Minutes of the Trust Board Meeting in Public of the Royal Cornwall Hospitals NHS Trust held on Thursday 6 June at 10.00 – 13.00 in the Medical 2 Seminar Room, West Cornwall Hospital

Present:
Mairi McLean (MM) Chairwoman (12.45-13.00)
Kate Shields (KS) Chief Executive (12.45-13.00)
Susan Bracefield (SB) Director of Operations
Brian Courtney (BC) Interim Company Secretary
Kerry Eldridge (KE) Director of People and Organisational Development
Bernadette George (BG) Director of Integrated Governance
Paul Hobson (PH) Non Executive Director
Karen Kay (KK) Executive Lead for Urgent and Emergency Care
John Lander (JL) Non-Executive Director and Vice Chair
Rob Leightfield (RL) Associate Non Executive Director
Sally May (SM) Director of Finance
Kim O’Keeffe (KOK) Director of Nursing, Midwifery & AHPs
Rob Parry (RP) Interim Medical Director
Sarah Pryce (SP) Non Executive Director
Margaret Schwar (MS) Non Executive Director
Gill Vivian (GV) Non Executive Director

19.79 Welcome & Apologies for Absence

a. The Vice Chair noted the Chairwoman and Chief Executive would be late because they were attending an important system meeting. Other apologies for absence had been received from Richard Smith, Associate Non Executive Director, Ruth Allarton, Associate Non Executive Director, Thomas Lafferty, Director of Strategy and Performance, and Kelvyn Hipperson, Chief Information Officer.

b. The Vice Chair welcomed Ella Stracey, Associate Director of Quality Transformation & Performance and Scott Bennett, newly appointed Non Executive Director as an observer.

19.80 Register of Board Member Interests

a. The Board received the Register of Board Member Interests. RL advised that he was updating his declaration in light of changes identified at the May meeting.

19.81 Patient and Service Story

a. The Board received a presentation from Jenny Thomas, Patient Experience Manager, and Johanna Floyd, General Manager, outlining patient and relatives’ experiences of the Cardiology service. The two cases had a number of common concerns relating to delays in appointments and treatment times, communication issues and lost patient notes.

b. JF outlined Case 1 which referred to a patient who was vetted as routine but should have been classified as urgent. In addition the patient waited a significant time to receive an appointment and/or treatment and there was a lack of MDT approach between RCHT and other providers of specialist cardiology services.
c. JF said that through working with the patient and relatives the Trust had implemented a new vetting process to risk stratify patients and thus improve efficiency at the point of referral. Furthermore, the Trust had introduced a harm review process of patients waiting longer than anticipated and all patients with a pacemaker or a complex device would be seen within six weeks. RTT in cardiology was currently 90% and Consultant capacity had now increased.

d. JF referred to the change made for patients who access services from other NHS Providers in the region to ensure that clinics that clashed with a bank holiday were moved to another day or patients offered an alternative slot.

e. With regard to Case 2, the patient's relative had made a formal complaint about the care received from the Cardiology department. An investigation took place and a Local Resolution meeting was held 6 months later and the case closed. Unfortunately the LRM was not successful, the patient's notes were lost and the family had not received a satisfactory response. JT advised that as soon as this was identified the family were contacted and received an apology. A review of the care and the previous process was undertaken to ensure that learning was achieved.

f. JT spoke of the changes to governance processes in the complaints department to track and monitor complaints through weekly governance huddles. Further support and training to staff to undertake LRM's was also in place and the allocation of a dedicated point of contact for all complainants had been implemented.

g. JT spoke of learning from both cases as the Trust had not delivered the care expected or managed these cases effectively and compassionately. BG welcomed the presentations and spoke of the changes in organisational culture to being more personalised.

h. It was acknowledged there were skills gaps in the Care Groups and the Patient Experience team in the management of Local Resolution Meetings (LRMs). This was being addressed with rigour. It was suggested this was built into the Being Brilliant leadership programme.

