THE NEWCASTLE UPON TYNE HOSPITALS NHS FOUNDATION TRUST

Minutes of the Board of Directors Meeting held on 22nd May 2013

Part A: Public Session

Present:
Mr K W Smith  Chairman
Professor P H Baylis  Non-Executive Director
Dr B C Dobson  Non-Executive Director
Sir Leonard Fenwick  Chief Executive
Ms S Kler  Non-Executive Director
Mrs H Lamont  Nursing & Patient Services Director
Mrs H A Parker  Non-Executive Director
Mr D Reynolds  Deputy Finance Director
Mrs L Robson  Business & Development Director
Mr D Stout  Non-Executive Director
Mr A Welch  Medical Director

In Attendance:
Mr S R Reed  Trust Secretary
Mrs A O’Brien  Director – Quality & Effectiveness (minute ref. 13/49(ii) only)
Dr A Price  Director of Infection Prevention & Control (minute ref. 13/49(i) only)

13/45 Apologies for Absence

Apologies were received from Professor C P Day, Non-Executive Director, Mrs A Dragone, Finance Director, and Mr E Weir, Non-Executive Director.

13/46 Declarations of Interest

There were no declarations of interest on this occasion.

13/47 Minutes of the Meeting held on 25th April 2013

These were agreed to be a correct record.

13/48 Strategic Items

i) Report of the Chief Executive

Sir Leonard spoke of the current issues being addressed by the Executive Team, including fostering relations with Clinical Commissioning Groups. Newcastle was somewhat challenging, while Gateshead was more positive. The NHS England Area Teams were thought to constrain the CCGs. Directors were undertaking further development of the competitive strategy and would share this with Monitor on 23rd May 2013. Examination of the scope for acquisition of Regent Point and the subsequent demolition of Cheviot Court was proceeding, although VAT on the purchase was proving to be a sticking point. Mrs Parker noted that the vendors were keen on a quick sale. Foundation Trusts could not easily recover VAT and neither could their wholly owned subsidiaries either but a Special Purpose Vehicle
could. The actual sum would be equivalent to the Stamp Duty land tax, of £600,000. Dr Dobson asked about the cost per square foot, which was under £25. Ancillary works would however be required, including highways and fit-out and these could be in the order of £750,000. The building was not well suited to multiple occupation. Mr Stout commented that the District Valuer’s valuation would provide some assurance of value for money, at £4.8 million in total. It was noted that there were some warranty issues on the building. The challenge of pressure on office accommodation at Freeman Hospital, including clinical, would continue and the Investment Committee would need a brief.

With regard to redevelopment of the Royal Victoria Infirmary, it was noted that Newcastle City Council councillors had visited the proposed site of the new multi-storey car park. The NCC planners favoured the building appearance but were not persuaded of the need for the volume of car parking. The planning decision had been postponed to June 2013, i.e. some nine months since negotiations had opened. Further dialogue was underway with the Council with regard to Queen Victoria Road and Richardson Road in terms of future clinical service expansion and jointly with Newcastle University.

It was noted that 2013/14 contracts had now been signed and Directors offered their congratulations to the business team. Attention would be paid to quality assurance initiatives in order to avoid fines by commissioners.

Sir Leonard commented that, in relation to further development of eRecord, the Trust was still to appoint a clinical lead from the Medical Director’s team. From 1st July, five Associate Medical Directors had been appointed: Dr M Wright, for governance & medical revalidation; Dr N Thompson for Community Services; Professor G Ford for Research & Development; Dr J McLelland for the Royal Victoria Infirmary; and Mr N Soomro for Freeman Hospital. Appointments to the next tier were now out for Expressions of Interest, including for the Clinical Director for Clinical Informatics, Training & Education Clinical Director, and two posts for Quality and Standards, one for each site.

