TRUST BOARD

Minutes of a meeting held at Education Centre, Good Hope Hospital

at 1pm on Tuesday 7th October 2008

PRESENT:	Mr C Wilkinson *(Chairman)*	Mr C Ham
	Mr D Bucknall	Mr R Harris
	Ms M Coalter	Mr H Rayner
	Mr I Cunliffe	Mr R Samuda
	Ms A East	Mr A Stokes
	Ms N Hafeez	Mr S Woolley

IN ATTENDANCE: Ms B Fenton
Ms C Lea
Dr I Gupta (*Item 5 only)*
Ms D Tomlinson *(Item 5 only)*
Mr S Emsley *(Observer)*
Mr J Step *(Observer)*

Action

08.125 1. APOLOGIES
Apologies were received from Mr M Goldman, Dr S Gossain and Mr P Hensel.

08.126 2. DECLARATIONS OF INTEREST
The Board were asked to note the Register of Directors' Interests previously circulated and, with the addition of a new interest for Mr David Bucknall, it was agreed that the Register was a correct record. Mr Bucknall's interest related to his Chairmanship of Rider Levett Bucknall and the shareholder relationship between Rider Levett Bucknall and More-Park Group, which was a provider of car parking services to the Trust.

08.127 3. MINUTES OF THE PREVIOUS MEETING
Minutes of the meeting held on Tuesday 2nd September 2008 were agreed as being a correct record.

08.128 4. MATTERS ARISING
The Board noted that the items relating to patients' safety and the transformation quarterly report had been put back to the November meeting as more time was required for consultation and delivery of the report.

08.129 5. REPORT FROM DIRECTOR OF INFECTION PREVENTION AND CONTROL
The Board noted that Dr S Gossain would be stepping down as the Director of Infection, Prevention and Control (DIPC) and they recorded their thanks for all the work that she had put into improving infection prevention and control within the Trust. The Board welcomed Dr Gupta and Ms Tomlinson to the meeting to present the monthly update on infection control and noted that Dr Gupta would be covering

the role as Deputy DIPC whilst a review of the role was carried out.

Ms Tomlinson then presented the monthly update on infection control.

MRSA

During August 2008 there had been two cases of MRSA against a monthly target of five. Root cause analysis had been required for all cases and these had been completed by the Trust as both cases had occurred 48 hours after admission. The investigations had demonstrated a lack of adherence to policy and the respective members of staff had met with Mr Goldman and been held to account for non compliance with infection control procedures.

C.Diff

C.Diff infections had decreased in August 2008. In 2008/09 to the end of August there had been 199 post 48 hour cases compared with a target of 255. There had been 3 root cause analyses for C.Diff in August 2008, which had again demonstrated a failure to follow the C.Diff care pathway. Ms Tomlinson confirmed that the requirement to follow infection control procedure was now included as part of the induction course and that failure to follow such procedure may result in disciplinary issues. This was working its way through the organisation and beginning to deliver a cultural change in the staff attitude and approach to managing infection control. She confirmed that infection control was included as part of the junior doctors' induction process and that where cases demonstrated clear trends or specific issues; master classes were set up for ongoing training and development. In this way feedback could be delivered to all staff so that the learning that resulted from the RCA did not stay within the specific area of concern.

Professor Ham suggested that the huge progress that was being made by the Trust's staff should be recognised and that they should be congratulated on their commitment to eradicating healthcare acquired infections. Ms Tomlinson confirmed that the first session of the study day always included a 'Congratulations and Well Done section', and infection control accreditation certificates were distributed for good practice to those wards or areas that had done particularly well. Mr Harris considered whether the target should be adjusted downwards internally to ensure that there was no slippage against performance. Dr Rayner confirmed that the Trust was not working towards the trajectory but had gone for an absolute measure of no cases and on this basis was aiming to eradicate healthcare acquired infections within the Trust.

