TRUST BOARD

Minutes of a meeting held at Devon House, Heartlands Hospital at 1.00pm on Tuesday 7th September 2010

PRESENT:	Mr Clive Wilkinson	Mr M Newbold
	Mr D Bucknall	Mrs E Ryabov
	Ms M Coalter	Mr R Samuda
	Mrs A East	Mr A Stokes
	Ms N Hafeez	Ms M Sunderland
	Mr R Harris	
	Mr P Hensel	
	Dr A Keogh	

IN ATTENDANCE:	Dr P Allen
	Ms L Dunn
	Dr R Stedman
	Miss S Gargeswari
	Ms L Jennings (Minutes)

Action

10.139 1. APOLOGIES
Dr I Cunliffe, Ms Beccy Fenton, Dr S Woolley.

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

10.141 3. MINUTES
Following a number of grammatical and factual corrections the minutes of the meeting held on 6 July 2010 were agreed as a correct record.

10.142 4. MATTERS ARISING
Monthly SUI alert system for SUI
This item is to be covered under Item 11.

10.143 5. CHAIRMAN'S REPORT
The Chairman had previously circulated a letter from Monitor confirming that the Trust was no longer in breach of its Terms of Authorisation. A meeting had been arranged by Monitor for 15 September 2010. Update briefings on safety and operational issues prepared by Dr Woolley and Ms Ryabov respectively would be taken to the meeting.

The Chairman confirmed that the process for appointing a replacement Non Executive Director for Prof C Ham was well underway and that interviews had been arranged for 13th September 2010.

STRATEGY AND PLANNING

10.144 6. FORWARD LOOK (MN)

Dr Newbold updated the Board on the Trust's engagement process. There had been a very good response to the Trust's four priorities at the many internal and external meetings he had attended. Many GPs had expressed a very positive wish to engage. The next Team Brief would focus on safety, emphasizing the importance of early in the day discharges. Dr Newbold had also met with two MPs, Andrew Mitchell MP and Lorely Burt MP, as part of this engagement process. Mr Bucknall said he believed that there was an appetite amongst the Sutton Coldfield GPs to replicate the initiative taking place in Solihull.

Dr Newbold confirmed that the Trust was about to go out to advert for a new Medical Director, which was being targeted both at internal and external candidates. He had written to all the internal consultants that day, explaining the inclusive process. He had also written to the Group Medical Directors to invite expressions of interest for acting up in the interim period. Mr Cunliffe's notice period ends on 30th September 2010.

The Chairman took the opportunity to formally thank Mr Cunliffe for the productive contribution he had made during his time as Medical Director both in the surgical and medical directorates, as well as to the Trust as a whole. He also recognised his continued contribution in his clinical role. Dr Newbold informed the Board that Mr Cunliffe was taking on a lead role on a national sport initiative.

10.145 7. SCT Community Services Bid (MN)

Dr Newbold informed the Board that Mr Hackwell's previously circulated paper would be taken as read. He added that the initiative would run in partnership and that in the main the proposal had been well received. There had been positive stakeholder feedback and the Trust had been well represented by Dr Peter Wallis. The official Bidding process had taken the place the previous day and the Trust expected to hear from the Care Trust at the end of the month. Dr Newbold said he was entirely satisfied with the Trust's preparation and reassured the Board that if the Trust was successful with its bid, a process of due diligence would commence and appointments to cover different specialisms would be made.

A discussion took place, with Non Executive challenge, around the financial implications as well as issues around liability and the taking on of additional skills. Dr Newbold explained that there were two separate processes: the first one being the bid and the second one the services provision. Mr Stokes reassured the Board that it was currently funded at cost and it was clear at the moment that the existing Solihull Care Trust deficit lay on the commissioning side. Regarding the additional skills, Dr Newbold explained that although the Trust did not have all of the direct expertise at the moment, it would have to develop these in the next few years as a direct result of the White Paper. He

was able to reassure the Board that the Trust did actually have a significant amount of the relevant expertise already. The reasoning behind the initiative was not so much to expand the business but to change how the Trust dealt with patient pathways, to get more people out of the secondary care sector in conjunction with its partners.

PERFORMANCE

10.146 8. Performance Balanced Scorecard – National and Local Targets (ER)

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

Monitor Compliance Framework – all 16 green

The Trust had now achieved green in all areas of the Monitor Compliance Framework, which did reflect the reduction in the A&E target to 95%.

CQC: National Priorities – 2 reds out of 6

Learning disabilities activities had been an annual target but the Trust had now been asked to report quarterly.

Heart disease audit had presented some issues last year but did meet it overall. Ms Ryabov highlighted it was red due to data collection issues.

