

## Trust Board

Minutes of the Trust Board meeting held in public on Thursday, 5 July 2012 at 10 am in the George Pickering Postgraduate Centre, the John Radcliffe Hospital.

<b>Present:</b>	Dame Fiona Caldicott	FC	<b>Chairman</b>
	Professor Edward Baker	TB	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
	Ms Sue Donaldson	SD	Director of Workforce
	Mr Christopher Goard	CG	Non-executive Director
	Mr Mark Mansfield	MM	Director of Finance and Procurement
	Professor David Mant OBE	DM	Associate Director
	Sir Jonathan Michael		
	Mr Geoff Salt	JM	Chief Executive
	Mr Andrew Stevens	GS	Non-executive Director
	Mrs Elaine Strachan-Hall	AS	Director of Planning and Information
	Mr Mark Trumper	ESH	Chief Nurse
	Mrs Anne Tutt		
	Ms Eileen Walsh	MT	Director of Development and the Estate
	Mr Peter Ward	AT	Non-executive Director
		EW	Director of Assurance
	Mrs Diana Garrod	PW	Non-executive Director
	Ms Alison Loftus-Hills		
<b>In attendance:</b>		DG	Executive Assistant (minutes)
	Mr Martin Owen	AL-H	Head of Regulation and Accreditation designate
	Mr Gurminder Khaira	MO	Board Observer from Deloitte LLP
		GK	Board Observer from Deloitte LLP

The Chairman welcomed members of the public and Martin Owen and Gurminder Khaira from Deloitte LLP.

**Declarations** – there were no declarations of interest.

### TB53/12 Minutes of the meeting held on 3 May 2012

The minutes of the meeting were **approved** and **signed** as a correct record.

### TB54/12 Action Log

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

With regard to the relocation of Head and Neck Cancer Services to the Churchill site which had been agreed at the May Board meeting, the Director of Clinical Services advised that the issues surrounding critical care and integration of theatre lists had been resolved so that the

relocation could be implemented at the end of January 2013.

It was **agreed** that the Director of Clinical Services would bring a report containing proposals for enhancing the provision of out of hours services at the Churchill Hospital to the September meeting of the Board.

### **TB55/12 Matters arising from the Minutes**

#### **TB37/12 Electronic Patient Record (EPR) update**

The Director of Planning and Information stated that the EPR Programme Board had agreed to undertake a review at six months of all the EPR projects to take account of any lessons learnt to be included in the forward plans and how to schedule the rollout of clinical functionality by trialling one example. The original methodology was being reviewed and alternative options for improvement were being considered. As part of this review at six months, the realisation of planned business benefits and the timetable for rollout of clinical functionality would be presented to the Board in September.

The Chief Executive noted that there had been discussions between the Director of Planning and Information and the EPR Team with the Director of Clinical Services and the Operational Service Managers to strengthen and improve liaison and assist in operational implementation of the system into clinical areas. The expertise and experience of the Deputy Director of Clinical Services in her past work at the Nuffield Orthopaedic Centre will be used to inform this work in implementing EPR into clinical areas.

Mr Geoffrey Salt emphasised the importance of listening to staff with regard to lessons learned on EPR implementation and received assurance that this would occur. Mr Stevens confirmed that he had met with the Joint Staff Negotiating Committee on this on 4 July.

#### **Action: (AS)**

*Document on the realisation of planned business benefits and timetable for roll out of clinical functionality to be presented to the September meeting of the Board.*

#### **TB/39 12 Safe and Sustainable - Item from Chief Executive's Report of 3 May**

The Medical Director referred to the Chief Executive's report in May in which the Chief Executive had confirmed that the Court of Appeal had found the Safe and Sustainable process for the public consultation on the future of children's cardiac surgery services to be fair, lawful and proper. He had confirmed that the Trust was working collaboratively with Southampton University Hospitals Foundation Trust to provide surgery for children with congenital heart disease under an interim arrangement.

Following the Safe and Sustainable consultation and appraisal process, the final decision had been made on 4 July and the Medical Director stated that Option B had been agreed which approved an integrated network for the Trust to provide children's cardiac surgery services with Southampton. The two Trusts would be working together to develop their plans.

The Chairman **noted** this welcome development.

**TB43/12 Draft Annual Business Plan 2012**

The Director of Workforce stated that with regard to the action for the workforce review to be reported to the Board in July, she confirmed that the workforce review had been completed with the Divisions. She noted that there was good alignment now with budgets and Cost Improvement Programmes [CIPs] and stated that the focus would now be on monitoring performance against the agreed workforce plans. She indicated that the current position was reflected in the Finance Report.

