

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

Un-Confirmed MINUTES of a Public meeting of the Board of Directors held at 09:30am on Thursday 28th April 2016 in Board Room 1, Level 1, King's Mill Hospital

Present:	Sean Lyons	Chairman	SL
	Ray Dawson	Non – Executive Director	RD
	Ruby Beech	Non – Executive Director	RB
	Graham Ward	Non – Executive Director	GW
	Clare Ward	Non – Executive Director	CW
	Tim Reddish	Non – Executive Director	TR
	Dr Peter Marks	Non – Executive Director	PM
	Neal Gossage	Non – Executive Director	NG
	Peter Herring	Interim Chief Executive	PH
	Paul Robinson	Chief Financial Officer	PR
	Shirley Clarke	Head of Corporate Affairs & Company Secretary	SC
	Jon Scott	Interim Chief Operating Officer	JS
	Julie Bacon	Interim Director of HR & OD	JB
	Suzanne Banks	Chief Nurse	SB
	Dr Andrew Haynes	Executive Medical Director	AH
	Paul Moore	Director of Governance	PMr
 In Attendance:	Eric Morton	Improvement Director	EM
	Alison Reynolds	Interim Head of Communications	AR
	Dr Michelle Platt	Nurse Consultant Critical Care Lead Nurse	MP
	Dr W Dudill	Member of the Public	WD
	Joanne Walker	Minute Secretary	
 Apologies:	Peter Wozencroft	Director of Strategic Planning & Commercial Development	PW

		Action	Date
	CHAIRS WELCOME AND INTRODUCTION		
16/089	The meeting being quorate, SL declared the meeting open at 09.30 am and confirmed that the meeting had been convened in accordance with the Trust's Constitution and Standing Orders.		
	DECLARATIONS OF INTEREST		
16/090	It was CONFIRMED that there were no declarations of interest relating to items on agenda.		
	APOLOGIES FOR ABSENCE		
16/091	It was CONFIRMED that apologies for absence had been received from Peter Wozencroft – Director of Strategic Planning & Commercial Development.		
	PATIENT STORY		
16/092	<p>SB introduced MP to the Board. MP presented the journey and experience of a 23 year old male patient (PP) who had endured an episode of critical care with a protracted recovery and a slow rehabilitation recovery.</p> <p>PP was admitted via ED with rapidly progressing bilateral weakness and loss of nerve reflexes. The increasing weakness was picked up by the Critical Care Outreach Team who referred PP to ICU in October 2013 with suspected Guilliane Barre Syndrome. This is a debilitating disease that begins with general muscle weakness and becomes progressively paralysing. PP described himself as being turned into a statue.</p> <p>PP spent 52 days level 3 (ICU), 8 days level 2 (HDU) and several weeks on a rehabilitation ward in the Community Hospital. PP returned home in March 2014 after spending six months in hospital.</p> <p>A patient diary commenced 24-48 hrs post admission by multi-professional staff, the patient's family and friends. The purpose of the diary is to help to fill in the time gaps when the patient has recovered.</p> <p>On 10th December PP was transferred to a ward in KMH describing himself as a paraplegic. On 24th December PP was transferred to the rehab ward at Mansfield Community Hospital from where he was discharged home on 7th March into the care of his parents having benefited from a multifaceted critical care rehabilitation service at SFHFT.</p> <p>SFHFT have rehabilitation pathway in a document prescription form which is required as part of the D16 and is completed by the multi professional team throughout the patients episode of care. CCOT ward-based follow ups are conducted for 100% of patients after a critical care episode on the wards. Critical Care follow up clinics are for all patients ventilated 4 days or more at 2-3, 6 and 12 months post discharge and are seen by both a nurse consultant and physiotherapist.</p> <p>PP is now back at work full time as a restaurant manager, has moved out of the family home back into rented accommodation and has returned to full independent living.</p>		

