TRUST BOARD

Minutes of a meeting held at Devon House, Heartlands Hospital at 1.00pm on Tuesday 5th October 2010

PRESENT:

Mr Clive Wilkinson	Dr M Newbold
Mr D Bucknall	Mrs E Ryabov
Ms M Coalter	Mr R Samuda
Mrs A East	Dr S Smith
Mr R Harris	Mr A Stokes
Mr P Hensel	Ms M Sunderland
Lord P Hunt	

IN ATTENDANCE:
Mr A Cotter, Coroner for item 5 only
Ms L Dunn
Dr I Gupta for item 8 only
Ms L Jennings (Minutes)

Action

10.158 1. APOLOGIES
Ms Beccy Fenton, Ms Najma Hafeez

10.159 2. DECLARATIONS OF INTEREST
The declarations of interest were accepted by the Board.

10.160 3. MINUTES
Subject to one amendment highlighted by Ms Sunderland to item 10.149, para 9 to read "but that incidents in grade 3 and grade 4 had halved in the last year" as opposed to two years, the Minutes were agreed as a correct record.

10.161 4. MATTERS ARISING
Maternity services – Insurance liability (MC/TN)
Ms Coalter confirmed that this item had been addressed at the July Trust Board meeting, where she had confirmed that the new training requirements of maternity staff, as a result of changes at Solihull, were in place and there had been no change in the insurance liability.

Mr Stokes drew the Board's attention to a very likely change in the CNST as a result of forthcoming changes to banding. This would be discussed at the Executive Directors' Committee and then brought back to the Board. Dr Woolley forewarned that it would be very difficult to stay within the band and meet the new requirements and prepared the Board to expect an increase in the premium. AS/SW

Monitoring nursing care – (MS)
Ms Sunderland was now circulating the nursing metrics to the Board and Governors, and so it was agreed that this item be removed from future agendas.

SCT Community Services Bid (MN)
Dr Newbold confirmed that Mr Hackwell would present a formal paper at November's Trust Board, as the Trust was now the Care Trust's preferred bidder. This was still to be ratified with the SHA, when the process of due diligence would begin. It was agreed to bring the Audit Committee and Trust Board forward half an hour on 2nd November and that SCT Community Services Bid be the first on the Agenda.

SH

LD

10.162 5. CHAIRMAN'S REPORT

The Chairman began by congratulating the following on their well deserved appointments/reappointment:

Lord Philip Hunt on his appointment as Non Executive Director.
Mr Steve Smith on his appointment as acting Medical Director.
Mr Richard Samuda on his reappointment as Non Executive Director.

Mr Smith agreed that the rotation of Group Medical Directors would continue and that he was scheduled in that capacity as well for this meeting.

The Chairman then welcomed Mr Aidan Cotter, HM Coroner, to the Trust Board and thanked him for coming. The Chairman explained to Mr Cotter that the Trust now had a set of safety indicators, which were thoroughly scrutinized at both the Governance and Risk sub Committee and the Trust Board itself. However had invited the Coroner to share his perspective on the Trust's management of SUIs and liaison with the Coroner's office.

Mr Cotter suggested he return in two or three months, so that the Trust could reciprocate by sharing its viewpoint on how he dealt with inquests. A summary of Mr Cotter's talk is below:

Mr Cotter confirmed that he was a pure lawyer and not a doctor. He had been a Coroner since 1984 and had held a number of positions. He had been in his current role for the last nine years and investigated approximately 5,000 deaths a year, out of which approximately 1000 inquests were held. His inquest rate was approximately 20% higher than the average. This was because he viewed it as his job to keep the public and Healthcare organisations abreast of what was happening.

He said it was not his remit to criticise the judgment of clinicians/nurses. He dealt with the concept of neglect, a gross failure to provide basic care that was related to the death.

