Board of Directors Meeting (In Public)

Minutes of the Board meeting held on Monday 28th November 2011 at 9.00 am in the Conference Room at The Queen Elizabeth Hospital, King's Lynn

Present:

K Gordon (KG)	**Chair**
J Hillier (JH)	**Non-Executive Director and Vice Chair**
S Green (SG)	**Non-Executive Director (Chair of HGC)**
S Haney (SH)	**Non-Executive Director (Chair of Finance Committee)**
N Harrison (NH)	**Non-Executive Director (Chair of Audit Committee)**
P Davis (PD)	**Non-Executive Director**
V Holliday (VH)	**Non-Executive Director**
P Wright (PW)	**Chief Executive**
M Henry (MH)	**Deputy Chief Executive**
G Hunnam (GH)	**Medical Director**
G Wilson (GW)	**Director of Nursing**

In attendance:

B Cummings (BC)	**Director of Performance and Informatics**
J Bate (JB)	**Director of Human Resources and Organisational Development**
L Proctor (LP)	**Interim Director - Integration**
F Rose Smith (FRS)	**Interim Director of Operations**
G Rejzl (GR)	**Company Secretary**
R Pearson (PR)	**Deputy Director of Finance**
L Taylor (LT)	**Infection Prevention and Control Nurse**
L Fretwell	**Corporate Governance Officer**

410/11 1. PATIENT STORY **Action**

Director of Nursing, GW, introduced colleagues Karen Brackley (KB) and Anish Thomas (AT)

KG of Newton Rehab. introduced the patient story, which concerned a patient's experience of the Trust's Stroke services.

Patient 'Mr Smith' spent 3 weeks in the QE after being brought to A&E by a paramedic team following a suspected stroke. Staff from the stroke ward were on hand very quickly and Mr Smith was thrombolysed with a blood thinning infusion.

Mr Smith reported his patient experience.

Positive:

- Very happy overall
- Good communication
- Friendly, respectful staff
- Good information
- Good meals and help with eating when required

Areas for improvement:

- Too long to answer call bells at times
- Only saw consultant twice during a 3 week stay
- Felt insecure on the ward at night
- An upsetting comment by an OT

Anish Thomas explained to the Board that the QE had been offering thrombolysis for 2 years and that the service had only gone 24/7 recently: so far, the service was developing well.

Anish Thomas reported that in respect of those areas for improvement identified through Mr Smith's feedback, the following actions had been taken:

- More staff helping at mealtimes
- Prompter response to call bells – RCN leadership programme and proactive communication with patients and relatives
- Consultant visited patient more than twice in 3 weeks. Communications issues being explored
- Communications – patients reassured that the hospital is secure at night
- Complaint regarding OT comment dealt with

KG asked about the pressures of development of the stroke service to 24/7 provision. It was explained that the service had been running 24/7 for approximately 6 months and that the key issue was the need to have a band 6 available by 'bleep' at all times. This was an increased pressure for managers in respect of resource and rota management. Although there were some peak workload periods, the service was coping well generally and there were enough staff available at night.

Following a query, it was confirmed that Mr Smith had spent his entire 3 week stay on the Stroke Unit. SG welcomed the proactive approach to communications with patients and relatives and queried whether this was happening across the hospital. GW confirmed that the learning and new practices are being disseminated across the organisation in line with RCN initiative methodology.

VH queried the issue concerning how many time the patient had been seen by the consultant during the stay. It was confirmed that the consultant had visited twice a week. It was however acknowledged that if the patient had perceived that he had only been visited twice in 3 weeks, then there was clearly some communication work to do.

KG thanked colleagues for their presentation.

411/11 3. WELCOME AND APOLOGIES

The Chair welcomed members of the public to the meeting, including Cllr Gary Sandell from the Health Overview and Scrutiny Committee.
KG also welcome newly appointed Chief Executive Patricia Wright to her first Board meeting.

Apologies were received from D Stonehouse.

