Trust Board

Minutes of the Trust Board meeting held in public on Wednesday, 13 March 2013 at 9:30am in the George Pickering Postgraduate Centre, The John Radcliffe Hospital.

Present: Dame Fiona Caldicott FC Chairman
Sir Jonathan Michael JM Chief Executive
Professor Sir John Bell JB Non-Executive Director
Mr Alisdair Cameron AC Non-Executive Director
Mr Chris Goard CG Non-Executive Director
Mr Geoffrey Salt GS Non-Executive Director
Mrs Anne Tutt AT Non-Executive Director
Mr Peter Ward PW Non-Executive Director
Professor Edward Baker EB Medical Director
Mr Paul Brennan PB Director of Clinical Services
Mr Mark Mansfield MM Director of Finance & Procurement
Ms Elaine Strachan-Hall ESH Chief Nurse

In attendance: Professor David Mant OBE DM Associate Non-Executive Director
Ms Sue Donaldson SD Director of Workforce
Mr Andrew Stevens AS Director of Planning & Information
Mr Mark Trumper MT Director of Development and the Estate
Ms Eileen Walsh EW Director of Assurance
Ms Jane Hervé Head of Midwifery (for item 10)
Mr Adewale Kadiri Deputy Head of Corporate Governance (minutes)

TB42/13 Apologies and declarations of interest

There were no apologies and no declarations of interest were made.

TB43/13 Minutes of the meeting held on 12 February 2013

The minutes were approved and signed as a correct record subject to the following comments and amendments:

- Mrs Tutt clarified that her comment on page 11 about the overspend on the capital budget referred to the fact that capital expenditure targets were genuinely difficult to achieve;
- Mr Cameron observed that an agreement to provide a paper exploring the statistical significance of recent changes to mortality rates for patients admitted at weekends had not been reflected on the action log. Professor Baker stated that a detailed analysis of this issue would be presented to the April meeting of the Quality Committee;
Action (EB):

A detailed analysis of mortality levels of patients admitted at weekends is to be presented at the April meeting of the Quality Committee

- Mr Mansfield stated that the level of over-performance against the contract referred to in the first paragraph of page 8 should be £18m and not £80m;
- Professor Mant asked that the last sentence of the second paragraph on page 5 be amended to read “Professor Mant expressed concern about patient feedback that they were not given adequate safety vetting information.”

TB44/13 Matters arising from the minutes and the action log

There were no matters arising from the minutes or the action log.

TB45/13 Chairman’s Business

Dame Fiona did not report any Chairman’s Business.

TB46/13 Chief Executive’s Report

Sir Jonathan highlighted the following sections from his report:

- He welcomed changes that had been agreed by the NHS Staff Council to the terms and conditions for staff on Agenda for Change contracts. These would bring about more flexibility and link remuneration more closely to local performance activity. He stated that there had been regular dialogue with local staff side representatives about what these changes would mean for staff.
- He reported that formal feedback had not yet been received on the Oxford AHSN application, but that a response was expected shortly, as the network would be expected to be up and running in the new financial year. Sir Jonathan announced that Nigel Keen had been appointed to be Chair of the Network. Mr Keen has an extensive background in innovation, finance and development and is Chair of Oxford Instruments and Isis.
- Sir Jonathan made reference to the changes to the funding arrangements for education and training which had only recently come to light. The new system will be implemented on the 1st of April, and its implications for the Trust will be urgently examined. This information would be incorporated into financial planning for 2013/14, and the Board advised of the outcome.
- As a result of the imminent local elections, it had not been possible to proceed with the consultation on the vision for the Horton General Hospital. It was agreed that the consultation would commence at the end of the purdah period.
- There had been further recognition of the work of clinical colleagues through the NHS Innovation Challenge Prizes. This work had been based on the EPR
system at the NOC and provided a more robust link between patients and investigations. Sir Jonathan also made mention of the BBC series Brain Doctors which was an example of the inspirational work of clinical colleagues. He congratulated all who had been involved in making the programmes.

Mr Ward congratulated Sir Jonathan on being invited to become a member of the National Advisory Group to review a number of hospitals with higher than expected mortality rates, and he asked its potential time commitment and whether this would affect Sir Jonathan’s work at the Trust. Sir Jonathan stated that his personal commitment would be minimal. He expected that there would be 2 to 3 meetings over the next 4 months, but that these were likely to be conducted electronically. He emphasised that this work would have no impact on his role at the Trust.

