UNCONFIRMED MINUTES OF THE SIXTY-THIRD MEETING OF THE BOARD OF DIRECTORS
THURSDAY 29 JANUARY 2015, 9AM, BOARD ROOM, KENT AND CANTERBURY HOSPITAL

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
Mrs J S Pearce	Chief Nurse and Director of Quality and Operations	JP
Ms E A Shutler	Director of Strategic Development and Capital Planning	LS
Dr P Stevens	Medical Director	PS
Ms S Le Blanc	Director of HR	SLB
Mrs J Ely	Director of Operations	JE
Mr S Bain	Chief Executive	SB
Mr D Baines	Interim Director of Finance and Performance Management	DB

IN ATTENDANCE:

Mrs S Lewis	Improvement Director	SL
David Hargroves	Clinical Chair for the Improvement Plan Delivery Board *(Minute No 01/15 – 07/15)*	DH
Sharon Cannaby	Programme Manager – CQC Improvement Plan *(Minute No 01/15 – 07/15)*	SC
Sally Smith	Deputy Chief Nurse *(Minute No 08/15-09/15)*	SSm
Liz Colman	Head of Patient Experience *(Minute No 08/15)*	LC
Helen O'Keefe	Associate Chief Nurse *(Minute No 09/15)*	HO
Finbarr Murray	Director of Estates *(Minute No 17/15)*	FM
Bruce Campion-Smith	Head of Equality and Engagement *(Minute No 18/15)*	BCS
Mrs S Swindell	Assistant Trust Secretary (Minutes)	SS

MEMBERS OF THE PUBLIC IN ATTENDANCE:

John Sewell	Elected Governor – Shepway	JS
Mr and Mrs J Smith	Members of the Public	
Sarah Andrews		

MINUTE NO.		ACTION
01/15	**CHAIRMAN'S WELCOME** NW welcomed members of the Board, Governors and members of the public to the meeting. JE has been confirmed as substantive Director of Operations and NW offered congratulations on behalf of the Board of Directors.	
02/15	**APOLOGIES FOR ABSENCE** Mrs A Fox, Trust Secretary Prof C Corrigan, Non Executive Director Mr P Presland, Non Executive Director Ms S Le Blanc, Director of HR	

03/15 **DECLARATIONS OF INTEREST**

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

04/15 **MINUTES OF THE PREVIOUS MEETING – 28 NOVEMBER 2014**

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

Matters Arising:

RE referred to page 4 of the minutes where It had been confirmed provision for the CQC improvements had been included in the accounts for this year. He highlighted that a paper for this meeting indicated there was no identified budget.

DB responded improvements had been funded by using development monies available to the Trust and contingency funds. DB agreed to clarify for the Board those expenditures linked to the CQC improvement plan, historically and in the future. DB

NW highlighted there would be additional expenditures resulting from the Board Governance Review and PWC Divisional Governance Review going forward.

05/15 **MATTERS ARISING FROM THE MINUTES**

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

<u>215/14 – Clinical Quality and Patient Safety Report</u>
NW expressed an urgency for addressing mandatory training compliance across the Trust.
JP reported a timeline was in place for procurement of alternative systems. In the meantime, dedicated areas had been identified for staff to use.
SLB would be asked to circulate outside of the meeting an improvement trajectory for Mandatory Training compliance. SLB
The action regarding an update on the position of the work being undertaken by HR to address recruitment and retention of overseas nursing would be carried forward to the next Board in the absence of SLB. SLB

<u>266/14 – Key National Performance Targets</u>
JE confirmed the report for today's meeting included length of stay. Reportable delayed discharges were reported daily and JE would be reviewing how this would be reported to the Board. She would keep the Board updated. JE
JE confirmed agreement had been received from the area team to the Trust's plans to continue 18 week RTT non-compliance until April 2015 to address the backlog position. Noted

06/15 **CQC ACTION PLAN UPDATE**

David Hargroves, Clinical Chair for the Improvement Plan Delivery Board, was in attendance for this item.

DH referred to the actions from the last Board asking for assurance about the existence of an evidence log, dashboard and risk register.

A dashboard had been finalised and was operational. An example was provided as part of the report.

With regard to an evidence log, SharePoint would be used as a platform. A template was being finalised and it was anticipated this would be operational before the next Board meeting.

DH went on to report the latest position against the CQC action plan, drawing attention to the following areas reported as red:

- Electronic policies and guidelines: the original timeline was ambitious. The revised timeline for completion was July 2015.
- A&E: Further assurance was required regarding a robust paediatric pathway (appropriately skilled staffing at all times).

