

**Meeting of the Oxford Health NHS Foundation Trust**

**Board of Directors**

Minutes of a meeting held on

Wednesday 27 April 2016 at 08:45

at Unipart Conference Centre, Garsington Road, Cowley,
Oxford OX4 2PG

**Present:**

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| Martin Howell | Chair of the Trust |
| John Allison | Non-Executive Director |
| Ros Alstead | Director of Nursing and Clinical Standards  |
| Jonathan Asbridge | Non-Executive Director  |
| Stuart Bell | Chief Executive |
| Mike Bellamy | Non-Executive Director |
| Alyson Coates | Non-Executive Director |
| Sue Dopson | Non-Executive Director |
| Anne Grocock | Non-Executive Director |
| Mark Hancock | Medical Director  |
| Dominic Hardisty | Chief Operating Officer |
| Mike McEnaney | Director of Finance |
| Kerry Rogers | Director of Corporate Affairs and Company Secretary |
| Lyn Williams | Non-Executive Director  |
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| **In attendance:** |
| Mandy Mckendry | Patient Involvement and Experience Project Lead – *part meeting* |
| Lynda Lawrence | Clinical & Quality Standards Manager - *part meeting* |
| Hannah Smith | Assistant Trust Secretary (Minutes) |
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| **BOD****59/16**ab | **Welcome and Apologies for Absence**The Chair welcomed staff and members of the public present.No apologies for absence were received.  |  |

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| **BOD****60/16**abc | **Declarations of interest**The Chair presented Paper BOD 42/2016, the Register of Directors Interests. Sue Dopson reported that she had interests to remove from the register in relation to: NIHR SDO Research Project 08/18008/242; consultancy for Research Advice, Imperial College London; and consultancy for Research Advice, Nottinghamshire Healthcare NHS Trust. No new declarations of interest were reported and none were declared pertinent to matters on the agenda. **Subject to the change to remove the interests listed above, the Board received the report.**  |  |
| **BOD 61/16**abcde | **Minutes of the Meeting held on 23 March 2016**The Minutes of the meeting were approved as a true and accurate record.***Matters Arising*****Item 43/16(e) Transition between services and early intervention, especially in relation to eating disorders**Sue Dopson confirmed that she would liaise with the Executive Assistant to the Chief Executive and the Chair to progress contact with the Oxford University junior deans. **Item 43/16(g) Whiteleaf snagging issues update**The Chief Operating Officer reported that works were planned to resolve ventilation issues and these were anticipated to be progressed by summer 2016. The Chief Operating Officer to continue to keep the Board regularly updated until all snagging issues had been resolved. **Item 43/16(h) Alliance working with Oxford University Hospitals NHS FT and the Older People’s Outcome Based Contract**The Chief Executive noted that the position was not yet sufficiently settled for a formal paper to be brought back to the Board. The Board confirmed that the remaining actions from the 23 March 2016 Summary of Actions had been completed, actioned or were on the agenda for the meeting: 43/16(a); 43/16(c); 43/16(h); 43/16(j); 46/16(c); 47/16(c); 47/16(g); and 50/16(c).  | **DH** |
| **BOD 62/16**abcde | **Chief Executive’s Report**The Chief Executive presented the report BOD 44/2016. He highlighted:* the submission to NHS Improvement (Monitor) of the FY17 annual operating plan and financial plan. The Trust had accepted the Control Total of a deficit of £3.3 million but planned to improve on this position and reach a deficit of £2.4 million;
* the challenge to implement the Five Year Forward View for Mental Health if the Trust did not receive the funding anticipated in the planning guidance to reflect parity of esteem between physical and mental health services. He noted that a stocktake of the position would be taken after the contracting round but that he had also raised the issue locally and nationally, including with NHS Improvement, NHS Providers, the Mental Health Network of the NHS Confederation, the Royal College of Psychiatrists, the Secretary of State for Health;
* the planned re-inspection by the Care Quality Commission (**CQC**) of three core mental health services in the week of 13 June 2016;
* the initial submission of the Sustainability and Transformation Plan (**STP**) for Buckinghamshire, Oxfordshire and Berkshire had been made in April 2016; and
* progress and next steps for the Biomedical Research Centre (**BRC**) application. Three of the four themes submitted had been accepted for progression to the next stage which would involve a more detailed submission and interviews in July 2016.

