

Trust Board

TB2008.29

Minutes of a meeting of the Trust Board held in public on Thursday, 20 March 2008, in the Robert Turner Lecture Theatre, OCDEM, at the Churchill Hospital.

Present:	Professor Adrian Towse Dame Fiona Caldicott Mr Michael Fanning Dr Ken Fleming Mr Chris Hurst Ms Caroline Langridge Dr James Morris Mr Brian Rigby Mr Andrew Stevens (part)	In the Chair Non-executive Director Deputy Director of Nursing Non-executive Director Director of Finance & Procurement Non-Executive Director Medical Director Non-executive Director Director of Planning & Information
Attending:	Ms Marion Fiddes Mr Mike Greenall Dr David Lindsell (part) Ms Moira Logie Mr Nigel Mander Mr Tim Thomas Mrs Megan Turmezei Mrs Jenny Kitovitz	Assistant Director of Estates Medical Director, Division B Chair, Division C Director of Operations, Division A Audit Commission Audit Commission Assistant Director of Governance Acting Board Secretary
Apologies:	Mr Trevor Campbell Davis Mr Mark Gammage Mr Ian Humphries Ms Amanda Middleton Dr Henry Reece Dr Colin Reeves Ms Kathleen Simcock Mrs Elaine Strachan-Hall Sir William Stubbs	Chief Executive Interim Director of Human Resources Director of Estates & Facilities Acting Director of Operations, Division C Associate Member Non-executive Director Director of Operations, Division B Director of Nursing & Clinical Leadership Chairman

Action

TB 17/08 Minutes of the meeting held in public on 24 January 2008

The Workforce note on page 5 would be altered to "The Trust is better than the SHA benchmark for all relevant indicators". Otherwise, the minutes were agreed as a true record.

Matters arising from the minutes

Chris Hurst confirmed that the Trust does not have to make the Unitary Payment until certification has taken place. Commissioning normally takes about a month to six weeks after

handover.

TB 18/08 Chief Executive's Report

Professor Towse referred members to the Chief Executive's Report (TB2008.18):

1. The Trust achieved a financial surplus in January and February, and should be in a strong position to achieve a £4 million surplus by year end.
2. Emergency access targets would be considered as part of the Service Performance report.
3. The FT plans would be discussed at the private meeting.
4. The Cancer Centre will open for patients in October.
5. Oxford will become one of six regional centres offering 'islet transplantation' from 1 April.
6. The recommendations of the IRP would be considered once David Lindsell and Andrew Stevens had joined the meeting.
7. The parents of the Russian quintuplets had expressed their thanks to the Trust and cited the skills of its clinical teams.

Performance

TB 19/08 Financial performance to 29 February (Month 11)

Chris Hurst referred to his report (TB2008.19). The financial results for February showed a trading surplus of £781k, which was better than planned, as more patients were seen than expected. Consequently, the cumulative position at Month 11 was £2.8m, which provides further comfort that the year-end target surplus of £4m will be delivered. South Central SHA was keen to ensure that organisations delivered to their agreed "control totals", which remains at £4m in the ORH's case. There was little residual financial risk in this year except for the quarterly hard close with the PCTs, which is due to be completed in April. The original programme of savings was expected to deliver c. £4m less than the original plan, but directors will have made broadly compensating additional savings in the second half of the year. The reduction in the planned surplus, from £7m to £4m, largely reflects the later delivery of additional work at higher cost, and the consequent pressure this has created for non-elective capacity (theatres and beds) which has driven further cost.

The rigorous process put in place at the start of the year to challenge and firmly ground all BRC themes has inevitably delayed the profile of the initial investment by a few months and

slow recruitment to some posts has also impacted. Consequently, there will be an underspend on the BRC revenue budget in the first year. This underspend has not been included in reporting the Month 11 position. The Trust has agreed with the National Institute for Health Research that the funding will be carried forward to 2008/09 and deployed over the next two years. Dr Fleming said he understood the underspend was c. £3m. Chris Hurst confirmed this and replied that Oxford was not the only Centre in this position, as most trusts expected to take around six months to get things underway. Chris Hurst informed the Board that the General Manager comes into post in April, and a comprehensive report on the BRC will be brought to the Board's public meeting in May.

