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

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Unconfirmed **MINUTES** of a Public meeting of the Board of Directors held at 9.30am on Thursday 19th December 2013 in Classroom 1, School of Nursing, King's Mill Hospital, Mansfield, Nottinghamshire, NG17 4JL

Present:	Sean Lyons	Chairman	SL
	Dr Gerry McSorley	Non-Executive Director (SID)	GMc
	Mark Chivers	Non-Executive Director	MC
	Claire Ward	Non-Executive Director	CW
	Tim Reddish	Non-Executive Director	TR
	Ray Dawson	Non-Executive Director	RD
	Dr Peter Marks	Non-Executive Director	PM
	Paul O'Connor	Chief Executive Officer	PO
	Dr Andrew Haynes	Interim Executive Medical Director	AH
	Susan Bowler	Executive Director of Nursing & Quality	SB
	Karen Fisher	Executive Director of Human Resources	KF
In Attendance:	Kerry Rogers	Director of Corporate Services /Company Secretary	KR
	Jacqui Tuffnell	Director of Operations	JT
	Peter Wozencroft	Director of Strategic Planning & Commercial Development	PW
	Yolanda Martin	Head of Communications	YM
	Craig Gunton-Day	Lead Governor	CGD
	Kevin Gallacher	Deputy Director of Income & Performance	KG
	Lisa Bratby	Minute Secretary	LB
	Sandra Hopkinson	Matron for general surgery and trauma and orthopaedics	SH
	Liz Williamson	Divisional Nurse Manager – Planned Care & Surgery (Patient story only)	LW
	Kerry Smith	Ward Leader , Ward 21 (patient story only)	KS
	Eddie Olla	Director of Health Informatics (Enclosure T only)	EO
	Gillian Alloway	Interim Information Governance manager (Enclosure T only)	GA

		Action	Date
	CHAIRS WELCOME AND INTRODUCTION		
13/161	The meeting being quorate, SL declared the meeting open at 9.30hrs and confirmed that the meeting had been convened in accordance with the Trust's Standing Orders. SL welcomed LW, KS and SH to the meeting.		
	DECLARATIONS OF INTEREST		
13/162	It was CONFIRMED that there were no new Declarations of Interest		

	APOLOGIES FOR ABSENCE		
13/163	It was CONFIRMED that apologies were received from Fran Steele		
	PATIENT STORY		
13/164	SB explained that the patient story this month highlights the changes that have been made recently regarding the way that complaints are addressed within the Planned Care and Surgery division and in particular how this change achieves much better results by working together with patients KS, LW and KS introduced themselves to Directors and explained that the patient story involved a lady called Vera who is 80 years old. Vera lives in a nursing home and suffers from severe dementia which causes her to become very confused and frightened when she is admitted to hospital. Vera fell and fractured her hip and as a consequence she developed a grade 3 pressure sore which was healing well. Vera was recently admitted to King's Mill Hospital with pain and complications due to a bowel problem (sigmoid volvulus). Vera's emergency pathway was ambulance admission, via the emergency department and transfer to the Surgical Admissions Unit (SAU). She was subsequently admitted 4 times in a 2 week period but 10 times in total. Every time she was admitted via A & E she waited over 4 hours which constitutes 40 hours pressure on an existing pressure ulcer. A complaint letter was received regarding this ladies care and it was decided that the division needed to think differently and respond to complaints in a different way. The division concluded that complaint letters rarely fully articulate all of the real issues for patients and carers and they do not portray all of their emotions and whilst a written response from the Trust is sent, this sometimes does not add any value for the complainant, or the Trust, and does not address the real issues at the heart of the complaint. A decision was made to arrange to meet face to face with Vera's family in their own home. Initially Vera's husband and daughter were very angry and spoke in very sharp tones. They used very pointed language such as "you left her for hours". Their body language was very negative and it was obvious that the whole family were very upset. During the face to face meeting the real needs of the patient and her family were revealed and these would not have been realised in a letter. By holding a face to face meeting staff were able to respond to the family's feelings and emotions, allowed the body language to be observed and the real issues to be identified. This open meeting also showed the family that staff were listening and really wanted to learn and change their practice. Staff said they were sorry and accepted that Vera's experience was not acceptable and the family heard and saw the		

	sincere apology in manner that it was intended During the meeting Trust staff ***promised*** to make some changes for Vera to improve her experience of future admissions. The promises that were made were that Vera's pathway would be better; the colorectal/ stoma nurse specialist would become an active link for the family for clinical advice and for support for future admissions and Vera would not have to wait in A & E and would be admitted directly to SAU for future admissions. In addition to the promises the family were also given the Matron's telephone contact number. SH highlighted that the word ***promise*** was made as this is precisely what the Trust wanted to do , promise to make a change. The changes that were promised were actioned quickly and this successful transition has meant that since November 2013 Vera has had no further admissions to hospital. The family now have a direct link to the Trust through the specialist nurse, the specialist nurse visited the nursing home the same week and educated staff how to recognise the early signs and symptoms of Vera's complaint and implement preventative rather than reactive care. Equipment has been left at the nursing home to enable the specialist nurse to visit Vera and undertake procedures preventing the need for hospitalisation. Through the implementation of this care plan Vera's family also feel supported. KS identified that the introduction of face to face complaint meetings is beneficial from a ward sister's perspective as this is an ideal vehicle of ensuring that the emotion behind the complaint is felt and it is very humbling to hear. It enables staff to view their care from a patient's perspective and encourages staff to "own" their behaviour and address their faults. Within the planned care and surgery division all complaints are now reviewed with this new approach in mind and wherever it is suitable, the complainant is asked if they would like a meeting in their own home. This demonstrates that the Trust is listening to people and really wants to learn and change practice. It also helps the complainant feel more valued. When feedback is given to staff the patient's words are used. The new approach is also helpful for staff as it helps to develop their skills, is effective in shaping values and behaviour and allows open discussion regarding attitudes and behaviours. It also enables the ward team to use the emotions from the meeting in discussions, puts the patient's voice in staff's minds when they are deciding how to act and encourages the ward team to own the concerns and make the changes that are required. Any individuals that are named in a complaint are given constructive feedback and support on what and how things can be improved. LW concluded the presentation by informing Directors that since August		

