

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

**Board of Directors**

Minutes of a meeting held on

31 January 2018 at 08:30

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

**Present:**

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| Martin Howell | Trust Chair (the Chair) (**MGH**) |
| John Allison | Non-Executive Director (**JAl**) |
| Jonathan Asbridge | Non-Executive Director (**JAsb**) – *part meeting* |
| Stuart Bell | Chief Executive (**SB**) |
| Mike Bellamy | Non-Executive Director (**MB**) |
| Tim Boylin | Director of HR (**TB**)[[1]](#footnote-1) |
| Alyson Coates | Non-Executive Director (**AC**) |
| Sue Dopson | Non-Executive Director (**SD**) – *part meeting* |
| Anne Grocock | Non-Executive Director (**AG**) |
| Bernard Galton | Associate Non-Executive Director (**BG**)[[2]](#footnote-2) |
| Mark Hancock | Medical Director (**MHa**) |
| Dominic Hardisty | Chief Operating Officer (**DH**) |
| Chris Hurst | Non-Executive Director (**CMH**) |
| Mike McEnaney | Director of Finance (**MME**)  |
| Pete McGrane | Clinical Director (Older People’s Directorate) and Acting Director of Nursing |
| Kerry Rogers | Director of Corporate Affairs & Company Secretary (**KR**)[[3]](#footnote-3) |
| Lucy Weston | Associate Non-Executive Director (**LW**)[[4]](#footnote-4) |
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| **In attendance:** |
| Charlie Molden | Quality & Clinical Standards Facilitator (Older People’s Directorate)  |
| Martyn Ward | Interim Director of Performance (**MW**) |
| Hannah Smith | Assistant Trust Secretary (Minutes) (**HS**) |

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| **BOD****01/18**ab | **Welcome and Apologies for Absence**The Chair welcomed members of the Board present and the governors, staff and members of the public who had attended to observe the meeting. Apologies for absence were received from: Ros Alstead, Director of Nursing & Clinical Standards; and Aroop Mozumder, Non-Executive Director.  |  |
| **BOD 02/18**abc | **Declarations of Interests**The Chair presented the report BOD 01/2018 which set out the Register of Directors’ Interests. No interests were declared pertinent to matters on the agenda. **The Board noted the report.**  |  |
| **BOD 03/18**abc | **Minutes of the Meeting held on 29 November 2017**The Minutes of the meeting were approved as a true and accurate record subject to the following:* GDPR (General Data Protection Regulation) to be a defined term throughout;
* BOD 197/17(e) “£5” to be amended to “£5 million” or “£5m”; and
* BOD 198/17(d) “effect” to be amended to “affect”.

***Matters Arising*****Item BOD 100/17(b) Chronic Fatigue Syndrome/Myalgic Encephalomyelitis (CFS/ME) service**The Chief Operating Officer provided an update on determining the pathway of care for CFS/ME. He noted that this would be revisited following the upcoming contract meeting with Oxfordshire CCG in the coming month. **Item BOD 190/17(o) General Data Protection Regulation (GDPR)**GDPR implementation was on the agenda for the Audit Committee meeting on 05 February 2018 and, potentially, for the Board Seminar on 14 February 2018.  |  |
| de | 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); BOD 180/17(c) (Board Assurance Framework – workforce risks at SO 5.1 and 5.2 to revise narrative and description); and BOD 192/17(f) (Performance Report – deep dive into specified areas). The Board confirmed that the remaining actions from the 29 November 2017 Summary of Actions had been completed, actioned or were on the agenda for the meeting: BOD 121/17(b) and 167/17(b); BOD 166/17(a); BOD 170/17(f); BOD 170/17(h); BOD 172/17(h); BOD 173/17(e); BOD 175/17(d); BOD 176/17(d); BOD 180/17(b)-(c); and BOD 187/17(a). |  |
| **BOD 04/18**abcdefghijklmnopqrst | **Chief Executive’s Report**The Chief Executive presented the report BOD 03/2018 which outlined recent national and local issues and included a Legal, Regulatory and Policy update.***Winter pressures and demand across services***The Trust was experiencing a busy winter but services had been coping well. The planning which had gone into preparing the GP Out-Of-Hours (**OOH**) service for a challenging period had worked well. Extra beds had been opened in community hospitals in the last month and Oxfordshire CCG had agreed to fund this additional capacity. Staff across Community teams, and Mental Health services which interfaced with the urgent care system, had been working over and above the call of duty to support the system at a time of great pressure. However, throughout the seasonal focus on Community services, it was still important to keep Mental Health services prominent in considerations. With no obvious respite in pressures, and with further details awaited on the allocation of funding, it was important to set realistic plans for the growing level of activity the Trust would need to respond to in the coming year. It would be unacceptable if Mental Health services ended up as the balancing item to other services. The Trust would, therefore, continue to work with commissioners to maintain focus on the need for investment in Mental Health, particularly given the relatively low proportion of funding allocated historically to Mental Health services in Oxfordshire. ***Financial Plan FY18***The Trust had been committed to helping the NHS respond to demand and pressure through the winter period whilst also maintaining core functioning of Mental Health services. However, the financial projection for the year-end had deteriorated from a surplus to a full year shortfall against the planned control total of £1.8 million. Although the Trust would continue to try to work towards achieving the original plan, which would help the Trust to start the coming financial year in a better position, NHS Improvement had been formally notified of the revised