University Hospitals Bristol NHS
NHS Foundation Trust

Minutes of an Extraordinary Meeting of the Trust Board of Directors held on 14 April 2014 at 13:00 in the Conference Room, Trust Head Quarters, Marlborough Street, Bristol, BS1 3NU

Board Members Present

- Robert Woolley - Chief Executive
- Paul Mapson - Director of Finance & Information
- Sean O'Kelly- Medical Director
- James Rimmer - Chief Operating Officer
- John Savage - Chairman
- Emma Woollett - Non-executive Director
- Guy Orpen- Non-executive Director
- Alison Ryan - Non-executive Director
- Jill Youds - Non-executive Observer

Others in Attendance

- Xanthe Whittaker - Head of Performance Assurance & Business Intelligence and Deputy Director of Strategic Development
- Alex Nestor - Deputy Director of Workforce and Organisational Planning
- Helen Morgan - Deputy Chief Nurse
- Charlie Helps (Trust Secretary)
- Pauline Holt (Management Assistant to the Trust Secretary)

Item	*Action*
1. Chairman's Introduction and Apologies The Chair welcomed everyone to the meeting and advised that apologies had been noted from David Armstrong, John Moore, Carolyn Mills, Sue Donaldson, Julian Dennis, Deborah Lee, Iain Fairbairn and Lisa Gardner.	
2. Declarations of Interest In accordance with Trust Standing Orders, all members present were required to declare any conflicts of interest with items on the Meeting Agenda. *There were no declarations of interest.*	
3. Chief Executive's Update *The Chief Executive updated the Board on the following matters:* The Chief Executive advised the Board that the Trust had no further information regarding the scope of the proposed review of Children's Cardiac Services to be led by Sir Ian Kennedy. He would update the Board when further information became available. *There being no further questions or discussion, the Chief Executive concluded his update*.	

4. Performance Overview and Recovery Plans Report

*The Board received this report from the Chief Operating Officer for **approval**.*

James Rimmer gave a brief overview advising that the paper set out the recovery plan for the Board to consider and approve. Containing four areas it focussed on access issues with analysis, steps taken to date, what the recovery should be and the action needed to deliver that recovery. Risks to that recovery were also provided in the back of the document. James said this was a high level plan underpinned by Divisional plans prepared by each Division and Specialties. The document, if approved, would be used for any meeting, if required, with Monitor.

Self-certification

James advised that Monitor had a new system of notification effective from Q3 2013/14 onwards. The Trust had self-certified in agreement with Monitor's assessment for the previous 4 quarters, showing the robustness of the Board's processes.

4-hour Analysis

The Monitor standard was 95% of patients to wait less than 4 hours or less in the emergency department before being treated, discharged or transferred.

James said that the Trust had had ongoing issues for many years, the root causes of which were a large rise in winter ambulance arrivals, an 8% increase in the over 75's (compared to the previous winter), and higher levels of admission to the Children's Hospital for 2 years, with the third year even higher showing winter pressures during Q3 year on year.

Work with KPMG had been undertaken to identify the root causes. Successes included reductions in ambulance delays and elective cancellations, development of ambulatory care pathways and utilisation of beds in the community.

The two-phase Patient Flow Programme led to fewer delayed ambulance hand-overs, patients spending less time on the wrong ward, and fewer cancelled operations. The one area where little progress had been made was that of delayed discharges, which highlighted a greater need for community care beds.

Breaking the Cycle Together had focussed on better care for patients and saw improvements in the Bristol Royal Infirmary achieving the 95% target across the Trust in the week. Outliers dropped from 30 to 3, 'green to go patients' dropped by over 20, occupancy was down to 92% and 4-hour performance went up. James added that no new standards had formed part of Breaking the Cycle Together; it was the result of cohesive working not only across the hospitals but with involvement

from partner organisations, community health and social care.

Looking forward – 7 elements of necessary change to the operating model had been identified. Breaking The Cycle had been one element and James said the rest needed to be delivered 'with pace'. He warned that Q1 was at risk but by embedding the operating plan quarters 2&3 would show improvement leaving Q4 at risk from winter pressures.

He concluded that the challenge was how to respond as a system. Meetings were to take place with the Clinical Commissioning Group and the Emergency Care Intensive Support Team with a view to working together to review the whole system to address issues for Q4. NHS England were also to look at winter pressures now rather than later.

Emma Woollett (in regard to the Children's Hospital) asked if the issues underlying performance were the same as those issues underlying at the Bristol Royal Infirmary. James replied that this was being examined and there would be no assumptions that root causes were the same.

Alison Ryan asked if Breaking the Cycle put other standards at risk. James replied that he could not see any negative output and that corporate meetings had stopped with key focus on safer care, clinical engagement, and escalating specific incidents for specific patients. As a result care had improved across the board.

The Chief Executive added that if Breaking the Cycle were operated on a continual basis normal business would stop. Volunteers had performed roles they were not employed for and the Chief Executive of Bristol Community Health had done a shift as Ward Liaison to assist the Trust. He concluded that the commitment from partner organisations was 'phenomenal and showed real engagement with the Trust'.

