UNCONFIRMED MINUTES OF THE SIXTY-SECOND MEETING OF THE BOARD OF DIRECTORS
FRIDAY 28 NOVEMBER 2014, 9AM, LECTURE THEATRE, QEQM HOSPITAL, MARGATE

PRESENT:

Mr N E J Wells	Chairman	NW
Prof C Corrigan	Non Executive Director	CC
Mr P Presland	Non Executive Director	PP
Dr J P Spencer	Non Executive Director	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
Ms S Le Blanc	Director of HR and Corporate Services	SLB

IN ATTENDANCE:

Mrs J Ely	Interim Director of Operations	JE
Mary Tunbridge	Divisional Director (Clinical Support Services) *(Minute No 273/14)*	MT
Marc Farr	Director of Information *(Minute No 273/14)*	MF
Andy Barker	Director of IT *(Minute No 273/14)*	AB
Mrs S Swindell	Assistant Trust Secretary (Minutes)	SS

MEMBERS OF THE PUBLIC IN ATTENDANCE:

Mr C Edel	Member of the public	CE

MINUTE NO.		ACTION
257/14	**CHAIRMAN'S WELCOME**	
	NW welcomed members of the Board, Governors and members of the public to the meeting.	
258/14	**APOLOGIES FOR ABSENCE**	
	Mrs S Lewis, Improvement Director Mrs A Fox, Trust Secretary	
	NW reminded the Board of Steve Tucker's recent resignation from the Board of Directors as Non Executive Director.	
259/14	**DECLARATIONS OF INTEREST**	
	SB, JB, PS and SLB were noted as nominated Directors of EKMS and SB/JB of Healthex.	
260/14	**MINUTES OF THE PREVIOUS MEETING – 30 OCTOBER 2014**	
	The minutes of the previous meeting were agreed as an accurate record, subject to the following amendments: • Page 7, third paragraph, last sentence should read: '…..percentages from the Friends and Family Test *as well as the net promoter scores* instead….'.	

- Page 8, last sentence should read: '…other *Health and Social Care* providers'.
- Page 9, 5th paragraph, last sentence should read: '…the patient had not been identified *as being at risk*.'

261/14 **MATTERS ARISING FROM THE MINUTES**

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

Minute Number 215/14 – Clinical Quality and Patient Safety Report
SLB reminded the Board of Directors of compatibility issues with the national e-learning system. The Trust considered waiting until IT issues had been resolved as part of the current ICT review. However, a decision had been made to procure a new learning management system. This would take 6-9 months to implement. In the meantime, IT would install locked down computers in each area as soon as possible.
The Board of Directors welcomed this solution and asked if SLB could look to shorten the procurement process. SLB/LS would provide an update at the next Board. — SLB/LS

SLB would report an update on retention challenges to the next Board. — SLB

Minute Number 243/14 – Quarter 2 Return to Monitor
The Quarter 2 Return had been submitted and discussed with Monitor. Formal feedback was awaited. — Closed

Minute Number 246/14 – Risk Management Strategy – Annual Review
The Board was content with the update that the definition of risk appetite was in line with the British Standard 33011 definition. — Closed

262/14 **CQC ACTION PLAN UPDATE**

The CQC action plan was tabled. The Board of Directors were reminded of the monthly submission timetable to NHS Choices which prohibited more timely circulation of reports.

SB reported the Programme Delivery Board had reviewed the high level action plan at a meeting on 21 November 2014. The report provided details of the achievements over the last month and main areas of concern.

The Programme Delivery Board consisted of a wide representation of staff including the Staff Side Lead and Staff Governors. The aim was to provide a communication bridge to staff within the organisation. A Clinical Lead for this Board had now been identified, Dr David Hargroves.

A draft report had been received from KPMG following their recent audit of data quality within the Trust. A stakeholder event would be held in early January 2015 after which the report would be finalised. This was one of the areas questioned by the CQC during their visit in March 2014.

SB reported the KPMG report provided a degree of assurance regarding the processes in place within the Trust. Recommendations were based on moving the Trust from 'good' to 'best in class'.