The Chair asked for an update on the contracting position. The Director of Finance replied that to achieve the £2.5 million additional revenue target, a further £0.8 million was anticipated from Buckinghamshire commissioners, £0.8 million from Oxfordshire commissioners, £0.4 million from Wessex and specialist commissioners and the remainder from transformation funding for Children and Adolescent Mental Health Services (**CAMHS**). He reported that there had been a productive meeting with Buckinghamshire commissioners and that the Trust would be providing them with further confirmation and validation of the Trust’s position. Lyn Williams asked about the contingency/reserves position. The Director of Finance replied that contingency of over 1 per cent of revenue was available but that work needed to take place to determine the allocation of specific amounts to particular initiatives and to resolve issues around non-recurrent Cost Improvement Programme (**CIP**) plans.Anne Grocock asked when the new Learning Disabilities Programme Director would start in post. The Chief Executive replied that Liz Williams would start in post from 01 July 2016. He noted that although the post would report to the Chief Operating Officer it would be working on behalf of the whole Oxfordshire Learning Disabilities system and considering matters such as the model of care, access to inpatient accommodation, access to senior clinical specialist cover and the viability of the current services. He confirmed that no formal or binding decision had been made about the Trust taking on Oxfordshire Learning Disability Services and the Trust would not take on these services if it could not be done properly within the resources available. If services were to be transferred then the timetable for this could be a year or more away. Jonathan Asbridge asked if NHS Improvement could take regulatory action to enforce or accelerate the transfer of these services. The Chief Executive replied that NHS Improvement had not yet indicated this. The Board noted the proposed new consultant appointment and ratified the appointment of Dr Francesca Battisti. **The Board noted the report.**   |  |
| **BOD 63/16**abcdefg | **Chief Operating Officer’s Report**The Chief Operating Officer presented the report BOD 45/2016 which provided an update on areas of excellence and issues of potential concern against: quality (safe, effective and caring); finance/CIPs; workforce; and performance (against key targets), for each of the Adult Directorate, Older People’s (**OP**) Directorate and Children and Young People’s (**C&YP**) Directorate. He tabled to the meeting some booklets which had been created by young people using Trust services for the purpose of raising awareness in schools about mental health (“Positive Mental Health, Years 4,5 and 6 – activities developed by young people in the CAMHS Participation Team”). He explained that the booklets were innovative and powerful advocacy tools for raising awareness of mental health and that he would be considering putting them forward for an appropriate award. The Board agreed and praised the booklets and recommended that the Chief Operating Officer consider national awards such as the BBC’s “All in the Mind Awards”, if eligible on timescales. The Chief Operating Officer highlighted the following issues from the report:* for the Adult Directorate, although waiting targets had been met, waiting times were significant and bids for increased resources to reduce waiting times had been made to Oxfordshire and Buckinghamshire commissioners. The Director of Nursing noted that the detail of waiting times and plans to address them should also be reported into the Quality Committee;
* for the OP Directorate, workforce pressures had resulted in a temporary closure at Witney EMU (Emergency Multi-Disciplinary Unity) and Trust staff working double shifts to bridge the gap at the weekend when primary care cover had not been available. He noted that if these workforce and cover issues were not resolved then it would impact upon the sustainability of these services; and
* for the C&YP Directorate, waiting times for CAMHS and the recruitment of CAMHS consultants as there were 7 vacancies across 5 counties. In response to a question from Anne Grocock, he noted that there were three different issues which were impacting upon the recruitment of CAMHS consultants: a national shortage of CAMHS consultants; local factors around the potential available workforce; and skills mix. The Medical Director added that there were also geographic issues with competition to recruit around Wiltshire and Bristol.

