Agenda Item: 03

The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust

DRAFT

Board of Directors (In Public)

Minutes of the meeting held on Tuesday 1 September 2020 at 10am via remote dial in arrangements

As part of the Trust's robust plans put in place to keep patients and staff safe, the Trust's Public Board of Directors meetings are not being held in public until further notice, consistent with arrangements in place across the wider NHS. The QEH Board of Directors therefore held a virtual public meeting on Tuesday 1 September (10 - 11:35 am). Board Papers were published in advance of the meeting, as usual, and are available in full on the Trust website.

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)
D Dickinson (DD)	Non-Executive Director (NED)
J Schneider (JS)	Non-Executive Director (NED)
C Fernandez (CF)	Non-Executive Director (NED)
S Roberts (SR)	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)
F Swords (FS)	Medical Director (MD)
A Brown (ApB)	Chief Nurse (CN)
C Benham (CB)	Director of Finance (DoF)

In attendance:

C O'Brien (COB)	Director of Patient Safety (DoPS)
P Tydeman (PT)	Director of Transformation (DoT)
C West-Burnham (CWB)	Director of Strategy (DoS)
A McCourt(AMc)	Deputy Director of HR (DHRD)
A Prime (AP)	Trust Secretary
E Corner (EC)	Lead Governor
L Mitcheson-Smith	Patient (agenda item 2)
K Strong (KS)	Matron Medicine Division (agenda item 2)
L Notley (LN)	Associate Director of Quality Improvement (ADQI) (agenda item 10)
M Pinkham	Head of Communications and Engagement

ACTION

138/20 1. CHAIR'S WELCOME AND APOLOGIES

SB welcomed Board members to the meeting. It was noted that all Governors are now able to attend the Board meetings in public to observe the virtual meetings and SB welcomed those present.

139/20 2. PATIENT STORY

SB welcomed Libby Mitcheson-Smith to the Board meeting and thanked her for taking the time to share her patient story with the Board.

Libby shared her experience of being a patient at QEH following admission to Stanhoe Ward during May 2020. Libby shared how she had experienced a very good service at the point of admission through the COVID ED area of the hospital. However, Libby's experience was not so positive on admission to the ward and she shared her experience of staff behaviours and lack of professionalism during her stay. Libby felt that staff should demonstrate compassion and good treatment at all times.

SB thanks Libby for sharing her story. A key objective of the hospital is to offer safe and compassionate care to all patients at all times. SB acknowledged that that was not the case for Libby and apologised for her recent experience. SB stressed the importance of learning from Libby's story and that action is taken to ensure these situations are not repeated.

KS has been leading work with band 7 and junior sisters on the ward to establish daily morning conversations with all patients and this continues, including documenting any concerns patients might have and ensuring patients know who on the ward they can escalate any concerns to each day.

SB thanked KS for informing of actions that have already been taken in response to Libby's experience. SB thanked Libby for taking the time to relate her story which the Board finds unacceptable and apologised for her experience. SB assured Libby that the learning she has shared with the Trust has been taken seriously and steps are being taken to improve patient care consistently across the Trust.

Action: ApB to report to Board on the impact of changes that have been made in response to Libby's experience. CN

CS informed the Board that she had met Libby during her admission and had invited her to attend Board to share her story. CS recognised that Libby is an expert patient, being very knowledgeable about her condition. CS invited Libby to talk to ward staff about her experience so that they can reflect on the learning. **Action: ApB to liaise with Libby regarding sharing her story with the ward sisters and nurses involved in her care.** CN

ApB presented a report updating on actions taken following the patient story that had been shared at the Board meeting in August. A key point for Jenny had been the transitional care for her adolescent daughter transitioning to adult services. The Women's and Children's Division had started work on this aspect of the service and this work has recommenced following COVID. Developments include work which is underway with the Norfolk Clinical Commissioning Group who will be providing funding for the creation of a transitional care nurse role which is supported by best practice evidence. Work will continue to take this forward.

140/20 3. MINUTES OF THE BOARD OF DIRECTORS' PUBLIC MEETING HELD ON 4 AUGUST 2020 – AND MATTERS ARISING

The minutes of the previous meeting held on 4 August 2020 were agreed as a correct record.

141/20 4. ACTIONS MONITORING

The Board reviewed and updated the Actions Monitoring Record.

The following actions were considered complete and were removed from the action log: 41, 44, 47, 48, 50, 54 and 55.

Action 32: – SB invited Non-Executive Director (NED) feedback on the approach to the Chairs' Assurance Reports for receipt in Board meetings held in public, enabling the ability to report those issues that need private discussion in the private part of the Board meeting.

