

# THE NEWCASTLE UPON TYNE HOSPITALS NHS FOUNDATION TRUST

## MEMBERS COUNCIL

### Minutes of the meeting held on 17<sup>th</sup> January 2008 at Freeman Hospital, Newcastle upon Tyne

**Present:** Mr K W Smith (Chairman)  
Appointed Governors 3 (out of 11)  
Staff Governors 5 (out of 7)  
Public Governors (Constituency 1): 4 (out of 9)  
Public Governors (Constituency 2): 6 (out of 10)  
Public Governors (Constituency 3): 2 (out of 3)  
(Attendance record attached)

Miss S Campbell, Assistant Director – Planning & Performance  
(item 08/10 only)

Mr L R Fenwick, Chief Executive

Mrs M Hornett, Nursing & Patient Care Director

Mr S R Reed, Trust Secretary

Mr B Steven, Finance Director

Dr T J Walls, Medical Director

#### 08/01 Apologies for Absence

Apologies for absence had been received from Mr D Allison, Operations Director, Mrs L Bates, Lady Ann Calman, Dr T Goodship, Mrs M A Hargreave, Councillor B Hindmarsh, Mrs N Kenny, Mr M Pettifor, Business Director, Dr M Prentice, Mrs E Randall, Professor R Stephens, Ms G Tiller and Mrs J Wrenn.

#### 08/02 Minutes of the Meeting held on 15<sup>th</sup> November 2007

The minutes of the meeting held on 15<sup>th</sup> November 2007 were agreed to be a correct record, subject to amendment of minute ref. 07/84(i) fourth paragraph to read "... and whether this would compromise the delivery of functionality".

#### 08/03 Matters Arising

##### i) IM&T Strategic Partner

Mr Fenwick reported that the Department of Health (DoH) and the Strategic Health Authority (SHA) were both aware that the Trust was the first in England to part from the Connecting for Health national IT programme. DoH had in fact been helpful and supportive. The Trust was now working towards the final agreement with the University of Pittsburgh Medical Center (UPMC) with specialist lawyers and could meet all contracts. A Project Director had been appointed (Mr Pat Graham), who would commence in early February 2008. Mr Graham was currently working for a major consultancy on the implementation of a new computer system for the Metropolitan Police. He had a track record in major project management in this field and had previously worked in IT at the

Department of Defense. He had been appointed on a two-year, fixed term contract with performance-related remuneration.

It was noted that other Foundation Trusts were now enquiring about the Trust's approach to major IM&T investment. Monitor was also aware of the plans and understood that the Trust could not wait until 2012/13 for the national programme to provide the required systems. The new clinical performance meetings demanded by the national NHS contract from 2009/10 would require the outputs which the new UPMC systems would provide. In any case, Cerner, the software partner of UPMC, was a major supplier to Connecting for Health.

In Pittsburgh there was joined-up healthcare and this model would allow the Trust to provide better information for GPs. The early modules would include e-Prescribing (which no-one else currently had) and the Cerner version of the Patient Administration System was already proven. "Anglicisation" would be the key. It was agreed that progress reports would be a standing Agenda item for future Members Council meetings.

Mr Harvey asked how Governors would be made aware of the programme and Mr Fenwick replied that a briefing paper, setting out the programme, key targets and achievement would be provided. At a suitable point, Governors would also be invited to visit sites to see the systems in action.

ii) Our Vision for Shared Care – "Vertical Integration"

Mr Fenwick reported that Mr Pettifor, Business Director, had advised of engagement with Newcastle Primary Care Trust Provider Services, to address a number of areas for rapid improvement of service delivery. Little progress had been made to date by the SHA and it was noted that Mr Barker, strategic lead for the SHA in this arena, was to visit the Trust in February. North Tees and Hartlepool, Durham and Darlington, Northumbria Healthcare, and South Tyneside Trusts were all also pursuing vertical integration in different ways. Governors were reminded of the presentation on the subject received at the September 2007 meeting. Further development would require a strategic shift by the SHA. The Trust was seeking to do its best for patients in Newcastle.

