UNCONFIRMED MINUTES OF THE SIXTY-FOURTH MEETING OF THE BOARD OF DIRECTORS FRIDAY 27 MARCH 2015, 9AM, LECTURE THEATRE, POST GRADUATE CENTRE, QUEEN ELIZABETH THE QUEEN MOTHER HOSPITAL, MARGATE

PRESENT:

Mr N E J Wells	Chairman	NW
Dr J P Spencer	Non Executive Director	JS
Mr R Earland	Non Executive Director	RE
Mrs V Owen	Non Executive Director	VO
Prof C Corrigan	Non Executive Director	CC
Mrs J S Pearce	Chief Nurse and Director of Quality	JP
Ms E A Shutler	Director of Strategic Development and Capital Planning	LS
Ms S Le Blanc	Director of HR	SLB
Mrs J Ely	Director of Operations	JE
Mr D Baines	Interim Director of Finance and Performance Management	DB

IN ATTENDANCE:

Chris Bown	Interim Chief Executive *(from 1 April 2015)*	CB
Nick Gerrard	Director of Finance *(from May 2015)*	NG
Mrs S Lewis	Improvement Director	SL
Jane Waters	Cultural Change Programme Manager (*Minute Number 28/15 to 44/15)*	JW
David Hargroves	Clinical Chair for the Improvement Plan Delivery Board *(Minute Number 33/15)*	DH
Peter Gilmour	Director of Communications	PG
Alison Fox	Trust Secretary	AF
Mrs S Swindell	Assistant Trust Secretary (Minutes)	SS

MEMBERS OF THE PUBLIC IN ATTENDANCE:

Mr C Edel	Member of the public	CE
Marcella Warburton	Elected Governor – Thanet	CW
Dr Philip Bull	Elected Governor – Shepway	PB
Roy Dexter	Elected Governor – Thanet	RD

Item Minute Number 33/15 was taken as the last item at the meeting to accommodate staff availability to attend. The minutes reflect the order of the agenda for consistency.

MINUTE NO.		ACTION
28/15	**CHAIRMAN'S WELCOME** NW welcomed members of the Board, Governors and members of the public to the meeting. NW also welcomed Chris Bown, the Trust's Interim Chief Executive and Nick Gerrard who will be commencing as Director of Finance in May 2015.	
29/15	**APOLOGIES FOR ABSENCE** Mr P Presland, Non Executive Director Dr P Stevens, Medical Director Mr S Bain, Chief Executive	

30/15 **DECLARATIONS OF INTEREST**

DB, PS and SLB were noted as nominated Directors of EKMS and DB of Healthex.

31/15 **MINUTES OF THE PREVIOUS MEETING – 29 JANUARY 2015**

The minutes of the previous meeting were agreed as an accurate record.

32/15 **MATTERS ARISING FROM THE PUBLIC MINUTES OF 29 JANUARY 2015**

The Board of Directors noted the updates on actions and the following verbal updates were provided at the meeting:

215/14 – Clinical Quality and Patient Safety Report
SLB updated the Board of Directors on the on-going issues with Mandatory Training. A virtualised app was being tested as purchasing a new system would take too long. In the meantime, Divisions had submitted a trajectory of compliance. The Strategic Workforce Committee (when established) would monitor compliance on behalf of the Board of Directors.

SL reported mandatory training compliance had been discussed at the Improvement Programme Board. The Improvement Board had requested a short paper on the current issues and actions being taken at the next meeting.

SL felt that compliance also should be monitored by the Quality Committee. SL would advise on appropriate reporting structure. — SL

The Board of Directors requested an update on mandatory training trajectories at the next Board meeting. — SLB

266/14 – Key National Performance Targets (KPI)
11/15 – Key National Performance Targets
JE confirmed the KPI report had been updated to reflect all comments received. Assurance on how indicators would be monitored and trajectories developed would form part of the next report to the Board. — JE

04/15 – Minutes of the Previous Meeting – 28 November 2014
DB would circulate budgets identified for CQC improvements to the Board of Directors. — Closed

08/15 – Clinical Quality and Patient Safety Report
JP reported work was ongoing to review variations in SHIMI and RAMI mortality data. A report would be brought to the Board when complete (attached to the Clinical Quality and Patient Safety Report). — JP/PS

The Complaints Steering Group had noted an improvement in the handing of Trust complaints. An update would be brought to the Board in two to three months' time. — JP

09/15 – Ward Establishment Review
LS reported the Associate Chief Nurse was a member of the clinical strategy workforce work stream. — Noted

A business case had been developed focussing on the need to right size the establishment and reduce reliance on temporary staff. An exercise would be — DB

undertaken by Management Board to prioritise all business cases with proposals to the Finance and Investment Committee (FIC).
JS asked (as Chair of the FIC) that the Committee also receive details of business cases identified as a lesser priority for transparency.