SB went on to say work was required to ensure coherent interpretation of data by various stakeholders. Ahead of the stakeholder event, meetings would take place with stakeholders to understand the key messages within the report.

In terms of the cultural change programme, SLB reported a programme manager had been recruited who would manage the 3 areas of the plan: cultural change, HR Strategy; and Communications and Engagement.

The Trust would be working with an external partner to embed cultural and behavioural change within the Trust through the following phases: diagnostic (stakeholder interviews); workshops to test the values; and work to embed values (linked to the leadership programme).

Engagement with staff would commence 1 December 2014. An internal communications position would be recruited to.

The Trust's raising concerns policy had been reviewed and re-launched but training was required to ensure staff were actively raise concerns.

Board of Directors discussion:

PS referred to other staff who had expressed an interest in committing their time to supporting delivery of the CQC action plan. SB confirmed meetings would take place with these staff to discuss their involvement, once the appointment of the Dr David Hargroves had been announced.

JP/NW referred to the We Care Values that had been previously endorsed by the Board of Directors. These had been co-designed by staff and patients and were familiar to staff – linked to the Leadership Programmes and shared purpose framework.

SLB provided assurance work would be undertaken to test these values to ensure they were still appropriate or whether refinement was required. She was not keen to move away from We Care as this was well known to staff.

NW referred to the NHS Choices submission and requested that future iterations include more tangible updates on progress with the actions contained in the Improvement Plan.

SB commented that limited text space was permitted on the return. He reminded the Board of Directors of the rating: 'Blue' (actions complete) and 'Green' (actions were on plan but not completed).

NW commented it was important the Board understood the process for collating an evidence base to support the CQC action plan. SB/JP confirmed work was in progress to develop an evidence log. JP added a dashboard was under development to ensure actions taken were having the designed impact. This would be monitored via the Programme Delivery Board.

LS referred to the actions classified as 'blue' within estates. Although these specific actions were complete, further work was being undertaken to ensure these were embedded across the organisation and similar issues would not therefore occur in other parts of the Trust's estate.

RE asked when the Board would see visibility of the financial implications of the CQC report. He further asked if clinical leaders had been given sufficient time and resource to implement and sustain the required improvements.

JB confirmed provision had been included in the accounts for this year and for 2015/16 based on estimated costs of implementing the CQC actions. These were being validated. A quantum of the estimated costs had been reported to the Finance and Investment Committee.

PS raised a concern that job plans for clinical leaders had not been structured to provide the required resource. This would have financial consequence in terms of back fill.

JS commented that the Trust position had moved on significantly in some areas since the visit in March 2014. Outpatients services were a specific example. He stated it was important the action plan addressed the current challenges faced by the Trust.

VO referred to specific actions which were linked to wider strategic pieces of work and asked if completion by March 2015 was realistic.

JP responded the development of dashboard would assist with tracking and would help ensure the indicators were appropriate.

JE further added staff needed to be clear of the core actions they were responding to and those which formed part of 'business as usual'.

Following a question raised by CC, PS confirmed clinical audits (national and local) were co-ordinated through the Clinical Audit and Excellence Committee. Work was ongoing to strengthen engagement.

Board of Directors decision/agreed actions: NW

The Board of Directors approved the submission to NHS Choices. NW would communicate minor amendments outside the meeting.

SC/JP

NW requested the following as part of the next report to the board:

- The risk register being developed.
- The dashboard.
- Assurance regarding the development of an evidence log.

SC

RE asked if the Board of Directors could be kept up to date with resource challenges linked to taking forward the CQC action plan.

SC

NW stressed it was important Board members receive the NHS Choices update with sufficient time to review and comment. He recognised the submission timescale would not permit circulation with the agenda and papers but requested the report was circulated on the Wednesday before each Board as a general principle.

SB

It was agreed the draft report from KPMG on data quality would be circulated to all Board members for information.

263/14 **FEEDBACK FORM MONITOR MEETINGS**

The Quarter 2 return had been discussed with Monitor and formal feedback was awaited. Discussions focussed on A&E, cancer and 18 week RTT.

