



**Minutes of the Trust Board Meeting held in public on
Wednesday 25th July 2012 in the Boardroom**

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
Ms Amanda Marnock, Director of Operations
Mr Andrew Thomas, Medical Director
Mr Robert Millinship, Non-Executive Director
Professor Tauny Southwood, Non-Executive Director
Mr Chris Monk, Non-Executive Director
Dr Liz Hensel, Non-Executive Director

In attendance:

Ms Joy Street, Company Secretary
Mrs Anne Gynane, Director of Workforce and Organisation development
Mr Stuart Lovack, Head of Estates (Agenda item 07/12/1265)

ACTION

07/12/1256 Apologies and welcomes

Apologies were received from Roger Otto, Non-Executive Director and Mrs Frances Kirkham, Non-Executive Director

The Chairman welcomed Amanda Marnock to her first meeting and also welcomed those members of the public who were present.

07/12/1257 Declarations of Interest

No other Declarations of Interest than those registered previously.

07/12/1258 Minutes of the Trust Board meeting held on 30th May 2012

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

- Typographical correction with regard to Mrs Frances Kirkham under director attendance listing
- Page 6, first paragraph, second sentence from 'identified' to referred' to be deleted.

07/12/1259 Action Points

- Members' Council Constitutional changes – some name changes will be made in October 2012
- Commissioning Update - Joy Street presented a paper outlining commissioning arrangements covering the relationships between parliament, regulatory bodies, local accountability, commissioning groups and providers. Any clarifications should be sought outside the meeting.
- Licensing information had been circulated by the Chairman
- Senior management structure update would be given at the private meeting
- DOD reported that the first CEO Question Time had been held and PROMs data had been circulated. The reasons for poorer performance remained unclear despite a review of a range of potential contributory factors. LJ advised that IGC had also discussed this and confirmed that the Arthroscopy Team was taking things seriously. IGC will continue to monitor this.

The Board noted the information.

07/12/1260 Chairman's Update

- The Trust's restaurant had been opened today
- The Chairman had chaired a meeting of aspirant Trusts in Birmingham which reiterated the importance of the ROH maintaining standards in line with new expectations. Kate Hall from Monitor will be invited to give a presentation at a future Trust Business and Learning Day.
- BM commented that Monitor seemed to be listening to Trust comments on the many changes underway. LJ confirmed that the Quality Governance Framework was a tool used by aspirant FTs and LW advised that this was being reviewed quarterly. DOD explained that it was probable that Trusts which scored themselves green across the board were quite likely to be red or amber when tested because the standard was high and it was more likely that Trusts would be red.
- CM advised that at one of his CQC workshops he had reviewed signage which remained poor and confusing. LW advised and GB confirmed that there was work underway led by the Estates Department. DOD explained that during the period of transition the Trust would make incremental changes. Once this was complete an external person would be used to advise. EH suggested that there was someone at Birmingham City Council and she would provide the contact details to AM.

07/12/1261 **Strategy and Organisation Development**
Patient Stories

LW circulated patient stories. (Noted that the ROH had been cited by NHS West Midlands as handling this issue well).

The first related to a patient listed early, but needing an X-Ray. She was then delayed and eventually cancelled (for the second time). The family felt that there may have been an element of racism as they were Asian. This case therefore should be considered in light of the later paper on equalities.

EH felt that the situation was exacerbated by the fact that the patient also had diabetes. The case demonstrated that there had been multiple errors, from deciding on the day that she needed an X-Ray. AM felt that with proper assessment the patient may not have needed to come in the day before and this was potentially avoidable. DOD felt this was a clear example of failure to plan which then causes the Trust to be reactive rather than pro-active. Currently some teams plan and over the coming months planning will be developed across the Trust. DOD's instinct was that the Trust was not institutionally racist. LW advised that the family was now satisfied and had a further operation date.

SB updated the meeting on the work in the PMO on the patient pathway – pre-operative assessment and planning were both being process mapped to avoid list changing wherever possible. A theatre staff member was driving this. CM reminded colleagues that at Surgical Audit this had been presented as an issue by Mr McBryde. AT was pleased that the new Clinical Director for this area was committed to this piece of work and had demonstrated a good understanding. DOD explained that once the processes were in place there would be a zero tolerance of changes and referred to the visit to Liverpool which exemplified the effectiveness of this approach.

CM asked if tracking of actions followed both the patient specific and Trust levels and DOD advised that the purpose of the story was to identify the generic issue and seek assurance that the Trust was working to avert such issues in future.

SB explained the process of following a patient in order to assess the pathway for real and how this fits into the PMO. He confirmed that immediate learning was put into place for obvious quick wins.

