

**Meeting of the Oxford Health NHS Foundation Trust**

**Board of Directors**

Minutes of a meeting held on

27 June 2018 at 08:30

Oak Room, Learning & Development

5th Floor, Unipart House, Cowley, Oxford OX4 2PG

**Present:**

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| Martin Howell | Trust Chair (the Chair) (**MGH**) |
| John Allison | Non-Executive Director (**JAl**) |
| Jonathan Asbridge | Non-Executive Director (**JAsb**) *part meeting* |
| Stuart Bell | Chief Executive (**SB**) |
| Tim Boylin | Director of HR (**TB**)[[1]](#footnote-1) |
| Alyson Coates | Non-Executive Director (**AC**) |
| Sue Dopson | Non-Executive Director (**SD**) |
| Bernard Galton | Non-Executive Director (**BG**) |
| Mark Hancock | Medical Director (**MHa**) |
| Dominic Hardisty | Chief Operating Officer (**DH**) *part meeting* |
| Chris Hurst | Non-Executive Director (**CMH**) |
| Mike McEnaney | Director of Finance (**MME**)  |
| Aroop Mozumder | Non-Executive Director (**AM**) |
| Kerry Rogers | Director of Corporate Affairs & Company Secretary (**KR**)[[2]](#footnote-2) |
| Martyn Ward | Director of Strategy & Chief Information Officer (**MW**)[[3]](#footnote-3) |
| Lucy Weston | Associate Non-Executive Director (**LW**)[[4]](#footnote-4) |
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| **In attendance:** |
| Donna Mackenzie | Patient Experience & Involvement Manager (**DM**) *part meeting* |
| Kate Riddle | Deputy Director of Nursing – attending for the Director of Nursing & Clinical Standards (**KRi**)[[5]](#footnote-5) |
| Hannah Smith | Assistant Trust Secretary (Minutes) (**HS**) |

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| **BOD****99/18**ab | **Welcome and Apologies for Absence**The Chair welcomed members of the Board present and staff, governors and members of the public who had attended to observe the meeting. Apologies for absence were received from: Ros Alstead, Director of Nursing & Clinical Standards.   |  |
| **BOD 100/18**a | **Declarations of Interests**No interests were declared pertinent to matters on the agenda.  |  |
| **BOD 101/18**abcdefghijk | **Minutes of the Meeting held on 24 May 2018**The Minutes of the meeting were approved as a true and accurate record. ***Matters Arising*** **Item BOD 82/18(b) Care Quality Commission (CQC) Oxfordshire local system action plan – progress update**The Chief Executive reported that work against the CQC Oxfordshire local system action plan was being led through a system-wide governance group of Oxfordshire chief executives from various health partners, senior representatives from the County Council and from the Oxfordshire Transformation Board. The plan for progressing the system action plan had also been presented to the Health Overview & Scrutiny Committee. *The Chief Operating Officer joined the meeting.* The Chief Operating Officer added that the Director of Nursing & Clinical Standards had been nominated as the Trust’s accountable person to this group and that the Deputy Director of Nursing had, in her stead, attended the meeting which had taken place yesterday. Progress reports would be provided to the Quality Committee. **Item BOD 84/18(k) – Board Strategy session invitees**The Director of Strategy & Chief Information Officer reported that he was progressing involving Lou Patten, Chief Executive of Oxfordshire CCG, and Fiona Wise, Executive Lead of the Buckinghamshire, Oxfordshire and Berkshire West Sustainability & Transformation Partnership (**BOB STP**), with future strategy sessions. **Item BOD 88/18(d) – Service Line reporting to include Learning & Development (L&D) data such as training levels and appraisal/PDR completion rates**The Director of Strategy & Chief Information Officer reported that this was in progress but subject to final data verification before it could be included in reporting. The L&D data was available and had been verified for the Adults and Older Peoples Directorates. However, the data for the Children & Young People’s Directorate was subject to further review following challenge. Service Line reporting to include L&D data (training levels and appraisal/PDR completion) was therefore still in progress for future reporting to the Board. **Item BOD 90/18(d) – Closing down actions/recommendations from Serious Incidents (SIs)**The Chief Operating Officer reported that, following testing, he was assured that actions/recommendations from SIs were being progressed but staff were reluctant to finally record their closure if there were still some ongoing elements even if the basic actions had been completed. He noted that this was an issue with the recording system but that existing governance structures would escalate operational risks which could arise from actual delays in progressing actions. The Trust Chair noted that it may be worth reviewing the categorisation of actions/recommendations so as to be able to distinguish between substantial actions to progress and those that had already been progressed but were at a stage of final tidying-up. The issue was not around web-holding but closing down/recording completion of actions. The Deputy Director of Nursing added that SI actions were monitored tightly and that assurance could be provided that these were being progressed appropriately. **Item BOD 70/18(c) Access to Healthcare for people with Learning Disabilities – to develop the report to include timescales for improving RAG-ratings, make clear whether progress had been as expected and track milestones for delivery**The Chief Operating Officer reported that the Executive had discussed that future reporting not be to the Board directly but escalate up through the Caring & Responsive quality sub-committee and then, if appropriate/necessary, to the Quality Committee. **Item BOD 45/18(b) – Out Of Hours (OOH) service – breaches of 3 of 9 performance indicators**The Director of Strategy & Chief Information Officer reported that these breaches had been resolved. The Chief Operating Officer added that the Executive had undertaken a thought-provoking review of the OOH service; he noted that there were also potential questions around the type of service or model which could be provided. He explained that although OOH may be treated as one service, it encapsulated 3 discrete