The Queen Elizabeth Hospital King's Lynn
NHS Foundation Trust

Board of Directors (In Public)

Minutes of the meeting held Tuesday 25 September 2018 at 11.30am in the Inspire Centre at The Queen Elizabeth Hospital, King's Lynn

Present:

E Libbey (EL)	Trust Chair
J Green (JG)	CEO
I Pinches (IP)	NED
I Harvey (IH)	NED
D Dickinson (DD)	NED
A Brown (AB)	NED
M Ashton (MA)	NED
D Thomason (DT)	NED
E Hardwick (EH)	Chief Nurse
N Lyons (NL)	Medical Director
R Jackson (RJ)	Director of Finance & Resources
J Wade (JW)	COO
K Charman (KC)	Director of HR

In attendance:

P Slinger (PS)	Improvement Director - NHSi
C Roberts (CR) – item 14	Associate Director of Patient Experience
J Alfred (JA) – item 14	Patient – for Patient Story
J Hannam (JH)	Associate NED
D Chessum (DC)	Head of Communications and Engagement
G Rejzl (GR)	Trust Secretary
L Le Count (LL)	Corporate Governance Officer – minutes

ACTION

CHAIR'S WELCOME

The Chair welcomed those present to the meeting – he acknowledged that papers relating to staffing challenges and options had been circulated to staff and Governors and advised that the agenda had been revised to accommodate the discussion.

He noted the attendance of Philippa Slinger, NHSi Improvement Director, who would be observing the meeting.

Camera crews were present at the meeting but the Chair advised that they were not permitted to film the meeting, in accordance with the provisions of the Trust's Standing Orders.

The Chair noted that this was IP's final Board meeting and thanked for him for his contribution during his 6 years as a Non-Executive Director.

INTEGRATED PERFORMANCE REPORT

The Board considered the report and discussion included:

93/18 1.CQC INSPECTION REPORT

The Board considered the CQC report and discussion included:

- EL advised that both he and JG had made public statements about the report and whilst the Board was disappointed, it accepted that it was a reflection of the CQC's assessment and the focus now is on moving forward and making the necessary improvements. The Board will be working with staff to address issues raised.
- JG added that as well as addressing the 'musts' and 'shoulds', the organisation needed to make a cultural change.
- As a result of being placed in Special Measures the Trust has been allocated an Improvement Director as well as receiving support from NHSi to assist with moving out of Special Measures. The Trust will also take up 'buddying' arrangements with other hospitals. A new committee, the Quality Programme Board (QPB) will monitor progress against 'musts' and 'shoulds'.
- An Oversight and Assurance Group (OAG) will meet monthly, led by the NHSi regulatory team and involving stakeholders from across the region. The meetings will focus on progress and will involve in-depth enquiries into areas of concern; JG is keen for front line staff to report on these.
- The action plan will be divided into 5 workstreams covering 94 'musts' and 'shoulds' – each will be led by an ED.
- The Trust has to respond to the CQC in relation to the action plan by 7th October – this is a statutory requirement.
- IP asked the EDs whether they considered the action plan to be sufficiently robust and whether the pace was appropriate - JG advised that some actions will take longer to address but that the EDs were establishing a good baseline.
- IP queried whether adequate resources were in place - JG acknowledged that the current resource was inadequate but that the planned external Board Review will highlight where additional resources are required. The Trust will receive some financial support from NHSi and this needs to be used wisely. IP sought assurance on pace – this will be monitored via the QPB and assurance will be provided when available.
- IH queried whether the workstreams included inter-dependencies / work across workstreams - JG advised that whilst some were specific there were those which would be interdisciplinary.
- MA noted that staff felt they were not listened to and sought assurance that a sustainable communication plan would be developed with staff to ensure they are heard; she added that communication should be two-way from Board-to-floor. KC accepted the challenge and advised that a high proportion of staff had attended one of JG's CQC briefings. Going forward, the EDs will be working with all levels of management looking at turning the 'musts' and 'shoulds' into actions and how this could include ensuring each member of staff having a voice.
- AB felt it was clear where accountability lay with each workstream and queried whether there was oversight resource in place - JG advised that there was a team in place and 2 additional staff were required. **EL asked KC to provide a report on communications to Workforce Committee.** **KC**
- DD noted the detail of the objectives and queried how the EDs will

maintain focus on the strategic element - JG advised this relates to engagement with the STP work and aligns with the Corporate and Clinical Strategies. These strategies link to form the 3-5 year vision, which is underpinned by the values and behaviours relaunch and Organisational Development.

