TRUST BOARD

Minutes of a meeting held at Devon House, Heartlands Hospital

at 1pm on Tuesday 2nd September 2008

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

IN ATTENDANCE:	Mr A Laverick (Item 6)
	Mr S Emslie (Observer)
	Ms B Fenton
	Dr S Gossain *(Item 7)*
	Ms V Harrison (*Minutes)*
	Ms C Lea
	Mr J Step (Observer)

Action

08.112 **1. APOLOGIES**
There were no apologies.

08.113 **2. DECLARATIONS OF INTEREST**
The Board were asked to note the Register of Directors Interests previously circulated. It was agreed that the Register was a correct record.

08.114 **3. MINUTES OF THE PREVIOUS MEETING**
Minutes of the meeting held on Tuesday 5th August 2008 were agreed as being a correct record.

08.115 **4. MATTERS ARISING**

Donated Funds Committee
MG requested clarification of the remit of the Donated Funds committee. — CL

Board Appointments
Adrian Stokes was interviewed in this respect and welcomed to the Board.

Health Commission Patient Survey Report 2007
The report had highlighted a number of issues relating to communication between doctors, nurses and patients. The Chairman advised the Board that the Executive Directors Committee would agree the actions to address the areas for — MG

improvement raised from the patient survey.

08.116 5. CHAIRMAN'S REPORT

Copies of the briefings and follow up reports for the Chairman's visits undertaken during July had been circulated to Board members prior to the meeting.

08.117 6. ICT DEVELOPMENT UPDATE PRESENTATION

Two documents were circulated to the Board by Mr Laverick detailing a pilot system being developed which provided a patient tracking system. Eradicating the need for paper based notes, the system provided a detailed history of the patient's visit to the hospital from admission to discharge, tracking areas visited, tests done and results, i.e the patient journey from admission to discharge. It also had benefits in infection control as the timeline could help pinpoint the time and location of infection. Using a traffic light system, in the event of the identification of infection such as MRSA or C.Diff, specific advice was given regarding the management of the situation. This system also highlighted past medical histories, including allergies, alerting medical staff to other potential clinical outcomes. The system had also been used to identify available beds.

The clinical data captured (via Dendrite) was also being made available to GP practices in the wider community. It was currently not possible to access GP records, but this aspect was under development as a basic patient history would prove useful for A&E admissions. Medical devices such as blood measuring equipment, when replaced, could be linked up with the system which automatically links to I-care.

The system also linked up with PACS, enabling X-ray and scan images to be viewed. It negated the need for handovers by the nursing staff as all information was readily available in electronic format. The discharge letter was also visible.

It was possible that patient access to the system could be made available for them to view their own records. A survey of 1200 people concluded that between 60 and 70% were in favour of this service. The main issues in this regard, however, currently centred around security.

With this in mind Mr Samuda raised the issue of intellectual property rights. Mr Laverick pointed out that whilst it may be possible for people to copy specific elements of the system, it would be difficult to copy the totally integrated system. It was noted, however, that discussions would be held with Simon Hackwell about how to protect intellectual rights.

Further concerns were raised about the obvious impact of the inevitable occasions of system failure, and the management of that 'down time'. Mr Laverick confirmed that the development of failsafe back-up plans was underway and that Dell and KPMG were reviewing the health of the IT system infrastructure and ability to manage the inherent risks. It was acknowledged that the nature of the system necessitates a 24/7 operation and therefore it was essential that adequate back-up contingencies are inbuilt.

It was agreed amongst the Board that there was a need to change the Trust's culture in handling paper records. Mr Goldman raised the issue of the number of medical records stored onsite, and supported Mr Laverick in promoting the project to end users, extolling its benefits. Different users would, inevitably, have different needs which would need to be accommodated.

Mr Laverick's presentation received unanimous approval amongst the Board,

and it was agreed that the Trust should fully support Mr Laverick with the engagement of staff to get the system fully integrated and utilised.

It was suggested that there may be some major investment required in replacing certain pieces of equipment quickly, in order to be able to interact directly with the system. The Board agreed that the cash should be made available, although making the proviso that it should, of course, be efficiently used. Mr Goldman concurred, adding that early decisions would need to be made for the system to remain state of the art.

David Bucknall arrived

08.118 7. REPORT FROM DIRECTOR OF INFECTION PREVENTION AND CONTROL

MRSA

During July there were only two cases of MRSA compared with a monthly target of 4 cases. One case arose on Ward 8 at Good Hope Hospital where the RCA found the focus of infection to be a lower respiratory tract infection. Although the patient had been screened on admission the positive MRSA result had not been documented in the clinical records. However, actions had been put in place to address this. There will be a review of RCAs.

The second case arose within 48 hours of admission and was therefore conducted jointly with BEN PCT. Although the patient did not have a history of MRSA they had not been screened on admission. Although this was a failure to follow policy, this had not contributed to the pre-48 hour bacteraemia. A study day focussing on this particular patient group had been arranged for all involved in catheter care across the health economy.

