Portsmouth Hospitals NHS
NHS Trust

Trust Board Meeting in Public

Held on Thursday 5 January at 11:00
Lecture Theatre, Education Centre, E Level
Queen Alexandra Hospital

MINUTES

Present:	David Rhind	Chairman
	Alan Cole	Non Executive Director
	Elizabeth Conway	Non Executive Director
	Mark Nellthorp	Non Executive Director
	Steve Erskine	Non Executive Director
	Tim Higenbottam	Non Executive Director
	Ursula Ward	Chief Executive
	Cherry West	Chief Operating Officer (joined at 12:30pm)
	Simon Holmes	Medical Director
	Julie Dawes	Director of Nursing
	Robert Toole	Director of Finance
	Tim Powell	Director of Workforce & Organisational Development
	Dominic Hardisty	Director of Strategy and Business Development
In Attendance:	Peter Mellor	Company Secretary
	Constantinos Yiangou	Consultant Surgeon Associate Medical Director
	Michelle Marriner	(Minutes)
	Joanne Borbone	Specialist Registrar (observing)

Item No **Minute**

1/12 **Apologies:**

Apologies had been received from Simon Holmes, Medical Director and Elizabeth Conway, Non Executive Director. The Company Secretary advised that Constantinos Yiangou was in attendance on behalf of the Medical Director.

Declaration of Interests:

There were no declarations of interest.

2/12 **Minutes of the Last Meeting – 1 December**

The minutes of the last meeting held on 1 December were approved as a true and accurate record.

3/12 **Matters Arising/Summary of Agreed Actions**

- Alan Cole referred to page 6 of the previous minutes. He reminded of the agreement that the Chief Operating Officer would report on the number of 52 weeks breaches and 18 week breaches in future Board reports and pointed out that they did not appear

to be included in this months report. The Director of Finance in response commented that a statement on 52 week waits was included on page 5 of the Chief Operating Officer's report. Two patients who were reported as 52-week waits at the end of November. Both patients have now been treated. 18 week breaches will be provided in future.

191/11: Minutes of the Last Meeting 3 November – The Director of Finance confirmed that the incomplete sentence had now been completed.

195/11: Chief Executive's Report – The Chairman confirmed that the Trade Unions involved in the industrial action had been written to and thanked for their professional handling of the situation.

199/11: Risk Management Strategy – The Company Secretary confirmed that the reporting structure had been updated to reflect 'NED representation' under the Governance and Quality Committee.

4/12 Notification of Any Other Business

There were no items of any other business.

5/12 Chairman's Report

The Chairman had nothing to report.

6/12 Chief Executive's Report

The Chief Executive advised that the Deputy Chief Executive of the NHS David Flory had published his report for the second quarter, July to September 2011/12. This provided a summary of the NHS financial position and performance against the national priorities set out in the NHS Operating Framework 2011/12. The report showed that the NHS had continued to perform strongly against the requirements of the NHS Operating Framework 2011/12 and had made good progress in beginning to make the savings and system transformation required to deliver the quality, innovation, productivity and prevention (QIPP) and reform challenge.

On 14 December 2011, £91.6 billion in Primary Care Trust (PCT) revenue allocations were announced for 2012/13, a total increase of 2.8 per cent. This included £87.5bn for PCT recurrent allocations, and £4.1bn for non-recurrent allocations supporting services in primary dental, pharmaceutical, general ophthalmic and joint working between health and social care. The allocations for our two major commissioners were as follows

PCT	Allocation for 2012/13	Increase	% increase
NHS Hampshire	£1,934,585,000	£53,040,000	2.8
NHS Portsmouth	£354,028,000	£9,688,000	2.8

The Chief Executive advised that a new framework to help aspirant Foundation Trusts to develop strong governance was now available. Through a combination of self-assessments and independent review, the tool would help give assurance that NHS Trusts were appropriately skilled and fully prepared for Foundation Trust authorisation. All aspirant NHS Foundation Trusts are required to participate. She thought it advisable to conduct a desktop review as soon as possible, which would allow time to rectify any issues that might arise. The Chief Executive suggested that this process be run concurrently with the Integrated Business Plan timeline.

The Chief Executive advised that an online interactive map had been published on 7 December 2011 outlining what services were going to be opened up to Any Qualified Provider (AQP) from April 2012. This will allow patients, commissioners and providers to see the range of choice of local health services that was available.

The Department of Health had published the National Cancer Peer Review Programme for 2010/2011, including a summary overview of the National findings. It focuses on compliance with specific measures included in the Manual for Cancer Services, which supports quality assurance of cancer services and enables quality improvement and the implementation of NICE Improvement Outcomes Guidance. She advised that this will be considered in detail by the Trusts Cancer Steering Groups.

