The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust

Board of Directors' Meeting (In Public)

Minutes of the Board meeting held on Monday 30th July 2012 in the Conference Room at The Queen Elizabeth Hospital, King's Lynn

Present:

K Gordon (KG)	Chair
P Wright (PW)	Chief Executive
S Green (SG)	Non-Executive Director (Chair of Performance & Standards Committee)
N Harrison (NH)	Non-Executive Director (Chair of Audit Committee)
J Hillier (JH)	Non-Executive Director (Vice Chair and SID)
V Holliday (VH)	Non-Executive Director (Chair of Quality & Risk Committee)
S Haney (SH)	Non-Executive Director (Chair of Finance & Investment Committee)
B Cummings (BC)	Director of Non-Clinical Services and Performance Management
M Henry (MH)	Director of Clinical Services
G Hunnam (GH)	Patient Safety Lead and Medical Director
G Wilson (GW)	Director of Patient Experience and Lead for Nursing and Non-Medical Professionals
D Stonehouse (DS)	Director of Resources

In attendance:

G Rejzl (GR)	Company Secretary
V Scott (VS)	Assistant Director of Communications
Dr P Moondi (PM) & C Freeman (CF)	Research and Development – Presentation
Dr B Watson (BW) & K McGuire (KMcG)	Patient Story - Presentation
M Posnett & J Murray	Deloitte's
H Milne (HM)	Corporate Governance Officer (Minutes)
Apologies:	L Proctor

143/12 1.RESEARCH AND DEVELOPMENT – PRESENTATION

Is it core business at the Queen Elizabeth Hospital Kings Lynn?

GW introduced Dr P Moondi and Carol Freeman to the Board. CF presented a detailed overview of the Research Governance Framework: Quality Research Culture and how the organisation supports and promotes high quality research as part of a service culture receptive to the

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development and implementation of best practice in the delivery of care.

The National Institute of Health Research (NIHR) Network's role was described and how the Clinical Research Network HQ feeds into the NIHR. The NIHR portfolio studies are usually based on funding source and there are no simple definitions. Grants are open to national, peer reviewed competition (DoH and charities) and Commercial Studies are often supported by clinical specialty groups (see slide 4).

NIHR funding for portfolio studies (1) – West Anglia Cancer Research Network fund which provides funding for a lead cancer trials nurse, a cancer trials administrator and 5 clinical research nurses.

NIHR funding for portfolio studies (2) – West Anglia CLRN provides funding for consultant investigations, research nurses/practitioners, support services (radiology, pathology, pharmacy, and chemotherapy), CLRN research facilitator and a generic research nurse and also funding to support the research governance team.

CF advised that the NHS Constitution states that Clinical research should be a priority in the NHS – yet data suggests that clinical research is not always embedded in NHS 'core business'. Details were given in the slide Patient Recruitment into Research Studies.

The Committee noted that the Trust had been involved in 37 studies involving over 800 people and was currently 2nd regionally in terms of patients involved this year.

Current areas of development identified from international clinical trial days were:

- Research Forum to be set up with a support group for all Research Practitioners within the Trust to share good practice and maintain high standards
- Monitoring and audit training has been completed for non-commercial trials.
- R&D is now part of the Patient Experience Directorate
- Grant applications have been submitted for research into care rounds and the 'Test Your Memory' (TYM) tool.

The challenges faced are:

- recruitment target this year is 1100 (results published on Guardian website)
- the increase in the number of Commercial Clinical Trials
- reduction in set up time and time to recruit to target
    - 70 day target from investigator application to R&D until first patient recruited
- the need to work towards readiness for an MHRA inspection

QEH Board Final.ppt

A general discussion took place at which time questions were put to CF.

Q1. How in the process does the system described set its priorities?

A. Good quality science is the first thing, critical care links/studies, a keen principle investigator who is particularly keen on an area and serves the interest of a particular patient group.

Q2. Does the Trust have a robust infrastructure in place to carry out commercial trials and where are the opportunities for trials?

A. A standardised contract has been agreed across the country. The opportunities are identified from expressions of interest, and fed into the company and the company then advise.

Q3. How can the Trust do more to try and improve visibility?

A. Word of mouth is the most powerful tool that can be utilised. Also undertaking research training.

Q4. How is the end result fed back to the Trust?

