady	Specialist Advisor to the Board	BB
	Richard Mitchell	Chief Executive	RM
	Simon Barton	Chief Operating Officer	SiB
	Dr Andy Haynes	Medical Director & Deputy Chief Executive	AH
	Julie Bacon	Executive Director of HR & OD	JB
	Shirley Higginbotham	Head of Corporate Affairs & Company Secretary	SH
	Peter Wozencroft	Director of Strategic Planning & Commercial Development	PW
	Paul Moore	Director of Governance & Quality Improvement	PM
	Suzanne Banks	Chief Nurse	SuB
	Kerry Beadling-Barron	Head of Communications	KB

In Attendance:	Sue Bradshaw	Minutes	
	Kevin Gallacher	Deputy Director Income & Performance	KG
	Rachel Barker	Matron, Ward 25	RB
	Gaye Summers	HCA, Ward 25	GS
	Alison Whitham	Head of Midwifery	AW
	Jenny Kightley	Communications Specialist	JW

Observer:	Keith Wallace	Governor
	Sue Holmes	Governor
	Helen Hollis	Governor
	Martina Morris	Senior Clinical Manager, NHSI
	Gail Shadlock	NeXT Director Scheme
	Morgan Thanigasalam	Clinical Lead for ICT and Staff Governor

Apologies:	Paul Robinson	Chief Financial Officer

Item No.	Item	Action	Date
16/868	**WELCOME**		
1 min	The meeting being quorate, JM declared the meeting open at 09.00 and confirmed that the meeting had been convened in accordance with the Trust's Constitution and Standing Orders.		
16/869	**DECLARATIONS OF INTEREST**		
1 min	JM declared his position as Chair of the Mid-Nottinghamshire Better Together Board and RM declared his position as Chair of the East Midlands Leadership Academy.		
16/870	**APOLOGIES FOR ABSENCE**		
1 min	Apologies were received from Paul Robinson, Chief Financial Officer. It was noted that Kevin Gallacher, Deputy Director of Income and Performance, was attending the meeting in his stead.		
16/871	**MINUTES OF THE PREVIOUS MEETING**		
1 min	Following a review of the minutes of the Board of Directors in Public held on 31st May 2018, the Board of Directors APPROVED the minutes as a true and accurate record.		
16/872	**MATTERS ARISING/ACTION LOG**		
1 mins	The Board of Directors AGREED that actions 16/635.4, 16/790.4, 16/790.5 and 16/793.5 were complete and could be removed from the action tracker. *Action 16/834* – PM confirmed he had spoken to the Patient Experience Team to confirm a sample of patient response letters had been sent to the Non-Executive Directors. It was noted that whilst the majority of Non-Executive Directors have received the sample letters, NG had not received any and CW had received an e-mail but had been unable to open the attachments. PM confirmed he would follow this up with the Patient Experience Team. It was agreed the action could now be removed from the action tracker. However, CW and NG to report back if the issue is not resolved for them within the next 2 weeks. *Action 16/842* – SuB advised some stickers in relation to the level of harm for falls have been added to ward posters but this is not yet complete. A similar exercise is underway in relation to pressure ulcers. It is anticipated this should be completed within the next 2 weeks. It was agreed this action could now be removed from the action tracker. Any follow up action would go via the Quality Committee.		
16/873	**CHAIR'S REPORT**		
2 min	JM presented the report, advising the new arrangements under the Better Together Programme in terms of strengthening governance and clarifying arrangements have been implemented and will officially come into effect from 1st July 2018. It is hoped the new arrangements will provide greater clarity with more formal information being reported to		

	boards on a quarterly basis. The vacant Non-Executive Director posts will be advertised within the next week; interviews are scheduled for 13th September 2018. JM acknowledged Paul Moore's last Board of Director's meeting. JM expressed thanks to Paul for the work he has done during his time at SFHFT. The Board of Directors were ASSURED by the report		
16/874	**CHIEF EXECUTIVE'S REPORT**		
4 mins	RM presented the report, advising receipt of the draft CQC report has been delayed. It is hoped this will be received on 10th July 2018. Ben Owens, Clinical Director for Urgent and Emergency Care, is due to meet with the CQC on 9th July 2018 to provide final details in relation to Urgent and Emergency Care. Therefore, the CQC are unable to circulate the report until that meeting has taken place. The Trust wish to evidence the organisation has made a lot of progress over the last two years but also recognise there is more progress to be made. Based on the feedback received so far, it is hoped the draft report from the CQC will be broadly similar to the self-assessment. SFHFT, with support from partners, has made a lot of progress over the last two months in relation to Urgent and Emergency Care. As things stand, it is expected the Trust will deliver the ED 4 hour standard for Q1. However, there are a number of risks going into Winter 2018/2019. The Trust will be working as closely and effectively as possible with partners to ensure firm plans are in place. RM expressed his personal thanks to PM for his support, acknowledging particularly his knowledge in relation to risk and governance. The work done by Ruth Harrison, Learning Disability Specialist Nurse, in relation to the Learning Disability review was acknowledged. The Board of Directors were ASSURED by the report		
16/875	**STRATEGIC PRIORITY 5 – TO PLAY A LEADING ROLE IN TRANSFORMING LOCAL HEALTH AND CARE SERVICES** ***STRATEGY DEVELOPMENT***		
19 mins	JM advised this report was being presented to provide the Board of Directors with an opportunity to discuss the process for strategy development, given the Trust's strategy will be revisited in the autumn. It was acknowledged the Trust is operating in a different world now in terms of system working and there is a greater expectation for public engagement. Increasingly there is a requirement for clarity about how the Trust meets some of the challenges it faces and addresses some of the risks, such as workforce, etc. Previously the NHS has had a traditional approach to strategy. It is important to build on that but also reflect the different environment in which the Trust works. It is important to think about how the strategic process can be strengthened and built on.		

