

Trust Board

Minutes of the Trust Board meeting held in public on Thursday, 6 September 2012 at 10 am in the George Pickering Postgraduate Centre, the John Radcliffe Hospital.

Present:	Dame Fiona Caldicott	FC	Chairman
	Professor Edward Baker	EB	Medical Director
	Professor Sir John Bell	JB	Non-executive Director
	Mr Paul Brennan	PB	Director of Clinical Services
	Mr Alastair Cameron	AC	Non-executive Director
	Mr Christopher Goard	CG	Non-executive Director
	Mr Mark Mansfield	MM	Director of Finance and Procurement
	Sir Jonathan Michael	JM	Director of Workforce
	Ms Sue Donaldson	SD	Chief Executive
	Mrs Elaine Strachan-Hall	ES	Chief Nurse
	Mrs Anne Tutt	H	Non-executive Director
	Mr Peter Ward	AT	Non-executive Director
	Professor David Mant OBE	PW	Associate Director
	Mr Geoff Salt	DM	Non-executive Director
	Mr Andrew Stevens	GS	Director of Planning and Information
	Mr Mark Trumper	AS	Director of Development and the Estate
	Ms Eileen Walsh	MT	Director of Assurance
		EW	
In attendance	Mr Adewale Kadiriri	AK	Deputy Head of Corporate Governance (minutes)
	Mr Richard Guest	RG	Partner, Ernst & Young (observing)

The Chairman welcomed members of the public and Richard Guest from Ernst & Young LLP. There were no apologies

Declarations – there were no declarations of interest.

TB76/12 Minutes of the meeting held on 5 July 2012

The minutes of the meeting were **approved** and **signed** as a correct record, subject to comments from Mr Peter Ward about the discussion on the Full Business Case for the Establishment of a Translational Molecular Diagnostic Centre. The Director of Finance and Procurement also clarified that the new Internal Audit provider had been awarded a 3 year contract with a one year break clause.

TB77/12 Action Log

The action log was reviewed. It was noted that a number of actions had been included on the agenda.

TB41/12 Relocation of Head and Neck Services

The Director of Clinical Services advised that a theatre schedule had been agreed in order to accommodate these services. He also assured the Board that the out of hours and high dependency proposals were deliverable and within the cost profile.

It was **agreed** that the Director of Clinical Services would take a report to the November meeting of the Trust Management Executive, after which it would come back to the

Board for their consideration at the earliest opportunity.

TB37/12 Electronic Patient Records

The Director of Planning and Information advised that planning was going ahead to address three areas:

- the issues with the partial re-build within maternity services,
- the re-positioning of the EPR team to move their accountability to the Deputy Director of Clinical Services, and
- a stabilisation exercise aimed at taking staff from areas where the system has been successfully implemented to those next on the list, so that lessons learnt can be shared.

The Director of Planning and Information explained that clinical engagement and sign-up is essential at this stage of the programme, and he agreed to bring a paper about this to the November Board.

TB43/12 Draft Annual Business Plan 2012/13

The Director of Workforce agreed to present the Workforce Plans at the Board Away Days on 3 and 4 October

TB58/12 Quality Report

The Director of Assurance reported that these actions are on the agenda for the Quality Committee meeting on 25 September.

TB65/12 Staff Engagement Programme Update, including proposals for staff recognition scheme

The Director of Workforce reported that work is in progress on setting up a staff recognition scheme.

Action (AS)

To present a paper on clinical engagement with the EPR system to the November Trust Board

Action (SD)

To present the Workforce Plans at the Board Away Days on 3 and 4 October

TB78/12 Chairman's Business

There was no Chairman's Business

TB79/12 Chief Executive's Report

Sir Jonathan Michael mentioned the changes to the Department of Health ministerial team following the recent Cabinet re-shuffle, including a new Secretary of State and changes to 4 out of the 5 junior ministers. He stated that the implications of this for the Trust and the NHS may not be immediately known. In addition, Sir Jonathan Michael highlighted the following points:

a) Professor Keith Willett

Professor Willett has been appointed Assistant Medical Director on the NHS Commissioning Board. He will be focussing on acute episodes of care and will be part

of the group of professionals working with Sir Bruce Keogh, Medical Director of the NHS, on taking the clinical outcome agenda forward. Sir Jonathan Michael explained that Professor Willett was previously the National Clinical Director for Trauma Care, and he was confident that this new responsibility would not adversely affect Professor Willett's work at the Trust.

b) Review of the Medical Sciences Division of the University of Oxford

Sir Jonathan Michael reported that this report will be taken to the University's Board next week, and that he will be at the meeting. He undertook to report back to the Trust Board in October.

