Surrey and Sussex NHS
Healthcare NHS Trust

Minutes of Trust Board meeting held in Public
Thursday 25th April 2013 from 09:00 to 13:00
East Surrey Hospital, Post Graduate Education Centre – Room 7/8

Present

(AM) Alan McCarthy	Chairman
(MW) Michael Wilson	Chief Executive
(PS) Paul Simpson	Chief Finance Officer
(JT) Jon Tomlinson	Interim Chief Operating Officer
(GFM) Gillian Francis-Musanu	Director of Corporate Affairs
(DH) Des Holden	Chief Medical Officer
(SA) Susan Aitkenhead	Chief Nurse
(YP) Yvonne Parker	Director of HR
(IM) Ian Mackenzie	Director of Information & Facilities
(RD) Richard Durban	Non-Executive Director
(RC) Richard Congdon	Non-Executive Director
(RS) Richard Shaw	Non-Executive Director
(AH) Alan Hall	Non-Executive Director (Designate)

In Attendance

Sacha Beeby	Trust Board Secretary

Apologies

(YR) Yvette Robbins	Deputy Chair and Non-Executive Director
(JP) John Power	Non-Executive Director

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. Apologies for absence were noted as listed above. The Chair announced that the board will continue to meet in public on a monthly basis and dates for new meetings are available on the Surrey & Sussex Healthcare NHS Trust website.	
	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 – 28th March 2013**	
		The minutes of the meeting held on 28th March 2013 were then approved as a true record.	
		1.3.1	**Action Tracker** **Action 1: Patient Story**

			DH confirmed that future patient stories presented to the board will represent non clinical experiences as well as clinical. **Action 2 : Medical Records** DH gave an update on the action plan around improvements to the storage and tracking of Medical Records. **Action 3 : IQPR Metrics** DH confirmed that additional metrics in relation to R&D would be available in future IQPR reports to better articulate and represent educational performance. **Action 4 : Corporate Objectives 2013/14** The board's comments in relation to the draft Corporate Objectives for 13/14 have been considered and incorporated into the final submission. **Action 5 : Board Assurance Framework / Risk Register Review** The board is due to review the BAF and SRR at a future Board Seminar to agree alignment of content. **Action 6 : Charitable Funds** The board was reminded to put forward proposals for charitable funding for specific programmes of work or equipment which will directly or indirectly benefit patients.
	1.4	**Chief Executive's Report**	The board received and read the Chief Executive's report in advance of the meeting. MW highlighted some of the key national issues within the NHS at the current time. The Department of Health has published an updated NHS Constitution following a consultation that sought views on a number of proposed changes. Following the publication of Sir Robert Francis' Public Inquiry into the failings at Mid Staffordshire Hospital, the constitution now reflects that the NHS' most important value is for patients to be at the heart of everything the NHS does. The results of the 2012 National Inpatient survey were published on 16th April 2013. The survey looked at the experiences of over 64,500 people who were admitted to an NHS hospital in 2012. Our 2012 survey shows dramatic improvements in scores across the board since the 2011 results, the most notable being the shift from thirty falling in to the 'worse' category to just one, and the Trust also scoring one in the 'best' category. This is good news for the quality of care and patient experience that we provide. However we recognise that there is still more to do. The TDA Accountability Framework, for NHS Trust Boards published on 5th April 2013**,** sets out a clear set of rules under which the TDA and NHS Boards should all operate. A copy of the full report was made available to the board in advance of the meeting. On 9th April the Trust was visited by Dr Stephen Dunn, Director of Delivery and Development (South) from the Trust Development Authority as part of his induction in the south east of England. He held meetings with the Chief Executive, Chairman