	PW advised the paper lays out the process the Trust will be engaging in for the remainder of this year to work on strategy development. There are two main components and the Trust is aiming for two main outputs. It is important to develop a compelling and meaningful narrative for staff and communities about where the organisation is heading over the next 3-5 years, partly contextualised by the environmental changes the Trust is facing. Over that period the Trust will be engaging in relevant discussions and debates in the organisation and shape the future based on the vision of where the Trust is trying to get to as an organisation, in particular the part SFHFT will be playing in the development of the integrated care system. The second element is more analytically based and a more internally focused piece of work. Various aspects of analysis about where the organisation is presently will be drawn together. Over the last 12 months some important pieces of work in relation to Maximising our Potential and the Nursing and Midwifery Strategy have defined and codified the Trust's intentions in key areas of its operations and these can be incorporated into strategy development. Additionally, the finance team have done a great deal of work in relation to patient level costing and developing a better understanding of the way in which financial flows work in the organisation, particularly the way in which this will impact on strategy development. This provides a better understanding of the various components of the services the Trust offers and the extent to which they contribute to the financial sustainability of the organisation. It is important to have wide and deep engagement with the Trust's communities, patients, carers and staff. The joint clinical services work SFHFT is undertaking with Nottingham University Hospitals (NUH) in the context of the Integrated Care System (ICS) will also be relevant. There will be increasing reference made to the way in which SFHFT is working in partnership, not just in Mid-Nottinghamshire but across the whole of the ICS. GW felt the Trust should look beyond what it does currently in terms of working with others, etc. and establish if there are opportunities for SFHFT to take on a larger involvement in some of the services, whether that's control or a joint venture, i.e. taking things that step further and being more aspirational. PW advised the Trust shouldn't be ruled by the orthodox. There is a need to think broadly if SFHFT is going to define itself as a leading provider in an integrated care partnership. This will require the Trust to think about the current boundaries and the current interfaces with other elements of health and social care and other services. RM felt there is no need for innovation in relation to strategy development, instead SFHFT aspires to be the best in all the things it is doing, looking within the NHS, social care and externally to identify what other organisations are doing well and replicate it in the Trust. SFHFT wishes to set a strategy that resonates with staff and patients. The Trust does not want to set a strategy and then never talk about it or set a strategy that is unrealistic. The strategy should make sense to patients, staff and partners and build on what will hopefully be a positive CQC report. It should enable the Trust to continue doing what it's doing		

	well but move into a position of influence and possibly control. BB felt the Trust should be clear about the extent to which it is proactive in attending to population health as opposed to reactive to demand for services. Moving into the new world of integrated care this is a real opportunity for SFHFT to be much more proactive. As an NHS organisation the Trust has a statutory responsibility to help to reduce health inequalities. Therefore, it would be useful if the Trust is proactive to see how the strategy could feed into the health inequalities agenda. NG advised he would like to see more information on how the Trust develops the strategy in the context of the whole system. SFHFT is only part of the system. When considering allocating resources, it may be resources that SFHFT has available are better spent elsewhere within the system to improve healthcare across the population. This is key in terms of both engagement and how the strategy is developed. CW felt, in terms of engagement, SFHFT should look at not just the generation which are currently extensively using the Trust's services but how to engage with the next generation of patients; what do they see from a changing NHS and how do they want those services to be delivered. Younger people are not a cohort which is likely to be involved currently in the Trust's services to the same degree as older people but their views on services is hugely important to the future. TR felt thought should be given to how the digital age supports the strategy and how it fits into the strategy going forward. RM advised that as an organisation and across the NHS there is lots of discussion about the impact of things like the digital age or Information Technology (IT) and Artificial Intelligence (AI) but there is work to do to improve understanding in relation to this. There is pre-existing technology which is being used, possibly in the NHS but definitely in other industries, which the Trust should be looking to replicate. AH advised of a recently published report which suggested £12.5 billion could be saved from AI. This would not lead to redundancies but staff would be moved from non-patient facing tasks to patient facing tasks. This is something the Trust will need to embrace. SuB has started doing some work on this around AI and it is something the Trust needs to be aware of. There are many healthcare systems outside of the UK which no longer have people answering phones. Instead there is an algorithm, which sounds like a human, and the evidence from industry is they are good at directing people to the right place. This is an obvious application. Currently SFHFT sends pictures between trusts in the East Midlands which is seen as leading edge. The next step is possibly to have AI which would identify which pictures need to be looked at. JM noted the Trust needs to be clear the vision is right, bearing in mind the issue relating to health of the population versus healthcare. Is the vision for this organisation in the context of the wider system slightly different? Additionally, time needs to be given to enable the Trust to think differently, particularly in relation to technology and how that helps with the Trust's workforce and younger people accessing healthcare.		