**Action (SD):**

*A detailed overview of workforce plans would be presented to the August Board Seminar.*

**TB56/12 Chairman's Business**

Dame Fiona Caldicott reported that Mr Christopher Goard had become a Non-executive Director of the Patient Safety Federation.

**Action: (JL)**

*Mr Goard's new interest to be recorded in the register.*

**TB57/12 Chief Executive's Report**

Sir Jonathan Michael noted that his report was largely self-explanatory. He wished to elaborate on two areas of his report:

**a) Oxford Academic Health Consortium**

After much deliberation, the guidance on designation of Academic Health Science Networks [AHSNs] had been issued by the Department of Health on 21 June 2012. The Trust is assisting in developing a shared approach to a submission for a wider Thames Valley AHSN with colleagues from across the region and strong support is being given from providers of healthcare, local commissioning groups, and higher education groups. The deadline for the submission of an Expression of Interest to become an AHSN is 20 July 2012, with a full submission by the end of September 2012 and that work is in progress.

Work on the development of an Oxford Academic Health Consortium [OAHC] with representation from health, academic and social care providers within Oxfordshire is also developing well. Support has been forthcoming for a submission of an application to become an AHSC during 2013 for accreditation from 1 April 2014.

**b) Health Education England**

Following the appointment of Sir Keith Pearson as Chair of Health Education England [HEE], it has now been announced that Ian Cummings had been appointed as Chief Executive of HEE.

**c) Dementia Challenge**

A joint proposal has been developed in conjunction with Oxford Health NHS Foundation Trust supported by health, academic and social care providers within the proposed OAHC for the NHS South of England Dementia Challenge of £10 million to support innovative

solutions to improve health and wellbeing for the population. This was being led by Professor John Geddes and had now been submitted to the Department of Health for support. The proposal focused on the management of dementia in care homes.

Mr Geoffrey Salt asked for further detail regarding the apportionment of the £10 million funding should bidding be successful and Professor Edward Baker explained the NHS South of England Dementia Challenge process. Professor Sir John Bell asked if at a future Board Strategy event this matter could be discussed more fully due to the rise in demand for management and care of the elderly with dementia.

It was agreed to invite the newly appointed Professor of Liaison Psychiatry at the University of Oxford to the next Board Strategy Day.

#### **Action (SD)**

*To include on the Board Strategy agenda and to invite Professor Michael Sharpe.*

#### **d) Oxford Health NHS Foundation Trust**

An announcement has been made that Mr Stuart Bell has been appointed Chief Executive of Oxford Health NHS Foundation Trust. As the current Chief Executive of South London and the Maudsley NHS Foundation Trust, he will bring a strong academic focus to the role.

It was **resolved** to receive and note the report.

#### **TB58/12 Monthly Quality Report**

The Chief Nurse presented the Quality Report.

She confirmed the arrangements now in place to deal with the increase in patient complaints in Cardiac, Thoracic and Vascular Division; Neurosciences, Trauma and Specialist Surgery Division; and Critical Care, Theatres, Diagnostics and Pharmacy Division. She said that key themes were delays/waiting times, communication, patient care and staff behaviour. Questions were posed regarding evidence of organisational learning arising from these complaints. The Chief Nurse outlined the outcomes from the return of the 'Let Us Know Your Views' leaflets which had seen an improved trend in the responses. Of 184 patients who responded to the question "would you recommend this hospital?", 182 responses were positive.

The Chief Nurse presented the seven quality dashboards which were appended to this paper and the indicators and data for each Division relating to key points for divisional activities were discussed.

With regard to Safety, Quality and Risk, the Medical Director noted the latest data for the Summary Hospital Mortality Index [SHMI] and Hospital Standardised Mortality Ratio [HSMR] were within expected limits. Professor Baker referred to the graph on Page 9 of the paper with regard to SHMI and HSMR data, noting that two did not quite align, but that there was evidence of a downward SHMI trend. He said that the SHMI was now the lead indicator with the next result expected within two weeks.

On clinical coding, Professor Baker said that with regard to oncology, meetings were being held to review notes to ensure accurate clinical coding and a complete record of co-morbidities in order to improve risk rating of expected outcomes.

With regard to hand hygiene in the Critical Care, Theatres, Diagnostics and Pharmacy Division action was being taken with regard to hand hygiene relating to the wearing of gloves, when unnecessary, and this issue was being dealt with by the Clinical Governance Committee.

The Medical Director detailed the nine SIRIs which had been reported to NHS Oxfordshire and NHS South of England SHA.

The Medical Director confirmed that the Quality Account 2011/12 had now been approved by the Quality Committee had been audited by the Audit Commission and had been submitted to the Department of Health.

For the first three months of this financial year 2012/13, the Medical Director confirmed that, with regard to infection control, there had been no MRSA bacteraemia in the Trust. This excellent achievement had been achieved with the assistance and hard work of frontline and aseptic staff.

