

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

**Board of Directors**

Minutes of a meeting held on

31 October 2018 at 08:30

Oak Room, Learning & Development

5th Floor, Unipart House, Garsington Road, Oxford OX4 2PG

**Present:[[1]](#footnote-1)**

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| Martin Howell | Trust Chair (the Chair) (**MGH**) |
| John Allison | Non-Executive Director (**JAl**) |
| Ros Alstead | Director of Nursing & Clinical Standards (**RA**) – *part meeting* |
| Stuart Bell | Chief Executive (**SB**) |
| Tim Boylin | Director of HR (**TB**)[[2]](#footnote-2) |
| Bernard Galton | Non-Executive Director (**BG**) |
| Mark Hancock | Medical Director (**MHa**) |
| Dominic Hardisty | Chief Operating Officer (**DH**)  |
| Chris Hurst | Non-Executive Director (**CMH**) |
| Mike McEnaney | Director of Finance (**MME**)  |
| Aroop Mozumder | Non-Executive Director (**AM**) |
| Kerry Rogers | Director of Corporate Affairs & Company Secretary (**KR**)[[3]](#footnote-3) |
| Martyn Ward | Director of Strategy & Chief Information Officer (CIO) (**MW**)[[4]](#footnote-4) |
| Lucy Weston | Associate Non-Executive Director (**LW**)[[5]](#footnote-5) – *part meeting* |
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| **In attendance:** |
| Donna Mackenzie-Brown | Patient Experience & Involvement Manager – *part meeting* |
| Hannah Smith | Assistant Trust Secretary (Minutes) |

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| **BOD****159/18**ab | **Welcome and Apologies for Absence**The Trust Chair welcomed members of the Board present, staff and the governor who had attended to observe the meeting. No members of the public were observing. Apologies for absence were received from: Jonathan Asbridge, Non-Executive Director; and Sue Dopson, Non-Executive Director.  |  |
| **BOD****160/18**ab | **Declarations of Interest**The Trust Chair presented the report BOD 122/2018 which included recent updates to the Register of Directors Interests. The following further updates/declarations were made in the meeting:* the Chief Executive had recently become a Trustee of Help for Heroes; and
* Chris Hurst noted that Community Health Partnerships, which employed his wife, had become part of the portfolio of NHS Improvement.

