The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

Minutes of the Trust Board Meeting held on Wednesday 28 March 2012 in the Board Room

Present:
Mr Laurence James, Chairman
Mr Donal O'Donoghue, Chief Executive
Mr Graham Bragg, Director of Strategic & Business Development
Mrs Lindsey Webb, Director of Nursing & Governance
Mr Steve Bloomer, Director of Finance
Mr Andrew Thomas, Medical Director
Mrs Val Doyle, Director of Operations
Mr Robert Millinship, Non-Executive Director
Professor Tauny Southwood, Non-Executive Director
Mrs Frances Kirkham, Non-Executive Director
Dr Liz Hensel, Non-Executive Director
Mr Chris Monk, Non-Executive Director
Mr Roger Otto, Non-Executive Director

In attendance:
Mr Michael Woods, Interim Director of Operations
Ms Joy Street, Company Secretary

ACTION

03/12/1167 **Apologies and welcomes**
Apologies had been received from Ms Anne Gynane, Director of Workforce and Organisation Development

The Chairman welcomed Donal O'Donoghue to his first Board meeting as Chief Executive.
The Board welcomed Mr Michael Woods who was in attendance as Interim Director of Operations. Mr Woods would become part of the Board once Mrs Doyle had left the Trust, pending final appointment of a substantive Director of Operations.

03/12/1168 **Declarations of Interest**
None

03/12/1169 **Minutes of the Trust Board meeting held on 29 February 2012**
The minutes were approved as a correct record subject to the following changes:

- 02/12/1147 should read January 2012 rather than 2011.

- Sir Philip Hunt should be amended to read Lord Hunt
- IGC Minute 02 /12 1161 - TC should read TS
- Minute 02/12/1157 to replace the word 'honest' with the word 'frank'.
- 02/12/1158 - SB argued that the ROH financial position would have to change so materially in order to trigger the need for a working capital facility. The words 'that it would give the bank cause to use their clause around significant change to financial position meaning' should be replaced with 'that it would give the bank cause for concern.

Actions from the February meeting were updated.

- **The Board formally noted that the settlement of £250K had been agreed by Shaylor and funds transferred.**
- **The Board received assurance that lessons of process in terms of handling communications when a member of staff is under review had been learnt. Actions had been put in place to ensure that all those involved were aware of the requirements of compliance.**
- **BBraun issues would be pursued by the new Theatre Manager led by MW.**

03/12/1170 **Matters Arising**

There were no matters arising not covered elsewhere on the agenda.

The Non-Executive Director pre-meet raised the following issues:

- Patient consent
- Anaesthetics
- SIRIs
- Sickness
- Budget –risks of CQUINs
- Ward Dashboard
- Junior doctor roles and responsibilities
- Complaints –additional information and the closing of the action loop and embedding of the lessons learned

03/12/1171 **Chairman's Update**

- Members' Council – a public meeting and workshop on constitution had been held. Independent facilitators supported the workshop and it was agreed that the number of constituencies be reduced but no further proposals were agreed.

The Board asked that FK, BM, LJ, DOD and JS meet early and seek advice of external lawyers as soon as possible and delegated the decision on the process of the current election to that group. It was also agreed that Neil Hart, as lead governor, be invited to join the group along with other governors as appropriate. **FK, BM, LJ, DOD, JS**

- FTN meeting had been attended where speakers from Monitor and CQC had been present. **A future session for the Board would be held to provide a comprehensive update on issues such as commissioning and regulation.** **LJ/JS**
- Cluster meetings on integrated care and public health promotion had been attended – like many of the current meetings; there was discussion but limited concrete information. CM commented that it was expected that Trusts would need to be responsive yet the commissioners had yet to convey what exactly they sought from providers.

03/12/1172 **<u>Chief Executive's Report</u>**

DOD had prepared a report that gave his initial views on the organisation.

1. Senior Management Team changes were considerable, AT was vacating the role of Medical Director and GB would be retiring in July. CM asked whether the suggested expansion of EMT was in order to develop the next level down of senior managers and DOD advised that it was but that it also brought additional expertise around the table.
2. Initial feedback from a review of IM&T showed that work was needed urgently in this area.
3. Engagement between management and the medical workforce needed further work. Service line management would be used to facilitate changes to the management structure with clinicians in charge of business units.

GB updated on the handling of defects in the Outpatient Department (including a leaking roof, failed lift shaft and necessary expansion joint, front doors and shutters). A rectification plan was developed and the construction company is unhappy that access is limited in order to mitigate effects on patients. Some work was undertaken in the last few days but not as per the agreement. CM advised that the Trust had practical completion and it was therefore reasonable to expect defects to be corrected at our convenience (within reason). It was agreed that no retention monies should be released.

BM congratulated GB on his success in creating a working relationship with Shaylors that had enabled closure on some elements.

