MINUTES FROM THE TWENTY-SEVENTH PUBLIC MEETING OF THE COUNCIL OF GOVERNORS FRIDAY 7 NOVEMBER 2014, JULIE ROSE STADIUM, ASHFORD

PRESENT:

Nicholas Wells	Chairman	NW
David Bogard	Elected Staff Governor	DB
Mandy Carliell	Elected Staff Governor	MC
Professor Alan Colchester	Elected Staff Governor	AC
Jocelyn Craig	Elected Governor – Ashford	JC
Geraint Davies	Nominated Governor – South East Coast Ambulance NHS Trust	GD
Roy Dexter	Elected Governor – Thanet	RD
Paul Durkin	Elected Governor – Swale	PD
Carole George	Elected Governor – Dover	CG
Brian Glew	Elected Governor – Canterbury	BG
Alan Hewett	Elected Governor - Shepway	AH
Vikki Hughes	Elected Staff Governor	VH
Reynagh Jarrett	Elected Governor – Thanet	RJ
Eunice Lyons-Backhouse	Elected Governor – Rest of England and Wales	ELB
Michael Lyons	Nominated Governor – Volunteers Working with the Trust	ML
Dee Mepstead	Elected Governor – Canterbury	DM
John Sewell	Elected Governor – Shepway	JS
Philip Wells	Elected Governor – Canterbury	PW
Junetta Whorwell	Elected Governor – Ashford	JW
Matt Williams	Elected Governor – Swale	MWi

IN ATTENDANCE:

Mark Austin	Assistant Finance Director *(Minute No. 61/14)*	MA
Stuart Bain	Chief Executive	SB
Jeff Buggle	Director of Finance and Performance Management	JB
Chris Corrigan	Non Executive Director	CC
Richard Earland	Non Executive Director	RE
Alison Fox	Trust Secretary	AF
Peter Gilmour	Director of Communications	PG
Helen Goodwin	Deputy Director of Risk, Governance & Patient Safety *(Minute No. 59/14)*	HG
Melanie Hill	Corporate Planning & Performance Lead *(Minute No. 61/14)*	MH
Rachel Jones	Director of Strategy and Business Development	RJo
Sandra Le Blanc	Director of HR	SLB
Sue Lewis	Improvement Director	SL
Jonathan Spencer	Non Executive Director	JSp
Dr Paul Stevens	Medical Director	PS
Dr Michelle Webb	Consultant Nephrologist *(Minute No. 60/14)*	MWe
Dee Boorman	Committee Secretary (Minutes)	DBo
Stephen Dobson	FT Membership Engagement Co-ordinator	SD

MINUTE NO.		ACTION
55/14	**CHAIRMAN'S INTRODUCTIONS** The Chairman welcomed Governors and members of the Board to the meeting.	

MINUTE NO.		ACTION

56/14 **APOLOGIES FOR ABSENCE AND DECLARATIONS OF INTEREST**

Apologies were noted from:

Cllr Patrick Heath	Nominated Governor (Local Authorities)
June Howkins	Elected Governor – Shepway
Derek Light	Elected Governor - Ashford
Peter Presland	Non Executive Director
Liz Rath	Elected Governor – Dover
Marcella Warburton	Elected Governor – Thanet
Martina White	Elected Governor – Dover

SB and JB declared their interest in both Healthex and EKMS and PS declared his interest in EKMS.

57/14 **MINUTES FROM THE LAST PUBLIC MEETING HELD ON 7 JULY 2014 AND MATTERS ARISING**

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

Updates on actions from the previous meeting were noted and the following verbal update was given:

51/14 CoG Committees – P&SE Committee
NW wished to strengthen the link between Governors and the Non Executive Directors as part of the plans to enhance engagement and communication within the Trust. Governors' participation was also welcomed in the We Care workshops. ELB, DM and NW agreed to meet outside the meeting to discuss the P&SE Committee's staff engagement work programme. — NW / ELB / DM

58/14 **PERFORMANCE UPDATE**

SB reported that the pressure on A&E had continued throughout Q2, with high levels of attendance across the sites. The situation at QEQM was compounded by the CQC's closure of five nursing homes in Thanet. The residents had had to be moved at very short notice into other facilities, including EKHUFT's beds, thus reducing capacity further. Performance throughout Q3 so far had been poor and it was not certain that the A&E target would be achieved in that Quarter either.