forecast which included £0.3 million of additional cost in relation to the Oxfordshire risk share agreement. ***FY18 contracts/Oxfordshire risk share*** The level of risk which was now expected to crystallise in the Oxfordshire risk share was lower than originally anticipated. Originally, there had been concern about a potential total exposure of £18 million of which £16 million related to the gap in the assumptions around elective and non-elective activity and the difference between the position of Oxford University Hospitals NHS FT (**OUH**) and the wider system risk. However, as it was unlikely that the originally anticipated activity levels would be realised, especially in relation to elective activity, a lower level of risk was expected to crystallise. The anticipated impact of the risk share agreement was, therefore, an additional £0.3 million to the Trust (over and above cost pressures already absorbed in Community Hospital and OOH services). However, not realising originally anticipated activity levels in elective care would lead to a waiting list backlog to be tackled; this position was also driven by recruitment issues across the local health economy and in OUH. The Director of Finance added that the risk to the Trust was also lower than it could have been because Oxfordshire CCG had been able to absorb the risk which had materialised in relation to OUH’s position and thereby dilute the impact for the partners in the risk share agreement. Due to the differing types of contracts in place between Oxfordshire CCG and providers, risk generated by OUH activity under ‘payment by results’ contracting would transfer instantly to the CCG through invoicing and price per activity; whereas, risk generated by the Trust’s activity under its block contract would have to be absorbed by the Trust unless it could be negotiated with the CCG. *Sue Dopson joined the meeting.* The Trust was in discussions with various parties around the arrangements for FY19 contracts. Although the Trust had benefitted during FY18 in elective activity not materialising as expected, elective activity was an area which the Trust could have little control over whereas it may be able to have a stronger positive impact upon non-elective activity such as urgent care. The Trust’s ongoing work with GP Federations would support this. The Chief Executive emphasised that: risk should be located where activity was in place to manage it; and actions which had been identified to mitigate risk should be supported and put in place. ***Workforce and staffing***The Chief Executive referred to his report and noted that initial results had indicated that the Trust had maintained its position in the national Staff Survey but had not achieved its aim to improve to be in the top 20% of trusts; the full national comparative data set was yet to be received and analysed. The next quarterly Linking Leaders events would focus on Recruitment and Retention. The Trust would also participate in the consultation on the draft health and care workforce strategy from Health Education England; the Trust would highlight the importance of considering area pay weightings, not just London pay weightings, considering the high cost of living in areas such as Oxfordshire. The Trust would also discuss high cost of living issues with partners in the local area including universities and other NHS providers. Bernard Galton referred to the draft health and care workforce strategy and noted that, in its focus on a 100% NHS workforce and the importance of reducing agency spend, it was potentially missing an opportunity to recognise agency staffing and a temporary workforce as a flexible asset, especially when organisations were going through major change or building in flexibility for the long-term such as the 10-year period of the draft strategy. The Chief Executive agreed that a temporary workforce could be a flexible asset but noted that ‘temporary’ or ‘flexible’ did not necessarily need to equate to use of agency. He emphasised the Trust’s progress in recruiting to its own internal staff bank of flexible workers who could benefit from more direct training from the Trust as well as providing more commitment to the Trust’s values. He noted that the draft strategy also did not take sufficient account of the benefit of working in partnership with other organisations, including in the third sector, whose workforce could also provide a flexible complement to permanent staff. However, given the cost of agency premiums it was not necessarily surprising that agency spend had been singled out for focused reduction. Bernard Galton noted that there could be a range of different types of flexible working but emphasised that there was still an opportunity to reframe the debate around agency usage especially as some of the targets for reduction of spend may be unrealistic. ***Freedom to Speak Up Guardian***The Chief Executive referred to his report and the Trust’s self-assessment against the 10 principles and 10 recommendations from the National Guardian’s Office. He noted that recruitment was underway for a new guardian to replace Mike Foster, following his retirement at the end of March 2018, and that following the appointment of a new guardian the Trust would progress the recommendations in relation to local networks and feedback about the guardian role. ***Care Quality Commission (CQC): (i) Trust inspection; and (ii) system-wide review***The Trust anticipated that its annual Well Led inspection, under the CQC’s new approach to provider inspections, was imminent. The CQC had also recently concluded its Oxfordshire system-wide review of system performance across providers and commissioners; the Oxfordshire draft report had been shared and the Trust had responded upon points of accuracy and participated in the quality summit to discuss. The