- EL reminded the EDs to ensure staff are engaged with progress.
- The Board approved the QPB ToR.
- JG will update the Board monthly on QPB progress.

The Board noted the CQC update

94/18 2. QUALITY

The Board considered the report and discussion included:

- IH referred to page 15 of the IPR, noting that indicators for Stanhoe / Tilney were red and asked EH if these were related to fill rates - EH felt it was difficult to make a direct correlation, although sub-optimal indicators were often related to poor fill rates. She added that a higher level of temporary workforce can result in failure to complete paperwork relating to the indicators.
- MA noted that during a previous discussion on quality, EH had indicated new systems / process were being initiated to performance manage and queried whether there was an update. EH advised that she was meeting with matrons and ward managers on a regular basis and escalating where necessary. The harm-free process is now more rigorous, with immediate actions where necessary. There had been an increase in falls / PUs during the last few months but the Trust is now seeing a reduction. Falls continue to be lower than the national benchmark.
- MA queried what mitigation was in place to address IPAC risks during the winter period – EH advised that the QIP is in place and being monitored through the Hospital Infection Control Committee (HICC) which met yesterday and received assurance in relation to cleaning / handwashing. An external peer review by NHSi is planned and work is on-going in relation to peer surveillance (ward areas). EH takes part in regular walks around the Trust with the Head of Estates, domestic supervisors and the IPAC Lead.
- IH referred to the 6 cases of C.Difficile and queried whether EH was satisfied with the steps in place - EH agreed that the new cases were disappointing but that monitoring was taking place. She added that the cleaning programme was responsive and she considered the placement of patients to be important.
- MA noted a high level of C-sections - NL confirmed that the rate was high at 32% but this was in line with the national level. He is working with national advisors regarding the Section 31 notice and their feedback suggests the C-section rate is not an area of focus. A Clinical Lead for maternity has been appointed and a Delivery Suite lead is due to start shortly, so there will be increased clinical ownership.
- AB noted the drop in emergency C-sections, a rise in the elective rate, and a drop in instrumental deliveries – NL was unable to explain the variations but explained that a month/month fluctuation is expected. There had been no related SIs. There has been a recent change in senior staff and NL suggested the variation could reflect personal practice; however, he would like to see the long-term trend before reaching

conclusions.

Staffing

- IP was disappointed that the Trust is failing to achieve its own appraisal / mandatory training rates and queried what actions would be taken - KC explained that compliance was higher than indicated but there was a delay in reporting. Targeted work has proved successful; however, the pace of improvement relating to mandatory training remains a concern, particularly as it was highlighted by the CQC. The implementation of 'My ESR' and the associated move away from workbooks represents a step-change and should have a positive impact. HR staff will be visiting areas with low compliance to help address any challenges**. An update will be given at Workforce Committee in October.** **KC**

<u>The Board noted the Quality update</u>

95/18 2b. Options to Release Nurse Staffing

The Board considered the report and discussion included:

