Chesterfield Royal Hospital NHS
NHS Foundation Trust

BOARD OF DIRECTORS

Minutes of the meeting of the trust's board of directors on Wednesday 26 October at 1.30 pm in the board room, Chesterfield Royal Hospital

Present:
Mr R Gregory, Chairman (in the chair)
Mr T J Alty, Executive Director - Corporate Secretary
Mr P Briddock, Executive Director – Finance and Contracting
Dr I Gell, Executive Medical Director
Mr M R Hall, Non Executive Director
Mrs P Liversidge, Non Executive Director
Mr E J Morton, Chief Executive
Mr A Tramontano, Executive Director - Chief Nurse
Mr D Whitney, Non Executive Director

In attendance:
Dr C Day, Public Governor/Chair of the Patient and Public Involvement Committee (for item BD194/11)
Mr J A Jones, Corporate Director - Allied Clinical and Facilities Services
Mrs N Tucker, Corporate Director - Performance and Operations
Mrs S Turner-Saint, Head of Communications

Apologies:
Mrs J Birkin, Non Executive Director
Ms D Fern, Non Executive Director

ACTION

BD194/11 Patient and Public Involvement

Mr Gregory welcomed Dr Day to the meeting in his capacity as a public governor and chair of the council of governors' patient and public involvement (PPI) committee.

Dr Day presented minutes from the PPI meeting of September 6 and took the board through a number of issues.

The following was of particular note:

Ward visits
Mrs Liversidge commented on the fact that governors had again highlighted the lack of hooks in bathrooms. Mr Jones reported that the estates team were working to affix hooks in all bathroom areas within the trust. He agreed to provide the PPI committee with a list of completed areas – and a timetable for those still awaiting the work to be done. **AJ**

Ophthalmology

Dr Day updated board members on the role governors were taking in respect of the new eye clinic development. It was noted that governors were not only involved in the capital project – but were also participating in the creation of new care pathways for ophthalmic sub-specialties. Dr Day stated that this opportunity had been welcomed by governors - and he reported that discussions to date had been open and supportive.

In response to queries about the eye centre plans from Mr Hall, Mr Jones confirmed that the centre would definitely have a vehicular drop off zone – with space for two cars. The few patients brought for ophthalmology out-patient appointments by Ambuline would be taken through the Scarsdale entrance.

Mr Gregory expressed his view that service improvement also needed to be happening in advance of the centre's opening – to ensure patients that the trust had already taken action to respond to their concerns. He questioned if this was being assessed?

Mrs Turner-Saint commented that the directorate - and the team of staff in ophthalmology - had worked incredibly hard to address complaint issues and themes over the past 18-months; and she estimated that complaints had dropped by around 75%. It was acknowledged that the issues within the consultant establishment (that is rapid turnover of staff and cumulative vacancies) had contributed to a number of problems. However, with the recent appointment of new consultants there was now an increased positivity and inclusivity which was benefitting the service. Dr Day agreed that this – and the new pathways – would provide a good base for further improvement.

Dignity in Care

Dr Day highlighted the national Care and Compassion report – and the sobering stories it contained about negative patient experience. In response, Mr Gregory recounted the symbolic launch of the Dignity in Care Programme, which he had participated in on October 24. This was a partnership pledge – with Derbyshire County Council and Derbyshire Community Health Services NHS Trust also signing up. All three organisations had offered a commitment to provide high standards of care and quality services, with dignity and respect at their heart. It was noted this mirrored public opinion within the trust's recent 'Best, True and Able' consultation exercise – when dignity and respect was 'voted' the top concern by more than 2000 respondents. Mr Gregory recalled a letter he had read out at the launch about the excellent care an elderly patient had experienced at the Royal before she passed away – and the profound effect it had had on her husband and daughter. Board members agreed this was a standard all wards should aspire to achieve.

In-patient survey

Dr Day commented on the PPI committee's disappointment that the in-patient survey results were at variance with comments received from patients during governor visits. It was clear that the 'snapshot' survey was not always an exact reflection of patient views – but that nevertheless it provided the trust with an opportunity to act on areas of concern.
Mr Tramontano confirmed that the trust was replicating the questions in the national in-patient survey – and that questionnaires would continue to be distributed to every patient on the day of their discharge.

Priorities for 2012 – in-patient catering provision

A provider for the provision of in-patient meals was currently being sought – as the contract for the service was drawing to an end. Mr Jones reported that three tenders were in the process of evaluation and that a recommendation was likely to be brought to the board in January 2012.