Key impact documents received from government and regulators included the following.

i)  **Compassion in Practice (NHS England)**

Implementation Plans which promised to transform care throughout England in all settings each and every day and for everyone, had now been published. The Plans covered six areas of action to achieve key values and behaviours relating to Care; Compassion; Competence; Communication; Courage and Commitment. During the next three years, there was a commitment to review and refresh the Plans on a quarterly basis, update the timescales and report on what had been achieved.

ii) **Clinical Commissioning Groups (CCG) Prospectuses (NHS England)**

NHS England had written to CCGs with advice on ‘how they might want to approach producing a CCG prospectus for their local population and that CCG clinical leaders will wish to ensure their local prospectus is published by 31st May 2013’.
iii) **Clinicians and patients to begin Review Visits at mortality outlier hospitals (NHS England)**

Teams of doctors, nurses and patient representatives were set to make their first visits to hospitals as part of the Keogh Review of the 14 NHS Trusts whose mortality ratios had shown higher-than-expected rates for the past two years. The review, led by Professor Sir Bruce Keogh, Medical Director of NHS England, sought to ascertain whether or not there were any sustained failings in the quality of care and treatment being provided to patients at these Trusts.

iv) **Review of Children’s Congenital Cardiac Surgery Service at Leeds (NHS England)**

NHS England had released the Review of Children’s Congenital Cardiac Surgery Service at Leeds Teaching Hospitals NHS Trust report. This report had looked at systems within the unit and came to the conclusion that ‘there were no immediate issues preventing a resumption of surgery’. The Review had been put in place further to safety concerns raised at the end of March 2013.

v) **Healthcare Professional Alert Notices (NHS England)**

An Alert Notice was the way that an NHS employer could make other bodies aware that a healthcare professional might pose a threat to patients or staff. A letter had been sent to all NHS Trusts and Foundation Trusts by Professor Sir Bruce Keogh, Medical Director of NHS England setting out the interim arrangements for issuing Alert Notices via the NHS Litigation Authority which operated the Alert Notice system.

vi) **Public perception of hospitals (IpsosMORI 23rd April 2013)**

A majority of the public believed some hospitals had a “tolerance of poor standards”, according to respondents to a national survey from polling firm IpsosMORI. The survey of public attitudes towards the NHS following publication of the Francis Inquiry report had revealed a public perception of a “listening deficit” in the NHS. Seventy-eight per cent of respondents to the survey believed the “tolerance of poor standards” seen in the case of the Mid Staffordshire NHS Foundation Trust scandal was likely to be replicated in other NHS hospitals.

vii) **Emergency Admissions to Hospitals: managing the demand (National Audit Office)**

The NAO had announced that it was working on the above publication, which was set to be issued in Autumn 2013. This study would examine the causes behind the steep rise in the number of emergency admissions over the last decade or so. It would also examine the impact that national interventions, such as payment policies and targets, had had on emergency admissions and readmissions and what could be done to reduce the number of such admissions and readmissions.

viii) **Inpatient Survey (Care Quality Commission 2012)**

It was to be noted that Newcastle was the best placed provider in the North East and Cumbria.
Monitor had joined a range of national partner organisations to ‘support local areas to tackle national barriers to integrated care and allow locally integrated services to flourish’.

This co-produced framework document set out a direction of travel to help integrated care become the norm.

Together the national partners were asking ‘Local areas’ to express an interest in becoming ‘pioneers’ to act as exemplars, demonstrating the use of ‘ambitious’ and ‘innovative’ approaches to effective and efficient delivery of integrated care. Such ‘pioneers’ were said to be those who could work across ‘the whole of their local health, public health and care and support systems, and alongside other Local Authority departments as necessary, to achieve and demonstrate the scale of change that is required’.

NHS England was set to target ‘shockingly low’ diagnosis rates of Dementia in England in a move that could see tens of thousands of people additionally identified and treated each year. The Secretary of State for Health had recently announced the drive to completely overhaul Dementia diagnosis as the Prime Minister’s Challenge on Dementia reached its first year since inception.

Monitor and NHS England were working to reform the way NHS services were paid for. They aimed to develop and design a new payment system which would deliver the best possible care for patients. For nearly a decade hospitals had been paid through the Payment by Results system. Both bodies were now inviting views as to how the NHS payment system could be reformed to ‘do more for patients’.

This Guide had been published on 10th May 2013. It built on previous guidance, bringing together in one place a ‘concise explanation’ of how existing and new NHS organisations were working closely together to deliver improved care for patients. The roles and responsibilities of each partner in the healthcare system were outlined in a way that was considered to be a ‘useful companion piece’ to the NHS Constitution.

