Trust Board

Minutes of the Trust Board meeting in public held on **Wednesday 11 September 2019 in the Training Room, Horton General Hospital.**

Present:	Professor Sir Jonathan Montgomery	JM	Chair
	Dr Bruno Holthof	BH	Chief Executive
	Mr Jason Dorsett	JD	Chief Finance Officer
	Ms Claire Flint	CF	Non-Executive Director
	Ms Sam Foster	SF	Chief Nursing Officer
	Mr Christopher Goard	CG	Non-Executive Director
	Ms Paula Hay-Plumb	PHP	Non-Executive Director
	Prof David Mant	DM	Non-Executive Director
	Ms Jane Nicholson	JN	Interim Chief People Officer
	Prof Meghana Pandit	MP	Chief Medical Officer
	Ms Sara Randall	SR	Chief Operating Officer
	Prof Gavin Screaton	GS	Non-Executive Director
	Mrs Anne Tutt	AT	Vice-Chair and Non-Executive Director
	Ms Eileen Walsh	EW	Chief Assurance Officer
In Attendance:	Dr Neil Scotchmer	NS	Head of Corporate Governance
	Ms Marilyn Rackstraw	MR	Corporate Governance Manager [Minutes]
	Katie Jeffrey	KJ	Trust Infection Control Lead
Apologies:	None		

TB19/09/01 Apologies, Welcome and Declarations of Interest

No apologies had been received.

There were no declarations of interest.

TB19/09/02 Minutes of the Meeting Held on 10 July 2019

It was noted that some minor amendments for clarity had been notified to the Head of Corporate Governance.

DM requested that paragraph 8 on p3 be revised to clarify that waiting times had increased with some risks associated with this which could be mitigated by ensuring that prioritisation was accurate and appropriate. The need for a safety net for patients who deteriorated while waiting was to be emphasised. He also requested that the paragraph emphasise that lessons from harm reviews be applied broadly across the Trust and not just for long waiting and cancer patients.

TB19/09/03 Matters Arising from the Minutes

SR noted with reference to p6 that she had reported seven 52 week breaches at the previous meeting but had subsequently discovered that this should have been eight.

JN noted that the Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) Reports were to be presented to the Board further to be data being considered at the July meeting, and agreed to circulate these to the Board outside of the meeting for information and final review.

Action: JN

TB19/09/04 Action Log

Outstanding items on the Action Log were reviewed. It was agreed that items could be closed as indicated.

The Chief Nursing Officer suggested that the forecasting item be picked up under discussion of the Integrated Performance Report.

TB19/09/05 Chair's Business

JM reported that the celebration of the theatres reopening following the refresh had taken place and congratulated those involved in the process.

He reported that Governors were well into the process of recruiting to the two non-executive director (NED) vacancies with further interviews to take place. It was noted that the quality of applicants had been high and recommendations were due to come to the Council of Governors in due course. The Chair thanked those contributing to stakeholder groups for their support.

The Chair gave thanks to DM and CG for years of very distinguished service to the Trust. He noted that this would be their last public meeting as NEDs but recognised that the Trust would have the benefit of their expertise for some weeks yet. The benefit of continuity in establishing the Foundation Trust was particularly valued.

TB19/09/06 Chief Executive's Report

BH reported that Heads of Agreement [HoA] with NHS England [NHSE] had been signed, which would allow the Trust to maintain the PET-CT service on the Churchill site. This was positive news for patients and staff and allowed the Trust to maintain its current excellent service.

The Trust was also in contact with InHealth for additional scanning services that could be provided initially through mobile scanners. This was in context of the need for growth in capacity and to increase access, which was a goal of NHSE.

The Trust was concerned to ensure that current clinically-agreed pathways were maintained and the HoA noted as an overriding principle that decisions relating to pathways will be clinically-led. MDTs would decide how to refer patients, interpret scans and advise patients on treatment options.

DM noted the importance of ensuring that clinicians were well informed across the Thames Valley. BH agreed and reported that this work would be led by the Thames Valley Cancer Alliance with a key role for Nick Maynard as Trust Cancer Lead.

JM thanked all that had been involved with particular mention of BH, MP and JDo as well as NM for liaising with clinical colleagues.

BH highlighted that David Walliker was due to join the Trust in October as the new Digital and Partnerships Officer.

Oxford University Clinic, the Trust's joint venture with Oxford University and the Mayo clinic, was due to open its first clinic in London in September, which would be a diagnostic facility.