	<p>MP advised the Board that £8.5k had been won from the East Midlands Academic Health Service Network to set up a process of psychological support. The aim is to train key members of staff across the critical care network with psychological support techniques providing them with monthly clinical supervision through a clinical psychologist to support those patients who are in greater need. What is actually needed is direct referral to a clinical psychologist but the funding has not been available. The D16 specification for adult critical care states clearly that there should be a referral pathway to the clinical psychologist in those particular cases of need. There is a scheme available 'Let's Talk Wellbeing' but there is a 12 week minimum waiting time.</p> <p>By the interventions above and the support from the Clinical Psychologist, the ambition is to reduce the number of patients that need Clinical Psychology.</p> <p>Once the project has been trialled in this region, the East Midlands Academic Health Service Network hope to roll the project out nationwide.</p> <p>PM enquired if the same psychological support was available across the Trust to those patients that are not in critical care and how this learning is being spread across the organisation. MP advised that a similar and very successful project had been conducted with the cancer nurses. What the psychologists are doing with the Critical Care Fraternity has already been done with the cancer nurses but at a slightly different level. The aim is to develop this to become bespoke to critical care.</p> <p>AH advised that he was very persuaded of the psychological impact of severe illness and the benefits of obtaining support through research monies. MP advised that a Masters student was conducting an evaluation of the project in the hope to be able to clearly demonstrate the benefits of this work using the data gathered. In addition, a significant amount of data gathered from 2008 onwards which includes patients PTS scores etc. could be analysed to provide significant evidence. AH offered his support to MP.</p>		
	MINUTES OF THE MEETING HELD ON 31ST MARCH 2016		
16/093	<p>Following a review of the minutes of the public meeting held on 31st March 2016, it was noted that item 16/068 was a post meeting note.</p> <p>The Directors APPROVED the minutes as a true and accurate record.</p>		
	MATTERS ARISING / ACTION LOG		
16/094	<p>Action 84 – It was agreed that the action be extended to June to enable the incorporation of joint work currently being undertaken with NUH.</p> <p>Actions:</p> <p><i>AH/SB to consider how the update from the patient's story relating to end of life care is presented to the Board in June.</i></p> <p><i>RB to be briefed by SB with regards to the end of life care update in preparation for attending the End of Live and Palliative Care meetings.</i></p> <p>Action 85 – JB confirmed that of the original 66 Philippine offers, 9 had withdrawn leaving 57 nurses still under offer of employment.</p>	<p>AH/SB</p> <p>SB</p>	<p>30/06/16</p> <p>26/05/16</p>

	<p>Of the 57, 5 have passed the language test (IELTS). Of the 52 that remain in the pipeline, 3 completed the language test in March and are awaiting results and 6 have booked to take the test in April. The remainder have sat and failed IELTS twice but intend to re-sit in April and May. Many have been very closed to achieving the pass mark. There is also an indication that the NMC may adjust the test/requirements in light of feedback received regarding the test. It was AGREED that the action is now complete and can be removed from the tracker.</p> <p>Action 86 – A trajectory of the agency spend has been included in the IPR in item 10. The action was confirmed to be complete and can to be removed from the tracker.</p>		
	CHAIRMAN'S REPORT		
16/095	<p>The Chairman presented his report and advised that the Governor elections were progressing well. As of 18th April, 3,450 ballot papers had been returned, representing 16.3% of the 21,186 ballot papers mailed to the membership. All Governor positions will be filled post-election. A handover event will be held in May.</p> <p>SL advised that Member Information Events had been scheduled for 4th and 5th of May at Newark and KMH whereby members of the public could attend to discuss the LTP.</p>		
	CHIEF EXECUTIVE'S REPORT		
16/096	<p>PH advised the Board of the impact that the Junior Doctor's strike of 26th and 27th April had posed on the demand of the Trust. For ED there had been a significant reduction in demand with 150 less admissions over the two days. For Ambulance admissions there had been 54 less admissions over the two days. 9 breaches of the 4 hour target had been reported during this period.</p> <p>The total number of patients cancelled over the two day strike was 341 - these were 306 outpatients, 13 inpatients and 22 day cases. JS advised that because the appointments were not cancelled on the day of the strike, the pressure for the Trust is to offer alternative appointments within the initial 18 weeks, alternative appointments have already been sent out. For any cancellations made on the day of the strikes, the Trust is obliged to offer appointments within 28 days.</p> <p>PM suggested that as no episodes of patient harm had occurred during the days of the strikes, thanks should be conveyed to the organisers, consultants and senior nurses to acknowledge their good performance in difficult circumstances.</p> <p>Action:</p> <p><i>A note on behalf of the Board of Directors is to be sent out to staff to thank them for their support on 26th and 27th April.</i></p> <p>AH advised that 30% of junior doctors joined the strike on day 1 and 28% on day 2. This equates to 77 doctors across the Trust.</p> <p>JS advised that there had been a rush of people attending ED on the evening of 29th April with 42 people in the department which had caused</p>	SL	26/05/16

