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Sheffield Teaching Hospitals **NHS**
NHS Foundation Trust

Minutes of the Meeting of the BOARD OF DIRECTORS held in PUBLIC at 9.15 am on Wednesday 17th July, 2013, in the Undergraduate Common Room, Medical Education Centre, Northern General Hospital

PRESENT:

	Mr. T. Pedder (Chair)
Sir Andrew Cash	Ms. K. Major
Professor H. A. Chapman	Mr. V. Powell
Mr. J. Donnelly	Mr. N. Priestley
Ms. V. Ferres	Mr. M. Temple
Mr. M. Gwilliam	Dr. D. Throssell
Ms. S. Harrison	Professor A. P. Weetman
Mrs. A. Laban	

IN ATTENDANCE:

Miss S. Coulson (Minutes)	Mr. A. Riley
Mrs. J. Phelan	Mr. N. Riley

Ms. T. Harding - item STH/162/13(a)

Mr. J. Catto	} Item STH/162/13(d)
Mr. M. Harper	
Mr. C. Powell-Wiffen	

Mr. K. Taylor	} Item STH/165/13
Mr. S. Haigh	

OBSERVERS:

2 Governors
3 members of the public

Prior to commencement of the meeting, the Chairman welcomed Mrs. Annette Laban and Mr. Martin Temple, Non Executive Directors, to their first Board meeting.

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Declaration of Interests

Ms. Harrison declared that she had been appointed as a Lay Member of NHS England Clinical Reference Group (Chemotherapy).

STH/157/13

To receive and approve the Minutes of the Meeting held 17th June 2013

The Minutes of the Meeting held on Wednesday 17th June, 2013, were **AGREED** and **APPROVED** and signed as a correct record by the Chairman.

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Relevant Matter(s) Arising

There were no specific matters arising.

Clinical Performance

(a) Review into the Quality of Care and Treatment provided by 14 Hospital Trusts in England by Professor Sir Bruce Keogh Presentation

The Chief Nurse/Chief Operating Officer gave a presentation on the above review She explained that, in February 2013, at the request of the Prime Minister and Secretary of State, Professor Sir Bruce Keogh undertook a review of 14 Trusts with persistently high mortality rates (outliers for last 2 consecutive years on SHMI or HSMR).

The key points to note were:

- There had been significant consideration regarding the methodology employed for the reviews.
- A significant amount of thinking re the methodology had gone into the process.
- The review was very broad in its design.
- Multi-professional teams including lay people, student nurses and junior doctors went into organisations for 2/3 days. They listened to staff and patients and held focus groups enabling cultural alongside technical assessment.
- Risk Summits (which were videoed) were held to agree priorities, develop action plans and provide support.
- The whole transparency agenda ran through the review.
- The common themes which emerged were:
 -"a spectrum of mediocrity"
 - Patient and staff engagement
 - Board and leader capability
 - Fragmented data
 - Complexity around mortality measures
"However tempting it may be, it is clinically meaningless and academically reckless to use such statistical measures to quantify actual numbers of avoidable deaths"
 - Geographical, professional and academic isolation (recruitment challenges)
 - Lack of valuing of and support to junior doctors and nurses
"..energy must be tapped not sapped"
 - Transparency – accountability and blame vs. support and improvement?
 - Data – reassurance or the forensic pursuit of improvement?
- 8 achievable ambitions were formulated following the review:

Ambition	Summary
1	Demonstrable progress towards reducing avoidable deaths versus debating what mortality statistics can and cannot tell us about quality <ul style="list-style-type: none">▪ Early Warning Systems and escalation procedures▪ Investigate the relationship between "excess mortality rates" and actual "avoidable deaths"▪ New national indicator on avoidable deaths in hospitals (case note reviews)