The new Sobell House Hospice outpatient facility was due to open its extension funded by Sobell charity for patients who were at end of life stage.

There were also celebrations of the Heart Centre 10th anniversary, and Maggies Centre 5th anniversary.

The Trust Board received the Chief Executives report.

TB19/09/07 Patient Story

SF presented the patient story which detailed the experience of two patients who had had procedures cancelled and rescheduled.

94 complaints had been received in 18/19 relating to cancelled procedures and admissions and the report explored the lessons learnt from the experiences of patients and provided assurance of ongoing improvements. The Trust currently undertakes surveys with patients who have experienced delays, and harm reviews are undertaken to ensure that patients are prioritised appropriately.

It was noted that the way in which the Trust cancelled and rescheduled patients and the information provided to them could be improved.

MP further advised that the previous model has been that harm reviews over 52 weeks were undertaken with an external chair. An internal chair, also the Director of Patient Safety, had been appointed and so now the Trust was moving towards assessing waits of 45 weeks and over, with the hope of improving this waiting time further.

Assurance was provided that clinical teams immediately reviewed patients who were cancelled on the day to reschedule with escalation where necessary. It was also emphasised that cancellation was a clinical decision with executive sign off to ensure that every avenue to prevent it had been exhausted.

A Theatre Productivity Group chaired by SR and MP had been established and was using the 6-4-2 approach to making bookings. The group was also looking at emergency capacity across all sites to ensure that this was sufficient for the long term.

MP reported that there were several reasons for cancellations on day, with different actions required to prevent them as appropriate, including patient unwell despite pre-assessment, running out of time, or being overtaken by an emergency.

CG asked what the Trust was doing to learn from other Trusts. SR confirmed that benchmarking was undertaken and learning undertaken both locally and across the Shelford group in terms of best practice.

AT highlighted that for her, the key issue was around communication and noted the need to ensure that the Trust was supporting and informing patients.

JD noted that many Board members would have personal experience of this and asked to what extent the Trust communicated the risks of cancellation in advance of admission. He suggested trying to maximise the use of capacity would increase the likelihood of cancellation if all didn't go to plan. EW noted that many people would

have made family and work arrangements for planned elective care and highlighted the need to make people aware that the possibility of cancellation existed. She suggested using Governor support to consider what would most help patients.

MP further reported that the Trust had started to use a scheduling tool based on data that gave an assessment of how long individual procedures would take to give better predictability of the time that a list would take.

JM noted the assurance that the Board could take that the complexities of the issue were recognised with different elements of work underway to address these.

The Trust Board received the patient story and subsequent assurance that ongoing improvements were being made.

TB19/09/08 Quality Committee Report

DM presented his report providing the Board with an overview of the Quality Committee's meeting held on 14 August 2019.

He reported that the Committee remained concerned about the persistent pressure on services and bed occupancy, which remained above the recommended level.

The Committee had identified the need for alignment between the divisional perception of risks and that of the Board, and the need to consider, with clinical involvement, the key performance indicators should be considered.

It was noted that there was a typographical error on p3 point g) and that this should of read that the patient was streamed in ED based on a verbal account by the paramedic without clinical assessment and discussion with patient in ED and that this approach ought to be an "ever" event.

The Committee had reflected on the Q1 Workforce and Organisational Development report. It was noted that Trust turnover had reduced from 14.2% (M12 17/18) to 13.8% at the end of Q1 but vacancies had risen to 10.2% of budgeted established. It was noted by the Committee that this vacancy rate was significant and that there was a link between capacity challenges and workforce challenges.

The Board received the Quality Committee Chairman's report.

TB19/09/09 Mortality Report

MP presented the Annual Mortality Report for 2018/19. Key actions and learning points identified in reviews completed during 18/19 were highlighted.

During 2018/19 there had been 2674 inpatient deaths reported at OUH. 2366 (89%) cases had been reviewed within 8 weeks. Of these reviews, there were 1304 (49%) comprehensive Level 2 reviews and 82 (3%) structured mortality reviews which include 33 structured reviews for patients with learning disabilities. The deaths which were not reviewed within 8 weeks did have a subsequent Level 1 screening review. There were two deaths judged more likely than not to have been due to problems in the care provided.

OUH was implementing the Medical Examiner system. Medical examiners were expected to be in place by April 2020. Medical Examiners were to scrutinise the circumstances and causes of deaths in acute trusts. They would also be a point of

contact and source of advice for relatives of deceased patients, healthcare professionals and coroner and registration services.

