The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust

Board of Directors' Meeting (In Public)

Minutes of the Board meeting held on 25th March 2013
in the Conference Room at The Queen Elizabeth Hospital, King's Lynn

Present:

K Gordon (KG)	Chair
P Wright (PW)	Chief Executive
S Green (SG)	Non-Executive Director (Chair of Performance & Standards Committee)
V Holliday (VH)	Non-Executive Director (Chair of Quality & Risk Committee)
A McCallum (AMc)	Non-Executive Director (Chair of Charity & Remuneration Committees)
I Pinches (IP)	Non-Executive Director (Chair of Audit Committee)
S Haney (SH)	Non-Executive Director (Chair of Finance & Investment Committee)
B Cummings (BC)	Director of Planning and Performance
G Wilson (GW)	Director of Nursing and Acting Director of Clinical Services
D Stonehouse (DS)	Director of Resources
M Blunt (MB)	Interim Medical Director
L Proctor (LP)	Director of Strategy & Transformation

In attendance:

G Rejzl (GR)	Company Secretary
H Milne (HM)	Corporate Governance Officer (Minutes)
V Scott (VS)	Deputy Director of Communications

ACTION

31/13 1. CHAIR'S WELCOME

The Chair welcomed the Board attendees and members of the public to the meeting.

32/13 2. CLINICAL PRESENTATION - Organisational Readiness for the Implementation of Revalidation

2. Appraisal Revalidation to Trust

Dr Siva Kumar delivered a presentation to the Board on the purpose of revalidation of doctors and the process for implementing revalidation in the QEH. Although planning was well in hand, Dr Kumar advised that the following issues remained to be addressed:

- Appointing and training a new responsible officer (RO) from 1 April 2013. **It was agreed that Dr Hunnam be approached regarding the**

extension of his RO role for a period of time. **PW**

- Improving the quality of data provided for medical staff as part of the revalidation process.
- Working with the BMA and local LNC to complete work on the Trust's policy on reskilling and remediation.
- Working with PGMEC to provide the Deanery with relevant information.
- Supporting improvements in doctors' training in the Trust to help towards their revalidation.
- Adapting the GMC Revalidation Governance Handbook Checklist and fulfilling all the recommendations by the GMC.

Following questions from the Board, PW commented that revalidation was a good process and the Trust must make it happen effectively. The observation was made that the process had been in place in general practice for some time and that there was much that could be learned from that experience.

The Chair thanked Dr Kumar for his presentation and requested that the Board be kept up to date with progress. **It was agreed that MB would inform the Board of any issues to which revalidation might give rise**. **MB**

33/13 3. ATTENDANCE AND APOLOGIES FOR ABSENCE

MH was absent through illness.

34/13 4. MINUTES OF THE PUBLIC BOARD MEETING HELD ON 25th FEBRUARY 2013 AND MATTERS ARISING

The minutes were agreed as an accurate record of the meeting. There were no matters arising.

35/13 5. ACTIONS MONITORING

The Board reviewed and updated the Actions Monitoring Record. Items 158, 165 (2012) and 1, 2, and 4 (2013) were agreed as complete and removed from the record.

36/13 6. DECLARATIONS OF INTEREST

None.

37/13 7. URGENT MATTERS

None.

STRATEGIC

38/13 8. CHAIR'S REPORT

The Chair advised the Board that:

- The process of recruiting a successor for SG, whose term as a NED ceases at the end of May 2013, had been launched by the Governors. The Board was asked to encourage anyone they may know who would be suited to this role to apply: a candidate brief was available .

- A meeting had been held with the Values Council and Board colleagues to discuss values – the outcome would be reported later in the meeting.
- PW and KG had attended a meeting with West Suffolk NHS FT whose issues around sustainability were similar to those of the QEH. This had been useful exchange and it was evident that the WSNHSFT was thinking on similar lines to the QEH on developing partnerships and joint working initiatives.
- PW would be joining the Kings Fund learning set on sustainability of small and medium sized DGHs from the end of April.

The Board noted the Chair's update.

39/13 9. CEO's REPORT

PW presented her report to the Board, advising that:

- Following the recent feedback session from the TMI work, a lot had been learned in terms of simplifying the journey through the hospital for patients. The Board would be involved in following up those actions as would the various patient experience groups.
- Two excellent senior appointments had recently been made and areas where it had proved difficult to recruit in the past now seemed to be attracting good candidates.
- The Trust was currently a member of both the FTN and the NHS Confederation; a decision should be made on whether both should continue.
- The Board was asked to note the letter received from D Nicholson, NHS Chief Executive & Chief Executive of the NHS Commissioning Board, which was attached to the report.
- The Board was advised that changes to the NHS constitution would take effect from April 2013 and other changes would be ushered in from the same date as a consequence of the Health and Social Care Act 2012.

The Board noted the CEO's update.

OPERATIONAL

40/13 10. PERFORMANCE REPORT

The Board discussed the performance dashboard, identifying performance to February 2013 against the Trust's KPIs, the forecast for the year ending in March 2013, and key risks to operational performance. The Monitor compliance framework position for Q4 was forecast as 1 (Amber / Green) due to failure to meet the A&E four hour waiting time standard.

