Agenda Item: 2

The Queen Elizabeth Hospital NHS
King's Lynn
NHS Foundation Trust

Board of Directors (PUBLIC)

Minutes of meeting held on Tuesday 24 September 2013

Present:

K Gordon (KG)	Trust Chair
V Holliday (VH)	NED
I Pinches (IP)	NED
S Haney (SH)	NED
A McCallum (AM)	NED
H Farley (HF)	NED
P Wright (PW)	Chief Executive
D Stonehouse (DS)	Director of Resources
S Beamish (SB)	Interim Director of Clinical Services
M Blunt (MBl)	Joint Director of Patient Safety and Medical Director
B Watson (BW)	Joint Director of Patient Safety and Medical Director
G Wilson (GW)	Director of Patient Experience and Lead for Nursing and Non-medical Professionals
B Cummings (BC)	Director of Planning and Performance
L Proctor (LP)	Director of Strategy and Transformation

Attendees:

G Rejzl (GR)	Company Secretary (minutes)
Hugh Neylan (KPMG)	Observing
Karen McGuire (KM)	Nurse Consultant – Critical Care outreach
David Gwilliam (DG)	Associate Chief Nurse - Emergency Services

Action

79/13 1. APOLOGIES

Apologies were received from M Blunt and H Milne.

KG welcomed governors, staff and Hugh Neylan from KPMG. .

80/13 2. MINUTES OF THE BOARD OF DIRECTORS' PUBLIC MEETING, HELD 23RD JULY 2013

Amendments were agreed at minute 68/13:

The Board:

- *Noted the briefing paper and thanked those involved in the presentation*

Agreed that TEC would be involved in the issue of dementia training and updates incorporated into the quarterly business plan report.

and minute 71/13:

- *21 SIs had been reported from 1st April-30th June 2013 of which 13 were pressure ulcers and 5 were falls resulting in harm. Responding to questions on the number and causes of SIs, GW advised that the findings had been reported within 48 hrs to WNCCG and that the process for RCAs to be*

delivered within specified timescales was on track. The actions arising were being monitored by the Patient Safety Committee, Falls Group and Pressure Ulcer Group as appropriate. A fuller SI report would be submitted to the private part of the Board.

Subject to the agreed amendments, the Board approved the minutes as an accurate record of the meeting.

81/13 3. ACTIONS MONITORING

The actions monitoring list was reviewed and updated (see revised actions monitoring table).

82/13 4. DECLARATIONS OF INTEREST IN ITEMS ON THE AGENDA

None.

83/13 5. URGENT ACTIONS

None

84/13 6. CLINICAL PRESENTATION

In advance of the programmed presentation, KG raised the topic of Patient Stories at the Board, for discussion, this having been the subject of recent regulatory review feedback.

KG asked for suggestions about how the Board hears the patient voice. AM was supportive of proposals for hearing patient stories at Board, believing them to be powerful, to have a strategic element and feeling that this should be part of 'business as usual'.

DS reminded the Board that this issue had been debated several months ago. He recalled that the Board's concern at that time had been the potentially intimidating experience for the patient. He queried whether there is best practice available elsewhere. VH indicated that the patient who had been due to present to the Board was one of her patients with family concerned about her care. VH confirmed that the patient and her family remained willing to present to a future Board / committee.

GW added that Fiona Cutts is experienced in supporting and coaching patients presenting to the Board.

HF referred to good national practice available and welcomed the DVD process as being less intimidating for the patient.

SB explored the broader issues, indicating that the 'patient voice' needs to be integral to everything the Trust does. SB challenged the Board asking whether the Board is proactive in listening or reactive. She stressed that the organisational culture - how we do things and listen to patients and staff is what is important.

PW alluded to the power of the current and learning about themes and trends from past complaints. She also observed the usefulness of themes and their potential to inform triangulation, adding that random stories might not produce the best triangulation.

<u>Action</u> - GW to re-present previously considered Board checklist. **DoN**

BW alluded to important learning from Keogh about review approach, adding that the Trust needs to adopt a more multidisciplinary approach e.g. mock CQCs.

It was agreed that the Board should receive a regular patient story but that 'how' the Board received it might vary.

<u>Action</u> – Chair and DoN to:

- **work though how best to handle patient stories at the Board.**
- **explore potential for Quality Committee and sub-committees through to the SQUABs to be sighted on the assimilation of learning** **Chair / DoN**

The Chair introduced the Clinical Presentation on Nurse/Matron perspective on the delivery of quality services at the QE, noting that this was a very important quality component in the meeting's agenda, which focussed on Quality and on how our regulators and stakeholders view the Trust.

KG introduced Karen McGuire and David Gwilliam and invited them to feedback on the Trust's Quality agenda from their senior nursing perspective.

DG reported that he had no sense that there is not a determination to deliver high quality care. He reported that teams were taking the regulatory feedback very personally and had responded in a very personal, passionate way. He indicated that providing support and encouragement for teams and individuals was very important.

DG reported that the priority for the senior nurses was safe staffing levels on a shift by shift basis and that in this respect, balancing capacity remained a challenge. He went on to report that the staffing template, though relatively new, was helping to provide focus. DG reported that in his experience of other trusts, all trusts will have new staff, from other countries and from closer to home. He indicated his understanding that in capacity planning, an element of clinical resilience needs to be factored in. DG reported that a pilot on dependency scoring was underway and that it was important to ensure that the Trust's capacity planning methodologies included tools to assess acuity to ensure that individual patient care was addressed as opposed to simply 'numbers' of nursing staff.

In respect of patient experience feedback, DG reported that Matrons are holding conciliation meetings with patients and that these might be a rich source of patient experience information for the Board. In his experience he reported that very few patients were willing to come to the Board meeting and that the Board might only hear about 'how we do things well' as it is an 'easier' message.