CF asked whether in future the report could have a more action-oriented conclusion.

Action: MP

JM noted that he was pleased that the Trust was honouring the importance of looking at learning disabilities, and also pleased to see that staff were raising issues and felt confident enough to do so.

JM noted that the descriptions provided identified learning but could not see evidence that the identified outcomes were subsequently delivered and asked how the Board could be assured that this was the case. MP responded that she and SF held the Divisions to account for delivery at the Clinical Governance Committee with evidence in the form of the extent of repeat of incidents.

EW noted that the learning section was powerful. She asked about the new national system and whether there were plans nationally around how all of this learning was to be picked up and shared. MP responded that there were regional medical examiners and lead medical examiners, and that a system to cascade learning points was being developed.

The Trust Board received the Annual Mortality Report.

TB19/09/10 Infection Prevention and Control Annual Report

KJ was in attendance to present this item. She highlighted the key achievements to the Board.

There were 51 OUH apportioned cases of *Clostridium difficile* identified after three days of admission for 2018/2019 against an upper set limit of 69. This was noted to be a significant achievement.

There was a national target for reducing gram negative bacteraemia by 50% by 2022/23. The Trust had made considerable progress last year and had achieved a 25% reduction. The Trust had been invited to speak nationally about its approach.

Prior to 2018 OUH did not have an on-going formal programme in place for Central Line Associated Blood stream Infections [CLABSI] surveillance according to strict definitions, although data submitted to ICNARC [Intensive Care National Audit and Research Centre] by adult ICUs had provided important on-going feedback.

Funding was received via the Urgent Care Pathway to implement influenza point of care testing [POCT] in emergency settings. This had improved flow through the Emergency Department.

It was highlighted that there was a fully staffed proactive nursing team in place which was driving many positive improvements across the Trust.

PHP noted a very comprehensive report, but asked whether the Board could assure themselves that mitigations in place were addressing the management of identified

issues. MP responded that KJ and Lisa Butcher [Lead Nurse & Manager for Infection Control, Infection Control] met every two weeks and that if any issues arose then they were discussed with the executive team to ensure a collaborate response, which was required for a cross-portfolio approach. This had also allowed incidents to be responded to very quickly.

DM noted that he found the Shelford comparisons helpful. He referred to the issue of the siting of cannulae and asked what action was being taken to improve this. KJ reported that a VIP [Visual Inspection] action group had oversight of a number of issues re siting, by whom, and recording. Safety messages had also been communicated. Staff were beginning to gain a better realisation that it was their individual responsibility to record, monitor and move if necessary.

SF noted that the next step was to develop a suite of infection prevention key performance indicators, for example, for hand hygiene. JM noted that the 'best in class' example might not be within the Shelford group and that although the Shelford comparison was fair in terms of size of Trust, suggested that it might be worth also looking at DGHs where they were regarded as sources of good practice in a way that was suitably scaleable.

EW highlighted that it was positive to see that where issues had been identified actions were clear but asked about remote units and noted that it was important to be thinking about these more remote locations to consider what programme of work might be needed.

MP thanked KJ and LB for their leadership and support, and this was echoed by the Board.

The Trust Board received the Infection Prevention and Control Annual Report.

TB19/09/11 Integrated Performance Report

**post meeting correction - the IPC section on Klebsiella was incorrect – the report should have stated 'An outbreak was declared on the neonatal unit following the identification of 10 isolates of a multi-drug resistant Klebsiella pneumonia. The outbreak was closed on 6th September'*

The report was presented by the Chief Operating Officer, Chief Nursing Officer and the Chief Medical Officer who each highlighted key points from their respective sections.

Urgent Care

In Month 4, OUH had achieved 86.83% against a trajectory of 90% in terms of urgent care. The Horton site achieved 88.6% and the JR 86.13%.

Bed occupancy levels were at 100%, and it was highlighted that the challenges remained around forecasting bed occupancy to try to achieve the 92% target over the winter period, with plans in place to close the gaps. Further detail on this was being regularly presented to TME and the Trust was in contact with system partners.

The biggest challenge regarding delays was with the HART service and long waits for domiciliary care. The HART improvement plan was making good progress, but staffing remained a risk. A 'discharge to assess' pilot had started in July with some success.

PHP asked about the proportion of urgent care breaches at night and work was going on regarding how colleagues worked at night. SR noted that there was senior decision making consultant cover until 1am but not across 24hrs, but that the Trust was working towards having this in place. A rolling advert to recruit was in place to assist in providing this. The Trust was also increasing middle grade cover, exploring international recruitment and examining whether patients were being directed to the right care. An advice line for GPs and paramedics, particularly to reduce the early evening activity surge, was in place.

