Healthier Communities, Outstanding Care

Sherwood Forest Hospitals NHS Foundation Trust

**UN-CONFIRMED MINUTES** of a Public meeting of the Board of Directors held at 09:00 on Thursday 4th July 2019 in the Boardroom, Newark Hospital

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| **Present:** | John MacDonald | Chairman | JM |
| | Claire Ward | Non-Executive Director | CW |
| | Tim Reddish | Non-Executive Director | TR |
| | Graham Ward | Non-Executive Director | GW |
| | Barbara Brady | Non-Executive Director | BB |
| | Neal Gossage | Non-Executive Director | NG |
| | Manjeet Gill | Non-Executive Director | MG |
| | Dr Andy Haynes | Medical Director & Deputy Chief Executive | AH |
| | Simon Barton | Chief Operating Officer | SiB |
| | Suzanne Banks | Chief Nurse | SuB |
| | Paul Robinson | Chief Financial Officer | PR |
| | Shirley Higginbotham | Director of Corporate Affairs | SH |
| **In Attendance:** | Sue Bradshaw | Minutes | |
| | Robin Smith | Deputy Head of Communications | RSm |
| | Rob Simcox | Deputy Director of HR | RSi |
| | David Selwyn | Deputy Medical Director | DS |
| | Alison Steele | Head of Research and Innovation | AS |
| | Prema Maharajan | Clinical Lead for the Diabetic Eye Screening Programme | PM |
| | Amanda Brooks | Failsafe Officer for the Diabetic Eye Screening Programme | AB |
| | Kavi Berry | Assistant General Manager – Head and Neck | KB |
| **Observer:** | Dr Jean Ledger | Research Fellow, University College London | |
| | Vicky Argyle | Trainee Graduate, Finance | |
| | Richard Shillito | Public Governor | |
| | Ian Holden | Public Governor | |
| **Apologies:** | Richard Mitchell | Chief Executive | RM |
| | Julie Bacon | Executive Director of HR & OD | JB |

| Item No. | Item | Action | Date |
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| **17/261** | **WELCOME** | | |
| 1 min | The meeting being quorate, JM declared the meeting open at 09.00 and confirmed that the meeting had been convened in accordance with the Trust's Constitution and Standing Orders. | | |
| **17/262** | **DECLARATIONS OF INTEREST** | | |
| 1 min | There were no declarations of interest. | | |
| **17/263** | **APOLOGIES FOR ABSENCE** | | |
| **1 min** | Apologies were received from Richard Mitchell – Chief Executive and Julie Bacon – Executive Director of HR & OD.<br><br>It was noted that Rob Simcox – Deputy Director of HR, was attending the meeting in place of Julie Bacon | | |
| **17/264** | **MINUTES OF THE PREVIOUS MEETING** | | |
| **1 min** | Following a review of the minutes of the Board of Directors in Public held on 6th June 2019, the Board of Directors APPROVED the minutes as a true and accurate record. | | |
| **17/265** | **MATTERS ARISING/ACTION LOG** | | |
| **1 mins** | The Board of Directors NOTED that all of the actions on the Action Tracker have a due date which is in the future. | | |
| **17/266** | **CHAIR'S REPORT** | | |
| **1 min** | JM presented the report, highlighting the recent Chief Nurse Awards ceremony, congratulating all the winners and staff who were nominated and shortlisted. JM advised there have been a lot of events recently celebrating the work of the volunteers. It was acknowledged SFHFT is lucky to have a large and active group of people who give their time to raise money and support staff, patients and visitors.<br><br>The Board of Directors were ASSURED by the report | | |
| **17/267** | **CHIEF EXECUTIVE'S REPORT** | | |
| **4 mins** | AH presented the report, advising the Non-invasive Ventilation Team have been shortlisted for and won a number of awards, both regionally and nationally. In addition, SFHFT recently won a national learning disability award, a regional communications award and had three finalists at the HSJ Patient Safety Awards.<br><br>SiB has authored a blog for the NHS Providers website describing how SFHFT achieved its winter performance. David Selwyn has recently joined the Trust as Deputy Medical Director. | | |