She advised that the Health Research Authority (HRA) had started on 1 December 2011, in its new role as the regulator of health research. Its central purpose is to protect and promote the interests of patients and the public in health research. The HRA will work with a range of stakeholders to combine and streamline the current approval process and promote proportionate standards for compliance and inspection.

The Department of Health has published a call for expressions of interest in becoming a pilot site to gather the information needed to inform decisions on the creation of a new funding system for palliative care for adults and children, and to consider the proposals of the independent Palliative Care Funding Review Report. Portsmouth Hospitals NHS Trust needs to consider whether it wanted to apply to become a pilot site. The deadline for submissions of interest is 31 January 2012.

The Chief Executive was pleased to announce that thanks to the tremendous hard work of the staff involved and the advanced planning which had taken place, the hospital had run much more smoothly over the Christmas and New Year period compared to previous years. She said that the partnership working with external providers had worked extremely well and she would write and formally thank them. It was agreed that the Chairman write to our staff to thank them for their hard work.
Action: Chairman

Mark Nellthorp suggested that the success of the system working so well together over the Christmas period be shared in the public arena - this positive publicity would help to further consolidate future arrangements with our external partners. The Board agreed.
Action: Chief Executive

The Chief Executive advised that the local Sustainability Group had recognised that it needed to refocus; therefore the terms of reference were to be reviewed. They would be brought to the Board for consideration.

The Chief Executive provided an update on the proposed reconfiguration of Vascular Services. She advised that Portsmouth Hospitals NHS Trust had been asked to provide a business case to show how it could be a stand alone vascular unit. An expert panel had been convened to consider whether the proposals met the criteria laid down by the Vascular Society of Great Britain. A member of our Council of Governors would be in attendance. Dr Julian Atchley and Mr Paul Gibb would also join the meeting via teleconference. Public consultation on the reconfiguration options was due to commence on 14th January 2012.

7/12 Integrated Performance Report

Quality:

The Director of Nursing was pleased to advise that the Venous Thromboembolism (VTE) assessment rate for November had once again improved to 93.74% compared to 91.67%

compliance in October. She advised that good progress was being made in terms of falls and pressure ulcers with 1 amber and 1 red rated fall in November and 2 grade 3 and 4 pressure ulcers reported in November.

She was concerned at the increase in the number of complaints during the month of November. There were a total number of 61 complaints in November against an objective of no more than 42. She advised that there were no themes in the complaints received. She was pleased to note that the number of complaints had dropped for December. The Chairman said that the graphs showing the number of complaints received per Clinical Service Centre (CSC) did not show the total number of patients who had attended the hospital during the period, therefore it was difficult to understand the percentage of those patients who make a complaint. The Director of Nursing confirmed that it was possible to produce the data at trust wide level but not at CSC level. The percentage of patients treated who make a complaint currently stands at approximately 0.8%. Steve Erskine asked if someone senior within the Trust carried out a detailed analysis of the complaints received. The Director of Nursing confirmed that she read every complaint received before forwarding to the relevant Executive Director to action within their department. The Chief Executive confirmed that she also read every response to complaints before they leave the hospital. She advised that there were a number of mechanisms in place to detect trends within the complaints.

The Director of Nursing advised that in terms of medication errors, there had been a decrease in compliance between October and November for the 2 indicators. This was due to the change in day in which the audit was carried out (audit days set by the Patient Safety Federation). The audit was usually conducted at the end of the week but on this occasion it was carried out on a Monday. The results reflect that there is not a ward based pharmacy service at the weekends. She confirmed that all Trusts within our Strategic Health Authority (SHA) area had seen a dip in results due to the change in the day the audit was undertaken.

The Chairman asked why there was a change in the way the statistics for End of Life Care were measured. The Director of Nursing advised that a debate had been held at the Governance and Quality Committee and it was agreed that Critical Care deaths should appropriately be excluded from data collection. The data was therefore rerun to show the impact of removing Critical Care deaths on compliance. As a consequence, without this cohort of patients, the Trust was achieving its 50% target of patients identified as dying being placed on the Liverpool Care Pathway. The Chairman said he wanted to ensure that the changes were made in line with other Trusts. The Director of Nursing confirmed that Dr Mark Roland, our End of Life Care Lead and also the lead for the SHA, had set the original target. The Company Secretary reminded of the questionnaire that was given to the family of those that had died at Queen Alexandra Hospital and that the level of satisfaction with the treatment of those patients had been very high. He asked if this data was still collected. The Director of Nursing confirmed that it was and that it would be included in next month's detailed Quality performance report.

Steve Erskine asked if 'Captains Rounds' covered all of Portsmouth Hospitals Trust estate. The Company Secretary confirmed that certain, more remote, areas were not covered. Steve Erskine suggested that the whole site and external areas be covered on an adhoc basis as he felt that it contributed significantly to both staff and patient wellbeing.