The Chair asked Board members to focus in particular on areas where performance was off track.

Quality and Risk

Emergency Pathway

Difficulties in meeting the A&E 4 hour emergency standard were beginning to affect activity in the rest of the hospital, including in some specialties the 18 week RTT position..

Mortality Rates

MB advised that the QEH RAMI was below average but at or around average for SHMI. The position was just satisfactory, but required careful scrutiny. The Clinical Outcomes Group would be involved in doing so, reporting to the Clinical Governance Committee any alerts that might come through.

The importance of monitoring all four mortality targets was stressed. Though the Trust had not met its internal targets in the year, performance on mortality had generally been good and on a par with its peer groups.

Pressure Ulcers (PUs)

Although a number of patients were coming into the organisation with PUs, there were currently no grade 4 PUs reported within the Trust. Work was ongoing and staffing levels were being closely monitored to ensure that any signs of PUs were not missed.

Hospital Acquired Infections

The Board was advised that the Trust is in a significantly stronger position than a year ago. The Trust reported 0 MRSA infections in February; the YTD figure remaining at 0.

VH enquired if Norovirus could be reported on in more detail. GW informed the Board that tests were carried out only when a patient was showing signs of the virus. Data showing the rigorous way the Trust was addressing the issue would be presented at a future meeting. PW commented that she was impressed by how well the Trust contained and controlled this situation.

Patient Experience

KG advised that the WNCCG continued to focus on patient experience, particularly the FFT.

GW reported that the Trust had had clearance on its FTT process following an inspection by the DoH. A new provider had been engaged from 1 February to analyse the FFT data and were able to include space for patients to leave free text comments. It was not yet clear how the National FFT scores would be calculated or what the targets would be.

In order to better communicate the FFT to patients, posters had been put up around the hospital and leaflets distributed in order to raise the profile of the survey. Staff in all departments were being made aware of the FFT scheme and how the Trust would be assessed via the survey feedback.

Complaints

Although no trend was clearly apparent, the indicators showed an increase in the number of clinical complaints: EDs had been tasked to review these. Of the 60 formal complaints received in February 2013, a total of 86 issues were raised including poor communication, cancelled surgery and staff attitude. There were no non clinical complaints.

PW observed that complaints were sometimes received regarding events of some months or years previously. These were difficult to manage as staff might have moved on and details were difficult to obtain. Plans for a real time

feedback system were going ahead. It was suggested that NEDs might see a sample of complaints and become involved in the complaints process to establish how they were handled. **KG undertook to follow this up.** KG

Workforce

DS advised that current sickness absence levels were high and the pressure of those absences was affecting performance. The process of following up cases of long term sickness absence was being adhered to and there had been improvements in nursing staff returning to work.

The Board discussed the difficult situation on nurse recruitment. A recruitment drive to appoint up to 60 nurses from Portugal was taking place. Other actions would follow. Fairs were taking place throughout the UK and the QEH is registered to attend these, although there was only a small 'pool' of registered nurses for every organisation to draw from. Other initiatives around local recruitment were progressing and 10 newly qualified nurses began employment in March. In addition agency nurses are being sourced when available.

The Board reflected on the need for the Trust to be proactive in better understanding its nursing requirements and improving its forward planning. Because of the focus on recruitment and retention, the situation with regard to completion of appraisals was worsening. DS advised that in order to rectify the position, the HR team was carrying out urgent work to establish when appraisals would be carried out. Appraisals were an important staff retention tool and their impact should not be overlooked. The same was true of training; under pressure of work staff found less time for completing training, which could have long term detrimental effects.

Performance and Standards

Performance since the end of December 2012 had deteriorated, with Q4 being very poor months. The A&E target – in effect the emergency access target - affected flow throughout the system. The issue was one of capacity, not an increase in activity. Escalation capacity had been opened wherever possible, but the constraint of nurse numbers limited what was possible within safe parameters.

LP advised that the hospital had been very busy over the previous weekend stretching physical capacity to its limits made more difficult by staff going off sick during the day.

In discussion, it was noted that all the resources of the EDs were being directed to resolving the issue, in collaboration with WNCCG, social services and community providers. However at any one time there was a cohort of patients who no longer needed to be in an acute setting, and a significant number in excess of 14 days.

Maintaining quality of care was critical in pressured conditions, and decisions were being taken with this factor as a priority. Although nurses shift patterns had changed, this had been done to improve patient care by ensuring continuity and better handover procedures.

Dedicated IT support had been secured for A&E together with a manager to oversee and support the department. Work was underway with care homes to reduce the need for them to carry out their own assessments before a patient

returned home. Clinical directors were undertaking reconfiguration of the assessment units. BC said that in A&E an additional 230 patients had attended compared to the same period last year.

KG said the Board appreciated the fact that clinical, managerial and support staff were under considerable pressure at the present time. PW asked for thanks to be noted to the directors and consultants in attendance in the Trust during weekends, and IP said the Board should recognise the effort and commitment on the part of all staff, including EDs. GW was thanked for her report analysing the complex factors affecting the present flow situation and the steps being taken in response.