Mr Harvey asked what Governors could do to support the Trust's efforts. Mr Fenwick said that hopefully Newcastle PCT would continue the constructive dialogue and debate the key questions. Governors had endorsed the policy and made a contribution to the strategy. Mr Pettifor had been well received by the PCT Provider Services team. There were likely to be some "quick wins" but also some debate about options. It would be interesting to see how contracts were set, especially in the light of Newcastle PCT's internal division between commissioning and provision of services. Mr Smith commented that it was in the interests of patients for vertical integration to be developed.

iii) Infection Control

Mrs Hornett presented an overview of the current situation with regard to Healthcare Acquired Infections. With regard to MRSA bacteraemia, there had been three cases in November 2007, all of them unavoidable, i.e. the patients arrived in the Trust already carrying the blood infection. In December

regrettably there had been five cases, clustered around Christmas week and of these cases two had been avoidable. There had been two cases to date in January 2008.

Given the increasing number of unavoidable cases, Mrs Hornett and Dr Walls had carried out a backdated review of all such cases in 2007/08. The patients had largely been tertiary referrals or significant trauma cases. There was still scope for improvements to care. All bacteraemias were now reviewed using the "headmaster's study" approach whereby the key clinical team were called in to see the Medical Director and Nursing and Patient Services Director to account for each case. This process now included PCT representatives where appropriate and would be reported separately in future.

Turning to *Clostridium difficile* (C. diff), it was noted that a local target had been set by the PCT for 2007/08 for patients over 65 years of age. There had been a slight rise in the rate of infections as the winter wore on.

With regard to the Department of Health MRSA Improvement Team visit of 13<sup>th</sup> November 2007, Mrs Hornett said that the draft of the formal report had been received on 18<sup>th</sup> December 2007, for comment by 31<sup>st</sup> January 2008. A meeting was to be held with the DoH team leader on 18<sup>th</sup> January.

Attention was drawn to the fact that the Healthcare Commission (HCC) would make an unannounced visit to the Trust at some time between 2<sup>nd</sup> January and 31<sup>st</sup> March 2008, specifically to examine compliance with the "Code of Hygiene" and its eleven duties, which were set out in detail in the briefing paper. Compliance with the Code also formed an element of the Annual Health Check Board declaration. The HCC visit would be an unaccompanied visit to wards and departments of their choice, for a rigorous inspection focused on Duties 2, 3 and 8, i.e.

- to have in place appropriate management systems for infection prevention and control
- to assess risks of acquiring Healthcare Acquired Infections and to take action to reduce or control such risks
- to provide adequate isolation facilities.

Preliminary feedback would be given at the end of the day and subsequently a formal report would be received, setting out any recommendations. In the worst case, an Improvement Notice could be served, as had happened at Barnet and Chase Farm Hospitals. Staff had been briefed in preparation for the visit and on the continuing need to maintain the relevant Infection Control measures and their impact on patient safety.

It was noted that the NHS Operating Framework for 2008/09 included Infection Control measures and revised targets for MRSA bacteraemias. It appeared that the Trust's target could revert to 47 from the present 37 cases per year. The first national target for C. diff had also been set, seeking a 30% reduction by 2011 and this was a significant challenge. The Framework proposed MRSA screening for all elective admissions by 2009 and it was noted that the Trust was already a long way towards achievement of this. No details were yet available of the proposed financial penalties for breaching these targets.

In terms of progress with the action plan, this was set out in detail in the briefing paper. The Governors' Infection Control interest group was to be convened soon. With regard to the SHA funding for infection control measures, the Trust had made a number of successful bids for additional staff and equipment, including wipe-clean PC keyboards for clinical areas. Movement detectors which triggered a recorded message about hand hygiene were to be installed at the entrances to wards and key departments. Floor inlays highlighting the location of alcohol gel dispensers were also to be fitted.