services which were joined because of the way in which they were commissioned: the night/home visit service (which he noted may sit better as part of a frailty pathway); the base visit service; and the telephone triage/hear and treat service. Aroop Mozumder noted that although he was supportive of reviewing ways in which these services were provided, he cautioned that sub-dividing may introduce more complexity and therefore more challenges in running services; he recommended also considering other areas/examples where services had been more amalgamated. The Trust Chair noted that the contribution of the OOH service, and similar services nationally, in providing people with an alternative to Accident & Emergency (**A&E**) services could be better publicised in the NHS and understood by the wider public. The Chief Executive noted that it was also necessary to understand how the service could operate most effectively and be able to explain what users could reasonably expect of it. However, during times when it was challenging to staff services, it was important to find ways to make such services robust and effective. The Board noted that the following actions were on hold for future reporting: BOD 75/18(b) and BOD 180/17(b)-(c) (Board Assurance Framework); and BOD 49/18(b)&(e) (Development of R&D reporting). The Board confirmed that the remaining actions from the 24 May 2018 Summary of Actions had been completed, actioned or were on the agenda for the meeting: BOD 83/18(b); BOD 87/18(h)-(i); and BOD 75/18(c).  | **MW** |
| **BOD 102/18**ab | **Report on Council of Governors’ (CoG) meeting on 13 June 2018**The Trust Chair provided an oral update of the CoG meeting on 13 June 2018. He highlighted the presentations which had been received, including in relation to: the Centre for Oxford Healthcare Improvement from Charles Vincent and Jill Bailey; IT interoperability from Dominic McKenny; patient experience from Donna Mackenzie; and the Associate Non-Executive Director update from Lucy Weston. He noted that the layout of the CoG meeting in the Whiteleaf Centre would still need some work to support an effective meeting and that it may be worth investing in more and different tables to support a café style layout for the future, subject to the views of governors. **The Board noted the oral update.**  | **KR** |
| **BOD 103/18**abcdefghij | **Chief Executive’s Report** The Chief Executive presented the report BOD 78/2018 which provided an update against recent national and local issues. ***NHS England and NHS Improvement closer working and regional developments including impact upon STP regional boundaries***He referred to his report and noted that Matthew Swindells, NHS England’s National Director: Operations and Information, had also visited the BOB STP. He referred to the moves being made to combine NHS England and NHS Improvement national functions into integrated teams reporting to both organisations or hosted teams working in one organisation on behalf of both. He noted the proposed creation of 7 integrated regional teams including a South-East region which would cover the Trust. Closer joint working between NHS England and NHS Improvement could create a new formal structure for STPs to operate within; each of the proposed 7 regions however would cover a few different STPs. STP regional boundaries were also subject to review which may result in changes to the make-up of the BOB STP but which were still speculative and to be confirmed. He highlighted that the changes were also likely to impact upon the evolution of Integrated Care Systems (**ICSs**) which may increasingly coincide with STPs; he noted that this may impact upon plans to enable Oxfordshire to move towards becoming an ICS and upon the evolution of commissioning. Within/below STPs, more provider collaboratives may emerge to manage more integrated health and care systems for localities and, within those localities, a number of neighbourhoods. The Chief Executive noted how these national developments may also link and coincide with: the moves which the Trust was already making towards Joint Enterprise with GP Federations (now known as the Oxfordshire Care Alliance) as also discussed at the Board meeting on 25 April 2018; and the Trust’s management of community services including community hospitals and community mental health services. The Board discussed the potential implications of these national developments including upon: the model of NHS Foundation Trusts and how different attitudes may be required in order to operate within provider collaboratives; the focus of commissioning at a more strategic rather than operational level; and the importance of the Trust developing neighbourhood/locality/place-based models of care and service models. The Chief Executive emphasised the potential for localised hubs to bring together community and primary care services which could then help to avoid unnecessary admissions to acute or A&E services and to deal locally with gatekeeping into emergency care, where it was safe to do so. He noted that it would also still be critical to unlock funding for mental health services, especially given historic underinvestment in mental health services in Oxfordshire in particular. ***Adequacy of funding for mental health services and agreement of local contracts***The Chief Executive reported that this week Claire Murdoch, NHS England’s National Mental Health Director, had also held a call with the BOB STP on implementation of the Mental Health Five Year Forward View, in which levels of mental health investment in Buckinghamshire and Oxfordshire had been discussed. He also reported on the independent work being conducted by Trevor Shipman, Non-Executive Director at Kettering General Hospital NHS FT, looking at levels of investment in mental health in Oxfordshire and Buckinghamshire. He emphasised the importance of being able to demonstrate the Trust’s efficient use of resources and the risks and consequences for staff and the financial position of continuing to absorb increases in activity and demand levels, which was no longer sustainable. He also noted the impact of specialised services spend in Oxfordshire which needed to be taken into account. Chris Hurst asked how Oxfordshire’s