ITEM: 13/098
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The minutes of the meeting of the Trust Board of Whittington Health held at 2.00pm on Wednesday 26th June in the Whittington Education Centre

Present:	Robert Aitken	Non-Executive Director (acting Chair)
	Greg Battle	Executive Medical Director, Integrated Care
	Anita Charlesworth	Non-Executive Director
	Jane Dacre	Non-Executive Director
	Dr Yi Mien Koh	Chief Executive
	Martin Kuper	Medical Director
	Paul Lowenberg	Non-Executive Director
	Lee Martin	Chief Operating Officer
	Richard Martin	Director of Finance
	Jo Ridgway	Director of Organisational Development
	Sue Rubenstein	Non-Executive Director
	Bronagh Scott	Director of Nursing & Patient Experience
In attendance:	Kate Green	PA to Jo Ridgway/Trust Board Secretary
	Louise Morgan	Trust Company Secretary
	Caroline Thomsett	Director of Communications

13/80 Apologies for absence

80.01 Apologies were received from Joe Liddane and Peter Freedman.

13/81 Declaration of interests

81.01 No board members declared any personal interests in the items scheduled for discussion.

13/82 Minutes of the previous meeting and action tracker

82.01 The minutes of the meeting held on 22nd May were approved.

82.02 Action tracker

10.03: The draft OD strategy had been discussed at the June Board Seminar and placed on the agenda for discussion at the Resource & Planning Committee to be held on 15th July.

39.02: The results of the listening exercise would be discussed at the July Board as scheduled.

44.03: Capacity and demand tools were being tested in three areas in order to determine which model best served staff. Lee Martin would update the Board in July.

47.05: The bespoke staff survey had been discussed at the June Board Seminar and further details would come to the July Board as part of a timed and costed paper covering all proposed OD initiatives.

53.02: Take-up of child protection training continued to be monitored by the Quality Committee on behalf of the Board.

61.05 It was planned to introduce a revised performance scorecard from next month.

79.02 The Transformation Board would be addressed under the monthly report from the Chief Executive.

13/83 Patient Story

83.01 Cassie Williams introduced Mishael Akpan, who leads the Mobility & Seating Solutions Service (MSSS). Mishael described the service as a small and unique specialised service based in the community designed in the main to support people with long-term mobility problems. Benefits to clients included enabling them to return to work and supporting schools. There were currently around twenty children with complex needs using the service.

83.02 Mishael introduced #####, a service user suffering from facioscapulohumeral muscular dystrophy (FSH), a progressive muscle wasting disease for which there is no cure. ##### explained that she had previously been using a mobility scooter, but this had given her severe backache. She had referred to the MSSC some 18 months ago and was now using a powered wheelchair. Explaining the extent to which this had improved her quality of life, she said that without it, she would need a carer; it had simply enabled her to have an independent life. Such mobility aids were crucial for people like her, and gave them a zest for life. The wheelchair provided by MSSS was the basic model funded by the service, but it was possible to make adaptations to suit the needs of the individual user – such adaptations needed however to be funded either by the service user or with charitable assistance.

83.03 ##### described the service as ‘fantastic’, saying that any requests or queries were responded to within a couple of days. She also emphasised the safety aspects of the wheelchair, giving as one example the fact that she was able to use it on icy ground, whereas previously if she had had to walk from a car to her front door she would have been afraid of falling. Her back was also much improved and she suffered less pain. When asked whether, in her view, the service could be improved in any way, she replied that she was aware it needed additional funding.

83.04 In answer to a question from Anita Charlesworth about how the service was publicised, Mishael replied that they made visits to GP forums, social services etc and had also held meetings with commissioners. Greg Battle asked whether the team aimed to achieve ‘a child in a chair in a day’ in line with the DH published high impact innovation described in ‘Innovation, Health & Wealth’. Mishael replied that if the aim was to provide the most basic of chairs, this could be done, given the necessary funding, but because of the complexity of creating bespoke chairs to suit the individual needs of the client more time was required.

83.05 Sue Rubenstein commented that she had been struck by the degree of personalisation involved, and there was real learning to be gleaned about understanding what service users wanted to achieve. In answer to a question from Dr Yi Mien about funding issues, Mishael replied that a key issue was around securing the resource to support young people with complex needs. On behalf of

the Board Robert Aitken thanked both Mishael and ##### for attending and presenting.