CH

Caroline Langridge enquired if it was possible to demonstrate where research was making a difference. James Morris replied that this was about translational research and that Phase 3 trials were outside the remit of the BRC. Translational research is the first phase in the process. It was agreed that the Board should receive six-monthly reports on research activity. In answer to a question, Chris Hurst commented that Alison Barnes is currently working on the marketing of the BRC, its work and achievements.

Chris Hurst commented that the profile of capital expenditure had followed a traditional 'S curve' this year but the timing of the Cancer Centre and Cardiac spend has resulted in a large proportion of the spend falling in the last month. He confirmed that spending is on track.

Debtors remained the same, whereas overdue debtors increased. At 88%, the 30 day settlement of creditors performance was better than target and an improvement on the previous two months.

Underlying cash holdings have been increasing over the last six months, partly because the BRC and the profile of the Capital Programme, which are both heavily skewed to the last quarter of the financial year. The emphasis is now on next year.

Caroline Langridge said she was pleased that private patient income had improved, but noted that there were no private neonatal services, and wondered how the costing of services for looking after the quintuplets had been arrived at. Chris Hurst said he would bring information back.

CH

TB 20/08

Service Performance Report to 31 January 2008 (Month 10)

AS said the report (TB2008.20) showed the position at the end of

Month 10.

Service performance targets

- The Trust would not achieve the 98% A&E target, but all within the department are working for as high a score as possible. The targets for emergency bed days and delayed transfers of care were also not being met.
- The Trust is performing robustly on elective targets, and is in a strong position.

Key performance indicators

- Emergency activity is above plan.
- More elective activity is planned to take place in the second half of the year.
- The Trust has achieved average lengths of stay and cancellation rates.

The timetable for some of the long term service redesign work has had to be extended because of the focus on meeting operational targets, although work is being done on theatres. Caroline Langridge enquired about theatre usage and requested a more detailed report on theatres. Ian Humphries said the Cancer Centre opening was happening at an opportune time, as JR theatres need to be updated too. A report would be brought to the May meeting.

Quality

- James Morris said that January was a bad month for MRSA and *C.difficile*. There were 11 cases of MRSA. He had carried out a comparative audit with February 2007 when there were also 11 cases of MRSA. In January nine were pre-48 hour cases, and a number of these were from community hospitals. This was a reversal from last February. In January there were no cases in ITU. In February 2007 at least five cases were judged to be preventable, but only one out of 11 cases was preventable in January 2008. Some were associated with end of life care.
- There were 4 cases of MRSA in February. The Trust, which is currently at 48 cases, has a target of 51 for the year.

Workforce

Trends were as in previous months. The agency budget is being exceeded.

Governance

TB 21/08 Annual Health Check and Declaration of Compliance

Michael Fanning introduced the paper (TB2008.21). Every year the Trust Board is required to submit a declaration of compliance with core standards and the duties of the Hygiene Code to the Healthcare Commission. This year the HCC has also provided trusts with a number of comparative indicators, to help Boards to inform their declarations. These showed, for example, that progress has been made on dignity and respect and patient and public involvement as highlighted in the outcomes of the annual patient surveys.

Favourable comments had been received about matron involvement and work with the infection control team during the HCC's inspection on duties 2, 4 and 8 of the Hygiene Code. Additional information had been requested, including the Trust's Decontamination and Infection Control Policies.

The Board noted that the Infection Control Policy had been updated after discussion with the lead Assessors to take account of the close working relationships in place between the infection control team, estates and facilities and the operational teams. The Board asked that the draft be submitted to the HCC and that the Governance Committee review the policy at its next meeting. In addition, the Governance Committee would review and endorse the draft policy on decontamination. The final versions of both policies would be brought to the next meeting of the Board for approval.

A draft report on the inspection is expected in early April for 'fact-checking' and the final report will be published after review by the HCC's national panel.