412/11 4. MINUTES OF THE LAST TRUST BOARD MEETING HELD IN COMMITTEE ON THE 24th OCTOBER 2011, ACTIONS MONITORING AND MATTERS ARISING

The minutes were subject to amendment;

423/11 "Review the scope for marginally reducing bed numbers ~~in Stanhoe"~~ add "… across the Trust"

376/11 replace "West Norfolk Community Care" with "Norfolk Community Heath and Care (NCH&C)" and "Cambridgeshire" with "CAMS"

Subject to the amendments being made, the minutes were agreed as an accurate record of proceedings.

In respect of matters arising and actions monitoring, it was confirmed that Smoking Shelter plans were progressing and that the topic would only be discussed again at Board if any exceptional issues arose.

KG explained that discussion had been held with JB and PW concerning a review of the whistleblowing policy. It was noted that the revised process was likely to involve a NED.

JH requested that the Organisational Behaviours and Values work be represented at Board for further discussion. She felt that due to a heavy agenda in October, the Board did not devote enough time to this item. **It was agreed that the paper would be represented with progress updates in January 2012.** **JB/GW**

SG queried what the HGC could do to support the Trust's work in delivering the CQC Action Plan. It was explained that due to the importance of the issues arising from the assessment visit, the Board had decided to keep the monitoring of the delivery of the actions at Board level for the time being. PW stressed the importance of avoiding duplication of work. GW added that the HGC had in any case a remit to oversee compliance against all CQC essential standards.

In response to a further query from SG, **BC undertook to provide benchmark information on C.Diff cases per 1000 beds at the next meeting. BC also undertook to include stroke monitoring on the dashboard at the next meeting.** **BC**

BC

The Board commissioned an update of the Actions Monitoring table to reflect progress and completed actions.

413/11 5. DECLARATIONS OF INTEREST IN ITEMS ON THE AGENDA

VH declared an interest in the winter planning item, (item 12).

414/11 6. URGENT MATTERS (SO 3.6 & 5.2)

KG asked about the likely impact on the hospital of the forthcoming strike. JB reported that it was anticipated that a normal service would be provided throughout. She noted that:

- Agreement had been reached with union representatives on a group of 6 people, picketing in a safe area.
- Striking staff had agreed to come in if there was an emergency
- The canteen was expected to operate normally
- Some staff who were supportive of the action had elected to come to work as they felt that the patients were their priority, but were donating their pay for the day to charity
- Favourable press coverage linked to other charitable staff initiatives such as the 'Movember' campaign was noted.

The Board asked for its appreciation for the way in which staff side had engaged with the Trust in this matter to be recorded.

The Board noted the update

415/11 2. CLINICAL PRESENTATION - CARDIOLOGY

Dr Rajah Nata made a presentation to the Board on behalf of the Cardiology team. Key issues noted included:

- 45% of admissions though MAU have cardiac problems
- Dr Foster alert earlier in the year – QE an outlier for mortality with coding Atherosclerosis – reviewed – recording / coding issue
- QE well below national average for myocardial infarction
- No mortality from unstable angina between April and August 2011 although capacity issues identified among Junior Doctors – resulting in less than 100% compliance regarding form completion
- No funding at present for Acute Coronary Syndrome Nurse
- Requirement for Telemetry facility
- Likely impact of forthcoming NICE guidelines on 24hour blood pressure monitoring – opportunities to have some of this done in the community to be explored further
- Working with radiologists to offer Cardiac CT – Papworth providing the only better service regionally
- 3rd Cardiologist started in post recently – I cardiologist post remains vacant

GH added that some of the issues raised had been discussed at the Board's Strategy Day and that the development opportunities discussed should be self funding as they related to the repatriation of work from Papworth. A business case on this was being prepared for consideration, and the Trust's work on the emergency pathway would address issues in respect of the inpatient work. He reminded the Board that the key outcome indicator in respect of the work of

the cardiology team is mortality.

GH went on to remind the Board that this year's Charitable Funds appeal was to purchase equipment and a new treadmill to support the work of the cardiology team.
In response to a query from KG, the cardiology team's top priorities were listed as:

- Development of cardiac ward
- Telemetry facility
- Echocardiology

VH queried whether the Trust was lacking in ambition in its charitable funds appeal aspirations. GH explained that £200,000 has been found to be the approximate limit in respect of local appeals.

