South Tees Hospitals NHS
NHS Foundation Trust

MINUTES OF THE PUBLIC MEETING OF THE BOARD OF DIRECTORS HELD ON TUESDAY, 25 MARCH, 2014 IN THE BOARD ROOM, MURRAY BUILDING, THE JAMES COOK UNIVERSITY HOSPITAL, MIDDLESBROUGH

Present:

Ms D Jenkins	Chairman
Prof. T Hart	Chief Executive
Mrs J Dewar	Director of IT & health records
Mr C Harrison	Director of human resources
Ms R Holt	Director of nursing & quality assurance
Mr D Kirby	Vice chairman
Mr H Lang	Non-executive director
Mrs J Moulton	Director of service strategy & infrastructure
Mr C Newton	Director of finance
Mrs M Rutter	Non-executive director
Mr J Smith	Non-executive director
Coun. B Thompson	Non-executive director
Ms H Wallace	Non-executive director
Prof. R Wilson	Medical director

In attendance:

Dr S Baxter	Chairman of senior medical staff forum
Mrs M Blatchford	for item 4
Ms R James	Deputy director of quality assurance
Ms K Linker	Chairman of staff side
Mrs A Marksby	Head of communication
Mrs C Parnell	Company secretary
Mr T Roberts	Clinical effectiveness specialist advisor

16 members of the public

1. APOLOGIES FOR ABSENCE

Apologies for absence were received from Mrs S Watson, Chief operating officer.

2. DECLARATIONS OF INTEREST

Coun. Thompson expressed an interest in any issues relating to Middlesbrough Borough Council.

3. QUESTIONS FROM THE PUBLIC

There were no questions from the public.

4. PATIENT EXPERIENCE STORY

Mrs Jenkins explained that the board starts each meeting with a patient experience story and these will be subject to annual review to assure the board that lessons are being learnt. She welcomed Mrs Margaret Blatchford to the meeting.

Mrs Blatchford described the experiences of her late husband Dr John Blatchford in the care of the trust following the diagnosis of terminal pancreatic cancer in October 2013. She commented that Dr Blatchford had always viewed the nursing care he received as above and beyond what could be expected and described the skills of surgeons who treated him as exceptional. However she recounted the various difficulties he faced between December 2013 and mid January 2014 in receiving the appropriate procedure for constant vomiting.

Unable to be found an oncology bed Dr Blatchford spent a considerable period of time as an outlier on ward 35 where he was not included on the appropriate ward round and therefore felt forgotten and increasingly anxious. Mrs Blatchford explained that as a result of the prolonged period of vomiting, on returning home her husband developed an aversion to eating or drinking.

She questioned whether the trust has carried out an audit of the clinical consequences of patients being outliers and also made a number of suggestions to improve the position, including designating each outlying patient a “shepherd” to improve communication of their needs with the appropriate team and a guardian to track them through the hospital and ensure they get the right care in a timely manner.

Prof. Wilson apologised for Dr Blatchford’s experience and also the frustration that Mrs Blatchford must have felt at the situation. He said that the trust had not audited the consequences of being an outlying patient as there was a lot of evidence available to show that patients do better when they are treated by staff with the right expertise.

He explained the difficult position faced by the trust during the previous winter when because of a huge increase in emergency admissions and difficulties in moving people on for further care there had been a large number of elective procedures cancelled and a high number of outlying patients. Since then the trust had made a considerable investment to improve the situation, but there were still a number of outlying patients, with particular challenges in gastroenterology which has seen a big increase in patients largely as a result of national screening campaigns.

Ms Holt thanked Mrs Blatchford for her suggestions to improve the situation, commenting that the key to avoiding such experiences in the future was ensuring patients were able to access beds on the most appropriate ward and if they cannot then every member of staff should undertake the “shepherd” role, making sure the patient gets the right care they need.

Directors thanked Mrs Blatchford for sharing her husband's experiences.

