Surrey and Sussex NHS
Healthcare NHS Trust

Minutes of the Trust Board meeting held in public on Thursday 27th January 2011 from 10:30 to 12:00 noon in the Post Graduate Education Centre, Maple House, East Surrey Hospital, Canada Avenue, Redhill, RH1 5RH

Present

Alan McCarthy	**Chairman**
Joe Chadwick-Bell	**Director of Strategy and Transformation**
Norma Christison	**Non-Executive Director**
Edward Cooke	**Non-Executive Director**
Richard Durban	**Non-Executive Director**
Rob Haigh	**Chief Medical Officer**
Ian Mackenzie	**Director of Information and Facilities**
John Power	**Non-Executive Director**
Yvette Robbins	**Deputy Chairman**
Mary Sexton	**Chief Nurse**
Paul Simpson	**Chief Financial Officer**
Michael Wilson	**Interim Chief Executive**

In Attendance

Bernadette Bluhm	**Chief Operating Officer**
Derek Cooper	**Chairman, Patients' Council**
Janet Miller	**Deputy Director of HR, representing Yvonne Parker**
Fionnula Robinson	**Director of Communications**
Anne van Vliet	**Trust Board Administrator**

Apologies

Yvonne Parker	**Director of HR**

1	**Welcome and apologies**		
	1.1	The Chairman welcomed members of the Trust Board, staff and public.	
	1.2	Apologies for absence had been received from Yvonne Parker, who was being represented by Janet Miller, Deputy Director of HR.	
2	**Minutes of Previous Meeting and Matters Arising**		
	2.1	The minutes of the meeting of the Trust Board held in public on 25th November 2010 were amended as follows:- Page 1 – Yvonne Parker to be shown as present at the meeting. Page 4 – the heading of item 5.1 to read: "Performance Committee *– a verbal update by Yvette Robbins from the meetings held on 26th October and 23rd November 2010."* **The minutes were amended and approved as a true record.**	

	2.2	**Matters arising on the minutes of the November meeting**		
		2.2.1	**H&S Annual Report** It was reported that the Chief Nurse was now the Trust Board member responsible for Health and Safety. She reported that it was not appropriate for the previous year's report to be amended. There were no health and safety issues to bring to the attention of the Board. **ACTION 1** **A statement on Health and Safety would be provided to the Trust Board in public in March.**	**1) M Sexton**
		2.2.2	**Update on Action Plan following the Mid-Staffordshire Enquiry** This item would be covered within the report by the Chief Nurse on Patient Safety to the Trust Board in private.	
		2.2.3	**Board Assurance Framework** The Chief Nurse reported that work on the Board Assurance Framework was ongoing.	
3	**Safe, High Quality Coordinated Care**			
	3.1	**Board Assurance Framework (BAF)** The Chief Executive reported that each executive director had updated his areas of responsibility on the BAF. A supplementary paper had been issued, giving a clear indication of the current position. **ACTION 2** **John Power asked for a key to abbreviations and improved formatting. The Chief Executive said that this would be attended to.** Yvette Robbins expressed surprise that the risk for delivering clinical strategy was as low as 6. Richard Durban noted that workforce was the highest risk and where most work was to be done. Norma Christison had reservations about the risks on cost and savings. The Director of Finance responded that the remaining risk to the organisation was about managing cost within the divisions in the final eight weeks of the financial year. He said the risk was reduced but there remained a managed level of risk.		**2) M Sexton**

		The Chairman asked what the risks were relating to the Cerner go-live in February. The Director of IT said that this would be an upgrade of the existing system and therefore far less traumatic than the Trust's move to Cerner in 2007. The main risks concerned staff engagement and changes to log-in from password to swipe card. The risks had been mitigated by the comprehensive training plan. The Chairman noted that there were some significant pieces of work related to reducing risks shown on the supplementary paper in relation to the heading "consistently deliver all patient access and contractual targets", and asked whether timescales were being set. The Chief Operating Officer replied that this would be within the remit of the transformation plan. A workstream would be dedicated to it and the plan would be developed over the next few weeks. The Director of Nursing was thanked and the report was received by the meeting.	
	3.2	**Presentation from Dr Ed Cetti on the Dr Foster Pneumonia Outlier Mortality Audit** The Chief Medical Officer introduced Dr Ed Cetti, Consultant Respiratory Physician. He said the work being done by Dr Cetti on the pneumonia pathway was a good example of the enhancing quality programme which was working to drive up standards. The work demonstrated a comprehensive response to the Dr Foster mortality alert. Dr Cetti said that the work he had been doing on pneumonia to enhance quality had started in the United States and had now been taken up across the South East Coast region on the Strategic Health Authority. The aim was to improve delivery of the pathway and to improve mortality. Main measures were: Oxygen assessment within 24 hours. Antibiotic prescription. Blood cultures performed before first antibiotics given. Antibiotics given promptly within 6 hours and aiming at 4 hours. Smoking cessation. Early results showed that SASH was doing well compared to peers in the region. Collection of data was proving to be a slow process. Accurate assessment and fast taking of blood samples was proving challenging.	

