Milton Keynes University Hospital NHS Foundation Trust

COUNCIL OF GOVERNORS

Council of Governors' meeting to be held at 10:00 am on 12 July 2021 via Microsoft Teams in line with social distancing requirements

No.	No.	Item	Purpose	Type	Lead
1	10.00	Chair's Welcome and Announcements	Note	Verbal	Chair
2		Apologies To receive apologies for absence	Receive	Verbal	Chair
3		Declarations of Interest Governors are requested to declare any interests they have in items on the agenda.	Note	Verbal	Chair
4		Minutes of the Council of Governors meeting held on 11 May 2021	Approve	Pg. 3	Chair
5		Matters Arising	Note	Pg. 17	Chair
6	10.05	Chair's Report	Note	Verbal	Chair
7	10.20	Chief's Executive Report	Note	Verbal	Chief Executive
PRESENTATION, INFORMATION and APPROVAL ITEMS					
8	10.35	COVID-19 Update	Receive and Discuss	Verbal	Medical Director
9	10.40	Accelerator Programme - Plan/ Programme of Implementation	Receive and Discuss	Verbal	Chief Executive/ Chief Operating Officer
GOVERNORS' UPDATE					
10	11.00	Lead Governor's Report	Receive and Discuss	To Follow	Lead Governor
11	11.10	Healthwatch Milton Keynes – Council of Governors' Report	Receive and Discuss	Pg. 18	CEO, Healthwatch Milton Keynes

GOVERNANCE					
12	11.20	2020/21 Quality Account	Receive and Discuss	To Follow	Director of Corporate Affairs
13	11.30	Annual Members' Meeting: 15 September 2021 (TBD - at the University of Buckingham Academic Centre/online)	Note	Verbal	Chair
14		Motions and Questions from Council of Governors	Receive and Discuss	Verbal	Chair
15		Any Other Business	Note	Verbal	Chair
16		Date and Time of Next Meeting 22 November 2021, 16.00 via (TBD: Teams/ In Person)	Note	Verbal	Chair

RESOLUTION TO EXCLUDE THE PRESS AND PUBLIC

The Council will consider a motion:

"That representatives of the press and other members of the public be excluded from the remainder of the meeting, having regard to the confidential nature of the business to be transacted, publicity of which would be prejudicial to the public interest" Section 1 (2) of the Public Bodies (Admission to Meetings) Act 1960

If you would like to attend this meeting or require further information, please contact:

Kwame Mensa-Bonsu, Trust Secretary Tel: 01908 996234. Email: kwame.mensa-bonsu@mkuh.nhs.uk

Milton Keynes University Hospital NHS Foundation Trust

MILTON KEYNES UNIVERSITY HOSPITAL NHS FOUNDATION TRUST COUNCIL OF GOVERNORS' MEETING

Minutes of the Council of Governors' meeting held in public at 10.00 hours on Thursday, 11 May 2021, via Microsoft Teams in line with social distancing requirements

Present

Alison Davis	Chair	(AD)
Alan Hastings	Lead Governor & Public Governor	(AHas)
Dr. Alan Hancock	Public Governor	(AHan)
Babs Lisgarten	Public Governor	(BL)
Ann Thomas	Public Governor	(AT)
Brian Lintern	Public Governor	(BLi)
Niran Seriki	Public Governor	(NR)
Lucinda Mobaraki	Public Governor	(LM)
Emma Isted	Staff Governor	(EI)
Elisabeth Maushe	Staff Governor	(EM)
Yolanda Potter	Staff Governor	(YP)
Tracey Rea	Staff Governor	(TR)
Maxine Taffetani	Healthwatch Milton Keynes Representative	(TK)
Andrew Buckley	MK Business Leaders Representative	(AB)
Andy Reilly	Milton Keynes Council Representative	(AR)

In Attendance

Professor Joe Harrison	Chief Executive	(JH)
Heidi Travis	Non-Executive Director	(HT)
Haidar Husain	Non-Executive Director	(HH)
Helen Smart	Non-Executive Director	(HS)
Terry Whittle	Director of Finance	(TW)
Kate Jarman	Director of Corporate Affairs	(KJ)
Nicky Burns-Muir	Director of Patient Care and Chief Nurse	(NBM)
Kwame Mensa-Bonsu	Trust Secretary	(KMB)
Julia Price	Senior Corporate Governance Officer	(JP)
Lui Straccia	Communications Specialist	(LS)

1 Welcome and Announcements

1.1 The Chair extended a warm welcome to everyone present at the meeting. The Chair noted the presence of BL, and offered the condolences of the Council, the Trust Board and Trust to him on the passing of his wife.

