UNCONFIRMED MINUTES OF THE SIXTY-FIRST MEETING OF THE BOARD OF DIRECTORS THURSDAY 30 OCTOBER 2014, 9 AM, THE BOARD ROOM, KENT & CANTERBURY HOSPITAL, CANTERBURY

PRESENT:

Dr J P Spencer	Non Executive Director (Chair)	JS
Mr S Bain	Chief Executive	SB
Mr J Buggle	Director of Finance and Performance Management	JB
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

IN ATTENDANCE:

Mrs J Ely	Interim Director of Operations	JE
Mrs A Fox	Trust Secretary	AF
Mr P Gilmour	Director of Communications	PG
Mrs D Higgs	Consultant Nurse, Critical Care (Minute No. 250/14)	DH
Mrs S Lewis	Improvement Director	SL
Mrs D Boorman	Committee Secretary (Minutes)	DB

MEMBERS OF THE PUBLIC IN ATTENDANCE:

Ms K Ashenden	Pfizer	KA
Mr P Durkin	Elected Governor (Swale)	PD
Mr J Murray	Deloitte	JM
Mr M Orchard	Observer	MA
Junetta Whorwell	Elected Governor (Ashford)	JW
Matt Williams	Elected Governor (Swale)	MW

Item 250/14 was taken out of order but is recorded as per the agenda for consistency.

MINUTE NO.		ACTION
232/14	**CHAIRMAN'S WELCOME** JS (Deputy Chairman) welcomed members of the Board, Governors and members of the public to the meeting.	
233/14	**APOLOGIES FOR ABSENCE** Prof C Corrigan — Non Executive Director Mr P Presland — Non Executive Director Ms S Le Blanc — Director of HR and Corporate Services Mr S Tucker — Non Executive Director Mr N E J Wells — Chairman	
234/14	**DECLARATIONS OF INTEREST** SB, JB and PS were noted as nominated Directors of EKMS and SB/JB of Healthex.	

MINUTE NO.		ACTION

235/14 **MINUTES OF THE PREVIOUS MEETING HELD ON 26 SEPTEMBER 2014**

The minutes of the previous meeting were agreed as an accurate record, with the following amendment:

Page 3. 215/14: for clarity the seventh bullet point should read:
"There were 41 incidents relating to staffing in August 2014. VO raised the possibility of correlation between staff shortages and a higher number of incidents of falls etc. but no link was evident".

236/14 **MATTERS ARISING FROM THE MINUTES**

The Board of Directors noted the updates from the previous meeting included in the report. The following verbal updates were noted:

195/14 Annual Review of the Patient Access Policy
There was concern that referrals back to a GP could result in an extra delay in the pathway. JE was linking with the CCGs on the policy, but stressed that any clinical conversations must emphasise the importance of speedy referrals.

215/14 Clinical Quality and Patient Safety Report
Ward staffing data was being worked on to provide the Board with the level of detail RE had requested. It was hoped to present it to the November Board.

219/14 Corporate Performance Report
Contract Issues were being escalated through the operational group reporting to the PMO and were escalated to the CCGs, particularly regarding bed flow issues in Thanet.

228/14 Chief Executive Report
Capacity issues were raised with Kent County Council and would be followed up in a written report when the data had been collated.

237/14 **CQC ACTIONPLAN UPDATE**

JP presented the first of the progress reports which outlined the High Level Improvement Plan, the key findings and 'must do' items. Whilst the Green rating reflected work was in progress, JP cautioned that it was at an early stage and there were likely to be delays in some areas in such a complex programme.

An Improvement Plan Delivery Board had been established as the over-arching board and appointment of a Programme Director and Clinical Lead was in progress. The Programme Management Office and team had also been identified.

MINUTE NO.		ACTION

A Risk Register, dashboard and issues log were being created and would be presented with the reports to the Board. It was a requirement for the Chairman, CEO and Improvement Director to sign off the monthly action plan report prior to submission to Monitor and NHS Choices, and the next upload to NHS Choices would be made on 10 November.

Effort was being put into aligning future meetings and processes to ensure that the Board was appraised of progress before it was reported. This month SB had provided JS with an update prior to the start of the Board meeting but went on to explain that the Improvement Plan Delivery Board had had its inaugural meeting only the day before; it had agreed that its future meetings would be held on the Wednesday before the Board meeting, which would give time for the draft monthly report on delivery of the action plan to be circulated electronically before the Board meeting, thus allowing the Board to have a discussion based on up to date information, and to ensure proper accountability to the Board.

Board discussion:

RE posed the following questions:

1. Recognising that the work was in the early stages, he asked when the costings would be visible.

   SB advised that this work was in progress and sought to identify different categories of funding, e.g.
   - capital funding that was already committed and needed to be re-prioritised or re-allocated
   - one-off unplanned expenditure
   - funding for 'business as usual' that needed to be performed differently, perhaps with realignment of resourcing
   - additional new recurrent expenditure relating to (for example) enhanced establishment.

