

## Trust Board

Minutes of the Trust Board meeting held in public on Tuesday, 12 February 2013 at 9am in the George Pickering Postgraduate Centre, The John Radcliffe Hospital.

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

### TB25/13 Apologies and declarations of interest

Apologies were received from Professor Sir John Bell and Mr Salt. There were no declarations of interest.

### TB26/13 Minutes of the meeting held on 9 January 2013

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

- Mrs Strachan-Hall asked that the second sentence of the third paragraph on page 4 be changed to read: "The feedback remained overwhelmingly positive **but the percentage that would recommend us** was likely to change when the Friends and Family Test was rolled out, as the feedback would be sought after patients had left the care environment."
- Mrs Strachan-Hall clarified that the statement attributed to her at the beginning of the fourth paragraph on page 6 had been made by Mr Salt

- Professor Baker asked that the second sentence of the fifth paragraph on page 8 be corrected to indicate that **significant progress** would have been made on improving performance against all the domains by the end of March.

### **TB27/13 Matters arising from the minutes**

Mrs Tutt requested clarification on the identified need to increase the availability of specialist services at weekends. Professor Baker explained that this was the major difference between the position during the week and at weekends, and that plans were already in place to increase the availability of endoscopy as part of 7 day working. Sir Jonathan added that the Board would need to consider in the round, all the steps that were being taken to address the apparent disparity identified by Dr Foster in mortality levels between patients admitted during the week and at weekends.

### **TB28/13 Action log**

#### TB07/13 Quality Report

Professor Baker indicated that it would take more time to report on the work to address surgical site infections, and asked that the item be moved from the March meeting, but as there is no meeting scheduled for April, he agreed to present an interim report in March.

### **TB29/13 Chairman's Business**

Dame Fiona did not report any Chairman's Business.

### **TB30/13 Chief Executive's Report**

Sir Jonathan highlighted the following sections from his report:

- Dame Fiona had been re-appointed by the NHS Trust Development Agency (NHS TDA) as Chairman of the Trust for a further four year term from March 2013, and Mr Salt had also been re-appointed for another term as Non-Executive Director. He reminded the Board that the responsibility for such appointments had passed from the Appointments Commission to the newly created NHS TDA, and that there would be more re-appointments in the near future.
- Robert Francis QC had delivered his final report on 6 February. This was a very sizable document of 3000 pages with 290 recommendations, the implications of which would take a considerable time to fully consider. He suggested that the Board should consider the implications for the Trust at their seminar in March. The Board agreed to this course of action.

**Action (EB/ESH)**

*The recommendations from the Francis Report and its implications for the Trust are to be discussed at the Board Seminar in March.*

- The planned transfer of Head and Neck cancer surgery from the John Radcliffe to the Churchill Hospital had been slightly delayed due to short term pressures in the theatre suite at the Churchill. This delay had been discussed with staff and patient groups and was expected to last no more than 2 months.

In addition, Sir Jonathan made reference to the Trust's decision to suspend emergency abdominal surgery at the Horton Hospital. Revised arrangements involving staff at the John Radcliffe had been in place and effective since 18 January. The decision had been made as a result of staffing pressures and a shortage of sufficiently skilled surgeons to deliver the service safely. The longer term future would be addressed within proposals on the wider reconfiguration of services at the Horton to be formally consulted on in late March or early April.

**TB31/13 Monthly Quality Report**

Professor Baker presented the first part of this report. He made reference to the mortality statistics and informed the Board that the SHMI and HSMR were both within expected limits. The SHMI is a rolling 12 month measure of the data, and the latest report, which covered the period from July 2011 to June 2012, showed that the rate had fallen again. The rate is now approaching its control limit. The monthly HSMR is more erratic, but there was nonetheless a downward trend in the monthly figures.

Professor Baker announced that a detailed review of the records of patients admitted at weekends was to be undertaken, and that this would be fundamental to improving the quality of services. He advised the Board that since April 2012, the Trust's mortality rates for patients admitted at weekends had been below average compared to other Trusts.