The Improvement Programme Board was taking a more stringent role in reviewing evidence to support delivery of all areas within the action plan.

DH referred to areas of concern/delay:

- Ensuring NICE Guidelines were being adhered to by all staff. This consisted of two factors: ensuring guidelines were up to date and were accessible to all staff.
- Key Findings from complaints: A revised complaints procedure was now in place, signed off by the Quality Assurance Board in February 2015.

Board of Directors discussion:

NW referred to critical improvement work required to establish a robust paediatric pathway and asked for assurance in terms of timelines for delivery. RE further asked what evidence was required to demonstrate progress.

JE and JP were working with Divisions to ensure an agreed pathway was embedded. Progress was being made, specifically at QEQM. However, estates work to establish a dedicated paediatric area at WHH continues. The recovery plan aims for a 'blue' RAG position in March 2015.

DH added he worked as a clinician in A&E on a weekly basis. He would obtain clinical assurance through regular discussions with staff.

SL provided assurance to the Board that when an area on the improvement plan reported 'red', she would expect to see a clear recovery plan in place.

VO commented the reporting methodology used in the report did not provide assurance to the Board and more evidence based reports were required. NW agreed and added the Board would need to be aware of areas not making progress and recovery plans in place. DH would take this on board for future reports.

JSp found the dashboard difficult to understand and asked if a glossary could be incorporated into future reports. DH would reflect on comments made and explained inclusion was intended to provide assurance a dashboard was in place.

SL explained Monitor use the dashboard as an assurance tool and it was important the Board of Directors understand the this tool and agree it provided appropriate levels of assurance.

JP reminded the Board of Directors assurance could also be external. She referred to work undertaken by HealthWatch to measure the impact of partial booking on patient experience as a specific example.

Board of Directors decision/agreed actions:

- The Board of Directors noted the updated position. — Noted
- NW reminded DH of the process for the Board to have sight of the NHS Choices Submission to enable the opportunity comment. DH agreed to ensure this was made available prior to Board meetings. — DH
- NW asked that the next report provided an update on progress against improvements in the paediatric pathway in A&E. — DH
- DH would reflect on comments made regarding the terminology used in future reports to provide more evidence based reporting. — SLB
- SLB would be asked to provide a specific update on the staff engagement programme at the next Board. — DH
- DH would reflect on comments made regarding the dashboard and the Board's level of understanding of assurance.

07/15 **PROGRESS AGAINST CQC RECOMMENDATIONS: IMPROVEMENT**

SL presented the report which summarised her view of the Trust's position against the CQC action plan to date.

SL recognised the CQC report was wide ranging with significant work to be taken forward and embedded. There was solid programme management now in place with a more stringent RAG rating process.

SL had spent time re-reading the CQC report and encouraged all Board members to do the same as the organisation had moved on significantly since the time of inspection.

SL stressed the importance of mapping all Trust ongoing programmes (quality, strategy) and action plans resulting from external governance reviews to ensure a consistent approach and timelines.

SL drew attention to recommendations in the report which the Board was asked to consider.

Board of Directors discussion:

PS commented communication underpinned all of the Trust's ongoing strategies and improvement plans. He referred to the recommendation in the report to review direct and indirect communications and asked SL to elaborate.

SL responded she would expect to see clear plans in place on how the communications would change as a result of the CQC Improvement Programme. It was important staff felt listened to. She referred to the PWC Governance Review which highlighted the complexity of tracking communications within all levels of the organisation.

PS referred to the importance of checking understanding of communications and challenges of obtaining this assurance in a large organisation such as EKHUFT.

He asked if SL could share any learning.

NW reminded the Board of the communications element to the staff engagement project to look at areas for improvement.

RE referred to the role of the Board and the importance of balance between supporting staff delivering and embedding improvements and holding to account.

RE and JSp provided their support to the notion to consolidate recommendations from all improvement plans into groups. They also supported the point made in the paper to move towards outcomes focussed approach. NW stressed it was important to evidence improvements put in place and begin preparations for a CQC re-visit without delay.

RE further added, and the Board and SL agreed, in some areas the Trust was reliant on action taken by external partners and commented the Board needed to consider ways in which it could influence this.

NW referred to the Board to Board meetings with CCGs which could be used to influence key improvement areas.

JE commented the Trust could evidence work undertaken jointly with the community on specific pathway issues.

JP stated the CQC report had brought a different dimension to improvements needed in the Trust to ensure Staff were appropriately supported and appropriately resourced.