Anne Grocock asked what plans were in place to address the issues around recruitment of CAMHS consultants and reduce spend on medical locum cover. The Medical Director noted that in the future trainees coming up through the system may be in a position to apply for posts. The Board discussed retention amongst trainees and how to encourage trainees to apply for posts with the Trust, including through offering opportunities in research and the opportunities that the BRC may offer. The Board discussed workload for CAMHS, how this compared to other services in other areas/organisations and whether expectations in other unreformed services were more likely to attract candidates. The Chief Operating Officer noted that a transformational plan was being developed as part of CIP planning and that this could be considered in more detail when the C&YP Directorate presented its “Directorate Focus” slot to a future Board Seminar, currently planned for the Board Seminar in October 2016. In relation to CIP plans, the Chief Operating Officer noted that the clinical directorates had started the financial year with reasonably robust CIP plans which they had committed to delivering and they were taking a longer term three-year view of future CIP plans so that the direction of travel was mapped out even if the detail of the future plans was to be confirmed. The Director of Nursing and Clinical Standards referred to the section in the report on the OP Directorate and: * expressed her concern with the comment that in relation to instances of “failure to rescue” in community hospitals that targeted training had had limited impact to date. She noted that care needed to be taken in how incidents were categorised especially if this referred to a recent incident where death had not been related to sudden deterioration and she emphasised the importance of appropriate oversight from acute care. She added that training was being extended and the CQUIN (Commissioning for Quality and Innovation payment) now included simulation training to support staff to recognise deterioration; and
* referred to the statement that bed pressures in Older Adult Mental Health services were driven in part by single sex accommodation needs. She asked whether this meant that there had been a high number of single sex breaches and noted that this should be clear in the report. The Chief Operating Officer replied that he did not believe that there had been a high number of breaches and that the statement was more linked to Delayed Transfers of Care.

The Board requested that the report be developed in the future to include another column or more detail to set out what actions were being taken to address the issues of potential concern listed. **The Board noted the report.**  | **DH** |
| **BOD****64/16**abcdefghijklm | **Quality & Safety Report:**  **Effectiveness**The Medical Director presented the report BOD 46/2016 which provided an update on: CQC action plans; clinical audit; NICE (National Institute for Health and Care Excellence) implementation; Mental Health Act compliance; infection control; AIMS (Accreditation for Inpatient Mental Health Services) for Older Adult Mental Health inpatient wards; Learning and Development and mandatory training; medication management; Research & Development; and Public Health. He noted that he and the Trust Professional Lead for Occupational Therapy had recently taken over responsibility for the Effectiveness quality sub-committee and that if the reporting was in too much detail for the Board then this could be changed in the future. The Medical Director highlighted that although the Quality Committee, at its meeting in February 2016, had supported proposals to reduce the Clinical Audit Plan, in practice it had not been possible to progress to reduce the workload given the number of nationally mandated clinical audits required for this year and the rollover of clinical audits from the previous year’s plan. The Trust Chair referred to page 22 of the report and expressed concern that the Trust was not legally compliant with all controlled drug legislative requirements; he asked why this was and what was being done. The Medical Director explained that mandatory target compliance was 100% therefore if any single aberrant result was identified then there was non-compliance against the entire relevant standard. The Chief Executive noted that although it may be challenging to always reach 100%, this message still needed to be emphasised to staff and any shortfalls followed up and acted upon. The Medical Director agreed and noted that new training had been introduced to support this, a new e-learning package was available and specific training was being provided for staff nurses. Alyson Coates asked whether audits needed to be expanded to include review of controlled drugs management, storage and usage. The Medical Director replied that these were already included and covered. The Trust Chair noted that this also demonstrated the challenges with reducing the clinical audit workload whilst there were nationally mandated areas to be measured and locally identified areas of concern. The Board requested that the Medical Director report back to provide assurance that effective steps were being taken to ensure that the Trust would be compliant across all controlled drug legislative requirements in all clinical directorates. John Allison commented that the report should include less detail but that areas of concern, such as the Trust not being legally compliant with all controlled drug legislative requirements, should be identified and highlighted in the Executive Summary. The current Executive Summary provided a route map of areas covered in the report not an analysis of areas of strength or weakness. The concern around legal compliance had not been identified in the Executive Summary but had been included in the body of the report. The Trust Chair agreed and added that there should also have been reference to the actions being taken to address this area of concern. The Director of Nursing and Clinical Standards cautioned that although the report contained a lot of detail, especially in the body of the report, this was helpful to inform the Board and provide an overview. She emphasised the potential danger of over-summarising and the risk of the Board drawing assurance from a simplified summary when the situation could be more complex. John Allison referred to the tension between the need to conduct clinical audits and the impact upon workload for the central Clinical Audit Team