Portsmouth Hospitals NHS
NHS Trust

Trust Board Meeting in Public

Held on Thursday 29 March at 11:00
Oasis Centre
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
	Cherry West	Chief Operating Officer
	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
	Susanna Kayley	(Minutes)
	Paula Taylor	Volunteer Inclusion Manager
	Glen Hewlett	Director of Development and Estates
	Alistair Glen	(observing)

Item No **Minute**

30/12 **Apologies:**

Apologies had been received from Ursula Ward, Chief Executive.

Declaration of Interests:

There were no declarations of interest.

31/12 **Minutes of the Last Meeting – 2 February**

The following amendments were noted from the minutes of 2 February 2012:

Agenda item 24/12, page 7, 1st paragraph – to read 'The Director of Nursing said that this had been designed…..'

Agenda item 25/12, page 9, 2nd paragraph – to read 'charitable funds had declined……

The minutes were then approved as a true and accurate record.

32/12 **Matters Arising/Summary of Agreed Actions**

197/11 – Foundation Trust Application – It was confirmed that the process was in train and that final versions of the necessary strategy documents would be sent to the Strategic Health Authority on 30 March 2012.

7/12 – Finance – The Chief Operating Officer updated and confirmed that an analysis of

demand management was being carried out and would be shared at a future meeting.

11/12 – Non Executive Directors' Report – This item has been completed.

23/12 – Assurance Framework – The Company Secretary confirmed that an internal audit had recently been concluded resulting in some recommendations. These, along with the recommendations from Steve Erskine, would be incorporated into the Assurance Framework.

33/12 Notification of Any Other Business

There were no items of any other business.

34/12 Chairman's Report

The Chairman advised that the Health and Social Care Bill had now received royal assent and had now become the Health and Social Care Act 2012. He believed that the Trust would have to think very radically about the services it provides in what would be a very fundamentally different NHS.

35/12 Chief Executive's Report

The Chief Operating Officer spoke in the Chief Executive's absence. She advised that as a consequence of the Winterbourne Care Home Panorama programme in 2011, it was expected that there would be a number of reports linking quality, patient safety and value for money. It is likely that these would be critical of current regulation and monitoring and point to the need for the NHS to be more rigorous in ensuring patient safety. As a result it is likely that more "Patient Led" Inspections will occur as it is considered that patients are more likely to spot warning signs.

The Chief Operating Officer stated that Dementia was now considered a national priority. There was concern nationally that the service does not get the attention it deserves. The Trust needs to review its Dementia Strategy and refresh it if required. This needs to be linked to the workforce plan as there is a need to get the right (properly trained) workforce in place to deliver the Service.

She advised that Academic Health Science Centres are a partnership between one or more universities and healthcare providers focusing on research, clinical services, education and training. It is intended that these centres would be established to ensure that medical research breakthroughs lead to direct clinical benefits for patients. A paper is due to be published at the end of March which will set out the way forward and will describe the relationship with the emerging Local Education and Training Boards. The key to success will be ensuring that all partners are equal and that no organisation is disadvantaged. The organisational structures that comprise an Academic Health Science Centres can take a variety of forms, ranging from simple partnerships to, less frequently, fully integrated organisations with a single management board.

In closing she confirmed that Improvement and Transformation will be led by the NHS Commissioning Board, which will be led by Jim Easton. A single Improvement Model will be used across the NHS and a single improvement body is being formed from over 50 NHS bodies currently involved in innovation and transformation. This was not a recreation of the Modernisation Agency.

The big issues which will be addressed include:

- Controlling input costs
- Driving provider efficiency
- Changing the pattern of delivery i.e., out of hospital care

36/12 Integrated Performance Report

Quality:

The Director of Nursing confirmed that there had been no cases of hospital acquired MRSA bacteraemias for February against a monthly trajectory of 0. Thus, the year-to-date position at the end of February was 5 cases against a trajectory of 4. There had been 2 cases of hospital acquired C.Difficile recorded in February 2012 against a monthly trajectory of 5. The Trust C.Difficile action plan continues to be implemented to ensure a sustained improvement in the prevention of and treatment of patients with C.Difficile. The Chairman asked if these targets could be reduced further. The Medical Director stated that some Trusts have a lower target than that of Portsmouth and are able to achieve them, however Portsmouth Hospitals NHS Trust has more high risk areas, for example NICU.

The VTE risk assessment figure for February was 92.9% (subject to validation). The Trust had achieved a quarter 3 figure of 92% compliance and was on track to achieve the quarter 4 target of 90%.

