

UN-CONFIRMED MINUTES of a Public meeting of the Board of Directors held at 09:00 on Thursday 27th September 2018 in Rooms Civic 1 & 2, Newark & Sherwood District Council, Newark

Present:	John MacDonald	Chairman	JM
	Claire Ward	Non – Executive Director	CW
	Neal Gossage	Non – Executive Director	NG
	Graham Ward	Non – Executive Director	GW
	Tim Reddish	Non – Executive Director	TR
	Barbara Brady	Non – Executive Director	BB
	Dr Andy Haynes	Medical Director & Deputy Chief Executive	AH
	Julie Bacon	Executive Director of HR & OD	JB
	Peter Wozencroft	Director of Strategic Planning & Commercial Development	PW
	Paul Robinson	Chief Financial Officer	PR
	Suzanne Banks	Chief Nurse	SuB
	Shirley Higginbotham	Director of Corporate Affairs	SH

In Attendance:	Sue Bradshaw	Minutes	
	Joanne Smith	Minutes	
	Denise Smith	Deputy Chief Operating Officer	DS
	Robin Smith	Deputy Head of Communications	RS
	Claire Singh	Team Lead & Specialist Physiotherapist in Amputee Rehabilitation	CS
	Kate Wright	Associate Chief Allied Health Professional	KW

Observer:	Gail Shadlock	NeXT Director Scheme	
	Ann Mackie	Governor	
	Ian Holden	Governor	
	Andrew Topping	Press – Mansfield Chad	
	Carl Miller	Associate Chief Allied Health Professional	

Apologies:	Richard Mitchell	Chief Executive	RM
	Simon Barton	Chief Operating Officer	SiB
	Kerry Beadling-Barron	Head of Communications	KB

Item No.	Item	Action	Date
16/962	WELCOME		
1 min	<p>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.</p> <p>JM congratulated Barbara Brady on her appointment as a Non-Executive Director for the Trust.</p>		
16/963	DECLARATIONS OF INTEREST		
1 min	JM declared his position as Chair of the Mid-Nottinghamshire Better Together Board.		
16/964	APOLOGIES FOR ABSENCE		
1 min	<p>Apologies were received from Richard Mitchell, Chief Executive Officer, Simon Barton, Chief Operating Officer and Kerry Beadling-Barron, Head of Communications.</p> <p>It was noted that Denise Smith, Deputy Chief Operating Officer, was attending the meeting in place of Simon Barton and Robin Smith, Deputy Head of Communications, was attending the meeting in place of Kerry Beadling-Barron.</p>		
16/965	MINUTES OF THE PREVIOUS MEETING		
1 min	Following a review of the minutes of the Board of Directors in Public held on 30 th August 2018, the Board of Directors APPROVED the minutes as a true and accurate record.		
16/966	MATTERS ARISING/ACTION LOG		
1 min	The Board of Directors AGREED that actions 16/847, 16/881 and 16/938 were complete and could be removed from the action tracker.		
16/967	CHAIR'S REPORT		
6 mins	<p>JM presented the report and advised interviews for a Non-Executive Director, with expertise in system working and OD, would be taking place on 3rd October 2018.</p> <p>Further discussions are taking place at both a national and Nottinghamshire level in relation to the Integrated Care System (ICS) in relation to different financing systems, the role of the ICS in regards to the Integrated Care Providers (ICPs) of mid-Notts and Greater Notts, legislation, etc. It is recognised there is still a lot of work to do. However, given the current national political environment it is unlikely things will progress quickly at a national level. There are some advantages to this as it provides time to shape the system at a local level.</p> <p>The National Plan was scheduled to come out at the same time as the budget statement, which has been brought forward to 29th October</p>		

	<p>2018. JM advised he attended a briefing on progress of the National Plan and has some concerns it is going to be very broad with 15 workstreams. Consequently, the document is likely to be a fairly high level document with lots of further work required on the detail.</p> <p>Discussions regarding health of the population have started at ICS level. The issue relates to a change in behaviour of the population, which is a much wider issue than just public health. SFHFT, like other organisations, needs to think about its role and how to change mind-sets.</p> <p>The Trust needs to balance quality, performance and financial effectiveness. There is a need to demonstrate that the Trust is doing everything it can in relation to controlling finances whilst maintaining and continuing the journey of improving quality and overall performance. As a Board of Directors, there is a need to get the appropriate balance across those different aspects without undermining the good work which has been done in terms of getting the Trust to where it is.</p> <p>The Board of Directors were ASSURED by the report</p>		
<p>16/968</p>	<p>CHIEF EXECUTIVE'S REPORT</p>		
<p>6 mins</p>	<p>AH presented the report in RM's absence. AH echoed JM's comments in relation to the need for balancing quality, performance and finance. The quality measures are strong and the Trust has sustained outcomes, indicating the processes for delivering outcomes are well embedded. Performance remains strong. There were a couple of days in the last 2 weeks when the day started with the Trust having no available beds. However, this was quickly resolved which is an indicator that the processes are embedded and staff have the culture of understanding of what needs to be done to manage flow. The Trust's partners in health and social care are also crucial to managing flow and the right discussions with partners are taking place at the right time.</p> <p>AH stated the Trust recognises staff have been under considerable pressure for most of this year and is, therefore, sensitive about the need to consider staff wellbeing, as well as patient care as we move forward.</p> <p>The financial position is difficult, not just for the Trust but also the wider system. SFHFT has to continue to drive its internal efficiencies whilst contributing to the wider system efficiencies. The clear message is this will only work by transformation, supporting change and enabling different ways of working. The opportunities the ICS and ICP brings are crucial for the Trust and for the system.</p> <p>The executive team have piloted the new leadership programme run by NHS Elect prior to it being rolled out across the organisation. This focusses on inclusivity, how to get teams working well together and creating a supportive environment from which resilience can be managed.</p> <p>10 staff have achieved their silver level badges in the national QSIR programme for quality improvement. Human factors training is starting to rollout across the organisation and positive feedback to this has been</p>		

