Portsmouth Hospitals NHS
NHS Trust

Trust Board Meeting in Public

Held on Thursday 25 October at 10:00
Lecture Theatre
Queen Alexandra Hospital

MINUTES

Present:	David Rhind	Chairman
	Alan Cole	Non Executive Director
	Liz Conway	Non Executive Director
	Tim Higenbottam	Non Executive Director
	Mark Nellthorp	Non Executive Director
	Steve Erskine	Non Executive Director
	Ursula Ward	Chief Executive
	Cherry West	Chief Operating Officer
	Julie Dawes	Director of Nursing
	Simon Holmes	Medical Director
	Tim Powell	Director of Workforce
	Richard Eley	Interim Director of Finance
	Dominic Hardisty	Director of Strategy & Business Development
In Attendance:	Peter Mellor	Company Secretary
	Sarah Balchin	For agenda item
	Alison Fitzsimons	For agenda item
	Barbara Topley	For agenda item
	Michelle Marriner	(Minutes)

Item No **Minute**

160/12 **Apologies:**

There were no apologies.

Declaration of Interests:

There were no declarations of interest.

161/12 **A Patient Story**

The Director of Nursing explained that on this occasion, the patient story would be delivered via a pre recorded video. The patient in question would be telling his experience of developing a pressure ulcer whilst an inpatient.

She welcomed Sarah Balchin, Alison Fitzsimons and Barbara Topley to the meeting who were in attendance to answer any questions that the Board might have about this particular patient experience or any other questions regarding pressure ulcers.

After the viewing of the video, the Chairman asked what conclusion could be drawn from this particular patient's experience. The Director of Nursing felt that it was an important quality metric and also showed the impact of a pressure ulcer on the patient and his family. Sarah Balchin felt that the key lesson was 'to always listen to the patient'. Barbara Topley felt that on this occasion, the patient's needs had been adhered to as he declined

the use of a pressure mattress. There is a strong reliance on equipment for the prevention of pressure ulcers.

Alison Fitzsimons explained that the way in which patients were assessed had now been completely changed. Nurses now spend much more time assessing patients than they did previously resulting in the most appropriate care for the patient.

The Chief Executive advised that grade 3 and 4 pressure ulcers had significant financial implications to the NHS but she reminded the Board that there was always a patient behind all of the figures and statistics. She agreed that there was a need for a more detailed assessment of patients and a need for sufficient availability of the correct equipment. The Director of Nursing advised that an audit that had been conducted had shown that whilst there was enough equipment, it was not always available as it was not always returned promptly.

Mark Nellthorp asked how long a pressure ulcer could take to develop and how a certain bed could help prevent it. Barbara Topley advised that a pressure ulcer could occur in a very short timescale. It starts from within the body and quite often had already started to occur before patients arrive in hospital. They can often take up to 14 days to appear. She advised that the surface of the mattress plays an important part in prevention and that certain beds can be electronically profiled to best suit the needs of the patient.

Alison Fitzsimons pointed out that whilst there had been a reduction in the number of hospital acquired grade 3 and 4 pressure ulcers, there had been an increase seen in the number of community acquired pressure ulcers. She felt that there was still a lot of work to be done in the community.

Alan Cole asked if there was a need for more public awareness. Alison Fitzsimons explained that each patient was given a leaflet about pressures ulcers whilst in hospital. There are also informative events such as the pressure ulcer awareness week.

Steve Erskine felt that the delivery of the patient story by way of video had been an effective idea. He would have liked to have been given more context in order to understand the patient's background before hearing his story.

The Chief Operating Officer asked that the patient be thanked for sharing his experience with the Board. The Chairman committed to write to the patient on behalf of the Board.
Action: Chairman

162/12 Minutes of the Last Meeting – 27 September

The minutes were approved as a true and accurate record subject to the following changes:

Page 2, paragraph 2 – Liz Conway advised that it had been Steve Erskine who had asked that question.

Page 4 – Liz Conway said that the minutes did not include her question regarding the lack of supplies of bladder cancer drugs.

Page 8, paragraph 2 – The Director of Strategy asked that the minutes read 'succession for a national programme', rather than 'failed IT programme'.

