NHS | HEART of ENGLAND NHS Foundation Trust

Board of Directors

March 2012

Tuesday 6th - 9.30am

SIMTR Conference Centre,
1 Damson Parkway, Solihull

Agenda

March 2012

1.	**APOLOGIES**	
2.	**DECLARATIONS OF INTEREST**	*(Enclosure)*
3.	**MINUTES:** 3 January 2012	*(Enclosure)*
4.	**MATTERS ARISING AND ACTION POINTS**	*(Enclosure)*
5.	**CHAIRMAN'S REPORT**	*(Enclosure)*
6.	**CHIEF EXECUTIVE'S REPORT**	*(Enclosure)*
QUALITY AND PERFORMANCE MONITORING		
7.	FINANCE & PERFORMANCE REPORT (AS)	*(Enclosure)*
8.	IPROC REQUISITIONS FOR APPROVAL (AS)	*(Enclosure)*
9.	UPDATE ON 2012/13 BUSINESS PLAN, BUDGETS & MONITOR ANNUAL PLAN (AS/SH)	*(Oral)*
10.	CORPORATE STRATEGIC GOALS (SH)	*(Enclosure)*
11.	RESHAPING HEFT (SH)	*(Enclosure)*
12.	INFECTION CONTROL UPDATE REPORT (MS)	*(Enclosure)*
13.	UPDATE ON NOROVIRUS (MS)	*(Oral)*
14.	NURSING & MIDWIFERY UPDATE (MS)	*(Presentation)*
15.	BOARD ASSURANCE FRAMEWORK & RISK REGISTER (SW)	*(Enclosure)*
16.	SAFETY SITREP REPORT(SW)	*(Enclosure)*
17.	T&O UPDATE REPORT(AA)	*(Enclosure)*
18.	HR & OD UPDATE (HG)	*(Enclosure)*
19.	ACAD (JS)	*(Enclosure)*
20.	CONTRACT ARRANGEMENTS 2012/13 (AS)	*(Enclosure)*
REPORTS FROM BOARD COMMITTEES		
21.	DONATED FUNDS COMMITTEE REPORT (PHe)	*(Oral)*
22.	FINANCE AND PERFORMANCE COMMITTEE REPORT (RH)	*(Oral)*
23.	FINANCE AND PERFORMANCE COMMITTEE MINUTES (30/1/12)	*(Enclosure)*
24.	GOVERNANCE AND RISK COMMITTEE REPORT (AE / SW)	*(Oral)*
25.	HR STRATEGIC COMMITTEE REPORT (PH)	*(Oral)*
26.	HR STRATEGIC COMMITTEE MINUTES (9/1/12)	*(Enclosure)*
27.	IM&T COMMITTEE REPORT (PHe)	*(Oral)*
28.	IM&T COMMITTEE MINUTES (10/2/12)	*(Enclosure)*
29.	MONITOR STANDING COMMITTEE MINUTES (30/1/12)	*(Enclosure)*
TRUST NEWS AND EXTERNAL ENVIRONMENT		
30.	COMMUNICATIONS UPDATE (LT)	*(Enclosure)*
31.	PATIENT ENGAGEMENT REPORT (LT)	*(Enclosure)*
COUNCIL OF GOVERNORS AND MEMBERSHIP		
32	UPDATE (PH / LD)	*(Oral)*
33.	COUNCIL OF GOVERNORS MEETING (16/1/12) (PH)	*(Oral)*
CORPORATE GOVERNANCE		
34.	SCHEDULE OF MATTERS RESERVED TO THE BOARD	*(Enclosure)*
35.	MONITOR STANDING COMMITTEE MEMBERSHIP	*(Enclosure)*
ANY OTHER BUSINESS		
DATE OF NEXT MEETING		

1 MAY 2012 Heartlands Education Centre

Board of Directors

March 2012

Apologies

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Board of Directors

March 2012

Declaration of interest

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REGISTER OF DIRECTORS and REGISTER OF DIRECTORS' INTERESTS

VOTING TRUST BOARD MEMBERS

NAME	DATE OF APPOINTMENT	INTEREST (if any)	DATE OF NOTIFICATION	DATE OF TERMINATION OF INTEREST
Dr Aresh Anwar	01.03.11	1. South Asian Health Foundation : Member of Diabetes Working Group	01.03.11	
Ms Mandy Coalter	24.07.06	1) Prior to Ms Coalter's appointment HEFT contracted 'Q Learning' to provide an Organisational Development programme. This contract is under review and since the Q Learning contact is a personal friend of Ms Coalter's, she has delegated all decisions about the future of the contract to Theresa Nelson (Head of OD). 2) Ms Coalter's husband, Lee Moreton, is a professional tennis coach and he will potentially be working with the Trust on the staff sports programme. Ian Cunliffe is the executive lead for the contract negotiations.	23.01.07 12.07.10	
Ms Anna East	01.07.05 01.05.10 01.09.10 01.08.12 01.04.12	1) Director of Dudley Building Society 2) Non Executive Director Midland Heart Housing Association 3) Regional Panel CEAA 4) Chair of Dudley Building Society 5) Non Exec Director of Entrust	01.01.08 25.10.10 25.10.10 13.10.11 13.10.11	
Mr Simon Hackwell	01.03.07	Board Director for a 1 year term of office at MidTECH - one of a network of nine regional NHS innovation hubs, established by the Department of Health to identify, protect and commercialise innovative ideas from within the NHS.	09.10.09	
Ms Najma Hafeez	01.04.07	Chair of Postwatch	01.01.07	30.10.08
Mr Richard Harris	01.05.08	1) Brambles Limited Shareholder and Chair of UK Pension Fund 2) Trustee of Action for Children Superannuation Fund. 3) Birmingham Community Foundation Trustee 4) RSA Academy - Governor 5) Flora Forster Students' Fund Trustee 6) Director and Shareholder, Gorilla Box Limited. 7) President, Solihull School Parents Association 8) Richard Harris' wife is a volunteer WRVS worker at Solihull Hospital	01.05.08 01.05.08 01.05.08 01.05.08 01.05.08 04.08.09 04.08.09 04.08.09	

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	14.09.10	(half a day per week) 9) Non executive director of Simplyhealth Group Limited 10) Member of the Audit & Risk Committee of the RSA (Royal Society for the encouragement of Arts, Manufactures and Commerce). 11) Trustee of StartHere a charity based in West London engaged in developing information databases on health, social services, housing services and a range of other information, all targeted at people in need, and in particular accommodating people who do not have access to computers or who are not computer literate.	19.07.10 4.11.10 29.11.11	
Mr Paul Hensel	01.08.05	1) Paul Hensel's wife has been appointed as a non executive director of the Royal Orthopedic Hospital. No conflict is foreseen but it is registered for the sake of good order. 2) Non Executive Director of Kplus Software Limited (small company involved in development and delivery of Mobile Data Solutions) 3) Non Executive Director of the John Taylor Hospice	30.01.07 22.02.07 08.02.12	01.08.07
Rt Hon Lord Philip Hunt PC OBE	01.10.10	1) Member and Deputy Leader of the Opposition, House of Lords 2) Self-Employed Consultant on NHS and wider health issues, t/a Phillip Hunt Consultancy 3) Trainer and Policy Analyst, Cumberlege Connections Ltd. (NHS leadership/awareness programmes) 4) Philip Hunt Consultancy consultant and trainer, 5) President, British Fluoridation Society 6) Trustee, Terrence Higgins Trust 7) President, Royal Society of Public Health 8) President, Health Care Supply Association 9) Chair, Birmingham University Policy Commission on Nuclear Energy 10) Member of the National Advisory Council of the Easy Care Foundation 11) Chamberlain Sixth Form College (where Lady Hunt is Vice Principal) has occasionally since 1993 utilised the services of HEFT OH Dept. There is no formal contact, neither Lord nor Lady Hunt are involved in the arrangement and the value is approx £1,500pa 12) Patron/Ambassador of Saving Lives	11.10.10 11.10.10 11.10.10 26.04.11 June 2011 June 2011 01.10.2011 17 Oct 2011 Nov 2011	17.08.11

Dr Mark Newbold	01.08.10	1) Member of Multidisciplinary Professional Advisory Panel of BabyLifeline (Charity)	01.01.2012	
Mr Richard Samuda	01.07.06 04.01.11	Non Executive Director of Horton Estates Limited Director of Warwick Racecourse	16 June 2006 (On Appointment) 04.01.11	
Mr Adrian Stokes	01.07.08 (as voting board member)	1) Director of HECL 2) Pfizer Virtual Customer programme	1) On app't 2) 20/6/2011	
Mandie Sunderland	01.12.08	Nothing to declare		
Dr Sarah Woolley	07.05.07	Energy & Home Condition Surveys Ltd – Company Secretary	16.03.07	July 08

Heart of England NHS
NHS Foundation Trust

REGISTER OF INTERESTS

NON VOTING TRUST BOARD MEMBERS

NAME	DATE OF APPOINTMENT	INTEREST (if any)	DATE OF NOTIFICATION	DATE OF TERMINATION OF INTEREST
Ms Lisa Thomson	23.10.08	1) Non Executive Director of Multistory 2) Trustee of a charity ... Redditch United Football In the Community	22.12.08 07.11.11	
Mr Andy Laverick		Nothing to declare	18.12.08	
Mr John Sellars	08.01.07	Nothing to declare	16.04.08	
Mrs Claire Molloy	01.05.11	Nothing to declare	01.05.11	
Ms Susan Moore	01.09.2011	Nothing to declare	01.09.11	

Board of Directors

March 2012

Minutes from previous meetings

Minutes of meeting held on 3 January 2011

12.001	APOLOGIES and WELCOME
12.002	DECLARATIONS OF INTEREST
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12.006	CHIEF EXECUTIVE'S REPORT
12.007	QUALITY AND PERFORMANCE MONITORING
12.007.1	Finance & Performance Report
12.007.2	Iproc Requisitions for approval
12.007.3	Update on Norovirus
12.007.4	Business Plan Q2 and Q3 Update
12.007.5	Solihull Local Safeguarding Children's Annual Report 2010/11
12.007.6	Organ Donations Committee Annual Report
12.007.7	Carbon Footprint Annual report 2010/11
12.007.8	Site Strategy Update
12.007.9	Safety SITREP Report
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12.008.5	Governance and Risk Committee Report
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12.008.7	Stakeholder and Community Engagement Committee Report
12.009	TRUST NEWS AND EXTERNAL ENVIRONMENT
12.009.1	News update
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12.009.3	Volunteering Report
12.010	COUNCIL OF GOVERNORS AND MEMBERSHIP
12.011	CORPORATE GOVERNANCE
12.011.1	Schedule of Matters Reserved for the Board
12.011.2	Division of Responsibilities
12.011.3	Committee Terms of Reference
12.012	ANY OTHER BUSINESS
12.013	DATE OF NEXT MEETING

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Minutes of a meeting of the
BOARD OF DIRECTORS
of Heart of England NHS Foundation Trust
held at The Education Centre, Good Hope Hospital
on 3 January 2012

PRESENT:	Lord P Hunt (Chairman) Dr A Anwar Mr D Bucknall Mrs A East Mr S Hackwell Mr R Harris Mr P Hensel Dr M Newbold Mr R Samuda Mr A Stokes Dr S Woolley
IN ATTENDANCE:	Ms H Gunter Mr A Laverick Mrs C Molloy Mrs S Moore Mr J Sellars Mrs L Thomson Mrs A Hudson (Minutes) Members of the Press and Public

12.001 APOLOGIES and WELCOME

Apologies were received from Ms M Coalter, Ms N Hafeez, Mr M Pye and Ms M Sunderland.

The Chairman welcomed everyone to the meeting and wished everyone a very happy New Year.

The Chairman welcomed Ms Hazel Holmes, Director of Nursing at Liverpool Heart and Chest NHS Foundation Trust.

The Chairman began the meeting by thanking David Bucknall who was retiring at the end of his term as Non Executive Director on 7 January 2012. Lord Hunt proposed a vote of thanks for all the invaluable advice and guidance Mr Bucknall had given during his time at HEFT and wished him well for the future. This was formally endorsed by the Board.

12.002 DECLARATIONS OF INTEREST

The following declarations of interest were noted:

Lord Hunt declared that his wife Selina Stewart, Vice Principle at Chamberlain Sixth Form College, is working with HEFT on a volunteer programme.

Mark Newbold declared an interest as a member of Multidisciplinary Professional Advisory Panel of BabyLifeline (Charity).

Richard Harris declared his appointment as a Trustee of Starthere (Charity).

Lisa Thomson declared her appointment as a Trustee of Redditch United Football in the Community (Charity).

12.003 MINUTES OF LAST MEETING

8 November 2011

11.126.2 Finance & Performance Report. Mr Stokes advised that the potential fines only related to C-Diff and not MRSA.

11.126.9 Board Assurance Framework & Risk Register inc SITREP. Dr Woolley advised that there were two red rated risks rather than four as stated.

Subject to above changes the minutes of the meeting held on 8 November 2011 were approved by the Board and signed by the Chairman.

12.004 MATTERS ARISING

The Schedule of Matters Arising was discussed and the following actions noted:

11.98.1 The Coroner has been invited to attend the next meeting of the Governance & Risk Committee in January 2012.

11.98.11 Harrop Inquest – no letter received as yet from the Coroner's office.

11.109 Update on Cluster working – on agenda.

11.110.1 Work is being undertaken on the Bribery Act and a paper will be presented to the next meeting.

11.124. Report on clinical changes – no update available as yet.

11.125 Never events- the Governance & Risk Committee is to consider this and the Assurance framework at its next meeting and an update will be presented to the next meeting.

11.126.6. Number of staff receiving flu vaccine – carried forward to next meeting.

11.127.3 PHSO Review of Complaint Handling. The Chairman has written to the Ombudsman.

12.005 CHAIRMAN'S REPORT

Lord Hunt presented a summary of his written report and drew the Board's attention to several items:

Congratulations to Najma Hafeez who has been awarded the 'Best CEO' in the Women of Culture Awards in the West Midlands.

Congratulations to the Trust Faculty team who have received the HSJ Awards 2011 in the categories of 'Workforce Development' for HCDU Foundation programmes (Step into Work Apprenticeship programmes) and 'Improving Care with Technology' for VITAL.

The Chairman and Richard Samuda attended the Volunteers Christmas lunch, thanking those present for all their hard work and service.

Andrew Mitchell MP officially opening the new and much needed Bereavement Suite at Good Hope Hospital in November 2011. This provides relatives with a purpose designed facility for staff to support relatives during very emotional and difficult times.

The Chairman had attended the Ward Sister Challenge along with many executive and non executive colleagues. It was a good opportunity to hear from frontline staff about what they needed in order to improve their services. Workstreams are now being taken forward including giving ward sisters more time to focus on their leadership role.

12.006 CHIEF EXECUTIVE'S REPORT

Dr Newbold presented a summary of his pre-circulated written report. The organisation continues to pursue its goal of being as open and accessible as possible with the Trust now having an official twitter account.

There has been lots of work undertaken on winter planning with the result that the Trust successfully managed the Christmas and New Year period.

Mrs East asked about the feedback on programmes at the Dr Foster Global Comparators Conference. Dr Newbold advised that the Trust is part of the stroke work stream and is working to understand the differences in order to focus on changes to improve outcomes. It is taking a while to understand differences but openness around clinical data is helping to move this forward.

Mr Harris asked whether Dr Newbold and Mrs Thomson had viewed the finance system during their visit to Addenbrookes? Dr Newbold responded they had not. Mr Stokes added that a site visit was planned to look at Addenbrookes financial systems.

The Chairman reminded Dr Newbold that once the George Eliot scoping work was completed it would need to come back to a future meeting. Dr Newbold confirmed that it would come back to the next meeting for discussion by the Board.

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12.007 QUALITY AND PERFORMANCE MONITORING

12.007.1 Finance & Performance Report

Mr Stokes presented a summary of his pre-circulated report setting out the finance and key performance indicators for month 8. The Trust has achieved the Q3 Monitor A&E 95% target and Mr Stokes circulated a paper showing the A&E performance of 95.9% for Q3 compared to 84.1% for the same period in 2010/11. The site teams will continue to monitor performance to ensure that the Trust achieves the Q4 target. The Chairman congratulated Mr Stokes and the teams on the tremendous amount of work that had been undertaken and for the achievement of the Q3 target.

There continues to be a backlog of patients waiting over 18 weeks and action plans are in place to address this. The Chairman asked if the Trust is dealing with the 25 patients who have been waiting over a year. Mr Stokes and Dr Anwar reassured the Board that these patients all had a clinical reason for waiting over 52 weeks such as not being fit for surgery or bariatric clinical reasons and they were reviewed regularly. Mr Stokes went on to advise that the situation is being monitored very closely and there is an expectation that by the end of Q4 the number of patients waiting greater than 18 weeks will have reduced.

Lord Hunt asked about what the expectations were for outturn for Q4, Mr Stokes responded that he would expect to see a similar result as for Q3.

The Trust had a surplus of £0.6 million in November and £0.2 million deficit year to date. The November position is ahead of forecast due to better than expected income, partially offset by greater than expected pay costs. The in-month position also includes a reduction in education and training income of circa £400,000 due to the impact of MADEL/SIFT mid-year review. Whilst this has moved the Trust towards a monthly breakeven position, the year-to-date position remains of significant concern. A discussion on future contract arrangements and level of income has been held with the Clusters and a paper will go to the Finance and Performance Committee in January looking at risks; following this a proposal will be presented to the Board. Mr Harris commented that a fixed-price contract was quite an unusual approach; however, it does have both merits and concerns and these would be discussed at the Finance and Performance Committee meeting following which it will be brought back to the Board in March.

Mr Harris advised the meeting that exploratory discussions had taken place on a proposal to look at using a provider from the private sector for insurance rather than continuing to use NHSLA. Mr Stokes and his team have undertaken some work to explore options. Mr Samuda and Mr Harris are to be included in this work. Mr Hensel asked if the Trust was taking a pioneering stance or are other foundation trusts also looking at alternative providers? Mr Stokes responded that there are approximately 20 other foundation trusts who are also considering the possibility of taking this route. This is the first year that the Department of Health has allowed foundation trusts to look at outside options. It was agreed that a paper will come at the Board, in due course, from Dr Woolley who was now lending work on this issue.

The Chairman commented that the financial position looks to have improved a little but nonetheless 2012/13 will remain a challenge. Mr Stokes added that the

financial position will always be a challenge and the organisation will need to look at efficiency challenges.

Mr Hensel asked for a report on new-to-follow up to be brought back to a future meeting. Mr Stokes will pick this up within his finance report.

Mr Stokes commented that the pay costs looked more under control in November; however, it would it be useful to understand these in context. The nursing pay bill still has work to be undertaken. Ms Gunter added that work on rostering should begin to show improved benefits. Job planning is focusing more around productivity and there is a strong focus to meet next year's efficiency challenge.

The Chairman asked for clarity on the following:

- If there was an issue with Doctor's attending corporate induction and if there was an issue about them being released to attend these. Dr Anwar advised that there are a number of inductions that need to undertaken (e.g. Deanery) and work is underway to address this.
- The number of outstanding staff appraisals. Ms Gunter advised these are being undertaken differently this year. She was not concerned about the number outstanding and was expecting that the target will have been achieved by next month.
- The red rating for Length of Spell. Mr Stokes advised that there was still scope for improvement; however, there was a lot of work being undertaken to improve long stay and discharges.
- How SUI's are formally reported. Dr Woolley advised that the Trust is linking in with the Cluster and PCTs around reporting.

12.007.2 Iproc Requisitions for approval

There were ten iproc requisition presented for approval:

- 654289 Marsh UK Ltd for Property, public/products liability service insurance renewal
- 652720 Leaseguard Services Ltd for 6 year lease contract for Alaris GH Plus Guardrail.
- 655906 Southern Electric Plc for provision of electricity at Good Hope Hospital
- 657754Total Gas and PowerLtd for provision of gas to Good Hope Hospital.
- 658045 AGFA Healthcare Ltd for PACS/CRIS maintenance.
- 658374 Health Protection Agency for Chlamydia Screening
- 658633 Solihull Care Trust for IT managed service for community service.
- 658989 Roche Diagnostics ltd to cover the Roche managed service contract for January & February 2012
- 659143 Abbott Laboratories Ltd for pathology managed service contract.

The Board approved the above requisitions.

12.007.3 Update on Norovirus

Dr Newbold advised that there had been no Norovirus cases in November however there had been one case in December.

12.007.4 Business Plan Q2 and Q3 Update

Mr Hackwell presented a summary of his pre-circulated paper. The paper sets out progress against the key objectives in the Business Plan. The following comments were noted:

- For Groups 1 and 2, the objectives set out in the Business Plan have been superseded by the Trust's reshaping priorities.
- Mr Samuda asked for an update on 7 day working for Group 1 and if the plan was realistic? Dr Anwar responded that 7 day working was determined by workforce considerations; however, all clinical teams on the Heartlands site have a representation over 7 days. 7 day working was still a challenge on the Good Hope site. 7 day manpower on the Solihull site was more problematical but work streams are in place to address this.
- Mr Harris raised the point that it was important to ensure that the plans and actions being taken this year would not be contradictory to longer term strategic planning. Mr Hackwell responded that he was confident that senior teams and the reshaping HEFT work would not destabilise longer term strategic plans. A report looking at the longer term plans would be bought back to the March meeting.
- Mr Harris then asked if the plans were consistent with financial CIPs and linked in with the reshaping HEFT work and finances. Mr Hackwell was confident that they are in line.
- Mrs Moore commented that the plans must be linked into individual site developments and that there is a balance between sites and Groups. She hoped that communication with the sites would be undertaken sensitively.
- Mrs Molloy added that the Board will receive a development plan on a single integrated plan for 2013 in due course.
- Mr Bucknall commented that the Group 3 cross-site strategy group had shown commitment to the ACAD outpatient project and there was need to ensure that any construction supports the delivery of services.
- The question was raised of how well the integration of Community Services had gone. Mr Hackwell advised that the integration had gone well although there had been some issues with ICT but these were being worked through.
- The Chairman asked why the number of births in the Solihull Birthing Centre was so low. Mrs Molloy advised that the number of births had exceeded the number of planned births although the figures were always likely to be low. Dr Newbold advised that lots of work around communicating and building confidence in the SBU had been undertaken and he was confident that the number of births will grow in due course. Mr Stokes added that the low numbers were not a cause for concern.

12.007.5 Solihull Local Safeguarding Children's Annual Report 2010/11

Mrs Molloy presented an overview of the pre-circulated report. The items of note were:

- The Trust is a member of the Local Safeguarding Children Board and the report is the statutory annual report.
- There are no areas of concern raised for the Trust.
- A number of inspections have recently taken place and OFSTED has undertaken a review in Solihull that has highlighted a number of issues for delivering named doctors and nurses.
- Ms Sunderland and Mrs Molloy have a plan to address the concerns raised and are due to meet with the local authority to discuss broader issues of

mental health.

- Mrs East raised the point that it needed to be ensured that committees do not duplicate reporting and asked that future reporting should come through Governance & Risk Committee.
- Mr Harris asked about the Trust's Safeguarding policies. Dr Woolley responded that this report is about safeguarding in the community. However, she confirmed that the Trust's policies meet all the statutory requirements and are in line with the relevant overarching Boards.

The Trust Board accepted the report and asked the Company Secretary for clarity on where the reports are to be presented and by whom.

12.007.6 Organ Donations Committee Annual Report

Mr Harris and Dr Julian Hull, Clinical Lead for Organ Donation, presented an overview of the pre-circulated report.

- The Organ Donation Committee (ODC) was established in 2009 and its membership was revised in 2011 to make the ODC more effective.
- The Terms of Reference for the ODC have recently been revised to promote positively organ donation at HEFT and facilitate greater awareness throughout the Trust of organ donation issues.
- The Committee is making good progress; however, it is still very challenging to identify every potential donor who comes through the Trust.
- Only 14% of families approached consented to organ donation.
- The number of staff on the organ donation register is very low.

Dr Hull advised that healthcare workers including Trust staff should be encouraged to support the Committee's work. The Trust is to support organ donation with a communication plan. There is a huge opportunity for the Trust to support and encourage staff and members of the public to sign up to organ donation. The ODC are visiting mosques and community meetings to talk about organ donation.

Mr Hensel asked if organ donation could be made opt out rather than opt in and would it make a difference to the number of donations received. Dr Hull advised that family need to know if family members are on the organ donation list but could ultimately still refuse organ donation.

Lord Hunt thanked Dr Hull for attending and presenting the annual report. The Board recognised the vast amount of work being undertaken to improve the number of donors and fully supported the efforts being made and suggested that Dr Hull and his team make use of the communications team to promote the message.

12.007.7 Carbon Footprint Annual report 2010/11

Mr Sellars presented an overview of his pre-circulated report.

- The demand for energy is ever-increasing at a national and Trust level.
- In 2008/9 the Trust committed to a carbon management plan with a target of reducing carbon emissions by 25% over a five-year period, with a further 20% saving over the following five year period.
- By the end of 2010/11 performance against target was slightly below planned levels.

- The Trust is currently seeking a commercial partner to further reduce energy consumption and developing a more environmentally sustainable approach to energy in order to target a further 10% reduction in demand.
- The Trust is also in advanced negotiations to install a CHP system at Good Hope Hospital.
- The Trust has invested in a range of other energy reducing measures including
  - Automatic personal computer shut down.
  - High frequency fluorescent lighting.
  - Heating throughout the Trust is computer-controlled which automatically operate at optimum levels over a range of environmental conditions.
  - All new build developments including the new ward block at Good Hope Hospital are built to the BREEAM Excellent standard, one of the best performing low-energy construction standards.
  - All new buildings have meters so that the Trust can monitor individual uses on wards.

The question was raised whether the budget for energy is held centrally and Mr Stokes advised that it was, and he believed this was the correct approach to take.

Mr Bucknall added that the Trust is 'ahead of the game' in its plans for reducing its carbon footprint but added that there is still lots of work to the undertaken although he was confident that it was moving in the right direction.

Mr Harris asked about the Combined Heat and Power plants that have been installed and whether these will deliver a cost saving strategy overall? Mr Sellars responded that the plant on the Heartlands site will pay for itself (from energy efficiency savings) within the next 5-7 years and the Trust gets the plant back from the investors in 15 years time. He added that Solihull will have paid back its investments within 7 years.

12.007.8 Site Strategy Update

Mr Sellars gave a verbal update on site strategy. Tranche 1 projects include:

- Ward block 1 at Good Hope and Bedford Road houses, both complete
- Construction has commenced at Good Hope on Theatres and the Emergency Department
- Work has commenced on Pathology at Heartlands
- The final business case for ACAD at the Heartland's site is to be presented in early Spring 2012, with construction commencing early summer 2012.

Tranche 2 work includes:

- Completion, managing, commissioning and logistics of tranche 1 projects.
- Continued assessment of Trust built assets
- Develop, agree and deliver ward refurbishment programme
- Site rationalisation plans
- Energy project
- Managing potential future developments across the sites.

Mrs Thomson advised that plans were in place to communicate relevant details of the work that is being undertaken. .8 .17

Mr Bucknall commented that in relation to the ACAD project some services may need to be sited outside of the building.

The Chairman confirmed that in terms of general enhancement of capital estate the Board is very happy for the Site Strategy programme to continue.

Mr Samuda commented that feedback from safety walkabouts usually included equipment downtime and he asked who was responsible for repairs and replacement. Mr Sellars responded that the Operational groups are responsible for equipment repairs and that budget is available for this; Mr Stokes added that the budget is always underspent. Mr Sellars added that allocation for new equipment is built into all new building projects and budgets.

Mr Samuda also asked about whether a safety audit of equipment was undertaken and Mrs East asked about the amount of equipment that comes to the end of its useful life. Mr Stokes responded that approximately £4m of equipment comes to the end of its useful life every year. Mrs East then went on to ask if Groups manage their own budget or was there a central budget? Dr Woolley responded that medical device management was hugely complicated and amounted to hundreds of thousands pounds per annum; however, the Trust has good system and a register in place to manage the process.

The Chairman asked for suggestions on how to take this forward and that the Board would like to understand more about medical devices, Mr Harris added that the Finance & Performance Committee was also looking into this area and would report back to the Board in due course.

The Chairman asked about general refurbishment of wards on the Heartlands site and how this was to be facilitated without a decant ward. Dr Anwar and Mr Stokes responded that it was possible to create capacity to provide a ward decant facility.

12.007.9 Safety SITREP Report

Dr Woolley presented the pre-circulated Safety SITREP report. A Q3 review is underway and the results of this will be presented to the March meeting. There are currently two red risks: the security system on paediatric ward and manual handling. Operations Committee have a plan and will be monitoring progress on these risks.

The Chairman asked if there were any lessons to be learnt. Mr Stokes responded that the authorisation process for capital spend is to be reviewed. Mrs East added that she was unsure why this report had been submitted to the Board, as it was being dealt with by the Governance & Risk Committee. Mrs East added that the Committee would report progress to the Board.

The Chairman asked about manual handling and Dr Woolley advised that this had only just come to Operations Committee and an action plan has been produced to deal with this.

The Chairman added that the Board would like assurance that both risks have been dealt with and asked that a paper is bought back setting out prioritisation of capital spend and the arbitration mechanism to deal with boundary issues.

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Dr Woolley advised that there had been two new SUIs, both involving medicine administration issues and the investigation outcomes will come back to the Board in due course. Dr Woolley reassured the Board that the Executive Management Board has agreed to undertake more detailed reviews to ensure issues are picked up and that the Trust is doing everything it can to minimise errors including communicating learning reports. Safety and Governance Directorate has recruited a new staff member who will be working with clinical teams and medical directors to engage staff and promote learning. Future reports will include a good practice and learning section.

The Chairman asked about SUI closedown reports for theatre staff and being confident in getting the challenge with other teams right. Dr Woolley advised that there is continued focus in team working and appropriate challenge; Dr Roger Stedman has drawn up a team behaviour compact for all staff to sign up to. The Simulation Strategy has been agreed and maternity, patient transfer and handover and theatre teams will be undertaking human factors training.

12.008 REPORTS FROM BOARD COMMITTEES

12.008.1 Audit Committee Report

Mr Samuda, Chair of Audit Committee, updated the Board on the main items of discussion at meeting held on 5 December 2011. These were:

- As part of the audit planning for 2011/12 time is being factored into the timetable to give an opportunity for all directors to comment on an early draft of the Annual Report of Accounts, to try to avoid too many last minute amendments.
- The Audit Plan and audit approach for Donated Funds was approved.
- The Committee was encouraged that KPMG would be undertaking a piece of work to review governance and assurances process as between Audit Committee, Governance & Risk Committee and the Board to ensure there are neither gaps nor overlaps.
- The Committee reviewed progress on counter fraud work and noted that KPMG would be bringing this and a Bribery Act update to the Directors Strategy Meeting in February.
- The Strategic Risk Register was reviewed and will be reviewed again in about six month's time.
- The technical training needs of committee members and thought about how best to conduct a self assessment process will be reviewed in more detail at a meeting in March.
- The meeting reviewed the Committee's Annual Business Programme to ensure it continued to meet the Trust's needs.

Lord Hunt asked about the discussion around the Heartlands Education Centre Ltd and if this had been raised for any particular reason. Mr Samuda responded that it was discussed as a point of Governance and would be picked up within the scope of the internal audit on partnership working.

12.008.2 Audit Committee Minutes

The draft minutes of the meeting held on 5 December 2011 were noted.

12.008.3 Finance & Performance Report

Mr Harris, Chair of the Finance and Performance Committee, gave an update of discussions held at the meeting of the 28 November 2011. The meeting discussed the following:

- The forecast for this year continues to be looked at in detail every month, giving particular focus to the assumptions and risks which underlie the forecast.
- Briefings on budget process have been held, outline budgets are due to be submitted in March. Budgets will be very challenging for the coming year.
- The Committee wants to see budgets that ensure the Trust is in a financially sound position, with full buy-in from staff.
- The importance of meeting key targets including the monthly Monitor position was explained.
- Treasury policies and the Royal London cash management arrangement by which we place money on deposit in order to maximise return and ensure that it is deposited with banks for absolute security. The Trust use a number of banks and the meeting agreed to deposit £20m with the Cooperative Bank.
- Currently the Trust spends circa £200m on non pay costs. The Committee is undertaking a review to ensure that the Trust gets the best deal.
- Pharmacy has a separate arrangement and work is underway to better understand these arrangements.
- The Committee is looking at the process for allocation of capital expenditure.