- The CQC had raised immediate concerns relating to staffing, particularly in some medical areas; the Trust put immediate actions in place by reducing capacity, closing the escalation ward and increasing staffing. The CQC was satisfied with these actions during their re-inspection.
- The Trust has faced challenges with the overall fill rate, particularly the day rate which dipped to 85% on occasions in August.
- The overall vacancy rate is a cause for concern. A review has been undertaken by EH / PS and the NHSi Quality Manager and a report generated.
- EH felt it was important to note that when staffing was reviewed recently it was considered alongside sensitive indicators such as patient complaints. The large number of vacancies (130) has been exacerbated by maternity leave and a high rate of sickness; the fill rate has been improved temporarily by the use of varied agency workers, which increased the fill rate to c95%. Although this rate was felt to be safe, the cost is not sustainable in the long-term. Consideration has been given to moving staff across the wards to achieve a 12% vacancy rate across all areas.
- EH was keen to assure the Board that daily reviews of staffing continue to take place along with discussions with site co-ordinators. United Lincs and Colchester hospitals will assist with peer reviews.
- JW explained that the Board was considering 4 options to be implemented in the short term, likely to be for 3-6 months.
    - Option 1 - no changes to the ward configuration, with an increase in the number of agency nurses (Tier 5 nurses). This would have a negative financial impact.
    - Option 2 - closure of Marham ward (elective surgical). This would impact medical outliers and surgical emergency patients as well as electives. The Trust would also have to suspend cancer / electives, and repatriate surgical and medical emergencies. Addenbrookes is unable to offer any capacity for QEH patients, and whilst NNUH would work with QEH to find a suitable option

for patients, it recognised the impact on the local population.
  - Option 3 – closure of Oxborough ward (medical) to redistribute staff. This would also release doctor time, improving quality of care.
  - Within Options 2 and 3 there are clinically-driven ideas to alter pathways to reduce Length of Stay. Both the medical and surgical workforce are galvanised to step forward and offer ideas. JG was confident the Trust would be able to change working practices.
  - Option 4 – a hybrid of Options 1, 2 and 3. This is the Board's preferred option as it increases agency usage as well as reducing some elective and medical capacity. 12 beds will close on Marham and 12 on Oxborough, enabling nurses to be redeployed across the Trust to improve quality.
- JG explained that the Trust needed to ensure it was prepared for winter pressures. He felt the Trust also had a responsibility to ensure it was supporting all patients within the community.
- IH felt that the Board had to accept the CQC's diagnosis and whilst staffing is adequate at times, the challenge needed to be addressed and the Trust should accept its obligations both to patients on waiting lists and patients waiting to be referred. He added that data suggests that patient complaints do not always correlate to staffing levels and that staffing by itself will not address the CQC's concerns. He preferred Option 4, as it provided a degree of flexibility whilst meeting the objective of addressing immediate staffing concerns.
- MA reminded the Board that 'WTEs' were staff who would be involved in ward moves and this needed to be handled carefully. She also felt EH needed to clarify staff competencies as different skill-sets were required for surgical and medical wards. EH advised that the issue had been discussed in detail with the nurses involved and the senior team. There will need to be review of staffing competencies / skills and this will be carried out on a 1:1 basis with the Practice Development team. She added that medical outliers are often cared for by the surgical nursing team on the surgical wards. MA queried whether this can be done at pace - EH believed so and she highlighted the professionalism of staff she had spoken to in relation to this. She acknowledged that there will be some staff who will not want to move and consideration will be given to how these staff can be supported through the decision-making process and this could challenge the pace.
- AB felt that none of the options were ideal in the long term and suggested the Board needed to consider new models of care, how to better utilise HCAs, and how to work with the system to manage demand and get patients out of the hospital. KC agreed that the Trust needed to work differently - there are several new roles and opportunities being developed on longer-term trajectories and this needs to be done in conjunction with short-term work. JG advised that revised care pathways are being suggested by medical colleagues and thanked them for their input. There are a number of other areas outside the Trust's control which would make a significant difference to the population / flow, such as management of MFFD patients in Cambs, a community IV service and community beds. The Trust is expecting to have an additional 25 nurses by Christmas and a further 60 by the end of March, which will make a significant difference.
- DD queried whether ward closure implications were different for medical staff - NL advised that there was a requirement for some

flexibility by medical staff but it was achievable. The options did; however, affect the HEE curriculum. If the Trust implemented Option 2 it would lose its foundation doctors within 2 weeks. Option 4 has fewer implications for doctors' training.