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| | Nationally there has been an announcement in relation to the pension issue which is largely affecting consultants, but does affect all high earners in the NHS workforce. Some progress is being made nationally but it is relatively slow. This issue is being monitored internally as an impact on the consultant workforce is becoming evident.<br><br>The Interim People Plan has been published. There is a need to understand the implications for the Trust and the Integrated Care System (ICS) as the plan places responsibility at regional level to solve workforce issues.<br><br>The National Patient Safety Review was published on 3rd July 2019 and the Trust will need to produce a response to this. The Trust is currently doing many of the things included in the review and, therefore, should be well placed to respond.<br><br>TR sought clarification regarding the junior doctors' contract. AH advised this was signed off week commencing 24th June 2019 and is the end of a two year process. There should be no immediate impact for the Trust as SFHFT has already adjusted to the areas it covers.<br><br>JM advised the Interim People Plan and the Patient Safety Report should be considered by the relevant sub-committees who will report back to the Board of Directors regarding the response, any changes which need to be made or if a more substantive review of the strategy is required.<br><br>**Action**<br><br>• **People, OD and Culture Committee to consider the Interim People Plan and report back to the Board of Directors regarding the response, any changes which need to be made or if a more substantive review of the strategy is required**<br><br>• **Quality Committee to consider the Patient Safety Report and report back to the Board of Directors regarding the response, any changes which need to be made or if a more substantive review of the strategy is required**<br><br>The Board of Directors were ASSURED by the report | **JB**<br><br>**SuB** | **07/11/19**<br><br>**03/10/19** |
| **17/268** | **STRATEGIC PRIORITY 3 – TO MAXIMISE THE POTENTIAL OF OUR WORKFORCE** | | |
| **4 mins** | **Allied Health Professionals (AHP) Strategy**<br><br>SuB presented the report, advising the AHP Strategy is in line with the Nursing and Midwifery Strategy and the Trust strategy. Over 200 staff, which equates to 50% of the AHP workforce, were consulted during the development of the strategy. The forums used during the consultation process will remain in place to monitor and embed the strategy going forward. Towards the end of 2020 the intention is to complete a combined strategy for nursing, midwifery and AHPs. SuB acknowledged the strategy does not align as well as it could with the ICS and requires further work before being signed off. | | |

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| | JM advised the AHP strategy had been discussed briefly with the Non-Executive Directors (NEDS), who feel the paper does not fully do justice to the work of the AHPs who play a vital role in supporting people at home and reduce length of stay in hospital, etc.<br><br>SuB sought clarification if this is in relation to the KPIs or the strategy. JM advised this mainly relates to the KPIs but the strategy may also require strengthening.<br><br>**Action**<br><br>• **Further work required to strengthen the AHP strategy and KPIs linked to it**<br><br>The Board of Directors CONSIDERED the AHP Strategy | **SuB** | **05/09/19** |
| **17/269** | **STRATEGIC PRIORITY 4 – TO CONTINUOUSLY LEARN AND IMPROVE** | | |
| **26 mins** | **Research Strategy – quarterly update**<br><br>AS presented the report, advising this is a summary of the year 2018/2019. During the year 2,121 participants were recruited into trials, which is a 31% increase on the previous year. At the end of Q4 of 2018/2019 there were 71 trials open. During the year 40 studies were opened and 19 were closed.<br><br>One of the key objectives for 2018/2019 was to increase activity into areas which were previously research inactive; this has been particularly successful in critical care and ED. There are currently three studies open in critical care, with a further study to open shortly, and there is currently one study open in ED, with another to follow soon. There has been good support from those clinical areas. In 2018/2019 funding of £11k was provided across the two areas to support clinical staff to work on trials. The critical care team recently held a research awareness breakfast session and have taken research on board. They are owning it and doing a lot of work themselves, with the research team co-ordinating the studies. AS advised the aim is for this to be replicated across the Trust.<br><br>In 2018/2019 the East Midlands Clinical Research Network (CRN) budget was just over £714k, which was a decrease of 4.05% on the previous year. Despite this the Trust managed to significantly increase performance. The budget for 2019/2020 has remained reasonably static, with only a 0.2% decrease. There was approximately £63.8k income from commercial activity during 2018/2019.<br><br>The research patient experience survey was re-launched from October 2018 to January 2019. During this time 197 participants were surveyed and the average satisfaction score was 96.8%. SFHFT is now part of the pilot for the National Institute for Health Research (NIHR) Participant Research Experience Survey (PRES) which is a national patient experience survey for research. Data has only been collated from January 2019 and is not yet available to the Trust. NIHR will provide support to analyse the data and identify areas for improvement. | | |

