West Hertfordshire Hospitals NHS
NHS Trust

Part 1 Board Meeting

Thursday 27 September 2012

M I N U T E S

Present:

Thomas Hanahoe	Chairman (TH)
Jan Filochowski	Chief Executive (JF)
Katharine Charter	Non Executive Director (KC)
Sarah Connor	Non Executive Director (SC)
Mahdi Hasan	Non Executive Director (MH)
Chris Green	Non Executive Director (CG)
Robin Douglas	Non Executive Director (RD)
Colin Johnston	Medical Director (CJ)
Anna Anderson	Director of Finance (AA)
Natalie Forrest	Director of Nursing (NF)
Chris Pocklington	Chief Operating Officer (CP)

In attendance:

Patricia Duncan	Company Secretary (PD)
Mark Vaughan	Director of Workforce (MV)
Paul Jenkins	Director for Partnerships (PJ)
Louise Gaffney	Director of Estates and Infrastructure (LG)
Elizabeth Rippon	Director of Communications (ER)

Apologies

Phil Townsend	Non Executive Director

Agenda Item		Action
1.	**Chair's introduction** TH opened the meeting noting it was JF's last prior to his taking up his post with Great Ormond Street Hospital Foundation Trust. The Chair, on behalf of the Board thanked JF for the significant contribution he had made to the Trust and for his leadership in the achievements made since he joined in 2007. JF responded that he had enjoyed working with the Trust and that it had been a pleasure to work with so many committed staff. The Chair wished JF well in his new post.	

	The Chair confirmed that the recruitment process had begun and interviews would be held during November and that NF had been appointed to the interim post until a substantive appointment was made. The Chair further confirmed that Maxine McVey had been appointed as Interim Director of Nursing. The Chair noted the very positive feedback on Trust performance, received from the SHA and included in the papers. The Chair then reflected on a recent visit by Anna Soubrey, Minister of State for Health, with Richard Harrington, MP. They visited different departments within the hospital and were briefed on the Watford Campus Project. The Minister expressed her support to the Trust in this initiative. The Chair noted that the Trust continued to receive unqualified registration with the safety and quality standards of the Care Quality Committee. The Chair reflected also on the recent Annual General Meeting which received the highest ever recorded attendance by members of the public. The Chair congratulated the Director of Workforce and his department for an initiative that had reached the final round of the Health Service Journal awards for staff engagement. The Chair also noted that the Trust had been awarded accreditation under the 'Healthy At Work' standard by the Strategic Health Authority. The Chair noted the continuing high demand for the Trust's emergency services and the considerable work under way to resolve issues both within and outside the Trust. Finally the Chair confirmed that the format of the Board meetings would change from November with the public session, part 1 beginning at 10.00 am and the closed session, part 2 would be held in the afternoon, beginning at 1.30 pm.	
2.	**(i) Apologies** Phil Townsend **(ii) Committee Membership** The Chair announced two changes to Committee membership. He advised that KC had stepped down as Vice Chair and thanked her for her support during her tenure. The Chair proposed MH for the position and this was seconded by NF and CG. The Board unanimously supported the nomination and MH was elected as Vice Chair. It was also noted that SC would relinquish her position on the Remuneration Committee to reduce her already extensive committee commitments and that the Chairman would become a member of the Finance Committee.	**Board Decision**: To approve the nomination of MH as Vice Chair.