5. MINUTES OF THE PREVIOUS MEETING

The minutes of the previous meeting held on 25 February 2014 were agreed as a true record, subject to the following amend to part of the minute for 9.1 Financial position for the period ending 31 January 2014.

It was agreed the sentence in question should read:

"Mr Kirby said that the challenge for the trust was on CIPs since they were below the level of the programme with the added pressure to recoup the position and build on net year."

Decision:
i) Approved the minutes of the meeting on 25 February 2014.

6. MATTERS ARISING/ACTIONS

The board agreed the following changes to the action tracker:

8.2 Update on Improve programme – Ms Watson to bring to April meeting
8.3 Mr Harrison to report back on the outcome of the Talent for Care consultation at the April meeting

Decision:
i) Tracker to be updated to reflect agreed actions.

7. CHIEF EXECUTIVE'S REPORT

Prof. Hart presented the report highlighting:

i) The women & children's division achieving CNST maternity standard level three with one of the best scores in the country after two to three years of work. Prof Hart commented that the achievement not only reflects the quality of patient care and safety offered by the service but also results in a reduction in the trust's insurance premium.
ii) Elements of the trust's quality indicators now being available on the organisation's website as part of the open and honest care: driving improvement programme
iii) The appointment of four heads of nursing as part of the move to seven clinical centres, with two more roles to fill.
iv) The success of the trust in bidding for a total of £1.4m of external technology funding for vital signs monitoring to benefit services at the Friarage and JCUH, and to support mobile computing in community nursing services.

v) The decision by North Yorkshire's scrutiny of health committee to write to the Secretary of State for Health asking him to review the proposals agreed by the local CCG to change children's and maternity services at The Friarage.
vi) Excellent feedback from the CQC after visiting all of the trust's premises and the publication of its latest intelligent report that assigned the trust a risk band of four.
vii) The standardisation of visiting times from 3-8pm starting on 1 April after talking to patients, visitors and staff. Prof. Hart commented that the change should ease the flow of traffic from the JCUH site and also help with infection prevention control by ensuring only two patients are at the bedside at any one time.
viii) The forthcoming trust's Star Awards for staff and three teams that have been short listed for the 2014 Advancing Healthcare Awards.

Coun. Thompson commented that the CNST achievement and external awards were further external assurance of the quality of services provided by the trust. She added that patients would welcome the change to visiting times.

Decision:
i) The board noted the contents of the report.

8 QUALITY OF CARE AND PATIENT SAFETY

8.1 Performance report for February 2014

Mrs Moulton presented the report that summarised performance in February 2014 against all key national targets and a range of local performance indicators. She highlighted that the trust was compliant with all cancer targets with the exception of 62 day target, and drew the board attention to the detail in the report of the ongoing work to improve the position including the introduction of an EBUS service that should help with delays in the lung service.

The board heard that the trust remained compliant with the four hour A&E target, achieving 97.98% in February. However there was a further five c.difficile cases in February taking the total position for the year to date up to 54 against the annual target of 37.

Mrs Moulton said the trust remained complaint with the 18 week targets for the incomplete and non-admitted pathways, but as planned failed the admitted target in February with a compliance of 85.5%.

Commenting on the HR measures Mr Harrison said there had been a slight increase in sickness level to 4.62%. This was lower than for the same period in 2012-13 and compared to regional data for trusts the organisation had the fourth lowest sickness rates for the year to December 2013. He added that there was a slight dip in the number of SDRs carried out, but the position was still better than for the same period last year and the trust continued to see incremental improvements in mandatory training.

Ms Jenkins queried what action was being taken to improve appraisal rates and Mr Harrison said managers receive monthly information on their service's performance as well as which members of staff are due for an appraisal in the coming months. Appraisal rates are discussed at the quarterly performance reviews and there are now plans in place to meet with managing directors on a monthly basis to discuss performance.

