Healthier Communities, 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 3rd September 2020 in the Boardroom, King's Mill Hospital

Present:	John MacDonald	Chair	JM
	Tim Reddish	Non-Executive Director	TR
	Graham Ward	Non-Executive Director	GW
	Neal Gossage	Non-Executive Director	NG
	Barbara Brady	Non-Executive Director	BB
	Manjeet Gill	Non-Executive Director	MG
	Claire Ward	Non-Executive Director	CW
	Richard Mitchell	Chief Executive	RM
	Paul Robinson	Chief Financial Officer & Deputy Chief Executive	PR
	Shirley Higginbotham	Director of Corporate Affairs	SH
	Simon Barton	Chief Operating Officer	SB
	Julie Hogg	Chief Nurse	JH
	Emma Challans	Director of Culture and Improvement	EC
	David Selwyn	Medical Director	DS
	Clare Teeney	Director of People	CT
	Robin Smith	Acting Head of Communications	RS
In Attendance:	Sue Bradshaw	Minutes	
	Janusz Jankowski	Guardian of Safe Working Hours	JJ
	Justin Wyatt	Charge Nurse	JW
	Lisa McCourt	Chief Medical Photographer and Department Head	LM
Observer:	Esther Smith	Corporate PA	
	Sue Holmes	Public Governor	
	Philip Marsh	Public Governor	
	Ian Holden	Public Governor	
	Ann Mackie	Public Governor	
	Rebecca Goodwin	Senior Ophthalmic Photographer/Medical Photographer	
	Lorna Catlin		
Apologies:	None		

The meeting was held in person and via video conference. All participants confirmed they were able to hear each other and were present throughout the meeting, except where indicated.

Item No.	Item	Action	Date
17/698	**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. Noting that due to the circumstances with regard to Covid-19 and social distancing compliance, the meeting was held in person, via video conferencing and was streamed live. This ensured the public were able to access the meeting. The agenda and reports were available on the Trust Website and the public were asked to submit questions prior to the meeting. In addition, four governors observed the meeting by video conference and were able to ask questions at the end of the meeting.		
17/699	**DECLARATIONS OF INTEREST**		
1 min	JM declared his position as Independent Chair for the Derbyshire Sustainability and Transformation Partnership. RM declared his position as Executive Lead of the Mid Nottinghamshire Integrated Care Partnership (ICP), Executive Member of the Nottingham and Nottinghamshire Integrated Care System (ICS), Chair of the East Midlands Leadership Academy, Chair of the East Midlands Clinical Research Network and Chair of the East Midlands Cancer Alliance. PR declared his position as Director of Finance of the Nottingham and Nottinghamshire ICS. CT Declared her position as Director of Human Resources for Nottinghamshire Healthcare. GW declared his position as Non-Executive Director for The Queen Elizabeth Hospital Kings Lynn NHS Foundation Trust. BB declared her position as Director of Operations (East Midlands) for Public Health England.		
17/700	**APOLOGIES FOR ABSENCE**		
1 min	There were no apologies for absence.		
17/701	**MINUTES OF THE PREVIOUS MEETING**		
1 min	Following a review of the minutes of the Board of Directors meeting held on 6th August, the Board of Directors APPROVED the minutes as a true and accurate record.		
17/702	**MATTERS ARISING/ACTION LOG**		
1 min	The Board of Directors AGREED that actions 17/678.1, 17/678.2 and 17/680 were complete and could be removed from the action tracker.		

17/703	**CHAIR'S REPORT**		
1 min	JM presented the report, highlighting there have been further discussions in relation to the ICS. The issue of leadership of the ICS has been discussed and a way forward has been agreed. The Board of Directors were ASSURED by the report.		
17/704	**CHIEF EXECUTIVE'S REPORT**		
10 mins	RM presented the report, advising Covid recovery and restoration of services continues. On 2nd September 2020 orthopaedic patients had their surgery at Newark for the first time since 2013. RM acknowledged the work of Steve Jenkins, Surgery Divisional General Manager, and his team for their work in establishing this service. In terms of cancer services, during Covid SFHFT has been able to continue to provide cancer services in conjunction with Nottingham University Hospitals (NUH). However, across the wider NHS and SFHFT, over the last 6 months the number of patients waiting in excess of 62 days for treatment on cancer pathways has increased. SFHFT should feel proud of the progress made as an organisation as there has been a dramatic reduction in the number of patients waiting over 62 days and 104 days for cancer treatment. Of the 21 providers across the Midlands who provide cancer care, SFHFT is performing the best in relation to this. While good progress is being made there is more work to do as there are patients, either on cancer or elective pathways, who are waiting longer than they would have done 6 months ago. The coming Winter months will be difficult. A lot of work has been taking place in relation to working with partner organisations. Agreement has been reached in the ICS in relation to how it will be led over the next 6 months. There is a need to ensure the agreed way forward works. Work is continuing to seek a replacement for the Independent Chair of the ICS as the current Chair has signified he would like to step down. The leadership framework for the ICS from April 2021 needs to be agreed well in advance of this date. MG acknowledged the work so far in relation to the Phase 3 response. She was pleased to note the Staff Excellence Awards will still be held this year, albeit in different way, as this is an important event for staff motivation. **Recovery Committee** JM presented the report of the Recovery Committee and noted the Trust is making good progress in terms of recovery. The Recovery Plan would be presented under the next item. The Committee discussed communications, which have been good so far but there is a need to build on this, particularly in terms of communication to patients. RM advised this is a multi-tiered approach. All patients received a letter advising of the steps being taken to provide safe care when they return to the hospital.		