A. The result is fed back from the company to the Trust but there is no formal process in place. However, it would be worthwhile looking into this in the future.

Q5. How is the 'grey' area between audit and research managed?

A. The research team work closely with audit and there are standardised formats to work to. There is no need to engage the research ethics committee if work is undertaken with the Trust's own staff and data and a letter would be issued stating that there were no material ethical issues. A list of the studies undertaken would then be placed on the R&D site.

Q6. What are the barriers to achieving 1100 participants?

A. A balanced portfolio is required and 'easy' studies will keep the numbers up.

CF advised that the key criterion to undertaking a study is usually if the company is willing to fund it. The costs are broken down into categories or offset against each case as it is presented. The potential for financial benefit to the Trust was discussed e.g. £200k from the cancer research network and it was agreed that the issue of whether there was a 'pot' available in the Trust would be discussed at a later date. PM advised that commercial trials are the areas where a profit can be made.

Nurses and other professionals are involved through forums, which are led by a nurse and everyone receives the same level of support. The Board noted that a 2nd nurse had recently achieved her PhD

The Board noted that the Trust has a good reputation in respect of R&D and PM observed that there is evidence that patients involved in trials, even the control group, do better than other patients.

The Board welcomed the presentation and agreed that Research and Development is core business for the Trust and further discussions are to take place as to how the Board can be kept informed of progress. **GW**

144/12 2. PATIENT STORY

GW introduced Dr Beverley Watson and Karen McGuire to the Board. BW

and KW recounted a patient story concerning a patient, ' Ernest', who had made a complaint following his admission.

Ernest had been acutely unwell and had been approached following a procedure to sign a DNA/CPR form. Ernest had not been consulted prior to the procedure about this form and refused to sign it whilst in recovery as he did not know what it was for and felt that he 'was not in a good condition to do so'.

Following his discharge, Ernest had dwelt on the issues, was having difficulty settling and bad dreams and had latterly written to complain about this situation and the circumstances surrounding it. On receipt of Ernest's letter he was invited to a meeting to discuss the situation with BW and colleagues.

The outcome from that meeting has resulted in the Trust changing the way in which patients are approached when in an acutely deteriorating condition. Each case should be evaluated individually and a decision made with regard to a DNA/CPR form within 12 hours of a patient coming into the hospital. This requires experience and an understanding of when to intervene.

KMcG advised that approaching the patient with regard to the signing of the consent form had been the appropriate course of action, although in this instance the situation had been handled wrongly due to the condition of the patient and the timing of discussing the DNA/CPR form i.e. while he was in no fit state to do so.

Following the meeting with Ernest, the Trust has received a letter from him expressing his gratitude for having been invited to the meeting to discuss his complaint.

The Trust acknowledged that in the case of Ernest the situation had been handled badly, he should not have been approached at the time due to his condition.

BW advised that there were no procedures in place at present to facilitate discussions with Primary Care and work needs to be undertaken within the Trust to recognise those patients who are on the Liverpool Care Pathway and fall into the Gold Standards Framework category i.e. within 12 months of end of life. Each patient would have to be evaluated by a clinician to determine what treatment is appropriate for that individual.

There have been issues both regarding discussing the issue of DNA/CPR and not discussing it thoroughly with patients and families. BW referred the Board to an NCEPOD report 'Time to Intervene' and advised that an action group needs to be formed to draw up an action plan to ensure all parties are consulted prior to an individual's treatment with regard to condition, expectancy etc.

The key issues discussed by the Board included:

- Consideration of DNA/CPR within 12 hours of coming into hospital and other NCEPOD recommendations
- 30% of patients in the Trust are within 12 months of the 'end of

life'

- Good examples in cancer care and the need to ensure outpatients are on the right pathway
- The need for improved communications

The Chair thanked Beverley and Karen for their patient story and offered the Board's thanks and best wishes to Ernest.

The Board welcomed the Patient Story

145/12 3. CHAIR'S WELCOME AND APOLOGIES FOR ABSENCE

The Chair welcomed everyone to the meeting and introduced the Board and visitors from Deloitte's who were attending as observers.

