West Hertfordshire Hospitals NHS
NHS Trust

Part 1 Board Meeting

Thursday 29 November 2012

M I N U T E S

Present:

Thomas Hanahoe	Chairman (TH)
Natalie Forrest	Interim Chief Executive Officer (NF)
Maxine McVey	Interim Director of Nursing (MMV)
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)
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

Anna Anderson	Director of Finance (AA)
Katharine Charter	Non Executive Director (KC)

Agenda Item		Action
1.	**Chair's introduction** TH opened the meeting by welcoming members of the public and noted the earlier start was due to an extended afternoon session of the Board. TH also welcomed NF as Interim Chief Executive Officer and MMV as Interim Director of Nursing. In the absence of the Director of Finance, NF would present the Finance Report. The Chair noted that in the wake of the allegations surrounding the late Jimmy Savile, the Secretary of State has asked Kate Lampard, a former barrister, to provide assurance to the Department of Health	**Action:** NF to report to Board on patient safeguarding **Action:** MMV and CJ to report on CQC

	on patient protection issues. David Nicholson, the CEO of the NHS, has asked all NHS Trusts to review their practices regarding access to vulnerable patients. NF will report to the January Board The Chair reported updates to the Never Events Framework Policy and on the publication of the Speaking Up Charter, which supports those who raise concerns about issues in the public sector. The Chair reflected on the CQC State of Care Report which highlighted three factors that can lead to poor quality care: 1. High vacancy rates and poor deployment of staff in some areas; 2. Too much emphasis on task at the expense of patient-centred care; 3. A culture in which poor performance or practice went unchallenged. The Chair noted the report's findings should be communicated to ensure all staff understand and recognise factors that can affect the quality of care. The Chair congratulated staff involved in a Staff Engagement project which was a runner up at the recent Health Service Journal awards.	comments to the December Board
2.	**(i) Apologies were noted and accepted from:** AA - Director of Finance and KC - Non Executive Director	
3.	**Declarations of Interest** None declared.	
4.	**Minutes** Minutes of 27 September 2012 were approved and signed as a true record.	.
5.	**Matters Arising** Action Point 2 of 27 September was amended and closed.	

6.	**Chief Executive's Report** NF noted recent appointments to the Local Area Team of the NHS Commissioning Board and to CCGs. NF informed the Board that a decision on vascular services was awaited. NF and CP reported on the continuing A&E pressures over the last few weeks noting that the situation was deemed of sufficient concern to report an SI around sustaining services. NF expressed concern that partners were not in a position to provide the support necessary to progress patients through their care pathway. NF was optimistic that more recent discussions to progress these concerns with partner organisations have been positive. NF noted we await a response from the Local Area Team of the National Commissioning Board (LAT). The Board received information regarding ambulance service decisions about where to convey patients which may contribute to pressures. CP noted that some patients experienced delays in their care being transferred to the Trust but assured that all patients receive appropriate assessment and triage of needs on arrival. It was noted that LG was leading a system-wide review of current pathways. N F reported the recent of an Improvement Notice from the PCT which may trigger a financial penalty to be applied and NF advised she would be writing to the CEO at the PCT to negotiate a solution.	**Action:** NF to update on vascular bid at end of December **Action:** LG to report on progress in the system wide review of pathways at a future meeting. **Action:** NF to write to Jane Halpin regarding potential fines
7.	**Foundation Trust** ER reported that the FT application remained lodged with DH. ER outlined the options going forward for re-submission which would be considered in more detail in part 2 of the meeting, with a view to agreeing a timeline. NF confirmed this decision would be communicated to the SHA.	
8.	**Integrated Risk and Governance Committee Report** MH noted his report and wished to thank the risk team for supporting the improvement in presentation of the organisation's risks, providing an at a glance, high level summary of the risk profile. MH noted that CJ would later brief the Board on a recently escalated risk.	
9.	**Risk Management Strategy** PD noted that the IRaGC had reviewed the changes and approved the revised Strategy commending it to the Board for ratification. The Strategy had also been reviewed and approved for ratification by the Audit Committee. The Board approved the updated Strategy.	