Ambition	Summary
2	<p>Confident and competent data/intelligence utilisation for the forensic pursuit of Quality Improvement (QI). Rapid access to accurate, insightful and easy to use data for boards, leaders, patients and the public</p> <ul style="list-style-type: none"> ▪ Accessible data sets building a picture on performance ▪ Collective responsibility for quality at board level with expertise for scrutiny ▪ Address skills deficits around the use of data to drive QI ▪ Review of Quality Accounts to provide a comprehensive and balanced assessment of quality
3	<p>Patient, carers and the public should feel that they are vital and equal partners in design and assessment, confident that feedback is listened to and acted upon</p> <ul style="list-style-type: none"> ▪ Realtime feedback beyond the Friends and Family Test (FFT) ▪ Strong relationships with Healthwatch ▪ Centrality of complaints; welcomed, reported on and actioned ▪ Support, development and training for Non Executive Directors and Governors ▪ Strengthen patient and public engagement
4	<p>Patients and clinicians have confidence in Care Quality Commission assessments including through active participation</p> <ul style="list-style-type: none"> ▪ Chief Inspector of Hospitals will build on methodology used ▪ Quality Surveillance Groups (QSG) to develop and support the Care Quality Commission through use of data and intelligence ▪ Provider boards to consider how to apply methodology to achieve Quality Indicators
5	<p>No hospital should be professionally, academically or managerially isolated</p> <ul style="list-style-type: none"> ▪ Increase engagement in research and innovation through Academic Health Science Networks ▪ Embrace the release of staff to external review activity
6	<p>Nurse staffing levels and skill mix will appropriately reflect caseload and severity of illness of patients and will be transparently reported to boards</p> <ul style="list-style-type: none"> ▪ Use of evidence based tools to determine staffing levels, signed off and published at least every 6 months together with assurance re impact on quality and patient experience ▪ NICE and NQB to publish guidance
7	<p>Junior Doctors will be seen as clinical leaders of today, harnessing their energy and creativity</p> <ul style="list-style-type: none"> ▪ Tap into the latent energy of junior doctors and harness the loyalty and innovation of student nurses as ambassadors for the hospital ▪ Junior doctors must routinely participate in trusts' Mortality and Morbidity (M&M) review meetings
8	<p>Understand the positive impact that happy and engaged staff will have on patient outcomes including mortality rates and make this a key part of the QI strategy</p> <ul style="list-style-type: none"> ▪ Innovative ways of engaging staff ▪ Action for all 14 trusts with the opportunity for them to lead the way.

During discussion the following points were discussed:

- The provision of dynamic data would be extremely challenging particularly in relation to Hospital Standardised Mortality Ratio (HSMR) and Standardised Hospital-level Mortality Indicator (SHIMI). It was noted that the Healthcare Governance Committee (HCGC) scrutinised such data as soon as it was available. Members felt that the Trust should consider engaging the excellent services of SchARR who had a good reputation for carrying out an evaluation of such data.
- The methodology used in the review was outlined in the report.
- Buddying was not mentioned in the report. However Andy Riley reported that the Academic Health Science Network provided a vehicle for buddying high and low performing organisations in order to share good practice.
- "Avoidable Deaths" - the Medical Director explained that the only way to identify avoidable deaths was to undertake a deep drill down into the HSMR and SHMI data and the tools to facilitate that at Directorate and subspecialty level had recently been made available by Dr. Foster. In addition, Directorates held Morbidity and Mortality Meetings and carried out individual case reviews. Vickie Ferres felt that the HCGC should explore the matter again.

The Board of Directors **AGREED** that:

- a copy of Sir Bruce Keogh's report should be circulated to Board members.
Action: Neil Riley
- the Trust Executive Group and HCGC should consider the report, analyse it against the Trust's Strategy, agree actions as appropriate and report back to the Board in due course.

The Chairman thanked the Chief Nurse/Chief Operating Officer for a comprehensive presentation.

(b) Infection Control Report

The Chief Nurse/Chief Operating Officer referred to her written report (Enclosure B) circulated with the agenda papers. The key points to note were:

- The Trust had not recorded any cases of MRSA bacteraemia during June 2013 and therefore it had been 87 days (up to 30th June 2013) since the last case of MRSA bacteraemia was attributed to the Trust.
- C.diff target performance was marginally off trajectory against the C.diff plan. The Trust had recorded 8 cases in June 2013. Therefore the year to date performance stood at 21 cases against a contract threshold of 19.

