MINUTES

Pennine Care NHS
NHS Foundation Trust

Board of Directors

Wednesday 1 March 2017 at 9.30 am
Boardroom, Trust Headquarters, 225 Old Street, Ashton-under-Lyne, OL6 7SR

PART I

Present:

John Schofield	Chairman
Martin Roe	Acting Chief Executive
Henry Ticehurst	Medical Director/ Acting Deputy Chief Executive
Keith Walker	Executive Director of Operations
Judith Crosby	Executive Director of Service Development and Sustainability
Emma Tilston	Acting Executive Director of Finance
Julie Taylor	Director of Business Development
Jose Fernandez	Director of Workforce
Joan Beresford	Non-Executive Director
Keith Bradley	Non-Executive Director
Sandra Jowett	Non-Executive Director
Michael Livingstone	Non-Executive Director
Ian Bevan	Non-Executive Director
Paula Ormandy	Non-Executive Director

In attendance:

Louise Bishop	Trust Secretary
Gillian Bailey	Assistant Trust Secretary
Beth English	Digital Communications Officer
Richard Walker	Director of Capital Investment and Estate Services – *item 6.3*
David Lees	Head of Capital Projects – *item 6.3*
Philip Paulden	Member of the public

Governor representation:

Steve Moss	Public Governor, Tameside and Glossop

1. Apologies for absence

Apologies were received from Tony Berry (Non-Executive Director) and Ian Trodden (Executive Director of Nursing and Healthcare Professionals).

2. Declarations of interest

There were no declarations of interest.

3. Update from the Chairman

The Chairman noted that Michael McCourt's final day as Chief Executive was on Tuesday 28 February 2017. The Board recorded its thanks and appreciation to Mr McCourt for his dedication and hard work during his 16 years service with Pennine Care, and wished him success in his new role.

The Chairman formally recorded the interim arrangements within the Executive team from 1 March 2017, pending the appointment of a substantive Chief Executive, noting that Martin Roe was Acting Chief Executive; Henry Ticehurst was Medical Director / Acting Deputy Chief Executive; and Emma Tilston was Acting Executive Director of Finance.

Item 6.3 was brought forward to this point

4. Previous meeting of the Board of Directors

4.1 Minutes from a meeting of the Board of Directors

The Chairman presented the minutes from a meeting of the Board of Directors (PI) held on 25 January 2017 to the Board for approval.

The minutes were approved as an accurate record.

Mr Livingstone enquired after an update on the recruitment of a Freedom to Speak-up Guardian. Mr Fernandez replied that the job description for the role had been re-evaluated and it remained at Band 7. Plans were being progressed to go back out to advert, confirm interview dates, and consider the membership of the interview panel.

5. Matters arising and action plan

5.1 Action plan arising from meetings of the Board of Directors

The Chairman presented the action plan arising from meetings of the Board of Directors to the Board for approval.

The Board approved the action plan. Mr Walker noted that item 8 (risks relating to agency usage to be recorded on the risk register) was now complete.

5.2 Board Strategy sessions: February 2017

The Chairman presented a summary of the Board Strategy sessions that had taken place during February 2017 to the Board for noting.

Mr Bevan welcomed the summary and requested that Board also have sight of the proposed future topics for Board sessions. Ms Beresford added that it

would be helpful to have access to associated presentations as part of the information Board received.

The Board noted the report.

5.3 CQC assessment / action plan update

Henry Ticehurst provided a verbal update on the CQC assessment and action plan to the Board for assurance.

Dr Ticehurst reported that the Trust was due to meet with the CQC on 1 March 2017 to review the action plan. Thereafter there would be monthly conference calls and a six-monthly meeting. Dates for the commissioner-led improvement board had yet to be set – the intention was to ensure that costs associated with the CQC, including transformational and digital funding needs to support CQC compliance, were taken through this forum.

