Surrey and Sussex NHS
Healthcare NHS Trust

Minutes of Trust Board meeting held in Public
Thursday 25th August 2016
Room AD77, East Surrey Hospital

Present

(AM) Alan McCarthy	Chairman
(PS) Paul Simpson	Chief Finance Officer / Deputy Chief Executive
(FA) Fiona Allsop	Chief Nurse
(AS) Angela Stevenson	Chief Operating Officer
(DH) Dr Des Holden	Medical Director
(PBi) Paul Biddle	Non-Executive Director
(RD) Richard Durban	Non-Executive Director/Deputy Chairman
(PL) Pauline Lambert	Non-Executive Director
(RS) Richard Shaw	Non-Executive Director

In Attendance

(GFM) Gillian Francis-Musanu	Director of Corporate Affairs
(MB) Mary Buckingham	Executive PA(Notes)

1.	**General Business**	
	1.1	**Welcome and Apologies for absence** The Chairman opened the meeting by welcoming Trust Board Members, members of the public, shadow governors and staff. Apologies for absence were noted from Michael Wilson, Alan Hall and Mark Preston.
	1.2	**Declarations of Interest – For approval** The Chairman asked whether any Board members had any additional declarations of interest; no additional interests were declared.
	1.3	**Minutes of the last meeting** The minutes of the meeting held on 28 July 2016 were reviewed. One amendment was agreed in relation to agenda item 2.1 page 4, 6th paragraph should read. RD asked if the patient had just been unlucky or were there system implications. With this addition, the minutes were approved as a true and accurate record.
	1.4	**Action Tracker** GFM updated the Board on the following actions: TBPU-02 GFM confirmed this was not due until the end of September. TBPU-05 GFM confirmed this was due at the end of September TBPU-06 GFM confirmed this action is now closed TBPU-07 GFM confirmed due date end of November There were no other matters arising.

	1.5	**Chairman's Report** *for Assurance* AM reported the launch of the Kent Surrey and Sussex Physician Associates School. Well done to everyone who has been involved in developing this programme. **The Board noted the report.**
	1.6	**Chief Executives report** *for Assurance* PS presented the report, noting that NHS England and NHS Improvement had jointly published proposals for the national tariff as part of a consultation. The summary included two major changes. Firstly to set a national tariff for two years which would include two price lists, one for 2017/18 and the second for 2018/19. The second is to move from using HRG4 currency design to HRG4+ which is more detailed and accounts better for different levels of complexity. The Trust will be responding to the consultation which is due on 26th August and will share this with the Board. **Action: PS** **The Board duly noted the report.**
	1.7	**Board Assurance Framework (BAF) and Significant Risk Register (SRR)** *for Approval and Assurance* GFM presented the report noting that there are 13 risks to the trusts strategic objectives, 7 of which are recorded as key strategic risks and red rated. There are 10 significant risks recorded on the Trust risk register. The Executive Committee review the BAF on a monthly basis and updated actions and mitigations. There were no changes to the risk scores this month. **The Board duly approved and took assurance from the report.**
2.	**Safety, Quality and Patient Experience**	
	2.1	**Patient Story** *for Assurance* DH presented this month's patient story. A 65 year old lady presented to ED with shortness of breath, she had a significant health history of respiratory problems. A diagnosis was made of pneumonia and there was a delay seeing the patient due to ED being busy. Whilst waiting for a bed, the family took the patient to use the disabled toilet by Boots (chemist) as the ED toilet could not accommodate her wheelchair. The patient became unwell and collapsed. A medical emergency team (MET) call was made and the patient was transferred back to ED. The patient was then transferred to the high dependency area which has four beds in ED where one nurse looks after four patients. From our investigation it was not clear as to which nurse had been allocated to look after the patient in that area. However a junior nurse was asked to settle the patient into the bay and perform the initial observations. A misunderstanding arose at this point with the agency nurse believing that the junior nurse was to provide on-going care. This was not however what the junior nurse understood and she left to look after other patients in another area. The result was that whilst automated readings of pulse and blood pressure and oxygen saturation were being performed, no one was documenting or acting on these.

