Trust Board

Minutes of the Trust Board meeting in public held on Wednesday 13 September 2017 at 10:00 in Seminar Rooms 4A/4B, George Pickering Education Centre, John Radcliffe Hospital.

Present:

Dame Fiona Caldicott FC Chairman
Dr Bruno Holthof BH Chief Executive
Dr Tony Berendt AB Medical Director
Mr Paul Brennan PB Director of Clinical Services
Professor Sir John Bell JB Non-Executive Director
Mr Jason Dorsett JD Chief Finance Officer
Ms Sam Foster SF Chief Nurse
Mr Christopher Goard CG Non-Executive Director
Ms Paula Hay-Plumb PHB Non-Executive Director
Mr Peter Knight PK Chief Information and Digital Officer
Professor David Mant DM Non-Executive Director
Mr Geoffrey Salt GS Vice-Chairman and Non-Executive Director
Mrs Anne Tutt AT Non-Executive Director
Ms Eileen Walsh EW Director of Assurance
Mr Peter Ward PW Non-Executive Director
Ms Susan Young SY Interim Director of Workforce

In attendance:
Ms Susan Polywka SP Head of Corporate Governance and Trust Board Secretary
Dr Neil Scotchmer NS Programme Manager

Apologies: None

TB17/08/01 Apologies, welcome and declarations of interest

The Chairman welcomed Ms Sam Foster, Chief Nurse and Ms Paula Hay-Plumb, Non-Executive Director to their first meeting of the Trust Board.

No declarations of interest were made.

TB17/08/02 Minutes of the meeting held on 12 July 2017

Minutes of the meeting held on 12 July 2017 were approved as a true and accurate record of the meeting.

TB17/08/03 Matters arising from the minutes

There were no matters arising that were not on the agenda.

TB17/08/04 Action Log

The Action Log was reviewed, and the status of actions agreed as recorded.

Updates were provided in relation to the following items:
Review of cash management processes

The Chief Finance Officer advised that the work on cash management processes was unlikely to be completed in time for report to the Audit Committee in September 2017, but confirmed that the internal auditors were undertaking work in respect of which a new timescale for report would be agreed.

**Action: JD**

Risk assessment of the impact of cross-site working on IR[ME]R compliance

The Medical Director advised that it was planned to submit a comprehensive update on IR[ME]R (Ionising Radiation [Medical Exposure] Regulations) compliance directly to a future meeting of the Board.

**Action: TB**

Scheduling of Committee Annual Reports

The Director of Assurance confirmed that Annual Reports of the sub-committees to the Board had been scheduled in the forward plan of business for the Board, and it was agreed that this action could be closed.

The Trust Board noted and agreed the status of actions as recorded on the Action Log.

**TB17/08/05 Chairman's Business**

The Chairman informed the Board that elections to the Council of Governors had taken place and the results published. A number of new governors would be welcomed to the Council. In addition, those governors re-elected were congratulated, and those leaving the Council would be receiving a letter from the Chairman to thank them for their contribution to the work of the Council.

The Chairman also noted that the current Council of Governors was due to have a joint seminar with members of the Board on Friday 15 September.

**TB17/08/06 Chief Executive’s Report**

The Chief Executive presented his report, in particular highlighting the issues referred to below.

The Trust had moved promptly to evacuate the Trauma Unit to two new wards following receipt of the fire safety report. Thanks were expressed to all members of staff for maintaining safety during the move, noting that this involved not just nursing and medical staff but also non-clinical staff such as the painters who had worked quickly to redecorate areas into which patients were being moved.

The Chief Executive also highlighted that the Annual General Meeting would take place on 11 October 2017, with a slightly different format from previous years. All were encouraged to attend and hear about developments in the past year.

Completion of the Hospital Energy Project was confirmed, noting that it would be officially opened in November 2017. It was recognised that this had been a long and difficult piece of work, which had impacted on the local community, but the benefits of cost savings and reduced carbon emissions were being realised, and the project had been shortlisted for a sustainability award.
Mr Geoff Salt, Non-Executive Director asked whether local residents would have the opportunity to attend the official opening event in November, and the Chief Information and Digital Officer confirmed that this should be possible.

The Chief Executive also reported that John Drew, the new Director for Improvement and Culture, would be joining the Executive Team in October 2017.

Other developments which were highlighted included:

- Commencement of the new band 5 nurse recruitment and retention programme, “Onward”, which it was hoped would improve retention in a staff group where the Trust had previously seen high turnover.
- Jane Hervé had now taken up her new role as Freedom to Speak Up Guardian.
- Professor Gavin Screaton had taken up post in the position of Head of the Medical Sciences Division.

Mr Salt suggested that Professor Screaton be invited to join the Board at a future seminar and this was supported by the Chairman.