With regard to Clostridium Difficile [C.diff], he said that the target for the Trust was challenging and an increase in the number of cases had been identified in April and May 2012. However, there had been a reduction of cases of C.diff during June. It would be an increasing area of infection control going forward.

Mr Peter Ward said that the number of SIRIs did not agree with the number of SIRIs in the divisional reports and that these reports were variable. The Chief Nurse thought that pressure ulcers were not reported in the divisional reports and that all cases of acute pressure ulcers had been pre-extant in patients on admission.

The Chief Nurse explained in detail the process of reporting on SIRIs and the resultant action taken by divisions and the Clinical Governance Committee and attention was being paid to future alignment of reporting. With regard to alignment, the Medical Director confirmed that there had been one SIRI in May.

Mr Peter Ward referred to the increase in complaints reported in the paper in the Neurosciences, Trauma and Specialist Surgery Division and said that in the Board submission to the NHS South of England SHA, the Trust noted the learning from complaints. The Chief Nurse spoke of the restructuring of the Complaints Department. She clarified how this information was shared at Divisional Board meetings and the work that was carried out at the Clinical Governance Committee to ensure that lessons were learned and appropriate feedback given to staff throughout the Trust. She explained the mechanisms of investigating complaints, how the information was shared, and how the learning was then fed back to staff, with patient consent, to improve future patient care. This included sharing information anonymously on the results of complaint investigations to staff through the Trust and she gave an example.

### **Action (TB)**

*It was agreed that the Medical Director would share the detailed divisional reports presented to the Clinical Governance Committee with Mr Ward.*

With regard to Patient Experience feedback for May, Mr Christopher Goard noted the improvement figure of 82 for telephone calls to the Patient Advice and Liaison Service

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[PALS] and wished for clarity that this was a genuine improvement rather than a change in method of data reporting. The Chief Nurse noted that it was essential that reporting was accurate and enlarged on the different methods of data collection and said that she would review this figure.

Mrs Anne Tutt welcomed the new standardised mortality review process being implemented across the Trust.

Professor David Mant expressed congratulations on the fact that no cases of MRSA were reported in the first three months of the financial year and noted this achievement by frontline staff. Professor Mant spoke about the trends in the report and the Medical Director confirmed that this was the last time the Quality Report would be presented in this format because in September the Board would move to integrated performance, quality and financial reporting with exception reporting for any deviations from the expected range of performance.

The Director of Assurance referred to assessment in the dashboards. She noted that last year following the Care Quality Commission [CQC] Review on Dignity and Nutrition and the resultant work to improve these areas of patient care, one or two reports in this paper did not appear to include actions undertaken.

It was **resolved** to receive and note the report.

**Action (ESH)**

*In future the revised Quality Report should demonstrate that where there was a lack of assurance there was evidence of investigation, and it was fully documented.*

The Director of Workforce asked that, with regard to divisional action to complaints, she proposed that work could be undertaken with the Divisions to share best practice.

In answer to a question from Mr Alisdair Cameron on cleaning standards, the Director of Development and Estate outlined how the cleaning scores worked, what the independent audits triggered and the resultant financial penalties when cleaning standards were not met.

Mr Geoffrey Salt said that as communication and delays in appointments were the principal causes of concern for patients, he asked for a review of this matter at either the September Quality Committee or the September Board meeting.

**Action (ESH)**

*To include an in depth view and action plan on the principal issues for Patient Experience being delays in appointments and communications to be covered by the Quality Committee in September.*

The Chairman noted that following the Executive Quality Walkaround at the Horton General Hospital under 'Environment' improvements had been made to staff changing facilities. This needed to specify that these would be occurring at the Horton Hospital as it was important for staff to see that their views were listened to at Walkarounds.

**Action (ESH)**

*Within the Quality Report, under paragraphs 42 and 43 to specify that the improvements were planned and had been made respectively to staff changing facilities at Horton Hospital*

**TB59/12 Six Month Post-Nuffield Orthopaedic Centre [NOC] Integration Update on Benefits Realisation**

The Director of Planning and Information presented this report which updated the Board on the delivery of the agreed benefits of integrating the NOC and Oxford Radcliffe Hospitals NHS Trust to become Oxford University Hospitals NHS Trust in November 2011.

He said that the paper outlined in particular the progress on the clinical benefits and financial benefits in terms of savings, and it was noted that significant progress had been made in a number of areas which included:

- Service Transfers
- Integrated Spinal Pathway
- United Electronic Risk Management
- Recruitment and Induction
- Delivering Compassionate Excellence
- Unified Clinical Trials Unit
- Trustwide e-Rostering.

This review at six months had been an opportunity to give granular detail to the benefits realisation of the integration. Some benefits had been listed in the original business case for integration, but some had materialised since the integration.