CQC Existing Commitments – all 7 green

PCT Contract Indicators – 8 reds out of 13

Cancelled Operations rebooked (5 days), Ms Ryabov explained that the numbers were relatively small, and one patient that they had not contacted was due to that patient being abroad.

Midwifery continuity of care, this specific issue was being discussed with the PCTs. Dr Allen confirmed that the midwifery team worked as a team as opposed to one named midwife. Talks were underway with the PCT to overcome what the Trust viewed as a misinterpretation, as the wording of the standard "Maternity Matters" stated "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. Mr Stokes confirmed that there was no financial penalty attached to that standard.

Dr Allen to clarify to the PCT and report back at next Trust Board. PA

Patient Reported Outcome Measures - Proms

Ms Ryabov explained that there were two sets of questionnaires, as there was one for outcomes post surgery too, but those results were not available yet. The report showed the data collection.

Number of Teenagers initiating Breastfeeding within 48 hours

The Trust was trying to reduce teenage pregnancy at the same time as encouraging those who did become pregnant to breast feed. The exception report set out the measures that the midwives had set out to help achieve this and it was a "work in progress".

Same Sex Accommodation
Guidance from 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 remains on delivering single sex accommodation.

Number of Appraisals completed
Ms Ryabov confirmed that appraisal completion had improved. The figures were about a month behind and Ms Coalter was producing a full report for Executive Directors, which would be fed back to the Board the next month. The CQC's concern centred around whether the Trust had a good training needs process, and it viewed the appraisal as a good way of identifying training needs. MC

Quality and Safety Nursing Metrics – just below 90%.
This showed a huge reduction in red wards. Ms Sunderland agreed to distribute the results to the Non Executive Directors following the Board meeting. MS

Mr Stokes confirmed to the Chairman that the targets including A&E, 18 weeks, Single Sex Accommodation and C.Diff could affect income if not met. Also the Trust could lose money if it did not meet the CQUINs targets.

Mr Stokes confirmed that he had just written to the PCTs asking for clarification of where the PCT Contract Indicators the Trust provided was circulated to and would feed back to the Board when he had received a reply. AS

Ms Ryabov confirmed that the top six actions were still being concentrated on, with the Estimated Date of Discharge being the main focus. A pilot was taking place with interactive white boards, with the nursing handover being updated in order to identify the presenting condition. This was to allow for a benchmark figure to intimate the EDD. Those wards without electronic whiteboards would use a normal board.

Dr Stedman explained that the EDD was a tool for inducing culture change and that aspirational targets were being used at the moment with the aim of closing the gap between actual and expected. Ward rounds and seven day week discharge was now across all sites and the aim was to achieve 40% discharge by 1.00 p.m. Ms Ryabov to confirm timing for roll out at next Board meeting. ER

Dr Newbold highlighted that this was about ingrained behaviours and culture and not merely an operational issue.

10.147 9. A&E 95%, 4 hour access target August position (ER)
This target had been met.

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

10.148 10. Monthly update on triggered risk summit (AK)
Dr Keogh attended the Board as Dr Woolley's representative. She took the above report as read and confirmed that many of the actions had already been taken. Dr Keogh confirmed that Dr Woolley would be able to bring the CQC draft SW

report to the Trust Board in October. Dr Woolley had arranged to meet with the CQC and Monitor regularly to ensure that the Trust was aware of any issues as early as possible. The Chairman confirmed he was pleased with the progress.

10.149 11. Governance and Risk Committee Update (AK)

The Patient Experience Report would be discussed under Agenda Item 14.

Audit and Effectiveness Arrangements

The Chairman welcomed Miss S Gargeswari, a Consultant Obstetrician, and Chair of the Clinical Standards Committee to present this previously circulated item. Miss Gargeswari highlighted areas of effectiveness and challenge. She was able to assure the Board that there was a very good structure in place for Audits as well as effective Governance and pathways throughout the Trust. It was web based which improved efficiency, was unified across directorates and was transparent for Group Medical Directors to see. This was being rolled out in September to all directorates. HEFT was one of the first trusts to set up a trust wide system. There had been significant change and many success stories.

One of the biggest challenges was the European Working Time Directive, which meant many junior doctors, who had done those audits, were not available. It was important to be realistic in terms of time allocation to do the audits as there was much reliance on goodwill due to limited administrative support.

The successful directorates were the ones that had planned ahead and built it into their budgets. It was important that action plans were converted into clinical activity and those successful directorates shared their best practice. The most effective action plans were the ones that made small changes over a period of time. The implementation of action plans was being monitored.