Mr Cotter's aim was to keep it simple, if basic medical care was not met and someone died, then it was recorded as gross negligent. As there had been specific incidents, which needed to be investigated and the findings acted upon

Mr Cotter had informed the CQC and Monitor. The Trust was found to be no different to other organisations of the same size. He understood that that was a two pronged outcome, however, it was his view that Birmingham should aim to be better than other organisations of the same size.

Mr Cotter wanted to highlight the following three areas:

1. Instant report forms
   The importance of sharing instant report forms with families.

2. Fast track Inquests
   These were perfectly normal inquests but fast tracked through the system, Mr Cotter would expect to hear and complete them within 7 days of the death. There were only one or two other Coroners who did this, his former deputies. There were many advantages. Mr Cotter would expect a member of the team to ring his office, providing details of the death, provide the nominated representative's details and three dates of availability to attend the inquest. There was pre allocated time in Mr Cotter's diary for such requirements. Mr Cotter's officer then contacted the family to explain the procedure. The inquest would last for 30 minutes. A family member would give evidence and then the surgeon would give evidence. In 95% of cases the families were satisfied and the process was concluded within seven days.

   Out of 630 families polled only six said they did not like the system. Many of the others said it provided closure. Other feedback was that it was "good hearing them tell you what they told us". Mr Cotter acknowledged that families themselves sometimes felt they were not told things when they had been because they had not been able to take it in due to being upset.

3. Rapport. When the surgeon or representative of the hospital attended court, they would catch the family's eye. Surgeons often didn't even look at the family or show any sign of recognition. To be recognised gave reassurance to the families and made them feel valued. Dress was also important as families expected doctors and the Coroner to dress professionally.

   Mr Cotter felt that HEFT did it well but that there was room for improvement.

Notwithstanding the above, Mr Cotter reassured the Board that most of the Trust's staff did a good job and the Trust's reputation was improving. Mr Cotter emphasised the need for ensuring patients were treated with dignity. He then went on to highlight the importance of getting the complaint handling right.

He also made the point that in every case of failure, there was more than one person involved. It was vital that nurses/clinicians took checking very seriously and did not fall into the trap of merely going through the motions. Mr Cotter finished by saying that the Trust was at least 40 times better now than it had been three years ago, however, there was still some way to go and complaint handling needed to be reviewed.

Mr Smith expressed his agreement that the fast track inquest was very successful and that the Trust should put an action plan together to have relevant triggers in place to set the process off. Mr Cotter confirmed that one definite trigger would be if someone died following surgery, but other than that the Trust would have to identify its own triggers. Any death which was or may be unnatural (court of appeal definition: death which is not natural), should be a trigger, thus that included all surgery.

SS/SW/MS

Mr Smith, Dr Woolley and Ms Sunderland agreed to meet to discuss ways of identifying triggers to ensure the fast track route was initiated when appropriate.

Dr Woolley emphasised to the Board and Mr Cotter that the Trust was committed to sharing the IR1 reports and Dr Woolley had shared it at meetings with families. She reassured the Board and Mr Cotter that staff were encouraged to be open and honest. The framework had been refreshed and a new training module was due to be launched directing staff to be open. Senior counsellors had been identified to support staff implementing the new system.

A discussion followed out of which the following key points emerged:

- Body language and approach to family by Trust staff at Inquests was crucial.
- Nursing records were very important and families valued the personal touch.
- The Trust's standards had improved remarkably over the last nine years and last three years in particular.
- Families appreciated medical conditions being explained in layman's terms so that they could understand what was happening.

Mr Cotter explained that if he recorded neglect all of any Board should be worried as it showed a gross failure to provide basic medical care. It would be good practice to ask him to come to the Trust and talk to a nominated member of staff when there was a recording of neglect. Notwithstanding the above, it was very important that families did not see Coroners and Boards as one. It was vital to be seen to be separate so that families had confidence in fair rulings. Mr Cotter suggested a way in which the Trust could learn about his perspective, without jeopardising his integrity with the public, would be to attend inquests regularly. Dr Woolley confirmed that the Governance and Risk Committee would consider the best way to action the above suggestion. The Trust did have internal data for inquests and trends were analysed on a 6 monthly basis and mapped to Coroners' rule 43.

