The Whittington Hospital NHS
NHS Trust

ITEM: 11/027
Doc: 01

Meeting:	Trust Board
Date:	23rd February 2011

Title:	**Minutes of Part 1 of the Trust Board meeting held on Wednesday 26th January 2011**

Executive Summary:	The attached is the record of attendance, presentations and discussion at the most recent board meeting held in public. David Fish (Managing Director) and Edward Lavelle (management consultant) of UCL Partners attended for discussion on item 11/010: UCLP update and back office programme. There were four governors and three other members of the public attending as observers.

Action:	Draft for agreement or amendment by the Trust Board.

Report from:	*Susan Sorensen, Corporate Secretary*

The minutes of the Whittington Hospital Trust Board meeting held at 13.00 hours on Wednesday 26th January 2011, in the Whittington Education Centre

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Present	Joe Liddane	JL	Chairman
	Robert Aitken	RA	Senior Independent Non-executive Director
	Anna Merrick	AM	Non-Executive Director
	Jane Dacre	JD	Non-executive Director (UCL)
	Rob Larkman	RL	Chief Executive
	Richard Martin	RM	Director of Finance
	Celia Ingham Clark	CIC	Medical Director
	Bronagh Scott	BS	Director of Nursing and Clinical Development
In attendance	Marisha Ray	MR	Non-executive specialist adviser
	Kate Slemeck	KS	Director of Operations
	Margaret Boltwood	MB	Director of Human Resources
	Siobhan Harrington	SH	Director of Primary Care
	Fiona Smith	FS	Director of Planning and Performance
	Philip Ient	PI	Director of Facilities
	Caroline Allum	CA	Deputy Medical Director
	Richard Jennings	RJ	Deputy Medical Director
Secretary	Susan Sorensen	SS	Trust Corporate Secretary

11/001 **Apologies for Absence** **Action**

Apologies had been received from Helena Kania. Siobhan Harrington had indicated that she would arrive late. The chairman welcomed four governors and three other members of the public attending as observers. He then introduced David Fish, Chief Executive of UCL Partners and Edward Lavelle, who had asked for an opportunity to address the board on the work of UCL Partners and report progress on its current "back office" project. This was item 10 on the agenda but it was agreed that it should be brought forward to the start of the meeting.

11/002 **Declarations of Interests**

There were no interests to declare.

11/003 **Minutes of the meeting held on 15th December 2010 (Doc 1)**

3.1 The minutes of the meeting were agreed as a correct record.

Action Notes and matters arising

3.2 The Board reviewed the action notes from previous meetings. There were six outstanding actions, of which four had scheduled dates for completion in February.

11/004 **Report from the chairman**

4.1 JL reported unprecedented interest in the two vacancies for non-executive directors, resulting in 54 formal applications. Shortlisting would take place over the next 2-3 weeks with interviews scheduled for 15th February.

4.2 JL reported that four candidates had been shortlisted for the substantive appointment of a Chief Executive. Interviews would take place on 4th February.

4.3 It was noted that board members had attended a recent conference sponsored by UCL Partners and Monitor on the theme of maximising quality and minimising cost. CIC had given a talk on the Whittington's ICO.

4.4 JL pointed out that it was Kate Slemeck's last board meeting before taking up her appointment at the Royal Free in February. He thanked her for all the hard work and many achievements in her ten years at the Whittington, including five years as Director of Operations.

11/005 Report from the Executive Committee (Doc 2)

5.1 RL introduced the report and gave an update on the development of the ICO which was now operating in shadow form, with teams coming together on a regular basis. The trust had made a successful bid to take over Haringey's children's services and had been appointed preferred provider. A due diligence exercise would be undertaken prior to proceeding to contract.

5.2 It was reported that Matthew Boazman (MBz) would be Acting Director of Operations following KS' departure. Additional general managers would be appointed in both medicine and surgery.

5.3 In response to a question on changes to LB Islington's provision of hospital social work for children, BS reported that she had attended a positive meeting at which it was established that although there would be no manager based at the Whittington, there would continue to be a social work presence. They were also working on securing a Haringey presence.

