Ashford and St. Peter's Hospitals NHS
NHS Foundation Trust

TRUST BOARD MEETING
MINUTES
Open Session
28th May 2012

PRESENT:	Ms Aileen McLeish	Chairman
	Mr Andrew Liles	Chief Executive
	Mr Clive Goodwin	Non-Executive Director
	Dr David Fluck	Interim Medical Director
	Mr Jim Gollan	Non-Executive Director
	Mr Peter Taylor	Non-Executive Director
	Prof Philip Beesley	Non-Executive Director
	Ms Raj Bhamber	Director of Workforce & Organisational Development
	Mr Simon Marshall	Director of Finance & Information
	Ms Sue Ells	Non-Executive Director
	Ms Suzanne Rankin	Chief Nurse
	Mr Terry Price	Non-Executive Director
	Ms Valerie Bartlett	Deputy Chief Executive
SECRETARY:	Ms Jane Gear	Board Secretary/Head of Corporate Affairs

Minute **Action**

Declaration of Interests

There were no declarations of interests in the proceedings.

O-43/2012 MINUTES

The minutes of the meeting held on 26 April 2012 were agreed as a correct record.

MATTERS ARISING

The Trust Board reviewed all of the actions from the previous meeting and the action log which provided a commentary on progress. The nominated leads confirmed that all respective actions had been completed, appeared as agenda items for the meeting or were on track within the agreed timescales.

The following points were noted:

O-44/2012 Corporate Calendar (Minute O – 19/11 Refers):

The Director of Workforce and OD confirmed that intention was to introduce the corporate calendar by the end of May.

O-45/2012 Register of Interests (minute O-54/2012 refers)

The Register of Interests had been updated to include the return submitted

by Simon Marshall, Director of Finance and Information.

There was a clear definition within the Constitution and Standing Orders of which interests had to be declared. However it was noted that Board members often chose to include a wider range of interests in their Register entry.

The Board NOTED the Register.

REPORTS

O-46/2012 Chairman's Report

The Chairman drew attention to the Surrey atrial fibrillation conference organised by the Trust. This had attracted international speakers including Professor Sir Magdi Yacoub. This had been an extremely popular and successful event which the Trust planned to repeat the following year.

An exhibition on the history at St Peter's Hospital was being held at the Chertsey Museum. The exhibition highlighted some of the steps taken from Stately Home to state-of-the-art healthcare and Board members were recommended to attend.

The 50th birthday celebration of the Friends of Ashford Hospital had taken place, hosted by Joint Chairmen, John Belstead and Simon Bhadye. It was encouraging that there was strong active support for the Friends who were looking forward to the forthcoming opening of a new shop manned by volunteers that would raise funds for the benefit of Ashford Hospital.

The Board NOTED the report.

O-47/2012 Chief Executive's Report

The Chief Executive drew attention to the recently held Member's Health Event which had focused on Vascular Services.

This has been an informative and interesting event for the public, highlighting developments in Vascular Surgery and the Trust's own services. It had been well attended with over 40 members of the public and was one of a series of events showcasing Trust Services.

The Board NOTED the report

QUALITY AND SAFETY

O-48/2012 Quality Report

The Medical Director and Chief Nurse introduced the Quality Report. This pulled together the dashboard with associated commentary on exceptions and the best care dashboard.

The quality quadrant contained a range of new and refreshed indicators. The trajectories and targets would be reviewed after Quarter 1 to ensure they were valid and realistic while still being challenging.

The following points in the report were highlighted:

- Future editions of the scorecard would include MRSA and C difficile.

- The annual target for MRSA had been set at one and the Trust had already reported one case of MRSA bacteraemia. The Trust's trajectory for C difficile was 20 and five cases had been recorded year to date. These were challenging targets and the Trust remained committed to maintaining the highest standards of infection control.

- The balanced scorecard included three high level indicators on mortality; summary hospital level mortality indicator (SHMI), HSMR and crude mortality. The SHMI was a useful indicator but was produced two months in arrears. The dashboard also included two diagnoses/condition specific mortality indicators; UTI and hip fractures. A review of palliative care coding had been undertaken and the data was being resubmitted to SUS (Secondary user Service). This would result in a re statement of the Trust's mortality indicators.

