Minutes of the BOARD OF DIRECTORS held on Wednesday, 19th October 2016, in Seminar Room 1, Clincial Skills Centre, RoyalHallamshire Hospital

PRESENT: Mr. T. Pedder (Chair)

Mr. T. Buckham	Ms. K. Major
Sir Andrew Cash	Mr. J. O'Kane
Professor H. A. Chapman	Mr. N. Priestley
Mr. M. Gwilliam	Professor Dame Pam Shaw
Mrs. C. Imison	Mr. M. Temple
Mrs. A. Laban	Dr. D. Throssell

APOLOGY: Ms. D. Moore

IN ATTENDANCE: Mrs. S. Carman, Mrs. J. Phelan, Miss S. Coulson (Minutes)

Ms. L Socci, Ms J. Wild } STH/184/16(a)

Dr. C. Bates, Dr. H. Parsons } STH/185/16 & STH/186/16

OBSERVERS:
4 Governors
2 Members of Staff
1 Member of Public
Ms. N. Hartley (Assistant Director of Human Resources)

STH/181/16

Declarations of Interests

Annette Laban declared that she was a Non-Executive Director of Marie Stopes International.

STH/182 /16

Minutes of the Previous Meeting

The Minutes of the Previous Meeting held on Wednesday 19th September, 2016, were **AGREED**, **APPROVED** and **SIGNED** by the Chairman as a correct record.

STH/183/16

Matters Arising:

(a) Junior Doctors Contract

(STH/170/16(b)) The Director of Human Resources briefed the Board on recent developments. The periods of industrial action announced at the last Board meeting for September, October and November 2016 had all been stood down after consideration by the BMA.

The junior doctors' contract had been introduced nationally and went live in October 2016, although it would not affect any staff at STH until December 2016.

The Trust had not received any further information on any future action that might be taken. There had been very little discussion since the strike actions had been stood down.

The Medical Director reported that four Listening into Action (LiA) events focussing on junior doctors had been set up in liaison with Jaki Lowe, LiA Lead. He also reported that Paula Eyre, Head of Medical Personnel, had offered to have 1:1 meetings with F1 doctors to go through the contract and some had taken up the offer.

(b) Clinical Update: Public Health in Maternity Care: A Patchwork of Priorities

(STH/171/16) The Chief Nurse explained that further to discussion at the September 2016 meeting a comprehensive report on the Trust's smoking cessation levels compared with other core cities across the country had been circulated with the agenda papers (Enclosure B).

(c) Short Term Intervention Team (STIT)

(STH/170/16(a)) The Director of Strategy and Operations reported that the Trust was seeing an increase in the queue of patients waiting to get into STIT and that the Sheffield City Council were not delivering the agreed number of packages of care. She reported that the position was creating significant operational pressures within emergency services and throughout the wider Trust because of the inability to discharge patients.

The Chief Executive has written to the Sheffield City Council and it had been agreed that an external review on STIT and CICS (Community Intermediate Care Service) was required as the current model was not sustainable. However, that would take time so alongside that the Trust needed a crisis response to the current position.

The Director of Strategy and Operations reported that she had attended a session with representatives of the Sheffield City Council and the Clinical Commissioning Group earlier in the week to discuss a recovery plan but emphasised that the task was hugely challenging. A higher number of basic staff was required than currently in place to run the service. At present there were only 100 members of staff to run the service compared to 200 which was the previous establishment. The Sheffield City Council had made the staff redundant and retained the savings.

The Chief Executive and Chairman stated that the time had arrived for the Board to formally record its disappointment at the position that had been reached and a formal communication from the Board would be sent to the Sheffield City Council stating that the model of employing public employees and employees from the independent sector to provide the STIT service was the wrong strategy and model as demonstrated by the number of times the service had collapsed. It was not possible to rely on the fragility of the independent sector and continually going out to tender for the service was not viable.