		and members of the Executive Team as well as having the opportunity to meet clinical and nursing staff on his tour of the hospital. His feedback has been positive and recognises the positive improvements we have made in terms of sustained performance, quality of services and patient experience in SaSH over the last 18 months. MW was pleased to report that the NTDA had been very supportive to the Trust during recent conversations and it is hoped that conflicting priorities for both the NTDA and NHS Commissioning Board do not compromise relationships with the Trust. The Trust will soon launch its brand new website. The new website will have a new look and feel to reflect the trust's new facilities and improved performance. The new website will give patients the information they need to know more easily, and offer all the data we publish in the essence of openness and transparency in a more accessible format. The report was duly noted by the board.
	1.5	**Annual Declarations of Interest Register** The board received and read the Annual Declarations of Interest Register in advance of the meeting. RC notified the board changes to his declaration in relation to his Chief Executive position at the Arthritis Association. The report was then accepted as a true record of the declarations made by members of the Board.
	1.6	**Annual Board Planner** The board received and read the Annual Board Planner in advance of the meeting. The planner is a flexible document which will be reviewed regularly and will respond to requirements of the board as it progresses its journey to FT status. March 2014 was not visible from the schedule and GFM assured the board that this was a technical error. The schedule should also reflect that the new monthly occurrence for board meetings was relevant to meetings open to the public, thus removing the reference to Seminars. The report was duly noted by the board.
2.	**Safety, Quality and Patient Experience**	
	2.1	**Clinical Presentation – Emergency Department** The Emergency Department presented an update to the board on some of the improvements made to services it provides and developments in workforce. Julian Webb, Clinical Lead for A&E introduced his senior team to the board. JW summarised the roles and responsibilities of his senior team and some of the

achievements that have been made within the department.

An example of those achievements included substantive clinicians covering all unprotected shifts. Locums were no longer permitted to work in the absence of a substantive clinician during vulnerable hours.

The department recognised the challenges of recruiting to nursing vacancies but the trust was not an outlier in this area.

In line with Sir Robert Francis' report into the failings at Mid Staffordshire Hospital, the board stressed the importance of supporting and supervising Health Care Assistants (HCA's) in their increasingly demanding roles and ensuring that they operate within their agreed responsibilities and expectations beyond this are not imposed.

The new Clinical Decisions Unit (CDU) has already resulted in some improvements to ED services by protecting the safety of patients whilst preventing unnecessary admissions and facilitating discharge of patients not requiring acute care.

MW noted that the response rate to the "Your Care Matters" patient survey needed to increase in order to provide a constructive, balanced analysis of patient feedback and experience.

JW added that issues and concerns around the privacy of patients when booking into A&E and this was due to be discussed at the department's next governance meeting.

Action: Trust to coordinate press release in advance of the publication of the 4-hour trolley waits in A&E – data which in fact was 18 months old.

JW concluded that a key area of focus for him would now be to engage with community partners and GPs to provide greater understanding and collaboration in terms of emergency services.

It was difficult to underpin how the department measured its clinical excellence but trends could be identified from complaints, compliments, patient feedback, mortality and investigation of serious incidents. Embedding clinical governance and structure as well as engagement from clinicians will greatly help to drive excellence.

JW and the board congratulated the ED team for their hard work and achievements.

The board further thanked the team for their presentation and comprehensive appraisal of the work that has been done by the team, the challenges it faces and the improvements it continues to make.

Recognising the challenges across the health system at the current time and the changing landscape of the NHS and the effect this will continue to have on the team, MW reminded colleagues that the primary focus must always remain that of the safety of its patients and asked the team what the board could do to support them during these challenging times.

JW responded that the greatest support and benefit would need to come from improvements to the provision of health care in the community, particularly during weekends.