The Symptomatic Breast 2 Weeks and 62 Day cancer targets were also missed in Q2. The Symptomatic Breast pathway had seen a rise in the number of referrals by Primary Care. Some of this was appropriate and driven by campaigns but some patients were unaware that they were on an urgent pathway. As these instances still counted as breaches of the target, further work was required with GPs to ensure that appropriate advice was being given at the point when patients were referred to the Trust.

Diagnostic capacity, particularly endoscopy procedures, was challenged which had impacted on the 62 Day target. Staff shortages had also resulted in a delay in the opening of the new endoscopy unit at WHH.

A recovery plan was in place and the unit was now open. SB was reasonably confident that performance in the diagnostic pathways would be recovered in this Quarter and the target would be achieved in Q3. Use of Choose & Book would help to alleviate the problems, but GPs' incentive to use the system had been withdrawn and they had reverted to paper referrals. However, there had been improvements in the cancer pathways recently and the Trust intended to ensure that the cancer targets for Q3 would be achieved.

Regarding the 18 weeks pathway, a backlog had built up, particularly in Orthopaedics and there were now c.1400 breaches. This was partly due to the de-commissioning of the community based service for Orthopaedics as those patients were now arriving at the hospital. The Trust had identified a way forward, which included a planned failure of the RTT target. There was recognition that the Trust needed to tighten up internal procedures but also awareness of the external factors that were out of the Trust's control and Monitor had indicated that a system-wide meeting to work through the issues might be required. Meetings were being held twice a year between the Trust and the Federation of CCGs and these provided another opportunity to build relationships and address the system-wide issues.

Council of Governors discussion:

BG posed the following questions.

1. Were the Non Executive Directors able to provide assurance that the Trust's response to performance challenges was sufficiently integrated, and that the Trust was doing all it should be?

   SB replied that the Trust had historically been willing to absorb bed pressures however last Winter, despite a plan and funded bed base, extra beds were put on wards and staff were too stretched. The Board had therefore agreed that it was no longer feasible to put up beds that were beyond planned escalation. NW added that was vital to make sure that all the action plans and activity were joined up; there was further scope for integration and the action plans needed to be more succinct. A key area of linkage was the diagnostic work as this created headroom in pathways. The Trust also planned to recruit a full time Chief Operating Officer to focus on integration and solutions.

   RE responded that he was certain about the actions that were required and the Non Executive Directors sought assurance that the opportunities presented at meetings with the CCGs were maximised. JS added that the Trust was able to instigate actions within its own system but CCGs did not have the same ability with GPs.

2. The CoG Strategic Committee was exploring the extent to which CCGs and other providers in the new local health economy structure were working together to focus on strategic developments. Did Non Executive Directors believe that enough was being done successfully with partners?

   NW stated that it was vital that the Trust worked with the local health economy. In the past proactive working had been lacking but he believed there was now a desire for more collaboration.

There was also a requirement to clearly communicate the details behind targets. Strategy needed to be addressed in a more integrated way and the Trust and CCGs were working on various approaches towards this which needed to be drawn together.

RE stated that an integrated approach was one of the most significant challenges ahead and assured the Council that the Non Executive Directors sought to understand and influence it more.

CC believed that the Trust needed to be more proactive, to work with GPs to understand the Choose & Book situation and rising referrals. He welcomed liaison with individual GPs as well as CCGs.

CG believed that percentages could mask what was actually occurring and welcomed visibility of the data underneath the targets. SB explained acute hospitals would not refuse to treat people but there needed to be reliance on the system as a whole. An example of this was the use of funding to create an Integrated Discharge Team.

JW asked about staff shortages, in particular in orthopaedic surgery. SB stated that the 26 orthopaedic surgeons were insufficient to meet current and growing demand. The Trust was working on how resources could be used more efficiently. The main deficit was in sub-specialty areas. PS added that Social Care had now implemented a seven days/week service and the Community Trust was running a pilot in West Kent for admission avoidance which it was hoped would be rolled out into East Kent.

