Minutes of the Extraordinary Board of Directors Meeting held in Public
Held on Wednesday 20 December 2017
At The Lodge, Lodge Approach, Wickford SS11 7XX

Attendees:

Prof Sheila Salmon (SS)	Chair of Trust
Sally Morris (SM)	Chief Executive
Andy Brogan (AB)	Executive Director Mental Health & Deputy CEO
Alison Davis (AD)	Non-Executive Director (part from agenda item 6)
Nigel Leonard (NL)	Executive Director Corporate Governance & Strategy
Mark Madden (MM)	Executive Chief Finance Director
Mary-Ann Munford (MAM)	Non-Executive Director
Amanda Sherlock (AS)	Non-Executive Director
Nicci Statham (NS)	Non-Executive Director
Nigel Turner (NT)	Non-Executive Director
Janet Wood (JW)	Vice-Chair

In Attendance:

Brian Arney (BA)	Public Governor
David Bowater (DB)	Appointed Governor
Sarah Browne (SB)	Deputy Director Nursing & DPIC
Pippa Ecclestone (PE)	Public Governor
Paula Grayson (PG)	Public Governor
John Jones (JJ)	Public Governor
Cathy Lilley (CL)	Trust Secretary (minute taker)
Dr Kallur Suresh (KS)	Deputy Medical Director
Faye Swanson (FS)	Director Compliance & Assurance
Cathy Trevaldwyn (CTre)	Public Governor
Clive White (CW)	Public Governor
Tony Wright (TW)	Public Governor
Alex Zihute (AZ)	Public Governor

The meeting commenced at 09:30.

SS welcomed Governors, members of the public and staff to the meeting Sarah Browne (SB), Deputy Director Nursing & DPIC who was standing in for Natalie Hammond (NH), Executive Nurse, Dr Sallur Kuresh (SK), Deputy Medical Director who was standing in for Dr Milind Karale (MK) and Faye Swanson (FS), Director Compliance & Assurance who would be co-presenting the Learning From Deaths Report.

169/17 APOLOGIES FOR ABSENCE

Apologies for absence were received from:

Natalie Hammond (NH)	Executive Nurse
Dr Milind Karale (MK)	Executive Medical Director
Malcolm McCann (MMc)	Executive Director Community Health Services & Partnerships

170/17 DECLARATIONS OF INTEREST

There were no declarations of interest.

Signed …… Date …….

In the Chair

171/17 MINUTES OF PREVIOUS MEETING

Subject to the following amendments, the minutes of the meeting held on Wednesday 25 October 2017 were agreed as a correct record:

- Page 1 Date of meeting to read 29 November 2017
- Page 7 item (v) 6th line to read: *She highlighted that there had been a 30% increase in the number of AWOLS* ***which was being investigated …***

172/17 ACTION LOG AND MATTERS ARISING

The Board noted that there were no outstanding or overdue actions.

173/17 NATIONAL AND LOCAL SYSTEMS UPDATE

SM provided a verbal update report on the progress of the four 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.

SS advised that she had attended the North East Essex & Suffolk Chairs' Group which had recently been established and was primarily an advisory group recognising that it was not a decision-making board. The decision-making body was the STP Programme Board chaired by Sheila Childerhouse, Chair of West Suffolk Hospital. AB would raise the importance of ensuring clear governance lines at the STP Board meeting he was attending later today. He advised that it was intended that this locality would be in the second wave of organisations working towards ACS status and pointed out the intention of there being three ACSs within the STP.

SM reported that the Herts & West Essex STP was progressing at similar pace and on similar lines. The current STP Programme Board lead Tom Cahill was standing down and would be replaced by Debbie Fielding, the Accountable Officer for West Essex CCG. NL advised that he had attended the Programme Board meeting yesterday where discussions included a debate about whether there should be one or four ACOs.

With regards to Essex Mid & South, SM confirmed that progress was being made with regards to the move towards becoming an ACS and the three acute hospitals were out to consultation with regards to the changes. A meeting has been held with Dr Anita Donley, the Chair of the STP Programme Board and informal Chairs Group was being established.