A detailed timeline of action taken in relation to 18 week RTT since January 2014 had been shared with Monitor.

Performance Review Meetings would continue with Monitor whilst the Trust remained in special measures. Monitor was likely to call a summit meeting with all stakeholders to ascertain a path response to recovery and to bring the Trust to a sustainable compliant position.

264/14 **CLINICAL QUALITY AND PATIENT SAFETY REPORT, TO INCLUDE:**

- **NURSE STAFFING DATA**
- **COMPLAINTS, CONCERNS AND COMPLIMENTS**

JP presented the report and highlighted the following specifically:

- Overall, good progress had been made against Harm Free Care indicators. However, Harbledown Ward had been placed into special measures for pressure ulcer performance and infection control standards. A deep dive was being undertaken to identify additional support required. JP reminded the Board this was a frailty ward and as a result was a challenging environment.
- Work was being undertaken to refresh the falls prevention programme.
- Health Care Acquired Infections reported an improved position in relation to *C.difficile* for October 2014. The introduction of hydrogen peroxide at WHH was being evaluated and the rollout would continue. Early indications were this was having a positive impact.
- It was noted the bed occupancy figure was incorrect and should read 91%. Work was ongoing with the information team to ensure data was accurately reflected in future reports.
- Work would continue with the CCGs in terms of the policy and criteria for mixed sex accommodation to ensure equality.
- Improvements were noted in relation to the Friends and Family test. Specific reference was made to A&E net promoter score performance which reported an improved net promoter score of 52 as at October 2014.
- Appendix 1 provided the published staffing data for October 2014. Work was being undertaken to understand gaps between actual and planned staffing levels to ensure a shared understanding.
- Appendix 2 provided a detailed breakdown of complaints, concerns and compliments as requested by the Board. The report provided details of the top issues and main areas of focus.

Board of Directors discussion:

VO referred to complaints related to document management and communication breakdown. She asked if there was any correlation with recruitment of overseas staffing.

JP responded there was no evidence to link to overseas recruitment. Complaints, incidents and staffing issues were triangulated to ascertain the wider picture and areas of concern.

In relation to falls performance, VO felt outliers (named wards) should be recorded in reports. JP responded the run charts included in the report provided details of where falls occurred.

VO congratulated the Trust on having no MRSA bacteraemias reported on wards for October 2014. JP welcomed the positive support.

NW referred to the 44 incidents related to staffing difficulties. Given the importance of this area, he asked how data had changed over a period of time.

JP responded the current e-rostering system was designed as a planning tool. Work was being undertaken with the provider to develop this into an assurance tool by the way of a live system.

NW referred to page 4 and the sharp increase in incidents related to communication breakdowns. Medical staff were reported as the highest group. NW stressed communication skills were important when dealing with patients and asked for details of the work being undertaken to address this.

SLB responded this links to the cultural change programme. PS added he would follow up complaints received personally with the clinician concerned.

PS commented the majority of complaints related to outpatients. Clinicians do not have control over their outpatients and operating lists.

RE referred to a process used by other Trusts where improvements were tested on a particular area initially prior to rolling out the formula across the Trust.

CC referred to MTW who reported a 47% response rate to the Friends and Family test and asked if learning could be shared. JP explained MTW employ specific staff to undertake this piece of work. In EKHUFT, this work is undertaken through ward teams and matrons.

Board of Directors decision/agreed actions: Noted

- The Board of Directors noted performance against quality indicators as at October 2014. SLB/JP
- The Board of Directors requested an update on the themes of complaints at the next meeting and the improvement work being undertaken, overall and specifically in relation communication issues. SLB/JP would take this forward.
- NW requested something be communicated in Trust News regularly promoting good practice. JP

265/14 **PATIENT STORY**

JP presented the report which related to the experiences of an 84 year old lady with confusion who was discharged inappropriately from the Clinical Decision Unit (CDU) at QEQM. The story described a breakdown in communications and discharge planning which caused distress to the patient and family who lived a distance away.

The complaint had been sent to the Parliamentary Health Service Ombudsman (PHSO) who upheld the complaint. The Trust had apologised to the family.

