TRUST BOARD

Minutes of a meeting held at Devon House, Heartlands Hospital

at 1.30pm on Tuesday 7th July 2009

PRESENT:	Mr C Wilkinson *(Chairman)*	
	Ms M Coalter	Ms E Ryabov (until 3.15 p.m.)
	Mr I Cunliffe	Mr R Samuda
	Ms A East	Mr A Stokes
	Mr M Goldman	Dr S Woolley
	Prof C Ham	
	Mr R Harris	
	Mr P Hensel	
IN ATTENDANCE:	Mrs C Lea	
	Dr L Gupta	
	Ms L Jennings (Minutes)	

Action

09.104 1. APOLOGIES

Apologies had been received from Ms Sunderland, Ms Fenton and Mr Bucknall.

09.105 2. DECLARATIONS OF INTEREST

The previously circulated declarations of interest were accepted by the Board. As Acting Chief Operating Officer the declarations needed to be updated with Ms Ryabov's details.

09.106 3. MINUTES

The minutes of 28th May 2009 needed amendment on page 3, third paragraph from the bottom to record that a "monthly" £2 million surplus was required. Page 2 second paragraph was also amended to reflect that medical and nursing vacancies could only be authorised by the Medical Director or Chief Nurse, the reference to Ms Coalter was removed. With these amendments the minutes were approved as a correct record and signed by the Chairman.

The minutes of 3rd June 2009 were amended on page 5 to insert a paragraph outlining that the ambulance waiting time to unload had been questioned by Mr Samuda and that the Trust figures did not tally with the ambulance data. Mr Goldman had agreed to supply a real time audit of the Trust's times against the Ambulance Trust times. With these amendments the minutes were approved as a correct record and signed by the Chairman.

09.107 4. MATTERS ARISING

4.1 Indicators of Safety

The paper set out a series of safety indicators which also took into account the trends from inquests and rule 43's. Dr Woolley confirmed that the Trust had

programmes of work in place to address the themes and the Governance and Risk Committee reviewed and monitored the action plans.

Mr Samuda questioned how incident reporting related to near misses. Dr Woolley confirmed that near misses are one category within incident reporting and that they had not been split out in the charts. It was agreed that Dr Woolley would look at how near miss reporting could be reported more clearly. SW

Dr Woolley outlined how the patient care data being collected by Ms Sunderland and Ms Dunn would also contribute to the overall safety picture that the Trust was collecting. Mr Samuda asked for clarification on the reasons for choosing each of the indicators as a safety metric. Dr Woolley replied that she had considered the DH quality and safety indicators and the IHI's metrics from the safer care programme sites and the metrics had been chosen on this basis. She had drafted a proposal for Prof Vincent to review the Trust's indicators but was still awaiting confirmation regarding this. He would be able to give an independent assurance on whether there were any more indicators that could be used to help measure safety.

It was agreed that the safety dashboard gave a wider context to the trends identified from the Rule 43's. Mr Goldman, however, expressed concern that the Board would end up looking at the same data but reported in different ways e.g. performance pack, safety dashboard, patient care matrix. Ms Ryabov outlined that the organisational restructure would help to address some of these concerns as there would be a standardised performance dashboard for each group which would include productivity, safety and governance.

Ms East confirmed that the safety dashboard would be reviewed regularly by the Governance and Risk Committee and that any issues would be reported to the Board via the Committee minutes. It was agreed that the dashboard should be included as an appendix to the minutes for reference until the structural reorganisation had been completed. SW

4.2 Bullying and Harassment
This item would be dealt with in Human Resources report later in the meeting.

09.108 5. CHAIRMAN'S REPORT

5.1 Board Development plan (CW/CL)
The draft plan was considered by the Board. Prof. Ham confirmed that the areas included the issues which were raised at the recent private NEDs meeting. He questioned whether it would be necessary to have 3 separate workshops as the themes were very closely related. Mr Wilkinson suggested that as the Trust was providing board development consultancy that the Trust's consultancy team be engaged to deliver the plan. Mr Goldman suggested that the Board should use an organisation who specialised in board development and that it would not be appropriate for management team members to be party to the kind of discussions that might occur.

Dr Woolley also suggested that the development plan should also include technical development of corporate governance arrangements and agreed that the Board needed to be facilitated by senior people with experience of facilitating boards and working with high level boards.

Concern was concerned over the timescales as the executive team development plan commenced in September. Mr Wilkinson and Mrs Lea agreed to resource CW/CL

external facilitation and to aim for November/December.