The Board then reviewed the detail of the proposed declaration as outlined in the paper which also covers the expected outcomes against existing national targets, new national targets and ALE. The final declaration must be made on line by no later than noon on 30 April 2008. This declaration will include comments from specified third parties: the SHA, the Joint Overview and Scrutiny Committee, the PPIF and, for the first time this year, the Local Children's Safeguarding Board.

The Board noted the processes that had been in place throughout the year to review evidence and to assure the position on compliance. A number of updates had been brought to the Board. In addition the Governance Committee and other Board committees including the HR and Commercial Committee had reviewed compliance with relevant standards throughout the

year. The Board Assurance Framework, monitored by the Governance Committee and reviewed by the Board at its January meeting, also provided assurances in support of the declaration.

In addition, the Executive Board had considered the Annual Health Check on a weekly basis.

Core standards

C11b – The Trust would declare not met but the action plan would show compliance by 31 March 2008. The HR Committee had been involved in the review of this and other standards relating to HR policy and practice.

C20b – The Board noted that an action plan had been in place since 1 April 2007 to deliver compliance against this standard by 31 March 2008. A number of assurance mechanisms have been in place throughout the year to ensure that compliance could be declared at the year end. The work had been informed by other reports from the HCC on dignity in the care of the older person. Both the Governance Committee and the Commercial Committee had been involved in reviewing compliance and CEAC had carried out an audit on specific aspects of privacy and dignity. A follow up report from CEAC has also been commissioned to provide additional assurances for this standard.

Existing and new national targets (Appendix B)

The Board noted the previous week's positive movement. The Trust has worked hard with Social Services and the PCT, and substantial resources have been invested into removing delays. Whilst the highest figure has been 88, there were only 20 delays last week, which coincided with the PCT census date, and it remains to be seen whether this can be sustained.

Thrombolysis call to needle time – The Trust is seeking clarification as to whether it will continue to be assessed on this indicator, since the majority of patients receive PCIs instead. The final outcome is still to be determined.

Emergency bed days – while there has been a 5% reduction from last year, and some growth is allowed for, thresholds had not yet been published. However, the Trust is likely to underachieve on this target.

Reducing health inequalities – the Board noted that these targets were expected to be achieved.

Waiting times for diagnostic tests – the Board noted that this target should be achieved at the year end.

Performance against the Auditors Local Evaluation (ALE)

(Appendix C)

The following points were noted on the current position for ALE within the five domains and individual KLOEs.

There had been some delays in the submission of information, although it was clear that there had again been a significant improvement in the presentation of evidence and information to the Audit Commission by the individual KLOE leads. In addition, the process had become more embedded as evidenced throughout the year at project team and Audit Committee meetings. The Audit Commission team had taken a full part in the project team's work and had continued to liaise with the team and individual KLOE leads.

The Board noted that work would continue, particularly in relation to financial standing, financial reporting and financial management. The final outcome for financial standing would not be known until the completion of the final accounts, due towards the end of June. The score for financial standing, expected to improve from weak to fair, would provide the final score for the Use of Resources element of the Annual Health Check. However, the Board noted that scores of three were to be expected in the majority of the remaining four domains.

The Board noted and endorsed the current position with respect to the Declaration and agreed that the final declaration would be reviewed by the Chairman, the Chairman of the Governance Committee, the Chief Executive and the Director of Nursing and Clinical Leadership. Any variations would be considered and should any significant lapses arise, Board members would be informed. The declaration would be published in May.

The Board noted that changes were to take place in the Annual Health Check for 2008/09 and it was agreed that a briefing paper would be brought to the next meeting.

ESH

TB 22/08

Cardiothoracic Surgery - HCC Action Plan

Megan Turmezei said the paper (TB2008.22) described the process used to deliver against the Action plan agreed with the HCC, the SHA and the Board. Regular meetings had been held with all those involved in delivering the plan and Version 22 represented the progress made since July 2007.

A significant body of evidence in support of the action plan had been presented to the SHA in January this year and at the subsequent meeting with the SHA the good progress had been recognised. Close liaison was being maintained with the SHA and their clinical governance lead was meeting with the Clinical

Director for Cardiac Surgery and the Directorate Manager for a further update, particularly in relation to the use of information and the development of protocols for the high risk patients.