2 Apologies

2.1 Apologies were received from Public Governors Ekroop Kular; Akin Soetan; William Butler; Jordan Coventry; and Claire Hill, Staff Governor Dr Raju Thomas Kuzhively; and Representative Governor Clare Walton. Apologies were also received from Non-Executive Directors Andrew Blakeman and Nicky Mcleod.

3 Declarations of Interests

3.1 There were no new declarations of interest received in relation to the items on the agenda.

4 (a) Minutes from the Council of Governors meeting held on 18 March 2021

4.1 The minutes from the 18 March 2021 meeting were approved as an accurate record of the meeting.

4 (b) Matters Arising/Action Log

4.2 The Action Log was noted.

5 Chair's Report

5.1 AD informed the Council that she had since March 2021 continued with her induction, which included attending meetings of the Clinical Quality Board and the BAME Network, and with the Freedom to Speak Up Guardian and the Head of Equality, Diversity and Inclusion. AD advised that she had attended the Membership Engagement Committee meeting, where the discussions had been focused on implementing improvement steps to develop the role of Governors and to increase the number of Trust members.

5.2 AD informed the Council that she had chaired another consultant interview panel and noted that the panel had successfully appointed a very good applicant. AD advised that, as part of steps to familiarise herself with the Trust, she was scheduled to visit some wards of the hospital from the middle of May 2021.

5.3 AD stated that the East of England NHS Region was proposing a new oversight framework for systems, to better manage how the constituent organisations were regulated. AD stated that she would be attending her first East of England NHS Provider Chairs meeting in May 2021 and noted that the focus of discussions would be around 'collaboration'. AD advised that she would keep the Council informed on future developments.

5.4 AD advised that the reviews of the Trust Board and its Committees, and the Council, had been completed and noted that steps would be taken to implement all the relevant improvement actions.

The Council **noted** the Chair's Report.

6 Chief Executive's Report

6.1 JH stated that the Bedfordshire, Luton and Milton Keynes (BLMK) Integrated Care System (ICS) had been selected as an accelerator system, under the auspices of the NHS England's National Accelerator Programme. To implement the Programme's remit, chosen 'Accelerator Sites' which included the Trust, were being required to quickly reduce the number of patients on waiting lists by restoring elective activity to 120% of the 2019/20 baseline by July 2021. JH noted that across the NHS, a significant portion of elective activity had been stopped in response to the COVID-19 pandemic, and this had resulted in record numbers of patients being on waiting lists. JH advised that, in the Trust, the number who had been on waiting lists for 52 weeks or longer had grown from 0 to about 800 at the end of April 2021. JH informed the Council that about £10m had been allocated to the BLMK ICS to provide funding for Accelerator Programme and noted that this was a very positive development for Milton Keynes and its environs.

6.2 JH stated to the Council that the 'International Day of the Midwife' events in the Trust, on 05 May 2021, had been very well-attended and supported. JH stated that preparations were underway in the Trust to mark the 'International Nurses Day' on 12 May 2021.

6.3 JH informed the Council that the funding for the construction of the Trust's proposed Women's and Children's Hospital, which was scheduled to be received in March 2021, was yet to be received. JH noted that the Pathway Unit construction project remained on plan and on track to be completed as scheduled in 2022. The 5-year project to replace the roof insulation across a large area of the hospital with solar panels was also progressing as planned.

6.4 JH advised that MKFM had in May 2021 given a special award to the Trust for the care provided to patients during the COVID-19 pandemic.

The Council **noted** the Chief Executive's update.

7 2020 Staff Survey Update

7.1 JH gave a presentation which provided a statistical update on the 2020 Staff Survey report and highlighted the main points as:

a. 67% of the respondents were frontline clinical staff, while 33% of the respondents were from Corporate and General Management areas;
b. The scores for two survey questions – 'Recommend the Trust as a place to work' and 'Recommend the Trust for care' – improved to scores of 74% and 76% respectively, from 66% and 70% in 2019. The scores for the Trust's comparator group were at 67% and 75% respectively;
c. The score for the survey question which related to staff experiencing violence from patients and their family members was at 17.5% in 2020, from 17.6, 15.4 and 18.3% in 2019, 2018 and 2017, respectively. The scores for the comparator group were at 14.8%, 14.1%, 14.4% and 14.2% for the period between 2017 to 2020. JH stated this would be an area of focus for the improvement steps which would be implemented;
d. The score for the question related to staff working (unpaid) beyond their normal hours was at 45.6% in 2020, from 51.3% in 2019. The benchmark scores were at 36.5% and 35% in 2019 and 2020, respectively. JH noted that though evidence indicated there had been an