DG emphasised that his key message was that nurses are passionate about delivering a quality service, are preparing for winter pressures and continue to support each other. Karen McGuire concurred.

The Chair indicated the Board's appreciation and support for its staff and nurses and asked KM and DG to let the Board know how it can best make connections and improve understanding of what is happening at ward level.

DS echoed what the senior nurses had said. He reported having seen a tension in how we are empowering our ward teams on the ground and the wider organisational requirements. He also observed that while there might be some

areas well-staffed and controlled, other areas were facing pressures.

SH asked what two things would DG and KM like to tell the Board, that would make a difference? DG responded by saying that the nursing numbers issues can't be resolved quickly. He added that senior nurses are spending more time working clinically to enhance the nursing numbers, so things like appraisals may slide for a period as staff can't do both and that compromises might need to be made in prioritising tasks.

DG and KM were asked what would empower ward managers. KM reported that honest conversations and joint meetings were needed with ward managers, specialist nurses and heads of department. Key themes emerging from the nursing staff were:

- please stop moving us around the building and reconfiguring capacity - allow us to settle and stabilise
- Clear decision-making is needed.

KM added that senior nurses are addressing the issues themselves and are trying to move people on a more permanent basis where possible.

SH went on to ask what the big things that would improve quality are. DG responded that a way needed to be found to free up senior nurses for supervision and ward 'presence'. SH queried how we could ensure that if we make the time that there is consistent compliance? DG responded that a senior nurse-level responsibility is 'holding to account' and that senior nurses were happy to be accountable but need 'the tools' to do the job effectively.

VH explored the embedding of 'culture' throughout the staff teams – asserting that good patient care should be self-directive. DG responded that all professionals should have a level of self-direction but that in his experience encouragement was also needed. He added that people are so busy, doing the best they can and sometimes find it difficult to look at their own practice and reflect.

SB queried the implications of the observations on patient care? DG replied that when things are so stretched, nursing and care becomes a 'list of tasks', which is detrimental to patient care. He added that 'Assess, Plan, Implement, Evaluate' becomes 'Implement, Implement, Implement, Implement'. SB asked for KM and DG's thoughts about how the Trust might address this issue. KM responded by observing that there was a need for teams to take some ownership back on an individual ward basis. VH added that some of the safest care is task-based (e.g. bundles of care). DG stressed that patients don't just want good care, they value the art of nursing as well as the science and these are the things they complain about.

BW asserted that doctors find developing working relationships with nursing staff very challenging when the nurses are moved so often. BW added that the Trust should take care not to 'blame people'; nurses are doing the best they can and she alluded to two nurses disciplined at mid-staffs re diabetic care. She added that blame is not the same as accountability and explained how issues are being addressed through a 'team' approach. It was also agreed that patient experience is not just a 'nurse' job. It was noted that the Trust is addressing this and that there is enthusiasm from some doctors.

PW asked KG and DG whether the Board agenda addresses the issues they have

raised and queried how the Board can get its messages through to the organisation. KM observed that there had been some improvements in communication already. She reported that the previous week's open meeting had been appreciated and that a sense of honesty and inclusion had been perceived. She added that there was now a need to encourage dissemination to teams. She also noted that the 'Soundbite' publication was appreciated. It was suggested that stabilisation of ward teams will also help with communication and that collaborative working / sharing is helpful. DW observed that with lots of things happening, the Trust might want to try to communicate regular progress against a plan e.g. progress update on nurse recruitment etc. KG welcomed the suggestions, observing that they would help the BoD to stay close the organisation.

The Board noted the Clinical presentation on 'The Nurse/Matron perspective on the delivery of quality services at the QE'

QUALITY

85/13 7. REGULATORY UPDATE

KG introduced the agenda item, noting that there would be a mixture of verbal updates and CQC Actions as some issues were still unfolding.

CQC Report (May Inspection) and Action Plan

PW formally presented to the BoD the CQC May Inspection report and Action Plan. The Board recognised that not meeting 9 CQC standards is serious and a poor position for the organisation to be in with very serious implications in respect of quality of care for patients. PW noted that many opportunities for discussing the implications of this position were being identified right across the organisation. PW observed that a number of actions in the action plan are due by the end of September and proposed that the update be reported back to a future meeting.

Following the CQC visit in May – several actions and events were reported to have taken place:

- 8 week stabilisation plan in place
- Risk Summit triggered – May 2013, which reiterated the CQC's concerns
- Risk Summit followed up by a Rapid Responsive Review (RRR) – similar to the Keogh reviews. This was a supportive inspection conducted by a multidisciplinary team.
- A further responsive CQC visit was undertaken at the same time as the RRR.
- The Trust has received the draft reports and they continue to raise concerns about quality of care in the Trust.
- Further Risk Summit – 12 September 2013

The Trust has agreed with NHS Midlands and East to publish the Rapid Responsive Review final report in the spirit of openness and transparency at a single item Board meeting in early October.

KG supported the suggestion to have the discussion in public. She emphasised the need to communicate the issues clearly and explain what the Board is doing in response.

Action - It was agreed that arrangements would be made for 2nd October and invitations issued. **PW/GR**

Position with Monitor

PW explained the key regulatory issues with Monitor – Monitor has issued enforcement undertaking requirements against the Trust's licence. PW went on to explain that Monitor has increasing concerns about the Trust's finances and quality service delivery. She indicated that Monitor may take further regulatory action.

It was noted that the CQC inspection had identified concerns about quality governance. The Trust had formally commissioned KPMG to review Quality Governance in response, the report being available at the end of October. It was noted that the review specification had been signed off by Monitor.