**The Board received the report.** |  |
| **BOD 161/18**abcdefgh | **Minutes of the Meeting held on 27 September 2018**The Minutes of the meeting were approved as a true and accurate record subject to “raise” at item 144/18(b), top of page 14, being amended to “raised”. ***Matters Arising*****BOD 142/18(l) Wantage Community Hospital**The Chief Executive’s report at paper BOD 124(i)/2018 included an update on Wantage Community Hospital. **BOD 143/18(i)-(j) Development of Performance Reporting**The Director of Strategy & CIO reported that work was continuing to rationalise reporting to focus upon performance (including clinical outcomes, not just patient experience) rather than contractual Key Performance Indicators (**KPIs**). The Board meeting in private would consider the development of an integrated performance reporting dashboard. **BOD 149/18(a) Safeguarding as part of Board induction**The Director of Corporate Affairs & Company Secretary confirmed that safeguarding was built into the induction programme. **BOD 152/18(c) Legal responsibilities of sponsor of research studies**The Assistant Trust Secretary reported that the sponsorship role included responsibility for: (i) identifying and addressing poorly designed research proposals; and (ii) ensuring that provision was made for insurance or indemnity cover liabilities. **BOD 152/18(b)&(f) Indemnity/insurance cover for sponsorship of research studies, specifically of Clinical Trials of Investigational Medicinal Products (CTIMPs) adopted by the Oxford Health Biomedical Research Centre (BRC)**The Medical Director reported that whilst NHS Resolution had confirmed coverage in relation to clinical negligence, there was a potential gap in relation to design and management of clinical trials which may therefore need to be separately covered by Research & Development. The Trust Chair reminded the meeting that approval of the Trust becoming sponsor of BRC-adopted CTIMPs, on the proposed interim basis, had been subject to confirmation of appropriate indemnity cover through NHS Resolution or other insurance cover. Therefore, until sufficient cover was confirmed, this was not yet finally approved. He requested a further update on the status of indemnity/insurance cover or confirmation that sufficient cover was in place. **BOD 153/18(b) Modern Slavery Act – to check the Trust was satisfied with the position of the agencies it used**The Director of HR reported that this would be considered/included as part of HR processes. The Board confirmed that the remaining actions from the Summary of Actions had been completed, actioned or were on the agenda for the meeting: BOD 143/18(k) – mental health clustering (on the agenda for the Board meeting in private); and BOD 109/18(d) – Effectiveness reporting especially in relation to Clinical Audit and improving clinical effectiveness (on the agenda).  | **MHA** |
| **BOD 162/18**abcdefghijkl | **Chief Executive’s Report** The Chief Executive presented the report BOD 124/2018 which provided updates against: recent national and local issues; and on legal, regulatory, compliance and policy matters. ***NHS long term planning***The Chief Executive referred to his report, and discussion at the NHS Providers’ annual conference, on the potential impact for mental health services of the Chancellor of the Exchequer’s Budget announcement. He noted that suggestions to inflate tariffs may stabilise acute provider deficits but it was not yet clear what would be suggested to stabilise mental health or community deficits and whether mechanisms, such as a change to commissioner/CCG allocations, would be considered. Within the local context, he provided an update on recent discussions on the approach which the Oxfordshire system may take as it continued to move towards developing an Integrated Care System (**ICS**), with more collaboration between providers on the management of local budgets to support healthcare for the local population. Oxfordshire CCG, providers and the county council had discussed moving away from tariff-based contracting arrangements (for acute services) and block contracts (for mental health and community services) towards more activity-based contracting which could also take into account the cost of running the local healthcare system, not just the cost for individual organisations. Moves towards becoming an ICS would also help to share funding pressures and local control totals. However, the relationship between cost, demand and capacity would need to be more clearly mapped in order to inform this wider systemic view. This should be possible, as the Trust had already evidenced in its Child and Adolescent Mental Health Services (**CAMHS**) where modelling had demonstrated that the Trust was already delivering beyond capacity but struggling to meet demand which was greater than that which had been nationally anticipated; however, there was work to do to apply the available data in Adult and Community services. *The Director of Nursing joined the meeting.* Aroop Mozumder asked whether areas with more advanced integration, such as Manchester, had demonstrated solutions to managing the tension between tariff and block-based contracting systems. The Chief Executive replied that there was not yet a clear answer and that tariff-based systems were still being operated. ***Financial performance***The Chief Executive referred to his report and confirmed that a Financial Recovery Plan had been established and a revised forecast had been submitted to NHS Improvement. The revised forecast was for a deficit of £8 million, which was £9.9 million worse than plan. The scale of the deficit, in light of the Trust’s overall efficient performance, was largely as a result of underinvestment in mental health services – which was currently under review with Oxfordshire CCG. ***Workforce***The Chief Executive noted that high agency usage continued and was proving stubborn to reduce. The Trust was continuing to discuss this with NHS Improvement and feedback had been that the Trust was taking appropriate action. He highlighted that: * the flu jab campaign was well underway, with an innovative promotional video; and
* recent Linking Leaders conferences had focused on disability equality and been powerful and positively received.

