

Board of Directors meeting: Thursday 16 July 2009

BD2009.66

Subject	Report from the Finance and Performance Committee			
Purpose of paper	To provide the Board of Directors with an overview of the Board's Finance and Performance Committee meetings of Friday 8 May and Friday 5 June 2009			
Board Lead	Chairman			
Background papers (if any)	-			
Action/decision required	To note the discussion, and any actions that the Committee approved.			
Key purpose	Strategy	<u>Assurance</u>	Policy	Performance
Strategic Goals	SG1: To be Hospitals of Choice SG3: To achieve financial sustainability and long-term growth SG4: To be an excellent employer			
Strategic Objectives	SO6: To provide demonstrably excellent clinical outcomes and indicators of patient safety SO7: To improve the overall patient experience by offering excellent customer care SO9: To maximise the Trust's contribution to the health and wellbeing of the local community SO10: To become a strategic, high performing and agile organisation supported by efficient and patient focused clinical processes, modern systems and business processes			
Links to: Board Assurance Framework/ Trust Key Risks/Annual Health Check element(s)	-			
Also considered by	-			
Resource and financial impact	As described in the text			
Consideration of legal/equality/diversity/engagement issues	As described in the text			

Acronyms and abbreviations used	-
Author	This report is based on minutes of the meeting drafted by the Board Secretary, and approved by the Committee at its subsequent meeting on Friday 5 June and Friday 10 July 2009

Report of the Finance and Performance Committee meeting of Friday 8 May 2009

Minutes of the last meeting

It was resolved to sign the draft minutes as an accurate record of the meeting of the Finance and Performance Committee of Friday 3 April 2009.

Matters arising from previous minutes

After discussion, it was resolved to circulate a revised schedule of meetings, placing a meeting of the Finance and Performance Committee in the last week of each month to consider financial and operational performance data from the preceding month, in advance of a Board meeting to be held in the first week of the following month; to review the terms of reference of the Finance and Performance Committee; to review the allocation of business between the Board and Board Committees; to introduce these and any other related changes from September 2009; and to receive the summary of outstanding actions.

Performance: Financial

In Mr Hurst's absence, Mr Lazarus reported on the year-end position. The annual surplus, the return on capital, and capital expenditure had been achieved at or below the targets set. No Month 1 results were available yet, but it remained critical to meet the cost improvement programme that had a current gross value of approximately £57m. In common with other non-Foundation Trusts, Oxford Radcliffe Hospitals was being monitored by South Central Strategic Health Authority (SHA) at fortnightly meetings. Responding to Ms Langridge's enquiry, Mr Murphy suggested that circulation to Board members of data that went to the SHA fortnightly would be of limited value because it did not cover a full month's activity.

Mr Rigby explained that he had been asked at the Board meeting on Thursday 23 April 2009 to discuss with Mr Ian Humphries, Director of Estates and Facilities, issues that the Non-Executive Directors had raised. As a result of that discussion, he recommended reviewing the IT projects in Category D, and deferring all projects in Category E, of the capital programme. Mr Covill added that the Planning Committee had allocated a priority to each scheme to assist selection, and Ms Langridge proposed that the Board deferred as much revenue and capital expenditure as possible.

It was resolved to review the IT projects in Category D, and defer all projects in Category E, of the capital programme.

Performance: operational

Mr Stevens reported. The Care Quality Commission had taken over responsibility for the former Healthcare Commission's ratings. The Trust faced risks in relation to delayed transfers of care; some national priority indicators, such as smoking during pregnancy and breast feeding; and audiology data recording. Local data appeared to suggest that the hospital mortality ratio had increased to 105.4% during January. Mr McLaughlin added that the general mortality rate for the Trust was satisfactory.

Responding to Ms Langridge's enquiry, Mr McLaughlin explained that Oxfordshire Primary Care Trust (the PCT) had commissioned stroke-care beds beyond the Trust, and

that their use was under discussion. Mr Covill added that the Trust was trying to secure use of ten similar beds at Witney, but their relatively difficult access made them unattractive to patients. Mr Campbell Davis suggested that greater vertical integration of services would assist this general issue.

Mr McLaughlin reported that performance data for April 2009 onwards would be summarised by headline and trend, to give the Board less, but more focused, information.

