

Board of Directors

BD2009.34

Minutes of the meeting held in public at 10.00am on Thursday 26 March 2009 in the Stable Block Committee Rooms at the John Radcliffe Hospital

Present	Dame Fiona Caldicott	FC	Chairman <i>in the chair</i>
	Professor Alastair Buchan	AB	Non-Executive Director
	Mr Trevor Campbell Davis	TCD	Chief Executive
	Ms Sue Donaldson	SD	Director of Human Resources (HR) and Organisational Development
	Mr Chris Hurst	CH	Director of Finance and Procurement
	Ms Caroline Langridge	CL	Non-Executive Director
	Dr James Morris	JM	Medical Director
	Dr Henry Reece	HR	Board Associate
	Dr Colin Reeves CBE	CR	Non-Executive Director
	Mr Brian Rigby CBE	BR	Non-Executive Director
	Mr Andrew Stevens	AS	Director of Planning and Information
	Mrs Elaine Strachan-Hall	ESH	Director of Nursing and Clinical Leadership
	Professor Adrian Towse	AT	Non-Executive Director
Attending	Mr Ian Humphries	IH	Director of Estates and Facilities
	Dr Hywel Jones	HJ	Chair, Division A
	Mr Andrew McLaughlin	AMcL	Chief Operating Officer Designate
	Mr Jerry Park	JCP	Board Secretary
	Mrs Helen Peggs	HP	Director of Communications
	Ms Kathleen Simcock	KS	Director of Operations, Division B
	Mrs Megan Turmezei	MT	Associate Director of Governance
	Dr S Lomax	SL	Specialist Registrar in Anaesthesia

Apologies No apologies for absence were received.

Action

Opening the meeting, the Chairman welcomed those present, including the four members of the public and Mr McLaughlin who would join the Board as Chief Operating Officer on Wednesday 1 April 2009.

She expressed personal pleasure at having received confirmation from the NHS Appointments Commission of her substantive appointment as Chairman of the Trust, and reaffirmed her commitment to the challenges of the post.

Declarations of interest

No member of the Board disclosed, or had disclosed since the last meeting, any interest deriving from the business of the Trust, or from the agenda of the present meeting.

BD 09/22 Minutes of previous meeting

After discussion, it was

Resolved

- **To sign the draft minutes as an accurate record of the meeting held on Thursday 29 January 2009, subject to the following substitutions on page 4: in BD2009.05 from *the British Research Council to the Biomedical Research Centre*, and in BD2009.06 to a resolution *To approve an allocation of £100,000 to support the strategy, subject to provision of further details by South Central Strategic Health Authority (SHA)*.**

BD 09/23 Matters arising from previous minutes

After discussion, it was

Resolved

- **To approve the schedule of outstanding actions, subject to noting in TB42 and 42a that the Human Resources Committee had been redesignated as the Workforce Committee; in BD2009.16 that the SHA would sign off the review at its meeting that day; and in BD2009.05 that the Charitable Funds Committee had allocated £200,000 towards the equipment required for robotic surgery.**

BD 09/24 Chief Executive's report

Mr Campbell Davis presented his report for the period since the last meeting. He drew attention to the following:

- He congratulated staff at all levels for ensuring that performance against national standards of patient care and finance were within the required trajectories for achievement by 31 March 2009. He instanced the work of Division A in maximising advantages at difficult times.
- The outcome of the Oxford application to become an Academic Health Science Centre (AHSC) would be discussed as the next agenda item.
- Several regulatory and accreditation bodies, including the Healthcare Commission (HCC) team charged with monitoring

local compliance with the Commission's hygiene code, had recently visited the Trust. So far, these visits had demonstrated the Trust's achievements. The HCC Standards for Better Health would be discussed as a later agenda item.

- He congratulated staff at all levels who had been involved in the transfer of patients and services to the new Cancer Centre at the Churchill Hospital. This change had received a very positive response from the public and media, despite requiring the local integration of previously disparate staff groups, and being a fundamentally more complex task than closure of the Radcliffe Infirmary had been. With the Chairman, he had welcomed the Prime Minister (the Right Honourable Gordon Brown MP) to the development on Friday 27 February 2009.
- The latest staff survey had elicited positive results, as well as some specific issues that the Board would need to address.
- Work in Oxfordshire on falls prevention, particularly among the elderly, had yielded significant improvements. The Trust had reached joint second position nationally, with 94%.