	<p>received. The national staff survey will be issued in the coming month. The Q2 Pulse staff survey results continue to show high levels of engagement scores. The organisation is very aware of some issues which will be addressed through the leadership programme.</p> <p>Preparations have started for next year's CQC inspection with contact being made with other Trusts to learn from their services.</p> <p>The Board of Directors were ASSURED by the report</p>		
<p>16/969</p>	<p>STRATEGIC PRIORITY 1 - TO PROVIDE OUTSTANDING CARE TO OUR PATIENTS</p>		
<p>23 mins</p>	<p>Advancing Quality Programme (AQP) Progress Report</p> <p>AH advised the AQP has been streamlined. Going forward, the AQP board will review evidence against each of the 'stems' in the four campaigns and a central repository for evidence will be established. Evidence for changes considered as embedded will be presented to the Quality Committee and, where appropriate, to the Board of Directors for approval. This will provide assurance actions have been delivered. A fifth campaign has been added which is the 'should do' actions from the last CQC inspection.</p> <p>This approach will streamline the way of working, provide Non-Executive Directors with better visibility of the evidence improvements are embedded and will provide a good evidence base for future CQC inspections.</p> <p>AH advised there are some key campaigns, particularly the Respect programme, which will be rolled out across the Trust over the next year. All plans are on track and there is a good level of visibility.</p> <p>TR advised the Quality Committee welcomes this approach. It will support quality improvement and help staff to correlate the evidence required for quality and CQC.</p> <p>AH drew attention to the 'doughnut' graphs which provide visual information whether an item is red (action needed), amber (action agreed), green (on track) or blue (embedded). This is in addition to the dashboard.</p> <p>NG noted there are 37 'should do' actions from the CQC inspection and sought clarification if these will be completed before 31st March 2019.</p> <p>AH advised some of the actions have been completed but are currently showing as red as the evidence is not available. This should change for next month's reporting.</p> <p>JM enquired if it would be possible to identify 3 or 4 higher level measures which should be presented to the Board of Directors and leave the detailed measures to either the Quality Committee or executive committees.</p> <p>AH advised he would discuss this with TR. AH explained the more detailed report had been presented to demonstrate the new way of</p>		

	<p>working to the Board of Directors. Going forward what should be presented to the Board of Directors will be the blue forms, where actions are embedded, and also exception reporting.</p> <p>Action</p> <ul style="list-style-type: none"> AH and TR to discuss and agree the key quality measures to be reported to the Board of Directors <p>JM raised a query in relation to clinical decision making and perspectives of risk. For example, when considering discharging a patient, the clinician will consider it from their perspective of risk; the community sister will consider it from their perspective of risk, etc. What is probably not considered is the patient's perspective of risk. Falls not level of mobility are measured and people consider actions from that perspective.</p> <p>What's important to the patient is regaining mobility and possibly them taking a bit more risk out in the community of having a fall might be more than offset by them having a better potential outcome by regaining early mobility. However, as a Trust mobility is not measured. The measures looked at as a Trust and nationally reinforce the risk aversion in clinical decision making. For easy movement across pathways to be achieved there needs to be a change to the way in which risks are assessed, decisions taken, etc. across the system.</p> <p>AH advised Liz Sargent, from the Emergency Care Intensive Support Team (ECIST) has delivered a series of roadshows to the Trust across all staff disciplines. Ben Owens, Clinical Chair for Urgent and Emergency Care is working with Liz Sargent nationally. The premise of that work is in relation to risk thresholds and the differences between different staff disciplines in an organisation and different organisations.</p> <p>AH went on to say, there is a need to be clear and open with patients about what they want and having different conversations focussing on the patient's needs as well as their medical needs. It would be useful to get staff across the Trust and partner organisations together to discuss examples and identify differences in risk thresholds and appetite.</p> <p>SuB advised the Allied Health Professionals (AHP) are currently doing a piece of work. For example, the physiotherapist is having conversations in relation to patients not having to wait for a full physio assessment prior to discharge if the physiotherapist has completed a summary. The Associate Chief AHPs have been to several forums with nurses and AHPs to have these conversations and are leading project work in relation to this.</p> <p>JM advised this is important information to understand how the organisation is changing. At an appropriate time it would be useful to have a workshop for the Board of Directors to assist with understanding.</p> <p>Action</p> <ul style="list-style-type: none"> Clinical decision making and perspectives of risk to be a topic for future Board of Directors workshop 	<p>AH</p> <p>AH</p>	<p>25/10/18</p> <p>TBC</p>
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The Board of Directors were ASSURED by the AQP progress report

Response to NHS Improvement (NHSI) Elective Care Expectations

DS presented the letter which the Trust has sent in response to a query from Ian Dalton, CEO NHSI, in relation to elective care expectations. DS advised a comprehensive response has been provided to NHSI and outlined the key points made, as well as the assumptions which have been made in developing the response.

GW sought clarification regarding what is being done to address the non-delivery of actions in Cardiology, Urology and Ophthalmology relating to Referral to Treatment (RTT) performance.

DS advised in relation to cardiology, a GP with special interest was due to start but unfortunately they haven't. Therefore, this has had an impact on cardiology recovery. Cardiology is related to non-admitted activity so that's where efforts need to be focussed. Waiting list initiatives are taking place with 'Super Saturday' clinics being offered. Work is underway across all specialities seeking ways to reduce outpatient review demand, i.e. outpatient reviews which don't need to take place.

In relation to urology, there has been an increase in demand relating to cancer, with this work being prioritised. The work of ophthalmology is covered by the review in outpatient demand.