improvement in the area of staff being remunerated for overtime work, a significant number was still not being paid when they worked beyond their normal hours;

e. 41% of the respondents believed there was enough staff to do their job properly, from 32% who did in 2019. The comparator score was at 38%;
f. 60% of the respondents were not looking to leave the Trust within 12 months, from 55% in 2019. The comparator score was at 57%.

7.2 JH advised that the next steps included utilising the "Staff Survey Goes Large" approach for various departments and teams to review the data local to them, the establishment of a working group to explore issues around staff levels and workloads, and actions to identify the location of spikes in violent incidents from patients and the public so an improvement action plan could be developed and implemented. JH stated that overall, the staff survey results indicated that the Trust was going in the right direction and was on track to achieving the target of being in the top 10% of NHS providers in terms of staff satisfaction. HS stated that though much work needed to be undertaken before the target could be attained, sight should not be lost of the significant progress achieved in some areas. HS highlighted those areas as including 'recruitment and retention rates' especially during the pandemic'; and the Trust's outstanding ability to clearly communicate with the staff, patients and the public during the pandemic.

The Council **noted** the presentation on the 2020 Staff Survey results

8 COVID-19 update

8.1 NBM advised that only 3 COVID-19 positive patients were on the Trust's Ward 22. NBM stated that patients who attended the ED after a trip abroad and were within the 10-day COVID-19 incubation period, were also being admitted to Ward 22. It was noted that Ward 22 was the most suitable area because it had the side rooms suitable for patients who needed to be isolated.

8.2 In response to AHan's query around the areas with long waiting lists, JH stated that the Ear, Nose and Throat, Orthopaedic, Ophthalmology and Urology Services had been particularly impacted by the Trust's response to the COVID-19 pandemic. JH noted that some of these services had been impacted because, as the treatments they provided was aerosol-generating, they were required by the COVID guidelines to significantly reduce the patients they treated during the pandemic. JH advised that the Trust had taken steps to increase capacity to ensure the patients on the waiting lists were treated as quickly as possible. JH stated that though Cardiology had been much less impacted by the response to the pandemic and the patient waiting list was improving, there was some concern that there would be an increase in demand for treatment as referral activity returned to pre-COVID-19 pandemic levels.

8.3 In response to AR's query around the waiting list for Cancer Services, JH stated that the new Cancer Centre had provided the hospital with the opportunity to continue providing treatment safely during the peak of the COVID-19 pandemic. JH noted that this had ensured that the Trust was not in the position of having such a long waiting list for cancer treatment, as was the case nationally.

The Council **noted** the verbal update on the Trust's response to the COVID-19 pandemic.

9 Government White Paper - Working Together to Improve Health and Social Care for All: Update on Developments

9.1 AD stated that the merger of the ICS and the CCGs in the BLMK area had been completed, and the Council would be updated on future developments. AHas advised that the Lead Governors in the East of England NHS Region had provided their response to the White Paper.

The Council **noted** the update.

10 BLMK ICS Strategic Priorities

10.1 JH presented the report and stated that the Trust agreed with the ICS's Emerging Priorities as stated and added the Council would be updated with future developments. AD advised that the Emerging Strategic Priorities had been developed from the output of workshops in which senior representatives from the constituent bodies of the BLMK ICS had participated.

The Council **noted** the report of the BLMK ICS's Strategic Priorities.

11 Refreshed Governors' Communications/Public Engagement Strategy

11.1 KJ presented the refreshed strategy and noted that, considering the COVID-19 pandemic had stopped most engagement activities, this was timely as the Governors prepared to restart engaging with their constituents and the public. KJ stated the purpose of the refresh was to enhance all Governor, Membership and Public engagement activities with the goal of increasing the number of Trust members. KJ asked for comments and suggested that any feedback be provided to LS and herself.

11.2 AD asked for feedback from members of the Council and advised that the development of the strategy should be a collaborative effort. MT noted that the draft strategy did not include any points on the role of appointed Governors in terms of the relationships with all stakeholders and stated that she will pass on comments and suggestions to KJ and LS.

