Minutes of a meeting of the Board of Directors of Heart of England NHS Foundation Trust held in the Harry Hollier Lecture Theatre, Partnership Learning Centre, Good Hope Hospital on 2 March 2016 at 12.00 noon

PRESENT:
J Smith, interim Chair
J Brotherton, Director of Operations
A Edwards, Non-executive Director
S Foster, Chief Nurse
J Glasby, Non-executive Director
H Gunter, Director of Workforce & OD
K Kneller, Non-executive Director
J Miller, interim Finance Director
J Moore, interim Chief Executive Officer
J Rao, Non-executive Director

IN ATTENDANCE:
F Alexander
M Cooke, Director of Strategy/ Deputy Medical Director
K Bolger, interim Deputy Chief Executive - Improvement
D Burbridge, interim Director of Corporate Affairs
R Cashman
A Hudson, Minutes
C Ryder, Deputy Medical Director
K Smith, Company Secretary

Governors
R Hughes
S Hutchings
J Thomas
D Treadwell

and members of the public.

16.026 APOLOGIES & WELCOME

The Chair welcomed everyone present to the meeting.

Apologies had been received from D Rosser.

The Chair noted the following changes:

- A Catto had been seconded to NHS England;
- A Lord and D Lock had resigned as Non-executive Directors due to an increase in their other business activities. The Chair recorded a vote of thanks for their commitment and attention especially during what had been a difficult period for the Trust and wished each of them well for the future.

The Chair welcomed David Burbridge as interim Director of Corporate Affairs.

16.027 APPOINTMENT OF FINANCE DIRECTOR - RATIFICATION

The Chair referred to the pre-circulated paper and advised that the Nominations Committee had met and approved the appointment Julian Miller as interim Finance Director (a voting director position) with effect from 3 February 2016. The Board ratified the appointment.

16.028 DECLARATIONS OF INTEREST

The Directors' Register of Interests was received.

16.029 MINUTES

The minutes of the meeting of 6 January 2016 were approved as a true record.

16.030 MATTERS ARISING & RECOMMENDATION TRACKING REPORT

There were no matters arising.

16.031 CHAIR'S UPDATE REPORT

J Smith gave an overview of the external meetings undertaken since the last meeting; these included attendance at the recent Birmingham & Solihull Overview and Scrutiny Committee with K Bolger and R Cashman where she had briefed councillors on the key performance and finance issues. The Chair had met with the Director of the Integrated Care and Support in Solihull to talk about the well-developed partnership work in the borough and had agreed to attend future meetings of the Leaders Board.

16.032 CHIEF EXECUTIVE'S REPORT

J Moore reported that the Government had identified an additional £8bn of funding which would be split into two allocations of £1.8bn, of which the Trust had been allocated £23.5m. The second tranche was subject to being part of the Sustainability & Transformation Plan (STP) which involved the local health economy working together in order to agree priorities; the agreed footprint for the trust included Birmingham and Solihull. Strict controls around how the funding could be spent would be applied. A considerable amount of work was being done with the Trust's partners and local authorities in this regard. The Trust had a lack of capital but was looking to generate savings of £15m - £17m internally to fund this; however more was required if the Trust was to upgrade essential buildings and equipment. J Moore had approached the Treasury direct and was optimistic that the Trust would obtain some funding from that source.

The Chair congratulated J Moore on being voted number two in the HSJ's list of top 50 Chief Executives nominated by their peers.

16.033 PERFORMANCE REPORT

K Bolger presented the report on the Trust's performance against national indicators and targets, including those in the Monitor Risk Assessment Framework, as well as local priorities. Material risks to the Trust's provider licence or governance ratings, finances, reputation or clinical quality resulting from performance against indicators were also reported, in order to give an overall view of the position of the Trust and set out the actions for those indicators that were failing to achieve compliance with targets.

Monitor Risk Assessment Framework (RAF)

Of the 14 indicators set out in the RAF ten were on target; the four targets missed comprised one cancer target, the 4-hour A&E wait target and the 18 week RTT incomplete pathway target and the in-month C.diff target. The Trust was working with key stakeholders to review and revise trajectories for four key national targets: A&E, 18 week RTT, diagnostics and cancer 62 day waits.

There had been a 17% increase in A&E growth that was peculiar to Birmingham. January's A&E 4-hour wait performance had been 84.3% against 83% in January 2015. The increase in attendance during January compared to the same month in 2015 had seen an average of 89 attendances more per day. Ambulance attendances were up by 10%; the Trust was working with CCGs to look at why the increase had occurred.