The opportunity for more procedures to be carried out in the community was discussed and it was agreed that further dialogue with GPs was key.

PW indicated her support for the Trust having a well-established cardiology unit. She went on to ask how the team had identified ways of being more productive, using its service line reports. Active discussion within the department was reported with clear ideas about how the service can be developed.

SG observed the obvious commitment of the team and queried whether control had been achieved in respect of the recording / coding of procedures. Dr Nata assured the Board that the Trust has an exceptional coding team, who are providing good support for the service.

In response to a further query concerning the potential for patient safety issues to arise, it was explained that while it is sometimes a 'stretch', patients receive appropriate safe care and are seen within 24 hours.

LP queried whether there is a 'joined up' service with the community, in particular respect of cardiac nurses. Dr Nata explained PCT funding arrangements.

KG thanked Dr Nata for his comprehensive presentation and asked GH about 'next steps'. GH explained that the Business Development Group were exploring the Cardiac Unit proposals, which involved only minor investment. He reiterated that Telemetry equipment was the top priority for the department.

416/11 7. CHAIR'S UPDATE

KG updated the Board on the November Governors' Council meeting, noting that the governors had explored the Trust's position in respect of the CQC assessment visit and its financial position.

KG noted with sadness, the death of Dr Malcolm Skinner, who was an appointed governor and a good friend of the hospital.

The Board noted the update.

417/11 8. CEO'S REPORT

PW presented her first CEO's report and update to the Board, noting in particular:

- Monitor's escalation visit on 22nd November – BC's paper sets out Monitor's process clearly. Monitor expected to communicate with the Trust in respect of likely recommendation Monitor's January Board in next few days.
- Consultations – CQC and Monitor – Trust has an opportunity to respond through Foundation Trust Network and directly. The Trust will respond to the proposed NHS Licensing arrangements consultation.
- Problem with IT network last week – Trust continuity plans invoked – very little impact on the organisation – thanks recorded to those involved
- Dr Foster report published today. The Trust has performed very well, being commended in some areas. Vascular Services raised as an issue – local solution identified and being progressed.

KG welcomed the format of the CE's report.

NH noted the Trust's Carbon Reduction achievement; querying whether this would have an impact on the Trust's Carbon Reduction target in the future. BC responded that there would not be an impact in the future and that this exercise was about the Trust's ability to capture information. It was confirmed that there had been a move away from the familiar measurement methodology used this year.

The Board:

- **welcomed the format of the Chief Executive's report**
- **noted the report**.

STRATEGY

418/11 9. QIPP

GH gave a verbal update. He noted that the system-wide workshop was meeting on 1st December to review investment /disinvestment plans. EDs would be pre-meeting to discuss the Trust's stance.

GH reported further that community matrons would be fully established by January, adding that this was not ideal as new systems can take up to 18 months to become embedded.

SG queried whether there was clarity in respect of the vision for the area. GH responded that the priority remained to reduce emergency activity to 08/09 level.

KG observed a disconnect between aspiration and what is happening on the ground: progress was not being made at the pace the Trust needed. GH thought this was a fair observation: delivery of the objectives would be likely to take some time yet. GH observed that the system-wide QIPP initiatives in West Norfolk were starting at a lower base than in other areas and were taking

some time to catch up.

The Board discussed the scale of the QIPP agenda, targets and metrics and noted that care would need to be taken in respect of understanding the difference between the activity patterns at the Trust and the more global picture. BC noted that the work would need to be dovetailed with the outcome of the Emergency Care Intensive Support Team (ECIST) work. It was further noted that the Urgent Care Network would be assisting with delivery of the ECIST recommendations and would be meeting in January 2012. It was agreed that an **update on ECIST and QIPP would be made to the Board in February 2012.** **BC/GH**

Having discussed the regional QIPP issues, NH queried whether Norfolk was behind other parts of the country. BC indicated that Norfolk was in the middle of the national 'leader board' and that some benefits had been secured in the North and South. She added that there was a consensus view that the programme was 'behind the curve' in the west of the county. MH indicated that there was evidence of a refocus on the west, adding that the Operating Framework would be likely to bring additional pressures. In response to a question from SG, MH confirmed that there could be more opportunities, though probably not more funding, in the west. The Trust would need to get itself into a position to capture any benefits. MH added that there had been some investment into West Norfolk, but the benefits were only just beginning to be realised.