He further added that a clear process was needed to look at internal services to

		better support patients during out-of-hours. Finally, improvements were needed to discharge processes which currently are not as efficient and robust as they should be. When demand on A&E is high, admitting those patients who are in need of further medical intervention becomes a challenge due to the availability of beds. This then puts additional pressure on the department to manage the care of those patients awaiting admission and those patients waiting medical review or clinical decision. Discussions are taking place with medical and operational teams to address this issue. The presentation was duly noted by the board.
	2.2	**CQC Inspection Feedback Report** The board received and read the CQC Inspection Feedback report in advance of the meeting. A routine unannounced inspection was undertaken by the Care Quality Commission on the 26 and 27 February 2013 to check that essential standards of quality and safety were being met. Their report has identified that we met all the inspected standards that they assessed on their visit. Although the report was very positive, there are some areas that could be improved and the Nursing Executive Group will be following progress against the action plan to respond to any recommendations and the board would be kept informed of progress. Some of the positive commentary related to the recognition that 'The A&E department at East Surrey Hospital currently receives approximately one hundred blue light ambulances a day and is therefore one of the busiest A&E units in the South East'. The profile of A&E during recent weeks was that of particularly high attendances and patients being admitted. Despite improvements to pathways through the hospital, the increase in complex patients has challenged the system. CCGs have requested an audit to review the legitimacy of A&E attendances but it is likely the recent launch of 111 has contributed to the increase in demand. SA added that a recruitment plan was in place to respond to vacancy gaps in the nursing workforce and to reduce agency spend. SA concluded that initial feedback had raised no surprises and that recommendations were already being implemented. The CQC recognised that there were no comprehensive care plans in place nationally and that the trust was not alone in needing to develop this area. The board thanked staff for their hard work, particularly with the ongoing pressures that still continue. We must however, not be complacent and the CQC can inspect at any time. The report was duly noted by the board.
	2.3	**Safety and Quality Committee (S&QC) Chair's Report** The board received and read the results of the National In-patient survey in 2012 in advance of the meeting.

		The results show significant improvement in our scores across the board since the 2011 results, the most notable being the shift from thirty falling in to the 'worse' category to just one, and the trust also scoring one in the 'best' category. The results reflected the extra capacity during August and improvements to internal systems which ensure patients are seen in the appropriate setting with reliable care. However, the board accepted that there was still much room for further improvement but this was overall a positive result for our patients and staff. AM and SA will discuss the results in detail at the next Patient Experience Committee. The clearest trend was notably around communication, but this may be inevitable as a large percentage of the questions related to communication. Development plans to address worse performing areas in relation to communication will be established but a change in culture is needed across the organisation and this will be an ongoing development. The report was duly noted by the board.
3.	**<u>Operational Performance</u>**	
	3.1	**Integrated Performance and Quality Report (Month 12)** The board received and read the IPQR for month 12 in advance of the meeting. JT summarised that for March 2013, the trust was expecting to be rated as 'Performing' for the quality of services based on integrated measures, CQC Registration and User Experience. Aggregate 18 weeks and DToC targets continued to show delivery of performing standard but the trust underachieved the 4 hour ED target for the month. The trust achieved all the quality of metrics in the DoH performance framework with the exception of the Cancer 62 days from screening (due to low numbers and patient choice) and RTT compliance in every specialty. The board noted the outstanding performance against the scorecard and the delivery of Infection Control targets against the previous year. The current process for patient discharges followed by the ward staff and supported by the discharge team, reflect historic agreements with both Surrey and West Sussex which have developed differently over the years and which mean we now operate two difference processes dependent on where the patient's GP is based. The Chief Executive has written to social services in both Surrey and West Sussex advising them of his instruction to staff to work to national protocols with immediate effect. This means we will be doing the following: • Issuing a Section 2 notice on admission where we believe the patient may have Social Care needs • Issuing a Section 5 notice when we have a clear date when the patient can be discharged from the hospital • Counting all patients in hospital beyond the date when they are medically fit

		for discharge – which is when they no longer need their care to be managed under a Consultant • Ceasing to complete the Health Needs Assessment Document (used in Surrey only) • Ceasing to undertake the full Continuing Health Care Assessment (using the Decision Support Tool) whilst they are still on an acute ward • We will continue to screen all patients using the national DH Checklist for CHC In the meantime we are discussing with the local CCGs how we can expedite the full CHC assessment without undue delay. MW further added that social care services have had considerable reductions in their budgets and are now unable to cope with the level of activity it receives. The complexity and acuity of patients has changed considerably and the community provision has not responded to this demand efficiently. The board was encouraged by the improvements to appraisal compliance and completion of statutory and mandatory staff training. However, requested further discussions at a Board Seminar around the organisations approach to recruitment & retention and evidence of success from recruitment drives. The board challenged the Never Event declared in March which related to a wrong site surgical procedure. The investigation was completed and identified human error and task related factors. An action plan has been developed to reduce the likelihood of reoccurrence. However, despite carrying out a WHO checklist prior to procedure, this failed to prevent the incident. DH clarified that the WHO checklist aims to prevent the likelihood of such an incident but was not entirely preventative. The board challenged the performance relating to Stroke and whether the hospital was a safe place for stroke patients to be in. Performance has improved but the division have since ringfenced beds within the Acute Stroke Unit to accommodate stroke patients getting the right care in the right bed. At the current time and during peaks in demand, those patients who are likely to benefit most from a specialist bed are prioritised to the ASU. The increasing volume of fractured NoFs presenting with medical co-morbidities has created significant staffing issues at the ortho-geriatric middle/junior doctor grades for day to day management. Plans are in place to ringfence beds to accommodate direct admission to an orthopaedic ward. The board was asked to note a correction to the report since its publication; the performance relating to *E.D 95% of patients seen within 4 hours* should be Amber, not Red. The number of NICE guidelines without a statement of compliance remains at two due to statements not being received from Medicine within the agreed timescales. This did not necessarily mean that the trust was vulnerable for legal liability and it was likely we were not declaring compliance for those guidelines which may not apply relevance to the trust. The report was duly noted by the board.
4.	**<u>Financial Performance</u>**	
	4.1	**Finance Report (Month 12) and**