Action: FC

Mr Peter Ward, Non-Executive Director noted that the Chief Executive’s report outlined commencement of a new 111 service, and asked whether it was anticipated that this would have an impact on OUH services. The Director of Clinical Services explained that these changes were commissioner-led, although the Trust had had input into the algorithms. He noted that the intention was that the revised service should, overall, reduce attendances at the Emergency Department.

**TB17/08/07 Staff Perspective**

The Chief Nurse presented the story provided by a junior doctor in her foundation year. The importance of recognising staff experience was highlighted, noting the correlation between a high staff engagement score and the overall quality of care delivered to patients. The doctor reported a largely positive experience with support from doctors and nurses in the team, emphasising the big transition from medical student to junior doctor. The doctors’ mess environment was highlighted as a safe haven for support from colleagues.

In relation to the issue of transition, the Medical Director assured the Board that all foundation year doctors were offered a week of shadowing and instructional events including a highly-regarded real time simulation using a bleep to train doctors in prioritising calls. The induction process was felt to be robust but further work was in progress regarding the adjustment of junior doctors to a work environment.

The Medical Director also recognised that protected space for doctors was important and that this increased their contentment, noting that this raised questions about which other staff groups should have such space provided. The former Director of Organisational Development and Workforce had previously explored a redesign of the doctors’ mess but this had not progressed. Professor Sir John Bell, Non-Executive Director emphasised that this made a difference to doctors and urged that the project for redesign of the doctors’ mess be reinvigorated if possible. It was confirmed that there was now momentum to revisit this with charitable support and the Chief Information and Digital Officer was taking responsibility for the project.
The Chief Finance Officer noted the junior doctor’s comments regarding uncertainty of salary and the Medical Director confirmed that a survey of the Trust’s doctors had indicated that a significant proportion had experienced such uncertainty. Work had been undertaken within Human Resources to address this, though it was pointed out that the new contract had introduced a number of difficulties and there were three different pieces of paperwork that required completion to calculate the salary.

In relation to emotional support, Mr Salt asked what the Trust should be providing in circumstances such as a doctor witnessing their first death. The Chief Nurse explained that the Trust was already looking at support for emotional resilience within the organisation and that support was also available through the foundation trainee group. The Medical Director highlighted that these doctors had formally nominated supervisors and access to other support if they experienced difficulties, noting that, compared to many staff groups, these were a highly supported group of individuals. He noted the difficulty in proposing a hard and fast rule regarding the support required after the death of a patient, as needs would differ between individuals.

The Interim Director of Workforce advised that the Trust also had an employee assistance programme telephone line in place which was available to all staff and could provide assistance under these circumstances.

Professor David Mant, Non-Executive Director highlighted the reference to the importance of senior nursing support and asked if this should be formalised. The Chief Nurse commented that her first impressions were of a very strong team ethos throughout the Trust. She noted that doctors were increasingly being assessed in a multi-professional way and there should be no hesitation in escalating through the nursing team where this was required.

Professor Bell commented that he was somewhat encouraged to note that the junior doctor had not highlighted any particular issues relating to the new contract arrangements.

The Medical Director commented that the junior doctor’s story raised the issue that clinicians sometimes did not seem to perceive writing notes and prescriptions as clinical work and that this perception needed to be challenged and changed. The Director of Assurance agreed that in balancing the demands of hands on patient care and being ‘overloaded with administration’, it should be recognised that much of the latter was an integral part of clinical care, underpinning compliance within the regulatory framework, and rightly constituting a fundamental part of professional duties. It was suggested that this should be addressed in the cultural change work to be led by the incoming Director of Improvement and Culture and the Chairman proposed that it might be helpful to use the terminology of ‘clinical admin’.

Professor Bell commented that clinical culture had changed in recent years, with less time tending to be spent face-to-face with patients, partly as a result of the increasing requirement on clinicians to enter data into the EPR (Electronic Patient Record). He emphasised the importance of ensuring that this process was as quick and efficient as possible, and the Chief Information and Digital Officer confirmed that this was the aim of the Trust’s strategic objective to Go Digital. As an example, he confirmed that a system of digital dictation via mobile phone was being piloted in the Renal Service.

The Chairman asked for clarification regarding whether historical notes would be available as part of the EPR. The Chief Information and Digital Officer confirmed...
that past notes relating to current patients would be scanned and other historical notes would be archived in line with accepted practice.

The Chairman commented that the junior doctor's story conveyed the powerful impact of experiences at the outset of a professional career, and suggested that might be discussed further with a representative group of junior doctors. She asked that the junior doctor concerned be thanked for providing this story.

**Action:** SF

The Trust Board reflected on the staff perspective, and noted the key learning points which had been drawn from it.

**TB17/08/08 Quality Committee Report**

Mr Geoff Salt, Non-Executive Director and Chairman of the Quality Committee presented the regular report from the meeting of the Quality Committee held on 9 August 2017.