Mr Geoff Salt welcomed the Patient Safety Award won by Dr Paul Altmann and his team. He was aware that there is much innovation going on within the Trust, and asked if the Board could be given an update of this at the away days in October. The Director of Planning and Information agreed to look into this in conjunction with the work of the Biomedical Research Centre.

Action (JM)

To report to the Board in October on the outcome of the review commissioned by the Oxford University Board of its Medical Sciences Division

Action: (AS)

An update on innovative practice within the Trust to be provided to the Board away days in October.

TB80/12 Monthly Quality Report

The Medical Director presented the first part of the report. He stated that action is continuing in response to the three Never Events reported since January 2012, including a review of theatres which had already taken place. The investigation into the third Never Event, which only came to light in July 2012 even though the operation took place in March 2012, did not raise serious issues, but will be considered by the Clinical Governance Committee. Professor Baker reported that compliance with the requirements of the WHO Surgical Checklist had been emphasised to the teams, and regular reports will be made to the Clinical Governance Committee. He stated that the swab policy is being reviewed and that a new version is shortly to be released. 11 other clinical policies are also under review.

The Medical Director informed the Board that the Trust is making good progress on meeting its quality priorities, which are linked to CQUINs. In relation to SIRIs, he reported that the one red graded incident was a false positive sample testing which is being investigated. One patient had been diagnosed with MRSA, but this is the first case of the year. Professor Baker reported that there was nothing that the Trust could have done about it as the patient was known to be an MRSA carrier before her admission. The C-difficile figures are back on target. The Medical Director reported that a lot has been done to achieve this, and it remains a challenging target.

The Chief Nurse presented the second part of the report. She informed the Board that the number of complaints received had risen, and that many of the issues being raised are the same as before – primarily to do with patient experience and outpatient processes. However, she reported that numbers had fallen in some divisions, such as

Emergency Medicine. Mrs Strachan-Hall also informed the Board that with effect from next spring, as part of measures to capture patient experience, patients will be asked whether they would recommend the Trust to their friends and family. An electronic system will be set up to capture this feedback, using a statistically appropriate methodology.

The Chief Nurse reported that mortality is within the expected range. A Dignity and Nutrition Inspection (DANI) had been held at the Horton Hospital. The initial feedback was that the unit was compliant on all five standards inspected and the full report is awaited.

In relation to SIRIs, the Board expressed concern about the length of time between the date of some incidents and the launch of the investigation. It was agreed that for the future a note will be inserted explaining the reason for the delay.

Mr Alisdair Cameron enquired whether efforts to address pressure ulcers had led to any significant reduction in their numbers. He also asked about the red rating for the CQUIN requirement on medical support for elderly patients. The Director of Clinical Services explained that the requirement had been rated red because agreement had not yet been reached with the PCT as to how the requirement would be assessed. He further remarked that steps were being taken to agree a system-wide strategy for older people and that a meeting will be held in October to discuss this. On the subject of pressure ulcers, the Chief Nurse explained that the Trust previously recorded around 10 to 12 and that the figure is now down to 3. She advised that the focus of clinical teams is on trying to reduce avoidable harm. The Trust has recruited a tissue viability nurse and is also receiving interim support from another Trust. The Chief Nurse reported that the Trust is well below the national average on pressure ulcers, and agreed to update the Board on trends.

In answer to the question why a patient known to be colonised with MRSA was reportable against the Trust, the Medical Director explained that the rules are that if the infection is diagnosed within 48 hours of the patient's admission, it is reportable against the hospital.