Apologies for absence were received from L Proctor

146/12 4. MINUTES OF THE PUBLIC BOARD MEETING HELD ON 28TH MAY 2012

Amendment to be made in the title of item 112/12

The minutes were agreed as an accurate record of the meeting, subject to the amendment being made.

147/12 5. ACTIONS MONITORING

The Board reviewed the Actions Monitoring Record

Progress updates were given (see Actions Monitoring Record – August 2012) and those actions marked as complete were agreed for removal from the Actions Monitoring Record.

148/12 6. DECLARATIONS OF INTEREST

None

149/12 7. URGENT MATTERS

None.

The Chair notified the Board that the Performance and Standards and Quality and Risk CKIs would be taken in the private section of the meeting.

STRATEGIC

150/12 8. CEO's Report

PW presented her update to the Board, highlighting the development of 24/7 Vascular Services. Proposals are out to consultation in a 10 week process. The Trust is actively involved and a Clinical Sub-Group has been formed. Consolidation of vascular services to improve outcomes is taking place and the Trust is working hard to ensure that vascular services are maintained locally, thus ensuring that other services are safeguarded. There are some details which still need to be worked though and the

Trust's surgeons are closely linked with N&N and Addenbrookes. MH and Nick Redwood are due to attend a meeting in August and the outcome of that meeting will give the Trust an early indication of what procedures will be commissioned at QEH.

In debate, the following issues were discussed:

- The financial costing has not yet been undertaken and the Trust needs to establish what the financial implications are once it knows what services it will keep. Understanding the potential risk re. loss of income and the potential for premium costs will be critical
- The Trust needs to emerge with the right sized cost base compared to income
- The project is being driven by clinical outcomes – patient safety and clinical outcomes
- GH advised that there could be patient safety issues unless the issues around transport are resolved.

It was agreed that the Board would be kept advised of any emerging issues around consolidation and updated following the consultation period. **PW**

The Board noted the CEO's update

151/12 9. CAR PARK STRATEGY

The Board considered the Car Park Strategy update report. BC advised the Board that the work is on track and looking positive.

BC explained the phasing of the work:

- Phase 1 – reassigning current car parking to create dedicated patient and patient visitor only spaces and an additional 35 spaces
- Phase 2 – creating an additional 200 spaces in the current 'bunded' area of the site, subject to Board approvals

The Board:

- **welcomed the progress report and confirmed that the implementation of the Strategy was moving in the right direction**
- **endorsed the strategy**

152/12 10. QE STRATEGY – PROGRESS AND TIMETABLE

PW presented the paper and updated the Board on specific timescales.

The Board was advised that the Strategy for the next 3-5 years is being refreshed and that the Trust needs to give consideration to broader strategic issues going forward. The Board was however, reassured that this work will not impact on the delivery of the Trust's current Business Plan.

Governor involvement in the development of the Trust's strategy was noted and welcomed.

The Board noted the update and endorsed the timeline for the Strategy

refresh

QUALITY

153/12 11. SAFEGUARDING

11a. Safeguarding Incidents

GW advised that there was nothing to report.

11b. The Winterbourne Report and Action Plan

GW emphasised that this was not an action plan and that the events that occurred at Winterbourne are not widespread or systemic but that the Trust nevertheless wanted to undertake a gap analysis of its services in against the issues highlighted in the Winterbourne report.

In response to issues raised during the Board's debate, GW reassured the Board that the Trust is doing well against the benchmark of the report. The Board noted that the Trust has an excellent learning disabilities service. Two areas of potential risk were highlight:

- in-depth training
- having a 24hr learning disability service.

It was reported that a risk assessment would be undertaken to assess the Trust's requirement for a 24 hour service.

GW advised that the Trust's policies would not be affected by the report. The Trust's policy is that the QEH does not restrain people in hospital – either physically or pharmaceutically, unless the individual is a Category A prisoner (accompanied by a prison officer).

The Board noted the contents of the Winterbourne Report and agreed that any issues arising from the review would be reported to the Performance and Standards Committee

154/12 12. SERIOUS INCIDENTS

GH advised that there was nothing to report in this forum

RISK

155/12 13. BAF

The Board was advised that the transition of the BAF across the two financial years has now been completed. As a refinement, the BAF now contains a Sources of Assurance Heat Map, supporting document. PW explained the Heat Map methodology, demonstrating how the Heat Map could be used to identify where additional assurances are needed.