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| | Last year there was a push on engagement and dissemination. There was a targeted communication and engagement plan. The team have worked on redesigning the website, patient stories, research promotional days, etc.<br><br>The team have been working with SuB and her team to recruit to the research academy. There have been some difficulties and different ways of recruiting to the academy are being considered. This includes trying to get interest from nurses earlier in their careers. The Trust has secured some sessions on the nursing degree course at the Universities of Nottingham, Derby and Lincoln and is in the process of negotiating with Nottingham Trent University to do sessions on their nursing associate and health care practitioner courses.<br><br>In addition to supporting studies which are adopted onto the portfolio, the research team are trying to support other activities across the Trust, using some of the commercial income to achieve that. For example, last year the team supported the 'Colour me Safe' project and this year the team is working with the orthotics team to support them with their patient experience project.<br><br>The strategic priorities for 2019/2020 are similar to those for 2018/2019 as it takes a few years of sustained focus to achieve objectives. The recruitment target for 2019/2020 has been set at 1,800. The team wants to build capacity and capability. Currently the Trust does not have any lead investigators who are applying for grants and does not sponsor any studies. An objective has been set to act as sponsor for a minimum of two studies this year. One of these is already being worked on. SFHFT is acting as lead site for a grant application and is lead site for a commercial study in paediatrics. A professor, who is research active, is due to join the Trust in August 2019. The team are in early discussions with them about sponsoring a large trial looking at aspirin.<br><br>NG sought clarification on how increased quality of care, patient satisfaction and financial benefits are measured. AS advised in research measuring the impact and outcomes has always been a challenge. The team are working on the knowledge repository, gathering information for any publications and changes in care from research activity the Trust has participated in. It is difficult due to the timeline from doing the study to any changes being introduced. One of the main impacts which was seen last year was from a study the Trust participated in called Changing Babies Lives' but it is very rare to be able to measure impacts in a short time period. This is not just an issue for SFHFT. A lot of the NIHR adopted work the Trust is funded to deliver is long term projects which are often not led or sponsored by the Trust.<br><br>BB felt research and service improvement go alongside each other and queried what links are in place between the research function and the work of the service improvement team. AS advised historically research teams have always worked separately. However, AS advised she had some initial meetings with Ceri Feltbower, Associate Director of Service Improvement, to look at how the research team can link in with her work. | | |

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| | BB queried how the research function in the Trust might support the local system, for example, the interface with GPs and primary care providers who do not have the same infrastructure as the Trust but it would help them in their endeavours to improve the journey for patients. AS advised from a national perspective with NIHR there is currently no discussion or ideas on how the research infrastructure is going to be changed to meet that service need. This will rely on the Trust, as part of the ICP / ICS to make sure research is there as a function. As it works now, research is very organisational. Primary care has an NIHR infrastructure, albeit this is not as good as for organisations. Primary care brings in the majority of recruitment but their funding from NIHR is a lot less. There are a group of research active practices but they are all separate. How to prepare for integrated care systems has been raised at national level. The infrastructure is in place, it just needs to be flexed. AH advised universities are in discussion with the ICS.<br><br>BB felt there is a need to worry less about organisation barriers and do what is right for patients.<br><br>CW queried how specific issues relating to the local community in terms of health needs could be looked at and how links could be made with similar communities, i.e. ex-industrial and mining communities, to use that to target research to be able to relate it not just to general patient benefit but specifically show benefit to the community.<br><br>AS advised CRN launched a funding bid this year looking at regional health needs. SFHFT has put in two bids. One of these, looking at leg ulcers in the homeless population, has been turned down. Another bid has been put in regarding e-cigarettes, the outcome of which is awaited. As a Trust we are constrained by the NIHR funding 'envelope' which is a protected funding stream for research into specific areas and is run in such a formalised way. Clinicians need to decide areas they want to look at and start to develop grant applications, otherwise as a Trust we will always be looking at someone else's issue. SFHFT has a target population in relation to respiratory. There have been discussions with two commercial companies but the Trust is unable to deliver their trials due to lack of the required facilities. There is a push from national research and development leads looking at what trusts can do outside of CRN. To be more flexible, the Trust needs to build up its own income and invest into research.<br><br>AH advised the Trust has recruited more younger generation consultants who have a different view on the research agenda. There is a cohort of consultants who have been in post less than 5 years so this presents an opportunity. What will make a difference to the population is trial entry, which may be through SFHFT or NUH due to their NIHR status. AH queried if information was available regarding trial uptake from the whole population of Nottinghamshire. AS advised this is increasing in terms of CRN recruitment figures but it is unclear what that equates to in percentage terms. The target is ideally for 6% of patients coming through the hospital to be entered into research trials.<br><br>AH queried if SFHFT and NUH combined would meet the 6% target. | | |