Following a question raised by VO, SB confirmed the CCGs were invited to attend Improvement Board meetings but declined. DH felt there could now be an opportunity to re-engage and agreed to take this forward.

JSp commented a comprehensive workforce strategy needed to link to the improvement programme.

SB provided assurance the critical points of failure in the CQC report had been addressed.

Board of Directors decision/agreed actions:

- The Board of Directors agreed the report from SL had been helpful. It was agreed the next Board Away Day would focus on a review of the CQC Action Plan and recommendations within SL's report. Divisional Director involvement would be sought. — SB
- SL agreed to work with DH to identify proposals for a unified (themed) approach to the different strands of the improvement work and reporting assurances at Board level. — SL/DH
- SB agreed to establish an executive group with NED involvement if appropriate to prepare for CQC re-inspection. — SB
- DH agreed to approach the CCGs to invite them to participate in Improvement Board meetings. — DH

08/15 **CLINICAL QUALITY AND PATIENT SAFETY REPORT, TO INCLUDE:**

- **APPENDIX 1 – NURSE STAFFING DATA**
- **APPENDIX 2 – COMPLAINTS, CONCERNS AND COMPLIMENTS**

JP presented the report and highlighted the following specifically:

- There were no MRSA bacteraemias reported in December 2014. One case was reported in November 2014 and was assigned to a third party.
- Three cases of *C.difficile* were reported in December 2014. This was an improved position and had continued into January 2015. Performance had moved towards trajectory levels but remained a high risk.
- HSMR national data had not been updated since July 2014. The Trust was using other mechanisms to monitor performance.
- Further discussions had taken place with the CCG to agree mixed sex accommodation criteria. It was anticipated this would be finalised by the end of this month. Clinically justifiable areas had been amended.
- Appendix 1 of the report provided the latest nurse staffing data. An improved position at QEQM and WHH was noted. A more comprehensive report would be discussed later on the agenda.

Board of Directors discussions (Clinical Quality and Patient Safety Report):

RE referred to delayed transfers of care and asked if the Trust had identified new initiatives to improve the position.

JE referred to the integrated discharge team now in place. Work would continue with the community to establish a consistent approach to decision making criteria at the point of discharge. She further stressed the importance of understanding community capacity and ensuring internal processes were robust.

SB commented there were workforce issues across community services in Kent and this strategic issue needed to be addressed.

VO complimented the Trust on the decreasing harm free care rate which reported at 91.9% for December 2014. She went on to refer to the nurse sensitive indicators and felt these reflected a disappointing position in relation to pressure ulcers.

With regard to harm free care, JP provided assurance the Trust was working with community colleagues to continually strive to improve reported rates.

JP went on to respond to VO's observations in relation to pressure ulcers. She referred to the overall trends which reported the Trust above trajectory levels. Robust improvement plans were in place for pressure ulcers and falls and these had been shared with the Board previously. JP would be pleased to discuss this work outside of the Board in more detail.

PS reported additional work was being undertaken to understand and monitor the Trust's mortality rate by reviewing the crude mortality and RAMI measure.

NW commented quality and patient safety performance reported a broadly stable position. He proposed a broader view be taken when developing the 3 year quality strategy to benchmark what can be achieved and what would be required.

JSp asked if there were lessons learned from the perfect week. JE responded this

was being evaluated and would be reported to the Integrated Care Board.

SB reported the Trust had reported three C.difficile cases in 60 days across the Trust. This was a significant achievement in light of the operational pressures faced by the organisation over the last few months.

Complaints Performance

Sally Smith (SSm), Deputy Director of Nursing, and Liz Colman (LC), Head of Patient Experience, were in attendance for this item. SSm provided a presentation to the Board on complaints performance. There had been an increase in formal complaints following the publication of the CQC Report. The number of complaints had now reduced to normal levels but further improvement work was being undertaken, including response times to complaints which reported an inconsistent position across all areas. Although the number of compliments significantly outweighed the number of complaints, there had been a decrease which was a concern.

The presentation included: the latest complaints data, main themes and hot spots; and recommendations and improvement work going forward. The Trust had also improved processes for raising awareness of the complaints process to patients.

Board of Directors discussion (complaints performance):

NW reported back the following key messages as a member of the Complaints Steering Group:

- There were challenges with response times, specifically receiving feedback at Divisional level;
- Sharing learning from complaints widely across the Trust was recognised as important to ensure that issues had been recognised and lessons learned;
- PALs was now available on all sites; and
- There was recognition there needed to be more medical engagement with the We Care Programme and communications improvement work.