Dr Day highlighted the work that governors had undertaken so far in respect of this contract. He invited non-executives to be involved in the next meal assessment - set to take place on November 25. In summary, a group 'followed' the meal from the kitchen to the ward (the ward to be visited was announced on the day not in advance) and then a food sampling exercise was undertaken. The plan on the 25th was to assess the provision of a lunch-time meal. Dr Day drew attention to the role of PPI members Mr Barry Whittleston and Mrs Pamela Wildgoose - who had both been heavily involved in the in-patient meal provision project.

In response to Mr Gregory's questioning, Mr Jones felt that the new contract should address the problems patients and ward staff had expressed their concerns about – such as the availability of snacks and the taste of soft and pureed foods (required by those on specific diets). Improved and closer monitoring was a priority. E-ordering would also solve the problem of the potential for patients to 'get lost in the system' if they moved bays or wards.

Mrs Turner-Saint reported that a wider educational programme would be undertaken to raise awareness of nutrition – and the importance of food in the patient care pathway and recovery. This in response to patients' and relatives' comments that the food was not 'what they would usually eat at home'.

Single point of access

Dr Day queried the proposal made by Derbyshire Community Health Services (DCHS) NHS Trust to host a single point of access on the Royal's site.

Mr Morton confirmed that an agreement had been struck with DCHS to trial the proposal over the winter months – as commissioners felt it would be a practical option to have DCHS involved in the care pathway (when a patient was brought through the emergency department). Whilst it was acknowledged that working within the four hour timescale would be challenging for DCHS, the overall aim was to ensure patients were appropriately cared for; in a 'place of safety' and were following the right clinical pathway for their needs.

Dr Gell stated that whilst there were differing views about the pilot, this was a good example of NHS services developing closer working relationships, which were constructive and in the spirit of collaboration.

Mr Gregory thanked Dr Day for bringing his and the PPI committee's concerns about this issue to the board's attention – and hoped that the detail of the single point of access pilot had offered some assurances. He noted the governors continued commitment to the patients' experience through a whole care pathway – not just the 'part' that took place in the Royal.

Quality accounts 2011/12
Mr Gregory asked if an improved process for the Quality Accounts had been established – allowing the Council of Governors to have a better input and a more detailed commentary within the report. Dr Day confirmed that the council would be asked to delegate responsibility for the Quality Accounts to the PPI committee. Dr Gell confirmed that a paper to that effect would be presented to Council meeting in November.

Mr Gregory thanked Dr Day for his briefing and the vital work governors were undertaking through the PPI committee.

BD195/11 Attendance of the corporate directors

It was noted that Mr Jones, Mrs Tucker and Mrs Turner-Saint were attending the board of directors in an advisory capacity.

BD196/11 Declaration of interests

The board **received** the declaration of interests pursuant to section 6 of Standing Orders. Board directors had no changes to the record.

Mr Gregory took the opportunity to congratulate two members of the board for their recent achievements. It was noted that Mrs Birkin had received an MBE for her work as a magistrate and with the Derbyshire Constabulary. Mrs Liversidge had become the first woman for 387 years to take up the role of Master Cutler in Sheffield.

BD197/11 Minutes of the meeting held on 28 September 2011

The board **received** and **approved** the minutes of the meeting of the board of directors held on 28 September 2011, subject to the following amendment requested by Mrs Birkin.

BD178/11 Joint meeting of the board of directors and council of governors (paragraph four, second sentence) – to be revised as follows:
Both non-executives felt that the Board of Directors was clearly accountable for approving decisions about the strategy. However, it was imperative that the board had full consultation with the governors, so that their views could be given complete consideration. However, for governors to jointly approve the strategy with the board could restrict their ability to effectively hold the board to account.

BD198/11 Matters arising from the minutes held on 28 September 2011

BD178/11 – Joint meeting of the board of directors and council of governors
In addition to Mrs Birkin's amendment (BD197/11), Mr Hall felt that the board as a whole needed to learn from the last joint meeting – and that greater clarity around the purpose of discussions was required. Mr Gregory agreed that an action learning point would be sensible.

In response to Mrs Liversidge's comments, Mr Morton summarised his belief that at joint meetings there was equal status around the table – for the purpose of networking, sharing ideas and information, debate and making contributions.

Board members agreed that this was the case - but that at future meetings it needed to be explicitly stated - so that both the board and the council had a greater understanding of their roles. **RG**

BD175/11 (BD161/11) – Quality Accounts
The position in respect of next year's Quality Accounts had been stated by Dr Day and Dr Gell earlier in the meeting (BD194/11).

