

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

**Board of Directors**

Minutes of a meeting held on

25 October 2017 at 08:30

in the Oak Room, Learning & Development,   
Unipart House, Garsington Road, Cowley, Oxford OX4 2PG

**Present:**

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| Mike Bellamy | Non-Executive Director (the Chair) (**MB**) |
| John Allison | Non-Executive Director (**JAl**) |
| Ros Alstead | Director of Nursing & Clinical Standards (**RA**) – *part meeting* |
| Stuart Bell | Chief Executive (**SB**) |
| Sue Dopson | Non-Executive Director (**SD**) |
| Anne Grocock | Non-Executive Director (**AG**) |
| Mark Hancock | Medical Director (**MHa**) |
| Chris Hurst | Non-Executive Director (**CMH**) |
| Mike McEnaney | Director of Finance (**MME**) |
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| **In attendance:** | |
| Mike Foster | Freedom to Speak Up Guardian (**MF**) – *part meeting* |
| Bernard Galton | Associate Non-Executive Director (**BG**) |
| Donna Mackenzie | Patient Experience & Involvement Manager *– part meeting* |
| Aroop Mozumder | Associate Non-Executive Director (**AM**) – *part meeting* |
| Kerry Rogers | Director of Corporate Affairs & Company Secretary (**KR**) |
| Pauline Scully | Service Director – Adult Directorate (**PS**) – *in attendance for the Chief Operating Officer[[1]](#footnote-1)* |
| Martyn Ward | Interim Director of Performance (**MW**) |
| Hannah Smith | Assistant Trust Secretary (Minutes) (**HS**) |

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| **BOD**  **165/17**  a  b | **Welcome and Apologies for Absence**  The Chair welcomed governors, staff and members of the public who had attended to observe the meeting.  Apologies for absence were received from: Jonathan Asbridge, Non-Executive Director; Alyson Coates, Non-Executive Director; Dominic Hardisty, Chief Operating Officer; Martin Howell, Trust Chair; and Lucy Weston, Associate Non-Executive Director. |  |
| **BOD 166/17**  a  b  c | **Declarations of Interests**  The Chair presented the report BOD 125/2017 which set out the Register of Directors’ Interests. The Board noted the following updates to make:   * remove the Chair’s interest in the University of West London as this was now time expired; and * include updates from Sue Dopson.   No interests were declared pertinent to matters on the agenda.  **The Board noted the report.** | **HS** |
| **BOD 167/17**  a  b  c  d  e  f | **Minutes of the Meeting held on 27 September 2017**  The Minutes of the meeting were approved as a true and accurate record.  ***Matters Arising***  **Item BOD 121/17(b) Proposed new structure for Operations**  The Chief Executive noted that the Executive would be reviewing the proposals for the new structure for Operations shortly and it may be possible to bring an update back in November.  **Item BOD 145/17(d) Finance committees’ oversight of the Oxfordshire risk share**  The Director of Finance noted that progress to achieve Finance committees’ oversight of the risk share was still slow and that his recent meeting with the Director of Finance at Oxfordshire CCG had been cancelled. He provided an update that the impact of additional costs associated with the Referral to Treatment (**RTT**) backlog identified by regulators at Oxford University Hospitals NHS FT (**OUH**) would have some impact this financial year but more into next financial year, assuming that OUH would be able to increase staffing levels in order to deliver the RTT plan. The Chief Executive added that there would be a meeting with NHS Improvement next week, as part of the follow-up to regulatory action at OUH, which would receive the definitive version of the RTT plan and from which the likely costs could be estimated. He cautioned that funding to cover the cost of the RTT backlog would therefore not be available for other areas such as mental health or primary care.  *The Director of Nursing & Clinical Standards joined the meeting.*  **Item BOD 150/17(e) Safer Staffing report**  The Director of Nursing & Clinical Standards confirmed that the Safer Staffing report was being developed to provide more detail on actions being taken to resolve issues with staffing levels in areas of persistent concern and that more information was provided in the report this month; this was an area which would continue to develop in the reporting to Board.  **Item BOD 156/17(b) Action for the Executive to consider the Trust’s processes for agreeing limitation of liability in R&D confidentiality agreements/non-disclosure agreements**  The Medical Director reiterated the current process in place for the Trust to take advice from the R&D governance team at OUH; he noted that the Trust’s R&D team had also discussed with other NHS trusts who had also expressed wariness about accepting unlimited liability. The Medical Director opined that although it was not comfortable to accept unlimited liability, no NHS organisations had yet been sued having accepted conditions of unlimited liability; and continuing to resist accepting such conditions could result in loss of opportunity to participate in certain research projects. The Chair noted that this reinforced the position and issues as outlined at the previous Board meeting, and it was for the Executive to decide.  The Board noted that the following actions were on hold for future reporting: BOD 60/17(h), 21/17(b) & 32/17(b) (Strategic Partnerships Report); 100/17(b) (CFS/ME service); and BOD 148/17(e) (Quality Committee escalation and reporting to Board). | **DH** |
| g | The Board confirmed that the remaining actions from the 27 September 2017 Summary of Actions had been completed, actioned or were on the agenda for the meeting: BOD 146/17(f); BOD 147/17(d); and BOD 160/17(e). |  |