	<p>additional pressure. On the morning of 30th April, there were 19 beds in medicine and 77 across the whole Trust. Some capacity had been closed down in stroke and other areas where capacity had been estimated.</p> <p>JS advised that a bank holiday plan was in place for the forthcoming weekend. The plan would extend beyond covering Monday 2nd May and was essentially running an enhanced service. The plan has been circulated and made available on the Intranet.</p>		
	LONG TERM PARTNERSHIP		
16/097	<p>PH presented a progress report and advised that the programme remained on track with no delays. The preparation of the business case was the most significant piece of work to be completed but the Steering group were confident that this would be completed within the required timeframe.</p> <p>SFHFT, NUH and NHSI attended a meeting with the Competitions & Market Authority (CMA) on Monday to provide an informal briefing regarding the context of the merger and the history of the journey through the regulatory process to date. The conclusion was that a phase 1 review would be required. This will involve the Trusts providing the CMA with a substantial amount of information (the majority of which has been collated through the due diligence process) followed by formal notification of the merger. The phase 1 review will take up to 40 days. The CMA will consider whether there is a competition issue, if they consider there is then a phase 2 review will be required which could take up to 26 weeks. PR advised that NUH's legal and economic advisors were conducting the preparation and collation of the information for the CMA so no additional burden would be placed on staff.</p> <p>A decision from NHSI regarding their guidance of the legal form is expected imminently after which, the two Boards will convene in an attempt to obtain alignment in agreeing the decision.</p> <p>NUH clinical staff and leaders are continuing to support the six major areas of CQC concern which are emergency and urgent care, deteriorating patient, care of the dying, patient safety culture, delirium pathway and clinical workforce planning. Additional leadership support has also been provided by NUH in other areas such as paediatric nursing, safeguarding, speciality leadership, clinical staff in shortage areas</p> <p>RD stated that the additional support that was originally requested had changed significantly and enquired if it had been refined sufficiently to suit the needs of the Trust. PH confirmed that it had.</p> <p>PM stated that one of the big areas where the trust had capacity issues was Radiology and enquired if the reason that short term support hadn't been provided by NUH was because they do not have the capacity to support it. AH advised that the Trust would be receiving support in Radiology and that the position as shown in the Francis Group report was much improved compared to two years ago. There has been no backlog in Radiology and the Trust is not limited on flow with most investigations being conducted in a timely manner. This has required a lot of support both with external reporting and out of hours working.</p> <p>There is a national shortage of radiologist which is particularly bad in the East Midlands and this has not improved over the past two years. The plan</p>		