JM noted that growing elective activity is a critical part of the Trust's strategy and queried what is being done to get this back on track and have all the possibilities for moving more work to Newark Hospital been explored. In addition, JM noted that elective ordinary activity is predicted to be down by nearly 7% and queried if 7% of capacity has been taken out.

DS advised there is a focussed piece of work in relation to theatres workstream. Work has been done in relation to financial recovery which has picked up some key actions in relation to increasing utilisation, getting more on every list and increasing the use of the independent sector. Surgery division are focused on what work can be put through the independent sector through Winter.

As part of their Winter planning, surgery division has been reviewing what additional work can be put through Newark. There has been no discussion in relation to the type of procedures done at Newark, but there have been discussions about increasing activity.

Currently there are no plans to take out the capacity but there is recognition of the need to further investigate the 7% reduction in activity.

JM noted the cost pressures resulting from increased use of the independent sector and if capacity continues at its current level but with 7% loss in terms of income.

	<p>NG noted income has dropped but costs have not decreased. If the Trust is to deliver financial improvement there is a need to see the costs come out as the income is not being generated.</p> <p>DS advised this would be discussed further with the divisions but felt the balance was that although there has been a reduction in elective work, there has been increased demand in non-elective work. The division have been managing that by flexing theatre time. There has also been a shift to day cases and outpatients work, which is different to what was expected at the start of the year.</p> <p>AH advised discussions are taking place in orthopaedics and general surgery and there may need to be a dialogue with the CCG and regulators as the Trust has been restricted on what theatres at Newark can be used for.</p> <p>PW advised the CCGs are focussing on demand management in relation to planned care and urgent care. The Trust needs to proactively anticipate and determine what capacity is required in the new environment.</p> <p>DS advised she would provide a comprehensive report to the Board of Directors in October to provide an update on the work which is underway rather than what needs to be done.</p> <p>Action</p> <ul style="list-style-type: none"> • Update to be provided to the Board of Directors regarding work being done to grow elective activity and maximising theatre usage at Newark Hospital <p>The Board of Directors were NOT ASSURED by the response to NHS Improvement (NHSI) regarding elective care expectations and requested a follow up to be presented to the Board of Directors in October.</p>	DS	25/10/18
16/970	STRATEGIC PRIORITY 2 – TO SUPPORT EACH OTHER TO DO A GREAT JOB		
37 mins	<p>Resourcing</p> <p>JB presented the report, identifying key points within it. JB advised the workforce plan shows activity at M4. Currently the Trust is using 1.5% more staff than plan. While some of the background to this is understood, work is ongoing to get more analysis and reduce some of the overuse as this impacts on the financial position.</p> <p>Medical vacancies are below 10% and there has been a sustained improvement in relation to medical vacancies. Some of the newly qualified nurses have started but there is still a gap, although this is seasonal. 58 newly qualified nurses are due to start in September and October. All of the nurses who were due to start in September did start, which is encouraging for the October intake. There has been some success with international recruitment of nurses. No-one has started yet but there are 20 people with job offers going through the process to enable them to take up post. There is an option to go for a second tranche with the agency the Trust has been working with if it is felt the</p>		

