Minutes of the Interim Board of Directors Meeting held in Public
Held on Wednesday 26 July 2017
At Stapleford House, 103 Stapleford Close, Chelmsford CM2 0QX

Attendees:

Janet Wood (JW)	Acting Chair (Chair of the meeting)
Sally Morris (SM)	Chief Executive
Andy Brogan (AB)	Executive Director Mental Health & Deputy CEO
Steve Cotter (SCo)	Non-Executive Director
Steve Currell (SCu)	Non-Executive Director
Alison Davis (AD)	Non-Executive Director
Natalie Hammond (NH)	Executive Nurse
Jan Hutchinson (JH)	Non-Executive Director
Dr Milind Karale (MK)	Executive Medical Director
Malcolm McCann (MMc)	Executive Director Community Health Services & Partnerships
Mark Madden (MM)	Executive Chief Finance Director
Mary-Ann Munford (MAM)	Non-Executive Director
Amanda Sherlock (AS)	Non-Executive Director

In Attendance:

Brian Arney (BA)	Public Governor
Lyndsey Barrett (LB)	Director & Senior Occupational Therapist, Sport for Confidence
Roy Birch (RB)	Public Governor
Cllr David Bowater (DB)	Appointed Governor
Pippa Ecclestone (PE)	Public Governor
Gertie Hendle (GH)	Member
John Jones (JJ)	Public Governor
Hasan Kayani (HK)	Public Governor
Cathy Lilley (CL)	Trust Secretary (minute taker)
Patrick Sheehan (PS)	Public Governor
Faye Swanson (FS)	Director Compliance & Assurance
Cathy Trevaldwyn (CT)	Public Governor
Michael Waller (MW)	Public Governor
Clive White (CW)	Public Governor
Judith Woolley (JW)	Public Governor
Tony Wright (TW)	Public Governor

JW welcomed Governors, Governors, members of the public and staff to the meeting. She also welcomed Faye Swanson, Director Compliance & Assurance, to the meeting who was standing in for Nigel Leonard, Executive Director Corporate Governance & Strategy.

SCo reminded members of the Trust's vision: *working to improve lives.*

065/17 APOLOGIES FOR ABSENCE

Apologies for absence were received from:

Nigel Leonard (NL)	Executive Director Corporate Governance & Strategy

066/17 DECLARATIONS OF INTEREST

There were no declarations of interest.

Signed …….. Date …….

067/17 PRESENTATION: SPORTS FOR CONFIDENCE

Lyndsey Barrett, Director and Senior Occupational Therapist at Sport for Confidence, presented the work of this pioneering initiative that supports people with and without learning disabilities to participate in a wide range of mainstream sporting activities. The initiative is a unique partnership between healthcare professionals, leisure centres and local sports clubs which sees OTs working directly with sports coaches and staff to make adjustments that create truly accessible sport and leisure opportunities. She provided an overview of the journey to date and highlighted the benefits of the programme for all contributing partners, for example developing the confidence of individuals to attend mainstream facilities, clubs and groups, and to develop social communication and interaction skills.

On behalf of the Board, JW thanked LB for the interesting and inspirational presentation.

068/17 MINUTES OF PREVIOUS MEETINGS

The minutes of the meeting held on Wednesday 28 June 2017 were agreed as a correct record.

069/17 ACTION LOG AND MATTERS ARISING

The Board received an update on the action log and noted the following:

- 048/17 Quality & Performance Scorecard – Harm Free Care: Detailed information was sent to SCu on 5 July 2017. It was noted that the community health services degree of harms were not in line with the NRLS (National Reporting & Learning System) benchmark figures due to the high numbers of pressure ulcers reported by these areas. However, the data used for these figures have not been subject to data cleansing and consequently could be subject to change
- 048/17 Quality & Performance Scorecard – Carers Assessment: The 'below the threshold' statement is below what the Trust would expect but it was acknowledged that there were times when a dip would be seen. However, it was anticipated that the target would be met for the year
- 051/17 Audit Committee – Consultant/Legal Expenses: MM confirmed that both predecessor annual accounts show the costs for merger.