	<p>for Radiology is to stabilise, which has been done, and then to use the EMRAD development through the East Midlands to move imaging and reporting around to where there is capacity, not just within Trusts. This is proceeding. SFHFT were the second Trust to sign up to EMRAD and the second Trust to go live. There are 7 Trusts signed up so far. The go live has encountered some issues which are being worked through but this has caused some acute pressure, NUH are supporting SFHFT with this and two radiologists have been on site for 10 weeks. There is ongoing dialogue as to how this support may continue going forwards.</p> <p>GW felt that the short term support was slow coming into the Trust and a lot more time was spent on the diagnostics than anticipated, but felt that this had been very beneficial. The support has changed substantially from the initial proposal but for the right reasons. The Trust now has the right support in the right places.</p> <p>PH advised that a dedicated merger website is currently being developed which is anticipated to go live next week.</p>		
	<p>INTEGRATED PERFORMANCE REPORT</p>		
<p>16/098</p>	<p>Mortality AH advised that the Dr Foster report had not yet been received although the projected figure for December is 92.</p> <p>Crude mortality has shown a rise through January and February which is expected due to seasonal variation. Clarification as to whether the HSMR will use December's figures or the subsequent two months figures has not yet been received but will be reported to the Board of Directors upon receipt.</p> <p>The Mortality Surveillance Group is fully established and moving towards reporting deaths. The pace of progress is good.</p> <p>Coding is tracked on a regular basis but issues earlier in the month can impact on the quality of an in month HSMR, although this shouldn't impact the long term position. PW is aware of this problem and steps have been taken ensure performance improves.</p> <p>SL stated that this was a tremendous improvement and enquired if there was a way of distinguishing between the ongoing weaknesses being addressed in terms of coding and clinical care. AH advised that the HSMR had been reduced by decreasing our observed mortality and by putting our expected mortality in the correct range of demographics of our local population, so it is a combination of the two. Dr Foster cannot characterise which contribution has come from where. However the analysis was of all deaths and as such, avoidable deaths could be included in the HSMR. The CQC will now be reviewing our Trust review deaths as part of their inspection regime and we are already ahead and doing all of the right things. The performance has been good and is consistent which suggests that the actions that have been put in place are embedded.</p> <p>Sepsis - AH advised that admissions sepsis reporting will be moved into assurance reporting through the Sepsis Recognise & Rescue Group. This is because the performance has been consistent for more than 20 weeks for</p>		

screening and treatment of Sepsis in front door areas. Inspections conducted by NHS England and by the CQC have confirmed this. The emphasis will be moved to deteriorating patients, particularly on wards, and will encompass Sepsis on the wards for which our performance over the last 10 weeks has improved. The aim is to achieve the same position on the wards as that of admission areas where every case is exception reported.

Falls - SB advised that during March there had been a total of 19 falls causing a degree of harm to patients within our care. There were no moderate or severe harms in March. The total number of falls resulting in harm in March last year was 176 compared to 105 in March this year.

The impact of the mobile workstation on Woodland Ward has been recognised and the ward sisters are keen to have them. Mobile workstations are being considered for additional wards.

Pressure Ulcers - The end of year figures show 19 grade 2's out of our maximum threshold of 36 which is good progress but unfortunately over the past 12 months we have seen 5 grade 3 and 1 grade 4. The learning has been shared and the tissue viability team are relentless in making sure staff follow the correct assessment.

Safety Thermometer – The Trust continues to perform at 95% harm free care. This is consistent month on month over the past 12 months.

Infection Control - The Trust remained within the annual threshold of 48 cases of Clostridium Difficile with 45 cases identified by 31st March, lessons learnt through RCAs have formed part of 15/16 and 16/17 work programme. The audit programme to monitor adherence to infection prevention and control standards shows some improvement in the overall audit results for all Q4 audits.

Serious Incidents – There has been a significant reduction of serious incidents with a total of 2 cases in March. This is down from 4 in February and the lowest position in 12 months.

Safeguarding - Training continues and has been reviewed to ensure it meets the requirements of the intercollegiate document and national capability framework. Safeguarding is part of the QIP and as such training, policies and procedures have been reviewed. The implementation of an Interim Head of Safeguarding is having a significant impact on the team and across the organisation as a whole. The team have developed a dashboard and will be conducting staff competency audits on all wards across the organisation, this will triangulate with the audit being conducted by 360 Assurance.

Mental capacity training in quarter 1 was 95% up to 97%, safeguarding adults in quarter 1 was 77% up to 94% and safeguarding children level 1 which is all staff started at 63% and finished at 89% for quarter 1.

Safer Staffing - Four wards were identified in March where fill rate fell below the 80% of the planned requirement, this is a reduction on February.

