Surrey and Sussex NHS
Healthcare NHS Trust

Minutes of Trust Board meeting held in Public
Thursday 31st March 2016 2016 from 11:30 to 13:30
Room AD77, Trust Headquarters, East Surrey Hospital

Present

(AM) Alan McCarthy	Chairman
(PS) Paul Simpson	Chief Finance Officer / Deputy Chief Executive
(DH) Des Holden	Medical Director
(FA) Fiona Allsop	Chief Nurse
(AS) Angela Stevenson	Chief Operating Officer
(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

(MP) Mark Preston	Director of Organisational Development and People (4.2)
(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 Michael Wilson and Gillian Francis-Musanu.
	1.2	**Declarations of Interest** No declarations of interest were declared.
	1.3	**Minutes of the last meeting – 25th February 2016** The minutes of the meeting held on 25th February were discussed and **approved as a true and accurate record.**
	1.4 **1.4.1**	**Action Tracker** CP updated the Board on the following actions: *TBU-01* DH provided a verbal update stating that Zara Nadim Chief of WACH had commenced a review of system to mitigate against the chance of samples not reaching the laboratory. The most viable option relies on barcodes and scanners, as such an options appraisal with costings is being developed. *TBU-02* is not due until 28.04.16 .*TBU-03 02* is not due until 28.04.16. *TBU-04* was actioned and is complete. There were no other matters arising.

	1.5	**Chairman's Report** *for Assurance* AM introduced the new development of local sustainability and transformation plans (STP) which will look to bring together all aspects of local healthcare planning and transformation. Michael Wilson has been selected to manage the local STP, which is exciting news for both MW and the Trust. The next five years will set interesting challenges as NHS, Social Care and Public Health services align to provide new services and pathways. The governance of the new STP is yet to be set in stone and will be discussed at Board once information is made available. AM went on to reflect that he and other representatives of the Board had attended a local lay members Chairs meeting which had been very useful. It is clear that although local health care providers have shared goals, the vision and methods of delivery vary greatly from service to service. In particular opinions on pressures, activity and need can be conflicting. The Board went on to discuss the differences in opinion that had been expressed over levels of growth of activity, the availability of workforce and funding allocations; agreeing that under the new STP collaborative work would be the only viable option. **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. PS introduced the report highlighting the recently published league tables for learning from mistakes based on staff survey and NRLS data. The Trust ranks within the top 30% of Trusts which is good and evidence of the focus over recent years. The national pilot to investigate the feasibility of adopting a mutual approach to ownership of Trusts has come to a close and the Cabinet had received a full report. The final findings are that it is not feasible to adopt mutual models in healthcare as the legal and VAT structures are not currently compatible. PS congratulated the Emergency Department for being declared the runners up in the national Friends and Family Test (FFT) champions of the year awards. PL stated that it was good to see the trust within the top 30% and asked what could be done to get an even better result. PS highlighted that the difference in scoring mechanism for the top 30% was small and as yet it was difficult to identify key steps to improve benchmarking. However the Trust continues to learn and focus on matters of patient safety. The Board asked that both the emergency department and Selina Young received its thanks and congratulations for being selected as finalists for the national FFT awards. **Action** GFM **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. PS 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 throughout March and had been considered by the AAC with a view to what issues would be recorded on the 2016/17 BAF. This will be discussed and agreed at the April seminar. PL asked for an update on risk 3.1 relating to recruitment and retention. FA stated 80 overseas nurses had joined the Trust and that there was a further 48 in the pipeline. This had gone some way to meet the gap. However the Trust continued to aim to recruit 10 overseas nurses a month. Turnover rates have dropped following focussed efforts on to retain staff. The overall picture is positive but it is still too early to reduce the risk rating of the issue. 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	Patients Story– *for Assurance* The Board received and noted the report in advance of the meeting. DH introduced the paper which described a patient story in which a patient had died from a pulmonary embolism (PE). The patient had had two episodes of care within two weeks and had passed away on the second admission. The case had been taken to Inquest by the Coroner who had given a narrative verdict stating areas of concern in practice relating to the management of Venous thromboembolism (VTE) during the first admission. The patient had been risk assessed as needing medication to reduce the risk of VTE, this single dose was not given as per Trust policy. DH and the medical team are very disappointed that in this instance an identified patient safety risk was not managed as per policy. All other main aspects of care provided on the first admission were satisfactory and as per the Coroners finding there is not a direct link between the outcome and the failure to administer the drug. The second admission had been managed well. DH went on to reflect that the management of VTE is a high focus for the Trust as it cannot demonstrate full compliance with NICE guidelines. The Trust is looking to increase compliance with the risk assessment, following changes in condition upon risk assessment, compliance audit for action taken and monitoring outcomes post discharge. This will be supported by mandatory changes to the Trust's patient tracking system and supported by the planed roll out of electronic prescribing. This issue is being discussed by the SQC. AM expressed his condolences to the patient's family and asked for clarification on the Coroners findings. DH confirmed that the patient was correctly assessed and that the issue was the failure to act, which was recorded as a concern as it could not be directly linked to the outcome. DH went on to reflect that throughout the first episode of care the clinical team had noted the assessment but not checked the completion of the action. PE is one of the leading causes of