TB47/13 Quality Report

Professor Baker presented the first part of the report. He advised the Board that mortality, on both the SHMI and HSMR measures, remained within expected limits. Nevertheless, work was continuing with a view to further reducing mortality levels, and each service was required to produce a quarterly report to determine the proportion of avoidable deaths and to identify and share the lessons to be learnt. The HSMR for non-elective admissions at weekends during this financial year was within the expected range. Sir Jonathan explained that the two measures were based on the ratio of observed to expected deaths, and that the National Review of which he was a member was considering those organisations where the ratio had been higher than expected for 2 consecutive years. At this Trust, the trend was downward.

There had been 4 SIRIs in January and all were being investigated. These included a fourth incident of a retained swab at Churchill theatres. It was essential that the necessary lessons were learnt, however, the number of both SIRIs and Never Events remained below expected levels.

Following the full roll out of Datix in October, there had been an encouraging step up in the number of incidents reported. As was to be expected, slips and falls, pressure ulcers and medication errors continued to form the majority of incidents.

On infection control, Professor Baker reported that the Trust remained within its expected range for MRSA with 3 incidents thus far. The Trust was also within the agreed rate for clostridium difficile (C diff), but it would be more difficult to sustain this to year end. The incidences of C diff had been reduced by 20%, and there was a strong focus on the wards, but the Trust may end up slightly above the threshold.

Surgical Site Surveillance (SSI) work had started in cardiac surgery, and the rate was being monitored carefully. Major changes had been made to the way patients were managed, and the mediastinitis rate was 2% with only 1 case recorded since
January. Work on reducing infection rates had now started in orthopaedic surgery and neurosurgery and this would be replicated across all specialities in due course.

Professor Baker advised the Board of a new section to the report, identifying potential quality concerns that had been raised by staff. He listed the issues raised as:

- ED consultants had raised the availability of urgent airway support for children. Interim arrangements had now been put in place and there was a new rota for consultant anaesthetists;
- Cardiac surgeons had raised the issue of staffing in theatres, and this was being picked up by the independent review of theatres that was already underway;
- Individual doctors had raised concerns about the level of support for foundation doctors in the surgical emergency unit and Churchill Theatres. The new rotas being introduced should provide more support but this was to be monitored.

Dame Fiona commended this new development which was in line with the recommendations from the Francis Report as well as the new duty of candour. Professor Baker explained that staff were keen to raise their concerns, and Ms Donaldson added that the Trust was in the process of reviewing procedures for enabling staff to raise issues, and that this initiative ought to be linked to that.

Mr Ward asked what had been done in relation to the SIRI from Emergency Medicine, and why it had not been included on the divisional list. Professor Baker stated that it was still being investigated. Mr Cameron asked if there was any statistical evidence to suggest that the surgical site infections in cardiac surgery had affected outcomes. Professor Baker stated that no changes had been noted, but that this was the focus of the work that was being done, although the rate of post-operative infections was not monitored nationally.

Mrs Strachan-Hall presented the second part of the report on patient experience and safety. She informed the Board that 5 walk rounds had been completed in January 2013, and that the 15 Steps Challenge methodology had now been released by the Department of Health. In relation to the Patient Safety Thermometer, she advised that on the day that the measurement had been taken, there had been a low number of falls. She made reference to the fact that there would be a CQUIN in 2013/14 calling for a 50% reduction in the number of pressure ulcers across the health economy. The focus on the work to meet this target would be on:

- Patients’ ability to change position
- Equipment, and
• Education across sectors, as many of the ulcers that ended up in hospital had been caused elsewhere in the system.

On patient feedback, Mrs Strachan-Hall stated that efforts were still being made to understand the differences in the number of complaints received from one month to the next. Many of these were linked to appointments, and numbers had been low in December, only to peak again in January. She gave an explanation of the scoring methodology for the Friends and Family Test, and stated that the Trust’s early results were favourable. The test had now been rolled out to every ward, and there was a requirement to achieve a 15% response rate in the ED by the end of Q1 of 2013/14.

Reference was made to the nursing quality indicators at paragraph 50 of the report, and the impact of having the escalation beds open was noted.

Mrs Strachan-Hall referred to the twice yearly listening events giving patients and members of the public the opportunity to provide their opinions with a view to them being incorporated into the Quality Account. The most recent event had been affected by the snow, but had provided a forum for frank and open conversations to take place on issues such as safer surgery and communication. Those who attended stated that they had felt listened to. The question was raised as to whether it was necessary to hold the event twice a year.