	2013 SH has resolved 10 complaints in the new face to face manner all with satisfactory outcomes and positive feedback being given from the complainant. RD questioned what criteria is used to determine whether a complaint is suitable for a face to face meeting or not. LW responded that if the complaint relates to a specific clinical procedures or a technical issue then this complaint would not be chosen. Currently the more personal complaints regarding attitude and behaviour are the complaints that are chosen to undertake the new regime. PM commended the divisional team on taking the new approach and stated that he was interested to learn that the new approach saved time by listening rather than writing. He expressed his concern , however, that this patient was admitted 10 times before an action plan was put in place and questioned whether the patient's GP was contacted as this patient's complicated health care required multidisciplinary involvement. SH responded that the specialist nurse has contacted the patient's GP and confirmation could be given if required. PM questioned whether the special pathway that is now in place for this patient is in place for other frequent attendees and also whether feedback is requested following a complaint resolution. SH confirmed that there are patients that have specific pathways in place but Vera was not identified as requiring this facility early enough. SH offered her assurance to the Board that divisional staff have learnt from this experience. Regarding feedback SB confirmed that from January 2014 a satisfaction feedback form will be issued to all complainants to gain their view of the way the Trust resolved their issues. SH confirmed that with regard to Vera she contacted Vera's daughter two days after the home visit and the subsequent visit from the specialist nurse to learn that the family were very pleased with the response. CW questioned whether the option of a home visit had ever been offered and the patient or family had declined. SH confirmed that only one home visit had been declined but this was due to the distance that was required to be travelled. In this instance a telephone conversation was undertaken and concise notes were taken which led to a plan being formulated and changes being made on the ward concerned. TR added his congratulations to the team for implementing this key change, offering the Board's assurance that the division will continue to be supported by the Board of Directors. TR requested that the divisional team liaise with their colleagues regarding any specific support that is required from the Board and relevant feedback be given to the next Board meeting. Directors concluded that whilst this initiative is commendable the lack of engagement from clinical colleagues is disappointing. AH agreed that	**SB**	**Jan 2014**

	earlier intervention and a greater understanding of behaviour is required from clinical colleagues and this message will be cascaded accordingly. At this point LW, KS and SH left the meeting		
	FEEDBACK ON PREVIOUS PATIENT STORY		
13/165	SB updated that the patient involved in the story presented to the November 2013 Board meeting has received a response to her complaint and the Trust are working with her to ensure that she is able to return to work as soon as possible. Plans are in place to present the story to a ward leader's event that is scheduled to take place in January 2014.		
	MINUTES OF THE MEETING HELD ON 29 OCTOBER 2013		
13/166	Following review of the minutes of the public meeting held on 29 October 2013 no amendments were proposed. Therefore the minutes were APPROVED as a true and accurate record		
	MINUTES OF THE MEETING HELD ON 7 NOVEMBER 2013		
13/167	Following review of the minutes of the public meeting held on 7 November 2013 the following amendments were proposed 13/138 – Regulatory – Discretionary requirements – Keogh – Directors expressed their concern that the high level of challenge from NEDs was not captured in an appropriate manner. It was proposed that the following statement be added to the beginning of this section "***During considerable challenge and questioning from NEDs the following points were discussed and actions were agreed as detailed below"*** Subject to this amendment the minutes were APPROVED as a true and accurate record.		
	MATTERS ARISING / ACTION LOG TRACKER		
13/168	The Board REVIEWED the matters arising / action tracker document in detail. The following updates were AGREED **Action 29 - Smoking shelters** SB reported that she had liaised with the CCG regarding the Trust's plans. However the shelters are not in place yet although planning permission has been requested for their installation. A further update will be given in January 2014. **Action 33 – Keogh Nursing staffing –** SB advised that an update pertaining to nursing establishment is provided in the Nurse staffing paper submitted to today's meeting. Therefore this action is **COMPLETE.** **Action 35 – Keogh – Fluid management –** SB updated that training pertaining to fluid management , red trays and jugs and all associated		

	elements has been undertaken via the Nursing care Forum. This action is now **COMPLETE.** **Action 39 – Keogh – Newark Strategy – staff engagement-** Directors noted that staff engagement was undertaken with Newark staff via the " In our shoes" events and further feedback would be given in the private session of the December meeting. This action is now **COMPLETE** **Action 40 – Keogh – Newark Strategy – Governor update** – SL confirmed that he meets all Newark Governors on a monthly basis with CW, JT and AH and these meetings will continue . **Action 41 – Keogh – Newark Strategy – Newark mortality** – AH reported that he had met with Amanda Sullivan regarding the Newark mortality figures and details of this are contained in the report scheduled to be presented later in today's meeting . An update will be given to the Newark Governors as proposed. **Action 43 – Keogh – Quality at Board level –** SL confirmed that a small committee was formed to consider tenders relating to the opportunity to offer external assistance to develop a Board Development Programme for the Trust. Representatives from 2 of the successful tenders were invited to attend a meeting at the Trust on 18 December 2013 and a successful candidate has been selected to facilitate a Board development session on 23 January 2014. No challenge is anticipated as this is an OJEU procurement. **Action 48 – Keogh – Patient Moves – Outliers –** It was noted that the Executive Team are still considering the most appropriate method of capturing information regarding how often outlying patients are visited by their medical team and how they are tracked on PAS . This remains a concern for Keogh and will be discussed in detail at the Executive Team meeting on 23 December 2013 as presently NEDs will not be assured regarding the level of this risk. A detailed report will be presented to the Board meeting in January 2014 JT advised that following a recent visit and assessment by the CQC this issue is not a concern for them and the Trust should be assured by this result. The CQC have raised concerns regarding how patients are risk assessed prior to being considered as suitable as an outlier and work to mitigate this concern are underway. GMc expressed his concerns that recent Board reports identify that 1 in 25 patients are moved more than 4 times and questioned whether this high level of moves is elevating the risk of patient harm. AH proposed that further work be undertaken to ascertain whether the 4 moves is associated with the patients complex medical needs or medical workforce pressures. MC requested that when feedback is provided, information pertaining to what exactly the risks are associated with patients moves and also the risks of being an outlier are and how these risks will be addressed.	**AH/SB**	**Jan/Feb 2014**

	QUALITY REPORT		
13/169	SB presented the monthly quality and safety report providing the Board with a summary of important quality and safety items and the key quality priorities. Directors noted that the report also provided updates pertaining to work associated with pressure ulcers, patient flow, complaints, the National Maternity Survey, the recent CNST assessment, infection control, vitalpac and a summary of the discussions that were undertaken at the last Clinical Governance & Quality Committee. <u>Patient re-admission</u> GMc drew Director's attention to the graph included on page 3 of the report detailing the 30 day readmission rates and noted that this graph suggests that 1 in 10 patients are readmitted within 30 day of their initial admission. GMc questioned whether these admissions were elective or emergency. GMc advised that whilst this level of information may not be required at Board level this should be available for close analysis by other bodies. JT responded that she is happy to engage with NEDs outside the meeting to understand the level of information that they would like to receive. GMc welcomed this proposal and requested that assurance is given that the Executive Team are regularly reviewing this data set and that they feel assured. PO offered his assurance that all avoidable admissions are reviewed regularly by the Executive Team. JT advised that Dr Anne-Louise Schokker is currently undertaking a review of all 30 day readmissions on behalf of the Trust and feedback will be given in due course. <u>Complaints</u> PM raised his concerns that the report details complaints data in the form of a number which does not give the Board a true indication of percentage and the scale of the issue. SB responded that a deep dive exercise is currently being undertaken, the results of which will provide a clearer indication of any themes and the scale of any specific issues. CW reported that she is aware that all requests to the Parliamentary Health Service Ombudsman (PHSO) have to be directed via the patient's local MP and encouraged the Trust to contact all local MPs to ascertain how they currently deal with these enquiries . PO responded that he is confident that all local MPs do contact the Trust directly if any concerns are raised and patients are also given the PHSO contact details in every complaint response letter that is issued. CW highlighted that doctor's attitude remains high in the graph detailing the subject of patient's complaints and questioned how this is being addressed. SB advised that investigating this issue is often problematic as patients do not name a specific doctor in the complaint but just refer to "the" doctor in clinic / on the ward / in x-ray , etc. In this instance the	**JT** **JT**	**Jan 2014** **Jan 2014**