	<p>process is successful.</p> <p>Work in relation to retirement and age demographics has been ongoing through the Workforce Planning Group. The work done so far has identified that different divisions have different challenges. Women and Children division have a slightly older workforce so they are very focussed on this risk, both for nursing and specific medical staff. Urgent and Emergency Care generally has a younger workforce so their challenges are more generally related to recruitment and retention as opposed to being linked to age demographics. However, the Trust is fully staffed with substantive ED consultants. This work is enabling divisions to develop specific action plans for this risk and to do further work.</p> <p>Progress with new role development is being overseen by the workforce planning group, including work on the feasibility of the acute care practitioner role.</p> <p>JB advised an update on the annual training, education and development report was included within the report presented to the Board of Directors, with the full report being available in the Reading Room.</p> <p>JB advised the flu vaccination programme for 2018/2019 had commenced with over 1000 staff being vaccinated in the first week, most of which were front line staff. This equates to 23% of front line staff being vaccinated in the first week. Nationally NHS England have stated an ambition for 100% of front line health care staff to be vaccinated.</p> <p>JB advised a self-assessment has been completed against the Best Practice Management Checklist which identifies the majority of the requirements are met.</p> <p>NG sought clarification as to why the establishment for nurses has increased, from 1327 to 1345 over the last two years and why the number of Band 5 nurse vacancies is at its highest for two years.</p> <p>JB advised August always appears to be the worst month for staff in post for front line nurses, mainly due to newly qualified staff starting from September onwards. The figures in the report show promotions. Band 5 front line nurses seem to have a quicker career path through the bands, meaning there is always the need to fill vacancies at Band 5 level. What is masked in the figures is staff who reduce their hours and/or take flexible retirement as people who retire and return on part time hours or bank shifts don't show as a leaver, but the whole time equivalent (WTE) is lost. The figures don't show how many hours were reduced in the month.</p> <p>SuB advised the budgeted establishment is all registered nurses and includes all specialist and research nurses. Therefore, these figures are not just nurses on the wards. If research capacity is increased with external funding, the Trust increases the number of research nurses. There has been an increase of two nurses in the research team in the last year. There is a robust process in place to review establishment as a confirm and challenge establishment review is completed and signed</p>		
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<p>off each year; there has been no significant increase. The establishment review is measured against national guidance, professional judgment and acuity.</p> <p>JB advised there is some fluidity around services with staff joining on TUPE arrangements when there is a service change. Therefore, establishments are never static.</p> <p>NG sought clarification on the source of funding for research posts and how that fits into the Trust's figures.</p> <p>SuB advised the funding comes from the Clinical Research Network (CRN) and feeds into the research budget, which is monitored separately. SuB drew attention to the fact that the Band 5 Registered Nurse budgeted establishment (which are nurses on the wards) has reduced over the last two years.</p> <p>PR advised funding for research is counted as non-clinical income and is coded directly onto the research cost centre. This has a nett zero but there is a need to set budgets for staff otherwise there will be non-budgeted staff in post to complete research.</p> <p>SuB advised that in relation to the electronic staff record (ESR), these staff are recorded as registered nurses and, therefore, are counted as such in the figures.</p> <p>PR explained the budgeted establishments are set within the annual plan which is signed off by the Board of Directors for the year. Whilst establishments change over time, they are fixed on 1st April for the year. The only amendments in the year would be staff recruited via a business case process or by direct additional funding.</p> <p>GW expressed concern that the Trust's staffing position is over on WTE and felt this should be looked at to gain a better understanding, bearing in mind that whilst there is additional non-elective activity, elective activity has decreased.</p> <p>BB stated it was useful to see the data broken down by age and by division but felt there are significant risks in relation to capacity and competencies and very senior staff as they leave. There is a need to profile where the risks lie. Once the divisions understand the analysis, they need to plan the next steps and how they plan to work with the wider community to attract people into the hospital in terms of the new workforce, for example, working with the local Further Education (FE) sector.</p> <p>CW noted there are a lot of applications for work placements and queried if they are people coming through the FE colleges or people in other care work sectors who are interested in particular roles. CW acknowledged it is helpful to have an understanding of why people don't have the flu vaccine but to work towards the 100% target it would be useful to understand these at an individual level.</p> <p>JB advised the Trust asks anyone who declines the flu vaccination to complete a proforma giving their reason for that. However, this has to be done anonymously. Therefore, the reasons for decline can be</p>		
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	<p>captured but not on an individual basis.</p> <p>CW queried if this is a healthcare and safety issue for staff who have direct contact with patients.</p> <p>AH advised a balance has to be struck between the need to protect patients and the individual's freedom of choice. There was a discussion for the 2017/2018 flu season about the mechanism for recording staff who declined the vaccination and the reason. However, this could lead to disengagement. The critical figure is 90% of staff vaccinated as that is when spread can be stopped. The national guidance recommends for high risk areas that staff who don't accept the vaccination should be moved to another area. However, for this Trust those are areas which would be left short staffed with the only option being to bring in agency staff. This is an example of balancing risk and finance. Uptake of the vaccine in these areas will be monitored through the first 6-8 weeks of the programme. It is not possible to achieve 100% vaccination rate as some people are allergic to the vaccine or have strong views.</p> <p>SuB advised the staff group who had one of the lowest uptake rates in 2017/2018 were the nursing staff. All matrons and heads of nursing were mandated to complete the training to enable them to give the vaccine. Already this year some positive peer pressure has been seen.</p> <p>JM advised while it would be fantastic to achieve 100% vaccination rate, there is a need to recognise there are good reasons why some people don't have the vaccine. The Board of Directors agreed the Trust should aim to achieve a minimum of 90% vaccination rate and develop a policy for high risk areas.</p> <p>AH advised the medical establishment is kept under review through the medical taskforce which has asked for a review from the divisions about excess posts. A number of factors have been identified. However, one issue identified through the medical task force was the additional winter posts from last year were not removed until it was raised through the medical task force.</p> <p>JB advised the Trust offers a wide range of placements and works with educational establishments for placements for both clinical and non-clinical roles. A report will be prepared for the Board of Directors to highlight the different types of placements.</p> <p>Action</p> <ul style="list-style-type: none"> • Report to be prepared for the Board of Directors to highlight the different types of placements offered by the Trust <p>JM acknowledged the good work detailed in the report but advised more work is needed to address the longer term issues, for example, considering age profiles and workforce and how issues relating to that can be managed in the future given the increase in demand across the system. There is a need to think about measures of productivity and how technology can be used to make staff more productive.</p>	<p>JB</p>	<p>25/1018</p>
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	<p>There is a need for greater transparency in terms of establishment and this should be picked up by the Finance Committee.</p> <p>Freedom to Speak Up – self review</p> <p>SH presented the Freedom to Speak up self-review advising this had been undertaken with the Freedom to Speak Up Guardians. Key actions from the self-review are to consider the current model for the Guardians. Currently there are four voluntary Guardians across the Trust. However, they don't reflect the diversity of the organisation. A Freedom to Speak Up strategy which aligns to the Trust's visions, values and strategic objectives will be developed.</p> <p>There is a need to understand the barriers to people speaking up and a more formal approach to auditing of concerns has been developed. The case studies from the Guardian's office should be utilised and a gap analysis against the recommendations needs to be completed.</p> <p>Guardians will present to the Board of Directors twice per year with ongoing actions being reported through the quarterly workforce and culture report.</p> <p>TR advised the Trust is in a good place but there are areas which can be improved. The number of concerns raised is low so barriers to speaking up need to be investigated.</p> <p>JM advised he and TR had met with the Chairs of Notts Healthcare and Nottingham University Hospitals (NUH). It was recognised there are differences in the model and these should be looked at by all organisations to try to get more consistency. There are areas where working together might be more efficient and may provide a level of independence if people are concerned about speaking up within their own organisation. The Board of Directors AGREED to add working closely with other providers to the list of actions from the self-review.</p> <p>Action</p> <ul style="list-style-type: none"> • Working closely with other providers to attain consistency to be added to actions from Freedom to Speak Up self-review <p>The Board of Directors APPROVED the Freedom to Speak-up self-review</p>	SH	25/10/18
16/971	STRATEGIC PRIORITY 5 – TO PLAY A LEADING ROLE IN TRANSFORMING LOCAL HEALTH AND CARE SERVICES		
30 mins	<p>Alliance Delivery Plan Progress Report</p> <p>PW presented the Alliance Better Together Delivery report, advising it relates to the position at M4. The original expectation of the plans was to deliver a reduction in commissioner spend of circa £24m. However, the expectation of delivery of the whole programme has been reduced to £16m. Discussions are ongoing about how the £8m gap will be made up.</p>		

PW highlighted the key risks and progress. There is a lot of activity focussing on the Home First Integrated Discharge Service. It is acknowledged difficulties in community bed capacity are a potential risk affecting delivery of this.