		preventable harm nationally and a significant challenge if the Trust is to achieve its aim of avoiding preventable harm. PL asked how the learning form the incident had been shared. FA stated that it had been presented at the patient safety executive and that the Chief of Medicine has personally decided to take the issue on. RS asked for an explanation as to what the failing was in this case. FA stated that the drug had not been prescribed following the risk assessment. The Board went on to discuss how this issue was a matter of personal accountability and that once you identify a safety issue you should see it through and that this could be seen in other safety issues seen in healthcare, administration of antibiotics, management of sepsis and actions to reduce falls. AH asked for assurance on Consultant engagement in this issue, DH suggested that benchmarking data such as mortality indicated strong engagement and good care but the ask is to get to a point were avoidable harm is reduced to the minimum. There were no further questions. The Board asked DH to write to the family to express its condolences. **Action DH** **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 report highlighting continuing good safe staffing figures and that the reports format will change in the new financial year. FA went on to discuss actions to improve retention; including investment in practice development liked to local Health Education Kent Surrey and Sussex HEKSS preceptorship activity and transition programs for band 2 staff. The first wave of nurse revalidation had gone well and the Trust was preparing the nurses in the second cohort. RS asked for assurances over staffing levels in obstetrics and the birthing unit. FA highlighted that this percentage represented two staff and as such could vary. The local team managed the issue well and to date there are no concerns over safety. The Board went on to discuss midwifery care levels. The Trust had improved its ratios from 1:34 to 1:32 with significant investment, best practice is 1:28 but this tends to be only achieved in national centres. The Trust is complaint with 1:1 care during established labour and 98 hours of consultant cover. RS asked for feedback on how well overseas nurses had embedded within the Trust. FA indicated that the recent cohorts of overseas nurses where working effectively supported by preceptorship and efforts to acclimatise everyone to local culture and differences in elements of care. DH spoke of the Junior Doctors industrial action focussing on the second planned activity in April, which will escalate to no emergency cover between 8am and 5pm. As such the Trust was reducing planned elective activity and developing plans to mitigate against the effects of industrial action. The job descriptions for the two new professors of medicine and nursing had

		been agreed with University of Surrey and adverts are being written. This will put the Trust at the forefront of developing new pathways and exploring models of care to support the five year forward view. AM commented that this was very good news for the Trust. AH asked what stance the Trust was taking relating to Junior Doctor industrial action. DH commented that the appetite for action was strong and that the Trust was supporting each individual's choice. PB asked what risk was attached to the cancellation of elective procedures. DH reflected that each delay adds an unknown element of risk, such as increased morbidity and potential for delayed in diagnosis of cancer. PL asked if the Trust could do more to support these patients. DH confirmed that all decisions are based on clinical priority with cancer treatment being the highest elective priority. AS reflected that this was not just an acute issue the balance of risk is significant with unprecedented levels of emergency activity. There have been recent cases were patients have been waiting an hour for a 999 ambulance attendance in such circumstances emergency risks trump elective care. AS confirmed that a review of recent activity and impact of industrial action would be considered by the Board at a later meeting. 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 improvement in stroke benchmarking quality metrics, the commitment to take a new approach to reduce falls with harm and the Trust's reduction in use of antimicrobials linked to increased risk of C. diff. DH reflected that it is probable that overall use of antibiotics within the Trust had remained static. Trust policy had been reviewed and the use of broad spectrum agents limited significantly. **The Board duly noted and took assurance from the report.**
3.	**Operational Performance**	
	3.1 ***3.1.1***	**Integrated Performance Report (M11)** *for Assurance* The Board received and noted the report in advance of the meeting. **Operational & Quality Key Performance Indicators** AS introduced the performance elements of the report, highlighting that the ED target had not been achieved in April, ambulance handover remains and issue but has improved since earlier in the year. There has been a step change in emergency activity and admissions in recent months which impacts on the Trust's ability to get patient's into the right bed first time and elective activity. It is anticipated that March's selective activity will be the lowest for the financial year.