Many of the actions on the C.diff action plan had been achieved and progress was being monitored on a monthly basis by the HCGC.

STH was the second best performer against the C.diff indicator when compared with its Shelford peer group.

- MSSA performance was off trajectory against the MSSA plan. The year to date performance stood at 22 cases. Although there was no threshold set for MSSA bacteraemia, the Trust had set itself a target of having 5 or less cases per month (60 or less per year).

The Board of Directors **NOTED** the Infection Control Report

(c) Healthcare Governance Report

The Medical Director presented the Healthcare Governance Report (Enclosure C) circulated with the agenda papers. He highlighted the following points:

- Information of Concern - The Trust had set up a process for dealing with such issues raised by the Care Quality Commission (CQC). All such matters would be reported through the HCGC.

During May, 2013, the Trust managed 'Information of Concerns' received about Weston Park, Spinal Injuries and Urology. No immediate patient safety concerns were identified and the outcomes of the investigations had been submitted to Care Quality Commission.

- External Visits, Accreditation and Inspections - Recommendations had been received in respect of 3 visits but no major concerns had been raised.
- Patient Incidents, Concerns, Claims and Inquests - Improvements had been made to the timeliness of reporting incidents on the Trust's electronic Datix system. It was also anticipated that the continuing roll out of the web based version of Datix would increase the numbers of incidents reported as well as continue to improve the reporting timescales

Attitude, Appropriateness of Medical Treatment and Communication continued to be the issues most frequently raised by complainants. That finding was echoed in patient experience information gathered through general feedback.

A number of current projects were aimed at making improvements in relation to attitudes and communications, and performance would continue to be monitored through the Trust's ongoing programmes of patient feedback. Questions relating specifically to staff attitude had now been incorporated into the Frequent Feedback survey programme which would enable more detailed collection of data at ward level.

48 new inquests were opened between January and March 2013:

- 10 related to post-operative complications
- 6 had no issues for the Trust except for confirming the circumstances of the patient's final admission to hospital.
- 6 cases related to intra operative complications
- 4 to drug reactions
- 1 case involved an in-patient fall.

All inquests involved an investigation to understand any lessons to be learned and to ensure that good practice was shared across the Trust.

- Never Events - The Royal College of Surgeons and NHS England were running a joint survey to gather information on how the NHS in England prevented and responded to 'never events' in surgery.

The Medicine Safety Committee had completed the commissioned Methotrexate Review and the actions had now been incorporated into the improvement plan to ensure appropriate oversight.

- Patient Information Report - Good progress had been made during 2012 to both maintain and develop the infrastructure for patient information. Regular review of resources ensured that patient information was kept up to date and an increasing number remained within the recommended 2-year review period (90%). As the Trust continued to carry out more operations/procedures as day cases it was vital that the information given to patients was up to date.

The Trust had commenced a new project to automate the production of patient information by a system called Interlagos. Work would continue during 2013 with a particular focus on migrating existing information and prioritising support for Community Services in using the new system.

- Patient Environment Group - The Group was Chaired by Mr. Chris Morley, Deputy Chief Nurse. Its Terms of Reference had been revised to include responsibility for the oversight of general areas (such as toilets, corridors etc.) and for actions from the PLACE assessments and also to reflect changes to the context in which the group was working and changes to the STHFT Governance Structure.

(i) Hospital Mortality

The Medical Director referred to the Quarterly Trust Mortality Report (Enclosure D) circulated with the agenda papers. The key points to note were:

2012/13 HSMR (Hospital Standardised Mortality Ratio) - The most recent rolling HSMR from Dr Foster for 1 April 2012 to 31 March 2013 was **96 (92-100)** for All Admissions. This was the rebased value and “as expected” when compared with Hospital Trusts nationally (taking into account trust case mix). The next data upload to Dr Foster was expected at the end of June 2013.

SHMI (Standardised Hospital-level Mortality Indicator) - The most recent information from the Information Centre, published April 2013, for 1 October 2011 to 30 September 2012 reported a SHMI value for STH of **0.90** (0.90 -1.12 *over-dispersion control limits of 95%*). This was “within expected range”. The next publication was expected July 2013.