JP went through the learning in the report and actions identified. These specifically related to alignment of communication processes.

Board of Directors discussion:

RE asked when the incident took place, recognising investigation by the PHSO could sometimes be lengthy. He referred to the learning related to the audit of 5 sets of records. He asked if this was for the CDU alone or across the Trust.

JP responded the incident occurred approximately 12 months previously. The audit of records was on CDU across two sites. The learning related to documentation: accurate completion of check lists and robust handover, particularly at weekends. Auditing records regularly focuses attention.

RE referred to accountability and asked for details of the role of the consultant in this particular incident. JP clarified the main issue was around communication and process issues related to discharge which was the responsibility of nursing teams.

PS commented the story encapsulated the fact dementia exacerbates within an acute care setting. This would become much more common going forward. The population of over 75s had increased by 25% over the last 10 years.

Following a question raised by CC, JP confirmed integrated discharge records were recorded on EPR. The EDN had not been completed in this case and this formed part of the learning.

VO felt this incident should have been picked up as part of adult safeguarding.

PP was concerned the family had not received the assurances they require as part of the investigation.

SB responded the Ombudsman had concluded there was no fault with the investigation. Concerns raised by them were in relation to the level of care the patient received.

SB signed the majority of all responses to Trust complaints. He reported the Trust had become increasingly open in responses provided. Further work was ongoing to demonstrate an understanding of the themes of concerns raised by patients.

Board of Directors decision/agreed actions:
The Board of Directors noted the report, learning identified and action taken. Noted

266/14 **KEY NATIONAL PERFORMANCE TARGETS**

A&E

JE reported non-compliance against the 4 hour standard in October 2014 at 92.8%. Challenges continue into November.

Site performance variations continue. QEQM had experienced a significant shift in attendance profiles which was linked to the move by SECAMB of the make ready station. Meetings were scheduled with SECAMB to understand this decision.

JE further reported there had been a noticeable surge in attendances from 8pm.

As part of the recovery plan, weekly meetings had been arranged with all partners to review their role and expectation in terms of the A&E target.

Additional seasonal resilience funding had been received within the health economy. An update would be provided in the next report on how this money had been allocated.

Board of Directors discussion (A&E):

A&E remained a significant item on the agenda of the monthly Performance Review Meetings with Monitor. Although more money had been allocated to the health economy, the Board of Directors recognised the need to continually drive internal efficiencies.

Following a question raised by NW, JE confirmed work was being undertaken to discharge patients early in the day. The aim from January 2015 was to implement a target discharge decision by midday.

NW received daily A&E performance reports and noticed challenges continued even when attendances were at normal levels. JE clarified surge attendances impacted on overall performance and recovery.

LS asked if the Trust was clearer in terms of additional capacity required to hold the system to account. JE responded the action plan needed to be strengthened to include actions to be taken by partners to ensure visibility. In terms of capacity, the seasonal plan needed to be reviewed. Partners would be asked to complete a template in terms of capacity.

RE commented when the NED Governance Group was in place, he was more in tune with the dynamics faced by the Trust. In terms of the report received by the Board of Directors, he asked if there were sufficient new initiatives to address historic challenges.

JE responded that there were a number of new initiatives: staff resources; new acute models; SAU: strengthened discharge processes; and strengthened ambulatory care pathways.

NW raised a concern which had recently been brought to his attention in relation to resourcing issues following the implementation of the second cardiac cath lab. This had impacted on delayed treatment for non-emergency patients. He requested that action be taken to address this problem which was having an adverse effect on patient experience and efficient hospital flows.

SB responded this was a complex issue. Implementing a second cardiac cath lab needed to be staffed robustly and safely. A business case had been developed. Due to the cost, formal approval was required in line with the Trust's Standing Financial Instructions. Discussions were taking place to address this.

18 week RTT Performance:

JE reported the Trust was non-complaint against the admitted RTT standards in line with the agreed plan to clear the backlog position.

The majority of the backlog was within orthopaedics. In addition, an issue linked to staff resources resulted in an increase in dermatology referrals during the summer.

Work was ongoing to clear long waiters and to improve pre-assessment and outpatient planning processes.

