GOVERNORS' CONSULTATIVE COUNCIL

Minutes of a meeting of the Governors' Consultative Council held at Heartlands Hospital on Monday 16th March 2009, 4.30 p.m. in the Education Centre

PRESENT:	Mr Clive Wilkinson (Chair)	Mr Richard Hughes	Mr Roy Shields
	Ms Famida Begum	Mr John Jebbett	Mr John Simms
	Prof Ian Blair	Dr Sunil Kotecha	Mr Lee Smith
	Ms Sheila Blomer	Ms Frances Linn	Ms Bridget Sproston
	Mr Aftab Chughtai	Ms Veronica Morgan	Dr Jagjit Singh Taunque
	Dr Mike Cooper	Mr Victor Palmer	Ms Marion Thompson
	Ms Carole Edwards	Ms Helen Parker	Ms Margaret Veitch
	Ms Valerie Egan	Dr Dev Sarmah	Mr Thomas Webster
	Dr Qulsom Fazil	Ms Yvonne Sawbridge	
	Mr Neil Harris		
IN ATTENDANCE:	Mrs Pamela Chandler	Dr Sarah Woolley	
	Mr Andy Laverick	Mr Janjua Riaz	
	Mr Adrian Stokes	Ms Lisa Jennings	Minute Taker
	Mr Neil Scott	Mr Paul Hensel	Ms Claire Lea
	Mr Richard Samuda	Mr Ian Ratcliffe	

The Chairman opened the meeting and welcomed everyone to the meeting.

09.12 1. APOLOGIES FOR ABSENCE

Apologies had been received from Mrs Barbara Hayward, Ms Ann Brierley, Mr David O'Leary, Cllr Ian Lewin, Dr Dev Sarmah apologies would be late.

09.13 2. MINUTES OF PREVIOUS MEETING

The minutes of the meeting held on 19th January 2009 were approved.

09.14 3. MATTERS ARISING

There were no matters arising that would not be covered in the main Agenda. The Chairman welcomed Dr Sunil Kotecha, new Care Trust Manager, to the meeting.

09.15 4. FINANCIAL UPDATE

The Chairman welcomed Mr Stokes to the meeting, who presented his previously circulated paper. The following key points were highlighted:

For the first time, there were some early signs of concern:
Month 10 of 2008/2009 was the first time the Trust had fallen short by £2m. Mr Stokes summarised the following contributory factors:

A&E increased activity had required additional recruitment. In addition capacity was increased on the Good Hope site with an extra ward and Assessment Medical Unit. During this time activity levelled off reducing income.

Reaction by Trust:
The Trust had undergone a large recruitment drive to fill vacancies and now had strict controls on agency and bank staff usage; stricter controls on saving plans had been put in place; the Trust was looking at how to ensure it achieved the right productivity matrix, eg, how long people stayed in hospital, how many operations etc, as these were crucial elements to getting it right.

Key Performance Indicators
A&E 98% 4 hour wait target. Since opening the new ward at Good Hope, have had 4 weeks of hitting that target.

Waiting Lists
Since the opening of the new ward, these have been hit and managed on a daily basis.

Infection Control
A huge success story but investment was made. Achieving targets by a few percent and beating last year on MRSA and C.diff. Sharp decline for C.diff, were getting 100 but now 40s and 50s.

Capital Investment
The new ward was opened at Good Hope in middle of February, this had been constructed within 4 months and was now starting to show early signs of assisting the Trust to meet the A&E target. Next year's capital had been decided and procurement was in place.

Midru Centre
This was in line to open in the first Quarter of the next financial year.

Mr Stokes took the committee through next year's waterfall diagram which illustrated that litigation cost would go up by £4m, resulting in £3m cost pressure, when taking into account the tariff. Litigation claims had increased all over NHS and so insurance had risen sharply. A year ago the Trust had 5% interest on £80, but due to economic climate would earn £3m less next year in terms of interest receivable. Investment would also be affected by the credit crunch.

Mr Stokes confirmed that there would be a surplus short fall of £7m on the 10 year plan. The Board was in the process of addressing that issue.

Questions were invited:

Q Where does that leave us with capital build projection?
A The first part around the site, would be unaffected as the Trust has cash for that, the second would depend on how able the Trust was to respond to challenge and if costs could be reduced, it would continue but if it seemed too much was being lost from revenue, would have to relook at it. There was a need for a balance between spend in capital and efficiency, thus continually under review.

