Agenda item: 3

The Queen Elizabeth Hospital King's Lynn
NHS Foundation Trust

DRAFT

Board of Directors (IN PUBLIC)

Minutes of the meeting held 1 June 2021, at 10:00am via MS Teams

Present:

S Barnett (SB)	Trust Chairman
A Brown (AJB)	Non-Executive Director (NED)
I Mack (IM)	Non-Executive Director (NED)
G Ward (GW)	Non-Executive Director (NED)
C Fernandez (CF)	Non-Executive Director (NED)
S Roberts (SR)	Non-Executive Director (NED)
D Dickinson (DD)	Non-Executive Director (NED)
C Shaw (CS)	Chief Executive Officer (CEO)
D Smith (DS)	Chief Operating Officer (COO)
L Skaife-Knight (LSK)	Deputy CEO (DCEO)
A Webster	Chief Nurse (CN)
C Benham (CB)	Director of Finance (DoF)
J Humphries (JH)	Director of People (DoP)

In attendance:

L Notley (LN)	Director of Patient Safety (DoPS)
G Raghuraman (GR)	Deputy Medical Director (DMD)
E Tabay	Director of Nursing (DoN)
Julie	Patient Story (agenda item 2)
S Gilder	Support Manager – Corporate Governance (minutes)

101/21 1. CHAIRMAN'S WELCOME AND APOLOGIES

The Chairman welcomed Board members to the meeting. All Governors are able to attend Board meetings in public to observe the virtual meetings and SB welcomed those present.

Apologies were received from Dr Frankie Swords, Medical Director, Carly West Burnham, Director of Strategy and Andrea Prime, Trust Secretary.

STANDING ITEMS

102/21 2. PATIENT STORY

LSK introduced the patient story and welcomed Julie to the Board.

Julie described her experience of contacting the Patient Advice and Liaison Service (PALS) to raise concerns about how she may be treated if she was to be admitted to the QEH as an emergency patient. Julie informed that Linda Purdy,

Associate Director of Patient Experience and LSK had contacted her on the same day of her enquiry to allay her fears and concerns. Julie feels that QEH is ahead of the game in terms of inclusion.

LSK informed that Julie had attended the LGBTQ+ Staff Network meeting last week to share her story with staff and discuss the prospect of working on education and training with staff through the work plans being delivered over the next 6 – 12 months.

CS thanked Julie and was pleased to hear that she has been reassured that she and all patients will be provided with their individual treatment care and needs in mind. There has been a change in culture within the organisation over the last 18 months that shows the Trust is responding appropriately to manage patient care. SB agreed with the need to take into account the patients requirements when offering treatment. It is really important to hear directly from patients to shape the correct approach to manage patient concerns. SB thanked Julie for sharing her story and for the input she has made behind the scenes this is very valuable to QEH.

LSK considered that Trust policies should be shaped by patients. The Trust is currently updating the Transgender Policy. Julie has critiqued the policy to improve and to ensure that it is fit for purpose. LSK thanked Julie in being instrumental in the Trust getting this right.

CF thanked Julie for sharing her important story. CF considered that patient experience should be at the centre of what the Trust is doing. CF is pleased that Julie will be part of the ongoing journey for training and education and was glad that she felt able to approach the Trust to resolve her concerns. CF asked Julie if she had any advice for other people about how they can approach QEH if they need to. Julie explained that she has shared with transgender networks to spread the word that the NHS is an inclusive body and patients should feel able to speak up when they need to.

SB thanked Julie on behalf of the Board of Directors for sharing her story and for her help in ensuring that the Trust offers care and access in the right way with due account of patient requirements. The Board offered Julie their best wishes for the future.

103/21 3. MINUTES OF THE PREVIOUS MEETING HELD ON 4 MAY 2021 AND MATTERS ARISING

The minutes of the previous meeting were approved as a correct record.

104/21 4. ACTIONS MONITORING

The Board received the actions monitoring log.

The Board agreed the following actions were complete and are to be removed from the action log: 101, 102, 103, 105 and 106.

The remaining actions were noted to be in progress for the timescales set out in the action log.

105/21 5. DECLARATIONS OF INTEREST IN ITEMS ON THE AGENDA

LSK reminded the Board of her previously declared interest in relation to agenda item 7 and 12. The Trust is working with IDP. LSK's partner is employed by IDP as previously declared in the Register of Interests.

106/21 6. URGENT ACTIONS (UNDER STANDING ORDERS PARA. 5.2)

None.

107/21 7. CHAIRMAN'S REPORT

The Board of Directors received the Chairman's report.

SB highlighted:

- The Cancer Wellbeing and Support Centre opened to patients in May 2021. The Centre was funded by the Trust's charitable fund. This is an excellent initiative and will provide support services to patients and their families.
- SB has written to say thank you to the supporters of the new hospital campaign. It is hoped that the key stakeholders will continue to work closely with the Trust to keep this item high on the agenda for decision makers and politicians to secure agreement for a new hospital build on the QEH site.