BM asked for feedback on the key things that were found as a result of this process.

SB

BM commented that the ethnic make-up of our patient population did not reflect that of the city. LJ identified that this in part reflected the commissioning patterns. GB confirmed that Bakul Kumar, from the Pain Management Service was to assume a new role in liaising with GPs and this may help to address these issues.

The second was an appreciative story from a patient who had surgery 15 years ago and who was happy to celebrate her on-going mobility.

This provided balance and other examples of good feedback were given.

TS asked that the stories should in future be put into context such as numbers of complaints and compliments.

07/12/1262 Service Line Management and Performance Management Structure

DOD presented an update on progress with the appointment of clinical directors, business managers and matrons under the Service Line Management structure. Dates for Trust Business and Learning Days had been set and plans for development and support were in hand as well as for performance management by directorate.

TS asked how business as usual metrics support research and innovation. DOD explained that the definition of activity, service and quality was broad and the connections between research and quality or service change would be made explicit as would any contributions to activity. DOD advised that some key priority objectives would be singled out for a period of time to tackle crucial issues head-on on a rolling basis. TS remained concerned at the parity of benchmarking for those undertaking research activity. DOD explained that there would be recognition of the different quality aspects of the job.

CM asked how the top-down/bottom-up connections would be made as in his experience giving staff the opportunity to develop their own objectives was really beneficial. DOD explained that this was a key element within Service Line Management and that the team's targets would drive these discussions as to the way in which the team would deliver. CM commented that the team may actually be able to influence the top-down target and deliver still further improvement.

EH commented that there might be operational overlap between the directorates (for example surgeon directorates needing to work on issues with the theatres directorate). She was also keen to understand how a silo mentality would be avoided.

DOD responded that the Trust was small enough to maintain dialogue and that if silos became entrenched this may necessitate a refresh. All Clinical Directors will meet together on the Trust Business Day for the Trust Activity, Service and Quality (TASQ) meeting.

AT felt that there were a range of services that touch all patients (such as outpatients) and the interface between teams would be critical to success.

DOD advised that ASQ would be explained to the Clinical Directors. Activity stretch targets were being identified by AM and SB; improvement trajectories will be set on booking times for each directorate; each Clinical Director will be given targets for complaints compliance and the second will support NHSLA level 2 by embedding the audit of case notes.

AM added that there was recognition of this as a new model and the Clinical Directors were enthusiastic and support for them would be provided. There was recognition that each team would need the support of others.

The Trust Board noted the progress made to date.

07/12/1263 Equality Objectives

AG presented a paper outlining proposed Equality Objectives to support the Trust in meeting its Public Sector Equality Duties in the next four years. As part of the legal requirement for the Trust to have Equality Objectives, publish these and complete identified actions; these must be reviewed and updates published annually

From the various reviews a number of key themes had emerged and one of these was around the gathering of data on a consistent basis. The action plan reflects these priorities and demonstrates how they will be achieved.

SB asked for assurance that if the provision of assurance was found to be administratively burdensome there was scope for a review.

SB asked whether the action plan was administratively onerous and essential in meeting the legal requirements. AG responded that this was felt to be a reasonable and realistic plan.

DOD confirmed that the Trust would meet its mandatory obligations and the Trust would use the data to develop its services.

AG confirmed that the plan had the support of EMT and had been developed with external input.

CM asked how the Trust ensured that as an employer it was making effort to ensure access to, for example, disabled people.

AG explained that the Trust considered the needs of job applicants on an individual basis as they arose. Disability Discrimination Act amendments to the estate were made if necessary and SB confirmed there was a budget for this.

LJ asked how the action plan would be monitored such that targets were achieved by April 2013.

AG confirmed that the Workforce & Organisational Development Committee owned the plan and Director of Operations would monitor this at an operational level.

Trust Board agreed and approved the Equality Objectives

07/12/1264 Investment Committee

No meeting had taken place

07/12/1265 Day Case ADCU Capital Business Case

GB and SL (new Head of Estates) presented a detailed paper and drawings which identified the costs to develop the ADCU service following a tender exercise within the context of the Development Control Plan. The restaurant had now been opened, the new private patient ward (now fully en-suite) would be open in August and the next development was the Day Case and Admissions Unit which will include the redevelopment of the stores, medical records, decontamination unit and plant room. This then would facilitate the essential development of new theatre accommodation.

ADCU development time will be 48 weeks which is longer than was expected and includes works on services which were not anticipated when the scheme was first planned.