quality summit had been a constructive opportunity to discuss where commitment to work jointly and consistently together could be improved at all levels in local organisations. The impact of workforce pressures and pay arrangements, especially in domiciliary care, had also been acknowledged. ***‘Never event’***The Chief Executive referred to his report and the sad news of the ‘never event’ which had taken place in relation to the tragic death at home of a child with disabilities who was receiving support from integrated therapies services. He highlighted that a ‘never event’ was very rare for the Trust and this was the first since he had been in post. An independent investigation had been commissioned and the Trust was committed to learning from this as much as possible. ***Academic Health Science Centre (AHSC) and Academic Health Science Network (AHSN)*** The Chief Executive referred to the AHSC and AHSN updates in his report. ***Buckinghamshire, Oxfordshire and Berkshire West (BOB) Sustainability and Transformation ‘Partnership’ (STP)*** The Chief Executive referred to his report and noted: the changes in Executive leadership of the BOB STP; the appointment of a new Interim Accountable Officer for Oxfordshire CCG; and the outcome of the judicial review of the Oxfordshire CCG phase one consultation of the Sustainability Transformation Plan for Oxfordshire. He highlighted the progress being made in relation to: * the 5 Year Forward View for Mental Health and the work of the Oxfordshire and Buckinghamshire Mental Health Delivery Groups to develop a crisis pathway; the Trust had also been successful in being granted winter monies for the delivery of crisis cafés and places of safety;
* New Care Models including: the Trust’s continuing leadership of the Thames Valley and Wessex Forensic New Care Model; confirmation that NHS England had approved the final business case for the Eating Disorders network and wished the Trust to proceed; and ongoing discussions to develop similar New Care Models for Tier 4 Child and Adolescent Mental Health Services (**CAMHS**) and specialist dentistry by April 2018; and
* the provision of Community Forensic CAMHS (including secure outreach) – the Trust had been successful in its tender to provide these services to NHS England Specialist Commissioning in the South West (Gloucester, Wiltshire, Swindon, Bristol, South Gloucester, Bath & North East Somerset and North Somerset) and Wessex (Hampshire, Isle of Wight, Dorset, Berkshire, Oxfordshire and Buckinghamshire) areas.

Anne Grocock asked about the possibility of legal challenge to the Buckinghamshire Accountable Care System (**ACS**) which the Trust was part of, in light of the legal challenge being brought against Accountable Care Organisations (**ACOs**). The Chief Executive explained the differences between ACOs and ACSs and that the basis upon which ACOs were being challenged would not necessarily apply to ACSs. The language of ‘accountable care’ came from the US, where ACOs took responsibility for the management of the healthcare of a local population. An ACO may be the formal result of providers agreeing to merge to create a single organisation. However, ACSs, like STPs, were more collaborative attempts by existing statutory bodies and partners (such as local authorities, providers and CCGs) to work together to make the best use of resources and take the lead in planning and commissioning care and providing system leadership. He highlighted the distinction between the ACO single entity approach and the ACS collaborative partnership approach, noting that the terminology may need to evolve to avoid confusion. The Trust Chair referred to the progress being made on Tier 4 CAMHS New Care Models and whether the commissioning could encompass the whole of the South of England. The Chief Executive noted that that level of geographical spread may be too unwieldy, especially as there would be very limited national resources to transfer over in terms of managing it, but that it may be possible for existing local entities and networks to collaborate more closely and make the best use of scarce resources. ***Appointments and awards*** The Chief Executive referred to his report and the following consultant appointments: Dr Keely Hindhaugh and Dr Caroline Broadhurst. He also congratulated Dr Clive Meux, the Trust’s former Medical Director, on being awarded an OBE for his services in caring for people with mental health difficulties. **The Board noted the report and ratified the consultant appointments.**  |  |
| **BOD 05/18**abcdefghijk | **Chief Operating Officer’s Report**The Chief Operating Officer presented the report BOD 04/2018 which provided an update on quality, people and sustainability together with a narrative of key issues being managed by the Operational Management Team. ***Quality***He noted that both the Buckinghamshire and Oxfordshire systems had now received the outcomes of the joint CQC/Ofsted ‘SEND’ (Special Educational Needs and Disabilities) inspections in relation to services for children and young people. The outcome of the Oxfordshire SEND inspection had been reported to the Board in October 2017; the outcome of the Buckinghamshire inspection had also now been published. In both inspection reports, areas for improvement at system level had been identified. The Trust had a role not just to discharge its own accountabilities as a service provider but also to support the system. He referred to his report and highlighted the work of the Emergency Planning Lead in conducting a comprehensive review of fire safety responsibilities across Trust sites. He noted that after 6 months he aimed to report back, potentially to the Audit Committee as may be appropriate, on how well changes following the review had been embedded. He provided an update on the consolidation of stroke