PS reported complaints formed part of the consultant development programme. Individuals requiring further support were identified. PS also felt the process for investigations needed to be streamlined.

SB referred to previous data published by NHS England which reported a 25% higher level of complaints in the South East and London compared to other parts of the country.

VO commented learnings needed to be identified and put in an improvement programme to ensure these were embedded across the Trust.

SL added links needed to be made to the duty of candour and JP confirmed this work had commenced.

PS commented the 'In Your Shoes' programme was effective. Listening to experiences of relatives and patients had a positive impact.

LS asked for assurance that the complaint themes identified did not mask other issues such as transport, cleaning and estates issues. She stated there was the

opportunity to undertake proactive work to take forward improvements across the Trust.

SSm provided assurance more detail was available in terms of the specifics of complaints and these were passed on to the appropriate areas.

JE commented the PALs service was a temperature gauge for emerging issues.

Board of Directors decision/agreed actions:

- The Board of Directors noted the latest performance position. — Noted
- NW requested the next report provide more detail on the work being undertaken to understand the Trust's mortality data. — JP
- RE asked if future reports could include complaints by staff group to identify particular hot spots. RE asked if research could be undertaken to understand the motivation to complain. SSm and LC would take this forward. — SS/LC

09/15 **WARD ESTABLISHMENT REVIEW (6 MONTHLY REPORT)**

Helen O'Keefe (HO), Associate Chief Nurse, was in attendance for this item.

HO explained the review undertaken covered adult wards, paediatric wards and critical care units as standard but this particular audit also included emergency departments, ambulatory care and theatres. She provided a presentation to the Board to include: A reminder of the Quality Board expectations; Investment into ward staffing during 2014/15; the methodology and tools used to conduct the review; conclusions; and priorities for action.

Board of Directors discussion:

The average ratio of registered nurses to patients did not exceed 1:8 during the day, but the ratio was higher at night. The Trust had reported above 13 patients per registered nurse in 6 areas. However, this would be reviewed to take into consideration twilight shifts.

There was a higher midwife to birth ratio in the community. This would be reviewed as part of the workforce strategy.

HO explained there was a disparity at WHH between the staffing levels reported and professional judgement. The levels reported were appropriate but the perception was different.

A review of staffing levels within emergency departments would be undertaken ahead of the publication of NICE Guidance (currently out for consultation).

SB reminded the Board of Directors there were different workforce models being explored by the Trust and this would need to be borne in mind when assessing against the national formulae.

RE asked how this audit would link to the Trust's broader workforce planning going forward. He referred to the increase in agency requirement and felt it was important to understand the current position and the future workforce strategy.

HO was working closely with the HR Team to develop the nursing workforce. She

provided an example where a change in the way HCAs were recruited had improved vacancy rates. She went on to say the workforce plan included the need to work in partnership with London hospitals to address retention issues. Guy's and St Thomas' in particular were interested in work with the Trust to enhance recruitment and to share costs.

JSp commented the continued pay restraint on permanent staff would impact further on retention issues.

NW stated there needed to be a more explicit view of workforce issues reported to Board.

JP responded that improving recruitment and retention was linked to the workforce component of the clinical strategy programme with the aim of identifying sustainable staffing levels. LS added the workforce workstream had not progressed as quickly as hoped and needed to be strengthened. She would be interested in linking the audit work undertaken.

VO referred to the proposals to manage staffing issues and asked how this was taken forward and embedded to ensure continuous improvement.

JP responded these were professional conversations which take place with staff on an ongoing basis.

Board of Directors decision/agreed actions:

- The Board of Directors noted the report and agreed future six monthly reports should be by exception. — Noted
- LS agreed to link the audit work to the workforce work stream of the clinical strategy. — LS
- JSp proposed, and the Board agreed the business case presented to FIC for additional investment include benefits achieved with the existing investment, action taken to optimise the current resource levels and consequences of not securing additional investment. The business case should also identify potential costs and whether these could be factored into the CQC programme or service development budget. — HO
- NW referred to page 2 of the written report which highlighted costs for NHS Professionals had continued to rise. He asked the Trust's workforce strategy include actions to address this. — SLB

10/15 **PATIENT STORY**

JP presented the report which reflected positive patient stories sent to the Trust by patients and their families. They demonstrated how care can continue to be delivered in an effective and caring way, despite operational pressures faced by the Trust.

SB referred to challenges faced by Clarke Ward and reported he received a number of compliments about the excellent care, communication and team working in this particular area.