The continued improvement in the quality of this report was recognised, and the MARS section was seen as particularly helpful. It was suggested that other divisions should do something similar.

Mr Salt informed the Board that at its next meeting, the Quality Committee would review the first results of the Friends and Family Test. He also made reference to the CQUIN on the reduction of pressure ulcers and stated that this must become a priority. On complaints, Mr Salt asked when the analysis of complaints about outpatient appointments would be available. Mr Brennan explained that in relation to Ophthalmology and ENT, changes had been made to the way the Trust interacts with GPs. Monthly audits were being conducted and reported to commissioners, and this had shown that there had been significant improvements in the relationship with patients and GPs. A trial programme had been in place, and a 10 month plan was now being implemented across each speciality based on the level of patient concern generated. He agreed to present to the Quality Committee the 3 reports that had been prepared, and the overall programme of work. Mrs Strachan-Hall added that this presentation could include a “deep dive” into an area where the work done had led to a reduction in the number of complaints.
Action (PB/ESH)

The overall programme of work that was being done to address concerns about outpatient appointments is to be presented to the April meeting of the Quality Committee along with 3 reports on the work that had been completed. This would include an analysis of steps taken leading to a reduction in the number of complaints received.

Mr Goard noted that there had been 7 cases of pressure ulcers on one ward and asked if this was disproportionate. Mrs Strachan-Hall explained that it was difficult to look at trends by ward, but that the matrons would be monitoring the situation on a monthly basis and they would look at issues such as education and equipment.

In relation to the Patient Safety Thermometer, Ms Walsh asked if the harms had been broken down according to whether they were deemed to have been avoidable or non-avoidable. Mrs Strachan-Hall stated that there was no such distinction within the tool, the only differentiation being between new and old harms. She observed that although the tool may evolve in the future, it was essential that staff continued to report incidents in the usual way.

Professor Mant observed that the issue of pressure ulcers was an ongoing one which generated significant numbers of complaints from GPs. He was concerned that the Trust may not be taking the appropriate steps and wanted to know how many of the ulcers occurred within the hospital setting and whether the Trust had benchmarked itself to see if its performance matched national best practice. Mrs Strachan-Hall acknowledged that some ulcers were avoidable and that the plan to address them would be reported to the Quality Committee.

Mr Ward raised questions about divisional performance against the national cleaning scores. Mrs Strachan-Hall explained that the National Cleaning Score assessments were carried out by a contractor and submitted to the Trust. They were not required to be done every month, but should be repeated whenever there was a low score. The question was raised whether the Trust should be using a different measure, and it was agreed that this would be referred to the Quality Committee.

Action (ESH)

The methodology for carrying out cleaning assessments is to be analysed and presented to a future meeting of the Quality Committee.

Mr Trumper stated that there should be measures in place to reflect the overall standard of cleanliness, but that there were presently gaps in information. He stated that a separate operational dashboard relating to non-clinical services would be presented to the Finance and Performance Committee.
Action (MT)

A dashboard giving details of performance of non-clinical services is to be presented to a future meeting of the Finance and Performance Committee

The Board resolved to receive the report and note the actions being taken.

TB48/13 Consideration of Patient Stories

Mrs Strachan-Hall presented this report and made reference to the patient story DVD that had been circulated in advance. This was the first to be received by the Board and told the story of a seemingly routine progression through the cancer pathway. However, there had been variability in the quality of the communication that the patient had received, and the story illustrated the need to make care more personal. Issues had also been raised regarding infection, prescribing and the perception of staffing levels. The Board was reminded that these stories were to help to set the tone for meetings. Mrs Strachan-Hall explained it had been picked up by a matron, and that it would be shared with the division.

It was noted that the patient had used Trust services over a long period of time, making it difficult to ascertain when individual events had occurred. It was agreed that there was a need for the interviewer to be clearer about the timeline of events.

On the wider issue of the source of patient stories, it was suggested that different types of stories should be made available, including the possible use of vox pop to obtain snippets of the experiences of a number of patients on particular issues, such as access to clinics. It was also agreed that a library of stories should be created and that one non-executive director per Board meeting would choose the story to be heard at that meeting. Mr Cameron suggested that instead of relying on recording of the story, a group of up to 30 patients who had lodged complaints about their care could be invited to have a dialogue with members of the Board. He acknowledged that this could be problematic, but might have a greater impact. These could then be compiled into a DVD in real time. Mr Salt recommended more flexibility and topicality, but also stressed the importance of getting a mix of things that had gone well, not so well and the average.