Modelling would be undertaken to determine actions required to move to a compliant position by April 2015. Discussions would take place with CCGs to ensure a joint understanding. It was anticipated Monitor would be supportive of this action.

Board of Directors discussion (18 week RTT Performance):

RE asked if there was sufficient capacity internally and externally to deliver compliance from April 2015.

SB stressed the need for a whole health economy response, specifically to manage existing referral patterns. Commitment to redesign of pathways was required to achieve sustained performance beyond April 2015.

It was anticipated Monitor would organise a summit meeting with key partners to ensure a coherent understanding and action across the health economy.

JE reminded the Board of Directors the Trust had not been compliant in orthopaedics long term due to capacity issues. Modelling work being undertaken would identify internal capacity and gaps. This would be reported at the next Performance Review Meeting with Monitor.

RE asked if there was sufficient capacity in other specialties to move the Trust to an overall compliant position by April 2015. JE confirmed there had already been significant improvement in other specialties.

Cancer Performance:

The Trust reported non-compliance against the two week symptomatic breast referral, 31 day subsequent surgery and 62 day GP standards for October 2014.

JE reported two week wait referrals were coming back in line. It was anticipated compliance would be achieved from December 2014. Symptomatic breast and 62 day GP Standard remained a challenge. In terms of the latter, lung, urology and colorectal were the most significant areas of challenge.

Communication by GPs to patients regarding their referral pathways remained a challenge.

Board of Directors discussion (cancer performance):

Following a question raised by VO, JE reported the Trust's clinicians continue to work with GPs to raise awareness of their responsibilities to communicate referral pathways to patients. Leaflets had been circulated.

Diagnostic Performance:

All modalities reported compliance with the exception of endoscopy due to staff

resource issues. It was anticipated compliance would be achieved from January 2015 at the least.

Board of Directors decision/agreed actions:

- The Board of Directors noted the performance position as at October 2014 and areas on non-compliance as reported. — Noted
- In terms of A&E, NW asked if detail could be added to the report of the number of delayed discharges. — JE
- Agreement would be sought from Monitor to continue non-compliance against 18 week RTT until April 2015. — JE

267/14 **CORPORATE PERFORMANCE REPORT**

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

The level of efficiency within the tariff for 2015/16 would be slightly less than previously publicised at 3.8% but would remain a significant task for the Trust.

There was likely to be a re-setting of non-elective thresholds from 40% to 50%.

Activity reported lower than plan for October 2014, driven by reduced elective activity. Non-elective activity remained above planned levels, with primary care referrals exceeding plan by 6%.

Despite a breakeven I&E position for the second consecutive month, the year to date position reported £1.8m behind plan after full application of the contingency.

The financial position was driven by high levels of expenditure, specifically related to temporary staffing and non-delivery of CIP.

The cash position remained healthy at £28m. This position drives the CoSRR rating of 4 in line with plan. Monitor confirmed they were comfortable with the strong cash and liquidity position reported by the Trust.

The forecast position for CIPs was £5/£6m adverse to plan. Executive Leads had been identified for each of the performance areas.

JS (as Chair) provided feedback from the Finance and Investment Committee meeting held on 25 November 2014:

Assuming the financial performance was sustained, the year end position was likely to report £2m adverse to plan. Risks included: finalisation of last year's contract with the CCG: and costs related to CQC improvements.

JB clarified £650,000 contingency had been allocated in the accounts associated with the CQC improvements. Work was ongoing to identify actual spend. He added the current working plan for next year reported a deficit of £2m. Work was ongoing to move this to a break even position. This included £6.5 contingency and a reserve related to CQC improvements. The working plan also assumed CIP continuation of £25m.

JS reported the FIC was concerned regarding the CIP continuation following non-achievement this year (2014/15) and would be monitoring this closely.

Board of Directors discussion:

Following a question raised by PP, JB confirmed the Dover build was on target as was achievement of the year end £30m cash balance.

Discussion ensued regarding the potential impact on staff costs to achieve compliance against the 18 week RTT. SLB had undertaken work to improve recruitment timelines. This would impact positively on temporary staffing.