	patients notes or pathway are reviewed to gain the name of all doctors involved in the patients care. If a specific doctor is named then they are invited to respond to the complaints letter and also undertake a review of the complaint and address or review their behaviour. SB added that there is currently a number of training courses available to nursing staff regarding how to address their behaviour and attitude but this training is not accessible by doctors presently. AH informed Directors that all junior doctors undertake attitude and behaviour training prior to beginning their employment but the issue appears to be how this training is put into practice. This issue will be investigated in greater detail. KF informed Directors that April Consulting Group are scheduled to facilitate another training session specifically for doctors to discuss future values and behaviours , the results of which will be included in the OD strategy. <u>Pressure Ulcers</u> PM questioned what the Trust has learnt from the data that is reported pertaining to avoidable pressure ulcers and how is the Trust is planning to use this learning. SB responded that the reduction of pressure ulcers is currently the Trusts number 2 priority and there is great focus and learning currently being generated. A pressure ulcer steering group is currently driving this work forward and will cascade all learning throughout the organisation. <u>Infection Control</u> PM highlighted that there is clear narrative regarding the Trusts allocation of alcohol hand gel at the entrance of each ward and at the bedside but stated that a focus is still required on the need for basic hand washing requirements . SB clarified that the narrative in the report is in response to Professor Brian Dearden's report and the focus on regular hand washing remains high on every healthcare professional's infection control regime. <u>Falls</u> KR reminded Directors that concerns were raised at the last Board meeting regarding the high level of falls that were reported and questioned how these concerns were being addressed. SB confirmed that the serious falls group are investigating this issue in detail and Dr Anne-Louise Schokker had reviewed every report of a fall and identified that no concerns are evident. <u>Vitalpac</u> GMc encouraged the Trust to obtain clear benefits realisation data ahead of the vitalpac roll out. SB responded that this information is currently available if required. MC expressed his concern that the Trust appear to have procured additional modules for the vitalpac system that are not being rolled out	**AH**	**Feb 2014**

	which, from a procurement perspective, appears to be incorrect. SB clarified that the Trust plans to roll out the basic vitalpac system and when clinicians are familiar and confident with the regular use of the basic system then the additional modules will be introduce. This will avoid information overload and facilitate a better way of learning and implementing a new system. AH added that the Trust plans to use all of the additional modules over time and would be agreeable to meeting with MC outside the Board meeting to discuss the roll out plan in greater detail Directors NOTED the content of the report and progress / position to date. SL encouraged all members to reflect on the examples of good practice that are detailed in the report and consider how examples of poor practice can be addressed.	**AH**	**Jan 2014**
	MEDICAL DIRECTORS MORTALITY REPORT		
13/170	AH explained that the Medical Directors Mortality report provided an overview of the key findings of the Dr Foster Hospital guide 2013 summarising how this report ties in to the Mid Notts Mortality Review and the Trust's position from April 2013 onwards. AH advised that The Dr Foster Hospital Guide 2013 was published on 6th December 2013 and showed Sherwood Forest Hospitals Trust to have the worst hospital standardised mortality ratio (HSMR) in the country. This reflects the position at the trust between April 2012 and March 2013 hence is looking back to a time when external reviews identified potential safety issues. The Trust has made a significant response to this historical position since April 2013 but progress will not be visible externally until the 2014 Dr Foster report is published. In response to a number of issues including the external review of Sherwood Forest Hospitals Trust and the change in service profile at Newark Hospital, the Mid Nottinghamshire Clinical Commissioning Groups commissioned an independent expert review of population based mortality across the locality between 2007 and 2012. This was published in full on 3rd November 2013. The combination of these two reports provides a unique opportunity to examine in greater detail the events surrounding the hospital mortality at the trust in the context of the wider population and develop a richer understanding to help guide future planning. PO added that the local public reaction following the release of the report was better than anticipated. YM added that this positive reaction was credited to all of the hard work that AH undertook engaging with the media in detail ahead of the report release providing a detailed background and good knowledge base. AH reported that the Trust needs to continue to improve coding levels to further improve the HSMR score. A focus is required on clinical staff ensuring that the correct coding information is provided in the patients notes which will , in turn , ensure that the patient data is interpreted		

	correctly by the clinical coder to ensure that the correct coding is achieved. The implementation of a new Integrated Care Record (ICR) should ensure that this process improves. JT added that a strengthened clinical coding team will be in place at the Trust from January 2014. This team will assist in the education of junior doctors in correct clinical coding and ensure that the data that is captured is as accurate as possible. JT clarified that in the past one of the issues was the level of uncoded data. This issue has been addressed and the focus is now on ensuring that the data is accurate. PO advised Directors that in some Trusts their 95% A&E target is improved by bypassing a Single Point of Access (SPOA) route for all patients, preferring to offer a referral system straight from the patients GP to EAU therefore bypassing A&E and removing the patient from the target group. At SFH a SPOA is given which may cause issues regarding achieving the Trust's A&E target but does ensure that our patients are given the best possible care. RD questioned how this SPOA influences the HSMR figures AH confirmed that if patients are admitted, who might otherwise have been sent home if seen by a senior medic, they usually will be discharged the next day after review so this is called "zero length of stay" cases. These cases will have a low risk of death but because HSMR is adjusted for activity, a Trust with a high proportion of these cases in their emergency admissions will have an artificially lowered HSMR. SFHT has a single point of access so low numbers of these cases. PM commended the Trust on the improvements that had already been made in terms of improving mortality rates and weekend working levels and encouraged the Trust to strengthen links with local nursing homes and other outside agencies to support patients that do not wish to die in hospital but express a wish to die at home. GMc stated that whilst it may prove to be extremely ambitious he encouraged the Trust to aim for the "gold standard" in terms of coding and undertake a full case note review of every deceased patient. MC remarked that there is a clear indication within the data included in the report that during the winter months the death rate increases which will, in turn, increase the mortality rates. MC questioned if there are any measures which can limit the effect of the increase on the Trust. AH responded that during the winter months deaths connected with flu, respiratory disease and falls do increase so clear forecasts need to be achieved pertaining to "expected" deaths during times of high pressure. CW questioned how the Trust intended to improve the weekend working figures. AH confirmed that this improvement will be achieved by improving the "front of house" services.		