AMc commented that the Board needed to focus on what it should do at a strategic level. With the Trust having to put all its effort into handling immediate operational problems, strategic issues were taking second place; this could not be a sustainable position.

DS commented that while this was true, short term pressures were severe and compounded by the fact that commissioners were still finding their feet. For the future the Trust had to have a better understanding with them about capacity need in view of the changing demographics of the area and the likelihood that pressure on the system would continue to grow year on year.

LP advised that three strategic options were under examination that held out the possibility of easing the situation in the longer run:

1. Healthcare at home;
2. Pilots on 'telehealth', drawing on experience in Airedale;
3. Capacity issues in the wider community.

PW reminded the Board that it should not lose sight of the work being done in POD 19 which was designed to secure a long term solution to emergency flow problems.

Turning to other indicators, the DNA rate was currently below the nationally reported figure of 10% but slightly above the local target of 5%. 70% of the Trust's services were now available through Choose and Book.

Performance on the 18 weeks target (specifically admitted RTT) had been affected by the patient flow issues experienced by the Trust; this would have an impact in the new financial year. The Board was advised that the Commissioners were aware of the position and negotiations were currently underway to establish where these patients can be slotted in.

There had been restricted admission to the stroke area in February because of norovirus infection on the unit, but this was a one off situation which had resolved.

Finance

DS highlighted key points for February as follows:

- For the month the Trust achieved an EBITDA margin of 1.4% (£186k) against a planned EBITDA margin of 4.2% (£560k), an adverse variance of 2.8% (£374k).
- For the month the Trust reported a net loss of £436k against a planned net

loss of £67k, an adverse variance of £369k.

- During February, bed capacity pressure to support emergency care had resulted in non-urgent elective admissions being cancelled. The consequence was elective in-patient activity below plan by 88 spells, (£335k).
- In the month the Trust scored an FRR of 1 against an expected FRR of 2 with a possible FRR for 2012/13 of 2 against a planned 3.

DS advised that the downside position was worse than that presented in February 2013 because of the difficulty of retrieving activity. However, there had been positive discussions with Commissioners on the level of penalties on A&E performance. Concerns were raised regarding the run rate for early next year if the Trust could not break out of the current cycle quickly. It was vital to deliver improved performance in Q1 of the new financial year.

The Board:

Reviewed performance across the Trust and signed off the performance report; Noted the Monitor compliance framework position at the end of the current quarter was 1 (Amber/Green) due to failing the A&E 4 hour standard.

QUALITY

41/13 11. THE TRUST'S VALUES

The Chair invited the Board to agree the draft Trust values which had been drawn up following discussion with members of the Values Council. These were:

- We are dedicated to providing safe, quality and individualised care.
- We treat all people with respect, kindness and compassion.
- We display courage in our actions.
- We innovate, and embrace new technologies.
- We value all staff equally and see teamwork as the basis of high quality care.
- We are open and honest in our relationships with patients, families and colleagues.
- We listen to learn.

Once adopted by the Board, the roll out of the values would be undertaken in conjunction with the Values Council.

The Board agreed the revised set of values.

42/13 12. RESPONDING TO FRANCIS

The Board considered a report from a study day held at the King's Fund. This would be an input into the QEH response to the Francis report which was being prepared by GW and MB.

The Board noted the briefing paper.

43/13 13. CQC SELF-ASSESSMENT OUTCOME

Board members had taken part in a comprehensive self-assessment against CQC standards, and the outcome was presented to the full Board. The overall CQC compliance position emerging from this work showed that the Trust assessed itself as compliant (rag rating green) in 15 of the 16 (1-2, 4-14, 16-17) essential CQC standards, with one standard (21) registering as a moderate concern (rag rating amber).

The Board was advised that following endorsement of the compliance position, the Trust would make a Statement of Compliance on its website and use the report produced from the self-assessment as supplementary evidence. KG invited BC and GW to proceed with the Statement of Compliance.

The Board endorsed the CQC compliance position following the self-assessment.

RISK

44/13 14. RISK REGISTER ≥ 20

The Risk Register was presented to inform the Board of the operational risks scoring 20 and above.

Risk 941 was identified as a financial risk – 'failure to deliver the surplus for the required investments'. The risk had been reviewed and reflected the difficulties that the Trust was experiencing.

Controls were in place to mitigate this risk including close weekly monitoring; however there was potential to go into deficit and the planned surplus was unlikely to be delivered.

The Board noted the risk articulated on the risk register and the mitigations.

GOVERNANCE

45/13 15. REGISTER OF DIRECTORS' INTERESTS

The Board was requested to advise any changes and forward to Helen Milne in order for the model to be updated.

The Board reviewed the register.

Date of **Next Public Board Meeting – Tuesday 28th May 2013** in the Conference Room @ 9.00 a.m.

SPECIAL RESOLUTION

The Board resolved that members of the public be excluded from the remainder of the meeting, having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest

There being no further business, the meeting closed at 11.40 the Chair thanking attendees for their contributions.