Achievement of access targets would form part of the additional surge resilience funding. Maintaining control was key.

JB highlighted Urgent Care and Long Term Conditions Division reported a break even position for October 2014 which was a reflection of tightened controls.

JE referred to the decommissioning of ICATs and the resultant impact on orthopaedics. The Board of Directors noted the varying ability of CCGs to meet financial challenges faced by the health economy, over and above the managed contract.

LS reported she was working with Divisions in terms of CIPs. The current position was £2-£3m adverse to plan. Divisions were working to identify non-recurrent schemes for the remainder of this year. When discussing plans for 2015/16 and beyond, the Trust needed to be explicit about non-recurrent schemes going forward.

Board of Directors decision/agreed actions:
The Board of Directors noted the financial performance position as at October 2014. Noted

268/14 **REVIEW OF ONGOING COMPLIANCE AGAINST SELF CERTIFICATION**

The Board of Directors confirmed performance was in line with reports previously presented to the Board. The reports incorporated a true reflection of the challenges faced by the Trust.

269/14 **QUESTIONS THE PUBLIC ON PAPERS WITHIN THE PERFORMANCE SECTION**

Mr Edel raised questions of the Board and the following responses were noted:

SB confirmed the CQC would almost certainly undertake an unannounced inspection to assess whether the Trust had taken sufficient action to address recommendations in their report.

The Trust would be mindful of difficulties members of the public who suffer from colour blindness may experience reading Trust reports (relating to RAG rated reports).

The Trust used a number of different tools for project management purposes.

The cost of implementing the CQC action plan was being quantified. Quality and safety issues would be addressed. SB stressed it was important improvements became 'business usual' for the Trust.

270/14 **DELIVERING OUR FUTURE: UPDATE ON CLINICAL STRATEGY WORKSTREAMS**

LS presented the paper which provided an update on the clinical strategy programme. The following key messages were noted:

Engagement with stakeholders had commenced in terms of plans, specifically reviewing activity and capacity analysis.

Individual workforce plans were becoming clearer in terms of future workforce requirements for proposed models.

A recommendation would be brought to the next Board meeting (closed session due to commercial sensitivities) regarding the strategic estates partner.

In terms of the outpatients work stream, work was ongoing with Divisions to prepare for extended working days. Estuary View was scheduled to go live on 5 January 2015. The Dover Hospital development was on plan for completion in March 2015.

Board of Directors discussion:

RE referred to the Education and Workforce work stream which had been delayed in becoming established. He asked if support was required from the Board. LS clarified the delay was due to staff absence but was confident this would now be resolved.

SB referred to transport investment and asked if all new routes had been established. LS reported additional links from the Ashford Train Station to the William Harvey Hospital and Kennington were all in place. Additional routes to Estuary View would be in place ready for the go live in January 2015. Additional routes to the new Dover Hospital would be linked to the opening.

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

271/14 **QUESTIONS FROM THE PUBLIC ON PAERS WITHIN THE STRATEGIC SECTION**

No questions were raised at this point in the meeting.

MT, MF and AB joined the meeting.

272/14 **CORPORATE RISK REGISTER – TOP 10**

JP presented the report which reflected an update as at 19 November 2014. She drew attention to the emerging risks and reported these would be monitored by the Quality Assurance Board and Integrated Audit and Governance Committee.

Board of Directors discussion:

NW referred to the aseptic risk which was ranked 8 on the register. He reported feedback from a patient who was complimentary about staff and the service received in Cathedral Ward but drew attention to the delay he had experienced in treatment because the supply of the drug he required had been held up in a motorway incident. NW asked for an update on progress to re-stablish the Trust's own aseptic unit.

MT responded manufacturing had commenced and was currently at 30%. She provided assurance work was ongoing to achieve 60% by April 2015. A strong lead had been appointed to the Department. External assessors were on site today (28 November 2014).

SB referred to the emerging risk related to staffing issues within the child safeguarding team. He asked how this was being mitigated. JP reminded the Board of Directors of the resourcing issues nationally. However, the Trust had established development roles for staff to obtain the knowledge and expertise required. She was confident these staff would eventually apply for permanent posts.