position on mental health investment compared to other local areas. The Director of Finance replied that it varied noting that whilst it was still relatively low in Swindon, it was better in Wiltshire and in Bath and North-East Somerset. The Director of Finance noted that contracts for FY19 had not yet been signed. Progress was being made in relation to Buckinghamshire but the deficit position of Buckinghamshire CCG was challenging and may result in funding not being sufficient to meet the requirements of the Mental Health Five Year Forward View; the Trust may therefore need to set appropriate targets for delivery against the available funding. Discussions were ongoing to ensure that the Trust did not make commitments it would not be funded to provide. Negotiations continued in relation to the contract for Oxfordshire; the work being conducted by Trevor Shipman, referred to above, may be helpful to establish a pathway to recover investment in mental health. The Chief Executive noted the importance and also the challenge of identifying longer term solutions to identify the funding to meet the requirements of the Mental Health Five Year Forward View. Alyson Coates asked whether the Trust’s financial forecast would need revision downwards in light of the potential outcome of contract negotiations. The Director of Finance replied that this should not be necessary. ***Workforce*** The Chief Executive referred to his report and the significant work which had taken place to cease use of agency Health Care Assistants (**HCAs**); he congratulated the team involved. ***Electronic Health Records***The Chief Executive referred to his report and the conclusion of contract renegotiations in relation to Carenotes and Adastra. He also noted that the Director of Strategy’s portfolio now included the role of Chief Information Officer and responsibility for Information Management & Technology.  |  |
| klm | ***BOB STP capital funding - Learning Disabilities (LD) and Didcot community hospital***The Chief Executive referred to his report and noted that the Board in private session would be considering potential options to create a new LD low secure unit to complete the LD forensic pathway and complement the existing medium secure unit at Evenlode. A bid for capital funding for this scheme would also be submitted as part of the latest rounds of bids for capital through the BOB STP, together with a scheme for the development of primary and community care integration in Didcot around the community hospital. He highlighted the importance of concentrating services around key sites in order to support the development of neighbourhoods and locality hubs. ***The Queen’s Birthday Honours – Child & Adolescent Mental Health Services recognition***The Chief Executive congratulated Dr Wendy Woodhouse on her OBE in the Queen’s Birthday Honours for her services to children and young people’s mental health, noting her contribution to Child & Adolescent Mental Health Services (**CAMHS**). **The Board noted the report and congratulated Dr Wendy Woodhouse.**  |  |
| **BOD 104/18**abcdefgh | **Chief Operating Officer’s Report**The Chief Operating Officer presented the report BOD 79/2018 which provided an update on quality, people and sustainability together with a narrative of key issues being managed by the Operational Management Team. ***Quality***He referred to his report and the first annual Carers’ Conference which had been held for staff, stakeholders and carer representatives. Further to the report, he noted that the Trust had conducted a survey for all services to self-assess against the Triangle of Care; the results had highlighted issues with insufficient ringfenced resources available at the point of care to support carers. He referred to his report and the ongoing discussions regarding mental health urgent care. He noted the impact of funding issues upon models of care and that the system was constrained from providing what would be optimal for patients, especially children and young people, due to finances, workforce availability and care pathway design. The suggestion from Oxfordshire CCG that an independent chair be appointed to resolve the situation may be helpful; no nominations had yet been put forward for that role. Aroop Mozumder referred to the provision of mental health urgent care and asked how the pathway would work for a young person who may present in crisis at A&E. The Chief Operating Officer noted that this may depend upon their individual presenting factors and circumstances but that they could be admitted onto an acute ward for up to 24 hours for observation and risk assessment and that liaison psychiatry provided by the Trust would be involved prior to potential referral into CAMHS. He explained that there could, however, be issues with inconsistencies in routes through the pathway and challenges with agreeing responsibility for delivering aspects of care, such as observations. He referred to his report and praised the Leading Together programme which he and the Director of Corporate Affairs & Company Secretary were participating in, noting that it was highly motivating and a welcome reminder of the benefits of co-production with service users to design service improvements. ***People***Phase 2 of the consultation on the restructuring of Operations had now launched and engagement events were being run for staff. Feedback had included some requests to take time to consider and work through detail; in response to this, whilst some areas may therefore move into new structures relatively quickly, other areas, particularly in mental health, may see a longer transformation period whilst structures were considered. This may result in new structures not being fully in place until October 2018. He referred to his report and thanked Sukh Lally for his contribution as Clinical Director for forensic services; interim arrangements/recruitment were being considered. He referred to his report and the chart which showed the run rate on spend on Additional Clinical Services over the past two years; 95% of this had been spend on HCAs. Although it was  |  |