12.008.4 Finance & Performance Minutes

The draft minutes from the meetings held on 24 October 2011 and 28 November 2011 were noted.

12.008.5 Governance and Risk Committee Report

Mrs East, Chair of Governance and Risk Committee, updated the Board on the meeting held on 12 December 2011.

- Trauma and Orthopaedics is an outlier in relation to the Dr Foster report. The meeting discussed performance and clinical outcomes. The EMB is already looking at this issue in detail and a report will come back to Governance & Risk Committee in due course.
- Simulation Strategy – Maternity and patient transfer to be the first to make use of this training.
- Audits are being completed in clinical areas.

12.008.6 Governance and Risk Committee Minutes

The draft minutes of the meeting held on 12 December 2011 were noted.

12.008.7 Stakeholder and Community Engagement Committee Report

Mrs Thomson reported that the inaugural committee meeting was held in December and debated exactly who stakeholders are. The Committee will be looking at how it can set and measure a baseline for the reputation of the Trust and how it conducts its business.

12.009 TRUST NEWS AND EXTERNAL ENVIRONMENT

12.009.1 News update

Mrs Thomson presented a summary of her written report which sets out the high level of activity in the external environment. There had been 73 pieces of positive media coverage.

The Chairman raised the point that media issue around bed numbers continue to be negative and need to have a more positive focus around reshaping of services rather than downsizing of the organisation and its services. Mr Samuda agreed adding that the national press stories tend not be in context; however, he added that the Trust is open with the media in order to help and inform and to give a balanced message to the public and patients. Mrs Molloy added that it was important to get the message across that the driver for change is not about closures but improving services. She added that there will be need to give the public reassurance of the effects this may have on carers and partners and to ensure that the Trust is communicating that appropriate services are in place to support them. Mr Hackwell advised that this will be undertaken within the Reshaping HEFT Communications strategy.

12.009.2 Patient Experience Update

Mrs Thomson presented the Patient Experience Report, as circulated. The report summarises the October 2011 results from the back to the floor programme and the main points were:

- 764 patients were surveyed about their experiences across all three sites in October 2011. The included 623 inpatients, 90 A&E patients and 51 phlebotomy patients.
- 54% of inpatients commented that staff had spoken to them about going home. The Jonah project will have a huge impact on patient information including being able to check patients notes to test whether they were aware of their discharge.
- 88% of inpatients felt their call buzzer was answered promptly.
- Patients report their experience with privacy and discharge was unsatisfactory in A&E. Pain control experience with A&E reception and patient's satisfaction with their overall experience in A&E has also fallen in October 2011 from the 90 patients surveyed. Significant improvements have been made and reception staff have received training on privacy and dignity
- Changes initiated into complaints process with the launch of new Patient Services Department. A full review of the Complaints Policy is to be completed in Quarter 1.
- 90% of patients would recommend to family and friends.
- 16% reduction in the number of formal complaints.
- The Trust now has a one line hot number with all calls being answered rather than going to an answer phone and all calls are now recorded.

Mr Samuda asked about patient experience feedback from GPs, Mrs Thomson responded that the Trust GP liaison team regularly ask GPs for feedback from patients; however, feedback tends to focus on negative rather than positive aspects.

Mr Harris asked if there was a link between improving performance, staff morale and patient experience feedback and if a difference has been seen. Ms Gunter was unsure but would investigate and report back.

Mr Hensel supported the value of voice recording and asked if the Trust makes these available to complainants. Mrs Thomson confirmed this was the case and added that complaint meetings are also recorded and sent to the attendees. Mr Hensel then asked if this had improved the immediate response time. Mrs Thomson advised that some cases may still go over the 25 days although the number had reduced significantly. Dr Newbold informed the Board that shortly before Christmas within one hour of receiving a complaint ward staff had dealt with the issues and Dr Newbold had emailed the complainant to say this had been resolved. He added that the number of concerns may see an increase but the number of complaints will fall overall.

Mrs Thomson added that no complaint is now a formal complaint unless specifically requested. If complaints are complicated they may benefit by going through the formal complaint process and if the Trust has any concerns then they will go to the source of the complaint. Mrs East added a note of caution that a culture of trying to quash complaints was to be avoided and this was duly noted.

Mr Samuda commented that the Trust can also learn from compliments as well as complaints. Mrs Thomson agreed and said that she always enquired if there were areas where the Trust could have improved.

12.009.3 Volunteering Report

Mrs Thomson presented a summary of the pre-circulated report, the main topics of which were:

- A new recruitment process has been implemented with effect from January 2012.
- A new structure has been implemented following consultation. The new structure will give more ownership at local level and engage better with site leadership.
- Mandatory training is now in place for all volunteers
- A workshop is planned to examine the role of the volunteers particularly in clinical areas to ensure that volunteers and ward staff have the same expectations. Following this, new volunteers profiles will be produced.

Mr Samuda noted that following the initiative with the Somalie community there are now 50 volunteers working at the Heartlands site.

Mrs Thomson added that the Trust is also working with the housing association to get volunteers back in to work.

Mr Samuda also asked about student volunteers. Mrs Thomson responded that her team was working with HR to ensure students get a better experience by encouraging them to undertake work experience rather than volunteering.

12.010 COUNCIL OF GOVERNORS AND MEMBERSHIP

The Chairman updated the Board on recent events and discussions at the Council of Governors meeting held on 21 November 2011.

- Governors raised continuing concerns about the Outpatients Booking System
- The Chief Executive briefly updated Governors about George Eliot.
- The meeting talked about the stringent financial controls in place.
- Simon Hackwell gave a presentation on Reshaping HEFT, which was well received.
- The meeting reviewed reports from the various governors committees that had met in the proceeding few weeks.
- The Trust is in the process of recruiting two new Non Executive Directors.
- The Governor Breakfast meetings continue to be held, with the meeting in December focusing on IM&T.
- The meetings discussed membership and the benefits of having smaller membership. It was agreed that this should be a shared decision between Governors and the Board.

12.011 CORPORATE GOVERNANCE

12.011.1 Schedule of Matters Reserved for the Board

Lord Hunt, presented a summary of the pre-circulated report. Provision A1.1 of the Monitor Code of Governance requires there to be a formal schedule of matters specifically reserved for decision by the Board of Directors. The document was approved by the Board in August 2006, and has now been updated with some minor consequential changes. The following items were noted:

2.6 Organisational structure at Director level – should read Board Director

5.5 Approval of the opening or closing of any back account. Mr Stokes advised that the Finance Director had traditionally made decisions relating to the opening of bank accounts.

7.5 Mr Hackwell asked that the wording be clarified and a limit included.

Following the above changes the document is to be presented to the March meeting for agreement by the Board.

12.011.2 Division of Responsibilities

Lord Hunt presented a summary of the pre-circulated report. Provision A.2 of the Monitor Code of Governance requires there to be clear division of responsibilities at the head of the NHS Foundation Trust between Chairing of the Board of Directors and the Council of Governors and the Executive responsibility for the running of the Foundation Trust's business.

Provision A.2.1 goes on to state that the division of responsibilities should be clearly established, set out in writing and agreed by the Board.

The document was considered and approved by the Board. .14
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12.011.3 Committee Terms of Reference

Lord Hunt presented a summary of the pre-circulated report.

- Following the governance review undertaken earlier in the year and the establishment of various new Board Committees, the draft Terms of Reference for the following committees, each of which have been approved by the respective Committee, were presented for consideration by the Board.
    - Donated Funds
    - Finance & Performance
    - HR Strategic
    - Nominations

The Terms of Reference as presented were approved by the Board.

- Terms of Reference for the IM&T Committee, Stakeholder & Community Engagement Committee and for the Remuneration Committee will be presented for approval at a future meeting.

- The Terms of Reference for the Audit Committee and the Governance & Risk Committee were not included as a review is currently being undertaken by KPMG looking at the respective assurance processes and this review will encompass Terms of Reference and these will be submitted for approval in due course.

12.012 ANY OTHER BUSINESS

There was none.

12.013 DATE OF NEXT MEETING

6 March, 2012

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Chairman

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Board of Directors

March 2012

Matters Arising

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BOARD OF DIRECTORS

Schedule of Matters Brought Forward and Action Points

Date raised	Minute No	Detail	Action	Due	Status	Completed
5 July 2011	11.98.1	Consider inviting City Coroner to future Board meeting	PH		Invited to attend January Gov & Risk Comm meeting	3/1/12
	11.98.11	Harrop Inquest Respond to Coroners letter when received Brief Governors	MN PH		No letter yet received	
6 Sept 2011	11.109	Update on working with the Cluster to ensure financial alignment	MN			3/1/12
	11.110.1	Bribery Act Impact	AS		Presentation from KPMG on 7/2/12	7/2/12
8 Nov 2011	11.122 (11.111.14)	Update on NED involvement in Consultant interviews	HG			
	11.124	Report on Clinical changes	MN			
	11.125	Never Event/Assurance Framework Update	SW	6/3/12		
	11.126.6	Number of Staff receiving flu vaccine	MS	6/3/12	To be covered in matters arising	
	11.127.3	Update on Complaint numbers and processes	LT		The Chairman has written to Ombudsman	
3 Jan 2012	12.002.9	Q3 SITREP	SW	6/312	On agenda	
	12.007.9	Update on Two Red risks	SW			
	12.007.9	Paper on prioritisation of capital spend and the arbitration mechanism to deal with boundary issues.				
	12.009.2	Explore link between performance, staff morale and patient experiences feedback.	HG	1/5/12		
	12.011.1	Schedule of Matters reserved to the Board to be amended and represented.	MRP	6/3/12	On agenda	

Board of Directors

March 2012

Chairmans report

.05

Chairman's Report - Update to Board of Directors March 2012

Safety, Quality and the Cost Improvements Programme

I, along with many of my NED colleagues, continue to attend the programme of safety walk rounds. I recently attended a safety visit to theatres in Solihull, which was very enlightening and discussed with staff the standards and processes in place to prevent and learn from any errors.

Visits/Meetings

Since the last Board meeting I have continued to go out and about visiting with Chairs and senior members of some of the Trust's external stakeholders; these have included:

Cluster Board to Board Meeting – Our first joint Board to Board meeting with the Cluster proved very successful. At this it was agreed to continue collaborative work and develop a concordat for joint arrangements.

Noor TV and Community Time – I met with representatives from Noor TV and we are continuing to review how we can work closer with local community organisations.

Waverley School – I met with Liam Byrne MP and the School's head to explore how we can work closer together to support job creation and opportunities for young people within our local communities. This is an aspiration I know that the MP shares with us and by highlighting the diverse roles available within the Trust we can continue to attract local people to apply for positions within the Trust.

Birmingham University – I have had an initial meeting to discuss on how we can become involved more formally with Birmingham University and I will keep the Board updated on these discussions going forward.

John Taylor Hospice – I met with representatives from John Taylor Hospice on developing stronger working relationships.

Birmingham City Council - I have also met with Elenor Brazil, Strategic Director for Children, young people and families at Birmingham City Council to discuss working opportunities going forward.

West Midlands Council Annual Conference – I was invited to attend and take part in a panel discussion at the West Midlands Council Annual Conference focusing on 'Getting to Grips with Local Government's New Role in Public Health'. Representing all 33 local authorities, the conference explored the difficulties facing us going forward and the need very much to work in partnership and collaboratively across the whole health economy.

Governors

The Governors' working groups are continuing and I am receiving very positive feedback that these are both valued and appreciated by those Governors involved. Some of the work they are undertaking is coming together and has already resulted in joint meetings between the Patient Experience Committee and the Membership Committee.

I am continuing with my early breakfast meetings and we are now focusing these on specific topics. The recently held event focusing on complaints proved very poplar and created a good debate.

Mark Newbold and I met with the Staff Governors and we are working together to improve their role and their visibility amongst our staff. From April we will be further raising awareness of the Whistle Blowing Policy and raising awareness of the role of Staff Governors with our employees, highlighting that any member of staff has access to me and the Board via their Staff Governor.

The Council of Governors meeting held on 16 January proved very successful as we developed our new format enabling Governors to present to their colleagues on the committee work they were undertaking within the Trust. I am looking forward to their updates at our next meeting later this month.

Along with some of the Governors we had a very successful and engaging visit to the Chest Clinic. Talking to the dedicated staff, it is clear that we have very supportive teams working in an environment which has already recognised needs to be addressed in the long term.

Patients Association Conference - 26 April 2012

We are working with the Patients Association to host the first ever West Midlands Regional conference on the Prime Ministers five point plan and the 'CARE' campaign. This will take place at Heartlands from 10am to 4pm with the speakers, their presentations and the audience debates relayed to Solihull and Good Hope Education Centres so staff across the Trust can join in.

Confirmed speakers so far include Jill Finney, Deputy Chief Executive CQC; Kathryn Hudson, Deputy Ombudsman, Parliamentary and Health Service Ombudsman; and Professor David Oliver, National Clinical Director for Older People, Department of Health.

Chairman's Lectures

Following on from the very successful Guest Lecture by Dame Carol Black our next Chairman's Lecture was equally productive with Professor Dame Sally Davis. Our professors and members of the research and development team were able to share their vision for the Trust and hear the current policies and activities being undertaken nationally. Over the coming year we will be continuing to invite clinical teams to hear from leading policy makers and key national figures to inform debate locally.

Charity Work

Our charity work continues and in January Solihull's unborn babies have benefit from a generous donation from Balsall Common Lions, getting 2012 off to a good start for the Baby Lifeline appeal. Thanks to the Lions, Baby Lifeline has made its first presentation of maternity and special care baby equipment since the launch of its £250,000. The £365 hand-

held fetal Doppler monitors an unborn baby's heart rate and will be used by community midwives as well as in the birth unit. In addition, a further presentation of 12 baby weighing scales (including three high specification ones) for the delivery suites at the three hospitals, as well as seven with special carrying cases for community use, took place at the same time from funds raised so far for the appeal.

HEFT nursing and midwifery badge – launch of application process

I am very excited and proud that the nursing directorate has launched the application process for those nurses and midwives looking to achieve their HEFT nursing and midwifery badge.
From this month Mandie Sunderland, chief nurse, and her head nurses have been inviting applications from those nurses and midwives meeting the following criteria:

- 100% attainment in VITAL
- Commitment to the HEFT Nursing & Midwifery Values
- Evidence of demonstration of those Values
- Complete and up to date evidence of mandatory training

Nurses and midwives who meet the above criteria will be invited to meet with their head nurse/midwife to discuss their application and receive endorsement.

Those who are successful will be invited to a formal ceremony where they will receive their badge and we will celebrate their achievement. Attainment of the badge will be an ongoing process and ceremonies will be held throughout the year.

The launch of this Trust initiative follows numerous discussions in recent years in which nurses and midwives across the Trust have supported the development of a nursing and midwifery badge that would be awarded to those who can evidence excellence in clinical standards, knowledge and professionalism.

Smoking Policy

For discussion at the meeting.

Board of Directors

March 2012

Chief Executive's Report

.06

AGENDA

Apologies .01

Declaration of interest .02

Minutes from previous meeting .03

Matters Arising .04

Chairmans report .05

Chief Executives report .06

Quality and Performance Monitoring .07

Board Committee Reports .08

Trust News and External Environment .09

Governing Body and Membership .10

Corporate Governance .11

Any Other Business .12

Chief Executive's Report - March 2012

Update on the Month

George Eliot Hospital

As you will be aware we were asked by a local trust, George Eliot NHS Trust, along with other providers to consider options to support them under a partnership arrangement. We have now decided not to pursue this formally. After a briefing session with the Council of Governors and much debate at Executive and Trust Board we have come to the decision that going into partnership with George Eliot does not fit in with the strategic priorities of the Trust which are to continue to develop and embed our three healthcare systems, and to develop our academic base in the context of the proposed Academic Health Science Network programme.

Restructure

The first phase of our proposals to realign the organisation to better support each of our Hospital sites as well as our centralised services is out to consultation. This proposal will take us from having five separate clinical groups to a matrix structure comprising three dedicated hospital based teams and two Clinical Divisions (Clinical Services and Women's and Children's).

These changes will embed the learning following a period of stability and improved performance over a period of months. In 2011 winter planning was started, and it was agreed to defer the second and final stage of the restructure until after the winter period. Instead, the Trust Board approved the implementation of a 'winter' structure and programme to ensure satisfactory performance over the challenging winter period.

The winter period has been managed very successfully, with December breaches being reduced by 50% and 66% on the Heartlands and Good Hope sites respectively, compared to the same month in 2010. It is clear that the creation of hospital-based teams has bought about a much greater measure of control, supported by greater 'buy-in' from staff who naturally feel an affinity with 'their' local hospital.

It is important to note that the Clinical Directorates will remain as the fundamental unit, will be increased in number, and will be based within the five teams as appropriate.

The consultation is progressing well and it expected to be finalised in the coming weeks. Following this we will then be working on the second phase which will involve aligning Clinical Directorate with the Site Teams and Divisions. Some Clinical Directorate realignment has been proposed by the Divisions and this will be discussed as part of this next phase.

For note Rebecca Fenton, who was previously on an external secondment, has left the organisation. There will be no direct replacement of this role.

Meetings and Events

I was invited to speak at a parliamentary seminar on the 'Nicholson Challenge'. The aim of this seminar was to provide parliamentarians from both Houses and all parties, and senior figures from across the health care sector, with the opportunity to enhance their understanding of the 'Nicholson Challenge', and the drive for the NHS to make efficiency savings of between £15 and £20 billion by 2015. I had an opportunity to address MPs and Peers openly and directly in relation to how the NHS will meet the 'Nicholson Challenge' expressing the need for working in partnership and collaboration as key principles for success.

I was also invited to speak at the Ninth National Conference on Complaints for Clinicians and Managers in Health and Social Care. This one day conference provided an important update on handling, resolving and learning from complaints with a focus on the patient perspective and lessons from the Ombudsman. Here I shared our learning and progress as well as the changes we have planned to ensure that we get early resolution for anyone raising concerns about the care we provide.

I was invited to speak at Keele University on their Consultants' Leadership Programme. This focused on the leadership challenges for consultants in the present environment exploring the health policy issues and their likely impact on clinical practice.

I was invited to take part in the Stage 2 screening interviews for Graduate Management Training Scheme where I assisted with the recruitment and selection of the 2012 intake of management trainees.

I attended a national policy-setting meeting held by Professor Keogh focused on Seven Day Working in the NHS. This is being driven by the finding of lower survival rates for patients admitted to hospital at the weekends, as well as the efficiency improvements that could be brought about. At this we discussed successes for implementation and shared our ideas for implementation. The work completed in this Trust by Mary Ross, in implementing seven day working for Therapies, was highlighted and praised at this event. This Trust already has an active programme being led by Medical Director Aresh Anwar and is continuing to make progress to ensure full clinical engagement.

Since the last Board Meeting Sue Moore and I have met with Andrew Mitchell MP. He commented on the improved feedback he is receiving on Good Hope Hospital in recent months, and remains very keen to work with us as we develop stronger links with the local community.

Board of Directors

March 2012

Quality and Performance Monitoring

Finance & Performance Report (AS)	(ENCLOSURE)
IPROC Requesitions for Approval (AS)	(ENCLOSURE)
Update on 2012/13 business plan, budget & monitor annual plan (AS/SH)	(ORAL)
Corporate Strategic Goals (SH)	(ENCLOSURE)
Reshaping HEFT (SH)	(ENCLOSURE)
Infection Control Update Report (MS)	(ENCLOSURE)
Update On Norovirus (MS)	(ORAL)
Nursing & Midwifery Update (MS)	(PRESENTATION)
Board Assurance Framework & Risk Register (SW)	(ENCLOSURE)
Safety Sitrep Report (SW)	(ENCLOSURE)
T&O Update Report (AA)	(ENCLOSURE)
HR & OD Update (HG)	(ENCLOSURE)
ACAD (JS)	(ENCLOSURE)
Contract Arrangements 2012/13 (AS)	(ENCLOSURE)

.07

From: Adrian Stokes

Title: Finance Executive Summary & Key Performance Indicators

The purpose of this report is to update and inform the Trust Board on the financial position for 2011/12

CURRENT PERIOD TRADING SUMMARY 2011/12

	Plan £m	Actual £m	Variance £m
Income	361.9	369.7	7.8
Other Income	25.8	31.2	5.4
Operating Expenses	(358.6)	(379.3)	(20.7)
EBITDA	**29.1**	**21.6**	**(7.5)**
Other Items	(22.1)	(21.8)	0.3
Net Surplus	**7.0**	**(0.2)**	**(7.2)**

- Income has over performed against LDP contracts by £2.3m in January and £12.6m year to date.
- The in month income position is approximately £1.0m higher than expected for January.
- Pay position is £6.3m deficit year to date against operational budgets.
- Non pay position is £13.8m deficit against operational budgets.

FORECAST TRADING SUMMARY 2011/12

	Plan £m	Forecast £m	Variance £m
Income	543.3	567.0	23.7
Other Income	38.7	42.1	3.4
Operating Expenses	(537.7)	(569.6)	(31.9)
EBITDA	**44.3**	**39.5**	**(4.8)**
Other Items	(33.2)	(32.5)	
Net Surplus	**11.1**	**7.0**	**(4.1)**

- Likely forecast remains at c£7.0m surplus.

STRATEGIC ISSUES

- Finance and Performance Directors perspective on position attached (attachment 1)
- Against the budgeted position, the Trust has a (£17.8m) overspend year to date.
- Income is lower than previous years whilst pay costs remain high.
- The Trust is planning an overall full year financial risk rating of 4. The Trust is achieving a Monitor risk rating of 3 at the end of January.
- Trust Q3 Monitor risk rating – Finance 3, Governance amber-red.

RISKS

- Slippage in CIP delivery in 2011/12 particularly in Group 1.
- Current expenditure run rate is unsustainable.
- Pay costs - Medical Staffing and Nursing and Midwifery.
- Rectification delivery.

FORWARD LOOK

- 2012/13 budget envelope - £11.4m recurrent plan.
- Revalidation of medical practitioners late 2012.
- Jointly Managed Risk Agreement to be presented to March Trust Board.

January 2012

Trust Wide Income and Expenditure

Form TF1A

Year to Date				Full Year			
Annual Plan £m	Actual £m	Variance Actual to Plan £m		Annual Plan £m	Forecast £m	Variance Forecast to Plan £m	2010/11 £m
434.4	449.4	15.0	Clinical income - NHS	521.3	544.1	22.8	493.8
0.3	0.5	0.2	Clinical income - Private patients	0.3	0.6	0.3	0.5
3.2	3.0	(0.2)	Research and Development	3.8	4.0	0.2	4.3
14.9	15.4	0.5	Education and Training	17.9	18.3	0.4	18.4
32.2	38.0	5.8	Other income	38.7	42.1	3.4	41.5
485.0	**506.3**	**21.3**	**Total income**	**582.0**	**609.1**	**27.1**	**558.5**
(296.8)	(319.3)	(22.5)	Pay Costs	(354.0)	(384.4)	(30.4)	(348.0)
(36.7)	(36.3)	0.4	Drug Costs	(44.0)	(43.3)	0.7	(41.8)
(47.5)	(50.9)	(3.4)	Clinical Services	(57.0)	(59.1)	(2.1)	(56.3)
(67.0)	(69.6)	(2.6)	Other Costs (excl. depreciation)	(82.7)	(82.8)	(0.1)	(78.8)
-	-	-	Reserves	-	-	-	-
(448.0)	**(476.1)**	**(28.1)**	**Total costs**	**(537.7)**	**(569.6)**	**(31.9)**	**(524.8)**
37.0	**30.2**	**(6.8)**	**EBITDA**	**44.3**	**39.5**	**(4.8)**	**33.7**
(0.1)	(0.1)	-	Profit / loss on asset disposals	(0.1)	(0.1)	-	(0.1)
(19.5)	(19.2)	0.3	Total Depreciation	(23.5)	(23.1)	0.4	(24.7)
(8.8)	(8.8)	-	PDC Dividend	(10.5)	(10.5)	-	(8.5)
0.8	1.1	0.3	Total interest receivable	0.9	1.2	0.3	1.1
(0.2)	(0.3)	(0.1)	Total interest payable on FT Financing Facility (FTFF)	(0.3)	(0.3)	-	(0.3)
-	-	-	Total interest payable on working capital facility	-	-	-	-
0.2	0.1	(0.1)	Other	0.3	0.3	-	-
9.4	**3.0**	**(6.4)**	**Net Surplus/(deficit) before impairments**	**11.1**	**7.0**	**(4.1)**	**1.2**
-	**-**	**-**	**Impairment Charge**	**-**	**-**	**-**	**(9.4)**
9.4	**3.0**	**(6.4)**	**Net Surplus/(deficit) after impairments**	**11.1**	**7.0**	**(4.1)**	**(8.1)**

Key performance Indicators (KPIs)

Year to Date				Full Year			
Annual Plan	Actual	Variance to Plan		Annual Plan	Forecast	Variance Forecast to Plan	2010/11
1.9%	0.6%	(1.3%)	Net I&E Margin (%)	1.9%	1.1%	(0.8%)	0.2%
37.0	30.2	(6.8)	EBITDA (£m)	44.3	39.5	(4.8)	33.7
100.0%	81.6%	(18.4%)	EBITDA achieved, % of projection	100.0%	89.2%	(10.8%)	
7.6%	6.0%	(1.7%)	EBITDA margin (%)	7.6%	6.5%	(1.1%)	6.0%
37.8	31.3	(6.5)	Revenue available for debt service (£m)	45.2	40.7	(4.5)	34.8
	3.0		Monitor Financial Risk Score	4.0	4.0		3.0

KEY ISSUES

- The 2011/12 over performance is £12.6m against plan.
- Trust wide pay is over spent by £6.3m at the end of January. Pay costs need to reduce further into the new year.
- Drug costs are met through NICE contract uplift in year and over performance.
- Non pay is over spent against operational budgets by £13.8m mainly due to energy cost, demand management and shortfall against CIP.
- The 2011/12 year to date shortfall against CIP plan is £4.6m and £6.5m against budget.

January 2012

Trust Wide Balance Sheet

Form TF1B

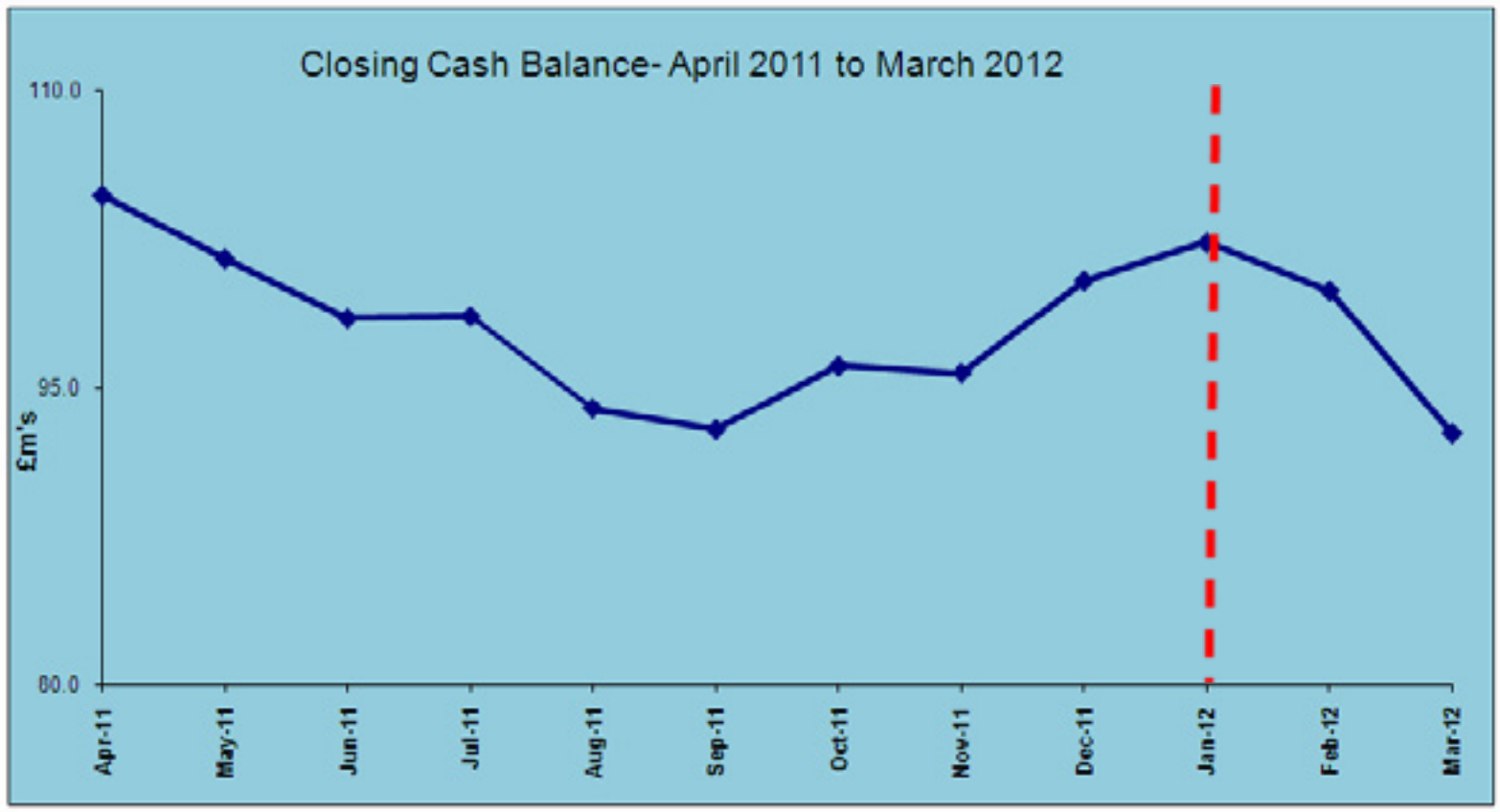
Year to date: Last Month Actual £m	Year to date: This Month Actual £m	Year to date: Variance to plan £m	Note		Full Year: Annual Plan £m	Full Year: Forecast £m	Full Year: Variance from Plan £m	31 March 2011 £m
295.0	295.4	(17.9)		TOTAL FIXED ASSETS	348.5	351.8	1.3	308.6
8.2	8.2	0.2		Stocks & Work in Progress	8.0	8.0	0.0	7.7
29.5	26.7	17.2		NHS Trade Debtors	14.0	14.0	0.0	9.8
3.6	3.3	0.3		Non NHS Trade Debtors	3.0	3.0	0.0	(0.7)
1.0	0.6	(0.0)		Other Debtors	1.4	1.4	0.0	1.3
3.4	3.7	2.0		Accrued Income	1.7	1.7	0.0	1.7
8.6	7.1	0.4		Prepayments	6.7	6.7	0.0	4.9
100.4	102.3	6.4		Cash at bank and in hand	85.0	90.0	5.0	98.3
154.8	153.5	25.8		CURRENT ASSETS	119.8	124.8	5.0	122.9
0.0	0.0	0.0		Bank overdraft / Drawdown Credit facility	0.0	0.0	0.0	0.0
1.8	2.2	(1.5)		NHS Trade Creditors	3.7	3.7	0.0	5.2
0.0	0.0	0.0		Non NHS Trade Creditors	0.0	0.0	0.0	0.0
2.9	2.9	(2.1)		Capital Creditors	6.0	6.0	0.0	4.0
5.6	4.4	0.9		PDC Creditors	0.0	0.0	0.0	0.0
13.9	13.9	0.9		Other Creditors	13.0	13.0	0.0	12.6
0.0	0.0	0.0		Payments on Account	0.0	0.0	0.0	0.0
63.5	61.4	13.6		Accruals	34.1	41.6	10.4	36.4
17.4	17.0	7.1		Deferred Income	9.3	9.3	0.0	10.2
92.7	91.8	18.9		CREDITORS : Amounts falling due within one year	66.6	76.0	10.4	68.4
62.1	61.7	6.9		NET CURRENT ASSETS (LIABILITIES)	54.2	48.8	(5.4)	54.5
1.7	1.9	0.4		Long term Debtors	1.5	1.5	0.0	1.5
358.8	359.0	(6.6)		TOTAL ASSETS LESS CURRENT LIABILITIES	366.2	362.1	(4.1)	356.6
5.0	5.0	0.2		CREDITORS: Amounts falling due after more than one year	4.0	4.0	0.0	5.2
9.4	9.0	(2.8)		PROVISIONS FOR LIABILITIES AND CHARGES	10.9	10.9	0.0	11.4
344.4	**345.0**	**(3.8)**		**TOTAL ASSETS EMPLOYED**	**350.5**	**346.4**	**(4.1)**	**339.7**
0.0	0.0	0.0		Foundation Trust Financing Facility	0.0	0.0	0.0	0.0
0.0	0.0	0.0		Other financing facilities	0.0	0.0	0.0	0.0
0.0	0.0	0.0		TOTAL LOANS	0.0	0.0	0.0	0.0
				TAXPAYERS' EQUITY				
211.1	211.1	0.0		Public dividend capital	211.1	211.1	0.0	211.1
48.1	48.6	(6.1)		Income and expenditure reserve	60.9	56.8	(4.1)	79.8
85.4	85.6	(0.8)		Revaluation reserve	86.1	86.1	0.0	46.1
0.0	0.0	(2.8)		Donated asset reserve	2.5	2.5	0.0	2.8
(0.2)	(0.2)	0.0		Other Reserves (Government grant reserve etc)	(0.2)	(0.2)	0.0	(0.2)
344.4	345.0	(3.8)		TOTAL TAXPAYERS EQUITY	350.5	346.4	(4.1)	339.7
344.4	**345.0**	**(3.8)**		**TOTAL FUNDS EMPLOYED**	**350.5**	**346.4**	**(4.1)**	**339.7**

Key performance indicators (KPIs)

Year to Date: Last Month	Year to Date: Actual	Year to Date: Variance to Plan		Full Year: Annual Plan	Full Year: Forecast	Full Year: Variance Forecast to Plan	31 March 2011
270.0	268.0	0.0	Days	268.0	268.0	0.0	268.0
68.1	68.6	(3.4)	Stock Days	66.0	66.0	0.0	69.0
15.7	16.6	(10.3)	Trade Debtor Days	11.0	11.0	0.0	17.0
1.1	1.4	1.1	Trade Creditor Days (excl. deferred income)	2.0	2.0	0.0	4.0
4.9%	4.1%	(2.2%)	Return on assets excluding PDC dividend	6.3%	6.3%	0.0%	5.4%
56.5	56.5	4.5	Liquid ratio	49.0	49.0	0.0	55.0

KEY ISSUES

- The total commitment against the capital plan at January is £22.1m with total expenditure of £13.6m.
- Operational expenditure slowed in month.
- Site Strategy expenditure is expected to increase due to the approval of the business cases for Pathology, GHH A&E and GHH Theatres.
- Total debt decreased by £2.3m during January, partly due to an increase to payment on account from Solihull PCT. This is an advance on the SLA payment due mid February.
- A final warning letter has now been sent to the Chief Executive at Birmingham City Council over debts of £3.6m from March 2009 to October 2011, mostly for delayed discharge penalties, stating legal action is imminent.
- The cash balance at the end of January was £102.3m. This is £6.4m above the plan with adverse operating performance of £6.8m and adverse working capital movements of £1.2m being offset by £12.8m under spend on capital expenditure.