i. RL sought assurance that the Trust would ensure cultural change was embedded, and that the Board could be assured there were no other similar historical cases. JT advised that through the organisation shift, following Duty of Candour, the complaints process was now more open. Cardiology had reviewed similar complaints and JT was confident governance system and processes were more robust.

j. PH noted the backlog was now 13 but questioned how confident the Trust was in reaching the 95% target of all complaints responded to within 30 days, considering the current performance was 57%. BG spoke of the aspirations and the continued focus on delivering this quality standard and progress would be monitored through the IPR.

k. RP sought assurance that there had been clinical engagement in both cases and JT confirmed there had been good engagement and LRM's must have a clinician in attendance.

l. GV asked how many complaints had been upheld by the Parliamentary Health Service Ombudsman (PHSO) and JT confirmed there were two cases year to date. KOK confirmed that she reviewed all complaints.

m. **Action:** It was agreed that PHSO data to be included in the IPR by July 2019.

n. JL and KOK thanked JF and JT for attending the meeting and presenting these two cases.

### 19.82 Minutes of Previous Board meeting

a. The minutes of the meeting held on 2 May 2019 were approved as an accurate record subject to the correct of typographical errors and the below amendments:
19.61 Patient and Service Story
c. Inclusion of the following Action: It was agreed that KOK and SB to actively look at rest facilities / private rooms and update the Board on their progress.

19.53 Mortality Report
a. The Board received the Mortality report noting that only one of the three deaths was potentially avoidable.

19.74 – Summary Assurance Report and Integrated Performance Report

Financial Performance
- With regard to CIP, the Trust achieved £10.6m savings but a high level of the schemes were non-recurrent.

i. Finance and Performance Committee: April 2019
- The Financial Plan 2019/20 remained in draft and subject to further review;

19.83 Matters Arising and Action Log
a. The Board received the Action Log from the last meeting and each action was reviewed in turn. The following matters arising were discussed:

19.70 – Quarterly Freedom to Speak Up Assurance Report
Following a second round of interviews, the Trust had not appointed to the Freedom to Speak Up Guardian. Expressions of interest were being encouraged from existing Champions keen to explore the opportunity of taking on the full time role. The Trust had engaged with the National Guardian Office (NGO) regarding the recruitment process. KE referred to the appointment process, the selection criteria and how the Trust would not compromise on this key appointment.

19.61 – Patient and Service Story
With regard to the action for SM and KOK to review private areas and rest facilities, one room had been identified and the environment was being updated. Ade, Site Manager, would officially open the space which the Board warmly welcomed.

19.84 Chairwoman’s Report
a. In presenting the report the Vice Chair drew the Board members attention to the following matters:
   - Paul Hobson, Non Executive Director had attended the Transformation Board on 9 May;
   - The Chairwoman had undertaken a shift in ED on 24/25 May 2019. MM spoke highly of the dedicated and hardworking staff during this busy shift;
   - The Chairwoman was a guest speaker at the NHS Providers Quality Conference on 4 June 2019 where she spoke of the Trust’s journey. The event was an excellent networking opportunity and MM had been invited to present at another future event;
   - Several members of the Board attended the Shaping Our Future Health and Leadership Forum on 5 June which focussed on the changes needed between now and 2050.

b. The Board resolved to receive the Chairwoman’s report.

19.85 Chief Executive’s Report
a. KOK drew attention to the following matters of business:
- John Lander, Non Executive Director, had announced his resignation with effect from 1 August 2019 as he was relocating out of the County. KOK and the Board thanked JL for his invaluable contribution;
- The Being Brilliant launch took place on 24 May 2019. The well attended event was extremely enthusiastic about driving improvements and the organisational culture change;
- The Trust’s quality improvement and transformation programme would be overseen by the newly refreshed Brilliant Improvement Board;
- The substantive Medical Director interviews would take place on 7 June 2019;
- The Trust successfully participated in the HOPE European Exchange Programme and welcomed two European colleagues to the Trust for two weeks in May 2019. The Trust received positive feedback from the individuals and had the opportunity to learn a great deal.
- There had been some brilliant service improvements and successes, which included the new facilities at Helston Birth Centre; raising over £30k at the Strictly-style event and the celebration with staff through national celebration days.