Mrs Rutter asked for an in-depth look at appraisals, including both the rates undertaken but also the quality of appraisals and this was welcomed by Mr Harrison, who said the quality of appraisals was raised as an issue in the recent NHS staff survey. Prof. Wilson highlighted the trust's progress in appraisal of clinicians as part of validation, with between 95 – 100% of doctors currently appraised, and Ms Holt highlighted that revalidation for nurses would be introduced in December 2015.

Mr Smith highlighted that some areas are only reporting 50% compliance with mandatory training and he questioned what the position would be with NHSLA if there was an incident and staff were found not to be compliant. Mr Harrison said the report was based on a 12 months rolling programme and he acknowledged there could be a risk if staff had not completed relevant mandatory training. He added that the trust was looking at what should make up mandatory training to ensure it is relevant to all staff.

Dr. Baxter highlighted the frustration staff often feel in trying to complete on-line training and Mrs Dewar agreed that there can be problems as training packages operate on a number of different systems. She added that the information governance team were working on an application that would make it easier for staff to access online training via a smart phone, and the IT team was working with HR colleagues to try to improve the current online systems.

Decision:

- **i) The content of the report was noted.**
- **ii) A report on appraisals for the April meeting.**
- **iii) A report on the plan and timescales for improving access to mandatory training for the April meeting.**

8.2 Update on ICT programme for Transforming The Care We Deliver

Mrs Dewar presented the report highlighting the development of three business cases to support key areas of IT infrastructure that will go to formal management group in April. The board heard that procurement was under way for the vital signs monitoring system and mobile IT equipment for community staff.

The IT team has submitted expressions of interest for the 2014-15 Nursing Technology Fund, and is planning to bid for extra top up funding for the vital signs monitoring system. Mrs Dewar added that the team was waiting to see the criteria for the Safer Hospital, Safer Wards fund but bids were ready go.

The meeting heard that work is still continuing to look at the potential of an open source solution, with presentation being planned for May to allow clinicians to see the HP and IMS MAXIMS solutions.

Decision:
i) The content of the report was noted.

8.3 Care Quality Commission final review of compliance reports

Ms Holt presented the CQC's report on their inspectors' visits to all of the trust's premises. She said both the written and verbal feedback from the inspectors had been very good, with particular comments about the openness and honesty of the staff they met. The meeting heard that while the CQC had made some small recommendations for improvements there were no significant issues raised and future inspections would be under the CQCs new inspection regime.

Coun. Thompson commented that the reports provide further external assurance to the board about the quality of the trust's services. Prof. Hart added that it was heartening, considering the difficult year the trust had faced in trying to tackle c.difficile infection, to have the CQC's positive comments on staff awareness and knowledge across all the areas visited.

Decision:
i) The content of the reports were noted.

9. BUSINESS SUSTAINABILITY

9.1 Financial period for the period ending 28 February 2014

Mr Newton presented the report identifying a deficit of £6.6m at the end of February, a slightly better position than the previous month. He assured colleagues that the organisation was on track to achieve a deficit of £5.2m by the year end, which would be half the deficit that had been predicted following the half year review. This position would produce a risk rating of a rounded 2 at the end of the year.

The meeting heard that the reduced deficit was as a result of the trust taking action in a number of areas including, procurement, bank and agency staff, and study leave, to make a significant reduction in costs. Mr Newton added that staff numbers had increased by 88 over the year, medical agency costs had grown, and establishment costs were above budgets, and they would be key factors for CIP in 2014-15.

Directors were told that nursing was under spent and in February the trust spent £400,000 on the independent sector as part of its plans to achieve the 18 week RTT target, bringing the total spend on the independent sector in year up to £2.5m. Mr Newton said that income was £11m ahead of plan, but it had associated costs mainly in pass through drugs.

CIP delivery had improved in month from 84% to 87% and was on track to delivery 90% by the end of the year. In month CIP had delivered £1.5m of savings and £800,000 of unused reserves had been used to support the programme. Mr Newton added that the cash limit was under constant pressure so the finance team was working hard to get in all the money owed to the trust, but he assured the board that the organisation will finish the year with cash above the minimum level.