Mrs Hornett reported that the Department of Health Cleanliness Strategy had been published in the past week and it was noted that progress within the Trust was already in advance of the requirements, as follows:

- Screening of elective admissions – already underway
- Screening of emergency admissions – substantial progress made
- Annual infection control inspections – Department of Health already visited in November 2007, Healthcare Commission to inspect at any time before 31<sup>st</sup> March 2008
- “bare below the elbows” policy already approved and implemented
- Matrons already in post in every Directorate and given clear and unequivocal responsibility for infection control
- Deep clean of high-risk areas completed.

There were still significant challenges to address with regard to infection control and hence patient safety but it was pleasing to note progress. Mr Smith commented that 30% of adult patients admitted were colonised with MRSA. The real issue for government and for PCTs was in educating the public. It was noted that the SHA was launching a hand hygiene awareness campaign on 21<sup>st</sup> January 2008.

Mrs Haigh asked how many wards had access to a steam cleaner. Mrs Hornett replied that steam cleaners were not used but the Trust was moving from the traditional mop and bucket (with colour coded mops for different tasks and areas) to the introduction of a “microfibre” cleaning system, which was more effective at removing spores and bacteria. Mrs Hornett said that she would enquire of Hotel Services whether steam cleaning was a technique which might be appropriate in certain areas.

Mr Venus endorsed the approach to enhanced hand hygiene signage at ward and department entrances. Mrs Hornett said that the key was ensuring that staff cleaned their hands prior to any patient contact. Professor Potts asked about the outcome of the Sheffield visit, as the hospital there had a low MRSA rate. Mrs Hornett replied that this was planned and feedback would be given. It was pointed out that all beds in the Trust were now electronic and hence had to be cleaned by hand, as a “carwash” system would damage the electric motors.

Mr Harvey said that he had recently been a patient and had noticed a number of differences in the execution of the awareness campaign, which needed to be consistent. Mrs Hornett replied that the new national format posters were being issued this week, along with instructions as to their locations. The Trust was also in the process of changing to a new provider of the alcohol gel.

Mr Atkinson congratulated the Trust on the efforts to address infection and encouraged the management team to keep up the good work. Mrs Hornett said that there was more to do in terms of putting policy into practice and keeping a relentless attitude. Staff had been advised that it was now regarded as a disciplinary offence not to comply with hand hygiene requirements. Professor Kendall-Taylor commented on the need to address visitors and their behaviour. Mrs Hornett reminded Governors that a new Visitors policy had recently been implemented. A protocol for bed cleaning was being developed. Mr Smith commented that the size of the Infection Control team had been doubled and now included specialist nurses to advise on insertion and care of patients' indwelling lines. Infection Control remained the Number One priority of the Board.

#### **08/04 Election Timetable**

Mr Reed reported that the elections for eight Governorships across the three Public constituencies were now underway, with a total of 92 nominations received. There had been only one nomination for the Staff post (in the Admin, Clerical, Managerial and Chaplaincy constituency) and thus the nominee would be returned unopposed. Ballot papers had been issued on 16<sup>th</sup> January 2008 and the poll would close on 7<sup>th</sup> February, with results announced on 8<sup>th</sup> February. Attention was drawn to the three complaints received about late delivery of nomination papers to Electoral Reform Services Ltd but these all appeared to be the responsibility of Royal Mail.

It was noted that those elected would have a three-year term of office but some thought would need to be given to the possibility of bringing future election terms into alignment with the Trust's authorisation date, to ensure an orderly annual cycle of elections.