	Directors NOTED the Medical Director's report and the key findings detailed within.			
	CHAIRMAN'S REPORT			
13/171	SL presented the Chairman's report giving an update on progress, plans and regulatory developments. The Board noted the written report. SL advised verbally that he had recently worked on 3 wards undertaking healthcare assistant duties and during 2 of these shifts he had heard 2 good news stories. The first related to a patient that desperately wanted to leave hospital, despite being terminally ill, to enable him to walk his daughter down the aisle. His wish was granted through the effort and determination of the doctors and nurses that were caring for him and the thanks for this effort which was obviously above and beyond the ward staffs normal duties are recorded in a letter, displayed on the ward communication board for all to see. The second patient was a lady, who was also terminally ill who wanted to return to her family in Pakistan before her life ended. Once again ward staff "pulled out all the stops" to ensure that this patient's wishes were respected. This fantastic gesture of goodwill is supported by a thank you letter and a photograph of this lady surrounded by her family in Pakistan. A third good news story was relayed to SL during a site walk round where he met the owner of a large local haulage company who informed SL that he was so impressed with the fantastic care that he had received at King's Mill Hospital, whilst he recently undertook treatment for cancer, that he had bought out his company private healthcare plan and encouraged all staff to take advantage of the fantastic local hospital care instead. This gentleman plans to further assist the hospital by raising funds to support cancer services at SFH during 2014. During one of the ward visits SL also met a gentleman that complimented the care he was receiving on the ward as he felt "safe" but informed SL that his experience on ICCU was very distressing as there was an absence of compassion and he felt very vulnerable. This issue is being addressed but clearly identifies that fantastic care does not thread all the way through the Trust and improvements are required. Directors NOTED the Chairman's report			
	CHIEF EXECUTIVE'S REPORT			
13/172	PO presented the Chief Executive's Report and updated that work remains on going to secure the Trust's share of the allocation of the non-recurrent additional winter monies.			

	PO drew Directors attention to section 2 of the Chief Executive's report highlighting the importance of Directors being aware of budgets outside the Trust. PO requested that Directors understand the magnitude of the financial challenges that are being faced by the council, and other agencies and the subsequent impact that these challenges will have on the health of the local population, particularly the impact on external services that the Trust relies on to support the Trust in delivering the provision of local health care. PO advised that at a meeting on 17 December 2013 with the Ashfield District Council Consultative Policy Forum the main focus of discussions was associated with regulatory action but 5 points which were of interest locally were also discussed , namely; 1. Mortality Rates; 2. Cost of the Private Finance Initiative Agreement; 3. The Plan for bringing the Trust out of Special Measures; 4. Accident & Emergency Performance; 5. The Friends & Family Test which shows the level of public confidence in the delivery of services. Directors NOTED the Chief Executive Report and the specific verbal updates that were given.		
	FINANCE , PERFORMANCE AND STRATEGY		
	IMPROVEMENT PLAN – MONITOR FEEDBACK		
13/173	PW advised that the Improvement Plan – Monitor feedback paper provided Directors with a summary of the feedback received from Monitor following the submission of the Trust's Improvement Plan on 31 October 2013. PW updated that a decision was taken to review the response at a special Risk Committee meeting that was held on 11 December 2013 so that all risks could be identified. The key next steps were identified as • Outputs of the risk workshop held on 11 December 2013 to be translated into a prioritised set of actions and mitigations • Further Board sessions to ensure alignment on way forward • Update to Monitor to be provided as part of the January Periodic Review Meeting • Board to Board planning session in January between the Trust and the CCG's to continue to align direction of travel. Directors NOTED the update given		

	ANNUAL PLAN 14/15 PROCESS		
13/174	PW presented the annual plan 2014/15 process paper explaining that the process for business planning is always changing and each year Trusts are tasked with modifying activity to improve processes and systems based on the previous year. This year, as an organisation the Trust are far more developed in understanding our high level objectives through the strategic development work that has been undertaken in the last six months. There are several inputs into our Annual Plan for 2014/15 which are : • Clinical Services Plan and Improvement Plan 31st October 2013 submission • Transformational and Service Improvement Events • In your shoes / In our shoes • Newton Europe Improvement Programme • Workforce Plan 2014/15 PW explained that Monitor's annual plan review process has also been updated. Instead of one combined submission at the end of May 2014, next year they are requesting: • two years' of financials supported by financial and operational commentary on 4 April 2014; and • a further three years' of financials supported by a strategic and sustainability commentary at mid to end of June. PW explained that this is a significant change to timings and an outline of the processes to be completed prior to the submission date is attached at appendix 1 of the Annual Plan report. PW advised that the Trust will be asking divisions to think more strategically, to focus on internal ambitions, objectives and challenges in the context of the external environment with a clear focus on the individual inputs to cross divisional and trust wide objectives through the development of Divisional annual plans. SL questioned what the appetite of engagement is currently within the divisions. PW replied that the appetite is variable. In emergency care and medicine there is a positive drive and a willingness to consider the impact of the plan. Within planned care and surgery there is still work to be done but the appetite is evident albeit at a low level currently. PW highlighted that it is vital that we ensure wide clinical and managerial engagement and participation in the development of the Annual Plan. Given the shortened timescale, it is proposed that a series of focused debates are undertaken utilising existing forums such as : Divisional Management Boards Medical Managers' Meeting Senior Nursing Forums Commercial Development Group		

	Once the Trust understands the high level objectives and work plan, an integrated improvement programme approach will be adopted across the organisation in developing our plan. Historically efficiency targets have been applied as a percentage by each Division. It is envisaged that for 14/15 these efficiencies will be linked to elements of the integrated improvement programme. PW highlighted that programme is outlined at Appendix 2 of the Annual Plan report. Divisional plans will form an integral component of the corporate annual plan, and support will be in place to develop plans and detailed analytics through service reviews. PW advised that the next steps in the planning process were • The Annual Plan submission will be developed and reported in line with Monitor requirements for delivery of an Annual Plan. • The plan will incorporate priorities identified within the Mid-Nottinghamshire NHS Integrated Care Transformation Programme, CCG intentions, supported by cross cutting strategies and our financial plan. • Reporting and monitoring will be managed through the Hospital Management Board and Board of Directors. RD questioned whether the Trust's commissioners input into the Annual Plan prior to submission to Monitor. PO clarified that the annual plan is formulated following a template set out by Monitor and as part of this template the Trust is encouraged to align our plan with commissioner's intentions. KR emphasised the need for the involvement of the Trust Governors to be clearly captured in the process timeline. A date has already been set in March 2014 for this key engagement with Governors but the involvement of Governors from the beginning of the process needs to be clearly denoted. Directors NOTED the process to be undertaken with the proposed submission to be reviewed and signed off at the March 2014 Board of Directors meeting	**PW**	**Jan 2014**
	INTEGRATED PERFORMANCE REPORT (IPR)		

