Heart of England NHS
NHS Foundation Trust

GOVERNORS' CONSULTATIVE COUNCIL

Minutes of a meeting of the Governors' Consultative Council held on 25 January 2010 in the Education Centre, Heartlands Hospital at 4.30 pm

PRESENT: Mr C Wilkinson (Chairman)

Governors:

Arshad Begum
Famida Begum
Kath Bell
Ian Blair
Sheila Blomer
Ann Brierley
Aftab Chughtai
Mike Cooper
Valerie Egan
Neil Harris
Patricia Hathway
Richard Hughes
Mike Kelly
John Jebbett
Sunil Kotecha
Heidi Lane
Ian Lewin
Frances Linn
Shahid Mir
Veronica Morgan
David O'Leary
Victor Palmer
Jim Ryan
Roy Shields
Lee Smith
Bridget Sproston
Liz Steventon
Jagjit Singh Taunque
Margaret Veitch
Thomas Webster

Non Exec Directors:

Anna East
Richard Harris
Richard Samuda

Exec Directors:

Mandy Coalter
Ian Cunliffe
Lisa Dunn
Mark Goldman
Simon Hackwell
Adrian Stokes
Mandie Sunderland
Sarah Woolley

Member of Public:

Jackie Edwards

IN ATTENDANCE: Mrs C Lea
Ms L Jennings (Minute taker)

For Item 4 Only:
Dr Pim Allen, Group Medical Director, Women and Children's
Dr Mike Wyldes, Consultant Obs & Gynae
Vicki Collins, Head of Midwifery BHH and GHH

10.01 1. APOLOGIES FOR ABSENCE

Apologies had been received from Ms Beccy Fenton, Prof Chris Ham, Ms Barbara Hayward, Ms Bethan Ilett, Mr John Simms, Mr Sarmah, Ms Yvonne Sawbridge

10.02 2. MINUTES OF THE MEETING HELD ON

The Minutes of the meeting held on 16TH November 2009 were agreed as a correct record.

10.03 3. CQC REPORT – MARK GOLDMAN

Mr Goldman went through the background to the CQC letter which had been previously circulated. He explained that the Trust had invited them to come in and review its governance process as part of the learning process following a SUI. The Trust had received a verbal report at the end of October in the presence of Monitor and had been advised us that the CQC had no serious concerns. A written report in the form of a letter was now on the Trust website.

Questions were then invited:

Q. What do you think is the main cause of SUI, for example a doctor being called and not turning up, do you think it is because the nurses are waiting too long before escalating?
A. A mixture of causes including the above mentioned. The Trust has now written a new policy with a built in escalation programme, to elicit automatic responses. By following the policy the nurse would have to go to the next level if the doctor did not turn up in 15 minutes. This removes the problem of nurses worrying about whether they should or should not escalate, as there is clear guidance.

Q. Are you also looking at how Consultants respond to challenge?
A. Yes, there is no point in getting juniors to challenge if seniors won't accept challenge but by making all staff aware of the policy of escalation, the problems can be rectified.

Q. Thank you for calling in the QCQ Commission, it was the right course of action to take. The Review looked at incidents from November 07 to November 08 but can you give me an update of SUIs since?
A. There is an average of 12 – 14 SUIs on an annual basis. For the purposes of perspective there were 116000 inpatients over the course of 08/09, so SUIs are not common.

Q Can governors receive a regular report on SUIs.
A. Yes

ACTION: Dr Woolley to produce a SUI report in due course for the GCC.

Dr Woolley highlighted that the actions being taken as a result of SUIs was a very important aspect. Although it is human instinct to think that mistakes should not happen, where there are humans there will be mistakes as humans are fallible and so she would like to work with the governors in developing systems around safety to minimise mistakes.

Q. The CQC review identified the top 4 underlying causes as poor documentation, lack of escalation to senior colleagues, lack of recognition of a deteriorating patient and non compliance with guidelines, all of which are inexcusable. It also suggests there are other causes too. Can the governors have the action plan and regular reports on the progress against the action plan?
A. The first point to make is that the CQC came in because the Trust invited them, in the desire to become as safe as it could be. Secondly there will never be "never events" in the organisation. The CQC recognised in their investigation that there were issues within the Trust that are everywhere, i.e. human error. The Board took responsibility by inviting the CQC in. It is important that governors fully understand the healthcare organisation and its complexities. Lessons are being learnt from other high risk industries, and are helping with the context of healthcare.