070/17 BOARD OF DIRECTORS QUALITY & PERFORMANCE SCORECARD

SM reminded the Board that the Board of Directors Scorecard presents a high level summary of performance against quality priorities, safer staffing levels, financial targets and NHSI key operational performance metrics and also confirms quality/ performance hotspots (variance against target/ambition) agreed by the Finance & Performance Committee as well as identifying trends.

The Scorecard identifies the key issues that are being considered by the standing Committees of the Board; the intention was therefore not to undertake further in depth scrutiny at the Board meeting.

SM confirmed that sixteen hotspots had been identified where there was a variance against target/ambition as at the end of June 2017 of which two relate to key NHS Improvement (NHSI) operational performance metric and two relate to the NHS Improvement quality of

care metrics. A number of task and finish groups had been established to work on reducing the number of underperforming KPIs; progress would continue to be monitored by EOSC.

Referring to the south mental health contractual reporting, SM advised that the overall performance against MHS contractual requirements as a hotspot in light of Contract Performance Notices issued and under performance against contractual targets. She confirmed that a mental health performance task and finish group had been established to improve performance. She reported that commissioners had highlighted there are three major risk areas for them: IAPT, CPA reviews and dementia diagnosis.

MAM commented that there were a number of KPIs seeing a deteriorating trend and queried how the Trust was performing compared to other community and mental health trusts. SM explained that most of the KPIs are local targets set by commissioners and it is therefore difficult to make national comparisons. However, other CEOs had confirmed that they are experiencing similar pressures and challenges, such as length of stay, delayed transfers of care, bed occupancy, etc.

Referring to the recent CQC publication, *State of Care in Mental Health Services 2014-2017,* across the country all mental health services that have been inspected have seen an increase in restrictive practices, access and waiting times, pressure on beds, physical healthcare staff shortages and significant variation in performance against KPIs.

SCo queried the reasons for the continued hotspot in relation to PbR clustering. SM advised that this had been discussed in detail at the Finance & Performance Committee meeting and confirmed that mitigating actions were in place including dedicated resource to support clinicians to address this issue. AB confirmed that he would expect to receive an improvement from September.

The Interim Board received and noted the report.

071/17 WORKFORCE RACE EQUALITY STANDARD REPORT (WRES)

MMc presented the Workforce Race Equality Standard (WRES) report which had been amended following discussion at the June Board meeting. He reminded the Board that the WRES was introduced in April 2015 in response to national research that showed significant disparity between the BAME and white staff experience in the NHS. The WRES is mandatory and requires all providers to publish data about their staff experience across a range of nine metrics; the purpose being to identify progress and shortfalls as well as ensuring actions are put in place to address areas of concern.

MMc highlighted the changes from the previous version received by the Board in June:

- Appendix number have changed to reflect a new appendix that provides the breakdown of information shown for metric 1 in the main report
- Each indicator heading now includes a description of whether 'lower' is better or 'higher' is better for ease of reading
- In appendix 2 the action around BAME representation on Band 8c and above recruitment has been strengthened to reflect that representation is mandatory and not advisory.

Following a concern raised by SCu in relation to the measurement required to be used and the correlation between the percentage of staff and percentage of population would result in a challenge for the Trust to be able to achieve the targets expected particularly where areas of BAME representation of the population the Trust serves is low.

In response to a query raised by SCu, MMc confirmed that there is national evidence to substantiate the business case explored in the report, for example, having a workforce which is representative of the population served by the Trust is likely to result in reduced agency costs.

In response to a question by SCo, MMc confirmed that the figures of BAME staff experiencing bullying and harassment from patients and the public and from other staff were based on the staff survey. This also applied to the statistics provided under BAME staff personally experiencing discrimination at work from manager and colleagues.

FS pointed out that CQC has confirmed that the WRES report will be part of its inspection and highlighted the importance of understanding what is required of an organisation to achieve both good and outstanding.

JW requested that the Quality Committee is provided with regular updates on the progress with the BAME activities.

The Interim Board:

1. **Received and discussed the report**
2. **Approved the Workforce Race Equality Standard Report for 2016/17.**

072/17 EDUCATION & TRAINING (MEDICAL PROFESSION) UPDATE REPORT

The Board received a detailed update report from MK on the education and training for all Trust medical staff. The report covered achievements, opportunities, key priorities, targets and the plans to address the challenges ahead for the Trust.