13/175	JT presented the Integrated Performance (Exception) Report giving an update on the performance summary for October 2013. The following points were brought forward for clarification. <u>A & E target</u> JT advised Directors that the December A&E 4 hour performance wait target as of 18 December 2013 stood at 93.9%. This underachievement was expected and there is a risk that the Q3 performance will fail against the 95% target. It is anticipated that the intensive support team will be attending the Trust in due course. JT updated that Monitor have recently changed the information that the Trust is required and now require more in depth details pertaining to patients that have breached the 4 hour wait. This collation of information is a useful addition as this can be used to demonstrate the increases in performance as well as the decrease. <u>Cancer 2 week wait</u> JT reported that current projections indicate that all but the 2 week wait relating to breast symptomatic cancer will be achieved for Quarter 3. This underachievement is due, in part to the fact that the Trust only has 1 breast surgeon and he has recently taken annual leave. CW expressed her concern that the Trust receives one Monitor compliance breach point each time a target is missed and the Trust already has three points in place. CW questioned what measures will be implemented if the Trust receives more than 4 points in one quarter. It was explained to Board the consequences of the Monitor point system. PM questioned whether Executives were assured that the Trust is putting in as many measures as possible to achieve the targets that have been set. JT responded offered her assurance on behalf of the Executive Team that every effort possible is being made to achieve the targets that have been set and action plans have been implemented to address problem areas. <u>Sickness absence</u> KF updated that sickness absence rates have risen in month to 4.56%. Work with managers to reduce these levels remains on going and an increase in sickness absence cases being escalated to senior management has been observed. However KF acknowledged this increase in activity is not being reflected in the overall absence figures. KF explained that she will be encouraging her HR colleagues to maintain a high level focus on short term sickness absence and ensure that quicker action is taken with repeat offenders. MC reported that he was recently involved in a sickness dismissal		

	appeal which was conducted 502 days after the employee first went on sick leave. This gap in resolution obviously needs addressing. SL expressed his disappointment that it appears that a number of employees are actively maintaining the absence levels slightly below the sickness management triggers. This is demoralising for diligent staff who regularly attend work RD questioned what employees perception of the occupational health service within the Trust is. KF responded that perception of this service varies and proposed that these variances be discussed in greater detail outside the meeting MC questioned how the current level of sickness is linked to the Trust's CIP as the cost of employing locum and agency staff to cover for sickness absence must be proving a burden that may not have been anticipated. KF confirmed that the Trust now employs 150 extra members of staff which should have driven a reduction in the locum staff spend. MC highlighted that the Trust currently has 300 vacancies and questioned whether the Trust employs 300 temporary staff. KF advised that if the vacancy was clinically facing then this position is likely to be covered. Admin and clerical vacancies, however, have only been filled in high pressure areas such as the recent PPC workforce change. KF agreed to complete an analysis of still in post, vacancies and valuable pay. Directors NOTED all points of the high level summary report and the progress / position to date.	**KF**	**Jan 2014**
	FINANCIAL PERFORMANCE REPORT		
13/176	KG presented the Financial Performance Report bringing forward the salient points as detailed below; The month 08 deficit of £15.5m is better than plan by £1.3m however the forecast out-turn is £2m worse than plan and the Trust is spending around £2m per month more than it earns. This current position has benefitted from some one off income gains along with Corporate CIP over performance. Our operating income remains ahead of plan & income has exceeded operating costs for the second month in a row. Clinical income was above internal Trust plan by £1.84m to the end of M7. Some income streams (notably outpatients) are above plan, but elective and non-elective are both below plan and we have accounted for substantial contract sanctions, including Non Elective Admissions above 08/09 baseline being paid at 30%, which have reduced our income by £1.45m in the period to the end of October 2013.		

	The headline clinical income position against plan is largely due to the commissioner assumptions on QIPP delivery not materialising. This has created an affordability issue for Commissioners who are challenging some of their liabilities in an attempt to close some of the gap however the Trust view is that this will not be sufficient to close their gap and discussions are on-going looking at options to address this at health economy level. In addition there is a need to get clear agreement with CCGs and other commissioners on what system balance looks like given a substantial number of health economy issues sit with the Trust. The Board will be kept updated on Progress with forecast out-turn and contract discussions.	**PO/FS**	**Jan 2014**
	Our capital expenditure to date of £3.06m is 78.5% of plan and is outside of the tolerance of +/- 15% of plan that was set by Monitor. The main areas of programme slippage are on medical equipment £0.62m and IM&T £0.12m. Work is underway to ensure achievement of the monitor target by the end of Q3.		
	National recruitment has not been at the rate required and international recruitment is being sourced to address this at pace. Other Trusts are also using this option and there is a potential risk that we may not attract the staff required. Significant emphasis is being placed on the induction of staff to ensure retention. KF added that the Trust has already signed a contract with 2 recruitment agencies to obtain international staff but the option of engaging with a third agency is being explored due to the slow level of progress being made. KF confirmed that newly qualified nurses are being recruited via our School of Nursing but the lack of experience of newly qualified staff is an additional risk for the Trust.		
	CIP savings are below plan in month and year-to-date however full year effect delivery is forecast above plan. A mitigation approach has been endorsed by Programme Board.		
	Following on from recent reports in the media pertaining to additional government winter pressure funding that is being made available to NHS Trusts RD questioned whether the Trust is able to access this additional support and if so, how it will be utilised. PO responded that there may be restrictions in place pertaining to how these additional monies can be spent and proposed that further consideration be given to this allocation at the Board to board meeting with commissioners the following month.	**PO**	**Jan 2014**
	SL observed that whilst month on month the Trust is reporting that it is on plan the plan is that the Trust's deficit is increasing month on month. SL challenge Executive colleagues to ensure that there is a suitable sense of austerity throughout the Trust and, for example, encourage all staff to turn off lights when they leave a room, reduce their reliance on photocopier, reduce paper wastage, etc. MC proposed that in 2014/15 each divisional cost line is linked with an appropriate CIP. Employees are currently putting an emphasis on cost improvement but there is not an equal focus on managing the cost line and the outcome on both	**SC/FS**	**Apr 2014**

	levels is paramount. KG agreed that it is important that costs are managed effectively and any inefficiencies and wastage is eliminated as a key part of basic budget management and control. At the same time we need to ensure the cost saving and transformational CIPs are seen and delivered as service change initiatives and staff are monitored on the delivery of the benefits expected from the service change. It is important for staff morale and on-going engagement to avoid monitoring and reporting mechanisms that confuse the two and potentially lead to CIP schemes being deemed as unsuccessful where they have delivered the benefits agreed by the Programme Board. PO highlighted that the Trust is facing a fundamental issue in 2013/14 as the Trust forecast out-turn position requires £217m income to cover activity delivered by it and to meet the cost of likely activity but the commissioners are currently challenging this at £212m which is a clear £5m difference. This also impacts on the 2014/15 starting position and the funding commissioners have available within the wider health system. The Trust must continue to deal with its patients and will not turn anyone away from A&E but at the same time the Trust is aware that payment will not be received for patients over and above the 30% emergency threshold. A clear understanding needs to be gained regarding which areas the Trust is currently spending money and not receiving funds to compensate. The board to board meeting that is currently scheduled to take place on 22 January 2014 will be a key meeting for discussion. MC questioned why the Trust is reporting an increase in non-pay expenditure if there is no increase in activity. PO responded that the change is a 20% increase in the acuity of majors patients with complex co-morbidities via the A&E pathway Directors NOTED the key areas of concern and the actions being taken		
	GOVERNANCE AND ASSURANCE FRAMEWORK – " ASSURING THE WAY AHEAD"		
13/177	KR presented the Governance and Assurance framework paper and updated that it was identified at the last Risk Management meeting that risk is everyone's business and the Board needs to be clear what they want to achieve. Universal oversight needs to be part of every "team" regardless of their position within the Trust. Each committee needs to be clear how it will discharge its duties and agree a robust structure to support the committee framework. KR identified that the Board also needs to agree a timescale to implement a new annual meeting schedule and a timescale to close down the current committees. KR drew Director's attention to the action points identified within the paper which were clearly denoted as • Note the content of the report and individually determine how the		

