North Cumbria University Hospitals NHS
NHS Trust

MINUTES OF THE TRUST BOARD MEETING HELD IN PUBLIC ON TUESDAY, 13 MARCH 2012 AT 1PM IN THE BOARD ROOM, WEST CUMBERLAND HOSPITAL, WHITEHAVEN

Present:	**Mr M Little, Chairman** **Mr M Bonner, Vice Chairman** **Mr M Evens, Non Executive Director** **Ms J Cooke, Non Executive Director** **Professor V Bruce, Non Executive Director** **Dr N Goodwin, Interim Chief Executive** **Mr A Mulvey, Director of Finance** **Ms C Siddall, Director of Operations** **Mr M Walker, Medical Director**
In Attendance:	**Mr D Gallagher, Director of Human Resources & Organisational Development** **Mrs R Duguid, Acting Director of Governance/Company Secretary** **Miss E Kay, Head of Communications & Reputation Management** **Mrs J Stockdale, Head of Corporate Affairs**

CLINICAL PRESENTATION – THE HEART CENTRE – DR ROGER MOORE, LEAD CONSULTANT IN INTERVENTION CARDIOLOGY AND LYNNE GORLEY, BUSINESS MANAGER

The Chairman welcomed Dr R Moore, Lead Consultant in Intervention Cardiology and Ms L Gorley, Business Manager, to the meeting.

Dr Moore presented to the Board details of the newly developed Percutaneous Coronary Intervention (PCI) service for Cumbria which was based in the Heart Centre on the Cumberland Infirmary site (see attached copy of presentation).

Dr Moore explained that following approval of phase 1 of the business case for the development of a local PCI service, the Heart Centre became operational in December 2011, providing an Elective and ACS PCI service. This service was provided Monday to Friday between the hours of 08.30 – 12.00. The business case for Phase 2 was currently being developed and it was hoped to commence this from December 2012, which would provide primary PCI with 24/7 acute service.

To date, approximately 592 patients had been seen in the new Heart Centre, all of whom would have previously had to travel to Middlesborough/Newcastle for their treatment prior to the commencement of this local service.

The Board were pleased to note that the angiography waiting times had also been significantly reduced to between 3-4 weeks instead of 6 weeks.

The Trust was currently in discussions with Morecambe Bay, and working through increased activity plans, with a view to south Lakeland patients receiving their PCI service in north Cumbria.

Following a recent visit to the Centre by the British Cardiovascular Intervention Society, they had indicated that they were pleased with the set up and development of the service.

Dr Moore outlined a typical PCI procedure to the Board.

Dr Moore explained that the procedure, including set-up, took approximately 40 minutes. He explained that in most other centres these procedures were carried out as day cases, and although patients were currently kept in overnight, the centre would be working towards this.

The Board discussed the data presented on the health needs of the local population in comparison to other areas across the North of England and Scotland.

In answer to a query regarding possible complications, Dr Moore outlined the procedure for the use of the 'blue light' ambulance, which had been trialled by the team.

Mr Bonner commented on his personal PCI experience at Middlesborough 3 year's previously and how the development of this local service was good news for patients in Cumbria.

On behalf of the Board, the Chairman thanked Dr Moore and Ms Gorley for their informative presentation and congratulated them on the success of the service.

TB24/12 **WELCOME AND APOLOGIES**

Apologies for absence were received from Mr P Day and Mrs C Platton.

TB25/12 **DECLARATIONS OF INTEREST**

No declarations of interest were recorded.

TB26/12 **MINUTES OF THE LAST MEETING**

The minutes were **AGREED** as a correct record, subject to the following amendments:

TB17c/12 Carbon Management Process – page 5, 2nd last paragraph, last sentence to read: 'A question was raised about the pay back details on projects 15 and 16."

TB19b/12 Patient Safety Walkabouts – page 11, 2nd last paragraph, last sentence to read: 'However, Mr Bonner reported that the ward was

working with Communications Department to produce patient & visitor focussed packs which would be available on the ward'.

TB27/12 **MATTERS ARISING AND ACTION PLAN**

There were no matters arising discussed.

The Acting Director of Governance/Company Secretary outlined the action plan, as follows:

TB84e/11: Update on Single Equality Scheme: action plan, with specific RAG rates tasks, on March Governance Committee agenda. Action complete.