163/12 Matters Arising/Summary of Agreed Actions

129/12: Chief Executive's Report – The Director of Nursing confirmed that the National Quality Board report would be presented at the next Trust Board Workshop.

150/12: Assurance Framework – The Company Secretary confirmed that the number

of the risk was now included on the Trust Risk Profile page of the Assurance Framework.

151/12: National Cancer Survey – The Director of Nursing advised that she had made a request to the Cancer Network but was still awaiting a response.

151/12: National Cancer Survey – The Director of Nursing confirmed that she had circulated the full report.

164/12 Notification of Any Other Business

The Company Secretary introduced the new Trust logo and strap line which was to be rolled out in the near future and to be included on all Trust documentation.

165/12 Chairman's Report

This report was noted by the Board.

The Chairman advised that a certificate of thanks was being given to all members of staff who had participated in the successful Open Day.

Tim Higenbottam suggested that the dates of the Public Constituency Meetings be emailed to the Non Executive Directors should they wish to attend one.
Action: Company Secretary

166/12 Chief Executive's Report

This report was noted by the Board.

The Chief Executive drew attention to the new respiratory illness SARS which had recently been diagnosed in Britain. She advised that the Chief Medical Officer had issued an alert to look out for symptoms in people who may have visited the Middle East. Steve Erskine asked whether this alert had been circulated externally. The Chief Executive explained that the alert had been circulated internally within the Trust and that it was the responsibility of Public Health to engage with the public. Steve Erskine felt that it might be useful for us to prompt them to do so. The Chief Executive asked the Medical Director to discuss this at the Clinical Leaders Group.
Action: Medical Director

The Chief Executive was pleased to announce that a constructive meeting had taken place on 3 October between the surgeons from Portsmouth Hospitals NHS Trust and University Hospital Southampton NHS Foundation Trust to consider how a network approach to local vascular services might be developed.

She paid tribute to Lisa Jayne Coles who had very sadly recently passed away. Lisa had been a very popular Consultant in the Emergency Department since 2008.

The Director of Workforce asked about the proposed 'new vision for nursing' and how it would be introduced into the Trust. He was concerned that it might cause confusion with our own internal vision. The Director of Nursing said that the proposed new vision was in the consultation phase and that views had been sought on the ideas within it. Nicky Lucey was leading on this piece of work and was currently mapping it against our own values.

167/12 Integrated Performance Report

The Chief Operating Officer emphasised some key headlines from the Integrated Performance Report:

<u>Quality</u>

- Pressure Ulcers – a total of 5 grade 3 and 4 pressure ulcers had been reported in September compared to 2 in August.
- Insulin prescriptions – there had been a drop in compliance in September to 97%.

Service Delivery
- Referral to Treatment (RTT) – the standards had been achieved at Trust level but not in all specialties due to clinical actions taken to bring forward treatment dates for longest waiting patients in one specialty.
- All Stroke performance standards achieved.
- PPCI 'Call to balloon' – target was not achieved due primarily to delays in the transfer of patients to the Trust and initial diagnosis delays in ED.
- 62-day Cancer – all three 62-day screening targets were not achieved
- ED Performance – target not achieved.

Activity
- Elective admissions 1.5% above plan
- Non elective admissions 4.5% above plan
- ED attendances 10% above plan in the month
- Outpatient follow up attendances are 2% above plan

Finance
- Recorded deficit of £7.4m on income and expenditure which reflects a £0.4m adverse movement from the month 5 position.
- Budgets have been significantly re-profiled in order to get a clearer picture of the true variances driving the financial position. This has significantly shifted the year to date budget target, meaning that the Trust is currently £6.7m adrift from plan.

Workforce
- Total workforce expenditure decreased by £262k
- Temporary workforce usage decreased to 6.4%.