11/006 Patient Safety Strategy Update Report (Doc 3)

6.1 RJ described the background to the focus on consultant ward rounds in this report. There was growing evidence from a literature search that increased consultant involvement led to quality and productivity improvements, and reduced the tension between training and service in the case of junior doctors. RL had written to all consultants in January 2010 requesting that they make progress towards daily weekday and weekend rounds.

6.2 The attached table indicated that weekday daily rounds were falling into place, with particular improvement in medicine and women's health. Weekends were proving more of a challenge. Discussions within medicine had indicated that full compliance may need more resource.

6.3 There was a discussion about how progress to compliance could be improved in which the following points were made:

- The requirement should be embedded in all future consultant contracts **MB**
- Weekday daily rounds should be achievable within current resource
- A visit to the North Middlesex Hospital, where weekend cover arrangements included daily ward rounds, had been arranged. **RJ**
- The board could be more assertive with late adopters, while maintaining consultant engagement and buy-in
- Deadlines should be set for weekday and weekend compliance
- Any additional resource should be the subject of a business case **MBz**

6.4 It was agreed that RJ should report back on progress to the April meeting of the Trust Board, including recommendations for separate deadlines for full compliance for weekday and weekend rounds. **RJ**

10/007 Nursing Strategy update (Doc 4)

7.1 BS presented the progress report in which it was noted that the Whittington Hospital's nursing strategy would be completed by the end of March 2011, and then developed into a strategy for Whittington Health for presentation to the Trust Board in January 2012.

7.2 Non-executive directors questioned the timescale and requested that the strategy should incorporate:

- o A reference to excellent patient care (in addition to the other objectives in the introduction)
- o Emphasis on the future role of nurses in the new context as educators and supervisors
- o Reference to training and continuing professional development in the introduction

7.3 BS responded that the timescale was already ambitious, but assured the board that several building blocks were already in place:

- o The provider alliance had developed a nursing strategy
- o There was a clinical nurse leadership programme
- o Ward forums and "safe rounds" had been introduced
- o A review of the visible leadership programme had been undertaken with a view to further development
- o A resource and capacity review was underway

11/008 Public Health White Paper (Doc 5)

CA pointed out that she had summarised the 100-page White Paper "Healthy Lives, Healthy People: Strategy for Public Health in England" on one side of A4. In addressing the potential contribution of the Whittington she reported that the trust had successfully bid for a Darzi fellow in clinical leadership. The project would be looking at the use of health risk assessments in the community to prevent illness and would be working with UCL. The board welcomed this development, particularly with the involvement of UCL, whose population health department was widely acknowledged to be an international centre of excellence.

11/009 Foundation Trust programme (Doc 6)

9.1 The board noted the revised committee structure and approved the establishment of the FT Programme Board as a formal sub-Committee of the board. It would meet the following day under the chairmanship of RA.

9.2 It was suggested that the ICO estates project would be problematic. PI said that the work on optimising the estate would follow-on from the development of the clinical strategy.

9.3 In response to a question on the budget for the FT application, FS said it would be informed by previous experience and would be discussed at the first meeting of the FTPB. **FS**

9.4 It was agreed that the FTPB would report back to every Trust Board meeting. **RA**

11/010 UCLP update and back office programme (Doc 7)

10.1 David Fish (DF) set the scene by describing the creation of five Academic Health Science Centres (AHSCs) in the UK of which UCL Partners was

one of three in London. He showed three slides illustrating the model of integrated education, research and healthcare which is well-established in North America and Europe. The period over which such a system becomes fully developed can vary but is typically up to seventeen years. AHSCs operate at international, national and local levels. UCLP for example leads the national cancer provider network but also supports local initiatives such as the Whittington ICO.

10.2 DF explained that UCLP had been involved in the work on the merger of back office functions as it was a vehicle for equity and fairness between all the partners. It would not have actively engaged in the initiative if only two or three of the partners were involved. He and Edward Lavelle (EL) were attending board meetings of all partners during January. EL elaborated on the progress set out in the papers. In response to a question from the chairman on what was being asked of the Whittington, EL replied that UCLP wanted to know whether the trust would contribute its share of £80k to the planning of stage 2 of the project.