The Board noted the update report.

108/21 8. CEO'S UPDATE

The Board received the Chief Executive's report.

CS highlighted:

- May has continued to be a very busy month for the Trust. There is focused effort on restoration and recovery.
- There has been significant demand for emergency and elective services.
- The Day Surgery Unit (DSU) re-opened on the 10 May 2021 and has been very busy as has the Sandringham and Endoscopy units.
- The Emergency Department (ED) has experienced significant demand with a record number of attenders on some days.
- The Trust is thankful to the League of Friends (LOF) for reopening the hospital shop. Staff and visitors are delighted and pleased to welcome the team back.
- The Trust has been selected as one of just ten Trusts nationally to take part in the national pilot for phase two of the Rainbow Badge. This will allow the Trust to showcase the LGBTQ+ Network and moving forward to develop towards accreditation in cultural and engagement developments.
- The Electronic Prescribing and Medicine Administration (ePMA) system has been successfully implemented on West Raynham and West Newton wards. Staff have provided very positive feedback. The system will provide improved patient safety and is being rolled out to all ward areas.
- CS joined a virtual call with Lady Philippa Dannett, Lord Lieutenant of Norfolk, and Ian Razzell, East of England Lead for the Veterans Covenant Healthcare Alliance to discuss the Trust's recent accreditation as a Veteran Aware Hospital. Feedback was provided that QEH is leading the way nationally in this field.

SH queried the visiting restrictions being partially lifted and asked what the position is for patients with dementia. AW responded that for patients who have specific needs, including patients with learning difficulties, dementia, paediatrics and those for End of Life (EOL), visiting is on a risk assessed basis and this may be more than restricted visiting. Visiting restrictions remain in place currently with regular review.

DD queried how long it will take to roll out Electronic Prescribing and Medicines Administration (ePMA) to the rest of the hospital. LSK responded that the Trust expects the full roll-out to be completed by September 2021.

IM commented on the increasing number of patients attending ED and queried what work the Trust is doing to assure that patients attending ED are appropriate and those who should be treated in Primary Care are able to do so rather than coming to acute hospitals for treatment. CS reported that the Project Management Office (PMO) is focusing on emergency flow to manage this more effectively. They are working closely with colleagues in Primary Care and the community system about avoiding admission to ED and how to go forward with effective discharges. There have been some days when the QEH ED has seen 216 attenders, this has been raised with the Integrated Care System (ICS) Chief Executive Officer (CEO) to highlight the challenges that the Trust is facing. One of the issues is emergency access. The Undertakings will be managed through the system to make clear the need for coordinated action and to consider what to do differently across West Norfolk. As there is not currently a GP streaming or walk in facility available in the local area, it is important that patients are informed how they can access treatment when they need it and what the alternatives are to attending ED. DS informed that the Trust is currently undertaking data analysis on the attenders to ED as it is likely that some could be managed in Primary Care. The data analysis is partially complete and there is a scheduled meeting with the system to agree further actions to urgently address the issue.

SB reflected on reports in the media on the difficulties to make appointments to see GPs and considered this could exacerbate current activity levels. DS informed that all local GP practices are open. The Trust is working with system partners to understand the balance between face to face and virtual appointments. SB considered that this may require some communication to the public to counter any misinformation.

GR explained that the Trust is strengthening internal processes for best-placed care. This includes the expansion of the use of the frailty phone, a secondary care network to support Primary Care and keeping patients as well as possible through the chosen discharge routes. The remodelling of the Urgent and Emergency Care Pathway will look at how the Trust will integrate with Primary Care to ensure that patients only attend the ED when it is required.

CF highlighted the increasing tourist traffic in the local area and queried how this links with the improvement plans and communication plan.

CS informed that the Trust is working collectively with Primary Care providers and the ICS on a communication strategy. The Trust is also active on social media to share the options for visitors who become unwell. This weekend, a message on who to contact for medical assistance was broadcast every hour via

social media outlets.

DS explained that there is a system resilience group that develops seasonal plans to manage the peak of the summer demand.

The Board of Directors noted the report.

	KEY STRATEGIC OBJECTIVES: QUALITY	**1. Safe and compassionate care** **2. Modernise hospital and estate**

109/21 9. BOARD ASSURANCE FRAMEWORK

The Board of Directors received the Board Assurance Framework report for Quality KSO1 and 2.

Key Strategic Objective (KSO)1:

- AW highlighted risk number 2679. This risk relates to an Individualised Plan of Care (IPOC) which should be put in place for every patient identified to be at end of life. Following a robust discussion at the Assurance & Risk Executive Group (A&REG), it was agreed that the likelihood of this risk should be downgraded due to the improvement work that is currently ongoing.

CS suggested that there should be a deep dive arranged regarding End of Life (EOL) and the outcome of the risk, specifically to get this right for patients and families as this was an inherent issue in previous CQC visits.