5.2 Medipark update
Mr Wilkinson outlined the concerns regarding the Medipark and the outcome of his recent meeting with Birmingham Council. The meeting had discussed whether the Medipark was going to go forward, who would lead, where the financial responsibilities lay and what the key milestones would be.

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Mr Waheed Nazir and Mr Simon Hackwell had been nominated to follow this up. It was agreed that the executive team would reflect on the possibilities whilst continuing to press for discussions about car parking and the bus interchange.

Mr Harris questioned how important this was to the Trust's long term strategy. Mr Goldman confirmed that it was very important in terms of developing the R&D position of the Trust. The Trust was trying to focus on supporting innovation and industry which was not a focus for other hospitals. Not proceeding with the Medipark would detract from this but at present the project was draining energy away from the Trust without much prospect of it going ahead. Maintaining the Trust's presence in the market place for R&D would be supported by the completion of the MIDRU and re-entering the AHSC bidding process.

Prof. Ham identified the Health Innovation and Education Centres as another opportunity although they had a slightly different aim which was to develop more appropriate training and education. It would become more relevant if the Trust were to proceed with its idea of a nursing training college.

STRATEGY AND PLANNING

09.109 6.1 Forward Look
Mr Goldman presented a short film clip looking at surgical developments and the development of robot technology with the Da Vinci Robot. He contrasted this with a recent paper from Prof Ham on NHS healthcare funding and development.
There were only 8 Da Vinci robots in the country, most of which were in London, costing around £1m each. Mr Goldman also highlighted a recent paper on commissioning by Matthew Swindells of Tribal.

Prof. Ham outlined that the best guess at present as to the level of savings within the NHS were approximately £15bn to £20bn. This level of reduction would require some hard questions about how to provide healthcare more efficiently and effectively. One key area would be to work much more closely with commissioners and to provide much more joined up provision of healthcare.

Mr Goldman suggested that the Matthew Swindells paper went beyond collaboration and into confrontation around commissioning power to drive a harder bargain. It would become a much more competitive environment. At the moment there were many mixed messages from the PCTs. Mr Stokes suggested that the Trust had to provide more solutions to the PCTs for them to consider whilst working with other acute providers to consider lateral developments. He was clear that productivity alone was not going to help the Trust deliver the financial targets that were being set for future years. This was made clear in the finance papers which were included in the Board papers this month.

Prof. Ham was of the opinion that there had been some good work produced by Working Together for Health and this had set a foundation to build on. Mr Goldman thought that limited financial benefits had been achieved but there had been practical changes for patients and the Trust had built a powerful relationship with BEN PCT. Another key relationship would be with NHS West Midlands. Mr Goldman was clear that if the changes were to be made in the timescale available then, given the current track record of transforming services in last 2 years, strategic investment from reserves would be required and this would mean sacrificing other plans.

Mr Stokes' monthly finance report made it clear that in the next 4 years savings would need to be in the region of £60m - £70m. Mr Stokes pointed out that SLR reporting and benchmarking could highlight areas of potential efficiency but something more transformational was required to address the remaining balance which would require greater collaboration with PCTs and other Providers. Mr Stokes' later paper went into more detail around this approach.

Mr Cunliffe pointed out that the changes would not just need to be within the community but also within the hospital. There would be critical decisions about which services to provide on which sites. It would need a crisis within NHS funding to make some of these decisions politically viable. Service Transformation would be absolutely vital to finding a way forward and this would need more emphasis on the prevention of illness thus avoiding hospital admissions and on more alternative providers coming into system.

Mr Harris was clear that there were a number of issues facing the NHS giving rise to extensive pressure and that the board and senior management were working hard to make major changes, however, he was concerned that this same sense of urgency was not evident at lower levels of management or within the clinical leadership. This was a serious problem which needed to be addressed and more engagement with the clinical leadership of the trust was vital.

Ms Coalter had spoken to a lot of the staff and there was a strong sense of realism and that there was a strong message from the workforce that they wanted to work with Trust to find different ways of dealing with the issues.

6.2 Organisational Turnaround Programme

The presentation set out the findings from the recent review by McKinseys who had been engaged to assess the viability of the internal turnround programme.

At present, the monthly finance report which was to be considered later in the meeting set out that at the end of quarter 1, it was possible for the Trust to be running in balance. Mr Stokes pointed out, however, that there was a high degree of income volatility. The Trust was now looking at a £35m savings plan over coming year.