The Trust provides medical education under the Learning & Development Agreement (LDA) with Health Education England (HEE) to over 100 trainees and is worth about £3m. However, MK highlighted that trainee doctor recruitment remained challenging nationally across all specialities with psychiatry being one of the worst affected areas. In 2016 only 50% of doctors joined speciality or GP training after completing the two years of mandatory foundation training after graduation; the figure was 71% in 2011 and 58% in 2014 demonstrating a downward trend. He advised that the Trust was however fully engaged in various national initiatives led by the Royal College of Psychiatrists and HEE to improve recruitment as part of the Trust's strategy to improve recruitment and retention of doctors in training.

MK also pointed that the GMC training survey results had shown engagement from the Trust's trainees (100%) and consultants had been one of the highest in the country. Preliminary results indicate that the predecessor Trusts have fared above average. The Multi-Professional Education Committee will review the survey results and develop an appropriate action plan.

In response to a question by JW, MK confirmed that future update reports will be presented to the Quality Committee in the first instance.

In response to a question by AD on the questions in the trainee survey, MK confirmed that there is a structured feedback for all trainees at the end of their placement on their experience of the training and the analysis will in future be presented to the Quality Committee.

The Interim Board received and discussed the report.

Signed …… Date …….

073/17 BOARD ASSURANCE FRAMEWORK (BAF)

FS presented the BAF as at 20 July 2017 which identifies the potential risks to achieving the Trust's objectives for 2017/18. She reminded the Board that the BAF provides a comprehensive method for the effective management of the potential risks that may prevent achievement of the key strategic and corporate objectives agreed by the Board and pointed out that the detailed BAF and CRR reports were presented quarterly.

There were 21 potential risks on the BAF as at 20 July 2017 and 15 out of 21 action plans had been developed to mitigate risks and in line with the Risk Management Framework the Board's standing committees had responsibility for oversight and scrutiny of allocated risks. JW commented that she had found this approach useful in helping to understand the actions being taken and the quality of the actions.

FS reported that progress had been made with the development of the CRR post-merger and recommendations were being made in respect of 25 legacy risks together with 14 new risks identified for the EPUT CRR. In addition, she pointed out that progress was being made on building the Datix Risk Register module for developing directorate Risk Registers for implementation Trust-wide. This was expected to be completed by the end of September.

FS advised that one new risk was being recommended by EOSC for escalation to the BAF in relation to fire safety systems and processes.

In response to a question by AD regarding risk 9 (legionella on the ward) on the NEP CRR, FS provided assurance that investigations had taken place and the ward identified; she confirmed that appropriate actions were in place. She also pointed out that there is a risk on the BAF regarding estate compliance and that mitigating action plans had been developed and appropriate actions being taken.

The Interim Board:

1. **Received and discussed the report noting the progress in respect of the development of the risk management arrangements**
2. **Reviewed the potential risks identified in the BAF 2017/18 (as detailed in table 1) and approved the risk scores**
3. **Approved the recommendations in respect of the EPUT CRR as set out in tables 3 and 4**
4. **Approved the escalation of a new potential risk (with a risk scoring of 5 x 3 = 15: If fire safety systems and processes are not suitable and sufficient there is a potential risk to patient and staff safety and that enforcement action could be taken by the Fire Service – with a proposed risk**
5. **Did not identify any further risks for escalation to the risk registers.**

074/17 STANDING COMMITTEES

(i) Finance & Performance Committee

AD as chair of the Finance & Performance Committee presented the report of the meeting held on 20 July 2017 and provided assurance that the performance - operational, financial and governance - were subject to appropriate and robust scrutiny.

AD highlighted the Committee's concern with the number of hotspots and emerging risks (16 and 11 respectively) that had been identified as a result of reviewing performance to June 2017 against agreed targets, five of which related to an NHS Improvement key indicator. The Non-Executive Directors had robustly challenged and received assurance that appropriate

mitigating actions were in place to address the hotspots and emerging risks including the establishment of various task and finish groups that would focus on reducing the number of underperforming KPIs.