It was agreed that on the basis of all these suggestions, a further conversation would be held at the Quality Committee.

Action (ESH)

A further discussion about the methodology for taking patient stories at Board meetings is to be held at the Quality Committee, taking account of the comments and suggestions from the Board discussion.
The Board resolved to note the contents of the patient story that had been circulated in advance of the meeting and note that actions were being taken to address the specific issues raised. The Board also resolved to note the report on receiving patient stories.

**TB49/13 Report of the Mid-Staffordshire NHS Foundation Trust Public Inquiry**

Professor Baker presented this report and advised the Board that the 290 recommendations in the report by Robert Francis QC had been arranged into themes. The government had announced that they would be responding to the themes rather than the individual recommendations. This was the second report into the events that took place at Mid-Staffordshire NHS Foundation Trust – the first had been published in 2010 and the accounts of patients’ experiences on A&E and on some wards had caused widespread shock. This Trust’s response to that report had focused on values, leadership and developing compassionate excellence.

Much had already been done in response to the first report, and it had been determined that the Trust’s response to this second report should follow on from that work. Mr Francis had concluded that the whole culture of the NHS was wrong and needed to change, and that people had lost sight of the purpose of the service. Contrary to advice, he had recommended the creation of criminal offences, but it was not clear that the government would accept that recommendation, and it was also unclear that the existence of criminal sanctions would improve the culture.

Professor Baker referred to the 5 themes identified in the Francis Report, and suggested that these were the immediate issues for the Board to consider. He drew attention to the recommendation that all organisations should consider the findings and announce at the earliest practicable time the extent to which it accepts them and what it intends to do, within one year, to implement those accepted. This was a big challenge to organisations.

Professor Baker questioned whether the Trust had done enough on changing its culture, and whether more needed to be done on complaints. On mortality, he acknowledged that the Trust needed a better understanding of the measurements, but must also do the work on the ground. He questioned whether the Trust was always quick enough to identify concerns or whether bureaucracy was sometimes allowed to get in the way.

He informed the Board that 11 briefings had been held to inform staff of the key findings from the report and what it meant for the Trust. These had all been well attended, and a summary of responses had been included in the report.

The Board commended the paper and thanked Professor Baker for producing it within such a short timescale. Mr Cameron commented that candour and openness
were major issues, and he questioned whether the introduction of criminal sanctions would be helpful. He suggested instead a radical commitment to continuous improvement in order that no member of staff would consider suppressing a problem, but he acknowledged that this was a long way from where the service currently was. Mr Goard stated that he had found the summary of issues raised at the staff briefings helpful as it indicated a real focus on the things that mattered: leadership throughout the organisation, nursing, staffing levels and the use of bank and agency staff. This gave a clear indication of where work was required. He suggested that the Listening into Action initiative could enable the Trust to use staff as agents for change.

Sir Jonathan remarked on a conversation he had had with Mr Francis at a meeting in which the latter had recognised the various pressures facing the NHS. The Mid-Staffordshire Trust had responded inappropriately to these pressures, but they were still there for all organisations. It would be difficult to respond to the recommendations in isolation of the wider NHS system, but that system was changing. In relation to the issues raised by staff, Sir Jonathan remarked that these were all things that could be achieved by staff locally if they were empowered to do so, but he acknowledged the context within which the Trust was required to operate. On complaints, he suggested that in some cases, complainants could be invited to Board meetings, but that this would need to lead to action being taken. He concluded that the Trust was making steady progress but that it is a long way from where it ought to be.

Professor Mant commented on the significant agenda facing the Board and expressed the concern that this could mean that patient feedback never got heard. He referred back to the suggestion made during the discussion on patient stories that non-executive directors became involved not just in choosing stories but also in holding discussions with complainants as a way of changing the culture. Dame Fiona remarked that this was a good start to the debate which she was sure would continue.

The Board resolved to note the contents of the report.