10.	**Board Assurance Framework** CJ reported the following updates which had been discussed at the Integrated Risk and Governance Committee: • **2719 increase in emergency demands** – The Trust has responded to the CQC request for information in connection with the use of the catheter lab as a surge facility. The ongoing challenges have led to a recommendation which was accepted that the risk score is increasing. • **2768 pathology-** CJ noted the ongoing delays in reaching a decision on consolidation posed a threat to staffing levels which were being managed but the delay was outside the control of the Trust. CJ noted a decision was expected in the New Year • **2828 Datix system functionality-** CJ noted that the current servers were part of the interim shoring up of IT infrastructure. He noted that further investment was required to purchase the software necessary to platform and purchase the web based risk register module and to take advantage of improved functionality of the system made possible in recent upgrade releases. The business case was being amended to reflect this. • **2136 Estates risk-** CJ regretted to advise that legionella counts in ITU were at potentially significant levels and interim mitigation arrangements were in place. However CJ noted replacement of pipework would mean closure of ITU which, in turn, could affect the functioning of the hospital. LG was working on a systematic plan for the chemical flush to mitigate this • **2766/2767/2136 and 2719-** all to be uprated with mitigation in place.	
11.	**Annual Plan Mid-Year Review** PJ noted the Annual Plan was submitted to the SHA in March 2012 and that this review provided an update on progress. The Board noted the report.	
12.	**Strategy Committee Report** CG reported good progress on the Watford Campus development which would be further considered in the Part 2 Board. CG confirmed that the Strategy Sub-Committee had been stepped down and that ongoing strategy development would be taken forward through a Strategic Development Group led by LG TH thanked CG on behalf of the Board for his past work on this committee.	

13.	**Clinical Strategy and Infrastructure Strategy - Strategic Reconfiguration** LG asked the Board to formally ratify the ***Delivering High Quality Care for You*** initiative, which was agreed. LG reported on progress with the estates rationalisation programme. Following discussions with the PCT Board and the CCG there have been discussions to review the wider strategy and the Trust has been represented at the Dacorum ***"Hot Topics"*** group to share information. LG outlined the issues around having an MRI scanner at all three hospital sites. The Board was concerned about the delay in receiving the financial information from Kier but was assured by LG that this would not impinge on the Board's opportunity to fully review the detail.	
14.	**Finance Report** NF reiterated AA's report noting that September was a difficult month for all organisations but that we have seen an improvement in October. As previously noted, the Trust may receive financial penalties in the form of fines for failed targets and mitigation actions are in place. NF noted we continue to hold the £7m reserved for the new road as it is not yet required for the construction. NF noted that as required by the Board, budgets have been devolved to divisions. SC suggested that as Service Line Reporting was now more embedded divisions should undertake variance control analysis. The Board discussed additional payments to consultants for work outside their contracted hours and noted the cost implications of weekend surgical lists. The Board agreed such costs need to be reduced and asked that measures are taken to reduce the need through improved utilisation of resources.	**Action:** Steve Clark to see NF and AA in January **Action:** NF to feed back on divisional input to variance control analyses
15.	**Integrated Performance Report** PJ noted that this was a report by exception and that areas showing red had an action plan in place which was being closely monitored. PJ reported that A&E performance dipped below 95% and that the 18 week referral to treatment programme continued to be challenged in 4 specialties. PJ noted that complaint handling was improving and the Friends and Family survey score was also positive for the Trust. MV reported concerns about the level of agency pay and a mitigating action was to fast track nursing vacancies resulting in the planned	

	recruitment of 28 new staff starting in December. This is aligned to other actions to ensure best use of resources. CJ reported that the mortality rates remain low noting the different methods of data capture for the two main sources of data, CHKS and Standard Hospital Mortality Index (SHMI). SHMI includes 30 day post discharge events but CHKS does not. CJ confirmed that events are reviewed at the Trust's Mortality Group but that currently there is no pathway across to primary care to review whether issues reflect our care of factors pertinent to other care settings. CJ noted indications are there is no link between non-arrival or late arrival of discharge letters to GPs and the Trust has relatively low rates of readmission. The Board noted the report.	
16.	**Finance Committee Report** CG stated the need for continuity, noting concerns about the changes to staff leading on the CIP programme which he believed created a risk to achievement of targets.	
17.	**Patient Experience- An overview of Local and National Outcomes** MMV introduced this report based on an analysis of a number of internal surveys on patient satisfaction, including a new category of paediatric inpatients. These demonstrate a number of positive assurances in areas such as meals and environment, however communication with medical and nursing staff continues to represent an issue of concern. MMV noted there is a project underway to improve the quality of patient information which may assist in improving communication between patients and clinical staff. NF outlined some of the measures undertaken, such as protected mealtimes that have led to improvements and TH thanked MMV for the report and was gratified to see the positive outcomes.	
18.	**Patient Experience -Briefing on Health Service Ombudsman's Annual Report** MMV introduced this report produced by the Health Service Ombudsman which covers a period of 20 months hence the Trust is reported as one with a higher number of complaints referred to the Ombudsman. Despite this, MMV advised that the Trust has fewer complaints upheld and of the 64 in the reporting period only 15 were upheld. NF confirmed that it was standard procedure in the NHS to refer all complainants to the Ombudsman if local resolution is not successful. The Board noted the report.	**Action:** To appear on Development Day agenda in December