Action: MT to pass on comments and suggestions to be included in the draft Governors' Communication/Public Engagement Strategy on the role of appointed Governors in terms of the relationships with all stakeholders.

The Council **noted** the refreshed Governors' Communications/Public Engagement Strategy.

12 Lead Governors' Report

12.1 The Council **noted** the report.

13 Healthwatch Milton Keynes (MK) – Council of Governors' Report

13.1 MT provided a verbal update and stated that Healthwatch MK was holding regular meetings with KJ and Matthew Sandham, Associate Chief Nurse, whose responsibilities included 'Patient Experience'.

13.2 MT advised that feedback received by Healthwatch MK included:

a. Concerns that as patients moved between waiting areas to or consulting rooms, there was not enough cleaning being done. MT noted that among the ideas shared with the Trust included the need for wipes (for the utilisation of patients) to be made available in all areas of the hospital;
b. Appointment letters indicated that patients could attend the hospital with support carers and companions, but the accompanying individuals were turned away when the patients arrived for their appointments; This had been resolved;
c. There would be a report on Healthwatch MK's work with the Maternity Unit to improve patient experience at the meeting in July 2021.

The Council **noted** the report from Healthwatch MK.

14.1 Motions and Questions from Council of Governors

14.1 The Chair noted the 13 questions and advised that the responses (attached) would be circulated all members.

Action: KMB to circulate the responses to all the questions to the members of the Council.

15 Any Other Business

15.1 There was none.

16 Date and Time of Next Meeting

16.1 **Council of Governors meeting –** 12 July 2021, 10:00 via Teams

11 May 2021 Council of Governors Meeting - Questions and Answers

No.	Question	Response
1.	BBC Red Button report on 05 April 2021 around the Coroner's comments about the death of a patient in MKUH, which included that "sepsis advice was disregarded".	The Trust received a Preventing Future Deaths Report on March 28 2021 following a Coronial Inquest into the death of Mr Nicholas Rousseau. The PFD relates to adherence to NICE guidelines and blood lactate levels. The Trust provided a response to HM Coroner on 29 April 2021, which the Trust also shared with Mr Rousseau's family. The proposed actions included in the response to the coroner included, to: a. Ensure that the MKUH sepsis policy is updated for November 2021; b. Repeat an audit locally of the management of patients with suspected sepsis against the eight Royal College of Emergency Medicine standards; c. Consider the case for the designation of a sepsis lead within the department with specific responsibilities for ensuring the profile of sepsis remains high.
2.	Are staff fully aware of the definition of a Serious Incident? If a reported SI is downgraded, is it still included in the Board Report?	Members of staff are encouraged to report all incidents or near-miss incidents via our electronic reporting system. In the report, they are invited to attribute a perceived level of harm (from nil through to catastrophic). Incident reports are then reviewed by local managers and the clinical governance team. Any incident with a perceived harm level of moderate or greater is reviewed by a multi-professional group, including executives, that meets weekly (SIRG). Decisions around whether an incident meets criteria for external reporting are made by the Chief Executive on the advice of SIRG. On occasion, incidents are initially reported externally (on the basis of information available at the time) and on thorough investigation are found to be either less serious and/or unpreventable. These are discussed

		with the CCG and may be downgraded formally. However, these incidents remain in reported figures. Of note, public Board is noted of serious incidents as they are declared rather than on completion of investigation.
3.	Re the 120% 'Acceleration Programme' - obviously, the increased activity will have a big impact on our Pathology services. Has this been considered, are there any plans to place funding in Pathology to help with the increased workload and the increased storage needs?	The necessary investment will be put into the right areas including support services to deliver the increase in activity where required in the Accelerator Programme.
4.	Are immigration requirements hampering international recruitment? Are requirements for international staff suitably strict for acceptable qualifications, use of English, culture differences, e.g., female nurses tending male patients?	All NHS staff must meet NHS Employers Standards. These are set nationally and include right to work and visa requirements. We are not actively recruiting from overseas at present. If individuals apply to us directly, or are passed to us by a national programme, we will consider them in the usual manner, but we are not undertaking large scale international recruitment campaigns at the present time. Regarding the point about immigration requirements. We have experienced some delays in obtaining visas for medics during the pandemic, but this is improving now as things get back to normal. Finally, it is also worth noting that due to the crisis in India the NHS has paused temporarily all recruitment from India.
5.	An extensive list of Risk entries on the Risk Register appear to be most concerning, as each of them has a red high risk against it (or have been rated as red). Are we in danger of being in Special Measures?	The risk register is a document containing risks – i.e. things that could happen (however unlikely) not things that have happened. The purpose of the risk register, as one of the foundations of being well governed, is to identify risks and take action to prevent those risks from materialising (i.e. stop them from happening). Because of the nature of healthcare, the impact (or consequence) of a risk materialising is often highly scored (we use a likelihood x consequence scoring method called