12/15 – Corporate Performance Reports
NW referred to the Trust's deteriorating financial position and asked how this would be communicated internally and externally. — Noted
CB stressed the importance of ensuring all staff had a clear understanding of the significant challenges faced by the Trust in the coming year and subsequent years and how they could contribute. A variety of communication methods would be used.

16/15 – Fit and Proper Persons
SLB agreed to provide a report regarding the current position. — SLB

20/15 – Delivering our Future Programme: Update on Clinical Strategy — LS
LS confirmed all actions were being taken forward with exception to the questionnaire to new patients at Estuary View for feedback purposes. LS would follow this up.

27/15 – Any Other business — Closed
This action was closed.

33/15 **CQC ACTION PLAN UPDATE**

David Hargroves (DH), Chair of the Improvement Programme Board, was in attendance for this item. He provided an update on progress with the CQC High Level Improvement Plan and the following was noted:

An exercise had been undertaken with Executive Directors to review original actions and timelines to ensure they were deliverable and realistic.

Page two of the report provided details of the status with RAG ratings from November 2014 to date. The Board of Directors noted an improving position.

Page three of the report highlighted actions which were not on track to deliver and reported as red. The report described the action required and assurances which were awaited.

With regard to preparation for the CQC re-visit in July 2015, DB reported a group of multidisciplinary staff would meet on a weekly basis to support site based teams. A communications programme would be put in place.

Board of Directors discussion:

LS referred to the 'Must Do 10' (ensuring all cleaning schedules were in place in all areas of the hospital) and stated this would report as 'red' until improvement had been sustained.

The Board of Directors discussed 'Must Do 19' (Ensure safety was a priority in A&E). JP reported estates work to separate children from adults in A&E was anticipated to complete in mid-April as further work at WHH was required. A series of moves would be required to create a dedicated area. Short term and long term

plans were in place with the latter concluding in Autumn this year.

The second element of the 'Must do 19' related to ensuring appropriately qualified nursing staff. The Trust was taking forward integrated workforce models and already had in place a good model of advanced nurse practitioners.
In addition, the Trust had procured a model of education programme from Christ Church University for adult nurses in A&E to become appropriately qualified to look after children in their care.

Must Do 25 (Ensuring the administration of all controlled drugs was recorded) had now turned blue. A revised policy was in place.

Key Finding 06 (Identification of risk to patients) was discussed. JP stated strict timelines had been set for risk and skin assessments for patients. Campaigns had been undertaken to improve awareness. Overall, this was improving. However, risks linked to operational challenges remain.

DB referred to significant challenges regarding mandatory training compliance. The Board of Directors were reminded of the update provided by SLB earlier in the meeting as to actions being taken (minute number 32/15).

VO asked whether mandatory training monitoring could be linked to the appraisal system. SLB responded the appraisal process was not electronic.

With regard to outpatient appointments, JE reported a programme of work was in place focussed on the physical environment and booking processes. The second element related to booking of follow up appointments and this was being systemised.

NW referred to the mandatory requirement for Trusts to display the latest CQC findings from 1 April 2015. He asked for assurance this would be put in place.

JP responded the CQC would design posters and the Trust would have 30 days to display. Work had commenced with the Communications Department to also establish posters informing of improvement work taken forward in the Trust.

RE recognised the significant work undertaken to date. He referred to the cultural change programme which would take time to embed and asked how this would be managed ahead of the CQC re-visit.

DH/NW agreed and stressed the importance of ensuring staff have a good understanding of the improvement programme and key outcomes.

RE asked if robust processes (and mitigating narrative) were in place to prevent actions currently rated as 'green' moving to a 'red' status.

SL stressed moving out of special measures for any Trust was not easy. She stated the Trust should aspire to aim for a much improved position ahead of the re-visit in July 2015. She agreed the staff engagement work would take time to embed but the Trust should be in a position to demonstrate plans in place and an improvement trajectory. She further added the CQC had learnt from previous inspections.

JS referred to the importance of the Board receiving updates against outcome

measures. DH reminded the Board of Directors of the development of a dashboard and this would be in place by the next Board meeting.

Board of Directors decision/agreed actions:

- The Board of Directors noted the latest position and stressed the improvement programme was to secure the long term sustainability of the organisation. — Noted
- DB referred to the data quality findings from the CQC report and the work commissioned from KPMG. He asked for Non Executive Director nomination for data quality. NW would take this forward. — NW
- It was agreed CB would test staff awareness of key areas of the improvement programme during routine visits. DH and SLB would liaise. — DH/SLB

34/15 **CULTURE CHANGE PROJECT UPDATE**

SLB introduced Jane Waters (JW), Project Manager for the Cultural Change Programme. SLB presented the report updating the Board of Directors on progress to date and drew attention to the following:

The 'Great Place to Work' vision had been updated (appendix 3) following consultation with a number of staff groups and governors.