Q. Regarding productivity, is it evidence that the Trust is contracting out when it should be or that it is attracting work from other sources.
A The Trust was resorting to external provision around certain activities, for example, Trauma and Orthopaedics, general surgery. Cancelled operations tended to be around the volume of emergency work that came into the hospitals, which had increased dramatically. PCTs were sending more than had said at the start of the year, this was focused around Good Hope and Solihull but there was some impact at Heartlands too. Referrals were also over, Trauma and Orthopaedics had had double digit growth.

09.16 5. HEALTHCARE STANDARDS REPORT

Dr Woolley explained that the Trust needed to sign off its declaration against national clinical standards that all NHS organisations had to meet and so her presentation aimed to provide background information into what the Health Care Commission did, which from April would be replaced by the Care Quality Commission. The 44 standards focused on 7 key areas: safety, clinical and cost effectiveness, governance, patient focus, accessible and responsive care, care environment and amenities and public health. Measures would be put in place based on the evidence used by the Governance team to check that the standards set by the Government were being met. There was a system of reporting to local internal committees for further scrutiny and at the end of the financial year, they were signed off by the Board, Governors and Governors Healthcare Standards working Group.

This year the Trust was looking to sign off that it was fully compliant with all 44 standards.

Questions were then invited:

Q Did the Trust ever say it would meet the standards and fail?
A No but one year HCC had different view to the Trust.

Q How do they validate it?
A Random assessment for some Trusts and "at risk" visits too. They come on site and look at lines of enquiry and ask about your systems.

Q Have we been randomly audited?
A No.

Q The new Commission takes over in April but are not telling us our guide lines until August, so do we stay with old ones until told otherwise?
A Yes and quite probably will remain largely the same when new ones do come in.

Q Is the CQC mainly responsible for infection control and HSE from April, with the rest following from 2010.
A My understanding is infection control only but Dr Woolley to look into that and feed back (**ACTION – Dr Woolley**).

Q How many extra civil servants will there be?
A They are actually reducing headcount. Will be based more around auditing and self reporting.

09.17 6. GOVERNORS HEALTHCARE COMMISSION REPORT

The Chairman explained that Ms Steventon's flight had been delayed and she was unable to be at the meeting to feed this item back and so Ms B Sproston had kindly agreed to feed back in her absence.

The Governors' Working Group was convened in February and they were asked to look at one of the Healthcare Standards, Mandatory Training, where the Trust had performed less well and some of the Governors on the Group attended courses and had been given a demonstration of on line training. The Group would reconvene in March to agree the Report.

Dr Woolley said she would like to give a special thank you to all the governors involved in the process.

09.18 7. IT DEVELOPMENT AT THE TRUST

Mr Laverick and Mr Scott's presentation took the form of a demonstration of live clinical and management information systems that had been created by the in-house software development team. Specific systems developed and demonstrated were:

Handover

Patients admitted to hospital had their care tracked and managed using Handover, which was a web based tool for nurses and allied health professionals to record information to manage current in-patients.

iCare Vortal

Where clinicians needed to review the past medical history for any Trust patient, they referred to iCare Vortal which was the Trust's patient-centric electronic patient record, spanning all hospital sites, and securely accessed by over 150 GP practices.

Reporting Suite

This system provided access to performance reports and was used for examining longer term trends and viewing aggregated information for groups of patients.

Questions were invited:

Q What is the process for alerts re vulnerable adults and child protection?
A This was being worked on and hopefully would have it within the Trust in 2 weeks.

Q Does it link into validation of appointments or will it, so people are not waiting too long?
A Outpatients is run by surgery, there is a new scheduling system that can find the next appropriate date called ultragenda. Outpatients are building those clinics for Good Hope, Heartlands and Solihull. With that comes much more flexibility with appointments being offered and also a pathway. Once system in place, would be able to manage the whole pathway.

Q There is a big issue in social care of children about the balance of nurse inputting and care. What would be the impact on that?
A IT are developing a way to take the nurse away from admin, with electronic handover and to minimize the amount of admin time, thus would just click and reduce writing time and unnecessary duplication. Can also be inputted at bedside.

It was pointed out that the sound system was not working very well.
ACTION: CL to discuss with Education Centre.