Ms Jenkins commented that the position was improving but the organisation must look to reduce its cost base as the situation will get tougher in 2014-15.

Decision:
i) The content of the report was noted.

9.2 Car parking

Mrs Moulton presented the paper reminding the board that it had had considerable discussion over the last two years about the parking situation on the JCUH, which it had recognised as intolerable. The trust has worked hard with Middlesbrough Borough Council and finally been able to reach agreement around extra parking spaces and a link road to improve the flow of traffic on and off the site.

However the board heard that the improvements do come at a cost, which directors agreed in principal at the last meeting should largely be funded by increasing parking charges to reflect the finance costs and RPI rises since the trust last increased its fees in April 2011. Mrs Moulton told the meeting that other local trusts had generally been uplifting their changes in line with RPI, and the trust's proposed increases are broadly comparable with other local NHS organisations.

As well as asking colleagues to consider the proposed increased charges Mrs Moulton also asked for consideration of charging blue badge holders, who were currently exempted from fees. North Tees and Hartlepool NHS Foundation Trust charge blue badge holders, as do a growing number of other trusts across the country. The board heard that there is no automatic exemption for blue badge holders, who already pay in private car parks, but the organisation must take due regard of the issues that they face and make reasonable adjustments.

Mrs Moulton drew the board's attention to an issue that had arisen at a trust in the south of England with regard to charging blue badge holders, but the challenge there related to how the parking scheme was managed. She assured that the trust already had arrangements in place to address badge holder needs, including a discounted rate for regular patient car park users.

Ms Linker said the issue had been discussed at a meeting of staff side representatives who were concerned about the percentage increase for staff parking and she predicted a negative response at a time when staff pay was being squeezed.

In response to a question from Mr Lang about the proximity of blue badge holder spaces to the hospital, Mrs Moulton said there were a number of different designated spaces although the sloping nature of the site meant some were more accessible than others. However she highlighted that the new car park being built behind the Trinity Holistic Centre would have 28 designated spaces with level access into the hospital.

Coun. Thompson commented that increasing charges was unpalatable and will be unpopular but it will result in significant improvement to car parking, which would be welcomed. Ms Wallace added that essentially the trust had been subsidising car parking from the money it should be spending on patient care, and Mrs Rutter said the discounted rate for regular visitors was very reasonable.

Ms Jenkins said its was important the trust increased its efforts to publicise and encourage people to use other means of getting to the hospital including the car sharing scheme, new rail halt, and transport provided by third sector organisations.

Decision:

i) To increase the parking charges for patients, visitors and staff as outlined in the report

ii) To introduce parking charges for blue badge holders.

10. GOVERNANCE

10.1 Mortality report for quarter three, 2013-14

Mr Roberts presented the 19th quarterly report to the board highlighting the introduction of peer review, with the trust partnering with Northumbrian Healthcare NHS Foundation Trust to validate each organisation's reviews of mortality. Ms Jenkins queried whether the regional monitoring group was an initiative instigated by the trust and Mr Roberts said the organisation was an early supporter of the work, which he believes is unique in the country.

Mr Roberts drew the board's attention to the latest Intelligent Monitoring Report published by the CQC in March 2014 that flagged the trust as having an elevated risk on the Dr Foster composite indicators for HSMR, in hospital mortality musculoskeletal conditions, as well as trauma and orthopaedics. He highlighted that without buying the Dr Foster information system the trust was unable to exactly replicate the indicators and the trust has raised this with the CQC.

The board heard that the musculoskeletal indicator is sensitive to patients with cancer co-morbidities and as a result may not be fit for purpose, but the trust is still investigating coding to check that the use of primary diagnosis is appropriate. Prof. Wilson had also reviewed 27 sets of notes to identify whether any issues could have been picked up prior to the CQC report.