It was noted that there had been no new cases at Solihull for the last 2 months, where all wards had received a full deep clean exercise as they had a decant facility available on that site. Dr Bucknall queried whether it would be feasible to move patients to the Solihull site to the decant facility in order to facilitate deep cleaning on the Good Hope and Heartlands site. Ms Fenton confirmed that the provision of modular wards on the Good Hope site would provide a decant facility and Mr Stokes confirmed that this ward would be in place by the end of January 2009.

Access was too complicated on the Heartlands site to enable such a structure to be put in place and so a more permanent structure needed to be considered. Mr Cunliffe confirmed that as soon as the Trust was out of the winter pressures then they would return to a deep clean and decant process. The Board noted, however, that each bed or area underwent steam cleaning in order to ensure that high standards of cleanliness were maintained.

08.130 6. CHIEF EXECUTIVE'S REPORT

6.1 Performance Report

The report set out a summary of the month 5 performance for the Trust in line with the 2008/09 score card. Both MRSA and C.Dif were green in month and year to date. All national targets were currently being met.

Of the 3 remaining red indicators, 2 of them related to finance but it was noted that this did not put the overall financial position at risk. The remaining red indicator related to R and D income, which had been impacted by the limits of what was classified as R and D income. The criteria for this would be widened to reflect the full remit of R and D projects currently under scope and would then show the Trust to be hitting the target. The target would be reset for next month.

The 3 main amber targets to be considered (under Access) were all hitting their national targets but not the local targets. The Board noted that although the Trust was on target to achieve all national targets at the year end, the current analysis of A & E data up to 17th September indicated that the target would not be achieved for Quarter 2. Monitor had been advised of the Trust's position for this indicator and a further report had been submitted for the Board's consideration at item 7.

6.2 Patient Satisfaction Score Card

The Net Recommender Index (NRI) had been piloted between April and September 2008. The NRI was a way of measuring patient satisfaction and quality of experience. Response rates had been erratic throughout the pilot varying between 0% to 100% from week to week and on average 34% of patients across the 6 wards had completed a feedback card. Feedback from frontline staff had suggested that they needed richer data to be provided from such a feedback mechanism. This would enable them to put targeted actions into place and whilst NRI had provided a helpful indicator of satisfaction it was too non specific for action plans to be developed.

As a result, the Trust had invested in patient experience tracker devices which had been developed by Dr Foster Intelligence. These were hand held electronic units which could be preloaded with 5 questions about any topic. The devices were handed to patients or carers at the bedside and could be used to rate the clinical area on a range of issues. As this was done in person at the bedside there was an opportunity to discuss issues further and obtain rich qualitative feedback. The feedback data would be provided in the form of a weekly electronic report from Dr Foster direct to ward leads. The first reports to be generated by these devices would be with the Trust in early October and the use of further devices in the Outpatients' department would start from mid October with feedback planned for November.

The contract with Dr Foster was for one year; after which time the Trust would have developed its own systems to capture patient feedback. Mr Samuda questioned the level of feedback that the Trust received from the GPs in the local Community. Ms Fenton confirmed that patients tended to complain direct to the hospital rather than via their GP. Dr Woolley also confirmed that the Communications Team worked with the GPs on their own experiences of working with the Trust and that there would be further work carried out on GP Satisfaction Survey.

Mr Harris questioned how the information that resulted from the devices was then supplied to the ward. Ms Fenton confirmed that feedback was real time and focused on the specific ward where the devices had been used. In due course this would enable the Trust to compare across wards so long as the same questions

were asked on each device. The plan was to keep the NRI but to add on the Dr Foster and all feedback would then be aggregated. In due course the Trust's own system would integrate into the nurse handover. The Trust would only be able to benchmark itself against other Trusts if the same questions had been asked. Ms Coalter also commented that the feedback could be used to reward behaviours in line with the Trust's values and that this would then feed into the new reward strategy which was being worked up.