and teams and staff involved in local clinical audits. He asked whether there was any merit in challenging the requirements for some national clinical audits or whether the Trust should restrict itself to only carrying out nationally mandated clinical audits. The Chief Executive replied that it would not be effective for the Trust to raise this challenge alone and that concerted action would be required. The Trust Chair noted that there was also a risk that if there were smaller or fewer audit reports then risks and concerns may not be escalated effectively up through the organisation and the Board may not be sufficiently aware of risks before they became issues. He emphasised the importance of openness in the Trust and the Board and other committees and groups receiving sufficient information to be able to identify and deal with concerns. The Director of Nursing and Clinical Standards added that there was also a danger in focusing on reducing workload at the expense of limiting awareness and understanding of what was going on in the organisation. Anne Grocock noted that it was also important to be able to monitor completion of actions and recommendations to ensure that these were carried out. The Trust Chair asked the Director of Corporate Affairs and Company Secretary to consider more widely than just for clinical audit how: the Board and the Executive could receive reporting in sufficient, but not excessive, detail to be assured about activity and the management of risks and issues; and how report authors could be supported to understand the importance of signalling up when there were areas of concern and implementing a culture of openness in the Trust. Lyn Williams expressed concern that at a time when the Trust was not legally compliant with all controlled drug legislative requirements, the Trust was also considering reducing its Clinical Audit Plan and the clinical audit workload without further consideration of the risks which may be involved. He emphasised the importance of an annual assessment of risks which may be suitable for further consideration via clinical audit, sourced from evidence from incidents and complaints, to inform the development of local action plans and the Clinical Audit Plan. The Chief Executive agreed that this assessment was important but noted that a distinction should be made between the type of action to take in response and whether this needed to be improvement action or audit action. He cautioned against ever more minute monitoring via audits of how things may be going wrong, at the expense of efforts to put them right. The Medical Director added that currently the Clinical Audit Plan and clinical audit workload was not being reduced as this had not proven to be feasible in the face of the national audits and other re-audits required. Lyn Williams noted that since the launch of the quality improvement initiative, there could be some consideration of the role of clinical audit within quality improvement. The Board discussed uses of audits. The Finance Director noted that audits should not be used as checking tools to inform the organisation of issues which were not already known; audits should confirm the structures in place and actions already happening. The Director of Nursing and Clinical Standards added that an audit could be a useful tool for taking an in-depth look into a particular area. The Trust Chair emphasised the importance of the Board being informed: in advance about risks which could become issues or about issues which were developing so that decisions could be taken in a timely manner; and about actions being taken to mitigate risks or to resolve issues. Sue Dopson added that even once issues had been resolved, it could still be important for the Board to be informed about this so that it could consider what had been learned and how learning could be disseminated appropriately through the organisation. Lyn Williams referred to the update in the report on Mental Health Act compliance which set out that although compliance had improved, further improvement was still required in relation to the presentation of rights under Section 132. He anticipated that recent change in the team may lead to loss of experience and organisational memory which could result in a risk that Mental Health Act compliance may not be sustained or improved upon. He emphasised the importance of supervision and support for the team during this period of transition and as a way of mitigating the risk. The Board agreed and noted that the Medical Director was responsible for Mental Health Act compliance and ultimately for this team. Anne Grocock referred to page 17 of the report and noted that it was positive that the first clinical audit project had been undertaken in which service users and carers had been involved. She suggested that it would be helpful in the future to report upon how service users and carers had responded to this experience, what they had done, whether they had found it helpful and whether the outcomes had been satisfactory. Mike Bellamy referred to page 9 of the report and actions to be progressed in preparation for the CQC re-inspection. He suggested that it would be useful to know whether failure to progress any of these actions was likely and would prevent the Trust from achieving an improved rating. The Trust Chair noted that this would be considered separately in the Quality Committee meeting on 12 May 2016 when updates against the CQC actions being progressed by the quality sub-committees could be brought together. Following consideration by the Quality Committee, a further coordinated update report could then be brought back to the next Board meeting prior to the planned re-inspection in the week of 13 June 2016. **The Board noted the report.**  | **MHA****KR****RA** |