rehabilitation beds at Abingdon and noted that this would complete in late February, ahead of schedule. ***People***He noted that phase 1 of the consultation for the proposed new structure for Operations was nearing completion. Phase 1 was around operational leadership at service director and clinical director level. Phase 2 would focus on posts for heads of service, service managers, heads of nursing and roles through to teams and wards. ***Sustainability***He emphasised the importance of changing the approach to the Cost Improvement Programme (**CIP**) to focus on the 4 areas set out in the report (reducing agency spend, non-pay improvement projects, productivity and new business opportunities) and taking a Trust-wide, rather than directorate-specific, stance. He thanked staff for their hard work over the Christmas period. However, take-up of the flu immunisation programme had been under target and next year, at the beginning of the flu season, there would need to be a different approach to this. He referred to his report and noted that Oxfordshire County Council’s review of mental health social care continued and that key decisions were expected in February 2018. Alyson Coates referred to the section of the report on Finances and CIP and the discrepancy between the Finance and HR establishment budgets, which needed to be resolved. She emphasised the importance of budget and establishment setting and of a workforce plan which supported the budget and asked why this had not been resolved for the current year. The Chief Operating Officer noted that it had been challenging to resolve this in just one year, especially as this had been a longstanding challenge, but that the Finance Team had been making progress towards reconciliation and there were plans to link into the e-rostering system. The Director of Finance added that there was a balance to be struck, especially in dealing with vacancies across different areas and needs, because whereas on inpatient wards it was critical to recruit up to establishment to support safe staffing, this was not necessarily the case in administrative or corporate functions. As financial controls became more integrated with safer staffing controls then differences between finance and safety needs could be resolved. Chris Hurst agreed that this was a complicated issue but noted that whatever level of resource the Trust was paying for, it was important to be assured that this was being used to the best of the Trust’s ability and appropriately matched to service demands. The Trust Chair noted that CIP could no longer be seen as a tool to drive efficiency in the NHS; the future may be around realistic budgetary control for all individual areas of operation. He emphasised the importance of ensuring that staff could work to budgets which they believed in and had agreed to deliver against. Jonathan Asbridge added that however ‘CIP’ was badged, he supported the 4 areas of CIP focus in the report and that these should be pursued as part of good budgetary discipline.Mike Bellamy referred to the section in the report on the Oxfordshire Transformation Programme. He supported the approach to move forward with pilot projects to build consensus and evidence for new models prior to engaging in formal consultation. However, he noted that consideration should be given to the amount of available resource which the Trust could provide for this.  | **DH/HS** |
| l | **The Board noted the report.**  |  |
| **BOD 06/18**abcdef | **Performance Report**The Interim Director of Performance presented the report BOD 05/2018 on performance against the Single Oversight Framework for November and December 2017 (Months 8-9). The Trust had met or exceeded 90% of the 931 performance indicators reported in November and 92% of the 931 performance indicators reported in December; the number of reportable indicators varied each month (depending upon the frequency of the reporting expected e.g. quarterly or monthly) and the Trust continued to achieve 90% 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 but the Trust had achieved its locally contracted targets); 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). He noted that performance reporting would continue to evolve towards more integrated reporting and the development of a new dashboard to bring together the domains. The Children & Young People’s Directorate remained the highest performing directorate having achieved 95% compliance against indicators. However, there were areas of underperformance in relation to:* Looked After Children annual reviews – there had been a decrease in performance due to a combination of young people refusing an annual health review and delays in placements out of county; and
* CAMHS waiting times, especially around the 4 week waiting times, although there had been some improvement in performance against the 12 week waiting time target.

The Older People’s Directorate had improved in performance from 75% compliance against indicators to 82% in November and December. He highlighted that:* revised stroke therapy indicators had been introduced in October 2017, following agreement with the CCG that these were a better reflection of stroke therapy input in community hospitals, and overall performance was improving;
* GP OOH services had been under pressure over the Christmas period and 4 of 9 indicators had been breached due to demand and reduction in GP availability over the period. However, the service had continued to ensure that patients were safe and supervised; and
* following exceptional work by the Patient Flow Lead, as set out in the report, the Delayed Transfers of Care (**DToCs**) which were solely in the control of the Trust were at the lowest level they had been for 12 months and, as at January 2018, had dipped to 5 which was the lowest ever recorded for the Trust.