		the 5x5 risk matrix) so even if a risk is very unlikely to materialise, it may still score highly. An organisation that is focussed on safety and is a large and complex as a hospital would be expected to have risk registers documenting risks at every level. Because we are transparent around how we work, we report our significant risk register in public. The risks all have controls and actions to ensure they are well managed, and any that cannot be managed are escalated to ensure appropriate mitigating action can be taken.
6.	Annual review of risks - if significant what is the impact on patient experience? Surely, they should be resolved within a year?	The aim should be for them to be resolved within a year – whether that's around patient experience, patient safety, business continuity etc. The annual refresh does not replace the regular review of risks that are carried out. The significant risks would usually be reviewed at least monthly, it should only be the lower risks that potentially have an annual review. The idea of the annual refresh is to look at the risks to see if they are still relevant. If they are, then ongoing work would take place. Where they are not, they would either be closed (if they are no longer a risk/relevant) or they would be re-written/updated to reflect the current risk to the organisation.
7.	Question for each of the Non-Executive Director Chairs of Board Committees: "Are you comfortable with the position of MKUHFT?"	
a.		Audit Committee Chair: "As audit and risk committee chair, I'm never "comfortable" about the position of MKUH. There's always more to do. We don't have enough resources to do everything we want. We make mistakes: we learn from them, but we still make mistakes. Not every patient has as positive an experience in the

		hospital as we'd like. So I am not "comfortable". We can definitely get better. "That said, I believe the hospital is safe, effective and well-led. Our staff are well-trained, very hard-working, and I know they really care for, and about, our patients, their carers and families. I can't fault the effort or motivation of all our people. Everyone is committed to looking after patients, including front line staff like doctors, nurses/healthcare assistants, AHPs, ancillary staff like cleaners, cooks and porters, and all the supporting staff like managers, accountants, IT, HR, premises staff, and security. "Part of the role of the audit committee is to look at financial and management reporting. It's our job to provide assurance to the board that the numbers are right. I am confident that our reporting is true and fair. We can rely on the information we're given. That's backed up by reports from our internal and external audit teams. "The other role of the audit committee is to look at risk. We think about what could go wrong. Over the last year we've been through the biggest challenge the NHS has faced since its formation and I'm incredibly proud of what MKUH has achieved, and how we've coped. There will be learning points, and there's much to do to catch up on treating patients who had to stay away during the pandemic. Overall, we understand our risks. We have effective (but not perfect) barriers in place to prevent them occurring, and good mitigation plans in they do."
b.		Finance and Investment Committee Chair: I am very comfortable that we are fully informed of the financial position and

		that there is an ongoing Covid19 impact that is being monitored and reported. We have a detailed report and discussion at F&I every month and ensure any appropriate matters are raised at Board.
c.		Quality and Clinical Risk Committee Chair: I am comfortable that the committee is well informed on quality and clinical risk matters. This includes both issues, mitigation/actions and good practice is celebrated and learning shared. I have also assured myself as Chair regarding governance. As a NED I visit wards and departments to ensure what is being reported is reflective of what's happening on the 'ground'. I have also attended subcommittee meetings. We have very detailed, in-depth discussions/debate on all agenda matters. We escalate any matters appropriately to the Board.
8.	External Audit Services - why has (the related risk) not been actioned earlier?	The external audit market has over recent years become less attractive for suppliers. This is due to several factors such as increased risk (to providers) following high profile accounting scandals, increased regulatory requirements and the relative commercial attractiveness of audit fees compared to advisory work. Several NHS organisations have failed to successfully appoint external auditors following a tender process upon conclusion of existing contracts. Milton Keynes University Hospital (MKUH) faces the same challenges in securing a high-quality external audit partner. To increase the success of a service tender exercise MKUH wanted to ensure lessons published by partners such as the Healthcare Financial Management Association were duly considered and reflected in advance of