In introducing the report, he highlighted that the current primary focus of assurance was on guarding against the risk that operational pressures were impacting on patient care. In particular, the Committee had spent considerable time looking at the impact of nurse staffing shortages.

Mr Salt also highlighted the presentation delivered by the Interim Director of Workforce, which indicated that pay was not the most significant factor affecting staff retention, but rather that the importance of the OUH values was cited as one of the main reasons why staff had joined the Trust, while a failure to demonstrate the OUH values would be one of the main things that would contribute to them leaving the Trust.

The Interim Director of Workforce explained that this had been based on a simple survey on the staff intranet covering what made people join the Trust and what made them stay. Over 1000 responses had been received in two weeks.

Beyond the importance of Trust values, opportunities for development and career progression, along with flexible working, were cited as the top 2 things that would encourage staff to stay. The factors most likely to contribute to staff leaving included a ‘general dislike of duties’ or a poor working relationship with a line manager.

Pay and benefits only featured ‘mid-table’ at most amongst the factors stated as having influenced staff joining the Trust, or encouraging them to stay. The cost of living, and the prospect of better pay elsewhere, were at the bottom of the table of 14 factors cited as contributing to why staff would want to leave the Trust. Lack of parking and travel costs were 5th and 6th from the bottom of that table.

Mr Salt highlighted the actions agreed, and the Chairman noted that the Board would await a further report at its next meeting.

**The Trust Board received and considered the regular report from the Quality Committee.**

**TB17/08/09 Quality Report**

The Medical Director introduced the Quality Report to the Board. This showed good progress on quality priorities. Reductions in cardiac arrest were linked to the roll out
of SEND (System for Electronic Notification and Documentation) and sepsis responsiveness also appeared to be improving. An event to increase sepsis awareness was taking place on 13 September. It had been agreed that priority four would be broadened to include mental health issues identified as part of CQC reporting.

It was highlighted that good progress had been made against quality priority five, cancer pathways, with the introduction of a daily ‘cancer huddle’ for all tumour sites now taking place via a teleconference with senior managers and clinicians. It was reported that this had had a major positive impact in reducing the number of on-the-day cancellations.

It was noted that further work was required on WHO checklist compliance to understand the challenges where 100% compliance was not being achieved. This would support the prevention of certain types of never event.

The Medical Director reported by exception that two recent never events had occurred since the reporting period that was covered by the Quality Report submitted: one never event had related to incorrect patient identification and the other to a retained swab. The latter was noted to be a failure of documentation and communication, rather than being related to the WHO checklist.

Mrs Anne Tutt, Non-Executive Director asked what action was being taken in relation to the WHO checklist, given that every member of staff should be clear about the requirements. The Medical Director suggested that it was important to get clinical teams involved in understanding the reasons for unwarranted variation, and appreciating that standardisation should release cost savings.

It was noted that issues related to mortality investigations were to be considered later in the meeting but the Medical Director highlighted that numerical indicators of mortality had been stable for a long time. He noted that the SHMI (Summary Hospital-level Mortality Indicator) was now significantly below 100 which was encouraging although he recognised that there was some dispute as to the value of this indicator.

The Chief Nurse then presented the sections of the report relating to patient experience and nurse and midwifery safe staffing.

In relation to nurse safe staffing levels, she reported that the situation was fairly fragile, requiring intensive and robust day-to-day management. Six-monthly reviews were reported to have been instituted for the Emergency Department and wards. Safe staffing meetings took place three times a day, to take steps necessary to maintain safe staffing levels (including the closure of beds), and to identify and manage any residual risk that remained. Further thought was being given to how assurance could be provided to the Board in relation to that level of residual risk, and its management.

Work was reported to be underway to recruit cohorts of nurses from the Philippines, Spain and Ireland. The Trust was also looking in partnership with Oxford Health to develop existing staff including care assistants, to combat the challenging local recruitment environment.

The Chief Nurse commented that the offer of flexible working could have a positive impact on staff retention, but recognised that there was also the potential that this
could have a negative impact on colleagues not working flexibly, and this was being taken into account in the review of the policy that was underway.

Mr Christopher Goard, Non-Executive Director highlighted the data on reported GP feedback and asked if enough was being done to ensure that all clinicians realised that the Trust was part of a pathway, and that the requirement of teamwork included the timely sharing of information with colleagues in primary care. The Chief Information and Digital Officer emphasised that from a technical perspective a large volume of information was exchanged electronically, including details about discharge summaries. He explained that the current upgrade to EPR would integrate access to both parts of the record to join them more naturally for clinical staff.

The Medical Director commented that the importance of communication was emphasised at induction. He suggested that GP feedback indicating an increase in difficulties experienced in obtaining clinical assistance was surprising given the work that had taken place to ensure that an immediate medical response was offered via a dedicated telephone line.