C.Diff

It was revealed that the number of C.Diff infections in July were slightly higher than June, although still below trajectory. Three patient deaths had met the criteria for RCA and investigations had been initiated.

The Trust had a low threshold for investigation, ensuring that if two or more cases were discovered on one ward within 28 days, an investigation would be launched. Weekly audits since these investigations have shown improvements in August as numbers have decreased again. It was noted that Ward 17 at Good Hope needed its floor replacing. The timing of this was, inevitably, difficult, due to the obvious impact on the use of the ward. It was suggested that some large retail companies may be able to share project information about how they manage the speed of transition, as clearly there were huge financial incentives for a fast installation. Mr Goldman would take this up with the Director of Asset Management. MG

Questions were raised as to cases were C D had been a contributing factor to the death of a patient. The Trust's RCA is triggered where the death certificate mentions C Diff. Of the three cases in July the RCA had not shown C Diff to be related to the cause of death.

The Board noted that the report from the DoH had now been received confirming acceptance of the action plans the Trust had in place to control infection. The report will continue to influence future IPC reports.

Multi-Drug Resistant Acinetobacter Baumanni

Dr Gossain informed the Board that there had been an outbreak of Multi-Drug

Resistant Acinetobacter Baumanni. This was extremely resistant to antibiotic treatment. Ms Gossain advised that this bacterium was, in the first of the three cases identified, brought in from abroad. Since it is found in – and *survives* in - soil and dust, a more rigorous cleaning programme had been undertaken, involving increased frequency, steam cleaning and sterilized cleaning to decontaminate. Environmental sampling of the area had, so far, yielded negative results. However, the Trust was now actively screening for it on specific wards and in ITU, on a 'search and destroy' approach, to manage the situation and completely eradicate it from the hospital. Mr Harris asked whether there was any obligation to declare these cases. Dr Gossain confirmed that the HPU and DIPC of BEN PCT had been informed, and there was no requirement to report this to MONITOR.

Health, Social Care and Partnerships Scrutiny Board
The Scrutiny Board had made 12 recommendations of which 10 were aimed primarily at the Trust. The September IC Operational Group would implement the actions required.

08.119 8. CHIEF EXECUTIVE'S REPORT

8.1 Performance Report
The report set out a summary of the month four performance for the Trust in line with the 2008/09 scorecard. Both MRSA and Cdiff were green in month and year to date. All national targets were currently being met.

8.2 Operations Committee Minutes
The Board noted the minutes of the Operations Committee held on 15th August 2008.

8.3 Report from HR Committee
The Board considered the report which had been previously circulated. Ms Coalter drew attention to the Annual Resource Plan and that the backlog of current vacancies would be filled by October 2008. The Trust Reward Strategy had been considered by the Committee, would be reviewed by the Executive Directors and brought to the Board in October.

The Trust's Staff Survey would be sent out in September and the findings reported to the Board at its November meeting, the survey was being conducted by MORI and would include recommendations on how to improve staff morale. It would also be possible to benchmark the Trust against other organisations.

Ms Coalter also highlighted the areas for improvement in the diversity profile of the Trust. Mr Goldman confirmed that the Trust was ahead of the legislative requirements as a result of the work already carried out by Ms Coalter and Mrs Baillie but there was still room for the Trust to improve on being a sympathetic and enabling employer.

Ms Coalter responded to questions on sickness by confirming that the Trust was on track to reduce sickness levels by 0.5% by the end of the year. The target would need to be reviewed for next year.

The new car mileage expenses policy set out in the report was challenged as it seemed to encourage driving and the use of larger cars. Ms Coalter explained that the policy had had to be adopted in order to be in line with Agenda for Change. Work would continue with the Estates Team to encourage green travel.

8.4 Mandatory Training
The status at the end of Q1 for Healthcare Standard 11b - staff participation in mandatory training had been "not met". The Board considered and agreed the action plan set out in the report which would enable the Trust to declare a "fully met" position by the end of 2008/09.

8.5 Solihull Energy Centre
The business case for the Solihull Hospital Energy Infrastructure Upgrade had been approved by the Operations Committee and was now presented to the Board for approval. The key points noted within the report were as follows:

- The present central steam boilers at Solihull Hospital need replacing. It was proposed to replace these with decentralised low pressure hot water (LPHW) boilers and to install a combined heat and power (CHP) unit and absorption chilling.
- The Facilities department had won a time limited grant of £1.42m towards this investment, to be spent by March 09.
- The Preferred option was to undertake the project via a PPP funded scheme.
- This investment was supported directly by the Business Unit's Strategy and Estates Strategy in the following ways: Energy, Carbon footprint, and risk based backlog maintenance reductions.