4. The Compact amendments had been received today and other organisations had agreed to sign. ROH legal advisors had suggested that it be made clear in writing that this was in no way legally binding and that the views of the co-operation and competition panel should be sought. FK advised that her first reading suggested items of potential detriment to ROH and she would like to read the latest version and the legal advice. **It was agreed that GB and FK discuss this further and confirm the efficacy or otherwise of signing.** **GB/FK**
   DOD and LJ were given delegated authority to sign as and when appropriate. **DOD**

5. Pathology reconfiguration was under consideration in the local health economy with the SHA taking the view that primary care pathology should be subject to a tendering process with a targeted 20% reduction in cost. The small specialist Trusts have been invited to participate in this if they wish.

TS asked that DOD give a perspective on the way the Trust should cement its external position. DOD suggested that the Trust should work more in partnership with others and be seen as a collaborator and should develop strategies to ensure it punched above its weight in terms of its services. Commissioners and CCGs would be key relationships to develop and the Trust should be as supportive as possible.

Patient Safety and Experience

03/12/1173 **Director of Nursing & Governance Patient Safety Report**

1. Serious Incidents requiring investigation (SIRI)

In-month had seen an increase to 5. BM felt that there was a high incidence of anaesthetic incidents and queried the balance of improved reporting and a genuine rise in occurrence. LJ asked how the Board could get assurance that matters were being handled without prejudice to, for example, HR processes. TS advised that IGC discussed these issues in detail and was concerned that the Board also went through them. DOD advised that he had ideas about how to manage the SIRIs and that these were key issues for the organisation and therefore more eyes reviewing these was not, for him, an issue. RO commented on the SIRI where an appropriate mattress had not been used but was assured that equipment was

available. He asked whether the findings of investigations translated into actions and LW advised that the External Audit Report indicated that this was not always the case and that processes would be improved.

2. **Falls – noted**

3. **Healthcare Associated Infection – noted**

4. **Ward Dashboard**

LW commented on the variations in performance and management actions being taken. RO felt that there had been a few incidences of non-completion of data and asked if it was clear why. LW said it had been reviewed and was often as a result of unforeseen absence without any handover of responsibility and this was being tackled.

5. **Surgical/Anaesthetic Audit**

TS felt that expectations of junior doctors might be unduly onerous and reflective of insufficient consultant input and too little appropriate escalation. GP trainees were nervous in some situations and additional training was necessary. DOD felt that junior doctors were yet to learn that following protocols was replacing clinical judgement and the consultants may in some case fail to utilise this. TS felt that the issue of responsibility lay with the consultants and induction, training and escalation were crucial determinants of success. AT felt that the diary exercise for doctors would greatly assist the Trust's understanding of how it applied its resource and help to identify how, for example, physician cover could be developed. It was recognised that juniors have very different training now which gives them greater skills in some areas and reduced skills in others when compared with the older consultant workforce.

6. **SMT Safety Workshop – progress report noted**

7. **Safety Thermometer Pilot – noted**

8. **PEAT Inspection – noted**

9. **Complaints – reporting would change from April and JS asked that if any Non-Executive Directors wished to be involved. EH volunteered.**

The Patient Safety and Experience Report was noted.

Statement of Compliance with MRSA Screening Policy

03/12/1174 STATEMENT OF COMPLIANCE WITH MRSA SCREENING POLICY

The Royal Orthopaedic Hospital NHS Foundation Trust has for many years had a policy of screening all patients admitted to the Trust for MRSA. The Trust is therefore fully compliant with the Department of Health's recommendation that all elective and emergency admissions to the Trust are screened for MRSA.

The Chief Executive and Trust Board are assured that all patients requiring an inpatient stay (elective and emergency admissions) are screened for MRSA and decolonised according to Trust policy should they require treatment.

03/12/1175 Medical Director's Report

AT highlighted the following key issues from the Medical Director's Report.

Metal on Metal Hip Replacements and Hip Resurfacings

AT circulated an action plan update on progress to date. He advised that this had highlighted a gap in Trust processes such that, when a major patient recall incident occurred there was not an automatic protocol to follow. This was now going to be rectified for future use through the development of a policy and plan for the handling of such events. MW will prepare this documentation. **MW**

AT felt that the overall volumes of demand for revisions were likely to be fairly low, but until patients replied to the questionnaires the detail would not be known.

LJ accepted the Trust position and asked what had been done for patients. DOD acknowledged that some patients had expressed concern immediately; some may be concerned but have taken no action and may be prompted by the letter and questionnaire.

AT said that there was information on the website which had promised a letter within two weeks (the Trust is late in enacting this). Patients who have written in or contacted medical secretaries have been responded to by their consultants.

TS advised that University of Birmingham had a world authority on bladder cancer who may be a valuable contact for understanding the issues of chromium effects on the incidence of bladder cancer.

AT would welcome advice on the cobalt issue and had identified a contact in Denmark who may be able to advise also.