The Medical Director explained that by using the new facility available from Dr. Foster, it was planned to start undertaking 'drill down' exercises into the headline information in the report in order to identify if there were any improvements that could be made.

The Board of Directors **NOTED** the Quarterly Trust Mortality Report.

(ii) Patient Experience Report – October to December 2012

The Chief Nurse/Chief Operating Officer referred to the Patient Experience Report for the period October to December 2012 which was available on the Trust's web site. She explained that the report included feedback from a wide range of sources, including surveys, frequent feedback, website feedback and complaints. The key points to note were:

- The report summarised the information received from patients and service users through the Trust's comments and general feedback processes and how comments received had increased from that type of feedback in 2012/13.
- The reported included progress made on implementing the Friends and Family Test which was now in place in the A&E Department and on 64 wards across the Trust.

- The implementation of the new Interlagos Advanced Publishing System would improve the quality of information available for patients.
- Staff Attitude was a key issue both in terms of positive and negative feedback. The Trust had engaged the help of an external company to help on the work to further improve staff attitude.
- Work was continuing to increase the number of comment cards completed.

During discussion the following question was highlighted as it had not received a high positive response across the Trust:

Have you or your family been involved in planning what will happen when you leave hospital?

The Chief Nurse/Chief Operational Officer explained that it could be a reflection of delay in affecting the patient's discharge.

The Chairman asked if the report needed to be produced on a more timely basis and the Chief Nurse/Chief Operational Officer agreed to look into that possibility.

Action: Hilary Chapman

(b) Surgical Outcomes

The Medical Director gave a presentation on Surgical Outcomes (copy attached to these minutes). The key points to note were:

- The importance of 'risk adjustment' of data
- All Trust Consultants' risk adjusted outcomes were as expected.
- One Consultant within the Trust had declined to release data. However, the surgeon's performance was within the expected range.
- The importance of preparing patient friendly outcome data to be available on the Trust website
- Continue to work with local media re interpretation of data to ensure public understanding.
- A concern was that referral patterns may be affected by the publication of the data. Therefore it was important for GPs, who were familiar with risk adjustment data, to explain the data to patients.

The Chairman thanked the Medical Director for an informative presentation.

STH/160/13

Financial and Operational Performance

(a) Report from the Director of Finance

The Director of Finance referred to his written report (Enclosure F) circulated with the agenda papers. He highlighted the following points:

- The 2013/14 Clinical Commissioning Group and NHS England contract documents were now virtually complete, although reaching agreement with Sheffield City Council on the Sexual Health Contract had been more challenging.
- The Month 2 financial position was disappointing with a £1,449.2k (1.0%) deficit against plan.
- The key on-going financial management actions were to drive the Efficiency Programme; work harder with Directorates and provide them with assistance; to focus harder on the Performance Management Framework work with financially

challenged Directorates and secure good general Directorate financial performance; to contain operational and cost pressures; to manage contractual issues and deliver contract targets; to deliver CQUIN schemes; and to maximise contingencies.

- The importance of clinical engagement to achieving the Financial Plan.
- From the recent announcements by the Chancellor of the Exchequer regarding 2015/16 NHS funding and the creation of the "Integration Transformation Fund" (to be held by Local Authorities), it was clear that the on-going challenge of achieving major efficiency savings whilst delivering key service targets, improving quality and coping with operational pressures would remain for the foreseeable future. It was first envisaged that the fund would be additional money. However, it was now believed to be coming out of the core budgets of Clinical Commissioning Groups, and could be in the region of £20 million for the Sheffield Clinical Commissioning Group.
- The Trust had already commenced planning for 2014/15 which was earlier than in previous years.
- The future was absolutely challenging and the Trust needed to reconcile all the quality issues with the resources available.

During discussion it was felt that the Trust should arrange an early discussion with the Local Authority and the Clinical Commissioning Group regarding the Integration Transformation Fund rather than wait until more information was available.

The Director of Finance emphasised that the agenda was huge and therefore it was important that the Trust focussed its efforts appropriately.