The Adult Directorate had declined in performance to 73% compliance against indicators in November and then improved to 75% compliance in December. There were areas of underperformance in relation to:* Improving Access to Psychological Therapies and more improvement work required to achieve the target of 8 week waiting times; and
* achieving timescales in cluster reviews in Oxfordshire and care reviews in Aylesbury.

John Allison asked if there were common themes or trends supporting the improvement in some performance which could help to ensure further improvement. The Interim Director of Performance replied that oversight and scrutiny by the Operational Management Team, combined with ensuring that service leads received and had time to engage with performance data, was helping to ensure that more responsibility was being taken for meeting targets. Jonathan Asbridge expressed his concern that some performance indicators may not be the appropriate ones for the Trust and that this may be particularly pertinent to those indicators which had not evidenced improvement; he noted that this may be worth considering in tandem with the CQC action plan. The Director of Finance noted that issues around whether the appropriate indicators and targets had been set for the Trust had already been highlighted to commissioners for discussion in relation to the FY19 contracts.  |  |
| ghi | Lucy Weston asked to what extent demand for services was reported, in particular the number of actual people on waiting lists, and whether this was a missing Key Performance Indicator which was not currently being captured. The Chief Executive explained that the contractual indicators which the Trust needed to meet for commissioners tended to be based around providing treatment within a specified timeframe; if demand and pressure upon services increased then the Trust was not provided with additional funding to support the additional work which may be required but was expected to absorb this, which led to pressure upon services. The Trust was, however, looking to quantify the impact of demand upon services. The Interim Director of Performance intended to include demand data in the new dashboard he was developing and which he had referred to above. Anne Grocock added that it was important to understand the number of actual people behind the percentages being reported. Although it was not necessarily acceptable if just one person had to wait longer than they should, there was still a difference in impact and potential indication of an underlying problem if delays were impacting upon patients in single figures as opposed to hundreds. **The Board noted the report.** |  |
| **BOD 07/18**ab | **Access to Healthcare for people with Learning Disabilities (LD)**The Chief Operating Officer presented the report BOD 06/2017 which provided: assurance against compliance with the 6 ‘Healthcare for All’ criteria and the new draft NHS Improvement ‘Provider Improvement Standards for LD’; and an update on the transition of LD services to the Trust. He highlighted that on a RAG (Red/Amber/Green) rating, all indicators were green or amber. Anne Grocock noted that a timeline to indicate when amber-rated indicators might turn green could also be helpful. **The Board noted the report.** |  |
| **BOD 08/18**abcd | **Learning from Deaths report**The Clinical Director and Acting Director of Nursing presented the report BOD 07/2018 on the governance in the Trust around reviewing and learning from deaths and themes and trends from April 2014 to December 2017. This was an interim report which would be followed by a detailed quarterly report to the Board meeting in February 2018. He highlighted that there were no changes to trends from previous quarters or an increase in the overall number of deaths; there were some seasonal fluctuations but the last peak had been in January 2015 in the wake of a flu outbreak. The majority of deaths were in people aged 75 and above, with physical healthcare conditions and who had previously been under the care of district nursing services in the Older People’s Directorate. Themes emerging from reviews of deaths were set out in the report, together with actions being taken, and covered: (i) physical healthcare for patients with a mental health illness; (ii) family/carer engagement and communication; and (iii) communication at points of transition and changes in care between teams, services or organisations. The Trust had been working voluntarily with the Healthcare Safety Investigation Branch around transitions following a death to identify improvements and learning nationally and internationally. Alyson Coates noted that the three themes emerging from the review of deaths were familiar and consistent with what had been reported previously. However, in comparing the actions being taken against each of these three themes, she had noted that the actions against theme (ii), on family/carer engagement and communication, appeared to be more high level and strategic than the more detailed operational actions being reported against the other themes. The Clinical Director and Acting Director of Nursing replied that there would be more detailed operational action to report if the points referred to in the response were drilled down into – for example the actions in relation to the ‘I Care, You Care’ (carers) strategy. Mike Bellamy emphasised the importance of being clear about how decisions were made about which deaths were identified as needing further investigation. He noted that, from a governance perspective, this was the critical decision point especially to ensure that potential incidents of poor care were identified early and investigated appropriately for relevant learning to be applied. The Clinical Director and Acting Director of Nursing agreed that this was important but noted that the majority of the Trust’s deaths were in the frail elderly population so it was also important to continue to consider how well the Trust was delivering end of life care. The Medical Director added that the Trust took care to investigate many deaths to try and establish if the care provided had been appropriate and the best available under the relevant circumstances.  |  |