- The scorecard now contained two indicators relating to Serious Incidents. The intention was to encourage reporting while seeking to reduce the number of Serious Incidents with significant consequence to patients.

- The scorecard included two indicators which had a high degree of correlation; patient moves and average bed occupancy. The common perception was that if occupancy was high, patients would be moved more frequently. The Trust would be able to understand if this was a true correlation.

- It was confirmed that the Net Promoter Score (NPS) was a fairly universal score of patient satisfaction. It was agreed to confirm whether the data presented included Outpatients and Paediatrics. **SR**

- The NPSA alert which was outstanding related to the risk of miss-matching spinal, epidural and regional devices with connectors. It was reported that the Trust had taken steps internally to mitigate the risk. The view from Trusts nationally was that the NHS needed to undertake independent testing of the wide range of medical devices available. The Trust would also be asking Dr Foster how this outstanding NPSA alert would feature on their risk register for the Trust.

- The report included the NHS safety thermometer which was a new approach to measuring and improving the delivery of harm-free care. It was agreed that the next Quality Report should provide additional clarification on the Tool, the methodology underpinning it and interpretation of the results. **SR**

- The Quality Report included greater detail on the results of the National Inpatient Survey which had been highlighted at the previous Board. Overall, the CQC report indicated that the Trust performance had improved. Out of 64 questions, the Trust demonstrated an "about the same" performance on 60 questions and a worse performance on four questions. This compared with 12 below average scores in 2010. The Board noted that divisional action plans were being progressed to address themes arising from the survey and that these were being monitored monthly through the Clinical Governance Committee.

- The number of complaints had risen, which continued to reflect the national trend. 74% of complaints were now responded to within agreed time scales, which, although short of the target, represented an improvement over March. Early intervention on complaints continued to demonstrate a positive impact.

- The best care dashboard now identified where wards were late in submitting their data. It was noted that Matrons were now undertaking audits on wards outside their direct responsibility. They would do this for a three-month period in order to develop an understanding of, and rapport with, the wards, thus enabling good feedback. The best care dashboard highlighted the need for continued improvement on nursing documentation.

The Board NOTED the report.

O-49/2012 Quality, Safety and Risk Management Strategy

The draft Strategy had been produced in order to provide a clear vision and clarity about the quality, safety and risk management culture the Trust required in order to promote the absolute importance of safety. It drew upon the gap analysis completed following the publication of the National Quality Board advice which had been reviewed by the Board in September 2011.

The Board welcomed the draft Strategy as a positive step forward. However, due to the committee cycle, it had not been discussed at IGAC or the Audit Committee. Board members highlighted the need for a sharpening of accountabilities within the Strategy and the need to ensure that the Board was able to measure its effectiveness. The Strategy, once agreed, would also fit into the auditor's review of risk management arrangements.

The Board NOTED the draft Strategy and that it would revert to the Board for final approval following review by the June IGAC. **SR**

O-50/2012 Annual Safeguarding Children Report

The Chief Nurse as Executive Director lead introduced the Report and highlighted the assurance it provided to the Board.

There had been a significant increase in the number of children subject to a child protection plan. This was in line with the national picture. The demand for child protection had increased by 52% since 2009 with the level of children in need increasing by 44%.

During the discussion, it was confirmed that the Trust was resolving internally the issue of social work support. In addition, it was confirmed that the Trust made many referrals to Social Services, all of which were clearly documented. Repeat referrals were reviewed by the Team and the Trust could be confident that they were escalated as appropriate.

To date, 93% of staff had been trained.

The Board NOTED the report.

O-51/2012 Annual Report on PALS and Complaints 2011-12

Overall, the Report identified a small decrease in the number of contacts with PALS (total 1354) and an increase in formal complaints (total 503). However, there was a good conversion rate as only 50 PALS concerns had gone on to become formal complaints.

The value of early intervention in order to prevent complaints becoming formal was well known. The Trust was using many avenues in order to resolve the issues at the earliest stage. Telephone contact by divisions to complainants was in place and positively received. The Trust had been trialling the use of patient's diaries with a mixed response; this was now being re-piloted in a revised format.