		SASH mortality from pneumonia had been notified as too high. Possible explanations were poor standard of care, incorrect coding of patients who do not have pneumonia, or excess of co-morbidities. The cases of 78 patients who died in the Trust between April and November 2010 were reviewed and an assessment was made of the overall quality of care for each patient. Coding and diagnosis was found to be robust. 83% of cases had community-acquired pneumonia. The majority were over 80 years old. One quarter of the cases were from nursing homes and/or bed-bound. There were many co-morbidities. 61% were seen by a consultant within 12 hours and an additional 34% between 12 and 24 hours. Three cases died within two hours of arrival. 87% of diagnoses were made by a junior doctor on arrival. This figure increased to 89% following consultant ward round. In 74% of cases the initial antibiotic prescription was correct, and 26% incorrect. The main problem was lack of giving a second antibiotic (Macrolide) which covers all possible causes of pneumonia. There were 11 cases that took longer than four hours to give antibiotics. The reason was delays in A&E during very busy times. However, there should be no delay between diagnosis and giving of antibiotics. Summary of deficiencies: In 66% of cases there were no deficiencies or undue delays. Of the remaining cases, the deficiencies were caused by choice of antibiotics and delays in prescription. Action was taking place to reinforce antibiotic policy. All junior doctors now carried a card showing antibiotic policy. An education pathway on Pneumonia was being followed. The process in Emergency Department was being reviewed to avoid delays. An IT solution was being developed for use in Emergency Department in order to identify Pneumonia patients quickly. Questions were invited. Richard Durban asked whether the most recent scores were available and Dr Cetti replied that these were awaited and he would supply them to the board when available.	

		Yvette Robbins said it would be useful to know whether the selection of patients had co-morbidities. Dr Cetti said this information was not recorded. John Power asked for clarification on the outcome of the eleven patients who received delayed diagnosis/antibiotics. Dr Cetti said this number was not unexpected. The patients would often not have a clear history, and the test results might have been ambiguous with unclear symptoms. If a patient had pain or breathlessness they would receive an early CT scan and be treated with antibiotics as a precaution. Those with delayed diagnosis received reduced quality of care, but it was difficult to give the right prescription until diagnosis was confirmed. Dr Cetti confirmed that the coding was very accurate. Edward Cooke asked how antibiotics were monitored. Dr Cetti said that the IT solution would enhance monitoring of care. The Director of Finance asked whether seasonal pressures on Emergency Department had impacted on treatment. Dr Cetti replied that choice of antibiotics was not affected by pressures but the speed of antibiotic treatment had an impact. Education and reinforcement was ongoing. Norma Christison asked whether this work would have an impact on mortality. Dr Cetti said he would expect to see improvement over six months. The Chairman thanked Dr Chetti for his contribution. The Chief Executive also gave his personal thanks for all the hard work and effort which Dr Chetti put in for the Trust. He said this example will help to develop clinical teams in the Trust.	
4	**<u>Engaging with the Community</u>**		
	4.1	**Chief Executive's Report** Michael Wilson asked the Trust Board to note that the Christmas period had been exceptionally busy throughout the Trust. He said staff had worked collectively and he wished to thank them all. In addition, members of the community had helped with patient transport, for which the Trust was thankful. He reported that, together with the Chairman and Director of Finance, he had talked to the Strategic Health Authority (SHA) about the Trust's current financial position, and a range of possible solutions had been discussed. There would be further conversations with the Department of Health and the SHA. This week the Trust had had an opportunity for discussions with GP consortia in Surrey and West Sussex on a range of topics.	

