**GOVERNORS' CONSULTATIVE COUNCIL**

**Minutes of a meeting of the Governors' Consultative Council held at Heartlands Hospital on Monday 17th March 2008**

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| **PRESENT:** | Mr C Wilkinson *(Chairman)* | Professor I Blair |
| | Mrs S Blomer | Mrs O Cargill |
| | Mr A Chughtai | Mr A Clements |
| | Dr M Cooper | Ms C Edwards |
| | Mrs V Egan | Dr Q Fazil |
| | Mr J Foster | Mrs M Garland |
| | Mr R Gillard | Mr R Hughes |
| | Ms B Ilett | Mr J Jebbett |
| | Mr M Khan | Cllr I Lewin |
| | Mrs F Linn | Mr D O'Leary |
| | Ms Helen Parker | Mr R Shields |
| | Mrs P Sumner | Ms M Thompson |
| | Mr A Weight | Mrs J Weight |
| | Mr T Whittle | Cllr K Wild |
| | Mr T Webster | |
| **IN ATTENDANCE:** | Ms M Coalter | Mrs L Dunn |
| | Mrs M Pittaway (Minutes) | Mrs D Robinson |
| | Mr G Robinson | Mr A Stokes |
| | Mrs S White | Dr S Woolley |

The Chairman began by informing the meeting of the recent deaths of two Governors: Cllr Alderman Don Lewis and Peter Grace. They had both served as Governors for a number of years and had been members of several Governors' Committees. Their hard work and dedication during their time in office had been very much appreciated and the Chairman informed the meeting that he had written a letter of condolence to the widow of Don Lewis and would be writing a similar letter to Peter Grace's widow on behalf of the Board and Governors.

**08.09 1. APOLOGIES FOR ABSENCE**

Apologies had been received from Ms Ann Brierley, Dr Syed Hussain, Mr Dan Jones, Mrs Julie Keogh, Mr Victor Palmer, Ms Yvonne Sawbridge and Mrs Catherine Wilson.

**Meeting of the Governors' Consultative Council on 12th May 2008**

The Chairman informed the meeting that the next Governors' Consultative Council on Monday 12th May 2008 would be a joint meeting of the GCC and Trust Board. The main Agenda item for consideration would be the Trust's Strategic Plan for the next 10 years. Further details confirming the date, time and venue would be sent out to Governors shortly by the Company Secretary. **Action: DR**

**08.10 2. MINUTES OF PREVIOUS MEETING**

The Minutes of the meeting held 14th January 2008 were approved by the meeting apart from: Mr John Foster had been omitted from the attendance list. The Minutes would be amended to record his attendance.

**Action: MP**

The meeting then moved to Item 4 of the Agenda.

**08.11 4. APPOINTMENT OF NEW NON-EXECUTIVE DIRECTOR**

The Chairman presented the Report of the Appointments Committee, which had previously been circulated to the meeting.

A vacancy had arisen for a Non-Executive Director due to the forthcoming retirement of Professor John Perry on 31st March 2008. The Appointments Committee met in January this year to review the balance of skills, knowledge and experience already contained within the NED's and concluded that, following the merger with Good Hope Hospital and the increase in HEFT turnover to £480m, there was a need to appoint someone to the Board with experience of operating at a senior level in the management of organisations of similar size and complexity to HEFT, preferably but not exclusively from the private sector.

The vacancy was filled by means of open competition and the Committee met to review draft Recruitment Information Packs, Outline Timetable and draft adverts and had indicated a number of changes and amendments to these documents which had subsequently been subject to further review and agreement. Three candidates were shortlisted and invited to attend for interview on 7th March 2008.

Following interview the Committee recommended that Mr Richard Harris be appointed as Non-Executive Director for a period of 4 years. Richard is a Chartered Accountant who was a partner in Pricewaterhouse, London, before moving to a senior finance role in two large FTSE 100 companies. His experience included treasury management, taxation, investment appraisal, acquisitions and divestments of businesses, risk management, governance and accounting.