In respect of the CQC report and Action Plan, KG stressed the need for the Board to develop its understanding of how the Trust is delivering against the agreed actions.

KG noted that there was a very clear proforma for actions from the CQC. It was noted that the CQC will want regular updates on action plan progress and that the Trust would formulate an acceptable approach. The Board meeting on 2nd October will be to present a report which describes where we have got so far. KG identified recurring themes observing that the Trust recognises issues but can be slow to respond.

AM queried the value of mock CQC inspections and asserted that the format of these needs to be reviewed. She queried whether there was a case for using them to 'spot check' some of the issues raised in 'real-time'. KG explained that she was troubled that the mock CQC inspections had not picked up the issues identified by the CQC. All concurred that processes needed to be strengthened.

VH queried how realistic the actions and deadlines are and how outcome-focussed they are.

SB replied by explaining the Trust's arrangements for A&E responses at night:

- The Trust now has a 3rd doctor on duty at night.
- Trust has a five point plan behind delivering the A&E plan
- Bed occupancy is accepted as key
- Nurse staffing levels challenge – do we keep the flow or close a ward to secure safe staffing across the trust. Closing beds has interrupted the flow.

SB indicated that clear internal analysis and focus will help the Trust to sustain improvements. She observed that the Trust doesn't currently have consistency and reliability. SB also reported that it would take another 6-8 weeks to reduce bed days to achieve flow.

BC reported that the Trust had agreed with commissioners to bring the learning from all external reviews into one consolidated plan to be monitored at Board and committee level. She added that all actions have been performance managed by TEC and individual performance reviews but that this monitoring now needs to be taken to the next level. It was agreed that there was a need to simplify and identify key issues to be addressed re. operational delivery, staffing, governance and information. The Board noted that the Trust is still receiving

final reports and needs to take a considered view about how the feedback and recommendations are consolidated.

HF indicated that she was still not clear about the Trust's progress on the action plan on the table. VH concurred, adding that she wants the Trust to demonstrate that it can achieve what it says it will do and address the outcomes rather than just 'box-ticking'.

KG indicated that she was in favour of drawing this into the single item agenda for next week. She queried whether anything that is currently, significantly off-track. BC reported:

- A&E – actions aligned with CCG and wider health systems. Ambulatory Care in place and a significant success. 95% against 4 hour target not yet achieved – will take time. GW reported that representatives from 30 nursing homes had attended a meeting at the Trust yesterday.
- Consent was noted to have an August deadline. Achievement was queried. GW reported that she is reviewing prioritising and time allocated to high priority mandatory training. She also reported that the Trust is interviewing for a significant number of healthcare support workers to work with patients with dementia.

PW observed that the dates refer to things being put in place but that processes are ongoing. She challenged by asking if the CQC were to come in tomorrow – what would they find? BC reported that actions are in place to strengthen staff understanding and lead to good practice. PW responded by indicating that the original issues identified during the inspections had been a specific issue relating to a specific ward. She indicated that the broader issue relates to how the Trust releases staff quickly to attend training.

HF observed that there were clearly some actions that will be resolved and no longer need to come to the Board but instead become observed practice. Ian Bruce was invited to speak. He observed that the reports were very nurse focussed but that it was equally important to medical staff training issues.

IP observed that the Trust needed to get much smarter about making sure we do things when we say we will. KG indicated that she hadn't heard that we haven't done things and that some immediate actions are about process engagement. PW accepted that the Board wishes to see the progress update rather than Trust's response to the CQC. She promised that this would be presented to the Board next week. She also reminded the Board that the Trust is being asked to produce a consolidated action plan by the end of October, accepting that this was not soon enough for some urgent issues and that action was already being taken in these areas. PW observed that a process was needed for Board monitoring of the consolidated action plan. BC endorsed what was suggested.

BW queried whether there is a plan in place to run a series of mini-mock inspections to test assurance on some key issues. SB observed that there was some confusion about enabling actions and outcomes. She challenged the Board's confidence that enablers lead to improved outcomes. SB reiterated the importance of being really clear about the outcomes. GW indicated that the Trust was likely to get support from the Governors and the CCG for enhanced CQC mock inspections.

The Board noted that the CQC inspection process has changed and that the Trust needed to align its approach and mock CQC methodology with the changing

regime and emerging intelligence. LP reported having undertaken a mock CQC inspection on the previous day and confirmed that similar observations had been made. It was asserted that the inspections needed to be multi-disciplinary and methodology review raised questions about how we work with other organisations. The Board agreed that the Trust needed its partners to help the Trust to e.g. the Urgent Care Board going forwards. SB – reported that the Local Area Team were scrutinising the UCB.

VH observed that there was little on medical staff themes in the report. BW agreed. BW and MB did however indicate that at a recent event, the quality of care discussion had not just been about nurses. Doctors and nurses had attended an event together to address issues through multi-disciplinary themed problem-solving.

KG summarised, noting that the Board must have a very clear understanding of delivery progress:

- what do we know with confidence has been done?
- what are the wider themes emerging, working with partners / A&E resilience etc?
- the way the Board will know is not just about report monitoring – but a 'go and see' process e.g. improved inspection methodology

The Board endorsed the proposed handling of the Trust's regulatory feedback and recommendations

86/13 8. RESPONDING TO NATIONAL QUALITY REPORTS

KG introduced the agenda item and explained that GW had been invited to draw together the main emerging national quality reports, indicating that the Board needs a good understanding of what the reports are saying and how the Trust is responding:

- The Francis Inquiry
- The Keogh Report
- The Cavendish Review
- The Berwick Report
- The Ombudsman's Review of Complaints handling

Francis

GW's report on the outcome of the Francis Inquiry set out Trust responses. GW reminded the Board of its previous handling. The Board discussed the Government's response to Francis and noted that minimum staffing levels had not been set by government. It was agreed that this would have been helpful. It was noted that the CQC's response had resulted in the appointment of an Inspector of Hospitals.