The Director of Planning and Information noted that in two areas further progress was required and these were a strategy for private patients as responsibility for private patient work at the NOC was to remain within the Musculoskeletal and Rehabilitation Division and there also needed to be a Trust-wide approach. The other area was a programme to reconfigure site cover and services and was linked to the relocation of Head and Neck Cancer Services.

Following discussion, the Chief Executive stated that the integration had been judged to be very successful and the Board wished to acknowledge the commitment of staff on the implementation of the integration. Mr Christopher Goard commented favourably on the flexibility and willingness of staff to ensure the integration had made good progress with minimal disruption to patients.

The Director of Planning and Information said that frontline staff had already come forward with further suggestions on clinical integration, such as the transfer of paediatric services into the Children's Division and these were taking place earlier than planned.

It was **resolved** to **note** the progress made and to **receive** a full report one year after integration.

**Action (AS)**

*To present a report on Post-NOC Integration Benefits Realisation giving granularity at the January 2013 Board meeting.*

**TB60/12 Oxford Academic Health Science Network [AHSN]**

The Chief Executive noted that he had already reported on this under the Chief Executive's Report. He said that the Board was being asked formally to agree that Oxford University Hospitals should be part of an Expression of Interest [EoI] for a wider Thames Valley AHSN following receipt of the final guidance from the Department of Health on 21 June 2012. The Board **agreed** that the Trust should be part of an EoI to become part of a wider Thames Valley AHSN.

The Chief Executive said that final comments had been requested from potential members of an Oxford AHSN by 13 July so that the final version can be prepared for submission on 20 July 2012.

Mr Peter Ward asked about cost or resource implications and the Chief Executive confirmed that resource was being given to this but in future there would be to be a governance structure.

**Action (JM)**

*It was **agreed** to circulate this draft version of the EoI to members of the Board for comment.*

**TB61/12 Response to Oxfordshire's Health and Wellbeing [JHWB]Strategy 2012-16 Draft Consultation**

The Director of Planning and Information presented this paper for information. This is a summary paper which was presented to the Strategic Planning Committee in June 2012, attended by Dr Jonathan McWilliam, Director of Public Health, and Mr John Jackson, Director of Health and Social Care, both members of the Health and Wellbeing Board. Dr McWilliam and Mr Jackson discussed the draft strategy for consultation at the Strategic Planning Committee.

Mr Stevens said that the Trust welcomed the opportunity to formally comment on the draft strategy for consultation.

He said that the Trust's comments on the draft strategy of the JHWB fell broadly into three areas:

1. There was good strategic alignment between the priorities within the document and the Trust's Integrated Business Plan and Long Term Financial Model and work needed to continue on that alignment.
2. With regard to partnership working and engagement, the Health and Wellbeing structures are commissioner led and therefore for the strategy to be meaningful, and if it is to be delivered effectively, the Trust must work to ensure that the structure for that engagement will be effective. Public education was also important.
3. In regard to defining and measuring success, the Trust did this through benchmarking to show that it achieves outcomes with costs which compare well to available comparators. At the last meeting of the Strategic Planning Committee there had been an interesting debate about setting a target for the number of people entering residential care, and the Trust has asked to be involved in those developments through



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partnership working. There is congruence in that the JHWB links its priorities and targets to national indicators.

Mr Geoffrey Salt said that it was important the JHWB was not seen as a joint board but as a united board. He therefore felt the Trust should be represented on the Board. He emphasised the importance of joint partnership working for the benefit of the local population.

The Chief Nurse stated that the JHWB Strategy had strong Board support as it contained the appropriate priorities and strategic aims.

Professor David Mant believed that the Trust's response to the draft strategy should be strengthened as the Trust contributed to the wellbeing of population of Oxfordshire. He said the response should emphasise that it could give valuable contributions to strategic thinking and the Trust did not believe the current arrangements were adequate as the Trust could assist with the monitoring function on the operational side.

After a discussion, it was agreed that the Trust should:

- **endorse** the strategic aims contained in draft strategy
- **accept** the recommendations contained in the draft JHWB strategy document
- **amend** its response in the light of the above comments.

#### **Action (AS)**

*To amend response before submission.*

### **TB62/12 Development of Strategies for Risk, Assurance and Quality**

#### **Risk and Assurance Strategies**

The Director of Assurance presented this paper which contained the collated feedback on the strategies which underpin the Trust's management of risk, quality and assurance.

She said that the draft documents had already been considered during June by the Quality Committee, by Board members at the Audit Committee Seminar and by the Trust Management Executive which comprised executive and divisional directors.