NHS Improving Quality had published a strategic intent document, which outlined the aims and values of the organisation. Set up on 1st April 2013, NHS Improving Quality worked to improve health outcomes across England by providing improvement and change expertise. The publication detailed how the organisation would deliver ten key improvement programmes based around the priority areas
set out in the NHS Outcomes Framework 2013/14, as well as four programmes to develop ‘capability and capacity’ within the healthcare system.

xiv) ‘OK to Ask’ about Clinical Research (National Institute for Health Research)

A national campaign was set to be launched on 20th May 2013. CCG clinical leaders in particular were advised to prepare for the Clinical Trials Day on 20th May 2013 and consider how best to channel patient interest in research in their local area.

ii) ‘Safe & Sustainable’ – Paediatric Cardiac Surgery

Sir Leonard commented on the latest developments. There was little progress to report on the Judicial Review. NHS England (which was the successor body of the Joint Committee of Primary Care Trusts) had filed papers to apply for leave to Appeal, but there was no progress whatsoever to advise of in terms of whether or not this right would be granted.

NHS England had issued a statement to say that it would not re-score any of the Trusts apropos the Safe and Sustainable standards at this point, and would focus on the Appeal.

It had been widely publicised that Paediatric Cardiac Surgery had been suspended at Leeds, the day after the Judicial Review hearing, following concerns about mortality data from the unit. Following a 10 day suspension, surgery had since recommenced. Sir Leonard commented that three consultant cardiac surgery posts, including a Head of Service, had been advertised in Leeds. Newcastle had assisted the Department of Health in its enquiries, including the submission, as requested, of a case history dossier. No feedback had been received at all on the dossier and it did appear that NHS England was ignoring the duty of candour. Local MPs had been briefed comprehensively.

Newcastle had received several requests for second opinions and transfers of care since the closure and re-opening. These were not currently causing any capacity concerns for the Freeman Hospital.

Directors also noted that the Secretary of State had asked the Independent Reconfiguration Panel to review the decision made by the JCPCT. This review was intended to take place in parallel to the Judicial Review, and the report was expected at the end of April 2013. It was understood to now be with the Secretary of State, albeit nothing further of substance could be advised of in this regard.

It was resolved:

to i) receive the briefing ii) note the fundamental risks that a reassessment posed to Children’s Heart Services across England whilst progress was halted and iii) note the inherent delays surrounding disclosure of the Independent Reconfiguration Panel review findings and the timescales now ensuing.
iii) Academic Health Sciences Network

Sir Leonard advised that he and Professor Day, Pro Vice Chancellor of the Faculty of Medical Sciences, had presented to the Department of Health on 20th May 2013. The Newcastle bid had been praised by the assessment panel and it was pleasing to note that Newcastle would receive a license from 23rd May. £4.6 million would be received in the first year but the need was for £10 million. The Board complimented the Chief Executive and Pro Vice Chancellor for taking the lead with the bid. CCGs were showing little interest in the AHSN, however.

13/49 Safety, Quality & Performance

i) Healthcare Associated Infection

Mrs Lamont introduced the briefing. There had been one MRSA bacteraemia in April 2013 and another in May. The target for all Trusts for 2013/14 was zero. With regard to Clostridium difficile, there had been nine cases in April (trajectory = 5.5), with five in May to date. It was noted that Norovirus outbreaks were diminishing. Measles was not regarded as a significant challenge, with only one case reported. The Chairman spoke of the challenge in meeting the 2013/14 targets.

Dr Price, Director of Infection Prevention and Control, was in attendance and commented that zero tolerance of MRSA bacteraemia was very tough and it was difficult to convey a message of achievement in 2012/13 yet face even tougher targets for the current year. The hand hygiene campaign was to be re-launched and Aseptic Non-Touch Technique re-emphasised. Documentation needed to be improved. The use of daily Chlorhexidine washes was to be piloted.

Mrs Lamont advised Directors that, within the Shelford Group, one London Trust had already had two MRSA cases; and Sheffield stood at 9+3 cases for C. diff. in April and May 2013. Dr Price commented that one of the MRSA cases in the Trust had been a very difficult case and the patient had removed multiple catheters and intravenous lines. Root Cause Analysis had identified process improvements for MRSA screening. Longitudinal analysis had shown no specific trends, which was reassuring. Communication of learning points could be improved further, however.

Dr Dobson thought that there were parallels with developing and sustaining a safety culture in industry and eventually fatigue and complacency set in. Zero tolerance needed to be reinforced and the safety culture reinvigorated. Professor Baylis thought that achieving a zero number was nearly impossible and enquired whether there were any financial penalties for healthcare associated infections. For MRSA bacteraemia, the Trust would receive no payment for the whole of the patient episode. For C. diff, there was a new penalty of circa £37,000 per case in excess of target and Monitor would also amend the Trust’s governance rating to ‘amber’.

Mr Stout asked about improvements to communications with staff. Dr Price was producing a briefing to cascade to clinical staff and to include Directorate Managers. Ms Kler enquired as to how multiple priorities were communicated at Directorate level. Mrs Robson identified these at the monthly Directorate Managers meeting, while Mr Welch did so at the monthly Clinical Policy Group.
Mr Welch commented that this was a reputational issue and the Trust needed to maintain its focus on patients and forget about the financial aspects.

Mrs Lamont advised that the Serious Infection Review process now included representatives of Clinical Commissioning Groups. Dr Price commented on the need for continued monitoring of antibiotic prescribing.

It was resolved:

to receive the briefing and note the current position.

ii) Quality Report

Mrs O’Brien, Director – Quality & Effectiveness, was in attendance and advised the Board that the format of the report had been altered to show the position as at this time last year and also national averages and targets. With regard to slips, trips and falls, the rate at 5.4 per 1,000 inpatients was below the national average; and it was highlighted that the Trust had the lowest rate of patient harm from falls in England.

For sharps and needlestick injuries, the trajectory for the month was 24 and actual incidents had been 19. For pressure ulcers, the target was for a reduction of 25% for this year on last year’s position. The total number of patient incidents reported had been 6.2 per 1,000 inpatients, which was comparable with the national average. The percentage of patient safety incidents resulting in severe harm or death needed review of the application of the criteria. The “never event” reported in April had been a retained swab, post procedure but prior to patient leaving theatre. There had been two others in the course of May. Mr Stout asked what happened in response to such events. Following detailed review, process change was introduced. The third case had been a surgical error and the clinician had been removed from surgical duties.

Turning to the mortality report, the Standardised Hospital Mortality Indicator stood at 94, which was in the ‘as expected’ range. In fact, on this measure no North East Trusts were outliers. Depth of coding had an impact in this arena. Mrs Lamont advised the Board that the Quality Report would now be submitted to Clinical Commissioning Groups.

It was resolved:

to receive the briefing and note the current position.

iii) Providing Clinical Assurance

Mrs Lamont advised Directors that this was the first monthly report since the updating of questions in the April 2013 Clinical Assurance Toolkit (CAT) survey. Major changes to the questions in April had lowered scores, particularly in staff knowledge. The overall score fell from 98.18% in March to 95.76%

The updated CAT scorecard contained all the latest question changes, along with a new page for the Friends & Family Test question. The highlights of the report were:
• Integrated reporting – with the creation of the new Community Directorate and the improved scores of community teams, the reports no longer needed to maintain the acute/community split. The new Directorate would appear along with all the others.

• Medicines – this appeared on the Assurance Measures page and looked at documentation and signatures around drugs for paediatric patients.

• Clinical Specialty – this was a selection of miscellaneous questions on the Assurance Measures page that were only answered in some specialties.

• Invasive Device Insertion – these questions on the Clinical Assurance page were around the observed practice of doctors carrying out cannulation and catheterisation on patients, ensuring that the procedures were carried out safely.

• Invasive Device Care – these questions on the Clinical Assurance page were formerly reported separately as Urinary Catheter Care, Peripheral Cannulae, Central Venous Catheters and Renal Dialysis. The questions had been streamlined and concerned the state of completeness of the documentation for invasive devices.

• Ventilators – these questions on the Clinical Assurance page concerned the documentation surrounding ventilators in critical care areas.

• Medical Staff – on the Staff Knowledge page, these questions were about infection prevention and control in subjects relating to the practice of doctors.

• MEWS – these questions on the Staff Knowledge page assessed whether staff knew what action to take regarding the recording of patient observations and reacting to the medical early warning scores.

• Patient Safety – these were Staff Knowledge questions asking 1) whether the staff member would recommend this Trust to their friends or family and 2) whether the staff member would know how to raise any concerns about patient safety.

• Friends & Family Test – this was a new page in the report, which displayed the Friends & Family Test results received from Quality Health. As well as showing the response rate (the % of discharged patients who responded), the report would show the likelihood of a recommendation and the Net Promoter Score (the national score given to all trusts).

Each month, an escalation report was sent to Heads of Nursing to highlight all areas with a ‘red’ total score for the CAT (below 91%). Matrons for the areas which featured in the report were followed up by the relevant Head of Nursing, thus ensuring outstanding issues were promptly addressed. In addition, now that the Community tool was established, any red areas were escalated to the Head of Patient Services in order that they could be followed up with relevant staff.

April had seen the most significant change to questions since the inception of CAT. This had necessitated significantly more in-depth analysis, testing and validation, and had meant that the publication of CAT results had been delayed. Overall, there were red scores across the board in staff knowledge, pressure ulcers (also linked to staff knowledge), discharge & transfer, clinical specialty questions and urinalysis.
The majority of the staff knowledge questions from March had been removed and replaced by new ones. It was intended that detailed staff knowledge reports (at a question-by-question level) would be circulated to assist in improving performance.

There had been ten areas with a red score for April, which was much higher than usual and much attention was needed. Matrons and Clinical Managers had been informed and asked for comments and actions.

Discussions around MEWS audits continued, to investigate the differences between CQUIN and CAT audits. There were fundamental differences in the method and sample size of the respective audits, as well as variance between the measures used, which explained some of the differences. The CAT audit of MEWS relied on the self-selection of patients by Sisters/Charge Nurses, whereas the CQUIN audit looked at all patients on selected wards. The Board would be updated with further developments as they arose.

It was resolved:

   to receive the briefing.

iv) **Eliminating Mixed Sex Accommodation**

Mrs Lamont reminded Directors that in June 2010 the Department of Health (DH) had published the “Revision to the Operating Framework for the NHS in England 2010/11” which had confirmed the Government’s commitment to Eliminate Mixed Sex Accommodation (EMSA). In line with the monitoring requirements of Commissioners, the Board received a bi-monthly report in relation to patient perception and reporting arrangements, the last report having been received in March 2013.

‘Real time’ surveys of patient perception continued and were reported through the Clinical Assurance Toolkit (CAT). Since April 2012 the process for collection of Patient Perception had involved the PALS Officers who now visited each inpatient ward on a quarterly basis, to seek patient views on a number of issues including mixed sex accommodation. The following two questions were asked:

- During your stay in hospital have you shared toilet or washing facilities with someone of the opposite sex?
- During your stay in hospital have you shared a sleeping area with someone of the opposite sex?

The results of the latest patient perception surveys undertaken in February and March 2013 were presented. As noted in previous reports, there continued to be variation in the monthly data. However, it was of note that this was the first occasion where it was reported that no patients had perceived that they had shared sleeping accommodation with someone of the opposite gender. It was also of note that of the areas in March where patients perceived they had shared toilet facilities, 9% were in outpatient areas and the Senior Nurse - Practice Development was working with matrons and colleagues from Estates to improve signage and access to same sex toilet facilities in these areas.
A policy was in place to ensure that any breaches of Same Sex Accommodation were reported immediately by staff to the relevant matron and Senior Nurse - Practice Development. This would occur if, in those areas where there were no agreed exceptions, such as a monitoring bay in Admissions Suite, or Critical Care units, men and women were placed in the same bed area. This differed from patient perception data, since a patient might believe they had shared mixed sex accommodation because they were on a mixed sex ward. Monthly breach reporting via Unify2 continued and data from the Trust had identified that no actual breaches of sleeping accommodation had in fact occurred.

It was resolved:

to i) receive the briefing and ii) support continuing work.

13/50 2013/14 Month 1 Finance Report

Mr Reynolds advised Directors of the financial position as at 30th April 2013. Clearly this was just the first month of the financial year and as the Annual Plan was yet to be approved, no specifics were reported, just the position.

Key issues described included that the Income and Expenditure position was a surplus of £491,000. The Monitor Financial Risk Rating (FRR) would be a 3 (on a scale of 1 to 5, where the higher the number, the better). It was noted that Monitor had introduced revised metrics for 2013/14 which meant that any Trust with a significant PFI scheme (including Newcastle) was highly unlikely to ever score higher than 3.

Mr Reynolds advised that the cash balance was high this month, at some £115.8 million. Mr Reynolds explained that cash was always high in April as the Trust put a great deal of effort into clearing payments in March in preparation for the financial year end; and expenditure was always relatively low in April.

It was resolved:

to receive and note the financial position for the period to 30th April 2013.

13/51 Items to Receive

i) Quality Governance – Monitor Guidance for Boards

On 22nd April 2013 Monitor had published a comprehensive document "Quality Governance: How does a board know that its organisation is working effectively to improve patient care?". This was being considered within the Trust and a report would be presented to the Board of Directors and Council of Governors in due course.

ii) Wellbeing for Life Strategy

The Health and Social Care Act 2012 required Councils to establish a Health and Wellbeing Board as a committee of the council. These Boards were seen as the
main leadership vehicle for improving wellbeing and health in an area and to create closer working between health, social care and other related services.

In Newcastle, the statutory Health and Wellbeing Board was called the Wellbeing for Life Board. In establishing the Board, the council had placed great emphasis on the importance of addressing factors such as inequalities that led to poor wellbeing and health, as well as improving services. The Trust was a member, along with representatives inter alia from the Universities and local Clinical Commissioning Groups.

The Health and Social Care Act 2012 also required the Council and Clinical Commissioning Groups to jointly prepare a Health and Wellbeing Strategy, although the Council alone must publish it. In preparing a strategy, the organisations must:

- Consult people who lived or worked in the area; and the local HealthWatch.
- Pay particular attention to how Joint Strategic Needs Assessment (JSNA) needs could be more effectively met under s75 arrangements (pooled budgets, etc). The strategy must include a statement of how health and social care could be more closely integrated.

The statutory Health and Wellbeing Board was then responsible for ensuring that the Council’s and CCGs’ Commissioning Plans accorded with the overall strategy. The content of the draft Wellbeing for Life strategy had formed from the conversations that the members of the Wellbeing for Life Board had had whilst it had been in its ‘shadow’ phase. The strategic level conversations had consistently focused around similar issues that were important to the wellbeing and health of people in the city and appropriate to the changing resources that were available to partner organisations.

A consultation draft of the Wellbeing for Life Strategy had been issued and between 17th April and 31st May 2013 the Board was inviting people who lived, worked or learned in Newcastle to consider the strategy and feedback views on the overall framework of the strategy and the commitments for 2013-2014. The public consultation was being carried out via the Newcastle City Council Let’s Talk Newcastle arrangements.

At the same time, each of the partner organisations, including the Trust, had agreed to undertake internal work to:

- Confirm the commitments that the organisation would be involved in taking forward
- Consider the ‘golden thread’ into their own organisational plans
- Consider how people within the organisation could be supported to understand the content and underpinning values/principles of the Strategy and how they could change the way they worked to support its success.

The Trust would respond formally by 31st May 2013, incorporating the views and feedback from staff and confirming the commitments that it would contribute.
It was resolved:

to receive the briefing.

i) **Inpatient Survey 2012**

Directors were advised that the Council of Governors had already been briefed on the Trust’s results in the national survey of inpatients. In headline terms, the Trust had demonstrated the best results in the region and amongst its Shelford Group peers.

A summary was received of the continuing work within the Trust which supported and ensured patient involvement and enhanced their experience. It covered:

- The Friends and Family Test
- SHA Patient Experience Benchmark Pilot
- Real-time patient feedback project
- National Patient Survey Programme
- Patient Perception Surveys
- Patient Reported Outcome Measures (PROMS)
- Shared Decision Making
- Take 2 Minutes
- The recent establishment of the Patient Experience Steering Group
- NHS Choices and Patient Opinion
- Quality of Patient Experience Governors’ Working Group

The briefing also included details of the findings of the National Inpatient Survey which had been undertaken in 2012 and which was reported during February 2013. The associated Care Quality Commission benchmark report was due for publication in May 2013 and this would enable the Trust to benchmark itself against other Trusts. The summary provided by the Picker Institute, which conducted the survey on behalf of the Trust, clearly showed that the Trust performed significantly better than other Trusts (for whom Picker carry out the survey) in a number of key areas. When compared to the 2011 survey, the Trust had improved significantly in seven questions and significantly worsened in only two areas.

The Commissioning for Quality and Innovation (CQUIN) payment framework linked a proportion of income to the achievement of local quality improvement goals. A single, composite measure taken from the results of five survey questions was included as a CQUIN indicator. It was highly encouraging to note that the CQUIN patient experience score for this Trust was 74.2, which was an improvement on the previous survey and which had resulted in 100% of the final indicator payment for this target being received.

It was resolved:

- to i) receive the briefing and ii) note and acknowledge the work underway and the positive results of the inpatient survey report and ongoing work.
ii) **CHKS 40Top Hospitals Award 2012**

The Chairman was pleased to advise Directors that, for the 13th consecutive year, the Trust had been awarded 40Top Hospital status by CHKS, a leading provider of health service performance and quality data. Only two other Trusts had attained the same enduring accolade – South Tees Hospitals NHS Foundation Trust and Kingston Hospital NHS Foundation Trust.

iii) **E. Coli Report**

Directors were advised that, at the request of Governors, this report had been produced by the Director of Infection Prevention and Control for consideration at the Council of Governors on 16th May 2013.

Since 2011, reporting 6f *Escherichia Coli (E. coli)* bacteraemia to the Health Protection Agency (HPA) had been mandatory. The Trust had participated in the voluntary reporting scheme since 2007. Overall, there was a picture of increasing rates of *E. coli* bacteraemia across England. Indeed, nationally, in 2011 there had been 29,777 reports for *E. coli*, which was a 10% increase compared to 2010 (27,062). In comparison, the total number of all bacteraemia reported via LabBase2 had remained largely static for 2010 and 2011 at 91,306 and 92,351, respectively.

By 2011, *E. coli* bacteraemia accounted for almost one third (32.2%) of all bacteraemia reports, compared with 29.6% in 2010 and 22.2% in 2007. Between 2007 and 2011 there had been a 35% increase in *E. coli* bacteraemia reports compared with a 7.2% decrease for all bacteraemia.

When the data were grouped by age, the rate per 100,000 population of *E. coli* bacteraemia was highest in patients aged 65 years and over and in those under 1 year of age. In both age groups, the rates were generally highest for males. Among those aged 1-14 and 15-44 years, the rates of *E. coli* bacteraemia per 100,000 population were highest among females.

There were a number of sources for *E.coli* bacteraemia but many patients presented with symptoms and signs of bacteraemia rather than with the primary event. Underlying causes included peritonitis, pyelonephritis, and lower urinary tract infection. These cases were not likely to be healthcare associated infections and were likely to be blood culture positive within 48 hours of admission (although some might develop bacteraemia at a later stage). Finally, community acquired urinary catheter associated infection (CAUTI) was also a common underlying cause which might be classified as a healthcare-associated infection (HCAI).

Within the Trust, there had been 338 episodes of *E. coli* bacteraemia detected in the period March 2012 - March 2013. Although the current reporting requirements did not distinguish between pre- and post-48 hours of admission in the same way as with MRSA, 159 (47%) cases had been post-48 hours in this period. It was likely that those bacteraemias pre-48hrs were not attributable to the Trust, although some episodes related to CAUTI might have arisen in other healthcare facilities.
The Directorates accounting for the highest proportion of the total were Medicine (37%), Surgery (25%) and Cancer Services (8%). Possible mitigating factors in these services were the general high throughput of patients, and in particular the high number of elderly patients who were vulnerable to UTI with or without urinary catheter use. Surgical complications and catheter associated infection following surgery, and an immunocompromised status were also factors in surgery and cancer services.

It was resolved:

to receive the briefing.

Exclusion of the Press and Public

It was resolved:

to exclude members of the press and public in accordance with the Health Services Act 2006 (Schedule 7 Section 18(E)) (as amended by the Health and Social Care Act 2012) and in view of publicity being prejudicial to the public interest.