The Board supported the inclusion of the Heat Map as an integral part of the BAF and noted that the RAG rating will change over time as more or stronger controls are put in place. It was agreed that this would be a useful tool for both the Board and the Audit Committee.

SG requested that more time be allocated to reviewing the document

during Board Development sessions.

BAF risk 2bii was discussed in respect of financial sustainability and the Board's expectation of improvement in this area.

PW advised that the BAF is a live document and that the EDs would be continuously updating it, also noting that where 'weak' sources of assurance were noted especially as a result of an absence of external assurance, TEC would be tasked to review and take action.

EDs

Executive Directors to review and take action on sources of assurance and bring back to the Board

The Board noted the BAF and supporting Heat Map

156/12 14. RISK REGISTER

The Board considered the Corporate Risk Register. It was noted that no commissioning date has been agreed as yet for the MRI scanner as some issues concerning cooling prevail but that staff training and testing are ongoing.

The Board were advised that with regard to the AQP bids, most of the tenders follow a common template.

The Board discussed the following issues:

- Board assurance and visibility that the Trust has capacity and capability to deal with AQP tenders in volume
- The AQP process
- The relative level of AQP risk in 2012/13 and subsequent years. It was noted that AQP is also recorded in the BAF as a risk
- AQP as an opportunity rather than a risk

BC to bring update to next F&I (August) regarding mainstreaming AQP and the Trust's approach to date. **BC**

In respect of Diagnostic Imaging Services, concerns were raised about the level of the Trust's investment to date. It was noted that Direct Access is quite low at the moment and that the Trust would be in a good position to bid against likely PCT tenders, due to its investment. It was explained that most imaging - 80-90% is done for in-patient work and is therefore core to the Trust's business. GH observed that a bigger risk was likely in respect of ultrasound, where less investment had been made. **GH undertook to review the risk scoring in respect of imaging.**

GH

The Board noted the risk register.

OPERATIONAL

157/12 15. INTEGRATED PERFORMANCE DASHBOARD

BC advised the Board that minor amendments had been made to the dashboard regarding the indicator presentation, which now includes trends, where available and where there is 'red' on the dashboard there are

corresponding comments. PW commented that the dashboard was now much more comprehensive although the supporting information format will need to be slightly amended and the report slimmed down for next month's meeting. She thanked BC and her team for their work.

It was noted that the Board's Committees would continue to have their sections of the dashboard presented with appropriate detailed information.

The Board endorsed this approach and noted the content of the report

158/12 16. PERFORMANCE REPORT

Key issues from each chapter of the report are detailed as follows:

Chapter 1 – Quality & Risk

1 There remains 1 outstanding Care Quality Commission (CQC) compliance action following the CQC unannounced visit in August 2011 and subsequent follow up visit in January 2012. This is a one moderate concern reported against it in relation to "Outcome 21: Records, including medical records, should be accurate and kept safe and confidential."
2 The Trust reported 1 Clostridium Difficile infection and 0 MRSA infections in June 2012. The trust is below trajectory for Q1, reporting 7 confirmed Clostridium Difficile infections against a trajectory of 14.
3 There were 3 Grade 3 Pressure Ulcers Reported in June 2012.
4 There were 6 Serious Incidents Report in June 2012.
5 The Net Promoter score for the Trust deteriorated in June 2012 (May data?)
6 Readmission rates rose to 3.2% for elective activity and 8.7% for non-elective activity in June 2012.

The Board's discussion featured the following issues:

- 'The Family and Friends Test' was confirmed as the same as the Net Promoter. GW advised that the Trust is reliant on patients/relatives responding and returning the postcard given on discharge; however it was queried if there were too many questions on the post card. GW confirmed that the Trust will use external facilitation of this measure more broadly, in part to reduce the burden on the Clinical Audit Team. It was observed that the Patient Satisfaction related CQUIN i.e. a 10% improvement on the baseline of 71% of patients recommending the Trust to family and friends would be a stretching target. A meeting is to be arranged to discuss how to ensure more completions of the Friends and Family Test to enable the Trust to meet the 10% return figure.
- In respect of pressure ulcers, GH and GW reported that they believed pressure ulcers at grade 3 were increasing. It was reported that in addressing this, a clinical summit had been held, the use of 'repose' mattresses in A&E was being explored and that the Anderson Model of pressure ulcer assessment was being introduced. It was further reported that the Trust was working towards elimination of this grade of ulcers by December 2012. It was agreed that appropriate follow-up reports should go to the Quality and Risk Committee