CM asked about refurbishment of the private ward as works will be going on underneath. GB advised that much of the noisy work had been done in advance of it re-opening, though there would be times when the ward would have to vacate. GB confirmed that the recommended contractor was also the contractor undertaking the current works on the private ward.

EH asked if the Trust had learnt from previous issues in managing contractors and was advised by GB and SL that the degree of risk in this contract was lower than for a design and build as had been the case with outpatients. The tenders for ADCU had been received against a specification to give greater cost surety.

BM asked about how the plan accommodated the impact of theatre decommissioning. GB advised that there had been some revisions to the possible location of theatres stimulated by DOD and the site of the nurses' home had been identified and this would, in turn offer scope for future growth. DOD identified there were a number of pros and cons to be assessed and the location of HDU would be considered as part of this. A coherent plan must be developed to secure 21st century standards if this can be afforded.

LW asked whether the footprint for HDU could be re-provided in a space that was not without natural light or cramped and GB advised that this was to be considered in more detail.

The Trust Board was advised that the current scheme represented value for money in a very competitive market and that the tender evaluation and clarification exercise had confirmed the preferred contractor to be the lowest submitted tender.

LJ confirmed that the paper contained costs which could rise if the programme were revised further. SB confirmed that there had been a top-up of £500k already and the proposal was £600k up from that. This would have to be found from other aspects of the Trusts' capital budget. LJ asked whether consideration had been given to any revisions to the specification in order to reduce the cost. GB confirmed this had been done and that EMT felt that the scheme was good and should not be dropped.

DOD confirmed he had reviewed the risk assessment of delaying theatre replacement and confirmed that risk increases over time.

SB confirmed that if approved, there would be a direct impact on funds available in subsequent years for business cases. Revenue savings as a result of ADCU would be of the order of £190K. GB advised that the 48 week build time meant that the final year of theatre spend would now be in the fourth rather than third year of the capital programme.

BM asked DOD if he was content that the IT development may be impacted by this decision and he explained that he was fully aware of the impact and accepted that there would be a time delay rather than a need to cancel any IT project long-term.

AT felt that this development was essential for improved patient experience.

LJ asked whether the labs currently at UHB were to be relocated and GB advised that there had been a renewed arrangement with UHB but the plan remained for relocation over time.

LJ asked for assurance that the Trust had followed due process and GB gave the detail to provide that assurance. SL gave detail on the evaluative processes used and confirmed that costs of preferred two bidders were within 2% of each other.

SL confirmed that by signing the proposal, there would be no impediment to future choices on site development or phasing.

The Trust Board approved the next phase of the Estates Development Programme which would cover the development of an Admissions & Day Case Unit (ADCU), replacement of the decontamination unit, refurbishment/centralisation of the stores function and re-provision of the medical records storage/ office facilities. The Board agreed that the Trust should place an order with the preferred construction contractor in the sum of £3,201,823.74 + VAT.

Performance Management
Corporate Performance Report

07/12/1266

SB highlighted the report at the end of Quarter 1 which showed the Trust as amber overall.

AM advised that in June all 18 week targets were met and activity had over-performed. Despite this she remained concerned that the Trust may not meet 18 weeks (92nd percentile) going forward. This was due to a rise in backlog, reduced referrals in August and anticipated theatre utilisation levels. Nonetheless the target may be achieved as a result of robust validation but her aim was to embed systemic changes in order to give greater confidence that the target was being actively managed. There are also concerns as two consultants were known to have long-term sickness issues.

SB supported AM's view and confirmed that he had independently reviewed information in order to understand the position.

GB supported this and reminded the Board that the action plan has items scheduled for completion in September.

DOD advised that the Executive Team would also consider whether or not to invite in the Intensive Support Team to help on the position towards the end of the quarter. One of the key solutions and key challenges was to move consultants from a position of regarding patients as their own and movement towards patients being owned by a team. BM asked if this attitude was common elsewhere in which DOD felt that the ROH was behind others probably due to its isolated position.

LJ asked whether the Executive Team was confident that by Quarter 3 this would move to a positive declaration. DOD explained the likely Monitor response if the Trust declared compliance and then reverted back to non-compliance. If the Trust were to give Monitor concern about Quarter 3 he felt confident that everything that could be done was being done.

LW asked if there were issues on pain lists as patients were waiting over 18 weeks and AM could not give specific detail but recognised that some doctors were so specialist that an individual's leave could tip the balance.

SB highlighted the financial risk rating of 4 as activity targets for the month had been exceeded although there remained some catching up to do as volume remained down and complexity was reduced. Work to allocate targets to the Clinical Directors would help catch this back.