| **BOD 168/17**  a  b  c  d  e  f  g  h  i  j | **Chief Executive’s Report**  The Chief Executive presented the report BOD 127/2017 which outlined recent national and local issues.  ***Winter planning***  The Chief Executive highlighted national attention to urgent care and winter planning; he noted the importance of preparing for flu, especially in light of the recent experience of the Southern Hemisphere, and ensuring that staff recognised the severity of the risk of flu for themselves and patients and therefore took up the opportunity to get their flu jabs. The Trust was planning for the potential impact upon the GP Out-Of-Hours system and for staffing levels which would be required over the Christmas and New Year period.  Aroop Mozumder asked about flu jabs for long term patients in community hospitals or patients lacking in capacity. The Director of Nursing & Clinical Standards confirmed that the Trust planned carefully for all these categories of patients and there was therefore a significant flu vaccination programme in community hospitals and through the district nursing service.  Aroop Mozumder asked about the percentage of free beds or the Trust’s availability capacity to meet surges in demand especially in community hospitals. The Chief Executive replied that staffing, rather than bed, capacity was the crucial factor to meet surges in demand. The Trust was contractually committed to provide a certain number of admissions to community hospitals over the course of the year; if it kept its current capacity open then it would be providing significantly in excess of what it had been paid for and at a cost to itself. Whilst the Trust would want to help the system, its ability to do so beyond what it had been funded to do was also dependent upon having the staff available to provide care.  ***Financial Plan FY18***  The Trust’s underlying position, once one-off benefits had been excluded, was a deficit position of £1.2 million, which was £0.2 million adverse to plan. The Chief Executive emphasised that the financial position was finely balanced and would require careful management over the remainder of the financial year; this would be challenging given the difficulties in achieving the Cost Improvement Programme (**CIP**) target and the starting point of good underlying basic levels of efficiency in services already. He noted that the Executive had discussed and agreed on the importance of being open and transparent in public about the challenges to improve the Trust’s finances from an already efficient position; it may be useful to ask for public opinion and perspective on what aspects of services provided may be unnecessary or could be done more quickly. This would require more data being made publicly available and work with the Trust’s governors, including building on connections with the wider community.  The Board discussed and highlighted the importance of raising awareness that:   * increasing demand for, and pressure on, services did not just relate to Accident & Emergency (**A&E**) services but was also a critical pressure on Out-of-Hours (**OOH**) and Child and Adolescent Mental Health Services (**CAMHS**). During the Christmas 2016 period, the Trust’s OOH service had dealt with 20% more patients than the previous year; * increasing demand for healthcare services was a long-term challenge for the NHS as a whole; * CIP savings would not be achieved through putting greater pressure on staff to develop savings; this would risk a cycle of ongoing deterioration. Long-term planning instead was required and would be monitored through the Finance & Investment Committee; and * an integral part of the Oxfordshire risk share agreement was a commitment by all parties to identify and fund the mental health service developments needed to implement the Mental Health Five Year Forward View in 2018/19. Oxfordshire however remained nationally low for per capita spending on mental health and the impact of this upon the health needs of the local population needed to be highlighted and given appropriate weight even in the face of other challenges such as A&E performance and Delayed Transfers of Care.   ***Delayed Transfers of Care (DToCs)***  The Chief Executive referred to his report and confirmed that commissioners had agreed to the Trust, for the next 6 months, providing the community (as opposed to hospital) reablement pathway to help to release capacity in the HART service (the Home Assessment Reablement Team – provided by OUH) to enable HART to meet its contractual obligations. The Trust had now started to provide the community reablement pathway.  ***Stroke rehabilitation services – Oxfordshire***  The Chief Executive referred to his report and noted that the Trust’s proposal to consolidate stroke rehabilitation beds at Abingdon Community Hospital would be a temporary measure and able to be reversed, subject to the outcome of phase 2 of the public consultation on healthcare in Oxfordshire. He reminded the Board that the proposal was about using beds in a different way, not closing them, therefore beds currently used for stroke rehabilitation at Witney Community Hospital would remain open as general community hospital beds.  ***Workforce***  The Chief Executive referred to his report which set out the most recent agreed actions of the Workforce Taskforce and noted that there was still more which the Trust wanted to do.  ***Freedom to Speak Up Guardian - national survey***  The Chief Executive referred to his report and noted that the recommendations from the national survey vindicated the Trust’s approach to the Freedom to Speak Up Guardian role, in particular: regular reporting to the Board in public (the most recent report was on the agenda for this meeting); and ring-fencing time for the role by making it a standalone post in the Trust, rather than linked to other responsibilities. He noted that the Trust’s current Freedom to Speak Up Guardian, Mike Foster, would be retiring from the role presently and he thanked Mike Foster for having established the role in the Trust with skill and judgement and having become an important and valuable part of the governance apparatus. |  |
| k  l  m  n | ***Buckinghamshire, Oxfordshire and Berkshire West (BOB) Sustainability and Transformation ‘Partnership’ (STP)***  The Chief Executive referred to his report and noted that NHS England and NHS Improvement were still considering the appointment of a new STP Lead, following the recent interviews.  ***Consultant appointments***  The Chief Executive referred to his report and the following consultant appointments: Dr Alexis Economou to a 5 PA consultant post with the City Adult Mental Health Team (**AMHT**) based at the Warneford; Dr Ayman Guirguis to a 10 PA Older Adult consultant post with the PIRLS (Psychiatric In-Reach Liaison Service) based at Stoke Mandeville Hospital, Aylesbury; and Dr Aleksandra Szpak-Lea to a 10 PA consultant post with the Chiltern AMHT.  The Chair referred the Board to the Legal, Regulatory and Policy update which was appended to the Chief Executive’s report and highlighted the useful summary of the King’s Fund report on making the case for quality improvement. He noted the importance of NHS leaders focusing on improving quality and delivering better care. The Director of Nursing & Clinical Standards noted that this type of work would be progressed through Jill Bailey and the Oxford Centre for Quality Improvement.    **The Board noted the report and ratified the consultant appointments.** |  |