On the Quality Account, Professor Baker made reference to one of the recommendations within the Francis report which stated that Boards must evidence compliance with each standard that applied to them. He confirmed that the metrics set out on page 4 of the report could be incorporated into the Quality Account and that the detail would be included in the quality priorities. Good progress had been made on CQUINs, with the exception of dementia screening. He explained that the screening was taking place, but that the Trust was unable to record to the level of detail required on its current paper based system.

One SIRS had been reported in December 2012 and this was being investigated. Reference was made to figure 4 on page 8 of the report showing that the Trust reported an average of 4 SIRS a month, which was within the PCT threshold of 5. It was likely that this figure would be renegotiated by the CCG. The total number of incidents, as set out in figure 5, remained relatively stable. It had been expected that there would be an increase in the reporting of incidents with the introduction of Datix, but that this had not yet materialised.

Rates of *Clostridium Difficile* (C diff) and MRSA were within the agreed trajectory. Professor Baker explained the difficulties in managing within the C Diff trajectory as a result of the complexities of the measurement system. Many of the incidents had originated from within community settings and in newly admitted patients, and so targets ought to be measured across the whole health economy. The target for this year was 88 and would be 70 for next year which would be very demanding. The third case of MRSA had been recorded in December, but the Trust was well within the target.

Mrs Strachan-Hall presented the second part of the report. She gave an outline of the NHS Patient Safety Thermometer, and indicated that CQUINs for next year would include a requirement to reduce the number of pressure ulcers across the health economy by half.

There had been a reduction in the number of complaints received, but many of the usual issues were still being raised, including appointments and transport.

Work was underway to roll out the Friends and Family Test across the Trust. Four wards had piloted it during December 2012, and this had been extended to all inpatient wards from the end of January. Mrs Strachan-Hall stated that data coming back from these pilots would be included in subsequent Quality Reports.

She mentioned the National Emergency Department Survey which had sought to capture the views of a random sample of 850 patients who had attended the department between January and March 2012. This had coincided with the implementation of the new IT system. Overall messages from the survey were that there was room for improvement on waiting times, but that patients had confidence in the quality and commitment of the staff.

Mr Cameron wanted to know what the real difference was in the quality of care provided to patients admitted during the week and over the weekend. Professor Baker explained that there were no issues in relation to the availability of senior medical staff, and indeed that Dr Foster had assessed the Trust as having one of the highest levels of coverage. He stated that those admitted at weekends tended to be more ill. In any event, the latest HSMR indicated that mortality within the Trust for patients admitted at weekends was now below average. The Board had a further

discussion as to whether there was any significant difference in the quality of care provided, and if identified what could be done to address it.

Professor Baker suggested that the availability of more specialist interventions at weekends would lead to an improvement in the quality of care and also change the statistics. Sir Jonathan suggested that a clearer report be presented to explain whether the changes in mortality rates over the last few months were statistically significant or not. Dame Fiona suggested that a conversation be had before the next Board meeting to agree on what should go into that report.

Mr Goard commended the improved format of the report, and the fact that complaint data had been shown against patient activity. He noted that the areas for improvement reflected in the Emergency Department Patient Survey all related to the provision of information to patients and their carers, and he asked about steps being taken to address these. Mrs Strachan-Hall indicated that the EMTA division had seen the findings, and had drawn up an action plan which included steps to improve the provision of information. She explained that the Quality Committee would be considering the executive summary of the report at their next meeting. Professor Mant expressed a concern regarding patient feedback that they were not always told what could go wrong.

Mr Ward remarked that the death of a baby had not been included on the list of SIRIs, in response to which Professor Baker stated that this had been reported in January rather than December. Mr Ward referred to the greyed out boxes in the divisional scorecards, and asked that the reasons for the non-availability of this data be provided. Mrs Strachan-Hall provided explanations, but acknowledged that the Board needed to be assured that relevant information was being collected and reported on.