		One Primary Care Trust in Surrey and three in Sussex will be merged into one cluster. They will soon be appointing their executive team. This will start a new way of working together. The Chief Executive invited questions from the Board. Richard Durban asked for a progress update on appointments to key positions in the Trust. The Chief Executive replied that good progress had been made. Clinical structures were in place, two new Associate Directors of Clinical Services had been appointed, and Service Managers would be appointed in February. Chiefs of Service were already in place. Recruitment of an Assistant Director to the Chief Operating Officer was underway. The Chief Executive was thanked for his verbal report.	
5	**Easier Access, Shorter Waiting Time**		
	5.1	**Integrated Performance and Quality Report** The Chief Operating Officer reported that over the past quarter there had been some improvements, but the Trust remained challenged on access targets. The increased activity during November and December caused extreme pressures on inpatient beds, which impacted on elective work. It would be necessary to put more work into planning for next winter. Fractured neck of femur was off target but, despite the cold weather in December, figures had improved. The action plan had already been implemented. The Trust was now offering longer theatre times for trauma. An external review of the trauma service been carried out in January by Professor Chris Moran of Nottingham University Hospital, and the written report was awaited. The report would be used to implement modernisation of the service. Cancer Services had shown a dip in performance last quarter due to a large number of unavoidable cancellations in December. Activity at Crawley was increasing, and although days had been lost due to generator failure, the time had been recovered. The teams were working more flexibly with time and space. Appointments were now being offered earlier than two weeks so there was time to rebook within the two-week target. The 18-week target had proved challenging due to demand for capacity during November, December and January. 255 operations had been cancelled in December. Considerable work was needed to recover the position. The 18-week national team would be working with the Trust on a recovery plan.	

		The Chief Executive added that the 18-week target was a national problem. Once the plan had been drafted the Trust would be discussing the operation of the plan with the SHA. **ACTION 3** **The Chairman asked for an update on the 18-week plan at the March Trust Board meeting.** The Stroke Service had missed compliance with the target of 90% for time spent in the stroke unit, but there was now an upward trend. The Trust had responded well to winter virus outbreaks and they had been successfully contained. Tribute was paid to the work of the Infection Control team to achieve this. Unscheduled care access had been the biggest challenge. The target had been challenging nationally and the Trust's results, whilst not good, were in line with the national picture. The Trust was shortly to embark on a transformation programme which included delivery of unscheduled care. Six workstreams were being developed. The Trust was looking for long-term sustained change through modernisation of pathways and delivery of safe quality care. The Trust had taken over management of the Urgent Treatment Centre, which would facilitate better and faster streaming of patients which a single point of triage. Job planning for Medicine would be implemented in February. This would involve shifting some activity to the mornings and facilitate discharges earlier in the day to free up beds faster. The Caterham Dene ambulatory care model had been commissioned to reduce admissions into the trust. Sessions of acute physicians had been increased at weekends. The Chief Executive said that key physicians were to be commended for adapting to the new way of working. The work being done at Caterham Dene was most important. GPs were pleased with the service whereby they referred ambulatory patients to the rapid assessment unit at Caterham Dene, where they were seen by acute consultants. **Action 4** **The number of patients attending Caterham Dene rapid assessment unit would be available at the March Board Meeting.** The Chairman asked what the clinicians' views were on the changes being asked of them. The Chief Medical Officer	**3) B Bluhm** **4) B Bluhm**

		responded that they were starting to understand the relevance of changes and the impact on the hospital. He said there was some reluctance to embrace culture changes but management was working with clinicians to get positive understanding. There was now greater involvement by clinicians with commissioning issues. It was important to keep lines of communication open between the Board and the clinicians. The Chief Executive used the Pneumonia pathway, as described in the presentation by Dr Cetti, as a fine example of clinically-led change which other services must follow. Yvette Robbins asked to what extent the Trust was engaging with patients in the redesign of services. The Director of Strategy and Transformation replied that the Trust was implementing new services in scheduled care nearer home. Local groups would involve patients and GPs to get their feedback. The Chief Operating Officer was thanked and the Integrated Performance and Quality Report was received by the meeting.	
6	**Effective Organisation**		
	6.1	**Finance Report** The Chief Financial Officer (CFO) reported that the year to date showed a deficit of £1.1 million, an improvement on the previous month, but still significantly adverse to the original surplus plan. He was pleased to give greater assurance on a break-even position forecast for year-end, due to renegotiating the contract with West Sussex and Surrey PCTs. There had been discussions with the SHA which would be providing some funding for specific costs. Additional funding made available by the Department of Health to reduce the additional costs of winter pressures may also form part of the year-end position. The CFO described the improved risk position in the report with the renegotiated contract but noted there were still small income disputes with PCTs and community services that needed to be resolved, and the risk of overspending from Divisions. It was noted that agency spend continued to be maintained at lower levels than earlier in the year (and 13.5% lower than last year), even though the full recovery plan target could not be achieved. All divisions were aware of the necessity to take action to control and reduce expenditure over the final eight weeks of the financial year. This included a meeting of senior divisional staff with the Chief Executive to ensure understanding of each individual's financial responsibilities. The cash position had been improved due to the sale of Fairfield House for £3.2m, and the management of creditors.	