b. **The Board resolved to receive the Chief Executive Report**

### STRATEGY

#### 19.86 RCHT Safeguarding Strategy

a. The RCHT Safeguarding Strategy for the next 3 years is based on national best practice and ‘easy read’ principles. Key stakeholders and service user groups were involved in the process of developing the strategy which has clear KPI’s and links with the Trust Vision and Values.

b. The IMPACT Hub would support greater integration of safeguarding and other vulnerable client services through the co-location of multi-professional teams. KOK referred to strengthened governance arrangements and timeliness of referrals that would be a positive patient outcome.

c. MS asked for clarity on the purpose of the IMPACT Hub and it was confirmed the building was an administration hub only and no clinical or front facing services would be delivered.

d. SP welcomed the strategy but asked how it would be embedded and how the Trust would monitor the outcomes/improvements. The Quality Assurance Committee receives routine assurance reports on the Safeguarding Services and this information would include data from the Safeguarding Children’s and Adult Groups which oversee the KPI’s associated with the IMPACT Hub. KOK suggested the Operational Group should also receive progress reports.

e. GV also welcomed the strategy and the system wide approach, but asked for assurance that the underpinning systems and processes were in place for system working in order that patients are not disadvantaged. KOK agreed to provide the Quality Assurance Committee with a high level summary assurance report on the system working and commissioner responsibilities. **Action:** KOK to provide a high level summary assurance report on safeguarding system arrangements and commissioning arrangements to the Quality Assurance Committee.

f. **The Board resolved to receive the RCHT Safeguarding Strategy.**

### FOR ASSURANCE

#### 19.87 Corporate Risk Report and Board Assurance Framework

a. The Board received the revised Board Assurance Framework (BAF) noting the principal risks had been developed in consideration of the Trust’s Brilliant Strategic Objectives and Pledges outlined in the Trust’s 2019/20 Operational Plan which was approved by the Trust Board in May 2019.
b. The highest rated risks on the BAF related to access and prioritising capital resource to maintain the estate and ensure service continuity through use of technology and delivery of quality care. The BAF had been subject to Executive scrutiny where it had been agreed to review the current gaps in terms of workforce and recruitment.

c. The report summarised the new principal risks and an update on the 22 risks on the Corporate Risk Register (CRR). The Executive Team had reviewed the CRR and it had been agreed to include patient flow and Child and Adolescent Mental Health (CAMHS) risks in the next iteration.

d. A robust process of review of historic risks was seeing them re-scored and removed, but new risks were identified through the process which would be complete by the July 2019 Board. PH referred to the discussion at Finance and Performance Committee in May 2019 regarding the risks assigned to the Committee. **Action: It was agreed that the final revision of the BAF and CRR would be presented to the August Trust Board.**

e. SP questioned whether the CRR and the BAF outlined the most critical risks, suggesting that workforce and system working arrangements were impactful but not rated accordingly on the BAF. BG welcomed the comments and spoke of the continued process to check and challenge the current principal risks and ensure they were the most relevant to the organisation.

f. As part of the governance and assurance process, KOK spoke of the risk surgery approach with the Care Groups through Performance Reviews. It was acknowledged that in light of the changes to the Care Groups, risk would be reviewed, closed and new ones added.

g. GV recommended the strengthening of our risk culture through the Organisational Development programme. BG referred to the ongoing cultural journey to being brilliant, and to the system wide risk register. The Board acknowledged the continued efforts to reconcile the CRR and BAF.

h. **The Board resolved to approve the content of the report, note the principal risks and corporate risks and the ongoing development of the risk management arrangements.**

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**19.88 Draft Quality Account 2018/19**

a. The publication of an annual Quality Account was a requirement for all NHS Provider organisations and was based on a national format which set out mandatory requirements. The draft Quality Account was presented to the Quality Assurance Committee on 28 May 2019.