In relation to CQUIN requirements, Sir John Bell advised that the Trust needs to get better at and move more quickly on innovation, as the requirement to innovate will soon rise significantly. The Medical Director agreed and informed the Board that the Trust will be recruiting to a post specifically to address this issue.

The Director of Assurance raised the issue of grading of complaints and SIRIs. She suggested that checks be made by the Clinical Governance Committee whether these are correct. She also enquired about the action that the Trust is taking to understand the experience of "hard to reach" groups including those with learning and physical disabilities. The Chief Nurse explained that steps are being taken to make Easyread and other accessible versions of documents more readily available.

Mr Peter Ward informed the Board that when he visited the surgical emergency unit, staff had complained to him about the length of the recruitment process. The Director of Workforce explained that the electronic system recently introduced should make the process easier and quicker. She added that there are presently very high volumes in

recruitment, but that the sign off processes within divisions sometimes contributed to the problem.

Mr Geoff Salt questioned why only 56 patient experience questionnaires were handed out in one month. In relation to complaints, Mr Salt informed the Board that at the next meeting of the Quality Committee, a paper will be presented for discussion focusing on the 60% of complaints that are raised about issues arising before patients get to hospital. The Director of Clinical Services stated that a buddying system is being introduced so that the clinics could continue to run in the absence of the lead consultant.

The Board **agreed** to **receive** the report.

Action (ESH)

A report to be presented updating the Board on trends of patients suffering pressure ulcers

Action (ESH)

Where there is a time lag between the reporting of a SIRI and an investigation being opened, the Quality Report should contain an explanation for this delay

TB81/12 Infection Control Annual Report

The Medical Director presented this report and advised the Board that much of what was in this report had already been reported to them during the year. It is an annual overview and will go to the Quality Committee for more detailed consideration.

The Medical Director stated that the Trust had made good progress on MRSA and C-difficile. Outbreaks have been dealt with quickly and effectively. There had been a norovirus outbreak, but this had not led to the closure of a single ward. MSSA was also on downward trend but not as marked. He advised that there was no room for complacency.

Mrs Anne Tutt commended the report, but stated that the Board needed to be assured that issues raised were being dealt with. The Medical Director explained that the purpose of this report was to present a broad picture but that the Quality Committee receives more detailed reports. He also reminded the Board of the regular reports that were presented to them.

The Director of Development and the Estate stated that although non-clinical environmental measures continue to improve, the Trust is investing in additional staff. He said that this will lead to a significant increase in numbers and capacity. Sir John Bell reminded the Board that the Trust is one of the leaders in using technology to fight C-difficile and that this needs to continue.

The Board **agreed** to **note** the contents of this report.

TB82/12 Medical Revalidation update

The Medical Director presented this paper to the Board for information. He stated that good progress had been made in this area, and that the Trust is working closely with the Revalidation Support Team as one of the organisations being observed. He stated that dates for the revalidation of all the Trust's doctors had been set, and that clinical leaders

will go through the process during the course of next year. The GMC will be writing to individual doctors in due course. Professor Baker expressed concern about the resource implications of this process going forward. He advised that the Trust may need to consider an IT solution, and it is possible that a business case could be made on this, in conjunction with job planning.

Mr Alisdair Cameron enquired whether doctors with professional concerns against them should have been accelerated through the process. The Medical Director explained that as far as the GMC is concerned, revalidation is not a way of managing poor performance. Although a doctor who is not revalidated could lose their licence to practice, any concerns about their fitness to practice would need to be dealt with separately. Mr Peter Ward raised the issue of doctors on honorary contracts especially those working in the Far East. The Medical Director explained that this is a very small number of doctors and that the Trust is tightening up on awarding such contracts.

The Board **agreed** to **note** the progress made.

Action (EB)

To consider making a business case for an IT solution to support revalidation, possibly in conjunction with job planning.

TB83/12 Action Plan for delayed transfers of care for providers

The Director of Clinical Services presented this paper. He stated that it is important for the Board to see what is being done across the whole health economy. He emphasised that this is a vital item for the Trust to solve and as such providers across the health economy have felt that they should take the lead in solving the problem. Mr Brennan informed the Board that in March there were 215 delays and that the figure is now down to 115. This is good progress but the numbers need to reduce further to a more acceptable level of around 40. The work that has been done since March has seen a drop of 80.