Clive Hamilton asked if Breaking the Cycle was an initiative to be kept in the Trust toolbox. The Chief Executive replied that it would, following evaluation to work out how the Trust derived learning from the exercise, and what they would do with that learning and what arrangements needed to be changed for the future.

Guy Orpen asked if the increased utilisation of community beds would lead to capacity issues in the community. James Rimmer advised that the next stage was to see if there was a need to increase these yet again and to analyse what the length of stay was in the community. He said that the Better Care Fund was working to change the mind set and get the whole community to move care closer to home.

In reply to a question regarding staff buy- in James advised that a daily wash up meeting had allowed staff access to executive directors and served as a feedback session. In addition a thank you event and chance for wider feedback was to be held.

The Chairman, on behalf of Board, said they wanted to hear that the Trust were as focussed as they could be to hit targets in each area. He cautioned against forecasting to Monitor a red for another quarter at the end of the year. The Chief Executive replied that the Executive would examine what they could sensibly forecast as realistic delivery and evaluate what the forward performance should be, and make sure this was consistent with the Annual Plan declaration. Jill Youds asked how the plans for the Operating Model would be handled and delivered. James replied that it had clinical and executive leadership in order to gain maximum ownership and with rigorous project management and senior clinical ownership adding value, this would increase pace, momentum and visibility. **Non-admitted Pathway** James explained that the standard called for 95% of patients to be treated within 18 weeks of referral. He said that it was flagged last year that there was a risk due to the transfer of head and neck patients from North Bristol. He said that it had been anticipated that Q1 and Q2 would be failed, however it was Q2 before any impact was seen, Q3 and Q4 were subsequently failed with predictions for a further 2 quarters. The root cause was not solely North Bristol patients but also some underlying process issues within the Trust. However progress had been made and the backlog reduced. Emma Woollett said that she understood that the transfer had been problematic as the Trust had not understood the size of the backlog that had built up before the transfer and additionally that ongoing demand had created capacity issues. She asked how much of this was backlog and how much was capacity versus demand in outpatients, or how much was a loss of high performance specialities. James replied that high performing specialities were primarily a cancer issue, but there had indeed been quite a significant increase in demand and business cases were addressing the capacity requirements. Emma noted that causes were 'outside issues' once again. James added that was partly true but also that if the Trust had been better sighted they may have seen the demand coming in order to get on top of it. Alison Ryan asked to what extent consultants reviewed the way they did follow-up appointments. Sean O'Kelly advised that there had been a certain amount of change but techniques and technologies could be used to better advantage. He concluded that there was scope for improvement but this needed to be closely aligned with primary care. Clive Hamilton asked how the absorption of specialised paediatric services would impact on access targets. Xanthe replied that the issues surrounding the transfer of head and neck had been examined with a view to making sure that the same	Action 267

mistakes were not repeated and that there was a clear protocol for the transfer of patients.

Cancer Standards

James explained the standard was that 85% of patients needed to be treated within the 62 day pathway, after referral by GP.

Regarding the more complex tertiary pathways he advised that over 80% of the tumour sites that failed the national standards now sat in the Trust's portfolio, leading to some unavoidable breaches.

Concerning the 31-day standard this had not been failed for 4.5 years. He described this as a 'robust target' that was predicted for achievement in the coming year. Q4 had seen unusual pressure on critical care beds and a large number of cancellations, leading to an unexpected potential failure of the quarter. However, the predictions for the year ahead were positive.

Wendy Gregory asked for clarification regarding critical care cancellations and said that other similar trusts appeared to be achieving better on tackling the 15% of patients who were not being treated in an appropriate timescale. James replied that the 85% 62-day target was not an aim and by taking a more specialised portfolio the need was to get better at delivering that portfolio. Xanthe added that telephone questionnaires with 5 trusts considered to be better performing equivalent providers had recently been undertaken with disappointing results. It had been difficult to identify things they were doing to improve pathways that the Trust was not already doing.

C Difficile

James advised that there had been a year on year reduction in C difficile and whilst the Trust had missed the target there had been significant improvement on the previous year. The limits for next year had increased and the Trust would have the opportunity to discount cases that were not hospital acquired. He concluded that regardless, the focus on making sure the Trust was doing all it could to reduce cases was key.

Summary

The Chief Executive said that the Board were asked to support the trajectories that were in the report, accepting that a risk assessment and not a trajectory for 4-hour Accident and Emergency waits had been shown. He said that it was not yet known how Monitor would escalate with the Trust, in the light of the Q4 performance, and the report was the basis of the briefing that would be supplied to them. However, this would be further developed in the coming weeks particularly around the

operating model initiatives. Non-executives and governors alike welcomed the Breaking the Cycle initiative and noted that the motivation for delivering better patient care was evident. **The Chairman offered thanks to staff that had worked on the plan and said that subject to the caveat on the Accident and Emergency performance forecast, the Board approved the plan.**	
6. Any Other Business *There being no further business the meeting closed at 14.30.*	
7. Next Meeting 28 April 2014 at 09:30 in the Conference Room, Trust Headquarters, Marlborough Street, Bristol BS1 3NU.	