	Thought needs to be given to what sort of analytics are required to test the strategy is deliverable and does the Trust have capacity to do the testing. In relation to Newark, it is known the aim is to increase income but by how much? What information is available from the market analysis? In relation to engagement, thought needs to be given to how to engage with younger people and whether the Trust should be looking at social media to widen engagement rather than just public engagement events which tend to be attended by the same people. There is also a role for the Trust's governors so thought needs to be given as to how to engage. The Trust needs to be clear as to how the strategy is developed in the context of the wider system. Therefore, thought must be given to how the Trust engages with some of the key partners. The Board of Directors were ASSURED by the report.		
16/876	**STRATEGIC PRIORITY 5 – TO PLAY A LEADING ROLE IN TRANSFORMING LOCAL HEALTH AND CARE SERVICES** ***PREPARING FOR INTEGRATED CARE PARTNERSHIP***		
25 mins	RM gave a presentation about the Mid-Nottinghamshire Better Together Programme, highlighting the successes so far but acknowledging there are other areas where further work is required. RM noted the work is important but difficult to achieve. It is important for the Trust to work more closely with partners in health and social care. It was noted the Better Together Programme has been re-set, with a clear purpose around system performance and transformation, in particular targeting the groups of patients who currently use healthcare services the most but also looking at groups of patients who will be service users in the future. Steps have been taken to improve accountability, having reshaped the Better Together Board with senior partners across health and social care in addition to the Transformational Board. RM felt relations with the Trust's partners have improved over the last couple of years. There is now a single control total and the Trust's executive team meet with commissioners on a weekly basis. Areas where resources can be pooled are being considered. There will be times in near the near future when SFHFT needs to take decisions which may not, from that specific decision, benefit the Trust as an organisation but will benefit patients and the public but it will definitely benefit the wider health and social care across Mid-Nottinghamshire. RM discussed the Principles and Rules of Engagement, highlighting a lot of discussions have focussed on reducing collective spend. The aim is to move towards evidencing where there are financial decisions to be made which will benefit everyone. There are four work streams, looking at urgent care, elective care, proactive and long term conditions and healthy and independent living. Ways of transforming out of hospital care are being considered. It is known there are lots of activities which currently take place in hospital		

	which can be delivered in the community with pre-existing resources and changes in resources. SFHFT has a key role to play in this area. The focus of work for 2018/2019 is in relation to planning for the next 3 years and looking to move into the delivery phase. SFHFT has to evolve the way in which it's working, the key to which is gaining confidence with partners in a collaborative way. AH advised the Trust has strong relationships with primary care. There was a clinical cabinet, which was on the governance structure, and which has representations from the 6 localities in mid-Nottinghamshire, mental health and acute consultants. Approval has been given to the clinical model for end of life care which will be provided across the system. The focus has moved on to the diabetic pathway, particularly looking at pre-diabetes and what interventions can be made to prevent patients from getting the disease or minimising the risk of complications. Cancer is also a focus within this realm as it is recognised more can be done, not just to deal with the current cancer cases but to prevent future cancers. The musculoskeletal model is attracting a lot of interest nationally. The partnership approach across all organisations for musculoskeletal has been in place for about 12 months and this provides expert physiotherapy triage for patients with back pain as well as looking at health coaching, i.e. non-medical intervention, with support, to help patients understand their back pain. In relation to hip and knee joint replacements, a shared decision making approach is being taken, ensuring patients understand what the outcome will be, that it is the outcome they desire and it's the right outcome for them. AH advised the locality hubs will be important. These are geographical locations where care will be delivered to populations. Mid-Nottinghamshire will be seen as 6 local populations and it will be possible to identify if there are any inequalities in terms of health outcomes across those populations, understand why and move resources to deal with this. In terms of external partnerships, research continues to move from strength to strength in SFHFT. The bulk of research is based around Nottingham University and the Trust is linked into that. In addition, there is a link with industry in terms of research which is strengthening. In terms of the use of IT, work has been done in relation to agency spend for both nurses and medical staff with an industry partner using IT but very much as an enabler for our internal processes. This has delivered significant benefits in terms of agency spend. GW felt whilst the driver has to be quality, it is important not to forget finances. Instead of looking internally at the Trust's own Financial Improvement Programme (FIP), the Clinical Commissioning Groups (CCGs) looking at their QUIPP and Nottinghamshire Healthcare looking at their equivalent, can these be joined together? There might be a cost increase in one area but potentially saving in another. If it can be evidenced across pathways, how much relates to which area and that everyone has 'bought into it', it provides a better chance of delivering financial as well as quality improvements.		

