The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust

Board of Directors' Meeting (In Public)

Minutes of the Board meeting held on Wednesday 29th August 2012 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)
N Harrison (NH)	Non-Executive Director (Chair of Audit Committee)
J Hillier (JH)	Non-Executive Director (Vice Chair and SID)
V Holliday (VH)	Non-Executive Director (Chair of Quality & Risk Committee)
S Haney (SH)	Non-Executive Director (Chair of Finance & Investment Committee)
B Cummings (BC)	Director of Non-Clinical Services and Performance Management
M Henry (MH)	Director of Clinical Services
G Hunnam (GH)	Patient Safety Lead and Medical Director
G Wilson (GW)	Director of Patient Experience and Lead for Nursing and Non-Medical Professionals
D Stonehouse (DS)	Director of Resources
L Proctor (LP)	Director of Strategy and Transformation

In attendance:

G Rejzl (GR)	Company Secretary
V Scott (VS)	Assistant Director of Communications
H Milne (HM)	Corporate Governance Officer (Minutes)
K McAllister (KMcA)	Specialist Vulnerable Midwife Referrals – Presentation
V Newton (VN)	Patient Story- Presentation

163/12 1. CHAIR'S WELCOME

KG welcomed attendees and advised that part of the meeting would be filmed as a short film was being produced about the hospital for purposes of transmission at the forthcoming AGM.

164/12 2. SPECIALIST VULNERABLE ADULT MIDWIFE REFERRALS – PRESENTATION

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GW introduced Kim McAllister, Specialist Vulnerable Adult Midwife (SVM), to the Board. KMcA presented an overview of the number of referrals to the Norfolk Specialist Midwife. This was broken down as follows:

- 348 referrals for the year ending April 2011-March 2012 equating to 14.5% of total birth rate of 2400
- 77 women were referred over the last quarter (April-June).
- The largest proportion of those referred were teenagers and pertained to 25% (20) of the total number of referrals. The SVM will see these pregnant teenagers individually on 2 occasions within the antenatal period in addition to their regular antenatal appointment with the generic midwifery team. As the SVM undertakes these herself there is a high demand for her time and support.
- Depression was the second largest reason for referral at 60% (18) and these women were seen on average 3-4 times throughout the antenatal period by the Specialist Midwife. However, in compliance with level 1 CNST there is no provision for the Community Midwives to provide the service.
- Domestic violence equated to 7% of the initial referrals made of which 42% of them required a referral to Children's Services in light of the severity and persistence of domestic violence – 27 of the initial referral's sent in to the SVM were already known to Children's Services and some of which were already subject to a child protection plan.
- Other categories such as housing problems, substance misuse, police involvement, safeguarding, learning disabilities, Eastern European, late booker, mental health issues, overdose, physical pain, severe mental health, sofa surfer, schedule 1 offender and support made up the remaining 75% referral rate for that period.
- KMcA advised that a plan of action had been developed and implemented which identified women during the antenatal period who have a current mental health problem or who are at risk of developing a mental health problem – this is in line with CNST Compliance Standard 4 – Criterion 6: Mental Health. At present the Trust meeting the requirement for Level 1 which is part of the role of the Specialist Midwife.
- The Board was advised that methadone babies were no longer admitted to the Special Care Unit and were now cared for on the ward.
- The outcome of the study enabled the SVM and the team to identify the most prevalent reason for referral, recognise key areas of need and allowed the clinicians to identify strategies and tools that may reduce the occurrence of incidents such as domestic violence by offering support and monitoring; as well as supporting future applications for additional services.

A question and answer session and discussion followed.

Q. With regard to the teenage pregnancy rate, where does public health come into this?

A. The Board was advised that Norfolk was in fact 'bucking the trend' by showing an increase in the teenage pregnancy rate as the rest of the country is on the decrease.

Q. What is the pathway for teenagers after seeing the midwife?

A. Unfortunately due to the vast workload there is no pathway in place. SureStart funding has ceased and the majority of girls are being seen again and again with recurring pregnancies. There is a PCT requirement to manage teenage pregnancies and community services should be picking up costs for contraceptive implants and injections. However, the implant needs to be performed by a well-trained practitioner.