#### **08/05 Appointment of Non-Executive Directors**

Mr Reed reminded Governors that one of their statutory powers was to appoint the Non-Executive Directors of the Board. Indeed, this power had already been exercised in the course of both 2006 and 2007. In 2008, the terms of office of up to five of the current Non-Executive Directors were due to expire. Mr Reed set out proposals for addressing both the appointment of replacements and the issue of the continuing stability and functioning of the Board of Directors. The Nominations Committee would be reconvened, to devise a job description and person specification for the Non-Executive Director role. An advert would also be drawn up and published. Existing Non-Executives whose term was due to expire would be free to apply, in open competition with any other candidates. It was noted that there was a need to appoint a Non-Executive Director with substantial financial experience, to chair the Audit Committee and it was proposed that, if necessary, executive search could be used for this and indeed all of the posts.

Given the difficulties experienced in past recruitments in identifying sufficient candidates of calibre, it was also proposed that Members Council considered delegating to the Chairman of the Nominations Committee, in conjunction with the Trust Chairman and the Chief Executive, the power to extend the term of office of those existing Non-Executive Directors whose term was due to expire

in 2008, by up to six months from their expiry date. This would enable sufficient time for the process to be worked through in stages in the course of the year and also ensure that the Board did not undergo a sudden and simultaneous loss of a majority of its Non-Executive Directors and a substantial influx of new appointees. Any such proposed extensions of terms would of course be subject to the ratification of Members Council at an ordinary meeting.

Mr MacDonald, Chairman of the Nominations Committee, said that he was ready to convene the committee, which comprised of Public Governors and Executive Directors. Professor Kendall-Taylor commented that two of the Non-Executive Directors had already had their terms of office extended by 12 months by Members Council and at the time it had not been thought appropriate to extend them again. Mr Smith said that the Trust needed to test the market via the advert and start the process off. The length of time required to complete the appointment process would need to be considered in planning for any future round of appointments.

The proposal to delegate to the Chairman of the Nominations Committee, in conjunction with the Trust Chairman and the Chief Executive, the power to extend the term of office of those existing Non-Executive Directors whose term was due to expire in 2008, by up to six months from their expiry date and subject to the ratification of Members Council at an ordinary meeting, was carried nem con.

#### **08/06 Future Development of Members Council**

Mr Smith gave an update on the work of the Members Council Development Group. The Governors' awayday in November 2007 had been successful and beneficial and the second awayday on 30<sup>th</sup> January 2008 would seek to move the development of roles and responsibilities forward. Mr Smith proposed that the Board of Directors should have an awayday in February, at which the outputs from the Governors' awaydays would be considered.

The programme for the second awayday would be finalised by the Development Group on 25<sup>th</sup> January and circulated in advance of the meeting.

#### **08/07 Audit Commission Governors' Workshop, 9<sup>th</sup> November 2007**

Mrs Eddy gave feedback on the workshop, which had been primarily aimed at aspirant Foundation Trusts. There had been a great deal of positive comment from Newcastle Governors and it did appear that the Trust was "ahead of the game" in the region. A Non-Executive Director of a Foundation Trust elsewhere in the North East had thought that Governors were not there to offer their opinions, which was clearly not the case in Newcastle. The report was received and accepted.

Mr Fenwick commented that he was an Appointed Governor of a neighbouring Foundation Trust, which tended to be parochial in outlook and also did not provide information to its Governors such as that provided in Newcastle, such as the Monitor quarterly reports, the financial and patient care performance of the Trust, or operational troubleshooting matters. It was noted that the Deloitte

report on MRSA governance had not acknowledged the role of Governors in relation to Infection Control, in terms of challenge and awareness.

## **08/08 Governors' Visits**

### **i) Northern Centre for Cancer Treatment (NCCT)**

Mrs Abrahams had attended the visit on 22<sup>nd</sup> November 2007 and was pleased to report that compliance with hand hygiene had been substantial and conspicuous. The patient environment was pleasant and patients tended to socialise. Staff were looking forward to the move to the new Northern Centre for Cancer Care and felt well informed about the commissioning and the move. NCCT was very well equipped and the Radiotherapy service included a Primatom linear accelerator, which had a CT scanner built in to it to allow for very accurate treatment. It was noted that at present there were only two other such machines in the country, both at the Cromwell Hospital, London. Mr MacDonald commented on the great efforts of the volunteers in providing information and support to patients and their relatives. The briefing was received and agreed.