Action 34: – A Board seminar session is planned for 10 September.

Action 42: – Funding has been secured and Healthwatch commissioned to undertake a review of improvements between August – October 2020.

Action 56: – Learning will be reported to the Quality Committee in November 2020 as part of the quarterly themed SI report.

142/20 5. DECLARATIONS OF INTEREST

None received.

143/20 6. URGENT ACTIONS (Under Standing Order Para. 5.2)

None.

144/20 7. CHAIRMAN'S REPORT

The Board received and noted the Chairman's Report informing of key updates and developments during August 2020.

145/20 8. CEO'S UPDATE

The Board received the CEO's Update informing of key external/internal events and activities.

CS informed that through observations of the popular press and HSJ it appears the CQC will be recommencing their inspection regime. The approach to inspections is likely to be different due to COVID. Legislation requires trusts in special measures to be re-inspected within a year and CS anticipates a clinical / service inspection is likely to take place some time in the autumn.

The Board noted the CEO's report.

COVID-19 UPDATE

146/20 9. POST COVID-19 UPDATE AND RESTORATION OF SERVICES

The Board received a report updating on the Trust's recovery and response to the COVID-19 pandemic.

DS informed that the Trust currently has no inpatients with COVID-19. The Trust has revised visiting arrangements with every patient being able to have one pre-booked visitor, every day for up to one hour. In addition women are able to bring a partner to antenatal scans and patients attending cancer diagnostic appointments are also able to bring a partner. Restoration of elective activity is progressing as planned. The ED reverted back to its original footprint at the beginning of August. Day surgery, which ED vacated, has been deep cleaned and reverted back to day surgery. Endoscopy activity has

returned to the endoscopy unit and the Trust no longer needs to reserve a theatre for COVID purposes.

Whilst JS welcomed the approach to visitors JS queried the safety and management of patients given the increase in visitors will increase footfall within the hospital, particularly in public areas. DS confirmed that the Trust has appropriate management arrangements in place including PPE and handwashing and gel facilities at all entrances, and markers on the floors to guide people's direction around the hospital. Staff are vigilant to ensure people comply with safety arrangements. ApB informed that in order to manage the expanding visiting arrangements the Trust is maintaining a booking process to avoid crowding in clinical areas. FS informed that a vital measure to reduce intra-hospital transmission is the requirement for every visitor to complete a questionnaire and screening before coming into the hospital. This is checked at the point of booking the visit and on arrival on a ward.

SR queried what can be done to improve the response rate to this year's National Staff Survey. LSK informed that communications and engagement plans are in place to start preparing early for the survey as well as the flu campaign. This year 80% of the surveys will be digital, which is a big shift from the 100% paper based approach to last year's survey. LSK will be reporting to the People Committee in September on actions being taken. The target is > 50% response rate this year.

IM expressed concern regarding the delay in appointing to the PTSD/CBT role given the unsuccessful first round of recruitment, as this an important service for staff. IM sought reassurance in how such key roles are being recruited to.

The Board noted the report.

QUALITY

147/20 10. INTEGRATED QUALITY IMPROVEMENT PLAN

The Board received a report on the overall progress against the 206 actions within the Integrated Quality Improvement Plan (IQIP). LN attended for this item.

LN highlighted the sustained progress which continues over the period. Two senior nurses have been recruited to give additional support to the Medicine Division focussing on fundamentals of care and documentation in particular, including on-the-ward clinical support. The Evidence Assurance Group (EAG) has declined some actions given their more complex and strategic nature which also require evidence that improvements are embedded and sustained.

Following a meeting on 28 August with HEE and the Medical Director, HEE have indicated they will be recommending the Trust is removed from enhanced monitoring following the lifting of the GMC conditions earlier this year. The Trust looks forward to receiving news on this recommendation towards the end of September.

LN reported on the visit by Ted Baker, the Chief Inspector of Hospitals, and the Trust's local CQC Inspector Alison Smith, on 11 August. This had been a positive visit providing an opportunity to show some of the improvements

made and giving an opportunity to talk to staff.

CS informed that the Trust has made good progress on completing the actions. CS reminded the Board that the action plan is a transactional action plan and it will take time to change the culture and behaviours within the organisation, which the Executive Team continues to focus on through work on the people plan and supporting staff to own the behaviour and culture issues.

AJB queried action 2.5.28 which had been signed off by the EAG in July and queried how this is triangulated with compliance with mandatory training in the Medicine Division. LN informed that when evidence is submitted to the EAG for sign off this needs to include evidence of change. The Division demonstrated improved safeguarding referrals are being made. The broader elements of safeguarding are also considered including training. It was recognised that work continues to be needed on mandatory training, which COVID has impacted on. As the Trust moves forward, actions in this area will be developed further in a next stage quality improvement plan.