BD175/11 (168/11) – Dates of meetings for 2012
Mr Alty tabled an updated timetable for key board and council meetings – designed to maximise the opportunity for more than one meeting to be held on one day (as requested by non-executive directors). In response to Mr Hall's query, Mr Alty stated that board members should take this update as the definitive list for 2012 meetings.

BD177/11 – The Chesterfield Eye Centre
It was noted from the update provided by Dr Day earlier in the meeting (BD194/11) that Sight Support Derbyshire were also involved in the eye centre development and the creation of new care pathways.

BD181/11 – Critical Care
In reference to issues discussed at last month's board meeting, in relation to the corporate risk register, Mr Morton felt it was timely to update board members on the cost improvement plan (CiP) put forward by the critical care directorate. This had already been discussed with the trust's other directorate teams – and had been positively accepted, whilst acknowledging the challenge of making it work.

The critical care directorate proposed moving to all day theatre lists by specialty from the beginning of 2012. This would save around £322K (the majority in the critical care directorate, but savings would also be made in surgery as a result of the changes.) The proposal would require all operating sessions plus some out-patient, multi-disciplinary team and audit sessions to be rescheduled. Consultant job plans would also need to be renegotiated. Mr Briddock would chair the project board for this CiP.

In response to questions from non-executive members, the following points were confirmed:

- The proposal would create greater flexibility within the theatre complex – and would allow for an additional laminar flow theatre to be created (improving access throughout the week for both planned and emergency orthopaedic surgery);
- One additional case would be factored in per theatre list, allowing for better continuity and fewer cancellations;
- Safety would not be compromised with this approach – staff would work the same hours, but theatre teams would be set up to allow for staggered breaks - to enable them to work effectively and efficiently;
- The proposals would allow for improved team development, which would also contribute to efficient theatre sessions;
- There would be the potential to create an admissions area to support the new proposals – and this would be crucial to its success.

Board members commended the directorate's positive approach to their CiP – but acknowledged that the plans would have left staff feeling uncertain and concerned. They were pleased to learn however that staff would be actively involved in determining constructive solutions to the all-day theatre list proposal.

Mr Morton felt that this was a positive step forward. The directorate had full ownership of the plan and would be making the decisions that would make it operational. He assured the board that this should be the first in a phase of efficiencies – and he was confident the directorate would deliver. For example, at a later stage, a GAP analysis could be undertaken to determine different ways of delivering services, addressing out of hours cover and the issue of ITU bed numbers.

BD183/11 – Quality report – attendance at induction
Mr Tramontano tabled a paper outlining the position as at the end of September. This demonstrated performance by directorate against a baseline (a minimum 8% achievement month-on-month) figure. Board members were pleased to see an improved position in a number of directorates, but felt that performance still needed to change in some areas. Mr Tramontano reminded the board that the trust's new i-Trent system would soon be operational in relation to induction - and directorates would receive a more detailed picture, which could be referenced down to individual staff members.

BD187/11 – Finance and Contracting Report
Dr Gell confirmed that all directorates were strengthening the process to recruit to middle grade appointments. He confirmed that the trust was planning to look to adopt a targeted overseas recruitment programme to source the level of medical staff required. There was also the possibility of positively utilising existing consultant contacts to source additional staff from overseas. Board members welcomed the steps being considered to try and reduce locum costs – but acknowledged these solutions, whilst a step in the right direction, would take time to come to fruition.

BD199/11 Chairman's items

Joint meeting
The board **received** the notes of the joint board of directors and council of governors meeting held on 27 September 2011.

One amendment was noted on the last line of paragraph 6, on page 6, which should read 'split between vision and mission'.

Appointment of the main contractors for the front entrance redevelopment
Mr Gregory invited Mr Jones to provide an update on the tender process to appoint the main contractor for the front entrance. Mr Jones drew the board's attention to the background to the tender process, reminding directors that the chief executive had already been given delegated authority to commission work as necessary.

Board members noted the tender scoring matrix, plus recommendations from both the project board and the loss adjustor. The board **supported** the outcome of the exercise and **approved** the recommendation that Styles and Wood be appointed as the main contractor for the front entrance scheme

Meeting with Monitor's Chair
Mr Gregory reported on a meeting he had attended with other FT Chairs, which was hosted by the Chairman of Monitor, Mr David Bennett.
Mr Gregory had taken the opportunity to highlight the key role foundation trusts had to promote integration, in particular as the growing number of foundation trusts in some geographical areas could be seen as confusing for patients, members (of existing foundations trusts) and the general public.