## **08/09 Governors' Questions and Items for the Next Agenda**

### **i) Organ Donation**

In the light of recent national media interest in a proposed "opt out" donor register, Mr MacDonald asked what arrangements were in place for organ donor registration. Mrs Hornett replied that information was available throughout the Trust and that there was a number of transplant co-ordinators for all appropriate organs, who provided counselling and support to the relatives of patients. Mr Fenwick said that UK Transplant managed the distribution of available organs to the recipients most likely to benefit. The Trust was responsible for a distinct catchment area for organ retrieval and had strong, informal contacts with a large number of hospitals, including across the whole of Ireland and Scotland as well as the North of England.

Dr Walls commented that numerically Newcastle General Hospital was one of the largest sources of donated organs in the country, due to the presence of the Regional Neurosciences Centre as well as A&E. The Trust also had a local corneal grafting programme but there were some difficulties in obtaining donated corneas, even though there had been a switch to a more proactive approach to seeking permission from relatives. Mr Brown endorsed the view that the co-ordinators were unsung heroes. Mr Brain wondered if it would be appropriate to make a clear and public statement in support of the "opt out" proposal. Mrs Abrahams thought that the public would need more information and education first and that there could be a whole raft of legitimate objections to the proposal. It was agreed to bring a briefing to a later meeting of Members Council and for the Transplant Team to be included in the Governors' visiting programme.

ii) Equality & Diversity

Professor Potts asked that a briefing be brought to a later meeting setting out the policy on Equality and Diversity, including the Healthcare Commission targets and how these were monitored.

iii) Funding of the TNH Project

Mr Atkinson asked for a briefing on the longer-term funding of the Transforming Newcastle Hospitals project and it was noted that this could be covered in the Executive Report later on the Agenda.

iv) Public Relations

Mr Harvey suggested that the Trust consider an active PR programme, in order to harness public perceptions of clinical services.

**08/10 Business Plan, 2008/09 - Update**

Miss Campbell presented an update on the annual planning cycle and the development of the business plan for 2008/09 and an outline for the subsequent two years. The plan had to be submitted to Monitor by the end of May 2008. The NHS Operating Framework had now been published, setting out key priorities for the year ahead. Detailed strategic analysis had been undertaken since autumn 2007, including assessment of the external environment and consequently key risks had been identified. These included Patient's Choice, security of income and maintaining efficiency in order to meet the costs of TNH. Directorates had been advised of the analysis and risks as the context for their service plans.

It was proposed to establish a sub-committee of Members Council to meet in February to address priorities, risks and the issues arising from the awaydays. The commissioning process with Primary Care Organisations was to conclude by 28<sup>th</sup> February. The risk analysis would also need to feed in any issues around Mandatory Services (as defined in the Terms of Authorisation of the Trust) and also a number of Board self-certifications. While the output was not a truly commercial business plan, due to the need to comply with Monitor guidance, nevertheless the plan would set the tone and direction for the next three years. Mr Fenwick commented that a "real" business plan would be challenging to commissioners in particular, given the lack of maturity in the commissioning process. For example, the new Children's Hospital would open in two years time but other Trusts were actively recruiting senior Paediatric staff. Occupational Health Service developments did not fit the Monitor framework but would undoubtedly be part of the Trust's business. The briefing was received and agreed.

A briefing paper on progress with the Annual Health Check for 2007/08 was tabled, for information and this was received and noted.