The Director of Assurance drew attention to key points across the strategies which had been summarised and to paragraphs 8 and 9 which detailed risk proximity and the high impact/low likelihood risks. She noted the feedback on strategy development contained in Appendix 1 and the decisions required. She said that paragraphs 10-23 contained detail on the implementation of the Risk, Quality and Assurance Strategies and the plans to implement these once they are approved. She stated that paragraph 24-26 outlined the strategy approval process.

The Director of Assurance noted that the Board had already debated in depth the whole approach to risk and assurance to improve the system. The area that had produced the most debate was risk proximity and different timescales for noting the proximity of a risk had been discussed at the Audit Seminar and Quality Committee.

After discussion, it was agreed that with regard to risk proximity, the timeframe scales

agreed are:

- Within 3 months
- 3 to 12 months
- Greater than 12 months.

The Director of Assurance referred to paragraph 8.2 on high impact/low likelihood of risks. At both the Quality Committee and the Audit Committee seminar particularly, discussion had taken place on the value of reviewing risks assessed as being of very high impact, but very low likelihood. These risks would therefore not necessarily be escalated for review by the Committees. The Director of Assurance requested that the Board consider building a mechanism so that these types of risks would be separate items within the risk register reports.

Mr Alisdair Cameron said that he was content for these risks to be identified separately within the risk register reports as they were low impact but could have high consequences. Mrs Anne Tutt noted it was sensible to identify these types of risks so they could be discussed in fora other than the Audit and Quality Committees to demonstrate the level of embeddedness within the organisation and to ensure these risks were explored fully.

It was **resolved** that the Director of Assurance would action the above points regarding agreed timeframe scales for risk proximity and identifying high impact/low likelihood risks by a separate mechanism within the risk register reports.

### **Quality Strategy**

The Medical Director spoke to the draft Quality Strategy. He noted that the Quality Strategy had been well supported by staff and that key staff and external stakeholders have been involved in its development.

The Quality Strategy had been developed by bringing together existing workstreams relating to safety and quality, and it will support the maintenance and improvement of clinical quality.

He said that ambitious quality goals had been set. In five years' time it was anticipated that the Trust would be able to measure quality precisely and would be scoring in the top decile in terms of outcomes. Strong feedback had been received on the need to develop ways of measuring this quality of care so that Oxford University Hospitals could, in future, lead the way on measurement. He noted that it was important to be able to measure and account for the quality of care with meaningful measurement.

It was noted that the PCT Cluster/Clinical Commissioning Group had praised the open and inclusive manner in which the strategy had been developed.

In terms of the Quality Strategy, a one page communication had been devised for staff and was being revised following feedback before circulation.

It was **agreed** that any further amendments to the Risk, Quality and Assurance Strategies should be sent to the Director of Assurance in terms of risk and assurance, and the Medical Director and Chief Nurse in terms of quality.

After discussion, it was **resolved** that the Chairman and Chief Executive will **approve** the

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strategies by the due date and that the finalised documentation would be circulated to the Board.

**Action (EW/Board)**

*Director of Assurance to amend the timeframe scales in the Risk Strategy.*

*Director of Assurance to include high impact/low likelihood risks as separate items within the Risk Register Reports.*

*With regard to the Risk and Assurance Strategies, Trust Board members were to forward any further amendments to the Director of Assurance. With regard to the Quality Strategy, Trust Board members were to forward any further amendments to the Medical Director and Chief Nurse.*

**TB63/12 OUH Trust Information Management and Technology Strategy [IM&T] 2012-2017**

The Director of Planning and Information presented this updated strategy which outlines the critical importance of full implementation of the Electronic Patient Record [EPR] across all clinical services to support service transformation and ensure improved patient care.

He said that the strategy had been presented to the Trust Management Executive and the Health Informatics Committee. It had been circulated to stakeholders for consultation, including the University of Oxford and NHS Oxfordshire.

The Director of Planning and Information said that the strategy covers three levels:

- 1) A robust IT infrastructure (hardware and software and standards and procedures) which delivers accurate information for clinical staff
- 2) Seeing the IT as an enabler of transformational change (such as EPR and work with the BRC on remote monitoring of patient information for long term conditions)
- 3) Input into the government's Big Data Agenda (examples being the exciting opportunities for collaboration with the University of Oxford, and linkages with other Biomedical Research Centres).

The Director of Planning said that the IM&T Strategy was aligned with the Trust's objectives within the Integrated Business Plan [IBP]. With regard to the patient safety and quality work carried out on the wards with EPR, he noted the Trust's success at the Patient Safety Awards on 4 July.

The Director of Planning noted that the next steps were to refine the strategy in detail and align it with the investment needed for the Long Term Financial Model [LTFM] which will be brought to fruition during October 2012.