Mr Gregory stated that his comments had been well-received and the issues he had raised would be taken forward for further discussion and debate.

BD200/11 Risk committee

Mr Gregory presented the minutes of the risk committee held on 17 October 2011 and summarised the following areas:-

RC64/11 – Risk Management Strategy for Maternity
The maternity strategy would be updated to ensure there was the same approach (as the corporate strategy) in detailing the escalation of significant risks.

RC70/11(iv) RC68/11 – Reconciliation of Clinical Data
In response to Mr Morton's request, Dr Gell and Mr Tramontano would provide a list of clinical data items for which the trust already had assurance in place (for example internal or external processes). This would be presented to November's risk committee.

RC71/11 – Fire
Board members noted actions proposed by the trust following the main entrance fire of June 2011. These included changing the process for closing off action points from risk assessments, amending some policies, reducing third party contractor service provision on site, creating tailored training packages for some staff groups; and ensuring better vehicular access on site for Derbyshire Fire and Rescue (particularly opposite the emergency department).

Mr Jones confirmed the trust had worked alongside the fire service – and would meet them again to finalise the action plan and timescales for delivery. He also confirmed that the fire had offered learning points for the fire service and that they had indicated they would also want to spend more time with the trust as a result – to understand and appreciate the risk assessment process.

In response to a question from Mr Gregory, Mr Jones confirmed that the Health and Safety Committee would monitor progress against the action plan. Mrs Liversidge enquired if the contract with the convenience store could be terminated early – and if this would involve a cost. Mr Jones confirmed that a legal opinion was being sought to determine if costs would be applicable, or if there had been a breach of contract due to the fire itself. It was noted that a business case to take on the convenience store as an in-house provision indicated that there would be financial benefits to the trust and that this would be a welcome initiative.

RC74/11 – High Level residual risks – windows
Board members were disappointed to learn that on recent inspection, window restrictors fitted to upper level windows had been tampered with – and in five separate locations had been removed. All staff had been issued with a formal e-mail notice; matrons had been reminded of the responsibility they had to their ward area - and Mr Morton confirmed that disciplinary action would apply if any staff member was found to be involved in this practice.

Mr Jones confirmed that additional restrictors would be placed in other non-clinical areas on the upper floors of the building. Mr Hall suggested that as an additional measure a warning sticker could be affixed to each window, to indicate that restrictors were not to be tampered with. **AJ**
Mr Jones agreed to look in to this possibility.

The board **received** the minutes.

Prospective National Industrial Action
Mr Alty took the board through a short paper detailing the proposed national industrial action, which could take place on November 30. It was noted that a number of unions were balloting for strike action only – and that there was the potential for a number of one-day strikes.

The trust had sent out information to staff (tabled) – to raise awareness of the possibility that they may need to make alternative arrangements, if for example public transport, schools and social services were affected. The results of ballots were awaited before any further communication could be sent out (November 3 onwards). Mr Alty informed the board that an informal meeting had taken place with JCC representatives and that they had been happy with the information provided to staff at this stage.

Mr Morton asked board members to note that if a strike did take place, the board meeting may need to be postponed, or relocated – especially if the trust needed to activate its major incident plan and establish a control room. It was hoped however that this would not happen.

In response to Mrs Liversidge's query, Mr Alty confirmed that any picketing during a strike had to be on a public highway and was limited in number to six at any one time.

BD201/11 Corporate risk register

Mr Morton presented the corporate risk register, which documented the high level risks affecting the trust. The two risks on the register (midwifery staffing levels due to maternity leave and medical staffing out of hours cover for ITU) and the controls in place to mitigate them showed no change from the previous month.

Board members noted that the new format of the report was due to the use of the trust's DATIX system, but felt that the colour key indicator previously used for the risk register was more effective. Mr Morton agreed to determine if this could still be utilised to provide greater clarity. **EJM**

The board **received** the update.

BD202/11 Clinical governance committee

Mr Whitney presented the minutes from the clinical governance committee of 27 September. He reminded board members that he had gone through these orally at the last board meeting.

He did however remind board members that the committee continued to invite directorates to attend meetings at regular intervals. This was designed to offer committee members assurances about the policies, procedures and processes in place within directorates. In September it was the turn of critical care.