Q. Can we have reassurance that when consultants go on holiday they have clear cover and that lessons that are learned are shared across the whole health service.
A. To answer your second point first, everything the Trust learns is shared with the National Patient Safety agency. The wrong prescription SUI has led to changes in the prescribing of that drug. With regard to the consultant cover, Mr Cunliffe was able to give reassurance that rotas were available at all time and checked regularly.

Q. Are locums not allowed on the ward until they have attended induction?
A. In the short term they will be on site and will receive local induction. In the longer term locums do attend trust-wide induction.

Q. The Coroner's comments in the recent Birmingham inquest were scathing - do you not agree?

A. Mr Goldman confirmed that he was there for the verdict. He agreed that it was not right that it had happened and that errors were made in pharmacy, procurement and in the checking. Unfortunately, due to the way the drug was packaged and labelled, it was possible to understand why the doctor concerned may have misunderstood, at the stage when he saw the labelling on the bottle. The Chairman had taken the same view and had insisted on seeing the bottle. So the Coroner was right in that there should have been more vigilance and it should have been picked up along the way.

Q. Did it go back to the manufacturer, if they had labelled it in a confusing way?

A. The Trust has had ongoing dialogue with the manufacturer but the problem lay with the fact that it was being used for a procedure it was not usually used for. Mr Goldman confirmed that the product was checked by the doctor and nurse and both misunderstood it. It had also passed through lots of checking which had given the doctor and the nurse a false sense of security and they failed to recognise the wrong dosage. It was lots of little errors by lots of people. The Trust does need to consider the feedback that was given to the company and needs to make it clear to the company that if they get a call for it to be used outside the usual practice, they need to make sure that dosage instructions are very clear. Dr Woolley agreed and added that the Trust no longer used that drug.

Q. How many of these incidents have resulted in disciplinary procedures?

A. There have been many internally and some have been referred on to the professional bodies. However, the Trust does try and separate learning from the individual's discipline. The Chairman added that the Trust had in excess of 10,000 employees and thus mistakes could not be prevented completely. However, it was the Trust's job to be constantly vigilant to minimise risk to patients. That morning Professor Charles Vincent, an expert in the area of safety had visited the Trust and been involved in a 4 hour training session with Dr Woolley.

10.04 4. STATEMENT ON SOLIHULL MATERNITY SERVICES

Mr Goldman introduced Dr Pim Allen, Group Medical Director, Women and Childrens; Dr Mike Wyldes, Consultant Obs & Gynae and Ms Vicki Collins, Head of Midwifery BHH and Solihull who had come to the meeting to answer questions on Solihull Maternity Services.

Mr Goldman gave a brief outline of the history behind the issue and then invited questions.

Q. Can someone explain why Solihull cannot be upgraded to the same standard as Heartlands?

A. That issue is about being able to find and employ paediatricians. As it is not seen as necessary to have them permanently on site they would have to be rotated and the College would withdraw those places. Mr Cunliffe added that it was about long term sustainability and short term voluntary solutions. The Trust had been looking to recruit at middle grade level but there was a national shortage and the Trust has not been successful in this recruitment. Thus there was a difficulty in recruiting staff who would remain on a long term basis as the job becomes unattractive. It is very important to look at issues long term and give consideration to this during the consultation period, which the Trust was supportive of.

Q. If the outcome of the consultation will be to bring paediatricians back into Solihull, then that is what the Trust should be doing now. The changes have been made without consultation and that is why the people of Solihull are annoyed. I am disappointed and let down by the lack of consultation because the people were promised that this would happen before any changes were made. I will take the case to the Houses of Parliament, as there does not appear to be any accountability.