JP confirmed where staff members were named in reports, they are informed and their efforts recognised.

Board of Directors decision/agreed actions:
The Board noted the report and recognised there was a need to balance the sharing of positive experiences with learning from incidents and complaints. Noted

11/15 **KEY NATIONAL PERFORMANCE TARGETS**

JE presented the report. She commented going forward she would need to ensure the level of information given to the Board was equal to the detail provided to Monitor and the area team.

A&E – 4 Hour standard

JE reported operational challenges continued in December with increased activity, extra beds and additional staffing. The target reported 88.5% for December 2014.

During January 2015, the Trust's performance had improved and 95% had been achieved on certain days. However, challenges remain and compliance in Quarter 4 was at risk. Performance would continue to be monitored on a day by day basis.

Discussions were ongoing with external partners to address health economy wide challenges. The Trust's performance was compromised by delayed transfers of care in particular. As part of the contract negotiations, there was recognition the integrated discharge team was a positive development for continued support.

NW reported there was significant external scrutiny and a directive had been received from Monitor to embed improvement. The Board would need to be assured the Trust was taking all action within its control.

JE responded this was work in progress. However, the number of patients seen and assessed in the first hour of attendance had significantly improved on both sites.

18 weeks RTT

JE reported increased demand continued in orthopaedics, general surgery and ophthalmology. She reminded the Board of the agreement to report non-compliance until April 2015 to enable the backlog to be addressed. This had been agreed by Monitor and the CCGs.

Plans were in place to bring the Trust to a compliant position from April 2015.

The backlog position appeared to decrease in December 2014. The CCG had commenced a validation process of referrals from mid-December. The Trust was monitoring the impact.

NW asked the backlog trajectory leading up to and from April 2015 be made clear to the Board in future reports. JE advised it would be down to a level that could deliver an aggregate of 90%. There were areas of possible slow growth but a review of pathways was being undertaken to mitigate this.

Diagnostics

The Trust reported a compliant position for December 2014. There were challenges in endoscopy and cardiology and this would be monitored.

Cancer

The Trust reported a high level of 2-week wait referrals in December 2014. This had impacted on January 2015 and it was unlikely the validated position would report compliance for the quarter as a whole. This was being monitored on a day by day basis.

SB highlighted previously non-achievement of the diagnostic target had impacted on cancer performance. As this target was compliant, he asked what other elements were contributing to non-achievement.

JE responded it related to activity volumes and availability of specialist consultants.

Board of Directors decision/agreed actions:

- The Board of Directors noted the performance position. — Noted
- JE would be reviewing the report and invited comments from the Board. The Council of Governors had made some proposals and these would be sent to JE. — JE
- NW asked the backlog trajectory up to and beyond April 2015 be made clear to the Board in future reports. — JE
- Detailed learning from the 'Perfect week' would be included in future reports. — JE
- JE agreed to circulate detailed assurance provided to Monitor on how indicators would be monitored and trajectories developed. — JE

12/15 **CORPORATE PERFORMANCE REPORTS**

DB presented the report as at December 2014 which had been discussed at the Finance and Investment Committee on 26 January 2015. DB drew attention specifically to: activity; income and expenditure; and cash position. The following key messages were noted:

- Activity reported 2.9% above plan in December 2014. However, year to date, activity reported 1.3% behind plan. Over performance was driven by areas of outpatients and day case admissions which had been underperforming.
- Other PBR contracts reported 3.9% above plan. Over performance was driven by cardiology, general medicine and NICU specialised care.
- Primary care referrals reported 4% above plan. The main growth area was T&O.
- The financial position at month 9 reported £2.9m adverse to plan. Key drivers were CIP shortfalls, winter pressures and two risks (RTT and high cost drugs). The forecast position had worsened for the same reasons. There had also been identified issues with aseptic suite write-offs and SCG incorrect charging for drugs.
- The COSR reported at 3 (lower than the planned 4). This would impact on I&E. Assurance was provided a COSR of 3 could be maintained.
- The cash position was £1.2m higher than plan.

JSp reported (as Chair of the Finance and Investment Committee) the Committee had discussed the deterioration of EBITDA and I&E in detail. This would impact on the cash position in the long term. The Committee would be reviewing the planning framework for next year to include: impact on contingency levels; and review of service development priorities. The Committee also discussed the financial constraints in the wider health economy and impact on the Trust's planning assumptions.

NW reported the External Board Governance review had put forward a recommendation to increase financial discussions at Board level. Although financial performance was discussed in significant detail at the Finance and Investment Committee, as challenges continue to increase, the Board of Directors would need to receive more comprehensive reporting.