| **BOD****65/16**abcd | **Draft Quality Account 2016/17 and Draft Quality Report 2015/16** The Director of Nursing and Clinical Standards presented Paper BOD 47/2016 the Draft Quality Account 2016/17 and Draft Quality Report 2015/16. The report also summarised the review process which the drafts had been subject to from stakeholders, the Quality Committee and the Audit Committee. The drafts had already been discussed with the Oxfordshire Health Overview and Scrutiny Committee. Meetings were scheduled to discuss the drafts with commissioners. A meeting would also take place later today to go over the draft in detail with Governors. The Director of Nursing and Clinical Standards highlighted that report set out the significant amount of work which had been done across the organisation in relation to quality. She noted that the four quality priorities for 2016/17 remained focused on the same overall areas as previously to:1. enable our workforce to deliver services which are caring, safe and excellent; 2. improve patients’, families’ and carers’ experiences through involving people in their own care and how services develop; 3. improve quality through service pathway remodelling and innovation; and 4. increase harm-free care. Mike Bellamy praised the Draft Quality Account and Draft Quality Report and suggested that: the priorities could be re-ordered so that the two patient-focused priorities were listed first; and the detail of the objectives under the priority to improve patients’, families’ and carers’ experiences be reconsidered as currently this may be too narrow and focused on feedback mechanisms. **The Board noted the report.**  | **RA** |
| **BOD****66/16**abcdef | **Inpatient Safer Staffing (Nursing)**The Director of Nursing and Clinical Standards presented the report BOD 48/2015 and explained that 6 of 32 wards had experienced difficulties in achieving expected staffing levels on every shift (they had only achieved 75% or less of shifts fully staffed to expected levels). However, all wards had maintained minimum staffing levels to remain safe to deliver patient care. She noted that a new recruitment period had commenced as student nurses were about to graduate from university. Mike Bellamy referred to page 5 of the report which set out the staffing position over a 18 month period and requested that more in-depth reporting be provided on staffing issues on Wenric, Wintle and Opal wards. He recognised that detail had already provided in relation to Kingfisher ward. The Director of Nursing and Clinical Standards to consider. The Director of Nursing and Clinical Standards highlighted the summary in table 2 on page 6 of the report which set out out-of-area placements from Adult and Older Adult mental health wards due to demand and capacity issues during April 2015-March 2016 (and not therefore due to out-of-area specialist placements which were clinically necessary and appropriate). This gave a view over a 12 month period of: the number of patients it had not been possible to accommodate on Trust wards; and the distance in miles these patients had had to be placed away from Oxfordshire or Buckinghamshire. Mike Bellamy requested that future reporting also set out the financial impact of out-of-area placements and whether the Trust also accepted these placements coming in from other organisations. The Director of Nursing and Clinical Standards noted that the report was still generated through the manual collation of data but that work was taking place so that the creation of this report would become less burdensome. The new rostering system was not yet capable of generating this reporting directly and with sufficient qualitative information to enable the Board to be appropriately informed in order to make judgements as to risks in this area. The Director of Finance noted that 70-80% of other NHS trusts used the same software so support for reporting requirements would be available. The Director of Nursing and Clinical Standards replied that the detail in which boards in different organisations received reporting may vary. John Allison asked how the Trust could reconcile the need to use agency staff (in order to ensure wards maintained minimum staffing levels to remain safe to deliver patient care) with the Monitor cap on agency spend with targets anticipated to reduce year on year. The Chief Executive noted that this had been discussed at a Board Seminar; although the agency cap did not just relate to nursing staffing levels, the Trust had reverted to Monitor in order to challenge the target which had been set and to provide more information. In response, Monitor had revised their profile for the Trust. **The Board noted the report.**  | **RA****RA** |
| **BOD****67/16**abcd | **Patient Story from the Adult Directorate***Lynda Lawrence and a service user (R) who had accessed services in the Adult Directorate joined the meeting.* R presented her story and experiences to the Board of over 23 years of engagement with mental health services since she first presented in her mid-forties. She had experienced inpatient admissions and community care including: detention, medication, ECT (electroconvulsive therapy), individual therapy, complex needs, various crisis services and support from Community Mental Health Teams. She had also experienced prone restraint and noted that this had put her off inpatient admissions until relatively recently. She praised the commitment of the many staff members she had engaged with but noted that over the years, the services which the Trust had offered increasingly felt like a crisis response and were inadequate to pre-empt her needs. In the past she remembered being admitted before a crisis could happen which could result in an overdose. She suggested that the Trust consider providing a crisis safe house where people could take refuge at an early stage before the crisis which they were experiencing became critical. She noted that there were examples of such crisis safe houses across the country which were staffed by people without formal clinical or nurse training but with first-hand experience. She said that if unwell people wanted to withdraw from family and friends because they were frightened of others and themselves, they may be able to get comfort from people in a similar position with first-hand experiences of crises. She highlighted the potential of a crisis safe house to help the Trust to gather direct feedback from service users. She emphasised the value of user involvement as a resource for the Trust. R said that the Trust should improve: the minimal presence of the Trust and other organisations in Banbury despite Banbury having three designated areas of deprivation; the paucity of psychological therapies for people with serious mental health issues; waiting times; lack of real user involvement; inadequate support for spiritual needs; central switchboard call-handlers who struggled to accept that she would not identify herself to non-clinicians; and the age criterion (69) for transfer to Older Adult services. She said that transfer to Older Adult services should be based upon service allocation rather than age and that it was frustrating that the Clinical Commissioning Group (**CCG**) and the Trust could not resolve this. She praised: the