13/84 Chairman's Report

84.01 Robert Aitken began his report by informing the Board that Joe Liddane was currently on leave looking after his parents. He himself had carried out visits to paediatric services in Holloway and sexual health services at St Anne's. Both had proved very interesting, and he urged Board members who had not yet signed up for patient safety walkabouts to do so.

84.02 Paul Lowenberg enquired what the route was for ensuring recommendations were implemented and improvements made in line with reports made after such visits, and Robert replied that he would be having a further debate with Bronagh Scott and Sue Rubenstein outside the meeting. Bronagh Scott added that feedback was provided to the services visited, and that reports were regularly received by the Quality Committee. Martin Kuper added that issues were also discussed at the Patient Safety Committee. He also reminded Board members that there continued to be two types of visit, the patient safety walkabouts and quality committee visits, and that a decision had been taken by the Board to amalgamate the two. Sue Rubenstein stressed that one of the primary purposes of such visits was to build engagement with staff, whilst also being aware that on occasion issues emerged that needed to be acted upon by the executive team.

13/85 Chief executive's Report to the Board

85.01 Dr Yi Mien Koh began her report with an account of the Transformation Board. This Board had been established by the commissioners some 18 months ago (PCTs at that time) but it had tended to stray into operational issues rather than maintaining a strategic focus. At the previous week's meeting, it had been agreed that there was a need to look again at its terms of reference, and in particular to make sure that any duplication with, for example, the Clinical Quality Review Group (CQRG). In summary terms of reference and work programme will be reviewed over the next few months.

85.02 The listening exercise had concluded at the end of May, and Dr Yi Mien thanked all those who had taken part. Three key messages had emerged:

- Around estates – there was obviously a great deal of love for the hospital site and there was a need to take a longer-term view, also taking account of the growing population.
- There were some concerns about providing care closer to home; not everyone was confident that sufficient resources were available outside the hospital to support them. There was a need to work more closely with our partner agencies. Having said this, a great deal had already been implemented and good results could be seen.
- On ward closures and reducing the number of staff – a strong message had been expressed about ensuring the necessary number of beds are available when people needed them.

85.03 Summing up, Dr Yi Mien said that the listening exercise had proved a very positive exercise, with important messages being raised. Revised plans and the new clinical strategy would be brought to the Board meeting in July.

85.04 The National Confidential Enquiry into Patient Outcome and Death had published its 2013 report on 14th June. It was noted that alcohol-related liver disease was prevalent locally, and a number of recommendations had been made to combat this, as well as the Trust having a related CQUIN and alcohol reduction being contained within our strategic goals.

85.05 Dr Yi Mien congratulated all current and former staff recognised in the Queen's Birthday Honours List. She also congratulated Lee Martin on his appointment as Chief Operating Officer.

85.06 Anita Charlesworth had noted the expression of interest in becoming an Integration Pioneer and enquired whether any further information was available at this stage. Greg Battle replied that Islington had long been at the leading edge in respect of integrated care so should be well placed to be selected. Martin Kuper added that Whittington Health was working closely with London Borough of Islington in support of the application.

13/86 Quality Account

86.01 Martin Kuper began by explaining that the lateness of this submission to the Board had been caused by one of the stakeholders raising some late questions, also the Trust's auditors had requested some additions. He paid tribute to the work carried out by Senga Steel, Caroline Allum and Caroline Thomsett in producing the document.

86.02 Greg Battle drew attention to the theme of reducing patient stay, and in particular the focus on how integrated care works for the needs of the patient. Anita Charlesworth commented on the notable improvements made since production of the previous year's Quality Account, and Paul Lowenberg agreed that the document was much crisper and sharper. There was acknowledgement that the section on achievement of CQUINs might be clearer in terms of exactly what the Trust had achieved, and Martin Kuper replied that there were plans to address this using the dashboard. This was a positive step since it ensured a Quality Committee overview in addition to the Board. In answer to a question from Paul Lowenberg about how the figure of 25% in Table 1 had been reached, Martin Kuper replied that this figure had been set by the commissioners therefore the Trust had little control over the target.