Professor Towse commented that as slips and falls were the single largest category of accident to the Trust's patients, this reduction was praiseworthy.

Resolved

To receive the report.

Strategy

Academic Health Science Centre (AHSC) and Academic Foundation Trust (AFT)

Mr Campbell Davis reported that, of the seven applications shortlisted nationally to become AHSCs, those of Birmingham and Oxford had been unsuccessful. It would be premature to analyse the causes of failure at the present meeting, but it was clear that a successful AHSC would depend on convincing and effective partnerships. A letter from Sir Ian Kennedy, who had chaired the panel of international experts that selected the successful AHSC applicants, set out the reasons for the outcome of the Oxford application. It was complimentary about the level of academic research in Oxford, and suggested that the Oxford team should reapply to become an AHSC in two years' time, as its present application formed a basis for future success.

Professor Towse said that the Trust had no alternative to working in partnership with the University of Oxford. Dr Reeves pointed

out that failure of the current AHSC application was not irrevocable, and the Trust should not despair of future authorisation. Responding to Dr Reeves' enquiry, Mr Campbell Davis affirmed his view that obtaining designation as an AHSC remained of fundamental importance, and advised that failure of the present application should not of itself affect the Trust's application to become an AFT: over one hundred FTs had been authorised, of which most were not AHSCs. Mr Stevens added that authorisation as an AFT would assist a future AHSC application by validating the Trust's governance arrangements.

Dr Morris said that the Trust and its partners would need to focus on the wider issues of public health in any future AHSC application. In the USA, Johns Hopkins Medicine in Maryland and Duke University Health System in North Carolina operated as major centres of academic research and development in geographical areas of significant social deprivation. Ms Langridge agreed, and suggested that the Trust and its partners should review the outreach of such major British centres of clinical research as Guys and St Thomas' NHS Foundation Trust.

Mr Stevens said that the Trust and its partners should take full account of the published AHSC applications, and went on to describe the emerging timetable for the Trust's AFT application. The Trust and the SHA had provisionally agreed that the Board-to-Board meeting between both parties should take place in September 2009 when a quarter-year's results for the Trust would be available. If the SHA supported the Trust's application at that stage, further processes with Monitor would follow, with a view to authorisation as an FT from the first quarter of 2010/11.

Resolved

- **To approve the report.**

BD 09/25 Plans and risks 2009/10: introduction

Mr Hurst introduced the paper. The suite of papers was designed to move the Trust towards its strategic goals in a dynamic environment, but identified the areas of greatest risk.

Responding to enquiries from Ms Langridge and Professor Towse, Mrs Strachan-Hall pointed out that the risk paper included objectives to meet the Trust's quality standards. The additional funding that would follow achievement of Commissioning for Quality and Innovation (CQUIN) standards would be an incentive to quality. Mr Stevens added that the Trust would consider with the PCT the opportunities, penalties, and risk-sharing that attached to CQUINS. The Chairman said that it was essential that the Board

understood the impact of the cost improvement programme on service delivery, safety and quality.

BD 09/25a Plans and risks 2009/10: business plan

Mr Stevens introduced the Business Plan. The Board of Directors had approved the strategic format at its meeting in November 2008, and it included approximately fifty objectives. The Plan was necessarily a 'snapshot' because only the service level agreement with Oxfordshire Primary Care Trust (the PCT) had been signed, and many associated performance measures had still to be detailed. The Trust would issue its Business Plan to its external partners, including associated district general hospitals and local authorities.

BD 09/25b Plans and risks 2009/10: capital plan and updated capital programme

Mr Hurst presented the report. The value of the programme had been reduced from £40m to almost £32m, including contingencies. The value shown in the Business Plan differed from that shown in the Capital Plan only because of differences in funding arrangements. Each capital scheme had been considered by the Executive Board; risk-assessed by the Physical Resources Group; and reviewed by the Planning Committee.