The Board of Directors **NOTED** the key financial issues and, in particular, the early position against the 2013/14 Financial Plan.

(b) Report from the Chief Nurse/Chief Operating Officer

The Chief Nurse/Chief Operating Officer presented the Activity and Access Report (Enclosure G) as at May 2013 circulated with the agenda papers. She highlighted the following points:

- The targets for the 18 week admitted, non admitted and incomplete pathways were met in May.
- New outpatient activity was 1.5% above target in May and 0.3% above for the year to date.
- Follow up activity was 1.2% below target in May and 0.4% below for the year to date.
- The level of elective inpatient activity was 5.3% above target in May and 4.1% above for the year to date.
- Non elective activity was 4.9% above expected levels in May and 6.3% for the year to date.
- The waiting list for inpatients increased by 34 and the outpatient queue increased by 880 in May.
- Accident and Emergency performance had been extremely challenging again but the Trust achieved the target in May with 95.3% of A&E attendances being seen within 4 hours. There had been a dramatic improvement in June 2013 and the Trust had achieved the target in Quarter 1. The year to date position was 93.8%.
- No never events were recorded in May and it was 107 days since the last never event.
- The outpatient queue was at its highest since October 2006.

In answer to a question, the Chief Nurse/Chief Operating Officer reported that winter planning arrangements were already underway led by Dr. Andrew Gibson, Deputy Medical Director.

It was noted that the Board of Directors were scheduled to visit the A&E Department on 18th September 2013, following the Board meeting.

In terms of cancer targets, the Director of Strategy and Planning reported that:

- the Trust had achieved all the cancer targets in Quarter 1 which was the result of huge efforts by all the teams involved. She emphasised that it had been 2¼ years since the Trust had not achieved a cancer target.
- Dr. Alan Gillespie had been appointed Associate Medical Director (Cancer) following David Hughes' appointment as Deputy Medical Director. He would take up the role in September 2013.
- the challenge of late referrals from District General Hospitals remained.

The Board of Directors **NOTED** the Activity and Access Report as at May 2013.

STH/161/13

Our Staff

(a) Report from the Director of Human Resources: Staff Engagement

The Director of Human Resources referred to the update on Staff Engagement (Enclosure H) circulated with the agenda papers. He highlighted the following points:

- In 2012 the Trust surveyed 5000 staff at the same time as surveying the 850 staff required for the Care Quality Commission NHS staff survey. This larger sample of staff enabled more directorate reports to be produced including a staff engagement score for every directorate.
- A template had been developed for every directorate which broke down the staff engagement score into the component factors of staff involvement, advocacy and motivation. That would allow directorates to identify their particular issues and where best to focus their efforts. Staff involvement was a key area and therefore Directorates had been asked to address that in their staff engagement action plans in addition to the 4 Trust wide priorities:
 - Raising awareness/embedding the PROUD values and behaviours
 - To ensure all staff have an appraisal and recorded on ESR
 - To find out why some staff do not feel able to recommend STH as a place to work
 - Ensure all staff know how to raise concerns
 - Plus at least 2 directorate specific actions
- A Trust Staff Engagement Plan, which included the staff survey action plan for 2013/14, had been approved by the Trust Executive Group and the Finance and Performance Committee.
- The Staff Engagement Executive Group had been newly formed and was chaired by the Director of Human Resources and Organisational Development and the first meeting was held on Tuesday 22nd May, 2013.

- The Trust Executive Group had approved that a NHS staff survey be undertaken for all staff for the following benefits:
 - Enabling more staff to share their views
 - Provide better quality directorate data for action planning
 - Reduce staff side concerns about confidentiality
 - Results being available in a timely manner which would Directorates more time to identify and follow up their specific issues through local directorate surveys and Let's Talk events before the next annual survey was due.

The following points were made during discussion:

- It was important that staff had meaningful appraisals.
- Although it was noted that the new appraisal process was being rolled out from the top down, members felt that appraisals for front line staff were extremely important and therefore asked whether some work could be started from the bottom up given that it was going to take 18 months to roll out the new appraisal process throughout the organisation. The Director of Human Resources explained that a training programme for appraisees accompanied the new appraisal process to ensure that appraisers were fully trained and comfortable in carrying out staff appraisals. However, he would look at whether there was a way that the roll out could be completed sooner.