TB50/13 Review of the Midwifery led unit in Chipping Norton

Mr Brennan presented this report and welcomed Ms Hervé to the meeting. He stated that the paper contained the complete review as well as the information supporting the outcome, including interviews with GPs, local people and staff. He referred the Board to the 4 issues that had been brought to the Trust’s attention and led to the review – higher than expected transfer rates, the culture of the unit, a fall in the number of births taking place there, and concerns raised by some couples who had used the unit. As a result of these issues, it had been decided to suspend births
at the unit and conduct the review. Mr Brennan made reference to the methodology for conducting the review, which included attendance at HOSC meetings, and he emphasised the independence of the process, even though it had been conducted by Ms Hervé as the Trust’s Head of Midwifery. Although all staff who had been interviewed as part of the review had the opportunity to be accompanied, none of them had opted for such support.

He highlighted the various sources of evidence received during the review, and summarised the findings. The key issues were:

- Differences in the culture and management between the previous and the new unit. Information was received from staff that Trust guidance was not being followed on a consistent basis, and that the service provided was inconsistent with that at other Trust units. The review highlighted positive and negative aspects to this;
- There were inconsistencies in the way that women were accessing the antenatal care provided by the unit.

The review concluded that it was appropriate to reopen the unit, but a number of recommendations for improvement were made, many of which would need to be addressed before reopening, scheduled for 1 July 2013. One key recommendation was that there needed to be a substantial increase in the number of births taking place at the unit to ensure that it remained viable. Mr Brennan explained that the key message in this regard was that in order to secure an increase in the number of births, there needed to be more interaction with local commissioners and GPs. Presently, only women from certain sections of the community appeared to be using the unit, and GPs did not routinely refer women there. The proximity to maternity units at the Horton General Hospital and Warwick Hospital was also identified as factors, as some of the women accessing those services could be using the Cotswold Unit. Ms Hervé was to work on a more detailed action plan to be completed and agreed by the end of April to enable reopening on 1 July.

Mr Cameron observed that no recommendations had been made in relation to accountability. He observed that before publicising the unit, the Trust needed to be clear why it would recommend it for women to use. Mr Salt commended the report, and observed that it was easier to reinforce the right culture in a bigger unit or organisation than a smaller one. He questioned why key leaders had not visited the unit more. On the numbers, he also asked about the level of provision that was deemed appropriate for the whole county.

Mr Brennan acknowledged that issues at the unit had not been picked up at an earlier stage, and agreed that senior managers ought to be visiting outlying centres more often. With regard to the configuration of services across the county, he stated
that the Trust needed to work more with the CCG to ensure safety. He observed that the direction of travel would support the growth of more midwifery led units, and that the review provided an opportunity to observe any differences between this and the Trust’s other two units as, it possessed all the features required for success. He reiterated the need to get the leadership and culture right, and ensure that Trust and clinical guidelines were adhered to. The success of the unit would depend on collaborative work to promote its use.

Mrs Strachan-Hall questioned the extent to which the care provided at the unit complied with national guidance on the safety of midwifery led units, and she suggested that the recommendations on the supervision of midwives be strengthened. She also advised that the recommendations should be implemented before 1 July if possible. Ms Hervé advised that the report on a study of midwifery led care had shown that care provided at such units was generally safe for the second and subsequent children, but not as safe for the first, but she acknowledged that more research was required in this area. She agreed to strengthen the supervision recommendations, and remarked that supervision had probably been happening, but it needed a higher profile. She stated that 1 July had been chosen because of the number of actions that needed to have been addressed, but she agreed that if the actions could be dealt with earlier, a request could be made to reopen the unit before July.

Mr Brennan emphasised that the work with GPs and commissioners needed to have been completed, and cautioned that reopening the unit before this had been done could lead to a loss of confidence by local women. Professor Mant noted that only 3 GP practices had responded to the review, and suggested that the top midwife in the area would need to work with practices to gain their confidence. It was agreed that Professor Mant and Ms Hervé would discuss this in further detail outside the meeting.

Sir Jonathan reminded the Board that the Trust had a legal obligation to comply with NICE guidance. He revealed that he had received a formal request from the leader of West Oxfordshire District Council for the unit to be reopened at the earliest opportunity. He suggested that the Board review progress against the action plan at both their May and June meetings. He acknowledged that it may be possible to reopen the unit slightly earlier, but that the Board must be assured of its safety first.

**Action (PB)**

*Progress against the agreed action plan to address recommendations from the review, is to be presented at the May and June meetings of the Board*
The Board resolved to note the contents of the review report, subject to the recommendations being strengthened, and to support the timeline for reopening the unit, subject to comments made about the possibility of reopening before July.