| ij | still early in the implementation of the plan to cease use of agency HCAs, since May 2018, the chart still illustrated that there had been a reduction in spend on Additional Clinical Services since May. He thanked HR, operational leads and heads of nursing for the work which had taken place including to deploy nursing staff in place of agency HCAs where this had been necessary. ***Sustainability***He referred to his report and noted that, in relation to the Oxfordshire urgent care system, the Trust was close to finalising the financial details of the subcontract to support Oxford University Hospitals NHS FT (**OUH**), which provided the HART (Home Assessment Reablement Team) service, to deliver additional reablement capacity. **The Board noted the report.**  |  |
| **BOD 105/18**abcdefg | P**erformance Report**The Director of Strategy & Chief Information Officer presented the report BOD 80/2018 on performance against the Single Oversight Framework for May 2018 (Month 2). The Trust had achieved 85% of the 385 performance indicators reported in May (comparable to achievement of 85% of the 449 indicators reported in April); previously the Trust had generally achieved 90% compliance overall. The number of reportable indicators varied each month (depending upon frequency of the reporting expected e.g. quarterly or monthly) but were reducing; work continued with commissioners to reduce still further the number of indicators. Indicators were also now divided into two categories: those with defined targets for reporting to commissioners; and those for context or monitoring only. Areas of underperformance were set out in the report. Workforce pressures and difficulties in recruitment and retention continued. The Director of Strategy & Chief Information Officer reported progress in designing a new automated data upload process to NHS Digital. Once testing was complete, this would: significantly reduce the need for the Performance Team to manually upload data into the national data sets, thereby freeing up time for two staff members; and would improve the quality of the overall data held at national level by reducing discrepancies. In relation to performance indicators for the Section 75 Agreement with Oxfordshire County Council, the Trust had achieved 97% compliance in April 2018 (Month 1), which was an improvement on 92% compliance in Month 12 and 91% in Month 11 (reporting was one month in arrears). Only 1 indicator for Oxfordshire had not been achieved; work was also taking place with the County Council to potentially change indicators. Buckinghamshire reported on a quarterly basis and was not therefore included this month. This was the second month of performance reporting following the organisational restructure of clinical directorates into new all-ages pathways; this would have the benefit of facilitating reporting on Mental Health, Community and Specialised Services but it would not be possible to compare like for like performance against the previous clinical directorates prior to Month 1, which would be the baseline (although the Trust’s overall performance against indicators could still be compared against previous months). It was therefore not yet possible to provide trend data for FY19. The All Ages Mental Health Oxfordshire Directorate (which also included Swindon, Wiltshire & BaNES (Bath & North-East Somerset)) had achieved 80% compliance in May which was a decrease compared to 87% compliance in April. Issues and anomalies were as set out in the report. Ongoing accommodation issues which were preventing IAPT (Improving Access to Psychological Therapies) services from achieving access targets had been escalated to commissioners and a review with the Executive would be arranged. The All Ages Mental Health Buckinghamshire Directorate had achieved 93% compliance in May which was an improvement compared to 84% compliance in April. The Community Services Directorate (Oxfordshire) had reduced to 68% compliance in May compared to 80% compliance in April. The Trust had highlighted to commissioners their responsibilities to provide support; the position was being carefully monitored. Pressures continued for Out Of Hours (**OOH**) services but only 1 of the 9 indicators (unfilled clinical shifts) was below the exception reporting threshold in May, compared to 2 of 9 indicators in April, and the service continued to ensure that patients had remained safe whilst under OOH care.  |  |
| hijk | The Specialised Services Directorate had achieved 88% compliance in May which was an improvement compared to 86% compliance in April; the community dental service continued to achieve 100% of its indicators. Work was taking place to resolve some anomalies/data quality issues which had been identified in relation to Learning Disabilities indicators. Previous escalation items which had been removed from exception reporting this month included: the number of care placement reviews in relation to the Oxfordshire S.75 Agreement; estimated discharge date (Oxfordshire); 6 week routine waits for Learning Disabilities; and average length of stay and Delayed Transfers of Care (**DToCs**). Although DToCs still remained a wider system issue, the Trust had recovered its own performance and was achieving its targets. The Director of Corporate Affairs & Company Secretary asked about reporting on Out of Area Transfers (**OATs**), noting that OATs had been highlighted in the Chief Executive’s Report at BOD 78/2018 and in the Finance Report at BOD 86/2018. The Director of Strategy & Chief Information Officer replied that headline numbers were available and noted that there was a distinction to be made between those OATs which were clinically appropriate to access specialist or long-term treatment as opposed to other OATs arising from increasing demand; he noted that reporting would need to develop to reflect those distinctions. **The Board noted the report.**  |  |