ACTION: To arrange a deep dive on End of Life Care. **CN**

AJB noted that one in six staff have not had their first COVID-19 vaccination. This is in contrast to the flu campaign in which 100% of staff were vaccinated. AJB queried if there were plans to discuss this on a one to one basis with staff to understand the reasons why they have not been vaccinated. SB noted that there will be group of staff who are unable to be vaccinated for legitimate reasons. There may also be individuals who need to understand the reasons for vaccinating and the Trust should share the information with them to ensure they are fully informed and to encourage uptake of the vaccination.

DS informed that the current data is that 88% of staff has had their first dose of the COVID-19 vaccination. The uptake of the vaccination remains a personal choice, as it is with the flu vaccination. The Trust continues to promote a lot of broadcast communication to staff to provide information and reassurance.

CS explained that this was discussed at the Black Asian and Minority Ethnic (BAME) forum. Some of the staff who attended the meeting have opted to talk to other colleagues at a personal level to promote having the vaccination. In the national press, it has been reported about the consideration of the vaccination becoming mandatory in staff contracts. The Trust has not yet received any official guidance on this. The Board of Directors will be kept informed of any developments.

IM considered that the Trust should be proactive and to share with the Board the reasons why staff are not having the vaccination. SB agreed, as a public body, the Trust recognises the need to recognise that this is personal choice

and it is also important to be responsible publically. The Trust needs to be satisfied it is doing all it can to encourage staff to have the vaccination to be safe for patients and staff.

JH explained that is being monitored closely at the People Committee and feedback will be provided to the Board. The Trust is monitoring legislation in terms of guidance and encouraging staff and can target effectively.

GW reminded that in the early stages, uptake was very positive on the COVID-19 vaccination. The more discussion and engagement with staff to improve the uptake, the better it will be. It made a positive difference to be able to show the good performance in the early stages of the programme.

Key Strategic Objective 2:

- CB highlighted that the alignment of the principle risk within KS02 is now aligned to the roof risk of 20, following discussions at the Board of Directors and the Finance & Activity Committee.

The Board of Directors noted the current position relating to the BAF and Significant Risks aligned to the BAF.

110/21 10. INTEGRATED QUALITY IMPROVEMENT PLAN

The Board received the report updating on the Integrated Quality Improvement Plan Programme (IQIP).

LN highlighted:

- The Trust has received two visits from external stakeholders in the past two weeks. First was a visit by Sue Holden, NHS England/Improvement Director for Intensive Support and the second, a visit by Ed Garrett, Chief Executive for NHS Ipswich and East Suffolk Clinical Commissioning Group (CCG). They visited several areas and have provided extremely positive feedback. This included Infection Prevention and Control (IP&C) standards and staff attitudes and behaviours. The outcome of the visits provided further assurance of progress.
- The decision was made at the Quality Forum in May 2021 to move five of the radiology actions to an Amber (at risk) rating. This is in response to the culture assessment report that has been completed. All of the actions will be included in the Radiology Improvement Plan that will be monitored through the Quality Forum from July with oversight from the Quality Committee going forwards.
- The Trust will submit an application in June 2021 for the remaining seven CQC conditions to be lifted. The Trust is currently collating the relevant evidence to support this application.

SB noted the Radiology position and that a further report would be tabled at the Quality Committee. SB expects that behavioural issues will feature in terms of culture and queried if it is intended for the People Committee to be engaged in this piece of work. DS explained that the improvement plan will be all encompassing. This will include operational issues, internal audit recommendations, Integrated Quality Improvement Plan (IQIP) actions and Getting it Right First Time (GIRFT). The Quality Committee has been identified

as the most appropriate forum to monitor progress. CS explained that the People Committee will be kept informed of progress and culture items shared through the People Committee.

SR agreed that the People Committee will continue to receive regular updates on this item to provide assurance.

AJB commented that it was good news on the application to lift further conditions. The Trust will still have Section 29 conditions under the 'Corporate' area that have a completion date of January 2022, AJB queried what these are. LN explained that these relate to more complex issues relating to documentation and include EOL care and Palliative Consultant input. The Trust does not apply for Section 29a conditions to be removed. The CQC will return to the Trust to specifically look at these conditions and will then inform via their report if the required improvements have been made and can be lifted. AJB queried if the expectation is that the conditions will not be ready until next year. LN informed that it is expected there will be improvements by the next CQC visit that is due in the coming months. The evidence will be available, but due to the complexity of the actions, it will take time to ensure these improvements are consistent across the Trust.

GR commented that it has taken time to implement some of the processes at departmental and divisional level. There is good oversight from the Senior Leadership Team. This is a unique opportunity to ensure quality assurance prior to the implementation of electronic patient records. It has taken time, but the Trust is moving in the right direction and will achieve this with good levels of assurance by January 2022.