		When the agency nurse returned to the bay the patient was being reviewed by the medical team and during this review the patient became acutely unwell, reported that she could not breathe and suffered a cardiac arrest. A resuscitation call was put out and CPR commenced at which point the patient's partner confirmed to the team that the patient had an active DNAR decision in place. The team stopped CPR and the patient was pronounced dead. The post mortem examination confirmed the cause of death as pulmonary embolus. A Serious Incident (SI) was declared on basis of an unexpected severe outcome. PL asked about the outcome of the SI. DH confirmed that the root cause analysis was fundamental to the investigation and showed a lack of communication between staff, this was partly due to looking after patients in different areas and at the time there were more than 70 patients in ED. The daughter stated that she felt it was a combination of too many patients and not enough staff. And hopes there will be lessons learnt from her mother's story so it does not happen to someone else. AM thanked the patient's partner (Mr Scott) and her daughter (Ms Gibson) for attending the Board meeting and for being willing to share their story. PL also expressed thanks to the family for sharing their story. She also asked about the use and recording of electronic observations and whether we needed to strengthen this area. DH responded by indicating that if the observations had been recorded or automatically sent on to senior staff it may have alerted staff that additional interventions were required at an earlier stage. Ms Gibson commented that that If a member of the nursing staff had come back to check her mother's observations and blood pressure it could have meant a different outcome. DH explained the staff could have also questioned the initial diagnosis more. PB also thanked the family for their presence at the Board. Directing a question to FA he asked whether this was an agency nurse who was called away and left a junior nurse on her own and questioned whether there was a process to stop this happening again. In response FA explained there is a process and expectation when a nurse leaves an area she will report to her colleagues before leaving. However there was confusion between nurses as to who was doing what and who was looking after that particular group of patients. RS asked whether the miss-communication was further exacerbated due to the member of staff being an agency nurse and queried whether she knew the expected process. In response FA confirmed that although this was an agency nurse they were known to the Trust and had worked in the department before and therefore knew the processes. DH commented that the sequence of events could have been questioned. In response Mr Scott noted that hindsight was a fine thing. AM asked whether the outcome would have been the same. DH indicated that other interventions may have taken around an hour and therefore it was likely

		that the outcome would have remained the same. PS asked whether we have reassurance in relation to this four bedded area that patients are not just left without appropriate observation. DH confirmed that patients are not usually left without appropriate observation however this issue arose due to the confusion about which nurse was looking after this clinical area. DH also indicated that there may not have been sufficient alarm about the initial collapse. In response to a question from RD, DH confirmed that the right people with the right skills had initially looked after the patient as a senior doctor had reviewed the patient before and after her initial collapse. Reflecting back on the communication issues DH also noted that there should be opportunity to re-evaluate the diagnosis, ED was very busy with over 70 patients and the severity of the patient's condition should have been noted. DH also explained that the family had been involved in the investigation along with the key members of staff which then enabled the whole story to be revealed. AM asked what lessons were being taken from this story. In response DH confirmed that for the short term we are reflecting back to look at timely and appropriate communication, and revaluation of diagnosis. Looking with ED at a future discussion at a Board Seminar. Also ensuring that doctors and nurses focus more on the diagnosis and electronic observations. Ms Gibson felt that her mother had been left on a trolley/bed for at least two hours and no one took any notice and this should not happen to anyone else. AM thanked Mr Scott and Ms Gibson for their openness in sharing their story with the Board. Ms Gibson asked whether a copy of the minutes of the meeting once approved could be sent to her. **Action: GFM**. A Governor, who was present in the audience, commended the Board for the way in which the patient's story was presented and discussed. **The Board duly noted the patient story.**
	2.2	**Chief Nurse and Medical Director's Report** *for Assurance* The Board received and noted the report in advance of the meeting. FA reported that the Trust had delivered planned verses actual staffing profile for July. The report showed a stable picture in relation to overall compliance. The red shifts on Outwood ward were managed by the clinical team with no concerns regarding patient safety. In relation to Care Hours Per Patient Day (CHPPD) work is ongoing in the background regarding nursing staff that are now using the health roster system. In relation to the agency cap the Trust use Mayday nursing agency as the main tier 1 provider and at the current time the majority of these shifts are above the agency capped rate. The Trust has submitted an application to be a pilot site for the proposed nursing associates role. If the application is successful we could have 10 nursing assistants in 2017. The Trust has now appointed the new Deputy Chief Nurse for innovation and