The Council were asked to approve the appointment of Richard Harris with effect from 1st April 2008.

This was approved.

**8.12 5. APPROVAL OF APPOINTMENT OF AUDITORS**

Mr Stokes presented a paper (previously circulated) summarising the Trust's proposals for the appointment of external auditors until the end of the financial year 2009/10. Pricewaterhouse Cooper's initial period of appointment of 3 years would expire at the end of the current financial year. The Trust had found PwC to be highly competent, professional and pragmatic and had provided valuable help and guidance, in particular surrounding the merger with Good Hope Hospital NHS Trust. There had been good continuity of PwC staff on audits and a good rapport established between key PwC and Trust staff. Retaining PwC for a further two years should ensure:

- Good continuity

- Good Stability
- Strong professional accounting advice
- Commerciality

Mr Stokes informed the meeting that a further tendering exercise for external audit services would be performed in the Autumn of 2009.

The Council were asked to approve an extension to the engagement of PwC as Trust external auditors to the end of the 2009/10 financial year.

This was approved.

**08.13 6. FINANCIAL UPDATE**

Mr Stokes presented an update on the Trust's financial performance April 2007 to December 2007.

**External Audit Review**

The extension to the engagement of PwC had been approved at Item 5.

**Income and Expenditure Position**

Mr Stokes informed the meeting that the Trust currently had a surplus of £13m and this was forecast to increase to approximately £20m by the end of the financial year.

**Financial Risk Score – Monitor**

The Trust was forecast to have a risk rating of 5 by year end.

**Additional Revenue & Investment**

Key Performance Indicators:

- The A&E 4 hour target rate was 98.05% at Q3, forecast to achieve 98% at Q4
- Waiting lists for Outpatients, Diagnostics and Inpatients were expected to reduce further, below the national target, and in line with the local target by Q4
- MRSA: It was forecast that the Trust would fail to meet the Q4 target but should achieve a year on year reduction
- C'Diff: The Trust was forecast to meet the reduction of 18.75% against the 2006/07 outturn in Q4

**10 Year Financial Strategy**

Mr Stokes advised the meeting that the Trust's 10 year financial strategy would be presented to a joint meeting of the GCC and Trust Board on Monday 12th May 2008, as already stated by the Chairman.

Questions were invited.

**Q** Do the suggested improvements contained in the Return to Service Healthcare Commission's Report have financial implications?

**A** Yes. However some additional monies should be available from the Primary Care Trusts.

**Q** Will we be getting a presentation on the improvements that will be put in place on the maternity services?

**A** Yes. This will be an item on the Agenda for the 12th May 2008 meeting.

**Action: SW**

**Q** In the timescales shown on the KPI Chart for waiting lists, does the timeframe of 5 weeks shown indicate the time from when a patient is seen in outpatients until the diagnostic tests?

**A** Yes.

**Q** What is being done to reduce the A&E waiting time in outpatients?

**A** A new initiative, See and Treat, whereby patients are assessed more speedily on arrival at Outpatients has been introduced and waiting times are reducing.

**Q** In relation to the A&E 4 hour target, when does the clock start ticking?

**A** As soon as the patient walks through the doors or is off-loaded from ambulance transport

**Q** I have heard that waiting time for off-loading from ambulances has increased. Is this correct?

**A** It does happen occasionally, but a new policy to ensure more rapid drop-off of patients has been introduced.

**Q** What are the average waiting times for A&E?

**A** These are not to hand at present but Mr Stokes will find out and respond directly when he has this information.

**Action: AS**

**08.14 7. PRESENTATION ON INFECTION CONTROL UPDATE**

Mrs Fenton presented an update on Infection Control.