   JP added that next year's contracting conversations with Commissioners, including demand, were also an important factor because some of the actions and improvements concerned the whole healthcare system.

2. RE sought assurance that the Board was taking into account the feelings of staff at ward and departmental level in view of the number of action plans and the overall improvement plan.

3. SB stressed the importance of reinforcing that the action plans did not relate to extra activity outside their normal business - it was work that the Trust needed to be doing in a different way. Staff needed to be reassured that there was one overall improvement plan and all the service development, quality and continuous improvement fitted into that. JE added that the Divisional Directors had started to agree and align where strands could be combined A review of capability, capacity and utilisation of skills needed to take place.

MINUTE NO.		ACTION
	RE also stressed the importance of effective training rather than simply being able to report compliance. VO made the following comments: 1. There was concern that the Green rating could give a false sense of security and she welcomed a more effective measure. SB advised that the Improvement Plan Delivery Board would report directly to the Trust Board in more detail than the overarching high level summary placed on NHS Choices. A dashboard was also being developed for the Board which would provide greater clarity regarding the progress being made on the actions underneath. 2. Partnership working was a key feature and VO asked how effective this would be in the light of the number of commissioning groups in place. PS believed that the action plan was deliverable; the associated paperwork formed much of the extra workload because the remainder was activity that should be happening anyway. The focus needed to be on re-aligning the way activity was done rather than imposing additional workload on staff. Embedding of the We Care principles would underpin deliverability. 3. What process would be put in place to enable the Non Executive Directors to hold the Trust Management to account and gain assurance about progress. SL stated that the NHS Choices submission, although high level, did provide reassurance that progress was being made. The reporting to the Board would have greater granularity. Clear KPIs were in the process of being developed as well as other mechanisms for checking progress. Partnership working was really important and the CCGs would be invited to join the Improvement Plan Delivery Board. JS summarised that all communications internally and externally needed to be up to date and effective. This was clearly in the early stages of development and a more comprehensive report would be given at the November Board Meeting based on the process described earlier. In addition, the good momentum so far achieved needed to be maintained and embedded. **Board agreed actions/decisions:** The NHS Choices Action Plan report was received and noted.	SB Noted

MINUTE NO.		ACTION
238/14	**IMPROVEMENT PLAN DELIVERY BOARD TERMS OF REFERENCE**	

SB presented an updated version of the Terms of Reference following the Improvement Plan Delivery Board's first meeting. The Divisional representation would be both clinical and managerial, and the Divisions would reflect on whether their particular actions were predominantly administrative, nursing or medical. As the work progressed, there may also be a need to devote more time to specific actions and relevant people would be invited to the meetings.

Board discussion:

RE queried the level of staff engagement and whether the elected Staff Governors had sufficient engagement with front-line staff. SB explained that he had gone out to the entire organisation seeking nominations of clinical leads but there was limited response. Interviews were scheduled to appoint a Clinician to lead the process and Chair the Delivery Board. The Staff Side Representative and four Staff Governors represented approximately a third of the membership - additional staff members could make the meetings too large to be productive. Discussion had taken place about the Board's link to patients and the public and it was planned to discuss its interface with other agencies, e.g. Healthwatch.

PS advised that a junior doctor had expressed interest in the clinical leadership of the Delivery Implementation Board and thought would be given to appointing both a senior clinician and the assistance of a trainee doctor. JP added that this would not be the only conduit for staff engagement and production of a communication plan involving staff was key.

JB asked whether the Improvement Plan Delivery Board should meet in public. SB advised that it had been considered but sourcing a location could be problematic. It was agreed that thought could be given to video conferencing. The Terms of Reference could be amended in future if required.

Board of Directors agreed actions/decisions:

It was agreed that

- the title of 4.5 should be amended to read "attendance by *others "*to allow members of staff to contribute their expertise on specific topics
- the membership may be amended to include a doctor in training — Agreed

Subject to the above amendment the Terms of Reference were agreed.

239/14	**CLINIAL QUALITY & PATIENT SAFETY REPORT**	

JP presented the report and the Board of Directors noted the main issues given in the summary of the report. Overall the report demonstrated some areas of improvement and others where additional focus was required. JP highlighted the following specifically.

MINUTE NO.		ACTION

Harm Free Care:
The Trust's performance was in line with national averages. There was further work required to influence issues related to patients who experienced harm in EKHUFT's hospitals rather than those already admitted with harm. Work on reduction and prevention of pressure ulcers had been very effective. The pressure ulcer reduction campaign was on track to achieve the 25% reduction improvement overall for hospital acquired avoidable Grades 2, 3 and 4 pressure ulcers. A further campaign had started in October to reinforce key messages around heel offloading and repositioning of patients, which were key learning from RCAs. The HOUDINI initiative to reduce the number of catheter related infections was also contributing to the reduction in harm free care.