- EL acknowledged that there was no easy option.
- JG felt it was likely that the Trust will face increased pressure when other trusts have an additional need for agency staff, depleting availability for QEH. He favoured Option 4 (incorporating Option 1); however, rather than cancelling all electives for the next 3 months he suggested this could be done on a week-by-week basis for non-urgent cases, dependent on staffing levels. He did acknowledge that this was likely to present some complications for staff.
- AB was pleased with this suggestion but felt the Board also needed assurance this process was working. He added that pace was vital; the Board should receive prompt feedback if performance goes off-plan, along with a plan for recovery.
- JG advised that data on ward staffing and indicators will be collated and circulated on a daily basis; EDs will make a decision on a Wednesday / Thursday in relation to elective surgery capacity for the following week.
- MA noted that the paper states JG is responsible for this but she considered NL / EL to be responsible officers.
- MA referred to long-term sustainability and noted that the Trust currently has c.60 MFFD patients which equates to 2 wards –reduction would make a significant impact. JG agreed, adding that the Trust is working with system partners on Discharge to Assess. He also felt that the Red2Green initiative would help. He is meeting with the NHSi Regional Director next week and will ask for support in relation to Cambs CCG which is failing to engage with the Trust.
- IH queried the impact on elective activity - JW advised that Option 4 would affect c15-25 patients per week which could be cancelled / not booked. This equates to c7-8% of elective patients (2-3% of all surgical patients).
- IP sought assurance that the Trust has the ability to assess safe staffing, which can be flexed at pace and is sufficiently robust to avoid challenge by regulators. EH confirmed that the Trust has the ability to match staffing, i.e. use of a daily monitoring tool to identify staffing including a breakdown by temporary / substantive staff. The Trust has also procured Allocate, which includes 'Safecare' which is responsive to patient acuity.

Questions

- S Clarke noted that inpatient admissions had increased by 10% and A&E attendances by 22% since the last CQC report and queried how wise it was to consider closing beds.
- D Coe queried the cost of using agency nurses (Option 1).
- P Kunes noted the movement of procedures to DSU and queried why this had not taken place already.
- J Dossetor noted that HEE would support the junior doctors for 3-6 months and queried whether it would continue to provide support in the longer term.
- S Clark queried whether the Trust was at risk of losing consultants / surgeons / nurses which would prove extremely challenging when the elective programme is re-started fully.
- E Corner queried what assurance the Board had that the medical /

nursing staff are satisfied with Option 4.

- P Tasker felt that any measure must be short term – if the Trust loses key medical personnel it will impact on A&E.
- B Lewis queried how local patients would get to other sites as many were reliant on public transport.

- EL acknowledged these concerns and agreed that there was not a simple solution to the challenging position the Trust finds itself in.
- JG advised that 'length of stay' will be addressed by changing pathways i.e use of AEC.
- The regulator will want to discuss financial implications of cancelling inpatients; the Trust is likely to breach the 52-week standard, which will impact on patients. The overall cost of £1.9m for Options 1 and 4 includes high-cost agency staff.
- NL advised that HEE understands the Trust's position and that although Option 4 would mean working differently the Trust would still fulfil curriculum requirements so would not be challenging the Trust for many months. He added that all Trusts will face increased pressures.
- NL agreed that movement of activity to DSU should have been undertaken earlier and he was humbled by staff working together to make changes in such a short timeframe.
- S Squire was surprised to see this short-term solution and sought assurance it was not a knee-jerk reaction. EL advised that attendances are increasing and the Trust's age demographic is not helping - he agreed this option was not a long-term solution and noted that this would have to be developed.
- JG agreed that a long-term plan is needed; however, there is an immediate problem to address; the Board needs to stabilise the position then look at the next 3-6 months across the challenging winter period. Recruitment is key for the long-term.
- JG felt that the level of staff present at the meeting indicates the level of staff concern and passion for the Trust.