Progress on priority areas was noted:

- Increased communications;
- Incorporation of recommendations from Divisional and Board Governance reviews into the staff engagement action plan;
- Implementation of a Cultural Change Steering Group with wide staff representation;
- Establishment of a project group to address issues identified by the CQC in relation to bullying and harassment.

Diagnostics had been undertaken by Hay to understand further the themes from the CQC report and these were noted at appendix 6. A report had been received from Hay and this would be reported back to the Board in April 2015.

Staff had been provided with the opportunity to put forward practical steps the Trust could put in place to make their working life better. The response rate was disappointing. However, themes would be incorporated into the improvement plan.

Work would be undertaken to ensure a consistent perception of bullying and harassment at all staff levels.

Board of Directors discussion:

NW commented that cultural change was a key area of focus at Performance Review Meetings with Monitor. He requested actions taken to date be reported at the next meeting. He asked whether processes were being put in place to gather tangible evidence to monitor the impact of the improvement programme.

SLB reported the friends and family test had increased by 2% (staff recommending the Trust as a place to work). A survey monkey would be undertaken ahead of the CQC re-visit as the next friends and family test results would not be available.

CB stated he intended to provide personal leadership to the improvement

programme. CB had spent time visiting areas of the Trust talking to staff. Staff recognised the themes identified by the Hay Group. Getting this right was fundamental to the organisation.

CB referred to the work undertaken by Professor Peter Spurgeons (University of Warwick) regarding clinical engagement. Clinical leadership was essential to the Trust's future sustainability.

SL had also spent time talking to staff. She commented that 2% improvement in the friends and family test was a good improvement in a short period of time. She proposed a positive message be sent to staff. SLB would take forward once the official report had been received.

SLB would be establishing a one day programme for all people managers which would include: roles and responsibilities; management style; communication with their team; resilience and support in times of pressure.

RE commented it would be helpful to establish a 'heat map' to exemplify good behaviours and focus resources to ensure a consistent change. RE further added the more the Board understands the areas of challenge, the more it could influence change.

SLB confirmed she would be using the staff survey results to develop a 'heat map'.

JS referred to the work linked to We Care, Quality Strategy and the Cultural Change Programme and asked that improvement work be promoted consistently.

SLB/JP responded it had been agreed to retain the We Care branding to ensure this was seamless for staff. Further work was required to ensure staff had an understanding of the links between all Trust strategies.

JE reported Divisions had been developing their own celebration events.

Board of Directors decision/agreed actions:

- The Board of Directors noted the latest position. Monthly updates would continue. — Noted
- SLB would circulate a positive message to staff regarding the improvement in the friends and family test once the final report had been received. — SLB

35/15 **CLINICAL QUALITY AND PATIENT SAFETY REPORT**

JP presented the report and highlighted the following specifically:

- The Trust reported 98.7% harm free care. Further work was required around falls prevention and urinary catheters.
- Pressure ulcers reported 21 with five avoidable and two category threes. Overall, the Trust had met the 25% reduction target.
- *C.difficile* reported 47 to date (year-end trajectory). Rates were low compared to Trust peers. The improvement trajectory of 2016/17 was set at 45.
- Appendix 1 detailed planned and actual staffing levels. Further improvements had been realised. Further work was required at KCH and work was ongoing with human resources.
- The Trust reported in the upper quartile for risk management and clinical incident reporting. Further work was required in terms of pockets of high and

low reporters.

- Bed occupancy remained high at 96.9%.
- There had been a reduction in readmission rates. Work was ongoing to understand the contributing factors.
- Good progress had been made against the CQUINs programme. All requirements had been met with the exception of the heart failure and COPD pathways where confirmation was awaited.
- There had been an increase in the number of complaints in February 2015. Further work was required in the Surgical Division.
- The Friends and Family Test continued to report an improving trajectory. In February 2015, the trust received the highest percentage recommended and NPS so far for inpatients and outpatients.

Board of Directors discussion:

RE recognised the report provided assurance to the Board in terms of quality performance and actions being taken. However, he was not clear what was being taken forward as a consequence of the data compared to the previous month.

JP explained some of the improvements would take time to embed but she agreed to explore the best way of reporting this going forward.

JP was working with the Information Team to triangulate the data in a more meaningful way to identify priorities. The Quality Strategy was the vehicle for embedding improvements.

NW referred to the significant amount of data available to the Trust which could be turned into intelligence. Data could be used to establish 'heat maps' to identify areas of focus.

JP responded she would be developing this report with the Information Team and would take into consideration comments received.