March saw an increase (from February) in the number of wards with an overfill. 29 of these wards related to an overfill of health care assistants. The 5 wards that required increased numbers of registered nurses and

<p>midwives is due to an increased patient acuity demand. The main reasons for this continue to be vacant posts and sickness.</p> <p>Action:</p> <p><i>The children’s safeguarding figures to be included in the table along with mental capacity training figures and safeguarding adult training.</i></p> <p>PM stated that one of the concerns raised by the CQC with regards to mental capacity training was that although training was conducted, individuals still didn’t understand it. SB advised that assessments were being conducted that will inform the dashboard. In addition, a survey has been issued to all staff that sections off certain elements including mental health and dementia to gauge the individuals understanding. If staff perform poorly then further training will be provided.</p> <p>PM enquired if for Safer staffing overfill, SB was confident that the wards are making the right assessment on 1 to 1 care. SB advised that new guidelines in relation to 1 to 1 care are being reviewed and that following a safe harm incident, the guidelines are being assessed for their fitness for purpose. The Nursing Taskforce Steering Group are also reviewing and monitoring 1 to 1 requests and capturing the information.</p> <p>Cancer - JS advised that the cancer targets for quarter 4 were achieved in all areas.</p> <p>There have been some changes to the rules of how cancer patients that travel between one organisation and another are treated, the impact of which is being evaluated.</p> <p>4 Hour Wait – JS advised that March was disappointing at 89.33%. The increased pressures include the demand into ED in Q4 which has significantly risen both in the number of people that attend the ambulance arrivals and the number of admissions. This has a big impact on patient flow and although the length of stay in key areas such as care of the elderly has reduced by quite a significant margin, flow was not maintained to the level required. This meant that performance in quarter 4 was worse this year than it was last year. Actions have been identified that are being progressed.</p> <p>JS advised that the reduction in length of stay has enabled the closure of ward 35.</p> <p>JS alerted the board to a 12 hour breach that had occurred in early April whereby a patient came into Newark whom was quickly identified as requiring admission to KMH. Staff quickly called for an ambulance but despite repeated calls, the ambulance didn’t arrive for more than 12 hours. During this time the patient was left in the minor injuries unit at Newark. EMAS considered the patient to be safe and comfortable and therefore not a priority. JS advised that EMAS had written a report in which SFHFT we were not invited to contribute. The report does not completely accept responsibility and as such the CCG are brokering a discussion with SFHFT.</p> <p>JS advised that for ED, regionally and nationally the Trust continues to perform very well and in February were ranked 22 out of 135 acute Trusts in the Country.</p>	<p>SB</p>	<p>26/05/16</p>
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PM enquired if in terms of admissions, the percentage increases was an accurate reflection of need or had the threshold decreased. JS advised that the number of ambulance arrivals point to an indication of need and that the ambulance service is good at getting conveyances accurate. If we have an increase in ambulance attendances it is an increase in need rather than an increase or change in our admission. Improvements to the ambulatory care pathway are being considered along with changes to the emergency assessment unit in an attempt to reduce admissions.

CW stated that one of the main causes of failures in referral to treatment was sleep studies and enquired if work was still being conducted at Newark who were reviewing new technology that enabled remote monitoring. JS advised that the demand for sleep studies has increased and although there is no longer a wait for paediatric sleep studies, there is still a problem with adult sleep studies. There has been a change that has increased the number of people requiring sleep studies and this is being investigated. JS was not aware if sleep studies were conducted at Newark but advised that the aim was to fully utilise Newark.

Diagnostic Waiting Times - JS advised that the Trust continues to achieve the target in Radiology in all modalities.

RTT in patients - previous validation was up to 92% but validation is now being conducted much more comprehensively.

Outpatient & Inpatient performance - Outpatient cancellations by hospital are 3%. This is an improved position. The DNA rates are showing new outpatients at 7.67% (8.71% nationally) and the follow up rate at 8.77% (9.21% nationally). The new to follow up ratio is 1:2.17 compared to 1:2.0 nationally. JS advised that an agreement has been made with the CCG that enables each clinical team to identify an appropriate new to follow ratio rather than having a blanket new to follow ratio based on an average for all specialities.