	The Trust has engaged with local media and a virtual Q&A session for the public was held on 26th August 2020. RS advised the Trust has issued an open letter and there will be a follow up to this addressing the themes identified through the Q&A session. RM advised progress is being made in relation to recovering services. The Phase 3 letter has been well received and provides clarity. However, it is a huge undertaking for any organisation and system to deliver all the elements of the letter. There is a need to manage expectations. The Trust's ability to deliver all the things it has said it will deliver is closely intertwined with being able to access funding outside of the current allocation. There is a need to invest in services in a way which is in line with the financial expectations which are being imposed on the Trust and the system. The Board of Directors were ASSURED by the report		
17/705	**RECOVERY PLAN**		
33 mins	SB presented the report, advising overall recovery is being used as an opportunity by NHSE/I to drive things through at a system level. Nationally recovery is focussed on activity levels, not on waiting time outcomes. This is a risk but the Trust is mitigating this by treating patients by clinical priority. Cancer services are broadly fully restored. The 62 day backlog at the end of August 2020 was 87, which is 10% of the waiting list. This is compared to 60 pre-Covid. The plan does not currently achieve the NHSE/I standards for October 2020 but the Trust's submission to the ICS was within 10% of the standards in terms of the 'ask' on delivery, which is similar to NUH and the ICS. There are a lot of variables with the key variables relating to enhanced infection prevention and control (IPC) procedures to reduce transmission of Covid. This disproportionately affects areas such as theatres and endoscopy. Some new guidance has been received recently in relation to infection control which is being closely looked at by DS, JH and SB to ensure they are happy with any changes which are implemented. This may lead to a slight increase in activity but this cannot be quantified at this stage. The plan is supported by additional external capacity in the independent sector. RM advised from discussions at the quarterly system review meeting on 2nd September 2020, it is clear the focus from NHSI in terms of access is 52 week waiters. Therefore, there is a need to continue to focus on these patients. There is also a focus on what organisations can achieve in terms of productivity for October 2020. The Phase 3 letter contains a series of actions and points which go beyond access, for example there are areas which have a connotation in terms of workforce, engagement, safety, IPC, etc. 31 points have been identified which are being worked through to ensure they sit appropriately in each of the Executive Directors' portfolio and map into the governance infrastructure. NG queried how the modelling has been carried out and sought clarification if the plan is to return to the pre-Covid position or to get to that position and make inroads into the backlog, querying if the Trust has the resources to deliver this.		

	NG noted the coming Winter, the potential surge in Covid and the fact staff are tired, feeling this is an inherent risk to the plan. SB advised NHSE/I's ask is to return to 90% of pre-Covid activity for elective, day case and outpatient procedures and 100% of outpatient first and outpatient follow up. There is an acceptance the more constrained infection control procedures will impact on productivity in areas which are carrying out aerosol generating procedures (AGPs). The backlog is a product of demand, capacity and activity. Work is ongoing with primary care to look at demand and how this can be safely reduced. Demand did reduce during Covid but has started to increase, although it is not yet at last year's levels. Primary care are more confident they can manage demand. Demand is down in a lot of elective areas and if the Trust can continue to manage demand safely and increase activity, over time the backlog should reduce. BB acknowledged the Trust is performing well against the benchmark of other trusts in the Midlands. In terms of the Phase 3 ask, the standards are not quite met. However, the gap to delivery comments in the report are plausible. It is likely NHSI will have assumptions in their aspirations. BB queried what the national team think is different to what the Trust thinks in terms of getting back to the required level. SB advised normally a target would be set which is stretching to help the Trust work hard to get as close to the ask as possible. It is likely many organisations, in submitting the draft plans, will be within 10% of the ask. This may lead to a recalibration of some of the expectations. At national level it is hard to model the impact of AGPs in different organisations. RM advised there is a need to spend taxpayers' money wisely and to ensure the wider NHS can evidence throughput is restored and the number of patients waiting for treatment is reduced as a return on the additional investment received. There is an expectation from NHSI for acute providers to deliver emergency care within 4 hours 95% of the time but the vast majority of organisations do not achieve this. SFHFT has built a reputation for delivering what it says it will deliver. While there is a need to stretch ourselves and be ambitious, there is a need to be pragmatic and realise how tired people are. The plan feels achievable but there may be some 'push back' about needing to do more but this is likely to be consistent across the country. CW queried if there is any change in behaviour for primary care referrals, i.e. GPs referring to SFHFT rather than NUH, where they would normally refer, as they know patients are likely to be seen quicker at SFHFT. As demand is down, there may be a problem building up in terms of undiagnosed cancer and other issues. How is the Trust looking to the future to ensure when people do get the confidence to go to their GP, or when they feel they have to go, SFHFT is in a position to take on that demand.		