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| | AS advised she would need to check that information. SFHFT do a lot of 'pick' activity where patients are identified to go into trials at NUH if SFHFT cannot do the trial. How those patients can be tracked will need to be investigated.<br><br>GW felt it is good to see improvement and there are some trials where SFHFT is taking the lead. The Trust should try to get involved with more leading or joint leading with NUH as that provides a link into the universities. GW advised AS to notify the Board of Directors of anything which could be done at Board level to support this.<br><br>TR acknowledged the ongoing issue of available facilities for research and queried if there were any other issues affecting growth. AS advised there needs to be a change in culture. There is strong integration with nursing and AHPs but this can be improved with clinicians.<br><br>TR felt innovative thinking should not be stifled by finances and encouraged AS and her team to continue to think innovatively.<br><br>SuB acknowledged the work AS has done to make a significant difference in embedding research to become normal practice within nursing and AHPs.<br><br>JM advised there is a need to maintain focus on how to measure the benefits of research. There are issues in relation to system working and it would be useful for AS to discuss these with AH. There is a potential benefit for the Trust in terms of encouraging recruitment. While this is starting to happen, clarification is required that the message about research is strong within the recruitment process.<br><br>**Action**<br><br>• **Clarification required that the message in relation to research is strong within the recruitment process**<br><br>The Board of Directors were ASSURED by the report | **JB** | **01/08/19** |
| **17/270** | **STRATEGIC PRIORITY 5 – TO ACHIEVE BETTER VALUE** | | |
| **17 mins** | **ICS/ICP Update**<br><br>AH presented the report, advising the Primary Care Network (PCN) is becoming firmly established in Mid-Notts with PCN directors being appointed. The networks of GPs are now empowered and progress is being made in relation to how they will interact with the Integrated Care Partnership (ICP) structure. There is a need to clarify how they will interact with the Transformation Board as a lot of change will be driven through the locality networks. This needs to be reflected in the ICP strategy.<br><br>In terms of existing work, the ICP Transformation Board is to focus on the programmes which are felt to be key both for developing change in the system and helping to manage the system pressures. | | |

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| | There was a discussion at a recent meeting of the Transformation Board in relation to transformation monies. These have been agreed for this year but on reflection it was felt the process was not as clear as it should have been. It has been agreed to do a piece of work to look at this and the lessons learned to suggest a better process for managing this next year.<br><br>The end of life collaboration from Mid-Notts was showcased at the ICP Board and there is a need to take some lessons from this. It has been requested to present this to the ICS Board as an example, as this is something which should be done across the whole of the ICS.<br><br>At ICS level there was a presentation from the south about a service which has been set up for patients who have physical symptoms for which there is not a clinical diagnosis. This presents a challenge for Mid-Notts ICP as to why a similar service is not offered in this area. There was a presentation from the East Midlands Academic Health Science Network (AHSN) which identified ten things which are in place in parts of Nottinghamshire. AH advised he is to undertake a piece of work to identify which of those ten things should be in place across the patch, how to make sure that happens and how to hold the ICPs to account for progress.<br><br>AH highlighted the Memorandum of Understanding (MoU). The local priorities for this year are largely aligned with the long term plan with the 'big ticket' issues being urgent and emergency care, proactive and personalised care, mental health and cancer. The local priorities are the clinical services strategy and alcohol. Some ICS structure is being developed which relates to architecture and outcomes framework.<br><br>The merger of the CCGs has recently gone out to consultation. The plan is to move to a single strategic commissioner, replacing the current CCGs.<br><br>BB felt it would be useful to see how progress is being made against the priorities in the MoU and what the implications for the Trust and the ICP are. AH advised part of the outcomes framework needs to focus on that. It was agreed 6 months ago alcohol issues would be a commissioning priority in 2019/2020. The next step is to establish how this has translated across the ICPs and to be clear what this expects to deliver in 2019/2020.<br><br>GW acknowledged the work Debra Elleston - Lead Nurse, is doing to promote the work within the Trust in relation to end of life care. AH advised the Trust has made huge progress in terms of end of life care over the last two years. The ReSPECT programme, which is currently being rolled out, is a key component of this work. It has been established there was no common training for staff in different organisations about basic end of life care; ReSPECT will help address some of these issues.<br><br>JM sought clarification regarding progress of the clinical services strategy. AH advised there will be seven key priorities and the workshops for six of those are underway. The expectation is the first output will be in September 2019. | | |

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| | JM noted the NUH / SFHFT partnership has been important and has done some good work. However, this appears to have lost focus. Given there are potential efficiencies of working closely with NUH, JM queried what work can be done to get this back on track. AH advised there have been a lot of distracting factors affecting progression of the partnership but advised there are many patients who are on pathways which straddle the two trusts. This is unlikely to change. The Strategic Partnership Forum has been the 'vehicle' through which much of those discussions have been delivered. Discussions are ongoing but these are at a more operational, less strategic level. The two executive teams need to discuss and agree the way ahead for the Strategic Partnership Forum.<br><br>**Action**<br><br>• **AH and RM to discuss and agree the way ahead for the Strategic Partnership Forum with their counterparts at NUH**<br><br>BB noted the mental health trust host a number of community based services which will support some of the clinical services strategy. Clarification was sought regarding their involvement in the discussions. AH advised the Strategic Partnership Forum is an executive to executive meeting between the two acute trusts. If that needs to change, it will be part of the current discussion.<br><br>DS advised in terms of the clinical services strategy, there is good representation from the community trust and there is a focus on mental health. There is a piece of work ongoing to stop the divide between mental and physical health.<br><br>JM noted there have been previous discussions relating to developing the strategy for Newark Hospital within the wider system and queried if those discussions are ongoing and/or need to be accelerated. AH advised internal discussions are ongoing but there is a wider system dialogue about Newark and its function as a key hub within the health and care environment for the local community. Discussions are happening through the ICP. As the PCNs are formed in Newark this will open up interesting discussions about how those services will be organised in the locality.<br><br>JM felt an approximate timetable needs to be agreed with the ICP. SFHFT statutorily has responsibility for Newark Hospital and, therefore, needs to be clear what the implications are for the Trust and the benefit for patients in the wider system. AH advised this will be part of the ICP strategy but he is not sighted on a timetable for this.<br><br>JM noted AHSN did a presentation to the Board of Directors a few months ago and it was stated the Trust wished to strengthen the way in which it works with the AHSN. JM sought clarification regarding progress of this. AH advised part of the piece of work he will be doing at ICS level is to establish a quarterly innovation meeting with AHSN, with all parties across the ICS being present. There is a need to ensure the ICP is aware of all the developments the AHSN has nationally and to learn from intelligence from other AHSNs. The AHSN is looking to work through that route rather than individual organisations. | **AH** | **01/08/19** |