DB was aware of the recruitment of staff from Europe and the training programmes in place, but the places were limited by funding and he believed that many people would be prepared to self-fund. SB agreed but the system was complex in that commissioning of training spanned three counties and the funding flowed through Health Education England. Additionally, in several months time doctors in training would be required to spend a greater length of their time in mental health and community settings which would reduce their time in the acute environment. The Executive Team had started to consider different models of delivering services including retention of staff.

Council of Governors agreed actions/decisions:

The report was noted. Noted

59/14 **CQC INSPECTION UPDATE**

HG gave a presentation which covered:

- Published reports
- Key areas for improvement
- The Trust's approach to improvement
- What we have done so far
- Involving and engaging our staff
- Communicating our progress
- Performance monitoring process

The Trust had accepted the key findings and 'must do' issues. The timeframe was challenging for the cultural change required and it was therefore important that staff were aware of progress and how they could contribute before the CQC's re-inspection. The Trust was committed to improving relationships with partners and commissioners.

SL explained her role to the Governors, being an independent person tasked with overseeing the progress and implementation of the action plan and its sustainability. SL had met many staff and Governors and was aware of the challenges of a multi-site Trust and complex health economy. SL believed that progress was being made and work was underway to change the culture of the organisation to enable staff to feel engaged.

Council of Governors discussion:

PW asked if the amount of green reflected an appropriate RAG rating measure. The format for the NHS Choices action plan was prescriptive and the chart depicted the Trust in the first days of Special Measures and would change as work progressed.

AC believed that there was a real opportunity to use the CQC's findings to drive improvement but asked where the resources for this would come from. SB advised that there was now an action plan as well as 'business as usual' to progress. Much of the plan involved the same activity but it would be handled in a different way. Some work needed to be re-prioritised and some would result in savings. Investment would be required for one-off issues but the Trust would need to remain within its budget and maintain financial discipline.

ML asked if it was possible for Governors to be informed as soon as data was available on the website as well as information arising from key meetings. NW confirmed that effective communication to staff and the Governors was vital and he would be discussing this with the Director of Communications.

JW asked whether complaints were being made by patients or staff. HG advised that the Complaints Team received written and verbal complaints from patients rather than from staff and Divisions were working hard to make sure that responses were addressing the problems raised without the need for further investigation. It could be difficult to respond to complaints via the Friends and Family Test as feedback was not always attributed to an individual so themes needed to be picked up. SLB added that the Raising Concerns Policy had been revised and was being taken through consultation. The internal auditors were satisfied that it reflected best practice.

JC asked if the re-structuring of the Complaints Team was a continuation of the earlier work or another re-model. HG confirmed that the original restructure was being developed in order to strengthen it further. The increasing number and complexity of some of the formal complaints required negotiation on a realistic timetable for a full response. Staff also needed to contribute to responses.

NW agreed to relay the above comments to the Complaints Management Steering Group. NW

MWi asked about the mechanisms that could be employed when the success of an issue depended on another partner. SL advised that Monitor's guidance was that issues that required unblocking to obtain a Green rating would be discussed at the performance Review meeting with Monitor and the other stakeholders.

BG commented as follows:

1. It would be useful to learn of the new senior appointments that had recently been made and to refresh the responsibilities and accountabilities of Board members and these new posts so that the Governors could be assured of proper integration.

2. How would Governors be involved in the external governance review?

   NW explained that Deloittes' work would include surveys and focus groups. The Governors confirmed that they wished to take part in the survey and NW agreed to advise Deloittes. A focus group for the Governors had also been scheduled for 20 November at 10:30 in the Board Room at K&C. Governors agreed to let AF know if they wished to attend. — NW / All

3. There was a sense that staff felt able to talk to Governors as an independent group and the Governors needed assurance that the Trust was moving in the right direction.

   NW advised that SLB was collating the cultural work, including We Care, workforce issues, raising concerns and engagement. They planned to meet to prioritise this and a summary of progress would be given at the next CoG meeting in January. External support would include contact with other Trusts.