There was an in-depth discussion about the CQC report with Ms Jenkins questioning whether there was an underlying issue with coding in the trust. Mr Roberts said the trust carries out a number of audits looking at coding but the issue with this particular measure may be the appropriateness of the initial diagnosis. The issue is being investigated and Mr Roberts agreed to bring the outcome of that work to the next board meeting.

Prof. Wilson said the report simply reflects numerical data, it is not indicative of the quality of care provided and this was raised with the CQC's local assessor, who was supportive of the work the trust is doing.

Ms Wallace asked what more the trust could be doing to improve mortality, clinical effectiveness and treatment outcomes. Mr Roberts said that the trust's mortality figures were still being affected by the previous winter and that would only change with time as the figures for last year worked their way through the reports. He said the figures for winter 2013-14 were likely to be considerably better because there had been fewer respiratory problems within the local population. The meeting heard that following NICE's masterclass with the board earlier in the year the trust had begun a project around rapid treatment of pneumonia, which Mr Roberts expected to have a positive impact on mortality figures.

Prof. Roberts commented that while the trust was committed to using every opportunity to improve mortality, including looking at itself critically and peer review, the board should remember the environment in which it is operating with three of the most deprived wards in the country on the doorstep of JCUH. Prof. Hart added that in terms of health inequalities for the most disadvantages parts of Middlesbrough the average life span for men was 14.8 years less and for women 11.3 years less than the least disadvantaged parts of the country.

Ms Jenkins pointed out that only recently Monitor had acknowledged that the trust was a major teaching hospital and not simply a provider of district general hospital services and she asked whether this mis-categorisation had an impact on mortality figures through inappropriate benchmarking. Mr Roberts said that different types of trusts did have different levels of mortality and it was important to compare like with like, although most measures of mortality only looked at national averages. However the board heard that generally being a specialist centre helped mortality, as the more treatment episodes a centre had the bigger the denominator that is used when looking at deaths, but Mr Roberts also pointed out that some specialist services did carry inherently higher risks, such as cardiac surgery.

Mr Roberts drew the board's attention to the unadjusted mortality figures highlighting that they still show the impact of last winter and the rise in mortality across the region. He added that the summary hospital level mortality indicator for July 1012 to June 2013 was 105, which was within the expected range, while the HSMR for the same period was 116 and put the trust as an outlier but this was due to the excess winter deaths across the

region, changes in national coding practice, and a drop in the use of specialist palliative care coding in the trust, which had been addressed.

Ms Jenkins asked the board if it was assured that none of the mortality data was indicating that the organisation's service posed a risk to patient safety and directors agreed that they were assured by the report and the explanations they had heard during the meeting.

The board was asked to support the trust in reviewing its electronic mortality reporting systems to ensure they meet current needs, and Mr Roberts said that the trust had used CHKS for a number of years but it was felt that there were now better systems available that the trust should adopt.

Decision:

- **i) Report on the investigation into the elevated risk in relation to musculoskeletal conditions to come to the April board meeting**
- **ii) The board agreed that it was assured the Intelligent Monitor Report did not show the organisation was posing a risk to patients.**
- **iii) The trust should move away from using CHKS data as soon as possible and adopt alternative electronic reporting systems for mortality.**

10.2 Selection of Quality Account priorities for 2014-15

Ms James presented a report that summarised the consultation process around selecting a minimum of three priorities for inclusion in the trust's Quality Accounts for 2014-15. Ms Jenkins asked Ms James if there was anything that she would have expected to be a priority that was not raised by the consultation, and Ms James said pressure ulcers had not been suggested by the various stakeholders who took part in the process, even though it is a high priority for the trust.

Ms Holt supported the inclusion of pressure ulcers and Ms Wallace suggested standardisation should be a high priority as it supported both the quality and safety agendas. Mr Smith expressed concern that the Quality Accounts process should mandate a minimum of three priorities when the organisation had a large number of safety and quality areas it focused on.

