Surrey and Sussex NHS
Healthcare NHS Trust

Minutes of Trust Board meeting held in Public
Thursday 25th February 2016 from 11:30 to 13:30
Room AD77, Trust Headquarters, East Surrey Hospital

Present

(AM) Alan McCarthy	Chairman
(MW) Michael Wilson	Chief Executive
(PS) Paul Simpson	Chief Finance Officer / Deputy Chief Executive
(DH) Des Holden	Medical Director
(FA) Fiona Allsop	Chief Nurse
(PL) Pauline Lambert	Non-Executive Director
(PB) Paul Biddle	Non-Executive Director
(RD) Richard Durban	Non-Executive Director
(AH) Alan Hall	Non-Executive Director
(RS) Richard Shaw	Non-Executive Director

In Attendance

(GFM) Gillian Francis-Musanu	Director of Corporate Affairs
(DM) Deborah Mayne	Theatres Matron (item 2)
(CP) Colin Pink	Head of Corporate Governance (Notes)

1.	**General Business**	
	1.1	**Welcome and Apologies for absence** AM opened the meeting by welcoming Trust Board members, members of the public, shadow governors and staff. Apologies for absence were noted from Angela Stevenson.
	1.2	**Declarations of Interest** No declarations of interest where declared.
	1.3	**Minutes of the last meeting – 28th January 2016** The minutes of the meeting held on 28th January were discussed and **approved as a true and accurate record.**
	1.4 **1.4.1**	**Action Tracker** GFM updated the Board on the following actions: *TBU-01* is not due until 31.03.16 *TBU-02* is not due until 31.03.16 and will be monitored by the Executive Effectiveness sub-committee *TBU-03* was considered at FWC in February and is now complete and closed *TBU-04* is included in agenda papers and is closed There were no other matters arising.

	1.5	**Chairman's Report** *for Assurance* AM discussed the output of the recent NHS Improvement launch event. The emphasis going forward will be an earned autonomy approach to delivery of services linked to management of budget against control totals. This will align with a performance framework based on; quality of services, performance, strategic change and budgetary control. AM went on to comment that Foundation Trust status was no longer the national aim. Going forward there will be a focus on improving safety, reducing variation moving towards the aim of providing a decade of quality. There will also be a focus on primary care provision and mental health, noting that although national focus steers towards acute care the majority of NHS patients fall into these categories. AM commented on the recent opening of the Cardiology unit by Lord and Lady Astor which is good news and another positive step for the Trust. **The Board duly noted the report.**
	1.6	**Chief Executives report** *for Assurance* The Board received and noted the Chief Executive's report in advance of the meeting. MW introduced the report highlighting recent developments on the implementation of the five year forward view which will now focus on quality of care, access and transformation. The national staff survey had seen the Trust rank amongst the top 20% for a range of 15 indicators, which comes on the back of 5 years of significant improvement. MW went on to state that as good a result as this is for the Trust there are still elements highlighted by the staff survey that need to be tackled. These relate to staff experience of violence and bullying from patients and the public which could include elements of unintentional aggression and staff perception of verbal aggression. The Board noted that the staff survey was a very positive result. Health Education England are working with the trust to explore and develop the roles of physician associates (PAs) which are seen as a key enabler for provision of medical care. The Board discussed the governance that supports PAs and took assurance that appropriate management is in place. MW has written to the Secretary of State to lobby for formal recognition and regulation of PAs such that the role can reach its full potential. AH and RD asked for updates on the junior doctors strikes. MW commented on how well the Trust had managed the impact of recent strikes and the effect of the strike that was cancelled at short notice. The Consultant body had worked well to manage the situation and ensure continuity of care. MW indicated that around 50 elective patients had been affected by the last strike and it is expected that a review of outpatient services would provide similar numbers. The Board noted that if the Trust did not impose the new contract as planned there would be an impact in future on the numbers of junior doctors sent to the Trust. **The Board duly noted and took assurance from the report.**