	SB advised this work has not been done yet and will be the next phase. In terms of the activity the Trust can deliver, this is a credible plan of what can be done at the moment with the constraints on proactivity. If there is a surge in demand, this is the activity which can be delivered. Therefore, the Trust needs to work with primary care to ensure they are mitigating referrals to the Trust. The cancer pathway is prioritised. TR queried how care homes fit into this plan. SB advised this would be more related to the emergency pathway. However, the Trust continues to do positive work with care homes and patients are tested for Covid before going back to a care home. JH advised the Trust is providing care homes with IPC support and supplying them with staff. For example, Trust bank staff have been used to support care homes when their own staff were isolating, etc. JM noted the ordinary elective graph in the report shows nearly 80% on 16th August 2020 but divisional plans show ordinary elective as being under 60%. JM queried why divisional plans are less than what has been achieved. SB felt this may be due to not counting like with like as ordinary electives includes much more than theatre work. SB advised he would check the figures. **Action** • **Figures for ordinary elective in recovery plan to be checked against divisional plans** PR advised the financing arrangements for October onwards are not yet known but the Trust has been asked to work on the assumption no further funds will be available for the second half of the year. This is not felt to be credible, given the usual increased costs over Winter due to additional demands and capacity. At a recent meeting with ICS colleagues there was considerable push back on the consolidation of the Trust's plan with the ICS plan, which in totality does not meet NHSI's requirements. The push back was the Trust should be able to meet the capacity requirements and this would not incur any additional expenditure. More work is required to understand the push back. Final submission of plans is 21st September 2020. The ICS Board will meet on 17th September 2020 to sign off the ICS consolidated plan. PR queried what the mechanism will be to share any changes which may need to be made to this plan as a result of the further work being carried out prior to the ICS Board as the Trust will be asked to confirm the plan has gone through appropriate internal governance. **Action** • **JM to liaise with RM to agree a mechanism for changes to the ICS Consolidated Plan.** DS advised there is some evidence of harm as a result of Covid but more work is required to understand if this is above and beyond the baseline of what might have been anticipated. While harm could be anticipated primarily in Covid patients, increasingly there is a need to recognise there will be more harm in non-Covid patients as well as an impact on staff.	**SB** **JM/RM**	**01/10/20** **21/09/20**

	A series of processes have been put in place and the Covid harm data set has been presented to the Quality Committee. Identifying true patient harm is likely to require significant retrospective analysis and comparison, which will take time. The initial harm identified in the data set is low level, for example an increase in instances of pressure sores, prone positioning on critical care, etc. but more intelligence is being gathered in relation to serious harm, for example, the impact of delayed presentation to ED, attendance to outpatients and diagnostics, the increase in backlogs and some staff related harm. The outcome of 42 case reviews of patients who had died with patient harm have been presented to the Quality Committee and these showed no lapses in care. The Trust is capturing the data from all deaths. The initial Dr Foster data shows SFHFT as an outlier to the national comparison but there are a number of understandable reasons for this as the Trust's patients are older and have more comorbidities. A greater understanding will be gained as more data is received. The Board of Directors should expect a level of harm will continue to be reported and this will be captured over at least two years. BB felt it may be nearer five years for some harm, particularly from cancer, to feed through. The important thing to note is mechanisms are in place to capture the information and learn from it. GW felt this will be a difficult period. It is easy to become reliant on looking at charts and figures but in many ways a lot of data is hidden in this phase as we do not know what we do not know, i.e. the number of patients not coming through the system who would ordinarily come through. There will be an ongoing impact. DS advised it is important to be 'curious' and to continue to look for and consider potential issues. JM noted a lot of detail regarding harm will be reported through the Quality Committee and requested the Committee consider the level of detail and appropriate timing for information to be shared more widely with the Board of Directors. **Action** • **Quality Committee to consider the level of detail and appropriate timing for information in relation to Covid related harm to be shared more widely with the Board of Directors.** The Board of Directors were ASSURED by the report.	**DS**	**01/10/20**
17/706	**STRATEGIC PRIORITY 3 - TO MAXIMISE THE POTENTIAL OF OUR WORKFORCE**		
16 mins	**Guardian of Safe Working** JJ presented the report, advising there are very few exception reports but this is starting to pick up to pre-Covid levels. There was an issue raised in relation to a clinical safety concern in surgery relating to supervision. The issue was minor but there is a feeling among junior doctors they do not have as much supervision as they would like.		