	AH advised the Transformation Board is reviewing the finances of the programmes, not just in terms of QUIPP but also in terms of total cost. The single control total starts to enable this dialogue. NG felt the key point is engagement and trust with partners. If the QUIPP doesn't deliver this year the CCGs would potentially increase their deficit and may take actions which would affect the Trust. There is a need for mutual trust, respect and communication for this to work at a system level and this is key to delivering quality and financial improvements. JM felt the hubs / local integrated teams are important. There is a need to build trust with primary care and the way SFHFT can build trust is to actively support those developments. Some thought should be given to how this organisation works as a partner to build trust. SiB felt the financial mechanism of how resources are shared around the system is a critical point of how trust is built. The Board of Directors were ASSURED by the report		
16/877	**STRATEGIC PRIORITY 5 – TO PLAY A LEADING ROLE IN TRANSFORMING LOCAL HEALTH AND CARE SERVICES** ***STRATEGIC PARTNERSHIPS - UPDATE***		
12 mins	AH advised the previous Strategic Partnership meeting between SFHFT and NUH was held in December 2017, the March meeting being cancelled due to bed pressures at both organisations. However, the pattern of bi-monthly meetings has now been re-established. Despite meetings not taking place, work has continued. The shared service with Urology commenced in November 2017 and this has been very successful, both in terms of clinical outcomes and workforce. More consultants have been recruited who will be joining the service over the next few months. There are currently 65 cancer cases being discussed each week in a joint Multi-Disciplinary Team (MDT) meeting. There has been an increase in referrals into the service both in Nottingham and in Mid-Nottinghamshire. The on-call arrangements, which see emergency admissions being diverted to Nottingham, is working well and delivering a better experience and outcome for patients. For non-cancer areas, such as kidney stones, there is improved MDT working and support. This is popular with medical staff who have been very supportive of the transition. Neurology has progressed and will be opened to 'choose and book' patients shortly, with a view to moving to the full service provided by NUH from the SFHFT site at the beginning of August. An agreed model for a shared service and an agreed model for an NUH@ service is in place. The clinical and operational governance and the financial modelling of those have been worked through. Therefore, there is a template set for other specialities. The quality of service which will be delivered by the NUH@ service will improve on and make the service sustainable. The Trust is tightening up the description of the support already in place for oncology, this being medical oncology support as opposed to cancer		

in its widest sense. Things which can be done differently are being considered, including bringing some of SFHFT's patients, who currently have to travel to Nottingham for treatment, back into this locality. A 5 year vision for this area of work is being developed.

Vascular has been an NUH only service for the past 2 years and this is being tied up into the financial model. Stroke has been a shared service for a number of years and the stroke service at SFHFT continues to provide high quality care. An issue that needs to be dealt with is Mechanical Thrombectomy, which is a process for removing a clot. Nottingham will be the regional service for that and an understanding of what the pathways will look like needs to be gained.

There are a few other short term areas which need to be worked on which the Strategic Partnership will pick up, for example, the rota for looking at patients who have had gastrointestinal bleeds. Currently this is done separately but there is a query if there is some synergy in bringing that service together.

Outside of clinical areas there is a business case which is progressing, both through the organisations and with STP approval, around sterile services. There is a joint options appraisal going forward.

Pathology services have been slightly disjointed. Ways of developing a network approach with NUH are being considered.

Work is ongoing in relation to Acute Clinical Services Strategy. Within this the strategic partnership is dealing with the short term issues, some of which relate to services which need to be made sustainable at SFHFT, while the Acute Services Strategy is looking at describing how clinical services work. NUH has a large district general function but also has a tertiary function of specialist work. There is a need to understand how SFHFT manages local work in the context of that specialist work. This is one of the things which the Acute Clinical Services Strategy is looking at, in addition to how that integrates into community services and mental health. There will be a number of themed service reviews over the next 12 months which SFHFT will be active partners in.

JM acknowledged this is a really important strategic partnership for the Trust and noted the issues for SFHFT are in relation to sustainability of local services, efficiency (for example sterile services and pathology) and how the estates are used across the two trusts. The Medical Directors from both trusts have worked well together but it would be useful to get wider engagement across some of the other executive functions, focussed on particular issues.

RM noted in relation to estates, the Chair of NUH has proactively referenced SFHFT has got very good estate in general, but with capacity for extra suitable acute patients, whereas NUH has variable estate but too many patients. This supports SFHFT's strategy to identify suitable patients who can be repatriated back to SFHFT. However, there is work to do in relation to theatres, intensive care and sterile services to support that.

	JM felt the Trust needs to consider if the clinical and managerial leadership capacity and capability is in place to take this agenda forward and what are the implications for the Trust. The Board of Directors were ASSURED by the report		
16/878	**PATIENT STORY – A PATIENT'S JOURNEY**		
33 mins	RB, GS and AW presented the Patient Story which related to a patient with a challenging condition and the challenges faced by the ward team during this patient's 6 week stay in hospital. RB noted the lessons learned as a result of this case are the need for early discussions with social care and CAMHS to gain background information on the patient, nursing resource support from CAMHS to be put in place sooner and regular MDTs to be arranged with transparent communication back to ward team. RB advised weekly MDT meetings are now held for all long stay complex patients in order to progress actions. The level of training required to support staff has been increased, using resources already available within the Trust (for example Learning Disability (LD) nurse, ADHD nurses and psychiatry team). A meetings guide for staff has been produced to provide clear communication following all strategy/discharge meetings and the self-harm pathway has been reviewed to prevent inappropriate admissions. It was noted that a business case was in progress to refurbish the room used by the patient during their stay in hospital. JM acknowledged this is an inspirational story in terms of what the team did, how they worked with other people and the care and commitment demonstrated. RM felt the compassion shown to the patient and their family by the ward team over a long period of time was incredible. RM enquired if more could be done in terms of information sharing and sharing of learning about how Ward 25 cared for this patient. SuB advised that a direct link could be set up. Phil Bolton is looking at restrictive practice. SH advised she visits Ward 25 on a regular basis and is always impressed with the staff. During this period SH was particularly impressed with the compassion shown to the patient and their family and also with how well the team supported each other on a daily basis. TR enquired if there was anything else the Board of Directors could do to support the team. AW advised some things are already in place. RB has a robust plan for managing children with complex needs and sets up the weekly MDT meetings within 7-10 days of admission. The team is now more child centric; previously the team tended to link with partners. RB acknowledged the support received from SiB and Denise Smith.		