| e | **The Board noted the report.**  |  |
| **BOD 09/18**abcde | **Quality and Safety Report: Patient Experience** The Clinical Director and Acting Director of Nursing presented the report BOD 08/2018 which provided a summary of: feedback received from patients and carers; actions taken in response to feedback; an overview of the national community mental health survey results for 2017; examples of patient involvement work; complaints and concerns received; and the development of peer support workers (for people with lived experience to work alongside clinicians to support patients and their families). He highlighted that the Trust had maintained a good score of 4.78 out of 5 against the rating for how involved patients felt in their care. He commended the Patient Experience & Involvement team for their work in this area and for embedding this in teams across the Trust. Anne Grocock noted that not all teams were yet using the ‘iWantGreatCare’ feedback tool and asked whether this was due to choice or opportunity if the rollout was still in progress. The Clinical Director and Acting Director of Nursing replied that rollout was still in progress across clinical directorates and work was ongoing to register teams and individual clinicians. *Jonathan Asbridge left the meeting.*The Board discussed the format of the report. There were differing opinions. On the one hand, the engaging and accessible style of the report was praised. On the other hand, the report was found to be not easy to read (the choice of black font upon blue background being particularly challenging). The information also needed to be rearranged in order to be interpreted; for example, the presentation of the outcome of the national community mental health survey results did not make it clear whether the Trust had improved, or not, relative to other mental health providers. **The Board noted the report.** |  |
| **BOD 10/18**abcde | **Inpatient Safer Staffing**The Clinical Director and Acting Director of Nursing presented the report BOD 09/2018, the format of which had been updated to distinguish between staffing levels for registered and unregistered nursing staff on each ward. The report also provided an in-depth review of safer staffing on Adult Mental Health wards and provided information on Evenlode ward (LD services), urgent care and OOH staffing and the SafeCare project rollout. He explained that during 06 November – 31 December 2017, average day and night shift fill rates for registered and unregistered staff were above the Trust target of 85%, through use of substantive, bank and agency staff as set out in the report. 9 of 32 wards had experienced difficulties in achieving expected registered nursing staffing levels on day shifts and 3 of 32 on night shifts; staffing was supported through unregistered staff so that wards remained safe to deliver patient care. The report set out the use of agency staffing which was 16% up to 24 December but increased to 17.4% in the week ending 31 December; this related in particular to staffing required for the additional beds opened within community hospitals as part of the system-wide response to winter pressures. He highlighted that there continued to be high acuity within services and high demand upon services. He noted in particular the vacancies in the 8 Adult Mental Health wards, as set out in the report. The Board considered the updated format of the report. Mike Bellamy noted that it was useful to distinguish between fill rates for day and night shifts and to distinguish between registered and unregistered staff. He suggested that it may also be helpful to consider whether restrictions on admissions to a particular ward correlated with instances of incidents and to reflect on whether sufficient action was being taken to reduce pressures on staff who may be dealing with challenging acuity or demand on wards. **The Board noted the report.**  |  |
| **BOD 11/18**abc | **Patient Story – Chronic Fatigue Syndrome/Myalgic Encephalomyelitis (CFS/ME) service**Charlie Molden joined the meeting and presented a recording of a patient who had been supported by the CFS/ME service and who had transitioned from support through the Children & Young People’s Directorate to the Adult Directorate. The patient praised the work of the clinician in the CFS/ME service who had recognised her name from a referral list, when she was re-referred by her GP as an adult, and who was then able to pick up and continue with the care she had received previously. The patient noted that without the support of the CFS/ME service, she would not necessarily have the strategies and various methods which she was using to cope with day to day life. She had also recommended the CFS/ME service to friends, family and other children at her school. The Board discussed the informal ways in which clinicians could make connections by recognising names on lists, offer additional value to service users by providing continuity of service and support transition across services. The Board noted that where this was taking place, this may amount to a level of activity and support which was not being fully recognised. Whilst it was positive that this could bring added value to service users, it would be useful if this kind of transitional support could also be seen to take place more by design and less by accident. **The Board noted the presentation.** *Charlie Molden left the meeting.* |  |