KEY ISSUES

- Month end cash balance remains strong at £102.3m.
- £30m has been placed for 12 months (maturing March 2012) with Lloyds Banking Group at a rate of 2.05%.
- £25m has been placed in a RBS fixed term bond (maturing February 2012) at a rate of 1.6%.
- In December £20m was placed for 3 months with Co operative Bank at a rate of 1.725%.
- The Trust also intends to use the Co-operative current account (0.85%) to deposit short term cash surpluses of up to £10m.
- £10m remains with RLCM.
- Most banks credit ratings have been downgraded in the last 3 months.

YEAR TO DATE

- The weighted average interest rate achieved on funds at the end of January was 1.47% compared to base rate of 0.5%.

FORECAST

- No planned borrowing in next 12 months.
- Considerable market turmoil as a result of Eurozone sovereign debt concerns.
- Capital spending is forecast to increase sharply in Quarter 4.
- Forecast based on delivery of £7.0m surplus.

FINANCE EXECUTIVE SUMMARY & KEY PERFORMANCE INDICATORS

Month 10 to 31st January 2012

Adrian Stokes, Finance and Performance Director

EXECUTIVE SUMMARY

The Trust has a surplus of £0.5m in January and £3.0m surplus year to date.

The January position is better than forecast and due to improved performance income in month and outpatient catch up from December.

Underlying pay costs increased in month with a net overspend of £0.2m. We still need to re-enforce controls as continued significant reduction in pay bill is required to achieve recurrent financial stability. Best Practice penalties continue and emergency, outpatient and daycase activity over performed in month. CIP delivery fell for a second month in January.

Income over performance was £2.3m in January and £12.6m over performance year to date. In month, this is approximately £1.0m higher than expected and is largely due to an increase in emergency and outpatient activity. The increase in outpatients relates to recovery of lower than expected activity in December and an increase in the N2FU ratio in January. The increase in emergency has been across all sites.

From a performance perspective 18 weeks and A&E are the key areas of concern. The infection control position is improving.

Outpatient DNAs remains as an open performance notice.

The table below summarises our current Finance & Performance position:

Category	Jan	Headlines
Finance		Best Practice Tariff Pay expenditure remains high CIP delivery
Performance		18 weeks – 95th percentile C.Diff A&E
Contracting		1 open performance notice but a low risk of escalation
Overall Position		

1. FINANCE

The Trust's income and expenditure position in January was a surplus of £0.5m. Against operational budget the Trust is over spent by £1.3m in January and overspent £17.8m year to date.

The table below shows the key issues influencing the financial position:

Category	Jan £m	Headlines
Medical Staffing	(0.3)	Expenditure remains unaffordable. Waiting List Initiatives spend of £0.1m Greatest pressures in Groups 3, 4 and 5.
Nursing & Midwifery	(0.2)	Expenditure remains unaffordable. Greatest pressures in Groups 1 and 2.
CIP	(0.6)	£0.5m slippage against plans and £0.6m against target in month. Most significant shortfall is in Group 1.
Overall Position		

1.1 Medical Staffing – Total medical expenditure remains unaffordable at £83.1m year to date. Further reduction is required in coming months. £3.6m overspent year to date.

1.2 Nursing & Midwifery – Nursing expenditure remains unaffordable at £127.9m year to date. Further reduction is required in coming months. £2.6m overspent year to date.

1.3 CIP – Actual delivery in January was £1.6m, £14.5m (76% of plans) year to date. The current forecast for 2011/12 shows expected delivery to be £17.87 in Category 4 and 5, with a further £0.3m in Category 3 and £5.6m in Category 2 and below. The challenge is to ensure remaining category 3 plans and below move to deliverable efficiency in the last quarter.

Although now in surplus, rectification of the key areas above is required as a matter of urgency.

1.4 Cash deposits – Our cash balance at 31 January is £102.3m, which is deposited as follows:

- £30m has been placed for 12 months (maturing March 2012) with Lloyds Banking Group
- £25m has been placed in a 9 month RBS bond, maturing February 2012
- £20m has been placed in a 3 month Cooperative Bank deposit, maturing March 2012
- £10m has been placed with Royal London Cash management
- The balance of funds remain in GBS. From February the Trust is planning to place up to £10m of short term surplus funds with Cooperative Bank in a current account paying 85bp

1.5 Monitor Targets – The Monitor three year plan has been submitted. The Trust is planning an overall full year financial risk rating of 4. The Trust has performed as below on the key Monitor targets;

- EBITDA margin at 5.97% is hitting the 3 financial risk rating. EBITDA is achieving 82% of plan indicating a 3 on achievement of plan
- The Trust is recognising a year to date surplus of £3.0m indicating a score of 2 on I&E surplus margin and 3 on Return on Assets
- Liquidity remains healthy at around 30 days meaning a score of 4 is achieved. More than 60 days of liquidity are required to achieve a 5 rating

Overall the Trust is achieving a financial risk rating of 3 at the end of month 10.

From a performance perspective the Monitor Risk Rating in month for Governance is Amber /Red.

1.6 Risk Register – The residual risk is currently £30.3m (£19.3m within the position and £11.0m outside the position). The main concerns remain with income and commissioning, pay related control issues, CIP delivery and non payment of PCT efficiency invoices.

2. PERFORMANCE

The table below shows the performance targets at most risk:

Indicator	Jan target	Jan actual	Headlines
C-Diff	9	11	The year to date position is 107 cases against a target of 116.
18 weeks -95th percentile (Dec)	23 weeks	22.9 weeks	Failure to meet this target for any month in the quarter will be deemed as a failure against the Monitor compliance framework
A&E 4 hour wait	95%	94.72%	Target missed in month, GHH performance 88.6%
Overall Position			

2.1 C-Diff - the Trust had 11 cases of c.diff against the in-month target of 9. A review of the impact of the new dual test is being undertaken which may allow us to report against old toxin test, which would be more favourable to the Trust.

2.2 18 weeks admitted RTT - the Trust has PCT contract requirements to meet the bottom line 90% target for this indicator, however the backlog of patients waiting over 18 weeks to be treated is putting the sustained delivery of this target at risk. The backlog position appears to be levelling out.

2.3 18 week -95th percentile – if Trust performance against this indicator does not improve it is likely that the Trust will fail Monitor compliance framework requirements for Q4. This is impacted on by the 18 week backlog and the increasing numbers of patients waiting over 26 weeks to be treated.

2.4 A&E 4 hour wait – the Trust failed this indicator on both the GHH and BHH sites in January, performance at GHH gives greatest concern to the delivery of this target

3. CONTRACTING

The following indicator is currently being formally performance managed by our commissioners in line with contractual performance management arrangements.

Indicator	Jan	Contract status	Headlines
Outpatient DNAs		Open Performance Notice	New OP 10.66% (target10%) Follow-up 9.67% (target 10%) PCT are expected not to escalate at present. Performance to be monitored.
Overall Position			

3.1 Outpatient DNAs – Performance has remained broadly consistent with previous months. Although the 10% target for New op has not yet been achieved. We expect the PCT to continue not to further escalate to an Exception Notice, but will continue to closely monitor performance to ensure that there is no deterioration.

3.2 Alerts – There are a number of indicators that require close monitoring. These are:

- 18 week RTT
- Infection Control – C.Difficile and MRSA
- Ambulance Handover

The most significant risk is currently 18 weeks due to the increase in the backlog position.

3.3 CQUINs

The Trust has a total of 18 CQUINs across 3 contracts worth circa £6.9m. The Trust is confident that 13 (72%) of these will be achieved fully with 5 being partially achieved with an associated value of £1.3m. The 5 at risk CQUINs are:

1) Referral to alcohol services
2) Maternity pre CAFF assessment
3) Community Services alcohol and smoking
4) Prescribing efficiencies and
5) Patient satisfaction CQUIN

4. ESCALATION

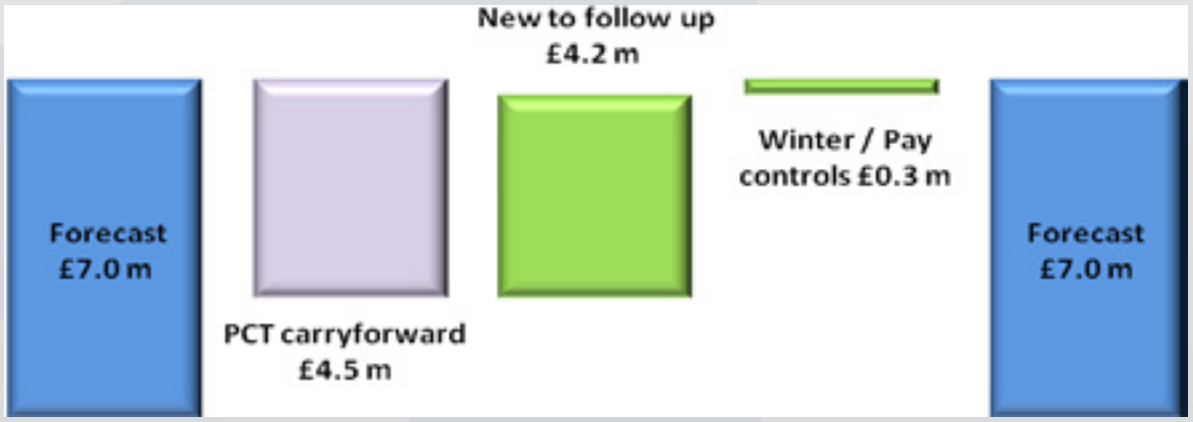
The following table represents the current escalation status for each of the groups and sites:

Group / Site	Local Management			Review at F&PC			Escalate to ED			Escalate to CEO		
	F	P	C	F	P	C	F	P	C	F	P	C
G1												
G2												
G3												
G4												
G5												
G6												
G7												
G8												
BHH												
SHH												
GHH												

G4 amber rated performance – C.diff managed through the Trust Infection Prevention Committee.

5. FORECAST

The forecast remains at c£7.0m surplus and the below diagram illustrates the impact of recent changes:



Forecast provisions at year end are as follows:

- Bad debt is at c£5.0m for 2011/12.
- No provision for revaluation impact.

6. CURRENT ACTIONS

The below actions are in place to improve the financial position for 2011/12:

- Executive vacancy control panel
- Pay controls including e-rostering, agency, bank and locum usage
- EMB sub group
- Theatre project
- CIP Programme Board
- Winter planning group

7. CONCLUSION

Year end is now a certainty. The future efficiency target is challenging and improvement in delivery of this and reduction in pay bill remain.

8. RECOMMENDATIONS

Any Group/Site with escalation rating to provide a rectification plan to Finance and Performance Committee which includes actions and trajectory for recovery.

A Stokes

Finance and Performance Director, Heart of England NHS Foundation Trust.

February 2012

TRUST WIDE FINANCIAL RISK REGISTER – 2011/12

Directorate	Description of Risk	Risk if no action taken		Action to be taken to mitigate risk	Lead	Date to be competed	Residual Risk		Progress / Completion
		Risk Score	Financial Value (£'000)				Risk Score	Financial Value (£'000)	
TRUST	CIP Non Delivery	15	£7.8m	Operational Groups tasked with achieving >85% deliverable plans by end of quarter 3.	Finance GOD's	On going	10	£5.6m	Focus on moving category <3 schemes to full delivery.
TRUST	Income & Commissioning	15	£26.3m	*See Income and Commissioning paper*	Finance	On going	10	£5.0m	*See Income and Commissioning paper*
TRUST	Volatile Energy Market	15	£2.0m	Purchase and implement Software to control energy usage, improve Trust Wide communication / awareness. Work with Procurement to ensure Energy continues to be purchased at best possible price.	John Sellars	On going	10	£1.7m	Implementation of CHP at Solihull & GHH. PASA prices confirmed as best option.
TRUST	Pay Related Control Issues	15	£6.0m	Medical pay controls to be introduced.	Finance GMD's	On going	12	£7.0m	EMB sub group focus on Trust Wide pay reduction.
Within Position Sub Total			**£42.1m**					**£19.3m**	
TRUST	Non payment of PCT Efficiency invoices	12	£10.0m	Letter of agreement and recognition of monies owed.	Finance	On going	12	£6.0m	Agreement of payment plan underway.
TRUST	Income falls further than forecast (£10.5m)	15	tbc	Regular review and notification of performance to operational business.	Finance/ GOD's	On going	15	tbc	Monthly income and contracting reports highlighting areas of concern.
TRUST	C Diff fines	15	£9.0m	Action plan in place and agreed with PCT.	Finance/ GOD's	On going	15	tbc	Ongoing monitoring and reporting. New dual testing introduced which may impact on overall performance.
TRUST	Revaluation impact	10	£10.0m	Constant review of market intelligence (ratios, press) to determine whether a decrease in value is expected in 2011/12. Agree interim valuation approach with PwC.	Finance	Mar 2011	10	£5.0m	National District Valuers Report shows land prices have stabilised in 2010/11. Confirmed no new buildings completing before March 2012.
Outside Position Sub Total			**£29.0m**					**£11.0m**	
Total			**£71.1m**					**£30.3m**	

KEY PERFORMANCE INDICATOR REPORT JANUARY 2011

MONITOR COMPLIANCE FRAMEWORK	STATUS	COMMENTS
MRSA bacteraemia	Monitor Q3 risk rating red amber	There were no further cases in December however the indicator remains red ytd, with 6 cases against a target of 7
Clostridium difficile		11 cases in January against an in month internal target of 9. Ytd targ is 116. Ytd outturn =107 cases.
A&E 4 hour target		The Trust failed this indicator on both the GHH and BHH sites in January, GHH only achieved 88.6%. Monitor review our performanc a quarterly basis

EXCEPTION NOTICES	STATUS	PENALTY	COMMENTS
No open exception notices			

PERFORMANCE NOTICES	STATUS	PENALTY	COMMENTS
Outpatient DNAs New & Follow Up	Open	None	Trust performing well against West Midlanc average PCT have stated they will take no further action as along as performance is maintained however performance notice remains open
A&E Ambulance Handover Plan	Open	None	Performance remained static at 51% in Janu The PCT have agreed to a yearend target of 50%, monitoring is will continue through th performance notice.

KPI SUMMARY POSITION JANUARY 2011

KEY ISSUES

18 weeks admitted RTT and 95th percentile target: The Trust continues to meet the bottom line requirements for thi indicator however the 18 week backlog is not decreasing and an increasing number of patients are waiting over 26 weeks for treatment which will impact on the delivery of the Monitor 95th percentile target. In December the Trust position was 22.9 weeks against a target of 23 weeks.

Emergency Length of Spell: Emergency length of stay has remained red for past 4 months. In January performance w just short of target of 7.9 days at 8.02 days.

31 Day Cancer : Performance against the 31 day cancer standard for patients requiring surgery has just dipped below the 94% target in month to 93.88%. The current ytd position is 97.99%. The breach primarily relates to capacity in Urology theatres a rectification plan has been developed by Group 2

ALERTS

Nothing to report

SUMMARY

18 weeks 95th percentile and the deterioration in the A&E position are the key areas of concern for the Trust.

TRUST KEY PERFORMANCE INDICATORS - External
February 2012

KPI REF	MONITOR COMPLIANCE FRAMEWORK	TARGET	In month Trajectory	10/11	Q1	JUL-11	AUG-11	SEP-11	Q2	OCT-11	NOV-11	DEC-11	Q3	JAN-12	In month Change	TRUST YTD	Contract Status
★M1	Reduction of Incidence of Clostridium (post 48 hrs)	< 131	9	*168*	**38**	**18**	10	8	**36**	**11**	**10**	**10**	**31**	**11**	↑	**116**	
★M2	Reduction of Incidence of MRSA Bacteraemia (post 48 hrs)	≤ 7	1	*9*	**3**	**3**	0	0	**3**	0	0	0	0	0	↔	**6**	
★M3a	Patients first seen by a specialist within two weeks when urgently referred by their GP or dentist with suspected cancer **mia**	≥ 93%		*94.04%*	93.95%	94.70%	94.65%	93.90%	94.42%	95.67%	95.80%	95.20%	95.54%	mia	↓	94.66%	
★M3b	Patients first seen by a specialist within two weeks when urgently referred by their GP with any breast symptom except suspected cancer **mia**	> 93%		*94.81%*	95.77%	93.40%	94.37%	94.70%	94.15%	97.79%	93.30%	93.33%	94.96%	mia	↑	94.95%	
★M4a	Patients receiving their first definitive treatment within one month (31 days) of a decision to treat (as a proxy for diagnosis) for cancer **mia**	≥ 96%		*98.62%*	97.90%	97.62%	97.50%	99.00%	98.03%	97.01%	97.81%	96.56%	97.15%	mia	↓	97.68%	
★M4b	Patients receiving subsequent treatment (surgery and drug treatment only) within one month (31 days) of a decision to treat - **Anti Cancer Drug Modality** **mia**	≥ 98%		*100.00%*	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	mia	↔	100.00%	
★M4c	Patients receiving subsequent treatment (surgery and drug treatment only) within one month (31 days) of a decision to treat - **Surgery Modality** **mia**	≥ 94%		*98.43%*	97.95%	100.00%	100.00%	100.00%	100.00%	100.00%	95.24%	**93.88%**	96.09%	mia	↓	97.99%	
★M5a	Patients receiving their first definitive treatment for cancer within two months (62 days) of GP or dentist urgent referral for suspected cancer **mia**	≥ 85%		*85.62%*	86.17%	86.67%	86.38%	85.90%	86.47%	85.20%	85.19%	85.37%	85.24%	mia	↑	85.96%	
★M5b	Patients receiving their first definitive treatment for cancer within two months (62 days) of urgent referral from the **national screening service** **mia**	> 90%		*99.44%*	96.97%	100.00%	**85.71%**	100.00%	97.56%	100.00%	100.00%	100.00%	100.00%	mia	↔	97.96%	
★M6	Referral to treatment waiting times - admitted (95th percentile) **mia**	≤ 23 weeks			18.93	20.13	21.81	22.17	22.17	21.56	22.65	22.87	22.87	22.92	↑	22.87	
★M7	Referral to treatment waiting times - non admitted (95th percentile) **mia**	≤ 18.3 weeks			15.21	15.31	15.42	15.58	15.58	16.14	15.52	14.00	14.00	15.61	↑	14.00	
★M8	Total time in A&E (95th percentile)	95% in 4hrs		*95.41%*	95.10%	97.15%	97.20%	96.48%	96.94%	97.24%	96.82%	96.26%	96.77%	**94.72%**	↓	96.11%	
M9	Access to Healthcare for People with a Learning Disability	6 questions measured at levels 1 (low) to 4 (high)		*6 questions at level 4*	6 questions	6 questions at level 4				6 questions at level 4					↔	6 questions at level 4	

★ *PCT Contract Indicator*

KPI REF	PCT MAIN CONTRACT INDICATORS	TARGET	In month Trajectory	10/11	Q1	JUL-11	AUG-11	SEP-11	Q2	OCT-11	NOV-11	DEC-11	Q3	JAN-12	In month Change	TRUST YTD	Contract Status
PC1	Patients receiving their first definitive treatment for cancer within two months (62 days) of urgent referral from a **consultant (consultant upgrade)** for suspected cancer **mia**	≥ 85%		*80.00%*	94.12%	**82.35%**	94.44%	92.30%	89.36%	100.00%	93.33%	93.55%	95.24%	mia	↑	93.26%	
PC2	A&E Time to initial assessment (95th percentile)	≤ 15 minutes			**40.00**	**32.00**	**28.00**	**26.00**	**29.00**	**27.00**	**32.00**	**35.00**	**31.00**	**33.00**	↓	**33.00**	
PC3	A&E Time to treatment decision (median)	≤ 60 minutes			53.67	52.00	42.00	50.00	48.00	52.00	51.00	54.00	52.33	50.00	↓	51.00	
PC4	A&E Unplanned reattendance rate	≤ 5%			**5.99%**	**5.85%**	**6.21%**	**5.88%**	**5.97%**	**6.02%**	**5.52%**	**5.57%**	**5.71%**	**5.84%**	↑	**5.89%**	
PC5	A&E - Patient left without being seen	≤ 5%			3.36%	2.65%	2.20%	2.75%	2.54%	2.54%	2.49%	3.10%	2.71%	2.81%	↓	2.87%	
PC6	% of Stroke Patients Spending 90% or more of their stay on Stroke Unit	≥ 80%	80.00%	*68.67%*	**76.22%**	86.67%	90.48%	85.09%	87.66%	91.87%	90.15%	88.19%	89.97%	83.70%	↓	85.11%	Performance targets met and withheld funds released.
PC7	Satisfaction of the Provider's obligations under each A&E/Ambulance Services Handover plan in ≤ 17 minutes	50% of patients by Mar12			**34.55%**	**35.22%**	**49.23%**	54.56%	**46.22%**	57.83%	50.55%	50.98%	53.13%	50.73%	↓	**45.28%**	
PC8	Delayed Transfers of Care	≤ 3.5%		*3.68%*	4.84%	4.28%	4.08%	4.30%	4.22%	4.54%	3.24%	2.19%	3.42%	3.58%	↓	4.09%	
PC9	30 day emergency to emergency readmissions	tbc			1,688	589	592	523	1,704	520	545	543	1,608	635	↑	5,635	
PC10	Admitted Patients Treated within 18 Weeks of Referral **mia**	≥ 90%		*90.00%*	92.80%	91.52%	90.45%	90.91%	90.97%	90.99%	92.10%	92.48%	91.86%	92.38%	↓	92.10%	
PC11	Non-Admitted Patients Treated within 18 Weeks of Referral **mia**	≥ 95%		*97.82%*	97.88%	96.76%	96.72%	96.97%	96.82%	96.34%	96.76%	97.34%	96.79%	96.62%	↓	96.76%	
PC12	Referral to treatment waiting times - incomplete (95th percentile) **mia**	≤ 28 weeks			16.39	17.24	17.20	17.66	17.66	17.62	17.96	18.09	18.09	18.09	↔	18.09	
PC13	Referral to treatment waiting times - admitted (median) **mia**	≤ 12.27 weeks			10.63	10.57	10.59	**12.36**	**12.36**	12.10	12.00	11.32	11.32	**12.85**	↑	11.32	
PC14	Referral to treatment waiting times - non admitted (median) **mia**	≤ 4.39 weeks			**4.71**	4.33	**4.60**	**4.81**	**4.81**	4.27	4.25	4.01	4.01	**4.78**	↑	4.01	
PC15	Hospital-Led Cancelled Operations on the Day for Non-Clinical Reasons, as % of Elective & Daycase Episodes	≤ 0.8%		*0.747%*	0.480%	0.290%	0.540%	0.520%	0.450%	0.540%	0.480%	0.380%	0.470%	0.390%	↑	0.471%	
PC16	Breach of clause 31.5 (cancelled operations rebooked within 5 calendar days following admission and cancellation)	≤ 12 per year	1	*97.33%*	0	0	0	0	0	0	0	1	1	0	↓	1	
PC17	Sufficient "appointment slots" are made available on the DBS C&B system	≤ 13%	13.00%	*14.36%*	**15.01%**	15.02%	10.71%	6.68%	10.79%	9.10%	12.15%	9.33%	10.22%	4.09%	↓	11.98%	
PC18	Percentage of women in contact with the service who have seen a midwife or healthcare professional for health and social care assessment of needs risks and choices by 12 completed weeks of pregnancy	≥ 90%		*84.29%*	85.46%	85.33%	87.50%	87.74%	86.83%	87.50%	85.39%	88.41%	87.11%	87.09%	↑	86.56%	
PC19	Increase in Breastfeeding Initiation Rates	≥ 69.19%	69.19%	*67.05%*	65.57%	65.33%	63.64%	66.81%	65.53%	65.65%	63.82%	65.57%	65.02%	67.58%	↑	65.57%	
PC20	DNAs at First Outpatient Appointment	≤ 10%		*12.79%*	11.45%	11.17%	11.08%	11.42%	11.23%	10.55%	10.56%	10.93%	10.67%	10.95%	↑	11.10%	Performance Notice is still in place. PCT are expected not to escalate at present. Performance to be monitored.
PC21	DNAs at Follow-Up Outpatient Appointment	≤ 10%		*11.68%*	10.57%	10.04%	10.45%	10.42%	10.30%	9.77%	9.34%	9.92%	9.66%	9.39%	↓	10.10%	
PC22	Follow-up Cataract outpatients	0			n/a	n/a	n/a	n/a	n/a	n/a	3mia	3mia	n/a	3mia		n/a	
PC23	Breach of the mixed sex accommodation requirements	0		*469*	18	10	0	0	10	3	0	0	3	0	↔	31	
PC24	Failure to agree the EMSA Plan in accordance with clause 4.25	Plan agreed			n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	↔	n/a	
PC25	Breach of an EMSA Plan milestone	No breaches			n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	↔	n/a	
PC26	% SUS data altered (from working day 5 to final position)	≤ 3%			1.00%	0.15%	0.32%	0.31%	0.26%	0.34%	0.35%	2mia	0.34%	2mia	↑	0.53%	
PC27	No. of SUIs with a report of investigation outcomes, including preventative and follow up actions, within 45 working days of the completion of the investigation (excluding complex cases)	Rolling YTD % for closed SUIs		*14.29%*	0.00%	0.00%	0.00%	33.33%	25.00%	0 Completed	40.00%	33.00%	37.50%	0.00%	↓	n/a	
PC28	No. of SUIs with extended deadlines agreed within timescale	Rolling YTD % for SUIs closed >45			100.00%	n/a	100.00%	100.00%	100.00%	0 Completed	100.00%	100.00%	100.00%	100.00%	↔	100.00%	
PC29	Respiratory TB	≥ 65% diagnosed			76.62%	66.67%	90.48%	89.47%	80.60%	92.31%	3mia	3mia	92.31%	3mia	↑	76.62%	
PC30	Erdington Sexual Health - treatment by consultant doctor	1 in 8 treated (<12.5%)		*7.15%*	5.69%	3.34%	3.97%	4.09%	3.82%	5.01%	5.44%	7.08%	5.81%	mia	↑	5.06%	
PC31	BCG vaccination prior to discharge after birth	tbc			82.77%	77.15%	84.15%	81.49%	80.93%	84.06%	78.60%	83.43%	82.12%	85.16%	↑	82.17%	
PC32	% CAD compliance	≥ 85%			59.71%	57.73%	67.90%	72.77%	66.05%	78.91%	74.77%	79.17%	77.68%	82.46%	↑	69.37%	

In month Change
Green arrow indicates positive change in month versus previous month, in relation to the target
Red arrow indicates negative change in month versus previous month, in relation to the target

mia = "data available 1 month in arrears"