Falls Prevention Programme:
Good improvement was made last year but this had stalled and the Heads of Nursing were considering whether to reinstate a collaborative to focus on falls prevention. There were six incidents in September which resulted in fractures and these were under investigation to ascertain whether there were any staffing or other contributory factors.

Infection Control:
Overall the YTD position regarding MRSA was good. The number of C.difficile cases in September was slightly above the monthly trajectory but remained ahead of the trajectory YTD and for the Quarter. Very few of the cases to date this year were due to lapses in care; however, there were four relating to prescribing of antibiotics and one case of cross infection. The Trust would be participating in a week long national campaign in November on antibiotic prescribing to raise the awareness of patients, the public and clinical teams. Harbledown Ward was being given additional support, with a deep clean and decontamination in order to reduce the level of infection.

Mortality Ratios:
Due to the transition from Dr Foster to CHKS, up to date data was not available for this Board Meeting but would be reinstated in the next month's report. The SHMI (Summary Hospital Mortality Indicator) was retrospective and publication of Q.1 data showed an improvement. However, it was volatile and Quarter 2 was demonstrating an increase so further work was required into the links between SHMI and end of life care/avoidance of admissions, particularly from care homes. Collaborative work in the whole health system to signpost people to the right area of care would help.

Incident Reporting System:
There were six serious incidents reported on STEIS and all were under investigation. They concerned a fall with fracture, a category 3 pressure ulcer, delays in diagnosis, inter hospital transfer and unexpected admission to the neonatal unit. There were thirty-nine incidents of staffing difficulties reported (including insufficient doctors). The Trust needed to be able to understand whether staffing difficulties were contributing to poor care or harm to patients.

MINUTE NO.		ACTION
	Fifty newly qualified nurses started work with the Trust in September, additional nurses had just arrived from Spain and Portugal, and twenty-five Registered Nurses from Italy had joined NHS Professionals. **Patient Experience:** There were no reportable mixed sex accommodation breaches in September, but there were six clinically justifiable occurrences which affected forty-seven people. Compliance around bathroom breaches was being addressed and Estates and Facilities were working on estates issues. **Complaints:** There was a higher number of complaints during September. These had increased since publication of the CQC report. This was a similar experience to other organisations in Special Measures. The main issues and themes for September related to delays in treatment in A&E, T&O and Pharmacy. There had been further complaints regarding doctors' communication style, particularly in A&E, and some areas of misdiagnosis. The vacancies in the complaints team had now been filled and the complaints process was being reviewed. Healthwatch had been invited to oversee this work to test the processes' effectiveness. The Net Promotor Score had been withdrawn by NHS England and from next month the Trust would publish percentages from the Friends & Family Test scores instead. **Board of Directors discussion:** RE asked whether it was possible to highlight 'hot spots' in future reports so that they could be discussed by the Board, e.g. three wards were of concern regarding falls, staffing and complaints. JP advised that 'heat maps' were used to triangulate issues because ward dashboards were not effectively showing issues at a glance. The peer review process was being re-visited which was uncovering more detail and there was an open invitation to the Board to join this. Consideration would be given to presenting the heat map work to the IAGC. RE was aware of the range of knowledge within the NHS about falls and asked what the themes and trends were that came to light through RCAs and what they meant for practice development. JP advised that the themes were very similar across the NHS and related to risk assessments, equipment, staffing levels, environment, and the proportion of patients aged over 80. The level of staffing required to care for the number of high risk patients with dementia was challenging and further investment may be required to support ward teams in this growing area. VO noted the apparent correlation between staffing and falls, in particular on Cambridge L ward, and welcomed further investigation. However, she queried the data because that ward was not flagged as having staffing issues.	JP