3.	**Declarations of Interest** None declared.	
4.	**Minutes** KC was present. SC advised the amendments required at the previous meeting were not accurately represented. Otherwise the minutes were accepted as accurate.	**Action:** Co Sec to amend.
5.	**Matters Arising** AA Confirmed that Dr David Gaunt had been appointed as the Clinical lead in the implementation of the IT Strategy in the role of Associate Medical Director, IT. PJ confirmed that the Board of the UCL Academic Health Science Centre had approved the Trust's request to join. PJ confirmed that 89% of staff had received mandatory training in Information Governance and the Trust was on trajectory to achieve the target at the year end. NF noted that two surveys were underway, a Younger People's Survey of Services and the Day Surgery Survey. The results of these would be included in the Patient Experience Report scheduled for the November Board.	**Action:** NF to include outcomes of YP and DS surveys in November's Patient Experience report.
6.	**Chief Executive's Briefing** JF noted the ongoing challenge of rising admissions which placed the Trust under considerable pressure in meeting quality of care and budgetary targets. However he reflected that the Trust continued to perform generally well with overall better performance, lower infection control rates, lower waiting times and higher standards of patient safety than when he took up post. MH observed that the current position merited consideration of introducing sensitivity analysis into reporting better to reflect the level of sustainability of the targets achieved. CP and PJ agreed they would be addressing this and linking to BAF reports.	
7.	**Watford Health Campus** LG presented her report and confirmed the appointment of Kier as the Development Partner, based on a bid that demonstrated partnership and sustainability as key guiding principles. LG noted a Campus Agreement would be signed.	
8.	**Integrated Performance Report, together with PMR self certification** PJ took the Board through the key headlines of this report and current performance. It was noted that the current position was a disappointment but that a number of actions were in train and were captured in LG's paper at item 10.	

	PJ noted the deteriorating position with regard to A&E performance but that this was within the context of a growth in admissions of 6%, ytd, although outpatient attendances were less than plan for both elective and non elective. CP reiterated the importance of the reconfiguration work in taking forward new models of care in partnership with key agencies.	
9.	**Finance Report, including Getting Better** NF noted the summary in the Finance Report and was pleased to report a step change in Divisional commitment during July and August, with some £6.6m of plans in place compared to £4.2m to the same period in the previous year. CP, AA and NF were jointly directing the development of savings plans with Divisions and NF confirmed that they had been informed that the original target plan remained at £11.6m. AA noted the strong drivers for change and that the work would continue to be driven by the Executive Team with the support of Guy Musson who would take up post as GB Project Director on 1 October. AA confirmed that all cost improvement programmes were assessed for their impact on quality and these assessments were shared with the PCT. KC noted that some schemes did not appear to be confirmed and NF advised these would be at Gateway by the next meeting of the Board. AA noted that green schemes were at £1m higher than in the previous year. The Board reviewed the Finance report and AA noted that she believed the assurance provided in her report was sufficient rather than the limited recorded in the cover sheet. In a response to a query from RD on support for the funding of the surge ward AA advised that confirmation of the PCT's contribution had not been received but indications were it would be in the region of £1.1m. RD also noted with concern the spike in the costs of temporary staff and MV advised this was partly attributable to accruals in invoicing and the impact of staff leaving and not being immediately replaced.	
10.	**Service Reconfiguration** LG briefed the Board on the programme of work being taken forward under the auspices of a recently established group which would direct a multi-faceted improvement programme involving both internal reconfiguration and external engagement to address issues. LG took the Board through the work underway to address capacity	

	issues which included a re-design of some pathways. She presented data showing year on year increases in emergency attendances (although paediatric attendances were similar to the previous year). LG noted there were implications for the patient experience in managing these rises, including an increase in patients being discharged to home from the ICU rather than being transferred to step down acute care. LG noted the introduction of ambulatory care which although treating 20 patients per day was not sufficient to mitigate the increase in demand. The Board discussion focused on ambulance attendances, GP referrals and the acuity of patients and CJ noted that a meeting was scheduled with the ambulance service and the PCT to consider trends and possible solutions. RD noted the multi dimensional approach to tackling the issues and MH agreed but noted the need for an indicative timescale to determine the impact and to consider the possibility of 7 day working. The Board was content to accept the plans in place which incorporated internal process issues as well as issues to be addressed across the patient pathway and involving health and social care partners.	
11.	**Infection Control Annual Report** CJ noted the disappointing position with regard to Clostridium Difficile which compounded the recently reported MRSA resulting in a limited assurance conclusion. He noted the Board had an opportunity to review the very good work in place reported in the Annual Report on Infection Control 2011/12 (item 11 (i)) He confirmed that 21 cases of clostridium difficile had been reported which compared to 17 cases in the previous year to date. The risk of not meeting the target has increased and CJ reported there would be financial consequences to failure as well as quality impacts. CJ believed the deterioration was linked to the pressures on the hospital and this was supported by the root cause analysis of incidents which identified that overall processes of care were appropriate. CJ noted that 50% of the cases reported were of a more virulent strain from which patients were more likely to relapse. He noted that the Trust was liaising with the Health Protection Agency and that the SHA were supportive of the actions in place. RD asked if the Trust had considered commissioning an independent investigation and CJ confirmed that the Trust had commissioned the Health Protection Agency. MH was reassured that the Trust's RCA process found no evidence of cross infection but asked if the Trust was able to compare trends with other Trusts and CJ confirmed this would be undertaken with the HPA.	