The Committee recognised the size of the policy harmonisation programme and noted that whilst some good progress had been made there had been some slippage to the timetable as set out in the PTIP. Assurance was provided that action was being taken to strengthen the communication of the harmonised policies. It was also noted that the Quality Committe e had requested that early testing of implementation takes place bearing in mind the risk associated with the scale of change.

In response to a question by SCo regarding the achievement of CIPs, MM advised that at the end of Q1 66% of CIPs had been achieved against plan but explained that they were not evenly profiled across the financial year, and in addition the position was further complicated by underspend in other areas. However it was expected that the position should balance as the year progresses.

SCo asked if all CIP schemes identified could be delivered. MM advised that it was not possible to provide complete assurance at this stage as in most cases time was needed to see if they had the intended impact.

Referring to previous 'end of year additional payments', SCo queried if there would be any further forthcoming opportunities. MM commented that there was still a shortfall of target as not all cost savings had been identified and that it was the responsibility of all Executive Directors to identify and deliver the CIPs and to find alternative options to address any gap.

In response to a question by MAM, NH provided an overview of the approaches being taken by the Trust in trying to reduce the vacancy rate and improving the retention of staff but acknowledged that this was a national issue. AB also provided assurance that with regards to safer staffing, where bank workers are used, the majority are known to the Trust.

The Interim Board received and noted the report, and confirmed acceptance of assurance provided in respect of action taken.

(ii) Quality Committee

As chair of the Committee AS presented the report of the meeting held on 13 July 2017 and provided assurance that robust discussions were held on a number of issues. She pointed out however that the meeting was not quorate and as a result certain agenda items that required decisions based on full debate were deferred, and in some cases chair's action was taken.

AS shared the learning from the two case studies concerning patients who had fallen and sustained a fractured neck of femur; both incidents had detailed RCAs undertaken and action plans were being progressed to take the learning forward. She also commented on the new combined Quality Report that focused on reviewing the trends rather than monthly performance.

The Board noted that the Committee had requested that two issues be escalated for consideration for inclusion in the CRR: continence assessment as part of falls risk assessment including access electronic forms, and presentation of safer staffing data and the accuracy of north Essex MHS inpatient establishments. In addition, the Committee identified for the BAF action plan on seclusion to be considered by the Mental Health & Safeguarding Committee.

The Interim Board received and noted the report, and confirmed acceptance of assurance provided in respect of action taken.

(iii) Investment & Planning Committee

JW as chair of the Investment & Planning Committee presented the report of the meeting held on 5 July 2017 and pointed out that the meeting was not quorate but was able to proceed with the meeting as no decisions were required to be taken. She provided assurance that robust discussions were held and that the duties of the Committee as detailed in its terms of reference were being appropriately complied with. Discussions included a review of the tenders in progress (12 in total) and a review and approval of the Trust's strategies and frameworks. JW confirmed that no new risks had been identified.

The Interim Board received and noted the report, and confirmed acceptance of assurance provided in respect of action taken.

(iv) Mental Health & Safeguarding Committee

As Chair of the Mental Health & Safeguarding Committee, MAM presented the report of the meeting held on 18 July 2017 which had been chaired in her absence by SCu. The Committee had considered the action plans in relation to the one risk allocated to the Committee on seclusion and had received assurance reports from its sub-committees including the Mental Health Operational Sub-Committee and Safeguarding Sub-Committee. SCu confirmed that no new risks had been identified

The Interim Board received and noted the report, and confirmed acceptance of assurance provided in respect of action taken.

(v) Audit Committee

As chair of the Audit Committee, JW presented the report of the meeting held on 12 July 2017. She highlighted that the Committee reviewed the internal audit plan for 2017/18 and had recommended some changes including, for example, a change in focus of the HR internal audit which would now include a focus on agency controls as this was crucial in relation to finances. In addition, the Estates internal audit would include a review of the statutory compliance with regards to legionella and a value for money review of the Derwent Centre refurbishment.

JW also advised that the Committee had also discussed the option of a review of the lessons learnt from the ransomware attack by the internal auditors, and it was agreed that costings would be identified in the first instance for review by EOSC before any implementation plan is put in place.

In response to a question by AD regarding the agency cap, SM confirmed that the Trust was using the tools that had been made available by NHS Improvement but advised that there were issues with the tools from a practical viewpoint.