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The Performance Team

TRUST KEY PERFORMANCE INDICATORS - Internal
February 2012

KPI REF	WORKFORCE	TARGET	In month Trajectory	10/11	Q1	JUL-11	AUG-11	SEP-11	Q2	OCT-11	NOV-11	DEC-11	Q3	JAN-12	In month Change	TRUST YTD
W1a	Staff in Post v Budget Established - Percentage	Between 95% and 100%		*95.41%*	95.85%	95.87%	96.28%	97.07%	97.07%	96.86%	97.31%	97.38%	97.38%	96.33%	↓	96.33%
W1b	Staff in Post v Budget Established - WTE Vacancies	n/a		*403.82*	366.80	365.50	329.17	259.76	259.76	278.97	238.15	231.97	231.97	328.72	↑	328.72
W2	Nursing Requests Filled by Bank/Agency	80%		*83.12%*	86.92%	86.82%	86.39%	86.02%	86.02%	89.34%	89.51%	87.59%	87.59%	87.97%	↑	87.97%
W2a	Nursing Requests: No. of Requests	n/a		*93,056*	7,979	8,384	8,149	7,735	7,735	6,269	6,034	5,287	5,287	6,193	↑	6,193
W2b	Nursing Requests: Total No. Filled	n/a		*77,351*	6,935	7,279	7,040	6,654	6,654	5,601	5,401	4,631	4,631	5,448	↑	5,448
W3	Nursing Requests Filled by Bank Proportion of all Filled Requests	85%		*89.58%*	87.16%	89.09%	91.00%	92.00%	92.00%	93.00%	94.00%	96.00%	96.00%	96.00%	↔	96.00%
W4	Medical Requests Filled by Bank/Agency	90%		*92.15%*	98.72%	98.71%	98.71%	98.11%	98.11%	98.85%	99.58%	98.29%	98.29%	96.85%	↓	96.85%
W4a	Medical Requests: No. of Requests	n/a		*10,040*	1,095	1,082	933	742	742	611	480	525	525	634	↑	634
W4b	Medical Requests: Total No. Filled	n/a		*9,252*	1,081	1,068	921	728	728	604	478	516	516	614	↑	614
W5	Medical Requests Filled by Bank Proportion of all Filled Requests	34% (Review if Zircadian system introduced)		*34.76%*	38.85%	37.73%	50.00%	48.00%	48.00%	58.00%	55.00%	49.00%	49.00%	55.00%	↑	55.00%
W8	Average Time to Recruit in Weeks - All Staff Groups	11 Weeks - (review in August)		11.6	11.0	11.0	11.0	11.0	11.0	11.0	11.0	11.0	11.0	10.0	↔	10.0
W9	Voluntary Turnover	< 7.25% - phased	7.30%	*7.23%*	6.62%	6.59%	6.53%	6.57%	6.57%	6.27%	6.10%	6.12%	6.12%	6.12%	↔	6.12%
W10	Sickness - YTD Moving Annual Average	< 3.90% by Mar-12	3.92%	4.05%	3.94%	**4.10%**	3.71%	3.75%	3.75%	3.85%	**4.30%**	3.82%	3.82%	4.17%	↑	4.17%
W11	New Starters Attending Corporate Induction - Doctors only **mia**	≥ 90%		*94.4%*	100.0%	100.0%	100.0%	**70.0%**	**70.0%**	91.0%	89.0%	0.0%	89.0%	mia	↓	**0.00%**
W12	New Starters Attending Corporate Induction - Excluding Doctors **mia**	≥ 98%		*99.4%*	100.0%	100.0%	100.0%	99.0%	99.0%	100.0%	100.0%	0.0%	100.0%	mia	↔	0.00%
W13	Trustwide Agency Spend **mia**	To be determined		*4.21%*	4.61%	5.19%	4.54%	3.64%	4.54%	3.30%	3.14%	2.86%	3.14%	mia	↓	2.86%
W14	Clinical Staff Undergoing Mandatory Training Since Start of Programme	2,000 (approx.) by Mar-12	1,600	*2,101*	**507**	161	141	159	461	193	175	130	498	100	↓	1,466
W15	Number of Appraisals Completed - Cumulative	8,000 by Oct-11	8,000	*7,910*	**858**	**1,659**	**3,404**	**5,643**	**5,643**	**7,389**	**7,756**	**7,864**	**7,864**	**8,049**	↑	**8,049**

KPI REF	QUALITY AND SAFETY	TARGET	In month Trajectory	10/11	Q1	JUL-11	AUG-11	SEP-11	Q2	OCT-11	NOV-11	DEC-11	Q3	JAN-12	In month Change	TRUST YTD
QS1	Elective Length of Spell	tbc		*3.83*	3.72	3.53	3.58	3.75	3.62	3.53	3.35	3.85	3.57	3.51	↓	3.62
QS2	Emergency Length of Spell	7.57 days	7.90	*8.52*	**9.01**	**8.26**	**8.65**	8.33	8.41	**8.67**	**8.74**	**8.09**	**8.49**	**8.02**	↓	**8.57**
QS3	Hospital Standardised Mortality Ratio (HSMR) **2 MONTHS IN ARREARS**	<=100		*97.80*	95.00	92.70	91.70	93.90	92.90	99.40	93.40	2mia	99.40	2mia	↓	94.50
QS4	Reduction of Incidence of MSSA (post 48 hrs)	≤ 37		*39*	14	2	2	4	8	5	3	3	11	4	↑	37
QS5	E-coli	Baseline to be set in 2011/12			22	14	5	12	31	7	5	6	18	14	↑	85
QS6	MRSA Elective Screening Rates (% patients screened)	100%		*93.00%*	97.49%	98.01%	98.40%	97.41%	97.93%	96.67%	97.73%	96.49%	96.99%	97.36%	↓	97.47%
QS7	MRSA Emergency Screening Rates (% patients screened)	≥ 95%		*82.63%*	92.64%	93.71%	92.27%	91.70%	92.67%	91.03%	90.53%	90.33%	90.70%	92.07%	↑	92.05%
QS8	Diagnostic waits	100% <6 weeks		*0.00%*	99.59%	99.82%	99.50%	99.12%	99.48%	99.73%	99.82%	99.82%	99.79%	98.55%	↓	99.51%
QS9	New to follow-up rates	tbc		*1.95*	2.61	2.62	2.58	2.63	2.61	2.57	2.61	2.59	2.59	2.73	↑	2.62
QS10	Patient Reported Outcome Measures (PROMs) in Elective Surgery	≥ 68%		*67.99%*	79.10%	78.50%	88.80%	81.40%	82.50%	79.60%	81.20%	80.80%	80.80%	79.75%	↓	80.86%
QS11	Patient Reported Outcome Measures (PROMs) - Hips	≥ 68%		*67.77%*	78.20%	75.00%	82.00%	73.60%	76.80%	77.40%	80.00%	83.30%	79.90%	86.11%	↑	79.19%
QS12	Patient Reported Outcome Measures (PROMs) - Knees	≥ 68%		*67.96%*	79.40%	73.90%	84.50%	88.80%	82.40%	80.00%	78.90%	82.10%	80.70%	81.14%	↓	81.14%
QS13	Patient Reported Outcome Measures (PROMs) - Hernia	≥ 68%		*69.24%*	82.60%	84.60%	95.20%	85.00%	86.70%	77.70%	80.00%	86.80%	82.50%	84.10%	↓	84.10%
QS14	Patient Reported Outcome Measures (PROMs) - Vascular	≥ 68%		*67.12%*	75.90%	80.00%	96.00%	74.20%	81.80%	82.19%	85.29%	68.90%	79.80%	72.73%	↑	78.38%
QS15	Nursing Metrics - Quality of Care	≥95%		*93.00%*	91.00%	92.00%	93.00%	94.00%	93.00%	92.00%	94.00%	93.00%	93.00%	94.00%	↑	93.00%
QS16	Nursing Metrics - Patient Experience	≥95%		*85.00%*	88.00%	90.00%	91.00%	92.00%	91.00%	92.00%	90.00%	91.00%	91.00%	93.00%	↑	91.00%
QS17	Compliance with national complaints policy - 75% resolved within 25 days **2 mia**	75%		*72.26%*	77.36%	81.48%	74.14%	78.95%	78.00%	91.67%	85.00%	2 mia	91.67%	2 mia	↑	80.38%
QS18	Data Quality of Inpatient Ethnic Groups	PCT Target > 90%		*92.81%*	93.96%	94.03%	94.28%	94.58%	94.30%	94.55%	94.89%	94.82%	94.75%	94.54%	↓	94.37%
QS19	Daycase Rates for all Basket of 25 Procedures	≥ 80%		*81.49%*	84.93%	82.33%	86.42%	86.77%	85.16%	86.51%	86.88%	86.67%	86.69%	87.00%	↑	85.74%
QS20	30 day elective to emergency readmissions	tbc			214	69	73	57	199	88	79	91	258	65	↓	736
QS21	Initial notification to the commissioner within one operational day of an incident being classified as a SUI **mia**	100% within 1 day		*100.00%*	100.00%	n/a	100.00%	100.00%	100.00%	0 Completed	100.00%	100.00%	100.00%	mia	↔	100.00%
QS22	Number of SUIs formally reported within 72 hours of declaration of SUI **mia**	100% within 3 operational days		*85.71%*	**75.00%**	**0.00%**	100.00%	100.00%	100.00%	0 Completed	100.00%	100.00%	100.00%	mia	↔	**94.12%**
QS23	No. of SUIs with a report of investigation outcomes, including preventative and follow up actions, within 5 days of the	>=90%		*50.00%*	100.00%	n/a	100.00%	100.00%	100.00%	0 Completed	100.00%	100.00%	100.00%	100.00%	↔	100.00%

In month Change

Green arrow indicates positive change in month verus previous month, in relation to the target

Red arrow indicates negative change in month verus previous month, in relation to the target

mia = "data available 1 month in arrears"

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PURCHASE APPROVAL

Presented to the Board of Directors – MARCH 2012

IPROC REQ. NO.	SUPPLIER	VALUE + VAT	DESCRIPTION OF GOODS RECEIVED	NARRATIVE
669585	Synergy Health	£180,000.00 + VAT	Top up for requisition number 637633 and order number 209506 for General and Surgical Linen. To cover period of 01.09.11 - 31.03.12 for Good Hope site only.	This order covers an existing contract that is currently out to tender.
670226	University of Birmingham	£391,369.78 + VAT	SLA post associated with Medical Education at the University of Birmingham Jan 12 – March 12	NHS Recharge
669843	Sandwell & West Birmingham Hospitals NHS Trust	£161,986.00	To cover invoice number 127756 in respect of Neurophysiology Provision for BHH, GHH, SOL hospitals from 1/7/11 to 30/9/11	NHS Recharge
671413	South Staffordshire Water Ltd	£163,000.00	Call off Order for the provision of Water Services to the Good Hope Hospital. Period of supply 1/4/12 to 31/3/13 All as per Customer References MC00005090/03, MC00005090/02 and UC02482305/01	Water charges, determined by Regulator.
671450	Severn Trent Water Ltd	£152,000.00	Call off Order for the provision of Water services to the Solihull Hospital. All as per Customer Account No 689 002 2761. Period of Supply 1/4/12 to 31/3/13	Water charges, determined by Regulator.
671424	Severn Trent Water Ltd	£289,000.00	Call off Order for the provision of Water Services at the Birmingham Heartlands Hospital. Period of Supply 1/4/12 to 31/3/13. All as per Account No 689 002 229 9.	Water charges, determined by Regulator.

CORPORATE PRIORITIES UPDATE

Trust Board meeting 6th March 2012

From: Simon Hackwell, Commercial & Strategy Director

Summary/Key Points

As part of the progress in defining its vision and strategy, 12 months ago the Board agreed four goals:

- Safe and caring
- Locally engaged
- Efficient
- Innovative

Underpinning these were 16 corporate priorities to be delivered over three years.

This report provides an update on progress against those 16 priorities after one year.

Overall, good progress has been made. Most of them are by nature ongoing aspirations rather than short-term task and finish projects, so they are likely to require three years (or more) to achieve a paradigm change.

Some areas require further thought by the Executive team and the Board because they represent a new direction of travel for the Trust.

Above all it is important that continued focus and attention is given to delivery against these in the context of a busy operational, financial and regulatory day to day environment.

Recommendations

The Board is asked to:

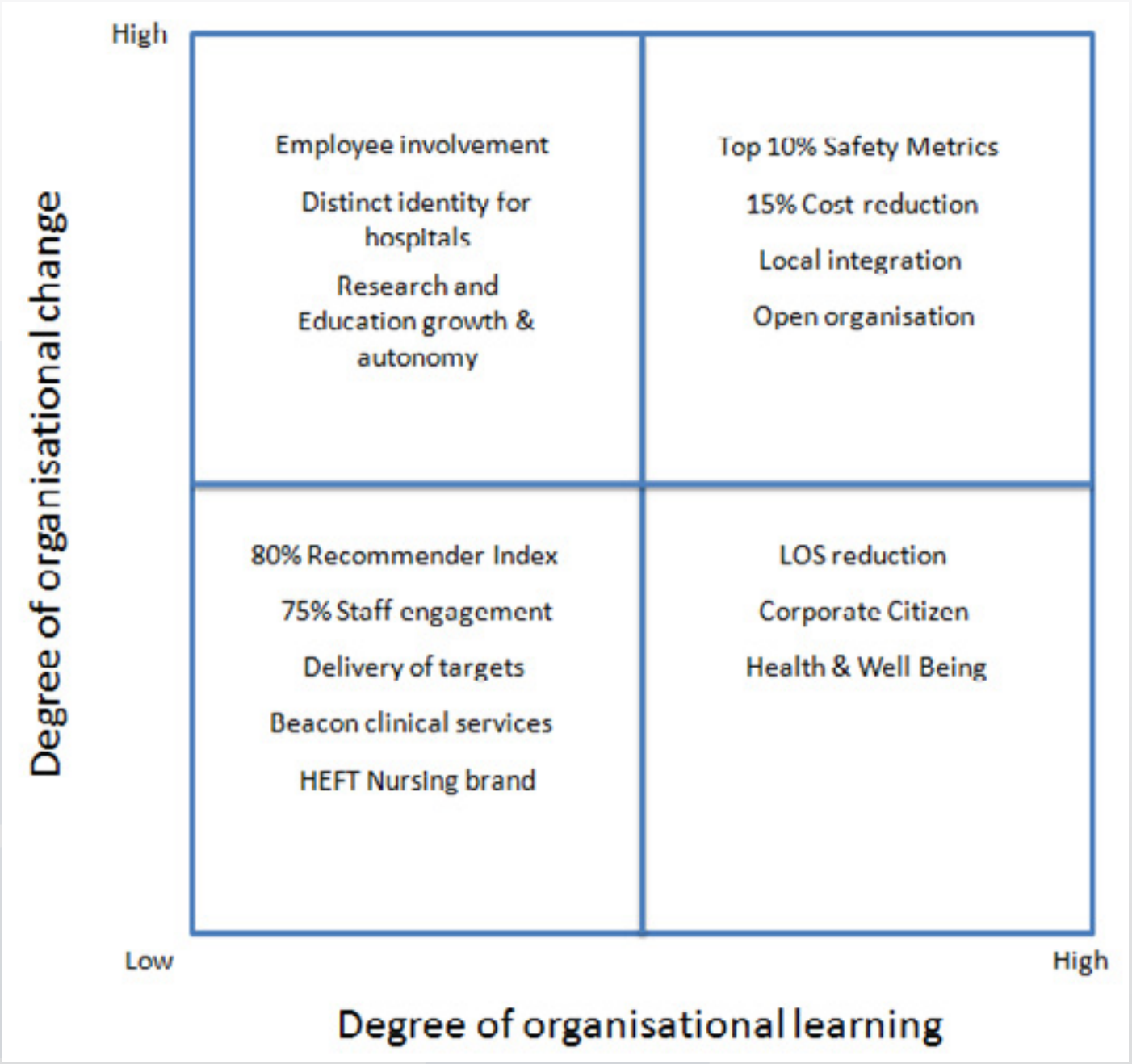
1. Consider the progress made against the priorities
2. Identify any priorities where further consideration and discussion by the Board would be helpful to help shape the scope and nature of the work e.g. openness, health and well being.
3. The frequency of monitoring against these priorities (currently on an annual basis).

1. The sixteen priorities

	Goal	*Strategic Priority*	*Executive Lead*
1	*Safe and caring*	Be in the top 10% in England for safety metrics performance	Sarah Woolley
2	*Safe and caring*	Have a 80% net recommender index score for patient satisfaction	Lisa Thomson
3	*Safe and caring*	Have 75% of our workforce agreeing that they are 'consistently engaged' with their organisation	Hazel Gunter
4	*Safe and caring*	Be recognised nationally for employee involvement in the running of the organisation	Hazel Gunter
5	*Efficient*	Achieved a 15% reduction in our costs	Adrian Stokes
6	*Efficient*	Have an average length of stay of no greater than 6 days for emergency admissions	Aresh Anwar
7	*Efficient*	Achieved a 50% reduction in the cost of sickness	Hazel Gunter
8	*Efficient*	Consistently delivered all our statutory and regulatory targets	Adrian Stokes
9	*Locally Engaged*	Have developed a distinct identity for each of our hospitals	BHH – Aresh Anwar GHH – Sue Moore SHH – Claire Molloy
10	*Locally Engaged*	Have driven local integration to enable the redesign of our key services and have achieved a complete service redesign for our frail elderly patients	Claire Molloy
11	*Locally Engaged*	Have demonstrated we are a good corporate citizen	Lisa Thomson
12	*Locally Engaged*	Be assessed externally on the contribution we make to health and well being promotion among our communities	Sarah Woolley
13	*Innovative*	Have identified and developed a number of beacon clinical services which receive national recognition	Simon Hackwell
14	*Innovative*	Have grown and, if appropriate, established separate business models for education, research and services to other organisations	Simon Hackwell
15	*Innovative*	Have established ourselves as the leading 'open organisation' in the NHS	Lisa Thomson
16	*Innovative*	Have achieved local, national and international recognition for the HEFT nurse brand	Mandie Sunderland

2. Organisational development

From both the perspective of organisational learning and organisational change many of the priorities present a significant challenge for the Trust as shown below.



Using this matrix it can be seen that in some areas delivery against these priorities is contained in the day to day activities and annual plans of the Trust's operational areas. While in other areas, the achievement of certain priorities will not evolve from 'business as usual'. This is reflected in the progress to date set out in the rest of this report. As ever, it remains important to find and sustain a balance between the necessary practicalities of running busy clinical services and the time available to pursue developmental work. In essence this is the Organisational Development (OD) challenge for the Trust going forward.

3. Progress to date

A brief summary of plans and progress against each objective is set out below along with an indication of next steps.

1. Be in the top 10% in England for safety metrics performance

Three year plan

- Year 1 – Defining organisational benchmark position.
- Year 2 – Select priority areas for improvement once defined.
- Year 3 – Review progress and identify further priorities.

Progress

- The Trust has a safety strategy in place to reduce harm across the organisation.
- The Trust is implementing a 2 year 'Learning to be safer' programme to support the strategy.
- The Trust is about to commence implementing internal high fidelity simulation training to educate teams on human factors elements of safety.
- Trust meets current clinical compliance requirements for regulators e.g. CQC, NHSLA.
- We have developed a basic suite of safety measures which are monitored by governance and Risk committee, however, we recognise that these are limited and do not give a fully comprehensive picture of the safety of our clinical outcomes for patients.

Next Steps

- Progress developing integrated scorecard ready for implementation from April 2012.
- Delivery of 'Learning to be safer' programme
- Definition and delivery of simulation programme objectives

2. Have a 80% net recommender index score for patient satisfaction

Three year plan

- Year 1 – Monitor and report on results against the 80% target. Provide this information online internally and externally. R3eview approach to data collection to include using the TV's to deliver this activity.
- Year 2 – Programme of intervention activity developed and delivered to support any area not achieving the standard. Also develop a sustainable mechanism for capturing the net recommender index score for community services
- Year 3 – Develop the online opportunity to capture the net recommender score and patient experience

Progress

- Measure inpatients on wards, A&E and outpatients monthly giving a rating per ward and area as well as an overall score for each site and the Trust.
- Measure by postal surveys over 200 patients per week who have recently left the Trust to ascertain their experience and score with regards to the net recommender index
- National surveys to be analysed to provide a net recommender index score per overall survey.

Next Steps

- Update the current patient experience reports to highlight progress on the 80% target and detail the actions being taken to support those not achieving the net recommender index score.

3. *Have 75% of our workforce agreeing that they are 'consistently engaged' with their organisation*

Three year plan

- Year 1 – Agree how to capture ongoing engagement data and what activities will be supported
- Year 2 – Develop staff engagement strategy to embed within culture, continue to measure
- Year 3 – Implement and embed strategy and activities, continue to measure
- Board updates will be provided twice yearly – May and November

Progress

- Have continually promoted staff engagement activities over the past 4 years eg. staff festivals, 'Answers on a Postcard', staff surveys
- Improvement has been seen in staff engagement overall of 5% (currently sits at 60%)
- Staff involvement guidance circulated to help improve engagement overall
- Options developed for capturing data and improving engagement to be presented to EMB.

Next Steps

- Agree the data capture plans
- Communicate objectives and processes

4. *Be recognised nationally for employee involvement in the running of the organisation*

Three year plan

- Year 1 – Provide further information and guidance to directorates, request that Trust Board/Directors cascade the priority within their own areas, test out improvement through survey, develop feedback mechanisms
- Year 2 – Implement feedback mechanisms around involvement activities within directorates, test out improvement through surveys, make part of the performance framework for senior leaders
- Year 3 – Continue to test out improvements through surveys
- Board updates will be provided twice yearly – May and November

Progress

- Detailed information and guidance has been developed and circulated to all senior managers on how to establish employee involvement at local levels with range of options
- Employee involvement forum is established for Good Hope Hospital
- Paper developed for Executive Team
- Question about senior managers involving staff in local survey 2011 had increased by 20% from 2009
- Question regarding line managers listening to ideas in 2011 local survey had increased by 9% since 2009.

Next Steps

- Develop feedback mechanisms (template)
- Develop local survey process

- Re-circulation of guidance/information (by Executive Team)

5. *Achieved a 15% reduction in our costs*

Three year plan

- Year 1 – Implement Trust Wide controls to mitigate risk in year i.e. EVCP.
- Year 2 – Identify and implement Trust Wide initiatives to further reduce costs underpinning requirement. Identify further Trust Wide 'level 3' initiatives as contingency.
- Year 3 – Ongoing implementation

Progress

- 73% efficiency delivered year to date.
- Significant shortfall in Groups 1, 2 and 5.
- 2011/12 forecast £16.4m category 4 and 5.
- Existing slippage carry forward.

Next Steps

- Presentation to Trust Board planned for early 2012 on final plans for 2012/13.
- Re-inforce Governance framework and quicken escalation in 2012/13.

6. *Have an average length of stay of no greater than 6 days for emergency admissions*

Progress

- Reduction in length of stay has been an operational priority for 2 years.
- Several approaches have been used to address this issue with variable / minimal success
- The current programme uses the approach based on the theory of constraints under the heading "JONAH "project.
- The project has had roll out across eleven wards at GHH hospital and currently rolling out across BHH.
- We have seen a reduction in LOS at GHH but the project at BHH is too early to evaluate.

Next Steps

- Establishment of a JONAH project Board
- Introduction of an electronic data capture tool
- Focused determination of project direction based on data from above

7. *Achieved a 50% reduction in the cost of sickness*

Three year plan

Year 1 – Continuing work with managers on improving sickness absence management. Prioritising top absentees in each group.

Year 2 – Absence management to be embedded in performance management criteria for managers

Year 3 -Negotiations with staff side on reviewing sick pay scheme.

Sickness absence levels are reported monthly. Full review of progress to Board six monthly.

Progress

- Sickness levels are currently at 3.94% for the last 12 months which compares with 4.05% for the year to March 2011. The average sick pay cost has reduced from £1445 per wte to £1347 per wte since April. A reduction of around 7%.

Next Steps

- Continue to provide absence statistics to managers.
- Ensure follow up for everyone who reaches a trigger.
- Commence discussions with Staff Side.

8. Consistently delivered all our statutory and regulatory targets

Reported to EMB and Trust Board on a monthly basis.

9. Have developed a distinct identity for each of our hospitals

Three year plans for each site are being developed and early vision work is contained in the Reshaping HEFT strategy as set out below. Further work will be presented to the Board in due course.

- Heartlands – very large hospital with some tertiary services providing a corporate and clinical centre for the organisation, including the Institute of Healthcare Research and Faculty of Education on site.
- Good Hope – a new model for medium sized District General Hospitals – utilising strong corporate support functions, cross site clinical working and effective local engagement.
- Solihull – An innovative integrated healthcare system – showing the way for smaller hospitals everywhere. Closely linked to HEFT community services.

10. Have driven local integration to enable the redesign of our key services and have achieved a complete service redesign for our frail elderly patients

Three year plan

- Year 1 – Building on the progress to-date
  - Identification of early 'organisational' priorities for service development
  - High level modelling of impact of service developments on bed base; agreement of the model of Physician general medical care and Elderly Care specialist support
  - Development of future model for Stroke services in line with Regional work on options for hyper-acute stroke delivery
  - High level activity and cost analysis to scope potential for alternative payment mechanism from 2012/13
  - Learning from others – active participation in local Frailty network
- Year 2 - Comprehensive service development and assessment of impact
  - Crystallisation of locality models and local priorities
  - Implementation of priority service developments including any service reconfiguration necessary
  - Evaluation of initial impact and further work to assess impact of implementation 'at scale' – potential support from Birmingham University
  - Monitor activity and cost; and develop a sustainable financial model
- Year 3 – Evaluation and scaling up for maximum impact

- Comprehensive evaluation of service changes - financial impact and assessment of benefits realisation
- Refinement of model in line with evaluation and sharing learning at a national level
- Progress reports against strategic priorities already scheduled for Board quarterly.

Progress

Work in support of this priority is being led and implemented at 3 levels:

1) Across Birmingham and Solihull through work facilitated by the PCT Cluster. A vision of the future model of care has been developed and supporting streams of work on generic frailty, stroke, dementia and end of life care established. The working groups are led by providers, with Claire Molloy jointly chairing the Frailty Group and clinicians and professionals from HEFT sitting on the other working groups.

2) At an organisational level to implement the elements of the proposed model we are responsible for; priorities include:

- Local frail elderly services on all 3 sites
- Integration with community services
- Old age psychiatry and support for dementia
- Assessment prior to admission – rapid access day hospital
- Discharge to assess for longer term care
- More early discharge and community rehabilitation

3) At a locality level working with specific stakeholders and partners – in Solihull this is through the Accountable Care Partnership; in Good Hope through a developing relationship with Clinical Commissioning Groups and Birmingham Community Trust; and at Heartlands through work with the City Council and Community Trust

Next Steps

- Finalise programme management arrangements and establish steering group and terms of reference (1st formal meeting on 15th December)
- Complete business cases for priority service developments (Mid January)
- Agree respective leadership responsibilities between 'organisational' and locality/site based (end December)
- Agree leadership and terms of reference for activity and financial modelling work and undertake to inform 12/13 contract (end January)

11. Have demonstrated we are a good corporate citizen

Three year plan

- Year 1 – Complete the NHS sustainable development commission review and from this develop a corporate responsibility framework and measurement with KIPs. Baseline data to be delivered with the community and stakeholders to determine the current position.
- Year 2 – Measure the outputs against the responsibility framework and report on rectification plans to support areas not achieving against the plan.
- Year 3 – Research to be carried out with the community and stakeholders to ascertain perceptions with regards to the organisation's position as a good corporate citizen

Progress

- Reviewed other external organisations approach and methodology to corporate citizenship
- Review the Trust's current performance against the NHS's good corporate citizen framework
- Develop a Trust specific corporate responsibility framework

- Develop a Trust Board Sub Committee to oversee and challenge performance against the framework

Next Steps

- Agree the corporate responsibility framework by approving scores for the Trust against the Good Corporate Citizen Framework, looking for ways to improve performance and agreeing the process for making this a regular check.

12. Be assessed externally on the contribution we make to health and well being promotion among our communities

Three year plan – not yet established

Progress

- A number of activities across all sites have been indentified – not well communicated and no clear strategy across the organisation.
- Many activities currently being undertaken in the community – again not well co-ordinated and linked into our hospital sites.
- A good model with the You+ shop
- Need for Trust to define Wellbeing strategy and appetite for this.
- Current thinking around a Public Health agenda at BHH

Next Steps

- There is a need to establish a clear way forward for this strategic priority area

13. Have identified and developed a number of beacon clinical services which receive national recognition

Three year plan

- Year 1 – Select first two beacon services and produce development plans.
- Year 2 – Select further services for beacon status and review progress
- Year 3 – Ongoing implementation

Progress

- HEFT currently has a small number of nationally recognised clinical services.
- EMG has agreed the criteria for beacon services
- The first service to be selected was Infectious Diseases. Three main achievements have been delivered to date:
  - agreement with the University of Warwick to appoint a new Professor, Senior Lecturer and Lecturer in Infectious diseases;
  - support to develop links with the HIV service in China (to date two exchange visits have taken place with further work planned);
  - support for the 'Saving Lives' national HIV testing awareness campaign (soon to be a charity in its own right).

Next Steps

- Selection of 2nd service currently underway (likely to be vascular surgery).

14. Have grown and, if appropriate, established separate business models for education, research and services to other organisations

Three year plan

- Year 1 – Establish Institute of Healthcare Research, develop a 3 year plan for the Faculty of Education
- Year 2 – Continue to grow the Research and Education businesses and review options around the best organisational form
- Year 3 – Ongoing growth and if appropriate development of new business models

Progress

- Director of the new Institute of Healthcare Research has been identified and will take up the role in April 2012.
- R&D activity has increased by 10% in 2011/12 and a number of new clinical academic appointments have been agreed
- Discussions around enhancing the medical education structure as part of the Faculty have commenced
- Discussions around the future role of the Faculty are about to commence

Next Steps

- Communications around the Institute of Healthcare Research
- 2011/12 Annual Report for R&D and the Faculty of Education
- Development plan for the Faculty

15. Have established ourselves as the leading 'open organisation' in the NHS

Three year plan

- Year 1 – Design and open organisation profile specific to the Trust and an assessment tool to measure performance.
- Year 2 – Measure the outputs against the gaps between best practice and current state. Report on rectification plans to support areas not achieving against the plan.
- Year 3 – Research to be carried out with the community and stakeholders to ascertain perceptions with regards to the organisation's position as an open organisation. Develop the concept to incorporate internal relatedness (staff become self aware, as a group have interpersonal relationships and are aligned to the organisation).

Progress

- Review other external organisations approach and methodology
- Review the Trust's current performance against a set assessment tool
- Develop a Trust specific profile

Next Steps

- Agree the core components of 'open' and measurement.

16. Have achieved local, national and international recognition for the HEFT nurse brand

Three year plan

- Year 1 – Continuation of work already in progress.
- Year 2 – Develop the HEFT Nursing and Midwifery quality monitoring system for dissemination to the NHS and beyond.
- Year 3 – Ensure major workstreams are published nationally and internationally. Recognition nationally and internationally of the HEFT nursing badge as a marker of expert practice and professionalism

Progress

- Introduction of nursing metrics to enable monitoring and delivery of standards of nursing care.
- Introduction of patient experience metrics to enable monitoring and delivery of standards of nursing care.
- The above metrics have been developed into an Internet based system which we have made available to other Trusts (*Testyourcare*).
- *Testyourcare* has been purchased by several NHS organisations both in the UK, EIRE and shortly to be trialled in Malta.
- Development of the Trust Nursing and Midwifery values
- Development and implementation of VITAL, an on-line assessment of competency comprising an e-learning module relating to standards of nursing practice.
- Development of the HEFT Nursing and Midwifery badge.
- Winner of Nursing Times Patient Safety Award 2011, winner of BAPEN national award for improvements in patient nutrition 2011.

Next Steps

- Production of Annual Report to the Board – first quarter 2012.
- Seek collaborative arrangements with national bodies where appropriate e.g. Royal college of Nursing, Nursing and Midwifery Council etc.

Simon Hackwell
Commercial & Strategy Director
24 February 2012

RESHAPING HEFT

Trust Board meeting 6th March 2012

From: Simon Hackwell, Commercial & Strategy Director

Summary/Key Points

The work undertaken on Reshaping HEFT has now been captured in one document – "*Reshaping HEFT: A clinically led service redesign strategy*". This is attached and will be used as an important piece of communications with internal and external stakeholders as the Trust begins to deliver the programme.

The Board is asked to consider the document and provide any feedback before it is finalised.

The Reshaping HEFT strategy will be considered at the Governor's Finance and Strategic Planning Committee on 1st March and via this committee will be presented to the Council of Governors on 14th March.

A draft copy of the strategy has also been sent to key local stakeholders prior to a more general distribution both within and outside the organisation.

A programme office is being established to oversee the implementation of the portfolio of projects contained in the strategy. The first step will be to develop project documentation for each project (including measurable benefits) and set out timescales and resources against each project. In some areas work has already commenced e.g. a review of stroke facilities across the Trust, but in most areas the serious work will begin in April.

The Trust Board will be kept fully informed of progress and where necessary will be asked to consider and endorse any significant proposals.

Recommendations

The Board is asked to consider the document and provide any feedback before it is finalised.

Reshaping HEFT

A clinically led service redesign strategy

January 2012

Reshaping HEFT –a clinically led service redesign strategy

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Reshaping HEFT –a clinically led service redesign strategy

1. Forward

I am pleased to present this document which sets out the main clinical priorities we believe we need to address over the next three to four years.

In effect, HEFT is a healthcare system comprising of three acute hospitals and a range of community services. This linked system, serving a very large population base, provides us with unique opportunities to review our services to ensure we 'localise where possible and centralise where necessary'. In this way we can maximise access to services close to home, whilst concentrating equipment and expertise where necessary to meet the highest quality standards.

Reshaping HEFT is a clinically led programme and is about making sure that the services we offer to our patients and GPs continue to be safe and of high quality in light of changing population needs and expectations. It sets out a clearer picture for each of our main hospital sites and the community services that we provide.