Q. Due to the growing concern that the situation is not improving, are there any plans regarding assistance for the SVM and her team.

A. There is a plan in place to merge the safeguarding teams with shared secretarial support to alleviate the pressure on the SVM.

Q. Who is commissioning in the future?

A. Maternity services is advising on commissioning for CCGs and the commissioners need to understand what the Trust can do to support.

The Board thanked KMcA for presenting to the meeting.

165/12 2. PATIENT STORY

GW introduced Val Newton to the Board. VN recounted a patient story concerning an 81 year old patient who had been an emergency admission to a ward in July 2011. The patient had been admitted with breathlessness and nausea after attending a haematology clinic for bone marrow investigations. The gentleman had a history of IHD and had been admitted to a residential home, with dementia, 1 month before admission to the QEH.

The family made a complaint in January 2012 and met the ward sister and matron. Following this the family met VN to discuss their concerns and what changes had been made as a result of their complaint.

The issues discussed and actions taken following the complaint are as follows:

- Nursing staff did not communicate well with the family
  - A standard has been developed within the division of how to ensure that any information that relatives require is available and how to contact medical teams if relatives wish to speak to them

- Some staff lacked compassion when caring for patients and their families
  - Work has been undertaken on values and behaviours and a

piece of work is commencing to develop the concepts introduced with iCARE.

- When asking nurses for information, the nurse would not always return and there was concern with regard to what was passed on at handover
    - A standard has been developed for shift handover to improve communication between teams and also clearly demonstrate who the shift leader or nurse in charge is so that families can identify who to obtain information from about the care being delivered

- Disruption of patients while bays were being steam cleaned e.g. patients were being left for periods of time sitting in one place whilst the area was cleaned
    - Changes to the ways that bays are cleaned have been put in place. Steam cleaning is not used which means the patient stays in their bed in the bays. The bed is moved forward to clean the area and then placed back to the original position

- When the family talked to the nursing staff about some of these issues, raising the type of care received previously at the Norfolk and Norwich hospital the nurse had commented that N&N were a bigger hospital and had more staff – when the family was referring to fundamental care
    - The skill mix is changingto 65/ 35 registered to non-registered – evidence shows that the levels of registered nurses impacts on the quality of care

- The patient was often left with food that was not appropriate for his individual requirement
    - There is now a focus on mealtimes ensuring that everything stops and mealtimes are protected. Clinical, non-clinical nurses and meal co-ordinators attend every meal shift on the ward to help patients at mealtimes ensuring any special requirements are met. A meeting is planned to raise awareness of continued efforts that need to be made to continue initial work undertaken

- Concern was raised regarding the amount of training staff have had in the care of patients with dementia
    - The Dementia Alliance has funded an 8a Lead nurse post which be a corporate role that looks at increasing staff awareness of care patients with dementia within the Trust - the post has been advertised

- Concerns were raised about a pressure ulcer that had been sustained
    - SHA have launched the ambition to eradicate all hospital acquired pressure ulcers (2, 3 and 4) by December 2012 – Stanhoe is to be the pilot ward to review changes to practice prior cascading new ways of working to other areas

The family had been invited to join the work the QEH is undertaking with patients to understand their experiences.

VN advised that the family had wanted hospital representatives to understand their concerns, and concluded that if their complaint resulted in other patients having a positive experience, then it would have been worthwhile.

The Board welcomed the Patient Story and asked for thanks to be passed to the family.

166/12 4. APOLOGIES FOR ABSENCE

None

167/12 5. MINUTES OF THE PUBLIC BOARD MEETING HELD ON 30th JULY 2012 and MATTERS ARISING

Wording to be amended in item 158/12

Matters Arising:

- Clarification in respect of the 'Friends and Family Test' CQUIN target was given by GW. It was noted that the Trust's target for 'Friends and Family recommending the Trust' was 71% and that the target response rate was 10%.
- In respect of Pressure Ulcers, it was confirmed that the Anderson Model is used only in A&E and that the Waterlow Model is used elsewhere.

The minutes were agreed as an accurate record of the meeting, subject to the amendment being made.

