Brighton and Sussex University Hospitals NHS Trust

MINUTES OF THE MEETING OF THE BOARD OF DIRECTORS

6 JULY 2015

Board

Julian Lee	Chairman
Lewis Doyle	Non-Executive Director
Antony Kildare	Non-Executive Director
Professor Malcolm Reed	Non-Executive Director
Dr Farine Clarke	Non-Executive Director
Stephen Woodford	Non-Executive Director
Christine Farnish	Non-Executive Director
Matthew Kershaw	Chief Executive
Spencer Prosser	Chief Financial Officer
Sherree Fagge	Chief Nurse
Amanda Fadero	Director of Strategy and Change

In Attendance

Dominic Ford	Director of Corporate Affairs
Keith Altman	Deputy Medical Director
Mark Smith	Interim Chief Operating Officer
Romesh, Rasanayagam	Clinical Director, Perioperative (item 7.2)
Steve Drage	Deputy Medical Director (Safety and Quality) (item 7.7 and 7.8)
Rick Strang	Director or Emergency Care (item 7.9)
Sally Howard	Director of Scheduled Care and Service Transformation (item 7.9)
Duane Passman	Director of 3Ts (item 7.14)

7.1 CHAIR'S WELCOME AND APOLOGIES FOR ABSENCE

Apologies were received from Michael Edwards and Kirit Patel, Non-Executive Directors, and Stephen Holmberg, Medical Director.

7.2 CLINICAL TEAM PRESENTATION – PERIOPERATIVE

The Clinical Director for Perioperative Services described the services provided by the Perioperative Directorate and its organisational structure. The services comprised the level 5 Theatres, Theatre Admissions Unit and Main Theatre Recovery at the Royal Sussex County Hospital (RSCH); Sussex Eye Theatres; Lewes Victoria Hospital Day Unit and theatre; 5 theatres, day theatre and Hurstwood Park theatre, day stay ward and pre-operative assessment at the Princess Royal Hospital.

The directorate had 114 whole-time equivalent (wte) medical staff with over 60 anaesthetic consultants and 48 junior doctors; 267 nursing staff and 101 staff in the Sterile Services Department (SSD), supported by a small group of administrative staff.

The annual budget of the directorate was £28.7m, derived from internal trading with admitting specialties, with 84% of the budget comprising pay, evenly split between medical and nursing staff and 16% non-pay.

The directorate performed 17,000 of the Trust's 27,000 operations each year, while providing anaesthetists for all operations, a number which would increase through site reconfiguration and new operating lists. It had a key role in supporting the Trust meeting its Referral to Treatment (RTT) targets by maximising theatre capacity and responding to 7 day requests. It also assisted the Trust with its cancer targets, ensuring clinical prioritisation through the cancer patient priority bed pass.

The directorate had a strong focus on safety and quality, minimising the use of agency staff and ensuring the requirements of the WHO checklist were adhered to. The directorate prioritised dedicated clinical governance sessions to enable this. There was also a bi-Monthly Trust Theatre Group, led by the Directorate Lead Nurse to share good practice with other theatres and ensure the recommendations of the external Theatres Review were implemented.

The directorate had ongoing concerns about patient safety through the inappropriate placement of patients in theatre recovery which had been highlighted at the Clinical Management Board. The directorate was also seeking to maximise theatre efficiency and utilisation looking at cancelled sessions and opportunities for increased capacity and start times and turnover times in theatre. A trial of fee per case for weekend lists at PRH was also being undertaken.

The directorate's key objectives were to manage and support the changes arising from site reconfiguration; expand the opening times of the temporary Theatre Admissions Unit to improve flow and patient experience; and complete the build of the Theatre Admissions Unit at RSCH. Approval was awaited for more theatre capacity through the second day case theatre at PRH and the service continued to push for improved patient flow to stop the inappropriate placement of patients in recovery.

The Board discussed ownership of the WHO checklist and the Clinical Director advised that the process was led by the Operating Department Practitioners (ODPs), with the participation of theatre and surgical staff, as required, in the different stages of the process. The Clinical Director further advised that participation in the WHO checklist was very good in theatres at the Trust, although further work was required to develop its application in radiology, cardiac and chronic pain procedures.