The review set out that there was a considerable level of risk around the delivery of savings plans in 2009/10 and that energy should be focused on those priority plans that would make the most difference. The risk adjusted level of likely cost savings was £12m.

Prof. Ham asked how much of the savings plan relied upon headcount reductions. Mr Goldman confirmed that these were minimal as headcount was being reduced through the vacancy panel. Ms Coalter confirmed that some

corporate areas were looking at possible redundancies.

This risk adjusted total of £12m plus the risk adjusted income savings meant that the risk adjusted total savings were £20m as opposed to the £35m initial plan. This risk adjusted total relied on strong performance management and prioritisation. The Board then considered the best, likely and worst case scenarios for the year end; £5.8m (Monitor target) had been confirmed as the likely case scenario. The impact of the additional CIP to be delivered (£2m) and the implementation of Plan B savings (£2.5m) take the forecast up from £5.8m surplus to £10.3m surplus.

It was agreed that additional headroom would be required to ensure that the Monitor target was achieved. This would require a further £2m of cost savings and £2.5m savings from Plan B as discussed at the last Board meeting. Plan B had been risk assessed and this was set out in more detail in the presentation; including possible pay reduction schemes and headcount reductions. The £2.5m savings were possible from the lower risk "voluntary" Plan B options.

Prof Ham asked whether the additional £2.5m savings were possible within this financial year and Ms Coalter confirmed that they were; some needed a period of 4 weeks to be introduced, others would take longer.

Ms Hafeez questioned who would be allowed to volunteer for the Plan B schemes as it would be very risky if the numbers of medical staff were affected. Ms Coalter confirmed that some schemes would only be for certain areas and that it would be important to manage expectations. The needs of the service would be paramount.

The impact of the additional savings meant that the likely case year end scenario would be a surplus of £10.3m.

Prof. Ham, whilst agreeing that the overriding objective had to be to focus on CIP delivery, suggested that more radical options within Plan B should be included just in case the low risk options did not deliver the expected levels of savings. This would require more time to work through as union support would be necessary. Mr Stokes explained that the success of the plan rested on the pace of recovery. Compulsory redundancies and a 4 day working week would take too long to impact the savings required. Reduction in the headcount through the management of the attrition rate would be more deliverable. Ms East recommended that planning for the higher risk options within Plan B should be started as she was not confident about the delivery of the CIP.

Mr Hensel also raised the concern that the PCTs may not be able to pay for over performance in the future. Mr Harris suggested that any plan must deliver a very good margin so that the most likely case of £10.3m is a minimum in case the CIPs were not achieved. He was also concerned about pace and timing as the Trust was already 3 months into the financial year. The implementation of the cost savings would be in some month's time and so a greater level of deliverable CIP should be set to ensure delivery of the Monitor target.

Ms East suggested that withholding incremental progression should be considered to improve the head room. Ms Coalter outlined that this had seemed a quick win, in fact it was a contractual and lengthy process to go through. The initial conversation with the unions was one of co-operation but they were unwilling to be the first to start changing agreements in Agenda for Change. Such an option would take time to deliver and be damaging to the Trust's

reputation. Mr Stokes suggested that the best option would be to withhold increments based on lack of performance. Ms Coalter agreed that performance management would be implemented but that this would not generate savings in the timescale required. To withhold all increments the Trust would have to start negotiations with unions or dismiss and reinstate and this would lose good will. A large scale redundancy programme would have a 90 day consultancy period and would involve redundancy costs. It would be better to manage headcount reduction through attrition.

Mr Goldman confirmed that the Trust would try to ensure that the voluntary options would enable staff to be called back in to position if needed, e.g. swine flu.

Mr Samuda reminded the Trust that many private organisations were having open discussions with their staff based on headcount reductions or pay reduction to keep their business alive.

The Board agreed that there should be a greater determination about delivering CIP, that more options in Plan B should be considered and that consideration should be given to withholding some increments within the existing rules. The unions should be prepared for the potential for harsher measures in the future. It was agreed to monitor the internal turnaround programme on a monthly basis through the Finance Report.

PERFORMANCE

09.110 7. Performance Balanced Scorecard – National and Local Targets

The Board considered the A&E 4 hour wait target. At the end of June the Trust had met its first quarter target at just under 98.2%. The current July position had been difficult but the year to date figure was still above 98%. The key area that was struggling was Good Hope, partly due to Ward 17 being unavailable due to refurbishment (C.Diff risk management) and pulling out of Robert Peel (too costly). These decisions were putting pressure on beds at Good Hope.