MINUTE NO.		ACTION
	JP advised that the masterclass at the November Board Meeting would help the Board to understand the data. NHS England required Trusts to report the monthly percentage fill rate for Registered Nurses and care staff by day and night against the establishment, including agency staff and overtime as well as planned staff. It did not give the full picture, however, of extra beds in place or demonstrate where there was additional pressure on the establishment on a particular shift. PS added that one of the contributory factors that was not taken into account was the location and layout of the ward. It was important that contributory issues were adequately considered. JS asked if ward spaces with better location/layout could be used rather than those wards which currently experienced a higher number of people falling. JP advised that the productive ward reviewed the areas to minimise the risk but a number of complex factors needed to be taken into account and there was doubt that falls by vulnerable people could be completely eliminated. VO noted that it was taking the Trust longer to recruit staff than the notice period: could the Trust introduce a longer notice period for departing staff to shorten staffing gaps? SLB was looking at delays. SB said that there had been a significant backlog over the Summer and HR had set a day aside to focus on the backlog. A more efficient process and reduction of the backlog should be evident in the next few weeks. **Board of Directors agreed actions/decisions:** The Board of Directors noted the report and actions in place to continue patient safety and quality improvement.	Noted
240/14	**PATIENT STORY** JP presented the story which demonstrated a lapse of care during the patient's stay which contributed to deterioration and death. It included opportunities where care could have been managed more efficiently and provided a great deal of learning for the clinical and ward teams. The RCA suggested the fall may not have been preventable but the fact remained that the risk assessment and other actions had not been carried out. There were additional beds on the Ward that were not part of its overall establishment and this was impeding the flow of discharging patients from QEQM. The establishment had since been re-adjusted and additional nursing and care staff had been recruited. **Board of Directors discussion:** PS asked if the patient had had a dementia assessment as it was known that mild dementia was exacerbated by acute illness. It was not believed that she had and the story highlighted the scale of care and level of observation required. PS was also concerned that although improvements needed to be made in the Trust in some areas, delay of transfer of care was a major problem and it had not been possible through any fora to effectively challenge other healthcare providers.	

MINUTE NO.

ACTION

The Board recognised that it had always been difficult to obtain speedy action by other agencies. There was an increasing level of activity and elderly population and more responsive behaviour was required. Capacity in nursing homes in Thanet had diminished recently and there was also some evidence of a slow-down in the processes that provide continued healthcare in the community. Another twenty beds would be coming on line, particularly for people with dementia and although there was capacity available, there was no agency who was matching the demand to ensure better flow for the Trust. JP believed that innovation was the way forward to effect change.

There was a lack of urgency and a way needed to be found to raise the profile with partners. There was concern that there was no mechanism to increase the capacity within the public sector and this linked to one of the highest risks on the risk register – delivery of the improvement plan, the pressure on staff at QEQM and lack of any perceived solution on the horizon. The Trust was under pressure from partners to increase internal capacity although this was not the correct way forward. Additionally, Winter resilience plans were not based on an assumption of a reduction in nursing home provision and it was strongly felt that the Trust needed to refuse to install extra beds.

RE stated that patient stories were shared in order to learn from them and improve and the Trust needed to be assured that the actions identified were carried out. The story also indicated that staff were under pressure and asked whether any additional support was provided to them. He also asked whether these stories were presented at any forum where partners were present. JP replied that they were used to back up some of the improvement work. They were more powerful when the relative or patient was willing to talk to a group, and this had happened, although thought could be given to extending this further.

LS suggested that the challenges be stressed at the forthcoming Board to Board Meeting with the CCGs and a pre-meet would enable serious thought to be given to how to present it strongly enough.

VO asked whether an alarm system could be put in place to signal when a patient was out of bed, particularly for elderly patients or those in a single occupancy room. JP confirmed that this was the usual standard following a risk assessment, although in this instance the patient had not been identified as at risk.

VO asked whether there was confidence that the staff recruited from abroad were able to satisfactorily complete documentation. JP confirmed that a lot of support was given to them, including twenty sessions of English tuition.

JS summarised that the Trust needed to do everything possible to resolve capacity issues with partners in an environment with reducing care home capacity. The Trust needed to stand by decisions made on the grounds of patient safety. The issues needed to be taken up at the Board to Board meeting with the CCGs.

MINUTE NO.		ACTION
	Board of Directors agreed actions/decisions:	
	The Board of Directors noted the key themes of the story and the actions in place to prevent a recurrence.	Noted
241/14	**KEY NATIONAL PERFORMANCE TARGETS**	
	JE presented the report covering September 2014. The month was very busy and the report highlighted the ongoing trend of pressure on the A&E 4 hr Standard, which was just missed for the month. Half term week saw a surge of activity between 5-7 pm. Internal analysis into the reasons for breaches had shown that physical space was a significant contributor. Changes at WHH and speedier response by specialties to A&E had improved the situation. Performance in October had proved equally challenging, with a shift to higher ambulance activity, greater acuity of patients and less minors, and the target was achieved for two days during one week. The benefits of the additional nursing staff, once trained, would be significant. There were now 10.5 wte A and E Consultants in post, which was supporting extended hours. The UC&LTC Division had put in place a development programme for specialty doctors and a number of them were now considering working as a Consultant in Emergency Care. The new Integrated Discharge Team model of care went live on 6 October at WHH, linking with the wider health economy. A locality reference unit was planned where all calls would be taken and the decision made as to whether an ambulance or alternative team was required. The building work and recruitment was underway and it was hoped to be fully functioning in November/December. This would support admission avoidance as well as helping to keep people at home safely. The team at QEQM was being recruited but the space was still being sought. In addition, the Surgical Assessment Unit went live in October at WHH and a number of patients every day were being assessed with minimal admissions. It was hoped to put this in place at QEQM in due course. **Board of Directors discussion:** RE stressed the importance of determining the agenda and the tactics for the forthcoming Board to Board meeting with CCGs and he requested that a pre-meet take place and a briefing note be produced in order to manage the debate at the meeting.	

