



**Minutes of the Trust Board Meeting held on  
Wednesday 25<sup>th</sup> April 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 Michael Woods, Interim Director of Operations  
Mr Robert Millinship, 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:**

Ms Joy Street, Company Secretary

**ACTION**

**04/12/1189 Apologies and welcomes**

Apologies had been received from Professor Tauny Southwood, Non-Executive Director and Mr Andrew Thomas, Medical Director

**04/12/1190 Declarations of Interest**

No other Declarations of Interest than those registered previously. 2012/13 forms were circulated at the meeting for signature to all members.

**04/12/1191 Minutes of the Trust Board meeting held on 28<sup>th</sup> March 2012**

The minutes were approved as a correct record subject to the following changes:

- 03/12/1169, final bullet point amend SB to GB
- 03/12/1172, section 4, remove GB from action responsibility.
- 03/12/1173, last section of paragraph one amend 'external' to read 'internal' audit.
- 03/12/1174, add 'The Board approved the statement of compliance'.

**04/12/1192 Matters Arising**

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

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

- SLM and IT were key issues as was activity.

**04/12/1193 Chairman's Update**

There was no update due to holidays and no external meetings.

**Strategy and Organisation Development**

**04/12/1194 Patient Stories**

LW introduced a new agenda item which was designed to allow the Board to review patient stories that illustrate how the Trust is performing. It allows feedback, provides context, and supports the ways in which patient experience influences strategy.

The first example was from a complaint which catalogued a range of issues of real concern to the carer of a patient who developed a Grade 4 Pressure Sore.

Board members were shocked at what they read but felt that sadly it was clear that this sort of situation could and had arisen.

FK felt concerned that the Board had no evidence of how the Trust learnt from something like this.

DOD felt that the Trust needed to think differently about this as such cases present huge challenges. He felt there was a fragmented approach to patient care, with higher than best practice approaches to reduction of silo working, and CM felt that, yet again, communication was at the heart of things. There was a need to work as teams which worked together to co-ordinate care such that the patient is seen holistically and the team takes mutual responsibility for their care. EH offered support from her professional arena on why this happens. **A Board workshop could be considered.**

**DOD/EH**

MW explained the impact of the current approach to nurse training which did not necessarily support best practice in terms of working due to the pressures within the course on other aspects.

BM felt the discussion went to the heart of matters and were similar to experience he had witnessed in another

Trust. Common sense was a phrase that should be remembered and applied more frequently within the Trust. GB commented that there were outpatient examples where staff did not seem to listen. SB reminded colleagues that the patient views expressed at a previous Board away day had been broadly similar and it was of concern to see that the fundamental shift had not yet been made.

DOD felt that the greatest probability of issues was around patients with complex needs, with multiple dependencies and these types of patients were growing in numbers.

The second example related to delays in X-Ray and consequent impact on car parking charges. The service from administrative staff was poor.

DOD felt this was another example of failure to deliver joined up care. CM felt that reception staff were absolutely key in any organisation as the front door to the service. GB, SB and DOD all commented on the benefits of the PMO approach to cementing good process but all agreed that it takes much longer than would be hoped to change all the people aspects of delivery.

LJ welcomed the discussion but reminded the Board that despite these examples of unacceptable care, the majority of patients were more than satisfied with their treatment.

FK remained unclear about what the Trust was going to do about the issues identified in the discussions. LJ reiterated the introduction to the item as that the discussion should underpin thinking when the strategy was being considered and inform the subsequent agenda items and decisions.

DOD felt that the message from the Board on their aspiration and dissatisfaction with such failures should be widely and consistently communicated in order to provide much better patient care.

**04/12/1195 Delivering Clinical Engagement – adopting a Service Line Management Strategy**

The paper presented by DOD outlined a strategy for the introduction of Service Line Management in support of greater clinical engagement and leadership. A presentation of a potential service delivery model was given for consideration which, although closely based on the current service model but with a triumvirate at the top – clinical lead (often a doctor), a matron and an operational business manager. The Executive Team remains the

superior executive accountability group and the corporate functions will provide dedicated and allocated servicing to each clinical directorate. There were 7 proposed directorates, with natural leaders for some of them.