6.3 Academy School Sponsorship
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Whilst the Board agreed with the aims of the project and that it clearly fitted with the vision of the Trust promoting Health and Wellbeing in an area of high deprivation, the Board was also concerned to understand the potential risks to the organisation of taking on such a responsibility. It was agreed that the Trust would continue to work towards an expression of interest and once it had appointed a project manager to oversee the development of the programme, then a presentation would be made to the Board, outlining the role of the Governors and the Head Teacher and the Trust's legal and moral responsibilities to the new Academy School.

Mr Harris confirmed that he had some experience of Governorship of a school through the Birmingham City Council and that the Governors relied on a significant number of advisors as the school was outside of the local authority control. Mr Bucknall asked that the presentation should be clear about the Trust's responsibilities and what the clear outcomes for each Partner would be and how success would be measured should be included in the report. Ms East also asked for clarity on what additional resources the Trust would require in order to deliver its responsibilities and how much time from the Executive team would be required to deliver this project.

6.4 Commercial Director's Report LD/ AS
Work was progressing well on the introduction of a combined Radiotherapy and Chemotherapy unit at Solihull Hospital for the treatment of cancer patients. A key feature of this facility would be a partnership with University Hospitals Birmingham who would provide expertise in the planning and delivery of radiotherapy services. A business case would be submitted in due course.

6.5 Involvement of Matrons in the Cleaning Strategy
The Board noted that the matron job description was currently being upgraded and consultation with the matrons planned for November 2008. This would allow for a focus on patient outcome as well as delivering ward to board reporting. The Board noted that the matrons worked collaboratively with Hotel Services to achieve sustained improvement in the cleaning standards at the Trust.

6.6 Car Parking at Good Hope
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6.7 Car Parking Business Case
The Board noted that this particular item of the Agenda had had the declaration of interest by Mr Bucknall in respect of the car park services provided to the Trust. A full business case would be prepared, which would include the whole package of measures included in the Board Report.

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OF INFORMATION ACT 2000

08.131 7. QUARTER 2 ACCIDENT AND EMERGENCY UPDATE

Quarter 2, 4 hour performance was currently at 97.61% as at 26th September 2008. Monitor had therefore been advised of the failure to comply with this national target. The implication against the Monitor compliance framework for Quarter 2 was a minus 0.5 against the total key standards. The rating overall, however, would be green due to the improvement in the MRSA and C.Diff returns. 4 hour performance year to date was 98.1% and the Trust was forecasting 98.4% for the year end. Activity levels had been higher this year compared to the same period last year. A & E had seen a 2.4% increase, Emergency Admissions a 1.3% increase. The Good Hope site had experienced the highest level of activity at 5% year to date.

A recovery plan had been circulated to the Board which summarised the pieces of work required to recover both the current position and to proactively anticipate the challenges that lie ahead for the winter months. The plan covered 6 key areas:

- Emergency Department
- Assessment Areas
- Downstream Wards
- Capacity
- Staffing
- Infection Control

The Board noted that a step change in the process and redesign of the discharge pathway and of the capacity and functionality of the assessment process on both the Good Hope and Heartlands sites was urgently required. Clinical engagement was crucial in securing sufficient discharges on a daily basis, to ensure patient flow through the emergency department to the assessment areas and onto the base wards across all sites of the Trust.

Dr Rayner confirmed that further capacity had been sourced at the Samuel Johnson Hospital in Lichfield and the Sir Robert Peel Hospital in Tamworth. Whilst this would cost the Trust money, the beds were staffed and doctored directly by the respective Trusts. The wards would then be overseen by 2 Good Hope Clinical Directors. The Board noted that there would be external factors which would impact on admissions, such as, fuel poverty for the elderly, less available income for the elderly provided by families and so additional capacity would be an ongoing issue for the Trust.

