The Royal Orthopaedic Hospital **NHS**
NHS Foundation Trust

Minutes of the Joint Trust Board Meeting held on Wednesday 27th June 2012 in the Boardroom

Present:
Mr Laurence James, Chairman
Mr Donal O'Donoghue, Chief Executive
Mrs Lindsey Webb, Director of Nursing & Governance
Mr Steve Bloomer, Director of Finance
Mr Michael Woods, Interim Director of Operations
Mr Andrew Thomas, Medical Director
Mrs Anne Gynane, Director of Workforce & Organisational Development
Mr Robert Millinship, Non-Executive Director
Mr Roger Otto, Non-Executive Director
Professor Tauny Southwood, Non-Executive Director

In attendance:
Ms Joy Street, Company Secretary
Ms Amanda Marnock (Director of Operations Designate)

ACTION

06/12/1236 **Apologies and welcomes**

Apologies had been received from Mr Chris Monk, Non-Executive Director, Mr Andrew Thomas, Medical Director, Mr Graham Bragg, Director of Strategic & Business Development and Dr Liz Hensel, Non-Executive Director

06/12/1237 **Declarations of Interest**

No other Declarations of Interest than those registered previously.

06/12/1238 **Minutes of the Trust Board meeting held on 30th May2012**

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

- Agenda item 05/12/1216, page 5, paragraph two should to include …'there was room for improved performance'…
- Agenda item 05/12/1220, page 10, last paragraph should read PS and not PB.
- Agenda item 05/12/1223, page 11, first paragraph should read 1000 bed days and not 100 bed days.

06/12/1239 Action Points

Action points were updated (please see action point notes).

- 03/12/1171 - Monitor has published a model constitution
- 03/12/1187 – DOD is undertaking a Question Time event on the 28th June.
- AG updated the Board on revalidation work undertaken by Andre Jackowski. 360 degree appraisal is core and external support had been commissioned to support this. 68% of doctors received an appraisal last year which AG advised was broadly consistent with other organisations. Work was still on-going with regard to gathering performance data. LJ asked if there was consistency across departments and AG advised that the methodology was consistent but there was variance in the degree of challenge and feedback. BM felt this was to be expected in the early stages. LJ checked that management action would be taken if staff refused the 360 degree appraisal and was assured this would be the case. **Andre Jackowski to present an annual report to the Board in September to provide clear indications of any delays or issues**. DOD advised that the BMA supported Trusts in ensuring that appraisals were undertaken. LJ asked what were the barriers to 100% of appraisals. AG felt that the discipline of timely appraisals was simply not embedded. LJ asked why this could not change as of now. DOD advised that this was part of the greater change process but that he would endeavour to achieve 100% completion of appraisals by the end of the year. **AJ**

06/12/1240 Chairman's Update

- LJ highlighted the discussions held at the Non-Executive Director pre meeting which included; timeliness of papers; PROMs data; activity; finance; utilisation; inpatient model of care; senior management structure.
- LJ had acted as an independent assessor at the Robert Jones & Agnes Hunt Trust in the recruitment of a Non-Executive Director.
- LJ had held a governor candidate briefing with 9 attendees. There were no candidates for the Heart of Birmingham position. There are 3 candidates for staff positions and other seats have 8 candidates each.
- DOD and LJ attended the Foundation Trust Network Chairs and CEO meeting. This had given a finger on the pulse of the health economy and alerted attendees to the secondary legislation with regard to the Health Act. NHS surplus had been better than expected but there were pressures on local authority budgets. There was an update on progress of Trusts in the pipeline for Foundation Trust with concerns expressed that many

may not meet the criteria. The National Commissioning Board, Care Quality Commission and Monitor had all given position statements. The National Trust Development Agency will be responsible for supporting Trusts to Foundation Trust. Academic Health Science Networks were described as supporting innovations and best practice and TS agreed with this analysis. This is a new body which will cover the whole research environment. DOD added that the Foundation Trust Network and the NHS Confederation were now working together. The new CEO of Monitor had given a thoughtful presentation. The new Chair of the Commissioning Organisation at regional level was also there.