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| | The Board of Directors were ASSURED by the report | | |
| **17/271** | **PATIENT STORY - DIABETIC EYE SCREENING SERVICE** | | |
| 21 mins | PM, AB and KB presented the patient story, which related to the work of the diabetic eye screening service. The story referenced the support provided to a patient with learning disabilities to enable them to access the service.<br><br>TR queried if information was available regarding the percentage of diabetic patients who opt out of eye screening. AB advised she did not have the information but could find that out.<br><br>TR felt any patient could have anxiety about the screening process and queried how the service highlighted in the story could be embedded with every patient, rather than focussing on patients with learning disabilities. It would be useful to establish the percentage of patients who currently opt out and how that could be reduced by the service provision which is in place.<br><br>AB advised the service is subject to quality assurance standards and targets. Patients who opt out are classed as excluded and exclusion rates are reported. Feedback is provided to GPs regarding the number of patients who are excluded and the reason for the exclusion. This enables monitoring to establish if there are high exclusion rates from certain practices and to try to determine the reasons for that. In relation to patients with learning disabilities, all GP practices are being contacted and asked to provide a list of all their learning disability patients so they can be identified within the team's system. Regular 'did not attend' audits are completed and patients are contacted to establish why they have not attended for screening and if there is anything which can be done to support them to attend appointments. As the team becomes more aware of patients who have a learning disability, further discussions can take place regarding the support they have in the community. It is high on the agenda for the national eye screening to improve uptake for patients with mental illness and learning disabilities and for patients in care homes.<br><br>KB advised at the monthly team meeting the team reflects on patients who have been difficult to engage with and look at ways to support them.<br><br>TR queried if patients who have opted out can opt in again. AB advised patients are only allowed to opt out for a maximum of three years. When this three year period ends, the patient is automatically invited for screening. Patients can change their mind at any time and contact the service to request a screening appointment.<br><br>SuB acknowledged the amount of work the team put into the individual highlighted in the story to enable them to attend their screening appointment.<br><br>AH queried if there was a local, regional or national view of how the service will need to develop to meet the potential growth in the number of diabetic patients in the future. | | |

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| | KB advised there are regular programme board meetings with commissioners, etc. Part of this process is to share good practice with other areas to look at ways of making the service more efficient and to look at preparing for the future. There is a regular tendering process and contractual discussions take place. Nottinghamshire have set up an eye health strategy board. Part of the agenda is to look at how eye health generally can be managed more proactively.<br><br>AB advised the national programme is currently looking into the possibility of some patients moving from yearly screening intervals to two yearly intervals as a way of relieving some of the pressure on the service.<br><br>PM advised learning disability patients may have other eye conditions in addition to diabetes. Part of the guidance from the Royal College of Ophthalmologists in relation to managing eye care for patients with learning disabilities is they should be seen earlier in the day when the hospital is quieter and be given multiple appointments, rather than trying to complete lots of tests on the same day. | | |
| **17/272** | **SINGLE OVERSIGHT FRAMEWORK PERFORMANCE REPORT** | | |
| **39 mins** | AH advised the main issue currently faced by the Trust is demand in both elective and non-elective care. The levels of demand are not seasonal and the Trust is under pressure as a result. However, the quality and safety measures are good. There are some concerns which have been raised and are being investigated in relation to discharge processes. It is expected there may be some issues in relation to communication. Sickness levels have had a seasonal peak but are reducing. There is a focus on staff wellbeing. From a financial perspective it is early in the year but the signs are good. Part of the Trust's position is bolstered by income from excess demand, but this is not good for the system. If demand is reduced that will constrain the Trust's finances and will require costs to be taken out.<br><br>**QUALITY**<br><br>SuB advised dementia screening remains in a positive position but this is currently being closely monitored as it has transitioned onto Nervecentre. This change in practice has resulted in a couple of issues. There has been a focus on completion and a junior doctor has been involved with this process to try to improve communication. It has been added to Nervecentre board profiles to provide a prompt when there is a board round. It is hoped these actions will encourage the teams to complete assessments electronically, as they are still being completed on paper. The advantage of completing the assessment directly onto Nervecentre is the instant automatic referral of patients who are identified as having dementia.<br><br>In relation to infection control there were four cases of Trust acquired c diff in May. There was one ward closure in May due to Norovirus which affected 17 patients and Trust staff.<br><br>There were two serious incidents in May, which brings the year to date (YTD) total to four. There were no never events and no falls resulting in moderate or severe harm. | | |