	There have been delays in the length of time taken for supervisors to sign off educational reports. The Guardian now routinely intervenes in any report not signed off within 14 days and signs these off. No incidents have been found where there is not a valid exception report. There have been no work schedule reviews as a consequence of exception reporting but this is likely to change over the coming period. The post vacancy rate remains low as gaps are supported by the Clinical Fellows Programme. Data in relation to locums filling vacant shifts will be available for the next report. There remains a concern nationally and locally that there is under-reporting of exceptions. Both junior doctors and consultants need to continue to be supported with the exception reporting process. The Trust encourages junior doctors to complete exception reports and trains consultants to respond to them. JJ advised he has worked hard with the Junior Doctor Forum and Chief Registrar to make it clear to junior staff the Trust wants them to exception report. There is a question of personalised work schedules not being used as live documents. This should be de facto what the doctors are doing and there is a need to impress this on the educational supervisors to ensure they are overseeing this. JJ advised it would be useful to have a web page for the Guardian to collate all resources for exception report training for junior doctors and to help understand issues in real time. It would also be helpful for the training of educational supervisors to be included as part of mandatory training. There is likely to be an increased requirement for better provision of hospital out of hours working, particularly workload and supervision. BB noted overall the Trust has recently been more successful in recruiting medical consultants and queried if the same was true for in training doctors in terms of the Trust being an attractive place to do part of their training. JJ advised juniors and consultants know if they have any issues they can discuss them and the Trust will work towards a resolution. The Trust needs to be more ambitious in relation to the partners it works with. If the Trust was creative and offered days away to Cambridge, London or Oxford, for example, it could recruit some of the best juniors. BB noted ST5 and ST6 colleagues have been using exception reports and queried if it is unusual for senior registrars to use the exception reporting system to resolve issues. JJ advised it is unusual but seniors are told to act as role models for junior staff. It has been impressed on staff that when they stay late, they must exception report. BB queried if there is anything further the Board of Directors can do to pursue the opportunities to attract more trainees into the area. DS advised vacancies are speciality dependent but the Trust is aiming to be a centre of excellence for trainees. If the Trust can attract trainees to come back and work for the organisation when training is complete, this will address recruitment issues.		

	MG queried if there was anything further the Trust could do in relation to the training of educational supervisors. JJ advised Health Education England (HEE) are responsible for the role of educational supervisors but because the educational supervisors are the point of contact for most of the Guardian reports, it is seen as superfluous to the HEE role. The Trust need to acknowledge the additional role, outwith the HEE role, but confirm the expectations. The short term solution is for the Guardian to get involved and sign off reports after two weeks. JM summarised that the Board of Directors fully supported the recommendations contained in the report and the suggestions in relation to making SFHFT more attractive to trainees. DS queried if the trainees' ability to access training is affected by the reduction in activity. JJ advised as there was not much training for a period of time, this is now being compressed. There is a lot of competition for people to be able to take up training slots. Normally people would cover each other but an exception report has been completed indicating a colleague could not go to training as their colleagues refused to cover due to so many others having been off. This will affect the Guardian report and wellbeing of doctors as they have to work harder to make up for lost training. The Board of Directors were ASSURED by the report		
17/707	**PATIENT STORY**		
17 mins	JW presented the Patient Story which highlighted a patient's battle with Covid-19 over a period of 81 days spent in hospital. JM asked JW to convey the Board of Directors' thanks to the staff on the ward, advising the Board recognise the impact of Covid on staff who need time to recover. RM queried how JW and his team feel about the coming Winter. JW advised staff are tired and there have been extremely busy periods, but there have also been periods where activity was well below normal levels. There is now some level of normality and staff are grateful that they feel busier and it feels like 'business as usual'. Staff have taken time off work but they have not been able to get away, which they have missed. However, the team are resilient and while it is not known what Winter will bring, the team are ready to take on whatever challenges they face. It is an established team but there have recently been 11 new starters who are newly qualified. However, they have 'stepped up to the mark', as have staff who were sent from other areas. JW advised he is proud of the NIV service. DS asked JW to inform critical care that Ricky is now back at work and eating and drinking. JW advised his team work closely with critical care outreach and they are informed when patients are being discharged.		

