Surrey and Sussex NHS
Healthcare NHS Trust

Minutes of Trust Board meeting held in Public
Thursday 27th June 2013 from 09:00 to 12:30
Room 7/8, PGEC East Surrey Hospital

Present

(AM) Alan McCarthy	Chairman
(YR) Yvette Robbins	Deputy Chair and Non-Executive Director
(MW) Michael Wilson	Chief Executive
(PS) Paul Simpson	Chief Finance Officer
(GFM) Gillian Francis-Musanu	Director of Corporate Affairs
(DH) Des Holden	Medical Director
((AC) Andrew Clough	Interim Chief Nurse
(JT) Jon Tomlinson	Interim Chief Operating Officer
(IM) Ian Mackenzie	Director of Information & Facilities
(YP) Yvonne Parker	Director of Human Resources
(AH) Alan Hall	Non-Executive Director
(JP) John Power	Non-Executive Director
(RD) Richard Durban	Non-Executive Director
(RC) Richard Congdon	Non-Executive Director
(RS) Richard Shaw	Non-Executive Director

In Attendance

Monica Palmer	Note taking

1.	**General Business**	
	1.1	**Welcome and Apologies for absence** The Chairman opened the meeting by welcoming Trust Board members, staff and members of the public. The Chairman welcomed Andrew Clough, Interim Chief Nurse, to the Trust.
	1.2	**Declarations of Interest** The Trust Board members confirmed that they had no additional interests to declare.
	1.3	**Minutes of the last meeting – 30th May 2013** Item 4.1 : Paragraph 7 Financial pressures were as a result of significant operational pressures, however remain **largely** on plan. Item 6.1.2 : Paragraphs 6 & 7 The Investment and Workforce Committee will begin to meet bi-monthly from July. An annual work plan has been agreed which includes strategies, annual plans, business cases and KPIs. This should, if all papers are of the right quality, provide the committee with the right level of assurance. Greater clarity is being provided regarding the role of the Committee in reviewing updates to the Integrated Business Plan (IBP)

		The minutes of the meeting held on 30th May 2013 were then approved as a true record.	
		1.3.1	**Action Tracker** 1. Expectations from the National Framework **Action 1**: MW to ensure that the Secretary of State's letter confirming expectations around the National Framework is shared with the board. MW to make sure that this has been sent out. 2. Hospital Pressures and Community Provider Discussions On Private Board agenda – action closed
	1.4	**Chief Executive's Report** The board received and noted the Chief Executive's report. On the 17-June, NHS England launched a consultation asking patients, public and NHS staff to help shape the future of urgent and emergency care services. Closing date for feedback is 11-August. They are not asking for feedback from Trusts and there is no formal route through to NHS England for Trusts to express their views. It was felt that the Trust's experiences and views should be fed into the consultation. Discussions in this respect to be continued in the Private Board. Local System Capacity – there are extreme pressures on the system. April was difficult with unprecedented demand for this time of year and the ability to maintain the 4 hour standard will be increasingly difficult in winter months. Analysis undertaken by the Trust, and sent to the Chief Officers of the CCGs, set out the Trust's serious concerns about the current lack of system capacity to manage patients who no longer require care in an acute setting. A response was received yesterday and the Board will be updated at a future meeting. Patients awaiting continuing healthcare is one of the biggest issues in the system. Issues include assessment, funding & Multi Disciplinary team (MDT) fit. Coding also needs to be improved in particular in respect of re-admissions. Des Holden outlined the benefits to the patients of not staying in an acute hospital when fit enough to be transferred into community care, although there is an inability of Communities Services to cope with an ageing population. A Finance Sub Group has been set up as part of the Local Transformation Board, which includes the Directors of Finance from CCGs, Community Services, Social Services and Councils, and this should improve communications between these organisations. The report was duly noted by the board.	
2.	**Safety, Quality and Patient Experience**		
	2.1	**A Patient Story** The board received and noted the summary of two Patients' Stories. As a result of these patients' stories, a ward round check list has been introduced, initially in AMU, but is now being rolled out to other medical wards. The surgical	