The Board further discussed how the directorate measured its productivity and the Clinical Director advised that its activity was submitted to a national data set which enabled comparison with other Trusts, in terms of activity per session, and the Trust was broadly a median performer. Work was being undertaken to reduce the cancellation of sessions, and review start times and turnover. The Clinical Director noted that theatre efficiency was greater on sites which were less subject to the impact of challenges arising from patient flow. The Board discussed the impact on patient safety of the placement of patients inappropriately in theatre recovery and the Clinical Director confirmed that while difficult decisions had to be made about where patients were placed when patient flow was challenged, this was a significant concern and had become a recurring problem. There were also concerns about the impact on patients of cancelled operations and the priority bed pass for cancer patients had been developed

to enable a clear process for clinical prioritisation when required. The Board also noted the importance of available ITU and HDU capacity in minimising cancellations.

The Chairman thanked the Clinical Director for his presentation.

7.3 DECLARATIONS OF INTEREST

There were no declarations of interest.

7.4 MINUTES OF THE PREVIOUS MEETING

The minutes of the meeting held on 6 June 2015 were approved as a correct record.

7.5 MATTERS ARISING FROM THE PREVIOUS MEETING

The Board noted the items detailed under the progress log.

7.6 REPORT FROM THE CHAIRMAN AND CHIEF EXECUTIVE

Chairman's Report

The Chairman noted his attendance at recent system-wide meetings.

Chief Executive's report

The Chief Executive reported on the successful completion of the site moves including the move of neurosurgery to the RSCH site, and the establishment of single site fractured neck of femur and urology pathways at PRH during the weekend of 19th to 21st June and thanked the staff across the Trust who had worked to make the move a success. The Chief Executive noted the strategic importance of the site reconfiguration programme in enabling the Trust to undertake its role as a Major Trauma Centre.

The Chief Executive also advised that the Trust was continuing to work with the NHS Trust Development Authority, NHS England, the Department of Health and HM Treasury to progress the approval of the 3Ts Full Business Case and helpful discussions in this regard had taken place at the National Programme Board on 3rd July.

The Care Quality Commission carried out a two-day unannounced visit to the Trust on 22nd and 23rd June, focused on the Acute Floor at RSCH, and including a short visit to the Emergency Department at PRH. The Trust was now waiting for formal feedback on the outcome of the visit from CQC and would use this feedback and the recommendations of the Emergency Care Intensive Support Team (ECIST), to make the further required improvements to emergency and unscheduled care. This would also be discussed in detail later in the meeting.

The transfer of Soft Facilities Management (FM) services from Sodexo to the Trust would now take place on 1st September to ensure that all of the issues relating to the transfer were resolved.

The initial feedback from the GMC visit in May had been positive. No areas of significant concern had been identified and the visit had found a number of areas of good practice.

The Trust's annual research strategy day had been held on 22nd June which demonstrated the wide spread of research activity and enthusiasm for research within the Trust. The implementation rollout of the Values & Behaviours (V&Bs) programme continued to make good progress and would also be discussed later in the meeting.

The Board noted the report.

STRATEGY

7.7 SAFETY, QUALITY AND PATIENT EXPERIENCE STRATEGY

The Deputy Medical Director (Safety and Quality) introduced the Trust Safety, Quality and Patient Experience Strategy, which had previously been discussed at the Quality and Risk Committee, and advised that the Strategy was framed around six key questions which were important to patients, their families and their carers and how the Trust would address those questions to ensure patient safety and quality. The Strategy also comprised the projects which would enable this and the governance of the implementation of the Strategy.

The Chairman noted the importance of the Strategy and asked how it would be monitored and the Deputy Medical Director confirmed that this would be through the established safety and quality governance arrangements, in the clinical directorates and through their reporting to the Executive Safety and Quality Committee and also including the Quality and Risk Committee and Board. The Board discussed how improvements and learning was undertaken following Serious Incidents (SIs) and the Deputy Medical Director advised that lessons were learned and triangulated from SIs, complaints, regulation 28 letters and safeguarding reviews, and implementation tested through the clinical audit programme. The Deputy Medical Director further advised that it was also important for the Trust to develop its quality improvement (QI) capability, through the agreement of an approved QI methodology and staff trained in its use. The Director of Strategy and Change advised that discussions were taking place with Health Education England, Kent Surrey and Sussex (HEEKSS) to progress this, and also with TDA and the outcome of those discussions would be reported to the Board.