**TB51/13 Foundation Trust update**

Mr Stevens presented this report, and informed the Board that the Trust was at the end of the SHA part of the process. All of the additional information requested in January had been submitted. The next stage of the process was for the SHA to review the information and formally hand the application over to the TDA, with whom steps were being taken to establish a point of contact. The Trust’s application could then be placed in one of 4 categories, namely:

- Immediate action
- Minor works required
- Major works required
- Alternative route required

Mr Stevens reported that the expectation was for the application to be placed in the second category because of the requirement to update the IBP, and it was anticipated that both the updated IBP and LTFM would be available in June/July. He also reported that further strengthening of the 2014/15 CIP programme was taking place, and that a major staff consultation exercise would be undertaken over the next 3-4 months as part of steps to embed a culture of openness and candour across the Trust. Each member of staff would be able to spend time with a member of the corporate management team.

He referred to preparations that were being made for elections to the Council of Governors. Dates had been placed in diaries to undertake work with members of the public and staff interested in standing for election.

The Francis Report had called for the FT pipeline to be slowed down, and it was suggested that the process may be delayed until the role of the CQC in this regard had been clarified. In the meantime, the need to maintain performance was reiterated, as the Trust had not met the A&E 4 hour waits target for this quarter. It was unclear what the impact of not meeting this target, and the ongoing difficulties on delayed discharges, would have on the application. Sir Jonathan indicated that the message from the centre was that efforts to meet targets should not be to the detriment of patient care, and the volume of activity meant that it was taking time to get patients through the system. He observed that the delayed discharge issue was particularly acute in Oxfordshire. His view was that these difficulties would be taken into account but that they would not be stumbling blocks to the application. However the Trust could not afford to have another area of sub-optimal performance.
Mr Ward questioned whether, in light of the present uncertainty around the process and the challenges that the Trust was facing, the work being done to prepare for FT status should be paused. Mr Stevens stated that although the TDA process was still in a skeletal form, and the structure had not been fully populated, the high level process had been established. He also reminded the Board that the Trust was not doing anything contrary to what was required to run the organisation appropriately.

The Board resolved to note the contents of the report

**TB52/13 Oxford Academic Health Science Network**

Sir Jonathan presented this paper to update the Board on the Network’s activities and plans. Mr Ward suggested that the Board might appreciate an update on the joint working agreement with the University of Oxford, and Sir Jonathan agreed to present a report on this to a future Board meeting.

**Action (JM)**

*An update on the joint working agreement with the University of Oxford is to be presented at a future Board meeting.*

The Board resolved to note the contents of the update report.

**TB53/13 Integrated Performance Report Month 10**

Mr Brennan presented this report and set out the key highlights as follows:

- Performance across most key access standards remained positive – VTE 90% (95% for March), mortality – just under 4%, RTT Admitted and Non-admitted targets achieved at Trust level and at specialty level for admitted, cancer standards met for December (the January unconfirmed figures also indicated that the standard was achieved);
- On the other hand, the Trust would not be able to meet the 4 hour A&E target for Q4. There had been significant increases in activity, with 117,000 patients seen, against a target of 102,000 and there had been 62,000 emergency admissions instead of the expected 42,000. 118 escalation beds were open, and it had not been possible to keep patients moving smoothly through the system. Mr Brennan reported that there were difficulties across all Trusts within the Thames Valley area;
- The number of delayed transfers had fallen to 94 before Christmas, but since then had risen to 180 and now stood at 170, mainly at OUH. Although the new system-wide discharge policy was being implemented, for every 9-11 discharges, there were 70 mainly acute medicine, geratology or trauma admissions;
- There had been a big increase in demand for diagnostic procedures including MSK, ultrasound and MRI. This had led to the 6 week waits being exceeded, but recovery plans were in place.

The Board discussed the adequacy of the Trust’s mitigation plans for the winter pressures. It was acknowledged that the ED and Acute Admissions teams had been severely stretched this year, and it was agreed that capacity should be set at the level that the Trust considers realistic, rather than relying on this year’s figures. It was also noted that the level of demand during the winter months had been rising continuously for some years. Mr Mansfield referred to TDA guidance stating that Boards were to set targets that were stretching and achievable. There was a lack of certainty about demand, and the Trust would need to continue working on demand management because of the 30% limit.

Mr Cameron raised the issue of permanent staffing within the Trust, stating that demand had been systematically understated, which had put pressure on the financial position and compromised quality. He considered that the Trust ought to be able to scale up and down without the need for recourse to agency staff. It was agreed that Ms Donaldson would address this in a future paper,

**Action (SD)**

The Board resolved to **note** the contents of the report.