	NG enquired if the patient had any medical interventions during their stay in hospital. RB advised the patient was initially admitted as there was nowhere else safe for them. However, the patient did have some medical issues and some interventions for a short while whilst in hospital. AW advised partners were querying if the patient's behaviours were being triggered by a physical cause. Therefore, in order to get to a point where they could be declared medically fit, it was necessary to go through a process of exclusion. The patient was medically fit within two weeks, with the remaining four weeks working towards a suitable and appropriate discharge.		
16/879	**SINGLE OVERSIGHT FRAMEWORK PERFORMANCE REPORT**		
36 mins	**OPERATIONAL** SiB advised the Trust achieved 95.7% for the ED 4 hour standard in May, placing SFHFT 15th of 137 trusts; this achievement is notable as medical admissions are currently 12% above plan. It is expected the Trust will achieve the standard in June and for Q1. It was reported at last month's Board of Director's meeting that there had been one patient who waited over 12 hours from the decision to admit in May. Unfortunately, there was been another case in June where the patient was waiting for a mental health bed. Actions have been agreed to improve waiting times for these patients with East Midlands Ambulance Service (EMAS) and Nottinghamshire Healthcare. The root cause analysis report for both of these cases is due on Monday 9th July 2018. This will be shared with NHS Improvement (NHSI). JM acknowledged that if the Trust achieves 95% for the ED 4 hour standard in Q1, this is a significant recovery from Winter. SiB advised the 62 day cancer standard was achieved in April and is above trajectory. This standard has been achieved in four of the last five months. However, it was noted there is still a backlog to be dealt with, the reduction of which remains a priority. Urology is key to this and an additional two Urologists are due to start at the Trust over the next couple of months. This will help in terms of reducing the urology backlog but imaging capacity remains a constraint. There has been a 25% increase in demand for urology services over recent months, which may be due to recent high profile cases of prostate cancer being reported in the media. It is anticipated there will be some dips in the 62 day performance over the coming months, but this will be kept under control. CW enquired how patients' expectations on the cancer pathway are being managed. SiB advised the Trust, working together with colleagues from NUH, is putting on extra capacity to get patients treated as quickly as possible and ensuring patients who do go over the 62 days don't have an extended wait. JM enquired if there is a clear plan in place for every patient.		

	SiB advised a cancer Patient Tracking List (PTL) meeting is held every week to look at every patient and identify when their appointment is and what is their predicted next step. There are a relatively small number of patients with cancer which enables them to be proactively tracked. SiB advised NHSI have accepted the Trust's trajectory. There is about three months backlog to clear, as per the trajectory, before getting to a more sustainable position. In relation to elective care, diagnostics achieved the standard in May. This remains on trajectory and this position is sustainable throughout the rest of the year. However, it is known that imaging capacity will be a constraint. The Trust has one MRI scanner and three CT scanners, one of which is at Newark. One CT scanner is currently down and this is due to be replaced in the autumn. Work is ongoing to attempt to increase MR scanning capacity and make the Trust more sustainable in the future in this area. Referral to Treatment (RTT) has improved and is now at 90% but this is outside the range of the trajectory. This is progressing but not as quickly as anticipated. The reasons for this are the waiting list has dropped, which is a positive thing for the future, but some of work around MSK, etc. of reducing demand into consultant led services and dropping the waiting list, changes the denominator which is being measured against. Additionally the transfer of neurology services to NUH was due to happen in July, but this will now be in August. This is worth 0.5% on RTT. Urology capacity has moved into cancer care and this is having an impact on elective work and workforce remains a critical issue for the Trust, particularly senior medical staff. Work is being undertaken with consultant colleagues to understand the root cause for a reduction in willingness to uptake waiting list initiative work. It is anticipated RTT will be approximately 90.5% next month. This is outside the trajectory. However, following a deterioration in RTT for 9 consecutive months, this is now an improving position and the aim is to reach 92% before Winter. JM noted the Trust is £350k down on elective activity across a range of surgical specialties and enquired what the reasons were for this. SiB advised in-patient elective care is down on plan. From an RTT perspective the Trust is significantly up on plan for outpatients and day cases, so from an activity point of view these two areas are doing well. The productivity work is in relation to inpatient elective work which is 49 cases down on plan. SiB advised he will be taking over the theatres workstream group and felt there is more which can be done in relation to planning of theatre productivity to get elective inpatient work back on plan. NG queried if the fact that activity is above plan but income is below plan is due to case mix. SiB advised orthopaedic work is critical as it brings in a high tariff. There is not the same level of case mix variability in orthopaedics as in general surgery, neurology and other specialities. Therefore, orthopaedics is a key area to bring the Trust back on plan and this will		

materially improve the financial position.

JM noted, given the strategic discussions, there is a need to ensure the Trust is doing well and productively on elective work. If the Trust wants to treat more elective patients in the future, it needs to provide an efficient service.

There are currently 40 patients who have been waiting over 52 weeks. All these patients have been offered an appointment date within 2 weeks. There are 9 patients which the Trust has been unable to contact. Of the patients seen so far, no harm has been reported.

TR enquired what the process is for trying to contact the 9 patients who have been uncontactable so far.

SiB advised contact details are checked with the GP practice. If the patient remains uncontactable for a period of time the clinician will ultimately review the case and take the decision whether to remove from the waiting list.

QUALITY

SuB advised in relation to dementia the Trust is on trajectory to achieve the target in September. The initial screening improved from last month's figures of 66.5% and is now 82.2%; 100% of those patients have been assessed and investigated. The figure for refer is just under 80%. It was noted these figures are for April 2018. The figures for May have recently been submitted and the target for 'find' has been met. This is a significant improvement.