The Director of Clinical Services noted that OUH didn’t have the data to assess how its performance compared with that of other organisations as the information relating to the issue of discharge summaries was the Trust’s own which had been shared with CCG colleagues. Since no other organisations provided information on their performance, it was not possible for the CCG to monitor the Trust’s performance against any benchmarks.

The Chief Nurse remarked that, based on her experience of other organisations, she observed that the Trust handled and responded to complaints to a high standard, and in accordance with a very transparent process. It was suggested it would be a useful exercise to find an organisation willing to be similarly transparent in comparing performance.

Mr Peter Ward, Non-Executive Director noted that the narrative provided in relation to some of the key indicators was not always clear about the actions being taken by the Trust. For example, the narrative explanation of why 73.49% patients were receiving stage 2 medicines reconciliation within 24h of admission (against a target of 80%) referred to the need for additional pharmacy ward based services on weekends, but did not stipulate the timeframe within which a business case would be developed to provide weekend pharmacy support in 4 further key admission areas.

It was explained that this work was linked to quality priorities re-engineering which would allow take home medicine to be processed faster following an initial write up by a pharmacist. This required doctors to enter medicines into the EPR in a way that should make reconciliation straightforward.

The Director of Assurance noted the chart on cleaning presenting figures for actual against the contract target. She suggested that the Board may wish to receive further assurance regarding whether the difference in scores was reflected in any variation in key clinical metrics, including infection control.

It was also noted that the list of clinical audits presented did not make it obvious which of them had highlighted areas for improvement, and which identified areas of good practice and suggested that the presentation of this data could be improved.
Mr Salt noted that, in relation to quality priority nine, Learning from complaints, a meeting had been held with an inclusive group of volunteers to look at complaints involving communications issues. He asked if the outcome of that meeting would be shared, and expressed the hope that the Trust was able to draw learning from all of patients’ experience, not just from complaints made. He suggested that it would be a helpful exercise to understand better what it was like to raise a complaint in the Trust.

It was recognised that the number of issues raised by the CCG was small as a proportion of GPs’ patients. However, it was recognised that the former Director of Planning and Information had played a crucial role in holding meetings with GPs in localities; building relationships, demonstrating the Trust’s commitment to addressing, and fostering collaborative system working. The need for the Board to be assured that this remained a priority was noted. The Director of Clinical Services confirmed that this remained an important focus, particularly in the north of the county, and was something in which he and the Medical Director would be closely involved.

The Trust Board noted the contents of the report.

TB17/08/10 Finance and Performance Committee Report

Mr Peter Ward, Non-Executive Director and Chairman of the Finance and Performance Committee, presented the regular report from the meeting of the Finance and Performance Committee held on 9 August 2017, noting that it had been chaired by Mrs Anne Tutt, in his absence.

The report recognised the significant challenges in operational and financial performance and highlighted as a key theme the requirement for collaboration across the system, especially in relation to patient discharges and weekend working.

The need to deal with the RTT (Referral to Treatment) waiting time backlog was noted, recognising the four month lead time required to achieve significant increases in capacity.

In relation to financial performance, the Committee had received details of the monitoring of deficits against control totals, noting that three out of five of the clinical divisions had reported significantly improved financial performance. The Chief Finance Officer had reported on progress on the modernisation of corporate services and the Committee had received an update on the capital programme.

Key risks identified by the Committee included those relating to financial plans with a reforecast of the 2017/18 position underway, to RTT where five focus specialties were currently being reviewed, and to four hour wait performance where further planning was underway.

Mrs Tutt commented that the Committee had specifically discussed the importance of understanding how quickly the impact of controls would be reflected in the numbers reported. She noted that lots of actions were being taken but if these were not effective it was important to be clear how quickly further interventions might need to be made. Mrs Tutt also suggested that the presentation of the financial information could be further improved, to make it clearer exactly where the issues lay.
The Chief Finance Officer explained that in relation to the impact of controls it was still fairly early days. However, there was now three months’ evidence regarding non-pay expenditure, indicating that a costs benefit of approximately £1m per month was being realised. This was a helpful contribution but insufficient in itself to achieve sustainability, which would depend upon more efficient deployment of staff and improved productivity.

The Finance Team was working on a methodology to show the Board a measure of underlying EBITDA performance. This would be shared initially with the Chief Executive and Mrs Tutt, as Chairman of the Audit Committee, before being presented to Finance and Performance Committee in October.

Action: JD

The Trust Board received and considered the regular report from the Finance & Performance Committee.

TB17/08/11 Integrated Performance Report Month 4

The Director of Clinical Services presented the Integrated Performance Report (IPR) for month 4. This showed more consistent and positive performance on cancer standards up to June (the latest month for which data had been available for the report). There was continuing progress on the 62-day standard for cancer referral to initial treatment and all other cancer standards had been achieved. Work was underway to reduce steps on all pathways with a focus on particular tumour sites. July data received indicated that 62-day waits were just below the standard with the other seven all achieved.

