THE NEWCASTLE UPON TYNE HOSPITALS NHS FOUNDATION TRUST

MEMBERS COUNCIL

Minutes of the meeting held on 15th November 2007
at the Dene Centre, Newcastle upon Tyne

Present:	Mr K W Smith (Chairman)	
	Appointed Governors	5 (out of 11)
	Staff Governors	4 (out of 7)
	Public Governors (Constituency 1):	3 (out of 9)
	Public Governors (Constituency 2):	7 (out of 10)
	Public Governors (Constituency 3):	1 (out of 3)
	(Attendance record attached)	

Mr D Allison, Operations Director
Miss S Campbell, Assistant Director – Planning & Performance (item 07/91 only)
Mr L R Fenwick, Chief Executive
Mrs P Dodds, Non-Executive Director
Mrs M Hornett, Nursing & Patient Care Director
Mr M Pettifor, Business Director
Mr S R Reed, Trust Secretary
Mr R P Shaw, Head of IM&T (item 07/84(i) only)
Mr B Steven, Finance Director
Mr I Stoneham, Interim Director
Dr T J Walls, Medical Director

07/82 Apologies for Absence

Apologies for absence had been received from Mrs L Bates, Mrs J Binns, Mrs F Butler, Lady Ann Calman, Mrs J Donnelly, Ms M Hall, Councillor B Hindmarsh, Dr M Prentice, Mrs E Randall, Professor R Stephens and Mr R Venus.

07/83 Minutes of the Meeting held on 20th September 2007

The minutes of the meeting held on 20th September 2007 were agreed to be a correct record, subject to amendment of minute ref. 07/65 fourth paragraph to read “He had been Chief Executive of Durham County Council and had led the Council to “excellent” status under the government’s national performance ratings. He had been Chairman of the committee which had been successful in attracting first class cricket to Durham. He had also been interim Chief Executive of Teesdale Council. This authority was a “poor” authority under the government’s national performance ratings and he had overseen a significant improvement in its performance.

With regard to minute ref. 07/68(ii), Ms Tiller clarified that Newcastle Primary Care Trust had not in fact decided against any form of vertical integration but was reviewing a range of services and models for future provision.

07/84 Matters Arising

i) <u>IT Security and IM&T Strategic Partner</u>

In response to a query raised at the previous meeting, Mr Shaw, Head of IM&T was in attendance and provided an overview of IT security measures within the Trust. Mr Shaw confirmed that NHS numbers were unique and were not reissued after the death of the holder. It was noted that at peak times the Trust saw email traffic of 5,000 per hour. A series of software programmes monitored emails and Internet access, including checking of incoming emails and images.

Mr Shaw then moved on to describe the Trust's approach to the identification of a strategic partner for IM&T services. The need to establish the Electronic Patient Record (EPR) was the key driver but there was also a requirement for some new as well as replacement systems, including A&E and Theatres. Healthcare was becoming more complex and increasing co-ordination of services for patients was necessary. In the past there had been funding restrictions at the national level. Integration of performance monitoring and management was a business requirement in the current environment. EPR would ensure that patients only gave their demographic details once and that tests were not cancelled or results lost.

The Trust had begun to test the market in September 2006, when it had become apparent that Connecting for Health (CfH) was not going to be able to deliver the promised systems within the timescales required for the Trust, including those aspects driven by the Transforming the Newcastle Hospitals project. A revised procurement had been launched in December 2006, following a study tour which had taken in the operational clinical systems in use in University of Pittsburgh Medical Center (UPMC). This procurement had been conducted under EU regulations and with continuing governance review. The Board of Directors was expected to reach a final determination in November 2007 whether to proceed with UPMC as the strategic partner and, if so, work would commence on-site in March 2008. A seven year contract would offer scope for the Trust to step back in to the CfH programme in 2013/14. The purpose of the partnership was to enhance the portability of data and thus the mobility of staff and patient care, including the scope for moving care closer to patients' homes.

Mr Atkinson asked whether the central contract providers objected to the Trust stepping out of the national programme and whether this would comprise the delivery of functionality. While the latter was not an issue (as the procurement had specified a system which was fully compliant with the national functionality requirements), there was no doubt that there were some financial effects which were masked at national level, since individual Trusts were not party to the contracts put in place by CfH. The Trust did have the powers to step out of the national programme and this had been confirmed independently. Any penalties did not appear to be capable of being raised against the Trust.