There was concern that there could be a conflict of interest for the Board lead for children and young people and NW and DM agreed to discuss this outside the meeting.

Council of Governors agreed actions/decisions:

There was concern that there could be a conflict of interest for the Board lead for children and young people and NW and DM agreed to discuss this outside the meeting. — NW/DM

60/14 **MORTALITY TRENDS IN YOUNG ADULTS**

MWe gave a presentation on a case note review of deaths in young adults. It included: what had prompted the review, initial data, the facts around Sepsis, omissions which may or may not have impacted on the outcome, and diagnoses where better care delivery might have made an impact. The Trust was not an outlier with regard to death by Septicaemia or pneumonia but there was room for improvement. The Sepsis Collaborative had been launched which would improve recognition, ensure timely and reliable delivery in the Sepsis pathway and introduce real time monitoring of the pathway.

Council of Governors discussion:

RJ asked at what level was there failure to recognise Sepsis - patients' observations were now entered on VitalPac and when a specific level of deterioration was reached, a doctor would be informed. MWe explained that the deterioration from uncomplicated to severe Sepsis was difficult to track - in the young adult population there was little evidence until they were within hours of death. There were instances when the appropriate response to observations did not take place, and when the observations were not particularly abnormal but other warnings should have alerted teams. Hopefully the work of the Sepsis collaborative will address these.

AH questioned whether clinical decisions to withdraw antibiotics conflicted with advice in the community. MWe explained that a balance needed to be struck and antibiotics needed to be prescribed appropriately. There was now acknowledgement that Sepsis was a health system-wide problem and the Sepsis Collaborative had benefited from engagement by SECAmb, the community and GPs. SECAmb had been running a pilot in Sussex involving a checklist for Sepsis, and this would be rolled out across Kent.

JC noted that blood collection was a simple blood test and asked if this would still be the case following the reorganisation of the pathology service. MWe confirmed that the service would be available on all three sites.

Council of Governors agreed actions/decisions:

MWe was invited to a future CoG meeting to report on the success of the Sepsis Collaborative. — Noted for planner

61/14 **BUSINESS PLANNING 2015/16 UPDATE**

MH took the Council through the planning process to date and MH and MA gave a presentation which covered: current assumptions and objectives of the planning process, key estimated dates and non-NHS income definition. The process was slightly behind last year's because of the integration of a variety of challenges, e.g. CQC report, delay in guidance and release of the tariff due to its possible re-structure.

Following consideration of the forecast outturn for this year, the NHS and non-NHS income had been split. The definition of NHS income was any activity that is commissioned directly for patients by an NHS Commissioner that is provided free to patients.

Council of Governor discussion:

RJ asked about the impact on CCGs' commissioning of some services from private companies e.g. physiotherapy, audiology and Stoma Care, particularly in Thanet. The One to One midwifery service to deliver a service to local communities would also have an impact on the Trust's activity and MH agreed to explore this. NW added that each month the Finance & Investment Committee reviewed a list of all the tenders that were in underway in the healthcare community. — MH

JW asked about the ease of obtaining payment for treating accidents from insurance companies and MA explained the process via the Department of Health.

BG stated that in view of the focus on the Trust's inter-relationship with others in the local health economy, it would be useful for the plan this year to explain how that partnership working would be achieved. He also welcomed inclusion of key areas of future procurement and comment on the current and future pressures on managing discharges and bed occupancy in the Trust.

NW advised that this would be discussed at the CoG Strategic meeting in December. It was important that the 5 year Strategy included how all the various healthcare elements would work together. JS was concerned that it would be challenging for the Trust's plans to be closely aligned to the CCGs'.

MH explained that the CCGs' Board meeting minutes were reviewed and any planning issues logged. Strategic Development also worked closely with them to align initiatives. The Trust was also fully aware of their commissioning intentions.

NW mentioned the letter from Monitor which included a number of clear benchmarks to take the strategic plan forward, encouraging the Trust to re-visit regulations, monitor whether implementation was on track, test whether underlying assumptions would hold true, examine whether the external environment had changed and whether the Strategy's goals were still appropriate to the local health economy's needs.