Mr Ward highlighted an issue raised at the Churchill all-staff conversation on money, where there had been frustration at the impact of patients choosing not to attend appointments. Mr Ward asked if there was leeway to exclude these patients from cancer performance calculations. The Director of Clinical Services recognised this issue but explained this could not be done and that this was one of the reasons that the standard was for 85% rather than 100% of patients. He noted that there was now a new referral form for cancer two week waits to try to ensure GPs were providing clarity to patients about the fact that they were on a cancer pathway. It was recognised that the emotional nature of this potential diagnosis meant that patients might want time to reflect.

It was reported that the RTT trajectory had been delivered for the fourth month in a row, though it was recognised that the trajectory did not match the RTT standard. Work relating to the Q1/Q2 plan was now being completed, with the focus on the medium term plan for Q3 onwards. The first stage of this was to develop an operational plan for an initial five specialties to be delivered by 29 September 2017. A second stage would then focus on a further five specialties with a plan to be delivered at the end of October 2017.

Currently, 74% of the patients in the Trust who were waiting over 18 weeks were waiting for treatment in these ten specialties. Amongst the biggest challenges were those faced in Gynaecology which had a significant number of patients waiting in total, and long waiting patients in particular. The specialty’s pressures related to benign work, specifically outpatient capacity and uro-gynaecology operating capacity.
Overall, it was reported that the Trust had approximately 53,000 patients on an incomplete waiting list, of whom in round figures almost 26,000 were awaiting a first outpatient appointment, 19,000 awaiting diagnosis or treatment decisions and 9,000 awaiting admission or treatment as a day case. There was a need to reduce the total figure to no more than around 40,000 which would be considered an appropriate and sustainable waiting list.

The first specialty session had been held with clinicians in Gynaecology, and was reported to have been well attended with further sessions to follow in other specialties. The process was to review how the number of patients treated could be maximised within existing capacity and how additional capacity could be provided where required, but at pace and minimising costs. The need to speed up diagnosis and decision was also recognised.

Mr Goard asked what were the principal risks to delivery of the Q2 activity plan for RTT. The Director of Clinical Services explained that the plan was in development, and confirmed that it was proposed that the medium term plan for the first five specialties would be submitted to the Board in October, and the plan for the next five specialties in November, though details might be required by the regulator in advance of those meetings.

Professor Mant queried whether the clinical services might themselves reasonably have been expected to develop operational plans for delivering additional RTT activity, but the Director of Clinical Services advised that, in the light of regulatory intervention, the engagement of executive directors was regarded as crucial. Also, there were issues that crossed divisions, requiring a co-ordinated approach. He reminded the Board that the Trust needed a robust plan that was not just focussed on operational delivery but linked to workforce and financial planning, and aligned with OCCC.

In relation to performance against the ED four hour wait standard, this was noted to be below trajectory at just over 80% in July 2017. It was noted that the Trust faced significant challenges in meeting this standard, including those caused by the lack of patient flow, which had been impacted by the reduction of bed stock resulting from the necessary move of the trauma unit, as well as a growing number of daily bed closures required to maintain safe staffing levels. Under current workforce pressures, the daily rate of bed closures had reached 88 beds at the time of report. The Director of Clinical Services advised that proposals were being developed to rationalise and realign the bed stock on a more sustainable basis, in the interests of protecting the safety and quality of patient care, and making the most efficient use of the capacity for elective activity.

A number of internal changes had been made to support the Emergency Department, including a direct telephone line for GPs to contact senior clinicians and avoid admissions, which had also been extended to paramedics. A similar system was now to be introduced for nine core specialties within the Trust linking with ED, so that ED clinicians could escalate issues and seek specialist advice more quickly. The Trust was working with Oxfordshire County Council to avoid blockages for patients within the Home Assessment and Reablement Team [HART] who were awaiting domiciliary care. With effect from November 2017, an acute physician would be present in ED from 1pm to 8pm and a minimum of two ED Consultants should be present in ED for the late shift, seven days a week.
Professor Bell asked about winter resilience, noting reports that this might be a bad year for 'flu which was likely to have most impact during January 2018. The importance of maintaining capacity over the winter was recognised, and the Director of Clinical Services confirmed that plans were being developed for consideration by the Quality Committee in October.

**Action: PB**

The Medical Director highlighted that efforts were being concentrated on immunisation against 'flu, with innovations such as a streamlined process for consent.

The Board received and noted the contents of the report.