The national Complaints Regulations no longer included a formal response time, but the Trust had agreed to maintain the prior standard of 28 days for a formal response to be sent. Although this had not been achieved in 2011/12, improvements were evident in 2012/13.

The PALS conversion rate suggested the service was working well and adequately resourced.

It was confirmed that compliments were being collated, although the number of informal avenues by which they were received made this more difficult than recording formal complaints. People who submitted formal compliment letters were being encouraged to report these via NHS Choices.

Arrangements were being made for all wards to have boards celebrating *Living Our Values* and compliments would be highlighted through this medium.

The Board was also advised that WOW! awards were being introduced and promoted. The WOW! Awards were part of a national programme enabling patients to nominate staff for getting things right for them and would be part of the Patient Experience Strategy and Staff Engagement Strategy.

Board members highlighted that the Trust had been addressing communication issues, but that this remained a major theme of concern in complaints. It was agreed it would be helpful to separate out written and verbal communication issues and also to identify whether complaints were about outcome of treatment or related to the patient's experience. **SR**

It was confirmed that the Division experiencing the greatest difficulty in responding to complaints in a timely fashion was being actively encouraged and supported and the aim was to have achieved 95% compliance with 28-day target by July 2012.

The Board NOTED the report.

O-52/2012 Director of Infection Prevention and Control Annual report 2011/12:

Dr Angela Shaw was welcomed to the meeting and presented highlights of her report, drawing the Board's attention to the following points:-

- During 2011/12, the Trust had reported two cases of hospital-acquired MRSA; these related to one patient. The Trust was within its DH target of 4.
- The Trust had performed well on hospital-acquired C difficile during

2011-12.

- The targets for both MRSA and C difficile were extremely challenging in 2012/13, reflecting the successful performance of the Trust in the previous year. It is disappointing to note that the Trust had already reported five cases of hospital-acquired C difficile and one case of hospital-acquired MRSA bacteraemia. It would be important to maintain the high profile of infection control over coming months. Dr Shaw confirmed that all possible steps were being taken to prevent incidences of C Difficile but that as 5% of the general population caried C difficile in their gut it was not an organism that could be eliminated totally as any of the carriers could develop C difficile infection if they needed to be given antibiotics…
- It was confirmed there was no nationally monitored target on MSSA. There had been nine cases reported during 2011/12, eight of which related to NICU. A focused meeting was taking place on NICU to see if any additional actions could be taken to prevent such infections.
- One of the audits undertaken related to colorectal surgery surgical site infection surveillance. The survey when performed in June 2010 had shown the rate of infection had fallen to 17.1%, but compared with 10.8% nationally. The survey had been repeated during October to December 2011 and the rate had risen slightly to 19.1% compared with 11.2% nationally. This related to 9/47 patients, of which 7 were actual wound infections. During the Board discussion, the Board was assured that the Team was focussed on reducing the infection rate with actions including trying to replicate best practice identified in highly performing trusts.

The Board NOTED the progress being made on infection control and thanked the Infection Control Team for their hard work and leadership.

PERFORMANCE

O-53/2012 Balanced Scorecard

The Balanced Scorecard contained a refreshed set of performance measures relating to 2012/13. The scorecard was accompanied by an over-arching commentary aimed at drawing together conclusions from the four elements of the scorecard.

Patient Safety and Quality:

This aspect had been addressed earlier on the agenda.

Work Force:

The Director of Workforce drew attention to the following dimensions:

- The targets for completion of staff appraisal and statutory and mandatory training would be included in the next edition of the report. The targets had been set at 98% compliance rate.
- An individual record of mandatory training would be attached with pay slips, so that staff were aware of the content of their centrally held training record, assisting validation and personal ownership.
- There was a high level of agency staff usage. Weekly meetings were in place to address this, primarily with acute and emergency medicine.

Clinical Strategy:

The indicators were set around three main themes; the urgent care pathway, market share and activity. The targets would need review after a three-month period.

DF

It was agreed that the re-admissions rate/target would be confirmed by the next Board report.