| **BOD 169/17**  a  b  c  d  e  f  g | **Chief Operating Officer’s Report**  Pauline Scully presented the report BOD 128/2017 which provided an update on quality, people and sustainability together with a narrative of key issues being managed by the Operational Management Team.  ***Quality***  She highlighted the positive outcomes of: the joint CQC/Ofsted ‘SEND’ (Special Educational Needs and Disabilities) inspection in Oxfordshire; and the AIMS (Accreditation for Inpatient Mental Health Services) accreditation which had been achieved by Cherwell and Sandford Older Adults wards and the AIMS re-accreditation of the Oxford Central and South Older AMHTs.  ***People***  She noted that the workforce challenge could not be emphasised enough. There were high levels of pressure on staff and attracting new staff remained the most significant challenge.  ***Sustainability***  Achievement of CIPs also remained a significant challenge. Pauline Scully agreed with the approach being taken by the Chief Executive and the Director of Finance to ensure as much rigour as possible in the process to identify CIP projects. She also agreed with the point made during discussion of the Financial Plan FY18, at item BOD 168/17(f) above, that CIP savings would not be achieved through putting greater pressure on staff to develop savings, especially at a time when the Trust was under demand and acuity pressure and short of staff.  In relation to Section 75 joint working with Oxfordshire County Council, she noted that a meeting had been scheduled to discuss the options appraisal following the review of the service.  Aroop Mozumder referred to the review of the crisis pathway and asked whether there were links between the increasingly complex and challenging patients the Trust was receiving and increasing staff turnover and difficulties with retention. Pauline Scully replied that retention difficulties were not necessarily linked to patient acuity; data on staff departures tended to highlight other reasons for leaving such as cost of living, especially in Oxfordshire. Bernard Galton asked whether the Trust offered incentives for people to move within the Trust to other less expensive areas/counties such as Wiltshire. Pauline Scully noted that staff were aware of the services offered by the Trust in other counties, and the roles they could apply for, and some parts of Wiltshire could also still be expensive.  Anne Grocock asked for an update on Improving Access to Psychological Therapies (**IAPT**) services. Pauline Scully replied that the Trust ran well-regarded IAPT services across Oxfordshire and Buckinghamshire and had been successful in securing funding to develop these services; this funding could be used to increase staffing levels but there was an estates-related challenge to provide space for more staff. As referred to in the report, this was why accommodation for IAPT services across Oxfordshire and Buckinghamshire was being reviewed |  |
| h | since the service had outgrown its existing accommodation and was likely to continue growing. The Director of Nursing & Clinical Standards confirmed that the review did not relate to concerns about the service but was important for potential expansion; this was not a service with the kind of workforce issues and shortages which others were experiencing.  **The Board noted the report.** |  |
| **BOD 170/17**  a  b  c  d  e  f  g  h  i  j | **Performance Report**  The Interim Director of Performance presented the report BOD 129/2017 on performance against the Single Oversight Framework for September 2017 (Month 7). The Trust had met or exceeded 89% of the 989 performance indicators reported; the number of reportable indicators varied each month (depending upon the frequency of the reporting expected e.g. quarterly or monthly) but the Trust generally maintained 90%, or close to, compliance overall. Areas of underperformance were set out in the report. Trends across directorates had been identified in relation to: workforce pressures and difficulties in recruitment and retention; clients in settled accommodation (as opposed to ‘stable’ accommodation – the difference between the two definitions still required resolution between the CCG and regulators); and priority metrics (however work had been completed to collect the required data so that it could be incorporated within the national data sets and it had now been included in the Data Quality Improvement Programme).  The Children & Young People’s Directorate was the highest performing directorate having achieved 95% compliance against indicators. However, there were areas of underperformance in relation to:   * Looked After Children – although performance in relation to completion of health assessments had improved to 95%, the target to reach was still 100%; and * CAMHS waiting times although, as discussed at the previous meeting, this had indicated that a new model of care was required and this was being developed. CAMHS 12 week waiting times in Oxfordshire had also deteriorated due to staffing issues in northern and southern areas of the county.   The Older People’s Directorate had declined in performance from 74% to 73% compliance against indicators; performance had also been impacted by changes to indicators and a number of new indicators for FY18. He noted:   * good performance and improvement against indicators for Oxfordshire Continuing Healthcare; * improvement in indicators for the OOH service; and * a decrease in performance against the community nursing indicator relating to patients having a named nurse who had seen that patient within a 3-month period. Issues were due to lack of available workforce.   