19.	**Implementing Revalidation for Doctors** CJ introduced this report noting revalidation will begin from 1 December and the Trust's processes to support this are based on national guidelines. CJ noted an indirect pressure is likely because of the time it will take for medical staff and appraisers to complete the documentation. However CJ was confident the Trust is prepared and that re-validation will provide further assurance in relation to fitness to practice issues.	
20.	**Harm Free Care** MMV apologised that the VTE figures had been incorrect and clarified the correct position. MMV briefed the board on the Harm Free Care initiative, of which the Board has received earlier briefings. MMV was pleased to confirm that the Trust's audit revealed 93% Harm Free Care status and whilst it may not be realistic to achieve 100% the Trust was working to the principle of continuous improvement and had set incremental targets above 93%. MMV confirmed that the audits inform proactive measures to minimise risk of harm such as providing non-slip slippers for vulnerable patients to reduce their risk of falling.	
21.	**Infection Control Report** CJ introduced the report on current performance for MRSA, MSSA, e-coli and Clostridium Difficile. For the latter CJ noted we had reached the annual target and the potential for exceeding this which would result in a financial penalty imposed by commissioners. CJ advised that as had been reported previously, the Trust is dealing with an increase in type 027 which has a 50% higher likelihood of recurrence. This, as with other strains, is likely to be linked to inappropriate us of antibiotics. CJ explained that the continuing high levels of activity create additional pressures in securing isolation areas but that weekly hand hygiene audits continue to demonstrate high levels of compliance.	
22.	**Serious Incident Summary** CJ reported an increase in SIs relating to Pressure Ulcers and continued to report no incidents relating to never events. MH was concerned about the root cause analysis conclusions drawn in areas of the report and CJ agreed to go through this with him. The Board noted the report.	**Action:** CJ/PD to meet MH to discuss RCA process.

23.	**Report from the Chair of the Audit Committee** SC noted her report had been circulated with the papers and invited comment. RD was concerned about the reported delays in the SLR benchmarking report and its quality. SC noted however that the audit of Gifts and Hospitality had been positive, as had the report outlining progress in Counter Fraud. There being no further questions the Chair thanked SC for her report.	
24.	**Patient Safety** NF noted there were no issues to report relating to threats to patient safety and that Heronsgate and ITU were the subject of a Quality Review visit by the PCT which generated positive feedback.	
25.	**Local Involvement Network (LINks)** Apologies had been previously received from Mr Kenneth Appel and therefore no matters were raised.	
26.	**Questions from the public** Questions were received on the following issues: • **Why ward visits no longer took place before Board meetings**. TH confirmed visits preceded Development Day meetings only. PD explained that the agendas for Board meetings were very full and it was not possible to accommodate the feedback from the visits meaningfully. In answer to a comment that the feedback was useful for members of the public to hear PD clarified that LINKs and in the near future Healthwatch, had a statutory right of access and provided formal feedback to Trust Boards. PD noted that LINks reports are published on the Trust website for information. • **Can a glossary of acronyms be made available.** TH confirmed this will be updated. • **Why is there no information on the Public Board Meeting of 20 December-** PD reported that an Extraordinary meeting of the Board was being planned and 20 December identified but that timings have yet to be confirmed. • **Can we have a one-sentence summary on the reason for the delay in FT application-** TH confirmed the Trust is revising its Integrated Business Plan and aligned to that its long-term financial model. • **Why are WHHT not represented at the PCT Board-** PJ advised the Trust is represented at CCG meetings and executives attend many senior meetings and confirmed there is a good working relationship with the PCT. • **Can we be assured that the needs of Dacorum patients, particularly the expanding ageing population, will be met by the Trust-** TH provided assurance that the Board is fully apprised of the challenges posed by demographic change	**Action:** PD to update glossary of NHS acronyms

	that the model of care for the elderly is receiving close attention.	
27.	**AOB** None received	
28.	**Dates of Next Meetings:** **31 January 2013 -St Albans Hospital** **28 March 2013 - Watford General Hospital** **30 May 2013 - Hemel Hempstead Hospital** **25 July 2013 - Watford General Hospital** **26 September 2013 - Watford General Hospital** **28 November 2013 - Watford General Hospital**	