		The Board discussed RTT targets increase in day case activity to balance impact of elective activity and breaches in the 2 week breast symptomatic targets. AM asked if we understood the increase in emergency activity. AS stated that it was too early to draw conclusions and suggested that the impact of community infections particularly flu was impacting on attendance and flow of patients. There is not a feeling that these are unnecessary admissions which is supported by the number of ambulance attendances to the Trust. RD asked that the Trust explore differences in activity from different catchment areas. AS agreed highlighting that Surrey has carried out significant initiatives that may have impacted on the picture. There is a visible trend in increase of patients coming from the south. FA introduced the patient safety element of the report highlighting the number of incidents, ongoing efforts to validate VTE and drop in safety thermometer metrics. Noting that although not included in the data the impact of diarrhea and vomiting recorded on the significant risk register had been felt. FA went on to discuss patient experience elements of the report highlighting pilots for extending visiting hours and the new standards of behavior that had been launched, which had been developed from themes identified in compliments and complaints. AM asked what the expected benefits of the visiting hours pilot would be. FA stated that evidence supported better outcomes for patients linked to support from family and communication with clinical teams. DH introduced the effectiveness element of the report focusing on mortality. The Trust's HSMR remains below 100% which is better than average. There is variation in condition specific HSMR which are being considered by specialties'. A representative of Dr Foster had visited the Trust and indicated that the Trust could do more to record comorbidities which would improve data quality.
	3.1.2	**Workforce Key Performance Indicators** PS introduced the workforce elements of the report highlighting elements of agency usage and the period of good recruitment and lower vacancy rates which has yet to see the planned reduction in agency. This issue is linked to registration of overseas nurses and the need to staff escalation. The pilot for theatres bank rate for staff agency use had been positive. Similarly there had been a decrease in the use of agency staff to support critical care.
	3.1.3	**Finance Key Performance Indicators** PS introduced the financial elements of the report. Stating that at the end of month 11 the Trust has a year to date income and expenditure deficit of £4.8 million. The Trust forecast for the year is a £6.6 million deficit after the donated asset technical adjustments, which includes the impact of further industrial action by Junior Doctors. Emergency activity and its impact on elective activity continues to be a significant issue. There is increased outsourcing of elective activity to meet needs of patients but this adds cost adverse to plan. Cash flow remains an issue, however a working capital facility of £12.5 million

		has been secured and funds are being drawn down which should support cash flow through to May 2016. Capital spend is on target to meet reduced budget agreed earlier in the year. The underlying recurrent position has worsened which will put pressure on delivery of 2016/17 budget. This has been accounted for. PS summarised by stating that the end of year forecast is a £6.6 million deficit with £1 million risk linked to the final position on CCG contracts. **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, highlighting the improvements in workforce reporting since Mark Preston had joined the Trust in January. The FWC had started to receive greater detail to support the data presented in KPI's. The Committee had reviewed the draft interim income and expenditure budget in detail, considering control targets, CIP, divisional budgets and risks. The Committee had voted unanimously to recommend the interim budget to the Board. The Committee had received a review of the Trust's implementation of leadership activities identified in the 'Rose Report' which was positive. Agency usage and initiatives had been discussed as had the Trust's completion of achievement reviews. The Committee had considered how SASH+ methodology and lean systems would be implemented, following the initial 40 leaders trained by the Trust with support from VMI. **The Board duly noted and took assurance from the report.**
	3.3	**2016/17 Interim Income & Expenditure Budget –** *for Approval* The Board received and noted the report in advance of the meeting. PS presented the interim revenue budget for approval which has been robustly explored and recommended by the FWC. The proposed interim revenue budget for 2016/17 provides a surplus of £15.2 million. The core budget is effectively a breakeven budget and the surplus position is based on receipt of £9.7 million of sustainability and transformation funding and the required "control total" notified by NHS Improvement. The Trust has provided four caveats detailed in a letter to NHS Improvement which would see the control surplus reduce if the items in the caveats are not resolved. The interim budget includes £9.2 million pound saving plan a £2.7 million productivity gains. There is a forecasted £6.8 million pound risk to delivery of this budget which is

		described appropriately, and takes into account £3.0 million of contingency. AM asked how much impact there would be on the budget if April's emergency activity remained as high as March's. PS agreed with the concern and commented that phasing of the income plan and any benefit from the emergency activity marginal rate caveat would mitigate this to some effect. PS introduced the interim capital budget which is £8.97 million and had been reduced below the anticipated capital reserve limit to allow for cash flexibility. The capital resource limit will be increased by the return of the £3.0 million transferred into revenue in 2015/16. The Board discussed the level of risk, delivery of quality gains and overall uncertainty of ability to deliver control target. PS noted this, stating that the approach to the budget set out in the paper described recognition of risk while maximising cash support and incorporating as much contingency as possible. Financial reporting in year would not accrue assumptions on MRET or payment of the sustainability and transformation fund until either was confirmed. PL and AM thanked PS and the finance team for producing an interim budget that passed muster during a period of significant risk, financial difficulty and strategic change. AM asked PS to ensure that as the Trust becomes closer to signing off the final budget elements of reserves and cost savings were allocated to divisional budgets soonest to enable greater accountability. PS stated that this would be the case. **The Board duly noted and approved the Interim Income & Expenditure Budget on the understanding that delegated responsibility for any final changes would be agreed by the Chairman and Chief Executive.**
	3.4	**Audit & Assurance Committee Update & Annual Report** - *for Assurance* The Board received and noted the report in advance of the meeting. PB presented the update report highlighting the review of the BAF and initial conversations to set the context of issues that could be included in the next financial year iteration. The Committee had gained assurance from management's report of losses and waivers and the regular feedback reports from the work of Internal Audit. PB went on to introduce the annual AAC report to Board, commenting on the positive support and assurance gained from Internal and External Audit. The Committee has adopted the best practice model of assurance based on three lines of defence/assurance as detailed in the report. The Committee noted the scale of the finance risk which the Trust manages well but is likely to become more challenging in the next financial year. Budget's, spend and mitigation will form a focus of AAC activity throughout 2016/17. With support from Internal Audit the Committee believes that it gains valid assurance of the systems of control that support the Trusts key business. AM asked for clarification on Internal Audits comment relating to Executive