The Interim Board received and noted the report, and confirmed acceptance of assurance provided in respect of action taken.

075/17 NATIONAL AND LOCAL SYSTEMS UPDATE

SM provided a verbal update report on the progress of the four Sustainability Transformation Partnerships (STPs) that the Trust is involved in: Mid & South Essex (Success Regime); Hertfordshire & West Essex; Bedfordshire, Luton & Milton Keynes (BLMK); and North East

Essex & Suffolk. All four STPs have progressed into the 'implementation phase' and an update on each locality was provided which were progressing at different stages and pace.

SM confirmed that the Trust's engagement with all STPS was strong with a common focus on improving quality and better value through integrated service provision. She reminded the Board that she had recently been appointed to represent community and mental health services on the Mid & South Essex STP programme board.

Updates were provided by SM in relation to Mid & South Essex STP, AB on the plans for North Essex STP, and MMc on West Essex & Herts STP and Bedfordshire, Luton & Milton Keynes (BLMK) STP.

The Board noted that STPs had recently been given published ratings for the first time – the first NHS England ratings of health economies rather than organisations. The greatest weight is given to whole system financial health, indicators of prevention and integration, and a judgement on 'system-wide leadership'. The rating is driven by indicators in three broad areas: hospital performance, patient-focused change, transformation; 12 metrics also contribute to overall rating. The ratings are 'baseline' and cannot be attributed to current STP leadership as generally have had less than a year working on plans in earnest. Five STPs were rated 'outstanding' with five 'needing most improvement', 20 rated as 'advanced' and the remainder as 'making progress'. BLMK was rated as outstanding despite difficult financial position, no clear plan for the three acute provider trusts, and the STP lead taking up a full-time national role.

The Board also noted the health economies that will receive a share of the £32m of extra capital funding that was pledged to the NHS in the spring budget. Money will be paid to the 15 'strongest' STPs over the next three years and funding allocations will be dependent on business cases being successfully approved as well as on robust wider estates and capital strategies that demonstrates that NHS surplus land disposals are being maximised. Mid and South Essex is to receive £15m to expand its capacity for diagnostics and improve outpatient services**;** Suffolk & North East Essex £10m for a new primary care hub in North Clacton, and relocation of a GP surgery in West Suffolk**;** and BLMK £5m to invest in primary care hub.

The Board received and noted the report.

076/17 QUALITY STRATEGY

NH presented the Trust's Quality Strategy for 2017-2020 that aims to promote and deliver a culture of openness, compassion and empowerment in line with the Trust's values, where all staff has the confidence and skills to champion and deliver outstanding quality of care.

NH outlined the key ambitions in the Strategy including the aim to train Quality Champions from clinical services and patients/carers as well as Quality Ambassadors from the senor leadership team over the next three years. There was also an ambition to increase the number of quality improvement innovations that are co-produced, sustainable and measurable, and to create a culture of continuous improvement by supporting staff with training on different methods of quality improvement. In addition there was an aim to achieve a rating of 'good' in the first year from the CQC as well as reducing the levels of harm in care and improving the quality of care delivery. She also highlighted that the Trust will aim to increase the patient, carer and family voice by addressing what is important to them.

NH confirmed that following approval, the Quality Strategy would be published on the Trust's intranet.

Signed …… Date …….

The Interim Board:

1. **Received and discussed the report**
2. **Approved the Quality Strategy for 2017-2020 (subject to the amendment of a few typographical errors).**

077/17 BOARD GOVERNANCE UPDATE

FS presented the update report on a range of governance and procedural issues. She highlighted the continued range of information and reports on STPs including Accountable Care Systems/Organisations, and drew the Board's attention to CQC's publication of the *State of Care in Mental Health Services 2014-2017* which she felt would be useful in the Trust's ambition to achieve a 'good' rating. In response to a question by JW, FS confirmed that a summary of this report would be presented to the Quality Committee.

The Board received and noted the report.

Action:

1. **Summary of the CQC publication *State of Care in Mental Health Services 2014-2017* to be presented to the Quality Committee (FS).**

078/17 BOARD CHAMPIONS AND LEADS

CL presented the report on the requirements for a Board 'champion' or 'lead' as identified by statutory or regulatory responsibilities. She pointed out that over the last few years there had been an increased focus on the designation of Board champions designed to engender Board level commitment and focus around key areas of service development or delivery.