It was resolved to approve the report; and to report to a future meeting of the Board or Committee on the investigation of the clinical specialty that was affecting the Trust's general mortality rate.

Performance: Infection prevention and control

Dr Morris reported. At present, there were no cases of *Clostridium difficile* in May, and the rate of MRSA was declining.

Responding to Ms Donaldson's enquiry about the recording of MRSA as a cause of death, Dr Morris explained that the immediate cause of death (such as bronchial pneumonia) was recorded on Part 1a of death certificates, and the underlying cause (such as Alzheimer's disease) on Part 1b. Responding to enquiries from Ms Langridge and Professor Towse, he added that the Department of Health measured MRSA rather than MSSA because the aggregate of staphylococcus infections had probably remained unchanged over ten years whereas the relative proportions of each had altered; and that a very small proportion of the Trust's patients contracted either.

Professor Towse suggested that the Board needed a fuller account of hospital-acquired infection, and the actions that the Trust took to address them. Mr McLaughlin explained that the Executive Board was to be replaced by a number of focused executive groups, one of which would consider the quality of patient care and could address this issue.

Dr Morris went on to speak to the report that he had tabled at the Chairman's request on the fitness for purpose of the Trust's Influenza Pandemic Plan, following the current international incidence of swine 'flu. The local strategy was to refer patients in the first instance to primary care, and to reassure 'the worried well'. So far, only one case of swine 'flu had been confirmed in Oxfordshire, and the daily review meeting at the John Radcliffe Hospital, initiated in the week beginning Monday 27 April 2009, had been suspended.

Several further requirements had been identified from the limited implementation of the Plan to date: more robust discharge planning for patients on the John Warin Ward at the Churchill Hospital; adequate facilities for pregnant women who presented with 'flu symptoms; the provision of further facilities for Emergency Department staff, such as protective screens for the receptionists; and support for the PCT in distributing anti-viral drugs. It was unlikely that any Trust could fully cope with a worst-case pandemic. Responding to Ms Langridge's enquiry, Dr Morris explained that the Trust would be expected to fund the cost of implementing the Influenza Pandemic Plan, but the final cost of any pandemic depended its extent and severity.

It was resolved to approve the reports; and to refer to the executive group for patient care the issue of hospital-acquired infection, and the actions that the Trust was taking, and should take, to address them.

Academic Foundation Trust (AFT) application

The Chairman explained that she had met Dr Bill Moyes and Mr Stephen Hay, respectively Chairman of Monitor and Chief Operating Officer, on Thursday 30 April 2009. Professor Towse had participated by 'conference call', and it was clear to both him and the Chairman that Monitor had prepared for the discussion.

The Chairman and Professor Towse described the issues that Mr Hay and Dr Moyes had raised. They had appeared willing to help the Trust. Although they had acknowledged that two new Non-Executive Directors had been appointed, and a programme of Board development initiated, they stressed that the conduct of Boards of foundation trusts should resemble that of boards of FTSE 100 companies. They had expressed surprise at the failure of the Oxford application to become an academic health science centre. Pointing to local governance issues that the critical 'historic due diligence' report by PricewaterhouseCooper's had identified, they had asked how the Board was assured of the safety and quality of patient care, especially when cost improvement savings were being removed from budgets. As the Trust had not invited PwC for follow up on its report, it was implicit that the Board should monitor the action taken on the issues raised.

Ms Langridge pointed out that the Board had been shocked by the 'historic due diligence' report, and had taken appropriate action. Mr Campbell Davis noted that the Board was due to review progress against both the consequent combined action plan and the Trust's key risks at its meeting on Thursday 21 May 2009.

Responding to enquiries from the Chairman and Ms Langridge, Mr Campbell Davis said that the Executive Team was reviewing the key workstreams deriving from the Trust's application for foundation status.

Mr Lazarus explained that the financial outlook had radically changed in two ways that made major cost reductions imperative. First, PCT growth would slow down considerably, possibly to zero. Second, reductions in tariff would squeeze the Trust's costs. The Trust's overall priority should therefore be to cut costs, increase income where still possible, and plan to provide services with other partners.

Responding to Dr Morris' enquiry, Mr Lazarus agreed that the PCT, and most commissioners and providers, faced similar problems. Mr Campbell Davis noted that the PCT was limiting activity to protect its own position, and Mr Covill said that the PCT was willing to support more radical models of care. Mr Stevens agreed that much greater clinical engagement was needed internally and externally to promote such changes.