Some of the services we provide at different sites and the way we provide care and treatment to our patients may change. It reflects a need to ensure that we can continue to provide safe and appropriate care in a changing world. In many areas we are looking to invest and extend the range of services we can provide to our local communities; in other areas it is about strengthening the services we currently provide. So to be clear, this is not about cost cutting rather a recognition that we need to change to meet the needs of our patients and maintain high quality care.

It is very important for me to underline that our Trust recognises that change cannot be effected by HEFT alone and that only by working in collaboration with our partners in health and social care can we bring about improvement and sustainability in our services. We are proud to be part of the NHS system and as such have no desire to work in isolation behind the walls of the hospital. Our success depends on the success of our commissioners, our GPs, community services and social carers to name just a few. We will therefore engage in close consultation and dialogue with our colleagues about moving forward with the projects set out in this document, and will listen carefully to any changes that may be suggested. In this respect I would welcome feedback from any of our partners on the contents of this document.

The areas of work set out in this document are in most cases still at an early stage of development and should not be taken as a fait accompli. Some may not come to full fruition, some may change and no doubt over the next three years other priorities may also come to light. What they are is a product of a number of discussions held with our senior clinical leaders at the end of last year around how we should respond to the challenge of providing safe and appropriate, and indeed efficient, care in a changing world.

Reshaping HEFT –a clinically led service redesign strategy

Many of our patients are elderly with increasingly complex clinical and social conditions, and many have ongoing chronic diseases which require expert care and treatment, that does not always need to be in a hospital setting. We deliver over 11,000 babies each year and care for many children and in these areas there are quite properly increasingly stringent requirements on safety and risk management. We also continue to see over a quarter of a million patients in our emergency departments each year; these and other 24/7 services we provide are a vital part of a local healthcare system and are highly valued by their local communities. We will continue to invest in these services and work with commissioners and others to ensure out of hours emergency care remains accessible and safe. These investments must be linked with improvements in efficiency, given that the NHS will continue to receive comparatively less resource than in previous years.

In short demand for our specialist care will continue to increase but not all of this care will need to be provided in a hospital setting and where it is we need to continue to make sure it is accessible, safe and of a high quality.

So there is a legitimate need to change and I recognise the uncertainty that this can bring. I understand the concern that people may have about the 'future look' of their local hospital. I want to assure you that the changes we need to make are about doing the right things for our patients and making sure what we do for them is right first time - and because of this I believe we will actually enhance and strengthen our hospitals and the role they play in the local communities.

The Board and all staff in the Trust are determined to ensure quality and safety remains at the centrepiece of our future strategy. The Reshaping HEFT programme clearly describes the next phase of our development as a large healthcare provider, and clarifies the future shape of each of our three hospitals. It also outlines a determination to move towards a 'well being' agenda, by providing clinical services in non-hospital settings that are aimed at improving health and helping people with chronic illness to stay well. This is an exciting new area for an acute hospital Trust, and one we feel links closely with the needs of our communities and also one that will lead to improvements in the effectiveness of our hospitals in the coming years.

Mark Newbold

Chief Executive

mark.newbold@heartofengland.nhs.uk

Reshaping HEFT –a clinically led service redesign strategy

2. Introduction

As the largest provider of acute care in the West Midlands, HEFT has an important role in helping to shape future healthcare in the communities we serve. Our catchment area for patients covers about one million people and while this overall number will remain relatively stable over the next five years there continue to be some important trends to which we need to respond. These include the increase in number of older patients many of whom will have complex and multiple conditions, an increase in the number of people who will have chronic (ongoing) diseases and an increase in the birth rate among certain parts of our population with a higher risk profile.

In thinking about how we might ensure our treatment and care is fit for purpose going forward I think there are five key challenges:

- Ensuring we offer the right care to the right people at the right time – whether this is in or out of hospital. In some cases this means our staff will be more focused on avoiding admission to hospital and in other areas it will mean earlier involvement of our teams in a patient's pathway;
- The need to work with colleagues and partners outside of HEFT to ensure pathways, treatment and care are more and more centred around the individual ;
- Continue to invest in services that will mean our patients have the opportunity to receive excellent treatment supported by published outcomes, seven day working and staffed with appropriate multi disciplinary teams;
- Providing services that value care as much as cure. This is particularly true for our older patients where the personal, social and psychological implications of their circumstance are just as important as the underlying illness;
- Improving our productivity so we maximise the skills and time of our highly talented workforce and enable our patients to get back home as quickly and safely as possible.

Good health is less expensive than bad health. Improvement in the quality of diagnosis, access to state of the art facilities, faster recovery times, reduced error and duplication all offer better value for money and reduce the chance of long-term disabling conditions. To continue on our journey of improvement we will need to work closer with our GP colleagues and other health and social care professionals and especially increase multi disciplinary working around chronic conditions such as heart disease, dementia and respiratory conditions. In practice this means HEFT clinicians will need to increasingly organise care around an individual's medical condition and their care pathway and less around traditional specialty means. For some severe and urgent conditions it may be necessary for patients to travel between our hospitals so that we can offer the highest quality of care for them and their families. Where this is the case we shall be clear and transparent about the evidence and

Reshaping HEFT –a clinically led service redesign strategy

outcomes that underpin this. Above all though our purpose remains to ensure we provide first class local hospital and community care for our different populations.

Reshaping HEFT sets out our key priorities in terms of service development. Ongoing work around operational improvement and enhancing the quality of day to day care continues, but it is important to highlight those areas where we feel we will need to focus a particular effort to ensure we can meet the needs of our patients in the future. This document captures these areas. They have been developed by our clinical leaders and will be implemented by them with support from our colleagues and partners.

Taken with improvements in our day to day work, I believe Reshaping HEFT offers the opportunity to significantly improve the quality of care we are able to offer patients and ensure the viability of all of our hospital and community based services for the patients we currently serve and those whom we will serve in the future.

Aresh Anwar

Medical Director

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Simon Hackwell

Commercial & Strategy Director

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Reshaping HEFT –a clinically led service redesign strategy

3. A vision for HEFT

Over recent months the Trust Board has engaged in a number of discussions around the future strategy for the organisation and its hospitals. To begin with it is important to be clear about purpose and direction.

Mission

What is our purpose?

Healthcare at the heart of our communities

Vision

Where do we want to be?

To provide services that inspire confidence, trust, and pride within the communities we serve

Priorities

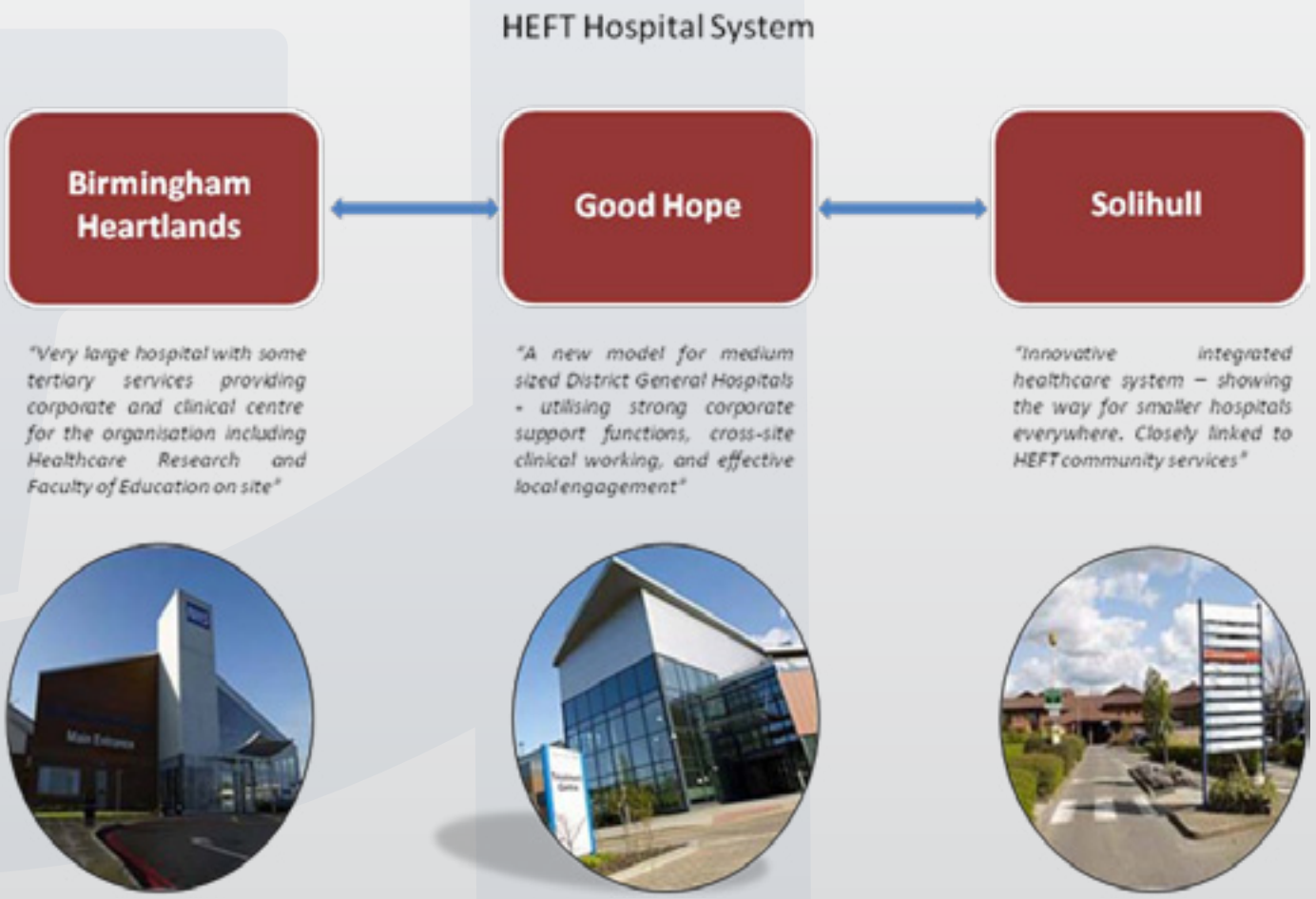
Tell us what is important and how we will measure ourselves

1. Safe and Caring
2. Locally Engaged
3. Efficient
4. Innovative

Reshaping HEFT –a clinically led service redesign strategy

Our hospitals

The Trust recognises that the future success of its three main hospitals is closely linked to them each having a clear identity and close relationship with their local GPs and communities. Going forward, each hospital will have increasing levels of autonomy to drive the development of their hospital and the role it plays in the local health economy. The diagram below sets out where we are in defining the distinct role for each hospital.



Birmingham Heartlands Hospital

Heartlands Hospital is a large site which sits in the heart of a dynamic community. It is increasingly the centre for more acute and complex care as it is home to a number of specialist clinical teams and facilities. For example, it is able to offer 24 hour high quality and complex maternity and surgical services to our population. It is also home to a number of regional services such as infectious

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diseases, cystic fibrosis, thoracic and bariatric surgery. Along with our other hospitals, Heartlands employs a number of nationally recognised clinicians who are at the leading edge of their profession.

Heartlands Hospital also leads on the Trust's academic work. It is home to our Faculty of Education. As a whole HEFT is one of the largest centres for training doctors, nurses and other clinicians in the country and the Faculty brings together our work in this area and has developed innovative learning packages which are being adopted across the country. Research and innovation is also centred at Heartlands. HEFT undertakes a large number of clinical trials each year and has ambitious plans to expand its translational research portfolio.

Given the large and diverse population served it is important that Heartlands hospital plays its part in not only caring and treating disease but an active role in safeguarding the future health of the community. The hospital will, therefore, be increasingly active in early intervention and prevention work and along with others play its part in contributing to the future health and well being of the communities it serves. It is planned, therefore, that Heartlands Hospital will use its expertise and resources to play an important role in public health over the next few years.

Solihull Healthcare

The vision for Solihull incorporates care outside of a hospital setting. As the provider of both community and hospital services, and through our emerging 'Accountable Care Partnership' with Solihull Council, local GPs and other partners, we have a unique opportunity to shape services across traditional care boundaries and to develop more coordinated and seamless care.

Our vision is for person centred care that is coordinated with shared assessment and planning and services that support people in the most appropriate care setting with seamless pathways between community and hospital.

We believe we can do things differently. We want care that supports our patients through the health and social care system from home to hospital and back again. We want pathways that keep our patients healthy and well; provide personalised care and support in their own homes and community settings; prevent unplanned admission and provide rapid access to diagnostic and expert services, and that are seamless and guide our patient the whole length of their journey.

We will continue to invest in the hospital (e.g. the development cancer services and surgery) and work with our partners in Solihull to ensure that appropriate and safe acute services are available to local people.

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Good Hope Hospital

‘Local enough to Care, Big enough to count’. The Good Hope vision is to deliver the very best care of secondary care, to provide an access portal to both community and specialist tertiary services ensuring a seamless transition for patients.

Like our other partner hospitals we believe that it is possible to bridge the gaps in care that patients report to us, when they transfer from one organisation to another. Whilst Good Hope is not formally integrated with the Community Providers that provide care to the local patient population, we have started to develop strong working relationships. Our joint venture with Birmingham Community Trust to provide smoking cessation services to south Staffordshire is one example, and our collaborative refurbishment of Community Ward 3 with the sharing of nursing metrics is ongoing.

Good Hope will continue to offer a local acute service with a full range of ambulatory and diagnostic services to the people of North Birmingham and South Staffordshire. We also offer access to more specialist services at Heartlands or other larger centres. Good Hope is also home to the Hollier Simulation Centre – one of the largest of its kind in the country where each year hundreds of clinicians are trained in human factors and team training, making a significant contribution to patient safety.

Reshaping HEFT –a clinically led service redesign strategy

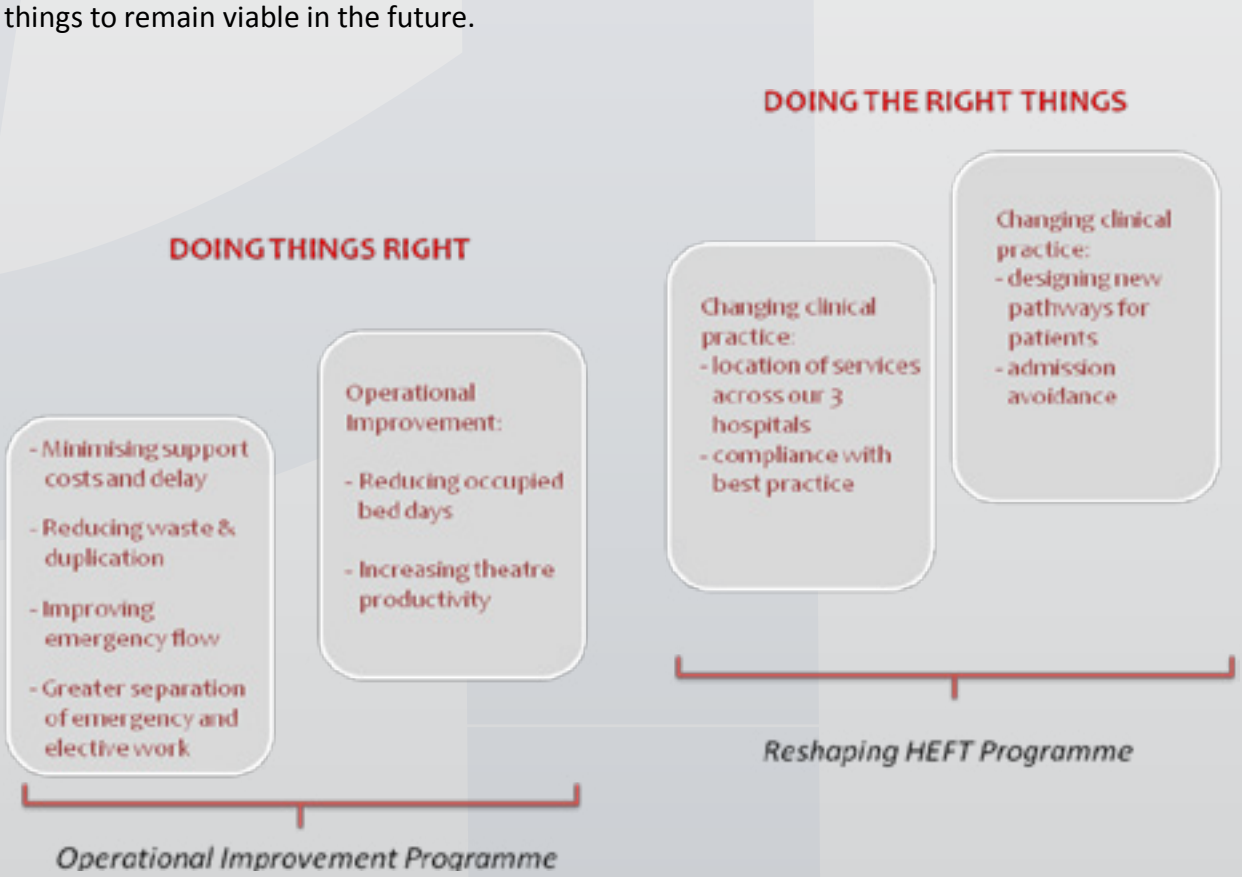
4. Reshaping HEFT

The overall objectives of the Reshaping HEFT programme are:

1. Raise awareness around the need to reshape our hospital system
2. Develop a clinically led plan to deliver appropriate care within the context of a changing external environment
3. To engage the wider Trust and our partners around options for consideration

During the autumn of 2011 a large number of workshops were held with senior clinical teams from our main bedholding specialties.

The main outputs from these workshops are summarised below and fall into two broad categories. The first category is about making use of current resources to most effectively deliver today's services to today's patients i.e. improving our operational management. The second category is about deciding how current operations need to change in order to deliver against the challenges in years ahead i.e. how we might need to reshape the organisation to make sure it is doing the right things to remain viable in the future.



> *Reshaping HEFT –a clinically led service redesign strategy*

The Trust is developing an Operational Improvement Programme (and in some areas performance is already improving) to run alongside the Reshaping HEFT programme. This document, however, focuses on the 'Doing the Right Things' side.

Reshaping HEFT – Portfolio of projects

Frail Elderly

Aim:

To work with our partners in building stronger clinical pathways for frail elderly patients that are focused around individual need.

Objectives:

- To provide local frail elderly services on all 3 sites that are integrated with community services
- To develop safe alternatives to admission
- To provide more early discharge & community rehabilitation
- Enhance partnership working with surgery in the care of frail older patients (i.e. hip fracture, general surgery etc.)
- To improve the integration of mental health services for older patients into the acute hospital

"There is a pressing need to build on and improve the pathways for our frail patients, and much of this is about preventing unnecessary admission to hospital."

Peter Wallis, Consultant Geriatrician
Clinical Director Elderly Care

Elective Care

Aim:

To develop a treatment centre for elective surgery at Solihull Hospital that is efficient, fit for purpose and an attractive facility for our patients.

Objectives:

- To develop a centre that facilitates a greater concentration of routine elective surgery on one site
- To provide the best patient experience in fit for purpose, attractive facilities
- To be as efficient as possible for our routine elective surgery
- To provide a greater focus on measuring outcomes from surgery

"Development of a dedicated treatment centre for some of our surgical procedures provides a great opportunity to improve the service we provide to patients, both in terms of the experience and outcomes."

Roger Stedman, Associate Medical Director, Solihull

Reshaping HEFT –a clinically led service redesign strategy

Stroke Services

Aim:

To ensure that we provide high quality, cost effective stroke services for our patients.

Objectives:

- To ensure that we have a clear direction of travel for the provision of hyper acute stroke care, whilst maintaining local rehabilitation services
- To further develop Early Supported Discharge Pathways at each of our 3 sites to improve stroke integration and patient outcomes
- To reduce the length of stay in hospital for stroke patients

"We will carry out an option appraisal to assess the optimum configuration for Hyper Acute Stroke Services at HEFT. We will also ensure that the rehabilitation and discharge arrangements at each of our hospitals continue to provide the best care for these patients"

David Sandler, Lead Physician, Stroke Services

Respiratory Services

Aim:

To transform the care of people with long term conditions by designing a patient centred service which will enhance self-care and keep them well in the community.

Objectives:

- To become a Multi-axial and Multi-professional Hub for managing Long Term respiratory conditions & co-morbidity management
- To replace the rigid model of fixed clinic appointments characterised by unnecessary delays with a responsive service capable of specialist-led rapid assessment and decision making
- Reducing Unscheduled admissions & readmissions through up-skilling/supporting primary care and enhancing self care and self efficacy of people with long term respiratory conditions & co-morbidities

"Like many others with respiratory problems, I find it very reassuring to know that I have access to your excellent facility at Heartlands Hospital. Breathing difficulties can occur without notice and develop rapidly so those such as myself greatly value being able to seek virtually instant advice from your unit via telephone."

Respiratory Patient, 2011

Reshaping HEFT –a clinically led service redesign strategy

Maternity Services

Aim:

To ensure we deliver maternity pathways that are both effective and efficient and we make it possible for women to be back at home with their families as soon as possible.

"We are proud to have the highest number of births at any Trust in the country; we are absolutely committed to ensuring women and their families have choice and access to a wide range of high quality services."

Mike Wyldes, Clinical Director

Objectives:

- To ensure that all women are back at home with their families as soon as possible.
- To reshape our pathways for normal births.
- To improve enhanced recovery and discharge following C-section.

General Medicine

Aim:

To ensure we are increasingly able to organise our services in the context of the patient as a whole and their particular circumstances and environment.

"Our patients don't care about the specialist / generalist debate. What they want is the right care, in the right place and at the right time."

Aresh Anwar, Medical Director

Objectives:

- To ensure best patient experience with high quality outcomes
- To ensure that we have maximum senior intervention across 7 days and promote Multi Disciplinary Team working as the norm
- To develop a cohort of beds dedicated to treating general medicine and as part of this create standard operating procedures for the wards delivering this care.

Day surgery

Aim:

Explore the feasibility of creating separate daycase businesses for routine elective surgery across our hospital sites.

Objectives:

- To explore options for improving daycase surgery productivity that can match the levels achieved in other sectors
- To improve the patient experience
- To ensure our clinical teams have greater autonomy in delivering this work.

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Diabetes

Aim:

To work with our partners to ensure the management of patients with diabetes is integrated, of high quality and provides good value for money.

"We recognise that HEFT needs to work more closely with its partners in primary and community care to ensure our services are part of an integrated approach to managing diabetes"

Sri Bellary, Clinical Director

Objectives:

- Ensure information is used to improve how care is delivered for the Diabetes Patient Population across primary, secondary and tertiary care.
- Design and evaluate initiatives to improve care at the most appropriate level for patients.
- Actively manage patients, not just through an individual care pathway, but throughout a complete care cycle.

HEFT@Home

Aim:

To look at the feasibility of HEFT providing models of care to enable patients to be cared for in their own homes.

Objectives:

- To support hospital discharge, helping people return home from hospital and reduce length of stay
- Preventing hospital admission by keeping people out of hospital by supporting them at home and offering help 24/7
- To provide medication home support and treatment
- To work with others in developing these services.

Reshaping HEFT –a clinically led service redesign strategy

Surgical specialties

Aim:

Review the location and configuration of surgical specialities to ensure that the provision of emergency and elective workloads is balanced.

Objectives:

- Ensuring that patients needs are put at the forefront of any redesign
- Ensuring patient safety and quality of care is maintained in line with national guidance and best practice
- Ensuring that patients are placed in the appropriate location and nursed by appropriate staff.
- Minimising elective cancellations

"We will undertake an objective, evidence based review of the location and range of our emergency and elective surgical services to ensure they offer the best care for our patients."

Charlie Hendrickse, Clinical Director

Community cardiology

Aim:

To optimise the management of patients with suspected cardiac disease in the primary care setting using evidence-based pharmacological treatments.

Objectives:

- To enable patients to take greater control of their condition
- To provide patient-centred treatment and support
- To reduce unnecessary hospital admissions and readmissions
- To work in partnership and improve communication between primary healthcare teams
- To work towards the delivery of the DOH policies, NSF and NICE guidelines on supporting people with long-term conditions
- To work closely with palliative care teams in managing end-of-life care

"The cardiology team is keen to explore, with our colleagues in primary care, new models of care for assessing, treating and managing patients - particularly those with chronic conditions."

Mike Pitt, Consultant Cardiologist
Gordon Murray, Consultant Cardiologist

Reshaping HEFT –a clinically led service redesign strategy

Cancer services in Solihull

Aim:

Establish a facility at Solihull hospital to allow the safe and timely delivery of high quality chemotherapy and supportive care to patients with cancer in a comfortable, local environment.

"We are committed to providing specialist cancer care in more local settings."

Jo Ewing, Clinical Director

Objectives:

- To provide local services for our patients in environments that are fit for purpose.
- To ensure that we can serve cancer patients better to ensure excellent patient experience and strive to hit targets that put our services in the very top echelons of the country.
- To ensure that despite increase in demand we can continue to offer patients innovative therapies as part of NCRN trials and other trials (we currently have the highest level of trial entry across the pan Birmingham Network).

Birmingham Chest Clinic

Aim:

Develop options around the future provision of the services that we currently provide from this city centre location.

Objectives:

- To explore the options around alternative sites in the city centre
- To ensure any services we provide in the city centre are accessible and in an appropriate environment.
- To explore options with other providers to offer multi use facilities e.g. health promotion, primary care, private providers.

In addition to these projects other specialties will be involved in supporting the Reshaping Programme either through their own service development plans or directly supporting the projects in the Reshaping HEFT programme (e.g. pharmacy, theatres, radiology etc.).

Reshaping HEFT –a clinically led service redesign strategy

5. Delivering the programme

Programme management arrangements for Reshaping HEFT

It is important to recognise and support that the delivery of Reshaping HEFT needs to take place either within the clinical teams or at a site level. To support the operational and clinical teams a structured programme and project management approach will be put in place.

The benefits of using a programme and project management approach are that it provides a framework for implementing business strategies and initiatives through the co-ordinated management of a portfolio of projects, to achieve benefits of strategic importance. At an **organisational** level, the top team need to be clear about strategic goals and activities overseeing the portfolio of major programmes, managing risk against capability, at a **programme** level, there is a key requirement to understand departmental priorities, identifying and managing risk and interdependencies with regular independent scrutiny of progress and at a **project** level, there is a key requirement for the team to have clear roles and responsibilities and a vision translated into a plan with milestones, regular reporting and review and stakeholder involvement from the start.

The programme will require a formal reporting structure with the establishment of a Reshaping HEFT Board meeting bi-monthly and chaired by the CEO. Membership will also include representatives from the commissioners. The Commercial Director will be the reporting link to EMB and Trust Board. Each project will have a Clinical and Executive lead who will report to the Reshaping HEFT Board. This is described below:

Reshaping HEFT –a clinically led service redesign strategy

Programme Approach

Our approach to managing this programme will be the adoption of a hybrid model which is tight on the co-ordination and reporting aspects but allows more freedom on the actual delivery of the projects. All projects will follow a consistent format (risks, benefits etc.) with common documentation.

To ensure this programme has appropriate Clinical Leadership a dedicated Clinical Programme Lead will be appointed and will be responsible for:

- Overall co-ordination of the Reshaping HEFT programme
- Ensure continued clinical buy-in to and involvement in the programme
- Ensuring there are appropriate resources in place to deliver the projects
- Lead on some projects
- Manage communications in the programme – act as first point of contact and be responsible for wider communications in the Trust
- Play an active role in liaison with commissioners around Reshaping HEFT
- Ensure consistent, accurate and timely reporting
- Manage any third party contributions to the programme
- Identify and manage interdependencies across the portfolio of projects

Role of Virtual Programme Office

To ensure that the directorates or sites are supported where appropriate, a virtual Programme Office will be set up.

This will consist of a small number of individuals who will work closely with the Clinical Programme Lead and whose primary role will be to provide support to the projects in the following areas:

- Data analysis and modelling
- Pathway redesign
- Business Case support
- Option appraisal / feasibility studies
- Support to the Clinical Programme Lead
- Project management
- Use of consistent documentation and library of resources

It is envisaged that the Programme Office will involve individuals who are already in post but able to provide support in these areas (e.g. Commercial Directorate, Site Programme Office, Service Improvement Specialists).

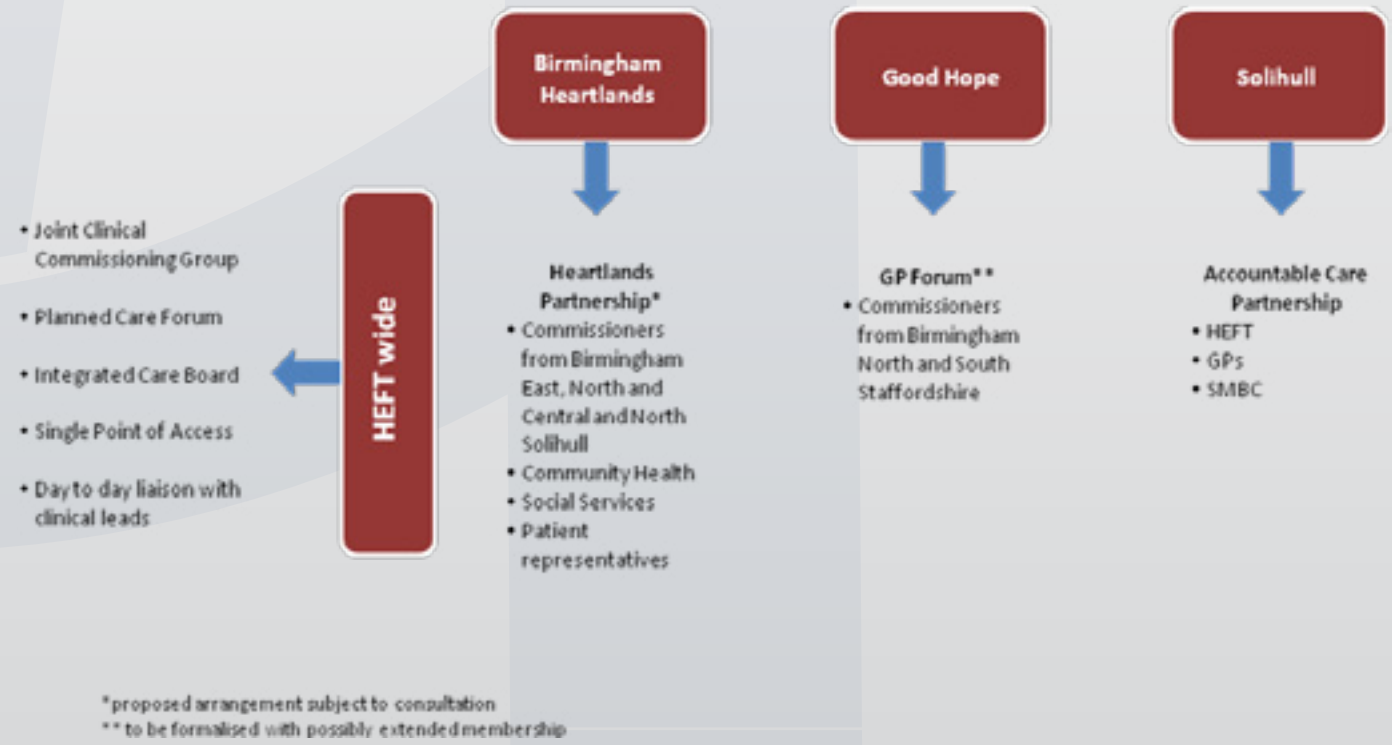
Reshaping HEFT –a clinically led service redesign strategy

6. Engaging with our partners

Our hospitals cannot be described or exist outside of the local health system in which they operate.

HEFT has made a commitment to change – to work beyond the walls of the hospital to reduce unplanned and avoidable admissions, reduce time spent at and in hospital and increase our focus and resources around the patient as a whole. None of this is achievable on our own. Reshaping HEFT in short is about working with others.

How we achieve this engagement with our partners will vary from hospital to hospital and service to service. Set out below is an overview of the main means of engagement with commissioners and other partners. As well as site led initiatives we acknowledge the work currently being undertaken in cross Trust groups such as the Joint Clinical Commissioning Group. At present it is proposed that these groups continue in their current form.