Board of Directors decision/agreed actions:

- The Board of Directors noted the finance and activity position as at 31 December 2014. — Noted
- The Board of Directors receive a detailed Corporate performance Report outside of the Board meetings. Members were encouraged to put questions to JSp (FIC Chair), DB or raise at the Board. — All
- PS stressed the importance of ensuring all staff were aware of the Trust's financial position and encouraged to be involved in discussions. — DB
- More comprehensive financial reporting and discussion at Board level would be taken forward. — DB/All

13/15 **QUARTER 3 RETURN TO MONITOR**

DB presented the report and the Board of Directors agreed it reflected an accurate financial and performance position as reported to the Board during the last quarter.

The Board of Directors declared, on assuring themselves of the evidence, that not all healthcare targets and indicators had been met. The Board of Directors agreed the exception reports supporting the areas of non-compliance listed below reflected an accurate position: — Agreed

- *C.Difficile*
- A&E 4 hour wait
- Cancer – symptomatic breast, 62 day GP, and 31 day subsequent surgery
- RTT 18 weeks admitted and incomplete

The Board of Directors, on assuring themselves of the evidence, declared the Continuity of Service Risk Rating was confirmed as Rating 3. The report stated rating 4 in error and this would be amended prior to submission. — Agreed

The Board of Directors anticipated the Trust would continue to maintain a continuity of service risk rating of at least 3 over the next 12 months. — Agreed

14/15 **REVIEW OF ONGOING COMPLIANCE AGAINST SELF CERTIFICATION**

SB stated the Trust had properly assessed risks and Quarter 3 performance reflected the forecast position.

The IAGC receives reports from the Trust Secretary comparing planned against actual performance.

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

Mr Smith supported NW comments that mandatory training compliance needed to be improved.

Mr Smith congratulated the Trust on the Grade 3 and 4 pressure ulcers which reported below trajectory. He further relayed a positive personal experience of CDU.

16/15 **DIRECTORS FIT AND PROPER PERSONS TEST**

In the absence of SLB, the Board of Directors endorsed the recommendation to implement the mandatory requirements for all new board director positions using the guidance included in the report, subject to the following:

- VO highlighted it would be a challenge to obtain a reference from a recent employer for NEDs. This would be fed back to SLB. SLB

SLB would be asked to clarify whether assessment was required for existing Board members and take forward as necessary. SLB

17/15 **ESTATES DEVELOPMENT PARTNERSHIP**

Finbarr Murray (FM), Director of Estates, was in attendance for this item. He provided a presentation which reminded the Board of Directors of the background to the estates development partnership and key drivers; delivery vehicles researched; principles adopted; criteria used; and assessment and outcome. The paper accompanying the agenda provided the detail.

The presentation also included a summary of the outcome of the assessment which included the benefits and KCC's suitability as a partner organisation.

LS reminded the Board this partnership would run alongside the clinical strategy.

The Board of Directors received a draft report in closed session in December 2014 and LS had responded to requests for timescales and assurances around the rigour of projects in terms of the benefits to the Trust's core business.

The partnership had been presented to the Council of Governors at their meeting in January 2015.

Board of Directors discussion:

RE confirmed the paper presented had answered concerns raised at the December closed meeting of the Board of Directors and supported approval.

JSp agreed and reminded the Board the partnership would not rule out other options available to the Trust.

JP stated going forward it would be sensible to articulate the benefits of the partnership arrangements more widely, specifically in terms of operational benefits and patient experience.

PS commented the partnership had the potential to improve recruitment and retention. He referred to opportunities for innovative simulation training facilities.

NW commended FM on the clarity of the report which laid out the advantages and disadvantages in a clear way.

Board of Directors decision/agreed actions:

- The Board of Directors endorsed the recommendation the Trust enter into a Public Estates Partnership with KCC and by doing so create a jointly owned separate entity by which the Trust can deliver its strategic aims and aspirations. Agreed
- The Board of Directors endorsed the following next steps to take this forward:
    - Establish governance and partnership structure – March
    - Key initial work streams in place - April
        - Finance
        - Legal
        - Programming
        - Service Improvement
    - Develop Master Plan aligned to Clinical Strategy - May
    - Dialogue with Monitor and CCGs

18/15 **ANNUAL EQUALITY REPORT**

Bruce Campion-Smith (BCS), Head of Equality and Engagement, was in attendance for this item. He presented the report which concluded that in almost all respects there was no difference in the delivery of services, patient outcomes and the treatment of staff based on protected characteristic status. The Equality Act 2010 Regulations required every public authority to publish information to demonstrate compliance.