10.3 In discussion, the following points were raised:

- UCLP needed to give examples of successes from partnership working
- Experience from the retail sector indicated a potentially long gestation period e.g. pharmacy
- Clinical engagement was a vital pre-requisite in terms of sharing good practice across the trusts
- Competing demands needed to be balanced
- Explicit buy-in from each organisation for each workstream was required
- There was an issue about capacity bearing in mind the ICO and FT projects
- Finance was already providing shared payroll services but was sceptical about the benefits of sharing other financial services
- There was a mixed view across the sector and “pick and mix” might be the best approach

10.4 In response, EL acknowledged that finance collaboration was difficult and there was a need to prioritise in the light of capacity constraints. However, his view was that in general the benefit of shared services was dependent on economies of scale. He felt that standing still was not an option and the earlier the platform was set up, the greater would be the benefit. He argued that if bi-lateral collaboration was working, it made sense to roll it out.

10.5 He agreed that clinical engagement needed to be established quickly and that the term “back office” function was not accurate as the project included pathology and imaging services. In response to a question he reported that the plans for radiology were not well advanced but there would be an opportunity to discuss in the future.

10.6 In terms of timing, EL said that the intention was to go out to tender at the end of January for consultancy advice to develop the business plan by April/May 2011. DF said that UCLP would take a position on further involvement depending on the level of support. It was pointed out that in addition to the requested £80k contribution, there would be the cost of

executive time. It was agreed that the Whittington needed time to consider the potential costs and benefits of participation. In response to the suggestion that UCLH should pump prime this stage, it was agreed that it was important to demonstrate commitment to the project through financial contribution. In summing up, the chairman expressed approval in principle for the project with a commitment to reach a decision on the requested £80k contribution as soon as possible. **JL/SH**

11/011 Dashboard Report (Doc 8)

11.1 FS introduced the report. Improvements to the presentation were noted including the insertions of targets and clarity on good vs. bad performance. In response to a query on the use of arrows to show the direction of change, previously proposed, CIC said that it could be misleading if the change was not statistically significant.

11.2 There was favourable comment on an apparent significant improvement in the incidence of mortality in low risk conditions. However, CIC said it should be interpreted with caution because of coding anomalies in the earlier observations.

11.3 FS said that the apparent reduction in Haringey's market share for out-patients could be a result of provider data discrepancies, although a reduction in the volume of Haringey referrals had been observed. It was suggested that GPs were being encouraged to refer to independent sector providers as the work was already paid for in the IS contracts.

11.4 It was noted that there was now a requirement for MSSA cases to be reported. BS said that there was no target at the moment, but they could start benchmarking meanwhile. BS reported a case of MRSA bacteraemia in the neonatal unit. This was the second case against a target maximum for the year of four.

11/012 Finance Report (Doc 9)

JL reported that the finance sub-group, comprising non-executive directors, the chief executive and three senior finance officers, had met the previous week to discuss the year to date position. A report would come to the next Trust Board meeting. **RM**

RM gave a high level summary of the month 9 position. Performance had been better than plan resulting in a cumulative surplus £1.4m above the year to date plan. There had been a £300k expenditure on temporary staff. Year-to-date income performance is only £100k below the agreed NCL cap for the year, so the position of zero further income is very close. CIP performance remained at 73% of plan as in the previous month. The trust was still on target to achieve break even at the year end.

In response to a question on whether next year's CIP could be brought forward, RM advised that schemes were implemented as soon as they were identified as apart of an ongoing rolling programme.