| **BOD 106/18**abcdefghijk | **Human Resources (Workforce Performance) Report**The Director of HR presented the report BOD 81/2018 which set out the position on workforce performance indicators including temporary staffing spend, the HCA agency reduction, vacancies, turnover, sickness, recruitment, health and wellbeing, management of concerns (whistleblowing), retention and Workforce Race Equality Standards (**WRES**). He added that national television advertising would also be taking place in relation to NHS recruitment and that the Trust intended to use the opportunities this could provide. He reported that a recruitment open day for nurses had recently been held at the Warneford but that although it had been promoted through local and social media there had been fewer candidates than had been hoped for. He noted that recruitment was also progressing for the position of Trust Chair. He highlighted the workstreams underway to address staff retention, including the workstream on stress and noted that a discussion had commenced, but not yet concluded, around talent management. Lucy Weston referred to the reported decrease in overall agency/temporary staffing spend and asked how this was being tied into Cost Improvement Programme (**CIP**) projects and budgeting. The Director of Finance replied that the agency usage CIP project had been reviewed yesterday; work was taking place on reducing spend not only on agency HCAs but also through transferring more staff onto the bank and increasing VAT savings, including in relation to wider Allied Health Professionals, through transferring to a direct engagement model. As previously reported, the Executive had agreed to invest in the Staffing Solutions team to ensure that there was sufficient resource to support the initiative and also to improve management and clinical supervision of bank staff. He noted that agency spend was also being considered in relation to administrative and clerical staff including in corporate areas such as Information Management & Technology and in Estates; he noted that there were some long lines of agency administrative cover in place to support two-month gaps following the departure of staff and noted that there would be a line by line detailed review of these taking place in July. Lucy Weston asked about the extent to which financial plans, such as CIPs, were aligned with operational plans and workstreams. The Chief Operating Officer replied that he was reasonably confident that the operational plans which should have a positive impact upon staff and resources would also help to achieve financial targets but the exact financial impact may not be known until they were tried and alignment may not be perfect. The Director of Finance highlighted the positive impact to date of reducing HCA agency usage and increasing bank usage, noting the decrease in agency/temporary staffing spend especially in Additional Clinical Services. John Allison referred to the report, noting that the reduction in agency/temporary staffing spend was partly attributed to the reduction in HCA agency usage; he asked what else had contributed to the overall reduction in spend. The Director of HR replied that there had also been a reduction in sickness absence (levels were at approximately 4%) and a slight improvement in retention (levels were at 14.4% but the aim was to reduce levels further to 13.5% by year-end). John Allison referred to the report and asked why many managers were recording “unknown” as a reason for sickness absence. The Director of HR replied that this was linked to current self-certification processes e.g. occasions when staff reported in sick but could not necessarily discuss directly with their manager and may be unwilling to discuss details with colleagues who were covering. John Allison referred to the workstreams to address staff retention and noted that, given the 3-4 years since he had joined the Trust during which time retention had been a known risk/issue, it was disappointing that it was now being reported that work had begun to understand why staff were leaving. He emphasised that this was a strategic risk/issue which required effective solutions. The Director of HR explained that this related to a change in how exit interviews were being conducted. The practice of conducting exit interviews had been in place for a while but had not been producing sufficient data; anecdotal evidence had also suggested that exiting staff sometimes chose not to be entirely forthcoming with their line managers. The process had now been changed so that HR Senior Business Partners conducted exit interviews; to date this had appeared to result in improved data collection. Lucy Weston referred to the supporting detail to the report and asked to what extent failures to publish rostering sufficiently in advance may correlate with high agency usage, staff stress and dissatisfaction in work. The Director of HR replied that this was not clear but there may be some correlation. The Chief Operating Officer added that the impact may vary depending upon the environment, noting that it was likely to be more useful for inpatient wards to publish their rosters in advance than for services such as eating disorders or community services which may require more flexibility. The Deputy Director of Nursing agreed that early publication of rostering was of particular importance for inpatient wards. Lucy Weston asked about performance against the WRES and expressed her concern about the percentage of Black & Minority Ethnic (**BME**) staff who had experienced bullying, as well as the lack of supporting narrative in the report to explain this. The Director of HR replied that in relation to the wider national picture, the Trust benchmarked in the middle of NHS organisations; whilst the position was still not good enough it was a challenging pattern to change. The Board noted that this was also a challenge across other sectors, such as in education for the local universities, not just in healthcare. However, improvement in this area would help to resolve strategic risks/issues in relation to recruitment and retention. Alyson Coates asked whether increasing resourcing and ambition to resolve this may also help to make the Trust an employer of choice and provide it with a unique advantage. The Chief Executive noted that whilst this was a serious issue to be tackled, solutions may lie not just in increasing resource but in changing mindsets. The Director of Finance added that responsibility for resolving these issues should be owned at every level of management, not just by dedicated resource, and that there would otherwise be a risk that management may devolve responsibility. *Jonathan Asbridge joined the meeting.