CM felt the paper was excellent and added that Clinical Directors should not only consider costs but also income. CM asked whether all EMT had the appetite to support this change.

SB said that he did support this but that it was a big step-change and there would be a number of elements to enable empowerment and earned autonomy among Clinical Directors. There may need to be further structural considerations but the principle was sound.

LW supported this and had worked in the structure. There would be impact on corporate areas and there would need to be a real willingness from Clinical Directors to make this work.

MW had worked in this model and felt it offered the ROH a real opportunity.

GB felt that the model was proven and it would deliver engagement, however remained sceptical of securing real interest and calibre for all posts.

AG was very supportive as the approach is known to enhance patient outcomes. There would be development needs in both corporate and clinical areas to underpin this.

FK went back to the paper and asked what was meant by accountability and DOD replied that it was holistic – from the simplest and most basic to the complex surgery. FK asked how long it might be necessary to wait for strong clinical leadership in those areas where there was no obvious candidate and DOD said that, if necessary the Board would be asked to support external recruitment. FK asked that further consideration be given to risk, for example, unexpected consequences such as intra departmental competition skewing business activity. DOD said that the PMO would consider risk in detail.

EH, having been a Clinical Director felt that delegation, share of access to scarce corporate resources and size of directorate were all critical factors in the success of this type of structure.

BM asked what would happen to the CSMs and was advised that it was likely some of the current post-holders would assume the business manager roles.

BM asked how the proposed structure would support improvements in patient care needed, as highlighted in earlier discussions, and DOD explained that team working, issue sharing and being closer to the patient should help.

LJ asked about cost. DOD advised that the proposals had not yet been costed but he would present additional cost proposals as necessary.

**The Board supported the CEO in progressing the strategy, including taking the steps necessary to implement a revised structure. It was agreed that the CEO would advise the Board if or when additional approvals of resource were needed in order to maximise the benefits of this strategy.**

**04/12/1196** **IM&T**

An external review of the IM&T Services at the ROH had been commissioned and the Board received a report of its findings. The reviewer was impressed with the commitment of the teams and with much of the work already achieved, but advised that there remained a considerable amount of work to be done if the Trust wished to derive maximum benefit from the Health Informatics Service as an enabler for service transformation and as an effective source of business and clinical quality information.

SB advised that the Trust had chosen not to invest in this area in the past and the document demonstrated the benefits of now making such an investment. GB acknowledged that the Trust had tried to find solutions in this area and the time was right to now get an individual to energise this strategy.

LJ fed back the view of the Non-Executive Directors that choices had been made in the past and that this was an area for change that was agreed as vital but delivery was of the essence. BM felt the key issue had been the identification of the right individual. DOD felt it was essential to establish the leadership credentials that fit the task and not appoint until someone was available who met these demands.

CM felt that patients were not all IT literate and the Trust must continue to cater for them.

**The Board discussed the findings and recommendations and approved the initiation of work consequent on that discussion including the appointment of an interim resource.**

**04/12/1197 Investment Committee – No meeting held**

**Performance Management**

**04/12/1198 Corporate Performance Report**

SB focused attention on the red and amber indicators. The overall amber was driven fundamentally by activity.

MW advised that cancer targets, admitted and non-admitted targets were achieved for quarter four and the contracted new to follow-up ratio was within agreed parameters.

Activity was much lower than planned partly due to more annual leave than anticipated in the planning phase had been taken. There had also been a case mix change which had off-set half of the financial loss. The modelled operational days for March (as had happened in September) had been higher than was achieved.

Work has been done with the team to ensure that there is now an early warning system so that the Trust has more time to implement remedial action.

KPIs are being introduced in Theatres in support of the necessary improvements. An urgent Clinical Director meeting will look at pooling and flexibility arrangements.