		attendance. PB commented that should there be concerns the executive team are asked to attend the meeting to discuss issues, this is true for amber red audit conversations and issues relating to the internal control framework. However should a question raise following a green/amber audit presentation the Executive responsible for this element may not be present to answer. AM thanked for PB for the report, there were no further questions. **The Board duly noted and took assurance from the report.**
	3.5	**Charitable Funds Committee Update** - *for Assurance* The Board received and noted the report in advance of the meeting. PL presented the report which included details of the opening of the cardiology unit and the deferral of the London Marathon entrance to 2017. The Trust is hoping to fill the vacant fundraiser post shortly having previously been unsuccessful. The Committee is happy that finances are being spent appropriately and divisions are regularly tasked with ensuring charitable funds are spent in a timely manner. The Board thanked Lord Astor for his contribution and support of the cardiology unit. **The Board duly noted and took assurance from the report.**
4.	**Risk, Regulatory and Strategy Items**	
	4.1	**Serious Incidents Quarterly Report** - *for Assurance* The Board received and noted the report in advance of the meeting. FA presented the report. There had been 15 SI's reported in Q3, 10 of which are falls with harm, the detail of which is included in the report. At present 18 incidents are under investigation none are in breach of national timeframes for completion. The Board discussed the CCGs role in signing off investigation reports noting that it was an important opportunity to increase transparency and identify further improvements that have not been included in associated action plans. RS asked for commentary on the MRSA case included in the report. FA commented that the child had been screened twice and it was probable that the child had become colonised with MRSA whilst in hospital although it was impossible to identity which contact would have caused transmission. As this was an MRSA bacteraemia it was recorded as a serious incident. The outcome for the child was good and she is expected to make a full recovery. **The Board duly noted and took assurance from the report.**
	4.2	**2015 Staff Survey** - *for Assurance* The Board received and noted the report in advance of the meeting.

		MP presented the report highlighting good national benchmarking and increased response rate (placing the trust in the top 20%). The report includes detail of the areas were the Trust had received very positive results, 17 indicators in the top 20% and the 3 areas which had been identified in the bottom 20%. Interestingly quality of appraisals well within the top 20% nationally whilst numbers appraised fell in the bottom 20%. The Board discussed how positive the staff survey had been and took assurance from its results and asked that an update report on actions taken be presented to FWC **Action MP**. The Board went on to discuss staff experience of violence and bullying which fell into the 3 indicators of concern. This has been an issue highlighted before and as such the Chief of Surgery had taken it upon themselves to investigate and unpick what lies behind this result as it is not identifiable in incident reporting data. **The Board duly noted and took assurance from the report.**
	4.3	**2016/17 Operational Plan** – *for Approval* The Board received and noted the report in advance of the meeting. PS presented the plan for approval that gave an overview of Trust plans encompassing operational, financial, workforce and quality improvements. This is a narrative document which is used for reference based on prescribed content AH asked the plan include commentary on alignment to CCGs plans and gaps between Trust activity and commissioned plans. The Board noted that there were other minor issues that could be updated such as ED attendance and activity. AM stated that he would discuss final amendments to the plan for submission. AH asked for an explanation as to the inclusion of a frailty unit in the plan as this was the first significant commitment to its development. AS confirmed that the plan was being worked up with East Surrey CCG and is a key supportive mechanism to reduce admissions and support the function of the integrated reablement unit. **Action** AS to bring frailty unit plan to Board when ready. **The Board duly noted and approved the plan as presented. Final sign-off of the plan was delegated to the Chair and Chief Executive prior to submission to the TDA/NHSI on 18th April 2016.**
	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.
	5.1.3	**Audit and Assurance Committee to receive and note** The minutes of the Committee were noted with no questions raised.
	5.1.4	**Charitable Funds 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 28th April 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:**