		communication and she starts on 1st November 2016. She has come from BSUH where she has been running the outpatient's innovation programme. PS noted that agency spend is staying the same. In response FA noted that we are standing still in terms of vacancies. Exit interviews are not indicating a single focused reason why staff leave the Trust. **Medical Director's Report** DH presented the report noting that the Medical Director and the Chief Operating Officer had attended a summit with South East Coast Ambulance Service regarding ambulance handovers. The summit was useful and good discussions had taken place. It was agreed that a suite of metrics were required to ensure patients do not come to harm. PS asked with reference to the patient story shared earlier noting that we have had more ED attendances in July than we have ever had at the Trust and whether the summit addressed all the issues in relation to ambulance attendances. AS responded by confirming that the Trust was vocal on this point and identified a number of factors and points of actions but there was no clear resolution yet. SECAMB talked about hours lost and delays in handovers. Currently they are looking at a system wide escalation plan. **The Board duly noted and took assurance from the report.**
	2.3	**Safety, Quality and Patient Experience** The Board received and noted the report in advance of the meeting. RS reported that the committee sought information about changes being considered in the Care Quality Commission regime and assessment process of Trusts and will report to the Board when further information is available. In relation to the Quality Report our goal is to be within the top 20% of Trusts national for patient safety. The committee has requested a report setting out how this should be measured and what metrics where available. This will go back to the SQC. Complaints and PALS were discussed and the committee discussed the significance of complaints and the way we respond. The committee was well assured about the process of handling complaints which has led to a reduction in re-opened complaints. The main themes in both PALS and complaints were the same: appointments, poor communication and staff attitude. The committee asked for further assurance about the effect of actions taken at a divisional level. In relation to Children and Adults Safeguarding quarterly reports were received and there were similar themes in both areas. The biggest challenge is to ensure staff training requirements are met. One issue the committee discussed were the many concerns raised out in the community but the Trust does not get a response as it is not our role to hold others to account. We have agreed that the safeguarding board will give a presentation at a future meeting and we will continue to seek assurance in this area.

		AM noted we need to get assurance and highlight to the different bodies the importance of feedback so that the loop is closed. PL confirmed that this will be brought back to the SQC meeting and further updates on progress will be provided to the Board. **The Board duly noted and took assurance from the report.**
3.	**Operational Performance**	
	3.1	**Integrated Performance Report (M4)** *for Assurance*
	3.1.1	**Safety & Quality Performance Indicators** FA reported the headline for July was that there were 6 SIs declared. There have been five outbreaks of MRSA on one ward currently there is an investigation and once this has been completed the outcome will be brought back to the Board. AM asked what the target was in terms of numbers of cases and FA confirmed that the target was 0. RS confirmed that there had been a presentation at SQC on what steps we take to ensure prevention and the committee was assured. RS asked about VTE and how we achieve 95% every month for 12 months. AS responded by confirming that we have changed the way we work and we ensure that we record VTE assessments in Cerner. We review case notes to ensure VTE is recorded and once we get to 95% we stop recording as that is the standard. Often we achieve more than 95%. . DH reported that mortality is lower than expected for our patient group.
	3.1.2	**Operational and Access & Performance Indicators** AS stated that the 4hr ED standard was achieved 95.3% in July 2016. RTT continues to deliver against incomplete pathways, but referral growth from the south presents a significant risk. AS also noted that there had been a problem in Rheumatology related to waiting times for appointments. We have now resolved this by focusing these consultants from the wards to concentrate on clinics. Cardiology has seen a huge increase in managing outpatients and referrals. In relation to ambulance handover we are currently undertaking a pilot in ED and early indicators show this is doing well. AS will bring back an action plan to the Executive Committee meeting for approval once the pilot is complete. Risks remain as before in our ability to deliver in the winter. AM asked whether the STP Trajectory is included and AS confirmed this related to the STF. PS also indicated that we may not need to include if we continue to meet our financial plan. AS confirmed it was still a struggle to maintain on a day to day basis and our winter plans will need to be robust to ensure that we will we manage. Last year we were achieving and this year we are but managing but this is still hard. Green does not always suggest it is easy to maintain all our standards.