SW

SW

Dr Woolley confirmed that she would make contact with the Trust's contact at the Coroner's office to look to further improving the relationship.

At the Coroner's suggestion, it was also agreed that the Coroner would be invited back to receive feedback from the Trust's perspective of his handling of inquests. The Chairman thanked Mr Cotter very much for attending and Mr Cotter then left the meeting.

Ms East and Dr Woolley gave assurance that every point raised by the Coroner would be addressed through the Governance and Risk Committee and then fed back to the Board. Feedback from staff who attended inquests and had dealings with the Coroner's office would be sought in readiness for the when the Coroner was invited back. SW/AE

STRATEGY AND PLANNING

10.163 6. FORWARD LOOK (MN)

Update on Paediatric Review

Ms Ryabov confirmed that representatives from the Children's Hospital who had been acting as "critical friends" were due to revisit the Trust in November and Dr Allen would report back on their findings at the December Trust Board.

Dr Newbold confirmed that closing date for Medical Director applications was at the end of that week and that there had been a large amount of internal and external applications.

In addition to working on the One Plan, winter planning was also in progress. It had been one of the busiest summers on record for HEFT as well as other Trusts and as a result the Chief Executive's team brief had been dedicated to the issue of the flow of patients through A&E to Discharge. Ms Dunn had produced a hard hitting team brief showing clearly the connection between A&E and discharge process.

Executive Directors would be visible throughout the process and would be there to support people through a very challenging time. The three key process changes that had been identified were:

1. Open discharge lounge on all three sites.
2. Bed management team to be divided into three so permanent team on each site for greater consistency.
3. Estimated date of discharge logged on arrival.

This was in place to strengthen the One Plan. The focus was on patient flow and the reason was for patient safety, not targets.

Issues with EDD were highlighted:

- There was a view that it was difficult to set an accurate one, however, there was agreement that it did provide a focus.
- High performing trusts with a good flow used it.
- One of the ideals was to use an electronic system so EDD became routine in handover. Although the Trust had an electronic pilot on ward 14 at Good Hope, there would be a manual system for other wards.

To complement EDD the Trust was using a "ticket home", which was an A4 sheet of paper which highlighted the Consultant's name, EDD and had a tick list for discharge, e.g. TTOs.

PERFORMANCE

10.164 7. Performance Balanced Scorecard – National and Local Targets (ER)

Ms Ryabov presented her previously circulated paper. Drawing particular attention to the below:

Monitor Compliance Framework

62 Day GP Cancers - red - plans were in place to increase capacity in Thoracics.

CQC: National Priorities

Stroke Patients - gone red from green - Work was in progress to identify additional stroke beds and work was being carried out on the wards. It was due to be completed and delivering from January 2011 onwards.

Heart Disease Audit - red - This was red due to data collection issues, Ms Ryabov expected this to be rectified by the end of the year.

CQC Existing Commitments – all 7 green

PCT Contract Indicators – 8 reds out of 13

Cancelled Operations Rebooked (5 days) - Ms Ryabov was looking into internal tolerance as if only one patient, it seemed misleading to be shown as red.

Complaints – This had fallen back to just above 62%. Work was underway to rectify this situation.

Midwifery Continuity of Care - It had been agreed in principle with the PCT to amend their interpretation in line with the standard which the Trust's current practices adhered to, as follows: "every woman will be supported by a midwife she knows and trusts throughout her pregnancy and after birth" and this was actually happening, albeit not just one specific midwife.

Same Sex Accommodation - Guidance from the SHA stated that the PCT did not have to fine a Trust when there was a breach, as clinical priority had to be the most important factor and as long as the Trust could justify the reason, they would avoid a fine. The focus remained on delivering single sex accommodation. HEFT was the Trust with the lowest number of breaches. The guideline stated that if the breach was due to clinical need and discussed with the patient, the expectation would be that it would not be classed as a breach in terms of the contract.