**Norovirus**

Mrs Fenton informed the meeting that there were increased reports of Norovirus nationally and that the season had peaked earlier (December) than in previous years. Strict criteria was in place and all wards that had been closed were deep cleaned prior to reopening. There had been a reduction in the length of ward closures due to the Norovirus in January but towards the latter end of February and early March the figures had again risen. Life-size posters had been introduced to highlight awareness and discourage people from entering the hospital if they had suffered from diarrhoea, flu-like symptoms and/or vomiting in the last 48 hours or had been in contact with anyone with these symptoms.

The Trust had begun the national deep clean initiative 6 months ago on a non-clinical area since an area needed to be completely vacated in order to be able to do this. Early in April the initiative would begin in the wards.

**MRSA**

Mrs Fenton informed the meeting that the national target was for a 50% reduction in MRSA over 3 years. The Trust had set up an Infection Control Taskforce and had introduced:

- A hand hygiene campaign; talking posters; "glow bug" on wards; ward 'champions'
- RCA process: tool from HEFT
- Appointment of a Senior Infection Control Nurse
- Audits of peripheral lines and catheters
- Policies and Procedures

A key tool in prevention of infection was root cause analysis and this was being undertaken by the Medical Director and Director of Infection Control within 48 hours of MRSA being confirmed. Numbers of cases at the Trust were small (80 this year) with a maximum of 4 per ward over the three sites. Head nurses were doing spot check reviews including looking at hand-washing procedures. The Infection Control Taskforce had a detailed action plan structure and progress was reported to Trust Board on a monthly basis.

The Trust's target this year had been to reduce the number of cases to 54. At the end of December 2007 there had been 80 cases and this number had now risen to 86. However a number of confirmed cases resulted from patients coming in with community acquired MRSA and the Trust had actually reduced the number of MRSA cases since last year by 18%.

**C'Diff**

Mrs Fenton informed the meeting that the Trust had opened a cohort ward in order to isolate patients with C'Diff and that this was proving to be very successful. There had also been a review of the antibiotic prescribing policy as antibiotics could also reduce 'good' bacteria that would fight infection.

Questions were invited.

**Q** Are policies and procedures being reviewed?

**A** Yes. Reports go to the Board on a monthly basis and the Trust is in the process of opening 2 MRSA cohort wards – one at Heartlands and one at Good Hope Hospital.

**Q** If C'Diff comes into the hospital from outside, could there be a case for people coming onto wards being asked to wear masks?

**A** People do wear masks when coming onto isolation wards i.e. the C'Diff patients' cohort ward. For clarification, Norovirus comes in from the community, but C'Diff is not from the community.

**Q** How do we compare with other hospitals in Birmingham?

**A** Taking the number of bacteraemias per 1000 bed bays, 6 Trusts within the region are worse that HEFT.

**Q** Is there more investment in deep cleaning at Birmingham Heartlands than in the other sites?

**A** BHH has the greatest number of beds.

**Q** What evidence is there of the efficiency of deep clean?

**A** This is a question for the Department of Health since it was they who decided that it should be done.

**Q** What is the likely reaction of Monitor to the MRSA figures and would they investigate further?

**A** No. Monthly monitoring would have required the Chairman, Mark Goldman and Beccy Fenton going down to meet with Monitor in London. This was not a requirement because the Trust's rates for MRSA are still reducing. Also, 48% of Foundation Trusts are currently missing their MRSA targets.

**Q** At a recent lecture I attended we were informed that the gel/handwashing procedure provided only 10 minutes protection. Is this effective?

**A** The Trust's policy is that the use of gel/handwashing procedures must be followed after every patient contact.

**Q** Following deep cleaning to a ward or area, are tests carried out to ensure that it has been completed satisfactorily?

**A** Yes. There is an inspection and a check-list is signed off.

**Q** I cancelled two operation dates as I was not happy about MRSA and C'Diff. How do others feel about surgery?

**A** This is a problem that needs to be resolved but it is important to get the practice in place to keep the numbers of infection extremely low.