	Trust might improve the information provided to Board to enhance decision making, focus and a forward looking orientation coupled with a deeper understanding of prospective risks, thereafter to form part of a Board strategy session to agree the way forward. • Approve the governance and assurance restructure • Agree a date by which the new structure will commence (by 31st March 2014) • Approve membership of Board Committees • Approve the frequency schedule and the annual cycle of business • Approve the ToR subject to further review by the Committees themselves, including approvals re membership CW requested that Directors utilise individual strengths to provide clarity on the membership of committee meetings and the expectance of NED attendance. KR identified that appendix G of the Governance and Assurance framework paper detailed the proposed new committee structure. Directors reviewed this appendix noting the difference between the sub committees under the Board of Directors and the Trust Management Board which will replace the current Hospital Management Board. PO advised that since the current Board had been formed the agenda had been set by external organisations such as CQC and Keogh and moving forward the Board need to be more proactive in its working practices. PM expressed his view that any clinical management meetings must be built from the bottom up so that assurance can be gained that measures are in place ,below board level, to address any issues that arise at ward level allowing the key Board committees to concentrate on high level issues. RD stated that in his capacity as the Chairman of the Audit Committee he felt that the committee structure did not require any changes to the current model. KR added that she encouraged all sub committees to adopt the Audit Committee model; being chaired by a Non-Executive Director allowing appropriate challenge to Executive colleagues. TR concluded that the Governance and Assurance framework paper was very informative and clearly denoted the direction of travel that the Trust needed to take and the key timeline to be followed to achieve successful implementation. GMc added that he also supported the paper but requested that further assurance be gained that the sub committees are developed to a standard that offers confidence and assurance to the Board that all issues will be dealt with or escalated quickly. GMc requested that in the new committee structure the Finance Committee dovetails with the Quality committee. Following a discussion regarding the involvement of Governors in the		

	new committee structure KR clarified that governors would only attend the Board of Directors sub committee meetings and would not be involved in operational meetings. The benefits of this involvement were considered in terms of assurance and TR concluded that Governors will challenge operational issues as this is their "business" on behalf of their constituents. Following a review of the committee membership matrix SB requested that JT be added to the membership of the Clinical Quality and Governance committee. Following a full review Directors AGREED that all of the key elements were correct. KR stated that a transition plan would be formulated and a paper would be submitted to the Board of Directors meeting in January 2014. Directors AGREED that all Board meeting and sub committee meetings that are already diarised in January 2014 and February 2014 will remain in diaries until the transitional plan is presented to the Board in January 2014. CW requested that dates be reissued to all committee members to ensure that diaries are up to date with all recent changes PO requested that measures be put in place to diarise all committee meetings denoted under the control of the Trust Management Board before the January Board of Directors meeting Directors NOTED the content of the report and AGREED to consider how the Trust might improve the information provided to Board to enhance decision making, focus and a forward looking orientation coupled with a deeper understanding of prospective risks, therefore forming part of a Board Strategy session to agree the way forward .	**KR** **KR** **KR** **KR**	**Jan 2014** **Jan 2014** **Jan 2014**
	GOVERNANCE , RISK AND ASSURANCE		
	MONITOR Q2 FEEDBACK		
13/178	KG presented the paper pertaining to Monitor Q2 feedback and requested that Directors NOTE the contents of this report		
	PROGRESS AGAINST GOVERNANCE PLANS (SUSTAINABILITY)		
13/179	**Board and Quality Governance** KR advised that a report to Board at its 29th October 2013 meeting described that as part of the Trust's Discretionary Requirements it was required to declare to Monitor it had achieved a sustained recovery to the minimum standard of quality governance required of a Foundation Trust (a score of less than 4 against Monitor's Quality Governance Framework) The Board, at the end of October 2013, declared its own assessment of its score against the Quality Governance Framework of 3.9 following the		

	work of the Trust since April 2013 including the activity and evidence collection and the confirm and challenge event which had been undertaken since its last assessment in September 2013. The Director of Corporate Services, highlighted shortcomings and areas for close Board focus and scrutiny in order to reduce the Board's score below 3.9 and sustain improvement going forwards, notwithstanding the significant amount of work that had been undertaken in terms of delivering against the Trust's Governance Plans (Board and Quality Governance and Financial Governance Plans. Under the requirements of the s105 notice and our discretionary requirements the Trust was required to obtain external validation on the delivery of improvements in respect of board and quality governance in particular whether the Trust had reached the minimum standard of quality governance required of a Foundation Trust. This report is attached as appendix Mii. PWC's view of our quality governance score is 5, which although a significant improvement, as they acknowledge, since their last score of 13, it falls short of the requirements of our s105 notice and discretionary requirements. Our view recognises areas for improvement no different to those highlighted by PWC, but self-assesses a score of less than 4 (3.9). Recommendations to the Board are • Arrange a meeting with PWC to close the gaps ,which are not significant, but necessary to be clear on where we can focus to enable us to agree a score of below 4 achievable at the earliest opportunity • The Executive Team to focus on areas for improvement such that we can agree with PWC our score of less than 4 • NED confirm and challenge session planned for January 2014 which will specifically look at the areas of significant difference • Quality Improvement Group commencing from January 2014 which will bring together all current external recommendation under the umbrella of the Quality Governance Framework • A further report on the QGF score to be submitted to Board at its January 2014 meeting. Directors NOTED the recommendations that were made. **External Assurance Report – PwC** Directors NOTED the PwC Independent review of the Trust's delivery of improvements to Board and Quality Governance – Draft report version 2 **Financial Governance External Assurance Report** Directors were asked to acknowledge that following the compilation of an action plan pertaining to financial governance, which was submitted to Monitor in January 2013, KPMG returned to the Trust in November	**KR** **KR**	**Jan 2014** **Jan 2014**