The end of life model is on target to deliver from 1st October 2018. The new set of pathways are clinically driven and will lead to better end of life planning.

The East Midlands Ambulance Service (EMAS) non-conveyance scheme is behind schedule and is being escalated in bi-lateral discussions with EMAS. One of the focal points of the work with EMAS is highlighting the number of people conveyed to hospital by ambulance where no significant diagnostic or treatment ensues.

Outpatient transformation did not commence at the beginning of August. Implementation plans have been finalised to accelerate delivery across at least 6 specialties. A significant element of this relates to patient initiated follow ups.

Greater visibility has been requested of the individual mental health and community schemes which are part of the contract re-specification and how these impact on the wider system.

Integrated Care System Development Update

PW advised there will be two Integrated Care Providers (ICP) in Nottinghamshire, one in Greater Nottingham and the other in mid-Notts, the foundations of which are provided by the Better Together Programme. Relationships with partners are strong, well-embedded and there is a degree of continuity with system leaders.

Local Integrated Care Providers (LICPs) will form the basic building blocks of the ICPs. The current assumption is there will be eight LICPs across Notts with four in mid-Notts. Work is ongoing, co-ordinated by the CCGs, to determine the composition of the LICPs.

CW queried if the management and decision making in relation to the ICPs to LICPs would be ground level up or ICP level down.

PW advised the expectation is the ICPs and LICPs will form integrated structures. They won't be separate organisations per se, but will be linked parts of the same structure. The LICP will be the most important component in terms of creating a consistent approach at locality level to taking responsibility for the health and wellbeing of the population and ironing out inconsistencies and variation. A strong leadership focus at LICP level is required. However, there is no additional resource to implement management structures and arrangements for LICPs.

AH advised LICPs will not all be the same due to the different populations they will be serving. However, governance, financial control, how the effectiveness of patient interventions are measured, etc. needs to be standardised. Locally the view is the ICPs should hold an oversight of LICPs.

<p>JM felt it is important to build on the good relationships which exist within mid-Notts in order to support the LICPs and change mind-sets to think more about a provider supply chain rather than commissioning and providers.</p> <p>GW expressed disappointment that there are four LICPs across mid-Notts, expressing the view this will make communication channelling and management harder than it needs to be.</p> <p>PW advised this has been acknowledged as a risk. There are some GPs who have effectively been commissioning for a while who will need to change their mind-set to recognise the move into the provider sphere and the different ethos to delivering integrated care. One of the key workforce challenges is how GPs balance their time between face to face patient contact and directing a multi-disciplinary team which focusses on health and wellbeing in a different way.</p> <p>AH advised the ICS is still evolving. The integrated care world is about being flexible, agile and adaptable. There is a need to ensure resources are used cost effectively across the system to deliver population health.</p> <p>TR sought clarification about how partners view the Trust.</p> <p>JM advised SFHFT currently has good relationships with partners but it is a changing dynamic. The Trust needs to demonstrate its part of a team of organisations developing the process, recognising the importance of developing the LICPs and actively supporting them.</p> <p>AH advised he recently attended a meeting of the mid-Notts Clinical Cabinet where an update was provided on the muscular skeletal programme, which is a true alliance and has existed for approximately 15 months. An update was also provided about end of life care as this is about to 'go live'. There is a sense that people understand it is a different way of working. The Trust is viewed by partners to be an important 'player' in relation to the changes in mid-Notts and in the Nottinghamshire developments.</p> <p>PW highlighted the key functions of the ICS, ICP and LICP, advising the ICS is likely to have a strategic commissioning function at county level. It is anticipated the CCGs as they are at present will merge into one strategic commissioning organisation, focussing on health and wellbeing related outcomes. It is acknowledged that different organisations have common challenges and it is hoped a common approach to dealing with the challenges in relation to demand, workforce and financial sustainability can be developed.</p> <p>The draft ICP contract is out for consultation from NHS England.</p> <p>JM advised a recent meeting of the Chairs and Elected Members Group received a progress report which related to how the system is currently performing. The group has requested information on how the system is changing and asked for a performance report to be developed which provides Boards with this information. It is acknowledged this will take some time as not all measures are currently available or compatible.</p>		
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	The Board of Directors were ASSURED by the report		
16/972	PATIENT STORY – JULIAN’S STORY		
18 mins	<p>CS presented the patient story which related to a patient’s rehabilitation following amputation.</p> <p>JM felt this was a very moving story and acknowledged the fantastic service provided by the physiotherapy team which has given the patient the opportunity to fight back. This is a good example of integrated care.</p> <p>AH enquired what psychological support is available for patients who have amputations.</p> <p>CS advised counselling and psychological support can be accessed in the community. Ideally each prosthetic limb centre should have a clinical psychologist but this isn’t always the case. Due to the amount of time patients spend with the physiotherapy team, which is time away from their family, the sessions do involve an element of counselling. Patients feel they can talk openly to the team.</p>		
16/973	SINGLE OVERSIGHT FRAMEWORK PERFORMANCE REPORT		
33 mins	<p>ORGANISATIONAL HEALTH</p> <p>JB advised some additional information had been included in the report this month in relation to sickness absence. A graph has been included showing the in month actuals, together with the rolling 12 month cumulative figures. This shows the trend line is coming down. A further graph has been added showing the rolling 12 month trend by division. This shows generally positive trends. There are a number of divisions consistently on or around the target, with corporate below target. The divisions which are above target are showing a generally downward trend.</p> <p>Mandatory training is still green and staff turnover is below the threshold.</p> <p>QUALITY</p> <p>SuB advised there are three exception reports this month. The first of these relates to serious incidents and never events. The Board of Directors had previously been made aware of the never event which relates to a retained wire in a patient’s arm. This and the three serious incidents are being investigated through the root cause analysis (RCA) process. The outcome of the reviews will be reported to Quality Committee.</p> <p>The second exception relates to the avoidable grade 3 pressure ulcer, which is one of the serious incidents. A review has been completed on the ward with the charge nurse and the senior divisional nursing team. SuB advised she was assured by the actions taken and the sharing of information across the divisions. SuB advised she has taken over chairing the weekly pressure ulcer meetings where every grade 2 and above pressure ulcer is discussed, whether this is avoidable or</p>		