* Bernard Galton asked whether work had been undertaken to unpack what was included within the definition of bullying. The Director of HR confirmed that this was taking place and that case studies were considered, although there was still more work to do; he highlighted the contributions of the Head of Inclusion, the Freedom to Speak Up Guardian and the Head of Spiritual & Pastoral Care. The Deputy Director of Nursing added that she had also conducted a deep dive review into reasons why Band 5 nurses left; she reported that the main reason for leaving had been to undertake caring responsibilities (for older relatives or children) closely followed by relocation. Following on from this, a new preceptorship programme for newly qualified nurses had been implemented; this may also help to track retention rates. The Board noted that the Board Seminar in June 2018 which had considered equality and diversity had been useful, as had previous focus at Linking Leaders’ conferences, but more Board time would be required on this area. Alyson Coates asked whether the Trust could leverage the experience of other sectors which may have had more success in attracting BME candidates and improving BME experience. The Medical Director noted that he and the Head of Inclusion had had a useful visit to Nottinghamshire Healthcare NHS FT and considered their governance structure around HR and equality and diversity; the Director of HR added that he would consider contact with Nottingham and/or North East London NHS FT. Aroop Mozumder recommended that the Board consider some case studies and also hear some lived-experience. He also referred  |  |
| l | to the supporting detail to the report and emphasised that the statistics against WRES indicator 6 (bullying by staff) should be drilled down into and improved. The Trust Chair requested that more Board time be scheduled by the autumn to consider equality and diversity further, noting that if this were to take place through a Board Seminar then a whole session or other half day may be required. **The Board noted the report.**  | **KR/TB** |
| **BOD 107/18**abc | **Patient Story**The Patient Experience & Involvement Manager joined the meeting and presented a video of a carer discussing her experiences with her son’s involvement in adult mental health services. In the video, the carer set out the dual role in which she had found herself as both a mother but also as a named carer to support her son upon his discharge from an inpatient mental health unit. She set out initial issues including: lack of support for her in her role as a carer; no one else being involved; a care package not being in place; follow-up actions not taking place; and little contact with anyone. She highlighted the turning point/improvement which she had experienced when their second care coordinator had been appointed and noted how she had felt that this had saved her and her son’s life. She noted how helpful the family therapy which the care coordinator had organised had been. She emphasised the importance of being approached by the care coordinator, noting that it should be the responsibility of professionals to reach out to carers and not the other way around. The Patient Experience & lnvolvement Manager explained that this video was available on the internet, the Trust’s website and was also being presented at the most recent Linking Leaders’ conferences. The Trust Chair noted the inspirational message which the final outcome provided. Jonathan Asbridge asked whether the Trust’s performance indicators tracked post-discharge follow-up and whether the Trust was being sufficiently proactive, or potentially over reliant upon social services. The Director of Strategy & Chief Information Officer replied that current performance indicators probably did not track this as they would be focused upon contractual delivery but that work would be taking place with ‘iwantgreatcare’ to deliver a new set of indicators. The Chief Executive cautioned against reliance on performance indicators |  |
| def | as a tool to track carer or patient experience, noting that if the wrong indicators were selected then the Trust could end up reporting that it had achieved to target although this was not necessarily what carers had wanted or what their experience had been. The Director of Finance noted that if the Trust was to focus on outcomes for patients then discharge planning and post-discharge experience should be an essential part of the service which it offered; he noted that an appropriate performance indicator may be a useful measure to ensure that if there were core standards that needed to be adhered to then these were being monitored. Aroop Mozumder noted that some GP practices now employed care navigators whose role included understanding the pressures which families were under and signposting them towards appropriate assistance; he recommended that the Trust also consider exploring this further in discussion with GP federations. The Chief Operating Officer referred to his update, at item BOD 104/18(b) above, and the outcome of the self-assessment against the Triangle of Care which had highlighted the issues which staff had identified around insufficient ringfenced resources available at the point of care to support carers. He noted the challenge to support staff to be able to deliver a good service to carers; some parts of the Trust were also better than others in supporting carers and the outcome of the self-assessment had identified different actions which different teams could take to improve. **The Board noted the presentation and thanked the carer for their story.** *The Patient Experience & Involvement Manager left the meeting.* |  |