17/708	**SINGLE OVERSIGHT FRAMEWORK QUARTERLY PERFORMANCE REPORT**		
54 min	**PEOPLE AND CULTURE** CT advised overall vacancies are being well managed but the Trust is still carrying some vacancies. Newly qualified nurses have started for the Trust, 40 overseas nurses are due to start in October 2020 and 20 trainee nurse associates will start at NTU (Nottingham Trent University) in October. Mandatory training is getting back on track following a pause due to Covid. Appraisals were also paused but are on the right trajectory to get back to the required position by year end. Sickness absence is typical of this time of year. In terms of staff out overall, there has been a reduction as the number of staff who were shielding or isolating due to Covid has reduced significantly. There continues to be an increase in activity in occupational health and there have been consistently high levels during Covid as the service supports Covid related activity, particularly the risk assessment process and supporting shielding staff in their return to work. The planning for the flu vaccination programme is on track. BB noted the Trust achieved good flu vaccination rates last year, but there was a lower uptake among medical staff. BB queried what plans will be put in place to increase uptake this year. CT advised work is underway and the expectation for this year has increased to 90% of front line staff being vaccinated. The Trust will work closely with all colleagues. RM advised last year flu vaccination rates were doctors 81%, qualified nurses 77%, other qualified medical staff 89% and support clinical staff 95%, giving an overall rate in excess of 85%. Year on year the Trust's flu vaccination rate improves and SFHFT compares well to peers. The vaccination rates in October and November are more important than the level reached in March, as staff need to be vaccinated for the Winter ahead. DS advised there has been some discussion in relation to mandating the flu vaccination but the Chief Medical Officer has shied away from that. The Trust's medical staff vaccination rate compares very well to peers and there is a need to build on what has been done previously. JH advised this year, due to social distancing, there needs to be a larger cohort of peer vaccinators, with the aim to have at least one peer vaccinator on every ward / department. As a nurse, you are more likely to have the vaccine if it is a colleague providing it. Peer vaccinators will be incentivised to give vaccines, as will those receiving it. RM advised conversations continue with primary care and CCGs about the collective approach through the mid Nottinghamshire ICP in relation to increasing vaccination rates across mid-Nottinghamshire.		

	MG felt it would be useful to gain an understanding of the reasons staff want to have the flu vaccinations and some of fears against having it. MG noted the increase in occupational health activity and queried if there was anything else which needed to be considered in terms of any other interventions which may be required. CT advised additional resource has been put in to support capacity in occupational health. There is an external appraisal of what other resources may be required to support the wider wellbeing offer. JM felt there are two types of interventions, one being proactive, such as risk assessments, testing, etc. and the other being impact on individuals who are seeking support. JM felt there is a need to understand why staff are approaching occupational health for support and queried if trend information was available. CT advised occupational health produce a report which details this information. This will be part and parcel of the wellbeing review which is being undertaken. The work undertaken to date has been largely proactive, providing advice on shielding, etc. and supporting returns to work and making the relevant adjustments. However, some of the wider impacts of Covid are becoming evident, particularly psychological issues are starting to manifest themselves. Some support in relation to this has been put in place through the partnership with Nottinghamshire Healthcare in relation to fast track referrals for staff in acute mental health distress. EC advised the Trust has been sustaining the offer which has been in place in relation to self-care and wellbeing and has also restarted some things which had been stood down due to Covid, for example, Schwartz rounds and Talking Heads sessions. Additional wellbeing dens have been set up, notably at Newark Hospital and in the library and Faith Centre at King's Mill Hospital, in order to increase access. Learning from Covid work was undertaken in June and July 2020 and during August 2020 the Trust started to communicate this learning across the organisation through virtual team briefs and follow up sessions. The learning now needs to be put into action. An engagement piece of work is starting week commencing 7th September 2020, "You said, together we did". The Trust will continue to communicate and engage with colleagues over the next 2-3 months in relation to learning and the actions which will be taken. Pieces of work in relation to reconnecting KIT and the way the Trust has supported colleagues have been recognised nationally. There is still more work to do and the Trust is keen to get a longer term offer in relation to psychological and physical support. MG queried if there was anything in the feedback which was a surprise. EC advised she has been surprised by the impact Covid has had on colleagues in terms of what they have been unable to do outside of work, i.e. seeing families, etc. Staff were very resilient inside work but were more affected outside work and there is a need to be mindful staff will bring those feelings to work. There is a need to support colleagues by acknowledging them as a professional but also thinking of them as a wife, mother, father, etc.		

	QUALITY CARE DS advised positives to report include a reduction in falls and pressure ulcers, but this is balanced with a number of exception reports. C.difficile (Cdiff) rates have increased steadily and this is a cause for concern. The cause is not clear, but is mirrored with reports from other organisations. Work is ongoing to investigate this further. There may be some link to increased community use of antibiotics which may be related to the way GPs are currently seeing patients. This will be worked through with colleagues across the system. There is no internal reason for increased Cdiff rates. Issues relating to the Friends and Family test and dementia screening have previously been discussed by the Board of Directors and work is ongoing. A project advisor has been appointed and will work with the Medical Director's office to try to understand the reasons for the slight increase in Hospital Standardised Mortality Ratio (HSMR) and establish if this is a cause for concern. BB queried if all the Cdiff cases have been Ribotyped and if assurance can be provided there is no transmission within the hospital. JH confirmed of the results which are back there is no hospital transmission. Some results are outstanding. BB noted from the graph in the report it appears there was a spike in Cdiff cases during the past two summers and queried if there is any learning to take from those spikes and how they were reduced. DS advised he was not sighted to anything which is seasonal. BB sought clarification if the Trust was still looking at four subgroups where there was a spike in terms of HSMR, namely liver disease, GI haemorrhage, fractured neck of femur (NOF) and lower respiratory. DS advised there are now five cumulative sum (CUSUM) alerts, with haematological malignancies being added, although this was also very small numbers. In terms of the original four areas, an internal review of all the case notes has been undertaken. Respiratory, upper GI bleed and liver disease showed no cause for concern and have been closed. In relation to fractured NOF, work is ongoing to gain further assurance and external guidance is awaited. The Trust was an outlier for alcoholic liver disease due to having a young age group of people presenting. There is significant work which can be done in terms of prevention and to try to get patients into a support programme when they first present. This will take time to develop. BB sought clarification on the timeline for the project advisor to complete their work. DS advised the adviser has been employed for 6 months but the role is likely to develop as some of the Covid work will come into this remit as data becomes available. In terms of clarifying if there is a real concern, this should be completed within 2 months and a report will be provided to the Quality Committee in November.		

	Action • **Update on HSMR to be presented to the Quality Committee in November.** NG noted one of the main drivers for the Trust being in special measures and getting a CQC inadequate rating about 5 years ago was the HSMR figures. There is, therefore, a degree of urgency to understand what is happening now and to ensure this is kept under control. There is a need to identify the underlying causes and differentiate 'technical' issues from a real increase in deaths. DS advised all the investigations undertaken so far have not uncovered anything of concern, but DS advised he was still not satisfied, which is why external help has been brought in. TR queried if the Trust is engaging and communicating with NHSI and CQC in regards to HSMR. DS advised data is shared and NHSI get their own data from Dr Foster. None of the outlier positions flag to the CQC as yet and Dr Foster describe them as minor data abnormalities. The Trust is keen to ensure it is being open and transparent with the regulators. **Action** • **DS to continue to keep the Quality Committee and the Board of Directors briefed on actions being taken, progress and any significant concern arising from the work regarding Quality** **TIMELY CARE** SB advised emergency care performance remains strong in absolute and relative terms. There have been lower levels of demand on ED but this is starting to increase. ED attendances are 85% of pre-Covid levels but admissions are higher. This appears to indicate there were a number of patients who previously attended ED when they did not need to who are not attending now. This provides a more accurate picture in terms of demand, although the increase in admissions is starting to impact on bed capacity. Demand remains a priority across the ICS, particularly the redesigned NHS111 service. This is likely to keep patients away from ED who do not need to attend ED but will not impact on admission demand. £2m of capital has been awarded to SFHFT for an ED expansion programme which will need to be delivered in the next 4 months. This will significantly expand majors, resus and the ambulatory emergency care unit. Cancer care performance was 64% in June. This was impacted by Covid although the Trust did try to maintain as much cancer care service as possible. The Trust's national ranking is relatively low. This may be due to the Trust being quick to change treatment models during the Covid period, whereby clinicians put patients on a number of treatments which were not definitive treatments and did not count as a 'clock stop'.	**DS** **DS**	**12/11/20** **Ongoing**