- LJ attended a Monitor workshop on Licensing. JS had also attended a meeting and confirmed that license conditions would be more onerous than the current arrangements with Monitor. Local tariff arrangements were also evolving. FK felt the Trust should prepare itself fully for the license and JS provided an assurance that this was in place but may require external support and resource.
- LJ, DOD and LW attended the Annual NHS Confederation Conference where the need to transform the NHS was re-affirmed, though it was clear this would not be without political ramifications. Themes included integrated care, health and wellbeing boards, patient experience. LW had attended a session on Health Watch and the project lead was dynamic and clearly wanted to develop beyond the LINKs model. She had also attended a session on workforce which was of major interest to the ROH. DOD felt that the NHS finance session gave a salutary reminder that financial strictures would continue long term and that Trusts would need to demonstrate that patients were better as a result of treatment.

Strategy and Organisation Development

06/12/1241 **Quality Update Report**

The paper provided a summary of the issues raised at the Board Quality Workshop on the 14th June 2012 identifying how these would be taken forward and recommended a revised score to the Quality Governance Framework (QGF) self-assessment undertaken in March 2012

LJ felt that his outstanding concern was for culture and workforce issues having priority. LW said that this would be part of the organisation development plan and the staff engagement strategy. AG would report on these in August.

LJ felt the benefit of external organisational perspectives was invaluable and asked how this could be applied to benefit the organisation. LW said that next time others would be invited and LJ reiterated that this was a matter of urgency. LW advised that there had been a revision to net promoter targets to stretch performance. **The Board asked for a timetable towards the October Strategy Refresh and DOD confirmed that this would be given to the July Board and followed by a Board workshop in August.** Stakeholder events would be held in the organisation as part of this process. **DOD**

FK felt that the day had been useful but was preaching to the converted and she wanted a set of actions against these issues. DOD felt it crucial that this was tied into the overall process. TS felt it would be useful to have a set of bullet points on key decisions as a checklist. DOD agreed this and confirmed that all these issues would be brought together in a coherent way later in the year. TS nonetheless felt that we should start now.

With regard to the QGF, RO asked if the scoring was consistent with Care Quality Commission reviews and LW advised that there was not a straight read across but that it was broadly consistent.

TS asked whether there was capacity to identify outliers in information analysis and it was agreed this was still weak. SB felt the scoring was fair but that this was a challenge. FK endorsed the later scores but felt that there was still a need to have agreed and tangible actions. LJ asked Directors if they were content and all agreed.

The Board:

- **Approved the revised self-assessment scores against the QGF and;**
- **Agreed a quarterly review of the QGF self-assessment to tie into the quarterly Monitor declarations.**

06/12/1242 **Inpatient Model of Care**

DOD introduced his report giving an outline of the current situation in respect of the medical care of patients at the ROH and to describe some of the options that may need to be considered in the future in order to develop a more holistic model which reflects the changing needs of patients and meets best practice.

DOD explained that the long-term choices may well necessitate significant changes in process and responsibilities on the wards and will necessitate investment in order to enhance the quality of 24/7 care. TS felt that the viability of the Trust depends on a longer term solution. He felt there was no sense of timescale or urgency on this. DOD responded to say that specialist Trusts do not have a model of care. The ROH has 24/7 cover by doctors and anaesthetists and the key decision was about appetite for change balanced against investment availability. By the end of Quarter 3 the analysis will be complete and the workforce consultation will begin with a view to a decision by the end of the year. SB confirmed that immediate cover would be available, but that an option appraisal of this would need to tie in with the overall business opportunity and presented a vital opportunity to support an additional 1200 patients.

LJ asked who was leading this project. AG advised that it was herself, Mel Grainger and Suzanne Nicholl. LJ asked if others had been engaged yet and was advised not. He strongly urged and pressed the point, that conversations take place, as his own experience suggested that it would be pushing at an open door with several anaesthetists.