Regular reports will continue to be made to the Governance Committee and it is expected that a final report will be presented to Trust Board and the SHA in July 2008. The HCC has now announced that it will conduct a follow-up review towards the end of April; this is expected to involve the review of additional evidence and on site interviews with relevant staff.

The Board noted the significant progress that was evidenced within the plan, commenting particularly on the work of the directorate and divisional teams in the robustness of their clinical governance arrangements and their ability to continue to evidence their progress.

Particular points were made as follows:

Caroline Langridge enquired whether the new cardiac development was on time. It should be ready in January 2009, and the reconfigured space six months later.

The Board noted that the CEAC audit on the consent process within cardiothoracic surgery had been completed and provided significant assurance. This report had been received by the Audit Committee and also submitted to the SHA and HCC.

CT4.1 - Protocols for the care of high risk patients in CTCC had been reviewed and updated. In addition, the overarching integrated care pathway was in place and further work was being done to finalise job roles within the multidisciplinary team. The support of the intensivists had continued and the Clinical Director had paid particular attention to ensuring the delivery of agreed changes within this service.

CT4.2 - The meeting with the Network had taken place and a further meeting was planned. The Network had expressed its wish to support the peer review of documents and protocols and to support leadership development, funded by the SHA. The final decision on how this would be taken forward had not yet been made.

The Board noted that the Society of Cardiothoracic Surgeons had been written to in September 2007. However, no response had yet been received to this letter. The Board also noted the active and continued engagement with this Society: all consultants were members; David Taggart is President-elect of the Society and Chandi Ratnatunga is the audit lead and regularly attends meetings.

CT10.3 - James Morris would meet with Oliver Ormerod and others to review consultant appraisals and to ensure that appropriate plans were in place for any personal development requirements. Members of the cardiac team and all the consultant surgeons were also to undertake 360° assessments as a pilot. It was noted that all consultants would be expected to use this method of assessment as part of the consultant revalidation process.

Dr Fleming asked how the body consultant was reacting to the report and both Megan Turmezei and Moira Logie commented positively on the good progress that continued to be made.

The Board received the action plan and noted the progress that had been made in all areas. It agreed that the Governance Committee would continue to review progress and it would expect a final report in July. However, it was recognised that the HCC follow-up process might impact on the timing of any final report.

TB 23/08

Business Plan 2008/09

AS said that that the Business Plan provides direction-setting for the organisation and coordination between departments at all levels. It is also a measure for performance. Strategic objectives were derived from the Strategic Review. This year's Business Plan also effectively serves as Year 1 of the Integrated Business Plan. The financial element has been informed by SLA discussions, and most of the Trust's SLAs for next year have already been signed off. The paper also seeks support for the broad envelope of the Capital Programme. The final section provides an analysis, showing risks.

The new appraisal process is being managed through Mark Gammage. Consultant appraisal needs to be integrated with the business planning process.

Work is being done on a new balanced scorecard which will be brought back in the new financial year. The quality elements from the Oxfordshire contract are shown in Appendix A. Oxfordshire PCT acts as coordinating commissioner for South Central PCTs. The meeting considered the risks and opportunities associated with penalties and incentives within the contract. The potential £3m variance resulting from these penalties and incentives is taken into consideration in the Financial Plan.

TB 24/08 Financial plan and budgets 2008/09

Chris Hurst presented the paper (TB2008.24) saying that it was important for the Trust to set out a budget that provided a high level of confidence that it would retain its position of underlying financial surplus. The Trust is recommended to plan for a £2.3m surplus next year. This is congruent with the Trust's medium term investment strategy and contains the requirement for cost improvement programmes (CIPs) to a challenging but achievable level.

The summary budget for 2008/09 sets out proposed budgets for all divisions. As SLAs have largely been agreed with PCTs, the income budget risk is lower than in past years. For the first time the PCT income budget has been profiled to take account of the number of working days (elective) and number of calendar days (non-elective) in each month. This means that in some months we plan to make a small trading deficit, on the trajectory to the year-end surplus of £2.3m. This occurs because the overall surplus is relatively modest in this year, but it will provide the Board with a more meaningful picture of trading performance.