The roles had been identified following a desktop review of statutory and regulatory guidance. In addition, EOSC had undertaken a review and validated the information and requirements. CL pointed out that the NED champions/leads had been identified with JW and where appropriate were linked to the responsibilities of the Board's standing committees. She confirmed that an annual review would be undertaken to ensure the requirements remain current and that no other roles are required. However, the list would be updated as required. As an example, CL advised that there had been a recent requirement for the inclusion of a Data and Cyber Security executive lead.

Subject to a change to the NED's role as the Baby Friendly Champion to oversee the responsibility for coordinating the planning, implementation, audit and evaluation of the standards laid out by the accreditation, the Board noted and approved the designated Board champions/leads as detailed in the report.

It was recommended that these roles should be communicated to staff and included in the new staff handbook which was being updated as part of the CQC preparation.

The Interim Board:

1. **Received and noted the report**
2. **Agreed the designated Board champions and/or nominated leads as detailed in appendix 1.**

Action:

1. **Board Champions/Leads table to be updated to appropriately reflect NED's responsibility in relation to the Baby Friendly Initiative (CL)**
2. **Board Champions/Leads to be included in new staff handbook (FS).**

Signed …… Date …….

079/17 CQC INSPECTION UPDATE

SM reminded the Board that the CQC would undertake an inspection of the Trust services within 12 months of its establishment to provide a baseline rating for EPUT. This date had not yet been confirmed. However, she pointed out that the notice period could now be as short as six weeks, rather than the original 20 weeks' notice.

SM advised that a CQC Compliance Executive Steering Group has been established to prepare for the inspection; the work being undertaken was now also focusing on pace as well as refocusing the Trust on quality as much as preparing for the inspection. She also commented that it was expected that there would also be unannounced visits by CQC potentially as early as October and possibly on those services which had previously received improvement notices.

Nine workstreams had been established and the Group was meeting on a bi-weekly basis to monitor progress within the workstreams as well as to identify any key areas that need to be taken forward at an Executive level. The frequency of these meetings will increase as the Trust approaches the inspection date.

JW queried the timescale for preparing and submitting the data pack for CQC. FS advised that this information will be required as part of the inspection regime and the request be at any time and up to six months in advance of the inspection but also as short as three weeks' notice. She provided assurance that the Trust had already commenced the data collection in preparation of the anticipated request.

Following a question by MAM, FS explained the challenges with the new data collection process and system including the reworking of data which now has to be provided in Word format rather than in pdf for uploading on to the CQC portal.

The Interim Board received and noted the verbal report.

080/17 REPORT & ACCOUNTS 2016/17 FOR NEP AND SEPT

MM advised that as there was not requirement for an Annual Members Meeting to be held for the predecessor Trusts – North Essex Partnership University NHS FT and South Essex Partnership University NHS FT – to receive the Annual Report & Accounts, he was presenting the Report & Accounts for 2016/17 for the aforementioned Trusts. He pointed out that these had been laid before Parliament in line with the NHS Improvement's Annual Reporting Manual requirements and would be published on EPUT's website once it has been established if there could be some minor changes to the photographs included.

MM confirmed that the report from the external auditors for the former Trusts would be presented for information and noting to the Council of Governors at its meeting on 16 August 2017.

The Interim Board received and noted the report.

081/17 SAFEWORKING OF JUNIOR DOCTORS

The Board received the quarterly report from MK on the safe-working of junior doctors that provided assurance that the doctors in training were safely rostered and that their working hours were compliant with the terms and conditions of their contract. MK confirmed that there were no exception reports.

The Interim Board received the report and noted that there were no exception reports.

082/17 ANNUAL APPRAISAL & REVALIDATION OF DOCTORS

MK presented the report on the annual appraisal and revalidation of doctors in relation to former SEPT and reminded the Board that as a designated body it has a responsibility to ensure that it is compliant with the Medical Professional (Responsible Officers) Regulation 2010 Act (as amended in 2013).