Staff questions:

- A Practice Development Nurse from Theatres advised that the 120 staff in Theatres were concerned – they felt that staffing numbers were inadequate, staff had not received a pay increase for 8 years and morale in general was poor. He felt that Option 2 could lead the Trust to become a nursing home; Option 3 was not viable for the Trust and Option 4 appeared to be 'business as usual'. He suggested an Option 5 by utilising 23 hour stays, which are not day surgery but do not require an overnight stay. He also suggested that HR may need additional support as it currently takes 2 months from interview to appoint staff and as departments cannot advertise a post until the staff member has worked their notice this means 4 months of additional pressures.
- Funding – the Trust had a deficit of c£20m last year and this is likely to increase to c£30m this year, which suggests a lack of Government funding.
- One staff member had just joined the Anaesthetics team and had been warmly welcomed to the Trust. They expressed concern that the hospital may lose A&E and medical trainees.
- D Barber asked PS to comment on the options - PS was clear that the decision lay with the Board.

- JG advised that the Executives will consider the 23 hour stays for surgery.
- KC acknowledged that the Trust cannot advertise a post until it becomes vacant but she hopes to hold a recruitment day every 7 weeks and this will include pending vacancies. The Trust is working with an agency on overseas recruitment; however, the NMC is the main stumbling block and this is being reviewed.
- MA noted that the Board had heard that this is a temporary measure for 6 months – she suggested that the success of the plan is evaluated and if it is not progressing then individuals can be held to account. EL agreed, adding that the Board needs to review progress monthly and consider the impact on patients and recruitment, and progression to the longer term. JG was in agreement.
- NL assured the anaesthetic trainee that he had spoken to HEE who advised that this short-term solution would not affect other trainees.
- MA felt that HEE would also look for assurance regarding the mentorship / nurse education agenda – EH advised that plans were in place with HEE and providers. The next NMC review will take place in the autumn; the mentorship register is intact and EH is aiming to increase it.
- S Clark felt that as recruitment is so challenging that the Trust must look after its existing staff.
- E Corner suggested that given the complexity of the solution it was imperative to communicate it clearly to the wider community.
- J Evans noted that some discharge issues relate to lack of community services and queried how supportive Adult Social Services was in relation to facilitating discharge. JG advised that the Trust has a good relationship with Norfolk Social Services, however Cambs has not engaged and represents a significant problem for the Trust.
- P Kunes advised that the Governors offered overwhelming support for Option 1.
- N Tarratt felt that the Trust must consider existing staff – whilst the option offers incentives for new staff, there is nothing for existing staff. JG agreed that the Trust could do better but it is not feasible to offer all staff a bonus.
- EL summarised by saying that the current situation is not desirable and the options outlined reflect difficult choices. The Trust must have sufficient staff to provide safe care to patients. Option 1 reflects the immediate response and Board colleagues want to progress this as far as possible, but Option 4 should also be applied in a flexible way for minimum disruption. The Trust needs to look at recruitment issues in both the short and long term; there should be minimum cancellations and rigorous reporting to Board.
- The Board thanked all staff who were able to attend,
- The Board approved Option 4, to be applied flexibly to minimise cancellations whilst continuing to recruit as many nurses as possible and provide safe staffing.
- EH clarified that the Trust planned on reducing beds on Oxborough and flexing beds on Marham. JW advised that 12 beds will be closed on both Oxborough and Marham but staffing will be reviewed frequently and if safe staffing allows capacity will be flexed over the following week.
- N Tarratt queried whether the Trust had adequate surgical and medical staff to be able to flex – JW advised that there is a significant surgical cohort who already look after medical outliers.

The Board approved Option 4

96/18 3. OPERATIONAL PERFORMANCE

The Board considered the report and discussion included:

- 18 weeks – performance is not at the desired level although it is slightly ahead of trajectory, with the caveat of today's decision.
- A&E – this has been the most challenging month to date. Although performance has been ahead of the recovery trajectory for the last 4-5 months, August saw a significant increase in attendances and there was no switch from 'majors' to 'minors' as expected. There were an additional 350 attendances in August, and the number of 'majors' put pressure on beds. There were an additional 400 attendances in July, which significantly exceeds the planned 3% year on year increase.
- Cancer – this remains a significant concern. The Intensive Support Team (IST) has visited the Trust and is compiling a report. There were no immediate actions required.
- IH queried the likely deviation from the A&E trajectory - JW advised that deviation occurred in August and will occur in September. Actions include full roll-out of Discharge-to-assess (D2A) and a proposed stretcher discharge lounge.
- EL noted that the age profile for A&E has changed – JW confirmed that the age profile has increased, along with an increase in length of stay (LoS). Potential reasons for this include failure to discharge patients or increased patient acuity. As there was no switch from 'majors' to 'minors' JW assumed that patient acuity had increased.
- IP queried whether any benchmarking with other local providers had been undertaken - JW advised that he was in contact with CUH, Peterborough and NNUH and all reported seeing an upward trend in activity with an increase of 6-10%.