Alan Cole referred to the recognition that a system wide approach would need to be developed in order to tackle the increase in ED activity. The Medical Director explained that a programme was underway where a whole new work stream had been developed based on the recommendations from the recent visit from ECIST. There was pressure on the commissioners to ensure that a system wide approach was delivered. Alan Cole asked for a copy of the action plan which had been developed
Action: Medical Director

The responsible Executive Director was asked to highlight any key points from his/her section of the report:

Quality
The Director of Nursing advised that we were at risk of not achieving the end of year target for reducing medication errors by 10%. A review had been carried out but had identified no themes. An improvement plan is to be delivered to CSC's by the Medication Safety Committee.

Steve Erskine referred to the shadow Monitor compliance framework and the reference to a previous error in reporting the learning disability indicator. He was concerned that this was not the first time that data had been reported incorrectly. The Director of Nursing felt that the use of the word 'error' was not appropriate. The Trust had been assessing against best practice and not the minimum standards as set out in the minimum standards. Having re-assessed, we were now compliant.

Operations
Steve Erskine asked if we were confident that the necessary improvements would be made to ensure achievement of the 62-day cancer targets. The Chief Operating Officer

said that she was. She confirmed that daily meetings were taking place to review and escalate each case accordingly which would make immediate improvements. The Medical Director said that there also some slippage in our own turnaround times which would be improved.

Finance

The Interim Director of Finance said that were three key issues which were significantly impacting the current financial position:

- Cost improvement programme – had now been 'RAG' rated.
- Contract strategy – plans in place to reduce ED contract issues which is the current biggest financial pressure.
- Overspend on pay – pay controls beginning to lessen the impact.

He advised that a reduction in activity had been seen within Orthopaedics, resulting in £1.5m loss of income. This appeared not to be due to a change in market share but because of a general reduction in demand. The Chairman asked if there was a plan for adjusting resources accordingly. The Chief Operating Officer advised that the activity where the reduction had been seen was in the areas of low clinical value. She reported that there was a problem with long Orthopaedic waiting lists throughout the country, whereas ours had reduced drastically. We could approach those Trusts with long waiting lists and offer to treat some of their patients.

The Director of Nursing asked if the activity had reduced as a consequence of not having 'Trauma Centre' status. The Medical Director said that this was apparently not the reason but a genuine lessening of demand.

Tim Higenbottam said that during a recent Patient Safety Walkabout, he had noticed a number of empty beds and asked how the bed rebalancing exercise was progressing. The Director of Nursing advised that some of the empty beds seen on the MSK wards were now being used for outliers. The Chief Operating Officer advised that the bed rebalancing programme was ongoing and beds would begin to be re-distributed next month.

Steve Erskine sought assurance that there was a clear financial plan for the rest of the year. The Interim Director of Finance said that there was currently a deficit of £400k per month which needed to be turned into £400k surplus per month. He said that we would need to turnaround by £14m by the end of the financial year. This plan for achieving this was by:

- £5m on non recurring items
- £5m contract changes. Discussions ongoing about how the contract can be corrected.
- £4m code reduction which is the area with the biggest risks.

Steve Erskine felt that it would be useful to see plotted on the income and expenditure graph, the expected year end position.

Workforce

The Director of Workforce advised that the plan to reduce the workforce spend by £250k in month 6 had been achieved but the real challenge would be in month 7. There are substantive workforce joining the Trust which will have a positive impact on the temporary spend but due to there being higher than planned activity, the temporary spend has not reduced as much as had been planned..

Liz Conway asked if all of the planned substantive nurses were now in post. The Director of Nursing advised that more would be joining next month.

Alan Cole asked how many beds were currently open. The Chief Operating Officer suggested sharing the bed reconfiguration plan at next week's Board Workshop.

The Director of Workforce reported an increase in Essential Skills compliance to 78.5% in August but this was below the Trust target of 85%. There would be new measurements in place next month as new modules are being introduced; this may cause a drop in compliance.

168/12 Quarterly Quality Report

The Director of Nursing introduced the Quarterly Quality Report, explaining that it provided a comprehensive overview of quality performance throughout the Trust, for Qtr 2. The format had changed reflecting feedback from both the Board and from the RSM Tenon review.