86.03 Robert Aitken enquired whether there were plans to produce an abbreviated version as in previous years, and Senga Steel answered that this was in progress. The Board formally agreed the Directors' statement and endorsed the Quality Account for 2012/13, and thanked Senga Steel, Caroline Allum and Caroline Thomsett for its production.

13/87 Quality Committee Report

87.01 Bronagh Scott introduced the formal report of the Quality Committee which had taken place on 16th May and which had focused on both the risks and the

achievements and innovations shared by the divisions. Paul Lowenberg asked for more detail on the Hanley Road practice. Bronagh Scott explained that there had been difficulty in making a substantive appointment, and Martin Kuper added that there was scope for using the Trust's management of this practice as a pilot for innovation through, for example, the use of telehealth techniques. Greg Battle informed the Board that shortlisting of candidates was planned for the following week and interviews would take place on 2nd July. The situation had been closely monitored in terms of safety and discussions had taken place with the Local Medical Committee (LMC). The practice had been deemed safe and functioning but lacking in leadership. Martin Kuper further noted the innovations under consideration might offer opportunities for attracting grants/funding, and it was agreed Dr Kuper would discuss this with University College London Partners (UCLP).

87.02 A report of serious incidents was brought to each Quality Committee. It was noted that QC had discussed the ongoing incidence of grade 3/4 pressure ulcers in community settings. BS advised that each grade 3/4 acquired pressure ulcer was investigated as a serious incident and reported to the CSU. She added that while the Trust is not an outlier in this regard there is much work to be done to fully understand the complexity of this. She added that the Trust is participating in an improvement programme with a number of other trusts to make further improvements in this area.

87.03 An unannounced Care Quality Commission (CQC) visit to the hospital had taken place on 3rd June. An extremely favourable draft report had already been received by the Trust, and comments were being fed back to CQC prior to receipt of their final report.

13/88 London Cancer Memorandum of Agreement April 2013 – March 2014

88.01 As part of the London Cancer Network there was a requirement for the Trust to agree an annual memorandum of agreement, and the Board formally agreed to this, whilst stressing that it should be given the opportunity to discuss any formal consultations issued by the network.

13/89 NHS Trust Development Authority (TDA) Self Certification

89.01 Dr Yi Mien Koh informed the Board that, under the new TDA process, the Trust was required to submit a monthly self-certification return by 17th of each month. The Board gave its retrospective formal agreement to the return submitted by the 17th May deadline. In answer to a question from Paul Lowenberg requesting more detail on the assurance process, Louise Morgan undertook to circulate a paper to the Board.

13/90 Integrated Performance Dashboard and Exception Report

90.01 Introducing this item, Lee Martin informed the Board that the dashboard was currently under review, both in terms of checking that it showed performance of the areas the Trust wished to monitor and that it provided the necessary assurance required by the Board. He added that staged improvement plans were being developed for areas of concern.

90.02 Highlighting areas of particular success, Lee drew attention to the high response rate achieved for the inpatient 'Friends and Family' test, and the results, within infection control, of MRSA screening and the hand hygiene audit. Bronagh Scott agreed that the infection control team had performed exceptionally well, but told Board members that this year's targets would prove challenging, in particular to have no cases of MRSA and below 10 Clostridium Difficile. It had been suggested that the team returned to face to face training and this was to be discussed at Trust Operational Board (TOB) the following week. Overall infection control practices appeared robust.

90.03 There had been improvement in health visitor new birth visits, suspected cancer waits and community physiotherapy waits. ED performance had been good over the last six weeks, and RTT performance had also improved. Complaints response times had once again proved challenging, however, plans were in place to achieve the required standard by the end of June. Lee acknowledged that the Trust's performance on complaints had been unsatisfactory and he was in discussion with Bronagh Scott about this. He was also working to improve take-up of mandatory training. Jo Ridgway added that she was also scrutinising the e-learning platform in order to ensure its fitness for purpose, and consideration was also being given to how best to accredit learning recently acquired in other organisations. It was also noted that there had been under-reporting in some areas due to staff carrying out their required training but failing to correctly record it. Jo's team had produced a guide to mitigate against this happening, and consideration could also be given to introducing a warning message on the computer screen.