There are 8 work streams that are fully supported by Oxford Health, the provider arm of Oxfordshire County Council and OUH. Under work stream 1 staff from all the organisations had been through a joint program of work emphasising a 'no blame' approach to partnership working. The workshops have been challenging but produced good feedback, and there will be further rounds to do with solving problems. The remaining work streams are more specifically about tackling the issues, with a more intense focus on supporting people at home. The last work stream is about getting all providers to accept other organisations' assessments. Mr Brennan expressed confidence that the partners will be able to agree a single process before the end of the calendar year. He explained that this is essential in getting the health economy below the figure of 40 delayed discharges and he wanted the Board to approve this approach.

Mr Christopher Goard agreed that this is one of the biggest problems facing the Trust and he asked if there would milestones along the way towards achieving a rate of less than 40. Mr Brennan stated that the plan was to get down to 103 by the end of September, 76 by December and that the drop to 40 would take place by the end of the Q1 next year. Mr Brennan gave a summary of the role of the re-enablement service referred to on pages 6-7 of the paper. He explained that the target is to have 40 patients within this service, and there are currently 33 using it. He agreed to keep the Board

updated on progress towards meeting the agreed targets.

Sir Jonathan Michael explained that the approach in workstream 3 is still supported, but changes in personnel have disrupted the pace of implementation. The constituent organisations will be spending a day next week getting back on board. In answer to a question about GP and CCG involvement, the Director of Clinical Services explained that a number of prominent local GPs are involved in the workstreams.

The Medical Director welcomed the work that is being done, but pointed out that incentives needed to be properly aligned within the system, such that partners are encouraged to want to take patients. The Director of Clinical Services agreed, and reported that this issue had arisen in discussions about agreeing a county-wide discharge policy.

Following discussion it was agreed to

- **Approve** the joint provider working arrangements and **note** the progress against each of the workstreams
- **Note** that a draft policy on choice will be presented to the Trust Management Executive in September

Action (PB)

Regular updates to be provided to the Board on progress towards meeting agreed DTOC targets.

TB84/12 Board Governance Memorandum/Operational Governance Memorandum

The Director of Assurance introduced these items. She reminded the board that they were familiar with the documentation and that not a lot has changed on the QGM. The actions that were being progressed are listed on paragraph 10 and the Board is being asked to approve an extension of the deadlines for a number of these, none of which were time critical. Ms Walsh directed members' attention to the Flash Report template in front of them and she explained that these will be circulated on Wednesday afternoons between Board meetings. She invited the Board to address the recommendations at paragraph 12.

It was resolved to approve the final QGF and BGM and accept the recommendations at paragraph 12 of the paper

TB85/12 Foundation Trust update

It was agreed to combine discussion of this item with the Self-Certification item later on in the agenda.

TB86/12 Oxford Academic Health Science Network

Sir Jonathan Michael reminded the Board that this had been discussed previously. There is a national development of Academic Health Science Networks (AHSN) and the Trust had been working with partners across the Thames Valley. This has resulted in an Expression of Interest being submitted and this has been accepted. Detailed proposals have to be submitted by October and National guidance is being developed. A decision on approval will be made towards the end of this calendar year. Sir Jonathan Michael informed the Board that 50 networks are being developed across the country and they

will each be required to have formal governance arrangements in place, but that this will take time to develop in agreement with partners. A short term hosting arrangement would therefore be needed in order to receive central funding. It is proposed that OUH acts as interim hosting organisation until the AHSN is established and moves towards incorporation. Sir Jonathan Michael will be the shadow accountable officer during this time. The Board was asked to support this process.