Patient Experience

Family and Friends Test – The Department of Health had published the requirements for this new initiative which would be launched in shadow form from January 2013 and would become a requirement from April 2013. Every adult in-patient and ED attendee must be asked the question every day of the year on discharge. This will amount to approximately 500 patients per day. The team is currently exploring how this could be implemented. The Chief Executive suggested that the Trust use social media to help gather responses. The Director of Strategy said that before social media could be used, a governance policy would need to be written. Liz Conway agreed that the use of the social media was important and that it required clear governance.

Governance Compliance

Care Quality Commission Quarter 2 self-assessment – The Director of Nursing advised that the Trust was overall compliant.

Clinical Effectiveness

Hospital Standardised Mortality Ratios – The Medical Director advised that the Trust position for the financial year 2012/13 was 101 which was above the national average, of 100. Previously reported provisional figures indicated that the Trust was below the national average. According to Dr Foster, a possible cause for the rise in Trust HSMR is related to an issue with coding within Palliative Care.

National Hip Fracture – once again, the results were very good.

National Institute for Health and Clinical Excellence (NICE) – the Medical Director advised that we would now be measured for compliance against the 19 standards published. We were currently fully compliant with 5, partially compliant with 9, 2 are not relevant, 1 is newly published and 2 awaited specialty response.

Patient Safety

Mark Nellthorp noted that for medication errors the report suggested that we had made a 50% improvement on last years figures, yet were still not compliant. He pointed out that the total figure for 2011/12 did not add up. The Director of Nursing committed to investigate.

Action: Director of Nursing

Steve Erskine asked if the number of patient claims were increasing and what was driving the increase. The Director of Nursing offered to investigate the figures and to look for increase/trends.

Action: Director of Nursing

Alan Cole asked if there was an optimum target for the Productive Program. The Director of Nursing advised that there wasn't but that the Trust had shown sustained improvement since the start of the programme. She said that she was unsure whether there could be a target as there was increasing evidence showing how much time should be spent on direct patient care and it would depend on the set up in each ward.

The Chief Executive said that the Trust would need to consider how the, soon expected, Francis report would impact on our initiatives. We need to be mindful that the report would, unsurprisingly, highlight errors made within the NHS and that public concerns would need to be managed.

169/12 Foundation Trust Pipeline Update

The Chief Executive reminded that there were still 103 NHS non Foundation Trusts and whilst most of them were expected to achieve Foundation Trust status, some would require additional help to do so.

There are a number of Foundation Trusts who are at risk of breaching their terms of authorisation as the NHS savings requirement is starting to impact.

The Trust Development Agency (TDA) recognises that the difference between Foundation Trusts and non Foundation Trusts was becoming tighter. It is now much more difficult to be authorised as a Foundation Trust and many Trusts who had previously been authorised would not be successful were they to apply now.

The latest iteration of the Integrated Business Plan (IBP) and Long Term Financial Model (LTFM) had been submitted to the Strategic Health Authority (SHA) on 21 September and feedback had recently been received. The next iteration is due to be submitted to the SHA in mid November.

Mark Nellthorp said that the feedback from the SHA at the readiness meeting was clear. He asked if we could pick one of those GP surgeries who do not currently refer the majority of their patients here and use them as a pilot to show the SHA clear evidence that work could be repatriated and the financial benefit of doing so. The Chief Executive agreed but felt strongly that the Trust did not have the luxury of time to just target one practice but that the initiative needed to be accelerated. The Director of Strategy said that there were 22 key GP Practices which could be targeted but that they all had different perceptions and some would be easier wins than others. Mark Nellthorp shared the Chief Executive's concern at the lack of urgency and that we needed to set dates to engage with those practices as soon as possible. The Company Secretary fully agreed with the need for urgency and believed that there was an appetite to get out and engage with those practices. The Medical Director and Company Secretary committed to writing to all of those 22 practices that had been identified, by next week.
Action: Medical Director/Company Secretary

170/12 Self Certification

The Company secretary advised that a key element of the Single Operating Model was self-certification. The self-certification needed to be approved by the Board to enable it to be signed by the Chief Executive and Chairman before being sent to the SHA on 31 October 2012. The self certification process would continue on a monthly basis until the Trust became authorised as an NHS Foundation Trust.

He confirmed that the errors that had been highlighted last month had been rectified prior to submission to the SHA.