MM explained that the report was presented in the format as stipulated by NHS England and included details about the quality assurance, clinical governance, Trust's performance on revalidation, action plans to strengthen the revalidation process, audits on concerns of doctors' practice and audits on the appraisals inputs and outputs. He confirmed that as of 31 March 2017 there were 90 doctors with a prescribed connection to SEPT of which 86 (95.5%) had an annual appraisal which was an increase of 3.6% compared to the previous year. Three appraisals were defined as 'approved incomplete or missed appraisals' of which one was a new starter who had not completed 12 months of employment with SEPT by 31 March 2017; one was on long-term authorised leave; and the other one was on long-term sick leave. There was one defined as 'unapproved incomplete or missed appraisal' but this had now been completed.

The Board noted the action plan in the report to improve the appraisals for category A1 fo the next appraisal reviews.

The Board agreed that the as there had been challenges with the data collection for NEP, that the annual appraisal and revalidation of doctors report would be presented to the next Board of Directors meeting in September for approval in order to meet the submission deadline of 30 September 2017. It was recognised that this was slightly outside of the usual governance process. The report would however be reviewed by the EOSC at its meeting on 26 September and would be retrospectively presented at the Quality Committee.

The Board:

1. **Received and discussed the report**
2. **Approved the compliance statement as set out in Annex E of the report which would be signed and submitted by the CEO on behalf of SEPT as the Designated Body to the Higher Responsible Officer at NHS England.**

083/17 EPUT BANKING ARRANGEMENTS

MM presented the report on that outlined the current banking arrangements for EPUT and the proposals for the opening of new bank accounts for exchequer funds and clients' money. He confirmed that the report had previously been considered by the Investment & Planning Committee who were recommending formal approval by the Board.

MM pointed out that in line with other NHS organisations, the Trust's main bank account is held with RBS. However, the legacy south Essex has maintained a commercial bank account with Lloyds due to the previous requirements to hold a committed working capital facility and to the Trust's encashment and cash-courier requirements around petty cash. He confirmed that RBS were able to effect a name change on the legacy bank accounts. However, Lloyds' due diligence team confirmed in late March that new bank accounts would be required to be set up for the main exchequer account and for clients' money. Taking account of the impending Finance Team consultation, it was agreed with Lloyds that EPUT would continue to be able to access the former south Essex account in the interim period.

MM advised that in order to open new accounts with Lloyds, the Board was required to approve a number of Board resolutions for the exchequer funds and clients' money accounts. The Board was also required to pass resolutions to effect a change in signatories and financial limits to the RBS account.

The Board unanimously approved the resolutions as detailed in the appendices to the report, and noted the next steps following the completion of the Finance Team's consultation and the appointment of the identified posts as authorised signatories within the bank mandates.

In response to a question by JH, MM confirmed that internal audit regularly review the control processes for the approval and signing of cheques.

The Interim Board:

1. **Received and noted the report**
2. **Unanimously approved that new bank accounts be opened for exchequer funds and clients' money with Lloyds Bank plc**
3. **Unanimously approved the resolutions in relation to the new exchequer funds accounts with Lloyds Bank plc as detailed in appendix 1 of the report**
4. **Unanimously approved the resolutions in relation to the new clients' money account with Lloyds Bank plc as detailed in appendix 2 of the report**
5. **Unanimously approved the resolutions in relation to the existing RBS account included in the bank mandate for the exchequer account as detailed in appendix 3 of the report**
6. **Unanimously approved the financial limits and authorised signatories for both the RBS and Lloyds Bank accounts as detailed in appendix 4 and 5 (respectively) of the report.**

084/17 USE OF CORPORATE SEAL

The Board noted that the seal had been used since the last meeting.

085/17 CORRESPONDENCE CIRCULATED TO BOARD MEMBERS SINCE THE LAST MEETING

The Board noted that there had not been any correspondence circulated to Board members since the last meeting.

086/17 NEW RISKS IDENTIFIED THAT REQUIRE ADDING TO OR REMOVED FROM THE TRUST RISK REGISTER

The Board noted no new risks had been identified.

087/17 ANY OTHER BUSINESS

None.