In the first quarter, the Trust is planning to make CIPs of c. £1.1m per month, which then increases by c. £0.5m a month in the second quarter and rises to over £2m per month in the third and fourth quarters. There is broad symmetry between the financial scale of investments planned for next year and the size of the CIPs required. This will provide some capacity for managing financial risk in the early part of the year, which is the greatest period of risk in terms of CIPs.

The budget reflects an overall increase in PCT and RTA income of 7.6%. A third of this is inflation and the majority of the real growth reflects the part year effect of the new Cancer Centre. Around 75% of the Trust's income comprises Oxfordshire PCT and specialist commissioning.

The Trust is targeting a 32% increase in Private Patient income – this is acknowledged to be relatively high, based on past achievements. However, it is posited on targeted increases in capacity and the relevant consultants have been actively engaged in the planning and marketing of this additional work. Whilst it is still planned to recruit a Director of Private & Overseas patients in the next year, Alex Barnes has been initially seconded into this post to provide immediate leadership. He has been in post for about a month now, and has already had a positive impact. Don West is continuing to bring external expertise to the team.

There will be a net increase in Research funding next year. While the Biomedical Research Centre will receive an increase of £5.8m, Culyer funding will disappear over the next few years.

In response to a question about whether private patients was included the Libyan contract, and if the Trust could target more services; Chris Hurst replied that it was included and there are some possibilities to grow this work more quickly. However, the Trust has been prudent and modest in its assumptions at this point to avoid compromising of the delivery of 18-weeks and/or exacerbating winter pressures.

Section 5 shows the budgets by Division. Chris Hurst commented that the PCT income budget will be attributed to clinical directorates when the budgets are uploaded into Oracle, to provide monthly trading accounts. This means that clinical directorates, by default, will be expected to make surpluses. To maintain the integrity of the trading accounts, it may be necessary for the Board to consider flexing budgets within the year to reflect any SLA variations agreed with PCTs.

The main financial risk is the delivery of the CIPs. A detailed report on the CIPs will be brought to the Board in May. Chris Hurst said he also planned to bring in external support to help with the work being undertaken on the forward programme of CIPs (over the following 4 years).

The opening of the new Cancer Centre is a large operational challenge and has risk of business interruption, which would rapidly compromise service income. However, we are using tried and tested processes and experienced staff to manage this process and this reduces the risk significantly.

Chris Hurst commented that the NHS Trust Break-Even Duty was at significant tension with the need to run the business in a responsible and strategic way. The proposed budget and latest LTFM satisfies the Duty over 7 years, not the 5 provided for in the Duty. To attempt to achieve the Duty over 5 years (ie. in the next two financial years) would require an unrealistic and damaging scale of CIPs. Chris Hurst has discussed the Trust financial strategy with the SHA and PCT finance directors, and the fact that it is at tension with the Duty. Both directors have confirmed their support for the Trust's financial strategy. Chris Hurst has not yet been able to meet Maria Grindley, but will update the Board when he has done so. Chris Hurst commented that Maria Grindley would have to note formally that the Trust will not satisfy the Break-Even Duty over 5 years. However, the SHA's and Monitor's primary requirements are to have

assurance that the Trust is trading profitably now and can demonstrate that this position will continue into the future. Maria Grindley will be obliged to report this technical breach to the Department of Health; either by incorporating comments in the Annual Audit Letter, or by writing to the Department.

In response to a question about service line reporting, Chris Hurst confirmed that, from Month 1, the Board report will incorporate simple trading accounts for the 13 clinical directorates. EB will shortly be reviewing the Business Case for investment in a Patient Level Costing system, which will enable the Trust to move to service line reporting.