MINUTE NO.		ACTION

SB mentioned the additional risk associated with the K&M emergency care pathway and Medway A&E; this had led to diverts and the capacity across the whole Kent system was being stretched.

SL asked where DTOCS numbers and trends were discussed and suggested they be shown in the Board report including all those who did not fit the criteria. JP advised that they were addressed by the relevant operational groups.

At QEQM in October there were some days which showed a normal number of people attending although performance was poor and JS asked what was behind this. JE believed that DTOCS, the risk of outliers on wards, and staffing levels could all have contributed to the poor performance.

PS stated that there was agreement between A&E and surgical teams regarding specialists' response times. He had asked for data because the surgical and medical consultants believed that they were not being asked to see a patient early enough within the 4 hours, and that diagnostic delays had also contributed to the 4 hour standard not being met.

RTT - 18 Weeks Target:
The plan had been to be non compliant in September. However, the increased referrals in T&O and other specialties were having an impact on the ability to manage activity and outpatients were being compromised. The Trust believed that the backlog could be reduced to below 1,000 by March 2015 by remaining non compliant to end Q4, but two CCGs had asked that the Trust be compliant in Q.4. This was not in the best interests of patients, nor consistent with delivery of a sustainable service the Trust.

VO asked about patient choice and SB advised that those people who may wish to have earlier treatment had been identified. Additionally, many of those in the backlog were elderly complex patients who were not able to be treated by the independent sector. JE added that the Trust had instigated and paid for an assessment and triage facility and a number of referrals were being directed to Orthopaedic Physios who were nonetheless referring more of them for orthopaedic surgery.

RE asked if the Trust was certain of the productivity of Consultants and teams. JE advised that the Surgical Division was carrying out a comprehensive theatre project with a number work of streams to look at individual Consultant productivity and all the processes. Too many cancellations were being made due to inadequate pre-assessment and this was being addressed.

Six Weeks Diagnostic Target:
The Clinical Support Divisional Director was now assisting with the performance against this target and supporting mechanisms were in place. There were still a few CT delays but it was believed an improvement would be evident next month. Workforce difficulties were the main problem, especially in endoscopy, and outsourcing was being considered.

MINUTE NO.		ACTION
	Cancer: Referrals had continued to increase significantly. The Breast Symptomatic target remained difficult to control and in September there were many patients who chose not to attend in the 14 day period, although capacity problems exacerbated this. A detailed plan had been produced and greater use of Choose & Book continued to be explored for cancer referrals. **31 Day Target:** This target involved small numbers and was narrowly missed. The problems mainly related to head and neck capacity and dermatology patients which should be resolved during October. **62 Day Target:** This related to a mixture of enhanced referrals in Urology and the Lower GI Colorectal pathway. Endoscopy diagnostics had impacted on this. Decision making by the MDT and accessibility to ITU beds was being addressed. **Screening 61 Day Target:** Numbers were small but this aligned to the Breast Symptomatic target and action was being taken to bring forward the urgent patients. JE summarised that at performance meetings with CCGs, it was important to express support to achieve the A&E 95% Standard and to work jointly to resolve issues in A&E, management of RTT and cancer pathways. **Board of Director agreed actions/decisions:** The report was noted. The Board stressed the importance of restoring compliance with the 4 hour A and E wait target as soon as possible (with support from better collaboration with partners); and separately supported the Trust's plan to be non-compliant for 18 weeks RTT in Q3 and Q.4.	Noted
242/14	**CORPORATE PERFORMANCE REPORT** JB updated the Board on performance to the end of September, which was discussed in detail at the Finance & Investment Committee earlier. **Activity:** Activity in September was higher than planned with the exception of follow-up appointments. The under-performance in that area was due to a change in classification of some follow-up activity. Overall, Primary Care Referrals were higher than planned by 8%. With the exception of the 2 Week Cancer pathway referrals, which were being jointly worked on, both A&E and T&O required resolution regarding management of the increased activity.	