**Q** What percentage of fatalities is attributable to MRSA/C'Diff infections?

**A** MRSA and C'Diff infections are not normally the cause of death and therefore not measured at the present time.

**Q** Are there any statistics that indicate whether the increase in people coming into the hospital with MRSA have acquired this in the community or developed this elsewhere i.e. have they been in another hospital recently?

**A** This is something that is currently being investigated.

**Q** What has been shown by the root cause analysis that has been undertaken?

**A** The main issue was one of compliance. It is difficult to pinpoint the source of the MRSA and the current focus was on data collected from 10 individual wards which was being analysed.

**Q** From the presentation on MRSA and C'Diff it seemed clear that anyone coming into the hospital could be carriers. Does the Trust agree that it is everyone's responsibility to pay scrupulous attention to hand-washing and hygiene?

**A** Yes.

**Q** What are the numbers of patients developing other infections, i.e. e coli and toxic shock?

**A** The figures are not to hand but quarterly reports from the Infection Control Team go to Trust Board and there have been no special cases drawn to the Board's attention.

**08.15 8. DEVELOPMENTS WITH THE CARE QUALITY COMMISSION**

Dr Woolley gave the meeting a presentation on the Healthcare Regulation: Future changes. The purpose of the Regulation was to improve safety and quality services for patients by replacing the Healthcare Commission, the Commission for Social Care & Inspection and the Mental Health Act Commission and bringing them together under the umbrella of the Care Quality Commission. They will be responsible for:

**Safety & Quality Assurance**
- New system of registration
- Enforcement powers

**Safeguarding Patients Rights**
- Patients subject to MHA
- Monitoring Mental Capacity Act 2005

**Information for patient choice**

**Minimise the burden of regulation**

Dr Woolley informed the meeting that the Care Quality Commission would have stronger powers of enforcement over the Trust as an organisation and would have the power to issue fines and prosecute for breaches of clinical standard. There would be an annual inspection of Infection Control practice.

Under the new Regulation the CQC's relationships with others were set out as follows:

- **Provider services**: meet standards
- **PCTs & LA**: commissioning services and contract management
- **SHA**: performance manage commissions
- **Monitor**: regulate FT governance, finance & delivery
- **Department of Health**: set standards, agree assessment system design & manage SHAs

**Timescale**

The Care Quality Commission would be established in October 2008, and commence regulation in April 2009. The new registration system would be introduced from April 2010. The implications for HEFT were still uncertain since to date there had been no details of the new assessment process or role clarity within the system. However, there would be stronger contract management and increased safety/quality focus for Boards.

Questions were invited.

**Q** Will all staff be CRB checked?

**A** This is already done.

**Q** This will affect the roles of the Chairman and members of the Governors' Working Group. Their roles will change in October 2008 and again in 2010. Governors are only elected to the Trust for a maximum term of 6 years. Should their term in office not be extended to allow for greater continuity when these and other changes come into force?

**A** It seems unlikely that there will be major changes in the first few years. As regards a change to the maximum 6 year appointment for Governors, there is a National Governors Association and this issue should be raised with them with a view to bringing a case for an extension to the attention of Ministers.

**Q** Is it correct that the existing targets will remain plus additional ones i.e. tougher enforcement? And what about the legislative timetable?

**A** Yes, existing targets will remain. The Care Quality Commission should be established and working by October 2008.

**Q** At a recent conference, a representative spoke about the role of the Healthcare Commission in the next 2/3 years. Surely they won't exist?

**A** They won't exist separately but will be part of the new Care Quality Commission when the existing organisations come together.

**8.16 9. GOVERNORS' HEALTH COMMISSION REPORT**

Roy Gillard, Chairman of the Governors' Working Group presented the report and informed the meeting that there would continue be a role for the Governors' Group to look at healthcare standards in order to give assurance that HEFT was meeting the Quality & Care Standards under the Care Quality Commission as they had been doing for the past 2 years.