Mr Geoff Salt agreed that this is a worthwhile enterprise but asked for an explanation of the relationship between AHSNs, Academic Health Science Centres (AHSC) and the Joint Health and Wellbeing Board. Sir Jonathan Michael explained that the Health and Well Being Board is a sub-committee of Oxfordshire County Council. The AHSN is a local collaborative initiative that is similar to an AHSC but works across a wider geography. The focus of AHSNs' work is to increase innovation for the ultimate benefits of patients, and involves Trusts, higher education providers and industry (40 organisations). He added that there will be a new bidding round for AHSC approval next year, and bidders will be required to be part of an AHSN. Mr Peter Ward asked whether the complexity of these organisations could increase the Trusts revalidation responsibilities. Sir Jonathan Michael emphasised that none of these consortia altered the legal accountability of each organisation.

It was **resolved** to **note** the work done to date and to endorse the role of the OUH as the hosting body for a period of time to be agreed.

TB87/12 Full Business Case for the provision of an Integrated Spinal Pathway

The Director of Clinical Services presented this paper. He explained that there had previously been multiple referral pathways into this service. It had taken longer than anticipated to bring forward this business case because of the need to account for the difference in the roles of neurosurgeons and orthopaedic surgeons. This new spinal service will be run by the MARS division, and there will be a single patient pathway. GPs will refer patients into the orthopaedic hub within MARS and staff in the hub will carry out an assessment as to how and where care is to be managed. Elective spinal surgery will take place predominantly at the NOC, conducted by orthopaedic surgeons or neurosurgeons. Paediatric scoliosis patients will be treated at the John Radcliffe Hospital under the auspices of the Children and Women's Division, while adult scoliosis patients will also be treated at dedicated theatres within the John Radcliffe Hospital. Mr Brennan informed the Board that the business plan had already been approved by the Strategic Planning Committee, and was being presented before them because the full year cost of the service will be in excess of £1million. Sir Jonathan Michael explained that this proposal was in the original business case for the integration of the Nuffield Orthopaedic Centre and the Oxford Radcliffe Trust. He saw it as an opportunity to provide an improved service.

The Director of Clinical Services stated that this integrated service would put the Trust in a better place in the event that the Department of Health decides to further concentrate specialist services. In answer to a question about the projected income, Mr Brennan stated that the Board could be very confident of achieving the £1.3million target, on the basis that a number of other centres doing similar work had reduced their output. He stated that the assessed income was on the conservative side and that the amount could be doubled.

Professor David Mant acknowledged that these are high risk procedures, and that failure could have an impact on the organisation's reputation. He advised that outcomes must be monitored carefully. The Medical Director acknowledged the point, but pointed out that the Trust has world class neurosurgeons and orthopaedic surgeons in place, and that this should be one of the Trust's star services. The Director of Development and the Estate pointed out that the financial aspects of the business case had been forensically examined at the Finance and Performance Committee. He explained that the financial benefit to the Trust was not significant, but that it was an important development from a quality and reputational point of view.

The Board agreed to **approve** the proposal and **accept** the recommendations set out in the business case. Members offered congratulations to the team for a job well done.

TB88/12 Full Business Case for the provision of Psychological Medicine

The Director of Clinical Services presented this paper. He explained that although liaison psychiatry provision is not strong across the country, there is evidence that it makes a difference to patient outcomes where available. Mr Geoff Salt agreed that the service is necessary, but questioned what difference seven members of staff can make in view of the number of patients that would be eligible to receive the service. Mr Brennan explained that the Trust is developing a broader strategy for psychological medicine, but that major benefits have already been identified in psychological services for the frail elderly. He added that length of stay can be reduced by 40% if non-physical health issues are recognised. Mr Brennan stated that in theory, the service could have a significant beneficial impact on rates of Delayed Transfers of Care.

Mrs Anne Tutt declared that she was very supportive of the proposal, having seen first hand where it could have been beneficial on the ward. The Chief Nurse explained that the availability of this sort of service had been raised by the Franics Inquiry, and that it was important that the service is developed around the patient. She explained that this was why an external provider had not been sourced. Professor David Mant saw this development as a good opportunity for parallel working with the BRC. Mr Brennan agreed, but emphasised that it was important to get the service up and running in the first instance. The Medical Director explained that providing a service of this nature was a key recommendation from the review of medicine. The Board noted the business case.

It was agreed to **note** the development of this service.