Ms Sunderland reassured the Chairman that a robust system for the recording of breaches was in place, ensuring an audit trail, to enable the production of proof of detail when required.

PROMs - Ms Ryabov was confident that this should be well on the way to green before the end of March 2011.

Internal indicators - Nurse metrics continued to improve; patient experience was

still slightly behind but was increasing every month.

A discussion took place as to why the Trust was on a number of reds and it was agreed that the reds that affected patient care and safety must remain the priorities. As the significance of the reds varied dramatically, Mr Stokes suggested that the Executive Directors provide the Board with a list of three matters of concern to focus Board discussion most effectively for each Trust Board meeting. Dr Smith reassured the Board that as a result of the One Plan and concentration on EDD, good practice would spread and in time become embedded in practice. AS

Job plans would be agreed by the Consultant with their Clinical Director and the responsibility lay with the Clinical Director to only sign off job plans that were compatible with the organisation's objectives. Mr Smith gave assurance to the Chairman that there was effective communication between himself in capacity as the Medical Director, the Group Medical Directors and the Clinical Directors through a variety of forums, which met on a regular basis to ensure the One Plan remained the focus. He agreed to provide the Chairman with a note from each of the Group Medical Directors confirming they were satisfied that the job plans now reflected the Trust's objectives. This should be ready within 3 months. As an example of the consultants adapting, Dr Smith outlined that due to the change in junior doctors' hours, Consultants were now carrying out short reviews on each patient on a daily basis, in line with the new job plan which stated an hour commitment 5 days a week, as opposed to the previous twice weekly reviews. SS

The electronic system provided a consistent format to standardise the job plans. Ms Coalter confirmed that Clinical Directors were utilising HR for assistance with the implementation of change, which indicated commitment on their part. Dr Smith assured the Board that Consultants worked over and above their contractual requirements and the organisation relied significantly on the extra value the Consultants currently gave. Dr Smith agreed to update the Board on the job plans in January 2011. SS

BUSINESS PLAN 09/10 PRIORITIES
We Provide the Highest Quality Patient Care

10.165 8. Infection Control (IG)

Dr Gupta joined the meeting to take questions and highlight issues on her previously circulated paper.

MRSA - Quarter Two had seen a small increase in numbers of MRSA but the Trust remained within trajectory if combined with Quarter One.

C.diff - There had been a slight rise but September was within trajectory. PCT had wanted 100% but after negotiation had agreed to 95%.

The government had compiled the figures using the Trust as a whole, which had provided a disadvantageous and misleading picture. The Infection Control Team

had then calculated rates for each hospital and the PCT wrote to the SHA on the Trust's behalf giving their support to this method. The SHA took heed of this and the Trust was now below average for C.Diff as at Quarter Two. Dr Gupta distributed data to illustrate this. Dr Gupta confirmed that she had looked at numbers by site and the Trust was by far the best in the region. Ms Dunn confirmed that she was due to attend a meeting to discuss where this information could be published and would feedback to the Board — LD

The Chairman and Board as a whole expressed their approval of this achievement.

Screening - There was still room for improvement with regards to Screening. To increase compliance there had been a teaching schedule launched and an increase in monitoring of screening, this was work in progress.

Norovirus - This had been particularly widespread last year. The Trust was now adopting a community strategy, involving trigger points, to try and prevent norovirus infected patients entering the hospital. Hydrogen cleaning could prevent re infection however that was a time consuming process. The focus was now on prevention and as such an effective awareness campaign was being developed. Dr Gupta agreed to provide a monthly update on Norovirus to the Board. — IG

Ms Sunderland highlighted some of the issues with lockdown, particularly with very sick terminal patients and commonsense and compassion had to be employed in allowing some visitors in.