BCS further reported the Equality Council for NHS England was currently discussing changes to the Standard NHS contract which would include a workforce race equality standard and the requirement to implement the equality delivery system. The change was anticipated from April 2015.

At present, the standard was based on race but it was likely this would extend to other equality groups. BSC drew attention to indications the Trust would be required to report the percentage of BME staff in bands 8-9 compared to the overall workforce; percentage of BME staff experiencing discrimination.

BSC would lead on developing report metrics and was working closely with SLB.

Board of Directors discussion:

PS highlighted the NHS had a different BME in comparison to its local populations. VO further commented areas of prejudice were complex. BCS responded the Equality Council had made no mention of staff BME in comparison to local population.

DB asked whether measures would be relative in terms of improvement and whether there were financial penalties. BCS responded this was not known until the guidance was published by the Equality Council.

VO referred to the monitoring report and noticed female workers tended to take more time off than male workers. In addition, part time workers were more likely to be absent compared to full time workers. She asked if sufficient support mechanisms were in place to manage this.

JP responded absences were not necessarily related to child care but were also related to responsibilities for older relatives. The Trust operated a flexible working

policy.

Board of Directors decision/agreed actions: Noted
The Board of Directors noted the report and approved publication. BSC/
The Board of Directors noted the potential changes to the standard NHS contract from April 2015. BSC would inform of the outcome via SLB. SLB

19/15 **QUESTIONS FROM THE PUBLIC ON PAPERS WITHIN THE DECISION SECTION**

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

20/15 **DELIVERING OUR FUTURE PROGRAMME: UPDATE ON CLINICAL STRATEGY**

LS presented the report and drew attention to the following:

- There was concern around the ability of clinical and operational staff to support the clinical strategy due to the continued focus on operational pressures.
- Estuary view opened 26 January 2015. Visits could be organised for interested Board members.
- The Dover development was progressing well. It was discussed at the Finance and Investment Committee the hospital would open in April 2015, a delay of one month.
- Positive engagement events continued with CCG colleagues. A more integrated approach to service care was being articulated and supported.
- The work to identify the number of inpatient beds on a hub site was being finalised.
- Public engagement had been finalised with support from HealthWatch.
- A presentation was planned at the HOSC for 30 January 2015. The CCG would also be attending to discuss integrated working.

Board of Directors discussion:

NW asked if staff engagement around the clinical strategy work was being progressed and asked for confirmation that wide understanding amongst staff would be in place prior to consultation.

LS responded the initial phase was to identify the potential hub and spoke model. This was planned for the March Board of Directors. In terms of engagement, this was improving and engagement events would continue. Staff requested understanding of the key drivers and it was important to articulate this when the options go out to consultation.

LS went on to say the interim and long term plans would need to be clearly explained as part of the consultation. The Trust's long term sustainability needed to be clearly articulated. Three sites were unsustainable long term.

SB raised a potential political risk as the general election draws near.

Board of Directors decision:
The Board noted the update as reported. The following proposals were put forward and LS agreed to explore these further:

- Timeframes would be mapped and clarity around the criteria for hub decision LS

(from a clinical and safety point of view) would be included as part of the consultation. LS

- Staff awareness and understanding would be progressed prior to consultation. LS
- The agreed partnership arrangement with KCC be articulated as part of the consultation. A view what the long term single hub site would also be considered. LS
- Costs would be clearly articulated in the consultation. LS

SB reminded LS of discussions to circulate a questionnaire to new patients at Estuary View to obtain feedback on the quality of services provided. LS agreed to follow up.

21/15 **CORPORATE RISK REGISTER - FULL**

JP presented the full risk register which was presented to the Board twice per year with the Top 10 presented in interim months.

Work was in progress to fully revise the full register with Executive colleagues.

JP invited views on the risk register and to identify areas for potential deep dives at the Quality Committee or Integrated Audit and Governance Committee.

RE had put forward proposals for development of the risk register at the Integrated Audit and Governance Committee. JP confirmed these would be progressed.

NW reported the External Board Governance Review had made specific reference to the way in which the risk register was used. This would be addressed as part of the Trust's response to the recommendations in this report.

Board of Directors decision/agreed actions:
The Board of Directors noted the report. Noted

22/15 **QUESTIONS FROM THE PUBLIC ON PAPERS WITHIN THE STRATEGIC SECTION**

SA commended the Board on its energy during the morning's discussions.