Mr Steven commented on the frustration at the lack of pace of CfH. The national contract had never been shared with the Trust and CfH would have preferred the Trust to stay in the programme. However, there did not appear to be any liabilities on the Trust. Mrs Hargreave asked if there were any issues of

transfer of patient records elsewhere if the Trust was not part of the national system. In essence there were not, although the current national system was essentially only comprised of basic demographic data. Mr Brain enquired whether any other Trusts were considering alternatives to CfH. Some had done so for particular modules but not whole systems as yet. Mr Brain asked whether the Trust's approach undermined CfH. The separate procurement would not affect functionality and financially, the impact, if any, was many years hence. Mrs Hargreave asked if there were any other partners to UPMC. The Trust was the first in the UK but there were partners elsewhere in the world.

Ms Hall wondered if the system would improve on the current paper record. Mr Shaw thought that the main benefit would be the additional information which could be included, from GPs and other healthcare professionals. Mr Atkinson asked whether existing patient records would be transferred or whether there would be a switch-over date to electronic records. The patient record would be compiled in four sections, so that, for example, results could be turned off. Existing records would be optically scanned. Professor Kendall-Taylor enquired whether GPs would be able to access all of the data, including test results. This would be so. Dr Goodship asked if the system would offer research functions. It would. Mr Fenwick thought that there would be greater automatic data capture and early warnings too. The Trust had already waited four years for the CfH programme and could safely wait longer but in less than a year would not have a robust Patient Administration System (PAS), as the service provider was withdrawing support. PAS did not provide a tracking facility for measuring the 18 week Referral To Treatment pathway, although was now promised for February 2008. The UPMC whole-system benefits would include quality assurance and monitoring. The Department of Health was comfortable that the Trust could rejoin the CfH programme in 2013.

Ms Hall asked how the accuracy of scanned data was assured and how patients would get a copy of their discharge letter. This would be printed off, as now. Mr Smith said that the Board of Directors had been reviewing the proposals in great detail and the reality was that the national programme had not delivered. Professor Kendall-Taylor asked if the Board was unanimous in its support for the proposal and Mr Smith replied that this would be determined at an extraordinary Board meeting, to be arranged specifically to address the IM&T strategic partnership issue. On a show of hands, Governors supported pursuit of a strategic partnership with UPMC nem con.

ii) Community Services Future – Vertical Integration

Mr Pettifor gave a presentation on the strategic intentions of the Trust and the various action plans underway in particular sectors, including Dentistry, Sexual Health and Care of the Elderly. Fundamentally, all of the proposals were intended to provide better care for patients, closer to home and at best value. Vertical integration was an organisational solution, where collaboration was furthered within one organisation. Collaboration was rooted in the opportunity for dialogue. A number of pilot schemes were proposed, to test different methods of working.

Mr Brain commented that there seemed to be different interpretations of "community care", which could include a hospital visit, or hospital services

coming out into the community. Mrs Hargreave supported implementation of the pilot schemes and thought that Care of the Elderly would be a key area.

iii) Infection Control

Mrs Hornett presented an overview of the current situation with regard to Healthcare Acquired Infections. Nine cases of MRSA bacteraemia had been reported in September against a monthly target of three. Of these, four cases were judged to be "avoidable" and five "unavoidable". 35 bacteraemias had been reported in the year to date (12 of them "avoidable"), against the year-end target of 37. Cases in October were provisionally three, with one "avoidable" and the others "indeterminate". Ward 15 of the Royal Victoria Infirmary had been closed for refurbishment and cleaning. There had been no reported cases in November to date. High rates in Medicine, Surgery and Care of the Elderly were consistent with the national picture but did present risks. The Trust was noted to be below average, i.e. good, in peer group comparisons with Foundation Trusts and teaching hospitals and based on cases per 10,000 bed-days.

Root cause analysis (RCA) was carried out for every case. In September, weekly scrutiny of avoidable bacteraemia with respective Directorate management teams had gained a fresh momentum. The Medical Director and Nursing & Patient Services Director led these reviews, supported by the Director of Infection Prevention and Control. In most cases, the Directorate team was joined at the meeting by the individual Consultant(s) and Ward Sister/ Charge Nurse(s) where root cause analysis pinpointed issues/situations which needed to be addressed in detail.