Caroline Langridge commented that, as the Horton is a small DGH performing the community hospital role, would it be possible to re-approach the SHA to secure funding from the Community Hospital Rebuilding Programme to allow some redevelopment of the site, with PCT support. She had also noted that the recent profitability analysis had indicated that Maternity was making a contribution of c. £14m towards overheads and other costs, and wondered if some of this gross surplus could be reinvested in Maternity services. Chris Hurst replied that future success and high performance will hinge on the move to clearer incentives and accountabilities, which would include arrangements for "gain share". However, the arrangements must; (a) be effective in aligning behaviours with the achievement of corporate strategic objectives and goals, and (b) must allow for the fact that the potential for individual services to make a contribution/ surplus varies with a number of factors (eg. anomalies in the setting of the Tariff, extent of donated assets, economies of scale etc.). Some services will be expected to contribute more than others. We plan to test proposals for incentives and accountabilities with directorate over the next few months. It was noted that Peter Donnelly will be discussing service level reporting at the FT Development Session on 11 April.

James Morris said another area of risk was C.diff penalties. Andrew Stevens pointed out that Appendix A of the Business Plan covered the targets which have been set under local agreement. Theoretically, the C.diff and 18-week penalties could have a maximum impact of over £2m. At its maximum, the C.diff penalty is calculated as 8% of turnover, which would be £8m. Derrick Crook and Sarah Walker had done work on this and concluded that statistically a trust could achieve the target but still incur a penalty. It is not an automatic penalty, and is at the PCT's discretion. It was agreed that it would be helpful to

have a note to clarify the penalty and level of investment being made in infection control. The 18-week penalty is much less, at £3 or £4m. However, Chris Hurst was confident the Trust would not incur this.

The Budget was approved in total. The Board endorsed the CIP, noting that a further report would be received. It also noted the principal risks, and the possible requirement for the flexing of income and expenditure budgets in year. After discussion, the Board also approved the Capital Programme.

TB 25/08 Accountability Reviews - update

Andrew Stevens said the Accountability Reviews are a means of monitoring implementation of the business plan, and entail a review of both targets and objectives. They are also a means of providing evidence for the key lines of enquiry for the Audit Commission's Local Evaluation. The paper also advises of results and suggests how the reviews should go forward in 2008/09.

The Board received the update.

TB 26/08 Patient and public engagement

Michael Fanning said that the paper (TB2008.26) brought together strands in a key strategy for the Trust, particularly in the development of its FT application and its membership strategy. It reinforced the Trust's vision and values, and set out structures and timescales for key objectives in patient and public engagement to 2010. These would be reviewed on an annual basis by the Board.

The Trust will continue to work with external organisations and stakeholders and stressed the importance of ensuring the engagement of all interest groups, including those from the north of the county. HOSC will continue to provide input, but the PPIF would continue informally until the new LINKs come into play.

The Board noted the paper and agreed the patient and public engagement strategy as outlined. It would request an update on progress in May 2009.

TB 27/08 Board committee minutes

Audit Committee meeting of 20 December 2007 - Megan Turmezei noted that the draft report on cardiothoracic consent procedures would be brought back.

Governance Committee meeting of 21 December 2007 - Professor Towse reported that the main items had already come to Trust Board.

Human Resources Committee meeting of 17 December 2007 - Dame Fiona said that another meeting had since taken place.

Commercial Committee meeting of 28 January 2008 - The Trust still needed to appoint a Business Director for private and overseas patients. Brian Rigby noted also that the Chairman, Sir William Stubbs, had signed the electricity contract.

Other matters

TB 28/08 Consultant appointments, sealing and publications report

Trust Board asked to be advised where consultant appointees came from in future.

Brian Rigby had recently chaired an Advisory Appointments Committee at the Horton, which had three extremely good candidates.

The sealings were noted.

Any other business

IRP recommendations on the Horton Hospital - David Lindsell and Andrew Stevens fed back on the IRP recommendations on the Horton Hospital. Professor Towse thanked them both for all the hard work they and their teams had put in. It was agreed that the implications of the IRP recommendations would be addressed at the next meeting of the Board.

ORH PPIF - Professor Towse expressed thanks on behalf of the Board to Jacqueline Pearce-Gervis and her colleagues for all their work as the ORH PPIF, which would be disbanded from 31 March 2008.

Date of the next meeting

The next meeting will be held on Thursday, 29 May 2008 at 10 am in the Stable Block Committee Rooms at the John Radcliffe Hospital.