	1.7	**Board Assurance Framework (BAF) and Significant Risk Register (SRR)** *for Approval and Assurance* The Board received and noted the report in advance of the meeting. GFM introduced the board assurance framework and significant risk register. The BAF detailed 13 risks to the trusts strategic objectives which had been updated by the Executive team through February. AM asked whether the expectations detailed in the recent tripartite letter would impact on the Trust's financial risk. PS commented that the emphasis of balance of patient care against the financial bottom line would remain part of the detail of strategic financial risk, noting that the level of risk could increase depending on CCG interpretation and actions. RS asked whether the elements of the BAF relating to staffing should decrease as staff turnover and survey results provided strong assurance. FA agreed in principal, reflecting that overall assurance was good but that a view of trajectory into June and July should be made before reducing the risk. No issues relating to the significant risk register where raised. **The Board duly approved and took assurance from the report.**
2.	**Safety, Quality and Patient Experience**	
	2.1	Clinical Presentation – *for Assurance* FA introduced Deborah Mayne, Theatres Matron, who would provide an update on the Trusts review of the WHO Surgical Safety Checklist, following a surgical never event in 2015. The incident had been raised by a patient who wanted to ensure that the chance of the incident happening again would be reduced. DM highlighted that the incident investigation into a wrong site surgery (left and right fallopian tubes removed) had identified that the checklist had been completed appropriately before the incident. The investigation had highlighted a number of issues mostly relating to human factors such as key staff leaving the theatre mid procedure to retrieve kit. There had also been no debrief at the end of the surgical list, as such no one was given the task of reporting the incident. The surgical team had resolved to setup a group to foster team building, agree safety objectives and review the design and use of the Trust's surgical safety checklist. The review had been carried out using team development sessions, generating good engagement and ownership of the changes made. The new checklist will be launched in April and audited during implementation. The Board discussed how the incident had occurred and what impact the redesign of the checklist could have. The surgery was a laparoscopic procedure, such that it would not have been obvious to the supporting team that the healthy tube was removed first by mistake, the surgeon had noticed the mistake and had gone onto remove the diseased tube. DM went on to comment that following the initiative there had been a 12% increase in no harm incident reporting which is a

		very positive indicator of change in reporting culture. MW thanked DM for the presentation and leadership throughout the work. MW asked how the changes would be socialised to the teams involved. DM noted that this new checklist had been developed by the wider MDT and trialled across three specialities, most staff are already aware of the changes. PL asked how the Trust was sharing its work with other services. DM commented on local sharing within a surgical safety standards network and Trust membership on national bodies responsible for strategic management of never events. DH reflected that it was encouraging to hear that visibility of the checklist had improved and that safety culture is developing. Initially the patient had been upset at the lack of corporate response linked to the failure to report the incident and the Trust needs to mitigate against the possibility of this reoccurring. DH went on to remind the Board that surgery is an imperfect system which safety and quality is wrapped around to reduce the likelihood of incident. Surgical teams tolerate last minute list changes, missing kit and staff leaving surgery. Reducing this frustration and variation must be a key objective for the Trust going forward. AM thanked DM for the presentation and the Board for the useful conversation, asking that DH/FA write to the patient to pass on the Board's apologies and reflect on the conversations of the meeting. **Action** **The Board noted and took assurance from the report.**
	2.2	**Chief Nurse and Medical Director's Report** *for Assurance* The Board received and noted the report in advance of the meeting. FA presented the Chief Nurse's report highlighting that the safer staffing profile continues to strengthen as the nursing vacancy gap closed, noting a drop from 18% to 12%. Health Education England are continuing to look at the nursing gap and as such are exploring the role of Nurse Associate. The Board discussed the proposal of the new role and noted that guidance on integration and regulation would help to flesh out the understanding of the model and strengthen the consultation process. FA highlighted that the Trust had requested that it formed part of the pilot which should better position the Trust to engage in the national conversation. DH indicated that he had nothing to raise as part of the Medical Directors report. There were no further questions. **The Board duly noted and took assurance from the report.**
	2.3	**Safety & Quality Committee Update** *for assurance* The Board received and noted the report in advance of the meeting. RS introduced the summary paper which detailed the activity of the February meeting. The Committee had taken assurance from developments in the complaints pathway and considered potential changes to PALS provision. The