In February, the Trust had a total of 16 confirmed Serious Incident Requiring Investigation (SIRI's), 4 of which were VTE incidents, 9 confirmed pressure ulcers and 1 grade zero pressure ulcer incident. 1 grade zero pressure ulcer incident was reported in January, the Trust was still awaiting PCT review to confirm whether this was to be classified as a SIRI.

3 amber and 2 red falls incidents were reported in February, against a trajectory of 2. To date, the Trust has had a total of 31 incidents (5 red and 26 amber) against a trajectory of 39 and is therefore, on target to achieve compliance with the year end target. There had been a noticeable increase in amber events in November and December and this had occurred again in February. Although on target to achieve a 10% reduction in falls incidents based on 2010/11 outturn, this increase has meant that the Trust has exceeded its monthly trajectory targets for November, December and February.

The Chairman asked that reasons explaining why figures had increased or decreased be included within future Quality reports.
Action: Director of Nursing

Liz Conway, following a presentation that she had attended at the Safety Working Group asked if the Trust was reviewing pneumonia management. The Director of Nursing replied that nothing had yet been finalised and that this was being followed up with Fiona McNeight, Head of Governance.

Steve Erskine asked if any themes had been identified from the increase in numbers for both safeguarding incidents and falls within the report. The Director of Nursing confirmed that there had been increased training for safeguarding and as a consequence staff were more aware of this and more checks were being carried out. Falls appeared to continue to be an issue mainly due to the increased numbers of people being admitted and the increased pressure this put on nursing staff. The Director of Finance stated that the Trust had invested in more hi/lo beds and falls monitoring equipment to assist with this. Tim Higenbottam stated that, following the Patient Safety Visits, he had suggested that the introduction of CCTV in those high risk areas might be beneficial.

The Chairman asked for an update on the sewage leak issue. The Director of Finance confirmed that a programme of works was underway with investigations currently being carried out, including testing of the gradients within the pipes. Once this had been completed a rectification programme would be devised. The Board repeated its concern and asked that it be kept fully informed of progress.
Action: Director of Finance / Company Secretary

Operations:

The Chief Operating Officer advised that Month 11 performance as it would apply for Foundation Trust against Monitor's Compliance Framework would be rated 2.5: Amber-red. This represents material concerns surrounding authorisation but remains an improvement on the previous month due to the achievement of the referral to treatment standard for admitted 18-week pathway.

Emergency Department Quality Standards

Arrival to assessment – Reported performance against the arrival to assessment standard deteriorated in February (27 minutes against a standard of 15 minutes). The Chief of Service and the General Manager for Emergency Services have put together an action plan. A component of this includes defining the care pathway and the roles and responsibilities of key individuals involved in delivering the care pathway to ensure the ED quality standards are met.

ED >4 hours – Performance for February was 90.36% against the standard of 95% and below target for the second time this year. Year to date performance is 95.76%. The Chief of Service and the General Manager for Emergency Services have put together an improvement action plan. This plan covers 7 workstreams to support capacity, processes and workforce alignment to delivering a care pathway that is designed to achieve all quality metrics.

Two key factors had resulted in much higher than expected breaches. Attendances in January and February were 9% up compared with the same period last year and the number of medically stable patients occupying hospital beds had frequently been above 70. These two factors had increased the numbers of 'wait for assessment' breaches and 'wait for a bed' breaches.

Non-admitted performance – The Trust significantly improved on non-admitted performance in February (92.9% compared with 77.7% for January), although remains below the standard of 95% non-admitted patients starting treatment within 18 weeks. Work continues at specialty level to reduce out-patient wait times by undertaking additional out-patient activity. Specialties have plans in place to achieve 95% in March.

Admitted backlog >308 – The admitted backlog size had increased in February (562 compared with 361 in January). This was as a consequence of increased numbers of >18 week wait patients to the waiting list (as specialties worked on reducing their out-patient wait-times) and increased cancellations in February due to emergency pressures; backlog size has been maintained at this level. We were achieving the aggregate position in most areas but some specialties were struggling including Orthopaedics.. The Waiting List Assurance Group is currently undertaking modelling to look at how the Trust might reduce backlog in high risk specialties and achieve 90% at Trust aggregate. The Trust would then seek support from the Commissioners to the non-achievement of 90% in specialties like Orthopaedics for up to six months whilst these specialties continue to reduce their backlog. The Chief Operating Officer sought Board approval for this approach. It was agreed to discuss further offline as the Board required further detail, this would be provided and then discussed at the Board Workshop on 5 April 2012.

