Heart of England NHS
NHS Foundation Trust

GOVERNORS' CONSULTATIVE COUNCIL

Minutes of a meeting of the Governors' Consultative Council held on 22nd March 2010 in the Education Centre, Heartlands Hospital at 4.30 pm

PRESENT: Mr C Wilkinson (Chairman)

Governors:
Arshad Begum
Kath Bell
Ian Blair
Sheila Blomer
Aftab Chughtai
Mike Cooper
Valerie Egan
Qulsom Fazil
Richard Hughes
Mike Kelly
John Jebbett
Sunil Kotecha
Heidi Lane
Ian Lewin
Frances Linn
Shahid Mir
David O'Leary
Victor Palmer
Jim Ryan
Dev Sarmah
Yvonne Sawbridge
Roy Shields
Lee Smith
Bridget Sproston
Liz Steventon
Jagjit Singh Taunque
Margaret Veitch

IN ATTENDANCE:

Non Exec Directors:
Richard Harris
Paul Hensel
Richard Samuda

Exec Directors:
Mags Barnaby on behalf of Ellen Ryabov
Mandy Coalter
Lisa Dunn
Mark Goldman
Andy Laverick
Adrian Stokes

Member of Public:
Mr and Mrs J Ray
Mr N.T. Blackford
Mr Gerry Robinson
Lisa Biddlecombe
Lindsey Smith
Mish Gohil

Staff:
Mrs C Lea
Ms L Jennings (Minute taker)
Rachael Blackburn
Louise Galvin
Ann Keogh

10.13 1. APOLOGIES FOR ABSENCE

Apologies had been received from Mr Ian Cunliffe, Ms Beccy Fenton, Ms Barbara Hayward, Ms Bethan Ilett and Neil Harris.

10.14 2. MINUTES OF THE MEETING HELD ON

The Minutes of the meeting held on 25th January 2010 were agreed as a correct record.

10.15 3. UPDATE ON MATERNITY SERVICES

This update had been previously circulated and the following points were raised:

Mr Jim Ryan queried the dates of the notification given to the Council. Ms Lea confirmed that the information had been sent by email and hard copy to those not on emails. The dates would be verified and documentation corrected.

Mr Stokes agreed to give an update to the Council on capital project costs and additional revenue costs involved in the need for additional midwives **(ACTION AS).**

10.16 4. UPDATE ON 4 HOUR A&E ACCESS STANDARD

Ms Mags Barnaby presented the above previously circulated paper on behalf of Ms Ellen Ryabov. She drew particular attention to the plans that had been put in place to achieve the 98% target as follows:

- Reducing average emergency Length of Stay to 7.1 days by March 2011 (releasing bed capacity).
- Reducing bed occupancy to 93% by March 2011 to improve patient flow.

Delivery of this would ensure achievement of the emergency access target in 2010 – 2011. The first quantifiable reduction in average emergency length of stay was expected by the end of March. Ms Barnaby confirmed that measures of this performance would be available in April 2010.

Questions were then invited.

Q. Could you clarify the patient journey which accounts for the 4 hours?
A. The clock starts ticking from triage and the department has 4 hours to assess, diagnose, treat and then discharge or admit.

Q. Is the graph adjusted for seasonality?
A. No, because over the last few years activity levels have been relatively consistent. The Trust has looked at month on month historical activity and multiplied accordingly; basing activity next year in line with this year.

Q. Please could you indicate the criteria of patient for which the Trust is aiming to reduce LoS and reassure the Council that patient care is not compromised?
A. This is very broad, these was no particular patient group. For example, many patients wait for take home medication and so the Trust was trying to improve processes around the medication dispensation. Also because the Trust had a high level of occupancy running at 96 to 97% at any one time, some patients who were admitted to hospital could have been averted to community care and therefore improvements to housekeeping were being looked at. Mr Goldman added that one element of the plan was for the hospital to have 7 day working.

Q. There has been research carried out in Leicester on how people who have had major surgery can be fed earlier and so sent home earlier, is this being considered at the Trust?
A. This would be in terms of elective patients, and there were times during winter pressures where A&E activity overtakes electives. The Trust had looked at how many beds were needed to maintain this level of patients and had taken account of emergency activity, the planned length of stay and how many beds that would be needed to go through to rest of year.

Q. Working with partners also affects LoS and the LoS would be different in all 3 hospitals, I think there was a discussion at the last governors' meeting about other areas in addition to length of stay – walk in centres etc.?
A. Yes it was a partnership with primary care. There were currently 6 streams of work – admission avoidance, our own admissions performance, complex discharge, simple discharge, LoS and 7 day working, all of which supported delivery of the plan

Q. Are we talking about smart management here rather than clinical judgement. As pointed out by Mr Goldman some of the readmissions are as a result of early discharge. Could the above plans lead to that mistake?
A. No, it is clinical judgement that is key and the plan had been developed by medical leads and matrons, not management. Mr Goldman added that it was not about getting patients home before they were ready – it was about getting them home as soon as they were ready. It was in the patients' interests to go home earlier.

