The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

Minutes of the Joint Governor & Trust Board Meeting held in public on Wednesday 26 September 2012 in the Boardroom

Present:

Trust Board

Mr Laurence James, Chairman
Mr Donal O'Donoghue, Chief Executive
Mrs Lindsey Webb, Director of Nursing & Governance
Mr Steve Bloomer, Director of Finance
Ms Amanda Markall, Director of Operations
Mr Andrew Thomas, Medical Director (part)
Mr Robert Millinship, Non-Executive Director
Professor Tauny Southwood, Non-Executive Director
Mr Chris Monk, Non-Executive Director
Dr Liz Hensel, Non-Executive Director
Mr Roger Otto, Non-Executive Director
Mrs Frances Kirkham, Non-Executive Director

Governors

Mrs Yvonne Scott
Mrs Stella Noon
Mr Robert Talboys
Dr Christine Parkinson
Mr Andrew Pearson (part)
Miss Karen Hughes
Mr Alan Last
Mr Neil Hart
Mr Richard Burden
Mr Joseph Blackledge
Mrs Kulwant Bahra
Mr Peter Arnold (part)
Mrs Marion Betteridge
Ms Dia Martin

In attendance:

Ms Joy Street, Company Secretary
Mrs Anne Gynane, Director of Workforce and Organisation development

ACTION

09/12/1279 Apologies and welcomes

Apologies were received from Ms Marion Thompson, Mrs Sue Arnott, Ms Jan Walshaw and Mr Kenneth Williams.

09/12/1280 Declarations of Interest

No other Declarations of Interest than those registered previously.

09/12/1281 Minutes of the Trust Board meeting held on 25 July 2012

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

- Page 9, agenda item 07/12/1266, Corporate Performance Report, the following sentence should include 'This was due to an anticipated rise in backlog'…
- Page 11, agenda item 07/12/1268, Quarter One Workforce Report, second paragraph should read as follows, 'AG advised that the idea of a contact centre'… and the seventh paragraph should include, ''Training, CPD and learning over and above mandatory training had been identified'…
- Page 12, agenda item 07/12/1269, Patient Safety Report, first paragraph …'but had been factual and balanced' to be deleted.

09/12/1282 Action Points

05/12/12 19 AG advised that the item would be discharged both in today's items and in the next workforce report.
06/12/1242 DOD updated on the inpatient model of care and investment in a half-time physician's post had been agreed.
07/12/12 61 Steve deferred the item to November pending completion of the rapid improvement event.

The Board noted the information.

09/12/1283 Chairman's Update

- Strategy workshop had been held
- Met Jenny Ord Chair of the Cluster and LJ had been asked to chair meetings of the West Midlands Regional Chair's meeting
- LJ had undertaken 3 days interviewing for Non-Executive Directors at Oswestry and Worcester where it had been difficult to secure appropriate candidates.

- The Chair and CEO had attended an NHS Midlands and East Corporate Event in Peterborough which focused on performance targets and quality. They met the local commissioning board lead.
- Seeking to recruit a new Medical Director. 10 applicants and a long list of 6. It is hoped that a good candidate can be secured due to high calibre of interest.
- Two Trust Business Days have been held. DOD updated that the days were going well and there had been positive challenge and increasing engagement. RO fed back from one of his visits with a staff suggestion that opportunity for more informal discussions would help before Executive Question Time and DOD confirmed that this was planned. YS asked if written questions were allowed for those too reticent to speak and it was advised this was possible. BM asked if the Members' Council was now up to strength and was advised that it was.
- NH and LJ had met with CQC colleagues to discuss how to develop relationships with governors. NH added that it was for the **Members Council to invite the CQC to the next Joint Governor and Board meeting.** **JS**
- The ROH had been shortlisted for two HSJ awards for finance and clinical support services but did not win either, though being shortlisted was a fine achievement in its own right. SN congratulated the teams.
- The ROH had also been selected for finals of the Nursing Times Awards in October.

Strategy and Organisation Development

09/12/1284 **Patient Stories**

LW circulated a patient story and explained the purpose as providing context for Board members rather than to review the item in its own right. The story circulated highlighted issues of communication which were referenced in the later agenda item on staff engagement.

BM recalled an issue of eighteen months ago about transfer of patients to other providers and also commented that this was a very well written piece from an articulate patient and that this may be a tip of the iceberg matter. CM also noted that there were clinical issues and LW confirmed that this has been through due process.