CS explained that the conditions are attributed to 'Corporate' if it is an issue that will affect every patient that attends the Trust, such as in this case when it relates to patient health care records. The Trust must get it right for every patient. The Clinical Review Programme has seen improvement in the documentation processes. This will only be fully resolved with the implementation of electronic patient records.

SB thanked LN for the update on progress.

The Board noted:

a) **Five of the radiology actions have been rated as 'at risk' in line with the development of the culture assessment report.**
b) **The Trust will submit an application in June 2021 to request the lifting of a further seven conditions from the Trust's license.**

111/21 11. INTEGRATED PERFORMANCE REPORT

The Board received the Integrated Performance Report (April 2021 data).

LSK highlighted the following:

Safe Domain:

- The Trust has achieved and exceeded the VTE screening target for the last eleven consecutive months.
- There were four cases of hospital acquired C Difficile in April 2021 and three cases of hospital onset E Coli , these cases are under review.

Effective Domain:

- The Summary Hospital-level Mortality Indicator (SHMI) has increased slightly but remains within the expected band.
- The Hospital Standardised Mortality Ratio (HSMR) has increased in month and it is anticipated to remain elevated over the next seven months due to the crude number of deaths due to the pandemic and notably the deaths at the peak of phase two in December 2020 and January 2021. This metric is discussed in detail at the Quality Committee. The Trust fully understands the issues and its response to the elevated HSMR rate.
- Recruitment to research studies has decreased significantly (15 recruited against a target of 65). This was expected as 94% of studies over the last year were COVID-19 related. The department is now restarting non COVID-19 studies and is re-engaging with colleagues across the Trust.

Caring:

- The Trust achieved the dementia case screening target in month and recognises the need to sustain this on an ongoing basis.
- There is a continued focus on the timeliness of complaints within 30 working days. It is noted that performance has deteriorated within month. The Chief Nurse is leading on the improvement and recovery programme. Complaint performance is discussed in detail at the Senior Leadership Team (SLT) and Quality Committee. Work is continuing with the complaints team and Divisional Leadership Teams (DLT) to ensure sustained improvements to performance.

Responsive:

- The four-hour Emergency Department performance was 82.1% in April 2021, against the target of 95%.
- Three patients were waiting over 12- hours within the ED for an inpatient mental health bed.
- The 18 week target was 69.1% in April 2021 against the 92% standard. Strategies are in place as part of the improvement and recovery plan of planned care metrics.

Well Led (Finance):

- The Trust has achieved the financial position for month 1 with a surplus of £12k against the planned deficit of £616k. The Trust also achieved the Cost Improvement Plan target for month 1. The financial position is discussed in detail at the Finance and Activity Committee and remains an area of focus with divisional-led savings programme with the need for transformational schemes moving forwards.

Well Led (People):

- An improvement has been noted for key people metrics. This has been discussed at the People Committee in detail. Mandatory training is now above target at 81.66% compliance.
- Sickness levels increased in the month of April 2021. The 12-month cumulative sickness rate, however, has decreased to 5.99% and this is a much- improved position.

LSK advised the Board of an inaccuracy in the IPR on the appraisal chart and apologised for this. The charts for the Medicine and Surgery Divisions has

duplicated rather than including the Clinical Support Services (CSS) and Women and Children data. The updated Integrated Performance Report will be placed on the Trust website after the meeting.

SH asked how IP&C is being monitored as there is an increase of cases. SH considered that there should not be a target for C Difficile and E Coli as the aim should be to have no cases, it should be connected to the ceiling of cases.

AW agreed that the target is not to have any cases. The cases for C Difficile have been reviewed and there is no correlation or cross infection in the cases identified. In relation to training, all staff have to complete the mandatory training. In addition, IP&C will provide individual areas with further support if identified through an incident or Root Cause Analysis (RCA). The further training is bespoke to the areas involved. When a ward changes area or the team has changed, IP&C will check compliance. The IP&C team are mobile across the organisation. The Trust recently had a routine visit from NHS England and Improvement (NHSE/I) and the Clinical Commissioning Group (CCG). The feedback from the visit was that they were very satisfied with the sustained improvement over the last 12 months. An operational IP&C group has been developed with all Divisions represented. The strategic IP&C group will work closely with Divisions to ensure they are compliant with standards and work with Estates & Facilities continues to maintain cleanliness.

GR explained that the Trust is continuing to review the use of antibiotics. A surge of C Difficile cases was seen during the first wave of the pandemic. This was contributed to by prevalent use of some antibiotics in the community and in hospital. The antibiotics guidelines have been revised, including the advice on duration. It is hope that the implementation of ePMA will help to reduce the onset and the spread of cases as a result of the surveillance that the system can provide.