		Committee had also received a summary of the actions to improve services for patients with long term mental health conditions such as dementia. The Committee had focused on falls incidents and reports from infection control which indicated that supporting systems such as white boards are not being used to their full potential. AM asked for assurance that the white boards project had been implemented. MW commented that it had been very successful in some specialties, in particular respiratory who are sharing their best practice with cardiology. There is an element of ensuring that the supporting software does what is required rather than forcing clinical teams to change how they work. DH agreed stating that work needed to focus on integration and navigation. All of which will drive the need and use of full electronic patient records. **The Board duly noted and took assurance from the report.**
3.	**<u>Operational Performance</u>**	
	3.1	**Integrated Performance Report (M10)** *for Assurance* The Board received and noted the report in advance of the meeting.
	3.1.1	**Operational & Quality Key Performance Indicators** FA reviewed the patient safety and caring elements of the report highlighting issues relating to management of urinary catheter which had impacted on compliance with the safety thermometer. There had been no new never events and VTE compliance was still being validated. FA went on to confirm that the Executive team would review VTE risk assessment compliance recording in detail shortly. Overall FFT scores remain high with the continuing need to drive response rate. The Carers support network is being trialled throughout March which looked to improve the experience of all those who provide long term care. PS spoke to the access elements of the report, highlighting ED performance, the use of escalation and local system capacity issues. The Trust had been under increased operational pressure for a significant length of time and a network wide summit would meet to agree mitigating actions. Elective activity continues to bear the brunt of the operational pressure and the NHS had not met the RTT standard for the first time. Despite this position the Trust continues to be one of the highest performing organisations nationally. MW reflected that the nation was seeing unprecedented levels of emergency activity, the 22nd of February had been the busiest day ever in the Emergency Department. Early impressions point to lack of trust in primary urgent care provision and '111', system driven by recent national media coverage.
	3.1.2	**Workforce Key Performance Indicators** PS presented the workforce elements of the report highlighting improving sickness absence and turnover rates which are driving a reduction in agency usage. The Board noted overall performance against achievement review targets which

		triangulated well with commentary from the staff survey. There is positive assurance in the staff surveys scores relating to quality of appraisal.
	3.1.3	**Finance Key Performance Indicators** PS introduced the financial elements of the report. Stating that the Board had agreed a forecast end of year deficit of £4.2 million which has been reported to NHS England and the TDA. This is driven by emergency activity, agency use and the cost of safely managing escalation areas. This forecast was subject to a further risk of £1.6 million and the impact of planned junior doctor's strikes. At the private meeting the board had agreed that these impacts should be added to the month 11 forecast, subject to any mitigation. Agreement had been reached with CCG's over the return of any ambulance handover fines, although for Surrey this would be only for the first 3 quarters of the year. There are positive trends in reduction of agency staff and spend, but there remains a risk to activity income linked to junior doctor's industrial action. The end of year position may slip to a £6.6 million deficit depending any industrial action impact. Nationally the provider sector financial pressures had reduced the EBITDA of foundation trusts to 1% and non-foundation trusts to 0.3%. The Trust's EBITDA was 3.8% at month 10 and the Monitor benchmark for financial stability is 5.0%. Following an application to TDA for Capital to Revenue transfer the capital spend forecast has reduced by £3.0 million to £14.1million. AH challenged the Board that it should have done more to drive the completion of cost improvement plans which would have impacted on the end of year position. PS agreed with the statement, highlighting that the Trust had had a good track record of delivering CIPS until this year. An internal audit report to the Audit and Assurance Committee had rated the process green/amber but delivery at amber/red MW reminded the Board that both locally and nationally the financial challenge had never been more acute since the national standardisation of nursing and midwifery ratios. The Trust had also built 5 wards since 2012, plus the IRU which is approximately another 100 nursing staff to find from the limited local pool of available staff. No further questions where raised. **The Board duly noted and took assurance from the report.**
	3.2	**Finance & Workforce Committee Chair Update –** *for Assurance* The Board received and noted the report in advance of the meeting. RD presented the report. The FWC had reviewed the financial and workforce position reported earlier and agreed with the commentary. The Committee had reviewed the completion of capital plans including theatres and considered the capital plan for 2016 (£9.0 million). The Board noted that this was a significant reduction in overall schemes but there was assurance to be