The Board had a discussion about the provision of information related to the use of antimicrobial drugs, and it was agreed that the audit of this use would be addressed at the Quality Committee as part of its consideration of clinical audit.

Mrs Tutt stated that she understood the difficulties in meeting the requirement of the CQUIN goal on dementia screening, and asked about the implications of not achieving this target. Professor Baker confirmed that the Trust would not receive the relevant payment, and that next year, there would be a new improvement target. He also explained that to demonstrate achievement of the goal, the Trust was required to submit data on each individual patient and reiterated that it was this requirement that was holding the Trust back. The Trust would nevertheless continue to do all it could to report this manually.

Dame Fiona stated that in relation to the work being done to reduce pressure ulcers, the Board should receive a report on the work with partners, to provide assurance that a common approach was being used.

### **Action (ESH)**

*A report is to be presented to a future meeting of the Board on the work that is being done with partners to reduce pressure ulcers*

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

### **TB32/13 Foundation Trust update**

Mr Stevens presented this report setting out progress against the timetable. He noted that following the Board to Board meeting with the Strategic Health Authority (SHA) in December 2012, there was no requirement for a further meeting with the SHA, but it had asked for further information to be provided by 1 March 2013. This included:

- Additional information around the cost improvement programmes for 2013/14 and 2014/15, and
- Revised letters of detailed support from commissioners

The Trust Development Authority would assume responsibility for the next stages of the application, and the Trust had already started working with it. There was a need to start preparing for the later stages of the process, but elections to the Council of Governors could not take place until the application had been passed to Monitor. However workshops were being prepared for prospective staff and public governors.

A major communications exercise was also being undertaken, not directly about the FT application, but in relation to strategy, values and staff engagement. The ambition was that any member of staff should be able to talk about how their work contributed to the achievement of the Trust's values and objectives.

Mr Stevens stated that the Francis report commented on the FT process, but noted that the CQC had already indicated their unwillingness to take on responsibility for this. He was clear that whatever the eventual structure, quality would feature more prominently in the process henceforth.

He referred the Board to 2 recommendations within the paper on elections to the Council of Governors:

- Method of election – it was recommended that the First Past the Post method be used, and

- How to fill vacancies arising within 18 months of elections – it was recommended that the second placed candidate would be asked to step in.

Mr Stevens confirmed that the possibility of this happening would be made clear to candidates at the outset.

The Board accepted both recommendations.

Sir Jonathan commented that although it could be assumed that all the 290 recommendations within the Francis report would be accepted, it was likely that there would be some delay, before there was a formal response from the Secretary of State.. The Board agreed that the Trust ought to proceed as planned until any changes were announced.

The Board resolved to **note** the contents of the report and **accept** the recommendations on elections to the Council of Governors.

#### **TB33/13 Planning Guidance 2013/14**

Mr Mansfield presented this paper. He explained that following reorganisation, the NHS received 2 sets of planning documentation in December 2012. “Everybody Counts: Planning for Patients 2013/14” had been issued by the NHS Commissioning Board, and contained detailed commissioning plans, while “Towards High Quality, Sustainable Services”, issued from the NHS TDA set out the process and expectations for planning and responding to commissioning intentions. A number of other documents had also been issued, notably,

- The draft tariff for next year - the potential impact of this document was being worked through with commissioners and was dependent on the mix of services;
- The PBR code of conduct - another crucial document, that set out how commissioning would be carried out; and
- The standard NHS contract for next year – this would form the basis for negotiations with commissioners

Mr Mansfield explained that there was still some uncertainty within the system, particularly in relation to the movement of specialist commissioning away from local commissioners to the National Commissioning Board. He stated that this transfer would have a significant impact on how the contract would work next year. He referred the Board to the TDA’s timetable set out on page 6 of the report.