BM expressed concern that the Trust was surprised by something that should have been known, annual leave being an example.

DOD advised that, for example, Theatres did not get notice of leave in a timely fashion, even if leave had been booked within the agreed timelines.

DOD advised that there was an emergency EMT meeting after the Board to look at this in great detail and rectify identified issues. Previous assurances would have been sustainable had there only been impact from a leadership change whereas there were other issues of impact too. LJ felt it was unacceptable that this happened given the assurance provided at the March meeting that everything was in place to deliver the target.

SB reported that a deficit against target surplus had been posted in the month. There had been improvement in control of costs over the year and reserve allocation had covered shortfall in income. There had been an impact as a result of the conclusion to the Shaylor claim in the period. Cash was considerably higher than expected due to phasing of capital spends on Theatres and the restaurant. Debtor days were also significantly reduced. Strong liquidity was evidenced.

RO asked SB to confirm he was still content with previous assumptions on forward budgets and SB confirmed he was. He felt that the Board had managed the overall financial position very well with pay and non-pay spend well controlled. Only one CSU had failed to deliver its CIP target and the one which failed was known to face a huge challenge and was being supported.

LJ agreed that the overall achievement was commendable but there were still issues to focus on going forward as great performance was difficult to maintain.

Commissioners had agreed the income figures and there would be much lower risk of bad debt than in previous years as a result.

**04/12/1199 PMO Report**

SB reported that the CIP was achieved overall and the areas indicated as red were being addressed by both project teams and executive leads. This would maintain and re-invigorate the process.

RO confirmed that the Audit Committee had again spent time in the PMO and was confident that the impetus remained.

**04/12/1200** **Assurance Reports**  
**Director of Nursing and Governance Patient Safety**  
**Report**  
**SIRIs**

The Board noted that there had been 1 SIRI in month, a decrease from 5 the previous month. There had been an additional red incident reported to the commissioners to be escalated as a SIRI for UHB as it related to their non-reporting of blood results.

Clinical Directors should be advised within 48 hours of a SIRI in their area.

**Falls**

The number of falls in 2011/12 had reduced for the second consecutive year. This was equivalent to a 4% reduction when compared to 2010/11. The Board noted that the falls CQUIN had been achieved in full for the year.

**Pressure Ulcers**

The Board noted the on-going reduction in incidence of pressure ulcers with overall numbers having reduced for the second consecutive year from 64 in 2010/11 to 54 in 2011/12 (15%). In-year there had been a reduction in grades 3 and 4 from 6 in Q1 to 2 in Q4. There will be a CQUIN for next year.

**Healthcare Associated Infection**

The Trust had achieved all of its HCAI targets for the year with a total of 6 cases of C.Diff against a target of 7. The Board welcomed the achievement and also noted that the C.Diff target for 2012/13 had been set at 6, however Monitor had agreed a de minimis level of 12. This would ensure that the governance rating would not be adversely affected in future, regardless of the target, providing the total number remained below 12.

Contractually the de minimis number would be 35 and the Trust would therefore need to exceed this amount before receiving a financial penalty.

**Ward Dashboard**

The overall position had improved with three areas now green and HDU and Theatres had improved.

The Board noted the data on ward performance. RO raised concern at the anaesthetists failing to wear gloves when cannulating and LW responded that this was a challenge but was being tackled.

### **Surgical/Anaesthetic Audit**

The Board welcomed the renewed attention given by the audit meeting to matters arising and the attribution of actions coming back to the next meeting for follow-up.

### **SMT Safety Workshop – progress report**

The Board noted progress.

### **Board Workshop – Risk and Quality Governance Framework**

A Board workshop had been held on 28<sup>th</sup> March 2012 looking at risk and quality. A more detailed paper would be presented at the May Board meeting.

### **Complaints**

The revised format was proposed for the Board with greater detail going to the Integrated Governance Committee. DOD suggested that Directors highlight any complaints of particular concern for consideration in more detail.