		taken from continued building of new infrastructure **The Board duly noted and took assurance from the report.**
4.	**<u>Risk, Regulatory and Strategy Items</u>**	
	4.1	**Standards of Business Conduct Policy –** *for Approval* The Board received and noted the papers in advance of the meeting. GFM introduced the policy which had been updated to reflect national changes in best practice relating to; fit and proper persons test, declarations of interest, bribery act and drugs and therapeutic commissioning. The policy has been reviewed by the Executive Committee, Audit and Assurance Committee, the Joint Negotiating Committee and Internal Audit. **The Board duly approved the policy.**
	4.2	**Update from the Shadow Council of Governors –** *for Assurance* The Board received and noted the report in advance of the meeting. GFM introduced the report of the second meeting. It had been a well-attended and vibrant meeting and received updates on patient experience initiatives and legacy report from the patient experience forum. AM thanked the shadow governors for their high level of engagement and perseverance stating that achieving FT status is still the aspiration of the Trust Board. **The Board duly noted and took assurance from the report.**
	4.3	**Sash Plus Update –** *for Assurance* The Board received and noted the report in advance of the meeting. MW introduced the report highlighting initial identification and work of the Trust's value streams. In particular the cardiology element of right bed first time which had seen significant reductions in consultant led review of emergency patients, which needs to embed. The Trust is now looking to develop and agree a compact with its clinical staff, which sets out expectations of behaviour. MW went on to reflect on strategic engagement with the national initiative, highlighting the very interesting work that the surgical teams had started in Leeds. The Board discussed how impressive the initial output of the cardiology value stream had been noting that elements of the work could be transferred to other specialities if it embeds effectively. The Trust must stick to the methodology and avoid the 'scattergun' trap, reducing variation is the key. DH highlighted how the work was impacting on ward rounds, in particular the initiative to include patient's families and carers in the ward round discussion. This could potentially improve quality of care and effectiveness of discharge arrangements whilst also increasing transparency of care.

		The Board noted that the staff compact was similar to the compact with the TDA and as such the Board should be seen to be modelling the behaviours within the staff compact. RD went on to ask how this would impact on other transformational and operational initiatives such as 'breaking the cycle'. MW stated that the Trust was looking to adopt the most useful elements of breaking the cycle and that reducing variation would become a key focus of all transformational initiatives. GFM was asked to share the Trust's video of the first SASH+ report out **Action.** **The Board duly approved and took assurance from the report.**
	Other Items	
	5.1	**Minutes of Board Committees to receive and note**
	5.1.1	**Finance and Workforce to receive and note** The minutes of the Committee were noted with no questions raised.
	5.1.2	**Safety and Quality Committee to receive and note** The minutes of the Committee were noted with no questions raised.
	5.2	**Any Other Business** There was no other business.
	5.3	**Questions from the Public** There were no questions raised.
	5.4	**Date of the next meeting** **Thursday 31st March 2016** at 11.00am in Room AD77, Trust Headquarters, 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.

These minutes were approved as a true and accurate record.
Alan McCarthy

Chairman: **Date:**