Responding to enquiries from Mr Rigby and Dr Reeves, Mr Hurst said that he did not believe that the programme could be further reduced. The lower capital budget than originally planned had already created a risk of underinvestment. Subject to risk assessment, capital expenditure might be suspended for two or three months, but thereafter its withdrawal would impact on national and local standards of care, on patient safety, and on productivity. Responding to Mr Campbell Davis' enquiry, he explained that every £10m of capital expenditure created a revenue cost of between £400k and £500,000k.

In response to Ms Langridge's enquiry, Mr Campbell Davis explained that there was no longer any ultimate accounting distinction between lease or outright purchase of equipment. Mr Rigby asked whether any scheme in the capital programme was not a mandatory requirement. Professor Towse pointed out that capital expenditure could facilitate strategic change, and for that reason should not be readily reduced; moreover, an effective revenue cost improvement programme would make a more significant contribution to the Trust's budgetary position. Dr Reeves agreed that, in an uncertain economic context, cost improvement programmes were intrinsically more critical to

financial stability than reductions in capital expenditure that might simply create alternative risks. However, there would be value in understanding which capital schemes would generate income.

BD 09/25c Plans and risks 2009/10: financial plan and budgets

Mr Hurst presented the report. The budget took account of the likelihood of further turbulence in the international economy, and included a net pay reduction and planned for a trading surplus. This was despite the increasing population that required treatment at the same time as PCT income flat-lined; the technical deficit created by the introduction of IFRS, which would impact on impairments, and could affect the bottom line on private finance initiatives (PFIs); the national requirement for an incremental 3% efficiency drive; and the price risk deriving from the national tariff.

The Trust should strengthen its relations with its partners, especially the PCT, in order to jointly review the risks to achieving planned activity in the service level agreement; to demonstrate the Trust's contribution to the public health agenda; and to resolve issues relating to education and research. The Trust's cost improvement programme must underpin this, not divert attention from it. As in 2008/09, the Trust must deliver the target surplus, which was critical to the Plan.

Ms Langridge and Mr Rigby suggested that the planned surplus of £2.3m was low, being less than that of previous years. Ms Langridge said that, as the Trust invariably closed each financial year with a smaller surplus than it had planned, it would be sensible to plan for a larger surplus in order to be confident of meeting the target sum. She also sought assurance that consultant medical staff were committed to using the new ward of twenty beds for private inpatients. Dr Reeves and Professor Towse made similar points. Mr Hurst said that he did not believe that a higher target surplus should be planned, but agreed that it would be increased if the contingencies around achieving it were not required in practice.

Responding to Dr Reeves' enquiry, Mr Stevens acknowledged that, as capacity would fall in alignment with predicted income, the Board must consider both how to market alternative services to the Trust's wider catchment area, and how to restore capacity promptly to meet any resurgent demand that carried guaranteed income. The Board had previously reviewed its marketing strategy in November 2008, but the Trust was already working on additional activity in (for instance) the Cancer Centre.

Mr Rigby pointed out that the monthly value of cost improvements

should average a sum approaching £4m. He suggested that the Board should have a clear indication each month of cumulative monthly savings targets, and actual performance against them. Ms Langridge added that the Board should consider a monthly progress report of reductions in the staff establishment.

Responding to Ms Langridge's further enquiry, Ms Simcock explained that the Trust employed some of its Cancer Centre staff flexibly, and could reduce capacity if it did not receive the income expected from that provision. Mr Stevens added that plans to transfer staff to alternative posts and locations as necessary would be presented to a meeting of the Finance and Performance Committee. Ms Donaldson agreed that calendarisation of the cost improvement programme would be essential, but pointed out that savings on the paybill did not depend on staffing reductions alone.

Dr Morris reported that clinical staff were concerned that notional reductions in referrals and ultimately in activity would not materialise, and that patients would be admitted as emergencies if they were not referred electively. The Chairman pointed out that the Trust had reached agreement with the PCT about the numerical range for referral numbers.