The Chairman queried if there were aspects of the CQC action plan that would be difficult to resolve. Dr Ticehurst confirmed there were, adding that there were significant challenges within the mental health acute care pathway and inpatient provision, which was why it was important for the CQC action plan and the Trust's Mental Health Strategy to be linked. Dr Ticehurst added that had had met with Warren Heppolette (Executive Lead, Strategy and System Development, GMHS&CP) regarding GM's and Pennine Care's MH Strategies, transformation, the CQC action plan, and IM&T requirements – it was essential these were all pulled together and brought to the fore in GM. The Chairman queried if the commissioner-led improvement board was sufficient to deal with all these factors or if it needed to be at GM level. Dr Ticehurst advised that both were necessary. NHS Improvement was involved in the improvement board, but there also needed to be a GM view of what should be a reasonably commissioned service, along with the 'must dos' and transformation in localities. The next stage was to arrange a meeting of other providers in GM regarding the challenges faced in order to inform the secondary care element of GM's MH Strategy and commissioning framework in GM. This was a complex undertaking to bring together numerous stakeholders and multifaceted pieces of work.

The Chairman commented that the risk with the above was timing, and getting everything in place in an already stretched system. Dr Ticehurst agreed, adding that the commissioner-led improvement board would not meet for the first time until March 2017 at the earliest, so it was important for the Trust to keep pushing this agenda. Ms Taylor noted that funding for mental health was not as advanced in GM as other schemes i.e. Healthier Together, which was disappointing but conversely it presented the Trust with the opportunity to take a system leadership role, with the opportunity to talk about its strategy and the need for collaborative working across the whole of GM.

Mr Walker commented that to turn Requires Improvement into Good within six months required investment now that was operationally sustainable. It was important therefore that the commissioner-led improvement board was

focused on attending to issues now and not pushing everything towards a longer-term strategic conversation. Ms Crosby added that there were risks to this because localities were submitting revised plans that did not include the Trust's CQC action plan. This also needed to be considered in the context of the significant investment Pennine Acute had received as a result of its CQC inspection, so there needed to be consistency with how the system dealt with these issues.

Mr Livingstone enquired as to the development of the Integrated Provide Hub (IPH). Mr Walker replied that, from an internal perspective, the IPH was the Trust's ambition to be a prime vendor for mental health in each locality, but progress was slow. There needed to be a GM-level discussion because the current model for mental health was not sustainable if it continued to be managed around contractual lines rather than looking at total spends that sat as part of system transformation. Dr Ticehurst added that this referred back to the next steps alluded to earlier to bring together GM providers and thereby influence the strategy for secondary care and the acute care pathway.

Mr Livingstone enquired as to whether the Trust had the capacity to take the above forward. Ms Taylor responded that within the PMO there was a proposal for programme management for the MH Strategy. The current resource to write the strategy would conclude at the end of March 2017, so there would need to be a discussion about how to resource the capacity for programme management going forward.

The Board noted the update.

5.3.1 Minutes from the Quality Summit held on 24 January 2017

Henry Ticehurst presented the minutes from the Quality Summit held on 24 January 2017 to the Board for assurance.

The Board noted the contents.

6. Strategy

6.1 Chief Executive's update: February 2017

Martin Roe presented the Chief Executive's report for February 2017 to the Board for information.

Mr Roe reported on four critical workstreams for the Trust. Firstly, the Trust's position within the LCOs, and the EDs were meeting with CCG stakeholders regarding proposals for hosting arrangements. There were also plans to meet with senior local authority colleagues. Secondly, there was the financial plan, and a workshop on the current position was scheduled for 2 March 2017 that would involve the Chairman and Mr Bevan. A separate briefing note had been circulated to Board members outside the meeting, which outlined the complexities of the financial position whereby the 'ask' for funding in order to achieve the control total and a balanced financial plan, which was being

pursued via various routes, totalled £20-21m. The paper had also been shared with NHSI. A Board session was scheduled for 22 March 2017 regarding the financial plans.

The third workstream was the CQC action plan, with Mr Roe expressing concern that the first meeting of the commissioner-led improvement board had yet to be confirmed. CCGs were re-submitting their plans and not including the financial consequences of the CQC action plan. The Trust would therefore be suggesting CCGs make a provision within their plans for possible call off during 2017/18. Without this funding commitment, the Trust's ability to achieve a 'Good' CQC rating would be compromised.