The Adult Directorate had declined in performance from 77% to 75% compliance against indicators. Indicators for the new Learning Disability service had now been included within the Performance Framework; a small number of indicators were underperforming but action was being taken within the service to resolve these and the Interim Director of Performance would be meeting with the Programme Director for Learning Disability to discuss.  Anne Grocock referred to the main report at p.3 and asked whether the performance data which NHS Improvement would be sourcing from publicly available sources would be accurate and whether there were risks around the quality of such data which could outweigh the potential benefit in saving staff time. The Interim Director of Performance replied that the quality of such data being provided to national data sets had been improving over the past 12 months and the Trust was now seeking assurance that the data was being processed and published in the right way. He acknowledged that there were still risks around data quality but the level of these risks had reduced since last year. The Trust was monitoring the quality of the data being made publicly available and challenging when issues were identified; for example, as had recently happened in relation to the IAPT service when NHS Digital had been challenged and, in response, NHS Digital had agreed and taken the data down. He added that work was taking place to increasingly automate the processes by which the data could be sourced from Trust systems; this would further reduce the amount of time staff needed to spend feeding data into the systems and, eventually, would reduce the amount of time required to provide data to local commissioners.  The Director of Nursing & Clinical Standards noted that although it was reassuring that there was greater confidence in the quality of performance data, the impact of what the data showed should be considered albeit some of the detailed focus could be carried out at directorate level. For example, she highlighted that missing the target on clients in settled accommodation could impact upon the Oxfordshire Outcomes Based Contract (**OBC**). The Interim Director of Performance replied that the issue with the target on clients in settled accommodation was around the use of different definitions by the CCG and regulators; the Trust was exceeding the target set by Oxfordshire CCG for the OBC around ‘stable’ accommodation. However, he noted that he would welcome a report or a group through which the Performance team could support teams to use the outcome of performance data to transform practices; the Chair agreed that it would be useful to try and identify how this could be set up and where this could be reported and this should be an action for the Interim Director of Performance to take forward.  Aroop Mozumder referred to the issues in meeting performance targets around DToCs and asked about local performance compared to national targets. The Interim Director of Performance replied that performance was not where he would want it to be compared to national average performance; this was primarily due to local system issues and he noted the impact of delays as a result of the HART service capacity issues. He referred to the Chief Executive’s report, and discussion at item BOD 168/17(g) above, and noted that the Trust’s provision of the community reablement pathway over the next 6 months was anticipated to lead to performance improvement.  The Board agreed that the next Board Seminar should receive a wider system briefing on DToCs.  John Allison noted that workforce pressures appeared to be having a significant impact upon some indicators. The Board discussed the potential benefit of clustering indicators to analyse the percentage which were being negatively impacted by workforce pressures and the percentage which may be underperforming for other reasons. The Interim Director of Performance agreed that this may be interesting to profile and consider causes of underperformance.  The Board noted that reporting against nearly 1,000 national and local (contracted) performance indicators per month (989 indicators in Month 6) placed a significant burden upon the Trust, especially upon staff time; the Board discussed whether progress was being made to reduce the number of performance | **MW**  **HS** |
| k | indicators. The Interim Director of Performance noted that whilst within some levels of Commissioning Support Units there was some acceptance that the direction of travel should be towards decreasing the number of performance indicators, this was not universally recognised and at other levels, more information was being demanded. The Interim Director of Performance explained that his objectives were to: reduce the amount of time/effort required by staff to manually input data; take a cautious approach to agreeing to contracts which would require/introduce a large number of indicators; and collect data into one significant feed as much as possible and invite commissioners to undertake their own analysis from it.  **The Board noted the report.** |  |
| **BOD 171/17**  a  b  c | **Access to Healthcare for people with Learning Disabilities**  The Director of Nursing & Clinical Standards presented the report BOD 130/2017 which provided an update on: compliance with the Healthcare for All criteria; the transition of the specialist Learning Disabilities service into the Trust; and draft new Provider Improvement Standards for Learning Disability. She noted that before this report could be published, the Trust would need to check whether/when the draft new Provider Improvement Standards for Learning Disability would be published as they may still be subject to embargo.  The report also provided a summary of the review of deaths of people with a learning disability within Oxfordshire’s commissioning responsibility between 01 April 2011 and 31 March 2015. The review had been published in July 2017 and was part of whole system work in Oxfordshire around mortality reviews. In September 2017, Trust staff had also completed the Learning Disability Mortality Review Programme (LeDeR) reviewer training.  **The Board noted the report.** |  |
