St George's Healthcare NHS
NHS Trust

MINUTES OF THE TRUST BOARD

26 June 2014
H2.5 Board Room, 2nd Floor, Hunter Wing, St George's Hospital

Present:	Christopher Smallwood	Chair
	Mr Miles Scott	Chief Executive
	Mr Steve Bolam	Director of Finance, Performance and Informatics
	Dr Ros Given-Wilson	Medical Director
	Mrs Jennie Hall	Chief Nurse
	Professor Peter Kopelman	Non-Executive Director
	Ms Stella Pantelides	Non-Executive Director
	Mr Mike Rappolt	Non-Executive Director
	Ms Sarah Wilton	Non-Executive Director
	Ms Bernie Bluhm	Interim Director of Service, Delivery and Improvement
	Mr David Hastings	Interim Director of Estates and Facilities
	Mr Peter Jenkinson	Director of Corporate Affairs
	Dr Trudi Kemp	Director of Strategic Development
In attendance:	Dr Jeremy Cashman	Clinical Director
	Miss Jacqueline McCullough	Deputy Director of Human Resources
	Mr James Taylor	Assistant Trust Secretary
Apologies:	Mrs Wendy Brewer	Director of Human Resources and Organisational Development
	Dr Judith Hulf	Non-Executive Director
	Mrs Kate Leach	Associate Non-Executive Director

14.83 Chair's opening remarks
Mr Smallwood welcomed all to the meeting.

14.84 Declarations of interest
No declarations of interest were made.

14.85 Minutes of the previous meeting
The minutes of the meeting held on 29 May 2014 were approved as an accurate record, subject to the following:

It should be recorded that Mr Jeremy Cashman attended the meeting in the absence of Dr Given-Wilson.

14.86 Schedule of Matters Arising
An update was received on two items of Matters Arising:

<u>14.68 Audit Committee – Annual Report and draft Work Plan</u>
Mr Smallwood asked for an update on the limited assurance the Audit Committee had received in a Fire Safety report. Mr Hastings responded that an action plan, including the completion of ward level risk assessments, had been formulated that was now being implemented.

Mr Rappolt agreed that the key issue involved ward procedures not being up to date. He reported that internal audit had been asked to re-audit progress in implementation of the action plan for the September meeting of the Audit Committee so the committee would review progress then.

Mr Hastings agreed with Mr Smallwood's point that a risk assessment needs to be carried out face to face, followed by a written report – he reported the field work would take place in August, with a completed report to be presented to the Audit Committee meeting in September. Mr Jenkinson added that the matter would also be picked up by the Board in its consideration of the Board Assurance Framework.

Schedule of Matters Arising: Communications Plan and Brand Development

Mr Jenkinson confirmed to Ms Wilton that arrangements were being made for a joint Board to Board meeting with the university's council, with the aim of meeting in September. **Peter Jenkinson July 2014**

14.87 Chief Executive's Report

Mr Scott presented his report to the Board and invited questions and comments from Board members. In doing so, he updated the report by noting that, under 'Research Strategy', it was now confirmed that the Trust had exceeded its CRN recruitment target by some 25% during the most recent recruitment year.

Mr Smallwood believed that the report was becoming too long. **Peter Jenkinson**

In response to Ms Pantelides' question about the closure of the strategic partnership with Kingston Hospital, Mr Scott reported that a formal partnership had been established for a number of years which had involved joint working – South West London Pathology being a good example. The programme of work had now finished, but while Kingston was still regarded as a key partner, it was more on a case by case basis, rather than maintaining the formal partnership for its own sake. This did not mean that Kingston was regarded more as a competitor than was previously the case.

In response to Mr Rappolt's question about the electronic document management and workflow (EDM) programme, Mr Scott reported that this was a different system to Cerner, which covered clinical document management. The EDM is in line with proposed timescales.

In response to Mr Rappolt's question about any discontinuity in provision arising from the procurement of new clinical information systems contracts, Mr Bolam reported that the Trust wished to withdraw early from its current national contract, the timetable for which has been agreed. New contracts would be signed shortly.

In response to Mr Rappolt's question regarding South West London Pathology, Mr Scott reported that Tony Barren was to be appointed its independent chair by the end of July. Mr Barren had an engineering and RAF background, and had overseen a similar initiative for the area covering Southampton, Portsmouth and the Isle of Wight. The project was going well and was expected to deliver on time. It was agreed that a post project evaluation should be considered by the Board in six months' time. **Miles Scott / Peter Jenkinson December 2014**

ACTION: The Board noted the report.