care she had received from the Adult Mental Health Teams especially with the resources available and in light of the changes over the years in community and crisis provision; her team based in Banbury which had recently reached the finals for Nursing Times Student Placement of the Year; the helpful and responsible administrative and reception staff she had dealt with; the way in which her transfer from one care coordinator to another had been managed (in 12 years she had only ever had 2 care coordinators but the transfer between them had been managed with care and respect); and the new 7 day service with longer opening hours. She expressed concern about staff wellbeing; staff being spread too thinly to cover services; and the amount of change in senior roles which meant that staff did not have the satisfaction of seeing a project through successfully. The Board thanked R for her presentation and her positive and negative feedback. The Chief Operating Officer agreed that age was an arbitrary designator of whether Adult or Older Adult services were appropriate and that a more person-centred care model may be helpful here. The Trust Chair noted that the Trust was working to reduce instances of prone restraint. R noted that she had also discussed this and worked already with the Director of Nursing and Clinical Standards on issues around restraint. The Trust Chair added that if the Trust had more financial resources then it would want to do more and offer more services. The Board discussed the type of crisis housing which R had suggested. R explained that she had in mind a place where people could go for a few days at a time and which they would be able to return to before a situation became a crisis, especially if they tended to experience crisis in a cyclical pattern. She explained that she envisaged a crisis house as a way of providing safe voluntary containment without proceeding as far as the formal containment option of an inpatient ward when responsibility was devolved away. The Board discussed support for spiritual needs and noted that a new Head of Spiritual Care was in place who was developing the service. The Board thanked R again for her presentation and welcomed her feedback and her willingness to work with the Trust. *Mandy McKendry, Lynda Lawrence and R left the meeting.*  |  |
| **BOD 68/16**abcd | **Learning Disability update – access to healthcare for people with learning disabilities, annual report**The Director of Nursing and Clinical Standards presented Paper BOD 49/2016 which confirmed that the Trust was compliant with national standards but noted that there was development work to do and which would be led by the incoming Learning Disabilities Programme Director once in post. The Director of Nursing and Clinical Standards explained that although access to learning disabilities services was integrated in community children’s services already, if the Trust assumed responsibility for services for adults with learning disabilities then this would necessitate a significant change in its existing services especially for Mental Health. If the Trust was to take on responsibility for these services then more information would need to be made available to the Trust about patients in the area with these needs and more work would need to be done to assess how the Trust’s services may need to change including at a corporate level to consider how service users with learning disabilities could be represented, for example through governors to represent service users with learning disabilities. Alyson Coates noted that there was a risk that the Learning Disabilities Transformation Board could suggest a solution which was not workeable for the Trust or which would not be adequately funded. Jonathan Asbridge agreed that this area was a risk for potential inclusion on the Trust Risk Register or the Board Assurance Framework and added that it would be helpful to know when the incoming Learning Disabilities Programme Director would be able to discuss in more detail with the Board. The Chief Operating Officer replied that the CCG and County Council could provide representatives to discuss with the Board more quickly but that the Learning Disabilities Programme Director would need time, once in post from July 2016, to work through the position and options which may take until September. Jonathan Asbridge noted that he would discuss this risk area again when he met separately with the Director of Corporate Affairs and Company Secretary on the Board Assurance Framework. Mike Bellamy added that as soon as reasonably possible, the Board needed to be informed about the progress of the work and review which would be carried out by the Learning Disabilities Programme Director. The Board discussed the information which was available to the Trust on service users with learning disabilities, which was currently recorded manually. The Trust Chair asked whether mechanisms were in place to identify and flag service users with learning disabilities and to make reasonable adjustments to their pathways of care. The Director of Nursing and Clinical Standards confirmed that protocols and means of flagging this were available. The Board discussed challenges with supplementing the information currently available with information from other local organisations. The Board noted that the Trust was, however, compliant with national standards based on the information currently available and noted that the CQC, in its recent investigation report, had also commented positively about the Trust’s ability to meet the diverse needs of all service users. **The Board noted the report.**  |  |
| **BOD 69/16**abc | **Finance Report**The Director of Finance presented the report BOD 50/2016 which summarised the financial performance of the Trust as at Month 12 for the year ended 31 March 2016. He highlighted:* EBITDA (Earnings Before Interest, Taxation, Depreciation and Amortisation) of £9.4 million, which was £2.8 million ahead of plan and an improvement on the position in the previous report when, at month 11, EBITDA had been £9.3 million and £0.7 million ahead of plan. The improvement was mainly driven by better than planned operational performance and the management of risks and contingencies;
* an Income and Expenditure deficit of £1.9 million which was £3.5 million ahead of plan;
* a cash balance of £14.1 million which was £1.2 million ahead of plan; and
* the Trust had achieved an overall Financial Sustainability Risk Rating of “2” for the financial year which was in line with plan.