Mrs Hornett tabled a briefing on the outcome of the Department of Health MRSA Improvement Team visit on 13th November. Three distinct actions had been recommended, namely:

1. Use of 2% Chlorhexidene for skin preparation before the insertion of intravenous lines, instead of Betadine.
The use of Chlorhexidene was recommended in Trust guidelines although, in some circumstances and for a variety of reasons, Betadine was still used. There was debate as to the reliability of the supporting evidence in relation to this recommendation.

2. Use Healthcare Commission colour coding for cleaning equipment and an increase in the number of mops and buckets per ward.
The colour coding scheme had not been adopted as the Trust was poised to move to a new 'microfibre system'. This eliminated the use of mops.
Some confusion may have arisen if the visiting team were not clear about the protocol for the changing of mop heads during the cleaning of a ward area. Further information was being submitted to clarify.

3. Introduction of the Visual Infusion Phlebitis (VIP) score for peripheral lines.
Plans were already in place to introduce this across the Trust in a standardised format. Many areas had already introduced local measures to improve the care of peripheral cannulae.

The full report of the visit was expected within three weeks.

It was noted that the Trust had submitted a bid against the second tranche of NHS North East funding for Infection Control.

Turning to Clostridium difficile (C. diff), there had been some increase in case numbers in recent years, in line with the national position but the Trust was currently below trajectory and hoped to maintain this, although winter was always a challenging time. A position statement with regard to the Healthcare Commission report on the C. diff outbreaks at Maidstone & Tunbridge Wells NHS Trust was received and noted. New Department of Health guidance had been received, including the role of Matrons and new guidance issued regarding the recording of MRSA and C. diff on death certificates, where consultants were to be involved for the latter. The need for further improvement was recognised in order to improve the overall position.

Mr MacDonald asked about eradication therapy. Mrs Hornett explained that patients were now largely screened upon admission and an array of treatments was then available to eradicate MRSA prior to surgery or other treatments. Mr Brain wondered if the Trust had considered targeting "frequent visitors". Mr Atkinson enquired whether any members of staff had been disciplined in connection with the 12 avoidable MRSA bacteraemias to date. No-one had as yet and it was perhaps not always appropriate.

Ms Tiller commented that the North of Tyne Chairs and Chief Executives Forum agreed that this was a priority area and was seeking to change the Healthcare Commission targets based upon absolute rather than relative values. Mr Brown asked what consideration was given to re-use by patients of items such as cardiac exercise testing equipment or x-ray machines. These were not targeted specifically. Ms Harvey thought that the "traffic light" notices on hand hygiene placed around the Trust were good but thought that handwashing by visitors needed to be tightened up. It was noted that weekly handwashing audits were undertaken and there was some covert surveillance and the best compliance was thought to be amongst visitors. Mr Smith stressed that Infection Control was the top priority of the Board.

07/85 Governors' Attendance

Mr Reed presented a proposal to monitor and implement the "three strikes" rule for Governors' attendance, as set out in the Constitution, to be introduced once Governors had been made aware of the proposal. Members Council supported implementation, with effect from the January 2008 meeting, so that the July 2008 meeting would receive a schedule of serial non-attending Governors (if any) for consideration.

07/86 Election Timetable

Mr Reed set out the timetable for the round of elections planned for winter 2007/08, to address time-expired one-year terms of office and some resignations. The timetable was agreed.

07/87 Future Development of Members Council

Mr Smith gave an update on the proposed programme for the Governors' away day on 23rd November 2007, which would include roundtable work and the interplay between Governors and Executive Directors. There was a view now that a second away day in late January 2008 would be profitable, concentrating on how Governors would work, whereas the initial away day would focus on what Governors did.

07/88 Governors' Visits

i) Food Tasting – Newcastle General Hospital

Mr Atkinson reported in the absence of Mr Venus. The general patient feedback was extremely good. The feeling was that there was sufficient food, it was hot, there was a good choice and that the quality was not bad. It was accepted that the chilled and re-heat system always affected both texture and taste, but given that, the feeling amongst Governors was that the system was sound and quality was good.

ii) Food Tasting - Royal Victoria Infirmary

Mr Atkinson reported that food was plated up in a preparation area and then transported to the wards and the trolleys plugged into high sockets. Some of the nurses cannot manage to pull the plugs out. It took 55 minutes for the food to heat up. It then took around 20 minutes to get all the trays distributed. Nurses had been trained in food hygiene & handling. Food was very hot and in fact too hot on some plates, in that it had scorched some of the gravy at the side of a few of the plates.