MINUTE NO.		ACTION
	Finance: As at the end of September the Trust was £2m behind plan after application of the contingency and profits from the Spencer Wing which continued to trade above plan. Although September saw a break-even position there were significant budgetary pressures building up in October. One cause of the adverse variance YTD was the shortfall in delivery of CIPs, mainly linked to pressure on beds and the bed closure programme. Overall cash remained healthy and slightly ahead of plan; this helped to underpin the Continuity of Service rating of 4. JB highlighted that in terms of this year's out-turn a major concern was the amount of winter funding that would be allocated to the Trust. The publication of the tariff had been delayed to around Christmas, which would put pressure on the ability to have a clear plan for 2015/16 in December. **Board of Directors discussion:** VO stated that there was inference that cost improvement plans were trying to be delivered by not managing staff vacancies as well as might be possible. JB replied that sometimes CIPs were being delivered non recurrently because Divisions were utilising under-spends but the underlying position was showing a c£.6m under-performance. The CIP had been set at £26m and the Trust was on track to achieve c.£20m and therefore the contingency was being used to offset the shortfall. It was believed that the year end position would be c.£2m adverse to plan, before any CQC action plan related additional costs. **Board of Directors agreed actions/decisions:** The update was noted.	Noted
243/14	**QUARTER 2 RETURN TO MONITOR** SB presented the submission which aimed to identify the Quarter's performance and any risks to future performance in subsequent Quarters. He sought agreement to its accuracy and whether the narrative was sufficient. **Board of Directors discussion:** JP suggested that the text relating to the financial risk was insufficient in terms of the forward plan. JB advised that this would be discussed with Monitor; the key components and forward financial look were as yet unknown as the tariff had not yet been published.	

MINUTE NO.		ACTION
	JB suggested inclusion of narrative regarding the strong cash balance but SB advocated not amending the text and leaving it for Monitor to raise any specific concerns that can be taken on board for future declarations. RE's observation was that the language used could be strengthened, i.e. 'joint work with CCGs is a key part of the plan' – at some stage this would need to be more specific ('in order for the Trust to be successful CCGs are required to ….'). VO asked if the submission was formally sent to the Chairs of the CCGs and SB explained that there was a mechanism for sharing it with them although more action as a result would be welcome. **Board of Directors agreed actions/decisions:** JS asked that references to A&E in sections 3 and section 5 be strengthened to reflect that closure of care homes (notably in Thanet) would have an impact on flow from the hospital.	AF
	Section 1: The Board of Directors, on assuring themselves of the evidence, declared that: ▪ the Continuity of Services risk rating for Q.2 was confirmed as Rating 4 ▪ and that they anticipated that the Trust will continue to maintain a Continuity of Service risk rating of at least 3 over the next 12 months.	Noted
	Section 2: The Board of Directors, on assuring themselves of the evidence, declared that not all healthcare targets and indicators have been met.	Noted
244/14	**REVIEW OF ONGOING COMPLIANCE AGAINST SELF CERTIFICATION** AF explained that non compliance regarding RTT, A&E and Cancer Standards had been reported. It had been hoped to meet the C.difficile targets but there were ongoing pressures. The forward look was therefore appropriate. There had been regular conversations with Monitor so they were aware of the issues. The risk section would allow the Board to test assumptions going forward. **Board of Directors agreed actions/decisions:** The update was noted.	Noted
244/14	**QUESTIONS FROM THE PUBLIC ON PAPERS WITHIN THE PERFORMANCE MONITORING SECTION** There were no questions raised.	

MINUTE NO.		ACTION
245/14	**DELIVERING OUR FUTURE**	

Clinical Strategies Work Stream Update

LS presented the report which included an update on the eight work streams. Clinical leads were now beginning to focus on the HRGs and the activity that they believed would flow into the single emergency high risk hospital and those that could be supported on the base sites. The report to the December Board Meeting would include recommendations and the work with KCC on trying to establish whether public to public partnership would deliver strategic change and the efficiencies the Trust needed in order to deliver its clinical strategy.

The first set of listening events had taken place and had been well attended. LS had presented the clinical strategy and progress to date. A number of other staff events were planned in the next few months and presentations were being given at internal meetings. There was also engagement with CCGs and on 5 November South Kent Coast Clinical Commissioning Group (SKC) planned to hold a Members' meeting at which 150 Primary Care staff would be attending. The Trust would man eight work shop tables relating to the different clinical areas and this would be an opportunity for them to challenge the Trust about what should move to a high risk hub and what could be delivered more locally. SKC and Thanet CCGs were also talking about incorporating care organisations which was another opportunity to see how some of the work crossed over.

Outpatients – Update on Implementation

The lease with Estuary View had been signed and building work was underway, with a plan to move in during December. The owners of the adjacent site had submitted a planning application for a facility with care home beds and the Trust had responded that it supported in principle such a strategic approach to healthcare.

Progress on the Dover Hospital continued towards an opening in March 2015. The internal work was focusing on workforce, job plans and support services to move activity out of the main sites. Additional funding was allocated to transport to support the rationalisation to six sites; all the links to Dover and Ashford were now in place. The route to Estuary View would be ready for the opening in December.