	CJ provided the Board with a summary of the processes of risk assessing patients. RD observed there were two aspects to consider (i) is the Trust doing all possible to reduce hospital acquired infection? and (ii) are there implications wider than the Trust? CJ reiterated that the Trust had reviewed its practice and the only issue in regard to infection control processes that could not be fully addressed related to current pressures. CJ noted the problems in accessing some wards to deploy the Sterinis clean as wards must be vacated do to this. CP noted this was inevitable with the current 95% occupancy rate. The Chair noted the progress outlined in the Annual Report but concluded that whilst infection control practice remained good, there were issues to address. MH requested that the Board is apprised of any 'by exception' findings from the HPA review and CJ agreed to do so.	**Action:** CJ to advise of any 'by exception' findings from the HPA review.
12.	**Board Assurance Framework** CJ introduced the summary report, the appendix having been made available to Board members electronically. He noted that much of the previous discussion related to key risks and that the BAF had been updated to reflect the current position. He apprised the Board of the background to the escalation of a risk relating to health records and noted that the risk relating to the CT scanner had reduced because the mitigating controls were effective in minimizing down time. There being no further issues raised, the Chair confirmed the Board was content to accept the current position.	
13.	**Safeguarding Adults Annual Report** NF introduced the Annual Report of the Safeguarding Adults programme and there being no questions relating to it, the Board approved the report.	
14.	**SI Summary** CJ introduced this report which recorded the serious incidents reported since the previous meeting and the actions in place to respond and learn from these and previous serious incidents. CJ was pleased to confirm to the Board that the Trust had had 12 months without a never event. The Board approved the report.	
15.	**CQC 6 Monthly Report** CJ reported that the Trust remained compliant with CQC outcomes for quality and safety and that he and NF, with PD had met the new local assessor and manager who advised CQC had no concerns and no issues had been raised.	
16.	**Quality Account – Quarter 1 Progress Report** NF introduced this report noting that good progress was being made	

	against the Trust's quality priorities. NF noted that progress in reducing caesarian sections was affected by the prevalence of a cohort of women who chose to have a section, despite there being no clinical need and their being apprised of the risks. The Board agreed choice was important but that more work was needed to reduce the number of emergency caesarian sections.	
17.	**Making Every Contact Count – Implementation Plan** NF introduced this paper noting this initiative was in its early stages but that it was important that Board members supported the aspirations in the plan. NF noted this was also a CQUIN target. The Chair on behalf of the Board welcomed this important initiative to utilize opportunities to address health promotion opportunities to patients during routine health consultations or admissions and endorsed the Implementation Plan.	
18.	**Unannounced LINks Inspections** NF introduced this summary of findings following two recent inspections which identified good care but offered some recommendations for further improvement. The report apprised the Board of forthcoming changes with the introduction of Healthwatch in October.	
19.	**Report of Integrated Risk and Governance Committee Meeting 13 September 2012** The Chair of the Committee, MH, noted his report and there were no questions raised.	
20.	**Report of the Finance Committee Meeting 13 September 2012** The Chair, CG, noted his report and commented on an extensive review of the Cost Improvement Programme and a review of the risks of not achieving the target. He advised that the Committee had requested a rolling up date of the position at each meeting to the year end and that the Committee had asked for a 2 year rolling programme, which had been agreed. NF noted that this would be a key objective for the new Programme Director, Guy Musson. LG noted that backlog maintenance works would continue as planned within the budget.	
21.	**Report of the Audit Committee Meeting 13 September 2012** The Chair, SC, noted her report and wished to raise to the Board the Committee's concern that the Gifts and Hospitality Policy was not currently being monitored because of a resource issue and the Committee believed it was important to ensure there was sufficient resource to support implementation of key control policies. MV noted he had met with PD to discuss the way forward and that a new member of staff would be joining the Secretariat. SC noted the outcome of the annual review of Audit Committee effectiveness and that the Committee had approved draft objectives for approval by the	**Board Decision:** The Board approved the objectives for the Audit Committee. **Chair:** To consider the advantage of objectives for