***Winter Preparedness – regional and local***NHS-wide planning anticipated a more severe winter period than last year; this was also likely in the local context of operational challenges during the summer heatwave, increasing workforce pressures and the period of sustained financial constraint. The Chief Executive highlighted the local work taking place to: (i) analyse projected weekly demand and capacity throughout the winter period; and (ii) design and implement measures to meet the gap, including collaborative work for the Trust to support post-acute reablement services. ***Care Quality Commission (CQC)*** The Chief Executive referred to his report and noted that the CQC would return over 06-07 November 2018 to follow-up its review of the Oxfordshire health and social care system. The Trust was also holding its own CQC quality summit, further to its well led inspection, on 01 November 2018 at the Whiteleaf Centre, Aylesbury. He commented upon the links between the two types of CQC review. *Lucy Weston joined the meeting.* ***Wantage Community Hospital***The Chief Executive referred to his report and provided an update, further to discussion at the previous meeting, on the request from the Oxfordshire Joint Health Overview and Scrutiny Committee (**HOSC**) for the Board to release reserved capital funds to undertake remedial works at Wantage Community Hospital. He confirmed that he had reported to the HOSC that it made little sense to expend significant sums of public money replacing a plumbing system which might subsequently require further changes just at the point that a process of consultation on what those potential changes might be was due to start; however, the Trust remained committed to funding plumbing replacement if that was what emerged from the consultation. The HOSC had understood the Trust’s concern and there would be a further discussion in November on the process for the consultation, to be led by Oxfordshire CCG. ***Legal, Regulatory & Policy update***The Director of Corporate Affairs & Company Secretary highlighted the Supreme Court judgement in the case of Darnley v Croydon Health Services NHS Trust and the potential implications for the Trust’s triaging procedures and the information provided about these in its urgent care and minor injury units. The Medical Director was working with Community services on this. **The Board noted the report.** |  |
| **BOD 163/18**abcdefghij | **Performance Report and Operational Perspective**The Chief Operating Officer and the Director of Strategy & CIO presented the report BOD 125/2018 on performance against national and local indicators. The Chief Operating Officer highlighted:* pressure on mental health services across Children’s, Adults’ and Older People’s services with increasing demand leading to more referrals and pressure on wards as well as to Out of Area Placements/Out of Area Treatments (**OAPs/OATs**) for Adults and Older People’s services; and
* since the report had been prepared, he reported a significant improvement in Delayed Transfers of Care which were at the lowest level they had been for a year. He noted that this was further to the appointment of Tehmeena Ajmal to the post of Winter Director and the remobilisation of the HART (Home Assessment Reablement Team) service provided by Oxford University Hospitals NHS FT to engage with the Trust’s community hospitals. The challenge would be to try to sustain this performance.