Board of Directors discussion:

RE asked the following questions:

1. He found it difficult to find the timeline in the report and asked for an update. LS advised that the engagement regarding the clinical strategy would continue until the end of April. It would then be collated into a consultation document that would go live in June after the General Election.

MINUTE NO.

ACTION

The Divisions were now identifying new clinical leads to support the work in their own Divisions although there were some challenges to overcome.

2. People were often unaware of where to access information about services; as these new services were developed, was the website being enhanced accordingly? LS replied that there had been little progress on this aspect as the focus had been on establishing the strategy. However, it would be picked up as part of the communications and engagement work.

JS asked about the extent of ward and clinical engagement, particularly internal. Clinical leadership roles were vital and he questioned whether sufficient support (PAs etc) would be provided. LS advised that engagement of clinical leads in Medicine and Surgery was encouraging and was increasing from Specialists. Women's & Children had been challenging but there was confidence that they had good internal clinical engagement to enable them to reach clarity on a proposal. Further work was required regarding breast surgery and with the general surgeons around acceptance of a central emergency surgery. The greater engagement had enabled LS to write to the Clinical Directors of CCGs which had engendered discussion.

PS added that the vision of the acute hub needed to be sufficiently imaginative. There had been limited progress on job planning but this was on the agenda. A programme was now in place for February for the medical and clinical leads.

JP stressed that co-adjacency work was essential and would require negotiation between clinical services. LS advised that the Divisions' views were being sought on clinical adjacencies and a flexible design was critical.

JE mentioned that some staff had asked about the new housing plans in Ashford and associated provision of healthcare, schools etc. An awareness of health services for that population was important and JE asked if all these strands were being brought together so that services could work in partnership. LS advised that Ashford Borough Council made the decisions around the infrastructure but the Trust could give thought to how to link in.

Board of Directors agreed actions/decisions:

The Board supported the ongoing work of engagement with partner providers, Commissioners and the public to gain involvement in the future clinical strategy.

The Board noted the progress made and the following general issues raised by the work streams:

- Clinical and managerial capacity to undertake strategic work balanced with operational priorities was a challenge
- Timeline for the implementation of the outpatient schemes would need to be carefully managed
- Issues around clinical adjacencies for each specialty and inter dependencies with other divisions were complex and require wide clinical engagement and involvement.

MINUTE NO.		ACTION
246/14	**RISK MANAGEMENT STRATEGY – ANNUAL REVIEW**	
	JP presented the Risk Management Strategy which had been reviewed by the Quality Assurance Board and the Integrated Audit and Governance Committee. The text in red reflected changes to the committee meeting structure which had previously been approved.	
	Board of Directors agreed actions/decisions:	
	JP agreed to work with HG on the 'risk appetite' on page 7 to determine whether it could be made more substantive.	JP
	Subject to the above, the strategy was approved.	Approved
247/14	**BOARD ASSURANCE FRAMEWORK**	
	AF presented this summary which had been through the committee meeting process during the last month. A number of items had been picked up during conversations since and would be built into the next iteration.	
	There was reference in the cover sheet to areas which the Trust would fail to meet part or the whole of an objective. AF highlighted Objective 3 regarding the staff survey and Annual Objective 10 – The Trust would be in Special Measures for the remainder of the year.	
	There were some annual objectives that did not have risks against them and AF would be working with Strategic Development to ensure they were described appropriately.	
	Board of Directors discussion:	
	RE mentioned that the report inferred that because Annual Objective in relation to maintaining strong governance structures was not mentioned in the Annual Plan, the Trust did not need to report it in the Annual Report on 2014/15. AF explained that this would be covered in the Annual Report but not under the Annual Objective section. The fact that the Trust was in Special Measures would feature throughout the Annual Plan, especially in relation to progress against the Improvement Plan. In the Trust's Annual Plan only objectives 1-9 had been put forward but mention would be made of the fact that EKHUFT was in Special Measures.	
	JS commented there were a number of objectives for which the substantive outcome was set for beyond the end of this year and may be at risk of slippage. The real risk lay in years 2 and 3 when delivery was expected. He suggested that it may be worth exploring the pinch points now. AF explained that the measurement and aim was to meet this year's time line.	
	JS noted that consultation on the clinical strategy would commence next Summer and it would be challenging as to whether decisions would be made in time to obtain clinical and financial contribution for 2016/17. The Finance and Investment Committee may need to discuss this as part of the next business planning cycle.	