The Accountable Care Organisation in Solihull has already been established and it is likely to have a major influence on the Solihull health and social care system as it begins to gather momentum.

At Good Hope, initial meetings have already taken place with local GPs and it is planned to establish a more formal group to support the development and improvement of pathways between primary, community and acute care.

Reshaping HEFT –a clinically led service redesign strategy

Birmingham Heartlands Hospital also needs closer engagement with its partners. It is proposed to develop a Heartlands Partnership in 2011/12 to facilitate this.

Across all the hospitals closer working with commissioners and other providers is intended to:

- encourage closer liaison between HEFT clinicians and GPs;
- ensure the services provided at our hospitals are appropriate and fit well with the models of care and patient pathways outside of the hospital;
- share understanding around operational weaknesses in the current system e.g. delayed discharge and agreement about how to overcome these;
- encourage joint working around service redesign and benefit / risk sharing. Agreeing common goals and securing the means and resources to deliver these;
- ensure a stable, managed and affordable transition is made from old to new models of care
- gain consensus over the future role of the hospital and its services (consultation and participation in Reshaping HEFT).

At an organisational level, recent history in the NHS can perhaps be best described as producing a set of financially driven relationships. It is clear that we need to move towards a more value based healthcare system where outcomes, integration and shared risk are more important. We recognise that changing this approach will not always be easy, but it starts with a commitment from the Trust Board and senior management and clinicians.

We believe closer working at a hospital level offers the best opportunity to change the debate and encourage partnerships. We look forward to engaging with our colleagues in primary care and others over the forthcoming months about how we can take forward and translate the aspirations into more specific proposals.

Reshaping HEFT –a clinically led service redesign strategy

Appendix – The portfolio of projects

Theme	Project	Key focus / outcomes	Initial delivery	Clinical Lead	Operational Lead
Development of new pathways	Frail Elderly Pathway redesign	Admission avoidance and early discharge	Pathway redesign	Peter Wallis	Ryan Irwin
Development of new pathways	Respiratory Day Hospital Pilot	Admission avoidance	Production of a business case for Respiratory 'Hub' pilot at Solihull hospital	Dr Mukherjee	Kate Duffield
Development of new pathways	Maternity Services Efficiencies	Reduced length of stay	Programme to support redesign within the Directorate	Mike Wyldes	Katy Dale
Development of new pathways	Diabetes Pathways	Management of care in the community	Design options for new pathways using data to support interventions	Sri Bellary	David Willis
Development of new pathways	Community Cardiology	Admission avoidance and management of care in the community	Development of a community cardiology strategy	Mike Pitt/Gordon Murray	Sharon Parkinson
Service Development	Elective Care Centre at Solihull	Concentration of elective care to increase efficiencies and improve patient experience	Activity Modelling		
Service Development	Review of General Medicine	Streamlined pathways for Gen Med - < LOS	Scoping exercise to determine best configuration of general medicine	Aresh Anwar	
Service Development	Day Surgery Models	Increased efficiencies	Feasibility Study		

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.86

Reshaping HEFT –a clinically led service redesign strategy

Service Development	HEFT @ Home Modelling	Early discharge, improved patient experience	Feasibility Study	Mary Ross	Simon Hackwell
Service Development	Cancer services at Solihull	Development of a Chemotherapy service on Solihull site	Business case to support development	Jo Ewing	Gaynor Hill
Stroke Services	Review of acute and rehab services	Streamlined pathways, early discharge and the concentration of hyper acute service delivery	• Options appraisal for Hyper acute stroke • Development of early supported discharge pathways	David Sandler	Jonathan Vaughan
Surgical Specialities	Review location and configuration	Ensuring provision of emergency and elective workloads is balanced.	Mapping current position and challenges for surgical specialities.		
Birmingham Chest Clinic	Alternative locations	Ensuring future provision of services are accessible and in an appropriate environment.	Development of a business case.	Richard Steyn	Simon Hackwell

.24
.87

Reshaping HEFT –a clinically led service redesign strategy

To	*Trust Board*
From	*Director of Infection Prevention and Control*
Date	*23rd February 2012*

Title	Director of Infection Prevention and Control Report

The purpose of this report is to update and inform the EDs on infection prevention and control performance and issues in October , November, December' 11 & January, 2012.

The report is provided to the Committee for:

Decision (approx 10 mins)	Y		**Discussion** (approx 5 mins)	Y
Assurance (approx 5 mins)	Y		**Endorsement** (approx 5 mins)	Y

Summary/Key Points:

- **MRSA Bacteraemia (post 48 hour)** : No cases Q3, 2011-12 and January'12. Time since bacteraemia over 200 days. ***Appendix 1***
- **C *difficile* infections-** 116 cases of post 48 hour against Objective of 107 until January 2012**.**
- ***C.difficile* change in reporting for Feb & March 2012**
- **HCAI ambitions 2012-13**
- **Norovirus activity**
- **IPC scorecard-** ***appendix 1***

Recommendations: The Executive Directors are asked to:
Notes facts and requirements for 2012-13

Strategic Risk Register Infection Prevention & Control not on Strategic Risk Register.	**Performance KPIs year to date** MRSA bacteraemia– Red C.*difficile* – Red. MRSA Screening- Green

Resource Implications (e.g. Financial, HR)

None identified

Assurance implications

- Health and Social Care Act (2008): Code of Practice for health and adult social care on the prevention and control of infection.
- NHSLA requirements

Information Exempt from Disclosure:

Nil

Report to Executive Directors &Trust Board
By Director of Infection Prevention and Control

21st February 2012

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1. MRSA BACTERAEMIA

The MRSA trajectory for 2011-12 is 7 post 48 hour bacteraemias.
Year to-date position is 6 cases: No cases since July 2011. ***Appendix 1 –MRSA dashboard***

This is the first Quarter (Q3) ever when there have been no MRSA bacteraemia both post and pre48 hours.
This is the first time HEFT has achieved more than 200 days from MRSA bacteraemia.

2. CLOSTRIDIUM DIFFICILE INFECTIONS

Objective for Oct, Nov, Dec 2011 and January 2012 was 12 cases
The table below shows CDI cases in detail, according to sites.
These include cases after dual testing for diagnosis which are also the cases currently reported on National Data Capture System.

Infection Control Update Report

Month	Post 48 hour
October	11 BH- 9,GH- 1,Sol- 1
November	10 BH- 7, GH- 1, Sol- 2
December	10 BH-7,GH- 1, Sol- 2
January	11 BH-4, GH-4, Sol-3

Total cases with 'new' dual test are 116. Total cases with 'old' toxin test are 100.
The new dual test was introduced in mid-September and since then there has been a reduction of toxin positive cases.

3. Reporting of *C.difficile* for Feb & March 2012.

It has been agreed by SHA and Commissioners (Cluster) that for Feb & March 2012, HEFT will report on national MESS database: PCR positives that are also toxin positive cases.
This will be in line with the Draft Cdiff guidance on reporting released in Feb 2012.
It is anticipated that this could bring our numbers within the trajectory of 131

4. AMBITIONS HCAI 2012-13

These are based on baseline figures between Oct10-Sept 2011 which were

Report to Executive Directors &Trust Board
By Director of Infection Prevention and Control

21st February 2012

MRSA bacteraemia: 10 cases
Cdiff: 172 cases

a) **MRSA bacteraemia - 6 cases**; monthly trajectory of one case every alternate month

b) Cdifficle infections- 124 cases; trajectory of 10,10,11 per quarter

5. NOROVIRUS

Norovirus activity has been much reduced this year as compared to previous years especially at BHH and GHH sites. However in recent years the activity has continued until April so all the preparations are still in place for management of outbreaks and Saturday winter service for Infection control nurses continue.

Month	Site	Bay closure	Ward closure	Days closed	Total lost bed days	From these closures norovirus was confirmed in
Dec	BHH	4	1	34	144	Ward- Rowan Bay-BH 22 & Beech
	Solihull	4	0	19	19	SOL 15 Bay
Jan	GHH	2	1	17	35	GHH 11 Ward GHH 24 Bay
	BHH	1	0	5	0	

6. IPC SCORECARD

Appendix1 attached

This shows monthly data on some of the audits e.g. hand hygiene and commode, cleaning scores, patient experience and MRSA Screening compliance.
It is planned in future to add more High impact interventions audit data e.g. venflon and catheter audits.
Some of these have also been agreed as part of newly formed KPIs for Infection Control from April 2012, to be monitored through CQRG.

Itisha Gupta
Director of Infection Prevention & Control
21st February 2012

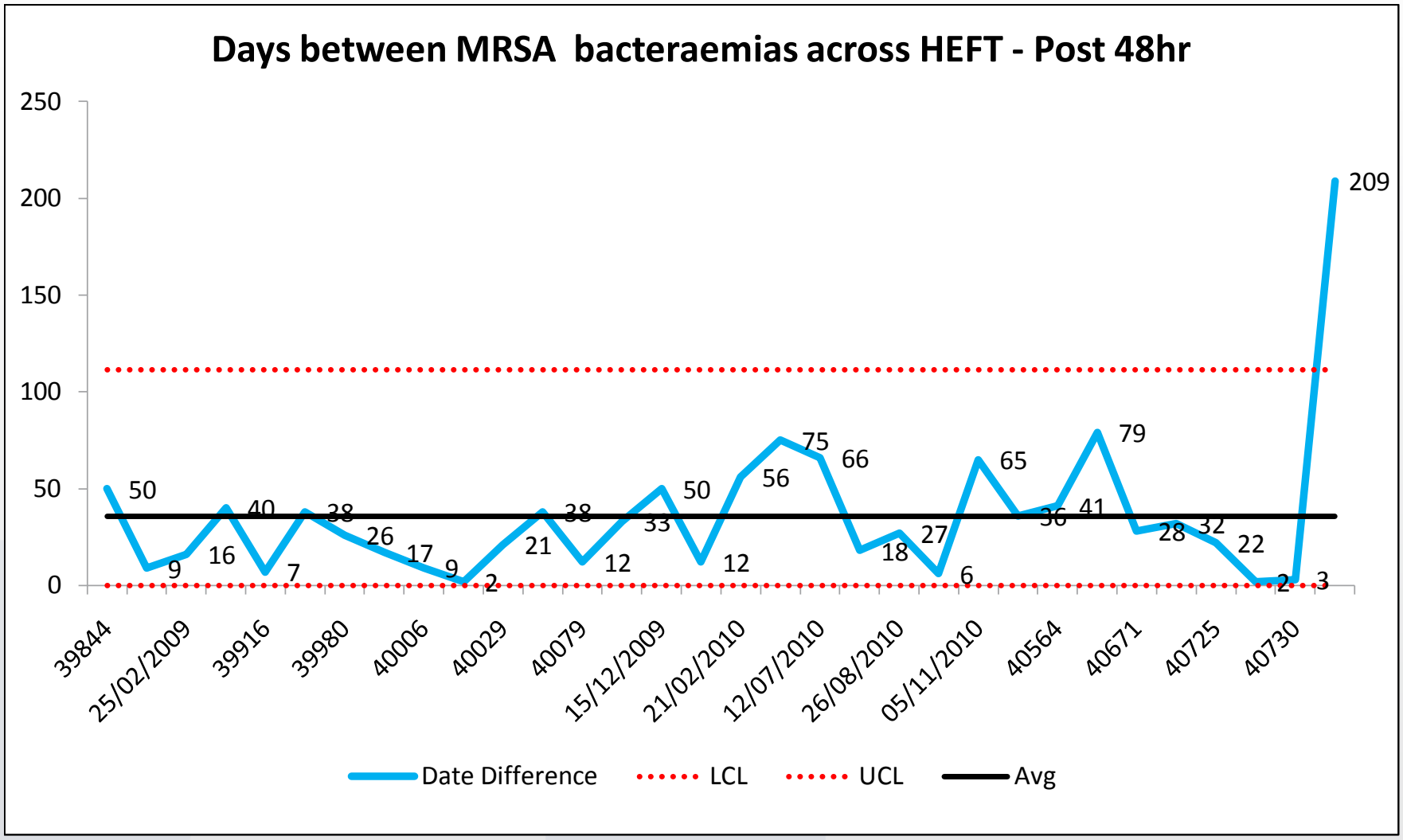
Infection Control
Balanced ScoreCard 2012

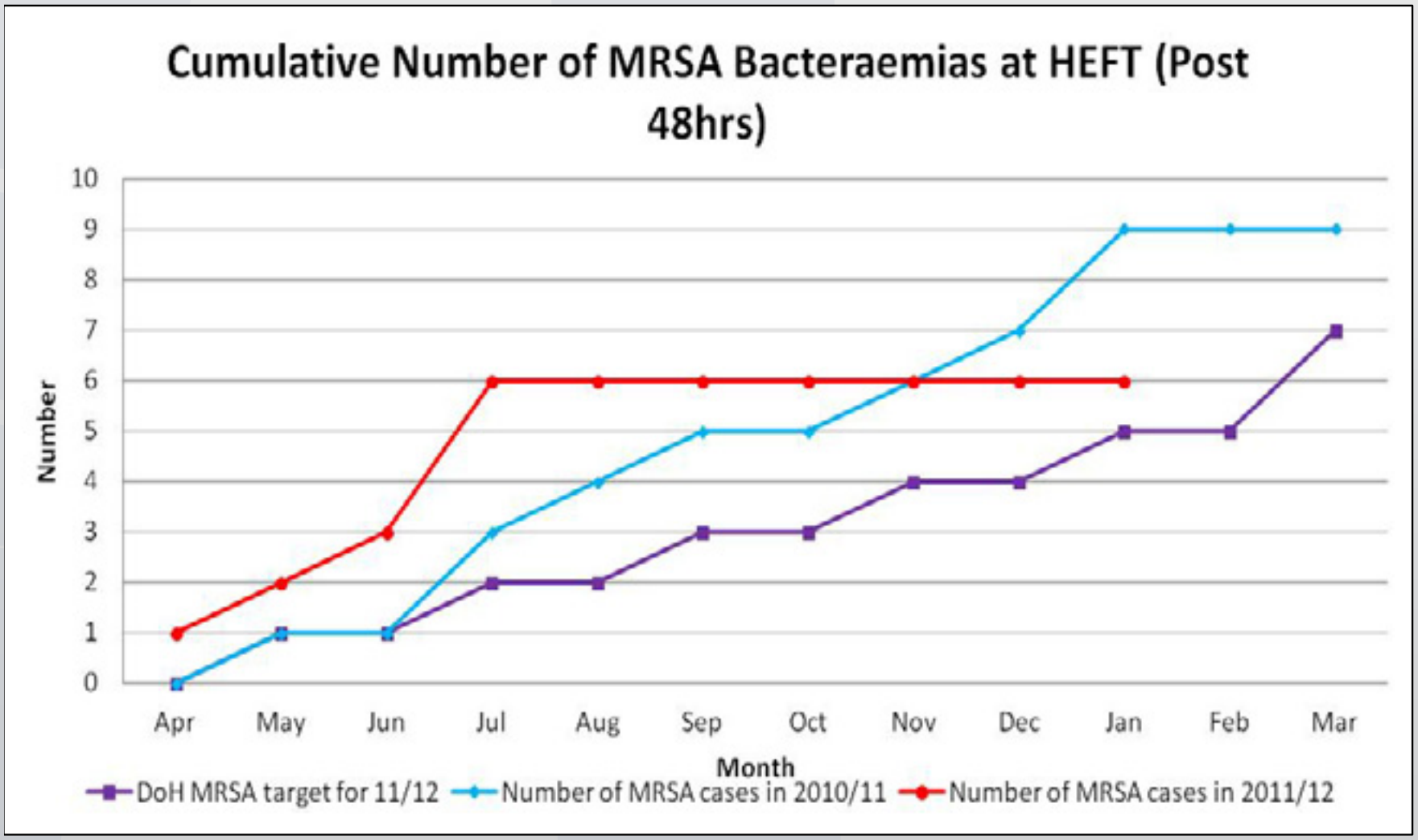
Indicator	Site	Target	Apr-11	May-11	Jun-11	Jul-11	Aug-11	Sep-11	Oct-11	Nov-11	Dec-11	Jan-12	Feb-12	Mar-12	Total YTD
High Impact Interventions															
Hand Hygiene	Heartlands	85%	88.6%		93.0%	92.5%	90.2%	92.2%	92.8%	93.0%	93.7%	90.2%			**91.7%**
	Good Hope	85%	93.2%		96.8%	97.5%	95.5%	97.4%	96.8%	95.8%	96.6%	98.8%			**96.4%**
	Solihull	85%	89.0%		**84.4%**	**83.3%**	**66.4%**	98.3%	96.1%	94.3%	97.6%	91.2%			**89.0%**
	Trust Total	**85%**	89.9%		92.0%	90.9%	**84.4%**	94.8%	94.6%	90.1%	95.5%	91.9%			**92.0%**
Commode Audits	Heartlands	100%	91.0%			93.0%			88.0%						
	Good Hope	100%	89.0%			97.0%			80.0%						
	Solihull	100%	88.0%			87.0%			84.0%						
	Trust Total	**100%**	89.0%			92.0%			85.0%						
Cleaning Scores															
Ward Cleanliness - Significant Risk Areas	Heartlands	85%	**80%**			**81%**			94%						
	Good Hope	85%	92%			90%			87%						
	Solihull	85%	97%			92%			96%						
	Trust Total	**85%**	90%			88%			92%						
Ward Cleanliness - High Risk Areas	Heartlands	95%	**93%**			**93%**			96%						
	Good Hope	95%	96%			95%			96%						
	Solihull	95%	99%			99%			97%						
	Trust Total	**95%**	96%			96%			96%						
Ward Cleanliness - Very High Risk Areas	Heartlands	98%	**96%**			**96%**			98%						
	Good Hope	98%	**97%**			**94%**			**96%**						
	Solihull	98%	99%			99%			98%						
	Trust Total	**98%**	**97%**			**96%**			**97%**						
Patient Experience - Infection Control Privacy & Dignity															
As far as you know do the staff wash or clean their hands between touching patients?	Heartlands	95%	**94%**	**94%**	98%	98%	98%	99%	99%	96%	98%	98%			
	Good Hope	95%	96%	98%	99%	99%	98%	98%	97%	98%	98%	100%			
	Solihull	95%	97%	**93%**	**94%**	**90%**	99%	99%	98%	99%	97%	99%			
	Trust Total	**95%**	96%	95%	98%	97%	98%	99%	98%	97%	98%	99%			
How clean is this ward (including toilets)?	Heartlands	95%	**92%**	**93%**	95%	97%	97%	96%	97%	**94%**	96%	96%			
	Good Hope	95%	96%	98%	98%	98%	97%	98%	97%	97%	97%	97%			
	Solihull	95%	95%	**93%**	96%	96%	98%	98%	99%	98%	96%	99%			
	Trust Total	**95%**	**94%**	95%	96%	97%	97%	97%	98%	96%	97%	97%			
MRSA Screening															
Emergency Screening Rate	Heartlands	90%	94.85%	91.69%	94.37%	93.31%	91.68%	91.59%	90.48%	90.34%	**89.65%**	92.86%			**92.15%**
	Good Hope	90%	91.80%	92.51%	92.27%	93.84%	92.02%	90.35%	**89.44%**	**89.23%**	**88.98%**	90.72%			**91.06%**
	Solihull	90%	93.52%	90.94%	91.74%	94.61%	95.63%	95.63%	95.53%	94.36%	96.12%	93.15%			**94.30%**
	Trust Total	**90%**	93.55%	91.88%	93.00%	92.00%	92.61%	94.00%	92.00%	94.00%	91.00%	93.00%			**92.05%**
Elective Screening Rate	Heartlands	95%	97.37%	95.45%	96.73%	97.36%	99.12%	97.07%	95.04%	96.75%	96.82%	97.11%			**96.93%**
	Good Hope	95%	98.18%	98.44%	98.25%	98.19%	97.26%	97.35%	97.54%	97.88%	96.92%	97.11%			**97.78%**
	Solihull	95%	98.43%	98.61%	98.10%	99.10%	98.40%	98.19%	97.93%	99.57%	95.10%	97.33%			**98.18%**
	Trust Total	**95%**	97.91%	97.08%	97.46%	98.01%	98.40%	97.41%	96.67%	97.73%	96.49%	97.36%			**97.47%**

Yes
No

.4
.92

AGENDA | .01 Apologies | .02 Declaration of interest | .03 Minutes from previous meeting | .04 Matters Arising | .05 Chairmans report | .06 Chief Executives report | .07 Quality and Performance Monitoring | .08 Board Committee Reports | .09 Trust News and External Environment | .10 Governing Body and Membership | .11 Corporate Governance | .12 Any Other Business


Days between MRSA bacteraemias across HEFT - Post 48hr
250
200
150
100
50
0
50
9
16
40
7
38
26
17
9
2
21
38
12
33
50
12
56
75
66
18
27
6
65
36
41
79
28
32
22
2
3
209
39844
25/02/2009
39916
39980
40006
40029
40079
15/12/2009
21/02/2010
12/07/2010
26/08/2010
05/11/2010
40564
40671
40725
40730
Date Difference
LCL
UCL
Avg


Cumulative Number of MRSA Bacteraemias at HEFT (Post 48hrs)
Number
10
9
8
7
6
5
4
3
2
1
0
Apr
May
Jun
Jul
Aug
Sep
Oct
Nov
Dec
Jan
Feb
Mar
Month
DoH MRSA target for 11/12
Number of MRSA cases in 2010/11
Number of MRSA cases in 2011/12

.5
.93

To	Trust Board
From	Safety and Governance
Date	February 2012

Title	Strategic Risk Register

Purpose of the Report:

- To provide an update in relation to the Trust Strategic Risk Register.

The report is provided to the Committee for:

Decision	**Y**	**Discussion**	**Y**
Assurance	**Y**	**Endorsement**	**Y**

Summary/Key Points:

- The Assurance Framework requires Trusts to identify and manage the risks that represent major threats to achieving the Trusts strategic objectives and its continued existence

Attachment 1 – Quarter 3 updated strategic risk register

Recommendations:

The Trust Board Committee is asked to:

- **note** the content of the paper;
- **agree** revised strategic risk register for Quarter 3

Resource Implications (e.g. Financial, HR)

-

Assurance implications

- Board Assurance Framework

Information Exempt from Disclosure:

- None

THIS IS A ONE PAGE SUMMARY ONLY

Safety and Governance Directorate
Board Assurance Framework / Strategic Risk Register

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1. Summary

The Board assurance Framework provides a structure and process that enables the organisation to focus on those risks that might compromise it achieving its strategic objectives and to map out the controls that have been put in place to ensure that the Board has sufficient assurance regarding the effectiveness of these controls.

Strategic risks are those that represent a major threat to achieving the Trusts strategic objectives or its continued existence. The Trusts new corporate goals and objectives have been defined as:

2. Quarter 3 Update

- The strategic risk register has been reviewed with each Executive Director.
- The updated risk register was presented to the Executive Management Board (EMB) in January 2012;
- Following review by the EMB, some changes were requested as outlined below:

  - SR1 (Future tariff efficiency) – was down scored to 3*4 (12);
  - SR3 (Implementation of the NHS reforms) – was no longer considered to be a strategic risk and should therefore be removed from the strategic risk register;
  - A new risk regarding the potential impact on patient flow from the 18 week target should be added to the register;
  - Consideration should be given in Quarter 4 to whether the report from the Francis enquiry should be included as a potential strategic risk.

- The updated strategic risk register (**Attachment 1)**, was presented to February EMB

3. Conclusion and Recommendations

The Trust Board are asked to:

- Review the proposed strategic risk register in **Attachment 1;**
- Confirm whether there are any further strategic risks which should be added;
- Endorse proposed actions outlined in this paper.

Safety and Governance
February 2012

Heart of England NHS Foundation Trust

Attachment 1

Strategic Risk Register

SR Ref	Exec Lead	Strategic Risk Description	Initial Risk Classification			Controls	Assurances	Current Risk Classification			Gaps in Controls	Gaps in Assurance	Action Plan	Timeframe
			C	L	Score			C	L	Score				
SR1	AS	**Future tariff efficiency - 15%CIP globally across the NHS** There is a risk that this will be too big to respond approriately without an impact upon existing services. This is compounded by a potential reduction in activity from other sectors as they seek to deliver their own CIPs Without careful management, this could impact upon the quality and safety of the services provided. **Linked Strategic Priority: Efficient** **Linked Goal: 15% Cost reduction**	4	4	16	* Finance Committee * Audit Committee * Trust Board Away day to discuss 3 year savings plan * Relationship building with external partners - including Birmingham City Council * CIP Board * Stronger vacancy control * Executive lead vacancy panel * Tighter controls on bank and agency staff * Job plan review * Medical Director meetings with all Directorats re plans * New escalation policy * Finance sub-committee of Executive Management Board	* Monthly CIP reports to Finance Committee * Annual Timetable approved at August Trust Board * Trust Board away day - December 2010 * Detailed CIP plans discussed fortnightly at CIP Board * Group CIP rectification meetings * Group CIP meetings (March 2011) * EDs paper February 2011 * Local Health Economy meetings * Board assurance on impact on quality and safety lead by Medical Derector * Trust Board finance reports * Block contract discussions	3	4	12	None	* Progress with delivery of the CIP * Expenditure is currently greater than income	See individual rectification plans	Ongoing

.3

.96

AGENDA

Apologies .01

Declaration of interest .02

Minutes from previous meeting .03

Matters Arising .04

Chairmans report .05

Chief Executives report .06

Quality and Performance Monitoring .07

Board Committee Reports .08

Trust News and External Environment .09

Governing Body and Membership .10

Corporate Governance .11

Any Other Business .12

Heart of England NHS Foundation Trust

Attachment 1

Strategic Risk Register

SR Ref	Exec Lead	Strategic Risk Description	Initial Risk Classification			Controls	Assurances	Current Risk Classification			Gaps in Controls	Gaps in Assurance	Action Plan	Timeframe
SR2	AA	**Patient Flow** Failure to successfully address discharge planning arrangements resulting in poor patient flow and unecessary delays to admissions, transfers and discharges. Leading to increased risk in urgent care pathway, including significant impact upon the capacity of A&E Department and the use of additional flex capacity. There is a risk to the corporate strategic priority of 'Safe and Caring' if performance does not improce **Linked strategic priority: Efficient, Safe and Caring** **Linked goal: Consistent delivery of targets**	5	4	20	* Work with commissioners to develop single point of access * Project group established to address 'expected date of discharge' as part of SOP * Monthly meetings with commissioners * Operational site capacity teams * Discharge Lounges operational at each site * Transformation Board * Clarification of site and group based reporting lines * Funding (£2m) set aside for winter plan provision * Operations Committee * Site leadership teams * Group teams	* Standard Operating procedures (SOP) for each ward * Acute care strategy document supported by ops committee * Monthly reports to ops committee * Monthly review of progress of key workstreams (sub-programmes: operational; nurse leadership; culture and behaviour; local health economy; business information), review of priority actions for each workstream * Monthly updates from all projects and corresponding actions. * Programme priority actions and interdependencies identified and monitored * Risk log * Winter plan update to EMB (Septemebr 2011) * A&E performance of GHH	4	3	12	* Clarification of accountabliity between site teams and Groups * Bed capacity in the community	* Winter Plan escalation process to EDs and Trust Board * A&E performance on the Heartlands site	* Acute strategic plan and individual workstream action plans * Manpower review	Ongoing

February 2012

AGENDA
Apologies .01
Declaration of interest .02
Minutes from previous meeting .03
Matters Arising .04
Chairmans report .05
Chief Executives report .06
Quality and Performance Monitoring .07
Board Committee Reports .08
Trust News and External Environment .09
Governing Body and Membership .10
Corporate Governance .11
Any Other Business .12

Heart of England NHS Foundation Trust

Attachment 1

Strategic Risk Register

SR Ref	Exec Lead	Strategic Risk Description	Initial Risk Classification			Controls	Assurances	Current Risk Classification			Gaps in Controls	Gaps in Assurance	Action Plan	Timeframe
			C	L	Score			C	L	Score				
SR9	AA	**18 Week wait (NEW February 2012)** Failure to successfully address waiting list arrangements resulting in excess waiting times for patients requiring routine surgical intervention. Whilst the Trust has achieved the 90% admitted target for 18 weeks aggregated across all specialties, from April 2012 the new operating framework requires each specialty to achieve the 90% admitted target **Linked priority - Efficient, safe caring** **Linked Goal - Consistent delivery of targets**	4	4	16	* Establishment of theatre productivity group * Operations Committee monitoring * Site Leadership teams * Group teams * Increase in site based operational management to support the waiting list coordinators with a daily focus on the current PTL lists	* Review of daily forward look to ensure correct clock start times * Lockdown of day case list weekly to ensure optimum patients per list * Extra theatre lists allocated in February and March across poorer performing specialities to target extra patients * Specialist lists now commenced	3	4	12	Clarification of accountability between site teams and groups and between groups	Bed capacity due to winter pressures	Theatre productivity with individual specialty workstreams	Ongoing
SR8	SH	**Ability of organisation to undertake strategic reconfiguration and development of new business models in response to longer term economic environment and reduction in health economy spending.** The economic environment means that there will be reduced income for the Trust in the future. The impact of the QUIPP agenda will require the Trust to embark on a transformation programme to ensure that it provides safe, quality services to patients in the most appropriate setting. Such an ambitious prgramme is not without risk - including reputational and financial. **Linked Strategic Priority: Safe & Caring; Locally engaged; efficient and Innovative** **Linked goals: All**	3	5	15	* Reshaping HEFT Programme Board	* New Corporate strategy agreed April 2011 * Annual Business plan * New vision, strategic priorities and corporate goals developed	3	5	15	* Detail of how this programme will be implemented			Ongoing

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SAFETY SITUATION REPORT

FEBRUARY 2012

Safety & Governance Directorate

- Executive Summary
  - Strategic & Red Operational Risks
  - SUIs
  - Aggregation, Regulation, Coroner
  - Role of Committees in reviewing risk

- Attachment 1: SitRep: High level SUIs, Inquests
- Attachment 2: Red Risks
- Attachment 3: Q3 Aggregation report
- Attachment 4: SUI Closedown reports

Executive Summary: February 2012

Strategic Risks

(score)
Future tariff efficiency: 15% CIP across the NHS (16)
Patient flow (12)
Implementation of the NHS reforms (8)
Future income (15) : Strategic reconfiguration and development of new business models in response to longer term economic environment and reduction in health economy spending.

Red Operational Risks

Risk Summary : Red	Site	Group	Date risk rated as red	Initial Score	Current Score *
Security systems on paediatric wards	BHH	5	Nov 11	15	15
Graseby pumps (models 3100 & 3150)	All	1	Apr 11	20	15
Manual Handling Equipment	All	HR	Dec 11	15	15
Proposed					
GP Assessment Area	GHH	1	Aug 11 Feb 12	20	16

* Score with mitigation in place: mitigating action to reduce the risk needs to take place within one month in order to reduce the risk to acceptable level (i.e. Amber)

Amber Risks

Operations Committee will undertake 6 monthly reviews of Amber rated risks across the Trust, with the first review taking place in January 2012.

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Executive Summary: February 2012

2011/12 SUI Status

Gp	Directorate	Site	2011 / 12	Description (N = Never Event)	Status
2	Gen Surg	BHH	Apr	Management of liver disease	Closed
4	Anaes	SHH	Apr	Incorrect induction of anaesthesia	Closed
4	Anaes	BHH	Apr	Drug error post Caesarean section	Closed
5	Paeds	BHH	Apr	Management of non accidental Injury	**Open**
2	Resp	BHH	May	Missed lung cancer	Closed
2	T&O	SHH	Jun	Retained foreign object **(N)**	Closed
2	T&O	SHH	Jun	Wrong size implant part **(N)**	Closed
1	Elderly	BHH	Aug	Fall resulting in death	**Open**
1	ED	BHH	Aug	Management of aortic aneurysm (AAA)	Closed
3	Ophth	SHH	Sep	Wrong lens - cataract surgery **(N)**	Closed
3	Ophth	SHH	Oct	Wrong lens - cataract surgery **(N)**	Closed
5	O&G	BHH	Oct	Retained foreign object - swab **(N)**	Closed
1	ED	GHH	Oct	Unexpected death of a 16 yr old	Closed
5	O&G	BHH	Nov	Management of cord presentation	**Open**
4	Critical Care	BHH	Nov	Inadvertent medication administration	**Open**
1	Acute Med	BHH	Dec	Community grasby pump set incorrectly	**Open**

Group Summary	2010/11 (Total)	2011 / 12 (YTD)
Group 1	5	3
Group 2	1	4
Group 3	2	2
Group 4	2	2
Group 5	4	3
Total	**14**	**16**
Open cases	0	5
Never Events	2 of 14	5 of 16

Site Summary	2010/11 (Total)	2011 / 12 (YTD)
Solihull	0	5
Good Hope	5	1
Heartlands	8	9
Other	1	0

Learning from SUIs:

• 6 SUI closedown reports can be viewed in Attachment 4. These will be cascaded via the Nursing and Medical Directors to clinical colleagues and will be available on the Safety & Governance intranet site.