Mr Wilkinson asked for more focus on weekend patient discharge. Mr Goldman confirmed that improvements were being made to discharge more patients on Fridays. Mr Wilkinson asked whether there was sufficient co-operation from the local authorities. It seemed that at the senior level there was little or no co-operation at the moment but it was much better at the discharge committee level.

The HSMR peak at Good Hope in January was still being investigated with Dr Foster. Dr Woolley had benchmarked HSMR across the region and the spike had been reflected across the region. HSMR was now back down to 90% across all three sites.

BUSINESS PLAN 09/10 PRIORITIES
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09.111 8. Infection Prevention And Control Report (Dr I Gupta)

Dr Gupta confirmed that since writing the report the total MRSA for the quarter was 6 cases against a trajectory of 11 and all the RCAs are underway.

<u>MRSA</u>
There had been 1 post-48 hour case of MRSA bacteraemia at HEFT against the trajectory of 4 for the month. The Trust trajectory for 2009-10 was 46 cases.

Prof Ham congratulated Dr Gupta on the good progress being made.
Mr Goldman confirmed that there had been a spontaneous visit from the CQC during the month who had commented that this was as good as it gets on cleanliness and control of infection. The written report was without blemish and gave the Trust a clean bill of health.

C.Diff
There had been 30 cases with 14 of these presenting as post 48 hour cases. HEFT trajectory for the month is 28 post 48 hour cases. The breakdown throughout the Trust was as follows:

- BHH 5 post 48 hour cases
- GHH 8 post 48 hour cases
- Solihull 1 post 48 hour cases

Norovirus
There had been only one ward closed in May due to outbreaks of diarrhoea and vomiting. A review had been conducted regarding outbreaks throughout the winter and this was presented which showed a substantial decrease in outbreaks resulting in bay and ward closures.

Mr Wilkinson commented that the Trust had done better than last year and asked whether this was reflected by other hospitals. Dr Gupta had not been able to benchmark the performance as comparative data was not available due to the swine flu work load.

Endophthalmitis following Cataract Surgery
In quarter 1 there had been 3 new cases and surgical review was underway. If this was inclusive an external review would be commissioned.

Swine Flu Update
Dr Gupta updated the Board on the latest developments in this area. Nationally routine swabbing had been stopped but the Trust had continued to swab to identify where infections were coming from and to slow down the spread of the virus. Any suspected inpatients were sent straight to ward 28 unless they were cystic fibrosis patients or maternity patients.

Dr Gupta advised the Board on the progress being made with immunisation and that for winter 2009/10 it was likely that there would be 2 vaccines (traditional flu and swine flu). Ms Coalter confirmed that it was very difficult to insist on staff being vaccinated.

Ms Hafeez raised concerns that if GPs stopped swabbing then patients were more likely to come to A&E. Dr Gupta agreed that this was a possibility but the greatest risk was people with underlying respiratory problems or pregnant patients. Ms Coalter agreed to find out about incentives for staff vaccination for other trusts. MC

The Board approved the report and agreed that in future there would be a quarterly written report for the Board and that the monthly MRSA figures would be reviewed as part of the Board performance pack. Minutes of the Infection Control Committee would be available upon request from the Company Secretary

09.112 9. Infection Control Annual Report

In the light of the previous discussions the annual report was accepted by the Board.

09.113 10. Benchmarking Report (ER)

Ms Ryabov presented her report which gave an overview of a process for potential Benchmarking Best Practice. This would involve a systematic review of of KPIs at local, regional and national levels. The process would strengthen the CIP. The benchmarking of best practice would be linked more to operations and would drive the quality agenda.

Mr Hensel asked for clarification on the criteria for choosing the 3 particular sources of external data. Ms Ryabov confirmed that Dr Foster had been chosen as it was already in use and was readily available; the NHS better value indicators was a recognised source and was based on national data and the Audit Committee Portal was also already used by the Trust and was updated regularly. The 3 sources also covered the areas that the Trust needed to concentrate on and provided an assurance on quality of data.

Prof Ham welcomed the report and asked that it should then build strong links into the new management structures. They must be fed the new benchmarking data to improve accountability particularly amongst clinical leaders.

Ms Ryabov confirmed that the benchmarking would be linked to the turnaround programme and she had set up and chaired a CIP work stream group.

It was agreed that LOS, pre-operative bed days and DNAs were key issues for the Trust. The benchmarking would improve engagement with clinical staff. It would help to focus the work of the transformation team.