The Board received and noted the verbal report.

174/17 CONTRACTING UPDATE

NL presented the report on the commissioning intentions for 2018/19 and the progress with contract negotiations. He advised that discussions are ongoing and are expected to continue up to the January deadline.

NL provided an overview of the commissioning intentions with material impact and highlighted that with regards to Learning Disabilities, South Essex CCGs have served notice to decommission this service. A transparency notice published on 8 December 2017 identified that there was only one capable provider – Hertfordshire Partnership NHS FT will deliver services in partnership with EPUT and ACE. He also pointed out that South Essex

CCGs are serving notice to reduce the bed capacity by 12 beds at Meadowview as a result of continued under-utilisation of older people's beds.

The Board noted that formal notice has been received by the Trust from Bedfordshire CCG on the re-procurement of the Community Services with effect from 1 April 2018. Assurance was provided that the Trust was supporting the disaggregation process to ensure the safe transfer of services. NL confirmed that the new providers had been selected; however there were challenges in relation to the allocation of the QIPP and CIP savings. MM pointed out that there was general agreement across the systems that a more collaborative approach is followed as these were system-based savings but acknowledged that the final figures needed to be agreed.

In response to a question by MAM, NL advised that there was support for the Trust's clinical transformation programme but no clear agreement on where the efficiency savings will fall. This could have an impact on the Trust's ability to meet its control totals.

Following a question by NS, SM confirmed that the Trust had reluctantly served notice to Waltham Forest CCG with regards to Whipp's Cross Urgent Care Centre with an expected end date of 31 March 2018.

Following a question by NT regarding block contracts, it was agreed that there would be follow-up discussions outside of the Board meeting.

The Board received and noted the report.

175/17 LEARNING FROM DEATHS REPORT

SB and FS presented the Learning From Deaths Mortality Review report for quarter 1. The report was in accordance with the national guidance and included information relating to deaths 'in scope' for mortality review for 1 April to 30 June 2017 and learning that has been identified within the Trust as a result of the mortality review. This would support the Trust in learning from deaths to improve the quality of services provided.

FS set the context for the report reminding the Board that in March 2017 the NHS Quality Board issued national guidance on 'Learning From Deaths' that required Trusts to put in a place a policy setting out their approach to mortality review from 1 October 2017 and to publish data relating to inpatient deaths from 1 April 2017. The approach to the mortality review was reported to the Board at its September meeting.

FS confirmed that the report meets the national timeframe for reporting. She pointed out that the mortality review processes and associated data/information were in their formative stages both nationally and within the Trust and as such it was anticipated that the Trust would continue to evolve these processes and refine reporting over time and in accordance with local and national learning.

FS explained that our 'scope' was detailed in our Mortality Review Policy; it includes some expected deaths due to natural causes, as well as unexpected ones. Trusts are required to publish the number of deaths in scope; the number of these reviewed under our Policy and the extent to which any of them were deemed to be due to any 'problems in care'. Also included are examples of learning from the reviews. She advised that the report sets out data for Q1 which goes beyond the minimum requirements as it includes not only all inpatient deaths in the Trust but other deaths that the Trust has decided should be in scope, i.e. deaths occurring in the community of service users with a recorded learning disability and

deaths of service users occurring the community meeting serious incident criteria. The Board noted that as Trusts were able to determine their own local approaches to undertaking mortality review and defining those deaths which should be in scope for review, the mortality data is not comparable between Trusts and there is no intention to benchmark them nationally.

In Q1, there were 59 deaths 'in scope' for review, 24 of which were inpatient deaths and 22 have been confirmed as due to natural causes. Assurance was provided that 55 of these deaths have been fully reviewed/investigated in accordance with processes in place at the time of the death with 4 deaths in the process of having the review/investigation concluded. The Board was assured that the Trust was taking proactive action to learn from deaths to provide insight and to potentially improve service quality noting a number of examples of learning outlined in the report.