LJ reminded the Board that the declaration required the Board to look forward for the next 12 months and this was dependent on clawing back activity. SB advised that it was but that the team believed it would be possible to deliver activity, despite difficulties. CM asked for confirmation that the controls suggested in the bridge diagram would deliver the beneficial results on an on-going basis. SB confirmed that this was broadly sustainable.

SB advised that a greater degree of spinal work was on the national tariff which did not generate a surplus rather than on local tariff work. Spinal underperformance was noted on specialist commissioning. DOD confirmed that SB would present the Spinal Team with the issues arising from this performance. BM felt that there had been improvements in spinal but AT advised that progress was inconsistent.

LJ asked if clawback, coupled with loss of a day's work in August due to the Trust Business Day could be achieved in order to maintain the targets. DOD reminded the Board of the consistent performance of the Trust and confirmed that all steps possible were being taken to manage this.

TS asked for detail on hands and feet which also looked poor over the year. DOD commented that a new foot and ankle surgeon had been appointed. GB agreed that feet had been an issue following the loss of a locum and team sickness. AT also felt that hand lists could be improved. SB advised that the impact of spinal surgery was much greater.

Control of non-pay and reserves had been good but pay spend (due to agency use) remained high.

07/12/1267 PMO Report

The key task was 'getting it right' which involved many teams in setting up PMO schemes to this end and LJ commented that moving around the organisation the feel was different with a move away from discrete projects to an embedded way of doing business.

LJ asked if the 1200 cases referred to in one of the plans were in addition to the current activity plan and was advised that it was.

07/12/1268 Quarter One Workforce Report

Assurance Reports

AG highlighted that there remained a culture of entitlement and absence of sanction. The audit earlier in the year had identified too great a degree of management tolerance. The public health issues of, for example, incidence of long-term health conditions, would have an impact. The action plan supports prevention of ill-health among staff with staff taking responsibility for their own health and paying particular attention to musculo-skeletal and stress. This, coupled with heightened management awareness and simpler procedures was aimed to have an impact. The top 20 staff would be focused upon. DOD noted the beneficial impact on colleagues when management action was taken appropriately with sick staff.

AG advised that the idea of contact staff which had been used successfully elsewhere could be useful and this would be discussed at EMT.

BM felt that this was a re-visit of previous conversations and that the management of sanctions did have an effect on staff behaviour. LW said there were examples of this being done, but it had to be done in a timely fashion and she had used this technique several times.

SB commented that the ROH was bucking the national trend and so the contact centre and active management was welcomed. DOD highlighted that change almost always had an adverse effect on sickness.

GB agreed that these tactics were vital and recommended that policies should be tightened and AG advised that new policies had been agreed. LJ felt that risk appetite should be considered to see whether the Trust should press cases. LW noted that some FTs have stopped sick pay for the first two days.

AG highlighted the external workforce assurance processes now in place and there were 8 red flag items for the ROH on first cut. LW confirmed that more work was to be done on this and better management focus determined around these things.

Training, CPD and learning had been identified as an area of concern. A process will now be designed to support the development of individuals where there is identified business need. This will be assessed on a return on investment basis.

LJ asked whether this meant skills training would be supported but personal (behavioural differences) would not and AG confirmed that it would be driven by business need. LJ felt that soft skills training was essential within the organisation.

AG also highlighted the national proposals for pay through changes to Agenda for Change which removes the automatic pay progression at the top of the pay scales and offering room to move down the pay scale if performance is relatively poorer. This would also allow single paypoints and allow for 360 degree input. This was currently out for consultation with feedback scheduled in September. Unless there is national agreement on this, then regional employers will move to take more local solutions.

LJ asked if AG had schemes in mind that should be put on the table for discussion and she replied that there were. LJ suggested that the Trust consider its position in this regard rather than wait for external impetus. DOD felt that timing had to be right and LW agreed that getting the thinking in train was a good idea.

CM felt that the Leading to Success Programme had been a success and he thanked AG and David Richardson. Those participants to whom he had spoken really wanted to maintain momentum,

07/12/1269 Director of Nursing & Governance Patient Safety Report

LW presented the Patient Safety Report and updated the Board on the coroner's verdict which had resulted in no blame apportioned to the ROH, or the issue of a Rule 43 which dictates learning that should be disseminated in the NHS. The biggest criticism was with regard to Trust documentation. Publicity had been received in the press but had been factual and balanced. DOD advised that LW, AT and Andre Jackowski would meet to agree any further action required.

EMT had received a medications incidents report from the Chief Pharmacist which had been useful.