Mr Stokes set out that benchmarking alongside service line reporting would assist the Trust in assessing the contribution of each directorate, e.g. acute medicine was in the top right hand quarter of the most profitable parts of the Trust and yet it depends upon LOS.

Mr Goldman outlined that the benchmarking should be seen as a plan for going forward and should not be confused with the turnaround plan.

Ms Ryabov would bring back a rolling 3 year plan in October. This would give an overview of the process for the board to consider. The tracking of benefits was important and this would be included. Dr Foster also provided an international perspective on benchmarking. ER

09.114 11. Mid Staffs Review

The review demonstrated that the risks the Trust was facing were being managed. The area that needed more work lay in reporting and assurance to the Board and the Governance and Risk Committee on the views of patients who used the Trust's services. A great deal of work was being carried out but there needed to be a clearer reporting line to the Board and the Committee.

The review had confirmed that the major issues raised at Mid Staffs were general issues for the NHS as a whole, the Board was assured that these issues were already on the risk register and were being managed.

09.115 12. Swine Flu Update

In the light of the previous discussions the update was accepted by the Board.

We Are the Local Provider of Choice

09.116 13. Ultragenda Update (IC/ER)

The report set out that the process had been ongoing for some time and was under a notice of improvement by PCT. Ms Ryabov expected that the migration of data would be completed by the end of September. The link to booking would then automatic. A training and communications process for staff was already in train.

Mr Wilkinson questioned the level of financial penalties for not delivering the system by October 2009. Mr Stokes confirmed that liquidated damages were the contractual penalty but that good relations with the PCT would minimise this. The worrying deadline was the Secondary User Services deadline (also 1 Oct 2009) since failure to meet this would impact the financial position as the Trust would be unable to supply appropriate activity data.

Mr Goldman confirmed that Ms Ryabov and Mr Laverick were working very hard and they were confident that the Trust would meet the deadlines. They were very clear about the requirement to do so. Mr Stokes was maintaining a close relationship with the PCT to mitigate any possible financial penalties.

The Board approved the implementation report and requested a report in December which would consider the strategic implications benefits of ultragenda which had up until now been overshadowed. IC/ER

We Are the Local Employer of Choice

09.117 14. Workforce Pay and Productivity Presentation (MC)

Ms Coalter presented her report on workforce pay and productivity. The background context had already been well debated within the meeting.

Mr Wilkinson highlighted that it was vital to obtain increased productivity out of AfC and that the next pay award round would be crucial.

Prof. Ham asked for more background numbers within the presentation particularly benchmarking indicators, e.g. how does the Trust's staffing levels to patients compare with other Trusts.

Mr Samuda asked for more detailed on incentivising staff and whether there was a pay issue. Ms Coalter confirmed that most of the research from the Trust's work force, was that problems in recruiting were not linked to pay but more generally to, risk issues, time commitment, giving up clinical work, and succession planning. The Trust was moving towards withholding pay increases for poor performance and the systems were in place to do this.

Mr Wilkinson suggested that a pay incentive and consideration of work life balance issues was required to encourage clinicians to move away from clinical practice to management.

09.118 15. Human Resources Committee Report (MC)

The Board accepted the Report and the update on measures to prevent bullying and violence at work.

We Are Financially Secure

09.119 16. Monthly Finance Report (AS)

Much of the report had been highlighted in the Forward look and the Turnround Programme discussion but the Board was asked to note the in month deficit of £0.7m, the year to date deficit of £2.3m and the key issues of pay control, unachieved CIP, CAT C income and over performance income. In particular, over performance against internal LDP's of £5.4m for the YTD was cushioning the Trust's performance. Continued over performance at this level would put the Health Economy into a deficit position.

Mr Stokes highlighted again that the Trust's cost cutting strategy was only a small part of the solution and that service transformation, benchmarking and productivity gains had to be an essential part of the solution.

The Board accepted the Report and requested strong performance on the control of vacancies and CIPs. It recognized that over performance put the PCTs in a precarious financial position and requested that agreement be reached with the PCTs on a commitment to finding a strategy for the region's health economy.

GENERAL BUSINESS

09.120 17. COMPANY SECRETARY'S REPORT (CL)

The Board accepted the Report and approved the Requisitions listed for Board approval.

09.121 18. ANY OTHER BUSINESS

There was no other business.

09.103 17. DATE OF NEXT MEETING

Tuesday 4th August – apologies Richard Samuda.

…… Chairman