| **BOD 172/17**  a  b  c  d  e  f | **Freedom to Speak Up Annual Report**  Mike Foster presented the report BOD 131/2017 on Freedom to Speak Up activity for the 12 months up to the end of September 2017 including: statistics on numbers of concerns raised; categorisation of the types of issues raised (there were no reported cases of serious abuse or neglect) and types of action taken; actions taken to raise awareness and change culture including visits to wards and other staff groups; national and regional developments; and effectiveness of Freedom to Speak Up processes. In terms of regularity of contact, Mike Foster received on average contact from 1-2 staff per week from across the organisation; he noted that he received less contact from inpatient wards (community and mental health) than he would have expected given pressures on those wards. Nationally, the Trust was not an outlier in terms of amount of contact and sat in the middle of trusts generally; in the last quarter, some trusts had received no contacts whilst others had received up to 50.  In relation to the types of issues raised, Mike Foster highlighted:   * demand and patient complexity, with teams describing increasing numbers of referrals of more complex patients and needing to care for them without a corresponding increase in resources; * bullying and harassment – although the Trust was not an outlier from other organisations in the national staff survey. This issue had been discussed through the Well Led quality sub-committee and the Trust would be launching a campaign to coincide with anti-bullying week in November 2017. It had been recognised that this was an area to focus on to achieve cultural change; and * service reorganisation – as highlighted by staff leaving the Trust who had gone on to find jobs elsewhere. He noted that service reviews might meet the needs of the greater service but not necessarily those of individuals; the Trust may have a leadership challenge to prepare staff to expect change in the nature of their work over time and to be able to continue to develop their skill sets in anticipation of change.   Mike Foster referred back to discussion under the Chief Executive’s report, at item BOD 168/17(j) above, and noted that the Trust had been an early adopter of the Freedom to Speak Up initiative and that, from discussing with colleagues nationally, it had been a sensible decision to establish a standalone role rather than one linked to other responsibilities. A positive indicator of general cultural change since the Freedom to Speak Up Guardian role had been introduced was that there had been no instances of staff contacting the CQC with concerns; this was a significant change from previous years and may indicate staff feeling more confident in raising concerns internally.  Aroop Mozumder asked if the CQC would inform the Freedom to Speak Up Guardian of the fact of any contact being made by staff to the CQC. Mike Foster replied that he had been able to confirm in recent discussion with the Trust’s CQC inspector that no staff had raised concerns; the National Guardian’s Office was also hosted by the CQC and locally individual guardians were encouraged to develop links with their local CQC inspectors. Aroop Mozumder asked if Mike Foster would feel under pressure if a whistleblowing matter was raised with him and if he discussed it with a CQC inspector, knowing that this might also trigger an unannounced CQC inspection. Mike Foster replied that he did not feel under any such pressure or concern and that the Trust had freely and promptly adopted the role of Freedom to Speak Up Guardian before it became mandatory; he recognised the Trust as an organisation which aimed to be open and transparent and which valued Freedom to Speak Up processes as an important part of patient safety.  The Board discussed the report and the role of the Freedom to Speak Up Guardian and noted that it was useful for the role to be standalone and independent of other responsibilities to the Trust as this may provide further assurance to staff in order to encourage them to come forward with concerns. The role also provided a useful window into the culture and internal health of the organisation. The Board also recognised that Mike Foster had particular knowledge and experience of the organisation and of local systems which was valuable in problem-solving, whilst at the same time being able to act independently and untrammelled.  Anne Grocock asked what further actions could be taken to feedback to staff about concerns they had raised and to provide reassurance about actions being taken. Mike Foster replied that in some circumstances it could be challenging to feedback publicly whilst still protecting the identity of the individuals concerned because even when names were anonymised, some situations or circumstances could be so specific as to render them identifiable. In other cases, staff raising concerns sometimes also requested that they did not want particular action to be publicised. Where possible, periodic updates were included within the weekly Communications email to staff and Mike Foster also presented to staff groups on wider themes, issues and changes. He also recommended setting up local networks of Freedom to Speak Up Champions or local leads and making greater use of Fair Treatment at Work Facilitators. |  |
| g  h  i  j | Bernard Galton asked whether staff leaving the Trust were formally signposted to contact the Freedom to Speak Up Guardian as part of exit processes. Mike Foster replied that this was not part of formal review on departure processes and that it was up to staff to choose to contact him. He noted that if clinical staff departures were connected to difficulties with their manager then those staff groups may also prefer to raise specific concerns through their professional lead.  John Allison asked about the number of potential whistleblowing cases, as opposed to wider concerns, which had been raised. Mike Foster replied that there had been 6 over the 12 month reporting period, which was consistent with previous figures. Of those 6, in approximately half of cases he had had some initial contact from the individuals involved before they became whistleblowing matters. John Allison noted that the Trust could take some encouragement from this relatively low number. The Director of Finance noted that reporting on whistleblowing could also be provided to the Board as part of the regular Workforce Performance Report.  The Board thanked Mike Foster for his work in establishing the Freedom to Speak Up Guardian role.  **The Board noted the report.**  *Mike Foster left the meeting.* | **MME** |