It was agreed that developing an inpatient model of care was a major need and opportunity for the Trust.

The Board:

- **Noted the position statement**
- **Received assurance that mitigations were in place to cover any short-term loss of physician cover**
- **Agreed that a worked up proposal be brought to the Board by the end of Quarter 3 with the objective of meeting the holistic needs of patients through the development of a revised and costed service delivery model and that interim updates be provided through the action points monthly.**

06/12/1243 **Performance Management Framework**

This item was deferred.

06/12/1244 **Senior Management Structure**

DOD had provided a report of which its purpose was to provide the Board with an indication of the ways in which roles and responsibilities with the senior team may be reallocated, subject to detailed consideration and approval by the Board's Remuneration Committee in July 2012.

TS commented that the separation of strategy, information and innovation was of concern. DOD advised of the need for an information expert to crystallise the systemic structures for the organisation. RO expressed support for the Service Line Management structure.

The Board noted the indicative management structure pending full debate by the Remuneration Committee at a meeting in July. LJ asked that an assessment of affordability be undertaken as well as robust benchmarking ready for the Remuneration Committee. **DOD**

Performance Management

06/12/1245 **Corporate Performance Report**

SB reported an improved position where Quality and Workforce were Green, Finance had moved to Amber and Key Performance Targets had been met.

MW circulated an Activity and Performance update report. The report demonstrated the trend in percentage activity versus plan to be improving. It is anticipated this will continue to improve and expectations are for activity to meet the plan in June.

The team are conscious of annual leave planning for July and August and are currently working on mitigations for unused sessions.

BM felt it was a good graph, particularly as it was going in the right direction and asked what were the key interventions resulting in improvements.

MW advised that daily monitoring, formal planning and clinical engagement all aided the position. The monitoring arrangements had been tightened, and forward thinking reinforced. Direct dialogue with clinicians had also become routine.

DOD added that expectations for the future were now clearly expressed, i.e. 6 weeks annual leave notice, booking of pre-operative assessment from first appointment and so forth, but there was recognition that this will take time to fully embed. The Clinical Service Managers are now also clear that they are responsible for the numbers throughout the patient pathway. Clinicians have also been made aware that activity is a top priority. SB confirmed that this was the case and that the work in the PMO was also being significantly refreshed.

RO was concerned at the PMO identified barrier of twin working across Theatres and asked MW how he would like to see the flow of patients develop. MW identified the use of a predictive mind set as key and referred in particular to the revised scheduling streams in the PMO which now aim to deliver the additional capacity (1200 cases) the Trust has committed to. This was then underpinned by a number of activity streams down to the level of needing to change consultant job plans. SB said that this delivered real engagement by teams on the ground who would be instrumental in finding solutions. DOD said that he was being clear that all job plans would need to change but that the approach would be coherent and collaborative.

LJ commended the real progress made and asked how the team could address issues such as unavailable beds. MW advised that active bed management processes were in place now but that for the interim this sort of fire fighting might be necessary but with the aim of prevention rather than cure.

LJ commented that despite the Discharge Lounge being in place, if patients were not going through there, this had not become embedded practice. MW commented that this was being addressed, as was list lock down to avoid changes. It was also agreed that there should be more clinical engagement in the PMO and this was in hand.
TS asked when the target of unused theatre sessions of 23 might be achieved. DOD advised that this is unlikely to be achieved until the Service Line Management structures were in place, i.e. by the end of March 2013.

DOD thanked MW for his considerable achievements in this arena and the Board supported this.

MW anticipated full compliance with the cancer targets and confirmed the 18 weeks target performance as met in May. He gave the caveat that activity to get the backlog down was still essential.

SB reported an in-month improvement on surplus against plan. If activity targets are met, the planned financial position can be achieved.

BM asked for clarification on disputed income and SB advised it was unavailable pending PCT progress. BM suggested that rather than move from Red to Green on Workforce, it should be Amber. AG advised that there may be issues on data accuracy but SB advised that there was a methodology in place that meant sickness drove the colour and therefore Green was accurate.