The strategy was discussed in detail, Professor Sir John Bell noted that the importance of the Board seeing the actions that would be taken to realise non-financial and financial benefits. The Chief Executive noted that country-wide NHS organisations were seeing non-financial benefits at present from EPR which were quality and safety. He said that the challenge for organisations was to now quantify these benefits.

Mr Alisdair Cameron asked if a clear set of principles underpinning the strategy including issues such as clinical engagement could be devised which the Board approved and he also requested that the governance was clearly defined to assist the divisions and this was

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endorsed by Mr Peter Ward. The Director of Planning and Information said that this was helpful and said that lessons learned from EPR integration had borne this out.

Mr Geoffrey Salt commented positively on the Executive Summary of the paper. He noted that he would have preferred a greater descriptive around the reasons and linkages, such as to the Quality Strategy. He commented favourably on the ambitious priorities in the document and asked which would be the two most important ones. In response, the Director of Planning and Information said that strategic objectives were those contained in the IBP and LTFM and in the next iteration the linkages to the Trust's strategic objectives would be made more explicit.

After discussion, the Director of Planning and Information said that the assumption built into the LTFM, which had been presented to the Board, contained the benefits realisation and this work was being updated at present. He said that the updated benefits realisation would be presented to the Board in September.

It was **resolved** to approve and **note** the progress on the OUH IM&T Strategy.

#### **Action (AS)**

*The Director of Planning and Information to present the IBP and LTFM to the Board in September 2012.*

#### **TB64/12 Foundation Trust Development Programme Update**

The Director of Planning and Information presented this update on progress made on the Trust's Foundation Trust development programme.

He noted that following agreement at the June Board meeting, public consultation had commenced. He said that the Trust aimed to recruit 1,500 members of the public during the consultation, through various initiatives.

It was noted that a proposal has been made to the Oxfordshire Clinical Commissioning Group and NHS Oxfordshire for joint work on demand management and capacity planning to agree a forward plan for resources and services. As noted earlier, the Trust was updating its IBP and LTFM.

The Director of Workforce commented favourably on the two public consultation meetings which had been held in Faringdon and Abingdon.

It was **resolved** to **note** progress made.

#### **TB65/12 Staff Engagement Programme Update, including proposals for Staff Recognition Scheme**

The Director of Workforce presented an update on the Staff Engagement Programme including proposals for a Staff Recognition Scheme for information and discussion. She said that there were two components:

- 1) Recognising and rewarding good ideas
- 2) Correlation with the Trust's values work.

She said that the start-up costs of the Recognition Scheme were £40,000 and she was seeking Board approval for the scheme. In addition to the award process, the Trust is working with other organisations, such as Age UK and Oxford Brookes University.

The Director of Workforce detailed the events on all Trust hospital sites in July on engaging and empowering staff through “Listening into Action” [LiA]. The Chief Executive emphasised the importance of motivating staff through empowerment and listening and asking staff what may hinder them from delivering the care they would wish. Key areas had included key systems and processes, changing day to day working practices to empower staff and all staff exhibiting agreed behaviours, such as helping signpost patients if they cannot find their way to appointments. Feedback sheets from the events held were being evaluated and contained positive feedback.

The Chairman commented positively on the LiA sessions and said that one suggestion was for a non-email day within the Trust. The Chief Executive commented on the engagement and enthusiasm of the staff and the benefits of actively listening to staff identify and suggest the solutions to their daily working practices, and he said that providing empowerment was critical.

Mr Christopher Goard emphasised the value of the Recognition Scheme and he noted that it would be interesting to hear from the Staff Survey how this motivated staff. Mr Geoffrey Salt endorsed Mr Goard’s views and said that with regard to the ‘Good Thinking’ Scheme, through which staff put forward their ideas for innovations on a quarterly basis, he would like to see more spontaneity with staff feeding up ideas on inception to line managers and more timely feedback being given. He stated that he would like to see peer involvement in suggestion making and assessment. The Medical Director and Mr Salt agreed that empowerment, personal recognition and praise was more motivating than certificates.

It was **resolved** to **approve** the Staff Recognition Scheme, and its start-up costs, and the update on Staff Engagement was **noted**.

**Action (SD)**

*Plan for annual Recognition Event in November 2012 and ways in which the Board could recognise staff.*

**TB66 /12 Review of Trust 2011/12 Business Plan**

The Director of Planning and Information presented this paper which presented an update on the delivery of the objectives in the Trust’s Business Plan 2011/12 which was agreed by the Trust Board in June 2011, and supported by the Trust Management Executive in April this year.

The Director of Planning and Information noted some of the year’s achievements which included:

- Integration of the NOC and ORH to form OUH
- Implementation of EPR
- Development of the Joint Working Agreement with the University of Oxford
- Progression of the Trust’s Foundation Trust application for accreditation

- A successful rebid of the Biomedical Research Centre [BRC] and Biomedical Research Unit [BRU]
- The achievement of almost all of the Trust's operational and financial targets.