PW observed that the Trust needed to push for increased momentum in respect of the QIPP programme, supported with clear information and quantifiable progress reports and numbers, as this would be needed by the Board for the Trust's business planning work.

The Board noted the update and resolved to review the QIPP position again, including its alignment with the outcomes of the ECIST work in February.

419/11 10. BUSINESS PLANNING FRAMEWORK

MH presented the Business Planning Framework. He indicated that the Operating Framework had been published and that the key issues remained quality outcomes, QIPP and sustained performance.

Having reviewed some of the outputs from the medical leadership Programme, JB queried how the Trust could involve clinicians more in the business planning process, observing that those clinicians without a clear SLM role felt that they did not have an opportunity to contribute. MH indicated that the way forward lay in the follow-up to the Clinical Strategy Day and agreement on a timetable for delivery of the initiatives identified. BC suggested that the follow-up could also be extended beyond the membership of the Trust Executive Board.

The Board approved the Business Planning Framework outlined.

REGULATORY

420/11 11. CQC INSPECTION ACTION PLAN AND PROGRESS UPDATE

GW presented the report, noting the RAG ratings and progress. She explained the work being undertaken in respect of weekly audits, particularly on nutrition and privacy / dignity, noting that while there were a lot of 'greens', there was a lack of consistency. There had been significant improvements at mealtimes in particular. GW also indicated that the role of the governors and the PCT in making spot checks and unannounced visits had been helpful.

GW noted for the Board that Yeovil Hospital, which was where the iCARE methodology had been developed, had been found to be fully compliant with all CQC essential standards.

KG queried how the Board could be sure that the changes called for by the CQC had been embedded. PW responded that as the PCT and Governor audits were showing the same issues as found during the CQC visit, then the Action Plan needed to be tighter. It was noted that the audits had raised concerns about 5 wards and a sharper focus on individual wards with Senior Nurses was suggested as a helpful next step. GW added that Denver Ward receives a lot of compliments and demonstrates consistent good practice and that the Trust should see what it can learn from this ward.

In respect of the audits and complaints trends, an improvement in nursing communications and attitudes was noted; as, however, were concerns about communication and attitudes among medical staff. The Board agreed that it was important for staff to understand that compliance with CQC standards was not just a nursing issue, but a whole hospital issue.

It was noted that GW, JB and PW were discussing how best to communicate these important messages throughout the organisation. GW's presentation to the Governors' Council was commended and it was agreed that clear messages should be communicated to all clinical and non-clinical staff.

In response to a question from KG on medical attitudes, GH conceded that the issue was a disappointment but that he accepted the criticism. Although there were exemplar areas within the Trust, the Trust was moving to 'naming and shaming' poor practice among medical staff e.g. hand hygiene. He added that from December, all junior doctors would receive a guidance booklet setting out standards on conduct and presentation and that these standards would be enforced rigorously. JH observed that the communication style for medics and nurses was different and that the Trust should learn from the way it communicated key messages to nurses i.e. face-to-face. GH indicated that it was individual practice which needs to be challenged and that Clinical Directors are the responsible leads on these standards. He added that non-compliance with standards needed to be challenged directly, not just by letter. PW added that the Trust's communications methodologies would be reviewed as soon as the new communications lead was in post.

VH queried the fluid balance chart review. GW explained that it was necessary to complete the entire chart to achieve 100% compliance with this target. She added that one ward was not totalling the scores on the chart and therefore failing the target. VH queried whether, since the charts were not an indicator of the standard of patient care, the record keeping process could not be made

simpler. PW observed that good record keeping seemed to be an issue at the QEH and suggested that the practice of those organisations achieving 100% should be looked at. She also observed that in respect of professional standards, staff would not consider giving a patient a drug and not recording it; they should not therefore give fluids and fail to record fully. GW clarified that staff were recording the giving of fluids and that the issue was with totalling. JH queried patient involvement in understanding and monitoring their own care. GW indicated that involvement was more about information than monitoring and that the patient's capacity needed to be considered.