Responding to enquiries from Professor Buchan and Dr Reeves, Mr Hurst explained that the timetable remained for achieving the Trust's break even duty and repaying the deficit of earlier years. This would meet Monitor's requirements.

Resolved

- **To approve the Business Plan for 2009/10**
- **To consider a schedule of critical and non-critical capital schemes at the meeting of the Board of Directors on Thursday 23 April 2009** CH
- **To approve the revenue budgets for 2009/10**
- **To review the marketing strategy at the Board of Directors meeting on Thursday 28 May 2009.** AS

Performance

BD 09/26 Financial performance to February 2009 (Month 11)

At the Chairman's suggestion, as the Board had considered the information at its informal meeting on Friday 20 March 2009, it was

Resolved

- **To take the paper as read, and to approve it.**

BD 09/27 Operational performance to January 2009 (Month 10)

At the Chairman's suggestion, as the Board had considered the information at its informal meeting on Friday 20 March 2009, it was

Resolved

- **To take the paper as read, and to approve it.**

Healthcare Commission: declaration of compliance with Standards for Better Health

Mrs Strachan-Hall gave the presentation. The Board had to determine and approve compliance with the standards for submission by 1 May 2009. The year 2009/10 would be transitional, prior to the introduction of the Care Quality Commission's standards. The domains, and their outcomes and supporting documentary evidence (including the Board assurance framework, the Trust risk register, and CEAC reviews) would be set out some time after the year-end. The process took account of counter-intelligence; audit reports; accreditation reports; inspection guides that local service managers had prepared; and third party comments sought from the Health Overview and Scrutiny Committee, the Children's Safeguarding Board, the SHA and (when it was functional in future years) LINKs. Reasonable assurance and significant lapses needed definition and consideration at all levels of service, taking account of the duration and nature of the exposure to risk

Responding to Mr Stevens' suggestion, Mrs Strachan-Hall agreed to review the domains and to suggest 'buddying' one other director with the lead for each domain, to add to Board confidence

Mrs Turmezei added that Internal Audit was monitoring five standards. So far, this was going well.

Resolved

- **To approve the report**
- **To review the domains and to suggest 'buddying' one other director with the lead for each domain, to add to Board confidence.**

ESH

BD 09/28 Healthcare Commission: compliance with Hygiene Code

Dr Morris presented the report. The HCC had carried out its review of the Trust's compliance with the national Hygiene Code in a measured and fair manner, and receipt of its final report was awaited.

Resolved

To approve the report.

BD 09/29 Privacy and dignity, and single gender accommodation

Mrs Strachan-Hall presented the report. All relevant patient accommodation had been rated against the standard.

Responding to Ms Langridge's enquiry, she explained that, as the Trust's capital programme did not include the associated physical adaptations, central external funding had been applied for.

Resolved

- **To approve the report.**

BD 09/30 Healthcare Commission: children's services follow-up review

Mrs Strachan-Hall presented the report. The action plan followed an HCC template. Most issues related to the training of staff in safeguarding children, which the Trust had now largely addressed.

Ms Langridge and Professor Towse expressed concern at the time taken to resolve some of the issues identified in the original report.

Resolved

- **To approve the report.**
- **To ask the Governance Committee to ensure that compliance with action plans deriving from external reports on clinical and social issues was monitored routinely.**

FC

Regulatory

BD 09/31 Consultant appointments, and signing and sealing of documents

After discussion, it was

Resolved

- **To approve the report, subject to noting that Ms Langridge, and not the Chairman, had chaired one of the listed appointments advisory committees.**

BD 09/32 Minutes of Board committees

After discussion, it was

Resolved

- **To receive the reports from the meetings of the Audit Committee on Thursday 11 December 2008 and the Finance and Performance Committee on Friday 6 February 2009.**

Any other business

There was none.

Motion to exclude the public

After discussion of the motion, it was

Resolved

- **To exclude representatives of the press and other members of the public from the remainder of the meeting, having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest.**

Time, date and place of next meeting

10.00am on Thursday 28 May 2009 in the Stables Block at the John Radcliffe Hospital

DRAFT