The Board noted the issues in terms of volume of demand and availability of skill mix during these peak periods.

CG asked about B5 nurses, noting that the Trust had had a positive trend for a year, followed by decline with turnover which had now significantly increased. He recognised that this was a national problem but asked what options were available in the short term as well as long term.

SF noted that the recruitment and retention plan would be presented later on the agenda but added that the Trust recognised that workforce capacity was its biggest challenge, with 40k of vacancies for registered nurses nationally.

OUH had seen a reduction in new nurses from Oxford Brookes University and were in discussion about accepting as many as possible through clearing. The Trust had a strong international programme and was considering what the maximum international numbers that could be absorbed were, given the intensive support that was required to these staff in the early stages of employment. Accommodation needs associated with these staff was also being considered.

The efficiency of rostering was being examined with KPIs to be brought into the current reporting. CF noted that she was pleased to hear all of actions being implemented but added that she felt that the staff engagement and retention issues which existed across many areas didn't come out strongly enough.

SR added that workforce and finance were not currently included in the IPR and colleagues intended to remedy this in time for October reporting.

CF highlighted that the HR function itself should have some KPIs, and asked if these could be included.

Action: JN

JM agreed that an update on the ongoing Culture and Leadership work should be brought to a future meeting of the Board.

Action: JN

Elective Care

SR reported that the waiting list size had increased during July but remained below trajectory, although it was recognised that the theatres refresh project had had some impact.

52 week wait patient numbers had stayed at eight which was regarded as pleasing. Additional support was being offered to look at validation of the waiting list.

Theatre productivity work was underway and the Trust was working with the CGG regarding planned care and capacity at the STP level was being reviewed, looking at speciality level where there were particular challenges, such as ENT, Ophthalmology, Urology, and Bariatric services.

Diagnostic waits had seen improvements in June but were expected to become more challenging due to the increase in referrals.

Cancer had seen a drop in performance in June with only four of the eight standards achieved. In July, however, only two standards had been failed, the 62 day referral to treatment standards for GP and screening referrals. Gynaecology, Lower Gastrointestinal and Lung cancers had seen increased referrals and there had been a particularly significant rise in Breast referrals.

DM asked about discharge summaries as he felt that the importance of timely communication with GPs was not adequately understood. He noted that there appeared to be particular hot spots, and that previously with targeted focus, the SuWOn division had achieved the target timescale for over 95% of referrals.

It was noted that implementation of the voice recognition system within EPR was expected to have a significant impact

JM noted this as a concern to pick up under matters arising at the next meeting.

Action: MP / SR

MP reported that in terms of fracture neck of femur data, the Trust was two standard deviations away from the national mean for the JR site. However HGH remained one of the best performing in the country. MP had met with colleagues to undertake process mapping, noting that the two sites were very different, particularly as the JR was a major trauma centre. One element of the problem had been recognised to be a coding issue, and remedial actions had been identified and were underway.

Two Never Events were also reported by exception, a wrong side block and a misplaced nasogastric tube. MP noted that she would report back more detail in due course once investigations had taken place.

PHP referred to the WHO audits and asked what progress was being made and the level of awareness across the board. MP responded that the importance of WHO checklists was being reinforced throughout the organisation and that she and SF had now written two letters highlighting responsibilities. MP had also visited departments to emphasise and gain a better understanding of any issues.

An event was being held on 8 October to look at the safe surgical checklist both inside and outside the organisation to re-energise the leadership on use of the checklist.

AT for clarity regarding the particular staff groups who were not consistently using the checklist. MP responded that in the previous year there had been eleven Never Events with nine in theatres linked to checklist, and that this year there had been four which were all in environments outside theatres. It was suggested that perhaps the requirement needed to be reinforced in a more systematic way outside of theatres.

The Trust Board reviewed and noted the Integrated Performance Report.

TB19/09/12 Finance and Performance Committee [F&PC] Report

PHP presented the Finance and Performance Committee's regular report to the Board highlighting the main areas of focus.

The Committee had heard that prior to the inclusion of incentive funding and the application of the marginal rate for emergency activity, the year to date position was a deficit of -£6.4m which was £0.1m better than plan. However it was informed that adjusting out one-off and non-specific prior year accrual releases, year to date performance would be a deficit of -£15.2m or £8.7m worse than plan due to a significant underlying income shortfall as well as a smaller issue with operating expenditure. The Committee had expressed concerns regarding this position and challenged the actions being taken to address it.