Professor Mant questioned the wisdom of planning for less capacity and then over-performing with heavy reliance on temporary staff for delivery. Mr Mansfield stated that discussions were continuing with local commissioners. He explained that the approach in the past had been to develop capacity on the basis of what the Trust

thought it would need. This year, the Trust had been more ambitious, but had subsequently over-performed on the contract to the tune of £80m. For next year, the approach would be to work with commissioners and seek to agree an affordable set of activity plans based on a good shared understanding of the level of demand within the system. As a by-product of the FT project, the Trust had already agreed some plans with commissioners in October, which would form the starting point for discussions.

Mr Mansfield noted the strategic changes to specialist commissioning, and emphasised the importance of this area of the Trust's work, stating that it could account for up to 45% of contract income next year, with the National Commissioning Board becoming the largest commissioner. He made reference to a document that had been produced, containing 158 service specifications which all providers would be required to sign. The Trust would also be required to do some precise business planning in relation to the transfer from local to specialist commissioning, as there would be some hard choices to be made. He stated that, strategically, the Trust intended to carry on providing its existing suite of services.

Professor Baker suggested that there was likely to be a move towards fewer larger providers, of specialist services, and stated that this presented threats and opportunities for the Trust. He stressed the importance of looking at the bigger picture rather than focusing on a narrow range of services. He anticipated that the National Commissioning Board were specifying clear standards around service quality and critical mass of activity and clinicians.

Mr Stevens set out 2 areas of risk that would require management next year:

- The level of non-recurrent contingency required by the planning regime; and
- The fact that CCG allocations had already been set irrespective of the NCB process

He also anticipated that the Board would have some important choices to make.

Mr Cameron questioned whether enough had been done to create flexibility in staff terms and conditions, as it was likely that there would be more demand than the plan accommodated. He gave as examples the possibility of having different standard hours from week to week, or the facility for members of staff on part-time contracts to work full time on occasion. This would better enable the Trust to manage under and over demand without needing recourse to expensive agency staff. Ms Donaldson confirmed that these possibilities were being considered.

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



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## TB34/13 Integrated Performance Report Month 9

Mr Brennan presented this report and noted its updated format. The first two pages contained a narrative overview of key performance and finance issues, followed by a revised version of the integrated report itself. Pages 10 and 11 showed, via traffic light indicators, how the Trust was meeting key targets. The quality and workforce sections were still being developed. Pages 12 to 34 provided more detail on an exception basis where performance had been red-rated.

Mr Brennan set out the following key themes at the end of December:

- Performance against VTE was above target and all cancer targets had been met
- The Trust had achieved 95.9% for Q4 against the ED 4 hour wait target despite the fact that there had been 2000 more attendances in December
- RTT Admitted and Non admitted targets had been met at Trust level, and had been met at speciality level for Non admitted
- Delayed discharges had fallen to 92 in December, but had started to rise again in January, which continued in February. The current level was 177 across the system
- There had been a large increase in delays for non-obstetric ultrasound in the MARS division and this was being addressed. Patients were now being booked at 5 weeks

Mr Brennan reported that the overall position was positive, considering how challenging January and February had been. The level of activity in the Emergency Department was running at 350 patients a day. There had already been a number of breaches, but this week had started more positively. He reported that the cancer data looked promising given the level of activity.

Dame Fiona commended the re-formatted report, stating that it was much clearer, and she acknowledged the work that had been done to achieve this.

Mr Cameron questioned the sustainability of the recovery plans regarding the 6 week diagnostic waits target, considering the target had only been met once in 12 months. Mr Brennan acknowledged this but reported that performance on eco-cardiology, endoscopy and non-obstetric ultrasound, which had been the main problem areas, was now improving. He noted that there had been a surge in demand for MRI but was unclear as to what was driving this.

In response to a question about the increase in the number of delayed discharges, Mr Brennan advised that the number had gone down from 201 to 92 between March and the beginning of December 2012, but that in the last 6 weeks, the level of activity across the system had led to further increases. He stated that all 3 organisations

were in agreement that admissions were appropriate. The majority of the increase had been in the social services area because the County Council no longer provided care directly, and its private sector contractors had not been able to respond quickly enough to the rise in demand. It was also acknowledged that the high level of acuity of patients' conditions was impacting on the amount of bed based care they needed on discharge.