| **BOD 108/18**abcde | **Inpatient Safer Staffing Report**The Deputy Director of Nursing presented the report BOD 82/2018 which, this month, provided more specific focus on: staffing establishment reviews; the impact of maintaining safe staffing on patient care; CHPPD (Care Hours Per Patient Day) reporting requirements; and implementation of the Safe Care acuity and demand data collection module on the Health Roster. During 23 April to 20 May 2018, average weekly daytime fill rates for registered and unregistered staff had been above the Trust target of 85%, being 95% or above for registered staff and 92% or above for unregistered. Average weekly night time fill rates had also been above the target of 85%. However, 8 wards had fallen below the 85% target for average daytime fill rates for registered nurses, up from 7 in the previous reporting period, but all wards had 96% or above of unregistered staff to ensure safe staffing numbers overall. Substantive, flexible and agency registered (nursing) staff had been used to fill shifts. Average weekly agency usage had reduced to 11.22% (with a peak of 14.3% and a low of 4.3% which was the lowest weekly percentage of agency usage in the last year); this was related to the project to reduce agency HCA/unregistered staff usage. There were no instances to link staffing levels with adverse patient outcomes or the project to reduce agency HCA usage; this was being monitored through the Trust’s incident reporting processes. Sickness absence had also reduced with levels for ward staff at 5%. She highlighted the challenges for the Highfield in reducing agency HCA usage but noted that the Highfield had engaged well with the project, as set out in the graph on Highfield agency use in the report. Although there had been a risk in relation to registered nursing vacancies, to date 33 student nurses had been offered jobs (to start post-graduation) including 6 posts at the Highfield. She referred to the report and the recent inpatient nurse staffing establishment review; there would be a change to align the budget to staffing levels and the review process would be followed by further work to take into account skill mix remodelling with new roles including Band 4 Nursing Associates. Alyson Coates referred to the report and the temporary reduction in beds at community hospitals, which also supported management of safer staffing. She asked at what point bed reductions or closures would impact on the system overall. The Chief Operating Officer replied that this could be discussed in more detail in the private session of the Board. The Chief Executive added that although community hospitals beds could be reduced during the summer period, there was also flexibility to increase bed numbers during the winter period to support the system. Jonathan Asbridge emphasised the potential for community hospitals to be a resource for research and practice development. The Deputy Director of Nursing replied that part of the skill mix remodelling work was considering this.  |  |
| fg | Lucy Weston noted that although there had been no instances to link staffing levels with adverse patient outcomes, she asked whether there were grey areas such as the impact upon quality of care, DToCs, patient outcomes or near misses. The Deputy Director of Nursing replied that work was taking place to develop a quality dashboard which may help to drill down into this detail. **The Board noted the report.**  |  |
| **BOD 109/18**abc | **Quality & Safety report: Effectiveness**The Medical Director presented the report BOD 83/2018 which provided a summary of the work of the Effectiveness quality sub-committee in particular in relation to: Clinical Audit; Drugs & Therapeutics; Learning & Development; the Mental Health Act and the Mental Capacity Act; physical health (including for those with mental health conditions); Psychological, Occupational and Social Therapies; public health; Research & Development; and the status of various clinical policies and procedures. Alyson Coates expressed concern about: (i) the level of strategic focus upon the area of Clinical Audit, noting that whilst the report set out completion of clinical audits and progress against the plan, it did not set out how satisfactory the outcomes of clinical audits had been and whether further actions would be required; and (ii) capacity and resourcing around Clinical Audit, the Mental Health Act office and the Resuscitation team to deliver Immediate Life Support (**ILS**) training (rather than Basic Life Support training). She noted that the Trust may need to consider increasing investment in these areas. The Medical Director replied that recent changes to the composition of the Clinical Audit Group had improved clinical representation and attendance, which would help to support completion of relevant actions, however more resourcing may be useful although this would also need to be discussed with the Director of Nursing & Clinical Standards. The Deputy Director of Nursing added that the work taking place around skill mix remodelling may also support this. The Medical Director added that the Mental Health Act office was also managing through a period of parental leave; issues with attending training were also linked to challenges with releasing staff from wards; and external support was being considered to help to move ILS training along. Aroop Mozumder noted that whilst the Trust was undertaking core Clinical Audit activity, it may benefit from more focus upon being innovative, proactive and upon clinical outputs and  |  |
| de | performance. The Medical Director replied that this may be an area where the new centre for Oxford Healthcare Improvement could help through work with the Clinical Audit team. The Board discussed how reporting on Effectiveness could evolve, noting that the current reporting was more retrospective, rather than providing a vision of the future, and that the way forward may be to be bold rather than tentative about action which was being undertaken or planned. The Chief Executive referred to page 6 of the report and the status update that a business case was being developed to see whether a fully networked temperature monitoring system (for medicines fridges) may be beneficial; he noted that as a decision had been taken to proceed with this then this action/decision should be reported, rather than a tentative statement about development of a business case. The decision had been evidenced in the Minutes of the 24 May 2018 Board meeting (in the section on the Chief Executive’s Report at item BOD 84/18(h) in those Minutes) as received by this meeting at paper BOD 77/2018 at item BOD 101/18(a) above. The Trust Chair requested that future Effectiveness reporting set out: (i) how concerns around performance and resourcing, especially in Clinical Audit, had been responded to; and (ii) how the Trust was becoming more innovative and proactive in improving clinical effectiveness and broader clinical performance, potentially through resources such as the centre for Oxford Healthcare Improvement. **The Board noted the report.**  | **MHa** |