Dr Reeves suggested that the Trust's financial position would not differ substantially from that of other NHS Trusts. It was unlikely that any Trust could achieve the cumulative cost reduction that the paper implied. He agreed that the Trust should relate to its neighbours, and develop plans to maximise its market share. The Board needed to understand the profitability of services by service line and speciality.

Ms Langridge said that the Board should be tougher in the decisions that it made. Responding to her enquiry, Mr Campbell Davis and Mr Lazarus explained that 80% of 2008/09 cost savings were recurrent, and 20% were non-recurrent.

Mr McLaughlin proposed that holistic solutions were needed, and more vertical integration with primary care providers should be explored. It would also be imperative to secure a beneficial extension of market share, and to avoid loss-making services. He believed that the new executive group on clinical strategy would support this process.

It was resolved to approve the report; and to consider the issues in detail at the Board's 'away day' on Monday 8 June 2009.

Oxford Academic Health Science Centre (AHSC) application

In Professor Buchan's absence, Mr Stevens presented the report, setting out some of his own perceptions that probably differed from those of Professor Buchan: an emphasis on medical education might have eclipsed the education and training of other clinical staff; authorisation as a foundation trust would support an application to become an AHSC; and the AHSC partnership should decide the role of a 'third entity' before setting it up.

Mr Stevens explained that a meeting of key stakeholders was due to be facilitated by Dr Keith Ruddle, Fellow in Leadership, Organisation and Change at the Said Business School. The Trust had obtained copies of some of the successful AHSC application documents, and he and Professor Buchan had met representatives from some of the project teams.

Mr Ovseiko added that discussion with the project leaders for successful applications had revealed that some had not conducted detailed consultation with either their own boards or those of stakeholders. However, Mr Covill said that he knew that the University College London Hospital NHS Foundation Trust had carried out detailed consultation.

Ms Langridge said that the Trust needed to review in detail its relationship with the University of Oxford.

It was resolved to approve the report.

Any other business

Board development

Mr Campbell Davis reported that KPMG representatives would attend Parts I and II of the Board meeting on Thursday 21 May 2009, to observe.

Ms Donaldson added that she was still working on the programme for the Board's 'away day' from 1.00 pm to 7.00 pm on Monday 8 June 2009. It would include consideration of the future of Oxford's application to become an AHSC.

Health Innovation and Education Clusters (HIEC)

Mr Campbell Davis reported that national guidance on the definition and creation of HIECs had been received. The SHA was considering the creation of a HIEC for the whole of the strategic area. Further Board consideration of HIEC would be arranged.

It was resolved to approve the report, and to consider HIEC at a future meeting.

Date, time and place of next meeting

Friday, 5 June 2009 in the Board Room of the John Radcliffe Hospital, following Board consideration of the Annual Report and Accounts, and related documents.

Report of the Finance and Performance Committee meeting of Friday 5 June 2009

Minutes of the last meeting

It was resolved to approve the minutes as an accurate record of the meeting held on Friday, 8 May 2009.

Matters arising from previous minutes

Dr Morris and Mrs Strachan-Hall said that 09/28 referred to general medicine, where two directorates were considering peer groups and reviewing 130 sets of patients' records in order to identify the nature of the 'blip' in results. The Care Quality Board would consider the end point of this exercise at its meeting on Wednesday 10 June 2009.

It was resolved to approve the action summary of previous meetings, subject to noting that a weekly meeting of the Executive Team had replaced some of the functions of the Executive Board; and that dissolution of the Executive Board and creation of alternative executive groups with specific responsibilities was within the Chief Executive's remit whereas reconfiguration of divisions or directorates was within the Board's.

Performance: financial

Mr Hurst presented the report. The Trust needed to claim a share of the resource available to Oxfordshire Primary Care Trust (the PCT) for data analysis.

Mr Salt asked what the annual profile of cost improvement programme (CIP) savings had been over recent years. Mr Parker suggested that the Trust should plan a rolling CIP, looking forward annually by two or three years, in order to achieve a more even curve that avoided 'dips'. Dr Reeves agreed that such a medium-term CIP would help to protect the Trust against a volatile external environment.