He sought the Boards agreement to sign declaration 2.

The Board agreed the self certification and the signing of declaration 2.

171/12 Assurance Framework

The Company Secretary drew attention to the top 8 risks. He asked the Board to assure itself that these risks were indeed the current risks facing the Trust and that adequate management processes were in place to mitigate them.

Steve Erskine said that after the earlier discussion of the clinical performance and quality metrics, he did not feel that these were fully and explicitly reflected in the risks. The Medical Director advised that those risks would appear in the CSC Risk Registers. The Company Secretary agreed to discuss his concerns at the next Risk Assurance Committee. The Chairman agreed that it was appropriate that the Risk Assurance Committee discuss it but insisted that if the Board believed something was missing, then it needed to be added.

Mark Nellthorp referred to risk 2.2. He felt that it was unique in that its consequence had increased as well as its likelihood. He asked for an explanation as to how the consequences had increased. The Company Secretary agreed to find out.
Action: Company Secretary

The Chairman summarised by saying that the Assurance Framework reflects those risks directly affecting the strategic objectives whereas the Risk Register reflects all risks within the organisation. The Company Secretary advised that a review of risk was currently underway to see how the risks might be better presented. Steve Erskine felt that it was not necessarily about how they were presented but more about how the Executive Team was managing them. The Chief Executive agreed.

The Company Secretary reminded that some risks might not be fully resolvable but would need to be managed as best they could. It would never be possible to be an organisation with no risks.

172/12 Proposed new annual planning process

The Director of Strategy reminded that the proposed new annual planning process had been previously circulated and all feedback had been summarised. It had been agreed that the Interim Director of Finance would now lead on the annual planning process.

The Interim Director of Finance advised that he would be meeting with each CSC throughout November. Tim Higenbottam said that the calendar of milestones was useful and asked how many of the milestones for October had been completed. The Interim Director of Finance acknowledged that this year's process was already slightly behind schedule and that a statement of what needs to be done will be complete by November.

Steve Erskine expressed concern at the slippage and believed that to ensure that there was no repetition of this year's poorly managed process; the Board should receive regular updates, more frequently than monthly. The Chairman asked the Interim Director of Finance to consider how this reassurance might be best provided.
Action: Interim Director of Finance

The Board supported the new annual planning process.

173/12 Reducing non elective admissions / plan for front door attendance

The Chief Operating Officer provided a summary of the internal plans for reducing non elective admissions and attendances at ED:

- Surgical non elective admissions – introduction of ambulatory care pathway (starts Monday).
- 'Community discharge area' – for those patients who have no acute need but there is difficulty in sending them back home. The Trust is working with Solent Healthcare and Southern Health to develop a pathway to ensure there is no need for that patient to be admitted to a bed (will be implemented on 1 December).
- Each specialty to have emergency outpatient slots. Currently working with CSC's to implement this.

The Medical Director said that there were some external schemes also underway:

- The Exbury Ward at St James Hospital available to use as 'step up' and 'step down' beds.
- Community triage service being set up which should prevent patients coming into hospital.

The Chief Executive said that she was due to meet with her counterparts from each of the community providers to discuss these various initiatives in more detail.

Mark Nellthorp had noticed that Acorn House, situated just outside of the entrance to the hospital, was up for sale and asked if the SHA might be minded to provide financial support to us to establish an out of hours alternative to our ED. The Medical Director advised that the Surgical Outpatient department was already being used out of hours for this purpose by the local out of hour's service. The Company Secretary queried the need for a patient to have to make an appointment to attend there. If that requirement was removed, the Trust would be able to re-direct several inappropriate attendees to our ED, there instead.

The Chief Executive felt that part of the problem was a cultural issue and believed that staff needed to have the confidence to push back and tell patients when it was not appropriate for them to be in ED. The Director of Nursing said that staff often do suggest an alternative but the difficulty arises when the patient still chooses to stay in ED.

The Medical Director confirmed that a Consultant had recently moved across from MAU to support ED. It is important to note that admissions had remained flat despite attendances at ED increasing. This demonstrated that our doctors were not allowing inappropriate admissions.