A. A formal consultation process has been started by the PCTs, and it is now being considered by the gateway group established by the Department of Health to ensure it was properly conducted. The likelihood is that there will be a general election in the interim and so it is likely that the formal consultation will commence when the general election is over. The Trust had consulted a lawyer regarding the Trust's responsibilities and possible consequences to the Board in the interim, if an incident were to occur, while the Board knew with absolute certainty that it was not operating under a safe system. The Board were advised that they could be charged with corporate manslaughter. Mr Goldman apologise to Councillor Ryan because, although he had made every effort to keep key personnel in Solihull briefed, he had not been to see Councillor Ryan and he felt he should have done. Mr Goldman said that he would make an agreement with Councillor Ryan to include him in the circle of people that he was trying his best to keep briefed in the best possible way, given that he had to work within a process that had to be adhered to. He highlighted that it was the commissioners that lead the consultation, but it was the Trust's service and the Board wanted to take responsibility for it. Mr Goldman acknowledged that Solihull had a good track record on safety and had very good midwives. However, it was changes in the regulatory framework that had caused this situation. Mr Goldman said that the Directors and Clinicians would go and talk to the people of Solihull and Ms Lisa Dunn had a programme of events that would involve talking great detail about what was going on.

Q. Why could the Trust not sustain interim arrangements until consultation had taken place. Mortality at Solihull is very low and at Heartlands it is bigger and there are all sorts of reasons why it may have worse outcomes if it was changed.

A. Mr Wylde explained that mortality was very much linked to the socio economic background of patients and so it was not a very good marker for a delivery unit, it would be better to look at SUIs. The Trust does look at all mortalities and then at individual cases and questions whether there were any issues about the site. There have been issues about the time it takes to get someone from one site to another. The Trust accepts that the midwives who are running the service at Solihull have given 100% commitment and more but all the doctors agreed that a better service would be provided if all births were moved to one place. The fact is that the population of South Solihull is healthy and may well be suitable for a midwifery led unit. There have been many reports all highlighting the danger and it would be irresponsible of the Trust not to act on the huge body of evidence. It is not possible to provide consultant care 24/7 in the areas of obstetrics, anaesthetics and paediatrics, and so decisions have to be made about what level of service can be provided and where.

Q. Can you reassure us that during this interim period the withdrawal of all the consultant support will not result in problems?

A. We are looking into this very closely because any change could cause potential problems. We will have more hours and clinical expertise on those units and so can reassure you on this.

Q. What happens if Mum is there for normal care and then it all goes horribly wrong?

A. Standard will be similar to home delivery and the plan will be that if there was a problem in the birthing unit, the patient would be taken to the nearest unit which would be Heartlands. It would be small numbers in this situation but it is a safety issue and one which will be managed.

Q. Could they have an epidural at Solihull?

A. No, it would be at Heartlands.

Q. Even if it was an emergency?

A. Even if it was an emergency they would be taken to Heartlands and picked up from this end. We can usually identify who needs it.

Q. Heartlands is already very busy, how will it affect Heartlands site?
A. Heartlands currently has 3 wards and there is a plan to move gynae out to deal with additional capacity that will be needed. Some will go to Good Hope but the majority will come to Heartlands and the principal base would be at Heartlands with Dr Wyldes. There is a detailed plan now for the additional bed capacity that will be needed.

Q. The neonatal unit at Heartlands is not very big, are there any plans to expand it?
A. The neonatal unit at Heartlands already deals with babies from Solihull so is already doing it. It is designated as a level 3 unit (one of 2 in the region) and so there is an implication for numbers and staffing levels. It will take time to develop but the Trust will be very strongly supported by the neonatal network. Some consultants' offices have been moved out recently and there is a staffing model now to put extra cots in. Higher level techniques such as head cooling are also being developed. An Obstetric Professor will be starting next month, which the Trust has been trying for a decade to secure.

10.05 5. UPDATE ON 4 HOUR A&E ACCESS STANDARD

Ms Ryabov informed the Council that subsequent to issuing her papers for this meeting she had had a meeting with the regulator and her presentation would reflect that (updated presentation to be included with Minutes)***.***

Ms Ryabov then invited questions.

Q. In your opinion how does the 24 hour drinking culture impact on the problems in meeting the A&E target?
A. There is an element of that. Of the 200 breaches 28 of them were intoxicated.