		Edward Cooke asked whether account was being taken of the necessity of small businesses to receive prompt payment. The CFO responded that payments to non-NHS organisations were prioritised. It was recognised that other organisations had cash flow issues and good communication was maintained with suppliers. The Chairman congratulated the team on the negotiations with the SHA and PCTs which had resulted in an improved financial position. The Chief Executive summed up by saying that the Department of Health had considerable understanding of the financial challenges faced by SASH and that discussions to resolve the Trust's longer term financial situation would continue. The CFO was thanked and the Finance Report was received by the meeting.	
	6.2	**Rules of Procedure** The Director of Strategy and Transformation had prepared a draft document to describe the roles of the Trust Board and sub-committees. She asked for the Board to agree the draft document. It was proposed to discontinue the Performance Committee, continue the Audit and Assurance, Nomination and Remuneration and Charitable Committees, and establish two new committees – Quality and Safety Committee and Investment and Workforce Committee. The Chief Executive added that the review of Board committees had been carried out following consultation with Monitor and the Department of Health. John Power observed that, whilst this was a useful consolidation of existing procedures, it was also a major restructuring of the Trust's top level governance, and thus merited greater consideration by the full Board than had thus far been available. He raised four points in particular. First, the need for a description of the overall structure and operation, particularly with regard to hierarchical information flows. Second, the need for an explanation of from where the AAC would draw the high level assurance on clinical governance overall, over and above the subset of safety and quality, that it needed in order to meet its newly integrated remit over both clinical and non-clinical assurance. He suggested that this might be met by the new committee covering clinical governance overall. Third, the need for the Investment and Workforce Committee not to become a Finance Committee, in line with DH guidance. And fourth, the list of Executive Team responsibilities might usefully make clear who was responsible for	

		the outward facing "business development/marketing" role. Richard Durban said the Board would need to be assured that there was a good system in place for each committee to give feedback to the Trust Board. Norma Christison observed that there were no service users on the committees. There would be further discussion at the next board seminar on the document, how the board would work collectively, duties of the directors, and membership of committees. The Chairman and the Chief Executive thanked the Director of Strategy and Transformation for her work. ***The Board gave agreement in principle that changes would be made to the Trust Board and Committees. The detail would be discussed at the Board Seminar in February.***	
7	**Better Information, More Choice** *No agenda items*		
8	**Revitalising our Environment** *No agenda items*		
9	**For information**		
	9.1	The minutes of the Performance Committee held on 24th October 2010 were received for information.	
10	**Any Other Business**		
	10.1	**SASH Targets** Derek Cooper, Chairman of the Patients' Council, commented that, although targets across the NHS were generally found challenging, he felt that SASH should be judging itself on its achievement of targets rather than comparison with other trusts. The Chief Operating Officer replied that it was not her intention to use under-performance as a benchmark, but to paint a picture of the current situation, both at SASH and nationally. The Director of Strategy and Transformation asked the Chief Nurse whether there were any quality or safety issues not addressed. The Chief Nurse reported that MRSA screening had been 100% compliant in December 2010. Validation was taking place and figures would be confirmed to the Trust Board in March. The Trust was performing well in relation to healthcare associated infections and every effort was being made to ensure continued progress in	

		relation to infection control.	
	10.2	**Access to Wheelchairs** Edward Cooke reminded the Board that, at the Trust Board meeting held on 5th August 2010, he had raised a question about wheelchairs. He had asked for improved communication, so that visitors to the hospital, and also staff on the Information Desks, knew where to access wheelchairs. The Board had been given assurance by the Director of Environment and Facilities that all departments had been reminded not to hold on to wheelchairs in their areas but to release them back into the system. The Board had been advised that there were ample wheelchairs in the hospital but that suitable storage needed to be identified. Edward Cooke wished to advise the Board that the staff on the information desk had been given no instructions on how to access wheelchairs. **ACTION 5** **Edward Cooke asked that the system whereby wheelchairs were available at the hospital entrances was communicated to the relevant members of staff and volunteers.**	**5) I Mackenzie**
11	**Date of Next Meeting** The next Trust Board meeting in public will take place on Thursday 24th March 2011 at 10:30, in Room 7/8, Post Graduate Education Centre, Maple House, East Surrey Hospital, Canada Avenue, Redhill, RH1 5RH.		

ACTION POINTS

1	**H&S Annual Report** A statement on Health and Safety would be provided for the Trust Board in public in March.	Mary Sexton
2	**Board Assurance Framework** John Power asked for a key to abbreviations and improved formatting. The Chief Executive said that this would be attended to.	Mary Sexton
3	**18 Week Plan** The Chairman asked for an update on the 18 week plan at the March Trust Board meeting.	Bernadette Bluhm
4	**Caterham Dene Rapid Assessment Unit** The number of patients attending Caterham Dene rapid assessment unit would be available at the March Board Meeting.	Bernadette Bluhm
5	**Wheelchair Availability** Edward Cooke asked that the system whereby wheelchairs were available at the hospital entrances was communicated to the relevant members of staff and volunteers.	Ian Mackenzie