Ms Harvey commented that the plastic containers used in the Burlodge trolleys appeared to taint some foods.

iii) Food Tasting – Walkergate Hospital

Mr Atkinson reported that a hygiene issue had been highlighted with regard to cutlery and also the general food delivery via "orange boxes" and a plea was made for a replacement trolley system if possible.

07/89 Governors' Feedback: Infection Control and Public Involvement

Mrs Hargreave presented a proposal for the introduction of a robust approach to challenging staff as to whether they had washed their hands. Members Council strongly supported this and Mrs Hornett was to lead on implementation. Governors interested in monitoring the approach were to advise Mrs Hornett of their availability.

07/90 Governors' Questions and Items for the Next Agenda

i) Musculo-Skeletal Outpatients

Mrs Haigh commented on the difficulty in contacting the MSU Outpatient Department in order to cancel or amend appointments. Mr Fenwick reported that the Directorate was in special measures with leadership change across the board and the Executive Team was monitoring performance.

ii) Medical Staff Committees

Dr Goodship reported that there was to be a joint meeting of the MSCs, to include introduction of the Chairman and feedback would be provided to Members Council at a later date.

iii) Identity Badges

Ms Harvey asked about "staff" identity badges for Governors and Mr Reed was to liaise with the Head of Portering & Security to see what arrangements could be made.

iv Armed Forces Serving in Asia Minor

Mr Atkinson asked whether there was any special provision for these servicemen and women. Mr Fenwick replied that there was and including the War Pensions provisions. There was also a close relationship with South Tees Hospitals in connection with the Catterick garrison. Dr Walls commented on the number of clinical staff serving as Reservists.

For future Agendas, issues proposed included car parking (with Mr Brewis in attendance); and staff catering facilities. Any other Agenda items were to be communicated to the Trust Secretary.

07/91 Healthcare Commission Rating for 2006/07

Miss Campbell, Assistant Director – Planning and Performance, was in attendance and gave a presentation on the Trust rating for 2006/07. The score was "excellent" for Use of Resources and "good" for Quality of Services, where the national core standards had been fully met, as had the existing national targets, while performance against the new national targets had been good. There had been two areas of insufficient assurance and the Infection Control standard had not been met, as a consequence of exceeding the MRSA bacteraemia target for the year.

It was noted that an appeal had been lodged with the Healthcare Commission regarding the digital hearing aids position and there had subsequently been significant improvement in the waiting list numbers.

Mr MacDonald asked if there was any conflict between Use of Resources and the move from analogue to digital hearing aids and wondered what the sum involved was. Mr Fenwick replied that it was in excess of £0.5 million but the "order" had never been received from commissioners.

07/92 Business Planning, 2008/09

Mr Allison tabled a briefing paper, which set out the annual business planning cycle and showing how performance review and management was bound in to the process. There was continual monitoring of the external environment and opportunities. November through to January was the key period, when Directorates drafted their proposals. There was then a "reality check" in February, prior to agreement of the plan in March. It was proposed to share aspects of the business planning guidance at the 23rd November away day and then give feedback to Members Council in late January / early February, possibly via the second away day.

07/93 Executive Report

Mr Fenwick reported on a number of areas of current interest. The half-year financial position was very strong and the risk rating of 4.8 was very good indeed. Patient care performance was good but infection control, 62-day cancer waits and 18 week Referral To Treatment pathways were all being monitored closely by the Executive Team. With regard to MPET funding, Mr Steven reported that it was understood that NHS North East had rescinded the need to repay the £3.4 million this year but reserved the right to claim it back in future years, although the Trust did not agree with the view that it should be repaid. There was thus a continuing risk of "wealth redistribution".

With regard to recent staff behaviour in relation to inappropriate and offensive images, it was noted that the Members Council of Northumbria Healthcare NHS Foundation Trust had also addressed this matter. In Newcastle, there had been six dismissals, three final written warnings and some demotions. The policy on such behaviour had been reinforced to all staff.