b. This year the Trust had reported details of the Junior Doctors vacancies and the key improvement in 2018/19 and following the Gosport Review, the account set out the Trust’s management of Freedom to Speak Up.

c. BG noted under ‘what did we say we would do in 2018/19’ the successes, the learning and the improvements in quality standards. In addition, the Trust outlined the priorities for 2019/20 under the heading ‘what are we going to do in 2019/20’. MS referred to the 28 May 2019 Quality Assurance Committee and the recommendation to clearly articulate how the priorities had been achieved in 2018/19 and outline KPI’s for delivery of the 2019/20 priorities.

d. The Trust had sought feedback from key stakeholders and clinical colleagues on the draft Quality Account and the final version would be integrated with the Trust Annual Report 2018/19.

e. BG confirmed that the Quality Account was a public document but was predominately produced for regulators. SP agreed with the comment to strengthen the narrative around how the priorities for 2018/19 had been achieved and MS suggested the quality priorities could be developed earlier in the process of developing the Quality Account.

f. KE requested changing the wording about the apprenticeship levy as this was incorrect.
g. The Board resolved to approve the recommendation to delegate authority to the Quality Assurance Committee on 25 June to approve the Quality Account ahead of publication on 30 June 2019 subject to inclusion of third party stakeholder views and the changes identified in the meeting.

19.89 Learning From Deaths Report

a. RP highlighted the overall mortality position which continued to improve with the current HSMR at 94.84. The Trust was focussing on priority death reviews. In Quarter 3 there had been 15 priority deaths which included 4 learning difficulties; 3 still births, 1 child death; 5 complaints; 3 concerns deaths. All the priority deaths had been reviewed and none were considered potentially avoidable.

b. There were seven deaths subject to Serious Incident (SI) investigation. The key themes were failure to escalate, and placement location i.e. lack of e-observation on the discharge lounge.

c. The alerting areas flagging included:
   - Fracture Neck of Femur – all deaths in this group had a prospective SJR but the Trust was not flagging as an outlier, therefore a data quality exercise was taking place. Early access to treatment and physiotherapy review were critical to improve mortality;
   - Liver Disease (alcohol related) – an in-depth review of data quality and coding had commenced and the outcomes were awaited;
   - Other perinatal conditions - RP provided assurance that following extensive review no concerns were highlighted regarding perinatal conditions.

d. JL welcomed the report noting the improved mortality position and spoke highly of the hard work of staff in providing care and support to patients. KOK spoke of the discussion at Quality Assurance Committee on the key themes and learning, and suggested future reports provide detail of the learning from themes. **Action: The Learning From Deaths Report to provide greater details of the learning from the key themes.**

e. SB referred to the increasing number of end of life patients receiving acute care due to lack of support in the community. The End of Life Care Board and the A&E Delivery Board were looking strategically at options to support EOLC patients and ensuring they have care plans in place.

f. The Board resolved to note the report and supported the on-going work.

19.90 Month 1 Finance Report

a. SM highlighted the key matters for Board members’ attention:
   - The Trust continued to work closely with system partners to achieve a steady financial position and ensure quality outcomes;
   - The Trust achieved a control total compliant breakeven plan, and therefore accessed income of £17.3m consisting of Provider Sustainability Funding (PSF), Financial Recovery Funding (FRF) and Marginal Rate for Emergency Tariff (MRET) funding.
   - PSF funding was dependant on quarterly financial performance.
   - The system plans which were re-submitted to the regulators on the 15th May holds the system deficit with NHS Kernow who had foregone their sustainability funding to enable RCHT to access all the £17.3m funding. Failure to deliver the financial targets would be unacceptable to the whole system;
   - A challenging but deliverable Quality and Cost Improvement Plan (QCIP) of £14m which was 3.2% of turnover and higher than last year. The current shortfall is £3.8m and the QI team is supporting care groups to develop plans;
- There was better management across the system through regular Finance meetings to review the financial position at a system level and the assumptions and the risks that sit within it;
- At Month 1 the Trust had a £300k underperformance (of which £200k was income);
- Agency remains a significant concern. The People and OD Transformation plans were instrumental in addressing recruitment, retention and deploying staff in effective ways.