088/17 DATE AND TIME OF NEXT MEETING

The next meeting will be held on Wednesday 27 September 2017 at 10:30 at The Lodge, Lodge Approach, Wickford SS11 7XX.

Signed …… Date …….

In the Chair

089/17 QUESTION THE DIRECTORS' SESSION

Questions from attendees, members, public and staff are detailed in Appendix 1.

064/17 RESOLUTION

In accordance with paragraph 34.1 of the constitution and paragraph 18E of Schedule 7 of the NHS Act 2006, the Board of Directors resolves to exclude members of the public from Part 2 of this meeting having regard to commercial sensitivity and/or confidentiality and/or personal information and/or legal professional privilege in relation to the business to be discussed.

The Board noted and agreed the resolution.

Meeting closed at 13:15

Signed …… Date …….

Appendix 1: Governors/Public/Members Query Tracker (Item 089/17)

Governor / Member / Public	Query	Assurance provided by the Trust	Actions
BA	Referring to the performance scorecard, queried the reason for the upward trend over the last three months for the delayed transfer of care	AB confirmed that this was regularly monitored but no specific trend had been identified although there had been an increase in admissions over the past year in both community teams and on the wards. He provided assurance that the Trust was working with Essex County Council to look at possible solutions as well as trying to identify other opportunities.	-
BA	Referring to the performance scorecard, queried the reason for the upward trend with regards to out of area placements	AB advised that there had been an increase in demand over the past year both at the Trust and nationally which was not surprising considering the societal pressures people faced, and this put pressure on the whole system. He provided assurance that the Trust was taking vigorous action to try to reduce the OOA placements.	-
BA	Noted the downwards trend in staff appraisals	SM explained that it was felt inappropriate to undertake staff appraisals for those affected by the corporate back office restructure. It was expected that the trend may continue until all consultations had been completed	-
JJ	Noted that the Trust's cash position was above the current plan; however there continued to be an ongoing dispute with NHSP, and queried when this would be resolved and if this would have an impact on the cash position	MM explained that last year so as not to distort the cash position, the board agreed to pay some money to NHSP on account, and it was expected that this approach would also be followed for 2017/18 whilst there continued to be ongoing and unresolved commercial discussions	-
JJ	Referring to BAF risk 3, queried the position regarding the ligature audit	SM confirmed that the ligature audit had been completed and an action plan developed that would be implemented over a period of time; she provided assurance, however, that some actions were taken immediately where identified	-
JJ/PE	Queried if the ligature risks identified by CQC had been addressed	AB advised that the CQC report did not identify the specific risks; however also provided assurance that key actions were taken immediately. In addition regular reviews are undertaken or as a result of any incidents to identify any ligature risks and appropriate action is then taken	-

Signed ……..… Date …….

JJ	Queried the reason for the potential under reporting on patient safety	SM advised that this had been discussed at Finance & Performance Committee. Reasons are two fold – either incidents are not being recorded or there are no incidents to record. She explained the actions being taken to support with Datix recording including the additional support and 'hot line' established to help improve the recording of incidents	-
TW	Expressed disappointment in the way that the proposals for the downgrading of Southend Hospital had been reported and the lack of consultation	SM acknowledged the challenges with media representation and the difficulty in managing reporting	-
RB	Queried why only 43 out of 65 recommendations from the internal audit had been implemented	MM advised that the remaining 22 recommendations were not due to be implemented as they were part of an annual cycle	-
PE	Queried if Governors could be provided with a briefing on the Annual Accounts	MM confirmed that this could be arranged	CL to coordinate date
GH	How do you ensure that communications with service users and carers are maintained when a service user is placed outside of area?	It was acknowledged that this was a challenge and a contributory reason to trying to reduce the number of OOA placements	
PE	Requested if the information requested by SCu on harm free care could be sent to her	NH agreed to send this information to CL for forwarding	NH/CL to circulate
PE	Asked about the progress with IT systems following the merger	MM advised that it had been decided that consideration would not be given to either a new or alternative system or the adoption of one of the current information systems until year 3 following the merger. The Trust was currently pioneering the health information exchange where information can be shared across the whole Trust	
CW	Queried if DBS checks were required for locum doctors	MK confirmed that this is required and is undertaken through the agencies	

Signed ……..… Date …….

In the Chair