The Board noted the Operational Performance update

97/18 4. WORKFORCE

The Board considered the report and discussion included:

- KC explained that several issues had already been discussed earlier in the meeting, particularly in relation to staff retention.
- There has been a significant increase in the number of staff in staff in post.
- AB asked why the Trust waited until someone left before advertising the post - KC explained that the vacancy needed to be verified prior to advertising and, financially, it was not possible to have an overlap. She acknowledged that carrying out post-by-post recruitment was time-consuming and in order to speed up the process (currently 6 weeks) the Trust will have a recruitment event every 7 weeks and this will include forthcoming vacancies.
- IP noted the comment regarding an overlap but suggested that as clinical gaps were often filled with expensive agency staff, it may be more cost effective to have a substantive overlap. KC agreed with the rationale but added that the Trust generally utilised bank staff rather than agency.

Transformation

- MA felt that this work was dependent upon getting an Improvement Lead to drive the project and this is currently on hold. KC confirmed that the project requires process re-engineering skills the Trust does not have currently – it would be a 'spend-to-save' short-term post. It was agreed that this would be an Executive-led project.
- **EL noted that all trusts are facing similar recruitment challenges and asked KC to consider how QEH can offer candidates something different.** **KC**

Workforce Race Equality Scheme (WRES)

- This work was started last year and the Trust has seen some improvements.
- Whilst allegations of bullying are acknowledged this is not solely related to race.
- The Lived Experience group looks at the whole impact of WRES rather than just statistics.

The Board noted the Workforce update

98/18 5. FINANCE

The Board considered the report and discussion included:

- RJ confirmed that the financial performance had slipped in August, with a control total loss of £2.2m which is £0.8m adverse to plan.
- There was a £700k reduction in clinical income.
- This report was discussed in-depth at Finance & Activity Committee.
- The Outline Business Case for the roof project is currently being discussed with NHSi.
- MA queried whether RJ had a clear plan in relation to the financial position – RJ confirmed that there were a number of plans in place as there are several drivers. MA sought assurance on achievability – RJ explained that outcomes will need to be reassessed after today's decisions, with a revised outturn position taking these into account.
- DD queried whether the costs relating to the CQC report had been included - RJ confirmed they had.

The Board noted the Finance update

QUALITY

99/18 6. CHAIR'S WELCOME AND APOLOGIES FOR ABSENCE

EL welcomed the Board to the second part of the meeting.

100/18 7. MINUTES FROM THE BOARD OF DIRECTORS' PUBLIC MEETING ON 31ST JULY 2018 / MATTERS ARISING

- Minute 69/18, 2nd bullet to read "…KC is aiming to increase this."

The minutes of the meeting held on 31st July were considered to be an accurate record of the meeting subject to the amendment above.

101/18 8. ACTIONS MONITORING

The Board reviewed and updated the Actions Monitoring Record.

Actions 02, 09, 14, 27, 31, 32, 33 and 35 were considered complete and were removed from the action log.

See Action Log for further updates.

102/18 9. DECLARATIONS OF INTEREST - none

103/18 10. URGENT ACTIONS (Under Standing Order Para. 5.2)

a. Allocate

- This is integral to the improvement of nurse rostering.
- AB queried the expected benefit to the Trust - EH explained that it was an upgrade of the current system and benefits include advice from experts at Allocate regarding safety, and a safe-care module which provides real-time information on staffing. It also notes when staff move wards mid-shift and can check acuity in real-time.
- There are implications for staff – they will need to update the system and be clear on the criteria for acuity. The system may also identify a lack of staff. EH advised that there is an implementation programme showing robust process for checking acuity.
- KC advised that the current system cannot differentiate between registered and unregistered nurses.
- JG advised that central STP money will help deliver this over 3 years.