The Director of Strategy & CIO highlighted improved performance in relation to the national workforce indicator. The Trust was making progress towards the 12% target from its previous position as an outlier at nearly 15% to its current improved position at 13.76%, which was the best reported position this year. Overall, the Trust had achieved 74% of targeted local contractual indicators in Month 6 which was consistent with performance in Months 4-5 but a decline from 77% achieved in Month 3 and 85% in Months 1-2. The Director of Strategy & CIO referred to the report and issues with letter production and the Trust’s ability to provide letters to GPs and patients within timescales specified by commissioners, due to a lack of administrative capacity. The issue was not around the initial letter (to provide a summary to the GP within 24 hours of a patient being seen by Trust services) but the follow-up letter to be provided within 10 days. The Medical Director confirmed that the follow-up letter had value as it formed part of the more detailed care plan but the issue was around the time by which it needed to be produced. The timing was being discussed with commissioners, especially in light of proposals to reduce it from 10 to 7 days in line with the Standard Contract. The Board discussed the importance of keeping GPs appropriately informed and noted that it would not necessarily be helpful to share more electronic health record data directly with GPs given the volume of other information which the electronic health record contained. The Board recognised that the follow-up letter was an important part of the care process but that its current treatment as a contractual KPI was unhelpful. The Board noted that this area was, however, subject to an improvement project through the Oxford Healthcare Improvement Centre. The Director of Finance advised caution in considering whether to compromise on contractual standards. He noted that if a standard was considered clinically important then it should be met each time; if it was considered less important then the challenge should be why it was included as a KPI. If patient outcomes could be guaranteed by meeting certain standards then to maintain quality, the standards should be maintained. However, if tolerances needed to be set around meeting particular standards then these should be carefully controlled and monitored. John Allison noted that the issues around letter production appeared indicative of a wider cultural issue within the NHS of over-governance which diverted time and energy away from delivering care at a time when trust in local providers and the system would be more helpful. The Director of Strategy & CIO referred to the report and highlighted that OAPs/OATs in Oxfordshire and Buckinghamshire continued to expose the Trust to significant financial risk; actions to try to address this were being taken. The Trust Chair commended the report and noted that it demonstrated the extreme pressure which the Trust was operating under. He acknowledged the work of the Executive to bring to the attention of NHS Improvement and local CCGs the impact of historic underfunding of mental health services and the challenging financial climate which the Trust was operating within. He asked whether the Board was doing enough to also highlight the extreme pressure being put upon the Trust or whether further emphasis upon this could become counterproductive. The Director of Finance added that the independent review conducted by Trevor Shipman had concluded and confirmed underinvestment in Oxfordshire mental health services; these findings had been considered by NHS Improvement which had suggested that this was a regional issue for resolution. The Shipman review findings may not translate into a short-term solution to funding pressures but the Trust needed to consider its financial position and future Going Concern status. The Chief Executive noted that discussion of the Shipman review findings had been taking place at Executive to Executive level but it may now be necessary for the Board to ask to speak to the CCG Board and to engage with NHS Improvement and NHS England at regional director level. He emphasised that this was the time to be persistent and indefatigable. The Board considered scenarios relating to the possible impact if the Trust continued to attempt to meet ever increasing demand without a corresponding increase in resources. The Trust Chair noted that given the Trust’s responsibilities towards the local population it served, it would not want to contemplate capping activity but its financial situation would need to be resolved in order to avoid this. The Chief Executive added that the Trust needed to be able clearly state: (i) what amount of work/activity it could deliver for the funding it currently received; and (ii) what a properly funded operation would look like. The Trust may also be able to share pressure with the wider system through a shared control total. Chris Hurst advised that the Trust emphasise the evidence that demonstrated it was operating beyond reasonable expectations in order to build a compelling strategic case for its financial position and to demonstrate that it had not just allowed a deficit to happen. Bernard Galton asked what other boards of mental health providers were doing in similar circumstances. The Chief Executive replied that the situation in relation to commissioners and local systems was different in different areas. The Director of Finance added that when he had compared the Trust’s position and efficiency on National Reference Costs with national funding levels and the efficiency performance of other trusts, the Trust had come out as more efficient. John Allison challenged further capital expenditure for the remainder of the financial year. The Trust Chair noted that capital expenditure would be considered further in the private session of the Board meeting. The Director of Nursing & Clinical Standards reminded the Board of the impact of operating pressures upon patients, patient experience and clinical outcomes, noting how these could manifest in relation to increased waiting times. She suggested that more could be done to make the link between operating pressures and individual patient stories. She noted that it may be an option to engage patient and service user voices more and to direct the narrative when it came to explaining increased delays or more OAPs/OATs. **The Board noted the report and supported the proposal for a Board to Board, or Chair to Chair, discussion on the Shipman review.**  | **SB/ MME****SB/ MME** |