**TB54/13 Financial Performance to 31 January 2013**

Mr Mansfield presented this report which reflected the current position, and was the first time a single report had been produced to the Board. He advised that the income and expenditure position remained on plan, and that the Trust was still on course to achieve 90% of its CIP target (£45m of £49.5m). Mrs Tutt noted that only £15.7m of the £19.7m divisional efficiency programme had been delivered, but Mr Mansfield assured the Board that the programme would be delivered.

In response to a question about R&D income, Mr Mansfield stated that there was a risk that any significant underspend against this budget could be clawed back. He pointed out that most R&D projects had long gestation profiles. A discussion had been held with the SHA, and there was a possibility that the policy could change after the end of the financial year.

Mr Salt observed that 6 AACs had already been held for new consultant appointments and that a further 11 were in the pipeline. He wanted to know if there was sufficient joined up thinking about the Trust's future staffing needs across all groups. Mr Mansfield stated that this was being considered as part of the Trust’s business planning process, and that sessions were being held with the divisions.
Detailed analysis was being undertaken of different workforce needs, including opportunities for role re-design.

Delivery of the capital programme was on track, and much of the plan was to be delivered at the end of the year. In answer to a question about the £600,000 variance in relation to the NICU, Mr Mansfield stated that because of the way the project had been phased, the Trust would be paying less during this year. The bulk of the work was meant to have been done in February, but would now be completed in July. He explained that the funds relating to the Kadoorie Centre were accounted for in a different way and were required to be reflected as income.

In response to a question about the impact of CQUINs, Mr Mansfield explained that there were 6 high impact schemes, 3 of which the Trust would probably be required to sign up to. Although the local CQUINs had been agreed, negotiations were underway as to what would trigger payment. There were also some other national schemes including, for example, pressure ulcers. He confirmed that meeting these schemes would not result in additional income for the Trust. The overall number of CQUINs had been reduced in favour of fewer higher impact schemes. Mr Goard confirmed that the Finance and Performance Committee would be monitoring performance against them.

The Board resolved to note the contents of the report.

**TB55/13 Staff Survey 2012**

Ms Donaldson presented this report. She stated that the key headline was that the Trust was building on work that had been done following the last survey, as a result of which the results had generally improved. She stressed that there was no room for complacency as there was still some way to go, and more work was being done on staff engagement linked to the strategic objective “delivering compassionate excellence”. It was too early to assess if the Listening into Action initiative and the staff recognition awards had had an impact on the results. There were detailed action plans in place to address those areas where improvement was required, and work was being done with divisions to assess these.

Ms Donaldson reminded the Board that turnover and sickness absence rates had increased, and as such, it was important to place the staff survey results within a broader context. She stated that the divisional overview mirrored the Trust position, but that there was a need to look more closely at the corporate divisions. A paper would be presented to the Workforce Committee, TME and then the Board recommending the conducting of more regular localised surveys across the Trust, and taking “pulse checks” of the views of patients and staff simultaneously.
Mr Salt commended the report, and acknowledged the significant progress made since the previous survey as a sign that much good work was being done. Sir John agreed that the report was helpful but was concerned that 1 in 6 of respondents had said that they would not recommend the Trust as a place to work. He observed that the responses indicated a lack of control, lack of involvement and stress, and he saw this as a leadership issue. Ms Donaldson indicated that although the number of staff who would recommend the Trust as a place to work had not moved in the national survey, the local version had shown some improvement, and that action planning had been based on the results of the local survey.

Professor Mant referred to the fact that almost half of respondents did not consider that there was enough staff within the organisation to enable them do their job properly, and he wanted to know how the Trust compared to others in this regard. Mr Brennan stated that in relation to the employment of doctors, the Trust was higher than the national average, and that the level of ward staffing was appropriate to the numbers of patients and their acuity. Ms Donaldson acknowledged that the survey scores were at the lower end of staff perception in this area, and suggested that more local comparisons would be helpful. She also reported that the turnover and sickness absence rate were being analysed by grade of staff and location.

Mr Goard suggested that analysing the data by division would be useful and could present a different picture. He also made reference to the more negative feedback on fair treatment following errors or incidents, and acknowledged that this was an area where it was often difficult to strike the right balance.

The Board resolved to note the contents of the report.