		a multi-year external audit tender exercise. In addition to the above reasons, it was also desirable to maintain the services of the existing external audit partner to ensure continuity of expertise during a change in executive finance leadership at MKUH. MKUH has been in discussions regarding a one-year contract award with the current external audit supplier utilising the national procurement framework. These discussions have progressed positively since March 2021 culminating in the recommendation to the Council of Governors to approve this proposal.
9.	The covid-19 epidemic obviously raised some unusual problems for MKUH with the need for the isolation of those infected or suspected of having the virus. a. What lessons have been learnt from this with a potential for reconsiderations of the layout of the hospital and or provisions within the various wards to enable a quicker response to any future pandemics? b. To what extent was the capacity of the hospital compromised by the configuration of the hospital as against the available staffing levels and equipment?	The COVID-19 pandemic has of course led to many challenges for the Trust. The key constraint under which we were operating (for example, space, staff levels, equipment) varied at different points across the year. Many of our wards, designed during the 1980s and 1990s are small by current design standards. This sense of a cramped environment is exacerbated by all the equipment associated with modern healthcare (including mobile and fixed computers), and more so by arrangements required for additional screens, and 'donning and doffing' stations for PPE. In some of our wards, we removed beds from use in order to ensure that a 2m social distancing for patients was feasible. Our previous investment in IT left us in a good position to have staff working remotely (rather than on wards) where feasible. We have been fortunate in being able to designate pathways for 'green' pre-tested planned care, and emergency admissions given the generous site footprint. We have also been able to divide our Emergency Department into separate distinct zones. Its layout is such that this is feasible in a number of

		configurations (according to the prevalence of COVID). The key learning in relation to the built environment would relate to three main areas: 1. The importance of clear signage and instructions (facilitating staff in doing the right thing at a time when guidance was rapidly changing) [we did well in this regard]; 2. The advantage of having a higher proportion of side rooms (particularly with en-suite facilities) [this is being addressed in our planned building work as part of the HIP2 programme]; and, 3. The importance of modern air exchange / ventilation (including in outpatient environments) [this is being addressed in our planned building work as part of the HIP2 programme]. As stated above, the key constraint under which we were operating varied at different points across the year. Physical space has not been the most pressing of our concerns. At various points, concerns around the availability of ventilators and the supply of both oxygen and medicines had to be very actively managed. Staff absences, particularly in the first wave of the pandemic when testing was not as easy to access and turnaround times were longer, provided perhaps the biggest challenge.
10.	The view of the hospital's menu for patients is complimentary, however 'Is there any Asian type food on the menu?' Naturally, this has to consider the various faith requirements and to some extent the variety of ethnics in our community.	Nicky Burns-Muir provided a verbal update, which indicated that the menu catered for all needs and was improving.
11.	The paper on the ICS's priorities does not mention the word PATIENT. Is this a top-down organisation rather than bottom up? Are there any Patients or Representatives at the top level?	Alison Davis provided a verbal update which indicated that there were Patient representatives and noted that the

		language referring to the 'public' was deliberate and aimed at being inclusive.
12.	Question 1. a. Should the Governors be concerned that 59% of staff who responded to the Staff Survey did not agree that 'there are enough staff for them to do their job properly'? (Staff Survey presented to the Board of Directors on 6/5/21) b. How can the Governors and members contribute to the Working Group To Explore Issues Around Staff Levels And Workloads? *Background information: In the Staff Survey, 41% of respondents answered positively to the statement 'There is enough staff to do my job properly'. i.e. 59% did not agree with the statement. This corresponds with my family's experience in that we were excluded from participating in decisions about our Mother's care as the ward staff were often too busy to answer the phone (we were told this by staff on the ward).*	Alison Davis commented that further information for context was needed for the Governors to consider this question. The information from the Trust is as follows:- a. We monitor our day to day numbers very closely and always maintain safe staffing levels. Unfortunately, in line with other Trusts, we do have vacancies and periods of time when colleagues are unwell. We cover the majority of these shifts with temporary staffing. Against the unprecedented backdrop of Covid our score improved significantly, (+9%) and is now better than comparators reflecting continued investment in our staffing. **(Please see below)** Our reflections are that we believe most people will have answered this question from an overall perspective. We know the NHS as a whole doesn't have enough staff or space to treat everyone straight away, most services having waiting lists and so we believe that most staff answer this question, not from a daily/shift perspective where we know we are safe, (and have been told that by mandated staffing levels and regulators) but from an overall perspective. b. The board as a whole will hold the executive to account to ensure that there are plans enacted to keep the hospital safe on a day-to-day basis, and for the work to continue to attract and retain staff here at MKUH. There is good evidence that the retention rate has improved considerably in the last 4 years, (12% reducing to circ 8% over this period) at a time when the hospital has continued to expand. It is for the governors to hold the NEDs and Board to account for progress against improvements within the hospital.