MINUTE NO.		ACTION
	Board of Directors agreed actions/decisions:	
	The recommendations were discussed and agreed.	Agreed
248/14	**CORPORATE RISK REGISTER – TOP 10**	
	JP reported that two new risks had been added to the Corporate Risk Register. Six emerging risks would be reviewed by the Quality Assurance Board to determine whether they should be added.	
	Board of Directors discussion:	
	RE asked about the risk regarding safeguarding team training. JP explained that the staff within the team were under pressure but the risk had been mitigated. The changes related to the numbers of staff who required training to Level 3 in order to care for young people between 16-18 years who would now be placed in an adult environment	
	JS asked how serious was the emerging risk on medical staffing for the Oncology Service. PS advised that locum support had been provided and the Cancer Board was aware of the issues.	
	AF noted that there was no mention of deliverability and implementation of the CQC action plan. JP advised that it would have its own Risk Register but also needed to be mentioned in the Corporate Risk Register.	JP
	Board of Directors agreed actions/decisions:	
	The Board of Directors agreed that the top 10 risks had been correctly identified.	
	Some of the narrative about mitigation and risk adjusted scores needed to be updated.	JP
249/14	**QUESTIONS FROM THE PUBLIC ON PAPERS WITHIN THE STRATEGIC SECTION**	
	There were no questions from the public relating to the Strategic Section.	
250/14	**VITALPACS PRESENTATION**	
	Deborah Higgs gave a presentation on use of this technology within the Trust. The next upgrade would enable it to be used for bed management. It was also now available for use within Maternity and Women and Children's Services.	
	Board of Directors discussion:	
	JS asked how widely this technology was used within the NHS.	

MINUTE NO.		ACTION
	DH explained that when it was introduced in July 2012 it was used by approximately eight other major organisations. However, there were now about twenty. Other similar products were available but VitalPac was the most sophisticated. RE stated that the greater the reliance on the infrastructure, the more important its reliability was and asked how the Board could be aware of the risk profile and assured that the appropriate level of investment was being made to make sure that the infrastructure was fit for purpose. DH replied that the Trust remained reliant on the workforce to respond to the information this tool provided. In a changing environment, it was necessary to demonstrate to the Board that performance would be improved through use of technology. It was important that it linked effectively with other systems. Staff required support when new technology was introduced, and a culture of readiness to proceed needed to be fostered. LS added that the Finance and Investment Committee had received some of the work underway with Clinicians to develop a strategy for IT. The tender process in the market place was the way forward and it may be beneficial to consider a more integrated system rather than separate elements. JS stated that as IT network dependence increased, system robustness became ever more important; budgets would need to reflect this. JP stated that the performance of upgraded PAS system was essential. The down-side to this development was that patients and relatives sometimes believed that staff were using their mobiles when using VitalPac and managing their perceptions would need to be borne in mind when introducing further technology. SB asked if it was possible to develop an app rather than having to rely on a separate scanner and DH confirmed that soft scanning was being investigated. VO asked about back-up arrangements and DH explained during any delay in uploading of information, clinical teams continued intuition was still important. Previous data was still accessible and correct although the most recent set of observations may not be visible. **Board of Directors agreed actions/decisions:** The presentation was received with thanks.	Noted
251/14	**BOARD COMMITTEE FEEDBACK** **<u>Finance and Investment Committee Chair's Report</u>** The report covering the meeting on 28 October 2014 was noted.	Noted

MINUTE NO.		ACTION
	Integrated Audit and Governance Committee	
	The report covering the meeting on 9 October 2014 was noted.	Noted
	Quality Committee	
	The report covering the meeting on 9 October 2014 was noted.	Noted
252/14	**CHIEF EXECUTIVE'S REPORT**	
	SB added that he had attended a Health and Wellbeing Board of Ashford Council. It was a well attended and positive meeting and there was a willingness to work with the Trust on a number of issues. The Board congratulated Andrew DiBiase, Consultant Orthodontist, who had been awarded the prestigious Maurice Berman Prize for Clinical Excellence by the British Orthodontic Society. They also congratulated all those staff who had been presented with a Trust Award.	
253/14	**FEEDBACK FROM COUNCIL OF GOVERNORS**	
	The next meeting was scheduled for 7 November.	Noted
254/14	**ANY OTHER BUSINESS**	
	Reports from Council of Governor Sub Committee Meetings	
	VO suggested that it would be beneficial for the Board to receive a brief report by the Non Executive Directors who were aligned to the Council of Governors sub committees on the last meeting they attended. This was agreed and AF agreed to give thought to the reporting mechanism.	AF
	Ebola	
	Information on handling of Ebola would be issued electronically.	
256/14	**QUESTIONS FROM THE PUBLIC ON PAPERS WITHINTHE INFORMATION SECTION**	
	There were no questions raised by the public.	

Date of Next Meeting:
Friday 28 November 2014 in the Board Room, Kent & Canterbury Hospital.

Signature _____

Date _____

Initials .....