| **BOD 12/18**abcdefghijklmn | **Workforce Performance Report** The Director of HR presented the report BOD 10/2018 which set out the position on workforce performance indicators including temporary staffing spend, vacancies, recruitment, turnover, sickness and Workforce Race Equality Standards (**WRES**). ***Agency and bank spend***The Director of HR referred to the minutes of the last meeting on 29 November 2017 and item BOD 197/17(e) in relation to use of the £5 million which could be saved if the Trust was not spending approximately £21-22 million per year on agency and agency premiums and was, instead, filling these roles with substantive or bank staff. He noted that if the Trust did not need to spend this on agency premiums then it may be available to be reinvested in training, leadership development, Learning & Development for staff or in more staff support or reward initiatives like the Employee Assistance Programme. John Allison asked at what level decisions were made as to whether to use agency staff in order to support safe staffing levels. He noted that there should always be awareness of the financial impact of such a decision. The Clinical Director and Acting Director of Nursing replied that ward managers or local team managers would make the decision in association with matrons and local operational managers. He noted that from his experience, these managers were very conscious of the cost implications and he had witnessed them carefully considering other alternatives which may be more cost effective before they resorted to agency use. The Director of Finance referred to the chart in the report on bank spend by directorate and asked about the marked and positive increase in spend on bank staff from the Older People’s Directorate during Q3. The Clinical Director and Acting Director of Nursing replied that this may be linked to the move of the GP workforce onto the bank. ***Recruitment and Retention***The Director of HR referred to the report and the new initiatives underway to support recruitment. Further to recently launched initiatives: the Trust had started to receive ‘refer a friend’ referrals; a new recruitment centre had been established in the Corporate Services building in Littlemore; a new post had been agreed to focus on marketing and use of social media to support recruitment; and further posts had been added to the recruitment team. The next quarterly Linking Leaders events would focus on Recruitment and Retention and would showcase examples of best practice in hiring and around retention, as well as highlight the consequences of worst practice and the risks of losing candidates during a recruitment process (especially if the process was protracted). Lucy Weston noted that she had heard anecdotal evidence of candidates for administrative posts finding work elsewhere whilst they were waiting for recruitment processes and checks to complete. He noted that there was still work to consider around pay and reward arrangements, in consultation with staff side union representatives and operational management. However, the consequences of significant changes for current staff in particular would need to be recognised and carefully considered. He referred to his report for the initial results of the national Staff Survey, which showed little change for the Trust compared to the previous year, and noted that the results would be discussed further at the February Board Seminar. In relation to retention, and the outcome of the Staff Survey, Lucy Weston noted the importance of building the Trust’s brand as an organisation staff felt loyal to so that it was not necessarily third in line behind loyalty to their immediate ward or team and to the wider NHS. The Director of HR agreed that this was important but noted that of more immediate impact to support retention may be developing line managers and empowering them to offer more support and career development for staff. ***Diversity and Inclusion***The Board discussed the approach to diversity and inclusion. John Allison expressed his concern that enthusiasm to provide supportive environments for staff may sometimes jeopardise respect for the private lives of those staff who may wish to protect their privacy. The Director of Finance agreed that allowing staff to maintain their privacy was important but noted that the Trust’s current approaches were to support managers not to make assumptions about the private lives of staff. The Chief Operating Officer added that it was important to create environments which were supportive to allow staff to choose whether to disclose information about themselves, or not. The Director of HR added that a new focus for 2018 would also be on disability issues. The Chief Executive noted that although he had been concerned that the Trust was not making the progress that it should in relation to equality and diversity issues, the Trust’s recent and improved performance in its second Stonewall assessment was a positive indicator that it was moving in the right direction. On the Stonewall index, the Trust had improved by over 100 places in the league table of employers. He emphasised the importance of progress in this area to also support recruitment, retention and engagement with wider communities. He agreed that the right to privacy was important, noting that ensuring that people were not inhibited from speaking up was not the same as obliging people to share. However, in the course of raising these important issues sometimes people could get carried away by their enthusiasm but it was a healthy indicator of the direction of travel of the Trust’s culture that this debate could take place. Anne Grocock referred to the report and the WRES indicators. She highlighted that the final indicator on the percentage of BME staff experiencing discrimination at work indicated that this was an area which should be reviewed; she asked whether the results of the national Staff Survey had also provided relevant information in relation to this. The Director of HR replied that he hoped to have this information when this was discussed further at the Board Seminar. Alyson Coates asked whether there was a gender pay gap in the Trust. The Director of HR replied that he would need to consider this, taking into account the clinical excellence awards for consultants. ***Development of reporting***Alyson Coates requested that reporting develop in the future to cover training levels and completion of appraisals/Personal Development Reviews, especially in light of the limited assurance findings of a recent Internal Audit review. **The Board noted the report.**  | **TB****TB** |