TB110b/11: Clinical Strategy Update: action ongoing.

TB17c/12: Carbon Management Plan:

1. Payback terms for projects 15 and 16 correct. Action complete.
2. In relation to capital agreement, the schemes currently total a cost of £300k plus VAT, prior to approval of any scheme each scheme will be reviewed to ensure that the pay back value and timeframe for payback are consistent with the investment required.

TB19a/12: Real Time Patient Satisfaction Report: CQC outpatient survey results to be reported at May Board meeting.

TB19b/12: Patient Safety Walkabouts: Feedback presented to Governance Committee quarterly. Action complete.

TB28/12 **STRATEGY AND POLICY**

a) **Acquisition Update**

The Interim Chief Executive presented the Acquisition Update report which outlined progress in relation to the acquisition process.

The Interim Chief Executive reported that Mr J Mackey, Chief Executive, Northumbria, had recently attended the Medical Staff Committee. 'Familiarisation' meetings between the Trust and Northumbria were in the process of being arranged.

In answer to a question regarding patient representation on the Stakeholder Group, the Interim Chief Executive confirmed that patient and public representatives were members of the group.

The report was **NOTED**.

b) **West Cumberland Hospital Redevelopment Update**

The Director of Finance reported that NHS Northwest had approved the Full Business Case and it was hoped to start on site in July, however, the approval of the Department of Health(DH)/HM Treasury was still required.

Mr M Evens enquired as to the Department of Health's anticipated timeframe for approval. The Director of Finance confirmed that this would be in the region of 7-9 weeks. He further explained that although there had been a change of procurement legislation half way through the process, legal drafting was being constructively worked through so that the procurement route complied with all the necessary requirements The key risk to the approvals process would be the availability of key individuals and, therefore, a meeting had been arranged for the following week so as to ensure DH and Treasury were fully aware of the importance of granting final approval.

In answer to a query as to who would be project managing the new hospital development following the resignation of Mr D Hounslea, the Director of Finance explained that for the time being Mr Peter Fairclough would temporarily pick up this role. However, as the project moved forward, the role would require different skills and it was, therefore, hoped to appoint to this role by July 2012. In the meantime, the Director of Finance and Director of Operations would lead on the project.

The verbal update was **NOTED**.

TB29/12 OPERATIONAL PERFORMANCE

a) **Performance Report**

a) **Operating Performance**

The Director of Operations presented the Operating Performance Report and the following key points were **NOTED:**

- A&E: Until the previous week, the Trust had (in month) been unable to achieve the 95% target due to the pressure within the system. All teams continued to work hard to support A&E in improving patient flow and reducing waits and ambulance turnaround times. The Director of Operations explained that the pressure being experienced by the Trust was also being experienced by other Trusts nationally. Although there was no current data which indicated the current increased trend for emergency admissions, this would continue to be looked at.

- Delayed Transfers of Care: The collection and verification of delayed transfers of care within the Trust had been

developed over the last few months. The Trust was now in a position to have confidence in defining/identifying accurately the numbers and type of delays being experienced. A detailed plan had been developed to address the key issues, with the aim of developing a 7 day hospital discharge service.

- 18 Weeks: Achieving the 18 weeks target continues to be a challenge, particularly in relation to ophthalmology and gynaecology. The Director of Operations explained that weekly update reports were being provided to NHS North of England as there were concerns as to the Trust's achievement of the 18 week target. Revised action plans, which incorporated additional capacity, had been agreed for ophthalmology and gynaecology and these had been forwarded to NHS North of England. The Director of Operations explained that although the position was improving, addressing the backlog of patients was affecting the Trust's performance, however, it was hoped that the April target could be achieved.

In relation to the mixed sex accommodation breaches, the Director of Operations explained that these related to ITU cases. It was **AGREED** that any exceptions would be included in the quality section of the report.

In relation to the cancer 31 day waits, the Director of Operations explained that the breach outlined in the report related to a patient who had chosen to be treated on day 38 due to a planned holiday, which could not be counted for within the tolerances.

The report was **NOTED**.

b) **Quality Report**

The Medical Director presented the Quality Report and the following key points were **NOTED:**

- CQUIN: The Trust's performance on the Commissioning for Quality Improvement (CQUIN) was being discussed with commissioners so as to finalise the targets for 2012/13. Specific targets focussing on mortality had been agreed.