Action: Mark Gwilliam

- The Chairman felt that the Staff Engagement Executive Group may need to meet more frequently than quarterly.

Action: Mark Gwilliam

- It was also felt that the Staff Engagement Executive Group should be accountable to the Trust Executive Group as well as the Finance and Performance Committee and that the Terms of Reference should be amended accordingly.

Action: Mark Gwilliam

The Board of Directors:

- **NOTED** the Trust Staff Engagement Action Plan for 2013/14
- **SUPPORTED** an annual full NHS staff survey.
- **NOTED** the Terms of Reference of the Staff Engagement Executive Group
- **NOTED** the minutes of the Staff Engagement Executive Group

STH/162/13

Delivering the Trust's Corporate Strategy 2012-17:

(a) Information Technology Strategy

The Director of Strategy and Planning introduced the item and Ms. Tracy Harding, Director of Informatics, gave a detailed presentation (copy attached to the minutes) on the Technology Strategy for the Trust. She explained that the Technology Strategy was a 5-year vision and roadmap for the development of Information Technology and was in three parts:

- Part 1: Technology Requirements - *Summarises the clinical and non-clinical technology requirements gathered from across the Trust during early 2013 and*

organises them into requirement themes that represent the major areas in which technology is required to support the Trust's strategic and operational needs.

- Part 2: Technology Strategy - *This part develops the Technology Requirements and shows how they will be met by a set of five strategic Technology platforms.*
- Part 3: Technology Roadmap - *This part details how the strategy would be achieved, laying out the proposed approach, the key assumptions made and the indicative timeline for the roadmap*

The Strategy's core purpose was to provide the single reference point for all information technology to be developed for the Trust over the next 5 years in a way that was at a high enough level to be accessible but with sufficient detail to enable detailed solution design.

Ms. Harding explained that the Trust acknowledged that its technology was not at the level it would wish and recognised that technology would enable more efficient, effective clinical decisions as well as improving the overall quality of patient safety and care. She explained that the delivery of the Technology Strategy would enable the Trust to devote more resources to patient care, to improve the holistic patient experience and to deliver more effective, reliable patient care. At the same time it would help staff work more efficiently and further improve safety. Patients would see significant benefits as staff would be able to spend more time with them and they would be much more involved in their own care.

Following discussion the Board of Directors:

- **APPROVED** the final version of the Technology Strategy
- **AGREED** that the Board should receive regularly updates on progress and asked the Trust Executive Group to agree an appropriate mechanism for that to happen.

(b) Fairness Commission Report

The Chairman explained that the Trust response to the Fairness Commission Report (Enclosure J) had been circulated with the agenda papers for information. The key points to note were:

- How implementation aligned with the Trust strategy "Making a Difference"
- The Trust's approach to the "Living Wage" proposal

The Chairman reported that since sending the interim response to Professor Alan Walker, and prior to discussion at the Board of Directors meeting, the Executive Directors felt that the Trust should be a member of the Health and Wellbeing Board and that point needed to be made stronger. The Trust Secretary would therefore re-draft the letter for the Chairman to sign making that point.

Action: Neil Riley

(c) Francis Report Action Planning: Final Outcomes

The Trust Secretary referred to his written report (Enclosure K) circulated with the agenda papers which provided an overview of the Trust's response to the Mid-Staffordshire Public Inquiry by Robert Francis QC.

He explained that the Trust was in the midst of a process of seeking how to address this extremely important, lengthy and complex report which contained 290 recommendations of which over 100 related specifically to activities of the Trust.

A piece of work had been undertaken to look and assess whether the Trust's Corporate Strategy was sufficiently robust to handle the recommendations of the Francis Report rather than developing a separate Francis Implementation Plan. That approach had been discussed with the Trust's leadership community who reaffirmed that it was a good approach and was the one that the Trust had decided to take.