168/12 6. ACTIONS MONITORING

The Board reviewed the Actions Monitoring Record

Progress updates were given (see Actions Monitoring Record – September 2012) and those actions marked as complete were agreed for removal from the Actions Monitoring Record.

169/12 7. DECLARATIONS OF INTEREST

None.

170/12 8. URGENT MATTERS

None.

STRATEGIC

171/12 9. CHAIR'S REPORT

The Chair gave a verbal update to the Board and advised:

- That the Governors' Business Group had met in early August to

have feedback from the recent Monitor meeting.

- The closing date for the NED applications was 28th August and the shortlisting and interview process would take place in early September to enable the Governors' Council to appoint a new NED to replace JH, when her term ends in October.
- A public meeting held by WNCCG suggested there was an opportunity to forge closer relations with the Trust's future commissioners, perhaps by way of a Board : Board meeting. It would also be beneficial to hold similar meetings with other local CCGs. **KG to establish ways to build up relationships with CCGs.** It was observed that the PCT was working on the transition to CCG Commissioning and that it was important to engage with Lincs and Cambs and Peterborough PCTs as well as NHS Norfolk **KG**

In discussion, the question was raised as to the commissioning roles from October and how these were to be handled. Did the Trust understand fully the risks in the present situation and is there enough mitigation around that risk? The Board was advised that it would be part of BC's role to build up contacts with the CCGs as the commissioning round approached. Wisbech and West Norfolk GPs would be invited to meet the Trust in October to build up the necessary local links. The nature of risk over the next 6 months until PCTs were abolished was raised. PW advised that the Trust had a good on-going relationship with the PCT in agreeing flexibility in the contract. The risk to the organisation in respect of the transitional commissioning period was discussed at length. It was noted that there was likely to be a recognition of the need to ensure system sustainability while the new commissioning arrangements became embedded.

The Board noted the Chair's update.

172/12 10. CEO's REPORT

The report was presented to the Board as an update on internal and external events and issues.

- The Board was advised that the Trust was inspected by the CQC on 14th August in respect of privacy, dignity and nutrition and that their report is expected imminently.
- The Trust has been advised that the Clinical Advisory Group has judged that the Trust's application to be a designated Burns Facility has met the minimum criteria. A site visit is to take place at the N&N site on 4th September. **PW will keep the Board informed of developments.** **PW**
- Meetings with key strategic partners since the last CEO update have included:
    - Norfolk System Leadership Group
    - Academic Health Science Network
    - Chair of the Norfolk Diabetes Trust
    - CEO of Norfolk Independent Care
    - Papworth Hospital –re Cardiology Services
- Section 1.3 is to be updated with details of names and start dates for recent consultant appointments.
- Consultation on Monitor's new regulatory role was underway.
- PW also updated the Board on recent media coverage, details of

which were in the paper presented.

The Board noted the CEO's update.

173/12 11. QE DEVELOPMENT STRATEGY – PROGRESS AND TIMETABLE

LP advised the Board that good progress was being made on conversations with specialties about their clinical strategies. Those departments who have not responded due to time constraints were being followed up. There is a good degree of understanding within most departments, regarding the challenges facing the QEH and its vulnerabilities but there is also the need to understand demand trends going forwards.

The Trust was now nearing the stage of compiling and analysing the information it had gathered and the steps to be followed next. The month ahead would be important, as work with the DH Leadership team will be underway. Commercial assessments i.e. testing out what the Trust has learned to date and how to move ahead would be done with support from the DH Leadership Programme. The DH Leadership team was also expected to be able to advise on how to develop a higher degree of understanding of market opportunities by departments.

The Board was advised that the opportunity to have further input and review of the emerging work would arise in October. Governors would be advised of progress at their September meeting and in greater detail in November.

The Board noted the update .

174/12 12. ACADEMIC HEALTH SCIENCE NETWORKS

GW presented the recently published guidance on Academic Health Science Networks, advising that this is national guidance and for information only. It was reported that GW is the Trust's representative at a local level and that she would report to the September Board in respect of local detail and progress. PW reported that the Trust expected to be an active participant in the AHSN Norfolk & Suffolk node.
In response to a query, PW reported that the LETB work related to a national education programme and that while in the longer term, the LETB and AHSN may merge; they were currently separate and funded separately.