Mr Brennan advised the Board that although the last 6 weeks had been difficult, he was confident that the plan being followed by the 3 organisations would work in the long term. He emphasised the organisations' continued commitment to joint working.

On theatre utilisation, the Board was reminded of the work being done with Newton, and that this would be reported in detail to the Finance and Performance Committee in due course.

Professor Baker reiterated the unprecedented levels of demand, both in terms of numbers and the level of acuity. There was an expectation that this would ease in the spring, but this period seemed more difficult than it had been at the same time last year. Sir Jonathan stated that this reinforced the need for integration across the entire system.

Mrs Tutt observed that the level of ED activity in the last 6 weeks would affect the Trust's performance in this quarter and wanted to know what the implications of this were. Mr Brennan stated that the Trust could absorb approximately 1500 breaches and still achieve the target, but there had already been 900, and as such, achieving the target would be a challenge. As the Trust could not assume that the level of delays would reduce, a range of actions had been taken internally, including ensuring that senior nurses were present at 8am ward rounds, increasing consultant presence from 6 to 8 hours a day, 7 days a week to maintain flow, and maintaining staffing levels to keep the escalation beds open. He advised that the quarter 4 target could be met, but that it would require a concerted effort across the board.

Professor Mant acknowledged the work being done across the three organisations to reduce delayed discharges, but enquired whether there were any structural issues in Oxfordshire that made the problem more difficult to tackle. Mr Brennan highlighted the fact that there were 200 rehabilitation beds not under the control of the Trust, which differed from the position elsewhere. He also noted the fact that the County Council did not provide care itself. To address this, Mr Brennan stated that work was being done to increase the utility of the community beds.

Mr Goard commended the charts included in the report, and suggested that the addition of trend lines would be a further improvement.

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

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### **TB35/13 Financial Performance to 31 December 2012**

Mr Mansfield presented this report and highlighted 3 points:

- The Trust remained on course to meet its year end income and expenditure targets, despite risks around the operational pressures
- The capital programme was on course and being proactively managed, with weekly meetings being held with programme managers
- Progress had been made on settling the balance sheet, but some volatility remained. He advised of the need to improve this in order to meet the FT challenge

Mrs Tutt observed that the capital budget had been overspent and described this as encouraging. She enquired if there were likely to be any accounting treatment issues this year. Mr Mansfield did not consider that there would be, as matters had been proactively discussed with the Trust's external auditors. He advised the Board that a paper on this would be presented to the Audit Committee at their meeting in March.

In response to a question as to whether the lower level of screening activity was a risk, Mr Mansfield acknowledged that pick up had been slower than anticipated, but that had changed.

Mr Ward raised a question in relation to the inclusion of projects funded from charitable donations within the capital programme, and Mr Mansfield explained that due to a change to the International Financial Reporting Standards (IFRS), these would be considered NHS assets.

A suggestion was made that research activity be commercialised, and Mr Mansfield advised that work was being done to better understand the impact of research on NHS activity.

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

### **TB36/13 Quarterly HR and Workforce report**

Ms Donaldson presented this report. In relation to sickness absence management, she announced that the rate remained below the Trust's target, despite the prevalence of colds and flu symptoms at this time of year. She advised that 59% of frontline staff had been vaccinated against the 'flu, which compared favourably with 44% nationally. On the management of turnover, she stated that steps were being taken to better understand why people were leaving. She was concerned about the pressure that turnover levels were placing both on the recruitment team and the divisions. Levels of appraisal had been sustained at 70%, and work was being done to improve this, with a focus on adopting an electronic approach to which the divisional directors were committed. Medical appraisals were underway.

Ms Donaldson acknowledged that the Trust was not where it would like to be in relation to statutory and mandatory training, but that the new approach had been successful. It was now possible to obtain details of each individual's compliance levels and target those who were not registered on the system.