| **BOD 164/18**abcdefghijklm | **Human Resources (Workforce Performance) Report**The Director of HR presented the report BOD 126/2018 which set out the position on workforce performance indicators and updates on: the Healthcare Assistant (**HCA**) agency reduction project; recruitment; health and wellbeing; management of concerns (whistleblowing); Equality, Diversity and Inclusion; retention; the NHS staff survey; the national pay review; temporary staffing spend; vacancies; sickness; turnover; and Workforce Race Equality Standards (**WRES**). He highlighted recruitment work taking place and drew the Board’s attention to the pop-up stands/banners in the room which were being used in schools, with armed forces and with other groups to support recruitment activity across a range of roles (not just clinical). The images were also available on social media and as leaflets and desktop flyers. The Trust Chair asked if a clear message was being disseminated about the job security associated with nursing roles. The Director of HR replied that the issue was with the student funding available now that this was a loan, rather than a bursary, system. The Board discussing monitoring of social media and job sites for reviews and comments about the Trust, including negative reviews. The Director of HR confirmed that the HR team monitored relevant social media and job sites for comments. Lucy Weston referred to the report and the 36 workers who were listed as being on a waiting list to complete their Care Certificate training, before they could start with the Trust, except that no places were available until January 2019. The Director of HR replied that this was being discussed and Learning & Development was attempting to put on more training courses. The Director of Nursing & Clinical Standards added that a temporary online, rather than intensive face to face, solution had been agreed to work through the waiting list; she cautioned that whilst it could be an option to fast track experienced workers, the Trust could not necessarily assume that the agencies they came from delivered the Care Certificate in the same way that the Trust did and this would, therefore, need to be checked.In relation to recruitment, the Director of Nursing & Clinical Standards reported that 92 new trainee nurse associates would be commencing in post with the Trust; upon successful completion of their apprenticeships and two-year foundation degrees they would be able to become registered nurses. She noted that the Trust had been successful in its advertising of this opportunity both to its existing HCA workforce as well as to external applicants. She emphasised that the new trainee nurse associates should be recognised as valued members of the workforce but noted that some work would need to take place to combat any suggestions that they may be ‘cheap labour’. The Director of HR added that the first few months’ experience for new staff would also be critical to encourage them to stay. The Chief Executive added that the new role also represented another opportunity to provide employment and training for a locally-based workforce. In relation to health and wellbeing, and dealing with stress, the Director of HR reported that an Employee Assistance Programme had now been agreed and would be available not only to support staff with workload stress but also with self-management. Work was taking place with Procurement to select the supplier for the programme. In relation to temporary staffing spend, the Director of HR reported the positive news that spend (financial and time spent) on the Trust’s internal staff bank was starting to overtake external agency spend. He noted that this was as a consequence of significant work from the HR team, including through projects such as the HCA agency reduction project. However, overall temporary staffing spend still remained very high. The Chief Executive noted that it would still be useful for the Trust to work towards supporting different and more flexible ways of working. The Director of Finance added that although external agency spend had reduced since March 2018, the reasons behind this and the pricing mix were not yet fully understood and there had also been some fluctuating spend during the period. This may indicate a different mix of agency workers, for example more highly paid agency workers given the reduction in use of agency HCAs. Or, it could be linked to an uptake of annual leave towards the end of the financial year in March – which would need to be anticipated in the future. Aroop Mozumder asked how agile the Trust had been in changing its skill mix on wards in order to support teams to provide services in different ways and to follow the example of GP services/primary care in supporting other clinical practitioners to take on tasks. The Director of Nursing & Clinical Standards replied that a review of the staffing establishment was about to complete and work was taking place to see how the nurse associates, as well as peer support workers, could become part of multi-disciplinary teams. The Director of HR reported that 1,000 staff members had already received their flu jabs, which was an improvement compared to this time last year. The Chief Executive asked if there had been any issues with supplies of the flu jab. The Director of HR replied that there had not and that the flu jabs had only been one week late in arriving. Bernard Galton asked about progress with the staff survey. The Director of HR replied that this was now open and links to complete the survey had been sent to staff. Staff were also being encouraged to complete the survey by being signposted to the work which had resulted from previous surveys. The Medical Director referred to the report and commented upon the deteriorating WRES indicator no. 3 in relation to likelihood of Black & Minority Ethnic staff entering a disciplinary process. The Director of HR noted that HR was considering an initiative which the Royal College of Nursing was piloting around cultural ambassadors to help organisations to understand these trends and to challenge unconscious bias. The Director of Nursing & Clinical Standards added that at an appeals stage of disciplinary processes, more work was also being done to ensure that decisions made were proportionate. Aroop Mozumder asked about support for staff from the EU. The Director of HR referred to the report, noting that further guidance was awaited from NHS Employers, but in the meantime the position for Trust staff had been considered by the Equality & Diversity steering group. The national picture was still uncertain but the Trust was working with neighbouring trusts to project a positive message to EU staff about their right to remain and support which could be offered for staff making a formal application. The relevant staff in the Trust had been identified. The Director of Nursing & Clinical Standards noted that the most significant challenge may not necessarily be with existing staff but to reassure the potential pipeline of new recruits that the UK was still an attractive place to work. **The Board noted the report.**  |  |
| **BOD 165/18**abc | **Inpatient Safer Staffing Report – 13 August-09 September 2018** The Director of Nursing & Clinical Standards presented the report BOD 128/2019 which, this month, provided specific focus on: maintaining safe staffing; and NHS Improvement safer staffing resources for urgent and emergency care services. Average weekly daytime fill rates for registered and unregistered staff had been above the Trust target of 85%, being 92% or above for registered staff and 89% or above for unregistered. Average weekly night time fill rates had also been above the Trust target of 85%. However, 11 wards were below the 85% target for average daytime fill rates for registered nurses (up from 6 and previously 8 in prior reporting periods) but all wards remained safe to deliver care. In terms of the registered skill mix against establishment, only 13 wards had in place an average of 50% or above registered staff skill mix. A mix of substantive staff (including ward managers and matrons, where required), flexible workers and agency staff made up staffing numbers and provided safe care. She noted the following challenges: * staffing having brought together the Witney and Abingdon wards into a single stroke rehabilitation unit;
* vacancies in the City Community Hospital; and
* levels of vacancies on forensic wards which needed to be managed through temporary staffing – and the links with patient acuity and violence and aggression.