The Director of Planning and Information noted that good progress had been against the majority of objectives and where those were still to be achieved; they have been included in the 2012/13 Trust Business Plan.

It was **resolved** to **receive** this report.

### **TB67/ 12 Trust Business plan 2012/13**

The Director of Planning and Information presented the fourth iteration of this document for discussion. The Business Plan for this financial year has now been updated to reflect the discussions at the Board Strategy Workshop in March and the associated development of the IBP and LTFM which form part of the application for accreditation as a Foundation Trust.

Mr Peter Ward drew attention to page 17 of the Business Plan where the workstreams were listed as he did not think these were consistent with the IBP. Mr Ward said that he believed the workstreams did reflect the strategic objectives, but there was a £14m capital adjustment in radiotherapy at Milton Keynes and Swindon which was not reflected in the Strategy. The Director of Planning and Information said that this was contained in the IBP. Mr Ward also asked if the corporate objectives could be congruent with those in the Quality Account.

The Director of Assurance drew attention to page 33 with regard to Primary Standards. The Director of Planning and Information confirmed that these Standards form part of the Monitor Governance Compliance Framework.

Mrs Anne Tutt referred to page 33 and the listing of Head and Neck Relocation (Churchill or West Wing) as the relocation to the Churchill site had been agreed. It was agreed that the figure already given could be inserted against this item.

After discussion, it was **resolved** to **accept** and **approve** the Business Plan 2012/13, with the above modification.

### **TB68/12 Full Business Case for the Establishment of a Translational Molecular Diagnostic Centre at the Churchill Hospital**

The Director of Planning and Information noted that the case was supported by the Trust Management Executive on 22 December 2011 and an updated version based on more detailed costing was supported by the Strategic Planning Committee twice, lastly in June. It will be funded from the Trust's Capital Programme and also from allocated BRC capital.

The Director of Planning and Information enumerated the factors which are driving the proposed provision of a Molecular Diagnostic Centre and the need to authorise redevelopment of block 4 at the Churchill into the core consolidated molecular diagnostics unit, biobank, and fresh tissue handling unit. He said that it would provide a platform for molecular diagnostics which was very much at the heart of future pathology services to underpin the Trust's patient care agenda.

Mr Alisdair Cameron asked for elaboration on the £2 million spend. The Medical Director noted that the Business Case is linked to the BRC and the Trust's pathology services and the need for the Trust to be a provider of leading quality services in the future. Mr Cameron asked if the services could be provided elsewhere but the Medical Director confirmed it was essential to proceed to attain the Trust's research objectives.

Professor Sir John Bell noted the importance of this growth area and how genome research and genetic sequencing are benefitting patients. He said that maintaining the cutting edge of technology was important for Oxford, involving the Trust and University.

Concern was expressed about single storey accommodation being built in the middle of the Churchill Hospital site. The Director of Development and the Estate referred to the option appraisal for this development and referred to Appendix A on page 16. He pointed to the importance of adjacencies (theatres) and access which was important for samples if the patient was still in theatre. He said that the proposal had sited the development there in cognisance of future development on the site to the north.

Mr Christopher Goard requested more financial detail on costing. In relation to **12.2 Test Development Pipeline**, Mr Goard asked for detailed explanation on the acronyms for translational development and how translational development relates to the strategy.

After discussion, the Chairman requested that the points raised were answered in a note by executive colleagues which would be circulated to the Board. This note must clarify the economic and clinical case and give additional information on the estate option. Subject to this, the Chairman and the Chief Executive will approve the Business Case.

The Chairman noted that the Non-executive Directors had not seen the Outline Business Case and it was agreed that in future these would be included on the Board agendas.

#### **Action (AS)**

*AS to provide additional information required for Full Business Case before sign-off, and to add future Outline Business Cases to Board agendas and advance notification of draft agenda items circulated to the Board.*

#### **TB69 /12 Shadow Integrated Performance Report**

The Director of Clinical Services presented the Shadow Integrated Performance Report. He advised that from September an Integrated Performance Report will be presented to the Board covering operational, financial, quality and workforce performance.

The Director of Clinical Services talked to the report, highlighting where targets had been met and those areas for improvement and detailing the action required.

He noted that the Trust's performance for cancer targets in May had all been met.

With regard to Delayed Transfer of Care [DTC], a revised provider service had been commenced and until three weeks ago there had been a downward trend in numbers of DTCs. However, these have risen to 170 across the economy as a whole, the majority of which were seen in OUH beds. Work is being done to reduce this number in collaboration with NHS colleagues and Health and Social Care to access community beds.