b. The Finance and Performance Committee had reviewed the Month 1 Report at the 30 May meeting, noting its concern with the financial performance, especially the impact of the increase in agency costs.

c. SP reported that the People and OD Committee would be receiving more information on mitigations to reduce agency spend. KE spoke of the robust recruitment plans to fill vacancies and reduce the agency spend, which will be monitored through the People and OD Transformation Board. The most influencing factor in use of agency/bank was short notice requests when vacancies and/or sickness arise. KE provided assurance on the systems and processes in place to review and approve agency/bank shifts, and referred to the critical drivers for change as being effective rosters for medical staff and supporting staff, and their managers, with managing sickness.

d. KOK referred to the recent influx of patients with mental health needs that required safe staffing ratios that necessitated agency/bank usage. KE spoke of the continued focus on looking at new models of care and ensuring skill mix was right.

e. PH spoke of the criticality of the medical e-roster to better manage medical staffing. Discussion ensued regarding the journey out of Special Measures and embedding new and effective systems and processes. The transitional period of embedding the new Care Group structure and leadership alongside the shift in culture, practice and the support required to deliver and train staff was ongoing.

f. The Board resolved to note and receive the report and the actions being taken to address agency/bank spend. The Board recognised the ongoing issues and would continue to seek assurance on the mitigations.

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### 19.91 Single Currency Interim Capital Support

a. The Board received a paper explaining the Single Currency Interim Capital Support Facility Agreement. The Trust submitted a bid for £4.8m of emergency capital funding in March 2018. This bid was successful and a facility agreement was received in April 2019. A loan agreement emailed to the Trust must be signed and returned with a signed utilisation request and a copy of this minute approving the execution and terms of the loan.

b. JL noted the Finance and Performance Committee recommended approval, noting that the Trust may need to draw down an additional £1.8m in year. The interest rate of the single currency interim capital support loan was 1.5%.

c. The Board resolved to approve:
- The use of a Single Currency Interim Capital Support Facility (i.e. interest charged at National Loan Fund EIP rate prevailing at the date of the agreement and a 25 year borrowing term);
- That the Director of Finance or in their absence the Deputy Director of Finance be nominated to manage the agreements;
- The planned use of the loan to fund Capital expenditure projects prioritised by the Trust that require emergency capital financing.
ii. Finance and Performance Committee: May 2019

b. JL drew out the key themes of the May 2019 Committee.
   - Information relating to the Month 1 position was disappointing;
   - Recommended for Board approval a Contract over £1m;
   - Received positive information and assurance regarding the ongoing management of the facilities management contract with Mitie. The Committee asked that future reports demonstrated themes and trends;
   - Received the draft Assurance Framework and requested some further changes prior to submitting to the Trust Board in July 2019 for approval.

iii. Quality Assurance Committee: May 2019 (Including 7 Day Services Board Assurance Framework)

a. MS summarised the key highlight of the Quality Assurance Committee in May 2019:
   - Received assurance through the Ward to Board report that no wards/departments had flagged as deteriorating. The Committee debated the level of sickness and management of absences;
   - Noted sustained improvement in pressure ulcer care and catheter associated urinary tract infections;
   - Noted a continued theme in the delay or omission of Venous Thromboembolisms (VTGE) prophylaxis. Learning had been identified and shared Trust wide;
   - Received the 7 Day Services Board Assurance Framework which tracked the Trust progress against 10 national clinical standards. Approved the Spring/Summer 2019 Board Assurance Framework (appendix 1 of the Summary Assurance Report), the audit areas for the next assurance round in Autumn/Winter 2019 and that the Committee and Board would receive a bi-annual paper with the Board Assurance Framework as an appendix.

iv. Audit and Risk Assurance Committee: May 2019

a. The Committee meeting on 24 May recommended the Annual Report and Annual Accounts for Board approval.

b. The Board resolved to receive the Committee assurance reports.