10.66 9. Update on the Single Equality Scheme (MS) + Pam Chandler

It had been agreed that this paper be postponed due to recent changes in legislation.

We Are The Local Employer of Choice

10.167 10. Quarterly OD & HR Reporting to Trust Board

In August 2010, the Trust Board had received a report 'Strategic Workforce Challenges' that set out the challenges that lay ahead for the next 3-5 years under the following themes: Leadership, culture and staff engagement, Workforce Planning, Workforce Development, Pay, productivity and health.

Ms Coalter took the previously circulated report and KPIs and data, as read and drew the Board's attention to key areas.

Employment disputes had spiked, Ms Coalter assured the Board that she was comfortable that the spike was as a result of legitimate performance management. Ms Sunderland added that the culture was such that staff no longer accepted poor standards from their colleagues.

With regards to the perception of leadership, nearby leadership fared better than far leadership. Dr Newbold had reported last month that part of the engagement

strategy was to harmonise top management objectives with front line staff. Ms Coalter was confident that perceptions would improve, feedback from the "back to the floor" initiative had been very encouraging. Last year the survey had shown that staff thought senior managers were very distant and remote and did not think or care about the staff. Ms Coalter thought this would improve because of Dr Newbold's initiatives and the challenge would be to maintain it. There were organisations that had demonstrated that through difficult times, perception could be improved through staff engagement and by management being open and honest. One of the Chaplain's had said to Dr Newbold of the staff "they just want to know you value what they do".

Workforce development
The Faculty were currently working on a broader set of KPIs to include in the Board pack. This would include, for example, promotion and progression rates for staff in the Trust, qualifications achieved and attrition rates from programmes.

The key focus for this quarter was to ensure CQC compliance on the one remaining domain with registration conditions. As of 27th September, 72% of Trust staff had received their annual appraisal during this financial year and this was a significant achievement. The data from staff appraisals, and other sources, was now being used to bring together the Trust training needs analysis and this would be discussed with the CQC early in October.

With regard to Mandatory training, Ms Coalter confirmed that it was her intention to introduce more e-line training. Mr Samuda raised the concern that if training was mandatory and not being met there was a safety issue, Ms Coalter agreed and assured that it was being treated as a priority.

Pay productivity and Health
Ms Coalter explained to the Board that there was some new data around Agenda for Change banding and average rates of pay. The Trust was generally in line with other Acute Trusts in terms of the profile of staff across Agenda for Change bandings, although the average rate of pay was slightly lower than others in the West Midlands. This was due to the fact that the Trust had more band 5s and less band 6 and 7s than other Trusts in the region. The issue of how to expand bands 3 and 4 was one of the issues that Ms Sunderland and Ms Coalter were looking at, as this offered potential for cost effectiveness and increased efficiency.

Ms Coalter would be bringing a review of pay and conditions back to the board in December. **MC**

The Strategic Health Authority had recently been working on a regional workforce productivity dashboard which should be launched later in the Autumn. This would provide good quality benchmark data in this area for future quarterly updates.

Sickness absence rates and staff turnover at the Good Hope site was higher than the other sites and was generally on the upward trend. This remained a key

focus in HR's work to address absence management and staff engagement.

Workforce Planning
Following an extensive workforce planning process during 2009/10, the Trust now had better quality data and information on workforce planning issues. The HR team and Nursing were working closely together to maintain momentum around nursing recruitment levels, particularly in the light of the Nurse establishment review and winter demands.

The KPIs for the key staff groups showed current vacancy rates and mitigating action. International recruitment for A&E middle grade doctors had finally been successful with all but one vacancy filled. Theatre nursing had been a concern for a considerable period of time, however there was a coherent plan to address this area that included recruitment, retention and succession planning and the Board should begin to see a reduction in the vacancy factor at the next quarterly update.

There were concerns about the Trust's ability to attract sufficient junior doctor levels for Anaesthetics and critical care due to recent Government immigration restrictions and recruitment efforts would focus on the European community. Pharmacy vacancies were being addressed in the Medicines Management follow up plan and a dedicated work stream was tackling a number of workforce issues.