The fourth area was the MH Strategy, and helpful discussions had commenced with Warren Heppolette (Executive Lead, Strategy and System Development, GM HS&CP). NHS England had expressed its concern that funding for mental health was not reaching providers and had asked, with a deadline of last week, for signed letters from commissioners and providers that all mental health monies were being delivered in line with guidance. Since then alterative proposals had come from GM, which had confused matters, and the discipline of signing these letters by the deadline had been lost. Mr Roe noted that should the funding for 'must dos' not be forthcoming, the Trust would be pushing for agreement in contracts that it could not be held to account for missing associated targets.

Mr Bevan sought comment on the extent to which the CQC was sympathetic if investment was not forthcoming, and the implications for the Trust if funding was not secured but the CQC, operating independently, re-inspected the Trust and there was no improvement. Dr Ticehurst replied that the Trust's action plan included timeframes that were indicative of when the CQC would revisit. The CQC were cognisant of financial pressures but these would not affect the outcome of the inspection – this was an objective view of the quality of services irrespective of funding. Mr Roe added that it was the role of NHSI to oversee the locality plans to move the Trust from 'Requires Improvement' to 'Good' as this fundamentally relied on investment from commissioners.

Given the importance of the Trust being fully involved in discussions about locality plans, Mr Livingstone enquired as to how Pennine Care would ensure it could influence this agenda. Mr Roe replied that the Trust had recognised it did not have sufficient ED presence within localities, and so twinning arrangements had been agreed in order to give EDs a greater understanding of issues. This would need to be supported by proposals around locality structures, which would be subject to discussions in PII of the meeting.

The Board noted report.

6.2 Health Informatics Steering Group highlight report: February 2017

Martin Roe presented the Health Informatics Steering Group highlight report for February 2017 to the Board for assurance.

Mr Roe reported that a crucial area was the pursuit of funding via business cases. The Trust had submitted three IM&T business cases to GM but had still not received feedback nor informed as to when a decision would be made. The matter had now been escalated to NHSI. At the end of March 2017, the Trust would need to make a decision about whether to serve notice on IT staff and therefore 'pause' the Health Informatics Strategy, or decide to continue to underwrite the costs for a further quarter. Dr Ticehurst commented that an electronic patient record was fundamental to the operation of the Trust, and it was inconceivable that GM would accept half its mental health services and a substantial part of its community services being unable to communicate with other parts of the system.

The Board noted the report.

6.3 Business case: refurbishment of Northside and Southside adult acute wards, Parklands House, Royal Oldham Hospital (ROH)

Richard Walker presented a business case for the refurbishment of Northside and Southside adult acute wards at Parklands House, ROH, to the Board for approval.

Mr R Walker reminded colleagues that Northside and Southside wards at Parklands House had been identified for refurbishment in 2014. The scheme had been delayed due to a number of issues, including the use of the decant ward at Tameside General Hospital for 18 months to support Manchester Mental Health and Social Care NHS Trust with the provision of additional beds. The scheme addressed a number of deficiencies that had been picked up as part of the CQC inspection and PLACE visits, and would take between 12-18 months to complete. The scheme cost was £2.245m including VAT. The Trust had examined the requirements of same-sex accommodation guidance as issued by the CQC; however the CQC had declined to comment specifically on the scheme. Mr R Walker requested approval to proceed with the scheme to ensure patients on the ROH site were provided with the best possible environment.

Ms Beresford welcomed the scheme; however enquired as to the impact on income generation from mental health beds. Mr K Walker replied that in the short-term there would be no impact as the decant ward was currently empty. Mr R Walker added that one of the reasons the scheme had been delayed was in order to generate additional income from the decant facility.

Mr Bevan sought assurance that the capital budget fully provided for this scheme, and it was supported by a robust risk assessment to mitigate any financial risks as a result of difficulties encountered during the project. Mr R Walker replied that the budget for the scheme had been allocated within the capital programme for the last two years, and the finance allocation was believed to be sufficient for the scheme and likely issues. The scheme might be slightly delayed in terms of construction time if issues such as asbestos were found; however the project team had used learning from schemes undertaken elsewhere in the organisation to anticipate problems.