| **BOD 110/18**a | **Medical Appraisal and Revalidation Report**The Medical Director presented the report BOD 84/2018 on appraisal and revalidation of medical staff, noting high levels for the past 5 years and further improvement during 2017/18. He praised the work of the medical appraisal and revalidation team in HR. Challenges were set out in the report, including the Trust’s work to support doctors whose honorary contracts had expired or who no longer had a connection with the Trust; these individuals had been written to in order to advise them that they would be discontinued and to provide guidance around working with the GMC (General Medical Council) around revalidation and seeking an appropriate responsible officer. Jonathan Asbridge noted the importance of the revalidation process for assurance about clinical practice and stated that doctors who no longer had a connection with the Trust should recognise their own responsibility to seek revalidation.  |  |
| bc | Jonathan Asbridge noted the contribution of the Medical Lead for Appraisal & Revalidation, and that this had been reported as being not remunerated. He emphasised the importance of supporting resourcing to maintain satisfactory medical revalidation and suggested that succession planning also be considered to support this important work in the future. **The Board noted the report.**  |  |
| **BOD 111/18**abc | **Guardian of Safe Working Hours (GoSWH) Report**The Medical Director presented the report BOD 85/2018 from the GoSWH and confirmed that levels of exception reporting were as expected. In relation to challenges which had arisen:* CAMHS advanced trainee rotas/work schedules had been reviewed and were being monitored for an anticipated decrease in the level of exception reports; and
* although Mental Health Act assessments had formerly been seen as voluntary work and separately remunerated by the County Council, these were increasingly taking place in the Trust’s own section 136 suites and may therefore need to be accepted as standard work – which could then lead to time being spent on these being subject to exception reporting.

Aroop Mozumder asked how the Board could be assured that all junior doctors were being safely supervised and at an appropriate level and whether this was within the remit of the GoSWH. The Medical Director replied that the Trust’s junior doctors were safely supervised with access to ST3-6 doctors and consultants on call. **The Board noted the report.**  |  |
| **BOD 112/18**abcd | **Finance Report**The Director of Finance presented the report BOD 86/2018 which summarised the financial performance of the Trust for May 2018 (Month 2, FY19). There was an Income and Expenditure deficit of £1.8 million, which was £0.8 million adverse to plan (compared to £0.4 million adverse to plan in Month 1). EBITDA (Earnings Before Interest, Taxation, Depreciation and Amortisation) was also £0.4 million adverse to plan which was consistent with the Month 1 position. The adverse variance was driven by: lower than planned additional income secured from commissioners; shortfall in CIP delivery; the costs of OATs (which had also been reported as high in Month 1); and high use of residential care services (also consistent with the previous year). He noted that although OATs had reduced, the level was still high but should be manageable and was being tracked weekly. The cash balance was healthy and £0.7 million above plan. Capital expenditure was £1.8 million below plan. The Use of Resources risk rating remained a ‘3’ (where ‘1’ was the best rating/low risk and ‘4’ the worst/high risk). NHS Improvement had also asked the Trust to review its financial plan in particular in relation to: reducing agency spend; CIPs; and contracts. The Trust had declined the offer to resubmit the financial plan whilst contracts were still being renegotiated, noting that the forecast would be considered again at the end of Quarter 1. **The Board noted the report.**  |  |
| **BOD 113/18**ab | **NHS Improvement – further Corporate Governance self-certifications** The Director of Corporate Affairs & Company Secretary presented the report BOD 87/2018 on the self-certifications required for the Trust to be able to confirm compliance with governance arrangements and training of governors. The proposed declarations had also been considered and supported by the Council of Governors in June 2018. **The Board APPROVED the Corporate Governance Statement**.  |  |
| **BOD 114/18**ab | **Corporate Registers – application of seal; and gifts, hospitality and sponsorship**The Director of Corporate Affairs & Company Secretary presented the reports BOD 88-89/2018 which set out the register of the application of the Trust seal and the register of gifts, hospitality and sponsorship. **The Board noted and received the reports.**  |  |
| **BOD 115/18**ab | **Any Other Business and Strategic Risks**The Deputy Director of Nursing asked that the Board thank staff who had worked hard on the project to reduce agency HCA usage and who had had to take a leap of faith to move in this direction. The Board agreed and expressed its thanks to all those staff who had made this possible. No changes noted to strategic risks.  |  |
| **BOD 116/18**a | **Questions from Observers**None.  |  |
| **BOD 117/18**a | In accordance with Schedule 7 of the NHS Act 2006, the Board resolved to exclude members of the public from Part 2 of the board meeting having regard to commercial sensitivity and/or confidentiality; personal information; and legal professional privilege in relation to the business to be discussed. |  |
|  | The meeting was closed at 12:04. **Date of next meeting: 26 July 2018** |  |

1. Non-voting [↑](#footnote-ref-1)
2. Non-voting [↑](#footnote-ref-2)
3. Non-voting [↑](#footnote-ref-3)
4. Non-voting [↑](#footnote-ref-4)
5. An officer in attendance for an Executive but without formal acting up status may not count towards the quorum – Standing Orders 3.12.2 [↑](#footnote-ref-5)