Cancelled inpatient operations stand at 0.8% (Target 0.8%). Theatre utilisation is 80.8% and stable. This needs further work to achieve the national standard of 85%

Finance - PR advised that at the end of September 15 the Trust submitted its forecast outturn figure of £53.26m. The actual outturn position achieved was a deficit of £53m thus improving the position by £260k. However there are two other factors that change the reported figure to the financial accounting figure, one of which is the £2m LTP costs that NHIS require us to reflect in our accounts. These costs incorporate SFHFT, NUH, Sheffield and Derby's costs and have been transferred into SFHFT's financial position. We have received public dividend capital to service this expenditure but no budget has transferred. Secondly there is a financial accounting adjustment that needs to be reflected in our financial accounts which is any increases or decreases in the value of our fixed assets. This adjustment has resulted in a significant reversal of impairments i.e. the value of our assets have increased by £28.5m resulting in a book entry within the income and expenditure accounts. This has reduced what has been reported as a deficit down to £20.5m.

The Outturn CIP delivery is £6.89m against plan of £6.50m.

<p>Workforce</p> <p>JB advised that the sickness absence rate in month was 4.14%.</p> <p>Appraisal - Trust wide appraisal compliance has increased in month to 90% for March 2016. There are 352 outstanding appraisals compared to 364 in February.</p> <p>Staff in post - has shown a slight decrease of 2.03WTE's. However the nursing trajectory has been modelled show the future position of nursing vacancies. This trajectory shows a significant predicted increase to staff in post in Sep of 64 with a further increase a year later. As such the position is expected to stabilise by Sep/Oct 2017. The trajectory also enables a review of variable pay and the reverse trajectory can be anticipated. The report does show a significant increase over budget of variable pay but also identifies why this is occurring. Variable pay costs of substantive posts will be saved.</p> <p>Work to produce a similar projection assisting the medical workforce is also underway.</p> <p>PH requested that the percentage component for staff flexibility within the trajectory be agreed for the Trust in order to provide a true position. SB advised that inconsistencies had been identified and further discussions would be held at the Steering Group meeting.</p> <p>RB requested that historical data be added to the trajectory for comparison purposes. JB advised that the trajectory is refreshed monthly as an actual.</p> <p>Action:</p> <p><i>The nurse recruitment trajectory to be amended to reflect the component for staff flexibility that would not normally be filled by a substantive postholder.</i></p> <p>Mandatory training - has shown a 1% increase.</p> <p>Vacancy control and recruitment – the new Trac system is vastly improving the speed of the recruitment process.</p> <p>NG stated that the last three months of the last financial year had shown an increased adverse variance on nursing pay costs. NG felt that it was disappointing to see from the trajectory that it would be another 18 months before the establishment was achieved. NG enquired if the position could be improved in view of the deteriorating position over the next six months. JB advised that the trajectory only included 5 nurses coming from the Philippines but 45 nurses are very close to the pass rate and if the Trust could support the nurses through the language test then a very significant boost could be achieved. JB felt it key to focus on this area. In addition joint recruitment drives are being discussed with NUH.</p> <p>CW enquired as to the impact that the legislative cap has had on agency spend. JB advised that the April cap was set at 55% of the agenda for change rate and that overall it has helped to bring costs down but the difficulties were for specialists nurses and medics etc. Last week's variable pay figures for nursing were improved with a reduction of 100 nursing shifts</p>	<p>JB</p>	<p>26/05/16</p>
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	<p>from the previous week.</p> <p>PM enquired if the age profile of staff had been taken into account and predictions made for staff retirements. JB advised that there is no set retirement age so it would be difficult to plot with any accuracy.</p> <p>SB advised that a continual increase in Therapies vacancies had become apparent and positions were becoming difficult to fill. As such work to produce a similar recruitment trajectory had been planned.</p>		
	QUALITY IMPROVEMENT PLAN UPDATE		
16/099	<p>PMr presented the report and advised that the plan was in its fifth cycle. The work conducted now begins to compete alongside the LTP and due diligence process. Good progress continued to be made with 95% of all actions within the QIP either complete, on track to complete or embedded. There are 12 red actions in total in the plan.</p> <p>Progress is being made to appoint clinical governance leads in each division and appointments have been made in 4 out of the 5 divisions.</p> <p>PMr advised of an issue that has arisen in relation to providing European paediatric life support practitioners on duty on all shifts within paediatrics. This is a training requirement but unfortunately the training trajectory wasn't achieved due to provisions that had to be made due to the recent black alerts. Steps have been taken to address the situation and training is being delivered either in house or off site.</p> <p>A number of actions relating to end of life service and training are red this month. This is because a review by an external company cannot be conducted until May. The review will be used to guide subsequent decisions that need to be made around the configuration of end of life care and training.</p> <p>With regards to safety culture, good progress is being made and the action is expected to be scored green next month.</p> <p>Extending the critical care outreach service is showing red. This action related to the aspiration to extend the CCOT service to 02:00 each day. The rotas were unsustainable with ongoing sickness and recruitment challenges hindering progress. The current model allows the service to be extended to 20:45 each day after which the hospital at night service is used. EM advised that the section 31 letter did not require the service to be extended to 02:00 and that this was an internal decision. EM suggested that the Trust look at the level of services that are being delivered in the other comparable DGH's, establish normal practice and set a target that is expected locally, not one that exceeds it. If the Trust were able to demonstrate what would be an appropriate level of care, this would satisfy the action.</p> <p>PMr advised that the focus of the paediatric resuscitation action was on the procurement of the trolley, however the underlying problem was identified to be the checking of the resuscitation equipment daily. Daily reporting checks and monitoring have been introduced in A & E, other areas were conducting appropriate daily checks.</p>		