The Chairman noted that an assisted shower room would be provided between both wards, and enquired as to how this would be managed in line with privacy and dignity requirements. Mr R Walker responded that all bedrooms would have en-suite shower facilities; however patients that required assisted facilities would be escorted and provided with nursing support at all times.

With regards to the female designated areas, the Chairman enquired if the Trust had considered one area of 12 beds rather than two separate areas of six. Mr R Walker advised that this had been considered; however 12 female beds together would mean that one ward would have a 50/50 split of male and female patients. Clinical staff felt strongly that two separate areas of six beds was the safer option. Professor Jowett recalled from the Board session on 15 February 2017 regarding the Trust's Estate Strategy that the project team had looked at how other organisations had reconfigured their wards. Mr R Walker concurred, adding that the team was closely linked with the Mental Health Network and would be speaking to them, in the absence of CQC endorsement of the plans, regarding these privacy and dignity improvements.

The Chairman queried if there was access to outside space on the first floor. Mr R Walker replied that the design had considered this however concluded that it was not able to give reasonable outside space at first floor level without increasing the risks to patient safety. The building had access to a ground floor internal courtyard, which currently was not used, but the plans allowed access to this area from the dining room. This was in addition to existing outside space at ground floor level. Access to this space also compiled with privacy and dignity requirements because patients did not have to go from one ward then through another ward to gain entry.

The Chairman enquired if there was sufficient therapeutic space in the design. Mr R Walker responded that there was dedicated therapeutic space in the design. The current ward was poorly designed and disorientating – the scheme allowed for more space in the two day rooms, and the use of glass walls provided more natural light. Staff bases would be placed in these areas, and because they were also near to the female areas, staff would be able to observe any male patients in the day areas.

The Chairman asked if staff areas had been provided for. Mr R Walker confirmed that staff had rest facilities that were positioned as such so staff could be called to the ward quickly in the case of an emergency.

Mr Moss queried if the design had taken in the views of patients. Mr R Walker verified that the project team had worked with staff and patients over the last 12 months on the scheme design. As the scheme progressed to the next stage, for example, colour schemes and fabrics etc, patients and staff would again be involved. The Trust was also working hard to ensure that the decant facilities provided appropriate accommodation as they would be used for 12-14 months.

The Chairman asked if there was a plan to support the families of patients using the decant facilities. Mr R Walker replied that decant plans had been considered for patients, their families, and staff; and the intention was to look at patients and staff based on the Tameside side of the Oldham catchment area.

Mr Livingstone recorded his support for the scheme; however, given the strategic importance of ROH as a 'super' site in GM, sought assurance that the Trust had a secure future on the site. Mr Walker advised that there had been some discussions with Pennine Acute regarding the outpatient facilities at Reflections and Cherrywood, which they might be keen to acquire. This would fit in with the Trust's strategy as adult outpatients and CAMHS would be better located in the town centre. There was no desire by the acute trust to acquire Parklands or Forest House.

The Board noted that the Executive Summary in the report referred to the outline business case for the scheme being approved at a Board development session in March 2016, and recorded that this be updated as these sessions were not decision making forums.

In line with the recommendation set out in the business case, the Board approved the costs of £2,245,000.00 inherent of appointing a principal contractor to deliver the refurbishment of the two adult acute wards within Parklands House on the Royal Oldham Hospital site.

7. Performance and Quality

7.1 Monthly Performance and Quality Assurance highlight report: January 2017

Keith Walker presented the monthly Performance and Quality Assurance highlight report for January 2017 to the Board for assurance. Mr Walker noted that the Q3 PQA reports had been discussed in detail at a meeting of the Performance and Quality Assurance Committee held on 29 February 2017.

Professor Ormandy enquired as to why CEST and IPDR compliance rates were not on the Corporate Risk Register. Mr Walker replied that a trajectory had been agreed with SDs around IPDRs in particular that the compliance target would be reached in the next three months. With regards to CEST, a review had been conducted, from which a number of actions were being taken forward, and these would need some time to embed. It was not felt necessary to place these items on the risk register at the moment, but this might need to be revisited if targets were still being missed in three months.