	Board. The Board approved the Audit Committee objectives and SC advised she would provide an end of year report on progress. SC asked that the Board consider the development of objectives for all Board committees. The Chair agreed to give this further consideration.	all Board committees.
22.	**Report of the Strategy Committee Meeting** CG noted his report and the focus of discussions and noted the forthcoming Strategy Away Day which would involve Divisional Directors. He noted that Directors had been asked to produce implementation plans to sit behind the strategy.	
23.	**Report from the Chair of the Charitable Funds Committee** KC noted the Committee had met prior to the Board meeting and signed off the annual accounts which stood at £1.5m at year end. She noted the funds spent £700K which represented an 80% increase in expenditure on the previous year, of which a large proportion was spent on ward based improvements. The fund realized income of £450K. KC noted recent communication with fund-holders to ensure spending plans were in place to utilize funds and to ensure there was better accountability for the disposition of funds donated. KC indicated she would work with ER to develop communications to support this. KC wished to work with ER to develop some communications around this. KC noted there was resistance to top slicing funds and PD noted the Committee was currently without a clinical representative. CJ agreed to write to the JCC to invite a nomination.	**Action:** PD to draft letter of invite for representation to be signed by CJ.
24.	**Patient Safety** The Chair noted that many issues were discussed during the meeting and invited members to raise any concerns they had that related to patient safety. There were no concerns raised and the Chair was content this indicated the Board was satisfied with actions in place to mitigate risks to patient safety.	
25.	**Local Involvement Network (LINks)** Mr. Kenneth Appel provided feedback to the Board on matters of interest or concern: **Hospital Food** – Mr. Appel commented that during his recent episode of care as an in-patient he was pleased to report that the food served was of a high standard. **Bus Services** – On requesting an update LG responded she awaited a response from the Council but that the Trust had no influence on bus services. **Health Campus** – Mr. Appel noted a concern about the extra traffic that would result and was advised that there were plans to upgrade	

	the car parking facilities on site ahead of the construction of the new road. **AAA** – Mr. Appel was concerned that his comments relating to this issue at the previous meeting may have been misleading. **Car Parking** – Mr. Appel noted there continued to be concern at car parking charges.	
	Ward Visits The Chair noted that the visits had focused on two areas, the catheter laboratory and a surgical ward. KC noted she was very impressed with the facilities at the catheter lab and the services provided but was concerned that the current pressures had created problems for the service. ER noted that the visit to the surgical ward had replaced a visit to the ambulatory care facility. The Divisional Director for Surgery presented his thoughts on possible solutions to improving the management of patients admitted to surgery through the acute care pathway. All Board members agreed the format of the visits had allowed more time to discuss issues with clinicians and that it offered important insight into key issues and how they were being addressed. The Chair welcomed the engagement of senior clinicians and suggested this format should be used for future visits and the Board agreed to this.	
	AOB There being no other business the Chair closed the meeting.	
9.	**Date of Next Meeting: 29 November 2012 at 09.00 hours in Lecture Theatre 1, MEC, WGH (part 1 at 09.00 to 12.00 hrs. Part 2 at 12.30 to 17.00 hrs)**	