PW and GW to ensure the Trust is up to speed and to report to the Board at a forthcoming meeting. **PW/GW**

The Board noted the report.

QUALITY

175/12 13. MONITOR'S NATIONAL QUALITY BOARD REPORT

The Chair invited the Board to note the contents of Monitor's letter of 16th August 2012 and advised that work should be undertaken immediately in

order to form a response. Discussion to take place in the September or October Q&R Committee meeting.

The Board commissioned the Q&R Committee to consider the NQB's report and make recommendations to the Board in respect of the Trust's response.

176/12 14. SAFEGUARDING INCIDENTS

GW confirmed that there were no serious safeguarding incidents to report this month.

The Board noted the update.

177/12 15. SERIOUS INCIDENTS

The performance report showed serious incidents for July 2012. GH presented benchmarking data from the Acute Trust Quality Dashboard provided by the NHS MEQO which confirmed that the Trust had a higher than average rate of reported patient safety incidents per 100 admissions (7.99 incidents per 100 admissions compared to a national mean of 6.32). However the rate for serious harms patient safety incidents per 100 admissions was lower than the national mean reflecting good practice (local value of 0.1 compared to a national mean of 0.42).

RISK

178/12 16. BAF

The BAF was presented to the Board to facilitate its review of strategic risk and the alignment of the BAF with divisional objectives and risk articulated in the Trust's Business Plan 2012/13. It was noted that the BAF would be brought to the Board every month as it was an important strategic risk tool. Comments regarding the utilisation of the heat map had been taken on board and a number of areas have been updated since the last meeting.

Following a query, the Board was advised that the Trust's weighting methodology used when reviewing the heat map, demonstrated that internal compliance monitoring would be a weaker source of assurance than external assessment.

NH commented that it was difficult to recollect how recent assurances were and it was agreed that date indicators showing frequency and last recorded date would be useful when assurances have been updated. **GR to update Heat Map with date indicators over the coming weeks.** **GR**

PW advised that the Board needed to start thinking about 2013 planning as currently the BAF is grouped under strategic key themes and corporate objectives which results in some duplication: where issues are similar the assurances need to be the same. The Board agreed to manage the BAF in its current format for the remainder of the year but to look at how to group issues going forward so as to avoid overlap.

Some of the assurances in the BAF were thought to be weak and the Board

asked how rigorous the Trust was being to ensure that the quality of assurance was maintained. The Board was advised that the BAF was a representation of identified key risks faced by the Trust and the means of identifying gaps in assurance as to how those risks were being managed. The suggestion was made that particular areas should be examined in greater detail in a particular month. This would be taken up at a future Board meeting.

JH commented that as assurance is less strong around workforce targets the Trust should have specific types of assurances in that area. DS commented that assurances were good in terms of metrics management around workforce but that the internal audit programme could be strengthened in relation to workforce/operational management and sickness management. This would be examined further.

The Board was advised that in future when referring to items from the BAF in Board papers the specific BAF reference was to be used.

GH highlighted to the Board two specific strategic risks relating to the NHSLA Action Plan and the planned visit on 4-5th September 2012, which was likely to be the last NHSLA visit in its current format. The majority of the work was complete but areas identified with any gaps would be reviewed w/e 31st August. The Board was also advised of the CNST visit planned for 1-2nd October 2012.

The Board noted the BAF and supporting heat map and confirmed that the BAF be taken forward in its current format.

179/12 17. RISK REGISTER

The Board was advised that the testing of the MRI scanner coils was currently underway and that the likelihood was that the risk rating would be reduced to 8 by the following month.

The Board noted the risk register.

OPERATIONAL

180/12 18. INTEGRATED PERFORMANCE DASHBOARD

BC advised the Board that the report is the next iteration of work to integrate performance reporting on patient safety, experience, quality, operational performance, workforce and efficiency into one consolidated report. From discussions held at P&SC and TEC the format has been updated and should be finally resolved for the September Board meeting. SG commented that the format of the dashboard was much improved and the structure and narrative was better.