Q. You did say that there are other Foundation Trusts that were better at this, it would be interesting to know what their model was to achieve that standard.
A. At next meeting the Council would be able to look at performance compared to other trusts and previous performance **(ACTION -ER).**

Q. Points to clarify on targets – bed occupancy down to 93% by March 2011 but the graph you have provided shows 90% so what are you aiming for? My other question following chart you are aiming for 98% 4 hour wait, but this is still not good enough. What is your underlying aim? Would rather see 98% in 3.5 hours than 99% in 4 hours.
A. The Trust was working for 90% bed occupancy by 2011. Mr Goldman added that a standard was created some years ago on the recommendation to the NHS by Prof George Alberti who studied A&E as a special interest. His view was that there would always be 2% of patients who should remain in A&E due to their condition and that it was in fact the safest place for them pending a decision so there had never been a reason to press for 100%. Whilst the point being made was valid the Trust had tobe realistic as to what it could achieve in the time frame. It was agreed to issue the averge wait times in A&E. **[ACTION – ER]**

Q. Are we duty bound to treat intoxicated patients?
A. We cannot refuse to treat a patient as an emergency but we are beginning to work with a number of agencies because alcohol plays a part in a lot of cases even indirectly. Regarding binge drinkers, there are frequent flyers and the Trust works with their GPs to see if they need ongoing support.

Q. We have triage, why can't patient be sent for x-ray at same time?
A. The Trust has advanced nurse practitioners who would be able to do this in minor injuries and the patient would only be kept in if necessary. The Trust is way ahead in its use of advance nurse practitioners and nurse consultants.

Q. The measures you are putting into place as outlined in one of the letters that was sent from Monitor to the Trust was an agreement that the Trust would receive independent advice from Dr George Albertie and appoint external consultants, have you done this?
A. Yes he had already been and has been invited back to speak to colleagues. The Emergency Care intensive support team were also working with the Trust.

Q. You had said earlier that the Trust was working on medication being ready for going home and Mr Goldman has mentioned about the possibility of early rounds for doctors, is this part of discharge planning?
A. Yes this was already in place.

Q. From a patient's point of view if they have been told they are going home today and then don't, it could cause disappointment, would it be better not to tell the patient they are going home until they are nearly ready to go?
A. The Trust needed to improve its TTOs, and then send people to the discharge lounge and medication will find them. Mr Goldman added that honesty was a trait of the Board, it would not try and deceive patients, but recognised the need to expose problems and deal with them.

Q. Practice in Moseley Hall meant that sometimes ambulance followed with medication – family could fetch medication from pharmacy.
A. Agreed there were lots the Trust could still do.

Q. Prescriptions – really only interested in new prescriptions and that would be much easier to start off with. Don't need loads of prescriptions.
A. Agreed this was an important point, and there was much more work to be done.

Q. I was reading in the Times about work being done on nutrition and how sometimes patients are not fed for 2 or 3 days but some doctors are now looking to putting the patients on hard food earlier and cutting down LoS by 2 or 3 days.
A. Mr Goldman confirmed that in the case of gastro rectal surgery patients, normal practice was to wait for the first bowel action, as the presumption was that until that happened, solid food should not be given. This was now being challenged. 90% of patients were now going home on day 2. It was acknowledged that the patient should always remain the main focus.

10.17 5. PRESENTATION ON MONTH 10 FINANCIAL POSITION Q3 MONITOR RETURN AND FORECAST YEAR END POSITION

Mr Stokes presented his previously circulated presentation re the first 3 quarters, he was pleased to report that the rating had gone to 4 for the third quarter. The big change was around the A&E target. Monitor had declared that the failure to meet that target resulted as a material breach of authorisation and the rating had changed from green to red. However, Mr Stokes was pleased to confirm that the Trust was now compliant in safeguarding. The Trust achieved the 18 week at the end of the 3rd quarter, but it was the A&E target that had caused the red rating.

In terms of finances it was looking likely that there would be a £10m surplus by the end of the year, the only uncertainty was what would be paid from PCTs. Although there was a large cash balance the challenges continued to be cost efficiency, target growing, which was becoming more and more challenging each year. The cash balance at the end of 2011 should be approximately £60m.

The PCTs were talking about reducing activity by £20m and so the Trust would need to understand where patients would be treated instead of in hospital. There would be £5m in the CQINN for targets still to be agreed with the PCTs.

The full submission to Monitor would be reported to the Board in May and this was crucial as this was what the Trust would be measured against on a quarterly basis. By quarter 2 of next year, the Trust would have to give Monitor a view of the future.

Questions were then invited:

Q. What were the sanctions for non compliance on CQINNs and secondly what was compromising child safety? And what was the cost of public private partnership to the Trust if any and what is the year on year cost if it exists?
A. To answer the safeguarding question first, there were many issues around systems and processes and by the end of the month the Trust would be totally compliant in safeguarding children. However CQC's definition of safeguarding now includes safeguarding vulnerable adults and so the Council would receive a presentation at next meeting. [**ACTION: MS]**. The sanctions for non compliance in terms of financial penalties were fines – 18 week wait, C.Diff (per individual case). The total potential fines were around £9m and the Trust had incurred none this year.