Ms Sunderland confirmed to the Board that there was a non ward based nurse review in progress to evaluate the effectiveness of the nurse specialist. As part of this review individual directorates were looking at nurse specialists to see if a) those in post were adding value and b) if there were areas they could be used in future to combat the shortage of junior doctors. Ms Ryabov explained that the issue around Junior Doctors was about managing the out of hours rota, whereas clinical nurse specialists operated within hours. The reality particularly in Medicine, surgery and A&E was more about consultant cover. The Trust did have pockets of very good practice and the objective was to develop those. The Board indicated that they were very pleased with the new way in which Ms Coalter had presented her data.

Mr Harris expressed concern that the increase in staff turnover, together with the feedback on managers and increased sick leave, were not healthy indicators. Ms Coalter confirmed that last year's survey had highlighted staff's concern over leadership and it was being addressed through staff engagement. She also confirmed that all directorates now had a vacancy management system in place to help with CIP.

The Chairman emphasised that it was important that the marking system for the Consultants Award Scheme was weighted to reward those Consultants who were fulfilling the organisation's objectives. Ms Coalter confirmed that she was going to hand this piece of work over to Mr Smith who would be taking up the work Mr Cunliffe had been doing.

We Are Financially Secure

10.168 11. Monthly Finance Report (AS)

The Chairman directed that the Finance report should start with the outline business case for the Outpatients/Ambulatory Care Department.

The key issues for the Board to be happy about before signing off a £40m plus investment (largest single investment with the next 3 years) out of a total capital programme of £120m were:

- The investment of a significant sum of money in capital at a time when the Trust's workforce numbers would need to decline.
- That the £40m had been rigorously challenged to ensure it represented the best possible value for money to deliver the benefits in Outpatients.
- The capital programme was already oversubscribed and at points in the next three years there would be difficult decisions around not investing that would be a direct consequence of this investment decision.
- Given the extent of the expenditure, the Board would be prioritizing this over any other large single investment.
- The success of this business case relied on a fundamental redesign process for Outpatients, if this was not done correctly, the benefits contained within this case would not materialize.
- Once the building had commenced, the opportunity to slow down on capital expenditure would have gone and only delivery of the efficiency targets would maintain the Trust's financial stability.

The Chairman asked if there was an alternative. Mr Stokes confirmed that doing nothing was not an alternative. The only alternative was doing the minimum which due to the way the building was set up was also very expensive, i.e., £20m for less than satisfactory outcome or a really good Ambulatory Care Centre for £40m.

Mr Bucknall raised his concern that Deloittes' overview was that the marketplace was a dramatically different place now to when the costs were agreed. Construction was now 15% cheaper than in 2008, thus the budget and scope had shifted. The design and construction team had followed the old model prior to this shift. Mr Bucknall said he would like the Board to consider a stand back to ensure value for money and best carbon footprint, albeit a short stand back.

Mr Stokes reassured that the governance system had been very rigorous, regarding carbon reduction plan etc and Mr Roy Shields, a governor who had been heavily involved, was an Architect at ARRUP. Dr Smith confirmed that the clinicians were happy with the design around the new patient pathway and all the Group Medical Directors had signed up to that. It would be a multifunctional building.

Mr Harris questioned what other investments had been seen as potential priorities and Mr Stokes said that at the Trust Board Away Day in early 2009, the 10 year plan had identified 3 potential large investments: 1) brand new A&E with critical care above it on this site; 2) Eight ward block at Good Hope with

connecting corridor; and 3) this Ambulatory Care centre.

There were two other major projects that were prioritized below the Ambulatory care centre. Firstly, the second ward block at Good Hope on the back of the large cost (circa £75m) with an alternative solution being sought to connect Richard Salt block to het Fothergill Block. Secondly the brand new A&E, this was on the grounds that the location of this was on the current site of the Outpatients and the Ambulatory care build is a prerequisite to that build. Dr Newbold reassured the Board that the Executive Directors had assured themselves that there were no significant projects, particularly around safety that were needed ahead of the business plan being presented now.