Action: Director of Strategy and Change

The Director of Strategy and Change added that the triangulation of lessons learned had been developed in, for example the Acute Floor Directorate, and monitored through its performance review, adding that the projects in the Trust Quality Account were also being mapped against the ten high impact changes to ensure that safety and quality was understood as everyone's business within the Trust.

The Board discussed the audience for the Strategy and its accessibility for patients and it was noted that a short version was planned, together with internet access to the Strategy. The Board also noted the importance of the Strategy and an agreed Quality Improvement methodology in supporting the recruitment of clinical staff.

The Board approved the Safety, Quality and Patient Experience Strategy

7.8 QUALITY ACCOUNTS 2014/15

The Deputy Medical Director (Safety and Quality) introduced the Trust Quality Account 2014/15, advising on its alignment with the Safety, Quality and Patient Experience Strategy. The Board was advised that the draft Quality Account had been considered by the Quality and Risk Committee and revised subsequently.

The Board approved the Quality Account 2014/15

OPERATIONAL AND FINANCIAL PERFORMANCE

7.9 BOARD PERFORMANCE DASHBOARD

The Chief Executive introduced the Board performance dashboard, advising the Board on the ongoing challenges to performance against the Accident and Emergency, Referral to Treatment (RTT) and cancer standards, and the recovery plans and trajectories which had been developed to improve performance in these areas.

Emergency and Unscheduled Care

The Chairman noted the challenges outlined by the Chief Executive and asked how the Board could be assured of and confident in the plans which had been developed in securing the improvements required.

The Director of Strategy and Change advised the Board that the Trust had not delivered sustained performance against the Accident and Emergency standard for some time. The key components of the urgent care recovery plan comprised enhancing capacity, particularly at RSCH but across the health and social care system; improving internal systems and processes, linked to the ECIST recommendations; and enabling clinical engagement and behavioural change to secure improvement. This included the development of capacity outside the hospital at Newhaven Downs and internally, including the additional capacity on Plumpton ward. The Director of Strategy and Change noted that the opening of the Newhaven Downs facility had been slower than desired, but the nursing workforce had now been recruited, and 20 beds would be opened in October and 20 more beds later in the winter period.

The Director of Strategy and Change further advised on the implementation of the ECIST recommendations including early discharge, the SAFER care bundle and the redesign of the care system in the acute floor, with the intention of developing earlier clinical decision-making in the patient pathway, ensuring better streaming of patients, developing ambulatory care and enhancing the capacity of the Surgical Assessment Unit. The Director of Strategy and Change also noted the planned system-wide improvements led by the CCG.

The Board discussed clinical engagement in the planned service improvements and in improving patient flow and the Director of Strategy and Change noted the leadership of the Clinical Directorates in designing the service changes but that further work was required to ensure broader ownership by clinicians of the challenges faced by the hospital and their resolution.

A Non-Executive Director asked about the implementation of the ECIST

recommendation regarding assessment and streaming and the replacement of triage with a clinical navigation role, and supported this recommendation from her observations of the acute floor and cohort area.

The Board further discussed the timeline for change, including the opening of the extra capacity, the need for focus on this area and the consequent need to re-prioritise in other areas and the confidence of the Executive team in achieving sustained improvement. The Director of Strategy and Change agreed that some developments would need to stop to enable the focus on improvements to patient flow.

The Chair of the Quality and Risk Committee noted that changes in levels of activity did not appear to explain the worsening of performance and the Director of Strategy and Change advised that the higher levels of acuity of patients conveyed to hospital had a significant impact on admissions and lengths of stay.

The Board asked when improvements in performance would be secured and the Director of Strategy and Change confirmed that the plan was to achieve 85% performance by the end of August and 90% by October.

Scheduled Care/Referral to Treatment (RTT)

The Director of Scheduled Care and Service Transformation introduced the report on RTT standards advising the Board on the scale of the challenge to delivering compliance with the recovery plan by October 2015 and the significant risks to delivery in individual specialties, including Digestive Diseases, oral surgery, orthopaedics and neurosciences. The Director of Scheduled Care and Service Transformation also advised the Board on the challenges to cancer waiting times and diagnostics.

The Director of Scheduled Care and Service Transformation noted that the Clinical Management Board had approved the Patient Access Policy which would provide a framework for the recording and reporting of activity and performance.

The Chair of the Quality and Risk Committee noted the importance of a stronger focus on elective care and the alignment of capacity and demand in building the foundations for improvement, together with process improvements to reduce the cancellation of clinics. A Non-Executive Director also reported on his recent visit to the Booking Hub, when the cancellation of appointments had been discussed and its impact on patients.