The extra capacity which had been sourced would provide cover through the Winter of 2008/09 but was not a long term solution. A long term solution needed strategic engagement from all of the stakeholders including the City Council and other local authorities. It was agreed that the Chairman should write to Sue Anderson at Birmingham City Council to arrange a meeting to discuss long term discharge planning and working together. Whilst these discussions were necessary, the Trust also needed to demonstrate that its own internal processes were the best that they could be. CW

Professor Ham confirmed that the short term was an immediate challenge that could be met through the Action Plan as set out. However, the long term strategic direction needed partnership working to discover new ways of working as Chair of the Working Together for Health Board, he would ensure that that issue was given priority. Ms Fenton also confirmed that the Lean Team was playing an active role in transforming working processes, working from ward level up to improve

efficiencies and patient care. Mr Bucknall also recommended that the Trust's Capital Programme should take into account the demographics of the area. Mr Stokes confirmed that the Project was currently working on a 1.4% growth in population and new housing developments which would result in an additional 50 thousand homes in the West Midlands. It was agreed that the Board should continue to monitor the situation at Board level.

08.132 8. PROGRESS REPORT ON NURSING STRATEGY

The Nursing Strategy "Influential Nursing", had been approved by the Trust Board in February 2008. The strategy had set out a standard for nursing that the public would recognise as the best and would ask for by name – this standard had been named "EMBRACE". The 3 key elements of the strategy were leadership, patient focused care, innovation all of which had been highlighted by the D'Arzi report. Ms Baillie confirmed that in due course all nursing staff would be trained to this standard but that at the outset the programme had been started with senior nurses. It was also being used in the recruitment of nurses to assess their quality and attitude.

Ms Coalter confirmed that currently 600 people joined the Trust each year but to recruit people to the EMBRACE standard would take longer and would require organisational development interventions to communicate both the attitudes and values that were required from the nursing staff. Ms Baillie pointed out that nurses were now being encouraged to challenge poor behaviour and attitudes and that there was a clear accountability structure in place.

The outcomes of the strategy would be seen in a fall in employment turnover, an improvement in the ratio between patient complaints and thank you letters. The results of the Dr Foster patient survey and the staff survey. Ms Baillie also confirmed that outputs of care were all being monitored and measured, for example, MEWS, Trips and Falls etc. This would provide a baseline position from which to demonstrate the improvements that the strategy was delivering. For those areas or wards that required significant improvement, then a turnaround team of EMBRACE nurses would be provided to support the improvement and development of those wards/areas.

Mr Wilkinson also raised concerns over the quality of the nursing recruits that were currently being taken on by the Trust. Mrs Baillie confirmed that recruitment criteria had been set for undergraduate nursing and these criteria required ownership by the strategic health authority and the universities. During these discussions there would be room to explore different models of training for nurses.

08.133 9. FINANCE REPORT

Mr Stokes presented his report. The Board were advised that although at 30th August 2007, the Trust's financial position against operational budget was overspent by £1.7m, the forecast remained on balance due to the bad debt provisions and over performance levels.

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Although over performance was high, there was no significant issues being raised by the host commissioners. Mr Stokes confirmed that in respect of the Trust's Capital Programme, a Programme Director had been appointed and that a modular block, at a cost of £2.2m had been agreed. He would bring a timeline of the key issues for the Capital Programme to the Board for consideration. One of the first decisions to be considered by the Board would be the permanent modular block on the Good Hope site. This would help to deliver increased capacity although was

not in top quartile for quality. The block had a lifespan of 60 years. Mr Stokes confirmed that there were options around the scope and fitting out of the block which would improve its quality. The block would save the Trust £25 - £30m and solve the Good Hope capacity problem for the next 60 years. It also brings forward the solution by 3 years. The Trust would then continue with the plan to refurbish or demolish other parts of the Good Hope site.

Professor Ham raised the issue of the current economic climate and its impact on the Trust's long term plans. There were discussions about Corporation Tax on Consultancy income and a windfall tax on Foundation Trusts with large surpluses. All of these issues needed to be included in a horizon scanning exercise by the Trust. Mr Stokes agreed to produce a report outlining these issues, which he would tie in with the new tariff when it became available. Ms East suggested that the internal auditors and external auditors should also have a view on the impact of the current economic climate and their views should be sought. AS