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| | In relation to discharge, one of the matron and AHP groups has been identified to have discharge as one of their projects going forward. Any concerns raised or incidents will feed into that group.<br><br>There are three patient safety alerts which are open beyond the deadline. Two of those alerts are now closed and one remains open. The one which remains open relates to the risk of cross infection from the use of portable fans. This is an issue across several trusts. A piece of work considering the best approach to this is ongoing. There is a financial risk if the guidance is purely followed as this states the fan should be disposed of after every use. In addition, there is a prohibition in the use of bladeless fans. The intention is for the fan to be dismantled and cleaned, including the motor, after every patient. However, neither Skanska nor nurses are prepared to do this due to the risk in relation to infection control and fire. The procurement team have been investigating but there is no manufacturer which produces fans for commercial or continuous use. This alert is unlikely to be closed for a while. There is guidance in place to mitigate the risk of potential fire caused by long periods of use, this being fans are to be turned off after two hours. This issue only affects the clinical areas.<br><br>There are four cohorts of international nurses. The first cohort of five nurses all passed their Objective Structured Clinical Examinations (OSCEs) in June and are now registered nurses. There is another cohort of seven international nurses and one health care assistant who are due to take their OSCEs in July. There are a further two cohorts which means there are a further eight nurses due to take their OSCEs in the next 12 weeks. Interviews for the Head of Midwifery have taken place but this post has not been appointed to. It has been agreed the Deputy Head of Midwifery will act up into that role for 6 months, with this being reviewed at the 4 month stage.<br><br>NG noted sepsis has been in the news recently and sought assurance SFHFT is maintaining high standards in relation to this. AH advised the Sepsis Group meets monthly and reports to the Deteriorating Patient Group who in turn report to the Patient Safety and Quality Group (PSQG). Sepsis screening is being monitored. Structured judgment reviews are completed if there are any deaths of a patient with sepsis. The sepsis lead nurse reviews all the Datix relating to sepsis on a daily basis. SuB advised the sepsis lead nurse has reduced their hours to four days per week. This has provided an opportunity to look at succession planning. Another role to work alongside the lead nurse has been identified.<br><br>JM noted a number of indicators have been quoted on the news in relation to the time taken to administer first antibiotics, etc. and queried how the Trust is performing. AH noted it has been quoted only 75% of patients are meeting the ‘sepsis 6’ bundle compliance for antibiotics within an hour. However, SFHFT has been achieving over 90% for the last three years<br><br>JM noted the complaints measure deals with the volume of complaints and queried if there was any information regarding the effectiveness of how complaints are dealt with, for example timeliness. AH advised a report is presented to PSQG each month with a more themed analysis report being presented quarterly. | | |

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| | This looks at response times, themes, etc. A piece of work has been completed looking at the complaints process as it is felt the quality of the responses can be improved. This will be reported to PSQG and by exception to Quality Committee.<br><br>JM felt the Board of Directors should be sighted to how effective the Trust is at responding to complaints and requested further information in relation to this be included in the quarterly SOF report.<br><br>**Action**<br><br>• **Information relating to the effectiveness of responses to complaints to be included in the quarterly SOF report**<br><br>**OPERATIONAL**<br><br>SiB advised the ED 4 hour wait standard was 92.6% in May and noted Newark Urgent Care Centre (UCC) achieved 99%. Overall this places SFHFT 17th of 117 trusts in the NHS. There has been a huge growth in demand for emergency care in terms of both attendances and admissions. This continued during May. All Winter capacity was closed during May.<br><br>Work continues in relation to patients who have been in hospital over 21 days. At the beginning of June the Trust achieved the NHSI target which was due to be achieved in March 2020. The task now is to sustain this performance, particularly through Winter.<br><br>The ICP led drivers of demand work has started. The target is for this work to be completed at the end of July. Some opportunities for the Trust have already been identified. The Winter debrief was completed recently. This will inform the Winter plan for 2019/2020.<br><br>In relation to cancer, the Trust achieved 80% against the 62 day standard. This equates to 73 patients being treated within 62 days and 14 outside of this timeframe. This area continues to be the most challenging area within access. Demand is high and work with partners has commenced relating to drivers of demand for cancer. The Trust is treating more cancers. The next piece of work is to disaggregate the information to tumour site level to establish if there are any tumour sites which may be an outlier and if there are any actions which can be taken to mitigate that demand.<br><br>From a capacity perspective there has been a delay in introducing additional MRI scanning capacity at King's Mill Hospital due to electrical supply issues. This has been resolved and the additional capacity will come on stream in the middle of July. However, there has been some loss of capacity in endoscopy, mainly due to the pensions issue as consultants are not wanting to pick up extra capacity. There is also pressure in histopathology due to the work required on samples being more complex and thus taking more time to complete. A histopathologist is due to leave the Trust shortly. To mitigate this, additional locum capacity has been introduced. | **AH** | **01/08/19** |