Against a CIP target of £5.1 million for the financial year, cost improvements of £5.1 million (of which £4.0 million were recurrent) had been delivered which was in line with plan and an improvement on the position in the previous report when, at month 11, cost improvements of £4.2 million had been achieved. **The Board noted the report.** |  |
| **BOD 70/16**ab | **Performance Report**The Director of Finance presented the report BOD 51/2016. He explained that all Monitor indicators and key metrics in March 2016 had been met with the exception of CPA (Care Programme Approach) review within 12 months which was 94.9% against a target of 95%. However, the overall targets for Quarter 4 had been met. He noted that future reporting would set out more clearly where cases of CDiff were determined to be due to lapses in care or not. **The Board noted the report.**  |  |
| **BOD 71/16**abcdefgh | **Workforce Performance** The Director of Finance presented the report BOD 52/2016 which set out the position on workforce performance indicators. He highlighted that: * enhanced Flexible Worker rates were now in place for services as set out in the report and that staff were already beginning to sign up to participate;
* new two month notice periods had been introduced for new staff and a consultation was taking place on notice periods for existing staff;
* a dedicated senior HR manager was supporting Adult services/wards which had struggled to recruit; and
* in relation to the NHS Workforce Race Equality Standard (**WRES**), the WRES action plan which had been agreed by the Extended Executive in January 2016 was being progressed; an initial update report would be presented to the Executive next month to drive this work forward and WRES information should be available for inclusion in this report to the Board from approximately June 2016.

The Trust Chair noted that activity in relation to recruitment and retention was still not having the desired effect upon improving outcomes. The Director of Finance replied that recruitment levels had improved and were higher than they had ever been but that overall staffing levels were being impacted by higher leaving rates and a decrease in retention. Services and HR were taking action and were recruiting 15-20% more than they had in previous years but the overall effect against the leaving rates was to maintain a standstill position. The Recruitment Action Group would also be resurrected within the next 2 weeks to review new approaches to resolving recruitment needs. Alyson Coates asked whether the Trust had considered sponsoring students or providing bursaries. The Director of Nursing and Clinical Standards added that she would be meeting today with local universities to discuss this kind of arrangement and what could be offered from available funding. She noted that work also went on to raise the profile of the Trust with students whilst they were at university. The Board discussed what the NHS as a whole was experiencing in terms of recruitment issues and whether this was impacted by particular common issues such as pay, cost of living, or sufficient workforce in the pipeline being trained. Mike Bellamy noted that as workforce was the Trust’s most significant expenditure and a high risk on the Trust Risk Register and the Board Assurance Framework that it may be necessary for the Board to spend more time on it, potentially at Board sub-committee level. Mike Bellamy added that as the Trust was in competition with other organisations to recruit staff, it could consider creating more placements and therefore more opportunities for staff to experience what working in the Trust was like in order to encourage them to apply to stay rather than seek opportunities and breadth of experience elsewhere. The Director of Nursing and Clinical Standards added that this also needed to be balanced with supporting existing staff, rather than pressing them to take on more students, and ensuring that facilities and estates had sufficient capacity to accommodate more people safely on site. The Board discussed retention issues and the importance, and potential positive impact, of the following upon improving retention rates: work/life balance, not just pay levels; staff engagement; and equality. Alyson Coates referred to the issue of delayed invoicing by an agency provider which had resulted in a spike in agency spend on the charts in the report now that the delayed invoices had been received. She expressed concern that this had happened and that the Board had previously received reporting on invoiced spend rather than actual spend incurred on a major cost line for the Trust. The Director of Finance noted that there was an external issue with a particular agency on the new agency framework which had not been invoicing properly and there had been an internal issue with the accruals system which had needed to improve links between Finance and Resourcing teams in order to capture activity which was being invoiced for at an earlier stage. He noted that the internal issue had been resolved as the internal system had been changed so that an accruals system was in place to accrue for matters for which invoices had not yet been received. He said that he asked teams to produce a report on the learning from this issue of delayed invoicing which could be shared out-of-session. The Board suggested that workforce risks and issues be considered in more detail at a Board Seminar and noted that discussion could also include: student sponsorship and bursaries, especially if sponsoring could be extended beyond nursing to allied healthcare; and the governance structures and oversight of workforce risks and issues. **The Board noted the report.** | **HS/MME** |