11/013 DNA target reduction: progress report (Doc 10)

13.1 KS introduced the report and said that the small improvement from 15% to 14% was less than had been planned. The target was 12% and the key

areas of focus to make further progress were:

1. Improving phone booking by keeping up to date records and mobile numbers
2. Consistent application of the access policy
3. Continuation of text message reminders to be supplemented by phone reminders depending on the result of a pilot in ophthalmology
4. Further analysis of hospital cancellations, looking at clinic templates and capacity

13.2 In discussion, a number of questions were raised and suggestions made:

- Patient survey to find out why they DNA
- More consultant engagement to ensure appointments are necessary (e.g. recent exercise in urology)
- Indentify cause of correlation between DNA rate and ethnicity/specialty
- Provide sufficient capacity to offer a choice of appointments
- Publicity about the risk to patients' health of not attending

13.3 It was agreed that a persistent drive on compliance with operational procedures needed to continue, with a view to achieving the 12% target as soon as possible. **MBz**

11/014 <u>Staff engagement action plan and progress report (Doc 11)</u>

14.1 MB invited comments on the report. An observation was made on the perceived mismatch between intentions represented in the strategy and some outcomes from the staff attitude surveys. MB responded that measures of success or improvement could be identified from the surveys as well as from indicators such as sickness absence, vacancy and turnover rates.

14.2 It was noted that the strategy would be developed and implemented though the forthcoming "Big Conversation" dialogue with staff and through the organisational development element of the foundation trust programme. **MB**

11/015 <u>Commissioning Intentions 2011-12 (Doc 12)</u>

15.1 KS presented the report and emphasised the objective of providing a consistent set of performance criteria across the NCL sector.

15.2 It was considered that while there were some significant challenges, the commissioning intentions were broadly in line with expectations and the prospect of "flat cash" had been factored into the long term financial model.

15.3 There was some discussion on the need for or benefit of decommissioning services, but it was agreed that the over-riding need was to align clinical and financial viability in the context of a contract for integrated services.

11/016 <u>Infection prevention and control quarterly report (Doc 13)</u>

16.1 The Board noted the contents of the report and the improvement in the rate of screening for MRSA. BS reported that performance was 92% for elective cases and 86% for emergencies, against a target of 100%. The lower performance for emergencies arose from some variations from the pathway, where patients had not gone through the pre-assessment process or had gone directly to a ward rather than via ED.

16.2 BS advised the Board that a Root Cause Analysis had been instituted for the MRSA bacteraemia reported earlier in the meeting. This had revealed that there was a screening issue in this case.

16.3 In response to a question, BS reassured the board that there were sufficient infection control staff to cover for Dr Julie Andrews' absence on maternity leave.

11/017 Patient Experience and feedback (Doc 14)

17.1 The report was presented by BS and it was noted that the analysis had been received by the Audit Committee at its January meeting. The report would be further developed to include litigation and incidents as well as complaints, PALs activity and patient feedback.

17.2 It was noted that the Patient Experience Steering Group had been established and had met twice. BS also wished to set up a Complaints Review Board, chaired by a non-executive director, to look at themes and trends and to monitor remedial action. This was under consideration. **JL**

17.3 In discussion of the analysis and its implications, the following observations were made:

- There are a number of problem areas and their identification is confirmed by triangulation of information from different sources
- In some cases, a denominator or benchmark would aid interpretation e.g in correlating adverse feedback with high volume of activity and stress levels
- There was a disconnect between the corporate stance and the number of complaints about communication and staff attitude
- There was a need to tailor questions for patients in different areas of activity
- The intranet was now open for tracking patient feedback and its presentation was under discussion
- The increase in PALs activity could indicate an increased tendency for wards to divert patients rather than deal with problems on the spot.
- The introduction of safe rounds was a step forward in providing greater equality between patients

17.4 BS agreed to take account of the board's comments in developing the report further. It would be brought to the board on a quarterly basis. **BS**

11/018 Clinical Governance Annual Report 2009-10 (Doc 15)

18.1 CIC apologised for the fact that this report had not come to the board earlier. It had been approved by the Clinical Governance Committee in June 2010 and reviewed in detail by the Audit Committee but needed to be presented to the board. The 2010-11 annual report will come to the board in the summer of 2011. **CIC/BS**

18.2 CIC drew attention to the reference to the Quality Account in section 9.1, and said that it was now timely to consider the priorities for 2011-12, taking account of the establishment of the ICO. Stakeholders would be approached and the Board was asked to send in ideas during February. **All**

11/019 Report from the Audit Committee (Doc 16)

The report from the Audit Committee was noted.