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| | Whilst everything is being done to support this area, it may require a more strategic plan to be developed. There is a business case for an additional MRI scanner but there may be other actions which need to be considered to support cancer access.<br><br>NG advised he is becoming increasing concerned about the demand pressure and felt the work AH is doing through the system is vital in looking at the issues over a longer term from a strategic point of view. There is a danger of demand exceeding availability of resources and this is a key risk which could become a reality.<br><br>JM queried, given the likely future workforce shortages, if there was an opportunity to look to the use of technology as a solution. SiB advised work is underway via the Outpatient Transformation Programme. The plan is to reduce outpatient follow ups by 13,000, which will partly be achieved through the use of technology. This is more strategic work and will not happen quickly, although there are some 'quick wins'. Medefer is being introduced which is a virtual system enabling a clinician in another part of the country to review a scan and make a decision regarding the patient's care. Technology is being used but it is the start of the journey.<br><br>MG sought further information in relation to a third of the breaches in relation to cancer being due to more complex cases and another reason for breaches being patient choice. SiB advised more complex cases are being seen in cancer, leading to more interventions with the hospital being required to establish the best treatment option. AH advised due to technology more treatment options are available and, therefore, establishing the right treatment options requires more steps. In terms of patient choice SiB advised this is due to patients requesting appointments at different times to those offered, which may be out of the 2 week window for patients referred on that pathway. Work has been done with primary care, requesting it is made clear to patients why they are being referred in quickly. Patients need to be motivated to attend their appointment.<br><br>SiB advised performance for diagnostics was 97.7% in May against a target of 99%. This is largely due to sickness in echocardiography which is now mainly resolved. It is anticipated performance will be back to 99% for June. Referral to Treatment (RTT) position was 90.8%. This continues to be relatively stable. There are no 52 week waiters.<br><br>**ORGANISATIONAL HEALTH**<br><br>RSi advised sickness absence has reduced for the fourth consecutive month to 3.82% and is the lowest level since October 2018. However, some challenges remain. There is still growth in the rolling 12 month average position, which has slightly increased in month. There are also challenges in meeting the target threshold of 0.8% for stress, anxiety and depression, which stands at 1.14% for May. Divisional areas continue to perform well in regards to general themes and trends. Diagnostics and corporate areas are below trajectory. | | |

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| | The top three reasons for sickness absence have remained static in month. There has been some progress in relation to gastrointestinal and musculoskeletal problems but there has been a slight increase in relation to anxiety, stress and depression. There are a number of options available to the workforce to support them in relation to stress, including face to face counselling, Employee Assistance Programme (EAP) and the listening ear service, which is provided by colleagues in occupational health. It has been identified many of the cases of stress relate to personal stress. During June a series of wellbeing walkarounds have been held. This will continue over the next quarter. The work in relation to MSK has shown continued progression.<br><br>It is important to use discretion in any sickness absence process. The Trust continues to empower leaders to make discretionary decisions and put the individual at the centre of the discussion, ensuring they do not return to work too soon. This approach may lead to a slight increase in sickness absence.<br><br>Turnover remains positive at 0.49% and there were more starters than leavers in May. The assessment centre model used for registered nurses continues to pay dividends. There is now a cohort of 20 overseas nurses and this has been a success for the Trust.<br><br>MG sought clarification regarding the take up by managers of the sessions to support them to manage sickness absence. In addition, MG noted there is currently a 12 week wait for counselling sessions and there is a review into this. Clarification was sought regarding the scope of the review. RSi advised, in relation to engaging with managers, various approaches have been taken, including team and 1:1 discussions in the leaders' own work areas. In addition, informal lunchtime sessions have been held. There have been some targeted interventions and take up has generally been positive. In relation to face to face counselling for staff, there have been some problems with the current provider in terms of service delivery and the service is currently under review. The aim is to complete an in depth review over the coming quarter in relation to anticipated service demand and delivery as there have been problems with the provider's ability to meet demand.<br><br>MG queried if there is anything further which can be done to support staff while the review is ongoing, noting 12 weeks is a long time to wait. AH advised this is being discussed by the executive team. RSi advised the Employee Assistance Programme is being promoted as staff can access that immediately.<br><br>**FINANCE**<br><br>PR advised at Month 2 SFHFT is reporting a YTD deficit of £9.7m before non-recurrent income, which is £120k ahead of plan. When the non-recurrent income of Provider Sustainability Funding (PSF), financial recovery funding and marginal rate emergency funding is taken into account, the deficit is £6.7m, which is also £120k ahead of plan.<br><br>Activity on the non-elective pathway is 8.6% ahead of plan, which leads to clinical income being £1.37m ahead of plan YTD, although there are associated pay costs which are currently £730k worse than plan YTD. | | |