KG confirmed that audits and unannounced visits would be continuing. GW explained the regular cycle of monitoring and meetings with key nursing staff. JH queried whether medical staff should also be involved in these regular meetings. GH cautioned that clinical teams were under pressure and could not always be spared during the day. He wondered whether what was being described was a failure of service line management. MH indicated that a review of SLM was taking place. He reported good engagement with the clinical directors: it was now important to engage effectively with the clinical leads. While he appreciated that clinicians were busy, they should use their allocated management time for the engagement suggested. MH added that it was important to improve opportunities for clinicians and managers to meet and engage and felt that less formal arrangements might be helpful.

KG summarised that it was clear that the measures discussed must be put in place and that it was up to executive directors to determine how. She added that NEDs wishing to participate in the mock CQC assessments should contact Mary Denmark.

The Board noted the progress update

OPERATIONAL

421/11 12. WINTER PLANNING

In presenting the report, FRS indicated that the final version of the Winter Plan has yet to be published. The local plan would be likely to be impacted by the ECIST outcomes and QIPP schemes.

FRS reported that community beds had been opened at the weekend. There was a move to redress the concept of 'opening beds' and move terminology closer to a 'community care' vocabulary. RP referred to a £500,000 contingency for winter planning but cautioned that its availability was dependent on the delivery of the recovery plan.

PW noted the issues in assimilating ECIST outcomes and the winter plan; ECIST dealing with year round internal issues, where the winter plan relied on region-wide criteria. SG queried how the Trust was linking with the Cambridgeshire winter plan, and FRS explained the networks and weekly engagement in place.

The Board noted the winter plans now in place.

INTEGRATED PERFORMANCE

422/11 13. INTEGRATED DASHBOARD

It was noted that the stroke indicators were missing from the dashboard and BC undertook to include these for the next meeting.

PD queried the mandatory training information, noting that both the target and attendance seemed low. JB responded, indicating that the 70% target had been agreed by the Board, but mandatory training was currently under review and that an increase in the target might be proposed. JB further indicated that **a review of individual area performance would be taken to HGC for consideration**. **JB**

PD said that he was concerned about levels of infection control mandatory training. GH explained that the target for medical staff was 100% and that failure to take infection control mandatory training meant that upon appraisal, clinicians would not be revalidated.

GW observed that the **safeguarding training target should be linked to CQC guidance and should be increased to 80%.** GW also asked for **conflict resolution training to be added to the mandatory training list**, as this was a CQC requirement. **JB**

SG observed that Choose and Book was performing better but was still 'red'.

The 'New to Review' ratio was also discussed by the Board. BC explained the benchmarking arrangements in place and the definitions of new / follow-up. It was noted that particular issues were experienced in gynaecology and ophthalmology where the Trust had vacancies. Issues in respect of ophthalmology were national; in gynaecology the issue was often related to the fact that there was often a mixture of inpatient and outpatient procedures, with the outpatient work being recorded as 'follow-up'.

VH queried the IG figures in the performance report and BC undertook to check them for the next meeting. VH also raised her concern about the HSMR, which she judged was still high and also the falls rate. KG indicated that these issues would be explored in the detailed papers to follow.

PW observed that there was a mismatch between the dashboard and the following papers in that the red issues highlighted on the dashboard did not always result in an exploratory paper. She also observed:

- Some indicators missing
- Medical outliers should be able to come off
- Workforce targets should be on
- Mandatory training target should be higher

PD queried whether there was a better way to report 'New to Review' and BC urged against using anything other than the nationally used methodology, but agreed that the Board should have clarity about the underlying issues. PW added that it was important that what was reported was counted correctly in order for the Board to be able to establish whether performance was outside normal expected tolerances.

PW undertook to conduct a review of the Board's performance reporting methodology, including the dashboard and supporting papers with the Executive team. **PW**

The Board noted the dashboard and resolved to review the format and content in January 2012, following PW's review with the Executive Team.