It was recognised that bed occupancy continued to be a key issue with a need to keep this at 92% or below to maintain the four hour standard. The Committee heard about plans to achieve the desired 92% bed occupancy during the period from July 2019 to March 2020. At the Horton a combination of flexible staffing, discharge to assess and length of stay reduction were expected to close the gap. The position at the John Radcliffe was more challenging. The solution would require the use of short term hub beds and the expansion of HART (Home Assessment Re-ablement Team) capacity, with workforce plans to ensure that sufficient staffing was in place to utilise the additional capacity. The Committee requested additional clarity regarding the approach to staffing which would support closure of the gap in bed capacity in the next Performance Report.

The Committee recognised the importance of the divisional performance reviews being aligned with messages from the IPR and KPIs. It was noted that there was a need to reset the baseline and to remain consistent in approach. Identification and escalation of risks needed to be part of this process.

EW noted her support for the divisional performance reviews being aligned. She noted that the information presented to the Committee had highlighted the need to reset a single baseline for autonomy levels across all divisions in order to have a level playing field and provide better support for divisions. EW further noted that the Board should consider the evolution of the performance management reviews and

how best assurance could be provided and what further information would be required, with the aim of building upon this at each quarterly review.

CF commended the report but asked if dates against key actions could be provided. PHP reported that the timescale was generally the next Finance and Performance Committee meeting; but that in some cases the Committee recognised that a two month time lag was too long.

The Trust Board received the Finance and Performance Committee Report.

TB19/07/13 Financial Performance up to 31 July 2019

JD presented the Report, noting the different format with the aim was of shifting the style towards that of the IPR to assist with integration.

The Income and Expenditure (I&E) position, excluding PSF/MRET was at a year to date deficit of -£9.4m, £5.4m worse than plan. In-month I&E performance was a deficit of -£3.0m, £5.5m worse than plan. Adjusting out one-off (£4.3m) and non-specific prior year accrual releases (£5.4m), year to date performance was a deficit of -£19.1m or £15.2m worse than plan.

JD noted that the main issue was performance on income. The Trust had been focussed on operational performance but activity levels in many areas of care showed levels broadly at the same position as the previous year. Actual WTE showed that the Trust had 550 more staff than the equivalent month in the previous year but that activity had not increased. It appeared that there was a mismatch between capacity issues and the number of staff deployed.

JD suggested that there were two possible explanations: 1) that small shortages of capacity had a big impact on activity (eg anaesthetic shortage), 2) that, recognising the need for different staffing levels depending on the clinical area and patient group, that there might still be a level of unwarranted underlying variation.

It was noted that the most significant issue would be the extent to which the income position recovered now that the theatres refresh programme was complete.

It was noted that the Trust had paused all new approvals of business cases until the Q2 forecast, with only emergency uses of contingency funding in the interim period.

SR responded that anaesthetic shortage was one part of issue but that wider theatre staffing issues were also a factor. She noted that of the Trust's 48 theatres, 8% closed were due to the refresh and were focussed on emergencies, cancer and long waiters which would have had an impact on the casemix. A project director had been recruited to focus on theatre productivity including 6-4-2 booking and scheduling.

AT noted that the Trust had mitigated the year to date position but if the pay costs and income situation were not managed, the situation would worsen with the challenges of winter still ahead. The right areas were being looked at, but action would be needed very quickly.

CG asked whether the £8.9m shortfall due to theatres was evenly spread across the Divisions. JD confirmed that this primarily affected MRC and NOTSSCAN.

MP reminded the Board that the ongoing national pensions issue meant that a large number of staff were not choosing to take on additional work.

CF noted that in undertaking a large amount of recruitment the Trust need to avoid the risk of commoditising staff which would ultimately lead to metrics deteriorating.

PHP highlighted the need for integration in messaging and noted that there was a need for visibility from the Board all the way through to front line.

JD confirmed that the routine reforecast to NHSI was due in mid Oct, and that the Board would receive information prior to this, at its seminar on 25 September. He noted that 9 October would be the next committee date for further consideration prior to submission to NHSI.

The Trust Board received the Financial Performance report.

TB19/09/14 Trust Management Executive [TME] Report

BH presented the TME report, highlighting its recent focus on the Integrated Improvement Programme [IIP], Culture and Leadership Programme and Strategy Refresh.