Key documents received included the following:

(i) Is anyone listening? A report on complaints handling in the NHS (Healthcare Commission October 2007).

This report highlighted what needed to be done if complaints were to be handled better for patients. As part of an in-depth audit, the Healthcare Commission visited a total of 42 Trusts, 32 poor performers and 10 good performers, to examine the reasons for poor performance and what could be learnt from good practice. Trusts were assessed against the Government's *'core standard on complaints handling'*.

There were 14 key findings together with seven recommendations for Trusts to take immediate action on and six recommendations for SHAs.

In summary:

- Do more to "open" the complaints systems and make it more accessible, especially for groups with special needs and people from minority ethnic communities

- Communicate their commitment to staff and patients that complaints need to be dealt with well and that should people make a complaint they will not be discriminated against
- Provide education and training for frontline staff specifically covering good complaints handling and discrimination
- Use audits, patient surveys and focus groups to systematically monitor whether care has changed or been altered as a result of a patient or carer making a complaint

The Complaints Panel was to address the report and advise the Board and Members Council of the relevant actions that need to be taken.

(ii) Investigation into outbreaks of Clostridium difficile at Maidstone and Tunbridge Wells NHS Trust (Healthcare Commission October 2007).

The Healthcare Commission conducted an investigation into this particular Trust following a referral from the SHA after a major outbreak of C. difficile in 2006. The investigation assessed the care provided to patients with this infection between April 2004 and September 2006 and also considered whether the Trust's systems and processes for the identification, prevention and control of infection were adequate.

Recommendations for national action following this investigation were highlighted and stressed that Boards must provide strong leadership in preventing and managing infection. The Commission also called for C. difficile to be managed as a serious medical condition in its own right, rather than just as a clinical complication.

In addition to the ongoing scrutiny at Board level the following were involved:

- Clinical Governance & Quality Committee
- Risk Management Group
- Clinical Policy Group
- Infection Control Sub-Committee
- Executive Team
- Members Council

(iii) Aspiring to Excellence: Findings and Recommendations of the Independent Inquiry into Modernising Medical Careers (September 2007)

Led by Professor Sir John Tooke, this was a comprehensive, well structured analysis and set of findings within a demonstrable evidence base that had brought about 45 recommendations across the following key headings:

- Clarification of policy objectives
- The role of the Doctor
- Policy development and governance
- Workforce planning
- Medical professional engagement
- The commissioning and management of postgraduate medical education and training
- Streamlining Regulation
- The structure of postgraduate medical training

It was most encouraging that the findings and recommendations reflected the experience, thoughts and opinions of the Board of Directors, senior medical staff and the Faculty of Medical Sciences in Newcastle. Dr Walls commented that the report had been widely welcomed throughout the Trust and feedback had already been provided to the consultation exercise. There was however a lack of clarity about the position for the summer 2008 rotation of training posts.

(iv) Caring for dignity – a national report on dignity in care for older people while in hospital (Healthcare Commission September 2007)

Many people were living a healthy and active life, but despite this, a substantial proportion of older people needed care in a hospital. Maintaining a patient's dignity and treating them with respect was of paramount importance to older people, but anecdotal evidence indicated that older people were often not treated in this way while receiving care in hospitals.

The Healthcare Commission decided to focus on 'dignity' as a key theme in the Annual Health check in 2006/2007 and to undertake a targeted inspection programme to assess the extent to which NHS Trusts are meeting the standards relating to dignity in care for hospital inpatients. The aims of this were to promote improvement in care, firstly through an in-depth look at those Trusts that appeared to be performing less well and secondly to identify and share examples of good practice.

The report recognised that there was evidence that Trusts were taking on board national concern about this issue and getting the right systems in place. An increasing focus on the quality of non-clinical care for patients was acknowledged and findings indicate that dignity, nutrition, and privacy was moving up the agenda and achieving higher levels of priority.

The report identified the following key areas for improvement: strong leadership at all levels; workforce training; involving older people in their care; supportive ward environment; and delivering personal care that maintains dignity. It was recommended that the following bodies were actively involved from a system practice and quality assurance perspective:

- Clinical Governance & Quality Committee
- National Service Framework for Older People Group

Mr Fenwick reported that Ms Clare Curran was to join the Trust in early 2008 as Director of Human Resources. It was noted that the Trust was bidding for national monies under the Biomedical Research Centre umbrella. The latest position with regard to the sale of the former Sanderson Hospital site was noted.