Board members questioned whether the target for the discharge rate was set correctly, as it did not appear to reflect differential staffing at weekends. It was agreed that the target should be aligned with the CQUIN target. **DF**

Financial Sustainability:

Overall month one reflected a stronger position than experienced in month one of the previous year, but the Trust remained behind plan. Income had been overachieved but the Trust had overspent on pay and non-pay and underachieved its CIP programme. It was confirmed that financial control was a major focus for the Executive Team.

The contract penalty line in the quadrant needed to be reset to reflect that the contract already assumed a level of penalty incurred. **SM**

In discussing the revised balanced scorecard, it was emphasised that the Executive Team would be scrutinising all targets which needed to have realistic but challenging aims. It would not be acceptable for targets to be reported as red throughout the year. Targets would be reviewed at the end of each quarter.

The Board welcomed the revised approach for the balanced scorecard and the introduction of an overarching commentary. However, it was also agreed that the Board needed to be able to identify sub-areas which were exceptions to overall Trust performance, for example if an aspect of performance was deteriorating in a Division but the top line was positive.

The Board NOTED the report.

O-54/2012 Compliance Framework and Trust Operational Performance:

The report identified that the Trust was consistently achieving all of the performance targets associated with the Monitor Compliance Framework with the exception of the four-hour standard on waiting times in the Emergency Department.

Monitor had introduced three national measures from the Operating Framework which related to referral to treatment waiting times. The Trust was achieving these additional targets and now formed part of routine performance monitoring. The Deputy Chief Executive advised the Board that a visit by a specialist external DOH Team had taken place and reviewed the Trust's compliance with 18-week targets. The visit had confirmed that the Trust was performing well and no additional help was required.

It was noted that the report format needed updating to reflect the changes in the Compliance Framework which have been introduced from April 2012/2013 in respect of CQC Compliance. **VB**

Overall, the indicative governance risk rating, year to date, for Q1 was

amber red.

The Board NOTED the report.

O-55/2012 Compliance with the Four-Hour Standard for Waiting Times in the Emergency Department:

The report provided an update on progress with delivering the four-hour standard for waiting times in the Emergency Department. Current performance stood at 95.12% meaning the Trust was just achieving the year-to-date target, however had missed the target in the preceding week. It was therefore apparent that while there have been a significant step change in performance, the Trust position remained fragile.

The Deputy Chief Executive advised the Board that ECIST continued to support to the Trust. The emergency length of stay had gone down which was one of the number of factors supporting the recent improvement in performance. However, it was clear there was considerable work still to do both within A&E and also achieving cultural change with the physicians.

The importance of identifying key impact changes in order that they could be ring-fenced and reinforced to protect recent improvements was highlighted. It was confirmed that the Trust had introduced debriefs both following challenges in performance and when achievements had been made.

Overall, the Trust needed to continue to embed the programmes of work and ensure that performance within A&E became stronger, the Clinical Commissioning Group needed to be proactive in managing demand, and flow across the whole hospital needed to continue to improve.

Board members were encouraged to visit A&E and support staff in their efforts. Board members would be invited to attend feedback sessions with ECIST. **VB**

The Board NOTED the report.

STRATEGY AND PLANNING

O-56/2012 Surrey Pathology Services Update:

Dr Ian Fry and Dr Andrew Laurie were welcomed to the meeting as Clinical Director and Medical Director of the network. The Board had previously received regular reports on the establishment of the network and had received an early report on implementation, including commercial matters, at the closed April Board meeting. The network had gone live from 1 April 2012 and the May report requested by the Board showed current performance.

It was highlighted that the reconfiguration was still in an interim phase and transfer of staff and equipment was not yet complete. There had been an initial decline in test turnaround when the newly configured service went live, but KPIs were now showing evidence of improvement. It was emphasised that as the physical moves were completed, the benefits of the changes were becoming apparent and staff morale was improving.

In addition to the KPIs, the Board was advised that an issue log was being maintained as staff identified concerns. Steady progress was being made in resolving these issues.

During the discussion it was confirmed that there had been considerable engagement with the staff group but the long period prior to setup meant that staff had been subject to a considerable period of uncertainty. It was acknowledged that a number of logistical issues could have been resolved earlier.