Quality and Patient Safety

14.88 Patient DVD - Mary's Story

Mr Smallwood reported that, henceforth, a divisional report or a patient experience DVD would be presented to each Board meeting, alternating each month.

Ms Connolly presented a Patient Safety DVD which consisted of an interview with a female patient who had agreed to provide feedback on the care she had recently received from her local National Health Service, both at hospital (St George's) and in the community (Merton).

Ms Connolly reported that the DVD had been seen at service levels and a number of actions were being taken forward in the community and within St George's Hospital. Most importantly the Trust was currently recruiting a Darzi Fellow to support the ongoing work to improve safe discharge, linking with the discharge service improvement work stream. Interviews were planned for mid-July and it was hoped to have someone in post by September 2014.

In response to Mr Rappolt's question about the dissemination of such feedback to community services, Ms Connolly reported that there were a variety of methods.

In response to Mr Rappolt's question about the improvement of discharge processes, Mrs Hall reported that a proforma is sent out to community services in every case; however, this was a relatively new service which was not yet cohesive, with training issues still to be addressed and questions remaining about (as in this case) clinical waste management and the wider question of infrastructure being in place to provide an early discharge service.

Ms Wilton believed that the unanswered telephone call reported in the DVD highlighted the fact that the Trust's method for dealing with calls was not fit for purpose. In response, Ms Bluhm reported that the issue now forms part of the Outpatients Improvement Programme, although she noted that it was a wider issue for the whole Trust, but which needed to be 'owned' locally. Mr Rappolt agreed with Ms Wilton's point, reporting that telephone directories were not updated as regularly as they should be. Mrs Hall reported that the matter was to be taken up by the Patient Experience Committee.

Mr Smallwood believed that the issue of dealing with calls was a pertinent one. Mr Scott reported that there was a need to work with clinical teams to address the lack of systems/control over the problem; however, he noted that, although Ms Bluhm would be establishing some standards through all of the work in the Service Improvement Programme, there was no overarching plan to resolve the issue.

Professor Kopelman believed that there was not enough focus on discharge, with training being particularly lacking. Mr Scott responded that discharge training would provide another focus for Ms Bluhm's work. Professor Kopelman also noted that clinical waste management was a matter for the relevant local authority.

Dr Given-Wilson reported that the new intake of clinical staff will receive greater focus on discharge training in their induction than has been previously been the case. The interface of different providers of care is challenging to manage, and so integrated care pathways are being formulated, bringing internal and external

teams together to work through the entire pathway. Mr Rappolt believed that the whole issue should be escalated to senior staff in the NHS or the Department of Health.

ACTION: The Board noted the presentation.

14.89 Quality Report

. Mrs Hall presented the quality report and highlighted a number of key points:

Patient Safety

Trend analysis for serious incident performance had identified three key elements: Nasogastric Tube Insertion, pressure ulcer profile and the follow up of patients requiring treatment. As a result, focus had been placed on them, particularly in relation to training and support, with some results already noted:

- No further Nasogastric Tube Insertion incidents since February 2014;
- Progress relating to harm resulting from pressure ulcers, together with the number of grade two pressure ulcers overall;
- Positive harm-free care results that exceed the national average.

The Trust's profile has been published using the National Safe Staffing Template, which has been a key indicator since the findings of the Francis Report and build on the recent establishment review of nurse and midwifery staffing within the 49 inpatient areas at St George's and Queen Mary's hospitals. Divisional assurance has been sought in relation to local escalation areas, but some issues of data quality have been identified – it will take a number of iterations of the report to rectify this.

Mr Rappolt noted with concern the indicators regarding safe staffing, reflecting his findings in a recent quality inspection of a paediatric medicine ward which identified staff shortages. Mrs Hall reported that staffing was a known risk on the ward in question, and a number of temporary staff were in attendance on the ward at the time of that inspection – this was now being reviewed, as was the case on other wards with similar challenges. She confirmed to Mr Rappolt that she had received a staffing alert on the day in question, whilst noting that it would have been a local decision regarding the use of agency staff. Mrs Hall agreed to ascertain the total number of alerts received and report back to the Board.

Jennie Hall July 2014

Ms Bluhm reported that, in addition to Chief Nurse alerts, discussions also take place at all ward meetings, with the option to 'flex' beds if necessary. There was a constant dialogue with Paediatrics to ensure it receives the support it needs. Professor Kopelman believed that there was a need to achieve understanding of recruitment processes across the whole Trust.