RO commented that the FRR would be affected if activity were not sustained.

06/12/1246 **PMO Report**

SB advised that the Trust had been shortlisted for its PMO work and Bone Infection Unit in the HSJ awards.

06/12/1247 **Board Assurance Framework/Corporate Risk Register**

To meet the requirements of the Risk Management Strategy the Board received a summary of the risks contained within the combined BAF/CRR to enable approval of the document for 2012/13.

BM commented that closed risks are replaced with new risks and LW advised that this was because the register related to a specific year.

The Board:

- **Approved the 2012/13 Board Assurance Framework/Corporate Risk Register (BAF/CRR)**
- **Noted that the BAF/CRR are dynamic documents subject to continuous review and as such are updated throughout the year.**

Assurance Reports

06/12/1248 **Director of Nursing and Governance Patient Safety Report**

LW presented the report and highlighted the following.

Serious Incidents requiring investigation (SIRI) Incident reporting

LW reported her on-going attendance at a coroner's inquest.

CDiff

To note that the Trust had one case in June

PROMS

DOD confirmed that the published results were very disappointing. In order to address any issues, considerable effort had been applied to getting data at surgeon level and had not yielded results at this stage. Some of the issues may be about the management of patient expectation but without more detailed information this was unknown. The quality of care has to be reviewed and it is not linked to infection, and other indicators seem to suggest satisfactory clinical outcomes.

LJ asked DOD to send a letter from the Board to all surgeons giving the PROMs data in order to ensure awareness that it was of concern and on the radar and to reinforce the patient perspective on our service as important. This should highlight comparative prior performance but set a clear benchmark of expectation that the ROH should be the best. The letter should also reinforce the factors underpinning the EQ5D to demonstrate that these will also apply to other specialties not related to PROMs, but nonetheless contributory to patient perception which will be critical to Trust reputation. **DOD**

RO was concerned that this may not have sufficient impact without consultant specific information and where it may not technically be statistically significant. DOD felt it should be handled by the Directorate which undertakes the procedures reported on through PROMs.

TS asked what steps had been taken to triangulate the data as the PROMs report was out in May. DOD reported that he had held meetings with AT and Professor Pynsent and the data from them shows better performance but does not provide comparable performance. Matt Revell, as Clinical Director for Clinical Outcomes & Effectiveness, had been asked to share data with Clinical Directors. TS asked if there had been a sample size effect. SB said that there may be but he could not quantify this and it would affect all Trusts. TS was concerned that at a national level consideration had not been given to the need for Trusts to utilise the data. TS also urged caution on having any degree of complacency as a result of statistical significance as patient significance is of primary concern.

DOD felt that the ROH needed to put in a process to parallel this that would give direct information.

BM supported the presentation of trends and felt that comparisons among Specialist Orthopaedic Alliance Trusts were the most useful and wondered if more detail could be provided through that route, but SB advised that this would be unlikely to provide further detail. JS commented that it may be possible to compare with others using different data sources such as the patient survey which may have impact on patient expectations.

06/12/1249 **Integrated Governance Committee Annual Report**
No meeting held

TS asked that the Board approve the workplan and Terms of Reference for IGC.

RO asked that IGC agendas be circulated to all Board members prior to meetings for information.

The Board approved the workplan (noting that this may later be subject to review following the revised Board schedule) and approved the IGC Terms of Reference.

RO and TS were also meeting regularly.

06/12/1250 **Audit Committee**
No meeting held

Board Committees & ad-hoc Groups not covered elsewhere

06/12/1251 **Remuneration Committee**
No meeting held

06/12/1252 **Items for Information**
None

06/12/1253 **Core Brief Items**
- SLM factual update – and Activity, Service, Quality

New Risks
FK felt that the key risk of clinical quality and the risk of published adverse quality information on Trust reputation

06/12/1254 **Any Other Business**
None

06/12/1255 **Date and Time of Next Meeting**
Wednesday 25 July 2012 at 8.30 am in the Board Room