One reportable case of C Diff had occurred in June and one non-reportable, LW confirmed that these were not connected.

Pressure ulcer incidents continued to reduce but falls had risen in this period, although they were more minor and among younger people which may be attributable to

changes in case mix.

DOD asked if the ward identified as having problems was aware that this had been drawn to the Board's attention and was advised that it had and that the Ward Manager in place was tackling this.

Noted that the Patient Safety Report next month will include individual theatre performance.

07/12/1270 Quarter One Governance Declaration

The Board received a report providing assurance on achievement of key targets and potential non-achievement. It was noted that this declaration was in line with the requirements of the Compliance Framework issued by Monitor for 2012/13 which had some variations from previous reporting demands

The Board approved the following submissions to Monitor:

- 1. Finance - Confirmation that the Trust would continue to maintain a financial risk rating of 3 over the next 12 months.**
- 2. Governance – The Board could not confirm that plans were sufficient to ensure: on-going compliance with all existing targets (after the application of thresholds) as set out in the attached Appendix of the Compliance Framework; and a commitment to comply with all known targets going forward. (This was due to the potential failure to achieve the 92nd percentile 18 week target in Q2 as detailed in the attached exception report).**

07/12/1271 Integrated Governance Committee Reports – 29/06/12 and 20/07/12

TS advised that the Committee was endeavouring to secure true integration from reporting committees into its work. TS hoped that Research & Development would move from its silo way of working towards engagement with clinical audit. TS explained that surgical, histopathology, radiology and anaesthetic audits were all part of clinical audit.

There had been a report that anaesthetic audit was on track and radiology in progress, but histopathology was yet to come together.

IGC welcomed the appointment of a Chief Information Officer and this person should ensure they also cover activity in Research & Development and Research & Teaching.

SB asked whether the Chair of IGC was happy with progress on PROMS data and TS said he was not from the perspective of the Trust being unable to get signals from the external data as to causality. TS was happy that surgeons had reviewed the data, were being positive in considering better practice and had reviewed additional data available. A visit to Oswestry was planned to see if lessons could be learned. LJ was pleased that the new Clinical Director had taken this seriously. TS reiterated that without knowing what the underlying causal factors were it was impossible to focus. TS felt that every representation should be made to say that the level of access to PROMS data was inadequate to inform action.

DOD felt that there was benefit to playing softly on the national issue. AT has asked for the deprivation index comparison which may suggest a correlation.

TS indicated that even if the next data set showed improvement, the Trust should retain focus on these issues as there will be no clarity on why performance has improved. SB asked whether the actions of the Clinical Director would support a greater degree of sharing of consultant specific information among surgeons. AT felt that the Chief Information Officer was key to this. DOD confirmed that the Trust owns the data no matter how sourced and managed.

GB highlighted that the absence of a medical representative at the IM&T Group had been unfortunate but matters had been reported to the Board.

07/12/1272 Audit Committee – 17/07/12

EH drew attention to the Board Assurance Framework and discussion about which were the really serious risks. It was felt that some risks may be in the wrong place. This had been referred to EMT and after consideration this will come back to the Board in September. GB reported that a sub-group of EMT had been identified to look in detail at the risks.

An evaluation of externally supplied audit services is to be conducted.

The Annual Report of the Committee was noted.

Board Committees & ad-hoc Groups not covered elsewhere

07/12/1273 Remuneration Committee – private agenda items only

Items for Information

07/12/1274 Preparation for the Olympics
The Board noted the report presented

07/12/1275 Directory of Services

JS gave a presentation on the Directory of Services which was being produced by the Communications Officer. DOD expressed his enthusiasm for this project and commended the officer for producing something as professional and good as this which compared very favourably to others he had seen. DOD explained that this will be taken to the Clinical Directors meeting next week for them to follow through in order to plug the gaps.

BM suggested this be tested with GPs to see how they would use it.

TS asked about the degree of buy-in to the concept of team and was there recognition that patients prefer referrals to named consultants.

DOD felt that the patients' needs were more about having a slick, effective service.

07/12/1276 Items for CEO Question Time

- Approved new build - ADCU
- Directory of Services
- Equality objectives
- Board focus on sickness
- ASQ - priorities

New Risks

None identified

07/12/1277 Any Other Business

The Chairman thanked Graham Bragg for his services to the ROH and the NHS. The Board members unanimously endorsed his sentiment.

07/12/1278 Date and Time of Next Meeting

Wednesday 29 August 2012 at 8.30 am in the Board Room – Strategy Refresh workshop

The Board resolved that representatives of the press and other members of the public be excluded from the remainder of the meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest.