COUNCIL OF GOVERNORS

Minutes of the Meeting of the
University Hospitals Birmingham NHS Foundation Trust
Council of Governors held on 14 February 2017

Lecture Theatre 2, Education Centre, QEHB

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Present: Rt Hon Jacqui Smith (Chair)
Mrs Bernadette Aucott
Mr Paul Burgess
Dr John Cadle
Mrs Edith Davies
Dr John Delamere
Mr Alex Evans
Mrs Aprella Fitch
Ms Margaret Garbett
Mrs Alka Handa
Mrs Sandra Haynes MBE
Mrs Bridget Mitchell
Mr Patrick Moore
Ms Yvonne Murphy
Cllr Valerie Seabright
Mrs Linda Stuart

In attendance: Dame Julie Moore (Chief Executive Officer)
Mr David Burbridge (Director of Corporate Affairs & Foundation Secretary)
Mr Tim Jones (Executive Director of Delivery)
Mr Andrew McKirgan (Director of Partnerships)
Mr Philip Norman (Chief Nurse)
Mr Mike Sexton (Chief Financial Officer)
Ms Cherry West (Executive Chief Operating Officer)
Mrs Imogen Acton (Head of Quality Development)
Ms Samantha Baker (Quality Development Support Manager)
Miss Sarah Snowden (Corporate Affairs & Governor Liaison Manager)

G16/122 Welcome and Apologies for Absence

The Chair welcomed everyone to the meeting.

Apologies for absence were received from Mr Paul Darby, Surgeon Vice Admiral Alasdair Walker, Air Vice Marshal Richard Broadbridge, Dr Tom Gallacher, Dr Elizabeth Hensel, Rabbi Dr Margaret Jacobi, Mrs Stephanie Owen and Dr Iestyn Williams.

Apologies were also received from Ms Fiona Alexander (Director of Communications), Mr Kevin Bolger (Director of Strategic Operations) Ms Catriona McMahon (Non-Executive Director) and Dr David Rosser (Executive Medical Director).

G16/123 **Quorum**

The Chair noted that a quorum was present and, accordingly, the meeting could proceed to business.

G16/124 **Minutes of the Meeting of the Council of Governors of 17 November 2016**

It was agreed that the minutes of the meeting held on 17 September 2016 were an accurate and true record.

G16/125 **Matters Arising from the Minutes**

There were no other matters arising from the Minutes.

G16/126 **Chair's Report**

The Chair asked the CEO to report on the recent decision made to cancel non-urgent operations at the Trust. The CEO explained that there had been a large increase in the numbers of patients attending the Emergency Department and this, combined with the problems of delayed transfers of care had led to this action having to be taken. The Trust has had little or no support from the Social Services in Birmingham or Solihull with the CCG only having offered to fund 4 additional beds.

On a separate matter, the Chair thanked the Communications Team for organising such an excellent Best in Care Awards evening. She encouraged everyone to nominate individuals they felt to have gone well beyond expectation in their roles, in as many areas as possible, as even if they didn't win the award, a nomination can mean a great deal.

G16/127 **Quarter 3 2016/17 Quality Account Report Update**

The Council of Governors considered the report presented by the Quality Development Support Manager on behalf of the Executive Medical Director.

The paper was taken as read. The majority of the Quality Improvement Priorities are in line to meet targets set for the end of the financial year. Three new questions have been added to the

Patient Experience Surveys for 2016/17. More work needs to be done on missed doses of antibiotics and non-antibiotics, and timely analgesia is currently running at 75% with a target of 85%. MRSA cases are at zero for the quarter.

One of the Governors raised a question on stroke mortality following recent coverage in the media regarding thrombectomy procedures being available 24/7 and saving many lives - could this be implemented at this Trust? The COO responded by saying that we are the only Trust in the area able to do this and it was an area being investigated. However it would require input from the Social Services from the Worcester and Sandwell areas in addition to our own as we would be receiving patients from Worcester and Sandwell and would need to ensure repatriation.

Resolved: To accept the report.

G16/128   Quality Account Priorities for 2017/18

The Council of Governors considered the report presented by the Head of Quality Development on behalf of the Executive Medical Director.

It is proposed that four of the current priorities be kept with additional questions and improved targets. The missed doses priority will remain as is, as this has not been met during 2016/17. Infection Prevention and Control will be removed as it is included elsewhere in the Quality Account; it is proposed to replace this with Reduction in Falls resulting in Harm or Severe Harm. It is also proposed to include the Timely Identification and Treatment of Sepsis in part 3.

The External Audit Assurance carried out by Deloitte covering 18 week referral to treatment time and A&E 4 hour waits will be completed in March. It was proposed that the Council of Governors choose another local indicator not audited previously for 2017/18 and in order to obtain "maximum value" and Falls with Harm was suggested as one that would affect patients over all specialities and relates to patient safety, experience and length of stay. Approximately seven patients a day across the organisation fall, with one on average resulting in harm. It was agreed that this would be a good new Local Indicator to audit and the Head of Quality Development will ask Deloitte to begin work on this.

Resolved:
To APPROVE the report with the changed and new Priorities for 2017/18;and

To APPROVE the proposed local indicator to be audited.

G16/129 **Patient Care Quality – Quarterly Report to include Infection Control Update**

The Council of Governors considered the report presented by the Chief Nurse. The paper provides an exception report regarding infection prevention and control performance. As requested at the last Council of Governors meeting, the paper also provides a summary of the observations of care project.

Infection Prevention and Control Performance

Clostridium Difficile Infection (CDI): The annual objective for CDI for 2016/17 is 63 cases or 17.6 per 100,000 bed days (currently around 70 cases).

Performance for Quarter 3 2016/17 was 24 Trust apportioned cases (beyond day 0+2), all of which were reportable to Public Health England (PHE) in accordance with Department of Health guidance.

In total, year to date, we have had 71 Trust apportioned CDI cases. This is above trajectory, 27 (38%) of these cases were considered avoidable.

A CDI improvement plan is in place with a specific focus on:
- Antimicrobial prescribing, choice and duration of use
- Timely isolation of patients with diarrhea and/or vomiting
- Improved timeliness of stool specimen collection
- Continuation of the deep cleaning of selected wards to reduce the bioburden of clostridium difficile
- Improved access to expert review of patients with clostridium difficile infection.

Meticillin Resistant Staphylococcus Aureus (MRSA): The annual objective for MRSA bacteraemia is 0 avoidable cases.

There were no Trust apportioned cases in Quarter 3. In total, year to date and as previously reported, we have had 3 Trust apportioned MRSA bacteraemias (April x1, July x1 and September x1).

Actions to further improve MRSA performance continue with a specific focus on:
- Hand Hygiene
- Correct use of Personal Protective Equipment (PPE)
- MRSA Screening
- Decolonisation
- Learning

Outbreaks of Diarrhoea and Vomiting: There were 2 outbreaks of diarrhoea and vomiting in Quarter 3 (confirmed norovirus). During November this resulted in the closure of West Ward 1 and during December this resulted in the closure of a bed bay on Edgbaston Ward (both older adult wards).

Observations of Care project

The aims of the Observations of Care Project are:

- To assess current standards of communication and compassionate care within inpatient clinical areas

- To identify, share and celebrate compassionate care being delivered

- To develop action plans for each clinical area or Trust-wide, dependant on results of the observations.

An audit tool was developed in order to capture communication and interactions (compassionate care) between our staff and patients across the Trust.

Immediate feedback is provided to individuals observed, whether this is praise for enriching interactions or guidance on how an interaction might have been improved. Ward senior sisters/charge nurses are also provided with immediate feedback. In addition a written feedback report and action plan is shared with the ward/department senior sister/charge nurse and relevant Matron.

This paper outlines the results for Quarter 3. A total of 13 clinical areas were visited and 795 interactions were observed. Chart 1 demonstrates the number of all observed interactions across all 13 areas.

Examples of interactions observed are also listed in the paper.

Details of the score categories are provided in Appendix 1 of the paper.

The results by clinical area, demonstrating the percentage of each type of interaction observed in both 2016 and the previous year are illustrated in Appendix 2 of the paper.

Summary:
- 65% of the interactions observed across all 13 areas were considered to be Enriching and 33.5% as Neutral.

  Neutral interactions are considered acceptable in many

*circumstances and to some
extent are expected during busy periods of a shift. However, consistently Neutral
interactions should be considered with caution due to the potential accumulative effect on patient experience.*

- Negative interactions were observed in 1.5% of the total number of interactions.

- Critical Care Area A and Wards 305, 409, 515, 624, 625 and 728 have demonstrated clear improvements in the types of interactions observed. In 2016 all 7 areas have seen a move away from Neutral interactions and an increase in Enriching and Positively Enriching interactions, when compared with the observations undertaken in 2015.

- Following the observations undertaken in the first 6 months of 2016, where clinical areas had been visited for a second time, the results for 2015 and 2016 have been compared and statistically analysed. This confirmed that there has been a statistically significant improvement from Neutral to Enriching interactions overall and will be detailed in the end of year report.

- The aim is to demonstrate that by continuing to raise awareness and encourage reflection on how we interact with others, whilst tackling the small number of negative observations at the time, we can further improve upon the quality and meaningfulness of interactions.

- The use of this tool continues to receive positive feedback from patients, relatives, staff and Governors.

Next steps:
- Continue to monitor and review for next quarter, specifically in view of discussing results with clinical leads

- Following a 12 month period of observations, a Trust wide view of the overall results will be published and actions developed

- Continue to provide 3 monthly reports to the Care Quality Group

- Seek to publish the project in a professional journal

Resolved: To accept the report.

G16/130   Performance Indicators Report

The Council of Governors considered the report presented by the Executive Director of Delivery.

The Trust has been monitored by a new Single Oversight Framework (SOF) since October 2016. Providers are segmented from 1 to 4 with 1 being the best performing and 4 the worst. UHB has been rated as 2 – only 5 other acute trusts have been rated as 1.

Of the 5 operational indicators, 3 were on target, 1 cancer target was not met and the A&E 4 hour wait target was not met – for the reasons described in the Chair's report.

The Trust receives funding from the NHSI Sustainability and Transformation Fund mainly based on various targets being met, including our Financial Performance. The failure to meet the Cancer Target indicator is seen as being out of the Trust's control – patients actively chose to delay their treatment due to the Christmas holidays and therefore their choices show as breaches by the Trust. There is confidence that this appeal will be looked on favourably by the NHSI.

With regard to A&E 4 hour waits; a large number of improvement work-streams have been implemented; however the success of these initiatives in a lot of areas will be marginal due to the high number of delayed transfers of care.

Some questions from the Governors included:
What is the Salary Sacrifice Scheme? This is where the Trust takes money out of the staff member's pay before tax to cover such items as the cycle scheme, child care vouchers etc.

Nursing applications are down year on year on a national basis – will this affect the Trust? No, we don't expect to see any issues around this for the next two years at least, as applications remain high in Birmingham.

Concern about nurse staffing levels at night – figures look like the numbers are falling? This is due to the fact that some areas work better with different ratios, so where normally 4 registered nurses work with 2 health care assistants, on some wards this works better with 3 registered nurses to 4 health care assistants thereby having an extra body on that ward. This is typical of Division C.

What is the number of average days lost due to long term sickness? Having 4% sickness levels, the Trust is in a better position than most

other areas in the NHS, but this is poor when measured against the private sector (1.9%). More problems have been seen with staff in lower grades – especially with musculoskeletal issues, although free and easy access is provided to Physiotherapy Services, this is rarely taken up until the staff member has triggered on the attendance system. The matter is not causing major staffing problems as there is an oversupply of Health Care Assistants in this area. Approximately 800 – 1000 members of staff are on active sickness monitoring at any one time.

There was discussion regardingconcerns raised by patients regarding the Trust's Outpatient appointments system. This is a matter that the COO has been working on with the Operational Delivery Group. Problems have been caused by an increase in referrals – especially in areas of high demand such as Neurosurgery and Dermatology, where some appointment waits have moved out from the normal 6 weeks to 12. There is a mismatch between the volume of patients referred and the capacity we have. Work is being done to reduce DNAs, reduce the number of face to face follow ups and also what alternatives might be available in certain areas – sometimes a nurse could take the appointment rather than a consultant.

Resolved: to accept this report.

G16/131   **Finance and Activity Report – Quarterly Update**

The Council of Governors considered the report presented by the Chief Financial Officer. At the end of Q3, the Trust is £250k ahead of plan. The underlying position remains constant with nothing new emerging in the last quarter that causes concern.

The Trust is in a very strong cash position with more than £60m in the bank – this is unusual within the NHS. However our financial rating is low (3 out of 4, with the best being 1) due to the technical issues associated with the PFI. This causes little concern as the rating holds very little reputational consequence or impact.

Questions from Governors included a concern about the £3m bad debt provision shown on page 76 of the report. The CFO explained that new arrangements were being put in place to help the Trust cope with overseas visitors without the means to pay. Any patient who isn't entitled to treatment must now be billed at the start (although this does not affect A&E patients), then if they don't pay we are entitled to recover some of the cost of the treatment from the CCG.

Resolved: to accept this report.

G16/132   **Annual Cycle of Business**

The Director of Corporate Affairs explained that no revisions had been made to the Annual Cycle and reminded that the Governors had three defined opportunities per year to meet with the NEDS.

Resolved: to approve the Annual Cycle of Business for 2017/18

G16/133   **Governors' Feedback**
No feedback received

G16/134   **Any other business**
No other business was raised.

G16/135   **Date of Next Meeting**
Tuesday 9 May 2017
6.00 p.m. – 8.00 p.m.
(5.30 p.m. – 6.00 p.m. Pre-Meeting)
Lecture Theatre 2, Education Centre, QEHB

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Chair   **Date**