13A QUALITY : IMRPOVING PATIENT EXPERIENCE

423/11 13a.1 HEALTHCARE GOVERNANCE COMMITTEE CHAIR'S KEY ISSUES – 24th November 2011

SG reported the HGC CKIs to the Board, noting in particular the assurance received in respect of 3 cases of uterine rupture occurring in women having a vaginal delivery after a caesarean section (within 5 years), where a peer and external review of the cases had revealed no causal links between the cases. Recommendations following the cases were being implemented.

SG also reported an escalated risk on the risk register, and assurance in respect of a procedure to ensure a consistent approach to the aggregation of information regarding complaints, litigation claims, incidents and the PALS service.

The Board noted the HGC Chair's Key Issues

424/11 13a.2 INFECTION CONTROL MONTHLY REPORT

Lesley Taylor, Infection Prevention and Control Nurse, was introduced to the Board by GH.

October was reported as having been a good month in respect of C.Diff. with just 1 case confirmed in month and 27 cases ytd, against the trajectory at month end of 23 and a HCAI reduction target at year end of 37. No cases of MRSA were reported.

The PCT had requested the formation of a scrutiny committee to review cases. This would meet for the first time in January 2012. They had suggested a link between the reconfiguration of wards and infection rates. LT was leading on a rolling programme of deep cleaning and procedures for cleaning following decant. She was in the process of reviewing her Infection Prevention and Control team.

LT said that 2 eye infections had been reported to the PCT as SIs, but that investigation to date had not suggested causal links.

Following a query from VH about guidance to clinicians concerning antibiotic prescribing, it was explained that ongoing audits of practice revealed compliance with guidance. VH also queried how guidance on cannula care was embedded and GH explained that training and rolling audit were the key methods of dissemination and monitoring.

PW alluded to the High Impact Intervention Audit appendix of the report and queried whether patient care or process was being reported. GH explained that while the audit was concerned with process, the key outcome was that no MRSA bacteraemia had been identified for over a year and that incidence was often related to cannula care.

BC explained the estates costing work that had been undertaken in respect of sinks and doors on bays and GH added that it was important to have hand-washing facilities as close to the patient as possible. **BC asked for a timeline from LT, so that capex provision could be made for 2012**. **LT**

Following a query from SG, LT explained that 2 infection control related complaints had been secondary complaints and were not linked. She reviewed all such complaints but conceded that they were sometimes difficult to follow up with staff due to the time between complaints being made and reviewed.

PW queried the housekeeper services for all areas and LT observed that ownership for housekeeping and cleanliness in individual areas should be shared between staff and patients.

GW queried whether an audit might be performed on Stanhoe and Tilney where there are sinks in bays to see whether they had improved compliance on hand hygiene. Having sinks in bays might allow for the closure of bays rather than wards where Norovirus was identified. **It was agreed that GH/LT would develop a business case.** **GH/LT**

The Board noted the Infection Control Report and commissioned the preparation of a business case in respect of IPAC estates works

425/11 13a. 3 PATIENT SAFETY

GH presented the report, noting that the Dr Foster monthly performance report had been published that day. There was an issue in respect of the Trust's key mortality target which could be due to the design of the emergency pathways. He added that the Emergency Care Intensive Support Team had challenged practice and had identified some related work streams.

On SIs, GW reported that the majority of these related to falls with patients sustaining a fractured neck of femur (#NOF). It was noted that there had been one fall in October resulting in #NOF. No grade 3 or 4 pressure ulcers were reported for the month.

PW challenged further on mortality, observing that when rebased, the Trust's HSMR was over 100 and increasing. GH said that the Intensive Support Team indicated that the Trust was managing the emergency flow differently from its peers. He explained that the Trust was looking at coding with Dr Foster to see where the Trust differs, noting that in respect of COPD the Trust is a major outlier. The potential for patients to be triaged with a consultant within 4 hours was discussed.

PW asked how the Board could be assured that what was being planned would address the issues. KG queried how the changes to the emergency pathway would improve the Trust's performance on mortality rates. PW observed that all available evidence showed that if senior, early intervention is missing, then

outcomes are likely to be poorer.