PP reported the Integrated Audit and Governance Committee regularly receive reports from the Safeguarding Team. He reminded the Board of the changes nationally to the standards of training required.

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

273/14 **PATIENT ADMINSTRATION REVIEW PROGRAMME UPDATE**

- **PATIENT ADMIN REVIEW (BOOKING AND RECEPTION SERVICES)**
- **18 WEEK PATHWAY REPORTING**
- **PAS PROCUREMENT**

Patient Administration Review

Mary Tunbridge, Divisional Director (Clinical Support Services) provided a presentation on the improvement work undertaken in outpatients and the key drivers for change. The presentation also identified key findings from the CQC report and mitigating actions.

Board of Directors discussion (Patient Administration review):

PS asked if clinicians would be able to manage their own clinic bookings in the future. He referred to overbooked clinics which cause challenges. MT responded it was important to co-align administrative support to clinical staff to appropriately book patients.

CC asked for details of the outcome measures, milestones and timescales for implementation. MT responded KPIs related to: DNA rates, full booking performance and capacity and demand. It was anticipated it would take approximately 18 months to roll out across the Trust.

JS referred to the opening of Dover Hospital and asked if full cooperation had been received from all Departments. MT provided assurance engagement work had been undertaken to review current and future service provision. Job planning would be undertaken to implement the extended working day.

18 Week Pathway Reporting

Marc Farr, Director of Information, provided a presentation on the improvement work being undertaken in the 18 week pathways. He explained the elements to the project: upgrade to the existing system; training staff who interact with PAS on how pathways work; and 18 week reporting (statutory reporting).

Board of Directors discussion (18 Week Pathway Reporting):

SB asked for assurance no patients would be affected by the system upgrade. MF reported a dedicated team would be established to transfer existing patients onto the system.

Following a question raised by VO, MF confirmed implementation of full booking would enable patients to receive appointments for their entire pathway.

SLB asked if the system could be future proofed to accommodate future changes to 18 week reporting. MF responded a testing environment would be established prior to roll out.

RE referred to the important role of the medical secretary and asked if this group of staff was full engaged. MF provided assurance awareness and training was in place and this group of staff would be included.

Following a question raised by JE, MF confirmed e-learning was due to be delivered to the Trust today (28 November 2014).

PAS procurement

Andy Barker, Director of IT, provided a presentation on the progress with the PAS and Maternity Replacement: Procurement process; opportunities; and governance.

Board of Directors discussion (PAS procurement):

AB reported assurance had been received from the Southern Acute Cluster Programme there would be no risks to the process as a result of delays between MTW and the TDA.

RE commented the plan described a coherent business design, delivery and technology phase. He added it would make sense to incorporate a fourth phase: exploitation. Noted

Board of Directors decision/agreed actions:

The Board of Directors noted the update.

274/14 **MEDICAL DIRECTOR'S REPORT: MEDICAL REVALIDATION**

PS introduced the report which was presented to the Board for information. The report provided an update on medical appraisal and revalidation.

Board of Directors discussion:

RE asked if the process had made a difference to clinical effectiveness. PS explained the way in which medical appraisals were conducted had been strengthened. In terms of appraisal rates, data was collated at Divisional level. Rates had improved but further work was required.

PS provided assurance there were no issues to draw to the Board's attention in terms of outcomes.

Following a question raised by JS, SLB reported it was too early to ascertain whether the system would impact on consultant turnover.

VO referred to the data and was concerned only 40% of doctors were appraised in the first quarter. PS explained appraisal dates can slip which were then recorded as incomplete. Data reported an improving position.

SB added he was satisfied PS was actively following up with each individual doctor to ensure appraisals were completed. Those who have not completed appraisals were not eligible for Clinical Excellence Awards.

JE asked if deferral processes were in place for consultants on long term sick. PS clarified there was a requirement for appraisal 6 months after returning to work.