	2019	2020	Difference	Comparator
	32%	41%	+9%	38%

13.	Are the Governors satisfied that the communication systems currently in place to communicate with patients' relatives meet the MK Way vision to keep patients and families 'informed, involved and engaged in their care and treatment'? *Background information: The Family Information Line was only open between 10am and 4pm Monday - Friday, not weekends, and it took up to 24 hours to receive information, by which time circumstances could have changed.*	Alison Davis noted that the Governors would need time to consider this question and advised that a response from the Trust would be provided for further context. That response is as follows:- The Trust has flexed the Family Line throughout the pandemic to reflect demand and have run it 7 days a week during very busy periods. We have gone to great efforts to keep families informed - setting up the Family Line, letters to loved ones, buying in iPads and the Nye system in critical care and across wards to enable virtual visiting, delivering packages of clothes and toiletries and so forth for patients from families, and endeavouring to provide regular communication from wards in unprecedented circumstances. At times during the pandemic this clearly was really challenging due to the number of patients in the hospital and the number of relatives to call - particularly prioritising patients nearing the end of life, potentially with many relatives to update and trying to facilitate online or telephone contact. We did not get it right every time for every family for which we apologise. We did put huge efforts in at every level to communicate frequently and well with the families of those in our care and have carried forward some of the learning during this period to improve communications with families on an on-going basis.

Updated : 05/07/21

Milton Keynes University Hospital NHS Foundation Trust

Council of Governors Action Log

Action No.	Date added to log	Agenda Item No.	Subject	Action	Owner	Completion Date	Update	Status Open/ Closed
1	11-May-21	11.2	Refreshed Governors' Communications/Public Engagement Strategy	Maxine Taffetani to pass on comments and suggestions to be included in the draft Governors' Communication/Public Engagement Strategy on the role of appointed Governors in terms of the relationships with all stakeholders.	MT/Lui Straccia	12-Jul-21	MT has met with Lui, and Lui has since agreed a programme of support for the Hospital's Council of Governors and membership communications with the Healthwatch MK's Commuications Officer.	Completed
2	11-May-21	14.1	Motions and Questions from Council of Governors	KMB to circulate the responses to all the questions to the members of the Council.	KMB	12-Jul-21	Circulated on 19 May 2021.	Completed

Report for the Council of Governors of Milton Keynes University Hospital FT

June 2021

Our Activity

In recent weeks we have begun working with MK Council Contracts and Quality team to carry out in person visits to Care Homes. With our frontline staff being fully vaccinated we have been able to carry out the resident consultation part of the Council programme alongside our own Enter and View programme.

There are some concerns in the Dementia Pathway Improvement Group about the low number of referrals by GPs to the Specialist Memory Service for assessment/ diagnosis of dementia. This will have an impact on people already in Care Homes, or in being admitted to MKUH with undiagnosed dementia. Could the discharge team be made aware so that, where necessary, discharge notes could ask GPs to make referrals?

Issues, concerns and compliments

- **Clinic appointments**

  We are starting to hear from people regarding long wait times to resume regular appointments at the various clinics held by MKUH. One gentleman gave us permission to share his story as an example:

  "I have Glaucoma in both eyes and am supposed to have a 6-monthly check at the eye clinic. My last one was cancelled because of Covid and now, with everything opening, I rung to find out when I would be booked in. They told me November is the soonest they can see me. That will be about 18 months since my last check now. I asked them if they were going to be giving out white sticks with every appointment!"

  With BLMK being selected as an accelerator site to reduce waiting lists, what actions have been taken to ensure that regular service will resume? (Recruitment? Longer clinic hours? Utilisation of non-NHS providers?)

- **Consultant Letters**

We have raised an issue with Matthew Sandham, Associate Chief Nurse, around the content of letters being sent from hospital consultants to GPs. We have had 3 letters shared with us by patients, written by consultants from two different departments. The letters were considered unprofessional and contained little to no clinical information, rather just the letter writers' opinions of the emotional state of the patient. These letters, once sent, are very difficult to remove from a patients record and add nothing to the health information.