90.04 Paul Lowenberg stated that he had noted two areas had remained static for around a year, one was complaints performance and the other theatre utilisation. In response, Lee assured the Board that he would hold further discussions with Bronagh on complaints, however priority had to be given to clinical staff carrying out clinical activities. He acknowledged theatre utilisation could be higher (figures did include unfunded sessions) and would hope to see it rise to c. 91%. Anita Charlesworth and Jane Dacre expressed concern over consultant cover and DNA and cancellation rates respectively, and on the latter, Lee replied that it had just been agreed with the commissioners that a new access policy was required which needed to be brought in line with national policy. This would come into effect once it had been signed off by Executive Committee.

90.05 Martin Kuper informed the Board that seven day cover had been agreed with most but not all consultants in medicine. Whittington Health was, however, the most compliant Trust within the sector. There needed to be a discussion around whether this was the most appropriate indicator, as full compliance would require extensive negotiation and significant investment. This could be addressed as part of the review of the dashboard. Sue Rubenstein emphasised that it was quite correct to have national standards, but there should in addition be local aspirations. Anita Charlesworth raised the subject of the reporting of clinical outcomes by consultant, and Martin Kuper undertook to check that all had signed up to this.

13/91 <u>Financial Report</u>

91.01 Introducing this item, Richard Martin informed the Board that the Trust had a small in-month surplus of £904k. There had been underperformance of CIP targets by some £699k year to date, with this month's seeing a slight improvement of

performance from the previous month's 62% to 64%. There was also a higher degree of risk around forecast delivery this year, with the chief element of this being around CIPs.

91.02 An Executive Team awayday held the previous day had agreed the following eight-point plan:

i) Temporary staffing review - Assess use against criteria which identifies any posts that are not imminently critical to patient quality, key mandatory targets or critical systems. Report back to EC with risk and impact assessment (Lead Lee Martin).

ii) Review all posts awaiting permanent recruitment - Similar approach to above. (Lead Jo Ridgway)

iii) Review any savings schemes that are slipping against their milestones and identify if additional investment/prioritisation would improve the forecast outcome. Continue with the ongoing monitoring of all schemes by the CIP Board and reporting to the Resources and Planning Committee.(Lead Lee Martin)

iv) Identify any schemes within the capital programme that could move into the following year as a way of preserving cash whilst risk assessing the impact upon patient care and performance targets. (Lead Richard Martin)

v) Non-pay controls - List of non-critical expenditure to be identified and gate kept by procurement with budget holders being advised of any exceptions requiring director sign-off. (Lead Richard Martin)

vi) Risk management - Areas of uncertainty that could translate into financial pressures such as agreeing revised income contracts with the new organisations NHS England and local authorities as well as CCGs following re-organisation of the NHS in April. Another key uncertainty is securing the appropriate funding for the properties that are transferring to the Trust from the now defunct PCTs. Removal/confirmation of these risks will reduce the range and scale of potential outturn scenarios. (Lead Richard Martin)

vii) Scrutinise the approval of new cost pressures and confine to those strictly unavoidable (Lead Martin Kuper).

viii) Any potential technical adjustments e.g. recalculate capital charges expenditure following recent asset impairment revaluation and the pending transfer of community properties to the Trust. (Lead Richard Martin).

91.03 The Board discussed the drive to reduce the use of bank and agency staff. Richard Martin reminded Board colleagues that changes had been made to the tax system for staff on the bank which should incentivise and increase the number of bank staff, and Bronagh Scott said there had already been a visible improvement. Jo Ridgway spoke of the need to move away from a cultural norm whereby the default position was to get an additional person in rather than try to spread the load. The executive team also needed to revisit controls – i.e. what level of staff was empowered to bring in additional staff. Furthermore the Trust was using too many agencies and thus not capitalising on the savings which come from economies of scale. Bringing in e-rostering was also under consideration; this

would highlight exactly where the gaps were. This work was being given the highest priority, and Lee stressed that it was not limited to nursing, although extremely good work had been done there. Paul Lowenberg expressed his concern that there was insufficient control over expenditure on staff and expressed the hope that demonstrable and sustainable improvement would be achieved within three months.