CB commented he would expect to see a correlation between falls, pressure ulcers and complaints with staffing levels. However, there were areas identified in the reports that do not have challenges with staffing.

JP provided assurance areas were analysed and identify areas for special measures and ward dashboards were in place. She clarified that the report provided all pressure ulcers and not only hospital acquired. She would look at segregating this.

Board of Directors decision/agreed actions:
The Board of Directors noted the latest performance position. — Noted
JP would be developing this report with the Information Team and would take into consideration comments received: segregation of hospital/community acquired infections; strengthen articulation of action taken; and development of 'heat maps'. — JP

37/15 **DRAFT QUALITY AND IMPLEMENTATION STRATEGY 2015/18**

JP presented the draft quality and implementation strategy which was a summation following a large piece of engagement work undertaken with staff and feedback from CCGs.

The quality strategy was a refresh and identified specific programmes for improvement. The strategy remained a draft as further consultation had yet to conclude.

The Trust's Quality Report would include a look back of achievements over the last three years.

JP referred to the different approach taken to the format to simplify for staff and welcomed feedback from the Board of Directors.

Board of Directors discussion:

CB commented there was an opportunity to integrate the cultural change programme with the quality programme. He further referred to the links between safe staffing levels.

SL agreed and added communication to all clinical staff was vital.

RE commented the strategy should be clear and succinct as possible.

JP reported the driver diagrams were well received by staff.

SL added this was a common way of presenting strategies. She proposed consideration be given to an upfront description and a section describing how the Trust would be implementing the strategy.

RE was assured by the discussion that this strategy was the right vehicle for delivering change.

Following a question raise by SLB, JP referred to the driver diagram on effective care which referred to improved facilities.

Following a question by CB, JP confirmed clinical staff had been involved in the development of the strategy.

Board of Directors decision/agreed actions:
The Board of Directors noted the draft strategy. Noted
JP confirmed the strategy would be finalised in April 2015. JP

38/15 **PATIENT STORY**

JP presented the report which described the experience of an elderly patient who developed pressure ulcers on both heels whilst in the Trust's care. The report highlighted lapses in care and actions taken. Improvement work had been led by the Ward Manager and Tissue Viability Team and since the learning and actions had been put in place, this team had not reported further deep pressure ulcers.

Board of Directors discussion:

RE commended the Ward Manager for taking this seriously. He referred to learning and actions (bullet points nine and 11) and asked if supervision at the time was at the right level whether this incident should have occurred.

JP agreed and referred to the work led by the Ward Manager in terms of leadership and the function of the team. This had been quickly addressed and good quality care was now in place.

Following a question raised by NW, JP confirmed root cause analysis had been shared across the Trust.

JS referred to the positive introduction of Assistant Ward Managers to relieve ward staff of administrative duties.

Board of Directors decision/agreed actions:
The Board of Directors noted the report and actions put in place. Noted

39/15 **KEY NATIONAL PERFORMANCE TARGETS**

JE presented the report which had been revised following feedback received.

A&E performance

For February, A&E performance reported 88.2%. Key drivers included high attenders and acuity of patients. This performance had continued into March 2015.

Challenges remain regarding the flow through of patients. Work undertaken with key partners had not gained traction as hoped. ECIST had been invited to work with the Trust and dates were being finalised.

Board of Directors discussion (A&E Performance):

NW referred to correspondence received from Monitor following the last Performance Review Meeting with Monitor where concerns were raised regarding A&E performance. Monitor had asked the Trust to ensure all actions had been put in place internally before they can take forward discussions with key partners.

NW referred to page four of the report which indicated further internal work was required.

JE agreed staffing and physical space remained a significant issue. Page 4 of the report identified the reason for the breach but did not provide details of the actual cause of the delay. Flow through of patients was a major concern. JE added further she was having further debates with key partners.

RE asked if the Trust could be certain ECIST would not identify issues already known to the Trust.

JE commented ECIST visited the Trust four years previously. They recognised things had changed, specifically activity patterns.

SL added ECIST would help with reviewing internal structures and processes. She encouraged the Trust to review the plethora of learning available externally. Monitor and SL would monitor the internal improvement but SL agreed significant work needed to be undertaken externally.

DB referred to analysis undertaken linked to tariff which would demonstrate the change in patient flow over time.

JP referred to Management Board discussions regarding exit block in A&E. Work was ongoing to support clinical leaders and clinical teams in terms of continued improvements.

LS referred to a visit by Ian Dodge (NHS England) in the community and a presentation made by the CCGs regarding the number of beds they believe they would be able to unblock. She added it was important the Trust was clear in terms of prioritisation (internal and external).

JE reported commissioning intentions from the community trust had been received. She had yet to review. She stressed the importance of developing a true capacity plan for East Kent.