Action: Chief Operating Officer

Mark Nellthorp asked if the slippage in the arrival to treatment time waits were due to capacity issues or because there was not enough senior staff on duty to deal with them. The Chief Operating Officer replied that large numbers of patients were attending in the afternoon or out of hours, with 45% coming in between the hours of 7pm to midnight. There seemed to be no common theme.

Steve Erskine asked what would make this ED >4-hour action plan different from previous plans. The Chief Operating Officer confirmed that the General Managers were now the

leads and a progress report would be given to SMT on a regular basis so there would be greater accountability than there had been with previous plans.

Finance:

The Director of Finance highlighted the key points from his previously provided paper. He advised that the Trust had a £(1.35)m deficit at the end of Febuary which was £(1.15)m adrift of the planned position.

Cost reduction efficiency "Savings" achieved at the end of month 11 totalled £22.4m compared to the planned position of £27.2m. This figure includes demand management schemes. Internal Trust savings are £22.1m vs. £22.4m adverse by £ (0.3) m year to date. This was however offset by the significant shortfall in performance against the cost reductions associated with demand management schemes which was currently £ (4.5) m.

The Trust is still targeting a break-even year end position in line with the ongoing recovery plan and subsequent additional investment agreed with PCT's. There remain significant risks regarding the achievement of this plan.

He advised that the Department of Health had recently visited the Trust regarding the Trust's Inventory Management System and had been most impressed.

Workforce:

The Director of Workforce highlighted key points from his paper and confirmed that the overall paybill (all pay elements) had increased by £140k to £20.9m in February. The cumulative paybill was £221m, compared to a plan of £211m, and was therefore £10m greater than the planned position for February 2012.

The adverse variance in the cumulative paybill was mitigated by considerable additional activity delivered in the first 10 months of the year (£9.6m including additional PCT funding, £12.7m excluding additional PCT funding). Unsurprisingly, this had resulted in additional workforce costs being incurred. The planned reductions in workforce expenditure had included £5.5m demand management savings in workforce, however this has not been fully implemented and therefore associated reductions in workforce costs had not been possible, as previously described.

Substantive workforce expenditure (i.e. NHS and Military) had increased by £81k, to £19.1m in February. The cumulative substantive paybill was approximately £2.2m above the planned position for February. This increase relates to increases in substantive staffing as vacancies are filled, particularly in Theatres, Emergency and Medicine.

Temporary workforce expenditure (i.e. combined bank, agency, and all premium payments) increased by £59k to £1.81m in February. Expenditure had increased in Emergency, Medicine and MOPRS, particularly within nursing and medical staff. Other increases have been Clinical Support, relating to vacancies; Head and Neck, due to backlog; and Renal, due to sickness absence.

The Director of Workforce confirmed that the Workforce Plan for 2012/13 would be more robust and would enable more effective performance management. There would also be a rolling recruitment plan in place which would mean that more proactive recruitment could occur.

He advised that Portsmouth Hospitals NHS Trust was the best performing Trust within the Strategic Health Authority area in terms of sickness rates, which was very positive. Mark Nellthorp asked if sickness related to permanent staff only and the Director of Workforce stated that it did. He was confident that the Trust could further improve on this to around 3%.

37/12 Quarterly Governance Compliance Report

The Director of Nursing confirmed that the Trust had received the final review of compliance report from the Care Quality Commission on 8 March 2012. This follow up inspection had been focussed on outcomes 1, 4, 5 and 9. The full report had been published on the Commission's website on 14 March 2012. The Trust action plan had been submitted to the Care Quality Commission and would be monitored monthly through the Governance and Quality Committee.

She advised that the Trust was currently negotiating the Quality Indicators that would be included within the 2012/13 Quality Contract. Once agreed, the requirements would be monitored locally by the appropriate Clinical Service Centre, and centrally through the Governance and Quality Committee. Compliance will be reported to the Board through the quarterly Quality Board report.

She advised that the Trust had undergone an unannounced visit from the Care Quality Commission on 21 March 2012 to specifically look at Trust policy and procedures regarding terminations of pregnancy. She was pleased to advise that the Trust were found to be fully compliant.

38/12 Foundation Trust Application

The Chairman updated on progress so far and confirmed that the Trust was examining the possibility of bringing forward its application to become a Foundation Trust resulting in an earlier authorisation date. He believed that a realistic contract for the forthcoming financial year was crucial for a sustainable long term financial future. Consideration of the extra pressure an accelerated application might place on staff also had to be taken into account. A final decision had yet to be taken and further discussion was to be held at next weeks Board Workshop.