PW observed that there is significant guidance concerning the role of the regulators. PW asserted that the Board shouldn't be waiting for the regulator to indicate what is wrong and that as a sector, a position where quality is regulator led should be avoided. She went on to suggest that the DOH – 5 point plan provided five strong headings against which the Board could develop its actions.

SH noted that Francis is prescriptive and punitive where the other quality reports are more holistic and cultural, tackling similar issues but handling solutions

differently. He queried whether the two approaches work together.

BC reflected on external messages, noting that if the Trust is forward thinking and self-aware, then its needs to consider the clear messages in all reports and reflect the Trust's approach in the quality strategy, supported by the strategies of individual professional areas.

KG pointed out the requirement for the Trust to respond formally to Francis, providing a statement indicating where the Board supports the Francis recommendations.

KG queried the duty of candour. GW referred the Board to the Trust's 'Being Open Policy' and confirmed that national guidance is awaited following consultation.

The Board reviewed the draft Trust response to the Francis Inquiry report in detail and made the following observations / amendments:

- **NHS Constitution to be cross-referenced on Board Front sheet – Co. Sec.** **Various**
- Contracts of employment to include explicit reference to duty of openness, transparency and Candour – **DS to update Trust response - DoR**
- **DoN to be involved in decisions concerning changes in medical staff – MD / DoN**
- **Nurse NED on Board to be considered through Board succession planning - Chair**
- **Board Development Programme to be reviewed to ensure that it addresses skills and capabilities issues highlighted by Francis - Chair**
- **Bereavement Office to ask for comments and feedback re treatment of deceased – DCS/DoN**
- **Expedite roll-out of iWantGreatCare – DoN**
- **Refer to Nurse revalidation in Trust response – DoN**
- **Ensure an appropriate level of clinical audit and alerting to issues identified – MD**
- **Ensure robustness of complaints process (need to avoid defensiveness) – DoN**
- **Need to review process for aligning litigation and complaints - DoN**
- **Need to consider publication of anonymised complaints and responses on website - DoN**
- **Review structured approach to development for aspiring leaders inc. mentoring and coaching - DoR**
- **Need to recognise value and contribution of all team members at all levels of the organisation – DoS&T**

KG summarised the key elements of the discussion and queried the point at which the Trust should publish its statement in respect of the Francis Inquiry.

The Board agreed:

- **Its responses to each of the Francis report recommendations**
- **That all Clinical and Operational strategies are to be reviewed in the light of these recommendations to ensure that the Trust plans and delivers care of the very highest quality**
- **To ensure that there are appropriate governance structures and processes in place to allow the Board of Directors to gain assurance that high quality care is being delivered at all times**
- **To review the role of the Board in leading the culture change required to sustain high quality care.**
- **That the Trust's statement should be prepared for the website by the DoN**

and Comms Team

Keogh

The Board noted that some recommendations relate to Francis and Keogh. The following issues were discussed during the Board's consideration of the report:

- BW pointed out that the 14 Keogh reviews relate to mortality outliers.
- The Board was invited to consider the issue of having chief quality officers at Board level and to consider whether the Board is satisfied that that Bev, Mark and Gwyneth fulfil this brief.
- The Board considered Partner Peer inspections as an extension of mock CQC inspections, noting that there is good evidence that internal peer review is a positive thing to do.
- Ambition 7 re - Junior Doctors. The Board was supportive of including trainees in quality work of the Trust. BW working with Andy Douds (Associate MD for Education).
- KG queried the Chief Quality Officer role, noting that the Trust has attached significant value to senior officers' involvement in quality. KG queried how changes could be made with the current configuration. PW indicated that she felt that BW, MB and GW have the breadth of knowledge to fulfil the brief but also queried what other organisations are doing? DS urged caution, pointing out the risks associated with spreading this role over more individuals and the potential for things to fall between the cracks. DS also raised the Trust's geographical isolation for discussion. BW agreed that this was a salient point, noting however that the Trust is involved regionally and nationally and adopting best practice from elsewhere. LP concurred, noting that the Trust has some very innovative and outward practice but that there remain some issues about geographical isolation.

PW observed that the Keogh review reports are the most useful of all the recent reports. She asserted that the most telling view was 'Boards trapped in mediocrity', noting that 12-15 months ago, the Trust was ambitious. PW went on to observe that following some 'knocks', the Trust has become more inward focussed. PW stressed that the Trust needs to deal with its current issues quickly and get itself outwardly focussed and ambitious. The Board noted themes in the report that currently chime with the Trust e.g. the need for listening and valuing staff.

GW reported that 2 of the Trust's members of staff had taken part in the Keogh reviews and that the Trust needed to assimilate the learning and intelligence.

The Board endorsed the Trust's response to the Keogh Report

Berwick Report

In reviewing the Berwick report, the Board noted the emphasis on Patient Focus through 10 recommendations and four overarching themes. It was noted that BW had summarised the QE context. A sense of needing to change the culture was agreed by the Board, noting that lots of people experience good quality of care but too many don't and the Trust needs to be more consistent. BW noted that colleagues are coming forward to be clinical governance leads and that the Trust is looking for people who can inspire and encourage to make our good practice happen everywhere.

AMc observed that the Trust is quite hierarchical at times and that the Board needs to hear from the front line more often e.g. AHPs, juniors etc. HF agreed, adding that there was also a need to involve cleaning staff and porters etc. HF observed that everyone is referred to by their band – which constrains what we can expect from people.