Mark Nellthorp asked what the working pattern of ED consultants was. The Medical Director advised that a Consultant was on duty until 7pm and then another Consultant until 12am. There was no Consultant cover between 12am and the morning.

Tim Higenbottam thought there was a need for a written plan capturing each milestone. The Chief Operating Officer agreed. Alan Cole said that due to the financial impact this would inevitably have, the data should be included in the weekly dashboard. The Chief Executive felt that a regular monthly report should be provided, showing progress against the plan. Mark Nellthorp said that as we have the data for total number of admissions and number of frail/elderly admissions, we should be able to record this daily. The Chief Operating Officer reminded that we had no control over the acuity of those patients who present at ED.

Liz Conway felt that this problem work needed to be clearly communicated to all local GP's. The Chief Executive said that the Portsmouth CCG fully understood the problem but had no direct control over GP's.

The Chairman summarised the discussion and confirmed that the Chief Operating Officer and Medical Director should report back each month on progress.
Action: **Medical Director/Chief Operating Officer**

174/12 Annual Audit Letter

The Interim Director of Finance presented the Annual Audit Letter which summarised the 2011/12 audit of Portsmouth Hospitals NHS Trust by our external auditors, the Audit Commission. The District Auditor, within his letter, issued an unqualified opinion on the Trust's financial statements.

Alan Cole, in his role of Chair of the Audit Committee, asked that members read the comments regarding the two PbR Data Assurance Framework Reports that had been conducted by the Audit Commission. He advised that Ernst & Young were to be the Trusts new external auditors from October 2012.

175/12 Finance Committee Report

This report was noted by the Board.

176/12 Charitable Funds Update

This report was noted by the Board.

177/12 Diary of Events

The Company Secretary introduced the Annual Work Plan for Trust Board meetings. He invited each Board member to review and send any contribution/addition that they thought should be included, to him. This would enable members to be aware of what was on forthcoming agendas.
Action: All / Company Secretary

Steve Erskine felt that the key milestones in the IBP preparation and Foundation Trust application process should be included.

178/12 Non Executive Directors' Report

This report was noted by the Board.

Steve Erskine asked when the review of the Patient Safety Walkabout Programme would be complete. The Director of Nursing advised that Lorna Wilkinson was in the process of carrying out the review and that changes would be implemented in the next 6 weeks.

179/12 Opportunity for the Public to ask questions relating to today's Board meeting

Isabel Pine (Governor) asked what the current number of medically stable patients in hospital was. The Chief Operating Officer replied that there were currently 68, although that figure had reduced.

Syd Rapson (Governor) said that Portsmouth Health Overview and Scrutiny Panel (HOSP) had been informed that the Southampton HOSP would be referring the ongoing issue around Vascular Services to the Secretary of State. The Chief Executive referred to a letter that had been sent by the Chair of the Southampton HOSP which stated that if a joint model for working was not agreed between the 2 Trusts, he would refer the issue to the Secretary of State. She advised that she had since spoken with the Chair to explain that a productive meeting had recently taken place between the clinicians from both Trusts and that a network model had been agreed in principal. Agreement to the proposed model was still awaited from the Chief Executive of University Hospital Southampton Foundation Trust. The network approach agreed between clinicians had been shared with Debbie Fleming, Chief Executive, SHIP.

Syd Rapson advised that the Northern Road railway bridge was soon to be the subject of renovation and that would have a detrimental effect on both staff and patients. The Chief Executive said that she was unaware of this issue but would investigate further.
Action: Chief Executive

A member of the public believed that there was growing anger in Britain about car parking charges in NHS Hospitals. He asked what profit Carillion made on car parking charges. The Company Secretary replied that he was unable to comment on the profit that Carillion make. He advised that the management of the car parks had been transferred to Carillion as part of the PFI contract and that if Carillion were not managing the car park, the Trust would have to replace that profit by other means. He confirmed that the Department of Health was fully supportive of car parking charges on NHS property.

180/12 Any Other Business

There being no items of any other business, the meeting closed at 13:15pm.

181/12 Date of Next Meeting:

Thursday 29 November

Venue: Oasis Centre, Queen Alexandra Hospital