	<p>unavoidable.</p> <p>The third exception is the friends and family test. The recommendation rate for maternity and outpatients is slightly off plan. This is reviewed weekly within the division. The response rates are discussed separately at the monthly ward assurance meetings.</p> <p>Despite the fall causing harm serious incident, the number of falls remains below the threshold and below the national threshold. There is a focus through the advancing quality programme on repeat falls and long bone fractures.</p> <p>In relation to the staffing position there was one area below the 80% fill rate in August but there were no adverse events as a result of that and a review was completed. Medicine has the highest number of vacancies at just under 100 Band 5 vacancies. However, they are now working jointly with Urgent and Emergency care in relation to a rotation programme. EAU is at its lowest vacancy position for two years. However, the caveat to that is they have a high number of newly qualified registered nurses. A clinical educator is in place to support them through their preceptorship programme.</p> <p>There have been four occasions when tipping points for staffing safeguards have been reached but this did not result in any associated harm. All staff on duty at the time have been sent a letter of apology. These incidents were as a result of a bank nurse not turning up for shift and not being able to fill the gap with an agency nurse and three other agency nurses not turning up for shift.</p> <p>A lot of work is ongoing in relation to recruitment. There is a celebration event planned for October for nurses who qualified in 2017. This will form part of the retention strategy.</p> <p>There have been three cases of clostridium difficile in August; this is within the monthly threshold. This brings the YTD total to 14 which remains within the 47 annual threshold. There have been no cases of MRSA in August. The pseudomonas outbreak, which was brought to the attention of the Board of Directors in August, continues to be investigated.</p> <p>There has been an improved position for dementia this month. Refer is at 98.7% with 100% for assessment and referral. The Trust is working towards the upload to Nervecentre in late autumn.</p> <p>OPERATIONAL</p> <p>DS reported the Trust is on track to deliver the ED 4 hour standard for Q2. There has been a slight deterioration in relation to ambulance handover times during August which has been attributed to the doctor changeover period. It is recognised when there is a new doctor intake waiting to be seen times increase, which means there are more patients in the department at any given time, reducing the capacity for handover.</p> <p>6 of the 7 cancer standards continue to be delivered, but there are still challenges in relation to the 62 day standard; July performance is below the standard and off trajectory. There has been a sustained increase in</p>		
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<p>2 week wait referrals since March 2018 and there has been an increase in treatments through July 2018.</p> <p>Diagnostics is on track and delivering. The expectation is this will continue to be achieved.</p> <p>RTT performance has held steady in August but is below trajectory. The size of the overall waiting list has risen in line with trajectory. There have been 14 patients waiting over 52 weeks in August, the majority of which are related to the historical validation work.</p> <p>There has been some improvement in ambulance handover times through September as new doctors have embedded. The expectation is there will be no handovers in excess of 60 minutes in September. There is an internal trajectory to reduce over 30 minute handovers to 10% or less. The team have a number of actions in place to help achieve this. Work is ongoing with EMAS in relation to improving the handover process with some of these improvements relating to accurately recording handover times. Some deep dive work has identified some human factors, with better performance when particular shift leads are on shift. Work is underway to understand what they might be doing differently and to share good practice.</p> <p>There was one 12 hour breach in August, which was a mental health patient. There were various factors affecting this patient's pathway, including the fact their first language wasn't English, which meant there was an initial delay in getting an interpreter. The patient was sectioned under the mental health act and the mental health trust were unable to provide a bed within 12 hours of the decision to admit. However, the internal gold and silver escalation processes were followed and proved to be embedded. Following this incident there have been some productive discussions with adult mental health services who are investigating what additional steps they can put in place. A revised escalation process has been agreed so that their timescales mirror SFHFT's. They are also doing some work with their bed bureau.</p> <p>August performance for RTT was 90.6%. It is currently being forecast that the standard will be delivered in November. However, this is dependent on the recovery plans of three big specialities, cardiology, urology and trauma and orthopaedics. In relation to trauma and orthopaedics, the independent sector is being utilised for some activity. That recovery plan is dependent on increasing admitted activity. The focus for cardiology and urology is non-admitted activity. There are waiting list initiatives in place, including cardiology 'Super Saturday' clinics. Work is ongoing across six specialities to reduce unnecessary follow up appointments. The size of the waiting list is on trajectory to reduce by March 2019.</p> <p>JM sought clarification if the specialties where waiting list initiatives and the independent sector were being used were underachieving on their planned activity and queried why extra activity was being commissioned if they are under plan.</p> <p>DS advised the use of the private sector for trauma and orthopaedics has been on a planned basis. Use of the independent sector is focussed on admitted activity. In regards to urology, the focus has been</p>		
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	<p>on prioritising cancer patients but to achieve 18 week delivery they need to focus on non-admitted patients.</p> <p>AH advised in relation to urology the shared arrangement with NUH hasn't provided all the anticipated back-fill. There are ongoing discussions in relation to this through SPF. There is a quarterly report from all divisions through the clinical activity manager. Where individuals 'owe' sessions these are being paid back. By the next quarter there should be a situation where waiting list initiatives are only done if planned activity is up to date.</p> <p>NG noted the report includes a national comparison of the Trust's performance in relation to the ED 4 hour standard and queried if the data was readily available for other performance measures.</p> <p>DS advised this could be included going forward.</p> <p>NG noted there is some fluctuation in performance in relation to the 62 day cancer standard and queried what could be done to make performance more consistent.</p> <p>DS acknowledged there was a dip in performance in July (down to 69.3%). There has been an exceptional increase in 2 week wait demand which has had a huge impact, particularly on diagnostic capacity. There has also been an increase in the number of treatments. Some of those patients will breach timescales and as they are treated performance will dip. There are two cancer pathways on weekly monitoring. The main focus is on diagnosis by day 28 as it is easier to plan timely treatments and to accurately forecast once the diagnosis is known. The challenge for the team has been in relation to the forecast changing due to not having a diagnosis. The focus for September has been on increasing diagnostic capacity. Waiting times, particularly in MRI, have reduced from 3 weeks to 2 weeks and biopsy waiting times have also reduced from 3 weeks to 2 weeks.</p> <p>DS advised consistency will come from the day 28 position and being able to treat patients within month. If a patient experiences a longer delay than anticipated, inconsistencies can come from moving breaches on to the next month. This leads to an improvement in performance in month but an impact on performance the following month, leading to the swing in performance. There are also small numbers in some of pathways. Therefore, a small number of treatments or breaches can make a big difference.</p> <p>NG queried if diagnostic capacity is the bottleneck in this pathway.</p> <p>DS advised diagnostic capacity and reducing waiting times is a key issue. The cancer team are doing a piece of work to identify what capacity needs to be increased by if the upward trend in 2 week wait referrals continues.</p> <p>AH advised the small numbers are relevant as one patient can make 33% difference. However, due to the small numbers there should be an element of control but there are some things the Trust can't control. For example, waiting for specialist input from Nottingham can introduce delays and some patients cancel procedures and appointments more</p>		
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	<p>than once.</p> <p>DS advised in some small specialities, performance was compounded by complex patient pathways in July.</p> <p>JM sought clarification regarding the level of confidence in the ability to deliver the 52 week, RTT and 62 day cancer standards, as noted in the response to the letter from Ian Dalton.</p> <p>DS advised there is a high degree of confidence RTT will be achieved before Winter, the forecast being to achieve this in November. In relation to the 52 week waiters, this is due to the historical validation work and there will always be some inaccurate clock stops leading to some unavoidable breaches. In terms of avoidable breaches, there is a high degree of confidence they will be eliminated. The 62 day cancer standard is more difficult to predict and there is less confidence this will be delivered but all the right actions are in place.</p> <p>In terms of management, there is a move to detailed week to week reviews for some specialties and the right triggers are in place for that. The sustained focus on 28 day diagnosis will make the single biggest difference to forecasting.</p> <p>AH advised there is some discussion at system level about new outpatient referrals, particularly cancer. Every new outpatient has, on average 2.6 follow ups. While trying to reduce unnecessary follow ups appointments the system is being fed by an increase in new patients.</p> <p>TR noted the increase in ambulance handover times relating to the doctor changeover and queried what plans are in place to mitigate that risk.</p> <p>DS advised this has been discussed with the divisional team who have acknowledged the doctor changeover time could have been managed better in August 2018. The learning taken from that relate to how annual leave is managed across the team and much closer management of the rota day by day in the key four week period.</p> <p>FINANCE</p> <p>PR advised at the end of M5 the Trust has a deficit pre Provider Sustainability Fund (PSF) of £21.87m, representing a slight improvement of £170k in month but this remains £30k behind the YTD plan. Full receipt of both Q1 and Q2 PSF funding has been assumed, leading to a post PSF deficit of £18.4m.</p> <p>The financial improvement plan (FIP) is behind by £1m, medical pay is adverse to plan by £2.8m, non-elective income and activity is above plan by £4m and income from elective and maternity activity is behind plan. The nett impact of this is supported by £2.4m of reserves.</p> <p>Agency spend has decreased slightly in month but is still £450k above the ceiling YTD. Implementing the Winter plan will leave an end of year position of £1.9m above the ceiling, which is in excess of the actuals for 2017/2018.</p>		
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	<p>Receipt of PSF in relation to Q1 and Sustainability and Transformation Fund for 2017/2018 has allowed the Trust to borrow less than planned for in month. £7.9m worth of borrowing has been deferred to later periods.</p> <p>The forecast is to achieve the control total for the year but with an £8.6m risk, for which a financial recovery plan has been developed. The risk to achieving the control total has slightly reduced from £8.9m to £8.6m in month, with the risk range being a downside of £11.3m and an upside of £4.7m.</p> <p>The financial recovery plan is in place and weekly meetings to ensure that delivers will start next week.</p> <p>NG noted that if activity reduces there is a need to reduce costs as the income falls.</p> <p>The Board of Directors were ASSURED by the report</p>		
<p>16/974</p>	<p>CYBER SECURITY – BOARD RESPONSIBILITIES</p>		
<p>5 mins</p>	<p>PW presented the report and advised a self-assessment has been completed against the recommendations resulting from lessons learned from the cyber-attack in May 2017. The self-assessment shows the Trust to be compliant or on track to be compliant with the recommendations by the requisite dates.</p> <p>There is more work to be done across the system with partners but no particular vulnerabilities have been identified.</p> <p>AH advised the ICS outline business case is scheduled to be completed in October. The full business case will then be submitted to begin work from April 2019. This includes strengthening cyber security across the ICS footprint.</p> <p>PW advised there is a requirement for Board members to undertake annual cyber security training but NHS Digital has not yet specified the content of this.</p> <p>SH advised this had been discussed at the cyber security board and the view of the Trust is to incorporate this in the IG training.</p> <p>PW advised a significant assurance report has been received from 360 Assurance in relation to business continuity, enabling the elements of the assessment related to business continuity to be marked as green.</p> <p>SH confirmed responsibility for IG and, therefore, cyber security sits with the Risk Committee and by exception to the Audit and Assurance Committee.</p> <p>Action</p> <ul style="list-style-type: none"> • Audit and Assurance Committee to reflect if there is an appropriate level of scrutiny in relation to cyber security <p>The Board of Directors were ASSURED by the report</p>	<p>SH</p>	<p>29/11/18</p>