The Chairman said that the Board took assurance that the right clinical audit system was in place and as a result there had been improvements made but that it also took onboard Ms Gargeswari's concern that there was a resource issue in terms of funding and expertise which meant that some action plans were not being implemented. The Chairman indicated that he was confident that Miss Gargeswari would be able to help with the expertise and that the implementation of action plans was critical. He went on to say that the Board did expect the Clinical Audit Board to be effective and deliver its objectives. He asked Miss Gargeswari to return in 6 months and report back to the Board on progress and resource implications. SW/SG

Mrs East confirmed that she had been impressed with the job that Miss Gargeswari had done. Mrs East offered to assist clinicians with the implementation. The Chairman confirmed that he would like Mrs East to continue her work and then report back to the Board on the resource issue. AE

The Chairman thanked Ms Gargeswari for her report and for the assurance she had given to the Board.

SIT REP

There had been one new SUI, when a gastric tube had been mistakenly inserted into the lung. There had been two incidents on two different wards. Dr Stedman

said that there should be two checks that should be done, however, all tests had fallibilities. In the one a chest x ray was not done when it should have been and in the second one the acetate had not been received when the x ray had been done. Ms Sunderland's team had sent out alerts re the process and they had been incorporated into nurse band 5 training, as well as for doctors. Dr Keogh agreed to find out the national incident picture which would be circulated to the Board. AK

Mr Samuda asked how claims correlated with the cost of the claim. Mr Stokes confirmed that the Trust paid a premium based on the number of beds and staff and that the higher the CNST rating the greater the discount. There was also a usage rating, with the cost increasing with the frequency of usage. The cost of CNST had risen dramatically for all organisations over the last two or three years. The Trust's usage premium was zero.

Regarding the safety metrics, Ms Sunderland informed the Board that the Trust had seen a dramatic improvement in reporting and documentation. However, it looked like prevalence was increasing in grade 2 but that incidents in grade 3 and grade 4 had halved in the last year and so it was reasonable to assume that the Trust's increase on focus on standards was what had increased the appearance of prevalence in Grade 2. Dr Keogh agreed to look at reporting methods and report back. AK

Compliance rates for MEWS scores were improving and violation classes were being run to see why people were not complying. These MEWS scores were very important to patient safety. Dr Keogh to look into whether the target of 100% compliance on observations after 30 minutes was realistic. The Trust was 100% on initial observations and MEWS. AK

Clinical Governance Annual Report
This was taken as read but Dr Keogh said that she would like to invite anyone to visit the Elderly Care Assessment Unit at Good Hope. Handover had been identified as the biggest risk. The staff implemented the change themselves and then introduced briefings. Dr Stedman confirmed that the Trust had gone live with the Hospital at night and it was going very well.

Information Governance Assurance
This report was taken as read and there were no questions.

10.150 12. Up-date on Paediatric Review (PA)

Dr Allen presented her previously circulated newly formatted report. She updated the Board that further to concerns raised re the design of the neonates ward, plans were now in place regarding improvements. The Design Team was going to be shortlisted that week and would be choosing between three options. Mr Stokes confirmed that a sum had been set aside within the Capital Programme.

Dr Allen 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. PA

10.151 13. The Safeguarding Annual Report (MS)

Ms Sunderland informed the Board that the Trust had a duty to comply on safeguarding both for adults and children. Ms Sunderland confirmed that the Board did not need to be concerned about the orange because it was from last year's report and all the orange had now been achieved. Ms Sunderland confirmed the Trust was now meeting the CQC standards and had built excellent partnerships with the Police.

10.152 14. Patient Feedback Report (LD)

Ms Dunn drew the Board's attention to the summary of the wards that had patient feedback collected during June 2010 as requested at the last Board meeting. On every site on every ward at least 15 patients would be asked questions to use for data and in addition 200 patients would be surveyed by post and this would be triangulated with the number of complaints and PALs incidents to give a clear picture. Ms Dunn confirmed that future Board reports would include actions that had been taken as a result of the patient feedback and the impact those actions had had. LD

Miss Dunn then informed the Board that a book had been produced which included a discharge form and the patient's EDD together with information about medication and its side effects, and an aid memoire for patients once they had gone home. There would be a folder at the bedside which would inform the patient and their relatives/visitors all about PALs and how to make a compliment or complaint. This was to be piloted on Ward 19. The book would belong to the patient.

Ms Dunn reassured the Chairman that coverage was increasing and different ways were being looked at about how to capture information from outpatients. Ms Dunn hoped that the Board would be able to see 100% coverage by the end of the year and by January 2011. Ms Dunn said it would be her wish to run the system to the end of the financial year before going public. As part of the CQC action plan nursing metrics had been going to PCT meetings already.