DD considered there are a lot of positive aspects within the report. DD queried the six areas that are red in the forward plan and risk assessment and what actions are in place to address this. LN informed that the detail of the six areas is contained within the earlier pages of the report. Three of the actions relate to broad actions including the development of the Divisional Leadership Teams (DLTs). As COVID has impacted on training and development it was considered that there is not currently sufficient evidence to demonstrate the difference the actions have made, with the need for more evidence of the impact of leadership training and appointments. LN and PT will be risk assessing all open schemes, and the six which are currently behind plan, as the Trust moves into the COVID recovery phase. Timescales for any at risk actions will be revised or additional support provided.

SR queried the sequencing of the outcomes of EAG meetings being reported to Board. LN outlined the process, which includes reporting through the Conditions Oversight Group, the IQIP Review Group and the Quality Committee prior to reporting to Board. LN reported that at the August EAG meeting a further 8 actions were signed off resulting in a total of 145 actions completed by the end of August (71%) and a total of 39 of the Section and Warning Notice actions completed (85%).

GW raised the importance of sharing progress and achievements with staff. LN informed that key messages and findings from the clinical reviews are shared with DLTs to share with their staff. **Action: a communications action plan to be developed. The communications plan to include a competitive element and clarity on where good progress against actions has taken place.** **ADQI / DCEO**

SB thanked LN, the team and the EAG for their work. SB thanked FS and the team for the positive position which has been recognised by HEE.

The Board noted:

- **the good progress against the planned trajectory**
- **the additional resource in place to support Medicine initially**
- **the deep dive planned for September**
- **the high level findings from the August Clinical Reviews.**

OPERATIONAL

148/20 11. INTEGRATED PERFORMANCE REPORT

The Board received the Integrated Performance Report.

CWB highlighted the following:

Safe;

- 4 new Sis (serious incidents) were reported to STEIS in July
- There has been a downward trend in the occurrence of Hospital Acquired Pressure Ulcers
- The number of CDiff cases has been slowly increasing but this is in line with the current national picture and targeted work is being undertaken led by the IP&C (Infection Prevention and Control) team
- positive performance in relation to VTE (Venous Thromboembolism) assessment which is at 98% against a target of 97.2%

Effective;

- Continued issues in relation to the organisation's weekend mortality rate which is the subject of two Structured Judgement Reviews and an independent review to be undertaken by Sherwood Forest Hospital
- C-section rates continue to fluctuate against the national targets. The local context was noted as well as the delivery of a detailed audit which was undertaken and presented to Quality Committee in June 2020 with associated actions
- Research continues positive work with recruitment continuing to exceed the agreed targets

Caring;

- The 90% target for complaint responses was achieved in July following a significant improvement in previous months
- Dementia Case Screening performance is in line with the locally agreed recovery trajectory

Responsive;

- Significant work is being undertaken in relation to COVID-19 restoration and recovery and alignment with delivery of the national targets for activity
- A&E performance was 84.6% for July
- 18 week performance was 46.63%
- Diagnostic performance was 38.6%
- Cancer 62 day performance was 79.4% in June against the standard of 85%

Well Led (Finance);

- The Trust will report a break even position for month 4

Well Led (Workforce);

- Sickness has increased slightly in July to 5.41%
- There has been a further decline in compliance for mandatory training which was at 75.92%
- The Trust appraisal rate has decreased further to 74%
- These metrics have been discussed in detail at the People Committee

DS and GW will be considering the access standards benchmarking

information that will be included in future reports to the Finance & Activity Committee. Compared to peers the Trust is average for 18 weeks and, like other Trusts, currently has a number of 52 week breaches. For the Trust the challenge is in day cases given the unit did not recommence activity until mid-August and a high number of patients waiting over 40 weeks. A trajectory is in place to clear 52 week breaches by the end of March. CWB is working closely with STP colleagues on the development of performance improvement trajectories, in alignment with JPUH and NNUH. Learning will be shared across the three trusts.

JS queried the areas of work which have not progressed due to maternity staffing. FS informed that maternity had experienced a challenging time over the last 3 months due to staff shielding and COVID related absences particularly within the consultant team. Various national and system programmes have been largely put on hold. ApB informed that maternity has not been fully optimised in terms of staffing. There are a number of new starters joining the Trust in October. ApB is working with the new Head of Midwifery to manage and mitigate workforce issues and, in readiness of implementation of Continuity of Carer, will be undertaking a review of establishments working with Birth Rate Plus.