With regard to the performance indicators, the issue of whether these indicators were appropriate and were what the Trust required was raised; it was agreed that the respective committees should decide if the indicators are the correct ones. PW observed that this task should be added to the Terms of Reference of the committees as appropriate.

The Board noted the contents of the report and the action being taken to address areas of performance which are not at target levels.

181/12 19. PERFORMANCE REPORT

Specific key issues from each chapter of the report are detailed as follows:

Chapter 1 – Quality & Risk

CQC Compliance

- There remains 1 outstanding Care Quality Commission (CQC) compliance actions following the CQC unannounced visit in August 2011. In January 2012 the CQC revisited the Trust to conduct a further unannounced inspection to review the outcome of the initial report and a further review of services within the Trust.
- Following the visit in January 2012 the Trust were found to have addressed the issues raised by the CQC following their visit in August but were subsequently found to have one moderate concern reported against "Outcome 21: People's personal records, including medical records, should be accurate and kept safe and confidential."
- The Trust is implementing a Board approved action plan to address this issue. All actions have been implemented and are audited weekly via rolling programme. Where noncompliance is found a robust performance framework is put into place.
- On Tuesday 14 August 2012 the Trust was visited by the CQC to assess Trust compliance against Outcomes 1, 4, 5, 7 and 13. A report from the CQC on the outcome of the visit is expected within 10 working days from the date of the visit.

Mortality Rates

The Trust aims to reduce RAMI by 5% per year (target of 75.7 in 2012/13), and the crude death rate per 1,000 admissions (16 per 1,000 admissions). Whilst crude mortality is within target levels, and the Trust' RAMI is not above benchmarked peers, June's performance is not at expected levels against the internal target.

- Crude mortality per 1,000 admissions in July 2012 = 14.8 (target achieved)
- RAMI in June 2012 = 84 (internal target not achieved)
- RAMI for April to June 2012 = 83 (internal target not achieved)

The Trust uses the CHKS benchmarking data to track variation in RAMI performance and there are 3 current alerts recorded. These are:

- High rates of birth trauma injury to neonates – this is being investigated by the Division for report back to the Clinical Outcomes Group.
- High rates of death in hospital within 30 days of non-elective surgery: this appears related to the recording of invasive procedures e.g. intubation in ITU, insertion of PICC lines for intravenous therapy. An in depth analysis of these patients is being led by Trudy Taylor, Head of Clinical Coding, with the support of the Elective Division.
- Low rates of weekend discharge for emergency admissions

as a % of the weekday rate: this was also identified by Dr Foster in the last Hospital Guide and forms part of the work on POD19.

These investigations will be reported to the Clinical Outcomes Group and subsequently to the Clinical Governance Committee. The outcomes of this work and the subsequent actions will be reported to Q & R Committee and the Board as appropriate.

Net Promoter

- All inpatients are now being given a postcard on discharge on which to record their answer to the question: "How likely is it that you would recommend this service to friends and family?."

  The responses offered are:
  - Extremely likely
  - Likely
  - Neither likely nor unlikely
  - Unlikely
  - Not at all
  - Don't know

  The postcards are self-addressed with postage paid to a third party organisation which analyses the results to produce the "Net Promoter" score which is reported to the Trust and to the Strategic Health Authority.
- Each Trust is required to survey at least 10% of their discharged patients each month. In June 2012 postcards were received from 4.29% of patients discharged from this Trust (down from 6.2% in May).
- To improve our response rate the discharge lounge staff now remind patients to complete their postcards and post them before they leave the hospital. This procedure was begun towards the end of June, too late to have an impact on the June response rate.
- An email has been sent to all matrons and ward clerks to remind them of the importance of distributing these postcards in relation to the Trust's income (it is a CQUIN target).
- In June 2012, the Trust net promoter score was 81 (up from 71 in May). The combined score across the regional cluster was 64 with a range from 42 to 89 (the Target Score set by NHS Midlands and East is 71).