Operations:

The Director of Finance presented this item in the Chief Operating Officer's absence.

The Director of Finance advised that when considering Portsmouth Hospitals NHS Trust performance against the Monitor Compliance Framework, the Trust would have an overall service performance rating of red for November. This was a decrease in rating compared

to our October position. The decrease in rating was, in part, due to there being 2 new cases of MRSA within the month.

The Director of Finance provided an update on the contractual and key performance indicators. He was pleased to note an overall improvement in the referral to treatment performance and reported that the backlog now stood at 533 against a trajectory of 308. He advised that a lot of work had recently been put into reducing the backlog. The Chairman asked if the backlog had increased during December due to the Christmas break as had been predicted. The Director of Finance confirmed that this data was not yet available but thought that it was likely that we would see a slight increase.

He confirmed that the 2 patients who had been waiting for more than 52 weeks had now been treated.

The Director of Finance advised that in terms of diagnostic waits, there were 3 >6 week waits reported at the end of November. The Operating Framework for 2012/13 would allow a tolerance of 1% which is approximately 25 breaches per month and we would currently be performing if assessed against this revised standard.

The Chairman asked why the Cancer graph on page 7 had a low median in the first half but a high median in the second half. He asked if there was a clinical reason to explain the increase 'blip' in September/October. The Director of Finance suggested that the Chief Operating Officer would be better placed to answer his question.
Action: Chief Operating Officer

The Director of Finance advised that in terms of Stroke Care, performance had dropped by 4% in November to 82.1% and remained below the target of 90%. Analysis shows that of the 14 direct admission breaches, 11 were due to appropriate clinical reasons. The other 3 breaches related to process issues. He advised that no other provider in the region has managed to achieve this target in the last 6 months and believe that this is being queried nationally suggesting that it might not be a realistic target.

There had been 2 breaches of the PPCI within 90 minutes of arrival (door to balloon) and 2 breaches of the PPCI within 150 minutes of call (call to balloon) targets in November. Various initiatives had been put in place to help meet the target.

The Director of Finance advised that whilst the recent emphasis had been to focus on reducing the Trust-wide backlog, it was vital to maintain focus on our military contract as well.

The Chairman noted the heavy use of acronyms within the Operational Performance Report and asked that, if they could not be avoided, a glossary be provided to make it easier for the public and the Non Executive Directors to understand.
Action: Chief Operating Officer

Finance:

The Director of Finance advised that the Trust had a £(1.7)m deficit at the end of November which was £(0.8)m adrift of the planned position. This was primarily due to an excess of unfunded activity being necessarily undertaken to meet national requirements in respect of delivering referral to treatment targets and to continue to meet patient needs in respect of acute / emergency work above contracted baseline. The Trust has agreed a financial recovery plan with commissioners for the remainder of the year that agreed an additional £3.7m would be invested by NHS Hampshire and NHS Portsmouth. This means that the cap of £2.75m is still in place but now operates on a higher activity baseline.

He advised that it had been agreed that the necessary funding would be provided to enable us to clear the Referral to Treatment (RTT) backlog.

The Trust's planned year end position is to achieve break-even on income and expenditure. The financial recovery plan and subsequent additional investment from commissioners is designed to support the Trust in achieving this aim. However, November has seen significant pressure placed on the Trust's financial position as the impact of additional workload materialised on the Trust's cost base.

Steve Erskine asked if there was a 'plan B' should the original plan of achieve break even not materialise. The Director of Finance advised that this would be covered more during the private meeting.

The Chairman asked if demand management had had a significant effect on the hospital. The Director of Finance advised that it was difficult to tell as there were so many variables but the success of demand management in the community had been less than hoped for. The Chairman asked for a review of the success, or not, of demand management and for it to be brought to a future meeting.
Action: Chief Operating Officer

Tim Higenbottam asked what effect this years activity levels, being so much above plan, would have on the the baseline for next year. The Director of Finance advised that it provided us with the starting point in negotiations with commissioners for next year. Tim Higenbottam asked if that would also allows the correct staffing level to be set and thus enable a reduction in the need for temporary staff. The Director of Finance confirmed that this would be considered as part of those negotiations. The Chief Executive said that the contract for next year must not be over dependent on the success of demand management.

Steve Erskine noted the slippage of some of the Capital schemes. He asked if the slippage had any impact on patients for example the purchase of new dialysis machines. The Director of Finance said that there were many challenges with the Renal dialysis machine scheme. The reason for the slippage was because the Renal Department had yet to decide on their requirements in terms of dialysis machines. The department was not short of dialysis machines but some of the machines were approaching the end of their natural life. Steve Erskine emphasised the need to plan each years capital spend carefully as our resources are limited. The Company Secretary agreed that the delay was caused by the department's inhability to agree on the specification and not due to the lack of capital available.