The 85% 62-day cancer referral target had been achieved in December at 85.36%; however maintaining the position was challenging with unvalidated performance at 76.5% for January. The 2 week wait from referral to appointment performance for December 2015 was 94.79% against the 93% target. The 2 week wait breast cancer target had been achieved for December.

Referral to Treatment time (RTT) had improved to 91.24%, which was ahead of trajectory, against the 92% target but it was proving difficult to achieve the last 0.5%. The Trust was working with the CCGs to ensure it was not agreeing to trajectories it was unable to deliver.

There had been 7 cases of C.diff in January against an in month target of 6. This was the second month in the current year that the Trust had exceeded its target.

National targets monitored through CCG contract

Of the 17 national targets not included in the RAF but included in the CCG contract the Trust had delivered ten with seven behind plan.

6 week diagnostics had improved to 96.88% against the 99% target; endoscopy continued to be the biggest problem with investment in equipment required in order to achieve and maintain targets.

The ambulance handover position was similar to that of December 2015; there had been a 10% increase in the number of ambulance attendances compared to January 2015.

There had been 2 confirmed cases of MRSA bacteraemia in January bringing the Trust total year to date count to 5; this compared to one case in 2014/15.

There had been two sleeping accommodation breaches affecting five patients; both events had occurred in HDU at BHH.

In January one urgent operation had been cancelled for the second time due to a lack of a critical care beds on both occasions; the patient had since been treated.

In response to a question from the Chair, K Bolger advised that recent discussions with the CCGs around growth, especially in respect of A&E attendances, had determined that options around managing the number of attendees were being explored that included looking to put in place a primary care facility at the front door, in order to move patients onto the right care pathway.

Activity would still be counted within the Trust's numbers. It would be important to ensure that finances were not adversely affected by such a change.

In response to a question from J Rao, K Bolger advised that the Trust had agreed to an audit of ED admissions to determine how patients were being treated; as the target made no allowance for acuity.

Local indicators – contract

There were a number of local contractual indicators that the Trust's performance was measured against; 22 were reported monthly, of these 16 were on target and six below target.

Breast feeding rates had dipped in January to 68.87% against the 72% target; an action plan to support delivery of the target was in place and had been discussed with the division at the recent Executive Performance Review Meeting. The Trust had achieved the target in February but sustainability was an issue.

Local indicators – internal

The Trust had a number of internal KPIs that were reviewed on a monthly basis under the headings of workforce and quality and safety. Those not being achieved included:

The January position against the workforce KPI's had shown no significant shift from the December position and continued to underperform in four areas; Staff in post versus budget establishment (excluding nurses); nursing staff in post vs budget established, average time to recruit – hiring manager and total time to recruit and voluntary turnover. The Trust was looking into measuring the targets that were in the Trust's control as opposed to those that were outside of the Trust's control.

The Trust continued to overspend, at 8.18% in January, against the Trust wide agency target spend of 3%; however, the Trust was complying with the Monitor rate caps. The overspend was due to activity levels and it was acknowledged that such an overspend was inevitable at times of high activity. There were around 160 nursing vacancies across Trust.

Delayed Transfers of Care (DTOCs) performance had improved slightly in January, by 0.51%, to 4.62%; cross-economy talks were being held with better support now in Birmingham. Staffordshire continued to be challenging. The number of DTOCs equated to a ward of patients at any one time.

There were 4 patients who had waited over 100 days for their first definitive cancer treatment; all of which were complex cases. The cancer team developed a forward look process to manage these complex patients better.

The Trust had cancelled 0.88% (71) operations at short notice in January against the target of 0.8%. There had been no breaches to the contractual target requiring patients to have surgery within 28 days of the cancellation of surgery since August 2015. **Action:** In response to a question from J Glasby, K Bolger agreed to undertake a review to ascertain whether there were any diversity issues for such patients (e.g. learning disabilities).

The target to record 90% of Admissions, Discharges and Transfers (ADTs) within 2 hours was missed in January at 77.01%. A review was underway to understand why compliance was so low; it was felt that the new organisation structure would have a positive impact on compliance.

Solihull community contract

The Trust contract with Solihull MBC focussed on performance of the Health Visiting Service managed by the Solihull Community Team. All the indicators were monitored quarterly and performance for Q3 showed that the Trust was only achieving 3 of the 9 indicators. The Chair noted her disappointment in the failure to achieve a better level of performance. K Bolger noted that the contract had not been integrated well by the Trust.

16.034 CLINICAL QUALITY REPORT

The Chair advised that D Rosser would be taking on the role of Interim Medical Director (and Responsible Officer) following A Catto's secondment to NHS England. C Ryder presented an overview of the report on behalf of D Rosser who was on leave.