#### **04/12/1201 Complaints Annual Report to the Ombudsman**

The annual report provided the Board with assurance that the requirements of the NHS Complaint Regulations 2009 had been met having considered the following information:

1. The number of complaints and identification of any deemed to be well-founded
2. The number referred to the Health Service Commissioner or the Local commissioner
3. The subjects of complaints, trends and comments on the handling process

The Board asked that an additional review of the decisions on complaints upheld or otherwise be conducted prior to submission. Subject to any amendments being needed, the Board:

- **Noted** the annual complaints report
- **Agreed** to the improvement plans for 2012/13
- **Approved** the report for submission to the SHA

#### **04/12/1202 Carbon Strategy Annual Report**

GB updated the Board as to the greater reporting requirements for next year and **agreed to circulate these to CM for information.**

**GB**

**The Board noted the report.**

#### **04/12/1203 Integrated Governance Committee Report – No meeting**

**04/12/1204 Audit Committee Report – Feedback from 19 April 2012**

RO highlighted:

- Receipt of draft financial statements and submission of these to the auditors. The Finance Team had been congratulated.
- Annual Report and Quality Accounts progress reports had been presented.
- Auditor action plans and year end reports were received.
- The Board Assurance Framework had been discussed.
- A major discussion on the Clinical Outcomes & Effectiveness Committee's submission on clinical audit had been held. This gave the Committee partial assurance. Internal and External Audit had advised that this was much improved on previous years and compared favourably with others. RO had met with TS to discuss this further and TS gave his assurance that this would be driven forward.

**The Board noted the report of the meeting.**

**04/12/1205 Audit Committee Feedback – Going Concerns/ Delegation Authority**

RO advised the Board of discussions on the Trust as a going concern where assurance could be gained from 100 day liquidity; £19m in the bank; forecast surplus; signed contract with commissioners; CIP management and track record. Auditors had supported the view that the Trust was a going concern.

**The Board gave delegated authority to the Audit Committee to approve the financial statements to Monitor once audited and the Board supported the assessment of the Trust as a Going Concern.**

**04/12/1206 Q4 Governance Declaration to Monitor**

DOD circulated the governance declaration paper. An action plan in support of Declaration Two would be prepared following the Board meeting.

**The Board agreed the Quarter 4 submission to Monitor and agreed that the Chairman and Chief Executive sign:**

- **Declaration Two of the Governance Declaration due to the uncertainty of delivery of the new target applicable from April 2012 to ensure that 92% of patients on an incomplete pathway should have not been waiting more than 18 weeks.**

- **Declaration One of the financial statement confirming that the Trust had met all financial targets.**
- **Declaration One of the In-Year Quality Board Statement confirming that the Trust had met the required statements in relation to Quality.**
- **On the basis that the Chairs of the Remuneration Committee, Audit Committee and Integrated Governance Committee agreed the statements outlined in terms of assurances received during the quarter.**

**Board Committees & ad-hoc Groups not covered elsewhere**

**04/12/1207 Remuneration Committee –**

No meeting held but the Non-Executive Directors had met with regard to the interview and appointment of a substantive Director of Operations.

A unanimous decision was reached by the interview panel and the Non-Executive Directors recommended the appointment of Amanda Marnock to the post.

The Board supported this appointment.

DOD thanked MW for his interest in the job and his continued support for the organisation during his interim appointment.

**Any Other Business**

**04/12/1208** AG advised that Unite were likely to strike on 10<sup>th</sup> May. It was not anticipated that there would be significant adverse impact on the Trust's activity.

**04/12/1209** DOD suggested the Board reflect on its performance today. LJ invited comment on the changed Board agenda.

- Patient stories were liked but greater clarity was needed on what/how to extract lessons and actions as a result
- It was suggested that implications for patient experience might be a useful paragraph on papers
- Agenda change was welcomed
- Timed agendas could be helpful

**04/12/1210 Date and Time of Next Meeting**

Wednesday 30<sup>th</sup> May 2012 at 8.30 am in the Board Room, jointly with Members' Council.