16/975	ASSURANCE FROM SUB COMMITTEES		
13 mins	<p>Audit and Assurance Committee</p> <p>GW advised a report was received at the last meeting of the Audit and Assurance Committee relating to clinical audit, which normally reports through the Patient Safety and Quality Group and Quality Committee. There have been some changes in responsibility and the Committee requested a more detailed report to be presented to the next meeting to gain a better understanding of the issues and the right level of assurance.</p> <p>There is an ongoing issue in relation to declarations of interest, but there has been some improvement with the number of non-compliant staff reducing from 500 to 370. This is an area which requires continued focus to reach a position where it is normal to complete the return each year. Actions which can be taken to put further pressure on staff to complete the return need to be investigated.</p> <p>Action</p> <ul style="list-style-type: none"> • AH to discuss possible ways of addressing the issue of declarations of interest with GW • TR and GW to clarify responsibilities of Audit and Assurance Committee and Quality Committee in relation to clinical audit work to avoid duplication of work <p>Quality Committee</p> <p>TR advised planning for the 2018/2019 quality account will commence in November 2018. A positive report was received from 360 Assurance regarding transfer of handover. It was recognised there are some areas for improvement for which work is in progress. Some of that improvement will be in place when transfer of handover is included in Nervecentre.</p> <p>SuB advised this had been factored into the Nervecentre planning. Another area being looked at is accountability handover between shifts. This is a separate piece of work and a process should be in place before Christmas.</p> <p>TR advised there has been no requirement to report to 'Each Baby Counts' for over 12 months. The Trust is committed to participate in the national 'Always Events' programme with the aim to minimise the negative side of positive patient identification and generate engagement with the patient to identify who they are.</p> <p>There was a challenge reported through PSQG, which the Quality Committee has asked for more focus on, relating to the shortage of 1 litre saline bags from the normal provider. The chief pharmacist has been invited to present to the next meeting to provide assurance on monitoring, control and ensuring there is a plan in place for any perceived shortage of drugs in the future.</p>	<p>AH</p> <p>SH</p>	<p>25/10/18</p> <p>25/10/18</p>