18 Week RTT Performance

February reported 77.9% for admitted. This was a planned non-compliance (as previously agreed by the Board of Directors) to address the backlog position.

JE was pleased to report the backlog position was reporting a downward trajectory for February and March (ahead of plan).

The Trust remained compliant against the incomplete pathways and non-admitted pathways.

Challenges remain in T&O and sub-specialty issues but progress was being made.

Referral management schemes put in place by the CCG had reduced referrals in T&O in February 2015. However, this remained volatile as the reduction had not continued in March 2015. CCGs were reviewing processes as a result.

A full review of musculoskeletal pathways had been undertaken.

A team of nine external staff had been provided to the Trust to assist with validation of all incomplete pathways. Based on feedback received no issues had been raised and all pathways had been managed correctly. JE would share the external report when available.

A revised trajectory of RTT performance had been developed to include chronological booking. Further detail and a revised profile would be provided in the next Board report. Detailed trajectories would be monitored via Management Board and Quality Committee.

It was anticipated the Trust would be fully sustainable in all specialties by October 2015.

Board of Directors discussion (18 Week RTT):

JE reported the PAS system had been upgraded on 17 March 2015. The impact of the switch over was minimal. An update would be included in the next report.

NW referred to discussions at the Joint IAGC/FIC in March 2015 regarding the need for clear trajectories in place. This would be agreed with CCGs in the first week of April 2015.

SL commended JE and her team for the work undertaken to develop a strong plan to achieve sustainable compliance. She commented there would be no further movement on the October 2015 deadline with Monitor.

Diagnostics

The Trust reported 99.4% compliance as at February 2015. Key drivers were increased demand and equipment failure within neurophysiology and gastroscopy.

NW asked if it was possible to build a calendar of anticipated national screening campaigns to help forecast increased activity.

JE responded public health issued this information in the past but current information was not consistent. However, the Trust was looking at this to plot the activity impact.

Cancer

The Trust reported compliant position with the 2 week wait and 31 day cancer targets. The 62 day standard was not achieved due to breaches in urology and lower GI, linked to delays in diagnostics.

Clinical engagement and leadership had improved on the Cancer Board.

JE Reported Urology compliance was at risk for March 2015.

Board of Directors decision/agreed actions:

- The Board of Directors noted the performance position as at February 2015. — Noted
- The Board of Directors welcomed the revised format of the report. RE proposed consideration be given to further information on key changes and monitoring any regression. SL added she would like to see more detail regarding real risks. — JE
- JE would share the external validation report on incomplete pathways once received. — JE

40/15 **CORPORATE PERFORMANCE REPORT**

DB presented the report as at February 2015. He tabled a presentation which provided an overview of Financial performance. Key messages included:

- Month 11 EBITDA was £1.6m adverse to plan and bottom line £1.3m adverse to plan.
- Year to date consolidated EBITDA was £9.5m adverse to plan and bottom line £8.5m adverse to plan.
- Forecast year end EBITDA was £10.6m adverse to plan (a deterioration of £0.8m to reflect an income risk on drugs and falls in PBR activity with NHS England. Further risk existed on RTT funding of up to £1.8m, and further aseptic stock write-offs of £630K.
- Year-end bottom line forecast deficit £7.4. (£6.5, adverse to plan). This included the benefit of the Dover impairment moving to £2015/16.
- Main drivers for shortfalls: premium pay costs; CIP shortfall; continuing expired aseptic write-offs; Divisional performance (£3.1 adverse to plan); and bottom line adjustment for one off items.
- The Trust's cash position was on plan.

An internal audit had been undertaken around aseptic stock. This had highlighted governance issues and a £630,000 to be written off.

A further risk was highlighted linked to 18 week RTT wave 1 monies. NHS England had informed the CCG it would not fund the full £1.7m bid. A decision of the final sum was awaited. DB added that there was a risk of non-payment of wave 2 RTT funding. A bill had been submitted for £680,000.

A worse case scenario at year end would be £13m EBITDA.

Overall the Trust reported a CoSRR of 3 against a planned 4.

Monitor was concerned about the Trust's financial position, specifically the speed of deterioration.

JS added (as Chair of the Finance and Investment Committee) the Committee had looked in detail at the significance of the short fall of the cost improvement programme and response the CQC report. There was a strong focus on mitigation.

Board of Directors discussion:

DB reported the Trust would be in a break even position without the adjustment for one off items.

NW referred to additional agency staff which had been identified as 'one off' items. He commented this cost may continue until the Trust right sized its resource and capacity.

Board of Directors decision/agreed actions:

- The Board of Directors noted the financial position as at February 2015. — Noted
- AF felt that going forward the risks should be documented with actions being taken. DB would address this. — DB

41/15 **REVIEW OF ONGOING COMPLIANCE AGAINST SELF CERTIFICATION**

AF reported the Board of Directors had accurately predicted in its last quarterly return to Monitor issues regarding 18 week RTT, A&E, cancer and deteriorating financial position.