19.92 Integrated Performance Report (14.2)

a. The Trust was in a transitional process of updating the IPR and aligning the KPI’s to the three strategic aims and objectives and in line with the agreed pledges set out in the RCHT Strategy. ES acknowledged the report remained ‘work in progress’ but spoke of the increased narrative providing greater level of assurance and less descriptive of the issues. JL said there was some inconsistency in SI reporting and there was misalignment with the financial position and the RAG ratings in the scorecard.

b. Action: It was agreed to include target and tolerances in future reporting. The format of the report to be reviewed in light of feedback from the meeting.

c. The key highlights of the report included:
   - Serious Incident levels remained in control limits with learning being achieved;
   - Sepsis management remained a key risk as inpatient screening for IV antibiotics within 1 hour was missed in month. Scrutiny was improving;
   - ED remained under sustained pressure; the safety checklist was being reviewed to ensure all documentation was complete;
Gram-negative bacteraemia remained a challenge across the County. A new system wide Group had been established to look at a systematic approach. The Director of Nursing, Midwifery and AHP’s would chair the meeting;

The number of informal complaints was now reported in the IPR;

System performance against the ED and MIU attenders (4 hours from arrival to discharge/admission/transfer) was now being recorded. The Trust had achieved the trajectory of 90%;

The Trust was seeing an upward trend of 12 hour trolley waits due to the sustained pressures through ED. A review of the ‘stranded’ and ‘super stranded’ patients (those with a length of stay of 7 days or waiting more than 21 days) to understand the challenges;

The average time to answer for Cornwall 111 was improving;

The 2 week Cancer wait had worsened and was below the national standard. There had been a higher volume of referrals, particularly in breast, due in part to a new GP referral process. SB provided assurance the backlog was now improving and the Trust aimed to achieve Q2 target;

Recruitment across theatres and anaesthetics remained challenging.

c. The Trust Board resolved to receive the Integrated Performance Report.

FOR INFORMATION

19.93 Clinical School Annual Report

a. The Annual Report had been presented to the Quality Assurance Committee on 28 May 2019. It was a positive story and a celebration of successful collaborations and achievements for non-medical workforce. KOK noted that a national celebration day took place which the Trust attended.

b. The Trust Board resolved to receive the Clinical School Annual report for information.

19.94 Learning Disabilities Annual Report

a. The Annual Report was presented to the Quality Assurance Committee on 28 May 2019. There had been an increase of c40% in attendance for patients with a learning disability and/or autism in 2018, and the Learning Disabilities team had restructured its skill mix to accommodate this increase.

b. KOK referred to the positive collaborative working with system partners and the build of the IMPACT hub which would co-locate health and social care partners together in one building.

c. A thematic review was undertaken and actions taken to make improvements in communication and the escalation of the deteriorating patient. The LD team was working with service users to progress the actions, which included the production of a sepsis awareness poster.

d. The Trust Board resolved to receive the Learning Disabilities Annual Report.

19.95 Board Calendar of Meetings and Glossary of Terms

a. The Board received the calendar and glossary and noted the Board would be considering the date of future Board meetings to better support the timetable of reporting data to the Board.
19.96 Board Forward Plan

a. The Board received and noted the Board Forward Plan.

19.97 Evaluation of Effectiveness of the Meeting

a. The following comments were received by Board members:
   - Good level of debate and challenge;
   - The Board welcomed the opportunity to be at WCH and thanked the members of the public for attending and the staff for their hospitality.

19.98 Questions from the Public

a. Jane Bernal sought assurance that there would be no acute sector bed closures until there was robust evidence that community based services have been successful in reducing demand. KS gave assurance that the Trust had not closed beds nor did it intend to close any. The Trust had indeed invested in more staffed beds. KS spoke of the changes to the stroke pathway and that stroke beds would be replaced with HASU beds.

Date of Next Meeting: 4 July 2019

The Trust Board in Public Closed at 13.00

The minutes were duly approved by

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