A senior consultant in one of the departments has agreed to review the letters and anything that is not clinical will be removed and hidden so nobody can view it and is they addressing the doctors who have written them in the first place. The Associate Chief Nurse has agreed that this is an area where it appears that consultants may need a refresher/ reminder on professional clinical note writing and will investigate how best to achieve this.

- **Patient Appointment letters**

As one of our staff had the pleasure of attending an appointment at the breast clinic recently, she took the opportunity to provide some feedback to the Associate Chief Nurse and the Director of Corporate Affairs as part of the established patient experience meetings.

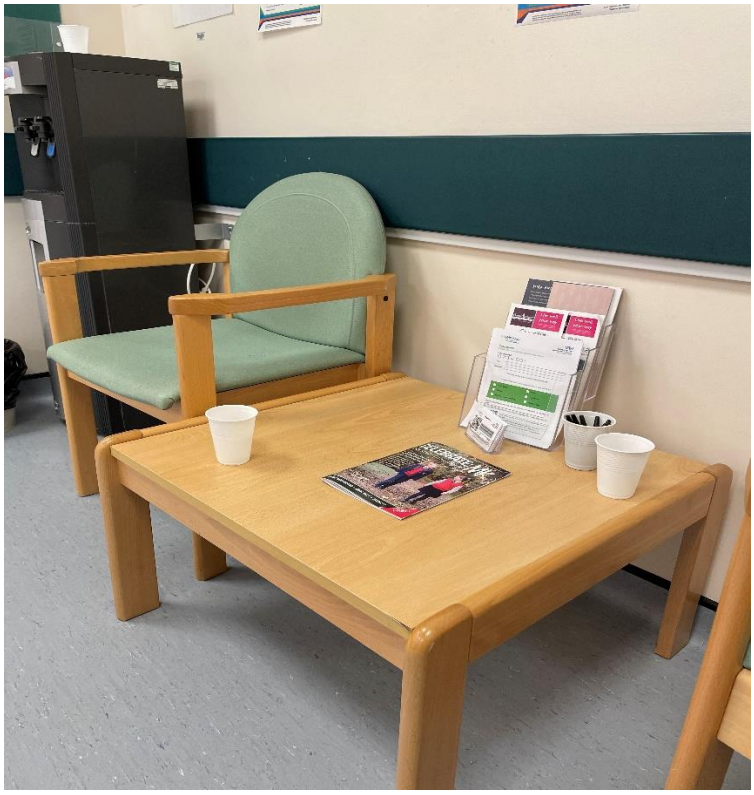
She spoke to 4 other women while at the appointment after seeing the clinic reception turn away the support people who had arrived with two women who arrived for appointments. all of them had received the same letter she had – inviting the patient to bring a support person if they would like. On arrival – the 3 women who had brought support people with them were told on entry "No, you can't have someone with you. They will have to wait outside". When challenged by two of the women, they were told "Yes – it's an old letter, we can't change it". One woman said that she had assumed she wouldn't be able to bring anyone because of COVID, and when she got the letter telling her that she could, it raised her stress and anxiety as she immediately felt that meant she must actually have something serious wrong. All three women had support people who had taken time off work to accompany them.

Form letters MUST be able to be changed quicker to reflect actual conditions/ directions for appointments. All four told patients informed Healthwatch Milton Keynes that they were already too anxious about having had the referral to the breast clinic to bother arguing but all of them were very unhappy about it.

Matthew Sandham was as disappointed as we were to hear these patient experiences and is working on having these letters changed immediately.

Cleaning

The photo below reflects what Healthwatch Milton Keynes have been raising in patient experience meetings. These half full cups of water were in the waiting room when the patient arrived at 2:15. They were still in the exact same place when she left at 4:30. She was in and out of the second (more private) waiting room, along with 4 or 5 other women and did not see any evidence of cleaning down surfaces in the time spent there. Having some wipes available could be part of the solution to this recurring theme. This patient also had to attend A&E on a different occasion and spent around 40 minutes in the waiting room, while it was busy, and well organised (social distancing and speed of people being seen), no cleaning of seats or other high contact touch points was observed.



This was also reported in the Patient Experience meeting and we have been assured that the cleaning is being done, that our suggestion of having wipes or similar available for patients to clean down chairs themselves has been included in a new protocol which has been developed. This will be shared with us once it has been signed off.