Q How long would it take to convert hand written records into electronic records?
A Do not just take standard form and duplicate, IT has been working with people who are capturing information to ensure that right information is captured and right tools used. Systems are not imposed, IT work collaboratively with people.

Q IT should not just upload information, they should review how information is compiled to improve whole system.
A We look at current paper system. Would only transfer system to electronic system if working well, if not working well would review. Thus first look at process of information by sitting down with clinicians, so not just duplicating and dumping, only taking what is good.

Q Who makes the judgment on that?
A It is a joint decision between IT, Nursing and clinical staff. Handover success because we worked with nurses and they have guided us.

Q Have you looked at voice recognition systems?
A Yes and we are currently looking at dictation but then using work flow to ensure it flows to right medical secretary. However, with voice recognition there is still a lot of work to do. Would take time to invest and train machines. Number of clinicians who are willing to train systems to recognize their voice and technology. Technology not quite there yet.

Q How much outsourcing is there?
A Today it is all in house but A&E was out of house before it was scrapped. We have created single view from several systems to take the best out of each. Time line had 20 different systems but looks like one.

Q It has revolutionized matters for GPs, for example could have blood result in 3 hours. Looking forward to being able to book directly too.
A Chose and book – can be used for outpatients and we can go beyond that too.

Q GP colleagues can access my system but as a Hospital Consultant I cannot do the reverse.
A We are working with PCTs on this issue.
Dr S Kotecha offered to pilot it.

Q Have all GPs signed up to this?
A This has gone to BENPCT and it is available for them to use.

Q How portable is data say, if patient wanted to move to Lancashire and take it with them?
A At the moment all information is in the Trust but work is currently being undertaken to make it available to national spine, but government needs to define what it looks like.

Q In terms of investment of having ICT technicians, what would that look like? More ICT coming in or would nurses be trained?
A A lot of money was spent to ensure that did not have problems in first place and there is a team of 150 behind Mr Laverick, so doctors and nurses would not have to spend their time on it.

Q Does the system have marketability?
A Yes definitely potential in that area once completed job in hand.

Q Who owns the copy right?
A The Trust, not the NHS.

09.19 8. EQUALITY AND DIVERSITY

The Chairman welcomed, Ms Pamela Chandler, Head of Diversity to the meeting. Ms Chandler introduced Ray ....., Deputy Head who she explained would jointly present

her paper with her.

Some key points raised from Ms Chandler and Mr ..... presentation was:

Equality and Diversity was about quality of care for all patients and all departments had action plans and KPIs. First undertaken within department but was also in place for directorates. Chaplaincy services aimed to respond to call for south Asian languages within 30 minutes of receiving calls.

The Chaplaincy team had been broadened to cover all sites, and had appointed 2 Muslim clerics, male and female. This was in response to the Muslim Community's concern that there was a gap, shown in survey results.

A Steering Group had been set up 2 weeks ago membered by directors and champion network individuals across the Trust. All anyone had to do was to identify any issue their department was experiencing and a member of the Equality and Diversity Team would go and assist.

Training was supported as most complaints were to do with staff attitude and a section was included in Corporate Induction.

There was an interpreting team who had been in place for 12 years and it looked at, among other issues, risk management issues around informed consent.

There had been a visit from Department of Health and it was hoped that the Trust would be a beacon site in the next 18 months.

The Diversity Team had worked with Mr Laverick's team around some very sensitive issues about data collection from patients. Staff needed to be sensitive about asking for information particularly around sexual orientation. There was a legal requirement to collect data and so it was very much around "how" it was asked for.

Work was currently underway with the HSA around meeting the standards regarding the Disability Act.

Questions were invited:

Q Do you have a representative for all major faiths?
A Not paid, but have being working collaboratively with Hindu and Sikh volunteers.

Q How to do you check that the equal opportunity policy is implemented?
A KPI and staff surveys, and look at complaints. Also working closely with staff in clinical areas and looking at the impact of assessment training too. Thus looking at principle of equality across the Board and local monitoring in place too.

Q Regarding the disability side of issue, such as Dyslexia and Neurological problems, what support is there?

Ms Linn volunteered to be involved in this issue to improve care offered.

09.20 9. GOVERNORS' STANDING ORDERS

09.21 8. DATES OF FUTURE MEETINGS

18th May 2009, 14th September 2009, 16th November 2009.

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Chairman