Investigations into doctors' performance

There were currently thirteen medical practitioners within the formal review process; eleven cases predominantly related to conduct matters and two to capability matters. A robust process was being followed. The number of cases felt appropriate, given the size of the Trust. A training programme was being developed to generate a wider pool of investigators.

Mortality indicators

The Trust's April-October 2015 HSMR of 91.8 was below the average for Midland's trusts of 92.7 and had shown a favourable downward trend; the Trust was positioned at 45 of 135 trusts nationally. There was about to be major rebasing but it was expected that the Trust would broadly maintain its ranking.

The Trust's July 2014-June 2015 SHMI of 95 was respectable but was subject to the caveat previously reported on the historic corrupt data issue, which would take time to work its way out of the data set.

There had been six new CUSUM/ HSMR condition alerts, which were based on the number of re-occurring medical conditions seen at death; a review was underway and a report would be presented to a future meeting. A review of cases had already been undertaken with no concerns raised.

In response to a question from J Rao, C Ryder advised that the Trust had received a letter from the DoH clarifying what was required for the avoidable deaths review; it was expected that the new organisation structure would aid future reporting.

The Trust consistently ran at 0.4 -.05 in relation to its CRAB score, below 1 was considered good.

Board of Director's unannounced governance visits

The first of the new style Board visits had been to ward 15 at Solihull Hospital, an orthopaedic ward. The visit had been well received by the ward staff and appreciated by Directors too. There had been some previous concerns around ward 15 but a new nursing team and an enhanced medical team was now in place giving reassurance to the Board. The Chair advised that the March visit may need to be rescheduled due to lack of NED availability.

16.035 CARE QUALITY REPORT

S Foster referred to the pre-circulated report that summarised the Trust's performance against national quality indicators and targets, including those set out in Monitor's Risk Assessment Framework, and local priorities.

There had been five Trust apportioned MRSA bacteraemias and one outbreak of CPE. There was Trust wide focus on hand hygiene, to reduce contamination, and on screening.

In relation to C. Diff, the Trust was leading the way in faecal transplant treatment, where positive results were being seen.

Performance against the total numbers of avoidable hospital acquired pressure ulcers, for both grades 2 and 3, had improved compared to the same period in 2014-15. There was poor documentation to evidence good care and poor ward leadership in some areas, so the focus was now on the address these issues.

The falls rate had increased in month to 6.99 falls per 1,000 occupied bed days. This was the highest rate recorded so far during 2015-16 and meant that the Trust was now above the year end trajectory of 6.36. However, the January 2016 rate was 6.99 compared to the January 2015 rate of 7.26. The in-month increase was not expected to be an adverse trend.

There had been a negligible improvement in the recording of ADTs on the Trust IT system in January 2016, increasing from 79.09% to 79.5%. Staff training and cover was under review.

Nurse recruitment plans were on track. A tender was out with an agency to provide EU nurses with suitable English language skills; open days were also being held at Trust sites.

The number of re-opened complaints cases had fallen; the quality assurance process with divisional teams continued to have a positive impact. There was a view that there were too many ways to provide feedback on patient experience; the Trust was looking to review this in order to provide divisions with good, themed, information. NHS Elect was providing customer care training.

A review of open visiting had been undertaken; there had been a positive response overall. There had been some negative staff feedback around cleaning and protected meal times; in response to which a revised visiting code would be developed and cascaded.

There were some risks around CQUIN delivery; a performance review was being undertaken.

In response to a question from J Rao regarding duty of candour, S Foster advised that the Trust was looking at closing the loop by sending closure reports to patients.

In response to a question from J Glasby, S Foster advised that the Friends and Family Test (FTT) texting worked will in A&E and could in paediatrics but not everywhere. J Glasby advised that he had previous experience of an App used in conjunction with real time messaging displayed on public facing website. However, the current concern about possible over-reporting was noted.

16.036 FINANCE REPORT

J Miller presented the report for the period ending 31 January 2016 (M10). The Trust had reported an Income & Expenditure deficit of £4.6m during January, leading to a cumulative deficit of £56.0m for the year to date (YTD). As part of the financial recovery plan, short term measures (enhanced controls) had reduced the monthly run-rate from an average of £7.1m per month in Q2 to an average of around £5.0m per month since October. However the easy wins had now largely been delivered and a longer term plan would be required to tackle the residual deficit. The YTD position represented an adverse variance of £47.8m against the planned deficit of £8.2m YTD. The main adverse variances were medical pay (£11.2m YTD), nurse staffing (£9.2m YTD), private sector capacity (£3.2m YTD) and slippage against CIP (£23.2m YTD) that included £14.1m related to prior year targets. The current underlying year end forecast was projecting a deficit of between £60.0m and £63.0m dependent upon the delivery of recovery schemes and the impact of winter pressures over the next two months.