Mr Whitney also recapped on the following points from the minutes:

Internal audit – it was felt that an internal audit of critical care would prove beneficial in future, as the service was likely to be added to the payment by results process (with a potential impact on income).

Care and compassion – an education strategy that went 'back to basics' was in the process of being drawn together and would include more directorate-based training.

Mortality – Mr Whitney reported that Dr Gell would visit the Wrightington, Wigan and Leigh NHS Foundation Trust in December, to examine the pro-active process in place to review deaths on a weekly basis. This approach had significantly reduced their mortality (HSMR) figures. In response to Mrs Liversidge's question, Dr Gell felt that the speedier review of deaths (and implementation of any improvement actions); and the quality of data and coding used had all played a part in reducing HSMR at the trust from 113+ to levels now in the 80s.

WHO surgical check list – it was noted that the completion of this documentation needed to improve. Despite the consistent success of the STOP moment adopted in theatres, the documentation was not always completed to the required standard. The critical care directorate were addressing the issue.

Potassium infusions – to reduce risk, the critical care directorate had adopted a change in protocol to stop the practice of having a second syringe of potassium available (at any one time) for patients receiving this treatment. Colour coded syringes had also been introduced and staff members had been through a rigorous re-training programme.

Anorexia case – the Derbyshire-wide care review of a patient with anorexia did not make any criticism of the care and treatment received at the Royal. However, it did highlight the need for improved communication between the different organisations providing care in these types of cases.

Mr Whitney went on to provide an oral report of the draft minutes from the committee meeting held on October 18 (with the medical directorate in attendance). He highlighted these areas of particular interest:

Sheffield Children's Hospital overnight naso-gastric feeding – board members were pleased to learn that a shared protocol was in place but concurred that whilst it was an improvement, it would not mitigate all the risks. It did however ensure improved dialogue with parents so they were fully aware of the risks and consequences associated with this type of feeding.

Pressure ulcer incident – following an incident where a patient had developed severe pressure ulcers, a trust-wide audit had been undertaken to ensure nurses were effectively managing pressure ulcer risks; and caring for existing ulcers appropriately.

Nursing metrics – Mr Whitney commended the medical directorate for the significant improvements its wards had instigated following the introduction of nursing metrics and the feedback, learning and improvement (FLIP) process.

Patient Safety Team Annual Report – Mr Whitney drew the board's attention to this informative report, which pulled all the aspects of patient safety together. He reported that board member's would receive a copy for debate at November's board meeting.

Post meeting note: The forthcoming NHSLA assessment requires board members to have reviewed this document. Mrs Turner-Saint will circulate the report in advance of the November 30 meeting, to enable board members to undertake this task. This will ensure all directors have an advance copy, in case proposed industrial action planned for the same day goes ahead, requiring the board meeting to be postponed (if the trust invokes its major incident procedure for example). **ST-S**

Thickened foods – in response to an incident regarding thickened foods, a number of recommendations and actions had been identified. Improved communication was a priority and as a starting point magnetic boards had been installed behind the patient's bed-head – to enable crucial information (such as dietary requirements) to be discreetly displayed.

Mortality – It was noted that the revised HSMR baseline gave the trust a rating of 103.

Mr Whitney summarised his oral report with a reminder that it was crucial that reported incidents led to learning, improvement; and that new working practices were embedded within the organisation.

He drew the board's attention to an interesting factor in the patient safety annual report, which detailed the triangulation between claims, complaints and reported clinical incidents. Whilst appreciating that not everyone made a complaint about their concerns (perhaps preferring to seek a legal resolution straight away) the trust should keep this triangulation under review - to assure itself that when a legal negligence claim or a serious complaint was made, the system already had a corresponding incident report to reference it against.

The board **received** the minutes from the clinical governance committee of September 27 and the draft minutes from the meeting of October 18..

BD203/11 **Report of the chief executive**

Mr Morton presented the report of the chief executive highlighting the following:

Corporate Strategies
Board members received six updates to corporate strategies already in existence. The summaries provided baseline positions that would feed in to the trust's strategic direction narrative for the next three to five years.

Board members commented as follows:

HR Strategy: the last line needed to reference staff performance in line with the level of competency required for the role. The summary may also need greater clarity around the development of an organisational development strategy (inclusive of manpower planning, succession planning and capability/capacity). **TA**

Clinical Quality Strategy: should reference 'fair-blame', rather than 'no-blame'. **IG/AT**

IM&T: Needed to reference how exactly the trust would use technology to integrate and work in partnership with GPs.