**TB56/13 Arrangements for approval of annual accounts**

Mr Mansfield presented this brief paper setting out the proposed timetable for approval of annual accounts for 2012/13. The Audit Committee would meet on 6 June to agree the audited accounts, followed on the same day by a Trust Board meeting to adopt and approve them for submission to the Department of Health.

The Board resolved to note the contents of the paper and approve the request for an additional public meeting at 5:00pm on 6 June.

**TB57/13 Initial Revenue and Capital Plans 2013/14**

Mr Mansfield presented this report and informed the Board that because of the uncertainty within the system, these plans were subject to change. He expected them to be affected by discussions with commissioners. The plans reflected the aspiration to achieve a 1% surplus.
Mrs Tutt questioned the rationale of having the 2012/13 income and expenditure plan as the starting point for 2013/14. Mr Mansfield explained that it was preferable to start with a plan rather than rely on outturn. He stated that account would be taken of outturn and differential performance and that this would ultimately lead to an alignment of income to expenditure. He emphasised the importance of incentivising the right behaviours, and that additional expenditure would need to be justified.

It was noted that some capital investment was taking place outside of the county, and Mr Mansfield explained that this was in relation to satellite radiotherapy services but that they were Trust services.

The Board resolved to **approve** the opening financial plan for 2013/14.

**TB58/13 NHS Trust Oversight Self-Certification**

Mr Stevens presented this paper. He informed the Board that the Trust had now made its January submission, and that work was being done to justify the level of assurance that supported the self-assessment.

The Board resolved to **delegate authority** to the Chairman and Chief Executive to sign off the submissions to the SHA on an on-going basis.

**TB59/13 Board Assurance Framework (BAF) 2012/13 and Corporate Risk Register**

Ms Walsh presented this paper. She reminded the Board that the BAF and CRR had been presented to them on 2 previous occasions during the year, and she highlighted changes to both documents. She advised that some scores had moved downwards, an indication that the process had started to work. Ms Walsh also referred to the extensive work that had been done on developing the Trust’s risk appetite.

Mrs Tutt commented that the general risk appetite statement provided a good summary of where the organisation was. Ms Walsh indicated that this work ought to be replicated within the divisions.

The Board resolved to **note** the updated Board Assurance Framework and Corporate Risk Register and **approve** the general risk appetite statement.

**TB60/13 Report from Board sub-committees**

(a) **Finance and Performance Committee**

Mr Goard presented this report and announced that at its next meeting, the Committee would be considering the possibility of a joint venture with Oxford Health NHS Foundation Trust in relation to the management of delayed discharges. It had also been agreed that CIPs would be considered over a longer timeframe, not just
financially, but qualitatively. There was a need to consider the uncertainty around specialist and non-specialist commissioning, and its strategic implications for the Trust.

(b) Quality Committee
Mr Ward presented this report and highlighted the key issues that had been discussed at the meeting in February as:

- The decision to suspend emergency abdominal surgery at the Horton General Hospital
- Churchill surgery
- The radiology backlog
- A discussion with the divisional director of EMTA regarding the changes in acute general medicine
- Endorsement of the high level quality priorities

The Board resolved to note the contents of both reports.

TB61/13 Consultant appointments and signing of documents

Sir Jonathan presented a regular report to the Board on the use of delegated authority regarding the appointment of consultant medical staff, the signing of documents and the use of the Trust Seal.

The Board resolved to note the contents of the report.

TB62/13 Any Other business

Sir Jonathan reminded the Board of the CQC inspection of the John Radcliffe Hospital that had taken place at the end of February. The inspection team had visited Wards 6A and 7C and 3 areas within the Maternity Department, and had considered outcomes 4 (care and welfare of patients), 8 (cleanliness and infection control), 13 (staffing) and 14 (supporting staff). The draft report had not yet been received, but the initial feedback had been positive. It was anticipated that the draft would be provided within 2 weeks for factual accuracy checks.

TB63/13 Date of the next meeting

A meeting of the Board to be held in public will take place at 09.30 on Wednesday 8 May 2013 in the George Pickering Postgraduate Education Centre, the John Radcliffe Hospital.

The Board then considered and agreed the following motion:

“that representatives of the press and other members of the public are excluded from the remainder of the meeting, having regard to the confidential nature of the
business to be transacted, publicity on which could be prejudicial to the public interest (Section 1(2) of the Public Bodies (Admissions to Meetings) Act 1960).