Action: Tony Pedder/Andrew Cash

This was an extremely serious issue for the Trust and it needed to be resolved as Winter was fast approaching. A new model needed to be implemented which delivered a smooth seamless service for patients.

Annette Laban and Martin Temple reported the support of the Healthcare Governance Committee and the Finance, Performance and Workforce Committee for this course of action.

Annette Laban commented that some organisations were now managing their own nursing home beds.

In answer to a query about how this fitted in the with STP, the Chief Executive explained that the STP was too high level at this stage but potentially in due course this aspect of social care may become part of healthcare.

STH/184/16

Providing Patient Centred Services:

(a) Clinical Update: Enhanced Recovery after Thoracic Surgery

The Chief Nurse introduced the item and Ms. Laura Socci, Consultant Thoracic Surgeon, and Ms. Jane Wild, Matron Practitioner were in attendance.

Ms. Socci gave a detailed presentation on Enhanced Recovery After Surgery (ERAS). The key points were:

- ERAS was a multimodal perioperative care pathway designed to achieve early recovery for patients undergoing major surgery.
- ERAS has been proven to reduce duration of post-operative care by 30% and reduce postoperative complications by 50%.
- ERAS improved the patient's experience and recovery after major surgery and could lead to a significant reduction in length of stay and potentially shorter waiting times due to a higher or faster turnover of patients.
- ERAS has also been established successfully in Colorectal Surgery, Gynaecology and Upper Gastrointestinal Surgery.
- Patients were mobilised two hours after their operation with portable drains fitted which allowed them to be more mobile. They were also prescribed a standardised analgesia regimen instead of an epidural. It was acknowledged that discharging patients home with portable chest drains did cause more work for community staff. However the community staff were able to contact the ward at any time if they had a problem.
- The Trust was not seeing any re-admissions as a result of early discharge.
- Patient education was key to ERAS as it was a partnership between the hospital and the patient. Although at the present time education sessions were not delivered due to the lack of financial resources together with difficulties in releasing staff from the wards to deliver that education. It was noted that carers and relatives also found the education sessions very helpful.
- Patient feedback was extremely positive.
- The appointment of an Advocated ERAS nurse had not been approved due to lack of financial resources.

During discussion the Communications Director asked if the Team had considered using videos and other social media to deliver the education sessions and offered to meet them to discuss various options outside the meeting.

Action: Julie Phelan

The Chief Nurse agreed to look at the provision of an ERAS nurse.

Action: Hilary Chapman

The Chairman thanked Laura Socci and Jane Wild for a very interesting presentation.

STH/185/16

Chief Executive's Matters

The Chief Executive referred to his report (Enclosure C) circulated with the agenda papers and invited each Executive Director to give a report on their respective areas in the Integrated Performance Report (Enclosure C1)

- Integrated Performance Report

  - Deliver the Best Clinical Outcomes/Report from Healthcare Governance Committee (HCGC)

    The Medical Director highlighted the following points:

    - Eight new serious incidents had been reported over the two month reporting period and all were under investigation.

    - The HCGC received a presentation on the Trust's approach to reduce patient falls. A number of initiatives had been put in place including, the testing of 'safety huddles' on a small number of wards and that approach had produced significant reductions in the number of reported patient falls. Frontline teams were actively being encouraged to work with the Improvement Academy to increase the uptake of that approach. It was acknowledged by the Committee that further work was required to reduce further the number of reported falls particularly those that resulted in significant harm.

      Dr. Peter Lawson was leading on a piece of work on falls management but there was still a significant amount of work to do on the environment and how patients were managed especially patients treated in single rooms.

      In response to a question, the Medical Director stated that it was difficult to compare STH's performance with that of other Trusts as there was no definition of what constituted a fall so therefore it was not possible to compare like for like. However he stated that STH believe it had a lower threshold for reporting than other Trusts.