In response to Professor Kopelman's question regarding the Patient Safety Thermometer, Mrs Hall reported that bedside training took place, but this data collection should be regarded as only a snapshot. In response to Mr Rappolt's point, Mrs Hall confirmed that 5.39% of patients received harmful care using this measurement; however, it needed to be considered alongside other indicators such as the global trigger tool, in order to produce a complete picture. In relation to VTE metrics, Dr Given-Wilson reported that three types of measuring and reporting are employed, which can result in lack of staff understanding and reporting errors. Mrs Hall also noted that, once revised establishments are engaged, there may be a deterioration in the statistics.

Mrs Hall agreed to provide an outline approach on recruitment to the Board

meeting in July, noting that achieving greater appreciation of what staffing needs might be was the main rationale for this exercise. **Jennie Hall July 2014**

Patient Experience

Mrs Hall reported a need to improve performance in this area – work will take place over the next few months, in particular regarding responsiveness to complaints, with a report to be made to a future Board meeting. Mr Rappolt believed that themes needed to be investigated; Ms Wilton confirmed that the Quality and Risk Committee (QRC) had requested that the divisions look at this in detail as part of their regular reports. Dr Given-Wilson believed that triangulation of themes as part of QRC discussions was a useful exercise. **Jennie Hall TBC**

Mrs Hall agreed with Ms Pantelides' point that high volumes of complaints was caused in part by the fact that patients are encouraged to complain, rather than dealing with the issue at the time. This was a cultural issue that required a shift in thinking.

Dr Given-Wilson reported that the first report of the National Emergency Laparotomy Audit (NELA) had not identified any mortality issues at the Trust. However, issues that were identified include the lack of an emergency surgical unit, the absence of a four tier EGS at all times; it is also a fact that processes for various elements of care are followed, but formalised policies to reflect them have not been ratified.

Dr Given-Wilson reported that, according to the WHO Theatre checklist audit, the Trust was achieving close to 100% compliance in many areas, although there were some issues regarding briefing and debriefing in neurosurgery, for example.

In relation to Mortality, Dr Given-Wilson reported that work is ongoing, with much action being led by the Mortality Monitoring Committee. This includes the changes necessitated by the electronic documentation pilot, whereby a deceased patient's records can be uploaded directly for review.

In response to Professor Kopelman's question about policies in relation to Serious Incidents, Dr Given-Wilson reported that work was being carried out in particular on face-to-face handover, although greater consultant engagement was required on this.

In response to Mr Rappolt's question regarding the National Diabetes Audit (Adults), Dr Given-Wilson reported that the Trust does submit significant amounts of data on diabetes to other similar audits, but a specified database is required here – this is to be introduced in October 2014 with staff training, the aim being for it to be part of everyday clinical activity by January 2015.

In response to Mr Rappolt's question on the development of a quality intelligence function, Mr Jenkinson reported that the Informatics Team were implementing the proposed system and an update would be presented to the next QRC meeting.

Mrs Hall reported that the Trust had recently received information on NHS England's 'Sign Up To Safety' initiative, which has arisen following the Francis Report and has a three year objective of reducing avoidable harm by 50% and saving 6,000 lives. It contained five pledges that cover issues such as culture, learning and transparency. Mrs Hall noted that she would examine the initiative and produce a response on behalf of the Trust.

ACTION: The Board noted the report.

14.90 Quality Account

Mrs Hall reported that the publication of an annual Quality Account by 30 June is a requirement for each trust. It had been developed with reference to the DH Quality Accounts Toolkit and gone through a number of iterations – it had been examined by the Executive Management Team, QRC and the Trust's external auditors, with other feedback provided by key stakeholders.

Mr Jenkinson confirmed Mrs Hall's point that the final audit opinion was expected within the next day or so; he also reported that there were some factual inaccuracies in the stakeholder comments, which would need to be corrected. He confirmed to Ms Wilton that further CQUIN data would be added to the Quality Account when available in the next two days.

In response to Ms Pantelides' question regarding the red rating for the reduction of hospital admissions on the priorities dashboard within the Quality Account, Mr Bolam noted that the numbers have increased, but that did not mean that it was a greater proportion than had been the case previously; Mrs Hall noted that it was red because an aim had not been achieved. Dr Given-Wilson reported that the commissioners accepted some readmissions, with problems in relation to the discharge system; nonetheless, it was not a great focus of concern.

Action: The Board approved the Trust's annual Quality Account.

14.91 Integrated Business Plan (IBP) / Long Term Financial Model (LTFM) – Board ratification

Mr Bolam reported that the IBP and LTFM as currently drafted reflected the discussions that had taken place at the Board development session on 10 June.

Major changes to the capital planning programme have had consequences for the LTFM, which may need further amendment following discussions with Monitor; pension and care and environment figures were now known, which may result in the suppression of some surpluses.