The Board supported the approach set out in BW's report and agreed that this needed to be worked up. LP identified an overlap between this work and Denison and also observed lots of correlation with the OD Strategy. The Board agreed that the work needs to be aligned and that it should also inform the development of the Quality Strategy.

SB observed that the Board needs to be clear about what Quality means and needs a very clear message. She went on to say that once the Board has set its ambitions for quality, everything else emanates from that. SB stressed that the Trust's people need to own this and that measurements also need to be in place.

PW observed that the Trust has an OD Strategy that needs to be updated. She noted that the previous iteration had been about building skills and that the next one needs to be about cultural development. PW also asserted that consistency was important and that the whole organisation needs to embrace the work.

KG summarised the Trust's response to the Berwick report and established a link between the work of LP and BW.

The Board endorsed the Trust's response to the Berwick Report

Cavendish Review

GW reported that the Cavendish report relates to Nursing Auxiliaries and Healthcare assistants and has 18 recommendations. It was noted that not all recommendations relate to the QE. Not all are relevant to us as HCAs work in locations other than hospital. Issues concerning the plethora of titles and uniforms were noted. GW reported that in the Cavendish Report, there was a lot of emphasis around the Director of Nursing. The requirement for healthcare assistant training to fall within Dir. Nursing remit was noted.

The Board was assured that all HCAs are fully trained and undergo comprehensive induction. GW reported that other Trusts had been contacted and the QE is doing as well as or better than other organisations. GW reported a new arrangement, in which the QE is participating from October, where student nurses undertake 1 year as a care assistant.

The Board agreed to reconsider the report in light of Nursing paper on agenda.

The Board:

- **noted the report**
- **noted the feedback from the Trust's own HCA staff**
- **noted the gap analysis**

Ombudsman's report on Complaints Handling

In presenting the report, GW asked whether the Board felt the Governors should participate in this work, through PEC.

HF observed that this was a useful document and DS queried whether there is there something about the roll-out of the FFT that aligns with this work.

GW reported that the Trust was trying to prevent complaints before they occur. She observed that out of hours cover may help with this, with matrons defusing situations before they become complaints. Increased PALS availability was also felt to be likely to address issues as they happen.

KG queried the impact of the move of complaints and PALs to Front of House. It was reported that to date it had made no significant difference and was closed at weekends. GW observed that reception staff at weekends would be helpful for assisting patients and families. She added that some trusts use volunteers to address this but note that we currently experience difficulties with getting people to work at weekends.

PW queried whether the Board want to do more on this, noting that it was an important issue in respect of access and reputation. HF asserted that she thinks the Trust should separate the role of the volunteers and professional reception staff. GW agreed, saying that with the current level of service, people have no way of knowing where their relatives are. **It was suggested that the Patient Experience Steering Group be commissions to review this matter.** **VN**

DS pointed out the cost implications of reception staff and HF added that there was also a cost associated with having 'professional volunteers' in respect of proper support and management. She added that she does not believe that the Trust currently has the structure to support professional volunteers.

The Board noted the report and endorsed the work being done in the Trust in relation to complaints

87/13 9. NURSING STRATEGY

Review of the Nursing and Midwifery Strategy

GW reported that the Nursing and Midwifery Strategy is approaching its review date. She referred to the 6Cs (Care, Compassion, Competence, Communication, Courage and Commitment) now in place, replacing the nationally agreed call to action on E4E. The Board was invited to endorse the preparatory work, and note that the revised Nursing Strategy will be presented for the next 3 years.

PW noted a lot of good work in pulling together the Strategy. She queried whether the Board feel that it has had enough input into the development of the Nursing Strategy and indicated that better signposting of work to the strategy was needed. VH queried how the Board can support the successful delivery of the strategy? GW responded, observing that the strategy is not a wish list – it is a record of what has been achieved. GW conceded that there remained some issues concerning compliance and consistency.

KG queried metrics and GW explained how these worked. SH queried the cultural implications of handover compliance. He added that it was clear that the Trust needs to get better at designing things and implementing them better so that people will comply consistently. He asserted that there was a need to be clearer about accountability. GW observed that the Trust may have been too paternalistic with people because they are working hard. GW stressed that this is unacceptable and won't happen again. VH stressed the need to reinforce messages so that people comply, understanding and accepting the rationale.

DS observed that the strategy refresh needs to define what 'good' looks like with calibrated measures indicating where the Trust performs against them. He added that the Trust should be sharper on the gap analysis so that we prioritise effectively.

AMc referred to the productive ward / operating theatre process, observing that there was a need to be consistent and keep things simple. PW alluded to a lesson for the Trust, which is that you can have a great strategy but it needs to be implemented effectively. She suggested utilising the internal audit methodology: 'scope, consultation and sign-off' applied to all strategies.

SB observed that Denison tells the Trust that it has a hard core of staff who are resistant to change. She added that the Trust must understand what is stopping them accepting and committing. She was clear that the Trust could not fail on the implementation of fundamental patient safety processes such as handover and needed to be very clear about our expectations and drive them through.