39/12 Assurance Framework

The Company Secretary highlighted key points from his paper. He confirmed the removal of risks 2.1, 3.2, 3.3, 3.4, 4.1, 5.2, 5.2A, 5.3 and 5.4, the increase of risk 5.1 to a risk score of 9 and the decrease of risks 1.2 to a risk score of 9, 1.3 to a risk score of 12 and 5.5 to a risk score of 6. He advised that all of the risks that were being removed other than risk 2.1 were being reviewed at the end of the financial year and that they were likely to re-appear in a form that illustrated the risk to the new financial year. The Company Secretary reassured Steve Erskine that none of the key issues would be lost during the review.

40/12 Carbon Reduction Strategy

Glen Hewlett, Director of Development and Estates, advised that the NHS Carbon Reduction Strategy for England set out a framework for NHS Trusts to develop and deliver a low carbon NHS while ensuring provision of high quality healthcare services. There were two elements to the work being undertaken; the success in one (Carbon Reduction Commitment – CRC) would directly impact on the Carbon Footprint contributing to achieving that centrally set target reduction.

<u>Carbon "Tax" (Carbon Reduction Commitment - CRC)</u>

Currently the carbon tax was focused on energy used within our building. Reducing the organisations consumption of energy and emissions of CO^2 would be the only way to mitigate against the financial implications of the ever-increasing cost of energy and the introduction of this new carbon tax.

Carbon Footprint

Good progress had been made since the Trust Board last considered the draft strategy in July. The energy reduction, water usage reduction and waste disposal reduction show gains above the straight line reduction required to achieve a 10% reduction in the Trust Carbon footprint. It was therefore proposed that these targets be stretched to achieve a 14.2% carbon footprint reduction by 2015/16.

Mark Nellthorp asked why the hospital was always so hot and did this not have a huge impact on the Trust's carbon footprint. Glen Hewlett advised that temperature management was more effective in the new part of the hospital and would improve elsewhere as the older areas were refurbished.

The Board noted the update to the Carbon Reduction Strategy and fully supported the strategy moving forward.

41/12 Volunteers

The Chairman introduced Paula Taylor, Volunteer and Inclusion Manager, who was in attendance to describe the role of volunteers within the hospital. Paula Taylor confirmed that the Trust had a total of 806 volunteers with a further 150 waiting to be processed, this involved CRB checks, essential skills training and attending the Trust Induction Programme. An increase had been seen in younger volunteers; unemployed people and people with learning disabilities.

Three volunteers were in attendance and talked about their roles and experiences as a volunteer. The Chairman thanked the volunteers for their outstanding contribution to the Trust and asked them and Paula Taylor to extend his, and the Board's, sincere thanks to all of the volunteers within the Trust.

42/12 Company Seal

The report was noted by the Board.

43/12 Charitable Funds Update

The report was noted by the Board.

44/12 Non Executive Directors' Report

Steve Erskine advised that this was the first formal briefing to the Board on the findings from the Patient Safety Walkabouts that had taken place during January and February 2012. This was a high level summary of findings and there were detailed action logs produced from each walkabout. Actions were managed and monitored within the relevant Clinical Service Centre (CSC). The Chief Operating Officer asked if the action plans could be provided so that they could be included in the monthly CSC performance reviews. Tim Higenbottam asked that a column be added showing the date by which the actions were expected to be completed.
Action: Company Secretary

45/12 Opportunity for the Public to ask questions relating to today's Board meeting

A member of the public asked for clarification regarding the screening of local vascular patients as he understood that they were not currently screened. He also sought assurance regarding Queen Alexandra Hospital's Vascular clinical outcomes. The Medical Director advised that all patients were screened, although this was not carried out at Queen Alexandra Hospital. With regard to the clinical outcomes, the Medical Director stated that information had been presented which had only looked at data from a very short period. This gave a misleading impression that Portsmouth Hospitals NHS Trust

had worse outcomes than it actually did. Looking at data over a longer period of time proved that Portsmouth Hospitals NHS Trust had very good outcomes. The member of the public was most grateful for the explanation and promised to share it with others.

46/12 Any Other Business

There being no other items of any other business, the meeting closed at 13:40pm.

47/12 Date of Next Meeting:

Thursday 26 April 2012 11:00am

Venue: Oasis Centre, Queen Alexandra Hospital