Q. How much of LoS problems are caused by people having nowhere to go and what can be done in the community to help?
A. There is a proportion that depends on social care's support particularly around elderly care. There is also a point about patient choice and perception and whether they feel they should be discharged and what they think the reasons are for discharging them, particularly to care homes. So that is a real challenge but the priority has to be those coming in that are acutely ill. There are issues around custom and practice of some doctors, for example 3.5 days is the national average for hip replacements, but there are 2 consultants in HEFT who have LoS of 10 days.

Q. From your presentation it appears that Solihull is a very high performing hospital in terms of A&E, how important is it to the Trust as a whole?
A. Very important and before the merger with Good Hope, HEFT was always above national target because of how well Solihull performed. The addition of Good Hope as a hospital means that Solihull doesn't have enough overall to support both Heartlands and Good Hope.

Q. I am very concerned about this. At the last meeting we were told the Trust was going to be ahead of last year and now it looks like it will be behind. If the Trust wants to achieve world status, it needs to be even better than the target. This is emotive everywhere.
A. The national target is the maximum wait. There is a local target in the system of getting people through in 3 hours and there are other targets too. With 650 people attending in an average day, that is 13 patients not being seen on time. But clearly where the Trust is now is not acceptable and there is currently work being done around changing behaviour. An external Consultancy firm who the Trust engaged to review practices, came back with an assessment that although the care was very good, the patient flow needed to improve. There is a mismatch between demand on system and the Trust's ability to manage the demand.

Q. The Trust is in the bottom section. I can understand focusing on that target but there are other ways as well to tackle this target. What if the Trust had a few more beds and headed some off at the pass and stopped them from arriving in A&E, that would also help and if people were encouraged throughout the whole region to go to the right place, then the Trust would not get so many inappropriate people turning up, so hopefully the people who are waiting the longest would not be in A&E. Are we looking at the whole spread? Finally, if the Trust is focusing on LoS, are the Board convinced that it can be turned around that quickly, being so far off the norm.

A. First the Trust is not just concentrating on LoS, it is also working with PCT colleagues on re admission avoidance and what is happening in the community with long term issues, particularly around keeping the elderly in the community, when appropriate. The PCTs have also invested very heavily in services, circa £82k each year, but it is not changing and the urgent care units are not that popular. There is a need to look at how this is managed and work in conjunction with Primary Care. The Badger Centre is available but the Trust is still at 97.19, just below 98, so the difference between success and failure is very narrow.

Q. Has bed blocking got anything to do with waiting 6 hours for TTOs.

A. It doesn't correlate exactly, but there is an issue with getting TTOs in timely manner. It is about improving the whole process. They can wait in Discharge lounge so the TTO issue is not one of the biggest issues.

10.06 6. PRESENTATION ON MONTH 8 FINANCIAL POSITION

Mr Stokes was happy to report an improvement and informed the Council that the Trust now had a financial risk rating of 4. It had turned a £2m surplus into a £6m surplus and all the ratings were green with Monitor.

There had been a large over performance against PCT contracts thus bringing in extra tariff. There had been a real push on making sure the Trust employed its own people in high cost areas such as Consultants. There was also a group determination to drive through CIP.

Mr Stokes highlighted the following points:

- £1m on pay per month had been taken out.
- Financial Forecast at end of March would suggest the Trust will have a £10m surplus.
- Following an evaluation of estate, modern equivalent asset evaluation, the value of land, buildings and houses had gone down. The Trust's assets were worth £40m less and there was a one off statement below line and the Trust has had to write off £10m of its asset value.

Future developments:

- Firming up on CIP.
- Expecting new tariff to come out in February.
- Next stage of site strategy, asking if it is still fit for purpose, this will be addressed formally with the Trust Board.

Mr Stokes invited questions.

Q. You have not mentioned anything about potential capping of revenue, can you talk us through that concept and when it may apply?

A. It is within the operating framework for next year. This year it is not an issue. In terms of next financial year it takes all emergency activity and once it has gone past last year's outturn, PCTs will only give 30% of tariff. The Trust also has to go through the process of tariff setting with PCT. Looking to sign contract by end of February of this year but will not have price list until 15 February 2010.