The Board approved the Allocate Urgent Action.

b. Loan Request

The Board approved the Loan Request Urgent Action

104/18 11. CEO'S UPDATE

The Board noted the CEO's update

105/18 12. CHAIR'S REPORT

The Board noted the Chair's Report

STRATEGIC

106/18 13. NORFOLK & WAVENEY STP update

- **EL suggested setting up a session with Governors to go through the options within the next few weeks. JG agreed. GR to arrange.** **GR**
- AB noted that the STP will receive £7.5m in Government funding over

the next 3 years for specific projects. JG advised that this will be used for developing digital projects across the 3 hospitals.

- IH asked for an update on block contracts – JG advised that the STP arbitration found in favour of the CCG proposal rather than QEH. JG is considering the Trust's position as the CCG proposal was £2m less than QEH was expecting and still included potential fines. He is looking at potential models for alternative contracts.
- EL queried whether the funding regime for next year is due for reconsideration - RJ confirmed it was due within 6 months.
- JG advised that the STP is working towards a move towards a single commissioner.

The Board noted the STP Update

107/18 14. CORPORATE STRATEGY

The Board considered the report and discussion included:

- This links to other strategies and is underpinned by Trust values and behaviours.
- **AB referred to Principle Risk 2 causes and suggested adding that all records are paper-based.** **GR**
- **Page 7, aim 6 'support our patients to age with dignity' – DT suggested considering adding 'family' to the sentence.** **GR**
- **Aim 4 'Sustain safe births' – to remove 'are' from the first bullet point.** **GR**
- EL felt that this now needed to be translated into a direct action plan.

The Board approved the Corporate Strategy

QUALITY

108/18 15. INTRODUCING THE NEW 'FREEDOM TO SPEAK UP GUARDIAN'

- EL welcomed David Trevanion to the role of Freedom to Speak-up Guardian and thanked MA for stepping into the role for the last few months.
- David was keen to see an open and transparent culture but acknowledged that this was a challenge, particularly at this stage. He felt that the role is well-recognised and he will support individuals who wish to speak up in an open and transparent way, rather than escalating concerns directly to the CQC.
- David felt that independence is key to the role and will communicate this to staff. He is also hoping to work in partnership with senior management.

The Board welcomed the new Freedom to Speak-up Guardian

109/18 16. PATIENT STORY

CR introduced Mrs Joan Alfred, Chair of the Downham Dementia Support Association. The recent experiences of Association members have highlighted how some areas in the Trust can provide excellent care whilst others have gaps in training. Joan has shared this information with the Complex-Elderly and Dementia Steering Group and is now attending the group as a representative.

- Joan was pleased to be able to attend the meeting as she and her husband have both received good care and respect at the Trust.
- One member of the group had been impressed by the care and respect shown to a patient with dementia on West Newton and West Raynham wards. Dedicated care was given throughout the day and night.
- Joan then reported the experience of a carer of an inpatient with dementia on Denver ward. The carer spent 7-8 hours per day on the ward as nurses found it difficult to cope with the patient when she left. On the day of the patient's operation, 2 doctors in scrubs visited the patient and tried to carry out an examination but the patient refused as they were unaware that they were doctors.
- The same carer reported that in Outpatient staff try to talk to the patient on their own despite knowing about the dementia but then need to call the carer back in as the patient cannot engage.
- Another patient with dementia was admitted to Windsor ward via A&E and whilst the care in A&E was good, on the ward no-one spoke to the patient and his wife felt apprehensive about leaving him there. She found it difficult to get information from staff and was deeply concerned when she was asked to take him home at 8.30pm as staff were unable to manage him.