| **BOD 72/16**ab | **Business Plan 2015/16 Quarter 4 report**The Director of Finance presented the report BOD 53/2016 which summarised progress to deliver the Business Plan and key achievements during Q4 for each project. **The Board noted the report.** |  |
| **BOD****73/16**abc | **Board Assurance Framework (BAF) Q4 report** The Director of Corporate Affairs and Company Secretary presented the report BOD 54/2016 which set out the position of the BAF as at Q4 and the strategic risks to the Trust achieving its 7 strategic objectives. She noted that the BAF would develop further in response to the development of Sustainability and Transformation Plans and that she and the Assistant Trust Secretary would also be meeting to discuss with Jonathan Asbridge. Anne Grocock noted that the risk at 6.1 in relation to incomplete and inaccurate data and records may need a higher risk rating. **The Board noted the report.**  |  |
| **BOD****74/16**ab | **Monitor in-year submission – Q4 self-certification**The Director of Corporate Affairs and Company Secretary presented the report BOD 55/2016 which supported the Board’s self-certifications. **The Board APPROVED the proposed self-certifications in the report and noted that declarations could be confirmed with the exception of the declaration that the Trust would maintain a Financial Sustainability Risk Rating of at least 3 over the next 12 months. This was not confirmed because the Trust anticipated achieving a rating of 2.**  |  |
| **BOD****75/16**ab | **Corporate Registers – register of application of seal and register of gifts, hospitality and sponsorship**The Director of Corporate Affairs and Company Secretary presented: the report BOD 56/2016 which set out the register of the application of the Trust’s seal; and the report BOD 57/2016 which set out the register of gifts, hospitality and sponsorship. She noted that she would be meeting with the Chief Pharmacist to discuss acceptance of sponsorship. **The Board noted the reports.**  |  |
| **BOD****76/16**abcd | **Patient Involvement and Experience Strategy 2016-19**The Director of Nursing and Clinical Standards presented the report BOD 58/2016 which set out the proposed new Patient Involvement and Experience Strategy for 2016-19. She highlighted the high degree of patient involvement in the development of the strategy and noted that the Board had already participated in the development of the strategy in a Board Seminar workshop in March 2016. She emphasised the three main aims of the strategy: person-centred care; acting on feedback; and patient involvement and co-design of services. She noted the actions to progress the objectives of the strategy as set out in Appendix 2. Anne Grocock praised the strategy but noted that as there were many actions to progress the strategy, it may be useful to prioritise them and include target dates and responsible leads. In relation to page 3 of the report and suggestions on how to be caring, she asked the Board to consider that showing respect may not be about treating others as you would wish to be treated but about treating others as they would wish to be treated. Jonathan Asbridge praised the strategy and the work of the Patient Experience and Involvement Project Lead in developing it but noted that the culture of the organisation would not change overnight and it was necessary to view the strategy in the long term. He asked how the implementation of the strategy would be resourced. The Director of Nursing replied that this would be through phrased resourcing but was still subject to more detailed discussion by the Executive. **The Board APPROVED the Patient Involvement and Experience Strategy 2016-19.**  |  |
| **BOD****77/16**a | **Audit Committee**Alyson Coates provided an oral update of the meeting of the Audit Committee on 20 April 2016. She reported that the Audit Committee had received a very advanced draft of the annual accounts and a positive Head of Internal Audit Opinion. The Audit Committee had also approved the evidence base for the preparation of the accounts on a going concern basis. She noted that the regional director of the Internal Audit function was now attending meetings.  |  |
| **BOD78/16**a | **Any Other Business**None. |  |
| **BOD****79/16**a | **Questions from the public**None. |  |
| **BOD 80/16** | In accordance with Schedule 7 of the NHS Act 2006, the Board resolved to exclude members of the public from Part 2 of the board meeting having regard to commercial sensitivity and/or confidentiality; personal information; legal professional privilege in relation to the business to be discussed. |  |
| **BOD 81/16** | There being no further business the meeting was closed at 13:00.Date of next meeting: Wednesday, 25 May 2016 |  |