Serious Incidents

- There were 3 Serious Incidents reported in July 2012.
- At present there are 32 serious incidents awaiting closure from 2012. Root cause analyses and action plans are completed and have been submitted for 14 of the incidents. There are presently 18 incidents under investigation.

Never Events

- There was 1 never event in July and this arose from a failure to obtain adequate consent for dental extraction. This is similar to the previous case in February 2012 and relates to a complaint several months previously, which was not reported as an incident. This reveals not only a failure to obtain sufficient consent but a failure to report via the normal clinical incident reporting mechanism, although

the episode was fully investigated at the time. The root cause analysis and action plan from this investigation, plus the previous dental never event, will be amalgamated and presented to the Patient Safety Committee.

The Board was assured that never events are kept under close scrutiny as there has been an increase. It was noted however, that the scope of Never Events had broadened recently and that formerly, Never Events related to a more limited range of incidents such as wrong site surgery, suicide and retained foreign bodies. JH was concerned that the two issues raised were about consent and asked for assurance that the problem did not lie with the Trust's consent process. GH advised that the issues were specific to the dental department and that the dental practice position is different as the situation can change from the initial consultation to the operation. However the process had now been changed and all those involved in the process know the extent of the procedure to be undertaken. Consent is taken by the person carrying out the procedure and re-evaluated at the beginning of each new process using procedure specific consent forms.

Pressure Ulcers

- All grade 3 and 4 pressure ulcers are reported as a serious incident and a root cause analysis is undertaken by the ward staff and reviewed by the Tissue Viability Nurse prior to submission.
- The Trust has joined a number of other Trusts in a collaborative exercise designed to work towards the elimination of hospital acquired pressure ulcers by December 2012. This will support the team on Stanhoe ward (chosen due to the increased numbers of pressure ulcers) by provision of training and tools. The expectation is that all wards will follow suit over the twelve month period. In preparation all wards have been issued with a Pressure Ulcer Setting Cross whereby each ward must record on a daily basis if any pressure ulcer develops on that ward or if they transfer a patient from another ward with a ulcer. The collaborative work was launched via Clinical Leadership Friday on 17th August.
- In July a Clinical Summit was held which included members of the multidisciplinary team. An action plan was developed identifying ways of reducing hospital acquired pressure ulcers.

Chapter 3 – Workforce

Sickness

- The target for the spring and summer months was for sickness absence to reduce to 3.5%. However, the rate remains at the winter levels of around 4.0 – 4.5%. Rates for the Trust compare favourably with other Trusts (based on data to the end of 2011-12). Since late 2011 there has been an upward trend in sickness for S&T and Healthcare Scientists. This correlates to uncertainty over job roles in pathology. The HR Business Partners are working closely with the Divisional Management teams to address the deterioration.

DS advised that there is a process in place to manage sickness absence and a robust system will be in place to help staff on wards. He advised further that the Trust performed quite well against other Trusts but less well against its own historic performance.

In response to a question, DS reported that the e-Rostering project was on track to go live on all wards by the end of August.

In response to an observation about IG training for doctors, BC confirmed that the current position was an improvement on the same period last year. GH added that the Trust had an arrangement in place with the Deanery that FI Junior Doctors receive mandatory training before starting work at the Trust. BC confirmed that the IG Training target was cumulative and that the Trust expected to deliver it by the end of March 2013.

Chapter 4 – Performance and Standards

A&E Performance Indicators

- The Trust achieved the A&E target for July 2012. Performance is reported at 96.6% against the target of 95% for the month of July 2012. YTD is at 96.6%.
- The Board of Directors had identified 97% as the Trust's internal operating target for A&E. PW indicated that while the executive were still striving to attain this target, it might not be attainable at a time when changes to service delivery were being implemented. She added that the target would not be slavishly pursued at the expense of patient care and other targets.

The Board was advised that the item regarding ambulance turnaround times was to be brought to the Performance and Standards Committee in September for an update.

Cancer

- The Trust achieved all Cancer targets for Quarter 1 2012/13. The Board of Directors was asked to note that performance for cancer is reported one month in arrears.

18 Weeks – RTT Treatment Times & Waiting Times (Patients Treated in July)

- The Trust continues to achieve the 18 week RTT waiting times for admitted and non-admitted patients.