SR noted that in terms of the HSMR rate, the weekend mortality has been thoroughly reviewed at Board and Committees and there is a good level of insight. SR noted the explanation within the report of what the Trust is doing particularly regarding palliative care coding moving forwards. The report refers to the above expected increase in HSMR and refers to this as a source of concern. SR queried what steps are being taken to address this going forwards. GR explained that the Trust does understand the key areas causing the HSMR rate. The Trust is managing the back log of coding with staff working additional hours. It is also related to the lack of a timely submission of coding for the national level of data. HSMR calculates the mortality rate over the year, any changes that are made will not be reflected until the next cycle. It will take time to recover and this will be evident in the data over time. The drop in activity when elective services were postponed during the pandemic also had an impact on the rate.

IM noted the poor performance in the response to complaints. IM informed that the Quality Committee is aware of this and has asked the Chief Nurse to address this in a sustainable way. IM queried the stroke metric and requested assurance that this is being addressed following a drop in performance after the initial wave of the pandemic. SB agreed that complaints need to be handled consistently and must sustain a good level of performance.

AW informed that complaints have been discussed at the Patient Experience

Committee and Quality Committee to identify the requirements for a sustained level of response. An action plan is being developed with different measures to monitor progress and to improve the performance.

CS considered the Trust must demonstrate learning from complaints and demonstrate services are improving as a result. There has been an impact due to ongoing changes in leadership within this area. AW as the substantive Chief Nurse, will now lead on and manage the complaints process.

DS responded to the query regarding stroke performance. Performance was maintained during the first wave of the pandemic as there was significant change in inpatient bed demand in both COVID wave one and two. In advance of the Coronary Care Unit (CCU) beds moving this month, the opportunity has been taken to review the stroke pathway with the stroke team. GR and FS are supporting the outcome of the review and there is also external facilitation from the emergency care intensive support team. This will allow the Trust to do things differently. It is expected that improvements will be seen in advance of the bed base changing.

GR informed that in terms of bed modelling and the use of CCU, this is a temporary arrangement. There is alignment with the teams to progress and the performance will improve.

CF noted that access to imaging is time critical in terms of stroke patients and asked if there were any concerns with this. DS informed that access to diagnostics for stroke patients is generally very good. Where there are delays, it means the Trust does not achieve this within the hour, but does not mean there are extended delays . There is protected capacity for the emergency pathway.

CF was pleased to see the improvement in dementia case screening and sought assurance on how the Trust is connecting with dementia support services in the community given the potential increase in referrals to their services now that screening levels are higher. GR responded that the improved dementia screening is already improving the referral and handover rate of newly diagnosed cases of dementia through the discharge letter process.

CF queried the pressure ulcer data which does not show an increase but the narrative suggests that there is. AW noted that there is a small increase. This remains below the tolerance level. However, the Trust is not complacent and is mindful that every pressure ulcer affects a patient and it is important to deliver the key actions.

CF commented on the presentation of data for the Friends and Family Test (FFT) and complaints. The data that is being reviewed is changing but the chart format has remained the same which can make it more challenging to compare performance. CF suggested it may be useful to indicate visually what is being looked at moving forwards.

DD commented on the vacancy level and noted that the turnover is generally good with improvements being seen over the last year. One area that is an outlier is the Allied Health Professionals (AHP's). DD queried what action is being taken to reduce the turnover and bring the vacancy level down. JH responded that the turnover rate is within the control limits. It is quite low for

the size of the Trust and so is not a concern currently. JH informed that there is ongoing work in the Clinical Support Services (CSS) Division to look at more development routes for the AHP's. This involves the Trust 'growing our own' and developing existing staff. There is also ongoing work with the widening participation team.

CS explained that recruitment to AHP posts is a national recruitment issue. The Trust has undertaken a bespoke recruitment campaign to attract AHP's to West Norfolk. The Trust is also reviewing the workforce model to consider how to do things differently. SB considered that the new school of nursing may expand and provide an opportunity for the Trust to train AHP's. CS agreed with this and explained that apprenticeship routes have also been considered and will form part of the review of the workforce model.

The Board of Directors noted the report, specifically the actions which are being taken to maintain and improve performance where appropriate.

112/21 12. HIP2, RAAC AND ESTATE STRATEGY PROGRAMME UPDATE

The Board received a report updating on the current position on progress being made in relation to the development of the Strategic Outline Case (SOC) for a new hospital, the progress to complete the 'short form' business case to access emergency capital funding associated with the structural integrity of the roof and the operational position regarding the ongoing survey of the roof.

CB highlighted:

- The Trust is progressing with the Strategic Outline Case (SOC) for a new hospital. This is being led by the Deputy Chief Executive and is scheduled for completion in November 2021.
- The short form business case to access emergency capital funding will be presented to the Board of Directors in July 2021.
- The 'tap and test' survey is now 45% completed. An additional deflected plank has been identified since the time of writing the report. It will take five months to complete the survey.

SB queried the total number of props to date. CB confirmed that there are currently 199 temporary steel props.

GW commented that the short form business case must fit in with the overall strategy moving towards a failsafe solution and the campaign for a new hospital. There is further work to do that requires careful scrutiny. An update was provided at the Extraordinary Finance & Activity Committee and areas for improvement within the business case are being progressed.