GH undertook to provide additional information and assurances to the Board in the light of the Dr Foster findings. **GH**

In response to a query from SG, GH explained the basis of the comparable data and risk analysis in the Dr Foster report. He confirmed that the 3 key causes of admission were cardio-respiratory, stroke and pneumonia.

JH queried whether the Clinical Outcomes Group had raised any concerns which might indicate underlying adverse trends. GH explained that the issues had less to do with trends and more to do with individual cases. He reported that 99.9% of deaths are unavoidable with co-morbidities identified. The COPD issue was a pathway issue, in the wider community as well as in the Trust. He explained that Dr Foster based its analysis on the first episode of care, making it important for the Trust to get an initial diagnosis correctly defined in the first 12-24 hours. It was confirmed that the Clinical Outcomes Group was accountable to the Clinical Governance Committee and through them up to the Board.

The Board noted the Patient Safety Report, commissioning additional work to enable the Board to understand the Trust's HSMR performance and receive assurance that the identified issues were being addressed. **GH**

426/11 13.a.4 PATIENT EXPERIENCE REPORT

In presenting her paper, GW reported that the Trust had been noted as an exemplar site for its use of the Net Promoter. Key issues identified as a result of the Patient Satisfaction Surveys were:

- Expected date of discharge – not being discussed with patients
- Medicines management – side effects of medications not being discussed
- Communications

PW noted that 36% of complaints being about communication and 40% being about care were clear messages for the Trust. Smarter conclusions needed to be drawn from the information presented e.g. this is what we saw and this is how we are dealing with it.

KG observed that the report was very positive about the PALS service and she asked for the Board's appreciation to be recorded in this respect. However, the negative feedback once again included complaints about car parking which were on the increase having reduced following recent communication

The Board noted the Patient Experience Report.

427/11 13a.5 SAFEGUARDING

To be taken in private session

13B FINANCE, ACTIVITY AND EFFICIENCY

428/11 13b.1 FINANCE AND INVESTMENT COMMITTEE CHAIR'S KEY ISSUES

SH presented the Finance and Investment Committee's Chair's Key Issues, noting in particular that the key messages were the pressing need to deliver the financial recovery plan and the F&IC's recommendation that the LTFM assumptions in respect of surplus and CIPS for 2012/13 should be used in the Trust's Business Planning and Budgeting for next year.

429/11 13b.2 FINANCE, CAPITAL, TEPS and ACTIVITY MONTHLY REPORT

PW observed that the finance report needed to be supported with better operational detail. RP said that the finance team were working hard with the divisions to deliver this year's plan and to progress plans for next year.

The Board discussed its requirements for external support for recovery plan delivery and planning for next year. The following issues originally discussed at F&I were developed through discussion:

- Procurement process
- NED involvement in selection
- Associated costs – savings to more than offset costs
- Requirement to deliver embedded, internal system improvements e.g. SLM / SLR
- Need for financial plans to be risk assessed for quality impact – PW reassured the Board that clinicians would be more involved in business planning than previously

KG was emphatic that the Trust must deliver its recovery plan to maintain credibility. PD asked for further assurance on whether there was effective control over the issues and greater clarity over why things were going wrong. NH stressed the importance of the Trust maintaining throughput of activity over the Christmas period, including clinics, in order to maintain income levels. MH indicated that meetings were due in respect of the emergency and elective pathways and that a plan would be formulated. SG added that it would be necessary for rigorous cost controls to continue in order to maximise the margins. It was noted that this issue had been discussed at length at F&I.

PW queried the capital element of the finance report, querying whether those capital plans were expected to deliver. BC confirmed that the Trust would spend in accordance with the profile sent to Monitor with the timing of the CDS work being the only current issue.

KG suggested that such was the importance of the delivery of the Recovery Plan, that monitoring between formal Board meetings would be required. **It was agreed that this would be organised and details circulated.** **DS/RP**

The Board noted the finance report and endorsed plans to commission external support for the delivery of the Trust's Recovery Plan and Business Planning for 2012/13.