## 08/11 Executive Report: Current Issues

Mr Fenwick reported on a number of areas of current interest. With regard to the Monitor Quarter 2 overview, the executive summary for the Trust was received and it was noted that the “amber” governance rating arose from the continuing challenge of the MRSA bacteraemia target. Monitor had required the Trust to procure an independent review of the self-certification process in this respect. At the start of the year, the Board had taken a view of the trajectory and did not wish to certify failure from the outset. Rather, the challenge had been to sustain efforts to remain within trajectory. However, it had become obvious by Quarter 2 that the target would be breached. The Sunderland, Gateshead and Northumbria Healthcare Foundation Trusts had all also been required to commission independent reviews.

Deloitte had been appointed in open competition to conduct the review and the key findings of the report were set out in the briefing, including the scope for further improvement in the governance arrangements. Mr Smith commented that the report described the extent of the work and focus, as well as significant challenge by the Non-Executive Directors, who had considered the trend and signed up at the start of the year, in order to keep up the pressure for improvement in MRSA management. The real nub of the report lay in the development of closer links between the annual plan, the quarterly returns to Monitor and the monthly Board reports and the Board was happy to pursue this. As a Foundation Trust, the Board was trying not to be risk-averse. Mr Fenwick said that the logical progression would be not to take MRSA-positive patients from elsewhere but of course that would fly in the face of the essential purpose of the Trust, to treat patients. There was a lack of maturity in the target-setting. Mrs Hornett pointed out that the Trust was already engaged in working across the wider community to address MRSA but with a catchment of up to three million this was a significant challenge.

Turning to Finance and the trading position, Mr Steven reminded Governors that, prior to licensing as a Foundation Trust, Monitor had had real concerns about how the costs of TNH were to be met. The context for the financial planning included the 18 Weeks RTT target, the government’s Comprehensive Spending Review, the development of the Children’s Hospital, and changing referral patterns. Consequently the annual plan (which actually covered three years) reflected these issues and 2007/08 had been a key year in generating a “buffer” of income, given increasing costs and an anticipated levelling off of activity from 2008/09 onwards. The Trust had been successful in its forecasting for 2007/08 and the forecast for 2008/09 would be developed over the next two to four weeks and presented to the February meeting of the Board for an early view of the next three years.

The cash position was such that Monitor was suggesting that Foundation Trusts should make greater use of such surpluses to reinvest in healthcare provision. In Newcastle’s case, a very substantial investment was to be made in IM&T with UPMC, to the value of £15 million over two years for a state of the art Electronic Patient Record. Income & Expenditure was slightly ahead of plan at a surplus of £17.8 million at 31<sup>st</sup> December 2007. Capital expenditure was beginning to catch up with required trajectory, as expected and would include £6.2 million for new linear accelerators in coming months.

Key financial risks included delivery of Service Level Agreement activity towards the 18 Weeks Referral to Treatment target and thus waiting list initiative costs; the use of the investment fund; management of emerging cost pressures; forecasting the costs of NICE-approved drugs; and recruitment to vacant posts (which had been used as an element of the savings plan).

Mr Atkinson expressed a concern as to how the Trust would address the medium and long-term costs of TNH in coming years. Mr Smith replied that the plan was for a rolling three-year period and the TNH capital programme was phased and hence the unitary payment went up in steps to 2012/13. Mr Steven added that staff were well briefed on the 2009/10 “pinchpoint” when more than 80% of the unitary payment fell due. A ten-year plan had been submitted to Monitor originally and had also been assessed by PricewaterhouseCoopers. The subsequent three-year plan had also been scrutinised intensely and had passed muster. It was well understood that the variables would change, given the volatility of the NHS environment. Mr Harvey asked whether there would be corresponding income from the capital investment. Mr Fenwick said that this would arise either through commissioning intentions or competition.

Mrs Hornett addressed patient care performance, where achievement of the 18 Weeks target, MRSA and C. difficile were all risk areas. Mrs Abrahams enquired whether the Trust was reimbursed for patients who did not attend for scheduled operations. The Trust did not and in fact the new NHS contract could make matters worse. Mr Brain commented that the volume of falls appeared substantial. Mrs Hornett recognised that this was an issue for all healthcare providers and plans were being rolled out for falls assessment and prevention.