The following issues were discussed:

- focus groups starting on 6Cs. BoD supported 6Cs as the basis for the strategy
- BC suggested that directors should comment on strategy development as a peer assist / peer review
- BW observed that the challenge will be to get medical buy-in to what will seem to be a nursing strategy. DS will need very specific actions for medics and other parts of the organisation.
- SB stressed that the strategy was more than just the 6Cs – need everyone in the room from all disciplines to work together to agree what 'good care' is.
- VH suggested a link to the Trust's Vision and Strategy.
- HF challenged by asking - what would this Trust look like for you to recommend this hospital to family and friends.
- LP observed a bringing together / joining up of values / behaviours / care strategy / clinical strategy.
- GW queried - should Care Strategy and Quality Strategy be one and the same thing. BC stressed that it would be important not to disenfranchise stakeholders.
- PW asserted the need to have an overarching strategy and a series of supporting tactical and operational plans. BC concurred, stressing the need to have linked strategies and understand how they fit in.
- It was noted that all 6Cs are reflected in the Trust's Values and Behaviours and that there was no disagreement on what needs to be in the strategy – just need to agree 'packaging'.
- BW supported the model of a single Quality Strategy – headed by GW, BW and MD with delivery monitored by the Quality Committee and the Board. Within the Strategy would be individual plans e.g. Nursing etc.

The Board endorsed the work underway to develop the Nursing Strategy.

Short Shift Patterns

KG indicated that she was aware of background in respect of nursing shift patterns. GW reported that there was a mixed picture at the Trust and that Cavendish was not in favour of 12 hour shifts.

GW reported that the latest work had involved empowering sisters to identify what they and their staff want. GW was clear that shifts having to start and finish at the same time (to facilitate effective handover) was the only prescriptive element. With wards being given a choice, it was clear that wards might be mixed or all the same shift pattern. GW reported that she needs to talk to e-rostering colleagues about the implications. HF queried whether there were plans in place for staff to move between wards. GW responded that this should not be necessary as most wards are likely to operate a mixture of shift patterns. GW reported that she was not expecting to be moving staffing as numbers increase. SH queried whether the Trust could use e-rostering to monitor roll-out and compliance**? GW and DS agreed to resolve arrangements re using e-rostering to monitor roll-out and compliance re. new shift patterns.** **DoN/ DoR**

PW queried whether the Board was confident that the Trust won't get kick-back because the sister made the decision and other staff did not have a say. VN reported that process had allowed for everyone to have input. PW queried whether there are any risks for 12 hour shifts e.g. less crossover time. PW also noted that the Trust would need to take care concerning working time directive compliance. PW observed that 'Lessons Learned' from how we changed the shift patterns are missing from the paper. GW explained the previous shift

consultation, indicating that she felt it had been a sound and rigorous process. It came at a time when the staffing was at its worst. GW stressed that the Board needed to accept that the Trust went to short shifts because it is best for the patients and that what we have in place now, is what is best for the staff.

In respect of 'Lessons learned' DS observed that the organisation was going through lots of change and queried whether the Trust had triangulated the impact on staff.

HF suggested that the Trust needed to decide what was to be monitored to evaluate the success of the implementation e.g. significant sickness on 12 hour shifts. SB suggested the need to monitor impact on patients' care and staff, including unintended consequences.

KG noted a strong message about monitoring the impact of implementation of the new shifts and agreed that GW and VN would devise metrics for review by the Board and other stakeholders. **DoN**

Nursing Numbers

PW and KG asserted that this was the most important paper on the Board agenda.

Val Newton explained the background to the issues:

- Nursing skills mix
- Nurse patient ratio
- Skill-set and competency of nurse
- Acuity

The Board noted that while there was no published national standard for nurse:patient ratio, there was select committee drive for minimum of 1:8 / 1:11. The Safe Staffing Directive was reported to have suggested 1:4 and 1:6 during the day.

The Francis and Keogh reports were reported to have suggested 6 monthly staffing review to the Board.

The Board noted that PwC had supported the Trust with a review and VN went through the paper and PwC's work, ward by ward.

PW thanked Val for her work in this respect. She stated that is very Important for the Board to have a clear understanding of the Trust's position. PW asked for factual accuracy corrections – e.g. Purpose: clarify against what criteria there is an 'underlying deficit'.

PW also asked for clarification concerning the TEC paper, as the TEC paper did not refer to nurse:patient ratio.

The Board was challenged on its assurance that where there is a discrepancy, the Trust had backfilled with bank/agency staff. VN reported that this was not always possible where there is high vacancy and high sickness.

KG asserted her intention to challenge any inference that the Board deliberately and collectively decided not to fund full nursing establishment.

BC queried the report recommendations. VN responded by explaining that 1:8 is

the minimum meaning that if people leave, then there is no headroom. She went on to report that the Staffing Alliance say 1: 8 is where significant harms may occur. The Trust would like 1:6 to provide headroom.

PW explained difference between one qualified nurse to number of occupied beds.

DS queried, whether the Board wants to agree a pace of change, noting that the changes won't happen overnight. He also queried whether the aspiration was attainable. KG suggested that the Board should agree the principles – then talk about how to deliver it. HF agreed but stressed the importance of establishing a 'safe' threshold.

PW stressed the need to apply the acuity model at all times. She observed that it was important that the paper does not outline the cost of acuity modelling. It may be that the ratio may be different where additional unregistered staff are brought in to care for patient with dementia, for example.

It was agreed that the Board be updated on a monthly basis to align decisions with emerging guidance. **DoN**

The BoD acknowledged, on the current bed numbers:

- the financial implications of its decisions at a minimum cost of £3,381,554
- its understanding of the potential impact on drivers for the BSP/ CIPs
- Its understanding in respect of the Trust's longer-term financial sustainability
- Its understanding that other Trusts will also be seeking to recruit additional nurses and the current national shortage
- The requirement to consider how alternative models of service delivery and provision of care might be impacted by the PwC sustainability project and system-wide review

During debate, the following issues were also discussed:

- implementation – implications for nurse recruitment
- BoD identified risk
- Need to recruit to vacancies and then to additional posts to bridge the gap
- The Board highlighted that there was no expectation that ward closures would deliver the desired outcome, although improved LoS achieved through efficiency and productivity might enable capacity to be closed

VH queried what the Trust is doing in the meantime to ensure safe care for patients. GW responded by saying that:

- Bank and agency continue to be utilised
- 3 times daily risk assessments / RAG ratings are undertaken on ward staffing
- GW signs off all rotas
- Need to stop moving people as far as possible
- Much more robust system for responding quickly to short notice issues – pool of nurses to be developed
- Specialist nurses and anyone holding a pin number doing a ward shift per week
- Weekly retrospective consideration of rotas
- Being more proactive than reactive – improving position

It was reported that the general wards had been dealt with so far. **VN and GW to come back to next Board meeting with specialist areas analysis.** **DoN**

DS pointed out that the Trust is managing the number of beds we have open but that if we don't ramp up the staffing there will be additional risk over the winter.