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Executive Summary: February 2012

Regulatory Matters

CQC: The final report for the August inspections has been received and the action plan has now been submitted to the CQC. Implementation of the plan will be monitored via the Nursing Performance Committee and the Group 4 Quality and Safety Committee. This report has implications on the Monitor Governance ratings.

NHSLA: The Trust was successful in achieving level 2 in the NHSLA Risk management standards assessment on 25th & 26th January 2012.

HMC Inquests

Rule 43 / Coroner's concerns

Rule 43s: 1 expected Rule 43 received (addressed to CQC) from an Inquest which took place in Jan 2011. Patient suffered Insulin overdose which was investigated as a SUI in 2008. Response being prepared.

Inquest Outcome:
• Acute Med (SH) 12-16 Dec 2011 (SUI): Verdict = died following an accident. No Rule 43.

Forward look: Potential for adverse verdict:
• General Surgery (GHH) 12-15 March 2012 (SUI)
• Obstetrics (GHH) 26th March 2012 (SUI)
• Respiratory (Chest Clinic) 14th May 2012 (Orange Incident)

Aggregated Themes: Q3 11/12 (Incidents, Complaints/PALS, Claims)

Theme	Trust Actions
Falls/Slips	Trust and Site falls groups in place, reviewing trends and learning from incident investigations. Nursing falls scorecard.
Medication	Safer practice medication working group. Think Glucose diabetes campaign. Nursing alert reminders issued.
Information / Communication	SBAR campaign. Nursing safety manual developed. Electronic handover. Changing patient safety culture by Safety walk arounds. Safety, learning & engagement manager recruited.
Delay Diagnosis / Results	Work completed to achieve NPSA alert (Radiology) Group 4 leading safety project on "Results Reporting"
Discharge	New Theme for Q3 11/12 for discussion.
Surgical "Never Events "	New theme for Q1 /2. Responsive safety review to SHH theatres. Staff reminder of relevant guidance /policy. Themes reviewed, no common root causes. Never Events SUIs were discussed at Friday Quality & Safety meeting on 06/01/12.

See Attachment 3 for full aggregation report

Committees involved in reviewing and managing red operational risks

Audit Committee

Trust Board

Governance & Risk Committee

To scrutinise the overall system of risk management across the organisation and provide assurance to Trust Board that risk management is operating effectively.

Executive Management Board

To receive exception reports and address any issues escalated from Ops Committee, where barriers exist to mitigating risk in an appropriate & timely way. e.g. Trust wide or Corporate.

Operations Committee

To scrutinise and address the management of operational risks and ensure appropriate and timely mitigating actions are taken by groups, directorates and sites.

Groups

Directorates

Sites

To mitigate and manage risks held within local areas.

Safety & governance are currently working to develop an improved system for risk categorisation and escalation.

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Author	TB
Date	10-Feb-12
Ref No.	
ED Lead	Sarah Woolley

NHS

Attachment 1

HEART of ENGLAND NHS Foundation Trust

Safety "SITREP"

1. SUIs

1.1 General

The new Serious Untoward Incident reporting protocol was formally introduced at the end of 2007/2008 in order to help provide assurance to BEN PCT that the services it commissions from Foundation Trusts are safe and of high quality. The report provides a summary of SUI reporting.

1.2 Performance Indicators*

Number of Open SUIs	4
Number of Over-Running SUIs	4 of 4

*Figures do not include MRSA/C.diff related incidents and are correct as of 10 February 2012

	Apr-11	May-11	Jun-11	Jul-11	Aug-11	Sep-11	Oct-11	Nov-11	Dec-11	Jan-12	Feb-12
SUIs Opened	4	1	1	1	2	1	3	2	1	0	0
SUIs Closed	0	0	4	0	1	3	0	5	3	1	1
Never Events	0	0	1	1	0	1	2	0	0	0	0

As of April 2009, the following performance indicators are being recorded:

Performance Indicator	Target	Performance Against Target (2011/2012)	Performance Against Target (2010/2011)
Time for verbal notification of SUI to PCT	1 day from identification	100% (16/16)	100% (14/14)
Time for submission of formal brief to PCT	3 days from identification	100% (16/16)	86% (12/14)
Time to close of investigation *(Closed SUIs)*	45 days from identification	36% (4/11)	14% (2/14)[a]
Time to submit action plan to PCT *(Closed SUIs)*	5 days from closure of investigation	100% (11/11)	100% (14/14)

1.3 Summary of Open SUIs (excluding HCAI) as of 10 February 2012

Date Identified	Issue Description & Organisational Impact	Immediate Management Plan	Owner	Status	Day 45	Days Open
02/12/2011	Datix ID: 129262 • Mr C and his family requested that he be discharged home for end of life care. He was commenced on a syringe driver; unfortunately a community Grasby pump was used instead of a Trust McKinley pump and set at the incorrect rate. The syringe ran through in 2 hours instead of 24 hours. • Mr C died during the early hours of the morning. • There are also issues being investigated regarding the prescription and why this gentleman was sent to hospital for symptom control.	• The syringe driver was isolated by the community services. • A Trust alert has been circulated to inform staff that: a. The McKinley T34 syringe pump is the only ambulatory subcutaneous syringe driver to be used in the HEFT acute care setting b. If a patient is admitted from the community with an ambulatory community syringe driver (e.g. Graseby MS16 or MS26) it must be discontinued immediately and replaced with a McKinleyT34, McKinley 100cm extension set and a new syringe used c. Medications for the subcutaneous infusion MUST be prescribed on the Trust McKinley T34 Syringe driver prescription chart.	**HEFT:** Acute Medicine, BHH **PCT:** South Birmingham	• The family are aware of the incident and have written a letter of complaint to the Trust. Family complaint meeting taken place at HEFT on 14th December 2011. • RCA meeting taken place 23/12/2011. •Additional information obtained from community services which has identified additional lines of investigation. •Initial toxicology results suggest low therapeutic doses of presribed medication. •Letter from family received re: management of complaint / incident / consent. **Updated: 10/02/12** **Next steps:** •Final draft report for consultation. •Respond to family letter. • Update family on status of investigation and to arrange meeting dates in March.	08/02/2012	47

25/11/2011	Datix ID: 128629 An incident was reported to state that, at approximately 17:00 hours, a patient had developed a broad complex tachycardia of 177 beats per minute. The consultant attended promptly to assess the patient. Initial thoughts were that she was experiencing an ischaemic cardiac event. The patient received synchronised conversion. During this time, it was noted that IV giving set cartridge was hanging outside of the Alaris infusion pump with the tap in an open position and the IV fluid bag which had contained approximately 200mls/16mg of noradrenaline had run through. The 3 way tap which was connected to her arterial line was also in an open position. The patient died on 20 November 2011 after treatment was withdrawn.	The pump and infusion giving set were isolated and are being checked by medical engineers and the manufacturing company. The manufacturing company anticipate that results to be available in 90 days. The medical devices department reported the adverse incident to the MHRA. A stock number check of IV giving sets on ITU is being conducted, in case any faults are identified by the manufacturers. The woman was a participant in the HARP2 study. After the incident, she was withdrawn from the study following a request from her family. Further information available states that she did not receive any of the study drug. The family are aware of the incident and investigation. Clinical Directors of Pharmacy and Critical Care informed of incident. BEN PCT notified of incident.	**HEFT:** Critical Care, BHH **PCT:** BEN	• Statements being obtained from staff. Meeting taken place with some staff but further meetings required. • The family are aware of the incident and were informed shortly after the incident occurred. They have submitted a formal letter of complaint. • Family have verbally agreed to SUI timeframe and incorporating complaint into SUI investigation. • Statements obtained from all staff. • Final meeting with all nursing staff invovled identified that no one can recollect removing the cartridge from the pump. **Updated: 10/02/12** **Next steps:** • Finalising report. • Nursing Alert re: need to close three way tap being drafted. • Update family on status of investigation and to arrange meeting dates in March.	01/02/2011	52
04/11/2011	Datix ID: 127566 Lady on Willow Suite, second pregnancy and term in spontaneous labour. Cord presentation identified by midwife. Membranes intact at this point but bulging out of vagina, foetal heartbeat normal. Midwife made plan for immediate transfer to delivery suite. Crash call put out. Doctors attended and patient returned to Willow Suite. Bladder filled by midwife. Vaginal examination by registrar caused accidental rupture of membranes. Immediately transferred to delivery suite theatre. Baby born in poor condition and transferred to NNU.	Rapid review meeting. Identified as SUI. Safety & Governance informed. Statements to be requested. Parents to be debriefed.	**HEFT:** Obstetrics, BHH **PCT:** BEN	•Final draft report reviewed however additional information required re: equipment issues that arose during resus. **Updated: 10/02/12** **Next steps:** •Follow up information obtained from RM •Contact family to inform of anticipated completion date/start arrangements for meeting.	11/01/2012	67
19/04/2011	Datix ID: 116556 Four week old baby was admitted to Birmingham Heartlands Hospital following convulsions. His convulsions continued depsite medication and an MRI scan and skeletal survey were performed, which identified acute on chronic subdural haemorrhages and metaphyseal fractures. Non accidental injury was suspected and safeguarding actions were initiated. The incident was reported to BEN PCT as a SUI (in line with SHA reportable incident requirements). Following initial investigation possible care concerns have been identifed and are being investigated through the safeguarding and SUI investigations.	Incident reported and child safeguarding issues considered.	**HEFT:** Paeds, BHH **PCT:** BEN	**Updated: 10/02/12** Further work required particularly in view of care proceedings. Additional statements and reports required from clinicians. (12/1/2012) •Draft report on hold pending care proceedings.	28/06/2011	204

2. Inquests (potential for adverse outcome)
With Inquest Date Set

Description	Management Plan	Owner
Datix ID: C2010.230 Patient passed away at QEH following surgery at GHH. Alleged two arteries damaged during laparoscopic cholecystectomy which resulted in patients's death. **Inquest Date: 12-15/03/2012, Incident Date: 07/02/2011**	Subject of a SUI, Datix ID 113024	**HEFT:** General Surgery, GHH **PCT:** South Staffordshire
Datix ID: C2010.137 Patient arrived from home feeling unwell. Relative reports patient unresponsive. Patient in HDU - very unwell, fitting. Stabilised and taken to theatre for grade 1 C-section. Emergency LSCS was performed on 17/09/2010. Ventilator switched off on 19/09/2010 following brain scan. **Inquest Date: 26/03/2012, Incident Date: 17/09/2010**	Subject of a SUI, Datix ID 109380	**HEFT:** Obstetrics, GHH **PCT:** South Staffordshire
Datix ID: C2010.214 Patient died in Birmingham Children's Hospital on 06/01/2011 from TB following attendance and treatment at Birmingham Chest Clinic. **Inquest Date: 14-21/05/2012**	Subject of RCA as part of serious incident investigation by the PCT.	**HEFT:** Respiratory, Birmingham Chest Clinic **PCT:** HoB

3. Rule 43 / Coroner's Concerns: : 1 expected Rule 43 received (addressed to CQC) from an Inquest which took place in Jan 2011. Patient suffered Insulin overdose which was investigated as a SUI in 2008. Response being prepared.

Red Operational Risks

Attachment 2

ID/Group	Date Risk Identified	Site	Source	Location (exact)	Description	Likelihood (initial)	Consequence (initial)	Score (Initial)	Controls in place	Synopsis (Action Plan)	Due Date	Cost	Likelihood (current)	Consequence (current)	Score (Current)	Progress (Action Plan)
						L X C = S							L X C = S			
Group 5	Feb-10	BHH	INCD	Paediatric wards	**Security Systems** Security systems on ward areas inadequate. Do not prevent children leaving the ward or staff being aware that a child has left the ward.	3	5	15	Posters placed on all exit doors to increase awareness. Door closure speeded up by estates.Security walkround performed. Parents reminded of security on admission. All children's ID bands checked daily.	• Reviewing all staff who had access to the Children's Unit and restricting access mainly to this children's staff group • Implementation of a "child absconder policy" so that staff had a clear pathway and guidelines to follow in the event of such an incident • Raising staff awareness of the need to be vigilant and of the need to encourage visitors to use the intercom system at the main entrance to the Unit and for staff not to allow tailgating. • Swipe out controls instead of push button controls – giving controls of who is within and exiting the Children's Unit • Improved CCTV – which would give greater visibility of the Children's area	Q1 12/13	£30,000	3	5	15	Capital funding agreed. Work expected to be completed by April 2012.
Group1	Apr-11	All	Med devices Committee	N/A	**Graseby pumps:** Continued use of Graseby Infusion Pumps:MHRA and NPSA guidance requires increased safety features and safe administration of drugs . Graseby pump does not offer the safety features of modern infusion pumps. 2 incidents in this year with Graseby pumps. Group 1 have 75 pumps to replace	4	5	20	Action plan Training and support of current graseby infusion pumps to continue until replacement	. develop and Implement replacement plan to replace Graseby pumps with Alaris GH pumps and Guardrail	Jun-11	leasing costs	3	5	15	Jan12: JF reports- order held up in procurement - Original contract now sent to lease company. Pumps expected to be in place by 14th February 2012. CERC up and ready in Solihull. Training planned.
Faculty	Jan-10	ALL	Manual Handling Advisory Group	All clinical areas	**Manual Handling** - There are insufficient manual handling aids available in the clinical areas to enable staff to move patients in a way that maintains client and employee safety.	5	3	15	Patient-specific items can be ordered by depts. Training in appropriate strategies and equipment use is provided to staff. Managers receive guidance on local needs to correct deficits to meet patient dependency levels	Survey of needs completed. Report submitted to Ops Committee. Options appraisal to be developed. Equipment purchase to be agreed and implemented once option approved and funds identified.	TBC	Circa £1.6 million	5	3	15	In progress: Ops & Nursing to work with manual handling team to reach a consensus regarding the amount of equipment required to address the risk.
Proposed																
Group 1	Feb 2012	GHH	RA	Gp assessment unit	**Gp Assessment area GHH:** Inability to safely assess GP referred patients in Acute Medical Assessment Unit at GHH. Mitigating actions from previous risk assessment not being maintain due to Site capacity managment.	4	4	16	. Ring fenced AMU trolley space' in male and female assessment areas • AMU co-ordinators . Safe staffing levels at financial risk . Trigger escalation system	Risk discussed at Group Q&S again- agreed to put on Group register to monitor. Acute medicine to raise at Site committee and gain full committment to mitigation actions so that risk can be managed and reduced again-asap.	**April 2012**	**unknown**	4	4	16	RG meeting with Site based team to gain permenant solution to risk issue.

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Trust aggregation of data (Q3 2011/12)

Attachment 3

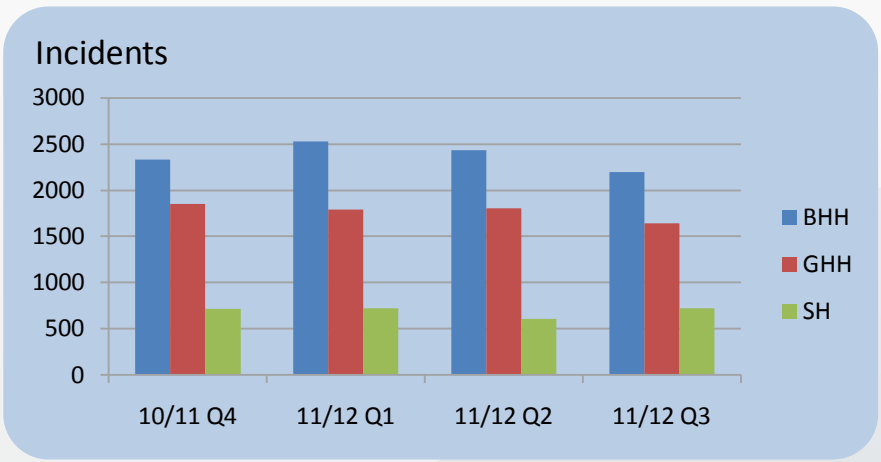
Incident Categories	Complaints Sub-Categories	PALS Sub-Categories	Potential Claims Categories	Serious Incidents Themes (6 monthly)
Falls	Clinical treatment	Compliment/positive feedback	Failure to perform operation	Communication
Tissue Viability	Misdiagnosis	Positive feedback	Failure/delay treatment	Documentation
Clinical Care	Information / Communication	Information / Communication	Failure/delay diagnosis	Medication
Medication	Bereavement Issues	Delay/cancellation of appointment	Other	Professionalism
Admission/Transfer/ Discharge Issues	Discharge	Clinical Care		Failure/delay diagnosis

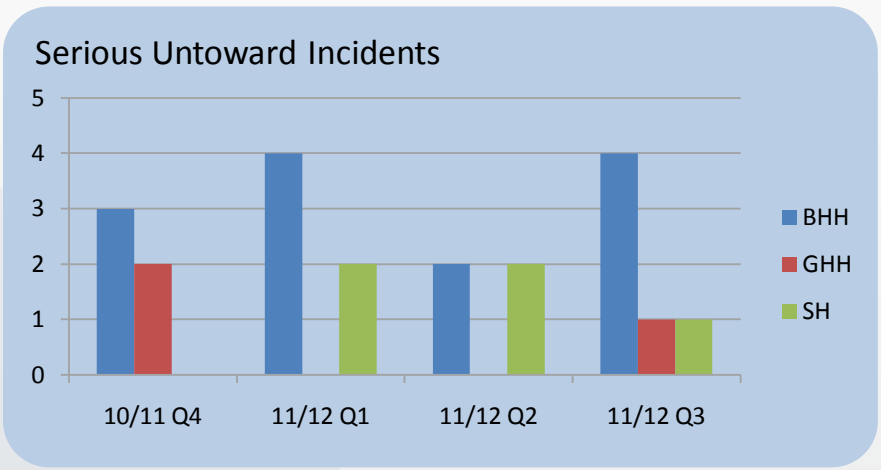
Trends	Trust actions
Falls / Slips	Trust and Site falls groups in place, reviewing trends and learning from incident investigations.
Medication	Safer practice medication working group. Think Glucose diabetes campaign. Nursing alert reminders issued.
Information /Communication	SBAR campaign. Nursing safety manual in development. Changing patient safety culture by Safety walk arounds
Delay diagnosis/Results	Work completed to achieve NPSA alert (Radiology) Group 4 leading safety project on "Results Reporting"
Discharge	New Theme for Q3 11/12. For discussion.

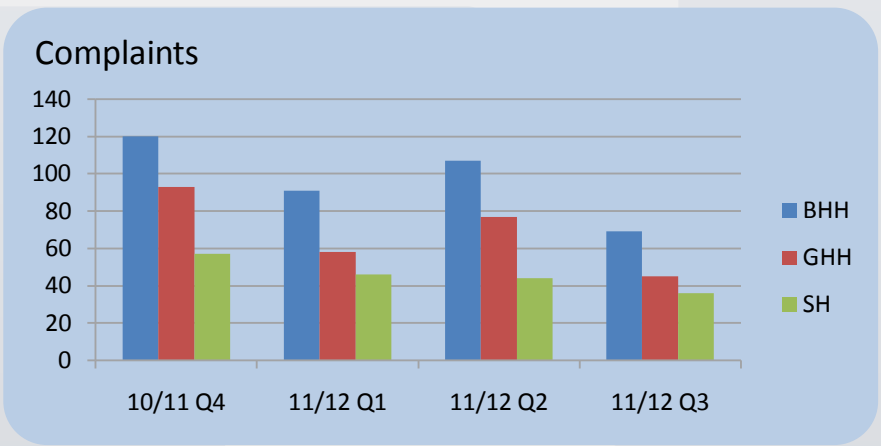
This report provides the top 5 category themes for Incidents. Complaints, PALS, Claims and Serious Incidents for Q3 11/12.

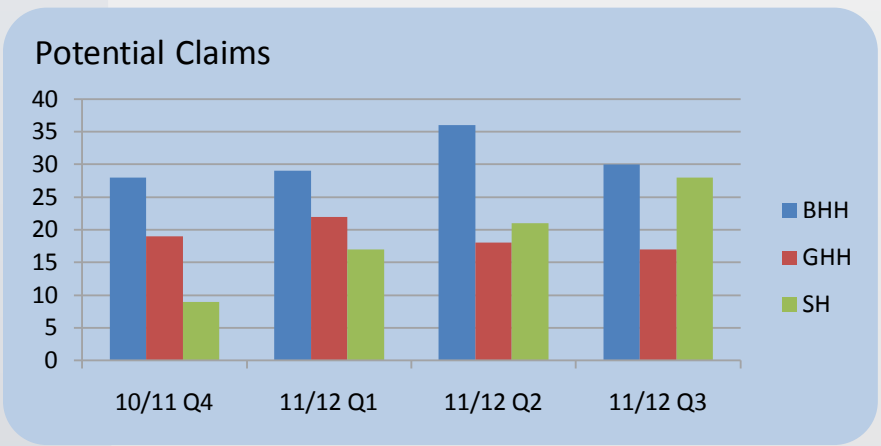
Falls remains a top category in incidents but has not appeared in the claims categories for this quarter. A new theme of discharge has been identified. Professionalism / Rudeness of staff was a new theme in Q2 11/12 and is no longer a theme is Q3 11/12.

Aggregation by Site (Q3 2011/12)









This data provides the levels of activity for Incidents, SUIs, Complaints and Potential Claims across the 3 main hospital sites. The Q3 11/12 shows consistent trends over the last 12 months, which will continue to be monitored.

1. SUI Closedown report

Reference Number: 125037
Incident Date: 22/07/11
Location: Solihull Hospital

Identified as SUI: 30/09/11
Completed: 28/11/11

Further Impact: Low Med High

Trust wide key learning points:

•Standardise pre-operative checking processes and associated documentation

•Ensure results are available prior to commencing surgery

Incident Theme(s):

• Wrong Implant
• Incomplete checks prior to Surgery
• Human error (transcription)

•Impact to Trust: Low

•Inquest outcome: n/a

•External Agencies: n/a

Staff implications: None

Supporting Staff actions: None

HR ongoing actions: None

Situation

During a cataract operation, the wrong strength lens was inserted into the patient's left eye, leaving him with a small refractive error post operatively. The patient was happy with the outcome of his refraction. This incident is termed a "wrong implant / prosthesis" Never Event .

Background

•In March 2011 a patient was found to have bilateral lens opacities, which caused problems with reading and driving, and was referred to Solihull Hospital cataract clinic. He was reviewed in clinic on in April 2011 and listed for left cataract surgery. A biometry test was performed to calculate which lens would be appropriate.
• On the day of surgery the procedure was performed by Mr Z. His normal practice was to look at the biometry test results, choose the appropriate lens, place a white sticker in the patient's notes and write the chosen lens power required on the sticker. On this occasion, Mr Z made a transcription error and the incorrect lens power was written on the sticker.
•The (World Health Organisation) WHO Surgical Safety Checklist (HEFT adaptation) and the HEFT Correct Patient, Procedure and Site Verification checklist forms were completed, in line with Trust policy, to ensure the right patient had the right procedure on the correct site.
•The theatre nurse looked at the white sticker in the notes for the lens required and selected the required lens. Mr Z would normally compare the IOL power on the sticker against the biometry test result whilst the patient was on the table. He clearly acknowledges that this did not happen on this occasion and is unsure why. The lens was implanted.
• The patient was happy with the outcome of his surgery and the error was only noticed during a routine follow up appointment when the optometrist checked the biometry print out.

Assessment

•In this case, a transcription error (as a result of human error) was made when writing the IOL power on the white sticker.
• A check which is normally carried out by this surgeon comparing the IOL power on the sticker against the biometry test result while the patient is on the table did not happen on this occasion. It is not known why.
• The patient will need glasses to correct his distance vision. Had the intended lens been implanted, he may still have needed glasses for distance vision and would have needed them for reading vision.

Secondary Findings:
•The biometry print out form is different at the Solihull and Good Hope hospital sites.
• Not all surgeons transcribe the required lens onto a white sticker. White boards are used as an alternative by some surgeons. This results in variation in practice for checking the lens prior to insertion.
• There are two surgery checklist forms to complete, WHO surgical safety checklist and HEFT Correct Patient, Procedure and Site Verification checklist.

Recommendations

• To implement a single process across the Trust for identifying and confirming the IOL power prior to insertion, and to standardise the biometry print out used across the Trust.
• To review the use of surgery checklists used in cataract surgery and consider the use of cataract specific documentation, using this case to raise awareness of changes in practice.
• To present this report to the Theatre directorate, the Ophthalmology directorate and Group 2 and 3 quality and safety committees.

2. SUI Closedown report

Reference Number: 126405
Incident Date: 03/06/11
Location: Solihull Hospital

Identified as SUI: 07/10/11
Completed: 29/11/11

Further Impact: Low Med High

Trust wide key learning points:

• Standardise pre-operative checking processes and associated documentation

•Ensure results are available prior to commencing surgery

Incident Theme(s):
•Wrong Implant
• Unavailability of biometry results

•**Impact to Trust**: Low

•**Inquest outcome:** n/a

•**External Agencies:** n/a

Staff implications: None

Supporting Staff actions: None

HR ongoing actions: None

Situation

During a cataract operation, the wrong strength lens was inserted into the patient's left eye, leaving him with a small refractive error post operatively. The patient was happy with the outcome. This incident is termed a "wrong implant / prosthesis" Never Event.

Background

• In February 2011 a patient was found to have bilateral lens opacities and he was referred to Solihull Hospital cataract clinic. He was reviewed in clinic and listed for left cataract surgery. A biometry test of both eyes was performed to calculate which intra-ocular lens would be appropriate, and two sets of biometry results were placed in the medical records, the medisoft print out and an additional test for the right eye as the biometry had been difficult.
• The patient was admitted to Solihull Hospital in June 2011 for cataract surgery. The Surgeon's (Mr A) usual practice is to look at the biometry test, choose the appropriate lens and write this on the white board located in the operating room. The only biometry result in the medical records that day was for the right eye. The medisoft printout was missing.
• Mr A assumed the result had been labelled incorrectly and this was in fact the reading for the left eye as the patient's right eye had corneal scarring, a dense cataract and previous retinal detachment surgery (and therefore assumed the technician had been unable to get a result for the right eye).
•Mr A attempted to check the biometry results on the medisoft database but was unable to access this at the time of the procedure, as the server was not available.
• The (World Health Organisation) WHO Surgical Safety Checklist (HEFT adaptation) and the HEFT Correct Patient, Procedure and Site Verification checklist forms were completed, in line with Trust policy, to ensure the right patient had the right procedure on the correct site.
• During surgery, the HCA selected and checked the lens with the scrub nurse. Both noted that the biometry reading was for the right side. They alerted Mr A to this and he indicated that he knew this and continued with the procedure. After the surgery was completed, the scrub nurse made a note in the Theatre register that the biometry readings were for the right eye only.
• The error was noted during the post operative follow up of the patient.

Assessment

• The patient's right eye had corneal scarring and a dense cataract affecting the biometry test that is normally done. This resulted in the need for a further test on a different machine and this was the result that was available in the medical records.
• At the time of surgery, the medisoft biometry printout was not in the medical records at the and the electronic version of the biometry on the medisoft system was not accessible. There is not a backup system for times when medisoft is unavailable.
• The nursing staff noticed that the biometry result was for the right eye and escalated this to the surgeon. The surgeon decided to proceed with surgery on the assumption that the print out available was for the left eye and labeled incorrectly (based on the poor condition of the right eye).
• Postoperatively the patient's vision was better than the expected outcome.
Secondary Findings:
•There are two surgery checklist forms to complete, WHO surgical safety checklist and HEFT Correct Patient, Procedure and Site Verification checklist.

Recommendations

• Ensure that the medical records contain the biometry and medisoft printouts the day prior to the operation and agree a process for cancelling surgery in the event of biometry not being available.
• To implement a single process across the Trust for identifying and confirming the IOL power prior to insertion, and to standardise the biometry print out used across the Trust.
• To review the use of surgery checklists used in cataract surgery and consider the use of cataract specific documentation, using this case to raise awareness of changes in practice.
• To present this report to the Theatre directorate, the Ophthalmology directorate and Group 2 and 3 quality and safety committees.

3. SUI Closedown report

Reference Number: 124842
Incident Date: 08/09/2011
Location: BHH

Identified as SUI: 04/10/11
Completed: 01/12/11

Further Impact: Low Med High

Trust wide key learning points:

• Remove all swabs from delivery before opening a new delivery pack to undertake perineal repair

•Document all swab counts before and after a procedure

Incident Theme(s):
•Retained foreign object
• Swab counting procedures
•Awareness of local guidance

Never Event
Retained Foreign Object

•**Impact to Trust**: Low

•**Inquest outcome:** n/a

•**External Agencies:** n/a

Staff implications: None

Supporting Staff actions: None

HR ongoing actions: None

Situation

The patient had a normal vaginal delivery followed by repair of a second degree tear. Approximately 10 hours later, whilst on the ward, she reported that she had passed a small gauze surgical swab vaginally, after going to the toilet. The patient was subsequently observed for signs of infection, and was discharged home later the same day.

Background

•The patient had experienced complications following a previous forceps delivery and episiotomy and had undergone refashioning of her episiotomy scar in 2010. She was awaiting a Fenton's procedure which was cancelled when she became pregnant again in 2011. In view of these previous problems, the patient was categorised as high risk.
•The patient had regular antenatal care during her pregnancy with her community midwife and was seen in clinic by an obstetric registrar at 34+3 weeks. After discussion of the risks / benefits of a Caesarean section, the patient decided to have a vaginal birth, followed by a Fenton's repair later, if required. Her request for a senior doctor to undertake any suturing that may be required was noted.
•At 38 + 6 weeks gestation the patient was admitted to the delivery suite (BHH) and went on to have a normal vaginal delivery of a healthy baby girl. As the patient had a second degree tear, an obstetric registrar (Dr C) was asked to undertake a perineal repair.
•Midwife A provided Dr C with the usual equipment necessary for the repair (including a second delivery pack, containing 10 small gauze swabs). Dr C recorded a count of 5 gauze swabs before commencing the procedure. Whilst Dr C was suturing, Midwife A handed over care to Midwife B.
•Both Midwives were in the delivery room during the final swab count (Midwife A completing her documentation). There are some differences in recollection of this swab count, however both Midwife A and the patient's husband recall that 9 swabs were counted and then a 10th swab was found in the refuse bag in the delivery room (there are 10 swabs in a pack).
•Dr C recorded that 5 gauze swabs were counted. Dr C recorded that vaginal and rectal examinations were performed following suturing and recalled that the vagina was clear and empty after the repair. 10 hours later, the patient passed a small gauze swab after going to the toilet.

Assessment

•The investigation team have not been able to establish exactly how a small swab was left in situ following the patient's delivery and perineal repair. They have not been able to discount the possibility that a gauze swab was left in the refuse bag following delivery, which was then, in error, considered to be the 10th gauze swab in the final gauze swab count following perineal repair.
•Following a previous incident and NPSA alert, Trust guidance on the management of perineal trauma was revised to require that the small gauze swabs contained in the delivery pack should be discarded, when undertaking a perineal repair, and medium swabs used instead. Attempts to change the contents of the delivery pack to exclude small swabs was not succesfull at this time. Dr C was not aware of this guidance and did not recall it being included as part of his local induction. Neither Dr C or Midwife B can recall what sized swabs were used for this perineal repair.
•Normal procedures for counting and recording swab counts were not followed on this occasion, it is not clear why this happened. The investigation noted that there is no specific place in the West Midlands Perinatal Institute (WMPI) birth notes, used by the Trust, to document swab counts before and after delivery, but there is for perineal repair.