Professor Towse pointed out that additional payment by Oxfordshire Primary Care Trust (the PCT) for clinical activity above the level specified in the service-level agreement (SLA) was capped at £440,000 for each calendar month. Mr Stevens added that, in providing activity for which the PCT would not pay, the Trust had used capacity for which other PCTs would have paid. Mr McLaughlin explained that the PCT had contracted on the basis of income rather than experience. Demand had to be managed, and the Trust's priority should be to reduce the rate of referrals from primary care. This issue was being addressed as data became available, but it was clear that insufficient progress would be made to allow the Trust to actively discuss the achievement of foundation status with Monitor by the autumn of 2009. Mr Hurst agreed that there was a real need to engage with primary care in controlling demand. Responding to Mr Salt's enquiry, he reported that excess demand by the PCT had fallen in Month 2. Responding to Ms Langridge's enquiry, Mr McLaughlin described the danger of breaching the mandatory 18-week maximum inpatient waiting period; and Mrs Strachan-Hall explained that deferred elective cases might simply increase the level of emergency admissions. Dr Reeves proposed that the Board should consider this issue at its 'away day' on Monday 8 June 2009.

Responding to Ms Langridge's further enquiry, Mr McLaughlin said that he was in discussion with relevant clinicians about transferring private patient activity to the Trust where the margins indicated that to do so would be profitable. Professor Buchan pointed out that additional private patient activity would both increase income and reduce NHS referral rates.

Mr Rigby suggested that the Trust appeared to be addressing the CIP with insufficient urgency at the same time that it was accepting additional activity for which it might not be paid. The Chairman pointed out that at least this possibility had been identified much earlier in the year, and asked why other PCTs were able to contain their referrals to the Trust within their respective SLAs.

Mr Parker reported that, of 502 CIP work streams, 300 were on track, or exceeding their targets; but that the remainder were adrift. The largest schemes should be directed centrally, but delivery of other schemes should be devolved in detail to directorates. Responding to Ms Langridge's enquiry, he suggested that the largest schemes included operating theatres, outpatients, procurement, private patients, overtime working, temporary staffing, and staff skill mix .

It was resolved to approve the report; to consider the management of excess referrals and activity at the Board's 'away day' on Monday 8 June 2009; and to review means of directing the largest CIPs centrally, while devolving detailed delivery of lesser schemes to directorates.

Performance: operational

Mr McLaughlin presented the report. The rate of delayed transfers was 3%. Mr Mike Fleming (Director, Horton General Hospital) was providing senior management support to, and examining working practice in, Accident and Emergency services at the Horton and at the John Radcliffe Hospital

It was resolved to approve the report.

Performance: infection prevention and control

Dr Morris presented the monthly report. Although it did not contain the results for May 2009, he explained that they were satisfactory, due as much to vigilance by ward staff as to the introduction of screening. Responding to Professor Buchan's enquiry, he said that the causes of the infections were known, and that three out of the four reported had been imported.

Dr Morris also presented the work programme for 2009/10, which he suggested the Committee should consider in more detail at its next meeting, with comments submitted meanwhile to him.

It was resolved to approve the report; to record the Board's appreciation of the work of Dr Crook, his immediate colleagues, and everyone else who had helped to keep hospital-acquired infection under control; and to comment to Dr Morris on the proposed infection prevention and control work programme for 2009/10, so that it could be considered in more detail at the next meeting.

Academic Foundation Trust (AFT) application, Academic Health Science Centre (AHSC) application and Health Innovation and Education Clusters (HIEC)

Mr Stevens presented the report. Executive Directors of the Trust and the SHA were due to discuss on Monday 15 June 2009 the Trust's application to become an AFT. However, this might be postponed following bilateral conversations between pairs of individual Executive Directors. The Oxford AHSC Implementation Steering Group was due to meet on Thursday 25 June 2009. National guidance on the formation of HIECs had been issued. A meeting with the postgraduate dean for the southern end of the South Central Strategic Health Authority (the SHA) area was due on Monday 15 June 2009; a dinner meeting was due of Thames Valley representatives; and an SHA stakeholder event was due on Monday 22 June 2009.

It was resolved to approve the report.

Time, date and place of next meeting

2.00pm on Friday 10 July 2009 in the Board Room of the John Radcliffe Hospital.