TB89/12 Operational Report

The Director of Clinical Services presented this report and summarised its key aspects. He explained that the position on the 4 hour A&E target at the end of July was 93.6%. It improved to 94.7% in August and he stated that the Trust should be above the 95% threshold by 9 September. He was confident that the Trust would be able to sustain this improvement through the winter. Mr Brennan reported that the elective/non-elective coding issues had been resolved. On data quality, he advised that all the figures in the report had been validated, with the exception of RTT incompletes, and those figures that were reported off PAS, such as multiple endoscopes. He added that those services would be in a position to report fully by the beginning of December. Mr Brennan expressed satisfaction that leadership within the Emergency Department and the Divisions is aligned, but he stated that the interaction between specialists and the

divisions still needs improvement.

The Board agreed to **note** the contents of the report

TB90/12 Finance Report

The Director of Finance and Procurement presented this paper and reported that the Trust's financial position is broadly on target, and major steps are being taken towards achieving the agreed surplus. He stated that the income figures on page 8 of the report reflected significant over-performance, and discussions on this are ongoing with commissioners. This includes working with them on validating information, as well as working through QIPP plans. Longer term discussions are also taking place around demand management. Some work is being done by management consultants on this issue, and will feed into the LTFM. Mr Mansfield stated that it is in the interest of all organisations that the whole health economy is in equilibrium, as evidenced by the delayed transfer of care issue.

Mr Alisdair Cameron expressed concern that the Trust is behind on delivering its CIPs and that the longer this continued the more difficult it would be to achieve the overall target. Mr Mansfield explained that there are some things that the Trust will not be able to deliver, in which case remedial packages would need to be put in place. He stated that discussions are ongoing with divisional directors after which these remedial schemes would come on line. In response to a question from Mr Peter Ward, Mr Mansfield explained that low risk in this context meant low-risk of non-delivery, rather than low risk to patient care. He expressed confidence that those low risk areas that are not currently delivering will be able to catch up.

The Board **agreed** to **note** the contents of the report

TB91/12 Workforce Report

The Director of Workforce presented this paper, and highlighted the following areas:

- Sick absence is below target, but that there was no room for complacency. Letters celebrating good attendance records are now being sent to staff across the Trust.
- The Trust is experiencing high turnover rates, such that a recruitment exercise is to be held in Scotland.
- The new electronic learning system is proving very popular with staff.
- The Listening into Action initiative is into the next phase, and the team have been inundated with volunteers. The link between improvements and training needs has been identified by staff, and it would be important to get staff more involved in linking values to the Quality Strategy.
- The Clinical Excellence Awards Scheme has been launched, albeit later than expected.
- The Trust is reviewing its whistleblowing approach.

Mrs Anne Tutt expressed concern about the growth in use of bank and agency staff, and wanted to know what was being done about it. The Director of Finance and Procurement explained that some bank use is legitimate, while other use is not, and that those divisions in the latter category were being asked to justify their use.

Mr Peter Ward expressed concern that some staff could be losing faith in EPR. The Director of Planning and Information stated that only clinical staff within Accident and Emergency and the Maternity Departments are presently using the system, and there is a need to ensure that the system is delivering its intended functionality. Mr Stevens confirmed that the Board's input in promoting the benefits of EPR would be helpful.

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

TB92/12 Integrated Performance Report

The Director of Clinical Services presented this report and explained that its format had been subject to consultation among Board members. However, it was not assessed as being ready to replace the individual performance reports. He stated that this report will therefore continue to be presented to the Board in shadow form, and invited further comments on its format from members. Mr Brennan agreed to bring a new iteration of the report to the next meeting.

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

TB93/12 Self Certification

This report was presented by the Director of Planning and Information. He stated that is the first self-certification return that the Trust had been required to make, following confirmation that all aspirant FTs are required to complete the assessment on a monthly basis. Mr Stevens advised the Board that most of the performance issues had already been dealt with, and explained that in this paper, FT performance management and Board performance were being brought together. The report was required to be submitted by the end of August. This has been done but before it was seen by the Board.