Council of Governors agreed actions/decisions: Noted

The update and presentation were received with thanks and noted.

62/14 **COUNCIL OF GOVERNORS DECLARATIONS OF INTEREST – QUARTERLY REVIEW**

AF had received some additional comments since publication. The Governors agreed to forward any changes to AF by 14 November. All By 14 Nov

63/14 **COUNCIL OF GOVERNOR COMMITTEES**

Communications and Membership Committee

BG gave the following highlights from his report.

As at November, the Membership had reached 11,401 public members, and he thanked the Membership Office and Communications team for this achievement over the year.

There was a risk that the newsletter would not be able to continue if more articles were not submitted. Communication with the membership was one of the Governors' key roles and the newsletter was one mechanism for this. MC agreed to confirm the deadline for the next edition. DM and RJo agreed to jointly produce an article on new arrangements in Outpatients. PD's article on ultrasound would also be taken forward by MC. MC DM/ RJo MC

RJ sought clarity on the guidance which appeared to ask for articles that were associated with the work of the Governors. NW advised that Governors should not be restricted by this; he believed it would also be helpful to have a Governors' perspective on the implementation of the CQC action plan.

Regarding development of IT, BG explained that the letter that was collectively sent about the CQC report had received very little feedback from Members. The move to electronic communication within other Trusts was evident and was EKHUFT's main direction of travel. However, this would not mean that hard copies of documents or other mechanisms, e.g. road shows, would stop.

Patient and Staff Experience Committee

DM presented the report and highlighted that the Committee was concerned that some staff felt unable to attend training programmes due to pressure of work. There was agreement that this was de-motivating and left a gap in skills, particularly relating to Child Protection. SLB agreed to discuss this with JP. SLB

Strategic Committee

JS reported that the committee had discussed the CQC action plan. A presentation on strategic estates and partnership had outlined the pros and cons of different arrangements. To allay some Governors' concerns, JS confirmed that there had been no change in the direction of travel for the Clinical Strategy; there has been slippage in the private patient plan, KPP and A&E for understandable reasons.

The proposal to drop the word 'Interim' from the Trauma Unit was noted – the unit was well regarded and the term had related to the unit's location rather than its status.

Nominations and Remuneration Committee

PW reported that the committee had met in October. NW had been asked if he would remain in post after September; although he remained committed to the work of the Trust, he believed it best to leave when his term ended unless it was significantly advantageous to the Trust to remain for a little longer.

The committee had agreed to meet in January 2015 following publication of the external governance review guidance. However, it may be necessary to meet beforehand to commence preparations for the Non Executive Director recruitment.

Approved

The Terms of Reference were approved.

Audit Working Group

The committee had not met since October. PW thanked RJ for his work as the lead Governor for this committee, particularly through the appointment process for the external auditors. KPMG held a training session in September which was well attended.

Council of Governors agreed actions/decisions:

Noted

The reports were noted.

64/14 **FEEDBACK FROM GOVERNORS WHO ATTEND WIDER TRUST GROUPS/ COMMITTEES**

The reports were noted. Noted

65/14 **QUESTIONS FROM THE PUBLIC**

There were no questions from the public.

66/14 **ANY OTHER BUSINESS**

Governors' Expenses

JC asked for an update on Governors' expenses. MC confirmed the reversion to paper submissions. It was thought that some Governors were receiving an incorrect rate as they had not completed the necessary documentation. NW clarified that 45p rate was agreed by the Council for Non Executives and Governors from 1 April 2014 and this would be backdated if necessary. SLB agreed to investigate problems outside the meeting and feed back to the Governors.

New Governor

Debra Teasdale of Canterbury Christchurch University was now a Partnership Governor.

Governor Elections

Governor Elections were now underway and several Governors had agreed to participate in the awareness sessions.

67/14 **DATES OF FUTURE MEETINGS**

The dates of the Council of Governors' meetings for 2015 were noted. Noted

DATE OF NEXT MEETING

Friday 16 January 2015 at Smiths Court Hotel, 21-27 Eastern Esplanade, Cliftonville, Margate.