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

275/14 **BOARD COMMITTEE FEEDBACK**

Finance and Investment Committee Chair Report
JS (FIC Chair) reported the main agenda items:

- The latest financial and activity performance was discussed (as covered in minute number 267/14).
- A presentation was received reporting the outcome of the assessment undertaken which demonstrated the Kent Pathology Partnership had not lessoned competition in market share.
- A first draft of the financial strategy was received by the Committee.
- An update on the ICT review was discussed.

Charitable Funds Committee Chair Report
VO (Committee Chair) provided the following feedback:

- The next major Appeal had been launched, focussed on dementia.
- The Committee received an update on the appointment of a new fundraiser.
- The financial position of the charity was reviewed. A specific discussion was also held regarding the status of legacies.

Following a comment made by CC, NW/VO stressed the major appeal would benefit dementia patients and their relatives across all hospital sites. As reported earlier in the meeting, the population of over 75s had increased by 25% over the last 10 years and the trend was likely to continue. VO would discuss making this more explicit through the Committee.

276/14 **CHIEF EXECUTIVE'S REPORT**

SB presented the report and drew attention to:

- Fundamental Standards Regulations.
- EKHUFT ebola preparedness.

277/14 **FEEDBACK FROM THE COUNCIL OF GOVERNORS**

NW reported main agenda items from the Council of Governors meeting held on 8 November 2014: Performance update; CQC Action Plan update; Audit of mortality trends in young adults (as received by the September Board); and a business planning 2015/16 update.

The Council undertook a recent effectiveness survey and the analysis of results were discussed in closed session. Two areas of focus were identified by NW: to strengthen engagement with membership; and to strengthen contact with Non Executive Directors.

The Council agreed to build into Meetings of the full Council an opportunity for a free discussion item – this would be included on the agenda for the closed session.

The Council was in agreement agendas could sometimes be too lengthy. As a consequence, where appropriate, presentations of general interest would be shared outside of the meeting cycle to allow more time for main business and statutory items. Finally, Committees would be encouraged to use the full Council to develop ideas around their work programmes.

The Council had also completed a survey undertaken by KPMG. A draft report had been received and once finalised would be shared with the full Council. Early feedback suggested EKHUFT Governors devote a higher than average amount of time to their role and overall feel sufficiently equipped to carry out their duties.

The 2015 Governor election process had commenced. Twelve of the 22 public/staff positions were up for election. A reasonable degree of interest had been expressed.

Feedback from NEDs aligned to CoG Committees:

VO reported back from the last Patient and Staff Experience Committee:

- Concern was raised by Governors regarding training shortfalls and ability of staff to attend.
- Issues about access to mandatory training were discussed. VO was pleased to note the actions being taken by SLB as reported earlier in the meeting.
- The Committee received a report from the Children's Safeguarding service. The Committee was concerned regarding training challenges.
- Governors on the Committee offered their services to work with the Trust in

terms of the CQC action plan. NW reported he had agreed with the Committee Chairs to wait until the staff survey results had been published. Also to obtain ideas from the wider Council.

NW reported following the resignation of Steve Tucker, as NED of EKHUFT, RE would align with the Council of Governors Communications and Membership Committee as NED representative.

The Board noted its gratitude to the continued work and support of the Council.

278/14 **ANY OTHER BUSINESS**

RE reported he had agreed to meet with a recently elected Governor to share his view of the role of NEDs.

SB reminded the Board of Directors this was JB's last meeting prior to leaving the Trust. The Board noted thanks to JB for the work undertaken during his time with the Trust.

279/14 **QUESTIONS FROM THE PUBLIC ON PAPERS WITHIN THE INFORMATION SECTION**

Mr Edel raised questions of the Board and the following responses were noted:

The Board of Directors noted the tear off slip on appointment letters would necessitate patients keeping their own personal record of appointments.

PS explained processes in place to monitor practice of clinicians. Concerns raised to the Medical Director were investigated. Regular appraisals were undertaken.

The following acronyms were explained:
- PAS – patient administration system
- PTL - patient tracking list
- SAcP – Southern Acute Cluster Programme

Date of Next Meeting:
Thursday 29 January 2015, Board Room, Kent and Canterbury Hospital

Signature _____

Date _____