MH confirmed that the situation regarding orthopaedics is improving and the Trust is focussing on productivity and efficiency to establish if there is more capacity it can use.

Choose and Book

- QEH performance is benchmarked against the national position. Performance is below the expected national and contractual position, but in reviewing Choose & Book performance and talking to the POD 37 team a tough improvement target had been set to be delivered by end of November.

Diagnostic Waiting Times

- Trust performance was below the national KPI. There were 6 Paediatric patients who did not have their Echo test within the 6 week target due to administrative error; there were also 2 Audiology breaches due to staff sickness and 2 Endoscopy breaches due to delays in referral and noncompliance with waiting list policy. All

staff have been reminded of the need to adhere to this guidance. These issues further support the decision of the trust to centralise bookings.

In terms of diagnostic waiting times, the impact of administrative issues identified on patients was explored. BC confirmed that all patients had been seen and that the issues were rarely abut capacity but were more often about sickness or equipment breakdown.

Did Not Attend (DNA Rate)

- The Trust's DNA rate for July was 5.4% which was above its target of 5%. BC advised the Board of the Trust's policy of reminding patients about their impending appointment. This had resulted in an early and significant improvement in the DNA rate. The telephone reminder service provider was reported to have been consulted concerning whether there was any more that could be done to address the DNA issues. As part of POD 37 on outpatients, work is being undertaken at specialty level to investigate performance at benchmarked peer group level and where there is variance determine reasons for this.

Readmission Rates

- The Elective Readmission rate for July was 3.7% which was above the target of 2.7%. Emergency readmissions for July were under target, with a performance of 8.6% against a target of 9.1%. GH advised that the Trust is in the process of commissioning some additional analysis from CHKS on readmission rates and will report back to the Quality and Risk Committee, once available. Improvements in patient pathways following implementation of POD 19 actions has not resulted in a deterioration of performance on readmissions. In relation to Elective readmissions, further investigation was needed to determine the cause. It was noted that Readmission Rates were to be explored further by the Performance and Standards Committee.

The Board noted the Performance Report.

182/12 20. FINANCE REPORT

The Board was reminded that a Finance & Investment Committee meeting would be taking place following the Public Board meeting to look specifically at divisional performance.

In presenting the report, DS noted that the cumulative position to date is broadly on trajectory but the headroom has been reduced. He alluded to income and activity issues identified and that the Trust needed to continue to drive on activity and income in order to achieve its financial risk rating target securely.

Summary of Income & Expenditure Position

- For the month the Trust achieved an EBITDA of £983k against a planned EBITDA of £1,175k, an adverse variance of £192k. For the month the Trust reported a surplus of £317k against a planned surplus of £538k, an adverse variance of £221k. The Trust EBITDA margin was 6.9% against a planned EBITDA margin of 8.2%, 1.3% below plan. For the month the Trust has scored an FRR of 4 against

an expected FRR of 4.

- Year to date the Trust achieved £2,246k EBITDA against a plan of £2,294k an adverse variance of £48k. Year to date the Trust reported a deficit of £167k against a planned surplus of £9k, an adverse variance of £176k. Year to date the Trust EBITDA margin is 4.1% against a plan of 4.2%, now 0.1% below plan. Year to date the Trust scored an FRR of 2 against an expected FRR of 2.
- An FRR of 3 by quarter 2 is currently marginal (forecast cumulative EBITDA of £351k below plan at September). The Trust plan aims to deliver an EBITDA margin of 5.0%, an FRR score of 3, by Quarter 2. Current EBITDA forecasts indicate an EBITDA Margin of 4.58% by Quarter 2 which when combined with the other factors in the overall FRR calculation indicates that it remains possible to achieve an overall FRR of 3.
- Overall the Trust is forecasting to deliver planned EBITDA by year-end. This includes the full utilisation of the Trust's contingency. The year-end forecast assumes BSP delivery as per the latest assessments. This is currently going through a further RAG-rating in Quarter 2 in order to ensure additional risk can be appropriately mitigated.