430/11 13b.3 F&I COMMITTEE RECOMMENDED BUSINESS CASES

None – Electrical Switch Gear and DSU Disinfectant Plant business cases approved at F&I Committee in line with scheme of delegation

13C WORKFORCE

431/11 13c.1 WORKFORCE MONTHLY REPORT

JB reported that the Trust had been one of only 20, which had achieved the NHS 2012 Challenge Award in recognition of Health and Wellbeing initiatives over the past year.

JB expressed concern that sickness levels linked to stress and depression were increasing and suggested that the Trust might need to invest more in counselling and other support. She added that quicker assessments were needed in respect of musculoskeletal conditions.

In respect of workforce planning, JB said that few teams were delivering the agreed plans and that partners would need to be more creative in role re-design. KG signalled that it was disquieting that the Trust was showing increased staff numbers when peer trusts' staffing levels were decreasing. Following a query from SG, JB explained the process for approving recruitment to staff vacancies, including the scrutiny panel's recommendations to EDs. However, PW noted that at 2,588, the Trust's staffing levels were currently below that planned in the Trust's Workforce Plan of 2,680 (2,596 for March 2012). She queried whether the posts were in the right places and suggested that the Workforce Plan be revisited. PW also noted an overspend on staffing budget. JB explained that some posts were linked to business development schemes that did not materialise. VH suggested that the Trust should explore the efficiency gains made at the N&N and James Paget hospitals, although PW urged caution in ensuring that the Trust was comparing like with like. PD asked the Trust to take a rigorous approach to sickness absence management. LP explained that where organisations have block contracts, staff reductions' were a key way to reduce costs, as they could not increase activity to boost income. The Trust would need to redesign care without compromising quality. During further discussion, the Board observed that:

- Terminology in the report was potentially misleading e.g. staff employed v. Staff in post
- Report and scorecard misaligned

The Board noted the report and commissioned a redesign of the Workforce Report and a review of the Workforce Plan. **JB**

13D OPERATIONAL PERFORMANCE

432/11 13d.1 PERFORMANCE MONTHLY REPORT

BC presented the report, drawing the Board's attention to the Trust's risk in respect of stroke, in particular. She indicated that the relationship with the commissioner was difficult in this respect and that a performance notice was expected. The Trust's performance in relation to TIAs had shown improvement

and validation of the September TIA figures was ongoing. GH indicated that the Trust had changed the stroke pathway and expressed concern that the Trust is clearly not recording data correctly. KG stressed the importance of the Board picking up on growing risks such as this. In response to a query from VH, BC indicated that only a small number of patients were impacted. PW added that as the Trust has 24/7 status for stroke it must provide effective support services, including PMO, to ensure that the service was efficient and effective and meeting national standards. KG stressed that the Board wanted this matter put right. MH told the Board that the issue would be escalated to the divisional bilateral meeting.

KG expressed her worry concerning 18 weeks, concerned that 8% of patients were waiting longer. JH queried the gynaecology and urology figures. BC confirmed that the figures related to cancelled inpatient elective procedures in the main and that in respect of gynaecology, the numbers were small.
PD observed that last month's report template had been used and not updated in some areas.

The Board:

- **noted the performance report**
- **urged the executive to address those areas at risk; in particular the risk in respect of 18 weeks and stroke**
- **Noted the position re. C. Diff**
- **Noted the forecast Compliance Framework position for Q3 as 'red'**

RISK

433/11 14. RISK REGISTER

The Board considered the Risk Register (risks> 20). KG noted that HGC had escalated a risk (888) in respect of the opening of escalation areas Work to mitigate the risk and reduce the requirement for escalation areas were ongoing. In relation to the endoscopy risk, mitigations were in place. On MRI scanners, works were 'out of the ground' and progressing.

The Board noted the risk register.

GOVERNANCE

434/11 15. BOARD FORWARD PLAN

The Board agreed its forward plan

16. COMMITTEE MINUTES

- F&I Committee Minutes – 24th August & 21st September
- HGC Minutes – 24th August & 21st September
- TEB Minutes – 23rd August, 13th September, 22nd September, 11th October and 25th October

There were no questions from members of the public.

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 13.50 pm