She informed the Board that the Workforce strategy launch had gone well, but that there was now a need to raise its profile. She indicated that future reports to the Board would focus more on progress against implementation of the strategy.

Ms Donaldson trailed the Leadership Development event planned for April 2013, which was about bringing the most senior leaders in the organisation together to improve understanding of the Integrated Business Plan and aligning individual and team objectives to those of the Trust. It would be about more than raising awareness of the FT application.

The findings and results from the 2012 Staff Survey were imminent and this would give an impression of how staff felt about working at the Trust. Ms Donaldson indicated that the initial results were promising. She undertook to present a detailed report to the Board in March.

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

*A detailed report on the trust's Staff Survey results is to be presented to the Board meeting in March*

Mr Goard noted that the Neurosciences Trauma Specialist Surgery division had the highest rates of turnover, and asked if any support was being provided to help them manage this. Ms Donaldson confirmed that her team was working with the division on it, but pointed out that work needed to be done with staff before they joined the organisation to help them understand what to expect.

In response to a question about the use of Values Based Interviewing (VBI) in Advisory Appointments Committee (AAC) meetings, Ms Donaldson stated that the intention was for a wider roll out of VBI and that it would be incorporated into AACs. She advised that a number of consultants had signed up for the training. Mrs Strachan-Hall added that staff who had used VBI had given positive feedback on it. Ms Donaldson explained that the 4 trial areas at which it had been used would be able to feed back at the end of the year on using it in real interviews.

Dame Fiona indicated that the Board would like to hear more about the projects referred to in relation to the Listening into Action programme. Ms Donaldson confirmed that there was information that could be shared, and that Board members would be invited to the events.

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

**TB37/13 NHS Trust Oversight Self-Certification**

Mr Stevens presented this report and clarified that the attached self-certification for December, had already been submitted. Delegated authority would be required for the sign off by the Chief Executive and the Chairman of the January declaration, which was not yet ready.

He explained that in December, the Trust's in-month Governance Risk Rating was Amber/Green as a result of non-compliance with the ED 4 hour wait target. The rating would return to Green in January following the Board to Board meeting with the SHA at which it was agreed that internally validated data would be relied on. He further explained that there was a process for deciding how responsibility for any subsequently identified breaches would be apportioned, and such an eventuality would be brought to the Board's attention.

The Board resolved to **note** the December return and **agreed** to delegate authority for the Chairman and Chief Executive to sign-off the January self-certification on its behalf.

**TB38/13 Report from Board sub-committees – Audit Committee**

Mrs Tutt presented this report and expressed her concern about the on-going internal audit work. As the internal audit providers had been engaged during the course of the year, they had started late and had a big programme to get through. She stated that there was not much visibility of the work that they had done, and that she had not yet seen any reports. Internal Audit had sought to reassure the committee that the reports would be delivered on time, but she remained unconvinced. Mr Mansfield agreed that this issue ought to be resolved, and confirmed that a number of reports were almost ready to be signed-off. He agreed to take the issue up with the Head of Internal Audit.

**Action (MM)**

*Discussion to be held with the Head of Internal Audit regarding the status of the outstanding reports*

Mrs Tutt informed the Board that the committee had agreed to commence its programme of deep dives into significant risk areas with effect from its March meeting. The process might require some refinement, but it was important that it is started.

She also raised the issue of the signing off of the accounts in relation to the timing of meetings. There was a discussion as to whether the Audit Committee could sign them off on the Board's behalf after which it was agreed that a recommendation would be brought to the next Board meeting.

**Action (MM)**

*A formal recommendation as to how the sign off of accounts should be handled is to be presented to the March Board meeting*

**TB39/13 Consultant Appointments and Signing of Documents**

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

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

**TB40/13 Any Other Business**

There was no other business.

**TB41/13 Date of the next meeting**

A meeting of the Board to be held in public will take place at 09.30 on Wednesday 13 March 2013 in the George Pickering Postgraduate Education Centre, the John Radcliffe Hospital.

The Board then considered and agreed the following motion:

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