- Readmission rates – It was reported that CHKS had been commissioned to undertake an in-depth study.
- Never Events and SIs - The majority of serious incidents relate to pressure ulcers because of the way they are reported; other serious incidents are low. It was agreed that more explanation each month as to the nature of the seriousness of any incident would provide a better understanding of what constitutes a serious incident. **Target position for this year is to be discussed at TEC and advised to next Board meeting.** BC confirmed that the never event will be picked up on the agenda. It was agreed that the 'target' for never events should always be 'zero'. **BC was asked to provide detail in the August report in respect of each SI** **PW** **BC**
- Targets for 'complaints needed – 10% reduction year-on-year to be added to dashboard

Chapter 2 – Workforce

1 Sickness absence rates are 4.2% against a target of 3.7%
2 Appraisal performance is 74.6% against a target of 90%.
3 Information Governance training is 80.2% against a target of 95%.

The Board's discussion featured the following issues:

- Sickness absence was noted as having an adverse trend. Junior ward staff was noted as the biggest area of concern. It was observed that the pace of organisational change, the BSP and the recent ward closure might be having an impact on sickness absence rates. It was however noted that sickness absence in unregistered staff was a national issue.
- Appraisal completeness – DS described the revised process, which saw senior managers' appraisals and objective setting aligned with the business plan timetable and the alignment of other staff with incremental and birthday dates. It is anticipated that this approach will improve rates.
- Information Governance Mandatory Training – BC explained the rolling process and the cumulative target of 95% by the end of March 2012. She did however express more concern about the people who had never undertaken the IG Training at all and explained the steps being taken to resolve this issue.
- GH explained the implications for revalidation in respect of appraisal completeness and mandatory training
- Physical assaults on QEH staff rose by 8 on last year's figure and it was confirmed that the Trust works in collaboration with the Police. It was queried as to why there were only 6 physical assaults reported to the Police when 8 took place. **Details will be collated and circulated.** **DS**
- NHS Resilience Project – **More detail is to be provided to give a better explanation as to what this Project is i.e. what is being done.** **DS**
- Reasons for Leaving - It was suggested that to gain useful information as to the reasons why staff leave, perhaps the Trust needs to be asking different questions during the exit interviews or to expand the 'Other' option to give more detail.

It was agreed that the performance report should cover 'in month' and 'ytd' position on appraisals and mandatory training. **DS/BC**

Chapter 3 – Performance and Standards

1 Trust A&E performance for June 2012 was 96.7%. Q1 was achieved with a performance of 96.7% which was slightly below the Trust aspiration of achieving 97%.
2 The Trust reported 81.5% against the 62 day cancer target for May (Cancer performance is reported one month in arrears). This was a result of 11 patients breaching the target. All other targets were achieved for the month, and forecast for Q1 is achievement of all targets.
3 18 week RTT targets at Trust level for admitted and non-admitted were achieved in June 2012. At speciality level orthopaedics did not achieve the 90% target with performance at 72.2%
4 The Trust DNA rate and the New to Review Ratio rate were above target at 5.5% (target 5%) and 2.5% (target 2.3%) respectively.
5 The Trust did not meet the targets for the following Choose and Book KPIs:-
   i. Choose and Book Booking % - 76% against a target of 90%
   ii. Choose and Book Appointment Slot Issues (ASIs) – 0.18 against target rate of 0.05

The Board's discussion featured the following issues:

- Cancer Targets – BC confirmed that the Trust had achieved all targets in Q1. It was reported that the Trust had failed to secure capacity to treat lung patients in May and that this risk had been reported in the last report. The potential for this to have been addressed through a re-focus of consultant time was explored, as was the impact on the patients concerned. It was reported that RCAs were in progress and it was also observed that only about 1 in 10 patients referred were found to have cancer. BC pointed out that these issues were highlighted in the report on p.37. **It was agreed that the Performance and Standards Committee would see the detailed reviews of the RCA's in their August report.** **MH/BC**
  It was observed that the alert and escalation process should also be reviewed.
- The Choose & Brook trend was improving but the DNA trend does need to be closely monitored as if patients DNA it is a waste of resource. **It was recommended that an 'Actual In Month' figure was detailed as well as a YTD figure.** **BC**
- MH advised that Q1 performance reviews for each of the Divisions is to take place on 31st July 2012 and that the Board will see the output of these reviews.