There was a red action relating to the training of all clinical staff in relation to referral to treatment times. Good progress has been made and 64% of eligible colleagues have been trained to date. Training continues.

PH advised that a harmonised approach with NUH had been agreed for developing an innovative approach to staff suggestions on how they are achieved and celebrated.

PMr summarised to the Board of Directors 14 blue actions that were recommended for embedding at the Quality Committee.

The Board of Directors ACCEPTED the recommendations from the Quality Committee.

There were no blue actions that required the Board of Directors formal consideration.

PMr advised that there was a challenge of the Trust's CQC Registration in that the Trust were not registered to assess or treat patients who are detained under the Mental Health Act. The Trust were invited to incorporate this under a formal notice and a formal application was submitted. As part of this process a number of different documents including specific statutory forms were required by the CQC that the Trust compiled and submitted in partnership with Mental Health Trust. AH will be the nominated as Board Lead supported by SB as Chief Nurse. Both AH and SB will receive training from the Mental Health Service providers.

In addition an agreement with the Mental Health Trust was made to conduct the Mental Health Act administration, processing and checking of detention forms as and when they are used. MHT's training programme will be utilised for this. An inspection of the Trust's mental health processes is expected imminently.

SB advised that training had been ongoing for a number of months which included self-harm, ligature and mental health awareness training. The staff survey is underway which sections off individual aspects of mental capacity, dementia and self-harm. The data is captured through various sources. This training will become part of the Trust's mandatory training programme from 1st April 2016. In addition a follow through audit has been instigated for 10 patients, both adults and children, who present with self-harm subsequent to admission.

PM advised that the cycle for May is proving challenging due to the time restraints relating to the due diligence process and LTP. The blue and blue green actions contained within the QIP will be removed in order to de-bulk the plan. The blue and blue green actions will continue to be subject to a process of assurance and checking.

SL enquired how the embedding would be tested. PM confirmed that KPI's are being developed for each workstream to ensure ongoing monitoring. Audits, inspections and checks of embedded actions will continue as part of the assurance process.