The Trust's privacy and dignity policy has been updated. The falls position remains below the national average. There is ongoing work in relation to falls. This is the third week of the 8 week 'Colour me Safe' pilot in Healthcare in the Elderly and rehabilitation wards. This has been well received by visitors, staff and patients and has been extended into trauma and orthopaedics as there has been a slight increase in falls in this area.

Infection control remains well below the threshold, with zero cases of MRSA. VTE compliance is above the national standard and this will be monitored as there has been a drop in the Midlands and East region.

In relation to the staffing position, there are still vacancies. It is anticipated 57 newly qualified nurses will start in September. The Trust is keeping in touch with these applicants as it is likely they will have been offered more than one post. Retire and return is becoming an issue. There are 6 RGNs planning to retire shortly, only 4 of which are planning to return. Work is ongoing in relation to retention, including working with NHSI.

The LD review, Changing our Lives, has been positive. NHSI have launched LD standards. SFHFT will be reviewing those and aligning them with the Trust's improvement plan for LD. In September there will be a requirement to submit the Trust's position against those standards. While this won't be mandated, SFHFT have chosen to submit this information. It is recognised there are some areas for development but

also a lot of positive responses.

TR enquired what the retention rate is of newly qualified nurses.

SuB advised staff are being retained but generally the age group of newly qualified staff leave after 18 months to 2 years, but this is not disproportionate to other organisations. This cohort of staff does not necessarily wish to stay in one organisation and/or doing the same job. SFHFT are introducing 'Love our Learners' sessions for RGNs who have been at the Trust for 12 months. The aim of the session is to get feedback about their experiences during their first year and establish if they want to move to another area or do something different.

SERIOUS INCIDENTS

PM advised there were four serious incidents in May. One of these relates to an historical matter and another is an ongoing matter involving the Police.

The other two cases are concerning as they reflect a general concern about the ophthalmology referral management process.

It was noted the end of Q4 / start of Q1 tends to see an increase in serious incidents which could be the legacy effect of Winter. The current position for June is only one serious incident.

NG noted it was reported last month that there were no underlying trends. NG enquired if this position remains the same.

PM advised the top three serious incidents have changed over the last few years as previously the issues were failure to recognise serious illness, problems with sepsis management and issues with falls management. However, SFHFT has learned and improved in those areas. The common underlying problems across the NHS tend to relate to communication, competence, team working and culture, which are issues the Trust have been tackling.

JM noted it is important the ophthalmology issues are followed through.

ORGANISATIONAL HEALTH

JB advised there are no exceptions to report this month. The sickness absence rate has been held at below 3.5% for the last three months. Appraisal performance in May was 95% and mandatory training is still above target. It was noted there had been some slippage over the last two months but it was noted there have been some changes to the frequency of safeguarding training. Staff turnover has dropped this month.

FINANCE

KG advised the position for May pre-Provider Sustainability Funding (PSF) was a deficit of £9.83m, which is £240k worse than plan. However, this is a slightly improving position in terms of run rate against Month 1. PSF has been assumed to be delivered for Q1 due to ED performance and control total, which would reduce the deficit to £8.5m

	but is still £240k adverse to plan. FIP is delivering to plan at Month 2, although there are concerns that the plan increases towards the latter end of the year. Agency locum costs are above the ceiling by £250k. Capital spend is slightly below plan but is expected to return to plan shortly. The cash position is good at £1.3m ahead of plan. The main components relating to the adverse position are elective income being below plan and medical pay is £960k adverse to plan. This is due to a combination of sickness, vacancies, capacity remaining open and waiting list initiatives. Non-elective income is £1.3m over plan and additional capacity remains open. A full year forecast will be undertaken at the end of Month 3 and reported to the Finance Committee and Board of Directors. FIP is high risk of non-delivery of the £17.3m plan and there is some uncertainty in relation to QIPP, the impact on demand and capacity requirements. CW enquired if elective surgery work, specifically gynaecology, was not coming through the acute sector or if the work is going elsewhere and sought clarification regarding this in terms of looking at projections. KG advised there is a reduction in birth rates and this is a national trend. No shift has been seen between any areas or repatriation, in or out, so this is also a national trend. Gynaecology is something which is being looking into as this is one of the areas where the CCG are looking at changes to practices and pathways. Therefore, this may have some impact. AH advised Model Hospital suggests SFHFT is an outlier on gynaecology outpatients in that the numbers are high. SIB advised work is ongoing in relation to this. The gynaecology waiting list is reducing. There is possibly some market analysis to be done. JM felt there is a need to understand if this is a shift or a trend. This is an area to be looked at when doing the deep dive at the end of Month 3. The Board of Directors were ASSURED by the report		
16/880	**MATERNITY ACTIONS - MINOR UPDATE TO MATERNITY SERVICES DATASET**		
13 mins	PM advised NHS Resolution (NHSR) operate Clinical Negligence Scheme for Trusts (CNST) which is an insurance against medical negligence and other issues. In January 2018 a scheme was launched to enable organisations to apply for a discount on insurance costs if they can demonstrate sufficient progress against 10 actions. NHSR are inviting Boards of Directors in organisations which provide maternity services to make a self-certificated return. NHSR will make a decision on how much discount the Trust may receive based on that return.		