It was noted the that the trust was encouraging the emerging Clinical Commissioning Groups - and therefore more GPs - to adopt the ICE system – which enabled direct receipt of pathology and imaging results, discharge summaries and clinical letters. GPs already using the system were extremely positive about its capabilities. This – along with access to other data, such as the 'Right Care' information for chronic care pathways - would allow closer working relationships, based on technological advances.

The strategy should also reference the trust's electronic staff rostering system – on plan for May 2012. **NT/PH**

Site Development Strategy: Mrs Liversidge commented that the summary ought to include the key aims that would contribute to carbon reduction and sustainability. Mr Hall also reminded board members of the current positions with regard to disposing of off-site accommodation based at Saltergate and Edmund Street – and queried if this should be factored in to the summary document. **AJ**

In response to a question from Mrs Liversidge, Mr Morton confirmed that any plans for future service re-configurations would come out of the overall strategic direction. Mr Gregory also felt strongly that within the narrative, the trust should reference its wish to be in the top 20% of all trusts in the country in everything that it does.

Infection control update
Mr Tramontano presented an updated position for both Clostridium difficile and MRSA – as of September 30 2011.

Board members were reminded of the background to the current targets, reduction rates achieved in the past; and the comparative position with other hospitals in the area.

It was noted that 24 cases of Cdiff had been recorded against a target of 22 (to date) but that the overall target to the end of March 2012 remained 48 cases in total. For MRSA, the trust had recorded four post 48-hour cases to date, which breached the annual NHS standard (two cases); and was at contract target (four cases). The Monitor standard is set at six cases for the year.

Mr Tramontano outlined the root cause analyses undertaken in respect of these cases and the action plans in place. To combat MRSA spores, wards had been issued with single patient use blood pressure cuffs and would no longer be using traditional fans. Instead, an investment in bladeless fans would be made.

The Health Protection Agency and NHS Derbyshire County had contributed to the action plans and were more than satisfied with the proposals in place.

The board **noted** the position and Mr Tramontano informed directors that as of October 26 no further case of either infection had been reported.

Mr Morton asked board members to reflect on the position in advance of completing the quarter return to Monitor (BD206/11).

Summary Hospital-level Mortality Indicator (SHMI)
Mrs Morton tabled a paper from Dr Foster, which outlined the SHMI indicator for the trust. He confirmed that this was a new national mortality indicator, designed to complement the existing Hospital Standardised Mortality Ratio (HSMR).

The new figures would be published on October 27 – and could be found on the NHS Choices website. The trust's Clinical Governance Committee would review the full SHMI report – and would receive an updated position each quarter.

Dr Gell highlighted the ability to 'drill-down' through the figures – examining specifics such as diagnosis. He did however, sound a note of caution – noting as an example that for stroke care the trust now had mortality rates of 100 (SHMI) and 120 (HSMR). It was important that a complete review was undertaken to understand the reasoning behind such differences – and was a timely reminder that these statistics were indicators and not definitive measures.

The board **received** the chief executive's report and **noted** the contents.

BD204/11 Performance management report

Mrs Tucker presented the performance management report for the period to 30 September 2011. An improved position was noted on the overall summary – but Mrs Tucker drew the board's attention to the MRSA standard, which had been recorded as 'of concern'. Mrs Tucker also pointed out the table on page 10, which highlighted performance against the standards in Monitor's compliance framework. Mrs Tucker felt that a rating of 'amber-green' met the current position, taking MRSA into account.

Board members were also asked to note the following:

Timeliness in A&E
The tables on page 19 and 20 showed excellent progress and directors commended the emergency care directorate for striving to achieve these challenging standards.

Delayed transfers of care
Board members were disappointed to learn that the trust was an outlier within the East Midlands – reporting 14 or so cases per month of delayed transfers due to social service issues. Mrs Tucker stressed the importance of timely transfer in relation to the winter plan – and hoped that the Dignity in Care partnership the trust had entered in to (with Derbyshire County Council and Derbyshire Community Health Services NHS Trust) would help to improve this area of concern.

Clinical handovers
Mrs Tucker expressed her on-going frustration with this target (page 27) and board members concurred that it was difficult to have influence when the trust was not responsible for measuring and reporting the standard, even though it is responsible for it's delivery. Mrs Tucker confirmed that all breaches were reviewed daily – and that after numerous discussions the trust would benefit from SHA investment in an electronic system for recording when the patients enter the emergency department, which should offer a greater degree of certainty and data quality control for the initial element of the standard.