91.04 Sue Rubenstein asked what lessons had been learned from failure to achieve some of the CIPs. Lee Martin replied that some of the schemes had not been sufficiently robust, and others had been halted because quality indicators had deemed it necessary.

91.05 Noting there had been a small overspend in midwifery, Anita Charlesworth reminded Board colleagues that any workplace tended to 'dip' a little or at least slow down when a new system was introduced, and asked whether provision had been made for the effect of the roll-out of EPR. Richard Martin replied that this had not been built into the business plan, or, Dr Yi Mien added, had it been raised at the EPR Project Board. Richard went on to explain however that the problems in midwifery had on this occasion been caused by a combination of sickness and the current closure of one area. Anita repeated the need for robust planning, and Martin said there was a need to look at the roll-out of EPR in conjunction with other change programmes. Jo Ridgway stressed that such considerations should be addressed in all business plans.

13/92 Audit Committee Annual Report

92.01 The quality of the Audit Committee annual report was commended by the Board and its content formally approved.

13/93 Board Assurance Framework (BAF)

93.01 Introducing this item, Louise Morgan said that no significant changes had been made to the BAF since it had last been seen by the Board. Paul Lowenberg pointed out that the document contained a number of items that had been due for completion between March and May and no indication was given about whether they had been. Louise Morgan replied that a refreshed version of the BAF would be produced for the Audit & Risk Committee on 11th July and then brought to the July Trust Board.

13/94 Comments and questions from observers

94.01 The answers to questions about future service plans and the estates strategy would come to the public Board as part of the response to the listening exercise in July.

94.02 A question was asked about how, when formal complaints made to the Trust were particularly complex, complainants were kept in touch. Bronagh Scott replied that significant progress had been made in this area, people were contacted at a much earlier stage in the investigation and they were kept informed of progress throughout the investigation. Lee Martin added that there had been a pilot within the Surgery, Cancer & Diagnostics Division whereby the Head of Nursing had

taken the lead in this area and this had proved particularly successful. It was suggested this could be further discussed by the Quality Committee in July.

94.03 In answer to a question about whether the Trust had ever imposed a gagging clause on any its staff and if so how many, Jo Ridgway said the Trust would not routinely do this although there were necessary confidentiality agreements within contracts. Dr Yi Mien added that NHS London had required a declaration from all Trusts stating whether any such clauses had been imposed over the previous five years and Whittington Health had replied in the negative.

94.04 In answer to a question about whether Whittington Health charitable funds could be made available to support patients such as #####, whose story had been heard earlier, Robert Aitken explained that most donations to the (limited) fund were made with a specific purpose and were therefore not generally available for distribution.

94.05 In response to a point about the difficulties of reconciling the increase in NHS budgets with the need to save more and more each year, Anita Charlesworth confirmed that the NHS budget grew just in line with inflation, but this was against a backdrop of a growing – and ageing – population. Another significant factor was the cost of drugs, some of which rose well above inflation.

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Action Notes Summary 2013-14

This summary lists actions arising from meetings held March to May 2013 and lists new actions arising from the Board meeting held on 26th June 2013.

Ref.	Decision/Action	Timescale	Lead
39.02	Results of and response to the listening exercise to be brought to the Board in July	July 2013	YMK/CT
44.03	Report on use of capacity and demand tools to reduce waiting times to be produced for Board members	July 2013	LMa
53.02	Board to monitor the take up of levels 2 and 3 Child Protection Training through regular updates to the Quality Committee	Bi-monthly	BS
61.05	Revised performance dashboard to be produced for the Trust Board in July	July 2013	LMa
70.03	Results of the in-patient survey to be discussed at the July meeting of the Quality Committee	July QC	BS
77.03	Board to review the Schedule of Delegation	Sept TB	LMo
87.01	Martin Kuper to discuss possible innovations and funding sources for Hanley Road with UCLP	July TB	MK
89.01	Paper to be produced describing the assurance process for the monthly TDA self-certification	July	LMo
90.05	To check whether all consultants were signed up to the principle of reporting clinical outcomes by consultant	July TB	MK
93.01	Refreshed version of Board Assurance Framework to be produced for Audit & Risk Committee	July A&R	LMo