	3.1.3	**Patient Experience** FA noted that our FFT scores for both ED and inpatient wards have dropped slightly in July. Maternity have achieved the highest FFT score for over a year. We will be launching our open visiting in early September to help families and believe there will be a value in their support with family members in hospital during ward rounds. Two Shadow Governors have agreed to become part of the Patient Experience Committee.
	3.1.4	**Workforce Performance Indicators** FA reported that retention has increased and sickness levels have decreased to 3.4%. Attendances for MAST training has increased, Achievement reviews are currently at 42% but there is still work to be done to reach the target of 90% by the end of October 2016. RS asked whether the outcome of the EU Referendum will effect recruitment and retention. FA responded by noting that initial concerns have settled but there has been a drop off in the number of European nurses available. AM asked what about recruitment of doctors. DH explained the biggest area we are having problems recruiting is Ophthalmology; we will now try to recruit abroad and continue to support the team. However across the region obstetrics and gynaecology have a vacancy rate of 25%.
	3.1.5	**Finance Performance Indicators** PS reported that year to date at month 4 the I&E deficit was £3.0m, £1.9m better than the planned deficit of £4.9m. The Trust has hit its quarter one financial targets and will be paid STF funds of £2.4m. The hospital has been very busy during the summer months. Month 4 sees income reduce for day cases and outpatients, with inpatient non-electives continuing to track below plan. As a result the risk to the forecast has been increased to £7.2m from £6.2m (excluding STF payments). Agency costs are stable but £115k adverse to the NHS Improvement plan. We need to reduce our agency spend and to increase our day cases and elective work to bring us on track for month 6. Cash is currently on track and helped by the £2.4m STF received from NHS Improvement. The Trust has drawn down £7.3m of its 2016/17 revolving working capital to pay our debtors. The Trust has applied for a £15.9m Capital Resource limit in the 2016/17 plan submission. The Trust is owed £3m from NHS Improvement in respect of the 2016/16 Capital Resource Limit undershoot. DH asked how we achieved £1.9m better than plan. In response PS confirmed that due to the fact there had been no further junior doctor's strikes we lost no income for elective work (which had been in the plan) and in months one to three other income categories were better than plan. **The Board duly noted and took assurance from the report.**