FK asked what lessons had been learnt and LW commented that this was detailed in the quarterly quality reports at IGC.

LJ added that the directorates were now made much more aware of their complaints and AP suggested that these be used within Clinical Directorates.

RB recognised that while not wishing to go into the detail, had anything happened and LW identified that she did not have the detail but could make it available. **DOD suggested that next time a story showing how resolution was tracked through could be helpful.** He also explained that making learning so embedded that in future it became planned and preventative was something all Trusts were tackling and he had been working with other orthopaedic colleagues on this. **LW**

EH asked if the Trust used a key worker system and LW advised it was used in Oncology and was asked to consider its use elsewhere. TS advised that the Trust was actively working on patient information and consent matters – both germane to this case.

SN felt the case was concerning as it appeared that an older patient had been offered shoulder surgery as a day case and was then in over the weekend when limited physiotherapy is available. AT felt it was hard to comment based on the information given.

TS felt that the purpose of the document was being lost in a detailed discussion and that the meeting should focus on it as context.

NH asked whether the satisfaction of the complainant was known and it was confirmed that it was.

09/12/1285 **Amendments to the Constitution**

Monitor has asked that all Trusts amend their constitutions to reflect the name change from 'Members' Council' to 'Council of Governors' and to make reference to the 2012 Health and Social Care Act that requires these changes. They have specifically asked that no further changes be made or agreement sought for other changes at this stage.

These amendments have been made and, subject to Board and then AGM (and Governor) approval, will be sent in two forms to Monitor – one track changed version and one clean copy. These will then be uploaded onto their website.

Frances Kirkham has kindly checked through the changes on behalf of the Board and has confirmed that these meet the compliance requirements set by Monitor.

BM provided a synopsis of earlier proposals to make changes to the constitution to meet the needs of the Health Act and explained that this was now on the back burner pending Monitor's go-ahead to make substantive changes.

The Board approved amendments to the Constitution to be put in place from the 1st October 2012 and agreed to propose this at the AGM, and approved submission of the revised documents to Monitor.

09/12/1286 **Strategy Update**

LW updated that there would be further sessions for the EMT and with Clinical Directors to take account of the external health environment and in light of Monitor's current review of some organisations with turnover below £200m. It is proposed that the final approvals will be in January and the Members Council will have another chance to be involved.

09/12/1287 **Staff Engagement Strategy**

In May 2012 Trust Board requested the executive consider development of a more strategic approach to staff engagement. The proposed strategy is the output of discussion with Executive Directors and a summary of actions had been produced that will be taken to deliver the strategy during the first year. It is proposed to engage with staff about this strategy and the actions in order to build commitment and ensure the planned actions are the priorities seen by staff.

AG introduced the report and explained that the strategic aims suggested were believed appropriate to support change. There would be a forum within each directorate to allow dialogue to take place and it was agreed that staff recommendation of ROH as a place to work would be a key measure of the strategy's success.

CM focused on the section on success and asked where these ideas had come from and AG responded that the information came from surveys, complaints and management understanding of issues. These would be tested with staff. CM said that the performance reviews were a valuable tool in this.

EH felt that the strategy lacked a definition of engagement and compared this with the John Lewis approach where definitions were made clear and staff were observed to see if they were achieving this. AG felt that the strategy took a helicopter view with high level

success measures. EH came back to say that this was therefore top down rather than bottom up and DOD felt that this document was about engaging staff in the mission of the organisation. He asked for comment as to whether the actions seemed appropriate. CM felt that this was about individuals. DOD agreed and pointed to areas of the strategy which reflected this.

KH asked if we knew why staff wouldn't recommend the hospital but was advised that the staff survey was anonymous and did not give the detail. KH referred back to the patient story and asked if 'communication' should be a higher priority in the action plan. AP said that the Trust wished to engender a philosophy of treating patients the way they would themselves like to be treated.

NH felt that the strategy was about how to tackle disengagement rather than engagement and that might be prompting the questions.

AL felt it was a good report and hit the buttons key to improving staff engagement.

FK asked about measurement and highlighted a sickness target that seemed lower than she would have expected. LJ expected to see numbers within the measures.

DOD noted that the Trust had been going through a period of intense change and this had resulted in some of the trends now seen. LJ felt that higher targets work in stretching staff (as long as they were not used to ascribe blame) but DOD felt that this could have a demoralising effect.