	2013 to review progress against the actions, obtaining evidence to confirm the completion of actions and meet with key officers to further confirm the completeness of actions and the process taken to manage the actions. The report circulated as appendix Ni details the findings of the review and confirms that 18 actions out of 20 (90%) have been completed, with two being in progress Directors NOTED the KPMG follow up review of Financial Governance report and AGREED that significant progress has been made against the agreed actions and that Monitor discretionary requirements in this regard have been met. **CQC Warning Notice Update** The CQC inspected the Trust in June (26th) and July (8th, 9th, 10th, 17th, 18th) 2013. The last inspection resulted in five compliance judgements, of which one indicated a 'warning notice' in respect of Outcome 16, *assessing and monitoring of the quality of service provision.* The action required was to produce a report outlining the actions that were to be taken to 'rectify' the report findings and meet the compliance standards. The report was submitted by the Trust on the 25th September 2013, as specified by the CQC. The report and action plan was accepted by the CQC and no further information was requested. The majority of actions in relation to the warning notice had already been included within the PwC Board and Quality Governance Action Plan and the Keogh Action Plan, but additional actions to support the CQC findings e.g. mouth care, were included within the two existing plans. These plans have received robust confirm and challenge through weekly meetings, board sessions and 'extraordinary' Non-Executive confirm and challenge events The Trust received a CQC follow up visit on 4 December 2013. This CQC visit only assessed the warning notice and future visits are anticipated to assess the Trust's compliance against the other 4 standards which were not previously met. The Trust will receive a report following the Teams review of the visit but it is anticipated that the warning notice has been addressed and subsequently reduced from a moderate concern to minor. Directors NOTED the Trust's current CQC position in relation to the Warning notice and NOTED that the Trust has been assessed and is awaiting formal feedback. Directors SUPPORTED the next steps required via the Executive Team and the Governance Support Unit. **Keogh** PO advised Directors that during the Trust Assurance visit, led by Dr		

	David Levy on 4th December 2013, judgment was made of the 23 actions denoted within the Keogh action plan against 3 criteria, fully assured, partially assured and not assured 17 actions were noted as partially assured and 6 were recorded as fully assured, the feedback being that actions which were judged partially assured had been completed but had not had yet had the chance to be fully embedded. It was clear from Dr Levy's informal feedback at the end of the visit that 'significant improvement' had been noted across the Trust, and that a number of tangible examples of improvements to the quality of patient care had been observed on the wards. The Trust awaits a formal report prior to Christmas, on which we will be asked to comment on its factual accuracy. A weekly focus on progress and monitoring of the actions will continue. Further actions were agreed at Trust Board in November 2013 and with the Executive Team. It was noted that these actions are identified in Appendix A of the Keogh update paper and reports will be submitted to various forums in order to provide assurance of delivery. PO asked the Board to note the actions that will be presented to these various forums as part of normal business and not necessarily identified under the Keogh heading. PO updated that two key issues remain outstanding: 1. As part of the ongoing work to further improve the Trust's complaints function, the existing complaints department is being restructured to support even better responsiveness from Divisions and departments. It is important to ensure that the significantly improved standards in the timeliness, content and management of responsiveness to complaints are not compromised during what may be a disruptive period for some staff. The changes proposed will help the Trust improve still further its identification of trends and its implementation of mitigating actions. 2. The latest position in relation to contractual arrangements with potential 'buddying' organisations is that the Trust is looking to agree its buddying with Newcastle Hospitals NHS FT to strengthen all areas that remain weak. CW questioned whether Mike Shewan is still working with the Trust as Improvement Director on behalf of Monitor. PO confirmed that Mike Shewan is still working with SFH as well as another Trust in Tameside. Directors NOTED the content of the paper		
	CARE QUALITY COMMISSION – REVIEW OF COLCHESTER UNIVERSITY NHS FOUNDATION TRUST		
13/180	KR reminded Directors that at the Board of Directors meeting in		

	November 2013 it was requested that an assessment be made of the Trust's position against the failings identified in Colchester Hospital's care for cancer patients. The report circulated as appendix Q is provided to give the Board an early understanding of the work undertaken thus far to explore if any of failings could be 'True for Us'. Directors RECEVED the report and AGREED with the current actions taken to date and to undertake a 'True for Us' exercise. GMc proposed that the option of obtaining a 3rd party assessment may provide further value. RD responded that he would liaise with the Trust's Internal audit team with a view to them providing a 3rd party opinion.	**RD**	**Jan / Feb 2014**
	THE JOURNEY TO PUTTING PATIENTS FIRST – DH RESPONSE TO FRANCIS INQUIRY		
13/181	SL reported that the DoH published '*Hard Truths: The Journey to Putting Patients First'* on 19th November, 2013 which is the Government's further response to the Mid Staffordshire NHS FT Public Inquiry. Since the publication of Robert Francis's inquiry the expectation has been that NHS organisations have been reflecting deeply on the inquiry's key messages and engaging with their patients and staff to consider what it means for their organisations. The DH cite that the best Boards have already driven this agenda forward and embraced openness and transparency and state that the Care Quality Commission (CQC) will assist the DoH identify where this is working well and where they can build on this work and share it with others. Jeremy Hunt wrote to Chairmen of Trusts early in 2013 and requested that all NHS hospitals set out publicly how they intended to respond to the inquiry's conclusion before the end of 2013. SL advised that it would appear that this Trust developed a joint Nottinghamshire Health Community response which on behalf of this Trust said *'we are absolutely committed to delivering high quality care, and regularly monitor our performance to enable us to detect at an early stage where there may be any deterioration. We strive for continuous service improvement and as soon as we identify any potential shortcomings we take action. As a FT we are accountable to more than 22,000 members as well as the public, our patients and our staff. In the true spirit of openness and honesty, our quality report is now the first item on our agenda to enable the Board of Directors to be assured of the quality and safety of the services we offer to our patients.'* SL confirmed that the Trust needs to be in a position to respond to the inquiry's conclusions, a response which is due before the end of 2013, and as such needs to capture any work that has already taken place so that the Board therefore understands any gaps where the Trust needs to take action to mitigate against any shortcomings. Importantly, and in line with the future focus of the CQC who will restructure their inspection focus to determine if we are safe, well led and		

	understand what patients say about their experience of us, we need to be in a position to be open about mistakes and candid about 'near misses', evidencing learning from errors and correcting those we have made. Where the Board fails to show the integrity expected, or where things really go wrong – the response will enable a turnaround and potentially criminal sanctions so it is important the Board of Directors is leading and fostering a learning culture and one that evidences the Trust is consistently striving to improve the care given to patients with '*proper accountability in place'*. KR recommended that the Trust adopt a 'True for Us' process for this inquiry, as appended to the circulated report, which will, where relevant and possible, be impartially validated by the Director of Corporate Services/Company Secretary's directorate and a report presented to Board's January 2014 meeting clarifying the Trust's position and required actions against the recommendations coming out of the Francis Inquiry. This will incorporate an action plan that ensures the Trust has plans in place to progress also the Government's proposals indicated in their response to ensure that the Trust is clear on the impact of the inquiry and prepared for the changes it will bring for the Board and for the organisation. Directors ACCEPTED the recommendations made and AGREED to pass any comments / amendments to KR ahead of the January 2014 Board of Directors meeting	**KR** **ALL**	**Jan 2014** **Jan 2014**
	NURSING STRATEGY		
13/182	In support of the Nursing and Midwifery strategy 2013-2015 paper SB delivered a presentation pertaining to the key messages relating to a key document that was released 3 weeks ago following a piece of work carried out by Ruth May Regional Chief Nurse for NHS England (Midlands and East) titled "**How to ensure the right people, with the right skills, are in the right place at the right time"** *A guide to nursing, midwifery and care staffing capacity and capability* Within this key document 10 expectations are detailed pertaining to nurse staffing, capacity and capability. The expectations are: **EXPECTATION 1:** Boards take full responsibility for the quality of care provided to patients, and as a key determinant of quality, take full and collective responsibility for nursing, midwifery and care staffing capacity and capability **EXPECTATION 2**: Processes are in place to enable staffing establishments to be met on a shift-to-shift basis **EXPECTATION 3:** Evidence-based tools are used to inform nursing, midwifery and care staffing capacity and capability **EXPECTATION 4:** Clinical and managerial leaders foster a culture of		