Q. In October last year the government put out a directive for no pay increase for staff above a certain level. What are you looking to use that for or will the government take it back?
A. They will take it back.

10.07 7. PRESENTATION ON COMMERCIAL DEVELOPMENTS

Mr Hackwell highlighted the vision for the entire Hollier Centre to undertake simulation training. He also drew the Council's attention to the demise of the Medipark venture, which was as a result of the economic climate. He was pleased to report that initial patient feedback from the service being offered out of Boots in Solihull was very positive.

Questions were then invited.

Q. Is the Boots clinic being staffed by HEFT staff?
A. Yes.

Q. Other Trusts are getting into partnerships with primary care, would the Board like to see more?
A. Yes, they are fully supportive of that.

Q. It is interesting that you have a service in Boots in Solihull. There is a problem at Heartlands, where the lower social economic community live, my thoughts would be why has the Trust not started with those groups to reduce mortality in the community?
A. That is a very good point and the Trust is working closely with GPs to provide services through GPs but I recognise there is more to do.

The Chairman added that the Board was looking at bids that were being invited for primary care services.

10.08 8. PRESENTATION ON HR & OD

Ms Coalter confirmed that she would focus on the staff survey outcome because she knew that the governors had concerns. The engagement of the workforce was critical and there were varying results around that. Ms Coalter confirmed that the Trust now did one survey, and had just done it. Just under 4000 had taken part and so the response rate had improved.

Ms Coalter confirmed that there were KPIs on staff satisfaction and there had been 7 questions to support that regarding, for example, recognition, support, able to take responsibility and there was also quite a complex weighting system which recognised that different Trusts had different types of workforces, as the dynamics of a workforce predominantly contracted out would differ from those who employed their own staff. Ms Coalter reassured the Council that there was a big campaign to rectify the areas where the Trust had not done so well, and there had been much work done against bullying and aggression, and there had been a dramatic drop in those areas. Training on diversity was going to be made mandatory and the process for that was already underway. Work had also been carried out around work/life balance. The local results were back for this year but the CQC would not be ranking the Trust until March.

Arrangements were in place for 120 of the Trust's top leaders to meet and go through results and look at the impact on engaging styles, to ensure buy in from all and ensure action plans drawn up based on results were actioned.

10.09 9. REPORT ON SAFEGUARDING

Safeguarding was now about adults and child safeguarding. Ms Sunderland highlighted that at the last governors' meeting, the Trust had declared a lapse with the HCC on the safeguarding standard. The findings of the review showed there were 7 key areas for development and the Trust was making excellent progress for addressing all of those areas. A key appointment had been made and it was the first time the Trust had ever had a Head of Nursing for children. Jackie Edwards who was at the meeting was taking the lead on the safeguarding children arrangements. The Trust was also going to go out nationally to look for a nurse consultant in safeguarding children.

If the CQC had not changed its standards, the Trust would be 100% compliant but they had changed the criteria and combined the safeguarding of children with the safeguarding of adults. A brand new appointment of a matron had been made specifically for the safeguarding of adults. By combining the 2 standards the Trust was not going to declare itself as fully compliant, rather it would say that it would be declaring full compliance by the end of quarter 2.

Q. What has the Trust done about appointments that have been cancelled by HEFT and children have not been seen for a long time?
A. It is something that we are raising through a flagging system and "do not attend" is part of this system.

Q. You will only know that on the front line, and so no way of flagging up, this needs to be improved.
A. We are bringing in a new system with GPs.

Q. GPs don't know it has been cancelled unless they are told.
A. Need to follow that through. I will come back to the Governors with detailed report (**ACTION** Mandie Sunderland).

10.10 10.TO RECEIVE AN UPDATE FROM THE GOVERNORS' HEALTHCARE STANDARDS WORKING GROUP

Ms Liz Steventon gave a verbal update of progress to the Council and agreed to circulate written update following meeting. It was agreed to disband the Healthcare Standards Working Group and to set up a new Quality and Safety Committee which would invite any governor with an interest to join.

10.11 11. ANY OTHER BUSINESS

10.12 12. DATE OF NEXT MEETING

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

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Chairman