The Board was advised that overall, inpatient and outpatient work was being turned around promptly and standards were good. Quality levels were roughly equivalent to those prior to establishment of the network, and were being monitored closely. There had been some negative impact on General Practice but these were indirect rather than significantly impacting on patient care. Improvements to the transport arrangements supporting General Practice were being implemented which would have a significant impact on turnaround.

Overall the expectation was that within the next two months the service would be consistently maintaining turnaround times and service levels. The importance of continuous communicating with GPs was known and being addressed.

The Chief Executive advised the Board that he was a member of the Tripartite Surrey Pathology Service Board which included all three chief executives and met monthly.

Whilst noting the interim stage of the re-configuration, Board members congratulated the network Clinical Director and Medical Director for leading a highly complex change programme.

The Board NOTED that report.

REGULATORY

FOR INFORMATION

O-57/2012 Trust Executive Committee Minutes

The Board NOTED the draft minutes of the TEC meeting held on 22 April 2012.

O-58/2012 Finance Committee Minutes

The Board NOTED the minutes of the Finance Committee meeting held on 18 April 2012.

ANY OTHER BUSINESS

O-59/2012 Patient Food:

It was highlighted that the Board had tasted the new patient menu introduced earlier in the year and congratulated the service on the improvements.

O-60/2012 QUESTIONS FROM THE PUBLIC

It was confirmed that the Ombudsman case referred to in the Quality Report related to care received by a patient nine years ago. The delay in the case reaching conclusion was outside the Trust's control.

DATE OF NEXT MEETING

O-61/2012 28 June 2012

Signed: ……
Chairman

Date: 28th June 2012

SUMMARY ACTION POINTS

Board Date	Minute Ref	Topic	Action	Lead	Due Date	Comment as at 18 June 2012	Status
26/05/11	O-87/11	**Quality Report**	Progress on the diabetes inpatient audit action plan to be reported back to the Trust Board at a future MDT presentation.	SR	~~24/11/11~~ 28/07/12	New NPSA alert received and change of alert lead. Update to July Board.	**---**
30/06/11	O-119/11	**Corporate Calendar**	Develop a corporate calendar for the NEDs	RB	29/09/11	Draft circulated	**---**
26/01/12	O-4/12	**Patient Appointment Telephone Bookings**	6 month update report on telephone response times	VB	26/07/12	Not due	**ND**
29/03/12	O-28/2012	**Board Assurance Framework:**	Progress refresh of BAF	JG	28/05/12	Draft discussed at IGAC and on Board agenda	✔
29/03/12	O-30/2012	**Quality report- Best care dashboard**	Six-month stock take showing performance trends.	SR	28/06/12	Verbal update to be given	
29/03/12	O-33/2012	**Information Governance Toolkit**	Ensure all Directors are up to date with Information governance training	AL/JG	26/04/12	Directors notified	
29/03/12	O-35/2012	**Sustainability**	Report back on progress with action plan	VB	27/09/12	Not due	**ND**

Board Date	Minute Ref	Topic	Action	Lead	Due Date	Comment as at 18 June 2012	Status
28/05/12	O-48/2012	**Quality report**	Confirm if NPS includes paediatrics and Outpatients	SR	28/06/12	The NPS included in the main Quality report is only adult inpatients	✔
28/05/12	O-48/2012	**Quality report**	Provide further detail of the NHS safety thermometer methodology and interpretation	SR	28/06/12	See Quality report in June Board papers	✔
28/05/12	O-49/2012	**Quality safety and Risk Strategy**	Revert to Board after IGAC	SR	28/06/12	Reviewed at IGAC 20 June 2012. Board agenda item	✔
28/05/12	O-53/2012	**Balanced scorecard**	• Confirm readmissions target • Target rate for discharge at w/e • Reset Contract penalty line	DF/SM	28/06/12	Targets reviewed and updated	✔
28/05/12	O-54/2012	**Compliance framework**	Update targets in the template to match 2012/13 Compliance Framework	VB	28/06/12	Completed	✔
28/05/12	O-55/2012	**Compliance with 4 hour standard**	Invite NEDs to ECIST debriefs	VB	28/06/12	Completed 29 May 2012	✔

Key

---	**On Track according to timetable**
✔	**Completed according to timetable**
ND	**Not due yet**