DOD advised that this would be discussed by EMT and targets agreed. **DOD**

LJ asked what assurance could be given to the Board that resources were in place to deliver these targets. AG said that the resources were not in place but that EMT had acknowledged this might need investment. TS said that intermediate milestones should be set and the board should be advised if any failures to succeed were likely and be given reasons.

AG agreed to define milestones and update the Board on progress. **AG**

EH would like the purpose to be made more explicit in terms of making the Trust better for patients and DOD felt that should be explicit in the overall strategy and linked to this one rather than be in here as such.
LJ asked if there were any softer matters for the Board itself – such as ownership and access or even happiness (noted as an external and extreme example). SB felt that anything used should be measurable.

The Board approved the Staff Engagement Strategy.

09/12/1288 **Investment Committee**
No meeting had been held

Performance Management

09/12/1289 **Corporate Performance Report**
SB introduced the report and drew attention to the amber rating driven by workforce and efficiency measures but offset by other green and amber subsets.

AM gave a presentation on activity in August. (AP left the meeting).

RO commented that the position was clearly of great concern and felt it absolutely right to begin giving serious consideration of the issues.

BM felt that it was absolutely right to look at this systemically rather than a series of quick fix and he welcomed this approach. He asked about how teams could fill vacant slots and AM advised that a flexible team approach, maybe with annualised job plans and this was a big piece of work.

RB asked how the desire for empowerment can be reconciled against the Operations Director signing off. DOD advised that some things were just not in place yet and the controls need to be put in first and then devolved once fully embedded.

LJ commented on how one CD had reflected to him, astonishment at what he was seeing from his colleagues' behaviour. DOD felt that it was hoped that collaborative working was possible but if this did not materialise there would have to be a full-scale negotiation of job plans.

SB felt that devolution of targets to those who can actually get things done was vital and that their awareness of matters was crucial.

CM felt that referrals were vital but that efficiency had to be in place in order to accommodate these. AM expressed confidence that this could be done and that the Clinical Directors were much more in tune with the need to make these things happen.

TS asked if there was awareness of the critical mass needed in a team to deliver this degree of flexible cover and working and AM responded to say that this was at the very early stage and needed working through. He also felt that annual planning of annual leave was a vital component. AM had also been talking to the Clinical Directors about legacy thinking so that there should be cross-cover and plans in place to ensure continuity of clinical service.

YS felt that patient expectations would need managing and that patients have confidence in their own surgeon. DOD felt that patients want a good operation at a time suited to them and that only a minority would only be satisfied with a named consultant. GPs and commissioners had agreed to work with the ROH on this.

NH asked whether Directorates would have delegated decision-making rights. DOD explained that this would come as part of their earned autonomy after demonstration of capability.

AM gave assurance that the backlog would reduce and activity would improve**. LJ asked that AM bring an anticipated activity outturn figure at the next Board meeting**. **AM**

AG gave a short presentation on Trust spend on agency staffing. The Trust is moving to a shared centre approach with four other Trusts in order to secure a shared medical locum service. In addition medical fellows will be recruited in the short term to reduce agency expenditure whilst a longer term medical workforce model is produced. Theatres have 13 new staff starting in October and November and have more vacancies to fill and this will reduce agency spend. Work is still to be done in clinical support to identify ways of reducing agency expenditure.

Trust sickness continues to be high and an outlier compared to other West Midlands Acute Trusts. Short term sickness is now reducing but long term absence is growing.

AG updated on the range of steps taken to support pro-active sickness management. Vacancies within the Trust had risen as a result of planned changes in workforce such as the ADCU and the re-opening the Private Ward which had been closed for a time.

AL asked if sickness numbers had included maternity leave which had been included (he suggested it should as it can have a significant impact). AG advised that sickness absence excluded maternity leave and wherever possible those on maternity were filled by fixed term or temporary appointments.

SB drew attention to the bridge diagram in the financial information and explained that whilst the trust's surplus was on target lower activity levels are being funded by a reduction in the spend on non-pay and reserves. He reminded the Board that reserves are used to fund unforeseen expenditure and developments and a continuation of the trend would reduce the trusts ability to invest in developments and innovation which could reduce activity further thus being a downward spiral. The Board should therefore be focused on the recurrent delivery of activity and financial position.