	However, they were treatments to make sure patients were being 'de-risked' in terms of wait for their operation. The Trust continues to try to achieve 100% activity in the cancer pathway, although endoscopy is key area where this cannot be achieved. The Trust is targeting patients who have been waiting over 62 and 104 days. CW queried if the number of patients choosing to decline appointments due to fear of Covid was known and if there are any services which can be provided to these patients in terms of outreach. SB advised he would need to check on the numbers but a lot of cases relate to imaging. This is a diminishing problem. Many things patients are coming in for are things which can only be provided in the hospital. **Action** • **Information regarding the number of cancer patients choosing to decline appointments due to fear of Covid and any alternative provision to be provided to the Board of Directors.** MG queried if there was anything to indicate there were socioeconomic factors for patients declining appointments or having a fear of coming to the hospital. JH acknowledged there is a lot more work to do in terms of patient health inequalities. The plan is to start looking at patients' experiences and looking at patients who do not attend would be a starting point. SB advised in terms of elective care, (Referral to Treatment) RTT performance in July was 66%. This is a product of the activity levels. The Trust continues to work with primary care to reduce some of the unnecessary demand and this will provide the opportunity to improve RTT performance. There are currently 217 52 week waiters and this is likely to increase due to the backlog. There is a trajectory to get to 192 by year end. A lot of these patients are in orthopaedics and ophthalmology. The increase in orthopaedic capacity at Newark Hospital will be very welcome. Ophthalmology had a lot of Covid related workforce capacity loss but colleagues are now returning to work. Diagnostics are at 60% and capacity is being increased, but endoscopy and respiratory is constrained by IPC. JM noted the trajectories and advised it is likely the focus will be on 52 week waiters. JM queried when the final recovery plan will be signed off. SB advised this will be during Phase 3. The only plans the Trust has been asked for at this stage are the plans to October 2020. During the Autumn, while ED demand is lower, there is a need to do as much elective work as possible. The expectations for the rest of the year are not clear. RM advised across SFHFT and NUH there are 489 patients waiting over 52 weeks. While this is high, it is comparatively low. NHSI's expectation is to get as close to zero as soon as possible.	**SB**	**01/10/20**

BEST VALUE CARE

PR advised the Trust continues to report a break even position at the end of Month 4, with the current financial regime being in place until the end of September 2020. The break even position is achieved through retrospective top up of Covid and other costs. Covid costs claimed retrospectively for Month 4 totalled £2.2m, £10m YTD. Other costs, i.e. costs in excess of the block contract value, were £1.8m in Month 4, making £5.5m YTD.

The Trust has started a more robust forecasting process month on month and is starting to consider future Covid costs, costs of Winter and recovery through Phase 3. Publication of the financial values for the period October 2020 to March 2021 is awaited.

Performance against the financial strategy continues to deteriorate. There is no requirement for the Trust to make financial improvements and there are no plans to do so during the Covid financial regime. Performance against the strategy deteriorates by £1.13m per month which is £4.5m YTD plus £12.1m adverse position at the end of 2019/2020. Therefore, the current deterioration is £16.6m adverse to the strategy which was agreed last year.

Capital expenditure is on plan for Month 4 and approval is awaited from NHSI on Covid related schemes. However, notification of £2m to invest in ED expansion has been received. Cash holding remains good.

The procurement league table score is included in the SOF. The Trust's score, based on Q4 data, is 40.3 which ranks SFHFT 117 of 133 organisations across the NHS. This is a significant issue in terms of the use of resources score with NHSI. The cost element of that score has deteriorated and work is ongoing to understand the reason for this. One of the actions is to challenge the performance of NHS Supply Chain. This was discussed at length by the Audit and Assurance Committee.

NG advised this remains an artificial regime where the Trust is funded by NHSI to what is required due to Covid. This position cannot continue and the financial regime in the second half of the year will be different to the first. Nationally public spending has dramatically increased during Covid and it is likely there will be a requirement for health services to 'tighten their belt'. There is a need to plan for the art of the possible for what can be achieved in the second half of the year, within the constraints of what funds are available. This may mean prioritising certain services over others and there is a need to develop a plan for the second half of the year with some prioritisation of services showing what would be taken out first should funding be restricted.

PR advised this needs to be in the context of the requirements and expectations of the Phase 3 letter and preparations for Winter. There is a need to bear in mind what the ask is and what the demand is on the Trust's services.