The Trust had not been graded red for either governance or finance. Key issues are Accident and Emergency performance and the care of people with learning disabilities. Mr Stevens informed the Board that a meeting had taken place last week with the SHA to review performance against the self-certification. He stated that the Trust is currently focussed on a range of FT related issues:

- Performance and sustainability (especially in relation to Accident and Emergency and performance against the 18 week target)
- Data quality – as set out in the BGM data quality assessment
- Embeddedness - that the Trust is confident that by the time it gets into the Monitor stage of the assessment the changes would be incorporated into organisational culture.
- Finance – especially in relation to alignment with commissioners

Mr Alisdair Cameron pointed out that the Trust had been graded red in relation to its treatment of debtors and creditors, and indicated that this would need to be addressed as soon as possible.

TB94/12 Reports from Board Sub-committees Audit Committee

The key issues highlighted by Mr Alisdair Cameron, chairman of the Audit Committee were:

- That KPMG had been appointed to provide internal audit and counter-fraud services
- That the Trust's External Auditor was transitioning from the Audit Commission to Ernst & Young in November
- On EPR, Mr Cameron indicated that there was a gap between what the Board was being told and what was happening on the ground across the hospital. He said that this would be picked up further at the Committee's next meeting in September.

Finance and Performance Committee

Mrs Tutt, chairman of the Finance and Performance Committee, reported that this was the first meeting of the Committee, and that there was a good discussion. The Committee's terms of reference were agreed and a programme of work discussed. She stated that a number of the issues that had been raised by the Board today had already been discussed at the Committee meeting

Quality Committee

Mr Geoff Salt, Chairman of the Quality Committee, highlighted the Quality Impact Assessment process in relation to CIPs. He stated that at the next meeting, the Committee will be looking at outcomes in those areas, and that during the executive walk-rounds, members will go out to some of the wards concerned. Mr Salt also indicated that at the December meeting, the Committee will explore future expectations of quality, and will receive a fuller paper on the impact that delayed transfers of care have on quality.

The Board **noted** the contents of the minutes of the three sub-committee meetings, and approved the format of the new Chairman's reports

Action (MM)

Audit Committee to review the potential gap between Board knowledge and the situation on the ground across the hospital and how best to take this forward.

TB95/12 Governance of Board Committees

The Director of Assurance presented this paper and explained that its purpose was to tidy up a number of governance issues. She highlighted the key issues:

- Voting arrangements – a check of the statutory instrument governing the Trust revealed that the issue of giving the Director of Development and the Estate voting rights would need to be deferred until after FT authorisation,
- Deputising arrangements – these were to be re-affirmed, while noting that a new permanent Deputy Chief Nurse will soon be starting work at the Trust,
- Arrangements for substitution of Non-Executive Directors – these have been incorporated into the Board sub-committees' terms of reference,
- Board Codes of Accountability, Practice on Openness and Conduct for NHS Boards – the Director of Assurance asked Board members to complete the form contained within their papers and to return them to the Deputy Head of Corporate Governance within 2 weeks,
- Register of interests – no Board members had additional interests to declare
- Gifts and hospitality – this will be brought back to the next meeting
- Annual cycle of business – this document will be replicated for each of the Board sub-committees.

- Schedule of meetings – a rearranged meeting of the Remuneration and Appointment Committee will take place on 9 January 2013. Due to the volume of business at the end of the calendar year, an extra Board meeting has been provisionally set for 6 December, subject to the Board to Board meeting with the SHA on 19 November.
- Committee governance – Chairman’s packs are to be set up for each of the Board sub-committees
- An exercise has commenced for the recruitment of a substantive Head of Corporate Governance and it is expected that the postholder will be in place by the end of October.

The Board **accepted** the recommendations.

TB96 /12 Consultant Appointments and Signing of Documents

The report on consultant appointments and the signing of documents was received.

It was **resolved** to **receive** the report and **note** the consultant appointments, the signing of documents and the contract ratification by the Chief Executive under the Limits of Delegation Policy.

TB97/12 Any Other Business

There was no other business.

TB75/12 Date of the next meeting

A meeting of the Board to be held in public will take place on Thursday, 1 November 2012 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 be excluded from the remainder of the meeting, having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest (Section 1(2) of the Public Bodies (Admissions to Meetings) Act 1960)”.