CS agreed that the failsafe project is huge, requiring extensive construction work and the movement of services. The Trust needs to get this right for patients, staff and the community. The proposition and plans will be going through the local management group, SLT and the Finance & Activity Committee. Once agreed, this will need to be delivered within 12 months. Communication will be imperative internally and externally.

LSK is the lead director for the new hospital case. CS expressed thanks to the community and local press for supporting with the case. The local community

have been truly fantastic and it is humbling to get the support that is needed. SB agreed and expressed thanks to the community on behalf of the Board of Directors.

The Board noted:

- **The position on the development of the Strategic Outline Case (SOC).**
- **The position with regard to the completion of the 'short-form' business case.**
- **The current operational position with regard to the survey, the temporary propping and temporary steel works.**

113/21 13. SIGNIFICANT RISK REGISTER (>15)

The Board of Directors received the report on significant risks contained within the Trust's risk register (all risks with a current score of 15 or more).

LN highlighted:

- There are nine significant risks on the risk register and these reside within KS01 and KS02 as discussed earlier in the agenda.

The Board of Directors noted the report.

KEY STRATEGIC OBJECTIVES: ENGAGEMENT	3. Staff Engagement 4. Partnership working, clinical and financial sustainability

114/21 14. BOARD ASSURANCE FRAMEWORK (KEY STRATEGIC OBJECTIVES 3 AND 4)

The Board of Directors received the report on the Board Assurance Framework (BAF) for Engagement KSO3 and 4.

Key Strategic Objective (KSO) 3:

- LSK highlighted that there are no material changes. There is strengthened assurance due to the improved General Medical Council (GMC) survey results for doctors in training.
- There is good engagement in cultural transformation and over 30% staff have attended the 'values into action' workshops.
- External culture support is ongoing in Maternity and Radiology.
- Interviews are scheduled this week for the new Equality Diversity and Inclusion (EDI) lead.
- The role of the Freedom to Speak up Guardian will shortly be advertised.

SB thanked LSK for the update. SR agreed that the update is positive. The People Committee will receive further updates on the culture work and staff engagement moving forwards.

Key Strategic Objective (KSO) 4:

- CB highlighted that the Trust has achieved the financial plan and delivered the Cost Improvement Programme (CIP) target for month one. Focus is needed on the transformational elements of the CIP and continuing programmes in savings and efficiencies.

SB commented that the Trust will want to ensure that the programme will have the necessary mix of savings in year and more recurrent savings.

GW agreed that the Trust must ensure a higher percent of recurrent savings. The Trust has a good programme and this is largely recurrent. A key element is to build on the plan and ensure CIPs are transformational within the Trust and working across the system. This is a good opportunity for the Trust.

CS highlighted that the CIP programme has been escalated in the SLT Chairs Assurance Report. Through the PMO and transformational work, it is important to improve services for quality and efficiency. This relates to the culture to do things differently and ensure provision of affordable, effective patient care to the community.

The Board of Directors noted the report.

115/21 15. INTEGRATED CARE SYSTEM (ICS) UPDATE

The Board received a report updating on key areas of work within the ICS (Integrated Care System).

LSK highlighted:

- The three acute Trusts in Norfolk and Waveney continue to discuss closer working arrangements and what an Acute Collaborative Provider will look like.
- A Tri Board meeting was held on the 25 May 2021 with the Norfolk and Norwich University Hospital and James Paget University Hospital to reconnect and to discuss the potential benefits for staff and patients with closer working relationships.
- In addition to establishing provider collaboratives, the Government white paper enhanced working strategically and producing models to work effectively at a local level. Norfolk & Waveney are leading on an engagement exercise to look at possible options for Place-Based Care and place footprints. QEH will input to the engagement exercise as part of the Board session scheduled for 9 June 2021.
- The findings of the engagement exercise will be shared via the ICS Partnership meeting in August 2021.
- Good work continues at a local level, notably the strengthened governance arrangements that have been agreed.
- The QEH intends to set up a Place-based Board and work plan to formalise the existing arrangements.
- The Clinical Leadership Board is now in place and has met for the first time to support the delivery of Place Based care in Norfolk. The Terms of Reference have been drafted.
- There is ongoing work to strengthen relationships links with CCG's in Lincolnshire. The QEH are now inputting in a number of fora. This includes representation on the Urgent and Emergency and Planned Care Boards in Cambridgeshire and Peterborough. The Trust is also attending forums in Lincolnshire.

SB queried how the Trust will ensure that the Governors are able to actively participate to shape Place-Based integrated care and to ensure that the views of the population are represented when making decision about how services

will be delivered. LSK explained that the Trust has worked closely with the two other acute Trusts to develop an engagement and communication timeline for the year to come. The timeline clearly identifies how to engage with all stakeholders throughout the process, including Governors. QEH's lead Governor has reached out to the Lead Governors in the two other Trusts to further strengthen relationships and improve communication. QEH Governors will continue to be fully engaged and involved via the Trust's formal and informal mechanisms.