	GW advised the issue in relation to NHS Supply Chain should not just be an issue for SFHFT and queried if it is known what other trusts are doing in terms of escalating issues. Given this is an issue across all trusts, this does not explain the Trust's poor position in the rankings. PR advised there are other reasons for the poor ranking. In some cases there is inconsistency of approach and the challenge to the procurement function is to understand the inconsistencies, acknowledge those in the league table and understand where the opportunities are for the Trust to improve its position and performance. This has been flagged with NHSI to use heads of procurement national and regional groups to take a view, not just on NHS Supply Chain performance but also the league table and to carry out some consistency checking. GW felt there is a need to be proactive. RM advised the second half of the year will be a challenge. A lot of additional money has been spent in the first half of the year but the Trust has been rigorous in the way the money was spent and behaved in a way which is in line with the guidance. Not all organisations have been as rigorous. The NHS as a single entity faces a difficult position as the total scale of the spend far outweighs what is affordable. Finance is difficult and is one of the top two risks to providing safe, timely care to patients this winter. The theme which runs through the Phase 3 letter is the importance of safe, timely care, which will inevitably come at a cost. This is through the lens of the Trust as a statutory provider but finance is the first thing which is being measured at a system level. There needs to be a consistent way of working across the Nottingham and Nottinghamshire system. JM felt the report is helpful and easy to read, expressing thanks to colleagues involved in its development. JM highlighted the areas where a better understanding is required as occupational health referrals, Cdiff and HSMR. JM recognised the good work in relation to access and recovery but noted there is more work to do in terms of finance, given the position against the strategy and run rate. PR advised on a monthly basis the Finance Committee receive a detailed analysis of run rates, both pay and non-pay, Covid and non-Covid. While not required to submit information to NHSI, the Trust has continued to monitor this and it will provide a solid base from which to look at forecasting. RM advised finance has to be viewed at system level as this is how it will be monitored. It may be beneficial for the chairs of partner organisations' finance committees to get together to do a collective assessment of the financial position. The Board of Directors CONSIDERED the report.		
17/709	**CONSTITUTION**		
2 mins	SH presented the report advising the Trust's constitution has been reviewed, having last been reviewed in 2014. It is a statutory responsibility of the Council of Governors. Therefore, a small working group to review the format of the constitution was established.		

	There are a number of changes which have been made, as highlighted in the report. The updated constitution was approved by the Council of Governors on 11th August 2020. If approved by the Board of Directors it will be presented to the annual members meeting on 28th September 2020 for final approval as there are changes to the constituencies. The Board of Directors APPROVED the amendments to the Trust's constitution		
17/710	**OUTSTANDING SERVICE – CLINICAL ILLUSTRATION**		
12 mins	A short video was played highlighting the work of the Clinical Illustration team. RM advised Jason Batterham, Medical Photographer/Videographer, put together an audio commentary of the video for the benefit of TR. This highlights not only the excellent quality of the output of the team but also the conscientiousness and diligence which was put in place to ensure all members of the Board of Directors could appreciate the work the team are doing. TR expressed thanks to Jason for the excellent and detailed audio commentary and to Sue Bradshaw, Corporate PA, for identifying the need. EC thanked the team for their work in supporting and publicising the Trust's wellbeing and cultural engagement work. CW felt the quality of the team's work is excellent and has considerably improved over the last few years. CW noted the private work the team undertake which supports opportunities for raising funds for the Trust and queried what can be done to ensure other parts of the community are aware of this and are able to utilise the services if capacity allows. GW noted the work the team does with the Communications Team and felt this has a huge impact and makes communications more effective. RM advised the Communications Team and Clinical Illustration are separate teams but work closely together. Clinical Illustration is a resource for the system and RM advised he would communicate through the ICP for people to channel their illustrations requirements to the team. TR noted this is the first clinical illustration unit in the country to have an apprentice and felt this provides an opportunity for learning in terms of the recruitment process as it highlights the non-medical opportunities available at the Trust.		

17/711	**COMMUNICATIONS TO WIDER ORGANISATION**		
2 mins	The Board of Directors AGREED the following items would be distributed to the wider organisation: • Staff Excellence Awards • AGM • Funding for ED • Recovery • Guardian of Safe Working • Patient Story and Outstanding Service • SOF issues - Occupational Health, Cdiff, HSMR and finances • Orthopaedic Surgery at Newark • Flu vaccinations		
17/712	**ANY OTHER BUSINESS**		
1 min	No other business was raised		
17/713	**DATE AND TIME OF NEXT MEETING**		
	It was CONFIRMED that the next Board of Directors meeting in Public would be held on 1st October 2020, in the Boardroom, King's Mill Hospital at 09:00. There being no further business the Chair declared the meeting closed at 11:45		
17/714	**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**		

17/715	**QUESTIONS FROM MEMBERS OF THE PUBLIC PRESENT**		
min	No questions were raised		
17/716	**BOARD OF DIRECTOR'S RESOLUTION**		
1 min	**EXCLUSION OF MEMBERS OF THE PUBLIC - Resolution to move to a closed session of the meeting** In accordance with Section 1 (2) Public Bodies (Admissions to Meetings) Act 1960, members of the Board are invited to resolve: "That representatives of the press and other members of the public be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest." Directors AGREED the Board of Director's Resolution.		