A comprehensive report comparing quarter 2 to quarter 3 submissions would be discussed at the Integrated Audit and Governance Committee.

42/15 **QUESTIONS FROM THE PUBLIC ON PAPERS WITHIN THE PERFORMANCE SECTION**

In relation to the complaints process, Dr Bull suggested that immediate verbal communication with the complainant would be both reassuring and could help to simplify the process by clarifying the main issues. JP confirmed this formed part of the complaints process.

Regarding consultant engagement, Dr Bull reminded the board that in the former directorate structure, annual away days for the medical directorate, involving all physicians and the whole executive team had been valuable, and recommended that this should be reconsidered.

JP reported PS had led engagement through the clinical leadership programme.

Regarding the ECIST visit, Dr Bull emphasised the importance of addressing both internal systems and at the same time addressing the community issues as part of the process.

JE confirmed there was a whole health economy board in place.

Regarding the patient story, Mr Edel asked if the patient concerned survived. JP confirmed this to be the case.

Mr Edel asked for assurance that the Trust complied with Data Protection and Information Governance regulations. JP responded the Trust was required to complete an Information Governance Toolkit which was assessed externally. The Trust had met all standards required.

Mr Edel commented it was often difficult to hear the Trust's automated telephone service and this could impact on the response rates for the Friends and Family Test. JP would look into this. JP

With regard to training of staff as part of the cultural change programme, specifically bullying and harassment, Marcella Warburton asked whether this would reach ward level staff. JW/SLB confirmed all levels of staff will be involved.

Marcella Warburton added that perception of bullying and harassment could often be inconsistent.

43/15 **STRATEGIC WORKFORCE COMMITTEE TERMS OF REFERENCE**

SLB reminded the Board of Directors the Deloittes Board Governance Review recommended establishing a Strategic Workforce Committee. She asked the Board to consider and ratify the proposed Terms of Reference.

Board of Directors discussion:

RE felt there was a conflict for Non Executive Directors holding 'responsibility'. The role of the Non Executive Director was to hold to account and seek assurance.

NW/AF stressed the Committee would be acting on behalf of the Board of Directors. Executive Directors would be held to account by NEDs at Committee

meetings.

JS felt the central purpose of the Committee was to monitor recruitment and retention of staff and should appear towards the top of the list of responsibilities. He further felt that the equality and diversity strategy needed more prominence.

JS asked if the Committee would have oversight of education and training. SLB confirmed the Medical Education Director would be a member of the Committee and would make this more explicit.

NW commented the Committee would need to be aware of workforce implications linked to approval of business cases. In addition, provision and compliance of mandatory training should be monitored.

DB referred to section 3.6 regarding monitoring of financial implications and proposed the Director of Finance or nominee be a member.

RE referred to 3.3 and asked if the Committee would have the tools to provide assurance to the Board of Directors the Trust had adequate staff. SLB responded the Committee would review and monitor the annual workforce plans.

AF added the workforce strategy should be signed off by the Board with detailed monitoring at Committee level.

RE referred to the role of the Integrated Audit and Governance Committee to be assured adequate processes were in place (internal control).

Board of Directors decision/agreed actions:

- The Board of Directors approved the ToRs, subject to the above amendments.
- SLB would organise the first Committee for April or May. Interim membership would be required until the new Chair and Non Executive Directors had been recruited. SLB would discuss with NW. SLB SLB

44/15 **QUESTIONS FROM THE PUBLIC ON PAPERS WITHIN THIS DECISION SECTION**

There were no questions raised at this point in the meeting.

45/15 **DELIVERING OUR FUTURE PROGRAMME: UPDATE ON CLINICAL STRATEGY**

LS presented the report which updated the Board of Directors on progress to date with the clinical strategy. She drew attention to the following specifically:

Outpatients Work Stream:

- Work continued to deliver efficiencies and take forward one stop services and extended working days.
- The work stream was looking at priorities for the next phase of capital spend.
- There had been a delay in the opening of Dover Hospital due to weather and roofing. More recently an electrical infrastructure problem further delayed opening. It was anticipated hand over would take place in May 2015, with opening of services in mid June 2015.

Surgical Services Work Stream:

- The report detailed three options for surgery which have now been proposed.
- A date had been identified with all clinical leads to discuss whether an interim move of medicine would be required. A full risk assessment would be undertaken by specialty.
- There would be a delay in commencing the consultation. It was anticipated a full timetable would be worked up for September 2015.
- Engagement with staff would continue. Awareness had improved but further work was required with clinical staff and administrative staff.
- Affordability of the strategy was being worked up and the workforce work stream was engaged with this piece of work.