The Trust had recently been notified that it would receive £18.6m of additional income from DoH as

part of the national capital to revenue transfer (to improve the overall performance of the provider sector). This would reduce the reported deficit correspondingly but did not change the underlying position going into next year as it would go back out as PDC.

Emergency admissions remained high at 8% above plan in January (+1.4% YTD). Encouragingly Elective cases (and day cases) were 1.1% above plan in the month (+2.4% YTD) despite emergency pressures.

CIP delivery for the current year stood at 73% of target at month 10 (£5.4m slippage) but the YTD savings included £4.9m of non-recurrent schemes that would need to be re-addressed in 2016/17.

Cash had reduced to £41.6m, which was £23.5m below plan. The latest year end forecast for cash was £17.9m, which implied that the Trust would be run out of cash around by May or June at which time the Trust would need to apply to the DoH for distressed funding.

The focus was now on financial planning for 2016/17, including identification of CIP and working with EY to develop the longer term financial recovery plan, which needed to be submitted to Monitor on 11 April 2016. The plan set out a £69m best case deficit, the Trust had been offered £23.3m through the STF but had to agree to a maximum deficit, or control total, of £13.6m. In order to achieve this, the Trust needed to find an additional £32m of savings over CIP. Suspension of fines and penalties should result in £10m-£15m of benefit and QIPP was expected to be paid at a fair rate on work undertaken; these caveats had been made in the Trust's submission for the STF funding. There was a potential further allocation of £200m available from the STF but how this was to be accessed was unknown at the present time.

The Chair noted that the financial situation was a major concern to the Board and that the Board had spent considerable time, earlier in the day, considering the financial recovery plan with EY.

16.037 OPERATIONAL STRUCTURES

K Bolger delivered a presentation that set out the new operational structure that would come into effect from 1 April 2016. There was a focus on transparency and clarity. The new structure would allow stabilisation of the organisation over at least the next 18 months. J Brotherton was confirmed as Executive Director of Operations and would be supported by a Head of Operational Finance; Head of Operational Performance; Cancer Services Lead and Deputy Director of Operations, which would be a part time role but would provide continuity if the Director of Operations was not available. The current Associate Medical Directors would become Divisional Directors who would be professionally accountable to the Medical Director but operationally accountable to the Executive Director of Operations. There would be five divisions; an overview of each of the divisions was given. The Chief Executive's Group meeting would bring all of the divisions together with the corporate leads. Then new structure would force working together rather than silo working as had experienced in the past.

K Kneller welcomed the clarity that the revised operational structure should bring.

The Chair advised that similar work was underway on the corporate functions of the Trust.

16.038 BOARD ASSURANCE FRAMEWORK & RISK REGISTER

S Foster advised that she and D Burbridge had been reviewing the Board Assurance Framework and Risk Register in order to understand the baseline position; D Burbridge would be taking it forward.

16.039 BOARD COMMITTEE MINUTES AND REPORTS

Audit Committee

K Smith advised that the committee had met on 20 January when D Lock had chaired the meeting; the Committee had been updated on the 2015/16 year end process and reviewed the process for approving reference costs. The meeting had received reports from the internal auditors, Deloitte, most notably on Budgetary Controls, including budget setting & reporting, temporary staffing, third party capacity for clinical activity and waiting list initiatives. Overall there were 26 high, 15 medium and 9 low priority recommendations.

J Smith reported that K Kneller would be taking over as Committee chair following the resignation of A Lord.

Donated Funds Committee

The Chair advised that the Committee had met on the 29 January; she had attended but the Committee was chaired by Paul Hensel. There had been a useful report from Mike Hammond, CEO of QEHB Charity who had been appointed to undertake a review of the Trust's Charity. The report and its recommendations had been received with interest and subject to further clarification the Board should see improvements from a stronger focus on fundraising and fundholders' spending plans.

Monitor Standing Committee

The Committee had met on 29 January to approve the Monitor quarter 3 return; the minutes were received.

16.040 POLICIES FOR APPROVAL

The Celebrity & VIP Visitor Policy and the Consent Policy for Examination or Treatment Policy were both taken as read and duly approved.

16.041 DATE OF NEXT MEETING

The next meeting was scheduled for 11 May 2016, to be held in in the Harry Hollier Lecture Theatre, Partnership Learning Centre, Good Hope Hospital.

The Chair asked the governors or public present if there were any questions; none were received.

The Board resolved "That representatives of the press and other members of the public be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest."

PART TWO

16.047 ANY OTHER BUSINESS

There being no further business the meeting closed.

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Chair