The Board discussed clinical engagement with the recovery plan, noting the important role of the Clinical Directors in leading improvement but also the need for broader clinical involvement.

The Board noted the current programmes of work underway and next steps and the associated risks in relation to delivery of performance against the Accident and Emergency and RTT standards

7.10 FINANCE REPORT

The Chief Financial Officer advised the Board that the Trust was reporting a £7.5m deficit at Month 2, £1.4m behind the plan submitted to the TDA.

Financial performance reflected continuing pressure on pay costs which were £1.7m above plan, arising from capacity pressures and agency costs for nursing and medical locums. Non-pay costs were also over plan by £0.7m. Income was £1m ahead of plan in the year to date. The cash position was tight and a working capital facility had been agreed with TDA.

A financial recovery plan was underway with a series of additional controls and targeted actions in place and agreed with the Clinical Directorates.

The Chief Financial Officer further advised that the TDA had not yet signed off the financial plan, noting the broader financial challenges across the acute sector.

The Board discussed the additional financial controls and the Chief Financial Officer advised that this included tight controls on agency spend and the increased use of purchase orders. The Chair of the Finance and People Committee noted the challenges to delivery of the CIPs programme and the varied engagement with CIPs plans The Board further discussed how performance could be incentivised and the alignment of quality and efficiency and it was noted that an earned autonomy process was in place with more and less frequent scrutiny of Clinical Directorates according to their performance.

The Board noted the Month 2 position and the identified risks and mitigations to the financial plan

SAFETY AND QUALITY

7.11 INFECTION PREVENTION AND CONTROL

The Chief Executive introduced the infection prevention and control report, noting that there had been 5 cases of *C. difficile* in May, slightly behind the trajectory and performance in this area continued to be monitored closely.

The Board discussed the frequency of the Board report on infection prevention and control and it was advised that it was a useful barometer of broader quality performance and that the current frequency of reporting should be retained, subject to review.

The Board noted the incidence of infections monitored both nationally and locally and the priorities of the IPC team over the coming months

WORKFORCE

7.13 VALUES AND BEHAVIOURS

The Director of Strategy and Change updated the Board on the Values and Behaviours Programme, advising that the programme was now being led and managed in-house. The key areas of development were: aligning People processes with the behavioural blueprint; the Leading the Way Too programme which would provide leadership and management development for over 500 managers from October; and targeted work to improved appraisal and staff engagement.

The Board discussed how the Trust obtained feedback from staff and the Director of

Strategy and Change advised that there were ongoing processes of staff feedback through meetings, wider staff engagement and surveys.

The Board noted the progress report and the plans for 2015/16

7.14 REPORTS FROM COMMITTEES AND PROGRAMME BOARDS

Audit Committee

The Board noted the report from the Chair of the Audit Committee.

3Ts Programme Board

The Director of 3Ts advised that overall, progress remained on plan, with the final FBC approval envisaged at the end of July 2015, with a start to the main scheme construction in January 2016.

The Chief Executive further advised that approval of the FBC in July was key to enabling the main scheme to commence in January 2016, and the Trust continued to work with partners to enable this.

The Board noted the report.

GOVERNANCE

7.15 TDA SELF-CERTIFICATION

The Board reviewed the monthly self-certification to TDA which included a declaration of non-compliance with 3 statements: 2 of those areas of non-compliance deriving from the outcome of CQC inspections, and 1 concerning ED performance.

The Board approved the declaration.

7.16 RULES OF PROCEDURE

The Director of Corporate Affairs advised that the revised Rules of Procedure incorporated the changes to the terms of reference of the Board Committees approved by the Board in April 2015 and the revised Executive Management Committee structure.

The Board approved the Rules of Procedure

7.17 OPPORTUNITY FOR MEMBERS OF THE PUBLIC TO ASK QUESTIONS

There were no questions from members of the public.

7.18 ANY OTHER BUSINESS

There was no other business.

7.19 DATE OF NEXT MEETING

The next meeting will be held on Monday 24 August 2015 at 9.30am in the Euan Keats Education Centre, Princess Royal Hospital.

7.20 CLOSED SESSION RESOLUTION

The Board agreed that representatives of the press and other members of the public be excluded from the remainder of this meeting having regard to the confidential nature of business to be transacted, publicity on which would be prejudicial to the public interest.