The Board approved the investment on the condition that they received interim milestone reports.

Monthly Finance Report
Mr Stokes presented his previously circulated report. There was a deficit of £0.2m in August, £3.1m year to date, which was slightly ahead of last month's forecast. Mr Stokes reassured the Board that it was a relatively good month. There was over performance of £11.5m year to date. The operational budget had overspent by £1.3m in August, £6.0m year to date. CIP delivery had slowed marginally in August to £4.7m year to date, which was a £1.0m shortfall against plans. Group 5 had some historic issues with CIP. Mr Stokes and Ms Ryabov were having a meeting with them to discuss a way forward. There had been a small reduction in medical pay costs in month. Further work was required to sustain and reduce further. However there was a growing risk as both BEN and Solihull PCTs had raised formal affordability issues.

Mr Stokes confirmed that an Away day with the Trust Board and Group Medical Directors had been planned for 17 December to discuss the issue of CIP. With regards to medical staffing, Mr Stokes confirmed that Dr Stedman was chairing a group to look at this as it remained the biggest issue and he would report back on this to the December Finance Committee. Mr Stokes updated the Board on progress with the attempts to recover the debt owed by Birmingham City Council, as it was the Trust's largest debtor owing £2m.

AS

A detailed discussion then followed around CIP, with considerable Non Executive challenge, out of which the following explanations/assurances were made:

Private Sector
One of the reasons work was given to the Private sector out of hours was to help prevent losing future business that in the future could be carried out within hours. Activity fell into 2 categories: emergency and commissioned.

The emerging GP Consortium would present the Trust with challenges around controlling demand. It would have to gauge level of activity to get the capacity right and also had to take £100m out of the cost base over a three year period.

The Trust's EBITDA outturn was better than the Foundation Trust average. It

was agreed that the Trust was facing extreme times and so had to undertake radical thinking at the Away Day in December and move forward with that. The Trust's own efficiencies were crucial, as that was the thing the Trust had control over but it should be recognized that the trust LOS reduction has to be a fundamental plank of the efficiency plan alongside some more radical ideas.

10.169 12. Housekeeping Tender Approval

Mr Stokes explained that this was a Heartlands contract, as Good Hope and Solihull had in house contracts.

[reserved – this section of the minutes is considered potentially exempt from disclosure under the Freedom of Information Act 2000 as disclosure may be prejudicial to the effective conduct of public affairs or may reveal information covered by Legal Professional Privilege.]

On the condition that the Board continued to monitor the financial standing of G4S, the recommendation for the Trust to remain outsourced and appoint G4S.was agreed. Ms Dunn asked if the decision could be embargoed until Monday 11th October. The Chairman agreed it could be.

10.170 13. BBraun Decon Variation Paper

Mr Stokes confirmed that the Trust had originally had an in-house contract for decontamination, however, rules and regulations changed and so it was outsourced to the above at a good price and good quality.

[reserved – this section of the minutes is considered potentially exempt from disclosure under the Freedom of Information Act 2000 as disclosure may be prejudicial to the effective conduct of public affairs or may reveal information covered by Legal Professional Privilege.]

Mr Stokes was asking for Board agreement to a 10% increase, subject to final legal sign off by the Trust's lawyers. This was agreed.

GENERAL BUSINESS

10.171 18. COMPANY SECRETARY'S REPORT

The Company Secretary's report and the attached sub-committee minutes were noted.

The Trust Board approved purchase requisition 588020 – Provision of Linen services as per mini Completion Agreement 2005 to Birmingham Heartlands Hospital & Solihull Hospital for the period August 2010 – March 2011.

10.172 19. DATE OF NEXT MEETING

Tuesday 2nd November 2010

Chairman