Board of Directors discussion:

CB reported Monitor was particularly interested in the affordability of the clinical strategy. He stressed it was critical the Trust was clear when it goes out to public consultation delivery would be affordable to the tax payer. Clinical and financial sustainability challenges were significant.

LS reported Monitor had requested a five year view and this would be submitted in June 2015.

JS stressed the importance of articulating coherently (as part of the consultation) all options. LS confirmed the long term strategic aim would be articulated together with interim steps.

Board of Directors decision/agreed actions:

- The Board of Directors noted progress to date. — Noted
- NW asked that future updates include financial implications and sources of funding. — LS
- NW stressed the importance of staff awareness of the direction of travel as the work progressed. — LS

46/15 **NATIONAL NHS STAFF SURVEY**

SLB presented the results of the NHS Staff Survey for 2014.

The overall response rate for the Trust was disappointing at 41%, lower than the previous year. SLB reminded the Board of Directors the CQC Report had been published immediately before the commencement of the survey.

In terms of findings, overall staff engagement had decreased, the trust scored in the highest 20% in one key finding, above average in four areas and in the lowest in 22 of the 29 key findings.

The report provided comparisons from 2012 and Appendix 1 showed the difference between 2014 and 2013 results and comparisons against the national average for acute Trusts.

Work was ongoing to analyse the results by Division to identify areas of focus. SLB reported high level observations to date: radiology reported the highest level of bullying and harassment; 22% medical and dental staff reported discrimination; and 50% of staff in Urgent Care and Long Term Conditions reported bullying and

harassment, 59% of which were staff in A&E.

In terms of discrimination, further analysis would be undertaken. Improvement would be linked to the cultural change programme.

Each Division would be provided with their report and would be asked to develop action plans. These would be monitored by the Workforce Committee.

Board of Directors discussion:

NW expressed his disappointment with the results. Delivery of the cultural change programme was critical.

NW asked SLB what action had been taken to raise awareness of the staff survey results with staff. SLB responded the public document was readily available and would be referenced through the improvement journey.

As Chair of the Board's Remuneration Committee, RE stated the whole Executive Team needed to be held to account for improvement and this needed to be reflected into staff objectives.

SL reminded the Board of Directors the CQC would use the staff survey to identify areas of focus.

DB felt there were a number of improvements which could be put in place immediately such as ensuring staff receive training. SLB and JP clarified the response related to difficulty in releasing staff due to operational pressures. This would need to be looked at by area.

RE stated the Trust needed to think about the extent to which it raised good news stories to improve the overall perception of the Trust.

VO joined the meeting.

Board of Directors decision/agreed actions:

- The Board of Directors noted the 2014 NHS Staff Survey Results. — Noted
- NW asked that the Workforce Committee report back to the Board in four/five months' time on areas of focus and actions being taken. — SLB
- NW requested the publication of the staff survey via the Trust's website include a statement of how the Board received it and actions being taken going forward. — SLB

47/15 **CORPORATE RISK REGISTER – TOP 10**

JP presented the Top 10 Risk Register. The following was noted:

Page 4 of the report ranked the highest 10 risks. A new risk had been added since the last meeting related to Health and Safety non-compliance. This risk had been analysed scoring 9, post mitigation 6 with actions to complete by September 2015.

Emerging risks were detailed on page 2 of the report.

Board of Directors discussion:

RE was comfortable with the emerging risks. However, he felt further work was required to identify risk mitigation. He referred to 1.71 and 1.72 related to Kent Pathology Partnership.

JS added the group of financial risks needed to be reviewed to reflect the current financial position. Financial risks needed to be integrated with the quality risks and were critical to delivery of the clinical strategy.

JS asked for clarity regarding the status of laminar flow at QEQM. LS stated that statutory testing failed on the second inspection. Appropriate work was being taken forward.

There was a discussion as to whether risks could be grouped, such as financial risks. AF felt it would be easier to not group them as some would have a different mitigation.

CB asked when the speech and language therapy risk would reach a conclusion. JE stated commissioners had agreed to accept outpatient speech and language therapy to allow Trust staff to concentrate on inpatients.

Board of Directors decision/agreed actions:

- The Board of Directors noted the Top 10 Risks. — Noted
- JP/CB would review the risks to identify links to wider improvement programme. — JP/CB
- JP stated the Risk Management Strategy would be reviewed in light of the Divisional and Board governance reviews. — JP

48/15 **QUESTIONS FROM THE PUBLIC ON PAPERS WITHIN THE STRATEGIC SECTION**

Mr Edel asked how many accredited laboratories there were in Kent. CB/JP explained accreditation was specific to every lab. The Trust would be reconciling CPA standards and the new ISO standards.