	From the paper presented to the Board of Directors it was noted the requirement was achieved in relation to 9 of the 10 questions. PM advised the exception related to the question, Have you reported 100% of qualifying 2017/18 incidents under NHS Resolution's Early Notification scheme? This refers to a requirement to report every case of a brain injury which requires the baby to be cooled. It was thought SFHFT were achieving this. However, NHSR have indicated they felt the Trust hadn't informed them through the scheme of four cases which occurred during June and July 2017. Therefore, the view has been taken that this requirement is not currently achieved. PM noted NHSR are the final arbiters and if their information is SFHFT are not meeting this requirement, it cannot be submitted as such. Therefore, the recommendation is for the Board of Directors to authorise the Chief Executive, as accounting officer, to submit the return on behalf of the Board of Directors with requirement achieved for all questions except the final question. AH enquired if there was scope in the return to give additional information in relation to the requirement which isn't met. PM advised it is an absolute return as either met or not met with no scope for additional information. In relation to the question, Are you using the National Perinatal Mortality Review Tool (NPMRT) to review perinatal deaths? AW advised this is an online tool and, therefore, it is difficult to evidence. However, this will be logged to provide a capture mechanism going forward. RM enquired what the process for submission is. PM advised it is a yes/no on-line return. NHSR's expectation is that boards will have reviewed the evidence before making the submission. RM advised ways of writing to NHSR to them the provide commentary will be investigated. TR enquired if this will be an annual assessment. AW advised the understanding is this is an incentive scheme to ensure board level patient safety in maternity services is on track. BB enquired if the issue relating to referral to tertiary units was experienced by other District General Hospitals (DGH). AW advised active cooling is a tertiary and not a DGH function. Therefore, this issue is not unique to SFHFT. The Board of Directors APPROVED the submission of the self-assessment to NHSR		
16/881	**NHSI CAS ALERT**		
7 mins	PM advised during the recent CQC Well-led assessment, the CQC also carried out a review in relation to implementation of CAS alerts and		

	exposure to Never Events. Two alerts were subject to review, namely, reducing the risk of oxygen tubing being connected to air flowmeters and the risk of nasogastric tube misplacement. CQC have not advised the Trust of any major issues in relation to this. SFHFT will not necessarily receive an individual report but will receive a report summarising the whole CQC review. A letter from NHSI has recently been received by the Trust's Medical Director and Chief Nurse highlighting concerns around CAS alerts. Of particular concern is that in some trusts, boards may be marking an alert as action complete when this may not be the case. The challenge for boards is some of the older alerts which are still relevant. In addition, there are risks where alerts require action to be developed rather than action plans to be implemented. It was recognised a number of alerts are vague, for example, an alert requiring an assessment to be completed and a plan developed can be closed on the system as complete without the plan being implemented. Alerts which span more than one area and historic alerts which describe how practitioners must act are also a risk. Therefore, it is proposed the Board of Director's governance arrangements are strengthened by considering how to undertake periodic testing / auditing of alerts which fall into the risk categories AH felt there is a need to consider if CAS alerts issued prior to 2013 were fully implemented and how these are monitored to confirm continued compliance. The Board of Directors AGREED periodic testing of CAS alerts should take place. The details of how this is progressed are to be discussed at Audit and Assurance Committee (AAC). ***Action*** • **AAC to discuss process for undertaking periodic testing / audits of CAS alerts, utilising Internal Auditors**	**SH**	**27/09/18**
16/882	**WORKFORCE REPORT – RESOURCING**		
24 mins	JB presented the quarterly workforce report in relation to resourcing, advising this report covers a wide range of areas due to it being the first report presented to the Board of Directors. The annual workforce plan, which links to finance and activity, has been submitted to NHSI. During Month 1 the Trust used more Whole Time Equivalent (WTE) than was planned for. However, the positive is agency spend has been reduced by more than was planned for. JB advised there has been a sustained improvement, with some fluctuation, over the last two years in relation to staffing levels for medical staff. Work is being undertaken to focus on specific specialties and services which are impacted so this can be effectively monitored. There tends to be seasonal fluctuation in nursing staffing levels as there is the student outturn in September / October which boosts numbers.		

There is usually gradual movement over the rest of the year. It was noted some nurses have moved from Band 5 to Band 6 on promotion. There are 57 newly qualified nurses who are due to start later this year, although it was acknowledged some students have already dropped out due to taking up offers with other trusts. However, there are two further assessment centres before September so this number should increase. The position regarding students is slightly improved on last year. However, it is a competitive market and the Trust is doing everything possible to retain students while they are waiting to take up post, for example, 'Meet and Greet' and 'Warm Welcome'.

In relation to international recruitment, there have been recent changes to the cap on Tier 2 visas which had been causing problems in relation to medical staff as people, despite meeting the criteria for Certificate of Sponsorship, couldn't get a visa due to there being too many applications in the month. However, this cap has been set aside for a period. The Trust will be undertaking an international recruitment drive for nurses utilising Skype, in conjunction with an agency another NHS Trust has had some success with.

JB provided an update in relation to Clinicians Connected, which the Trust signed up to through Derby last year in the hope of getting more international medical staff. There has been some success in identifying people but the required employment checks are taking a lot of time to complete. It is unclear if this scheme will be continued. However, the Trust only has to attract 1½ medical staff per year using that system for it to prove cost effective.