| **BOD 173/17**  a  b  c | **Quality and Safety Report: Incidents, Mortality and Patient Safety**  The Director of Nursing & Clinical Standards presented the report BOD 132/2017 which provided a summary of incidents and deaths reported up to September 2017 and a review of trends in incident data over the previous 3 years. The majority of incidents related to: violence and aggression; skin integrity; or self-harm. The increase in skin integrity/pressure ulcer incidents had been investigated and lapses in care had been identified in 2 out of 15 incidents; Non-Executive Directors had also been involved in the reviews of these incidents. She added that the new Learning Disability service was doing well in reporting of incidents and was using the Trust’s incident-reporting system well.  In relation to mortality data, she highlighted the amount of work taking place to learn from deaths. The overall number and rate of deaths had not changed over the period from April 2014 to June 2017, apart from in January 2015 in line with the national trend relating to the impact of flu. The majority of deaths were in people aged 75 and above, who had previously been in the care of the district nursing service. She noted that the fluctuation over January 2015 indicated that local mortality peaks could be linked to deaths related to flu and that this reinforced the importance of flu vaccinations. Key themes for learning from the review of deaths were: physical healthcare for patients with a mental health illness; family engagement and communication; and communication at points of transition between services and at changes in care. The report set out actions being taken around these themes. The report also referred to a Regulation 28/Preventing Future Deaths report received from a local coroner; the action plan which had been put in place in relation to this case would be reported in more detail to the Quality Committee.  Anne Grocock noted that there had been historic issues with ligature risks and asked what progress had been made on dealing with these. The Director of Nursing & Clinical Standards replied that a significant amount of work had been completed on reduction of ligatures; this was in line with national evidence that in inpatient mental health environments, there was a positive correlation between reduction in ligatures and reduction in rates of inpatient suicide. The Trust was moving to reduce all possible ligatures in areas where patients could be on their own, for example in bedrooms and bathrooms. The Trust’s overall ‘good’ CQC inspection rating was evidence of the progress which had been made. Anne Grocock noted that she wanted to be certain that the Trust’s extensive programme of ligature reduction was not being constrained by financial pressures. The Director of Nursing & Clinical Standards replied that it was not. Chris Hurst added that the Finance & lnvestment Committee had also reviewed the performance of the capital programme and noted that the Finance and Estates teams had been effective in maintaining and bringing forward ligature reduction schemes. The Medical Director added that some risks might, however, remain linked to items of patient clothing/property such as shoelaces, ties and dressing gown cords. Unless these were banned entirely then these risks, which were not related to the Trust’s environments, would continue to need to be managed. Pauline Scully added that there was also a national increase in the use of such ligatures in the home. |  |
| d  e  f | John Allison asked about the amount of staff time taken for incident investigations and whether this could be reduced or staff time more usefully deployed elsewhere, especially if investigation had demonstrated that incidents were generally not the result of lapsed care. The Director of Nursing & Clinical Standards replied that the Trust used initial incident reviews to help to decide early on in investigation processes whether more detailed and time-consuming review may be required; the CCG supported the Trust in looking at less labour-intensive ways of investigating appropriately. However, if incidents met the threshold for national grading as Serious Incidents, or if they were included within CQC or Mazars guidance as needing more detailed review, then this would take place. Providers of mental health and community services, as opposed to acute services, were also subject to greater expectations to review deaths within the local population even where these deaths may be expected.  The Chair asked to what extent recurring themes for learning from the review of deaths were reflected in the Quality Account. The Director of Nursing & Clinical Standards replied that the majority were included in the Quality Account but she would also check this with the Head of Quality Governance.  **The Board noted the report.** | **RA** |
| **BOD 174/17**  a  b | **Inpatient Safer Staffing**  The Director of Nursing & Clinical Standards presented the report BOD 133/2017 and explained that during 14 August – 10 September 2017, 9 of 32 wards had experienced difficulties in achieving expected staffing levels on every shift and had therefore needed to use agency and/or sessional bank staff. However, all wards had maintained minimum staffing levels to remain safe to deliver patient care. The report set out the extensive use of agency staffing which had peaked at 47.2%; work was taking place to increase long lines of agency staff to reduce unfilled shifts and increase staffing consistency. Registered skill mix was also a concern as there were only 4 wards with 50% registered staff skill mix whereas the remainder of wards were below 50% and 7 wards were below 35%; recruitment and retention work to fill registered nurse vacancies continued to attempt to mitigate this.  Since 01 July 2017, the Trust had also become the provider of Learning Disability services through Evenlode ward; this ward was not currently on the electronic Health Roster therefore |  |