		division has also decided to adopt it with modifications. The introduction of these checklists enables and aims to engender a culture within the team so that everyone (from consultants to junior nurses/healthcare assistants) can make a valuable contribution to the care of a patient. This has been embraced by the junior doctors who now have a framework in which to review a patient. In response to a question of when patients would be seen by a consultant, reviews are done within 12 hours of their stay and then on a daily basis. Both Gastro & Endoscopy rotas have been introduced and there is an ability to call on senior consultants. The Trust is currently working towards a 7 day week Consultant rota in respect of Care of the elderly. Traditionally, ward rounds are based on a hierarchical structure. The aim is to break this down at the bedside and to get Clinicians to see the value of changing behaviour. This would need Champions to change this and this is being looked at. Visiting times are also being reviewed in order to allow relatives the opportunity to be present at ward rounds. This would allow them to contribute, challenge and questions the patient's treatment. The report was duly noted by the Board.
	2.2 **2.3**	**Board Assurance Framework (BAF)** **Strategic Risk Register** The board received and noted the Board Assurance Framework. The BAF detailed a total of 24 significant risks to the Trust. The Board were asked to note and consider if the descriptions of the risks were appropriate. A summary paper has been included to highlight the issues and to set out the start point and the point where the Trust is now. There are 6 red rated risks. The Significant Risk Register will be presented at future meetings, as it is still being developed. Discussion followed on the various risks, wording and ratings of the BAF. Further discussions will be held at the next AAC meeting. A major problem, which was not clearly visible in the BAF, is the number of patients who should not be in an acute hospital bed. If this does not change, winter will be very difficult. Capacity is a major risk but it was questioned if this was reflected adequately. More clarity is needed over the risk. AM asked for reassurance that the actions are the right actions to mitigate the risks. Other questions raised were • whether a rating could ever be 10 out of 10. • The rating for workforce and staff engagement measures were too rosy . In relation to the finance risks, there is still an underlying liquidity problem. Bills are being paid late in order to maintain cash flow. Sustainability of estate and infrastructure – this has been rated red as, while there has been a large investment on the Estate, this has not been on the basic infrastructure of the hospital. The Estates requirement is an agenda item on the Investment & Workforce meeting being held next week, which will be looking at

		requirements over the next 5 years. The Capital budget has been agreed but full approval of the business case has not been received from the Treasury. In terms of IT, the Trust is one of the only ones in England which has a truly integrated PACs system. Risks will change throughout the year as it is a living document. GFM asked for approval of the BAF, as it stands, on the basis that it will be changed and improved over time. The report was approved duly noting the challenge to the risk scores which would be reviewed at the AAC.
	2.4	**Quality Account** DH presented the 2012-2013 Quality Account document, which is in its final format and due to be uploaded on the NHS Choices website by 30th June. All comments threaded throughout the report were made by patients and it is aimed at both the public and staff. An internal audit was carried out to acknowledge and gain an understanding of the re-admissions percentage. If re-admissions were discounted, the Trust would sit as average. It was felt that it would be helpful to know the outcome for each patient. In terms of the comments from our stakeholders, where comments are incorrect, these are noted. A paragraph stating what changes have been made is included in the report. The Chair thanked DH for the good comprehensive document. The report was approved by the Board.
	2.5	**Clinical Governance Review** DH gave a verbal update on progress with the changes to the Clinical Governance team. A review of the Governance team has been undertaken with an external Consultant brought in to give feedback on how complaints are handled and complaints and PALS data used. They will stay to continue to work on improving systems. The consultation has been agreed and is being taken forward. Interviews have taken place for the divisional Complaints Managers. The individual team members have the ability but there is a high turnover in staff and there is a need to ensure that the corporate leadership is in place. Consideration is still being given to an Associate Director being in overall charge. New operating procedures are being put in place. The required data on complaints still needs to be added to the new version of the IQPR, which will come to the Board at the July meeting. The report was duly noted by the Board.