The Board had been invited to a meeting on 23 September to bring all three pieces together as basis for the 2020 business plan.

EW further reported that TME had been closely tracking corporate risks including the risk of financial delivery, which would continue to be monitored through TME.

The Trust Board received the TME report.

TB19/09/15 Nursing and Midwifery Retention Action Plan 12 Month Update

SF presented the paper which provided progress on the action plan and highlighted future considerations for retention.

It was agreed that the next iteration of the plan would provide a more inclusive focus on clinical retention.

The Trust Board received assurance that the action plan was progressing as intended.

TB19/09/16 Emergency Preparedness, Resilience and Response – EU Exit Planning

SR presented the report as the Senior Responsible Officer for EU Exit Preparation. She provided assurance that National guidance around being prepared for EU Exit was being followed in ensuring that the Trust had good local resilience and continuity plans in place.

It was noted that there was a requirement not to stockpile locally but that the Trust was preparing for possible disruption in supply chains with this risk being managed nationally.

EW noted that there would need to be coordination from the centre to stop organisations from compounding risks for local partners.

SR agreed and highlighted that communications to staff, patients and the local population were very important, whilst recognising that any issues might develop slowly over a period of time rather than suddenly.

CF noted that this was likely to occur over the winter period and enquired as to whether there would be much flexibility in capacity to address any issues.

SR responded that the Trust was required as a matter of course to have standard emergency plans in place and to ensure that the right staff were trained appropriately. EW agreed and emphasised that the focus needed to be on patients and front line activity

JM asked that SR communicate with NEDs as required between meetings should further details emerge.

The Trust Board received the update.

TB19/09/17 CQC Action Plan Update

EW presented the action plan update, highlighting that the request for a Gantt style chart had been actioned.

All actions remained on track with the exception of the creation and implementation of a Board development plan, which had been deferred pending support from the new Interim Director of Corporate Affairs.

The Trust Board received the CQC Action plan update.

TB19/09/18 Responsible Officer's Revalidation Annual Report

MP presented the Annual Report providing details of the Trust's performance in relation to medical appraisal and revalidation, a review of governance arrangements, an analysis of risks and issues, a resulting action plan and an overview of priorities for 2018/19 for review.

Compliance had improved across all staff groups during the period. However the most noteworthy improvement was for doctors in the "other" category (those in non-consultant, non SAS roles) with a reduction of unapproved incomplete appraisals from 74 to 18 despite comparable numbers of doctors being appraised.

Doctors whose appraisals were 90+ days overdue or had failed to comply with their action plan were referred to their divisional management for possible disciplinary action. This had significantly reduced the number of doctors who remain non-compliant for appraisal for long periods of time and had allowed the team to give targeted support to doctors who are struggling. Interventions had included referrals

to Occupational Health, personalised training and IT / administration and support to enable doctors to complete their appraisals in a timely manner and reduce the need for deferral at the point of revalidation.

The Trust Board was asked to note the Statement of Compliance attached as Appendix 1 of the report which confirmed that the Trust, as a Designated Body, was in compliance with the Regulations. This was also due to be signed by the Chief Executive and Chair as required by NHS England.

JM noted his gratitude for the large amount of effort that went into the report and that this was a key mechanism to ensure that Trust doctors were doing their best for patients.

The Trust Board received the report, and associated assurance provided.

TB19/09/19 Remuneration and Appointments Committee Terms of Reference

The paper was presented setting out revised Terms of Reference for the Remuneration and Appointments Committee, following a review by the Committee.

The Trust Board approved the revised terms of reference.

TB19/09/20 Consultant Appointments and Signing of Documents

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

The Trust Board received the report.

TB19/09/21 Any Other Business

The Chair reported that Mrs Anita Higham, Governor for Cherwell, had written to tender her resignation following discussions which had confirmed that she could not be both a member of the Health Overview and Scrutiny Committee [HOSC] and a Governor of the Trust.

The Constitution was currently under review but early advice relating to this matter was that the national position suggests that this was a conflict of interest that the roles should not be held by same person. The Chair noted that AH had recognised that the HOSC was very important to the success of the local system and had therefore decided to stand down as a Governor.

Gratitude was expressed for AH's service and support over the years.

TB19/09/22 Date of next meeting

A meeting of the Board to be held in public will take place on **Wednesday, 13 November 2019** at **10:00** in the Wing Tat Lee Seminar Room, Osler House, Oxford

The Trust Board approved the motion that representatives of the press and other members of the public be excluded from the remainder of the meeting, having

regards 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).