**TB17/08/12 Financial Performance up to 31 July 2017**

The Chief Finance Officer presented the report on financial performance, highlighting a positive movement in month which resulted in the Trust reporting EBITDA\(^1\) in July 2017 at +£5.4m, which was a £3.1m improvement on the previous month. This was noted to include:

- EBITDA improvements of £2.5m for NHS activity and £0.9m for other activity;
- An increase of £0.2m on costs not related to activity; and
- £2.7m year to date (non-recurrent) recalculation in respect of the Marginal Rate Emergency Tariff [MRET] and OCCG risk share

The Chief Finance Officer highlighted positive trends on costs, with reductions in both agency staffing and non-clinical pay costs. However, it was to be noted that clinical staff numbers were also going down, with measures of output reducing (e.g. elective procedures per day). In order to deliver RTT standards and financial targets this would need to be improved. The Trust first needed to maximise the proportion of patient-facing time for clinical staff, and to increase productivity, although benchmarks indicated that the Trust already performed comparatively well on many productivity measures.

The Interim Director of Workforce noted that the pay controls introduced earlier in the year had been tighter on filling non-clinical vacancies than clinical, and suggested that the reduction in clinical staffing was in part a seasonal issue over the summer. There were currently 86 nurses and 31 midwives due to join the Trust. Of 50 new starters at the Trust in the week commencing 11 September, 49 had been clinical and the other was a charity fundraiser.

Mr Ward remarked that performance of the Children’s and Women’s Division appeared to be some way off that of the other clinical divisions, and it was clarified that a significant reduction in the birth rate in Oxfordshire had been a factor in reduced activity levels, and a consequent impact on revenue. This had not been foreseen as a reversal of the existing trend, and work was reported to be underway with the University of Oxford to model this further.

Mrs Tutt asked the Chief Finance Officer to comment on the ytd EBITDA of +£6.8m, which was £5.8m behind plan, reflecting a shortfall in the delivery of savings. It was confirmed that a cross-divisional change programme was behind schedule, and efforts were being concentrated on striking the appropriate balance between

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\(^1\) Earnings before interest, tax, depreciation and amortization
providing sufficient support from the centre, without undermining local engagement in the development and delivery of initiatives which aligned operational, financial and workforce planning, to deliver high quality care more efficiently. Mrs Tutt suggested that the financial reforecast needed to reflect what could realistically be delivered, and the extent to which this was likely to be back-loaded. The Chief Finance Officer confirmed that he and his team would continue to work with the divisions to ensure that the re-forecasts was appropriately stretching, but deliverable.

Professor Bell remarked that closure of the gap was only likely to be achieved when bolder steps were taken at a national level to implement and incentivise technological advances that would support a step-change in productivity.

The Board received and noted the contents of the report.

TB17/08/13 Trust Management Executive

The Chief Executive presented the regular report to the Board on the main issues raised and discussed at the meetings held in July and August 2017, highlighting that there continued to be a strong focus on the achievement of targets and standards for quality, operational and financial performance.

TME had in particular scrutinised development of a fully integrated operational plan for RTT activity, aligning operational, workforce and financial planning.

Mr Goard sought assurance that the control panels were achieving reductions in costs, rather than merely creating a drag on the ability to make necessary expenditure.

As Chairman of control panel on non-clinical pay, the Chief Information and Digital Officer confirmed that a number of benefits had been realised. It was noted that the panel had observed a reduction in the number of requests submitted, indicating that a greater level of scrutiny was occurring at divisional level. Panels were also introducing discipline in considering whether services were being provided in the right way, an example being the redesign of A&C grades in the NOTSS division. Job descriptions were being mapped across the Trust to ensure consistency. It was emphasised that the clinical impact of decisions was assessed carefully.

As Chairman of the control panel on clinical non-pay expenditure, the Medical Director noted that it provided support for the procurement team to deal with issues that had been long standing but not previously escalated, for example where relationships between clinicians and suppliers could subvert procurement processes for medical equipment. Without support the procurement team could struggle to encourage appropriate discipline in clinical teams.

The Medical Director noted that the control panel on clinical pay expenditure faced complex issues as there was less clear evidence that divisions could quickly develop novel strategies to avoid the need for like-for like replacements. Further work was required to confirm which roles should be approved automatically, without the need for scrutiny, and which should be subjected to closer review. It was acknowledged that the control panel could sometimes create delays as to exercise correct control it had to insist on a sufficient data set.

As Chairman of the control panel on non-clinical non-pay expenditure, the Chief Finance Officer remarked that this had the lowest risk of adverse impact on clinical care, and so was the panel within which the tightest control tended to be exercised.
Central application of controls by the panel was delivering savings of 1-2%, though it was acknowledged that this represented a relatively expensive way of delivering savings at that level, and the intention was that the discipline of controls exerted by the panels would over the longer term become embedded throughout the organisation.

The Trust Board received and noted the contents of the report.