	<p>EM stated that the period was significant as the Trust was 6 months in post quality summit and halfway through what would have been an annual programme of works. The system that is now in place is robust and still progressing and as LTP discussions continue, there will be a convergence and some actions will not progress any further or become embedded. This is they will be picked up by the NUH joint working. These actions should be flagged and the information funnelled.</p> <p>EM advised that the relationship between the LTP and QIP should be hardwired and it was good that the reports that are going to the fortnightly Steering Group meetings have a cross reference to the QIP but they needed reinforcing. The contribution of the LTP discussion and the Trust being able to deliver the QIP needs to be understood.</p> <p>EM explained that the QIP was intended to get the Trust to a 'satisfactory' outcome from a CQC inspection but with the Nottingham support work the organisation could aspire to achieving 'good'. The CQC invariably inspect within 12 months of a quality summit and as the Trust is six months in, this could occur at any time. Mock inspections and preparation for an inspection would be advantageous.</p> <p>Action:</p> <p><i>Themed scripts to be provided to Executives for reference during senior walkarounds.</i></p>		
	USE OF TRUST SEAL		
16/100	SC advised the Board that the use of the Trust Seal had not been required during 2015/2016.		
	NHS IMPROVEMENT Q4 RETURN		
16/101	<p>SC presented to the Board of Directors the report to safeguard debate and thorough understanding of the Board certifications to be submitted to NHSI to ensure all Board members are clear of their responsibility to be confident of the accuracy and appropriateness of the declarations being made.</p> <p>SC requested that the Board of Directors pay particular attention to the Finance and Governance Declaration with regard to its confidence in achieving/sustaining against the Financial sustainability rating and the Governance declaration in achieving targets for the next 12 months, as defined in the narrative submission within the declaration.</p> <p>The Board of Directors AGREED the Declarations, Exception Report and supporting paperwork for onward submission to NHSI.</p> <p>The Board of Directors AGREED relevant amendments and additions having regard also to a prospective assessment of anticipated performance and the potential for breach.</p>		
	GOVERNOR MATTERS		
16/102	SL advised that the Governors Elections would close this evening. The results of the elections will be disseminated in due course.		

PMr

06/05/16

	ASSURANCE FROM SUB COMMITTEES		
16/103	<p>Finance Committee – NG advised that the Committee had recognised the improvement in the financial report, in that the forecast that was compiled in September 2015 with the outturn figure, subject to audit, came in £250k. This is a tremendous improvement to the position as at March of 2015. NG advised that the deterioration in the variable nursing pay over the last three months was discussed in depth at the Finance Committee meeting and assurance was obtained that the actions were becoming embedded within the organisation although it was disappointing to note that establishment would not be achieved until 2017.</p> <p>The Board CONFIRMED that the committee would continue to be the Finance Committee and it was not necessary to amend to the Finance & Performance Committee.</p> <p>Audit & Assurance Committee – RD advised that a committee meeting had been conducted last week to predominantly discuss the annual report and accounts. One huge caveat is the requirement for flexibility due to the LTP. RD confirmed that the annual plan and the internal audit plan for 2016/2017 were both agreed at the Audit & Assurance committee meeting.</p> <p>Quality Committee – PM advised that the Quality Committee had held an extraordinary meeting to review the QIP and Quality Account 2015/16. The Committee had been agreed that the process this year had been very good and much improved to previous years. A further meeting is planned prior to sign off of the Quality Account. PM thanked all those involved for the work they had contributed.</p> <p><i>The Board expressed their gratitude to Nigel Nice for his contribution as an observer of the Quality Committee.</i></p> <p>Board Risk Committee – PMr advised that the Committee had reviewed in detail the risks and challenged the degree of risk exposure for the Board Assurance Framework. This has resulted in risks in the BAF being scored and further consideration given to the inherent, current and target risk scores.</p> <p>Action:</p> <p><i>The BAF to be included on the Public agenda.</i></p> <p>Charitable Funds Committee The Board RATIFIED the proposed imagery of the Charitable Funds Committee logo.</p>	SC	26/05/16
	COMMUNICATIONS TO WIDER ORGANISATION		
16/104	There were no items requiring communication to the wider organisation.		
	QUESTIONS FROM MEMBERS OF THE PUBLIC PRESENT		
16/105	There were no questions from members of the public.		
	ANY OTHER BUSINESS		
16/106	Board Room – PH advised that arrangements were underway to relocate the KMH’s Board Room into a larger room on level 1. The relocation is anticipated to become effective by the next Public Board meeting.		

	DATE OF NEXT MEETING		
	It was CONFIRMED that the next meeting of the Board of Directors would be held on 26 th May 2016 at 09:30am in the Board Room, Level 1, King's Mill Hospital.		
	There being no further business the Chairman declared the meeting closed at 12:05.		
	Signed by the Chairman as a true record of the meeting, subject to any amendments duly minuted.		
	Sean Lyons Chairman		Date