JS queried how patients are selected to participate in the Friends and Family Test (FFT). ApB informed that all patients should be offered the FFT but recognised that not everybody can respond and patients had not had visitors during COVID who would normally give assistance to respond. **Action: ApB to check how the FFT questions are offered to patients in the Trust.** **CN**

JS queried the Trust's capacity for non-obstetric diagnostics scans, being 1,500 a year under requirement. DS informed that work is underway to secure additional capacity for ultrasound which is now back up to 90% of pre-COVID activity levels. The team have done well to reintroduce services but there is a backlog to manage.

JS had hoped to see an improvement in the well led statistics on appraisals, mandatory training and sickness and queried how progress on this is monitored through the Divisions. AMc informed that this is discussed in divisional performance review meetings with all the Divisions being required to have an improvement plan and trajectory. DD considered that the overall sickness level masks significant variation in some areas of the hospital. There is a need to keep monitoring this at the People Committee and target action in specific areas.

DD welcomed the improvement in responding to complaints over the last year. DD considered that there appears to be a high proportion of complaints which are reopened (at around 30%) and raised the need to improve the quality of the response to complaints. ApB was pleased with the improvement in response rates and recognised that the next step is to improve the quality of the responses.

GW informed that the Finance & Activity Committee have agreed to spend a greater proportion of its time over the coming months to focus on access standards, particularly trajectories and benchmarking, taking a deep dive approach at each meeting to a specific access standard area, the first focusing on 52 weeks.

SR informed that the People Committee scrutinise trajectories around mandatory training, appraisals and sickness and has requested improvement trajectories to be presented to the September meeting of the Committee. CF considered there is a need to understand what the barriers are to inform action plans.

CS informed that when clinical reviews are being undertaken as part of the IQIP programme, feedback is triangulated with what patients' feedback about their care. When out and about around the hospital CS asks patients what they think about their experience at the hospital. CS informed that there are a number of reasons people are not completing mandatory training including accessibility, availability of training on the system, COVID and staffing levels. The situation is different in each area and it is therefore necessary to understand each area to ensure accessibility and that these aspects are meaningful for all.

SB considered that appraisal is a contractual right, giving individuals the opportunity to speak about their performance with their line managers. Mandatory training is mandatory and it will take management effort to improve training rates.

The Board noted the contents of the Integrated Performance Report, specifically the actions being taken to maintain and improve performance.

149/20 12. DIVISIONAL PERFORMANCE AND ACCOUNTABILITY FRAMEWORK

The Board received the revised Performance Accountability Framework.

DS informed that the revised framework gives Divisions clarity of expectations for the year ahead alongside activity, income and expenditure and CIP delivery requirements. The framework links to the Trust's annual planning cycle, corporate KPIs and performance development reviews. The Divisions have welcomed this framework.

SB considered it to be a good framework and queried the support for Divisions so that they can effectively take part in the performance management framework. DS confirmed that there is support underpinning the framework. CWB and team are reviewing, for each indicator, where the data will come from and how it is provided to Divisions. CB, DS and PT will address training requirements in relation to finance and contracting. Contracting arrangements will link into Divisions in the future but arrangements are different this year due to COVID.

IM considered that the framework could be challenging for some of the divisions. IM considered there needs to be greater visibility of the training and support packages in place.

AJB considered the framework is an important piece of work to give a granular view of how the Divisions are performing. AJB considered this will provide a performance baseline ahead of EPR (electronic patient record) going live which will help to measure performance and benefits.

CF suggested there needs to be shared understanding at the divisional leadership and service levels of why this framework is needed and why it is important.

DS accepted the need to ensure divisions have the support they need to deliver against the framework. The requirements detailed within the framework are not new but gather together in one document the national expectations that are already in place.

SB considered that it is important within the implementation of the framework that Divisions have the opportunity to showcase to Executive Directors their achievements and progress including achievements in research and innovation. DS informed that all performance development review meetings start with a positive item celebrating successes and concludes with the ability for each division to escalate to the Executive Directors any issues from the divisional leadership teams.

The Board noted the report.

150/20 13. WORKFORCE RACE EQUALITY STANDARD AND DISABILITY EQUALITY STANDARD

The Board received the Workforce Race Equality Standard (WRES) and Disability Equality Standard (DES) report on key areas of activities to support a diverse and inclusive workforce through the development of the QEH People Plan and in response to the NHS People Plan and the Norfolk and Waveney Plan.

LSK informed that WRES and DES was discussed at the August People Committee meeting where it was considered that progress is beginning to be made on developing a better understanding of the make-up of the Trust's workforce, for example, the QEH has a higher proportion of BAME staff than other trusts in the region. There is a need to develop a better understanding of the data at divisional and staff group level and this work is underway.