AT advised the Board that the Surgical Audit meeting had held a discussion on the two-stage consent process. A new lead from the consultant body was needed to develop robust understanding of how this should be taken forward. FK had attended the meeting and was very concerned at the varied views expressed.
LJ asked how the Board could get assurance on this. AT felt this should be discussed in detail at IGC. DOD felt that consent audit could benefit from being undertaken on a regular monthly sampled basis rather than just annually.
The conclusions of these discussions should be brought back to the Board. **AT**

The Board noted the Medical Director's report.

Strategic Issues

03/12/1176 **2012/13 Budgets**

SB introduced the budget and confirmed that managers had agreed their elements of this. The 30th March was the deadline for contract signing and if this is not met there is an automatic process for going through arbitration.

- The budget plans for a £2m surplus.
- Contract for 2012/13 reflects the outturn activity mix of 2011/12
- There is a tariff deflator included
- PBR changes have resulted in a gain for ROH around specialist spinal activity (this is likely to be a one-year gain)
- CQUIN attributable percentages are higher and designed to drive the quality agenda with work built into normal business baselines in subsequent years. This is a gain for ROH but not without risk. A paper was circulated giving the most up to date position with only two red risks remaining – electronic discharge (including outpatients) and enhanced recovery (volumes). Controls will be put in place through lead officers and this will feed into the CPR and be part of the PMO as appropriate for review by governance committees and EMT. SB and LW agreed that the nature of the CQUINs necessitates a greater degree of focus and rigour which is being built into the monitoring and management processes.

This gives a better position than anticipated and is supported by commissioners not taking such a strong line on procedures of limited clinical value.

- Non-pay pressures include NHSLA premium rises
- A development fund has been identified for use by EMT to support new initiatives throughout the year

- The cost improvement target has been largely achieved as a result of the controlled PMO activities and this frees up thinking for years two and three.

CM asked for confirmation that this was realistic rather than pessimistic or optimistic and SB advised that it was based on a real perspective from teams on what would happen. He felt the Trust should be aware of the risk that there may be system changes that could allow surpluses to be taken away if they were built up to a high level.

DOD asked SB what was happening for other organisations and SB advised that most Trusts had been able to agree activity and finance and it was understood that one Trust was considering a block contract arrangement. DOD felt that the system remained volatile and so development money should be used for "invest to save projects" and GB added that this should also cover growth opportunities from which additional income could be derived.

LJ asked if clinical colleagues had an insight into these issues and DOD commented that service line management would support this. GB advised that three Clinical Directors had been involved through EMT. Other consultants would be unaware and this would be presented to Clinical Directors and LW would present CQUINs at Surgical Audit.
AT recognised that consultants would need sessions on, for example, their role in health promotion. Additional sessions following audit could give opportunity for this.

The Board approved the budget

03/12/1177 **<u>3 Year Annual Plan</u>**

SB gave a high level presentation on the 2012/13 Annual Plan and focused on years two and three. **The Board noted this.**

Financial stability was noted and the benchmarks showed ROH had moved closer to RJAH which had been best in field among specialist Trusts. The expectation in that ROH reference costs will improve this year but it remains to be seen whether ROH has kept pace with the relative improvement of others**. The Board noted this update.**

03/12/1178 **<u>KPI Report - Finance</u>**

The Board noted the Finance KPI Report

Business and Governance Reports

03/12/1179 Corporate Performance Report (CPR)

The Board noted the CPR

VMD assured the Board that the new targets for 2012/13 were being prepared for and that if the admitted backlog were to be maintained below 300, the Trust would remain compliant with the new target of 92% of total complete pathways, admitted and non-admitted. MW has received a handover on this issue and currently is running at 91.5%.

03/12/1180 FTN/Confederation Membership

The Chairman reminded the Board that these were now two separate organisations requiring two subscriptions. ROH may join one or both.

03/12/1181 Board Review/Appraisals

The Chairman circulated the Board performance appraisal summary.

LJ will produce an action plan for the April Board meeting. **LJ**

Reports on the work of Board Committees

03/12/1182 Audit Committee – No Meeting

03/12/1183 Integrated Governance Committee – No Meeting

03/12/1184 Remuneration and Nominations – No Meeting

03/12/1185 Investment Committee – No meeting

03/12/1186 Trust Board Terms of Reference

LW advised that these were prepared for NHSLA and asked that the Board agree Section 4 and then cross-refer to the Standing Orders.

These will be reviewed in 6 months.

03/12/1187 Items for Core Brief

The following items were agreed for the April CEO Core Briefing (DOD to consider ways to communicate to medical workforce in future)

- Key priorities from the CEO report (amended as appropriate for staff audience)
- Budgets
- Metal-on-Metal
- Health Bill
- CQUINs

03/12/1187 **Any Other Business**

GB advised that the Forelands Ward at BMI was due to close at the end of this week and recorded his thanks to the team. LW will let CQC know of this as it changes the Trust's registration.

LJ recorded his gratitude to VMD on behalf of the Board for the significant success in maintaining strong performance within the Trust and wished her every success.

03/12/1188 **Date and Time of Next Meeting**

Wednesday 25 April 2012 at 8.30 am in the Board Room