Chapter 4 – Finance and Investment

For the month the Trust has scored an FRR of 1 compared to an expected FRR of 2. Year to date the Trust scored an FRR of 2 as per the plan. Year to date three of the individual metric have scored 2 (EBITDA Margin %, Net Return After Financing % and I&E Surplus Margin %). The Financial Efficiency criterion is the only one that combines two metrics (Net Return After Financing % and I&E Surplus Margin %) and since both of these have scored a 2, the Financial Efficiency criterion also scores a 2.

The Board elected to review the detail as part of the separate finance and activity report.

Monitor's Self-Assessment of Performance May and June 2012

The Trust confirmed the outcome of their Monitor self-assessment of performance in June 12 as Green due to the revised Compliance Framework for 2012/13. Currently May's performance is showing as Green-Amber due to the 62 day cancer performance.

The Board noted the Performance Report.

159/12 17. FINANCE REPORT

The Board was reminded that a separate Finance & Investment Committee meeting would be taking place following the Private Board meeting to look specifically at divisional performance.

With regard to Item 4 – Business Sustainability Programme (Appendix 3), DS advised that the dashboard was to be amended to show data for 'In Month' as well as 'ytd'. The Board was advised that the latest PMO report indicates that the forecast gap remains significant at £1.5m, but that overall the BSP is on track to date. It was reiterated that there is no room for additional slippage. Delivering a FRR of 3 in Quarter 2 is tight at the moment, but achievable and that areas where activity is off plan needed to be addressed.

PW advised that the decision made by the BSPG in June was to address the gap and any slippages on existing programmes and to ensure that complacency in teams is fully understood as not acceptable. The BSPG will continue to look at pipeline schemes but will ensure that all existing programmes are reassessed for additional opportunity, before resourcing additional schemes. The PMO is now up to full strength and is getting the pipeline moving at a realistic level, with anticipated delivery in several areas i.e. Outpatient POD and POD 19 (Emergency Pathway). A specific meeting had been arranged with Executive Directors and Clinical Directors to address how the gap might be bridged.

MH reported that the Trust was 300 day cases down and that a recovery plan was being developed for delivery in Q2.

GH advised that West Newton Ward had been closed and that the patients had been moved. All elective cases were admitted on 30th July 2012 and work is to be done to ensure this is maintained for August.

NH commented on the non-elective adverse variance of £132k. It was observed that if non-elective activity was lower than expected, then shouldn't the Trust have had the capacity to deal with more elective work. It was reported that the issues in each specialty are different and that it was wrong to assume that the elective issues related only to cancelled operations. DS went on to explain the impact of excess bed-days and the emergency cap on the non-elective income. The need for the Trust to be 'nimble' in managing its activity was observed by the Chair.

PW explained that the surgical division has a plan to reconfigure their bed

base which will ensure fully ring-fenced elective beds are established and that surgical emergencies are co-located with the SAU. This proposal will be considered by TEC in August and, if agreed, should ensure more proactive management of the inpatient elective pathway.

In response to a query concerning Day Surgery, BC commented that not all day cases pass through the day surgery unit. DS confirmed that there is enough work on the Trust's order book.

It was confirmed that all underperforming specialties would be attending performance meetings in August.

The potential for Waiting List Initiatives and premium costs to be incurred through recovery plans was discussed. It was stressed that in respect of POD 17, Job Planning Pod for Consultants – premium costs incurred must be delivered within budget and activity.

DS confirmed that there is a clinical under spend in the Clinical Support Division with expenditure expected later in the year and that the figure of £326k detailed in item 6.6 is not an over spend, as it is being funded from the Transformation fund.