3.	**Operational Performance**	
	3.1	**Integrated Performance and Quality Report (Month 2)** The board received the Integrated Quality and Performance. For May 2013, the Trust is expecting to be rated as 'performing' for the quality of services based on integrated measures, CQC registration and user experience, following abnormally high levels of adult Emergency Department attendances in April . The Trust has the 2nd best performing emergency department in the country. There were no incidences of MRSA and two incidences of C-Diff during May. Processes for delayed Transfer of Care have gradually improved. The number will continue to increase but will reflect what is in the hospital & system. The percentage has increased from 1.7 in April to 4.7 in May due to the National policy being used as the definition. The Cancer Breast symptomatic two week wait target was breached in month due to machine failure. The delayed transfers of care KPI has underperformed in the month. The Trust has been unable to discharge an increasing number of patients who do not require acute care into the community. The Trust is working with partners in the local health economy to resolve this issue. The trust continued to achieve the 90% Admitted target with 2 non compliant specialties - general surgery and Trauma and Orthopaedics. Page 9 – IQPR report – May figures should read: Friends & Family ED 61 Response Rate ED 4.7% The response rate at 18% is 3 points above where the Trust needs to be. Your Care matters – a vast amount of data is coming through. 10 key drivers have been identified and are measured through dashboards. Common complaints are noise & privacy in A & E and communication. Issues are resolved and addressed wherever possible. It was generally agreed that respondents tend to tick "likely" as opposed to "extremely likely". All Trusts are treated in the same way so is no reflection on SaSH. Advice on drugs upon discharge is not a key driver but is one of the lowest scoring scores. All concerns are acknowledged. Mortality – there are still fracture neck of femur (#NoF) outliers. The figures were good until a couple of months ago. Stroke – these figures are reviewed on a weekly basis. #NoF and stroke were traditionally reported because they were significantly high figures. More narrative could be included but work is being done at every step of pathways to address concerns. Workforce – 15 Portuguese nurses have started and are being given a 3-week induction from 12th to 22nd July. This is being organised by the Matrons. The NMC pin numbers have been the only problem. The applications are in a decision queue. Until they receive their numbers, they have to work on an HCA basis and are paid

		on that basis. The retention rate over the next 2 years could be tracked but there are many factors that could affect this including the state of the Portuguese economy. The reason for the increase in the establishment figures between Dec-12 and May-13 and flat in Total in Post is due to the increase in the vacancy rate. The question was asked about opportunities for Clinical Trial Nurses at ESH - this role is very specialised and there is the problem of physically finding space to accommodate them. Discussion was held about the role of the chaplains and whether the vacant post should be filled. It was confirmed that chaplains fulfill a broader range of duties than purely pastoral. The new IQPR next month will be based around the Trust's core objectives. The report was duly noted by the board.
4.	**Financial Performance**	
	4.1	**Finance Report (Month 2)** The board received the Finance Report. The Trust is on plan with a breakeven position, with an adverse variance against income and understanding against reserve budgets offsetting divisional overspends. The Trust is still measuring against an interim budget as no agreement has been received from the Treasury in respect of £5.5m. The TDA is negotiating with the Treasury about this problem, which does not affect just this Trust but other Trusts across the country. This should be resolved within the next 2-3 weeks. The savings plan for 2013/14 is £11.1m and at M02 £0.7 has been achieved, above the plan submitted to the TDA. The late contract signature, increased operational pressures from winter and savings performance within Divisions have created a difficult start to 2013/14. The Trust still has no certainty over the payment of the second year instalment of planned non recurrent support. By month 3, the trust should be aware of how much it will be receiving. Operational pressures at M01 leave their mark on M02 but the position is better with less non elective activity and more elective. Agency spend has been uplifted by 18% which can be used to recruit. Liabilities exceed the Trust's assets and the liquidity ratio is higher than expected. All the clinical divisions, with the exception of WaCH, are adverse to their budgets for month 2. There is a shortfall in savings in Surgical & CSS. Savings for drugs are the main issue for CSS. The number of Medihome beds has been reduced. The divisions have challenged themselves to deliver savings earlier than the TDA plan and although ahead at month 2 are still below the budgeted level. Last year, surgery underachieved on savings. Control of surgical activity is now being reviewed on a weekly basis through the PMO. There has been a high number of ambulances arriving with 107 arriving last night (not as high as 6 months ago) but there is a need to understand the reasons for