| c  d  e  f | separate narrative reporting on its staffing levels was included in the report. The e-rostering system was still planned to be rolled out to Evenlode ward in November 2017. During the reporting period, although the expected staffing level had not always been achieved on Evenlode, the ward was not full and acuity had been low due to a limited number of new admissions.  The Director of Nursing & Clinical Standards highlighted the work set out in the report which was taking place in relation to:   * staffing establishment – to review inpatient staffing levels against patient acuity and bed numbers; and * productivity work taking place through the NHS Improvement/Lord Carter 90-day rapid improvement programme, including further improvements to e-rostering. This would also be discussed further at the Board Seminar in December 2017.   Chris Hurst asked whether the data revealed clear patterns of difficulties in filling shifts. The Director of Nursing & Clinical Standards replied that some of the productivity improvement work was beginning to show this; she noted the importance of considering how well resources were being rostered.  The Chair noted the report provided a useful insight into a range of new initiatives which were underway to attempt to tackle workforce issues.  **The Board noted the report.**  *The meeting took a break for 10 minutes and reconvened at 11:17.* |  |
| **BOD 175/17**  a  b  c  d  e | **Patient Story – Learning Disability service**  Donna Mackenzie joined the meeting and presented a recording of the experiences of various carers of people using the Learning Disability service. Carers aged in their 70s and 90s expressed their concerns with the support which may, or may not, be available for their adult children with learning disabilities and uncertainty over availability of supported living, especially once carers were no longer able to help. Carers expressed the hope that if they were no longer alive to care for their adult children then the authorities would care for them as if they were their own children and ensure that whatever handicaps they may have, their right to life and to a decent life would be respected. Carers also expressed their concern at the pressure and responsibility which may be put on siblings of service users and the additional support which they may also need.  Donna Mackenzie noted that the Patient Experience Governor sub-group which had recently met had heard similar views expressed by the carer governors present; these were common experiences and concerns of carers within mental health and community services.  Aroop Mozumder asked what support the Trust could offer to siblings and other new or less experienced carers of service users with learning disabilities to inform them of their rights and help them to navigate processes. The Director of Nursing & Clinical Standards replied that the Trust was in a good position to be able to offer this kind of support as it was already experienced in doing so from a mental health perspective. However, service users with learning disabilities also often presented with complex and challenging physical health needs, which could be exacerbated with age, and which would require the support of the local authority and other agencies.  The Chair noted that it would also be useful for local authorities and county councils to hear this account and the voices of the carers, especially as there was a recurring theme around lack of long term planning leading to uncertainty around the future of services users with learning disabilities. The Director of Finance added that, from discussing with multi-disciplinary teams, difficulty in obtaining social care support which then resulted in the Trust supporting cases for longer than would be expected was a theme. The Chief Executive noted that there was a wider theme around needing to support inter-generational transition within people’s lives, not just transition between health and social care services. It should be predictable that as service users and carers aged, they would transition into needing different support. This was also the type of theme to feed into the Quality Account, which could be a mechanism for unpacking the actions which could be taken to make a difference.  **The Board noted the presentation.**  *Donna Mackenzie left the meeting.* | **RA** |
| **BOD 176/17**  a  b  c  d  e | **Workforce Performance Report**  The Director of Finance presented the report BOD 134/2017 which set out the position on workforce performance indicators including temporary staffing spend, vacancies, recruitment, turnover, sickness and Workforce Race Equality Standards (**WRES**). Nominations for the Staff Recognition awards had also now closed with over 170 nominations having been received.  He highlighted:   * slight reduction in agency spend although this was still high and 75.83% above the agency ceiling set by NHS Improvement; * increase in spend on the staff bank, which was a positive sign, which now included GPs in the OOH service who had moved onto the Trust’s payroll; * turnover and vacancies remained high; and * the development of the workforce management system which was now able to provide more information on why certain levels of staffing were required in certain areas. As the system developed into an increasingly active tool which provided more transparency, it should enable staff resource to be mobilised more readily based on actual need. He noted that this would also be discussed further at the Board Seminar in December 2017.   The Director of Nursing & Clinical Standards referred to the reporting on the WRES and asked whether this could be analysed in more detail and progress considered. The Director of Finance acknowledged this was a useful area of focus and confirmed that more detailed reporting on WRES demonstrated improving trends in relation to applicants’ ethnic origin and the likelihood of BME (Black & Minority Ethnic) applicants being appointed to posts.  The Chair asked whether more information could be provided about the cost to the Trust to meet staffing requirements as a result of increased demand and how increased patient acuity and workload pressures related to increased usage of agency staff. The Director of Finance replied that HR was working on being able to produce this level of reporting.  **The Board noted the report.** | **MME** |