23/15 **MEDICAL DIRECTORS REPORT: ALCOHOL NCEPOD SELF-ASSESSMENT**

PS presented the report. One of the concerns raised by the CQC report was the need to strengthen the Trust's response to NCEPOD reports.

The NCEPOD report 'Measuring the Units: A review of patients who died with alcoholic related liver disease' was published in 2013. The Trust had undertaken a self- assessment against the recommendations and this was included in the report presented. The self assessment concluded development of a comprehensive alcohol related disease service was required within the Trust.

The intention of the paper was to ensure Board understanding of what was required and resource implications. PS was looking at mechanisms to help develop the ideas in the report.

The Board agreed the end result would be a more comprehensive service than presently received.

NICE Guidance Compliance

PS drew attention to the CQC recommendation related to compliance with NICE guidance. He reported the Trust was reviewing all Trust data for pace making (by site and by individual) in line with NICE guidance and national benchmarking data. Nationally, 73% of pace maker insertions were dual chamber. The Trust reported 55%. There were specific reasons why dual pacemakers were used and a comply or explain approach was being taken.

The Trust had written to comment on NICE guidance and recently published national audit and aggregated hospital data. Awareness would be raised in the Trust.

24/15 **BOARD COMMITTEE FEEDBACK**

Finance and Investment Committee Chair's Report
The Chair's report was tabled due to the timing of the Committee meeting. JSp drew attention to the following:

- The Committee received an update on the HIS review.
- An update on the 2015/16 business plan was received. Projections were presented for the year ahead and subsequent years. This demonstrated further improvements were required to secure long term sustainability.
- The CIP Programme was being approached with more rigour.
- A detailed discussion took place on the Trust's financial position as reported under minute number 12/15.

Remuneration Committee Chair's Report
RE presented the report which updated the Board on the executive director and CEO recruitment processes to date.

Integrated Audit and Governance Committee Chair's Report
This report would be deferred to the next meeting.

Quality Committee Chair's Report:
A report was not available due to timing but NW verbally reported feedback to the Board:

- Positive discussions took place around clinical audit with division representatives in attendance and agreement reached on the need to ensure it is more effectively taken forward in the Trust.
- Following receipt of the External Board Governance Review, the Committee would review its chairmanship, membership and frequency.

JSp referred to feedback from the External Governance Review that the Finance and Investment Committee stray into operational performance discussions. There were links between activity and finance and this would need to be reviewed.

25/15 **CHIEF EXECUTIVE REPORT, TO INCLUDE: TRUST SEAL ACTIVITY**

The report was noted. SB drew attention to section five which included the latest

Trust Developments and initiatives. He referred to the imminent opening of the end of life for relatives at Kent and Canterbury Hospital. NW emphasised that this had been made possible following generous support from the League of Friends.

26/15 **FEEDBACK FROM COUNCIL OF GOVERNORS**

NW provided the following feedback from the 16 January 2015 meeting:

- The Council received an update on the Staff Engagement Project. The CoG Patient and Staff Experience Committee would be further engaged.
- The Council received three possible options for the local indicator to be tested as part of the Quality Report production. A vote would be conducted over the next week.
- The Council received an update on the 2015/16 business plan developments. The Joint NEDs and Governors meeting in February would receive a further update and a draft written plan for comment.
- The Estates Development Partnership was presented.

Going forward, NW explained Council meeting agendas would need to be strengthened to link to the key role of Governors to hold to the NEDs to account. NW would explore this with the Lead Governor. NW

27/15 **ANY OTHER BUSINESS**

JSp asked if a visit could be arranged to the endoscopy unit at WHH. LS would take forward. LS

RE was the NED representative on the NHS England peer review of trauma services. The outcome was positive and demonstrated sound staff engagement.

VO attended level 3 child safeguarding training. She reported the content and quality was excellent. During the margins of the day staff had fed back concerns about not being informed of construction work in physiotherapy outpatients and concerns regarding the additional pressures during the 'Perfect Week' pilot.

SL reported the 'Star Chamber' proposed by Monitor was unlikely to take place as the preliminary work had been successful.

SB reported a Deanery Visit had taken place in Anaesthetics. Feedback had been positive, specifically from junior staff across all areas visited.

NW made the Board aware of the press interest in the remuneration of the Interim CEO. Assurance was provided the Remuneration Committee of the Board had reviewed benchmarking data and public sector payment rules.

Date of Next Meeting:
Friday 27 March 2015, Lecture Theatre, QEQM

Signature _____

Date _____