The Board discussed the issues raised in the Finance and Activity paper at length, including:

- Variance - downward trend. DS reassured the Board that the Executive team was aware of the risks to delivery with the BSP and the continued to drive hard to achieve the required savings. Current concerns were less about delivery and more about the speed of change.
- The potential impact of other issues e.g. pathology cost of change
- Volatility and the need for enough recurrent change to be secured to ensure a sound start to next year
- The impact of the external market on activity and income e.g. ophthalmology
- The view that the deficit in activity is retrievable
- The need for more precision over the next few months
- Monitor's understanding of the Trust's issues and their observation of evidence of better planning, albeit with some volatility and vulnerability due to lack of margin.
- EDs' weekly review of the recovery plan and evidence that close monitoring is having a positive impact
- The deliverability of the budgeted EBITDA , the need for appropriate contingency levels and the fact that the Trust is in the early stages of the BSP in terms of financial realisation. DS indicated that although it was not fully transparent, the cost of change costs represent significant contingency. He indicated that he was loathe to change the EBITDA forecast at the moment , pointing out that the Trust was reporting a significantly reduced pay bill and that although off track this month, the EBITDA margin remained solid at £1/2m ahead on this time last year. **It was agreed that an assessment of the outstanding risks would be undertaken for September 2012.** DS observed that the assessment criteria should focus on: **DS**

    - Is the Trust delivering the plan?
    - By how much is the Trust adrift?

    - Does it still deliver and FRR3

- BSP – it was confirmed that the forecast was that the BSP would be off plan by £500k by the end of the quarter, not in month.

The Board:

- **Noted the report**
- **Agreed that an assessment of the outstanding risks would be undertaken for September 2012**
- **Commissioned the Finance and Investment Committee to explore the detail of the Trust's Financial Position**

183/12 20a. BSP REPORT

The paper provided an update on the delivery of the Trust's Business Sustainability Programme and the July 2012 position.

The report gave more detail around programme risks and it was noted that the RAG ratings had been changed to reflect the way Monitor rates risk. The 12/13 forecast had been revised to £8.7m with unidentified savings of £1.5m.

It was noted that the report for the September Board would be amended to provide a forward look in addition to the 'in month' position, including an assessment of the year-end risks for each POD.

Consultant job planning was noted as Amber/Red'. It was explained that savings are now forecast for delivery in Q4, in part due to the Waiting List Initiative project being suspended for a month to endure activity is delivered.

VH queried the BSP impact on Quality and it was explained that the key indicators being tracked to provide early warning of an adverse impact on Quality were:

- Complaints
- Delayed treatment
- Bed movements (impact of ward closure)

PW confirmed that overall, solid progress has been made over the first quarter on the planned developments whilst continuing to deliver existing core services and without adverse impact on Quality. **Quarter 2 report will be brought to the October Board.** **PW**

The Board noted the BSP Report.

184/12 21. BUSINESS PLAN 2012/13 – IMPLEMENTATION UPDATE

The paper updated the Board on progress in delivering the 2012/13 business plan, specifically progress in Q1 across the organisation. BC confirmed that quarterly meetings were taking place with the divisions on the progress they had made against each of their key objectives and what work remained to be undertaken.

It was noted that the Trust's Business Planning Activities would be beginning earlier this year and that the impact of this on the timetable would be significant.

Key issues discussed by the Board included:

- NHS Contract – HR implications
- Potential impact of transition from PCT to CCG Commissioning / contracting
- Trust development of business planning skills, tools and sophistication – corporate support for specialties

The Board noted the paper and the progress made to date.

GOVERNANCE

185/12 22. 2012/13 ANNUAL PLAN REVIEW – MONITOR LETTER

KG referred to the letter from Monitor dated 31st July2012 circulated with the Board papers. The Board observed that the response to the Trust's APR submission had been as expected.

The Board noted the content of the letter

186/12 23. BOARD OF DIRECTORS' – REGISTER OF INTERESTS

The Board was reminded to update the Register of Directors' Interests and return the update to GR.

Date of Next Public Board Meeting 24th September 2012, QEH Conference Room @ 9.00 a.m.

There being no further business, the meeting closed at 12.20pm