**The Board noted the report.** |  |
| **BOD 166/18**abcde | **Quality & Safety Report: Effectiveness**The Medical Director presented the report BOD 129/2018 and explained that, further to feedback from the Board, this represented a new style of reporting which focused on key lines of enquiry rather than updates against the activity of the various sub-groups. He highlighted that the Clinical Audit programme, for the first time in a while, was reporting as on target in terms of audits conducted but there were still some issues with audit ratings achieved. The rating of the audit in relation to resuscitation equipment was noted as this had not met the required standard and there had been reports of it taking up to 30 minutes to complete the checks. The Director of Nursing & Clinical Standards noted that this would be reviewed further through operational and nursing teams. The Director of Corporate Affairs & Company Secretary referred to section 3.6 of the report and asked whether this was linked to issues with take-up of resuscitation training which was reported as showing only 72% compliance. The Medical Director confirmed not as this particular audit had focused upon the equipment checks, not the practices. However, attendance at resuscitation training had been reviewed; action being taken included moving towards deliberately over-booking the courses in anticipation of some late cancellations each time, in order to prevent the situation of the courses becoming booked up early but participants then failing to attend. The Medical Director referred to section 2.12 in the report on the national revision of reporting mechanisms for pressure damage, which would no longer distinguish between inherited or acquired pressure damage. The Trust had formerly been able to distinguish between those pressure damage cases which it had inherited from other providers and those which had been acquired/originated whilst a patient was under Trust care. The new reporting arrangements were likely to increase the number of pressure damage cases reported by the Trust. However, the new reporting arrangements may also reduce differences and inconsistencies in regional reporting. The Director of Nursing & Clinical Standards noted that from a patient’s perspective, it may not matter where a case had originated but how it was treated and what information/education was available to support patients and their carers. The Medical Director referred to section 4.3 of the report and the examples of excellent practice which had been highlighted on a recent National Institute for Health Research visit. Aroop Mozumder commended the new form of reporting for the clear layout and relevant detail provided. **The Board noted the report and welcomed the new format.**  |  |
| **BOD 167/18**abcde | **Patient Story** The Patient Experience & Involvement Manager joined the meeting and read out an interview which had been conducted with a carer whose daughter had accessed the Children’s Speech & Language Therapy (**SLT**) Service in Oxfordshire after she had stopped talking. Feedback about the SLT therapist and the difference they had made in just 6 sessions was very positive. The family had however commented: (i) that the SLT service had not been proactive in explaining the model of care; and (ii) upon the low frequency of the therapist’s visits. The therapist visited every 6-8 weeks and the visits were noted to feel more like visits than therapy sessions. The family had wondered whether their daughter could progress even more if the therapist visited more often, considering how far their daughter had already progressed. The family had described the therapy as life changing for their daughter and had commented that without it, she may not have been able to start school when she did. However, it was difficult for her parents to help her with her exercises and they had felt that they needed to access a lot of advice and support with this. The Board discussed resourcing for the SLT service, noting that the model of care had changed recently and although children received an intensive period of SLT support, the ongoing expectation was for parents and teachers to be trained to provide support and carry out exercises. Chris Hurst referred to the comments from the family and emphasised the importance of explaining the model of care, and what was available, early in order to manage expectations. Lucy Weston asked about support/training for schools, noting that a multi-disciplinary approach was expected under this model of care. The Director of Nursing & Clinical Standards confirmed that a significant amount of work took place with schools involving multi-disciplinary care planning. John Allison noted that resourcing availability should also be explained to service users and their families, especially where this could help to families to understand the need to provide support. The Board considered access into the SLT service and noted that referrals could be through a number of routes including GPs and school health nurses. In the case of this patient story, the patient had received her initial assessment within 3 months of referral but had then waited a further 6 months before commencing treatment. Chris Hurst asked whether assessments were triaged to give different weightings according to need/urgency. The Director of Nursing & Clinical Standards confirmed that immediate