The Board tasked the execs with dealing with the funding issues and recruitment.

The Board:

- **Reaffirmed - on the general adult acute wards – a skill mix of 65% registered and 35% unregistered (confirmed that this is within costings presented)**

- **Agreed QE aspiration - registered nurse:patient - 1:5 (day) and 1:8 (night) (richer establishment with better ability to cope with absence)**

- **Agreed zero tolerance below registered nurse : patient 1:8 and 1:11 (day/night respectively) – to be reviewed in with a view to raising aspirations and improving standards.**

STRATEGY

88/13 10. QUALITY STRATEGY DEVELOPMENT

Covered in other business (item 9).

The Board endorsed the Quality Strategy approach and timeline

89/13 **11. CHAIR'S UPDATE**

The Chair reported on her key activities, undertaken since her last update.

- NED meeting with Non-Exec colleagues from CCG – **KG to determine how this can be progressed through a Board:Board format** **Chair**
- Meeting with MP was reported as having been productive. The Board agreed that it is important that MPs are supportive of the Trust.

The Board noted the Chair's update.

90/13 **12. CEO'S REPORT**

PW presented the CEO's update. Key issues discussed were:

- Monitor is recommending 3 yearly review of Board governance. Trust needs to confirm expectations, mindful that the Trust has assessed financial and quality governance recently.
- **Cancer Peer Reviews - generally very good feedback. Upper GI issues were identified. Immediate action was reported to have been taken and updates will be reported back to future Board.** **MD**
- PLACE inspection – feedback quite good, with some issues identified on food (including preparation). **TEC will bring back a recommendation to the Board concerning potential for changed practice.** **CEO**
- Appointments – the Board noted that several high calibre senior appointments had been made recently, irrespective of the issues currently

facing the Trust.

The Board noted the CEO's update.

OPERATIONAL / PERFORMANCE / FINANCE / WORKFORCE

91/13 13. PERFORMANCE REPORT

The Board reviewed the Trust's Integrated Performance Dashboard.

Quality

The Board considered the Quality Dashboard, exceptions and commentary.

Quality key issues:

- Response rate to Friends and Family Test (FFT). The Board noted that a paper is to be presented to TEC about encouraging more take-up and response. Trust FFT score of 72 in the reported month was noted by the Board as a significant improvement although there is still a lot of work to do in this respect. PW observed that while it was useful to have a breakdown/commentary, an explanation of what the table is telling the Board would be helpful. PW queried how the Trust compared itself with other Trusts. It was explained that the indicator has differing complex national and local arrangements e.g. 'detractors' are not included in national figures. National CQUIN confirmed. The Trust is not currently on track to achieve CQUIN for Q2. It was noted that nurses / doctors etc. are not permitted to give patients the forms. **The Board tasked the executive team with doing everything possible to achieve the target response rate and improve the Trust's scoring as far as possible.** **DoN**
- **PW – page 20 – responses on NHS Choices – to be corrected.** **DoN**
- **Roll-out of iWantGreatCare – GW to take report to TEC.** **DoN**
- **RAMI** – The Board noted that the RAMI target is an internal target and BW reported that the Trust is not an outlier on any mortality indicator. BW explained that the commissioned CHKS report had indicated the areas the Trust should look at closely. PW observed that nationally, RAMI has been increasing. BW added that according to the RAMI 2013 model rebasing, there is no rise in the Trust's RAMI. In response to a query from BC concerning how the Trust assesses deaths, BW explained the University Hospital of Birmingham model and the Trust's review of deaths, using the NCEPOD model, with overall learning captured. **BW also explained the roles of the Clinical Outcomes Group and the Mortality Review Group Review. BW undertook to report on the process and any current alerts to the next meeting of the Quality Committee.** **BW** In response to a further query, PW explained that while there were often distortions with small numbers, **the biggest discrepancy between expected and actual deaths was for Non-Transient Stroke. BC and BW undertook to address this issue through reporting detail.** **BC/BW**
- Pressure Ulcers - the Board expressed its concern regarding Pressure ulcers at grade 3 and urged continued vigilance and optimum use of the Trust's new mattresses.

Operational Performance

The Board considered the Performance Dashboard, exceptions and commentary.