**TB17/08/14 CQC Final CQC Action Plan**

The Director of Assurance presented the final action plan for submission to the Care Quality Commission [CQC], in response to the CQC’s Report after its inspection of the Trust in October 2016. The final action plan was now more focused on outcomes rather than process, with supporting material presented to demonstrate progress achieved to date, as the basis upon which the Board could gain assurance.

The Director of Assurance advised that the CQC’s initial recommendation to check cardiac resuscitation equipment on a daily basis had now been changed to recommend weekly checks. The previous recommendation had been based on the CQC looking at a chest opening trolley and not a resuscitation trolley. The covers had now been changed to ensure that they were more clearly distinguishable.

Mr Ward welcomed improvements made to strengthen the link between actions and outcomes, but suggested that the closure of an action should be dependent upon demonstration of its impact, not merely its completion. The Director of Assurance took the point, but suggested that monitoring completion of the action plan was distinct from the on-going monitoring of compliance, which should be part of normal business.

The Trust Board approved the Final Action Plan for submission to the CQC.

**TB17/08/15 Update on Oxfordshire Transformation Programme; following outcome of Phase 1 Consultation on Health and Care Services in Oxfordshire**

The Director of Clinical Services updated the Board on the current outstanding issues following completion of phase 1 of the public consultation on health and care services in Oxfordshire, led by the Oxfordshire Clinical Commissioning Group [OCCG].

Prior to the decision taken by the OCCG Board on 10 August 2017, it was noted that the Joint Health Overview and Scrutiny Committee [JHOSC] had referred the temporary closure of obstetric services at the Horton General Hospital [HGH] to the Secretary of State for Health, who had requested the opinion of the Independent Reconfiguration Panel (IRP). It was understood that the IRP had now reported back to the Secretary of State, but the content of the report was not yet known.

Upon the OCCG Board’s deciding on 10 August to accept the recommendation for a single obstetric unit for Oxfordshire (and its neighbouring areas) at the John Radcliffe Hospital and a permanent Midwife Led Unit (MLU) at the HGH in Banbury, JHOSC had now referred that decision to the Secretary of State for Health.

In addition, it was noted that leave had been granted for judicial review of the decision to carry out a two stage consultation process. Although the Trust was not involved in the judicial review, it was recognised that it placed further uncertainty on the overall position until the outcome was known.
The Director of Clinical Services reported that OCCG had confirmed to JHOSC that, whilst the referral process was on-going, the HGH MLU would continue to run with the current staffing model and provision of a dedicated ambulance. It was noted that this was at variance from the level of service provided at all other MLUs in Oxfordshire, and a full review of comparative performance and next steps proposed was to be undertaken for report to the Board in November 2017.

Action: PB

The Director of Clinical Services further reported on the recruitment campaign for obstetric middle-grade doctors and special care baby unit (SCBU) nurses to work at HGH. At the time of report, it had not been possible to recruit sufficient numbers of middle-grade obstetric doctors to sustain the rota required to deliver obstetric services at HGH, nor were there sufficient numbers of nurses to staff SCBU. On the basis of legal advice initially received, it had been proposed that recruitment should be paused pending the outcome of the full review outlined above.

However, in the light of further legal advice received since submission of the paper, and taking into account the upcoming judicial review as well as the referral to the Secretary of State, it was agreed that this should be considered further by the Board at its meeting to be held in private on the afternoon of 13 September 2017.

Post-meeting note: At the meeting of the Trust Board held in private on the afternoon of 13 September 2017, it was agreed that recruitment should continue as currently and that the Board should continue to receive regular updates regarding the status of recruitment of both middle-grade obstetric doctors and SCBU nurses.

Action: PB

The Director of Assurance advised that the review of performance at all MLUs would need to take into account transport times and patient experience.

Mr Salt highlighted that at the extraordinary meeting of the OCCG Board at which the decisions had been taken on phase 1 of the consultation, GPs had spoken persuasively in favour of the need to make changes on the basis of safety, quality and patient outcomes; not on the basis of cost savings.

The Medical Director drew the Board’s attention to the recent report of the Royal College of Obstetricians and Gynaecologists in which it was stated that 88% of sites with an obstetric unit had reported difficulties in filling obstetric middle grade rotas.

The Trust Board received and noted the update.


The Medical Director explained that, with the support of the Deputy Medical Director, he had taken on this element of the portfolio formally carried by the Director of Information and Planning, who was acknowledged to have undertaken significant work to promote the agenda for public health.

The Board was asked to note the report and plans for the coming year.

In relation to immunisation against influenza, Professor Mant asked whether this could be made mandatory for all members of clinical staff who had a role in managing frail patients even if not for everyone. The Medical Director advised that legal advice would be required, noting that under US law it was only possible to make the ‘flu vaccine mandatory where express provision had been made in the contract of employment, the introduction of which could be considered.

In relation to initiatives aimed at promoting the health and well-being of staff, the Chief Finance Officer suggested that it would be helpful to link these to metrics such as sickness absence or staff survey results to show what was being delivered, though recognising that cause and effect may not always be very direct.