The Board approved the execution, delivery and performance of the project agreement and all related documentation in relation to the energy scheme contract for Solihull Hospital with Ener-G Combined Power Limited and authorised the Chairman and Chief Executive to execute (under the Trust seal or by hand as appropriate) such documents.

08.120 9. ANNUAL REPORT ON SUSTAINABILITY
The report set out the range of measures taken to minimise the use of energy and water, encourage the use of more sustainable modes of travel and transport reducing waste and increasing recycling. Advice had been taken from the Carbon Trust.

The Board was impressed with the positive action being taken and the ambitious plans for the future. The Board asked that more publicity be given to the Trust's performance in this area and that in future the Trust should ensure that its performance in this area should be externally verified or benchmarked. JS

The Trust should also ensure that any costs of implementing this programme were made clear and that all initiatives should be consistent with the Trust's best interests. It was also agreed that the provision of more inter-site shuttle buses should be considered along with the withdrawal of travel expenses for travel between sites. JS

08.121 10. GOVERNANCE REPORT
Table 1 of the report set out the key strategic risks for the Trust. The ranking had been agreed in partnership with the Executive Directors using a risk assessment scoring system. The risk register would be reviewed quarterly by the Executive Directors. The red risks for 2008/09 were currently set out as:

Staff Capacity
Workforce Capability
Patient Flow and Capacity
Workforce Redesign
Infection Control

Responsiveness of services
Patient Satisfaction

The amber risks for the same period were:
Financial Strategy
Safety
Failure to keep pace with competitors
Business Development Strategy

The register had also been discussed at the Audit Committee and it had been requested that the ten year capital development programme should be included as a red risk as it would impact significantly on the Trust's reputation with its patients, staff and neighbours. The Trust would need to maintain clinical outcomes and patient safety whilst managing the capital programme.

Action plans for addressing these risks had been included in the report but the Board requested that KPIs for each risk be worked up so that progress could be monitored. It was agreed that some of the risks would also have qualitative measures as well.

The Board agreed that Dr Woolley and Mrs Lea should work on integrating this risk register into the Board agenda so that the Board could see that it was regularly reviewing the progress made on managing these risks. SW/CL

08.122 **11. FINANCE REPORT**

Mr Stokes presented his report. The Board were advised that although at 31st July 2008 the Trust's financial position against operational budgets was overspent by £1.1m, the forecast remained on balance due to the bad debt provisions and overperformance levels.

11.1 2008/09 contract

An outline of the progress being made on the 2008/09 contract was considered by the Board. The main impact of the new contract would be the financial penalties that could be imposed for failure to meet pre-determined Targets. These targets included: Achievement of 18 weeks Referral to Treatment for both Admitted Patient Care and Non Admitted Patient Care; Reduction in Clostridium Difficile and Information Provision.

The negotiation process to deliver an agreed contract between HEFT and all commissioners had been centred on working closely with Birmingham East and North PCT to agree all required changes. BEN PCT were acting on the behalf of all other PCT's and therefore it was proposed that a joint paper would be produced which will detail the content of the contract that had been agreed. This paper would be presented to the Board of both organisations for approval and signature in October.

The contract was not due to be signed until 1 April 2009 but early signature would help to maintain a strong working relationship with BEN PCT. Mr Stokes confirmed that the Trust was not expecting to incur any penalties before April 2009 but that penalties could be incurred for events that were outside of the control of the Trust. It was confirmed that the contract would provide an appeal process for any contract disputes.

11.2 Possible Changes to Tariff

Mr Stokes outlined the possible impact of some of the changes that were currently being considered for the tariff in 2008/09, however, the actual changes

were unlikely to be released until October/November.

11.3 A&E Benefits Realisation Review Plans
Mr Gould attended for this item and demonstrated how the business case for the £1.4m improvements to A&E at Good Hope ensured the delivery of quality through investment. The BRRP system ensured that all of the benefits set out in the business case were either on track or had been delivered

The system operated by Mr Gould and his team ensured that if this project or any other failed to deliver or began to fall behind in its delivery of benefits then the problems could be identified early and worked through. This would ensure that the Trust's investments continued to drive out the benefits. Review meetings were held along the life of the project and at completion the project would become part of the core business.

08.123 12. COMPANY SECRETARY'S REPORT

12.1.Meeting Of The Board's Remuneration Committee
A meeting of the Remuneration Committee had taken place on 1 July 2008 to agree the terms and conditions for the appointment of the Chief Nurse (Director of Patient Care).

12.2 Job Descriptions For The Chairman And Chief Executive
The revised job description for the Chief Executive was approved.

12.3 Minutes Of Board Committees
The Board noted the content of the following Minutes of meetings:
Finance Committee, 28 July 2008
Audit Committee, 1 July 2008
Governance & Risk Committee, 11 August 2008

08.124 13. DATE OF NEXT MEETING

Tuesday 7th October 2008

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Chairman