- Advancing Quality: Recording of smoking cessation advice continued to show areas of underperformance. Although these figures involved only a small number of patients, further work was required to raise awareness and increase smoking cessation advice.

- Complaints: The monitoring of complaints received had been added to the dashboard. Work was underway to further improve the reporting of complaints to ensure that these

could be reviewed per hospital site and specialty to identify trends in complaints received from patients.

- Mortality: In January 2012, the Trust Board received an update on how the Trust was reviewing the mortality data, following the launch of the Summary Hospital Mortality Indicator (SHMI) in October 2011. Whilst the indicator was an attempt to develop a single indicator across the NHS for mortality, it was important to highlight that there were a number of significant complexities in how mortality data was measured, analysed and presented.

  Significant work had been progressed during the last two months on reviewing specific mortality outliers, as well as developing a more robust process for reviewing hospital mortality.

  Dr Foster's Mortality data (2010/11) published in the Dr Foster Hospital Guide identified the Trust as an outlier in relation to post surgical deaths. The Trust had reviewed this data for 2010/11, which showed the RR (relative rate index) as 163. This equated to 50 actual deaths with expected 30.6

  The RR index is elevated through only 2 of the 48 groups, with the outliers being:

  1. Excision of colon & rectum showed a RR of 312 (actual deaths 14 against expected 4.5)
  2. Rest of upper GI shows a RR of 365.8 (actual deaths 5 expected 1.5)

  All of the other HRG groupings were within the expected range.

  The RR for the 6 months (April 11 to Nov 11) now showed a RR of 92. This equated to 29 actual deaths with expected 31.6.

  The CHKS data showed surgical mortality to lie within mid-range. Regional Colorectal data showed the colorectal team were mid-range compared to Northern & National Colorectal audit.

  However, it was important that the Trust review the cases identified in the outlier groups and, therefore, an audit was currently being undertaken on all 19 cases. This audit would be concluded by 31 March 2012.

  The Trust had reviewed its mortality data by using the CHKS Risk Adjusted Mortality Tool (RAMI). The RAMI gave each patient who died a 'predicted mortality' rating, which took into account a patient's age, long term conditions or other

diseases or co-morbidities. This rating confirmed whether the patient had a low predicted mortality or a high predicted mortality, based on what they were admitted into hospital with, their confirmed diagnosis and other contributory factors/co-morbidities.

So as to understand in greater detail the Trust outliers, the most significant areas of excess deaths were identified and reviewed for patients with a 'low predicted' mortality. The outcome was reassuring in terms of the care provided for these patients. However, the audit had identified the need for further work on the coding of deaths across the Trust. All of the 54 cases had a low predicted mortality; however, from the clinical audit results this was not reflected, for example some of these patients were on an end of life care pathway.

One of the quality account priorities for 2011/12 was to develop a Trust wide framework for mortality to ensure a consistent approach across all specialties. In March 2012 the draft framework was discussed at the Clinical Standards Group, and will be implemented during April 2012.

The Medical Director's Office would also review the predicated mortality on CHKS for that reporting period (which would be 2/12 behind) from the Division to cross check the mortality data against the 'live' process of reviews.

The Medical Director added that it was clear from the audit work which had been completed that irrespective of what information tools were used, reviewing hospital deaths on a weekly basis was key to understanding mortality in greater detail.

The report was **NOTED.**

c) **Workforce Report**

The Director of Human Resources (HR) presented the Workforce Report and the following key points were **NOTED**:

- Staff in post had reduced by 12.31 WTE from December 2011.
- Overtime had risen in January and this had related to the additional staffing for the escalation beds.
- The Trust's sickness rate had risen to 4.61%.
- For the year up to 31 January 2012, 66.47% of staff had completed the mandatory training programme.

In relation to the 11% turnover, Mr Evens queried whether there were any specific differences between the two hospital sites. The

Director of HR explained that there was no significant difference, however, had expected turnover to decrease particularly given the national position. The 'exit' interview process was to be reviewed so that this could be undertaken centrally, as part of the staff survey action plan.