| **BOD 177/17**  a  b  c  d | **Finance Report**  The Director of Finance presented the report BOD 135/2017 which summarised the financial performance of the Trust for the period ending September 2017 (Month 6, FY18). EBITDA (Earnings Before Interest, Taxation, Depreciation and Amortisation) was £0.7 million adverse to plan and Income and Expenditure was also £0.7 million adverse to plan. However, once one-off benefits such as receipt of additional Sustainability & Transformation funding had been excluded, the position was £1.1 million adverse to plan. The adverse variance was mainly driven by: under-delivery of CIP; provision of the CQUIN (Commissioning for Quality and Innovation payments) risk reserve which the Trust was required to set aside; and the net effect of other service pressures (despite the positive impact of £1 million underspend in Corporate services).  The cash balance was healthy and £9.9 million higher than plan. The capital programme was £1.9 million behind plan but additional programmes to address risks in certain areas had been included and the capital expenditure forecast was to be reasonably close to plan by year-end. On the Use of Resources metric, the Trust had maintained a rating of ‘3’ (where a rating of ‘1’ indicated lowest risk and ‘4’ indicated highest risk) due to agency costs being higher than planned spend and the NHS Improvement agency cap.  The Director of Finance noted that a mid-year review of the financial forecast would be considered at the Board meeting in private. He confirmed that NHS Improvement had been notified that the Trust would be reviewing its forecast due to significant financial risks and may need to revise its forecast.  **The Board noted the report.**  *Aroop Mozumder left the meeting.* |  |
| **BOD 178/17**  a  b | **Consultant Clinical Excellence Awards (CEAs)**  The Medical Director presented the report BOD 136/2017 which set out proposals from the Medical Staffing Committee for the following performance indicators against which allocation of CEAs would be assessed:   * physical health – which was noted as an important area of focus for the Trust and the CQC; * user involvement/Care Programme Approach (**CPA**) indicators – this was a challenging area for the consultant body as consultants did not solely influence CPA therefore a new factor had been included around review of medication which consultants would directly influence; * mandatory training – including equality, diversity and human rights training rates to be improved to at least 90% and conflict resolution training to be maintained at above 90%; * medical student teaching – and ratings of placement quality. Although the Trust had been highly rated for its student teaching, this had become an area of significant pressure due to increasing clinical workloads. However, this was an important area which the consultant body wanted to maintain and was therefore included; and * medical appraisal – and timely completion of appraisals.   **The Board APPROVED the proposals in the report.** |  |
| **BOD 179/17**  a  b  c  d | **Business Plan Q2 Report**  The Director of Finance presented the report which summarised progress of the Trust’s Business Plan against the Strategic Priorities for Q2 (July-September 2017).  The Director of Nursing & Clinical Standards provided an update on progress to deliver the Oxford Centre for Quality Improvement which linked with Strategic Priority 3 (to support teams to improve the safety and quality of the care they provide). She noted that there had been progress in putting contracts in place and that premises had also now been secured on the Warneford site. Recruitment to the team was also progressing well and some appointments were in the pipeline.  The Director of Finance noted that in relation to Strategic Priority 7 (to embed and enhance the electronic health record) there were currently challenges with the software provider not delivering on expectations.  **The Board noted the report.** |  |
| **BOD 180/17**  a  b  c  d | **Board Assurance Framework (BAF) Q2 Report**  The Director of Corporate Affairs & Company Secretary presented the report BOD 138/2017 on the position of the BAF and the risks which could cause the Trust to fail to achieve its Strategic Objectives. She noted that following the Board’s recent Strategic Away Day on 13 October 2017, further work would still need to be done to update and refresh the BAF following discussion of the Trust’s strategic direction.  The Board discussed the risk at SO 2.3 around financial exposure and agreed that the risk relating to achievement of CIP should be separated out.  The Board discussed the workforce risks at SO 5.1(A&B) and 5.2 and noted that the narrative and description of the risks may now need revision.  **The Board noted the report.** | **HS**  **HS** |
| **BOD 181/17**  a  b | **Delivering the Trust’s Strategy**  The Chief Executive provided an oral update on the Board’s Strategic Away Day in October 2017 and noted that the notes of the day had been circulated to the Board for review.  **The Board noted the oral update.** |  |
| **BOD 182/17**  a  b | **Updates from Committees – Quality Committee (01 September 2017), Audit Committee (12 September 2017) and Finance & Investment Committee (21 September 2017)**  The Board considered the minutes of the meetings at papers BOD 139-141/2017. Chris Hurst highlighted the Finance & Investment Committee’s discussion on CIP and the review of the capital programme.  **The Board received the minutes.** |  |
| **BOD 183/17**  a | **Any Other Business and Strategic Risks**  None. The Board noted that the strategic risks had been considered and discussed at item BOD 180/17 above. |  |
| **BOD 184/17**  a | **Questions from Observers**  Gillian Randall, Governor, asked about workforce turnover and what work was taking place to retain staff and find out more about their reasons for leaving. The Director of Finance agreed that this was important and was also a challenge which the Board regularly raised; however the response rate from staff to participate in exit interviews would need to be improved. |  |
| **BOD 185/17**  a | 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; and legal professional privilege in relation to the business to be discussed. |  |
|  | The meeting was closed at 12:34  **Date of next meeting: 29 November 2017** |  |

1. An Officer attending a Board meeting to represent an Executive Director member during a period of incapacity or temporary absence without formal acting up status may not exercise the voting rights of the Executive Director (Standing Orders of the Board 3.11.8). [↑](#footnote-ref-1)