IM noted that the ICS is leading on the engagement programme and that this has nearly finished. IM requested assurance of meaningful engagement that involves the public. Six options have been presented and the expectation would be that there would be a paper to demonstrate the strength and challenges of the models. Potentially there may be public meetings or written or online materials available. If the engagement process was required to be strengthened, IM queried if the ICS would extend the period of engagement to ensure meaningful public engagement.

SB informed that this point is made consistently by the QEH at the ICS Board meetings. The communication and engagement piece has to be repeated continually for key messages to be received and if the engagement exercise to garner opinion needs to be on grander scale, this will be discussed at the next meeting and the points will be articulated on behalf of the Board.

CS informed that she has contacted Healthwatch who have also expressed concern regarding the perceived level of engagement. The Trust recognises that 30% of patients are from Lincolnshire and Cambridgeshire and the representation needs to be correct. The preferred option is to ensure synergy for the other flows coming through the Trust and to ensure to take this forward.

CS noted the importance of learning from other organisations in driving best placed care.

SB summarised that the Trust will continue to contribute at local and ICS level, as an anchor organisation to play a leading role when discussing with stakeholder and partners on the geography that is being supported in Norfolk, Cambridgeshire and Lincolnshire.

The Board of Directors noted the report.

116/21 16. FREEDOM TO SPEAK UP REPORT

The Board received the report on Freedom to Speak Up (FTSU). DT attended for this item.

LSK highlighted:

- The report provides strong evidence that the Trust is creating a strong FTSU culture within the organisation. On review of the trends over the last 12 months, significantly fewer cases are being referred directly to the CQC and this remains a downward trend.
- The number of internal speak up referrals has increased from 25 last year to 75 this year. 16 of those cases were speak up concerns regarding Maternity

and this led in part to the external culture review.

- Over half of the speak up cases received were related to line management concerns and staff not feeling able to raise issues directly with line managers.
- The number of concerns related to bullying remains fairly low.
- 40% of FTSU cases are anonymous and the Trust recognises the need to do what is possible to make staff feel confident that they will not suffer detriment if they speak up.
- There is a clear plan for the next 6–12 months. The plan includes equipping managers to have the right conversations with staff. This is included as part of the Trust-wide culture transformation programme and also includes respectful resolution.
- Succession planning is underway to replace the Freedom to Speak Up Guardian who will step down at the end of August 2021.
  There are plans to further expand the FTSU Champion community.

SR informed that this item is scrutinised at the People Committee and FTSU quarterly meetings. The increase in cases is a positive reflection of the organisational culture. It is expected that referrals will reduce moving forwards. The reduction in referral to statutory external routes is recognised. SR thanked DT and the 19 FTSU champions for their successful efforts. It was recognised at the People Committee that it would be helpful to have a clear understanding of the triggers as to when the Trust should be concerned about the number of referrals in order to respond quickly. SB asked DT's view on when the number of referrals received should be seen as a concern.

DT explained that he is pleased at the current levels of referrals. DT informed that it is important to note that some of the referrals account for complexities of certain department, a number of staff may contact and all will relate to one issue. An example of this is maternity and radiology. It is important to look at what is being brought up as key issues and the number of staff raising particular issues. The trends have moved away from patient safety and now relate to cultural issues, managerial, staffing. This is a reflection that the cultural transformation is occurring and is being encouraged. There is no right number but it is important to know the issues that are being raised and the areas they relate to.

CF queried if the way that the Trust uses FTSU is co-ordinated across the acute trusts in the region. CF also commented on the importance of staff knowing the impact and the changes that are made from their referrals to know that they are being listened to and changes made as a result.

CS complimented the work that LSK and DT have done to transform FTSU. The efforts have been recognised by the CQC. It is important for the FTSU results to be analysed in detail. It is recognised that some of the issues would not have resulted in a FTSU referral if they had been managed appropriately by line managers. The Trust should see a reduction in the number of referrals as the culture programme progresses.

IM commented that this is good work. Despite the considerable progress made, the internal audit report in January 2021 had assessed FTSU as partial assurance. IM requested assurance that the nine recommendations from the audit report are all incorporated into the work plan. LSK will confirm this is the case outside of the meeting.

ACTION: To provide an update on the progress of all of the internal audit recommendations for Freedom to Speak Up. **Dep CEO**

DT commented that currently some staff do not feel able to approach line management. This is a key issue to be addressed by the culture transformation. DT attends quarterly meetings for the eastern region where there is national guardian office input. There are plans to further professionalise the role to standardise this across the country. A more systemic view of data collection will be useful moving forwards.

SB thanked DT on behalf of the Board. DT's professionalism, kindness and confidentiality has made a huge difference in progressing FTSU and the Trust is grateful for his input. The Board expressed their best wishes to DT for the future.