07/94 Improving Patient Care

Mrs Hornett introduced the update briefing on three longer-term developments within the Trust, i.e. Strengthening the role of Sisters and Charge Nurses; Being with Patients; and the Productive Ward programme. Governors had received presentations on each of these in the past year. Members Council expressed delight at the briefing and recognised that the combined programmes would deliver genuine improvements in patient care. Professor Potts said that she

had attended a Being with Patients training day and commended it to all Governors. Mrs Hornett agreed to circulate the schedule of dates for 2008.

07/95 Regional Health & Well-Being Strategy

The briefing paper on the NHS North East initiative was received. Mr Pettifor commented that the main thrust of the proposal was to move money out of diagnosis and intervention and into disease prevention, with greater delivery of rehabilitation, opportunities for community-based services, including treatment of obesity and cancer. On the latter point, Mr Allison said that this would be more about holistic cancer care and not just treatment.

07/96 Caring for Dignity

The briefing was received and noted.

07/97 Draft Privacy & Dignity Policy

The draft policy was received and any comments on it were to be submitted to Mrs Hornett.

07/98 Visitors Policy

The policy was received and noted. Mr Brain thought there was a need for greater flexibility on visiting times and the Sister's / Charge Nurse's discretion, in recognition of different work patterns of relatives. Mrs Abrahams asked about a ban on flowers. The Trust position was that there were designated wards where patients were at very high risk of infection and flowers were banned in those wards. Mr Brown commented that the Community Advisory Panel had reviewed the policy in draft and had supported the agreed visiting times. It was noted that a leaflet for visitors was being prepared.

07/99 Dress & Appearance Policy

The policy was received and noted. Mrs Hargreave wondered about the efficacy of staff taking uniforms home to launder.

07/100 Date and Time of Next Meeting

The next meeting would be held at 2.00pm on Thursday 17th January 2008.

MEMBERS COUNCIL

GOVERNORS ATTENDANCE, 15th NOVEMBER 2007

2	Mrs Heather Abrahams	Y
2	Captain Kenneth Appleby (*resigned*)	XXXXXXXXXXXXXXXXXXXXXXXXXXX
2	Mr Peter Atkinson	Y
1	Mrs Linda Bates	APOLOGIES
3	Mrs Jennifer Binns	APOLOGIES
2	Mr Malcolm Brain	Y
A	Mr Paul Briggs	Y
A	Mr Alf Brown	Y
A	Professor Alastair Burt	Y
S	Mrs Faye Butler	APOLOGIES
A	Lady Ann Calman	N
S	Mr David Crawford	Y
1	Mrs Jane Donnelly	APOLOGIES
S	Mrs Joan Duckett	N
S	Mrs Christine Eddy	Y
1	Mr Jack Foley	N
S	Dr Tim Goodship	Y
1	Mr Eric Green	Y
2	Mrs Grace Haigh	Y
2	Ms Margaret Hall	APOLOGIES
A	Mrs Mary Ann Hargreave	Y
2	Mr Maurice Harvey	Y
1	Ms Sandy Harvey	Y
1	Mr Ray Hayes*(resigned)*	XXXXXXXXXXXXXXXXXXXXXXXXXXX
A	Councillor Brenda Hindmarsh	APOLOGIES
S	Dr Malcolm Holliday	Y
2	Professor Pat Kendall-Taylor	Y
2	Mrs Naomi Kenny	Y
3	Mr Laurie MacDonald	Y
3	Mrs Ruth Moore	N
1	Mrs Elizabeth Ann Potts (*resigned*)	XXXXXXXXXXXXXXXXXXXXXXXXXXX
1	Professor Jean Potts	Y
A	Dr Mike Prentice	APOLOGIES
1	Mrs Ethel Randall	APOLOGIES
2	Mr Stanley Smith (*resigned*)	XXXXXXXXXXXXXXXXXXXXXXXXXXX
S	[Staff Governor vacancy]	XXXXXXXXXXXXXXXXXXXXXXXXXXX
A	Professor Royston Stephens	APOLOGIES
A	Ms Gina Tiller	Y
A	Mr Raymond Venus	APOLOGIES
1	Mrs Jacqueline Wrenn	N