Mr Gillard advised the meeting that membership of the Working Group would shortly change. He was not seeking re-election as Governor in the current elections and there were currently 2 other vacancies. Governors were invited to put their names forward to fill the vacant posts.

Questions on the report (copies of which had previously been circulated) were invited.

**Q** In an effort to improve privacy and dignity for patients, what is being done to eradicate mixed sex wards?

**A** This varies from hospital to hospital but the next meeting of Governors' Consultative Council on 12th May 2008 would be a joint meeting with Trust Board to consider the Trust's10 year strategic investment programme and this would be one of the issues discussed.

**Q** There is an increase in the number of elderly and frail patients coming into hospital as the population is getting older. If cubicle ratios increase surely this will necessitate additional staff in order to monitor these high risk patients?

**A** Obviously these two factors have to come together and these will be considered at the meeting on 12th May 2008.

The Chairman thanked Mr Gillard for his service to the Governors Working Group as this would be his last meeting. The meeting were then asked to approve the recommendations contained in the Report with a view to implementation during 2008/09:

- The Governors' Working Group continues with the process of assessing the Trust in relation to Healthcare Standards
- A revised methodology is developed in relation to ward visits which allows the Governors to choose which wards to visit
- The possibility of developing joint working arrangements with the PCTs will be explored

The recommendations were approved.

The Chairman left the meeting at this point and the meeting returned to Item 3.

**8.17 3. APPROVAL OF NON-EXECUTIVES DIRECTORS' AND CHAIR'S PAY AWARD**

Professor Ian Blair presented the report on the meeting of the Governors' Consultative Council Remuneration Committee that had been held on 11th February 2008. An abstract of the Minutes had previously been circulated to members.

**External Comparison of Non-Executive Directors Pay**

The Committee had expressed concern that it was becoming increasingly difficult to 'benchmark' the levels of remuneration for Non-Executive Directors as their roles and responsibilities changed within an expanding Trust and the internal market within the NHS for Non-Executive Directors continued to develop. It was agreed that an external market evaluation of Non-Executive pay should be completed before the next meeting of the Committee to allow for a comparison with pay in other Foundation Trusts and other sectors of industry.

**Terms of Reference**

The Committee had agreed that it was important to ensure continuity in committee membership as this inevitably changed and that this should be reflected in the Terms of Reference of the Committee. The Committee had asked the Company Secretary to circulate the Terms of Reference for review and it had been agreed that any issues regarding these that required further discussion would be the subject of a separate meeting.

**Non-Executive Directors Remuneration**

Following detailed consideration, the Committee had unanimously decided to recommend a 3% increase, effective from 1st April 2008, across the board for the Chairman, Chair of the Audit Committee, Chair of the Governance & Risk Committee and all Non-Executive Directors.

Questions were invited.

**Q** What exactly does 3% equate to if we are not aware of the current remuneration for these posts?

**A** There are different levels of remuneration, i.e. for the Chair, Non-Executive Directors

who Chair Committees and the other Non-Executive Directors. However the remuneration is published within the Annual Report & Accounts and is therefore in the public domain. In light of the merger with Good Hope Hospital in April 2007 and the additional workload it was felt that in order to encourage really good candidates to apply for these posts the remuneration should be in keeping with the retail price index and this had been one of the recommendations of the Committee last year.

**Q** What appraisal procedures are in place for Non-Executive Directors in order to evaluate and reward them for their performance?

**A** These could be looked at under the Terms of Reference i.e. Workloads under the appraisal system.

The Governors' Consultative Committee were asked to approve a 3% increase, effective from 1st April 2008, across the board for the Chairman, Chair of the Audit Committee, Chair of the Governance & Risk Committee and all Non-Executive Directors.

This was approved.

**08.18 10. DATES OF FUTURE MEETINGS**

12th May 2008
15th September 2008
10th November 2008

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**Chairman**