With regard to MPET funding, Governors were alerted to the threat to the SIFT element of the funding bundle. SIFT had traditionally been granted to support the additional infrastructure required for medical education but the SHA now appeared to regard it as fair game for “wealth redistribution” across the region and this could potentially exacerbate the impact of the TNH costs. The Trust was working with other designated teaching hospitals to set out the case for retention. The North East was the first area of England facing possible attrition in this manner.

Healthcare Acquired Infection had been addressed extensively under 08/03(iii) above. With regard to the Sanderson Hospital site, planning permission had now been granted but the reduced density of the development had reduced the capital receipt by some £640,000 in consequence and would not now be received until 2008/09. For the Newcastle General Hospital site, there had been positive press reaction to the planning applications, which had been detailed for the Tesco development and in outline for the rest of the site, on a tripartite basis with the University of Newcastle upon Tyne and Tesco. Two thirds of the site would remain in NHS hands for mixed economy development. The plans had been lodged on 18<sup>th</sup> December 2007 but Newcastle City Council had not yet registered them for consideration. There was support from the Regional Development Agency but it was not clear where the Government Office for the North East stood. The redevelopment opportunity for healthcare included reprovision of the Minor Injuries Unit and a location for the Occupational Health Service, self-funded from the site sale receipt and of

greater square footage in total than the Tesco development and without any land needing to be bought. Tesco were keen to see the provision of some health services within their store and this could include, for example, Audiology testing. Tesco also wished to work with the University in developing the activities of the Ageing and Vitality campus.

In relation to information governance, there had been national publicity in recent months regarding data losses by government departments and the NHS Chief Executive had written out to all Trusts to seek assurances. Dr Walls reported that all data transfer procedures had been reviewed and tightened up where necessary. The Trust did send images to other hospitals for use in outreach clinics and other follow-up and this was now done via a secure and recorded means of delivery and was in any case moving towards a fully electronic method of transmission.

Mrs Hornett reported that the investigation of staff involved in the distribution of offensive material was now in its final phase and a number of staff had been suspended and were being moved towards disciplinary action.

The key impact documents from government and Monitor were noted and attention was drawn to the Trust's very positive outcomes in the latter report.

Mr Fenwick highlighted that the "CNST" rating of services affected the insurance premiums payable by the Trust and Maternity services had been inspected on 12<sup>th</sup> and 13<sup>th</sup> January. Informal feedback suggested that a Level 3 rating would be retained, which was rarely achieved.

With regard to healthcare services for people with Learning Difficulties, Mr Fenwick reported that he was the Acute sector Chief Executive on an independent Inquiry at present and greater problems had been identified in community settings than those in hospitals. The Trust would need to take stock in light of the eventual Inquiry report and this could perhaps be a focus for sub-committee of Governors, as part of the wider Equality and Diversity agenda.

The NHS Operating Framework for 2008/09 appeared to indicate that Primary Care Organisations would receive an uplift of 5.5%.

The Tooke report on medical education, "Aspiring to Excellence" had attracted widespread support for its recommendations across the medical profession. A new recommendation was the establishment of NHS: Medical Education England (NHS:MEE), which would be significant in relation to MPET. It was proposed that NHS:MEE would administer MPET centrally and the Trust would support this approach, although there was not unanimous support amongst PCTs and SHAs. Members Council resolved to support this recommendation.

## **08/12 Monitor NHS Foundation Trusts Review of Six Months to 30<sup>th</sup> September 2007**

The executive summary of the Trust's half-year position and the sector analysis of all Foundation Trusts were both received and noted. The key issues had been highlighted under item 08/11 above.

**08/13 Date and Time of Next Meeting**

The next meeting would be held at 2.00pm on Thursday 20<sup>th</sup> March 2008.

## MEMBERS COUNCIL

### GOVERNORS ATTENDANCE, 17<sup>th</sup> JANUARY 2008

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