With regard to the four hour standard for patients in A&E, it was noted that performance had fallen. By 4 June performance had improved to 95% but fell again in the latter half of June, giving a total of 89.2% for the month. An action plan was being implemented and the Deputy Director of Clinical Services was leading on this.

The Director of Assurance asked about the impact of the four hour standard for patients in A&E not being met. The Director of Planning and Information explained the grading system within the accountability framework for aspirant FTs. The A&E target was key. Discussions were being held with the SHA regarding the June figure for A&E performance.

The Chief Executive noted the importance of the work detailed in the action plan which had been implemented to rectify A&E performance to regain the 95% target.

Mr Alisdair Cameron said that he had visited the A&E Department with the Medical Director recently and he noted the operational challenges. The Director of Clinical Services said that changes were being made in the A&E Department to address the capacity issues.

Following discussion, it was **resolved** to **note** the report.

### **TB70/12 Financial Performance to 31 May 2012**

The Director of Finance and Procurement presented the financial performance for Month 2 up to 31 May 2012. He noted that the Trust is achieving its financial plan after the first two months of the year. He stated that the planned surplus for 2012/13 is less than 0.5% so the margins for deviation from plan are small.

He noted that commissioning income for all commissioners including specialist services was £1.9m better than plan, taking into account the adjustment against the NHS Oxfordshire contract for over-performance against plan. This additional activity against the Contract produced over-expenditure on pay of £1.16m above plan due to bank and agency staffing.

The Director of Finance and Procurement noted the financial risk rating, using the criteria applied by Monitor which scored 3 in May. He drew attention to some of the risks to the Trust in achieving its financial duties during the year. The key risks were identified, and included:

- Divisional failure to deliver the agreed CIPs
- Slippage on agreeing the remaining CIPs for the year
- Over-performance against contract as NHS Oxfordshire will not fund the first £4 million of over-performance
- Emergency activity
- Non-payment for avoidable re-admissions
- Delayed Transfers of Care.

Mrs Anne Tutt said that the previous report contained an analysis on research costs and it was agreed that this would be included in the next report. She said that it would be also helpful for the Board to have an in depth understanding on the CIPs.

Mr Peter Ward noted long term debt with Ramsay Healthcare. An interim payment had been



requested and was awaited.

It was **resolved** to **receive** and **note** the report.

### **TB71/12 Audit and Finance Committee (May and June)**

The Director of Finance and Procurement said that the Audit and Finance Committee meetings in May and June had largely dealt with the final Annual Accounts position. Mr Alisdair Cameron said that the Trust had appointed a new audit provider, KPMG, which had been given a one year contract. The focus in the next few months for the Audit and Finance Committee was assessing the risk management system.

It was **resolved** to **note** this.

### **TB72/12 Quality Committee (June)**

Mr Geoffrey Salt made some brief comments on:

- **Patient story** – Mr Salt noted the patient had felt very supported by the Trust. Mr Salt said there was an improving programme of patient stories to look at specific issues on the patient pathway six times a year.
- **Quality impact on CIPs** – The Committee had received assurance that there is now a process in place to look at robust risk assessments in all divisions. Examples of these will be presented to the September Quality Committee.
- **DTOC** – Following a discussion, the Director of Clinical Services is to present a document, circulated in advance on DTOCs to ensure that patients are receiving the treatment required in the Trust's hospitals given the delay to their discharge.
- **Quality Walkaround Programme** – The Chief Nurse tabled a revised Walkaround Programme and received advice from Non-executives Directors present that the actions arising from the walkarounds needed to be clear, measurable, specific and reported back. The Chief Nurse would circulate the revised Walkaround Programme.
- **Never Events** – the Medical Director presented a report on adverse events and it was noted that an external review was being conducted to give external validation
- **Clinical Governance Committee** – With regard to minutes, it was important for there to be early circulation of minutes. The Chief Executive explained the sequencing of meetings which had led to this delay but noted that the revised sequence of meetings would ensure that the Board and its Sub-Committees receive timely minutes and an overall summary for each meeting held.

The Chief Executive suggested that in future all Sub-Committee reports should consist of a verbal update from the Chairman of that Sub-Committee plus a written summary of key issues discussed and decisions made to accompany the formal minutes of each Sub-Committee.

### **Action (all Chairmen of Board Sub-Committees)**

*In future all Sub-Committee reports should consist of a verbal update from the Chairman of the Sub-Committee plus a written summary of key issues discussed and decisions made to accommodate the*

*formal minutes of each Sub-Committee.*

It was **resolved** to **note** the above.

**Action (ESH)**

*The Chief Nurse to circulate the revised Walkaround Programme to Board members.*

**TB73 /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 and signing of documents.

**TB74 /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, 6 September 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)”.