The Board held detailed discussions on the mortality review process and the data provided in the report. SB highlighted that the mortality review is a very new process which continues to be challenging, nationally and locally, with respect of gathering and analysing the data. It will become more meaningful as we learn from our own experiences, and those of other NHS Trusts. Members noted that the report is considered in detail by the Quality Committee as part of the Board's assurance process and will consider the emerging themes identified from the learning review.

On behalf of the Board, SS thanked the teams led by MK, NH, FS and SB involved with the production of the comprehensive report.

The Board:

1 **Received and discussed the report**
2 **Considered the learning identified within the Trust as a result of the mortality review for Q1.**

176/17 SAFEWORKING OF JUNIOR DOCTORS

KS presented the report that provided the compliance report for the period 1 July to 31 October with regards to doctors in training are safely rostered and that their working hours are compliant with their terms and conditions of their contract. He confirmed that the Trust has established robust process to monitor the safe working of junior doctors.

KS highlighted that there has been one exception report during this period. This was raised by an on call Foundation Year 2 trainee due to the increased workload at the Mental Health Assessment Unit in Basildon which resulted in the doctor missing the break from work. He provided assurance that the doctor was supported by her clinical supervisor and was later given time off in lieu.

The Board:

3 **Received and discussed the report**
4 **Noted that there have been no major concerns raised by the Junior Doctors Forum**
5 **Appropriate action has been taken following the exception reporting.**

176/17 CQC INSPECTION UPDATE

The Board received an update report from NL on the unannounced visits in early November to inpatient mental health wards; the reports were expected imminently. There would be a

10 day period for the Trust to check the factual accuracy of the reports and provide feedback to the CQC. He provided assurance that action either had or was being taken following previous inspections and that the Quality Committee receives the detailed reports on all CQC inspections including the monitoring of action plans. SM provided assurance to the Board that weekly meetings were held to progress actions to avoid any slippage.

SS commented on the importance of unannounced visits which provided learning opportunities.

As reported at the November Board meeting, NL advised that the CQC had confirmed that the Trust would receive 12 weeks' notice prior to the comprehensive inspection. A task and finish group had been established to drive the preparations for the visit which also included the provision of data prior to the inspection visits.

The Board received and noted the verbal report.

177/17 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.

178/17 NEW RISKS IDENTIFIED THAT REQUIRE ADDING TO OR REMOVED FROM THE TRUST RISK REGISTER

The Board noted no new risks had been identified.

179/17 ANY OTHER BUSINESS

None.

180/17 DATE AND TIME OF NEXT MEETING

The next meeting of the Board of Directors will be held on Wednesday 31 January 2018 at 10:30 at The Lodge, Lodge Approach, Wickford SS11 7XX.

181/17 QUESTION THE DIRECTORS' SESSION

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

SS closed the meeting by asking NL to summarise how the Board had demonstrated through its deliberations and reports the Trust's vision and values. NL explained that the report on the mortality review demonstrated the Trust's vision of working to improve lives and also the value of openness. This report and the actions being taken also clearly demonstrate compassion through working with the families and empowerment again by working with families but also staff.

Meeting closed at 10:15.

Signed …… Date ……

In the Chair

Appendix 1: Governors/Public/Members Query Tracker (Item 181/17)

Governor / Member / Public	Query	Assurance provided by the Trust
JJ	Queried how the control limits had been set in relation to page 9 of the report, recognising that these would be adjusted in future	FS confirmed that the figures had been recommended by the Trust's Director of Public Health who was an expert in this field
JJ	Referring to the figure on page 9 of the report, queried the number of unexpected inpatient deaths and if this was included in the table	FS explained that the terminology used in the report was 'natural causes'. 22 were natural causes and 2 were patients on leave at the time of the deaths. **Action:** It was agreed that the figure would be reviewed and adjusted to provide clarity and avoid misinterpretation

Signed ……..… Date …….