Since the publication of the report, meetings had been held involving the Trust Executive Group, Board of Directors, Governors, Care Groups, Directorates, Nursing and Midwifery and Leadership Forum. A number of themes emerged from those discussions which had been developed into 4 commitments of which patients were at the centre:

- Learn from patient experience
- Ensure appropriate Nurse and Midwifery Staff ratios
- Support and develop safe teams
- Demonstrate great leadership

At this point in the journey the Trust had come to the view that the above commitments were what it needed to focus on through its Strategy.

The above commitments, in addition to being aligned to Trust's Corporate Strategy, had been considered alongside the initial Government Response: *Patients First and Foremost* and external strategic developments such as *Compassion in Practice*.

It was noted that:

- the commitments would be tested throughout the summer in collaboration with key partners and wider staff groups.
- once agreed, the commitments would be adopted as the key improvement objectives within the Annual Quality Report for continued delivery in 2014/15.
- the Healthcare Governance department had created a spreadsheet to monitor each recommendation but decisions would need to be taken about which recommendations related to Trust services. It was clear that the Trust could not handle everything and judgements and priorities would need to be made on what it could action. It was noted that some issues would come out nationally and therefore would be dealt with centrally.
- communications would play a crucial part in reassuring patients and the general public that this could not happen locally.

The Board of Directors **SUPPORTED** the approach outlined in the paper and suggested that the same process should be followed for other reports that the Trust needed to address.

(d) Full Business Case for the purchase of a Da Vinci Robotic Surgical System: For approval

Mr. Jim Catto, Consultant Urologist, Mr. Michael Harper, General Manager, and Mr. Chris Powell-Wiffen, Deputy General Manager, were in attendance.

The Director of Strategy and Planning introduced the item and made the following key points:

- The business case had been through the Capital Investment Team (CIT) and the Trust Executive Group and had received their support. However due to the cost involved (£2.6 million) the approval of the Board of Directors was required.
- The focus of the use of the technology would mainly be for cancer patients with procedures and diagnoses including radical prostate cancer surgery, radical cystectomy for bladder cancer, hysterectomy, throat cancer and colo-rectal cancer.
- The business model was a collaboration of across 5 surgical specialties i.e. Urology, Gynaecology, Colo-rectal, Endocrine and Head and Neck Surgery.
- That Capital Investment Team had stipulated that Commissioner (NHS England and Clinical Commissioning Groups) support be secured given their liability for the additional cost of robotic consumables which were classified as cost per case tariff exclusions. Consequently the business case was discussed at the Regional Cancer Board (Strategy Group) on 5th July, 2013 and the response had been favourable. However the Trust was awaiting formal written confirmation from the Clinical Commissioning Group/South Yorkshire Commissioners that they would cover the cost of consumables. The Director of Strategy and Planning emphasised that without that support the business case would not be able proceed.
- If all the necessary support was received an installation date of October 2013 was the target.

Mr. Jim Catto, Consultant Urologist, gave a presentation on the benefits of purchasing a Da Vinci Robotic Surgical System. The benefits included:

- The improved handling speeded up the performance of complex surgical procedures in hard to access areas such as the pelvis, retroperitoneum and oral cavity.
- The improved ergonomics and reduced operating times leads to less operator fatigue and reduced incidence of repetitive strain injury.
- The technology allowed the learning curves of complex procedures to be shortened by a log factor (compared with standard laparoscopy), leading to reduced operating time and improved outcomes earlier in the adoption process.
- Improved training facilities for more junior surgical trainees.

He explained that, in terms of patients, the above benefits would result in improved functional outcomes, less blood loss (and associated transfusions), decreased length of hospital stay, less pain and quicker return to normal activities. For the Trust, they translated into better long-term utilisation of operating theatre facilities, reduced risk of litigation for poor clinical outcomes, reduced risk of occupational injury to the surgical workforce and improved status as a Cancer Centre.

Following discussion, the Board of Directors

- **APPROVED** the purchase of Da Vinci Robotic Surgical System contingent upon Commissioner support and available capital funds
- **NOTED** that the cost of the second console may be secured through Charitable Funding.
- **REQUESTED** that a robust benefits realisation programme be carried out.