Workforce:

The Director of Workforce advised that the overall pay bill had increased in November by £820k to £20.6m. There were several contributory factors that had caused the increase in the pay bill; failed demand management schemes, activity in excess of plan, extra work due to reduce the backlog and an increase in pay banding for some nurses. The total workforce capacity had increased by 147 FTE in November including substantive workforce and temporary capacity. He said that it was critical that the staffing levels be set correctly for next year.

Mark Nellthorp said that he had been surprised to see a decrease in substantive staffing in the Emergency Department and that he was concerned that the spend on temporary staffing within the Medicine for Older People, Rehabilitation and Stroke (MOPRS) CSC, accounted for over a quarter of the costs. The Director of Workforce advised that there was always a struggle to sustain staff within MOPRS. There was work underway to rebrand MOPRS to help make it more appealing as a career for staff. He advised that one of the reasons for the increase in temporary staffing was to appropriately resource the winter capacity. The Director of Nursing advised that the opening of ward E4 had also contributed to the increase in temporary staffing and that this cost was posted against MOPRS CSC. A review of staffing in ward G3 had also resulted in an increase in temporary staffing whilst the review was undertaken.

Alan Cole sought assurance that there was the right balance of temporary and permanent staff in all areas of the hospital at all hours of the day to ensure patient safety. The Director of Nursing said that the Ward Sister would always ensure a certain number of permanent staff and then backfill with temporary staff where necessary. There were 3 bed meetings each day when staffing issues would be discussed and, if necessary, staff would be moved around accordingly to ensure appropriate cover at all times. She advised that the long term plan was to recruit a substantive workforce and to use the minimal number of temporary staff.

The Chairman asked if the Board could be reassured that the correct workforce planning would take place for the next financial year. The Director of Finance replied that it is about agreeing the right level of activity on a monthly basis and having a credible plan in place. He advised that he would ensure that the plans were shared at a future Trust Board Workshop.
Action: Director of Finance

8/12 Foundation Trust Application

The Chairman confirmed that there existed a well-defined time table for submissions and drafts of our Integrated Business Plan. This document was not yet in the public domain but would soon be so.

9/12 Assurance Framework

The Company Secretary advised of 1 new risk identified during the month of November:

- **5.2A** – The Trust fails to achieve the required referral to treatment targets for non-admitted patients and reduce the 18 week admitted backlog.

The scoring for risk 4.2 had been re-assessed and the score had decreased as a consequence.

Tim Higenbottam noted that a lot of new staff had been recruited recently and that seemed to contradict the recent redundancy programme. The Chief Executive confirmed that the Trust would always continue to recruit to business critical posts. The Chairman asked if the number of people recruited could be clearly shown in future performance reports. The Director of Workforce confirmed that it could. The Chief Executive confirmed that this information was already provided in Team Brief and that the slides could be shared to prevent creating extra work.

Steve Erskine felt that the ratings for risks 6.2 and 6.3 seemed relatively low considering the previous discussions. He asked that consideration be given by the responsible executive to a possible increase in score.

10/12 Charitable Funds Update

The report was noted by the Board**.**

11/12 Non Executive Directors' Report

Steve Erskine advised that he and the Company Secretary had recently conducted an interesting walkabout of the recently opened St Mary's Community Hospital and that he had enjoyed a most informative visit to the IPHIS department.

He advised that during the last patient safety walkabout, it had been agreed to make the walkabouts slightly more formal by having a discussion before the walkabout to identify potential problem areas and a meeting afterwards to conclude the findings.

He advised that he had also attended the Volunteers pre-Christmas coffee event. The Chairman considered the Volunteers to be a vital part of the organisation and made an invaluable contribution. He suggested that some of the volunteers be invited to a future meeting to make the Board aware of some of what they do.
Action: Company Secretary

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

A member of the public advised that he had noted a significant improvement in people's attitude towards the hospital over the last few years and commended the staff and the Board for their hard word.

Mark Nellthorp agreed saying that he regularly travelled by taxi to Queen Alexandra Hospital and frequently received feedback from taxi drivers recognising a significant improvement in people's attitude towards the care that they had received.

Jim Harris, Hampshire LINk advised that certain trends were discernible within the feedback that he received about Queen Alexandra Hospital. The most common concern was in the care received after being discharged from the hospital. He asked if anything could be done with local councils to ensure that this issue was resolved. The Director of Nursing confirmed that care in the community was recognised as an issue nationwide. The Chief Executive advised that it had been recognised by all external partners that there was a need for improvement. The Chairman confirmed that significant ring fenced funding had recently been given to Local Authorities across the country to address this particular issue.

13/12 Any Other Business

There were no items of any other business and the meeting closed at 13.00pm

14/12 Date of Next Meeting: 2 February 2012

Venue: Lecture Theatre, Education Centre E Level, Queen Alexandra Hospital