Mr Bolam reported that the Chair and Chief Executive had signed off the formal submission to the TDA and to Monitor on 20 June – formal ratification of that submission was required today.

Action: The Board ratified the approval of the IBP and LTFM submitted to Monitor on 20 June, noting the amendments that had been agreed at the 10 June Board development session.

Governance and Performance

14.92 Trust Performance Report

Mr Bolam reported that the new format of the report reflects the use of the NHS TDA and Monitor regulatory requirements – a process was ongoing to establish thresholds.

Red key priority areas include A&E, which it would seem will not hit its Q1 target – with this the third quarter in a row, this would raise concerns with regulators. Ms Bluhm explained that a change of measuring had taken place in April – if the previous methodology had been employed, the figure would have been 2% higher and the 95% target would have been achieved. It was therefore misleading to

compare the Q1 figure with that for the previous Q3 and Q4. It was unfortunate that the impact of making the measurement change had been lost because of the service missing the target; however, it was the correct course of action to make the change, the new systems were the right ones and there was a need for the Trust to stand by its decision.

Ms Bluhm reported that a three pronged approach had been adopted to improve the performance against the 95% target:

- Work in A&E itself, which was transactional, using workforce and 'business as usual', escalating where necessary – an action plan had been devised covering, for example, the inpatient pathway, including the need for a rapid assessment process; in addition, an ambulatory scoring matrix had been developed, together with a changed validation of breach process and the 24/7 use of specialty escalation bleep holders;
- Working with wards regarding patient flow – a joint approach by Ms Bluhm and Mrs Hall regarding site management more generally;
- Working with partners regarding discharge improvements.

Ms Bluhm noted that work still needed to be done; it should also be appreciated that these changes of approach were not just applicable to A&E – they should be part of a drive to win hearts and minds of all working within the Trust.

In response to a request from Ms Pantelides, it was agreed that, even if targets were missed, it was helpful to include improvements achieved in the narrative of the report.

Mr Bolam reported that the Trust's performance against the TDA Accountability Framework KPIs was assessed as 4 out of 5. However he advised the board that there may be a mismatch here, following clarification of the way that the Trust reports Never Events which meant that an additional never event should be reported for the period. If reported differently, the Trust's CoSSR position would be amber/green, rather than green.

Mr Bolam reported that RTT was subject to a contract query from commissioners, but that money was to be made available during the summer to assist with a national drive to reduce waiting times.

Mr Bolam explained to Mr Smallwood that "incomplete pathways" in the report referred to those patients who were still being treated and therefore remained in the system.

In response to Ms Pantelides' question regarding whether the Trust was benchmarking itself against appropriate comparators, Mr Bolam acknowledged that other trusts could be added if it would prove beneficial. Ms Wilton welcomed the new format of the report.

ACTION: The Board noted the report.

14.93 Finance Report

Mr Bolam reported that the Trust had an income and expenditure deficit of nearly £2.8m for month 2, with the income profile slightly down because of the number of Bank Holidays during the month and some payment timing issues, but activity being slightly ahead, which was encouraging. A weekly tracker for each division was scrutinised, which was resulting in sharper reporting.

Mr Bolam reported that cash in May remained low, largely due to the large amount of debt owed by NHS England – this situation has now been escalated. A revised capital plan was being promulgated without any major alerts and progress reported. The CIP programme is slightly ahead of target. Overall, the trading position remains challenging.

Mr Smallwood reported that the Finance and Performance Committee, at its meeting on 25 June had received an update from Ms Bluhm on the Service Improvement Programme. The resulting discussion on capacity had brought up the fact that 57 beds should be added during the course of the year, which may lead to a reduction in length of stay times. In addition, theatre capacity was to be increased, with more sessions, including weekends. In the discussion on the CIP programme, it appeared that the divisions were largely optimistic as to their progress – the risk remained, but it was noted that actions had been taken to manage the risk.

Mr Smallwood reported that the committee had expressed concern regarding the significant NHS England debt. Mr Rappolt agreed, believing that assurance was required. Mr Bolam responded by noting that £226k is subject to query by NHS England, out of a total of £10m. The response that had been received quoted inaccurate data, which the Trust had corrected; if no satisfactory conclusion is reached shortly, it will need to be escalated to the Board Chair writing to NHS England.

Ms Wilton noted that the committee had been disappointed in the lack of headway achieved by the Service Improvement Programme. She believed that more Board insight was needed on progress that was being made; Mr Smallwood noted that this was an issue that would return for further consideration by the committee.