The Board then considered the recommendation to find the 2008/09 model contract subject to the areas highlighted for GUM, excess bed days calculation and the Trust's incentive proposals. The 2008/09 contract covered all acute services that the Trust provided for all of its Commissioners. BEN PCT was the Trust's coordinating Commissioner and was acting on behalf of all other associate Commissioners throughout the contract negotiation process. Mr Stokes' report set out the key changes to the contract which would have a significant impact on the Trust. The range of outcomes was best case £0.4m to worst case -£13.7m. The likely position was forecasted as £0.2m. The Board noted that over the previous 2 financial years there had been no cause to turn to the contract to resolve any issues. This was as a result of the strong relationship that the Trust maintained with its PCTs. Relationships were managed at all levels of the organisation, from executive directors on an individual basis and at both the Tripartite and PMG Forum, and through various clinical networks. Mr Stokes confirmed that the contract didn't require signing at this stage but that to do so would jeopardise the strong relationship between the Trust and its PCTs.

The Board discussed the mandatory nature of the contract given that the Trust had Foundation Trust status and the freedoms that that provided. The details of the contract, however, were contained within the operating framework and there was an expectation from Monitor that the Trust would comply with the model contract. Concerns were raised regarding the potential fines that could be levied as a part of the new contract but the potential downside to not signing the contract could be that the PCTs would set their own prices for HRGs and not apply the tariff. This would not be in the Trust's best interests. It was agreed that not signing the contract would set the Trust not only against the Department of Health but also Monitor and would be detrimental to the relationship with the Trust's PCTs. On this basis it was agreed that it was in the Trust's best interests to sign the contract.

Mr Stokes confirmed that there were no additional costs in the running of the contract or in providing the extra information that it required since these procedures had already been established. He also confirmed that following an internal assessment the Trust was confident that it could deliver the KPIs contained within the contract and that this would lead to the best case or likely case scenarios set out in the report. The Trust's existing data systems were already able to capture all of the information required, particularly in relation to choose and book, to be able to deliver the terms of the contract. Mr Samuda queried that where there was over performance of the contract, whether there would be any potential to set it off against any penalties due in other areas. Mr Stokes said that this would depend on the relationship with the PCTs and that he would be writing an overriding letter of conduct which would be delivered with the

contract, similar to the letter of the conduct issued 2 years ago. This new letter would include C.Dif and the 18 week activity and would mitigate any fines that could be charged through the contract.

Mr Stokes agreed with Professor Ham that the letter of the contract did not express the spirit of the current relationship between the Trusts and the PCTs but that in practice the relationship was such that any issues were worked out collaboratively. Professor Ham pointed out that it would be in the PCT's best interest not to impose fines unless absolutely necessary as they would not want to jeopardise their working relationship with the Trust. Ms East questioned the length of the contract and queried when it could be renegotiated. Mr Stokes confirmed that the contract had a 3 year term and he would be negotiating for an annual review. This would mitigate the risk of signing the contract. Although the Trust needed to be clear that if it signed the contract then it would be legally bound by it. Professor Ham also made the suggestion that the contract should run in a shadow form until it was required in April 2009. Mr Stokes undertook to negotiate this with the PCT but thought it was unlikely they would agree.

Mr Wilkinson suggested that before the contract was signed the Chief Executives and Chairs of the respective Bodies should meet to agree the parameters for the contract and that subject to that meeting the authority to sign the contract should be delegated to the Chief Executive of the Trust. The Board agreed with this proposal. CW/ MG

08.134 10. COMPANY SECRETARY'S REPORT

The Board noted the Minutes of the Finance Committee, 29th September 2008.

08.135 11. ANY OTHER BUSINESS

There was no further business to be discussed.

08.136 12. DATE OF NEXT MEETING

Tuesday 4th November 2008.

2009 Dates:

Tuesday 6th January	Tuesday 3rd February	Tuesday 3rd March
Tuesday 7th April	Tuesday 5th May	Tuesday 2nd June
Tuesday 7th July	Tuesday 4th August	Tuesday 1st September
Tuesday 6th October	Tuesday 3rd November	Tuesday 1st December

Tuesday 5th January 2010

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Chairman