Annual Budget 13/14

The board received and read the Finance Report in advance of the meeting.

PS summarised that the trust has delivered its financial plan for 2012/13. The trust has corrected last year's deficit and delivered, with a small surplus of £0.3m. The Trust also delivered its £10m savings programme, delivered its capital programme within its resource limit and did not need to borrow additional cash.

The I&E position was supported by one-off funding from CCGs although the Trust did better than expected. The underlying deficit was also better than forecast earlier in the year, at £9.2m.

PS added that the Audit & Assurance Committee had signed the draft accounts based on unaudited data within the expected timescale.

The financial cost pressures of winter have recovered well and clinical divisions delivered their agreed control totals at the year end. Agency costs, despite improvements on the previous month, are 17% higher than this time last year.

PS highlighted that a contract with the CCGs had not been signed and negotiations continued in relation to Payment by Results of activity and Transitional Funding. If those negotiations are not successful before 30th April 2013, the TDA will take the trust through the arbitration process.

The surgical division failed to deliver its savings plan and weekly discussions with the Chief Executive and Chief Finance Officer have now been escalated as a consequence. The board noted the exceptional circumstances which have affected the division during the past year and recognised the additional pressures within the division as a result.

It has been encouraging that Chiefs of Services have been proactive and involved in finance discussions relevant to their divisions and are supporting the Associate Directors in the accountability of their budgets.

PS concluded that the unprecedented levels of activity at the current time will undoubtedly have an adverse financial affect going forward.

Action: The board requested presentations from each of the divisions following a similar format and structure of content to that conducted by the Emergency Department earlier in the meeting.

PS assured the board that all cost savings and reductions to budget were clinically approved by the Chief Nurse and Medical Director to ensure the quality and safety of care provided to patients was not compromised as a result.

PS concluded that an extraordinary board meeting may be required to approve the final budget.

The board noted that should the negotiations go to arbitration, the board may need to set a budget with a deficit. However, if a deficit is set, this will affect the trusts FT Programme.

RC expressed serious concerns at encouraging the board to sign up to a budget which will put additional pressure on the Trust.

		The board resolved to call an extraordinary board meeting in the case of setting a deficit or a significant increase to the savings plan. Otherwise, it would delegate authority to MW, AM, PS and RC for sign-off. The report was duly noted by the board.
5.	**Other**	
	5.1	**Any Other Business** No further business was discussed.
	7.2	**Questions from the Public** There were no further questions raised by members of the public.
	7.3	**Date of Next Meeting** **Thursday 30th May 2013** at 10:30 in Lecture Theatre, Post Graduate Medical Centre, Crawley 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	**4-hour trolley wait – press release** Communications team to coordinate a press release in advance of the publication of the 4-hour trolley waits in A&E – data which in fact was 18 months old.	**J Tomlinson / G Francis-Musanu**
ACTION 2	**Clinical presentations from divisions** The board requested presentations from each of the divisions following a similar format and structure of content to that conducted by the Emergency Department earlier in the meeting.	**D Holden / J Tomlinson**

These minutes were approved as a true and accurate record.

Alan McCarthy

Chairman: **Date:**