	<p>AH advised the Trust is now using the national supply. The Trust is compliant with national requirements and there are no risks attached. However, this highlighted other issues over the last 14 months which has led to seeking assurance from the chief pharmacist that they have a process they are following to scan for these issues and responding accordingly to them.</p> <p>TR advised assurance was received in relation to actions being taken and the investigation regarding the never event referred to earlier in the meeting. The BAF was reviewed and there were no amendments.</p> <p>NG sought clarification on the Trust's position to secure supply of drugs post Brexit.</p> <p>AH advised the national guidance is that hospitals do not need to take any action as this is being looked at nationally.</p> <p>Finance Committee</p> <p>NG advised an extraordinary meeting of the Finance Committee took place on 24th September 2018 to discuss the financial recovery plan which will be discussed at the meeting of the Board of Directors held in Private.</p> <p>The Board of Directors were ASSURED by the report</p>		
16/976	COMMUNICATIONS TO WIDER ORGANISATION		
mins	<p>The Board of Directors AGREED the following items would be distributed to the wider organisation</p> <ul style="list-style-type: none"> • Patient Story • Different approach to AQP • The need to balance performance, quality and finance • Operational areas at risk • Financial position • Freedom to Speak Up • Cyber security 		
16/977	ANY OTHER BUSINESS		
min	No other business was raised.		
16/978	DATE AND TIME OF NEXT MEETING		
1 min	<p>It was CONFIRMED that the next Board of Directors meeting in Public would be held on 25th October 2018, in the Boardroom, King's Mill Hospital at 09:00.</p> <p>There being no further business the Chair declared the meeting closed at 12.15pm</p>		

16/979	CHAIR DECLARED THE MEETING CLOSED		
	<p>Signed by the Chair as a true record of the meeting, subject to any amendments duly minuted.</p> <p>John MacDonald</p> <p>Chair Date</p>		

16/980	QUESTIONS FROM MEMBERS OF THE PUBLIC PRESENT		
3 min	<p>A question was received from Ann Mackie, Governor. The overarching principle of the integration process is that savings must be real across the system. Savings in one part of the system should not be made at the expense of another part of the system. Can the Trust demonstrate that the savings to the system which are coming from the use of private providers is greater than the costs that would be incurred by the Trust in running the residual services at Newark or Kings Mill Hospitals because the infrastructure is still required to pick up the complications and post-operative care of the private services.</p> <p>JM advised a brief should be prepared to be shared with the Board of Directors and the Governors in response to this. The Trust needs to be clear it is optimising the use of NHS resources and facilities.</p> <p>Action</p> <ul style="list-style-type: none"> • Brief to be shared with the Board of Directors and Governors in relation to optimising the use of NHS resources and facilities, particularly regarding the use of private providers 	PW	25/10/18