JH asked how confident the Executive Directors were that the FRR of 3 can be delivered in Q2. PW responded, reminding the Board that the Trust is ahead of where it expected to be in the quarter. Appendix 1 shows better performance in April and May but less positive in June so the Trust needs to be smarter 'in -month'. The divisions are focussing on this and the Executive Directors are confident that the position will be retrieved through continued management of vacancies, reductions in Bank staff usage, the closure of a ward and the development of specific recovery plans for services which are reporting a variance from plan.
In respect of the BSP:

- Some phasing risks were identified
- The milestones for Q2 have been reviewed and there has been no further deterioration
- The PMO are currently reviewing Q3 milestones

In summing up, the Chair welcomed the executives' confidence and indicated that the Board now looked to the executives to deliver.

The Board noted the Finance and Activity Report.

160/12 18. CHAIR'S KEY ISSUES (CKIs) FROM COMMITTEES OF THE BOARD OF DIRECTORS

The CKIs from the Performance & Standards, Quality& Risk and Finance & Investment Committees were taken off the Public Board agenda and moved to the Private Board agenda.

Audit CKIs – NH recommended that the Board receive a copy of the strategic audit plan aligned with the BAF. **GR**

The Board noted the Audit Committees Chair's Key Issues

TEC CKIs:

The Board noted:

- **that the Trust has been invited to support a joint bid to become a Burns facility with the N&N**
- **the On-Call Policy was ratified by TEC and will come into effect as from September 2012**
- **ongoing issue in respect of letters being copied to patients and the costs involved - The PESG is to consider how the Trust communicates with patients and GW to canvas views from a Patient Experience Workshop being run on 19th July 2012**
- **Risk Register reporting and monitoring at TEC in development**
- **the R&D Operational Capacity Statement was approved by TEC and can now be downloaded onto the NIHR Website as appropriate**
- **the Investigation of Complaints policy was ratified by TEC**
- **the Committee agreed to appoint an interim Chief pharmacist for 6 months and then go to advertisement**
- **there is a 10 week consultation on-going around vascular services. A further meeting will be arranged to discuss in further detail**
- **the Team Brief presented to senior managers to be cascaded throughout the organisation**
- **the Governance Structure review will be amended to include financial section in the Policy on Policies**

The Board discussed the risks associated with revised contracts in Pharmacy. PW alluded to a number of issues in Pharmacy of which the change to on-call arrangements was one. She indicated that the position would be clearer by the end of the week. GH indicated that fewer issues had been identified in respect of the Radiology consultation. It was noted that staff-side had been fully involved in the consultations. KG observed that the future would concern being tough on terms and conditions.

GOVERNANCE

161/12 19. Q1 COMPLIANCE FRAMEWORK RETURN

BC advised that there had been significant changes from last year's processes with Monitor and that the scoring methodology had changed. She reported that no penalty score will be applied to the Trust regarding the 'moderate' CQC concern.

The Board confirmed Statement 11 that - 'The Board is satisfied that plans in place are sufficient to ensure: ongoing compliance with all existing targets (after the application of thresholds) as set out in Appendix B of the Compliance Framework; and a commitment to comply with all known targets going forwards'.

The Board confirmed that there are no matters arising in the quarter requiring an exception report.

The Board advised that they cannot confirm Statement 4 – 'The Board anticipates that the Trust will continue to maintain a financial risk rated of at least 3 over the next 12 months'.

The Board agreed the Trust's Finance and Governance Statements for Q1

and authorised BC to apply the Chair's signature and upload the return to Monitor

162/12 20. REPORT ON EFFECT OF NHS CONSTITUTION

GW reported that the EoE SHA has led on the NHS Constitution since its inception and that the Secretary of State had latterly reaffirmed that he will hold all organisations to account for having regard to it. GW confirmed that the link to the NHS Constitution was on Trust's website but that there was now a need to raise its profile.

PW observed that in Business Planning activities, it would be helpful to look at ways of embedding the key principles and values of the NHS constitution. BC commented that the NHS Constitution was embedded in the Trust's key contract.

A presentation on the NHS Constitution to the Governors' Council was suggested.

The Board noted the contents of the report

Date of Next Public Board Meeting – 29th August 2012, QEH Conference Room @ 9.00 a.m.

There being no further business, the meeting closed at 12.40pm