	professionalism and responsiveness, where staff feel able to raise concerns **EXPECTATION 5:** A multi-professional approach is taken when setting nursing, midwifery and care staffing establishments **EXPECTATION 6:** Nurses, midwives and care staff have sufficient time to fulfil responsibilities that are additional to their direct caring duties **EXPECTATION 7:** Boards receive monthly updates on workforce information, and staffing capacity and capability is discussed at a public Board meeting at least every six months on the basis of a full nursing and midwifery establishment review**.** **EXPECTATION 8:** NHS providers clearly display information about the nurses, midwives and care staff present on each ward, clinical setting, department or service on each shift*.* **EXPECTATION 9:** Providers of NHS services take an active role in securing staff in line with their workforce requirements**.** **EXPECTATION 10:** Commissioners actively seek assurance that the right people, with the right skills, are in the right place at the right time within the providers with whom they contract. Directors noted that within the document clear responsibilities for Non-Executive Directors of the Board and the Chief Executive are clearly stated and these were noted accordingly. JT advised that the drive to formulate and move forward the Nursing and midwifery strategy to is clear but it is disappointing to see that there is not the same level of engagement from AHPs, medics and doctors. PO responded that as nursing and midwifery colleagues form the largest group of employees this seemed to be the most appropriate group of staff to engage with primarily and stated that the same level of clinical engagement will be encouraged with other medical colleagues moving forward. Directors NOTED and APPROVED the Nursing and Midwifery Strategy.		
	INFORMATION GOVERNANCE TOOLKIT UPDATE		
13/183	EO and GA presented the Information Governance Toolkit update which had been prepared for consideration by the Board of Directors to outline the Trust's performance against the Information Governance Standards as set out in the Information Governance Toolkit. GA explained that the IG Toolkit is a performance tool produced by the Department of Health (DH) and now hosted by the Health and Social Care Information Centre (HSCIC). It draws together the legal rules and central guidance and presents them in one place as a set of information		

	governance requirements. This paper outlines where we as a Trust plan to be by the submission date of 31st March 2013. The 2013/14 IG forward Work plan identified accountable officers within the Trust for each standard to be achieved, with the expectation that performance against standards will be monitored and supported via the IG Group on an on-going basis throughout the year. However, a number of leads have not had the time or resource to review their standards, due to other work pressures in the Trust and it has fallen to the IG team to undertake this workload. `KR identified that significant issues had been identified in the past with staffing levels in the IG team and questioned whether these issues had now been addressed. GA confirmed that although 2 members of staff had recently left they had been replaced with staff that have a good knowledge of IG. A subsequent review of the current position of the IG toolkit by the IG team identified a number of standards that currently do not meet level 2 requirements. However East Midlands Internal Audit Services carried out a review of our current IGT scores and action plan during November 2013 and gave significant assurance that the outstanding standards can be met and suggested that if the actions documented were completed the Trust should achieve level 2 on all standards. The draft report will be received on 17th December 2013. GA added that Individual standard action plans have been developed by most of the leads and the IG team to meet the level two requirements by end of March 2014. Currently it is anticipated that the deadline may actually be met by mid February 2014. The progress against the action plan will be closely monitored and any issues will be highlighted to the Board. Current achievement progress stands at 75%. The remaining 25% relates mainly to the ratification of policies and meetings which need to be held and allowing time for staff to complete the outstanding work. SL encouraged Executive colleagues to push the key message through the Trust that staff must be allowed the time to achieve the deadlines that had been set. Of the 45 standards, 10 standards have still not had an action plan compiled by the standard lead despite reminders by the IG team. However an overarching action plan has been developed by the IG team and will be discussed at the next Trust IG meeting on 18th December 2013. GA advised that she would submit a report to the Board in March 2014 for consideration to outline the Trust's performance against the Information Governance Standards as set out in the Information Governance Toolkit. PO questioned what the implications of not meeting the deadlines are. GA confirmed that failing the meet the deadline would precipitate an		

	audit from Monitor and would raise a number of issues with HSCIC. KF reported that she was aware that ensuring that Trust staff undertake IG training has been problematic and questioned how this would be addressed moving forward. GA confirmed that this issue had been considered by the IG group and a plan will be formulated that will encourage departmental IG leads to feed through information on a monthly basis against their departmental target. SL requested that a brief update be provided to the January and February 2014 Board meetings giving a progress report against the deadline of March 2014. Following discussion and consideration Directors APPROVED the scores to enable submission to HSCIC in order to meet the deadline of the 31st March 2014.	**GA**	**Feb 2014**
	AUDIT COMMITTEE		
13/184	RD advised that the last meeting of the Audit Committee meeting was held on 25 October 2013 and these minutes were presented at the last Board meeting. No further updates were given.		
	CLINICAL GOVERNANCE & QUALITY COMMITTEE		
13/185	PM advised that a full update of the Clinical Governance & Quality Committee that was held on 27 November 2013 was detailed in the Quality Report earlier on the agenda.		
	RISK ASSURANCE COMMITTEE		
13/186	Directors NOTED the minutes of the Risk Assurance Committee meeting that was held on 9 October 2013. No further updates were given.		
	FINANCE AND PERFORMANCE COMMITTEE		
13/187	Directors NOTED the minutes of the Finance and Performance Committee that was held on 24 October 2013. No further updates were given.		
	REMUNERATION AND NOMINATION COMMITTEE		
13/188	Directors NOTED that a meeting of the Remuneration and Nomination Committee had been held on 1 August 2013		
	CHARITABLE FUNDS COMMITTEE REPORT		
13/189	Directors NOTED the minutes of the Charitable Funds Committee that was held on 6 August 2013. No further updates were given.		

	ANY OTHER BUSINESS		
13/190	There was no other business to discuss.		
	DATE AND TIME OF NEXT MEETING		
13/191	It was CONFIRMED that the next meeting of the Board of Directors would be held on Thursday 30th January 2014 at 9.30am in Lecture Theatre 2, Education Centre, and King's Mill Hospital.		
	There being no further business the Chairman declared the meeting closed at 15.35 hrs.		
	Signed by the Chair as a true record of the meeting, subject to any amendments duly minuted. …… …….. [Name of Chairman] **Date** **Chairman**		