Q. Do the CQC have power to fine?
A. Yes but they have not formed the criteria for this yet.

Q. Are there any large PFI schemes outstanding?
A. No there are not any large PFI schemes, only the new entrance (£30k a year) and the boiler scheme.

Q. Are we spending enough money on membership, given the difficulties in obtaining sufficient numbers of nominations for governors?
A. Mr stokes agreed to look into this **[ACTION – AS]**

10.18 6. UPDATE ON CQC REGISTRATION PROCESS

Ms Louise Galvin, Head of Governance and Safety improvement attended the meeting to present this previously circulated item. Ms Galvin highlighted the key developments:

The Trust had submitted its proposal of registration and of the 16 requirements that were self assessed, the Trust had declared itself compliant with 13. The remaining 3 were Safeguarding Adults and Children, staffing and supporting workers.

Following the Trust's declaration, the CQC had visited for an unannounced assessment. They came to talk about complaint arrangements, safeguarding adults and governance arrangements. The Trust had had some feedback but no formal feedback as of yet. It was anticipated that the CQC would put a compliance condition on safeguarding adults and supporting workers. This would be of the nature "improvements required".

Questions were then invited:

Q. Without going into too much detail, what are regulations 22 and 23 – staffing and supporting workers.
A. These were very wide regulations, very outward focused, for example how people are recruited. There had been some concerns following the feedback from the staff survey, and the biggest issue was around appraisals. Rectification plans had now been put in place. In addition Ms Sunderland had done a lot of work around nurse staffing ratios which had given rise to a robust plan to enable the Trust to declare compliance by the end of the summer.

Q. At the last meeting we asked about safeguarding and you were going to come back on the processes for cancelled appointments.
A. The Trust has now looked into this and can now see who cancelled and supply their details to GPs.

Q. Will it work with the vulnerable elderly too?
A. Yes.

10.19 7. TO APPROVE THE RECOMMENDATION OF THE APPOINTMENTS COMMITTEE TO APPOINT A NEW CHAIRMAN WITH EFFECT FROM 1 APRIL 2010

Richard Samuda explained to that the Council were being asked to accept the following recommendations:

To accept that no recommendation for the appointment can be made from the three candidates shortlisted and that the Committee will reinitiate the appointment process.

To authorise the Company Secretary to amend the Trust's Constitution to allow for a "Rest of England" constituency in place of the "Patient" Constituency. Such amendment to be agreed by a formal meeting of the Council and then by Monitor.

To note the Deputy Chair, Anna East, to act up in the interim.

The following questions were then asked:

Q. Did we only do one advert?
A. Executive search was used and so 160 potential candidates were spoken to.

Q. There is a very good reason why the constitution says patient constituency and if it is widened to “rest of England”, it could fall foul of employment law.
A. Ms Lea to take advice (**ACTION - CL**).

Mr Palmer then asked for permission to address the Council from the front. He outlined his involvement in the carousels which had formed part of the interview day for the appointment of a new Chair. He had subsequently carried out basic commercial searches on the candidates and in his view one of the candidates fell far short of the commercial acumen required in a prospective candidate for chairman. Mr Palmer requested that the whole process of selection and recommendation be improved with a more rigorous due diligence procedure that checks the veracity of a CV and that a fuller CV be presented to the carousel groups prior to any interview to enable a more informed discussion to take place. Mr Palmer then asked for the full support of my fellow governors in this matter.

Mr Samuda assured Mr Palmer that his suggestion that due diligence had not been carried out would be verified with Saxton Bampfylde. In addition Mrs Lea explained that some candidates had not given their approval to having their name given out in advance due to commercial sensitivity. Mr Samuda agreed that the points raised would be considered by the Governors’ Appointment Committee when it met to review the improvements to be made within the Chairman appointments process.

Q. What was the makeup of the Appointments Committee?
A. Mr Samuda named the governors in the Appointments Committee and said that Mr Jagjit Taunque (a member of the Appointments Committee who had not been able to be part of the process because of circumstances beyond his control) had been scheduled to lead one of the carousels but he was unwell and so Mr Palmer had stepped in for him.

Q. Can we look to see if there are any other changes that are needed to be made to the constitution to make the most of the cost that would be incurred?
A. Yes we will do that.

Q. Can the Board consider succession planning for future?
A. Yes and it is paying close attention to this matter at moment.

Q. Why was a candidate shortlisted who could not give 3 days?
A. The 2 days would be very long days and we believed the candidate was a potentially very strong candidate for the Board.

Ms East then thanked Mr Wilkinson for his dedication to the Trust, adding that he always put the best interests of the Trust, staff and patients first and that she was sure everyone would join her in her thanks and best wishes for every success in the future.

Mr Wilkinson added that it had been a real privilege to chair the Board and Governors and that he had seen much progress made and there was still more to do and he was sure it would go from strength to strength.

10.20 8. DATES OF FUTURE MEETINGS

24th May 2010, 20th September 2010 (AGM), 22nd November 2010

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Chairman