The Director of Assurance commended the work, noting in particular the section on the health and wellbeing of staff, and highlighting the known correlation between this and the delivery of good patient care.

The Chairman asked that the Board’s commendation of work undertaken be fed back to all those who had contributed.

The Trust Board received and noted the report.

**TB17/08/17 Mortality Review Strategy and Standardised Mortality Review Policy**

The Medical Director presented the paper, including the updated Mortality Strategy, revisions to the Standardised Mortality Review Policy and an extract from the mortality dashboard. The aim had been to address new requirements through adaptation of existing well-evolved processes without undermining these.

It was noted that this was different to the approach being taken by some Trusts who were pursuing a Medical Examiner model in which 1 to 2 WTE (whole time equivalent) experienced consultants were paid to review the case notes of every death, and telephone every family, to see if they had concerns. It was confirmed that at an NHS event attended by the Chairman of the Quality Committee and Deputy Medical Director earlier in the year, feedback from the pilot sites was reported to have been put back to 2019.

Professor Mant expressed strong support for the approach outlined, and asked for confirmation of the timescale for review. The Medical Director suggested that the current model should apply for at least the remainder of the current financial year, subject to review between six months and a year, noting that benchmarking information would become available once trusts began submitting data.

The Medical Director recognised the large contribution made by the Deputy Medical Director to this work.

The Trust Board received and noted the Mortality Review Strategy and Standardised Mortality Review Policy.

**TB17/08/18 Annual Review of Serious Investigations Requiring Investigation and Never Events 2015/16**

This was recognised as another strong piece of work which had been led by the Deputy Medical Director and her team. Given constraints on time, and in the absence of the Deputy Medical Director in attendance, the Chairman asked that
discussion of the report be deferred to a future meeting, when the Deputy Medical Director could be in attendance to participate.

Action: TB

The Trust Board received the Annual Review of Serious Investigations Requiring Investigation and Never Events 2015/16, detailed discussion of which was deferred.

TB17/08/19 Director of Infection Prevention and Control Annual Report 2016/17

The Medical Director introduced this mandatory report which highlighted major indicators and actions that were required. He explained that the appendices related to two decontamination issues with which the Board was familiar.

With zero avoidable MRSA bacteraemias permitted, there were noted to have been 5 avoidable MRSA bacteraemias and one unavoidable (taken > 48 hrs after admission) assigned to the OUHFT during 2016/2017. Themes from the cases had been identified and would form the basis for learning opportunities for 2017/18.

There were 53 OUH apportioned cases Clostridium difficile [cDiff] identified after three days of admission for 2016/2017 against an upper set limit of 69. This meant that cases of cDiff had been below the upper ceiling set for a further year.

Mr Ward sought confirmation that the objective standards required for theatre cleaning that was directly delivered by the Trust were equivalent to the standards required in relation to the PFI estate. The report highlighted that the Infection Control Team had visited all OUHFT theatres, and the Standard Operating Procedure drawn up by Theatres, Anaesthetics and Sterile Services Clinical Directorate had been shared with other directorates through the Cross Divisional Theatres User Group.

The Trust Board received and noted the Director of Infection Prevention and Control Annual Report 2016/17.

TB17/08/20 Patient Experience, Complaints and PALS Annual Report 2016/17

The Chief Nurse presented the report, advising that she intended to take the opportunity to reshape it in future years, to help inform where improvements might have the highest impact.

The quality of complaint responses was reported to be very high, and the contribution of clinical teams and of the Complaints Department was recognised. In particular, it was noted that complainants were often offered the opportunity to meet with clinical teams at an early stage, and that compliance with the 25 day standard was also very high.

The Chief Nurse informed the Board that an offer had been received from the Parliamentary Health Service Ombudsman to visit the Trust, and the intention was to respond positively to this approach.

Mr Salt suggested that the aim should be to bring all feedback together, including both complaints and compliments, and that it would be helpful to identify a small number of key themes, to focus on what action was being taken to address them.

The Trust Board received and noted the Patient Experience, Complaints and PALS Annual Report 2016/17.
TB17/08/21 Consultant Appointments and Signing of Documents

The Chief Executive presented the regular report on activities undertaken under delegated authority, and recent signing and sealing of documents, in line with the Trust’s standing orders.

Mr Goard suggested that there was scope for the process of Consultant Appointments to be improved, and it was agreed that this would be reviewed by the Interim Director of Workforce.

Action: SY

The Trust Board received and noted the report.

TB17/08/22 Any Other Business

There was no other business.

TB17/09/15 Date of next meeting

A meeting of the Board to be held in public will take place on Wednesday 8 November 2017 at 10:00 in the Conference Room, Oxford Centre for Enablement, Nuffield Orthopaedic Centre.