- EL thanked Joan for sharing the accounts, and it was always useful to hear how services can be improved.
- EH thanked Joan for the feedback; she was pleased to hear that patients had received some dignified, compassionate care and the Trust needs to ensure this is replicated across the Trust. She added that staff across the Trust must be able to care for patients with dementia and their families.
- AB advised that his mother is living with dementia and he was familiar with the issues raised in the stories. He reported that it is difficult for clinicians to engage with the patient in this circumstance and there are issues with safeguarding / confidentiality when the patient's family wants to get involved in their care.
- RJ felt there was a communication issue raised – the Trust should expect doctors to introduce themselves to patients and to wear their name badge. NL acknowledged that he was looking to reinstate this practice.
- MA queried what type of therapeutic care model the Trust has for agitated patients – EH advised that there was no structured care model however some areas have Patient Support Workers to carry out distraction therapies and the Trust has started to implement an Enhanced Care Team.
- CR added that 'John's Campaign' is being rolled out across the Trust, with the emphasis on carers as partners in care. They will have access to meals / breaks and will be able to stay on-site as long as they wish, knowing that the patient is supported when the carer leaves. Wards will use the 'My Life' software.
- EL thanked CR, noting that this would be her last attendance at Board as she is retiring in October.

<u>The Board noted the Patient's Story</u>

110/18 17. REVISITING THE PATIENT STORY

The Board considered the report and discussion included:

- EH referred to hydration, advising that the housekeepers' role now includes supporting IPAC improvements, which meant less time for direct patient care. EH is ensuring that the delegation of the drinks trolley is taken forward.
- Lights remain on until 11pm for the drugs rounds and will then be dimmed as soon as possible.
- There has been a roll-out of soft-close bins.
- **MA queried whether there had been a conclusion to the investigation raised following the patient story in May - KC confirmed that the investigation has been concluded and MA / KC / EH to discuss outside the meeting.** **MA / KC / EH**

The Board noted the Patient Story update

111/18 18. QUALITY IMPROVEMENT UPDATE

The Board considered the report and discussion included:

- EH reminded the Board that actions remain open in relation to the CQC visits in April and May and to Sections 29 and 31. These actions will be updated; however, some will move onto the full action plan.
- IP referred to page 4 and queried whether overdue actions were impacting on patient care - NL advised that issues with safety huddles related to communications on the wards but the risk will be mitigated. Other issues relate to process and providing assurance to the Board but do not impact on patient care.
- IH queried whether any resilience was being built into the plan i.e. sickness - JG advised that this was an issue if an individual has a specific skill-set and staff will be moved around if necessary.
- AB felt the Trust needed a plan, which demonstrates all inter-dependencies.

The Board noted the Quality Improvement update

RISK

112/18 19. CORPORATE RISK REGISTER (>15)

The Board considered the corporate risk register and discussion included:

- NL advised that work is being undertaken to address articulation and pending risks but work on actions to address risks still needs to be developed. An expert from NHSi is coming in to review the risk register.
- EL queried risk 2486 (non-compliant fuel) – RJ advised that action has been taken to remove the fuel, which was non-compliant due to its sulphur content.
- GR advised that she and Lou Notley had begun to review the improvement plan, the 'musts' and 'shoulds' and the risk register in order to align them.

The Board noted the Corporate Risk Register update.

REGULATORY AND GOVERNANCE

113/18 20. PERIODIC REPORTS - *none*

114/18 21. REGISTER OF DIRECTORS' INTERESTS

The Board noted the report.

The Board noted the Register of Directors' Interests

115/18 22. BOARD OF DIRECTORS – FORWARD PLAN

The Board noted the Forward Plan

Questions

- P Tasker advised that the Cancer Delivery Board was aware that the CQC priorities had been put forward as a factor in the 62-day breach and queried whether this could be reviewed - NL advised that it had been reviewed and the breaches relate to sickness by 2 consultants rather than a change in priorities.

- P Hipkin raised an issue with communication in relation to appointment letters as she had recently had an appointment cancelled and reinstated at short notice. **She suggested that text messaging would beneficial in this instance. JW to address.** **JW**

Date of next meeting of Board of Directors (Public) meeting – 27th November at 11.30am in the Inspire Centre.

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 3.45pm