Ms Pantelides believed that up to date detailed information on CIPs and the Service Improvement Programme was required by non-executive directors. Ms Bluhm agreed that enhanced recovery and theatre utilisation could be added to the slides that were provided.

Steve Bolam
Bernie Bluhm

ACTION: The Board noted the report.

14.94 Workforce Performance Report

Ms McCullough reported that the Trust's performance in relation to workforce indicators was similar to that of other London teaching hospitals. Work was being done to address increased voluntary turnover, with a supply issue which may necessitate some overseas recruitment. Ms McCullough believed that a sickness absence figure of 3.5% was not unusual; the Bank and agency spend remained an ongoing pressure, caused in part by certain specialty issues.

In response to Mr Rappolt's question about e-rostering being tied into Bank and agency spending, Ms McCullough confirmed that it meant more beneficial real-time information could be gathered.

Ms Pantelides believed it was of merit to have comparators in the report, but was uncertain as to whether voluntary turnover figures were being captured correctly – there was a need to dig deeper to establish reasons such as better pay and more promotion opportunities. Ms McCullough responded by noting that targeted work is ongoing – face to face exit interviews are conducted, as well as an online exit questionnaire being available. It was of concern that 42% of staff who leave the

Trust do so within two years of joining. Ms Pantelides believed that ascertaining the reasons for this statistic needed to be linked to the work on staffing establishments.

Ms Pantelides believed that it would be helpful to have a breakdown of Bank and agency figures, rather than a combined total. **Wendy Brewer**

Ms McCullough agreed with Mr Smallwood's request that, in future, the report needed more detail within it on the actions that were being taken to address issues that arise from the data that is presented. **Wendy Brewer**

ACTION: The Board noted the report.

14.95 Compliance Report including Board Assurance Framework

Mr Jenkinson presented the full Board Assurance Framework, following its revision against the annual objectives agreed at the previous meeting. It was noted that the final version would come back to the July Board meeting, when all objectives have been risk assessed.

The number of red ratings had increased, for reasons discussed elsewhere during the meeting, with ratings based on consequence and likelihood.

Mr Jenkinson reported that a compliance action plan had been submitted to the Care Quality Commission (CQC) following its February inspection, which incorporated all required actions. The wider action plan, encompassing all recommendations from the CQC would be monitored by the QRC and externally by the NHS TDA via the Clinical Quality Review Meeting with commissioners.. The CQC's Intelligent Monitoring Report that had recently been received had identified two issues: Never Events resulting from mortalities in Trauma and Orthopaedics and potential under reporting of staff health and safety training. No elevated risks had been identified.

In response to Mr Smallwood's question about a data quality risk, Mr Jenkinson confirmed that this was not a new risk but a reporting of the existing risk which the board were aware of.

In response to Mr Rappolt's question about where failure to deliver infrastructure projects would sit within the Framework, Mr Jenkinson responded that it would either be in the 'catch all' for operational performance, or in Estates compliance. Mr Hastings added that a risk entry would be made in relation to delivery of the capital programme.

In response to Ms Wilton's question regarding the effectiveness of divisional risk registers, Mr Jenkinson reported that they remained a work in progress, with some improvements made by divisions under the scrutiny of the Organisational Risk Committee. He noted that more non-clinical risks were now being identified, with others captured through work on the Integrated Business Plan, for triangulation against other risk registers. This process had helped the governance of all divisions.

ACTION: The Board noted the report, including the Trust's most significant risks and external assurances received.

14.96 Annual Business Plan 2014/15: TDA Feedback and Board Assurance

Mr Jenkinson reported that the finalised document had been approved by the TDA, having sought some assurance in relation to a number of quality issues. Dr Given-Wilson noted that the issues in question were covered in the Quality Account.

ACTION: The Board noted the report.

General Items for Information

14.97 Use of the Trust Seal

Mr Smallwood reported that there had been no use of the Trust seal since the last Board meeting.

14.98 Questions from the public

Miss Hazel Ingram agreed with the points made earlier regarding deficiencies in the Trust's telephony system, giving an example where a patient had been unable to contact the relevant staff member in relation to their treatment.

Miss Ingram made the point that, in her view, too much reliance was being placed by the Trust on community nurses at present. She also believed that Patient-led assessments of the care environment (PLACE) had resulted in the Frederick Hewitt ward being well-staffed once again.

14.99 Any other business

Mr Jenkinson agreed to reflect on Ms Wilton's view that the Equality Impact Assessment forms that are completed for each Board paper are not being used properly and ought to be in a different format. **Peter Jenkinson**

14.100 Date of the next meeting

The next meeting of the Trust Board will be held on 31 July 2014 at 10.30am.