Time to surgery following fractured neck of femur (NoF)
Mr Whitney acknowledged the improving position against this standard and commended the directorate for continuing to work to meet timescales – ensuring patients with a NoF received timely and appropriate surgery.

Emergency re-admissions for long term conditions within 28 days of discharge
Board members queried the appropriateness of this particular standard – which they felt was an incomplete measure, given that it did not reveal the infrastructure available to patients in the community.

It was felt that patients may be re-admitted because they needed a place of safety for their condition – with the hospital being the only available option at a point in time (for example in the early hours of the morning). Mrs Tucker noted the board's concerns and confirmed that the standard was open to debate through the contract process.

Mr Gregory thanked Mrs Tucker for her comprehensive report, which the board **received** and **noted** the performance.

BD205/11 Finance and contracting report

Mr Briddock presented the finance and activity monitoring report for the period to 30 September 2011, drawing attention to the detailed financial position outlined on page 2.

The financial risk rating was as planned (4.5) and whilst there was an adverse variance in the overall income and expenditure position of £1390K, this predominantly related to impairments resulting from the front entrance fire.

Clinical income remained under recovered by £142K, but this again was an improved position, resulting mainly in over-performance on non-elective admissions. Delayed commencement of schemes and later ordering of equipment had resulted in an underspend on capital expenditure, which was expected to return to an 'on plan' position towards year-end.

In summary, Mr Briddock confirmed that under-performance on income, together with pressure points in a few directorates, was being contained within activity and contingency reserves; and that the position was being proactively managed. In response to a query from Mrs Liversidge, Mr Briddock estimated that final year-end spend on agency staff (primarily locum medical cover) would be around the £7 million mark.

Board members noted that the adverse variance resulting from the fire would be largely offset by the insurance claim within the current year and that overall, the forecast outturn for the year remained on plan.

Mr Gregory thanked Mr Briddock for a clear summary - and the board **received** the report and **noted** the contents.

BD206/11 Six monthly (Q2) return and self-certification to Monitor

Mr Morton presented this item.

In light of discussions held during the meeting (BD203/11 and BD204/11) board members opted to make the following declarations:

- Declaration one (finance) – green
- Declaration two (performance) – amber/green

Board members agreed that it was appropriate to report the MRSA target as 'a risk' at this stage. However, the situation would be kept under close review, to enable the board to re-assess this rating at the end of 2011.

On this basis, the board **approved** the six monthly (Q2) return and self certification to Monitor.

BD207/11 Chesterfield Eye Centre

Mr Jones presented this item, outlining the tender process for the scheme, the proposed plans to date – and the evaluation of submissions. It was noted that five contractors were approached, but that in the event, only three had opted to put forward a bid for the contract.

Board members reviewed the scoring matrix and noted the preferred option of Derby based company, Tomlinson (who had also built The Den) at a cost of £1.4 million. Financial costs had risen slightly from the original business case submitted to the board (by £150,000). This due, in part, to a decision to build into a second courtyard to increase clinical area capacity. Furniture and equipment costs had also increased as a result.

The board agreed that it was sensible to offer a greater degree of 'future proofing' and supported the additional expenditure. On the basis of the tender evaluation the board **approved** the appointment of Tomlinson as the main contractor for the Chesterfield Eye Centre.

BD208/11 Audit committee

Mr Hall tabled the draft audit committee minutes of the meeting held on 19 October and thanked Mrs Reay for turning them around for the board meeting. He highlighted the following points:

New internal audit grading system – reports would follow a revised format which used colour coding to reflect position and rating.

Internal audit reports – a list of internal audit reports would be provided to the clinical governance committee, so they could determine which reports they would review.

Audit fees – in future the annual report of the audit committee would include the fees for both internal and external audit services. It was noted that the external audit fee for 2010/11 had been £72,000 (£15,000 for the review of the trust's quality accounts). The amount had been minuted at the Council of Governors meeting for completeness.

Counter Fraud – Mr Hall reported that the counter fraud service and finance were to be commended for the work they had undertaken to prevent payment of duplicate claims made by a clinical staffing agency.

Charitable fund accounts – the accounts had been approved, but Mr Hall noted that the valuation of assets had been undertaken in June 2011. He had queried if a more up to date position should be calculated for the board of trustees meeting in November. An additional disclosure would be made and Mr Hall felt this was good practice – to ensure the valuation of assets were closely monitored.

Audit committee appraisal – An annual self-assessment had revealed no major changes. The committee were considering the option of undertaking a 360 degree appraisal - widening input to committees including risk, clinical governance and the board.