We Are The Local Employer of Choice

10.153 15. Progress Report on the Workforce Development Strategy and Faculty of Education (MC)

Ms Coalter reminded the Board that the above had been brought to the Board about a year ago and there had been a successful official launch in March 2010. This had been publicised on the website. There was now a quality assurance mechanism in place as well and it was CQC compliant. The CQC was particularly interested in the training needs analysis particularly about clinical staff having the right skills, appraisals were a key part of that. The Trust was now doing more in-house delivery. It provided good value for money, with a Masters Degree costing £3k.

Apprenticeships had been particularly successful. Key areas of need were now being targeted such as Theatres, and the assistant practitioner's role. Ms Coalter felt there was commercial viability and the Trust was looking to expand its partnership arrangements.

The courses would be validated by Universities and so could be used in other organisations too. Ms Coalter explained that there was a Faculty Board that had been running for 12 months which oversaw the governance of the Faculty. It was also reviewed at the HR Committee. The standard of quality was externally reviewed through the accreditation process and all funding came from the HR budget.

10.154 16. Whistleblowing procedures (MC)

Ms Coalter confirmed that this item had been brought following discussion at a previous Board meeting, when she had been asked to come back to the Board with the processes and procedures. The policy had been audited a year ago, and met with quality assurance. However, it was not widely used and there was an action plan, involving EDs being champions for people raising concerns, which needed to be well communicated. This would be reviewed regularly at HR Committee to check it was working on the ground. Ms Coalter reassured the Board that despite much media interest generally on whistle blowing re the gagging of clinicians, the Trust did not have any history of that. Ms Coalter agreed to provide the Board with half yearly reports regarding Whistleblowers. MC

We Are Financially Secure

10.155 17. Monthly Finance Report (AS)

Mr Stokes presented his previously circulated report. There was a surplus of £1.8m in July, £3.3m year to date, which was in line with previously reported estimate. Medical staffing continued to run higher than budget and CIP was growing and was a challenge going forward. This was offset by over performance by PCTs. However there was a growing risk as both BEN and Solihull PCTs had raised formal affordability issues. Mr Stokes confirmed that CIP and medical staffing were the areas being concentrated on and drew the Board's attention to the best (£14m surplus), likely (£11m surplus) and worst (£8m surplus) scenarios. The likely forecast remains £11.0m.

Mr Stokes drew the Board's attention to the Trust's attempt to recover the debt owed by Birmingham City Council, there were two meetings planned over the next few weeks, as it was the Trust's largest debtor. Mr Stokes is to bring analysis of the debt and issues to next Board meeting. AS

Monitor had written (letter in Board papers) to confirm that the Governance rating was now Amber-Green with a Financial Risk rating of 4.

Dr Stedman and Mr Stokes were meeting with PCTs the next day re contractural led demand, which would require the Trust to justify rations. Concerns were raised over dependence on over performance and the need to know more about how the tariff worked against cash. Mr Stokes clarified that at a simplistic level, over performance using in hours activity was very profitable, however out of hours or private could see the Trust making a loss. Ms Ryabov added that unplanned activity and emergency activity was also problematic. Overall activity had increased and so the directorates had to balance cost improvements with managing activity. Mr Stokes reassured the Board that there was constant pressure to drive down costs and drew the Board's attention to the CIP breakdown.

A detailed discussion took place around the challenges of reducing costs. The Trust only had control over planned demand and there was a need to reduce length of stay and improve care pathways, which would involve dramatic culture change and this would only take place over time. Mr Stokes said there was a need to reframe how capital investment was looked at, the Trust was in a good position in terms of cash.

Dr Newbold pointed out that these were unprecedented times, and put much pressure on front line staff. Ms Coalter added that one of the Trust's greatest challenges was that the Trust has no memory knowledge on dealing with this level of change, however there were lots of examples outside the NHS about saving money and improving quality. Thus there was a need to reach out and learn from others. Ms Coalter confirmed that she had arranged visits from a number of private companies to talk with HR about this.

Mr Stokes agreed to put more detail into next year's CIPs and to continue to show clearly the relationship between quality and safety and finance and to show the reductions and the thinking behind them. Mr Stokes agreed to take Mr Harris and other interested Non Executive Directors through the processes. AS

Dr Stedman pointed out that the reduction of cost could sometimes improve quality and safety.

GENERAL BUSINESS

10.156 18. COMPANY SECRETARY'S REPORT

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

10.157 19. DATE OF NEXT MEETING

Tuesday 5th October 2010

Chairman