Performance Key issues:

- The Trust has failed to achieve A&E target performance. The trajectory was noted as slowing down but on an incrementally upward track. The Board noted that the Trust has in place a five point action plan and Urgent Care Board Action Plan. SB reported that the Trust's current focus was on flow and bed occupancy. The Board agreed that A&E is a measure of quality, which the Trust will not meet for this quarter and is highly unlikely to meet for the year. It was noted that Monitor has taken enforcement action elsewhere. KG stressed the importance of keeping the matter under close scrutiny and concentrating on the quality of service for our patients.
- Page 29 – Nursing Metrics. It was noted that while the metrics were not showing 'red', PW was nevertheless concerned that the Board does not have adequate sight of issues at ward level. BC observed that in respect of the fluid chart score, each clinical area is significantly adrift of expectations. GW reported that she has done an in-depth analysis and that the biggest issue is not about hydration for patients but about 'adding up' the scores. She explained that if the addition is wrong, then the audit scores a zero. GW went on to explain that workshops were being undertaken and that with greater accountability, there was expected to be an improvement in respect of this recurring issue. **It was agreed that fluid chart issues would be reported to the next Quality Committee (actions taken and improvement trajectory)**. VH queried whether the fluid score is aligned with Early Warning Systems, asking whether she could be assured that the Trust is picking up every patient who is deteriorating in a timely manner? **KG commissioned the Quality Committee explore the matter in more depth to establish whether there are any issues that are impacting on quality of care.** The Board gave clear direction concerning its expectation of 100% compliance with completion of fluid balance charts.

DoN

VH / DoN

Workforce

The Board considered the Workforce Dashboard, exceptions and commentary.

Workforce key issues:

- Nursing numbers (discussed in detail at item 9)
- Turnover
- Sickness absence was noted as remaining at 'red' though slightly better than last month. Processes were reported as being very actively managed. PW queried the Board's confidence that the Trust is doing everything it can about sickness. SB reported that managers were checking, though performance reviews, that the absence policy is being applied.
- Appraisal traction. DS reported that he was not yet able to assure the Board that there was a complete recovery trajectory position currently. DS reported that from an HR perspective, everything the HR team can do is being done. PW advised that the Trust had been criticised for not successfully addressing appraisals and training, as indicators of caring for and supporting staff. The Board welcomed the report that Associate Chief Nurses are beginning to address these issues as nursing numbers begin to improve. Ds advised that low appraisal levels was an issue in other areas as well as nursing.

Finance

Discussion on the finance section of the Performance report was deferred until the private session of the Board meeting.

The Board noted the Performance Report

92/13 **14. A&E PLANS – 'WINTER MONIES'**

KG indicated that the allocation of winter monies was very welcome. She went on to query how the monies would be used and whether the additional funding would have an impact on winter.

PW summarised.

- Money for additional capacity in A&E – PW indicated that plans must be agreed quickly or the capacity won't be in place in time. Agreement was reported to be expected by the end of week
- Additional money for project with Hospital at Home (H@H) – PW reported an ongoing discussion with WNCCG and the community trust concerning whether this is the right model. It was noted that agreement was yet to be achieved and that there was significant risk associated with this project
- PW noted that winter funding was contingent on 75% of staff having a flu vaccination. She noted that vaccinations may not be available nationally to achieve 75% across the NHS. DS indicated that we are seeking support from the health system in this respect. HF suggested that the Trust should be feeding back that it has issues with this pre-requisite.

The Board was advised that the winter monies are being managed by the CCG not the Trust. The Board also noted that the funding was non-recurrent for two years, and that where the funding was used for pump-priming – additional funds would need to be found for next year.

The Board noted the position in respect of winter monies to support A&E services.

RISK

93/13 15. RISK REGISTER ≥ 20

Responding to an external view that the Board was not sighted on staffing risk due to methodology for visibility of risks at 16 and 20, PW explained that the NPSA scoring matrix was used for scoring the Trust's risks.

The Board noted that there are currently 8 risks at a 20 (1 last month) and discussed whether it wished to see risk at 15 and above or endorse continuance of arrangements for TEC to see risks at 15 and over.

The Board endorsed IP's suggestion that the Board should see risks over 15.
PW reassured Board that TEC had reviewed the current risks in detail.

The Board discussed in depth:

- Risk 969 – Winter Planning – the Board considered the implications for staff capacity and infrastructure, noting that the Trust may be forced down the route of opening additional beds.
- a new risk regarding anaesthetic machines – being reprioritised /re-profiled.

- Risk 926 & 929 – IT infrastructure risks – decisions to be taken outside meetings structure.
- Monitor engaged in capex planning – tension between managing liquidity and clinical risk through investment in equipment that is at risk.

HF queried the Patient Centre. BC confirmed that the work is progressing.

BoD agreed to look at all risks above 15 and will consider actions taken and ask for additional mitigations where necessary.

REGULATORY & GOVERNANCE

94/13 16. CORPORATE GOVERNANCE, ASSURANCE AND ESCALATION FRAMEWORK

PW explained that the Corporate Governance, Assurance and Escalation Framework had been reviewed at the Board's last meeting in 1st draft and that amendments had been made following Board input outside the meeting.

The Board welcomed a clear narrative, explaining the Trust's processes and structures.

The Board approved the Corporate Governance, Assurance and Escalation famework for implementation.

95/13 17. THE CONSTITUTION

KG explained proposed material changes to the Trust's constitution, as recommended by the Constitution Working Group. Material amendments were described as relating largely to the assimilation of the provisions of the Health and Social Care Act 2012 and consequent revisions e.g. the proposed invitation of Freebridge Community Housing to appoint a governor to the Governors' Council.

The Board approved the draft revised Constitution and noted that the approved, revised draft would be submitted for ratification to the governors and members at the Annual Members' Meeting.

96/13 18. REGISTER OF DIRECTORS' INTERESTS

The Board reviewed the Register of Directors' Interests. PW asked for the voluntary organisation in Leeds to be removed from the register. HF asked for West Norfolk Strategic Partnership to be added to her declaration. **GR to make revisions to the Register of Directors' Interests** **GR**

97/13 19. ANY OTHER BUSINESS - None

Special Resolution: 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.

Date of next Board of Directors' meeting (in Public) – Tuesday 26th November @ 9am 2013 @ 9am, QEH conference room

There being no further business, the meeting closed.