In relation to retention, the Workforce Planning Committee has started to drill down into retirement ages and demographics. Overviews have been completed looking at the overall age distribution within the Trust, particularly focussing on people aged 50+ and breaking this down for the nursing workforce. This is particularly challenging as nurses have a special class status in the pension scheme which enables them to retire on a full pension at age 55. As 40% of the nursing workforce is aged 50+, projections are being looked at. 20% of the nursing workforce is aged 55+. It was noted these figures include people who have already retired and returned to a substantive post but it doesn't show people who have retired and returned to do bank shifts.

26% of medical staff are aged 50+ but they don't get the special pension status. However, there is challenge, particularly in relation to senior medical staff, relating to new Inland Revenue rules around lifetime and annual allowances for pensions, which could lead to people reflecting and taking the decision to retire earlier. This needs to be looked at by specialty and a plan developed for individual services.

JB advised a lot of information is produced weekly with the rostering services report in relation to bank and agency usage which is useful for wards and managers in their operational use when considering allocating and utilising staff.

Model Hospital metrics, which is used as a tool to benchmark across the NHS, are now available. This is still in its infancy so there is a danger it may not be comparing like for like. However, this is becoming a useful tool. In relation to vacancies, SFHFT is not far from the

	national median in respect of medical staff. The data in relation to RGNs is being checked as it was thought this showed all registered nurses. However, it appears that it is the Trust's Band 5 position which is showing for March. There are other useful areas within the model hospital metrics in relation to retention rates and sickness rates. Some new roles are being developed. In order to bridge some gaps within the workforce different approaches are being considered with the possibility of introducing new roles. For example, the role of Doctors' Administrator is being trialled in trauma and orthopaedics. If this goes well it will be rolled out further. An early review in relation to this with be conducted through the Workforce Planning Group. Work is ongoing to gain an understanding of the new levy in relation to apprenticeships. However, the Trust has a target of 48 apprentices and there are 36 in place so far so this target should be hit. Work is ongoing in relation to wider system working, considering data in relation to the workforce the system has available and is using and how this is categorised in terms of skill group, etc. More work is required in this area. NG enquired what assumptions are made as to when people will retire given they've got flexibility and how that fits into predictions for vacancies in the future, for nurses in particular. JB advised it is difficult as there is no longer a fixed retirement age. It has to be recognised that for nurses age 55 is a trigger and whilst it is difficult to develop detailed plans, this does enable the Trust to gauge the risk in relation to plans. Best and worst case scenarios can be developed and consider somewhere in-between those for retention. The Trust is not yet as sophisticated as that in its planning, but these are things which are being built in. Work is ongoing to identify key posts, such as consultants and medics. Divisions need to know their staff, have those discussions and risk assess the service. This has to be put into the context of the external picture and knowing wider workforce availability. JB advised another concern in relation to the pension issue for medical staff is that eventually this will not just relate to older people as medical staff may start to plan their working life differently if they think they are going to face pension contribution issues early in their 50s. They may consider a better work life balance earlier in their career so they can work longer but have a better balance throughout. JM felt it is right to start looking forward and developing some scenarios which will give an idea about what the range is and, therefore, what the range of the workforce challenge is. BB felt the patterns seen at SFHFT would be replicated in primary care so it is not possible to bring people in from another part of the system; workforce planning needs to happen across the whole system. JB advised there is a close link between the strategy, service change and workforce planning.		

	AH advised Southampton have developed Physicians Administrator posts, which is similar to the Doctors' Administrators role at SFHFT. There is a different Physicians Associate role but in this Trust it was felt administrators would be more helpful. The assistant in theatre is a First Assistant which is usually a highly trained nurse. There are a number of those being trained in the Trust so the alternative role market is being considered. However, the consultant workforce is being overwhelmed with the amount of supervision required as deanery junior doctor trainees, non-deanery junior doctor trainees, clinical fellow programme and specialist nurses all require supervision. CW enquired if there are secondment opportunities for staff at SFHFT or within other parts of the healthcare system in partner organisations around the region to experience different aspects of the system, enabling people to grow and develop within the NHS. JB advised there are things like rotational nurse being developed through STP work where individuals can get experience of different healthcare settings. This has an advantage in terms of retention but also broadening skillset and awareness and helping to create seamless pathways. There is more work to do in relation to this. The Board of Directors were ASSURED by the report		
16/883	**FIT AND PROPER PERSON REQUIREMENT ANNUAL REPORT**		
1 min	SH presented the Fit and Proper Person Annual report, advising the Trust is compliant with the revised guidance from January 2018. The Board of Directors were ASSURED by the report		
16/884	**ASSURANCE FROM SUB COMMITTEES**		
1 mins	No sub-committee meetings have been held since the last Board of Directors meeting.		
16/885	**COMMUNICATIONS TO WIDER ORGANISATION**		
mins	The Board of Directors agreed the following items would be distributed to the wider organisation • Patient Story • Performance • Wider system working • Workforce		
16/886	**ANY OTHER BUSINESS**		
1 min	No other business was raised.		

16/887	**DATE AND TIME OF NEXT MEETING**		
1 min	It was CONFIRMED that the next Board of Directors meeting in Public would be held on 26th July 2018 in the Boardroom at King's Mill Hospital at 09:00. There being no further business the Chair declared the meeting closed at 12.15pm		
16/888	**CHAIR DECLARED THE MEETING CLOSED**		
	Signed by the Chair as a true record of the meeting, subject to any amendments duly minuted. John MacDonald **Chair** **Date**		

16/889	**QUESTIONS FROM MEMBERS OF THE PUBLIC PRESENT**		
	No questions were raised		