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| | The Financial Improvement Plan (FIP) delivered £630k at the end of Month 2, which is £20k behind plan YTD. A risk to full year delivery of upwards of £6m has been identified and external support is now in place to help mitigate that risk. In terms of agency expenditure, this stands at £520k below the ceiling set by the regulator YTD. Capital spend is £20k better than plan. A letter has recently been received from NHSI requesting the review of capital programmes across the ICS due to removing 20% of expenditure in this year. An ICS plan has been put in place.<br><br>The cash position is slightly below plan by £130k, although this is above the ceiling required by the Treasury. Following the submission of all provider trusts' accounts for 2018/2019, SFHFT has been awarded an additional £570k of PSF, which will further reduce the Trust's borrowing requirement in 2019/2020. This figure will not be accounted for in 2019/2020 but will be a prior year adjustment when the accounts are produced at year end.<br><br>As Month 3 has been closed, there will be a full forecast produced which will be reported through to the Finance Committee and Board of Directors.<br><br>JM noted a large proportion of the additional income appears to have been used for additional pay and sought clarification in relation to this.<br><br>PR advised in Month 1 many staff received a one off payment and the plan did not reflect this as accurately as it could have. Work is ongoing to try to understand the relationship between income and pay. Initially this is being done by division, particularly to try to understand the links in the emergency pathway.<br><br>The Board of Directors CONSIDERED the report | | |
| **17/273** | **WELL LED REVIEW PROGRESS REPORT** | | |
| **2 mins** | SH presented the report, advising this is an update to the Well-Led review which reported in December 2018. As a result of this review there were 20 recommendations, 10 medium priority and 10 low priority. 15 of those recommendations have been completed. Three are still in progress, of which two are low priority and one medium priority. There are two recommendations which are ongoing, which are medium priority. The view is these two recommendations will be continually ongoing. This work means the Trust will be well placed when the CQC visit and do their Well-Led review.<br><br>The Board of Directors were ASSURED by the report | | |
| **17/274** | **OUTSTANDING SERVICE** | | |
| **5 min** | A short video was played highlighting the work of the infection prevention and control service. | | |

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| **17/275** | **COMMUNICATIONS TO WIDER ORGANISATION** | | |
| 2 min | The Board of Directors AGREED the following items would be distributed to the wider organisation<br><br>• Research<br>• Staff awards<br>• Patient story<br>• ICP / ICS update, particularly PCN development, end of life and CCG merger<br>• Performance, recognising there is an increasing demand for services but the Trust is performing well. Areas to highlight within this are sepsis, international nurses and improvements in diagnostics | | |
| **17/276** | **ANY OTHER BUSINESS** | | |
| 1 mins | No other business was raised. | | |
| **17/277** | **DATE AND TIME OF NEXT MEETING** | | |
| 1 mins | It was CONFIRMED that the next Board of Directors meeting in Public would be held on 1st August 2019, in the Boardroom, King's Mill Hospital at 09:00.<br><br>There being no further business the Chair declared the meeting closed at 11.25am. | | |
| **17/278** | **CHAIR DECLARED THE MEETING CLOSED** | | |
| | Signed by the Chair as a true record of the meeting, subject to any amendments duly minuted.<br><br>John MacDonald<br><br>**Chair** **Date** | | |

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| **17/279** | **QUESTIONS FROM MEMBERS OF THE PUBLIC PRESENT** | | |
| 4 mins | Ian Holden (IH) – Public Governor, Newark, noted it was good to hear the challenge in relation to the ICS / ICP maintaining focus on Newark Hospital.<br><br>Richard Shillito – Public Governor, Newark, felt the Trust should be a consultee in planning advising there are 8,000 houses due to be built in the area and queried if there is any planning within the Trust in relation to this. JM felt the Trust should get involved with the consultation. In terms of planning within the Trust, the projected demand is important in developing the view for Newark Hospital. AH advised this is something the ICP needs to have a handle on as the issue is wider than the hospital. While some of the services will be delivered from Newark Hospital, the wider issue is the healthcare and social care of the whole population. It was noted the district councils are present at the ICP board. | | |