The diversity agenda is being taken forward through the staff engagement programme to create an inclusive culture and one where the diversity of Team QEH is celebrated. The QEH People Plan will be taken to the September People Committee meeting and will include priorities from the national people Plan, Norfolk and Waveney People Plan and the Trust's Corporate Strategy. The QEH People Plan will include measurable diversity goals. Delivery of the People Plan will be supported by dedicated resource including a new Head of Culture and an Equality and Diversity Lead.

Action: the next iteration of the report to include more detailed information in relation to all QEH staff groups. DCEO

Action: LSK to check the population figure in page 5 of the report. DCEO

JS queried whether there is information on the turnover rate of BAME and disabled staff, with comparators across the county and region. **Action: LSK to circulate information on the turnover rate of BAME and disabled staff.** LSK is working towards bringing together all equality, diversity and inclusion intelligence into one information dashboard. DCEO

DD considered that whilst good progress is being made on WRES there is a need for more progress on the DES agenda. LSK informed that in 2019/20 improvements focused on the BAME community. Through the People Plan

there will be a more rounded plan which will include support for staff with disabilities moving forward as captured in the QEH People Plan.

ApB welcomed the report which links to the Chair's commitment to ensuring the Board is fully engaged in reverse mentoring. SB reiterated the Board's commitment to this agenda. In future reports SB would like to include feedback from staff on what they feel the impact of the Board's commitment has been.

CF queried how much staff engagement there has been in the development of the People Plan. LSK informed that the plan has taken longer to develop to enable engagement with staff and groups across the organisation. It has taken time to engage and, being the first of the corporate strategy underpinning work plans, will be used as a test case for engagement.

CS informed that she has been appointed as the Norfolk and Waveney system senior responsible officer (SRO) in relation to Health Inequalities and is the identified Board level Champion for the Trust.

The Board:

- **Noted the key data and information within the report**
- **Endorsed and agreed the action plan and proposed KPIs/indicators**
- **Agreed to support and champion diversity and inclusion as Board members.**

RISK

151/20 14. SIGNIFICANT RISK REGISTER (>15)

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

COB reported that the significant risks have been reviewed by all three Committees of the Board and the Senior Leadership Team (SLT). This month the report includes one new risk in relation to non-invasive ventilation in side rooms in wards. Because of the Trust's estate and capacity, alternative plans have had to be put in place for patients in side rooms. This was a significant risk during the peak of COVID and is therefore included within the risk register but with the mitigations in place this risk should quickly reduce.

The Board:

- **Noted the contents of the report**
- **Received assurance relating to the management of existing significant risks**

REGULATORY AND GOVERNANCE

152/20 15. REGISTER OF DIRECTORS' INTERESTS

The Board received and noted the Register of Directors' Interests.

153/20 16. SENIOR LEADERSHIP TEAM TERMS OF REFERENCE

The Board received the Senior Leadership Team Terms of Reference.

CS informed that the Terms of Reference have been reviewed to ensure appropriate integration of the quality agenda.

The Board approved the Terms of Reference.

154/20 17. INVESTMENT AND INNOVATION EXECUTIVE GROUP TERMS OF REFERENCE

The Board received the Terms of Reference for the Investment and Innovation Executive Group.

It was noted that the Terms of Reference have been approved by both the SLT and Finance & Activity Committee.

The Board approved the Terms of Reference.

PERIODIC REPORTS

155/20 18. BOARD OF DIRECTORS – FORWARD PLAN

The Board received and approved the Forward Plan.

156/20 19. AOB (to be agreed with the Chairman)

There was no other business.

Questions from Governors

D Todd, Staff Governor, queried the visiting arrangements and whether patients could have a different visitor as their one visitor each day. ApB confirmed that it can be a different person each day because the Trust is capturing and retaining details for track and trace through the booking process.

E Corner, Lead Governor, queried the diagnostic situation and how long it is taking for outcomes of scans to be relayed to patients, being aware of an MRI scan which took five weeks for the outcome to be delivered. DS informed that results should not take this long. **Action: DS will check the reporting timescales and provide information following the Board meeting.** COO
FS informed that images are available to be viewed immediately by the requesting clinician but the final report takes time to be generated by the Radiologist. It is then available to view electronically.

Date of next meeting of Board of Directors (Public) meeting – Tuesday 6 October 2020 at 10am via remote access.

The Board resolved that members of the public be excluded from the remainder of the meeting, having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest.

There being no further business, the meeting was closed at 11:35 am