11/020 **Review of the Board Assurance Framework (Doc 17)**

20.1 The Board received the report which had been updated to include new risks associated with the ICO. It was noted that the timetabling of the BAF review and the risk register review needed to be aligned. The BAF needed to come to the board quarterly.

20.2 In response to a comment on the number of high priority actions, FS pointed out that this reflected the timescales of implementation of some key actions in order to progress the ICO transaction by 1 April.

11/021 **Risk Register (Doc 18)**

BS explained that the Risk Register brought to this Board meeting was the outcome of the September review. It was discussed by the Audit Committee at its November meeting but did not come to the board because of pressure of business. The December review of the Risk Register would come to the March Trust Board and BS recommended that it should come twice yearly to the Board thereafter.

The board agreed the bi-annual review of the risk register (as set out in the table at the back of the register). Any comments on the current version should be sent to BS. **All**

11/022 **Questions from the floor on matters considered by the board**

The chairman proposed that any questions from the floor should be informally in the break between part 1 and part 2.

11/023 **Any other urgent business**

It was noted that the infection control team led by Julie Andrews had been shortlisted again for a national award. There being no other business the chairman concluded Part 1 of the meeting.

10/141 **Dates of next meetings**

Board seminar and Part 1 Trust Bard 23rd February 2011 (WEC Rm 6)
Trust Board 23rd March 2011 (WEC Rm 6)

SIGNED……. (Chairman)

DATE…….

The Whittington Hospital NHS Trust
Trust Board Action Notes 2010-11

February 2011

This paper provides an update on progress on actions outstanding from April to November 2010 and identifies actions arising from the latest meeting on 26th January 2011.

All actions to June 2010 complete

Actions outstanding from July (original list 11), September (original list 7) November (original list 8) and December (original list 10)

Ref*	Outstanding Action	Position as at February 2011
1007.7	Follow up on Audit Commission's Board Assurance checklist re Board Development Programme **JL/RL/MB**	For Board Seminar February 2011
1011.2	Chairman and Chief Executive to take action on behalf of the board in finalising the ICO business case for submission to NHS London **JL/RL**	Business Case ready to be presented to NHS London.
1012.6	Re Dashboard report. Refresh to take on board Monitor's quality checklist following close of consultation – for March board **FS**	Work in progress – discussed with CIC and BS. Quality requirements to be presented in April report
1012.7	Consider level of detail required for Board monitoring in the development of an Executive Information System (EIS) – for April Trust Board **GW**	SH to follow up with GW. Capacity constraints because of preparation for nhs.net (email)
1012.8	Demonstrate data reliability e.g by commissioning internal audit study. **FS**	David Emmerson to give presentation on data quality at February Trust Board seminar
1012.9	Prepare presentation on CIP **RM**	For February Trust Board seminar

Actions arising from Trust Board 26th January 2011

Ref*	Decision/Action	Timescale	Lead and support
	UCLP: Merger of back office services		
1101.1	Undertake cost-benefit analysis to inform decision on requested £80k contribution for Stage 2 and advise UCLP	As soon as possible	**SH**
	Patient Safety Strategy		
1101.2	Report back on consultant ward rounds in 2-3 months, Consider deadlines for full compliance on weekday and weekend consultant ward rounds	April Trust Board	**RJ**
	Foundation Trust Programme		
1101.3	Establish FT programme board as formal sub-committee of the Trust Board. Terms of reference to be approved	March Trust Board	**SH**
	Clinical Governance: Quality Account		
1101.4	Submit ideas for 2011-12 priorities to CIC	As soon as possible	**All**
	Board Assurance Framework/Risk Register		
1101.5	Ensure full alignment of BAF with risk register and confirm cycle of refreshment	April Trust Board	**FS/BS**