The Board of Directors noted the report.

KEY STRATEGIC OBJECTIVES:	**5. Healthy lives staff and patients**
HEALTHY LIVES	**6. Investing in our staff**

117/21 17. BOARD ASSURANCE FRAMEWORK

The Board of Directors received the report on the Board Assurance Framework for Healthy Lives KSO5 and 6.

Key Strategic Objective (KSO) 5:

- GR highlighted that the breast and cervical screening programmes have been re-established and the backlogs have been cleared.
- The Cancer Wellness Centre is now open and doing well.
- A proposal to implement a system wide clinical single tracking list is being discussed. This would be a positive development.
- The risks regarding HSMR have been addressed in a previous agenda item.
- An area that requires improvement relates to the management of the backlog of clinical guidelines. There is a plan in place to manage this moving forward.

Key Strategic Objective 6:

- JH highlighted that there is an overall improved stability of the Key Performance Indicators. Many are within normal cause variation and these continue to be monitored.
- A key focus is the development of a leadership skills academy to take staff from induction and support their development as their career progresses.

The Board of Directors noted the current position.

REGULATORY AND GOVERNANCE

118/21 18. CHAIR'S ASSURANCE REPORTS

18a. Finance and Activity Committee
The Board of Directors received the Chair's Assurance Report of the Finance and Activity Committee meeting held 19 May 2021.

GW informed that the Committee had escalated the development of CIP schemes. The Committee had also requested a deep dive of diagnostics and MRI for further assurance regarding these areas. There is much more work to do and the Committee will monitor this closely. The Committee have emphasised the requirement to see the business case related to MRI as soon as possible as this will take time to implement.

18b. People Committee
The Board of Directors received the Chair's Assurance Report of the People Committee meeting held 19 May 2021.

SR reported that the Committee had discussed the key metrics. It was recognised that staff sickness is on a downward trend which is positive. The Committee considered the need to have an understanding of long term trends within the more challenging metrics. The People Committee have requested more work on the underlying causes to get to grips with how to ensure the Trust gets back on course. The Committee raised the issue of the EU exit. 240 staff in the organisation are yet to complete an application of their settled status. There is only so much the Trust can do to influence this. There are strenuous efforts being taken to update staff and the People Committee will review the position again in June 2021.

18c. Quality Committee
The Board of Directors received the Chair's Assurance Report of the Quality Committee meeting held 25 May 2021.

IM commended the extremely successful advancement in dementia screening. This will have a positive effect on patients experiencing dementia and has been recognised nationally as good work. The Quality Committee supports the Duty of Candour project that is currently ongoing. There will be learning for other hospitals nationally as to the approach the Trust has taken. In terms of the patient safety themed quarterly report, action is needed to sign off outstanding Serious Incident (SI) action plans. There will be a further refresh of the maternity improvement plan for next month. This will include additional clarity for the actions that are still to be addressed. Following the patient experience quarterly report, the Committee are not yet assured of the complaint systems and there is considerable work ongoing with governor colleagues. The Committee will be receiving future updates.

CF updated that she has connected with LN and AW regarding the progress of the maternity improvement plan. This included the additional work with culture and focused intervention led by JH to support clinicians to take forward the plan. CF has also linked with the risk and governance manager to understand some of the delays on the closure of SI action plans.

18e. Senior Leadership Team
The Board of Directors received the Chair's Assurance Report of the Senior Leadership Team (SLT) meeting held 18 May 2021.

CS highlighted that the SLT identified three areas for escalation. The SLT reiterated the need for ownership of all complaints and the requirement to respond appropriately and ensure learning. In regards to recovery plans, particularly in relation to referral to treatment and diagnostic performance, detailed work is required through the Divisional Leadership Teams (DLT) to ensure clarity of trajectories and actions needed. In terms of CIPs, the Trust will need to ensure focus on transformational changes with an immediate focus on workforce metrics in relation to agency and bank spend and the process for authorisation.

SB commented that it was evident that a huge amount of work has been undertaken in all Committees and thanked the Board of Directors and the teams involved for all of their input.

The Board of Directors noted the Chair's Assurance Reports.

119/21 19. REGISTER OF SEALS

The Board received the report on the Register of Seals.

CB confirmed that the Board is asked to note one Register of Sealings entry in relation to the Acute Procurement Collaboration Compact. This is in regard to procurement work from the acute trusts in the ICS.

The Board noted the Register of Seals.

120/21 20. REGISTER OF DIRECTORS' INTERESTS

The Board received the Register of Directors' Interests.

The Board noted the Register of Directors' Interests.

CLOSING BUSINESS

121/21 21. ANY OTHER BUSINESS (to be agreed with the Chairman)

None.

122/21 22. BOARD EFFECTIVENESS

What has gone well / Even better if
No comments received.

Date of next Board of Directors' meeting (in Public) – Tuesday 6 July 2021, 10:00am, via Teams.

The meeting closed at 12:00.