The Chairman recalled that the Trust had introduced a new policy last year linking IPDRs to pay progression, and queried if this was now being applied. Mr Walker responded that the new policy was being used and over 100 training sessions with managers had taken place. The issue around the gap

in compliance levels was where targeted intervention was required to ensure staff received an IPDR, in line with policy. Assurance had been received from the DBUs that this could be achieved in the next three months; however thereafter there was a question of sustainability, which linked to the investment required in services.

The Board noted the report.

7.2 Corporate Risk Register summary

Henry Ticehurst presented the Corporate Risk Register (CRR) summary report to the Board for assurance. The full CRR had been subject to discussion at the Performance and Quality Assurance Committee held on 28 February 2017.

Ms Bishop noted that, following the previous Board meeting, she had met with Professor Ormandy regarding the format of the report. These changes were currently being worked through with the system supplier and would appear on next month's report.

The Board noted the report.

7.3 Board Assurance Framework summary

Louise Bishop presented the Board Assurance Framework (BAF) summary to the Board for assurance. The full BAF had been subject to discussion at the Performance and Quality Assurance Committee held on 28 February 2017.

Professor Ormandy sought on update on why the risk to achieving objective 4.2 (develop and implement place-based models of care) was rated as 'red'. Ms Taylor explained that the Trust's ambitions within the LCOs were based on timeframes earlier in the year; however, due to factors outside the Trust's control, the pace around the development of the LCOs was slower than anticipated so the Trust was not where it had hoped to be.

The Board noted the report.

7.4 Finance dashboard: January 2017

Emma Tilston presented the Finance dashboard for January 2017 to the Board for assurance.

Ms Tilston reported that, at the end of January 2017, the reported position was a surplus of £1.95m. The forecast outturn was a surplus of £2.295m, which was in line with the Trust's control total. A risk to this was securing the £1m VAT rebate in relation to the change in VAT status for the initial build of Prospect Place. The Trust had taken the opportunity to raise this issue with the Secretary of State for Health, and had since provided information to Mr Hunt's office.

With regards to the efforts to reduce agency spend, Ms Tilston noted that expenditure on bank staff had increased overall by 19% (£1.6m) compared to the same period last year but, despite this, agency costs were still higher than planned. A detailed review of agency spend had revealed that £2.8m was associated with delivery of key objectives and in support of system-wide pressures, i.e. opening of intermediate care beds and the delivery of national targets. With the former, there was income associated with these beds and where these were known about in advance the Trust would negotiate with the CCGs if agency staff would be required in order to cover any premium costs. With national targets, funding was not available to cover the premium element of using agency staff to deliver new targets.

With regards to CIPs, the Trust had largely achieved this year's target but there were elements delivered non-recurrently. The CIP target for 2017/18 was approximately £8m, which included £1.8m of local pressures and non-recurrent schemes carried forward into the new year.

As a result of agency expenditure being ahead of target, this had impacted on the Use of Resources (UOR) metric, which would be capped at 3. NHSI had confirmed that this would not affect Trust's segment rating. Capital expenditure was behind plan; however this meant that cash balances were ahead of plan.

The Trust would be required re-submit its plan to NHSI during March 2017, however the precise date had yet to be confirmed.

Mr Bevan queried whether, given this year's experience with agency expenditure, financial plans were robust enough for next year and whether there might be changes in headcount. Ms Tilston replied that headcount was based on budgeted establishment – sometimes bank and agency had to be used to cover services hence it was costs that were managed to stay within budgeted pay allocation but headcount would remain the same. Despite the fact that bank usage had increased, some processes had taken time to put in place and this delayed the impact on agency usage. The Trust's target was to continue to reduce agency spend next year by using the processes it had established this year. Mr Fernandez added that, following the Performance and Quality Assurance Committee held on 28 February 2017, DBUs would be tasked with providing information on their recruitment requirements for the next 12 months. As agreed at PQAC, this would then go to EDs ahead of the circulation of a briefing note to the Committee thereafter. In addition, he and Sally Naughton (Assistant Director of Operations) would be meeting with SDs to discuss bank and agency requirements. With regards to the curtailment of agency A&C and non-qualified clinical staff, Mr Fernandez reported that a number of appeals had been lodged when the ban first came into force however none had been received in the last two weeks.