STH/163/13

Chief Executive's matters

There were no matters to report.

STH/164/13

Chairman and Non-Executive Directors' matters

There were no matters to report.

STH/165/13

Clinical Update - Right First Time: Presentation

Mr. Kevan Taylor, Chief Executive, Sheffield Health and Social Care, and Mr. Steven Haigh, RFT Programme Manager, were in attendance for this item.

Mr. Taylor updated members on progress of the Right First Time Programme and covered the following areas:

- What has been learnt so far:
 - Length of stay and bed occupancy for frail older people can be reduced
 - Delays in transferring patients' care to the right level can be reduced
 - Winter and seasonal pressures resulted in high A&E and emergency admission rates and had a negative financial impact across the whole health and social care system.
- Next Steps:
 - Care planning for the 15000 people at high risk in the community
 - Development of the "discharge to assess" model across Sheffield Teaching Hospitals NHS Trust and Sheffield Health and Social Care bed base
 - Development of Intermediate Care Bed stock to include EMI (Elderly Mentally Ill) and Home of Choice
 - Development of current CICS (Community Intervention Care Service) and STIT (Short Term Intervention Team) services into a single service model – Active Reablement
 - Development of new model for Community at Night to increase resilience out of hours
 - Increase dementia liaison capacity
 - Develop the Single Point of Access
 - Develop Urgent Care Centres at the Northern General Hospital and Sheffield Children's Hospital.
- Opportunities
 - Reduce ACS (Ambulatory Care Sensitive) emergency admissions at front door according to NHS Institute guidance.
 - Bring level of ACS (Ambulatory Care Sensitive) emergency admissions from less well performing practices up towards that in better performing practices.
 - Reduce length of stay for all emergency admissions to the best in the core cities.
- Challenges

- Gaining confidence across the system that there was sufficient capacity to handle demand
 - Financial pressures for Commissioners and providers
- Measures of success
- Less avoidable admissions to hospital
 - Length of stay in hospital would be reduced
 - Better patient experience

During discussion the following points arose:

- It was important to avoid duplication of work being undertaken by other bodies such as the Urgent Care Board.
- It was recognised that this programme was the beginning of a programme of significant cultural change.
- In answer to the question “What would good would look like?”, Mr. Taylor responded that it would be “A patient would only be admitted when really necessary and discharged within an hour of being fit for discharge”.
- The importance of joint commissioning.

STH/166/13

For Approval/Ratification:

(a) Medicine Code

The Medical Director explained that the Medicine Code provided standardised guidance to all Healthcare Staff within the Trust involved in the use of medicines. He reported that it had recently been revised to incorporate new guidance relevant to Community Services. The updates included:

- Duties and responsibilities and training sections updated in line with NHSLA standards
- Clinical checking and medicine reconciliation
- Substance misusers
- Homely remedies
- ICE electronic discharge prescriptions
- Alternative outpatient prescriptions (i.e. Boots at Royal Hallamshire Hospital)
- Controlled drugs

The amended version had been scrutinised by the Medicines Safety Committee and approved by the Trust Executive Group. However the Department of Health required it to be signed off by the Board of Directors.

The Board of Directors **RATIFIED** the revised version of the Medicine Code.

(b) Common Seal

The Board of Directors **APPROVED** the affixing of the Common Seal to the following contract:

- Contract between Sheffield Teaching Hospitals NHS Foundation Trust and Henry Boot Construction Limited for works to form office accommodation for the A&E Department (CSSD Refurbishment) at the Northern General Hospital

(Contract Value - £761,260.00 and forms part of the 2010/11 Capital Programme)

STH/167/13

To Receive and Note

(a) **Declaration of Interest Register**

The Board of Directors noted that the Trust's Declaration of Interest Register had been updated to include that Shirley Harrison had been appointed as a Lay Member of NHS England Clinical Reference Group (Chemotherapy).

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Any Other Business

There were no additional items of business

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Date and Time of Next Meeting:

The next Board of Directors Meeting would be held at 9.15 am on Wednesday 18th September, 2013, in the Undergraduate Common Room, Medical Education Centre, Northern General Hospital.