	3.2	**Finance & Workforce update** RD introduced the report highlighting the post implementation report for the Macmillan Centre on 27 January opening which came in below the planned capital budget and would like to congratulate everyone involved. RD reported that the committee noted that for the Cardiology Unit the Trust invested £4m for a new Lab with the initial aim to increase NHS activity including private patients. The development of private patient's scheme has not happened due to capacity constraints in the hospital. The Committee discussed the SASH+ work and new ways of working with the three value streams. A paper on the future income plan would be produced and shared with the FWC at a future meeting. **The Board duly noted and took assurance from the report.**
	3.3	**Audit & Assurance Committee Update** PB introduced the paper highlighting that the Audit Committee updated its Terms of Reference to include responsibilities as the Audit Panel which will tender for external audit services and will make their recommendation to the Board. The Audit Panel would include additional membership of either the Chief Finance Officer or the Director of Corporate Affairs. **The Board duly noted and took assurance from the report and duly approved the updated terms of reference of the Audit and Assurance Committee.**
4.	**Risk, Regulatory and Strategy Items**	
	4.1	**Consultant Re-Validation Statement of Compliance -** ***For approval*** DH presented the report which is an important piece of work which Adam Stacey Clear, as the Responsible Officer for Revalidation is responsible for. The Board noted that Mr Stacey Clear reads every appraisal form. This is an annual requirement for all 300 doctors for revalidation which shows that a doctor is up to date and fit to practice through appraisal and clinical governance. This year the presentation listed those doctors that had late appraisals without prior permission. These have now all been completed. PL asked who had oversight of the complete process and could raise any concerns. In response DH confirmed that Mr Stacey-Clear had full oversight and meets regularly with the Trust Medical Director. Also any concerns could be discussed directly with the GMC. DH and AS-C also attend quarterly meetings with the GMC Officer. The Board has the ability to reject any revalidation as this would come to the board for approval. PL thanked DH for this assurance. PB asked whether consultants doing private work are covered by revalidation cover this. DH confirmed that private patient work is also included. AM confirmed that this is a very good position for the Trust and passed on this thanks on behalf of the Board to Mr Stacey-Clear.

		The Board duly noted and took assurance from the report and approved the annual consultant re-validation statement of compliance.
	4.2	**Shadow Councilor of Governors update** – for assurance GFM fed back on the most recent meeting from the Shadow Councillor of Governors meeting held on 12th July. The meeting was well attended with very positive input from all governors. The key focus on of this meeting was: ➢ Update form CEO Michael Wilson ➢ Presentation on the development of the STP ➢ Update from the Governors ➢ Update from Membership Development Group The shadow council group noted the resignation of the nominated governor from East Surrey CCG due to current work pressures. DH raised the point that it is quite important that we continue to have a representative from the East Surrey CCG so it was agreed we should seek a new nomination. **Action: GFM** **The Board duly noted and took assurance from the report.**
	Other Items	
5	**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** The minutes of the Committee were noted with no questions raised.
	5.2	**Any Other Business** No further business was discussed by the Board.
	5.3	**Questions from the Public** One formal question from the public had been received in writing in advance of the meeting which was a question from Jane Ritchie a shadow governor: Who monitors recruitment and retention of staff other than doctors and nurses and do they report to the board? Is the Board aware of any problems and will an increase in these staff be required before a "truly seven-day" service" can be implemented by 2020 as promised by the government. DH responded to the question by confirming that Divisions and the Executive team receive monthly information on vacancy levels and retention of all staff for monitoring and action within services. This information is considered at the Trusts Workforce Committee (which is a sub-committee of the Executive Committee) and also at the and Finance & Workforce Committee which is a sub-committee of the Board. DH noted that we quite often talk about doctors and nurses and allied health professionals in our reports but maybe we should review and give a more

		rounded report on all staff. Will take away this suggestion for further consideration. In terms of seven-day services this is a priority for the Trust and we currently provide regular information on our progress to NHS England. A number of our services are already provided 7-days a week; however there is clearly more work to do across the whole NHS to achieve the government commitments.
	5.4	**Review of the Meeting** The Board agreed that the patient story was a very important part of the meeting and commended the family for being willing to come to share their story. Overall was a good meeting.
	5.5	**Date of the next meeting** **Thursday 29th September 2016** at 11.00am in Room AD77, Trust Headquarters, East Surrey Hospital The Chairman confirmed that the **Trust Annual General Meeting** would take place on **Thursday 29th September 2016 at 6.00pm** in the Post Graduate Education Centre.

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:**