In addition to the minutes, Mr Hall reminded board members that a recommendation had been made by the audit committee following consideration of a paper to introduce an e-portal system for the management of tenders.

The committee recommended that the board approved the introduction of the e-portal - ahead of the formal review and approval of the procurement SFI in 2012. This would allow the e-portal to come into use from October 27 2011. Mr Hall confirmed that this would have immediate cost and control benefits.

The board **received** the draft minutes and **approved** the introduction of the e-portal ahead of the formal review.

BD209/11 Advice centre report

Mrs Turner-Saint presented the advice centre report for July to September 2011 drawing attention to the following:

Complaint categories
From September 1 the Advice Centre had adopted a new rating system for categorising complaints. After a review of complaint cases, the level 4 category, which was reserved for the most serious complaints had been expanded. This to include complex multi-directorate episodes of care and complex multi-agency care pathways.

The change was felt to be necessary to acknowledge the seriousness of these issues. Mrs Turner-Saint highlighted the fact that this group of complaints had the greatest potential to lead to both reputational damage and legal claim.

Advice Centre contacts
Despite the fact that there were 632 contacts during the quarter, Mrs Turner-Saint confirmed that 'front door' traffic had reduced since the main entrance fire. This was however, in contrast to an increase in written complaints received and enquiries by telephone. Mrs Turner-Saint was reassured that patients and relatives were still able to get in touch easily – and that the number of people 'calling in' would once again rise when the main entrance re-opened.

Level 4 complaints
The review of complaint categories (highlighted above) had resulted in seven case files being placed within the level 4 category this quarter – an increase of six on the previous quarter.

Trends and themes
Mrs Turner-Saint pointed out the overall picture chart – which showed the key complaint themes for the organisation at the end of this quarter. Board members noted the top three – clinical care, communications and interpersonal relationships and appointments, changes, delays and cancellations.

In response to Mr Gregory's enquiry Mrs Turner-Saint confirmed that trends and themes relating to one particular ward or area could be drawn out of these figures and would be spotted through the complaint handling process and records. Mr Tramontano supported this – outlining a recent episode of similar complaints about a ward Mrs Turner-Saint had drawn to his attention – enabling prompt action to be taken.

The board **received** the report and noted its contents.

BD210/11 Organ donation annual report

Dr Gell introduced the executive summary of the organ donation annual report, highlighting the profile and inclusivity of the organ donation committee, which was chaired by Mr Whitney and had been regionally commended for its approach.
The board was pleased to learn that eleven people had received a life changing transplant thanks to work undertaken by the transplant co-ordinator and the critical care team.

It was confirmed that the families of donors receive a personal letter indicating how many people have benefitted from the donation process. Mr Whitney also reported that the trust was looking to use charitable funds to create a tree of life in recognition of organ donation. Board members welcomed this proposal.

The board **received** the summary.

BD211/11 Corporate citizenship committee

Mr Jones presented the draft minutes of the corporate citizenship committee held on 27 September. The board's attention was drawn to the following:

WRVS partnership
Board members were pleased to note that the WRVS partnership (where WRVS volunteers would assist with patient feeding) would be trialled on Basil Ward from November 2011.

Wind Turbine
The borough council's planners supported this initiative, but were mindful of the need to address local concerns. A form of pre-consultation was being considered in order to seek local views.

Princes Trust
The trust was likely to have 11 individuals (aged 16-25) on site as part of the Princes Trust initiative, working within areas of the central services directorate. Board members were delighted that the trust had been able to support this initiative.

Waste Management
Board members were pleased to note the position in respect of waste – in that non-clinical waste products had overtaken clinical waste. This offered cost efficiency and the ability to recycle more of the trust's waste products. It was noted that 96% of the trust's household waste was now recycled.

The board **received** the minutes.

BD212/11 Date and time of next meeting

The members noted the date and time of the next meeting –

Wednesday 30 November 2011, Board room, Chesterfield Royal Hospital
12.00 noon – 1.00 pm – charitable funds meeting with the trustees (with lunch)
1.00 pm - 4.30 pm – board meeting

Note: If national strike action goes ahead, the board meeting may be postponed or re-located to the education centre. Board members would be kept updated.

BD213/11 Any other business

No issues were raised.

BD214/11 Open discussion

Board members agreed that the open format of board meetings no longer required this item to be on the agenda. Board members with specific points to raise could do so through AOB – discussing them in advance with Mr Gregory.