		this and a review was being carried out this morning. The critical point is how many patients require admittance. A new Quality indicator has been introduced measuring the time from arriving in ambulance to entry to the hospital. Opening beds has to be a matter of judgment. A paper on capacity will be presented to the Exec team in the next few weeks. Elective day case inpatients is 8-9% below forecast. This is not due to a decrease in demand but a lack of CCG finance. No clear activity plan has been received from the CCGs. AM asked for it to be noted that the Board feels uncomfortable working with a budget that has not been agreed and which has a £5.5m shortfall. The report was duly noted by the board.
5.	**<u>Other Items</u>**	
	5.1	**Any Other Business** **Yvette Robbins attended the FTN meeting and shared some headlines around changes in CQC's regulation of hospitals.** The CQC's role is around monitoring and improvement across NHS and Adult social care. Enforcement responsibility will move to Monitor & TDA for hospitals. Strong independent expert evidence-based judgments by teams of experts, conducting longer, more thorough people-focused inspections. Specialist teams headed up by Prof Mike Richards as Chief Inspector of Hospitals will use intelligence from provider and commissioners to pursue "key lines of enquiry". CQC is on the side of users of services, with rigorous testing, commitment to safe high quality care and legally binding. If CQC identify a failure and improvements required are not delivered within the period of time allowed, then special measures will be adopted by TDA or Monitor. Inspections will focus on 5 key questions: Safe? Effective? Care? Responsive to people's needs? Well led? From yes no to ratings with respect to compliance on 16 standards, move to ratings of Outstanding, Good, Requires Improvement or Inadequate on each question for each area of service within the hospital they look at e.g. A&E, Maternity as well an overall rating. Suggested increasing importance of role of audit and peer reviews. CQC can and will inspect sub-specialities where intelligence indicates risks. CQC will continuously monitor trusts to identify failures and risks using hard and soft intelligence around local and national information, reference to "smoke alarms" and" tin openers". To encourage openness and candour, trusts need to tell CQC of issues as they arise and CQC will moderate ratings/actions! Change from corporate bodies held to account to individuals at Board held to account for quality of care, underpinned with changes in law. CQC Consultation paper for hospital regulation, named "New start", was launched in June (closing 12 August) with pilots commencing in October. Full roll out from Jan 14 completing by Dec 15 for all hospitals giving priority to aspirant FTs. Questioned on the value of past judgments from CQC, they are still legal currency but Boards need to take a judgment. The Board noted the update.

	5.2	**Questions from the Public** There were no questions raised by members of the public.
	5.3	**Date of next meeting** **Thursday 25th July 2013** at 10am in Room 7/8, Post Graduate Education Centre, East Surrey Hospital.

Note: This is a public document and therefore will be placed into the public domain via the Trust's website in the interests of openness and transparency under Freedom of Information Act 2000 legislation.

	ACTION LOG	Person responsible
ACTION 1	**Expectations from the National Framework** MW agreed to share with the board the Secretary of State's letter confirming expectations around the National Framework. MW to make sure that this has been sent out.	**M Wilson**
ACTION 2	**Clinical Governance Review** The new arrangements to be confirmed at the next Board meeting.	**D Holden**

These minutes were approved as a true and accurate record.

Alan McCarthy

Chairman: **Date:**