09/12/1290 **PMO Report**

SB presented the PMO Report and highlighted that the Trust is on-track and slightly ahead of CIPs this year, but the challenge is for next year and requires tangible changes to the way the Trust works. In order to secure the future, staff will have to ensure they can make essential changes for next year.

09/12/1291 **Assurance Reports**

Director of Nursing & Governance Patient Safety Report

LW presented the Patient Safety Report and highlighted two serious incidents, one which related to a pressure sore and the other to a fracture.

There had been an increase in falls and the Short Stay Ward was seeing a more complex group of patients with, for example, confusion or dementia and training is being put in place.

Trends in complaints are being reviewed in detail as the number had risen.

The Board noted the report.

09/12/1292 **Annual Report Safeguarding Adults & Children**

LW presented the Annual Report's for Safeguarding Adults and Children. Both reports are to inform the Board on the progress made by the Trust in Safeguarding Vulnerable Adults and Children's systems and processes and to identify the key issues that form part of the on-going work for the safeguarding team.

The reports evaluate the outcome of previous objectives, and states objectives for 2012/2013.

KH commented that the training numbers for adults was of concern and LW advised that the Safeguarding Committee had discussed this in detail.

The Board noted the reports.

09/12/1293 **Inpatient Survey**

JS presented the report on the Inpatient Survey and provided an overview of the results of the 2011 national inpatient survey and an associated action plan.

Results are analysed by CQC and Picker and overall demonstrate that whilst the Trust continues to perform strongly when compared to other organisations, in the top 20% of best performing Trusts in 8 out of 9 areas, compared with 6 out of 9 areas last year. (The Trust is not scored in the Emergency/A&E area)

CQC results

The high level scores published by CQC demonstrate significant improvement in comparison to last year with no questions or areas in the bottom 20% of worst performing Trusts.

The Trust scored significantly better on 29 of the 75 questions this year (39% of questions) and remained about the same on the remainder. There are no questions where the Trust had scored significantly worse.

Patient experience CQUIN

The Trust met its agreed target for the Patient Experience CQUIN for 2011.

Action Plan for 2011 Survey Results
An action plan had been developed and had been circulated to relevant heads of departments for detailed targets. Updates will continue to be monitored by the Quality Committee via the Public and Patient Services Manager. Work is continuing to improve the overall performance for waiting list and planned admissions.

The Board noted the results of the 2011 national inpatient survey and supported the development, agreement and monitoring of an action plan to address the findings by the Quality Committee and EMT.

09/12/1294 Integrated Governance Committee Report – 20 September 2012

TS provided feedback from the Integrated Governance Committee meeting held on the 20 September 2012.

Clinical audit and outcomes had not been discussed due to the unavailability of the Clinical Director for Outcomes & Effectiveness.

Patient consent had been a key area of discussion and the Internal Audit Report showed improvements in the complaints process.

BM asked about areas of concern such as theatres and anaesthetics and LW advised that an external review would be reporting back to the Trust with a thorough independent assessment of procedures within this area. This had been instigated as a result of a high number and wide range of incidents in the theatre/anaesthetics area. This work would probably be reported to the Board verbally in November and again in early 2013.

CP noted that there were red items in the patient safety report not covered in the feedback from IGC and TS responded to say this was a summary report and LW gave a much more detailed response on levels of reporting and challenge on medication matters. KH commented that much more work was being done about learning from incidents.

RO advised that next month the Audit Committee was considering the effectiveness of Internal Audit and asked TS if he was satisfied with the quality of their work and TS felt the latest report had been good.

Update noted

09/12/1295 **Audit Committee Report**
No meeting held

Board Committees & ad-hoc Groups not covered elsewhere

09/12/1296 **Remuneration Committee – private agenda items only**

09/12/1297 **Items for Information**
None

09/12/1298 **Items for Executive Question Time**

- Finance forecast
- Engagement strategy
- Medical Engagement Survey results

09/12/1299 **Any Other Business**
NH asked about Members Council consideration of ADCU and whether, in light of the financial position, it was sensible to continue.

SB confirmed that the business case proved there would be savings as a result and the task now was to ensure control of costs.
A report on ADCU will be provided at the next Board meeting and will be shared with the Members Council. **SB**

09/12/1300 **Date and Time of Next Meeting**
Wednesday 31 October 2012 at 8.30 am in the Board Room

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.