    - The resuscitation equipment update described improvements in performance relating to the checking of resuscitation trolleys, though further work was still required. A number of initiatives had been put in place, including the training of 350 support workers to perform the equipment checks, and exploration of the possibility of remote electronic monitoring of defibrillators. Monitoring of incidents confirmed that no patient safety risks relating to resuscitation equipment had been reported.

- The Hospital Mortality Report highlighted:
  - HSMR – Most recent 12-month rolling 1st June 2015 - 31st May 2016 (updated 18th August 2016) - 99 (95-104) for All Admissions and "as expected" when compared with hospital trusts nationally. HSMR was updated monthly.

- SHMI – Most recent 12-month rolling:
  - 1st January 2015 – 31st December 2015 (published 23rd June 2016) - 0.94 (0.90-1.11 over-dispersion control limits of 95%). This was in the "as expected" range and rebased. SHMI was updated three-monthly. The next publication was expected 22nd September 2016.

- Crude Mortality – Most recent 12-month rolling:
  - January 2015 – 31st December 2015 - 3.18 (3539 deaths / 111,388 spells) vs. national rate of 3.26 for all non-specialist acute providers

The Chief Nurse reported that disappointingly the performance on control of infection was not where she would like it to be and more detail would be given in the Deep Dive report by the Director of Infection Prevention Control.

- Provide Patient Centred Services

The Chief Nurse highlighted the following points:

- Complaints – 90% of complaints were responded to within 25 working days.

- FFT response rates inpatient – the response rate in August 2016 was 30%, which was in line with the internal target.

- FFT response rates A&E– the response rate in August 2016 was 22.3%, which was above the internal target of 20%.

- FFT score inpatient – the score for August was 97%, which was above the internal target of 95%.

The Director of Strategy and Operations highlighted the following points:

- The number of referrals received in August 2016 was 0.6% above target. For the year to date there had been 5.9% more referrals than expected.

- New outpatient activity was 6.3% below target in August 2016 and was 6.6% below target for the year to date.

- Activity levels were below target in August 2016 and the Trust was working through a whole host of issues across the organisation regarding pathways and processes to get back on track. In addition there was a huge amount of work taking place with the operating directorates regarding filling clinics and theatre lists.

- In August 2016 there was an average of 113 patients whose discharge was delayed compared to 110 in July 2016

- The number of patients on incomplete pathways at the end of August 2016 was 46,257 compared to 50,264 at the end of July 2016, 48,870 at the end of June 2016 and 51,805 at the end of May 2016. As at the end of September 2016,

43,019 of those had a waiting time of less than 18 weeks (93%) and therefore the national target was achieved.

- The local waiting time standard for non admitted patients was not achieved in August 2016, with 92.5% of patients being seen within 18 weeks against a target of 95%.

- In August 94.3% of patients attending A&E were seen within 4 hours compared to the standard of 95% but was in line with the improvement trajectory agreed with NHSI and NHS Sheffield CCG of 94%

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- For quarter 1 all the cancer waiting time targets were met except for 31 day decision to treat to treatment and the 62 day GP referral to treatment target. The key challenge within STH on those two indicators was urology capacity. An extensive Chief Executive led recovery plan was developed and has been enacted to improve performance. The current position for cancer waiting times for quarter 2 showed all the standards being met apart from the 62 day GP referral to treatment target. The performance for all pathways as at 26th September 2016 stood at 81.6% against a target of 85%. However, the performance for STH originated pathways stands at 90%.

- For diagnostic tests, during August 2016, 97.78% of patients were seen within 6 weeks compared to the target of 99%. The target was missed by only 97 patients. There were 97 tests overall where the target was not met and those were in Peripheral Neurophysiology, Urodynamics and Cystoscopy.

- The percentage of patients whose clinical handover from the ambulance service to A&E took longer than 15 minutes had improved for the fifth consecutive month to 68.9%. The number where the handover took more than 30 minutes had improved since last month with only 0.25% taking more than 30 minutes.

The Chairman commented that there had been a lot of interest in the national media recently about ambulance turnaround times. The Director of Strategy and Operations stated that the Yorkshire Ambulance Service performance had continued to improve month on month over the last five months. She felt it would be useful and timely if next month's Deep Dive focussed on ambulance performance.

Action: Kirsten Major

Concern was expressed at the percentage of outpatient appointments cancelled by patients and whether it would be possible for the Trust to send Choose and Book to patients rather than via GPs. The Director of Strategy and Operations agreed to look into that suggestion and if possible would arrange for it to be piloted in a suitable clinic.

Action: Kirsten Major

- Deep Dive – Infection Control

Dr. Christine Bates, Director of Infection Prevention Control, and Dr. Helen Parsons, Consultant Microbiologist, was in attendance and gave a presentation on the Trust's performance on infection control. The key points to note were:

- MRSA - There had been zero cases of MRSA in 2015/16 but the Trust had recorded 2 MRSA bacteraemia early in 2016/17. STH had taken the decision not to reduce screening patients for MRSA unlike other organisations.

- *C.difficile* was affecting both campuses. In 2015/16 the Trust recorded 78 cases and as at the end of September 2016 it had already recorded 52 cases. In the main the cases presenting were >8 days after admission and therefore there was an increased likelihood that the infection had been contracted within the hospital. A root cause analysis was undertaken into each case and patients were isolated immediately. The Trust was looking at the management of patients with diarrhoea and practices for cleaning of commodes as it was thought that may be a particular problem.

- An Action Plan was in place and was monitored by the Healthcare Governance Committee which Dr. Bates attended on a regular basis. The Infection Control Team also met on a monthly basis to work through the plan.

- MSSA - In terms of MSSA bacteraemia STH performed relatively poorly compared to other similar sized Trusts. It recorded 43 cases in 2014/15, 72 in 2015/16 and as at the end of September 2016 35 cases had been recorded.

  The plan was to pilot decolonisation of patients on admission on a few wards. That would require patients to wash in a solution although it was acknowledged that it would not be appropriate for some patients. It was noted that this practice would cost in the region of 25p per patient so if rolled out would be a significant financial pressure.

  Dr. Bates was also arranging to contact Leicester to see if there were any lessons to be learned from them on how they have overcome MSSA problems.

- Ecoli - The Trust collected data on the cases of ecoli which had resulted in a 40% increase in workload but there were no targets attached to Ecoli.

- The recently published Government response to the Review on Antimicrobial Resistance (2016) stated that the government was aiming to reduce healthcare associated Gram-negative bloodstream infections (that included E Coli) in England by 50% by 2020**.** The Government intended to do that by publishing guidance on preventing Gram negative infections and publishing locally comparable data on key infections. That guidance and improved data would give the Infection Prevention and Control team the opportunity to review and refresh the strategy for how it addressed E Coli bacteraemia.

In Summary:

- MRSA was stable

- C.Difficile – was a cause for concern. The actions required had been identified but putting them into practice would be difficult in the current climate.

- MSSA –It was not clear why the Trust appeared to be a poor performer. Possible actions to improve its performance were likely to have a financial cost.

- Details were awaited on the 50% reduction target by 2020 of Gram-negative bloodstream infections which included Ecoli.

The Chairman thanked Dr. Bates and Dr. Parsons for a comprehensive presentation.

- Employ Caring and Cared for Staff

  The Director of Human Resources highlighted the following points:

  - Sickness absence in August 2016 was 4.28% compared to the target of 4%. The year to date figure was 4.16% compared with 4.28% for the same period the preceding year. The figures can be split as follows:

    - Long term 2.58% (YTD)
    - Short term 1.58% (YTD)

  - The Trust was continuing to explore the potential use of an absence management system. A review was now underway regarding the alignment of the system within the Trust. However, any proposed system must be able to function alongside existing systems, ESR and E-rostering to avoid unnecessary duplication of data entry and ensure timely flow of data through payroll.

  - The Trusts Managing Attendance Policy was under review with Trade Union colleagues following completion of an intensive engagement exercise with key stakeholders including the Trust Executive Group and a wide variety of Trust managers. The policy would provide guidance in relation to the management of short term intermittent absence.

  - Five Health Check Assessors had now completed their training and would start to action the assessments in the Hotel Services Directorate.

  - The Flu Campaign went live three weeks ago and for the first time the opportunity to have a flu vaccination was open to all staff. To date 39.29% of staff had been vaccinated and the Director of Human Resources was confident that the target of 75% of front line staff being vaccinated would be achieved. The definition of front line staff was "staff who were involved with direct patient care or had direct patient contact".

  The Chief Nurse highlighted the following point:

  - Safer staffing – overall, the actual fill rate for day shifts for registered nurses was 88.1% and for other care staff against the planned levels was 102.7%. At night these fill rates were 91.4% for registered nurses and 110.6% for other care staff. On a number of individual wards the fill rate fell below 85% and various reasons which were discussed by the Healthcare Governance Committee.

- Spend Public Money Wisely

  The Director of Finance highlighted the following points:

  - The Month 5 position showed a £5,717.4k (1.4%) deficit against budgets (excluding contingencies). That was an improvement of just over £0.5m in August 2016.

  - There was an activity under-performance of £7.5m after 5 months, a deterioration of £1.1m in August 2016 The year-to-date underperformance continued to be split fairly evenly across outpatients, elective and non-elective activity. Each specialty has produced recovery plans aiming to deliver significant improvement by the end of the year.

- There was a small overall underspend on pay to the end of August 2016. Bank and Agency staffing costs were £5.3m lower than for the same period in 2015 from a combination of payment caps, conversion to fixed term or permanent appointments, additional recruitment, enhanced controls and lower levels of IT Programme expenditure.

- There was a £0.9m under delivery (11.8%) against efficiency plans for the year to-date.

- Overall, Clinical Directorates reported positions £6.2m worse than their plans, largely driven by the activity and efficiency positions. The deterioration in August 2016 was much lower than the trend at Month 4.

- The Financial Plan and current position assumed receipt of £19.3m of national Sustainability and Transformation (S&T) funding. To receive that funding the Trust had to meet conditions set by NHS Improvement on a financial "Control Total" (70%) and service target trajectories (30%). A Control Total of £5m surplus (equating to I&E surplus of around £3m) had now been agreed with NHS Improvement. The Q1 funding has been confirmed but there were risks around future quarters on delivery of both the Control Total and service trajectories, particularly A&E.

- The STIT issue was critical and the Trust was looking for compensation for what has happened.

➢ South Yorkshire and Bassetlaw Sustainability and Transformation Plan (SY&BSTP)

The Chief Executive reported that all 44 final Sustainability and Transformation Plans would be submitted on Friday 21st October 2016.

The SY&BSTP would include:

- A public facing version of the plan including the priorities for 2017/18
- Strategic case for change
- Back Office submission
- Refreshed financial submission
- Draft strategic commissioning intentions

It was agreed that as soon as the Plan had gone public the Communications Director would circulate it to all Board members, Governors and staff. If an extraordinary meeting of the Board was required to discuss it, the necessary arrangements would be made.

Non-Executive Directors expressed their concern as they were not clear on what the Board's specific role was in terms of the SY&BSTP. It was noted that that concern was shared nationally by Non-Executive Directors. The Chief Executive reported that the key priority was to look at the governance arrangements for the SY&BSTP early next year.

The Director of Finance stated that the Trust had to submit an Operational Plan to NHS Improvement by 23rd November 2016 and also had to agree contracts and that would have to be done in the context of the SY&BSTP.

STH/186/16

Deliver the Best Clinical Outcomes

(a) Infection Prevention and Control Annual Report 2015/16

Dr. C. Bates, Director of Infection Prevention and Control, was in attendance.

The Board of Directors **RECEIVED** and **NOTED** the Infection Prevention and Control Annual Report 2015/16 (Enclosure D) circulated with the agenda papers.

STH/187/16

Spend public money wisely

(a) 5-year Capital Plan and Capital Programme: update

The Director of Finance referred to his report (Enclosure E) circulated with the agenda papers and highlighted the following points:

- The Capital Programme remained manageable for 2016/17, but the 5-Year Plan then moved into an increasing and significant over-committed position for the following four years. That over-committed position may be exacerbated as new schemes and priorities emerged over the 5-year period.

- The following schemes had recently been approved:
  - Replacement Fluoroscopy Equipment
  - Patient and Staff Wi-Fi (February 2017)

- In the past, it was agreed to pursue a couple of loans. The first loan application had been submitted to the Independent Financing Facility for £9.7 million for the Theatres on Q Floor at the Royal Hallamshire Hospital.

- The Draft Operational Plan had to be submitted by 23rd November 2016 to NHS Improvement.

- There were some uncertainties nationally around capital spend. The suggestion was that the NHS was heading for potential national controls. Providers planned to spend £4 billion on capital but the national "pot" was £2.7 billion. Funds had been taken out of capital and put into revenue.

- Key issues for delivery of the 2016/17 Capital Programme and 5-year Plan were progression of the IT Programme, various theatre schemes and the Weston Park Hospital Refurbishment (WPH) scheme.

- With regard to the WPH scheme the WPH Strategy Steering Group had been established and the Estates Group had also started meeting. There was a significant amount of work to do to put together a plan of what needs doing although it was noted that some schemes were already on going such as the WPH Aseptic Unit.

- Funding solutions for future years were identified in principle but required further consideration on application and timing.

- Capital planning/prioritisation and scheme "value engineering" continued to be crucial in securing maximum value for money from extremely constrained resources.

- Proactive action would need to be taken to ensure that slippage in 2016/17 was kept to an acceptable level and expenditure plans for the medium term were robust.

The Board of Directors:

- **APPROVED** the latest 2016/17 Capital Programme and **NOTED** the significant over commitment on the 5 Year Plan which would need to be addressed via an appropriate combination of the funding solutions proposed.

- **NOTED** the list of "possible" schemes on the 5 Year Plan (set out in Appendix A) which, along with other likely schemes, would emerge over the five year period and would require further consideration and careful prioritisation.

- **NOTED** the risks outlined in the report.

- **NOTED** the importance of capital planning/prioritisation and "value engineering" in securing maximum benefits from limited capital and revenue funding.

STH/188/16

Chairman and Non-Executive Director Matters

It was agreed that John O'Kane would attend the NHS Providers Meeting for Non-Executive Directors in Leeds on Monday 24th October 2016.

Professor Pam Shaw reported that the interview for becoming a Cancer Experimental Centre had taken place on Tuesday 18th October, 2016. The outcome would be announced on 24th November 2016.

STH/189/16

For Ratification

(a) Helipad Operational Procedure

The Board of Directors **RATIFIED** the Helipad Operational Procedure.

STH/190/16

Any Other Business

(a) Sheffield Test Bed

The Chief Executive reported that Malcolm Grant, NHS England and sponsor of the Sheffield Test Bed, was visiting the Trust that evening and the following day to look at the Sheffield Test Bed.

The Chief Executive would be happy to make arrangements if any members of the Board wished to visit the Sheffield Test Bed.

STH/191/16

Date and Time of Next Meeting

The next meeting of the Board of Directors would be held on Wednesday 16th November, 2016, in the Undergraduate Common Room, Medical Education Centre, Northern General Hospital at a time to be confirmed

Signed: ……. **Date: …….**
Chairman