The Director of Finance queried the levels of HR support to the divisions. The Director of HR explained that the ratios of support did differ for each Division, however, this was currently being addressed with a view to equalising support.

Mr Bonner enquired as to whether the overtime values were correlated against sickness levels in specific areas. The Director of HR explained that the Divisions 'drilled down' into issues such as these and reported their findings to their divisional boards.

The Board discussed the Trust's appraisal reporting and how these appeared to be at the same level as the previous year. The Director of HR explained that rates continued to remain at best flat across the totality of the Trust.

Professor Bruce commented on the Trust's mandatory training documentation and felt that this did not appear to be 'user friendly'. As this was an area in which the CQC had indicated that improvement was required, the Director of HR would relook at this documentation with the Education & Training Department.

The report was **NOTED**.

d) **Finance Report**

The Director of Finance presented the Finance Report.

At the end of January the Trust was reporting a surplus of £301k against a planned surplus of £740k, resulting in an adverse variance of £439k.

Income in January had increased by £737k compared to December due to increased levels of elective (including daycase) and outpatient activity. This included the newly developed cardiology PCI service, which had started in December and which was continuing to increase activity levels up to its capacity. Total income was now £4.1m ahead of the cumulative plan, of which £3,5m was for NHS Clinical Income, £0.3m relates to Non NHS Clinical Income and £0.3m was for Other Operating Income.

Pay was overspent by £161k in January, increasing the cumulative overspend to £2,115k. Nurse bank and overtime costs increased in the month as a number of the Trust's escalation beds had to be opened and staffed for use in December. As a result of this and other pressures, the number of WTE worked increased from 2,990 WTE in December to

3,027 WTE in January. Expenditure on agency medical staffing increased by £20k in January to £470k bringing total expenditure on agency staffing to date to £4,615k.

Expenditure on non-pay in month was £5,907k which was marginally higher than in December (£5,886k). All non-pay budgets remained overspent with a cumulative overspend of £2,112k at the end of January. Higher than planned activity levels along with the inflationary pressures associated specifically with the PFI continued to drive higher than planned expenditure levels.

CIP delivery improved in month; £7.5m of efficiency savings had now been implemented against the plan of £15.2m. The Trust's latest forecast outturn against the target was £8.5m. The shortfall in the target would be carried forward into the new financial year. This meant the Trust would continue to have to have to make efficiency savings over and above the national target of 4% as it worked to become financially sustainable without external support.

Additional income had been secured to cover the shortfall in the delivery of the CIP target. This should now enable the Trust to deliver its forecast surplus of £1m and achieve its other financial duties with the exception of the Better Payments Practice Code which would not be achieved due to ongoing liquidity issues.

The Director of Finance concluded that the level of income in January was significantly higher than planned, however, pay and non-pay costs had also increased. CIP delivery had improved in month and the Trust was now confident that it would achieve the year end forecast of a £1m surplus. Planning for 2012/13 was now well underway with budgets being finalised.

The report was **NOTED**.

ACTION: Director of HR to relook at mandatory training document with Education & Training Department.

TB30/12 **GOVERNANCE AND ASSURANCE**

a) **Patient Safety Walkabouts – Feedback from Non Executive Directors**

Ms J Cooke and Mr M Evens gave a verbal update to the Board following their patient safety walkabouts to Kirkstone and Overwater Wards earlier that day.

Ms Cooke and Mr Evens had spoken to patients in this area who had no issues of complaint to raise and were happy with their care. They had also spoken to the nursing staff and were impressed with how 'on the ball' they had been considering how pressured the

areas were. The key issue raised by staff seemed to be using elective beds to meet emergency demands. Ms Cooke and Mr Evens commented as to how everything on the wards had been properly labelled and seemed well organised.

Positive feedback had been given by the staff on the Trusts incident reporting system.

Ms Cooke and Mr Evens extended their thanks to Mr R Heaton and his team.

TB31/12 **STANDING COMMITTEES OF THE BOARD**

a) **Governance Committee – January 2012**

The minutes were **NOTED** by the Board.

TB32/12 **ANY OTHER BUSINESS**

No further business was discussed.

TB33/12 **DATE, TIME AND PLACE OF NEXT MEETING**

Tuesday, 17 April 2012 at 1pm in the Board Room, Cumberland Infirmary, Carlisle.