There was a detailed discussion about the options and board members expressed the view that the Quality Accounts should, if possible, reflect a broader range of the quality indicators that the trust monitors.

As part of the discussion about organisational priorities Mr Smith raised concerns about changes to the Transforming the Care We Deliver (TCWD) programme board. Prof. Hart said TCWD should encompass not only technological and IT advances, but also the wide range of improvement projects going on across the trust to improve patient care. As a result she was looking at how various programmes and projects report into the trust's existing governance structure.

Decision:

i) Ms James to consider some overarching terms that would reflect the trust's broad range of quality indicators and agree those with the Quality Assurance Committee prior to inclusion in the Quality Accounts.

ii) Prof. Hart to provide an update on changes to the programme/project reporting structure to the next meeting.

10.3 CQC Intelligent Monitoring Report March 2014 and a summary of the CQC's new approach to inspection

Ms James told the board that the report covers 90 indicators and uses statistical thresholds to determine whether organisations have risks or elevated risks in a number of different areas. These risks are then used to determine an organisation's position in a banding of one to six, and the bandings are used by the CQC to prioritise inspections.

The trust's banding moved from the top band 6 in October 2013 to a banding of four in March 2014 due to issues highlighted during the previous board discussion on mortality, Monitor's ongoing investigation of the trust, and the consistency of uploading data to the National Reporting and Learning System, which the trust had since addressed.

Ms James added that more detail about the new inspection regime standards are expected shortly and the trust will consider those, as well as themes from the first wave of the new inspections, to inform a mock inspection process for the trust.

Ms Jenkins asked whether the trust measured the same 90 indicators so that it could predict any issues before the publication of the report. Ms James said that trust tracked the majority of the indicators and Prof. Hart suggested that the trust also look at the themes coming out of complaints in preparing a mock inspection process.

Decision:

i) The content of the report was noted.

11. ORGANISATIONAL CAPABILITY

11.1 NHS staff survey 2013

Mr Harrison presented the reporting, highlighting that the key areas had been discussed at the previous meeting. He suggested that the three main areas that the trust needed to do further work around were staff motivation, appraisal, and presenteeism.

The board heard that the work would be taken forward across the trust via a network of staff experience reps, and each centre will also analyse their results and come up individual issues to target. Mr Harrison added that working through the Health Promoting Hospitals framework would help to address key areas for action.

Ms Jenkins asked for quantitative targets against which progress could be measured. She also raised concern about the rise in staff reporting incidents of bullying and asked for further detailed information about this area, although she suggested that some staff may perceive more robust management of sickness absence as bullying.

Mrs Moulton said that such information was difficult to aggregate from the survey data, but Mr Harrison suggested information from the grievance process could also be used to see if there was any correlation with the survey results. Prof. Hart suggested that the response to the questions about bullying should be examined alongside those in relation to staff's views about the trust being a good place to work.

Ms Holt said the introduction of the Friends and Family test for staff could be used to get more useful data from the workforce, and Mr Harrison said the trust will be obliged to survey staff on a quarterly basis starting in July and reporting back in August 2014. Prof. Hart suggested including feedback from medical and nursing students as well as volunteers to get a fuller picture of the trust's culture.

Decision:

i) The board supported the areas for action as outlined in the report with quantitative targets set to measure progress.

12. FOR INFORMATION WITHOUT DISCUSSION

12.1 Minutes of the Quality Assurance Committee meeting on 12 February 2014

Decision:

i) The minutes were received.

13. ANY OTHER BUSINESS

To mark Mrs Dewar leaving the organisation Ms Jenkins thanked her for her considerable contribution to the board and the trust over a number of years, and presented her with gifts on behalf of the board.

14. NEXT MEETING

The next public meeting of the Board of Directors will take place on 29 April 2014 at 10am in the Board Room, Murray Building, The James Cook University Hospital, Marton Road, Middlesbrough.