needs would be recognised. The Director of Strategy & CIO confirmed that triaging was consistent across service lines but demand would impact upon waiting times for first stage treatment. The Board discussed waiting times and whether they could function as an indicator of an imbalance between demand and resourcing/funding. The Chief Executive commented upon the challenges with deciding where to prioritise allocation of resources, noting the particular difficulties faced by Adult mental health services. The Board considered information-gathering to assess the impact of waiting times upon patients. The Director of Corporate Affairs & Company Secretary noted the need for research or available clinical evidence to measure the impact upon patients effectively and reliably. **The Board noted the patient story and thanked the family who had provided it.** *The Patient Experience & Involvement Manager left the meeting.* |  |
| **BOD 168/18**abcde | **Finance Report**The Director of Finance presented the report BOD 130/2018 which summarised the financial performance of the Trust for September 2018 (Month 6, FY19). He reminded the Board that the FY19 financial plan had always been challenging with known risks to delivery as it required capping cost pressures from FY18 and achieving additional income from commissioners. The Month 5 position had seen a significant shortfall against plan driven by inability to achieve planned income from commissioners or to cap cost pressures in operational services, especially in relation to OAPs/OATs and residential care in the Adult Directorate. However, pressures had been building over the year and, as indicated last month, a financial reforecast had been approved and submitted to NHS Improvement. The reforecast position was £7.6 million adverse to the operating plan (once Provider Sustainability Funding (**PSF**) was excluded) or £9.9 million adverse when including PSF. He noted that the Trust was currently an outlier in the South of England having revised its forecast during Q2 but that it had been decided to notify NHS Improvement promptly and set out a forecast which the Trust believed to be attainable and realistic. The Month 6 position was an Income and Expenditure (**I&E**) deficit of £5.9 million, which was £3.5 million adverse to plan (compared to a Month 5 position of a deficit of £4.3 million). EBITDA (Earnings Before Interest, Taxation, Depreciation and Amortisation) was £0.5 million, which was £3.9 million adverse to plan (compared to Month 5 which had been £2.5 million adverse to plan). Cost pressures continued but improvement was anticipated in relation to OAPs/OATs and more scrutiny had been implemented in relation to reinvoicing for residential work. The cash balance was £16.7 million which was £0.3 million behind plan (compared to £21.8 million in Month 5 which had been £2.6 million above plan). Capital expenditure was £0.5 million which was £0.8 million below plan. The Use of Resources risk rating remained an overall ‘3’ (where ‘1’ was the best rating/low risk and ‘4’ the worst/high risk) although this was expected to drop to a ‘4’ under the reforecast position. The agency metric was already rated as ‘4’ due to agency spend above the NHS Improvement ceiling and additionally the I&E metric and capital service cover were rated as ‘4’ due to the operating deficit. The Trust Chair referred to the year-end reforecast cash position and noted that this was low at £6.6 million. The Director of Finance agreed and commented that normally the plan would be for a year-end cash balance of £10 million to support sustainability. **The Board noted the report.**  |  |
| **BOD 169/18**abcde | **Operational Plan – Q2 Report**The Director of Finance presented the report BOD 131/2018 on progress in delivering the Operational Plan. The Trust Chair asked whether the activity currency table would need updating as it seemed to suggest that CAMHS referrals were down against plan although other data would imply that there was increased demand. The Director of Strategy & CIO explained that increased demand had not happened in quite the way that had been anticipated based on the original model which had predicted increasing demand. The Chief Executive noted that modelling needed to better set out what was achievable with the available resources as opposed to what was aspirational or requested of the Trust, even if that identified a gap between what the Trust would be able to do going forwards compared to what it had done in the past. The Director of Nursing & Clinical Standards suggested that the report include more narrative to remind readers what the Trust had set out to do and how well it was achieving against its goals. The Director of Strategy & CIO referred to the report and highlighted: * the development of revised quality governance frameworks for the four new clinical directorates;
* the Improvement Scholars Programme for staff who wished to undertake one-year in-depth training in Quality Improvement to increase the advanced level of capability in the Trust;
* work taking place around CQUINs (Commissioning for Quality and Innovation payments);
* progress against the key programmes around: the Mental Health Five Year Forward View; New Care Models; the Oxfordshire Care Alliance and Care Closer to Home; and Learning Disabilities Transformation; and
* development towards an Oxfordshire ICS.