49/15 **BOARD COMMITTEE FEEDBACK**

Finance and Investment Committee
JS reported back from the 24 April 2015 meeting. The majority had been covered under minute number 40/15 above:

- Detailed discussion regarding the deteriorating financial position and a more stringent operation plan for 2015/16.
- Detailed discussion regarding cost improvement programme for 2015/16.
- A presentation on new information management initiatives.
- Performance matters arising from the corporate scorecard.
- Update on horizon scanning and commercial tenders.
- ICT review and replacement update.
- Outstanding actions related to Kent Pathology Partnership.

Remuneration Committee and Nominations Committee
RE reported the Committees last met on 19 March 2015. Items discussed:

- Review of Chief Executive and Executive Director end of year performance evaluation.
- Annual review of the pay policy and agreement to re-run the benchmarking of Executive and very senior manager pay.

The Board of Directors approved the revised Terms of Reference for the Committee.

Integrated Audit and Governance Committee
RE presented the report from the meeting held on 19 January 2015. The following was received at the Committee:

- Update on the process for the Annual Report and Quality Report production for 2014/15;
- 2014/15 accounts policies;
- Losses and special payments reports;
- Single tender waiver report Q1 and Q2; and
- Reports from Internal and External Audit.

Charitable Funds Committee
VO presented the report from the meeting held on 23 February 2015. The Committee received the following:

- Update on the Major Appeal (Dementia);
- Fundraising update; and
- Finance and expenditure report.

The Board of Directors ratified the following recommendations:

- The part 36 settlement in the legacy of J Peters; and
- The administration budget of £93,069 for 2015/16.

49/15 **CHIEF EXECUTIVE'S REPORT**

CB observed that forward, the format would be changed to include a statement on the state of the nation and a personal commentary on the Trust's internal position.

Key messages from the report included:

- Update on the national tariff payment system.
- Changes to the timetable for submission of the annual planning timetable.
- Latest Trust developments/initiatives.
- Latest publications and consultations.

50/15 FEEDBACK FROM COUNCIL OF GOVERNORS

NW reminded the Board of Directors of the outcome of the recent Governor elections. Five new Governors were now in place and three seats were subject to by-elections which were anticipated to conclude in May 2015.

The last meeting of the Council of Governors took place on 16 March 2015. Topics at the meeting included:

- CQC Action Plan update;
- NHS Staff Survey Results;
- Presentation from KPMG on the national Governors' survey.
- The Board Governance review (Well Led) and Trust action plan.

The KPMG survey reported EKHUFT Governors as being more engaged compared to the Trust's peers.

The Council of Governors Strategic Committee would be discussing the Board Governance Review further at their April meeting and their views would need to be

reflected in the Board's action plan.

NW had been working with the Lead Governor to review the effectiveness of the Council of Governors. Governor agendas would be aligned to key responsibilities of the Governors. The Lead Governor would be involved in agenda setting meetings going forward.

NW stated input at the Council of Governors Meetings from Non Executive Directors needed to be more formalised. Governors had a key role in holding Non Executive Directors to account for the performance of the Board of Directors. Board Committee Chairs would be asked to report on the work of their Committee. This would also help strengthen Governor/Non Executive working relationship.

RE commented that the role of the Non Executive was wider than the Board and he would be pleased to discuss some of the challenges with the Council of Governors.

VO had been uncertain about the appropriate nature of Non Executive contributions at Council of Governor meetings.

Non Executives aligned to Governor Committees were invited to report back updates. The following was noted:

VO reported from the Patient and Staff Experience Committee:
- A presentation had been received on the latest East Kent Hospitals Charity Major Appeal on Dementia;
- The Committee would be involved in the Trust's Cultural Change Programme.

JP commented the Patient and Staff Experience was a strong Committee and historically worked well with the Trust to support staff and patient projects.

RE reported the Communications and Membership Committee had not met since the last Board meeting. A meeting was planned for April 2015.

NW reported the Strategic Committee was due to meet at the end of April 2015. The Nominations and Remuneration Committee was engaged in the recruitment process for Non Executive Directors and the Chair.

51/15 ANY OTHER BUSINESS

VO reported she had received the Lifetime Achievement Award for Construction.

NW reported a positive visit from Jeremy Hunt, Secretary of State for Health and Charlie Elphick, MP, to the Dover Hospital site.

Ian Dodge from NHS England had visited Kent to look at the Prime Minister Challenge Fund received by South Coast Kent CCG for primary care into Royal Victoria Hospital. The visit had been well received. The visit also included Deal Hospital.

52/15 QUESTIONS FROM THE PUBLIC ON PAPERS WITHIN THE INFORMATION SECTION

Marcella Warburton stated she welcomed the changes to the Council of Governor agenda.

Date of Next Meeting:

Friday 24 April 2015, Board Room, William Harvey Hospital

Signature _____

Date _____