Mr Roe advised that the Trust had recently received correspondence on the agency position nationally. The Department of Health was pleased with the overall reduction in agency spend; but one area where progress was still needed was medical locums and renewed guidance had been issued.

Dr Ticehurst added that medical recruitment was very challenging and so he was scheduled to meet with Mr Trodden, Mr Fernandez and Dr Fernando (Director of Medical Education) to discuss how services might be provided for differently, for example, via the expanded use of nurse roles as part of the wider workforce strategy.

The Board noted the report.

7.5 Mental Health and Community Health governance report: January 2017

Henry Ticehurst presented the Mental Health and Community Health Governance dashboards and narrative for January 2017 to the Board for assurance.

Dr Ticehurst reminded colleagues of the report presented to the Performance and Quality Assurance Committee on 28 February 2017 regarding the Mortality Review Group, which had been established to review the decisions made about the investigations of deaths reported to the Trust.

With regards to the dashboards, reported incidents of slips, trips and falls had increased; however Dr Ticehurst reiterated the importance of a healthy reporting culture and that the severity of harm relating to these incidents had fallen (in line with the Trust's Quality Account priorities). Dr Ticehurst advised that a significant amount of work was ongoing across the organisation on falls prevention, and it was agreed that Board would receive a précis of this work outside the meeting.

The number of complaints had increased in month. The Trust had comprehensive procedures for handling complaints, including a complex complaints process to ensure that learning was disseminated across the organisation. The Trust also hit its targets in relation to responding to complaints.

Mr Livingstone requested an update on the reported incident of a young person admitted to a S136 suite. Dr Ticehurst advised that this young person with a long forensic history, had recently moved to the area from the south of England. The young person was admitted to a S136 suite and placed on Section 2. There were no adolescent beds available at that time. Due to the high risk the young person posed to himself and others, the decision was taken to continue to nurse him in the suite – he was then transferred to the PICU at GMW.

Mr Livingstone enquired after an update on the two-year old child reported as subject to suspected non-accidental injuries. Dr Ticehurst advised that an update would be circulated outside the meeting.

The Chairman noted that the number of unsafe discharges reported this month (23) appeared high. Dr Ticehurst advised that all the incidents were non-Pennine Care and no serious harm was reported. Zoe Molyneux (Associate Director of Quality Governance) and Matt Walsh (Patient Safety

Lead) liaised with the acute trusts regarding unsafe discharge incidents, and any serious cases were escalated to the Medical Director for a conversation with the acute trust equivalent.

The Board noted the report.

8. Audit Committee

No business was discussed.

9. Board Governance

9.1 Information circulated to Board since last meeting

The Chairman presented a report on information circulated since the last Board meeting.

The Board noted the report.

9.2 Briefing note from the extraordinary meetings of the Board Appointment and Remuneration Committee held on 20, 25 and 27 January 2017

The Chairman presented a briefing note from extraordinary meetings of the Board ARC held between 20 and 27 January 2017 to the Board for information.

One correction to the briefing was noted in relation to the meeting held on 20 January 2017 – Professor Jowett was not involved in the interviews for a potential external interim CEO.

The Board noted the contents of the briefing.

10. Council of Governors

10.1 Feedback from a meeting of the Council of Governors held on 14 February 2017.

The Chairman presented a briefing note from a meeting of the Council of Governors held on 14 February 2017 to the Board for information.

The Board noted the report.

11. Patient Story

Henry Ticehurst presented a patient story to the Board for information. The story involved a complaint regarding the telephony system at the Business Management Centre. The complainant's issue was resolved to her satisfaction, and had since found using the service to be a much improved experience.

The Board noted the contents of the story.

12. Any other business

12.1 Liaison diversion services

Lord Bradley enquired as to an update on the impact on staff and operations from the rollout of the new liaison diversion services in GM. Mr Walker agreed discuss this further with Lord Bradley outside the meeting.

13. Date and time of next meeting

The next meeting of the Board of Directors will take place on Wednesday 29 March 2017 in the Second Floor meeting room, Horton House, Southlink Business Park, Hamilton Street, Oldham, OL4 1DE, commencing at 9.30 am.

JS/MR/LB/GB/010317