**The Board noted the report.**  |  |
| **BOD 170/18**ab | **Register of Gifts, Hospitality and Sponsorship**The Director of Corporate Affairs & Company Secretary presented the report BOD 132/2018 and explained the decision to facilitate the acceptance of a gift voucher, after a patient had been discharged, on behalf of the relevant team rather than the individual clinician. She noted the NHS England guidance on conflicts of interest which stated that vouchers should always be declined and confirmed that the clinician was well aware of this position for the future. The Board noted that this was a sensible outcome in the circumstances. **The Board noted the report**.  |  |
| **BOD 171/18**abc | **Update on delivering the Trust’s strategy**The Director of Strategy & CIO presented an oral update of the Board’s recent Strategy Day on 12 October 2018. He noted the focus around the theme of system leadership. The Board had also: reviewed progress in more detail around the key programmes referred to in the Operational Plan Report at item BOD 169/18 above; and considered investment priorities for the Trust. He noted that the Board may need to revisit the discussion on investment priorities in the context of emergent themes for investment from ICSs. Chris Hurst noted that although the Board had considered consequences, benefits and risks around potential areas for investment, it had yet to develop how this would be achieved. The Director of Corporate Affairs & Company Secretary noted that although Board Away Days had focused recently upon development of Strategy, there was also a role for them to support Board Development and the ways in which Executives and Non-Executives could respond to volatile, uncertain and rapidly changing situations. The Director of Nursing & Clinical Standards added that it was useful for the Board to consider how it may need to adapt and develop in order to achieve system leadership. The Director of Finance emphasised the importance of quality, sustainability and staff engagement and noted that the Trust should aim to be outstanding in these areas as the platform upon which other achievements could be built. He noted that this needed to become part of the strategic discussion for 2019. The Chief Executive agreed and commented that for 2019, the Trust could consider setting a threshold beyond which it would not compromise in these areas and which would underpin delivery of its key strategic programmes. **The Board noted the oral update.** |  |
| **BOD 172/18**abc | **Partnerships Update Report**The Director of Strategy & CIO presented the report BOD 133/2018 on partnership working, including ongoing work to complete an audit of partnerships which the Trust was engaged in. He highlighted: the creation of a Central Partnerships Register; findings from the governance self-assessment questionnaire, which had highlighted work to do with some partners around information governance; and work to develop the Partnership Standard so that new partnerships could be based upon a set of criteria. Approximately 60% of partnerships were with statutory bodies and the remaining 40% with the third sector. The Board discussed the level of assurance which would be useful in relation to the governance arrangements of the Trust’s partners. The Chief Executive commented that being a statutory body was not necessarily a guarantee of consistently good governance. The Director of Corporate Affairs & Company Secretary noted that it would be useful to set processes in place for the Trust to be informed if a partner had received an adverse regulatory finding so that the impact could be appropriately risk-assessed. The Chief Executive asked about the Oxfordshire Care Alliance and when that would be brought back to the Board for a final decision. The Chief Operating Officer noted that this was currently sat with him to work through and he would report back. **The Board noted the report.**  | **DH** |
| **BOD 173/18**a | **Any Other Business and Strategic Risks**The Director of Corporate Affairs & Company Secretary reminded the Board of the commencement of the next cohort of the Trainee Leadership Board who would be mentored by Board members. |  |
| **BOD 174/18**a | **Questions from Observers** Vicky Drew, Staff Governor observing the meeting, asked whether the nurse associates (upon qualification) would be available to work on the staff bank. The Director of Nursing & Clinical Standards replied that this would be possible once they had gone through their registration process, preceptorship and embedded their expertise through a substantive role.  |  |
| **BOD 175/18**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 11:51. **Date of next meeting: 30 November 2018**  |  |

1. Quorum is 2/3 of the whole number of members of the Board (including at least 1 NED and 1 Executive) i.e. where voting members of the Board are 12 (from October 2018), quorum of 2/3 with a vote is 8. [↑](#footnote-ref-1)
2. Non-voting [↑](#footnote-ref-2)
3. Non-voting [↑](#footnote-ref-3)
4. Non-voting [↑](#footnote-ref-4)
5. Non-voting [↑](#footnote-ref-5)