| **BOD 13/18**abcde | **Finance Report**The Director of Finance presented the report BOD 11/2018 which summarised the financial performance of the Trust for the period ending December 2017 (Month 9, FY18). EBITDA (Earnings Before Interest, Taxation, Depreciation and Amortisation) was £1.2 million adverse to plan but Income and Expenditure was £0.1 million favourable to plan, mainly due to the gain on the asset transfer of the Slade site from Southern Health NHS FT and from additional Sustainable and Transformation funding that related to FY17. However, once these one-off benefits had been excluded, the position was £1.9 million adverse to plan. The adverse variance was mainly driven by: under-delivery of CIP; provision of the Commissioning for Quality and Innovation payments (**CQUIN**) risk reserve which the Trust was required to set aside; and the net effect of other service pressures such as staffing spend on Adult inpatient wards and in community hospitals. The cash balance was healthy and £13.3 million higher than plan. The capital programme was £2.3 million behind plan and the capital forecast for the year-end had been revised as a result. 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. Following the mid-year review of the FY18 plan and forecast, the forecast has been revised downwards to a full year shortfall against plan (excluding Sustainability and Transformation funding) of £1.8 million. The main risks to meeting the full year plan were: delivery of the £7.4 million CIP target; pressures in services; and risk associated with the Oxfordshire risk share agreement. NHS Improvement had been formally notified of the revised forecast. **The Board noted the report.**  |  |
| **BOD 14/18**abc | **Business Plan Q3 Report**The Director of Finance presented the report BOD 12/2018 which summarised progress of the Trust’s Business Plan against the Strategic Priorities for Q3 (October - December 2017). He noted that the Interim Director of Performance would be leading on the development of strategy and business planning which would be discussed further at the Board Strategy Day on 02 February 2018. The Board noted that the only project which was red-rated was achievement of CIP against strategic priority 5 (to ensure the Trust was high performing and financially viable). **The Board noted the report.**  |  |
| **BOD 15/18**abc | **Board Assurance Framework Q3 Report**The Director of Corporate Affairs & Company Secretary presented the report BOD 13/2018 on the position of the BAF and the risks which could cause the Trust to fail to achieve its Strategic Objectives.The Board discussed the new risk at SO 1.5. Mike Bellamy noted that this should be extended to also cover the impact upon staff, not just upon patients, of needing to continue to care for challenging patients who may not be in the most appropriate environment but whom the Trust was not able to find alternative suitable placements for. **The Board noted the report.**  | **HS** |
| **BOD 16/18**ab | **Corporate Registers**The Director of Corporate Affairs & Company Secretary presented the reports BOD 14/2018 on the Register of Gifts, Hospitality & Sponsorship and BOD 15/2018 on the Application of the Trust Seal. **The Board noted the reports.**  |  |
| **BOD 17/18**abcd | **Updates from Committees – Finance & Investment Committee 09 November 2017, Quality Committee 15 November 2017, Charity Committee 20 November 2017 and Audit Committee 07 December 2017**The Board considered the minutes of the meetings at papers BOD 16-19/2018. Anne Grocock highlighted the Charity Committee’s consideration of requests for resilience training from the Older People’s Directorate and the Children & Young People’s Directorate; she noted that the Charity had been concerned to ensure that funds were being spent appropriately and that best use was made of available internal resources. Alyson Coates reported that the Audit Committee had received 2 limited assurance Internal Audit reviews since the last meeting in December 2017 in relation to: CQUIN contract performance monitoring; and data quality. These would be discussed at the next Audit Committee meeting on 05 February 2018. Although the Board had recognised the need to improve and invest in the area of data quality, she noted that the Internal Audit review had indicated that there was not yet sufficient assurance that the information being reported to Board was as robust as it needed to be. **The Board received the minutes.**  |  |
| **BOD 18/18**ab | **Audit Committee Terms of Reference**Alyson Coates presented the report BOD 20/2018 and explained that the Audit Committee Terms of Reference had been amended to allow for any Non-Executive Director to be able to deputise for any member of the Audit Committee and be included in the quorum; this would be helpful on those rare occasions when quoracy was at risk and also to extend responsibility and insight of the Audit agenda more broadly amongst the Non-Executive Directors. **The Board APPROVED the amended Audit Committee Terms of Reference.** |  |
| **BOD 19/18**abc | **Any Other Business and Strategic Risks**The Trust Chair noted that this was the last Board meeting for Anne Grocock and Mike Bellamy and that it was taking place on the day of their retirement from the Board. He thanked both for their fantastic and huge contribution of work to the Trust over many years. He also noted that this was Tim Boylin’s first meeting as a new Executive member of the Board, non-voting, and that Aroop Mozumder and Bernard Galton would move from Associate Non-Executive Director, non-voting, positions to full Non-Executive Director, voting, positions with effect from 01 February 2018. The new position of Director of Strategy & Performance, non-voting, would be subject to discussion at the Nomination & Remuneration Committee meeting later on 31 January 2018. **The Board noted that the strategic risks had been considered and discussed at item BOD 15/2018 above.**  |  |
| **BOD 20/18**a | **Questions from Observers** Karen Holmes (Staff Governor) asked about the Trust’s performance on take-up of the flu vaccination compared to other trusts. The Director of HR replied that the Trust was in the bottom quarter of trusts and was aware that its performance on uptake of the vaccination would need to improve.  |  |
| **BOD 21/18**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 12:01**Date of next meeting: 28 February 2018** |  |

1. Non-voting [↑](#footnote-ref-1)
2. Non-voting [↑](#footnote-ref-2)
3. Non-voting [↑](#footnote-ref-3)
4. Non-voting [↑](#footnote-ref-4)