Recommendations

•Source delivery packs that only contain medium gauze swabs
•Review induction process to ensure that guidance on the swabs during perineal repair is routinely included at medical staff induction.
•Ensure that all midwives and doctors are educated in the correct size of gauze swab to use and correct procedure for counting swabs and documentation. Review staff awareness of this procedure
•Ensure that all midwives and doctors are advised to dispose of all gauze swabs after a delivery, and before opening a new delivery pack to undertake perineal repair
• Suggest to the WMPI that their birth notes are reviewed to incorporate a swab count check prior to and after the birth of a baby.
•Share findings of this report and recommendations with the patient and individual staff involved in the incident.

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4. SUI Closedown report (Draft)

Reference Number: 115724
Incident Date: 4-10/03/11
Location: Heartlands Hospital
Identified as SUI: 04/04/11
Completed: 14/12/11

Further Impact: Low **Med** High

Trust wide key learning points:

- Effective communication of patient's risk factors to the Multi-disciplinary team.

Incident Theme(s):
- Management of high risk surgical patient
- Communication

- **Impact to Trust**: Medium
- **Inquest :** Pending
- **External Agencies:** n/a

Staff implications: None

Supporting Staff actions: None

HR ongoing actions: None

Situation

The patient was admitted to BHH ED in March 2011 experiencing severe abdominal pain and an umbilical hernia. The surgical team diagnosed a small bowel obstruction and deteriorating renal function. The patient had a history of alcoholic liver disease and previous encephalopathy. Surgery was performed 3 days later and the patient became progressively unwell with deteriorating renal failure, developed decompensated liver failure and died 3 days after surgery.

Background

- The patient had undergone an elective upper gastrointestinal endoscopy and drainage of ascites at Heartlands Hospital as a day case procedure in March 11. At home, he gradually developed abdominal tenderness and vomited on multiple occasions and made a self referral to the Emergency Department (ED) of Heartlands Hospital the next day, experiencing severe abdominal pain.
- He was admitted to the AMU, a treatment plan was initiated and 2 days later he was referred to the surgical team following the results of an abdominal x-ray. The registrar diagnosed a small bowel obstruction and deteriorating renal function. He was seen by a consultant gastroenterologist who noted a history of alcoholic liver disease and previous encephalopathy.
- A pre-operative assessment was undertaken by a anaesthetic specialist registrar in and the ASA grade was assessed as 2 (mild systemic disease). Surgery was performed the following day and the patient returned to the surgical ward. He became progressively unwell with deteriorating renal failure, and developed decompensated liver failure. He was seen by critical care outreach and because of his poor prognosis, transfer was not considered to be appropriate and a 'do not attempt resuscitation' (DNAR) order was instituted. Following further discussions with the gastroenterologists, the DNAR order was rescinded and the patient was subsequently admitted to ITU.
- Despite intensive support, the patient continued to deteriorate. A 'do not attempt resuscitation' order was re-instituted and he died 3 days after surgery.

Assessment

- An abdominal x-ray was not performed until 3 days after the patient attended. This delayed the recognition of the diagnosis of bowel obstruction.
- It was necessary for an operation to be performed to resolve the patient's bowel obstruction, as unrelieved bowel obstruction is universally fatal.
- In light of the assessment of the patient's risk factors (25% risk of decompensation of liver disease); it would appear that an ASA score of 2 (mild systemic disease) was incorrect.
- After the operation, from an anaesthetic perspective, the patient appeared to have been warm, comfortable and well hydrated. He was transferred to a general surgical ward. There is no reference on the operation notes to any particular potential complications.
- The nursing staff on the ward do not routinely nurse patients with liver failure. In hindsight, transfer to an HDU bed may have been more appropriate given the patient's co-morbidities and behaviour.
- The significant risk for postoperative complications [identified by the hepatologist] appear not to have been communicated to the anaesthetist, doctors or nursing staff looking after him. The patient was reviewed regularly on numerous occasions by nursing and medical staff who were clearly concerned about his condition and took steps to deal with those concerns. There was a difference of opinion between the gastroenterology team and the ITU team regarding the need for ITU care.
- His care was appropriately escalated to ITU at on the 09/03/11. It is not known if the patient being treated in HDU/ITU as opposed to on the ward would have altered the outcome.

Recommendations

- Feedback should be given to ED staff to consider the diagnosis of mechanical obstruction in patients presenting with abdominal pain and vomiting and to consider obtaining abdominal x-ray, as soon as possible.
- The Trust's 'Electronic Handover' should be reviewed and altered to enhance communication between doctors and transfer of responsibility between consultants.
- High risk patients should be managed peri-operatively in critical care areas where there is clinical indication for this.
- This case should be presented at the M&M meetings for the surgical directorate and anaesthetic directorate and Quality and Safety Meetings for Groups 1&2.
- All patients with cirrhosis requiring major, necessary surgery should have a MELD score calculated pre-operatively to give an assessment of risk of decompensation which is communicated to the anaesthetic team.

5. SUI Closedown report (Draft)

Ref Number: 118100
Incident Date: 19/12/09
Location: BHH ED

Identified as SUI: 16/05/11
Completed: 28/11/11

Impact: Low Med High

Trust wide key learning points:

•Systems should be in place to agree the handover of patient care from team to team.
•Patients with outstanding test results should not have an out-patients appointment rescheduled.

Incident Theme(s):
•Reporting of results
•Appointments
•Handover of care
•Communication

•**Impact to Trust**: Low

•**Inquest outcome:** n/a

•**External Agencies:** n/a

•**Staff/HR actions:** None

Situation

In December 2009 a 78 year old man attended the Emergency Department at Birmingham Heartlands Hospital with right sided chest wall pain. Following the review of a chest x-ray taken during his admission, he was discharged home with a plan to have a CT scan of his thorax and upper abdomen as an outpatient and a follow up appointment 4 weeks after discharge. The CT scan was performed and reported on in January 2010 with a possible diagnosis that included metastatic disease and also TB. This report was not seen by the patient's consultant until June 2010 when a diagnosis of lung cancer with metastases was made and the patient was for palliative treatment. He died in April 11.

Background

•The patient attended A&E in Dec 09 complaining of intermittent right sided chest pain with a degree of swelling. He had first noticed a bump on the right lower side of his chest in October and had been experiencing varying degrees of pain for the last 9 months, which worsened when he coughed. The plan was to take blood samples and x-ray.
•He was admitted to the Acute Medical Unit (AMU), under the care of Dr F and after review by an FY2, hard bony nodule in the lower right rib of the patient was noted. As a result he was referred for more senior review with the suggestion that a CT scan be undertaken. He was then transferred to Ward 8 under the care of Dr B at 02:30 the next day.
•He was seen by Dr A (the on-call consultant for that week) on the morning ward round. There was no clinical evidence of TB and it was decided that the patient should have a repeat chest x-ray, CT scan and give a sputum sample with an out-patients appointment to see Dr B within 4 weeks. He was discharged with a prescription of non-steroidal anti-inflammatory tablets.
•The CT scan was performed at an outpatient appointment in Jan 10 and reported on 10 days later stating *"the differential includes metastatic disease and also TB. Referral to Chest MDT recommended. We will be discussing the imaging findings in the next relevant site specific cancer MDT. Please note you are still required to refer this patient urgently under the 2 week wait scheme"*. A High Priority Notification was sent to Dr A.
•An out-patients appointment was made to see Dr A in mid March 10 but appropriate staff were unavailable and the appointment was rescheduled to 5 weeks later. This was then rescheduled once more (this time at the patient's request as he was visiting Pakistan) to 5 months later. Upon his return at the end of April the patient's condition appeared to have worsened and he contacted the Trust to ask if his appointment could be brought forward. The appointment was rescheduled to see Dr A the following week.
•At the appointment Dr A noted a painful right sided chest wall lump and a separate right middle lobe shadowing. A series of diagnostic tests were performed over the next 3 weeks confirmed a diagnosis of small cell carcinoma of the lung. A repeat CT scan showed *"a large soft tissue mass in the right lower chest wall. This measures 9.2x6.2x8cm. This is intimately related to the diaphragm and is difficult to separate from the diaphragm. The suggested radiological staging would be T4, N2, M1b."*

Assessment

•After the patient's initial attendance in December 2009 he was appropriately scheduled to have a CT scan in January 2010. The scan was performed on 15 January 2010.
•There was no formal handover of care from Dr B to Dr A and Dr A was unaware that the patient had attended subsequent out-patient appointments until he saw him in June 2010.
•Dr A was also unaware of the results of the CT scan that were sent via the HPN in January and it is not clear if the results were sent to Dr A of Dr F.
•At the time of the incident there was no process for following up results where an appointment had not been arranged or had been rescheduled.
•There was a delay in rescheduling the out-patient appointment. As there were no records kept of the request the reason for the delay is not known.

Recommendations

•All clinicians should ensure they have an appropriate system in place to manage the handover of patients from team to team.
•The Access and Booking Team and ICT should develop a system on Ultragenda to flag patients that should not be rescheduled. The team should ensure that this process is audited.
•Directorates should develop systems for identifying patients whose appointments are "not for rescheduling", particularly patients who have outstanding test results.
•Develop a combined ICT and clinical reporting project for an electronic follow up system.
•The ICT Directorate should review the HISS and Ultragenda systems to ensure that they can be updated when the responsibility for care changes from one clinical team to another.

6. SUI Closedown report (Draft)

Reference Number: 113024
Incident Date: 08/02/11
Location: GHH
Identified as SUI: 24/08/11
Completed: 8 Dec 2011

Further Impact: Low Med High

Trust wide key learning points:

• Effective communication within multi disciplinary team that includes details of incidents and subsequent management plans.

• Consider the need for additional consultant support in unexpectedly complex procedures.

Incident Theme(s):

•Recognition of complication (hepatic ischaemia)
•Documentation and communication on internal transfer

•Impact to Trust: Medium
•Inquest outcome: Due March 2012.
•External Agencies: n/a

Staff implications: None

Supporting Staff actions: Yes

HR ongoing actions: None

Situation

Patient attended Good Hope Hospital (GHH) for an elective laparoscopic cholecystectomy which was converted to an open case. During the procedure, there was an injury to the portal vein which was repaired. Postoperatively it became apparent that she had developed hepatic ischaemia/ necrosis. The patient was transferred to the liver unit at the Queen Elizabeth Hospital (QEH) the following day and subsequently died 2 days later.

Background

•In September 2010, the patient experienced an onset of acute cholecystitis, was seen by a consultant surgeon and treated with antibiotics. An abdominal ultrasound scan confirmed a distended gallbladder containing at least one large gallstone.
•She attended an outpatient appointment in October 2010 and a date was arranged for her to have a laparoscopic cholecystectomy. In Feb 11, the patient attended for surgery and the surgeon commenced a standard laparoscopic cholecystectomy uneventfully, but within 10 minutes, he converted to an open procedure because of dense adhesions .
•During the dissection of the gallbladder (fundus first technique), a significant venous haemorrhage occurred from the region of the porta-hepatis. No obvious bleeding point could be identified immediately and bleeding was controlled by compression with surgical packs. Consultant assistance was sought from a general and a vascular surgeon. The vascular consultant attended first, and when he arrived the bleeding had been controlled. On removal of the packs, there was "copious" venous bleeding which was traced to the portal vein. A tear in the portal vein was identified and repaired using a vein patch taken from the patient's ankle. On initial release of the vascular clamps, there was a stenosis in the portal vein. A revision of the patch, to widen it, was performed to the consultant's satisfaction. Using a Doppler machine, good portal venous blood flow was confirmed.
• The cholecystectomy was completed and the surgeon sought additional advice from QEH. In theatre recovery, the patient was commenced on a morphine PCA for pain relief and had received morphine in theatre. Her blood pressure (BP) was noted to be low on occasions and she was reviewed by the anaesthetic registrar. The patient received IV fluids and a blood transfusion, which appeared to improve her BP.
•The anaesthetist agreed that the patient was suitable for transfer to a general surgical ward. Following her transfer to the ward (overnight), the patient's BP dropped and a raised MEWS was calculated. These concerns were escalated to the CCOT and medical team. The morphine was considered to have caused a drop in her BP as it improved following the administration of naloxone. Later that afternoon, , a duplex scan was performed which showed no portal venous flow. A CT scan showed a thrombosed portal vein and an avascular left liver and an ischaemic right liver. These findings were discussed with QEH and she was transferred later that day.

Assessment

• Mr C was a competent surgeon trained to perform laparoscopic cholecystectomy, however he had only performed – 12 open procedures
•A portal vein injury occurred and also injury to both hepatic arteries, which was not recognised at the time. The damage resulted in subsequent hepatic failure.
• Under the circumstances, it would have been appropriate for another consultant surgeon to stay to assist Mr C to complete the procedure, considering the intra-operative complications encountered.
•There were 3 episodes of clinical deterioration during the first post operative night consistent with opiate toxicity and which were managed as such.
•It is not clear what specific information had been handed over from theatre staff to ward staff in relation to the intra-operative injury and repair to the portal vein.
•No HDU bed was available and no discussion about creation of a HDU bed was apparent. However, the theatre team and the anaesthetist felt she was suitable for transfer to a general surgical ward. With the benefit of hindsight, It would have been appropriate to create an HDU bed either immediately post operation or during the course of the night when several MEWS triggers occurred.

Recommendations

•The liver specialist at QEH has offered to provide further experience to the surgeon in open gall bladder surgery.
•The surgical directorate should develop a system where a second consultant surgeon assists during complex or unexpectedly complicated procedures to provide technical and moral support necessary in such cases.
•The operating surgeons should be reminded to ensure that all postoperative instructions are documented and actioned including medication in line with the WHO Safer Surgery checklist. Regular audits should be undertaken to monitor compliance.
•The EP team will be asked to review the process for recording the administration of naloxone.

Report to Trust Board – February 2012

Trauma and Orthopaedic Department

Background:

The Trauma and Orthopaedic department is a large department working across three hospital sites. Both trauma and orthopaedic care are provided at Good Hope Hospital, whilst Heartlands hospital provides trauma care with elective orthopaedics provided at Solihull Hospital.

The department employs 21 Consultants, 25 staff grade doctors and associate specialists and 27 junior doctors. It carries out 11,727 procedures including surgery on 800 patients with fractured neck of femur. The department has undergone significant change and has integrated with the ortho -geriatric department. Mortality and complaints have been dropping with an improvement in response rate to the latter.

Situation:

This paper presents some of the work streams that have been put in place by the Trauma and Orthopaedic department to address issues highlighted by a number of reports from external organisations during a process of routine review or following an invited review.

The work streams broadly fall into 3 categories

1) Education and supervision of juniors
2) Productivity and efficiency
3) Enhancing quality of care

Concerns raised by the Deanery:

A number of routine deanery visits raised a number of concerns throughout 2010 / 2011. Whilst the deanery highlighted a number of areas of good practice including:

Addressing challenges: The T&O department have addressed many challenges and note that practice is changing as a result.
Educational Supervision: All trainees have a nominated Educational Supervisor and appraisals and assessments are being completed utilising e-portfolio. In addition, trainees reported that good feedback is received from consultant supervisors.
Junior Doctors Forum: There is an active forum in place for the foundation trainees of which is appreciated and trainees confirm that they are given the opportunity to voice their concerns if they have any issues.
Training Opportunities: Although theatre and clinic exposure is limited, trainees confirmed that when they are in attendance they provide good training opportunities.
Protected Teaching: All trainees are able to attend protected teaching sessions and confirm that all are bleep free.

It was suggested that a number of issues needed to be improved including

1) Improved registrar cover with a improved cover for trauma – addressed
2) Improved theatre exposure – being addressed
3) Improved access to IT – being addressed
4) Greater clarity of the role of the FY1 – Ortho-geriatric vs Orthopaedic component of posts

The department has actively addressed the issues raised and a detailed response is attached in ***Appendix A***

Productivity and efficiency:

Based on concerns centring around a potential loss of productivity in an increasing challenging financial environment the trust commissioned an external review, using T&O as a test directorate to try and identify themes that needed addressing. The report highlighted areas with potential for improvement which broadly fall into 3 categories:

1) Productivity
    a. Theatre
    b. Job Planning
2) Length of stay reduction
3) Procurement

The department have been fully engaged in a programme to address issues highlighted and an action plan and progress has been presented and continues to be presented and monitored through the Finance and performance committee.

Enhancing quality of care:

The management of fracture neck of femur has had a significant national focus as a number of steps in management of patients have been identified which result in improved outcome – as such it has also provides one potential surrogate marker of the quality of care provided. Locally implementation of this has been rewarded with enhanced payments which have also provided a means by which implementation can be measured. The trust has been identified as a poor performer when compared to the national comparator data (http://www.nhfd.co.uk/003/hipfractureR.nsf/NHFDNationalReport2011_Final.pdf).

In response to the above concerns a number of action have been put in place:

1) The CEO, Deputy CEO and Medical Director met with the consultant body on the 15th December 2011 to highlight concerns

Actions

a) A new Trauma lead (Mr Shrivastava) has been appointed and a number of action plans are in the process of being implemented
b) An external review of the fracture neck of femur pathway has taken place and a new pathway has been introduced / re-enforced – (**Appendix B**)
c) A number of balanced score cards have been introduced to monitor outcome and help drive improvement (**Appendix C, D, E**) – this has provided a template which we hope to extend to all specialties

Conclusion:

The challenges currently under scrutiny must be viewed within the context of a large volume of work. Mortality hasn't as yet shown a long term and consistent decline but the early metrics from the ward at BHH suggests that quality of care is improving with the measures instituted and some of the information we have suggest that we are now matching some of the current national comparator metrics. There are a number of areas that require continued input and monitoring by the governance and risk teams.

NHS West Midlands

LEP Improvement Action Plan and Progress Report

This improvement action plan is to be used following actions identified as part of a LEP quality review. The action plan is to be completed by the designated lead at the LEP (e.g. Clinical / College Tutor) agreed with the relevant lead at the Deanery (i.e. Lead reviewer / Head of School / Associate Dean for Quality / Dean) and then signed off and monitored as appropriate by all parties. The LEP is required to send in progress reports at agreed intervals.

***Note**: Copy in all action plans and progress reports to: QAmedical@westmidlands.nhs.uk*

LEP Name:	Heart Of England Foundation Trust	**Placement Site(s) Covered:**	Heartlands Site
Specialty(ies) relating to:	Trauma and Orthopaedics HEFT	**Date of related review visit:**	28.07.11
Clinical Tutor:	David Burkitt	**Clinical Tutor Email:**	david.burkitt@heartofengland.nhs.uk
Postgrad Centre Manager:	Mr David Twist	**Postgrad Manager Email:**	David.twist@heartofengland.nhs.uk

	Identified Issue	Actions planned to address issue	Lead	Date Due by	Progress Updates (Complete this when sending in progress report only)
1.	Service Arrangements (Changes in the Specialist registrar on Call pattern)	Was a significant issue raised in the last Deanery meeting? Since September 2011 major changes have taken place.	Mr Banerjee Mr Rahman Mr Srinivasan	Already in Operation	The Specialist registrar is currently resident and 1st on call to the A&E. This has had profound effect to the working pattern of the FY1 and FY2 doctors attending the casualty. They are no longer on their own in the casualty, but always have the presence of the specialist registrar (day and night). The juniors have already reported positive feedback.
2.	Individual On call Rotas	Day Time Rota	Mr Srinivasan Mr Rahman Mr K Droulias Dr David Swain	Individual on call rota with weekly schedules	The Fy1s are grouped under the supervision and guidance of the Care Of the Elderly Physicians for educational appraisals etc, but still in the entire educational training for the Trauma and Orthopaedics. All the educational sessions within the Trust, Deanery and the directorate of T&O are bleep-Protected.
3.	Fixed Theatre sessions for training f or ST1 ST2 s	Fixed Theatre sessions for the ST trainees	Dr Srinivasan Dr D. Swain Mr Droulias	Specific time tables issued	After discussion with the COE physicians, Dr Swain and Dr K Rajan, we have specific time tables for the trainees with allocated training sessions to attend the theatres. These sessions will be covered by the juniors under the COE teams

					and the Bleeps are covered by them. This has been informed to Dr A. Anwar, medical directorate HEFT, and Mr Banerjee, CD T&O
4.	Information and technology issues , lack of adequate computers	To acquire and double the present number of computers in both rowan and Beech wards at heartlands Hospital.	Mr Srinivasan Mr D. Burkitt Mr B. Banerjee	Discussions in progress Mr Burkitt would kindly support the issue	Decision expected to be taken in the next eight weeks. David Burkitt has written to Stuart Dale, Directorate manager, but to date (October 2011), has not had a response. This is a directorate issue.
5.	Educational issues : audits and research projects	To involve all the junior doctors in the audits etc within the directorate Audit and Research issues	Mr Srinivasan Mr Rahman Mr J Ramos	All the educational supervisors would reiterate the need for the audit and research projects while working with them	Will be discussed again in the audit meeting on the 7th October 2011
6.	Ward round and senior supervision	To reinforce the ward senior medical cover, doing ward rounds, discharge plans	Mr Srinivasan Dr D Swain	Additional, daily ward round by the resident registrar to see the patients, identify and support the medical manageme	The new resident on call rota for the registrars has already improved the working life of the FY doctors on call, on the ward and they now have better time schedules to attend the operating rooms, better discharge plans, better liaison with the Geriatrician team

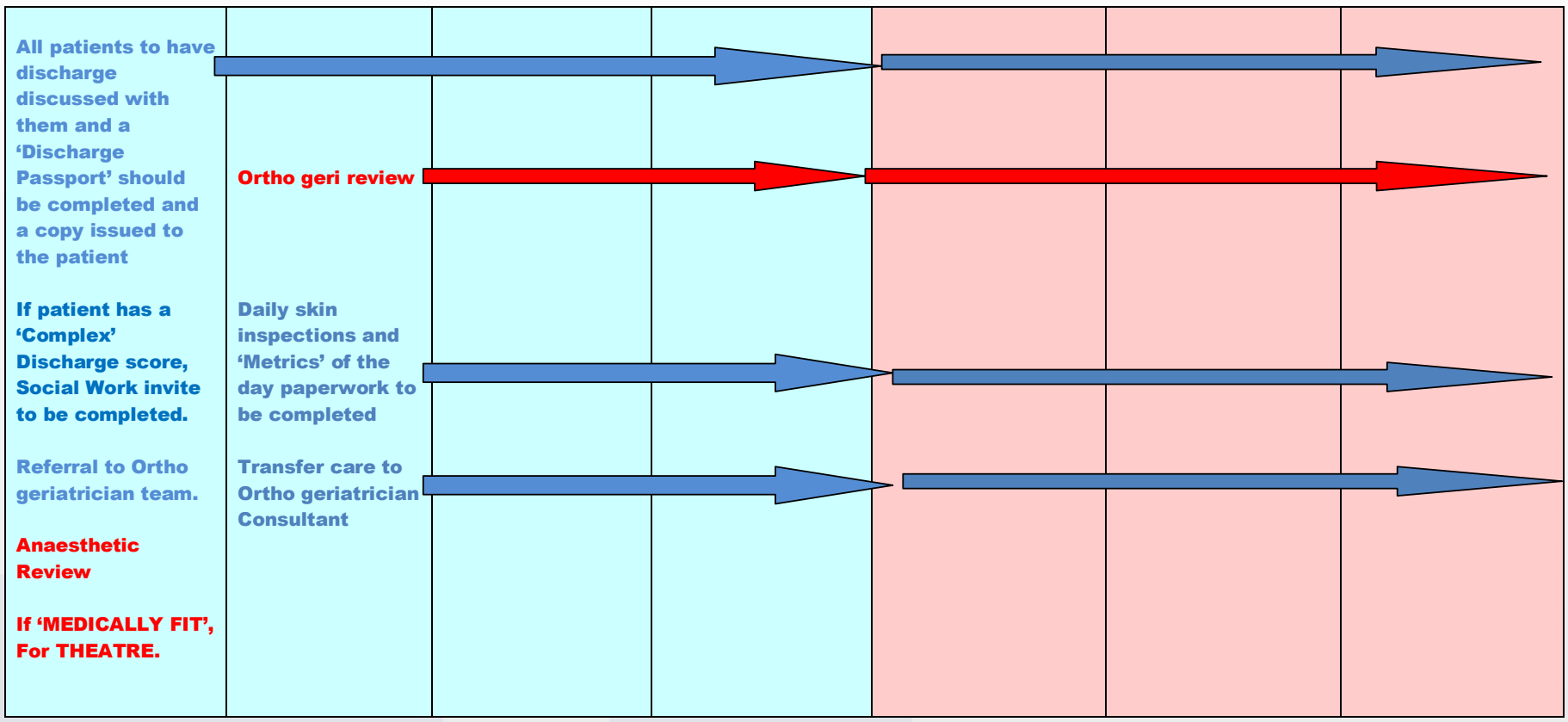
				nt of the elderly patients waiting for their hip surgery	

Date of action plan finalised by LEP:	13th October 2011	**Progress update to Deanery required by:**	1st September 2011	**Date progress report sent to Deanery:** (Complete this when sending in progress report only)	

Agreed by:

LEP Lead Name:	Mr Kuntrapaka Srinivasan	**Position:**	Education Lead, T&O	**Email:**	Kuntrapaka.srinivasan@heartofengland.nhs.uk
Deanery Lead Name:	Ms Adele Dyble	**Position:**	Education Development Manager	**Email:**	adele.dyble@westmidlands.nhs.uk

SIMPLE AND COMPLEX DISCHARGES*				COMPLEX DISCHARGES ONLY*		
DAY 1	DAY 2	DAY 3	DAY 4	DAY 5	DAY 6	DAY 7
Triage and clinical assessment by the A+E team **Confirmation of fracture (NOF) by Trauma team** **Admission to Trauma Ward WITHIN 2 HOURS of being accepted by Trauma Team** **Completion of routine investigations** **Completion of full Nursing Admission within 2 hours of arrival on the ward** **Completion of all nursing care plans and appropriate referrals** **Discharge Planning Score to be calculated and documented in medical notes and on the Jonah Board.**	**For 'COMPLEX' discharge category, section 2 to be completed** **EARLY mobilisation. If medically stable sit out at 12-18 hours post operatively** **Medical review and documentation of medically fit status** **Monitor oral intake according to condition with a daily intake of 2 litres to be maintained** **Joint Therapy Assessment/ treatment to be commenced.**	**Routine check bloods to be reviewed and actioned** **TTO completion for 'SIMPLE' discharges**	**'SIMPLE' discharge patients to discharged from hospital** **For 'COMPLEX' referrals, Social Worker assessment to be undertaken**	**Routine check bloods to be reviewed and actioned** **TTO completion for 'COMPLEX' discharges** **Transfer of Care to be completed via Electronic Handover**	**Section 5 to be completed.**	**'COMPLEX' discharge patients to be discharged from hospital.** **Routine check bloods to be reviewed and actioned**



= ESSENTIAL TO FRACTURE NECK OF FEMUR PATHWAY OUTCOME

= TRUST REQUIREMENT / POLICY

= LOCAL REQUIREMENT / POLICY

T&O Balanced ScoreCard

2010/11 & 2011/12

The Performance Team

Indicators	Ward	2010/11 Apr-10	May-10	Jun-10	Jul-10	Aug-10	Sep-10	Oct-10	Nov-10	Dec-10	Jan-11	Feb-11	Mar-11	2011/12 Apr-11	May-11	Jun-11	Jul-11	Aug-11	Sep-11	Oct-11	Nov-11	Dec-11	Jan-12	Feb-12	Mar-12
Nurse Metrics																									
BHH	Beech																								
	Rowan																								
SH	Ward 15																								
GHH	**Ward 14**																								
	Ward 15																								
Patient Experience																									
BHH	Beech																								
	Rowan																								
SH	Ward 15																								
GHH	**Ward 14**																								
	Ward 15																								
Complaints																									
BHH	Beech																								
	Rowan																								
SH	Ward 15																								
GHH	**Ward 14**																								
	Ward 15																								
In-Hospital Mortality (T&O Trustwide)																									
Spells																									
Actual Deaths																									
Expected Deaths																									
Relative Risk																									
HSMR (FNOF)																									
BHH																									
SH																									
GHH																									
Trustwide																									
Long Length of Stay (FNOF) - **TRUSTWIDE**																									
Spells																									
Long LOS Spells																									
Expected Long LOS Spells																									
Relative Risk																									
28 day Readmissions (FNOF) - **TRUSTWIDE**																									
Spells																									
Readmissions within 28 days																									
Expected Readmissions within 28 days																									
Relative Risk																									
Outpatient DNA Rate																									
New																									
Follow-up																									
Trustwide																									
Productivity Metrics																									
Elective LOS																									
Emergency LOS																									
Patients Treated by Private Sector																									
Theatre Metrics																									
Cases per Session																									
% List utilisation																									
% Session time utilisation																									
Hospital-led Cancelled ops on the day																									

FNOF Rehab Balanced ScoreCard

2011/12

Measure	Aspiration		30 Jan 12	6 Feb 12	13 Feb 12	20 Feb 12	27 Feb 12	5 Mar 12	12 Mar 12	19 Mar 12	26 Mar 12	2 Apr 12	9 Apr 12	16 Apr 12	
	Description	Measure	Week 1	Week 2	Week 3	Week 4	Week 5	Week 6	Week 7	Week 8	Week 9	Week 10	Week 11	Week 12	Overview Rating
Patient Experience															
	Percentage of pts received		#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	
	Percentage of patients		#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	
Process on Trauma ward															
MDT assessment on day 2 post op	Percentage of patients	100%	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	
TOC referral day 3 post op	Percentage of patients	100%	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	
Decision from TOC re exit route by day 4 post op	Percentage of patients	100%	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	
Procedure Utilisation															
			#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	
			#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	
Patient management on Rehab ward															
Day 1 -individualised plan set	percentage of patients	100%	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	
Daily evaluation if rehab plan on track	percentage of patients	100%	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	
Day 1-social work referral	percentage of patients	100%	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	
MDT review every 7 days	percentage of patients	100%	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	
Discharge / LOS															
Discharge from ward	within 14 days	85%	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	
Discharge from ward	within 18 days	100%	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	

NOTES:
Where a measure is indicated as **Local** this requires the Trust to establish a current baseline for each specified measure

Key	
Target achieved this week	G
Target failed this week	R
Data source not provided	

NHS Institute for Innovation and Improvement

prototype

Trademarked

Yes
No

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FNOF Balanced ScoreCard
2011/12

Measure	Aspiration		1 Feb 12	8 Feb 12	15 Feb 12	22 Feb 12	29 Feb 12	7 Mar 12	14 Mar 12	21 Mar 12	28 Mar 12	4 Apr 12	11 Apr 12	18 Apr 12	
	Description	Measure	Week 1	Week 2	Week 3	Week 4	Week 5	Week 6	Week 7	Week 8	Week 9	Week 10	Week 11	Week 12	Overview Rating
Patient Experience															
Admission to dedicated unit	Percentage of patients	90%													
Predicted discharge date pre-op	Percentage of pts received	95%													
Discharge on or before estimated discharge date	Percentage of patients	75%													
Admission															
Admit to ward within 2 hours of diagnosis (Clinical)	Percentage of patients	85%													
Operate within 24 hours of admission	Percentage of patients	65%													
Operate within 48 hours of admission	Percentage of patients	94%													
Pts assessed pre op by geriatrician	Percentage of patients	75%													
Assessed for bone health	Percentage of patients	80%													
Assessed or referred for multidiscplinary falls risk	Percentage of patients	80%													
Use of standardised assessment process	Percentage of patients	Local													
non operative patients	Percentage of patients	<3%													
Procedure Utilisation															
Daily trauma lists	hours per week	Yes/No													
Daily MDT trauma meetings	Meetings scheduled	Yes/No													
Patient mobilisation															
Mobilised within 24 hrs of surgery	Percentage of patients	95%													
7 day therapy provision	Therapy provision	Yes/No													
Early MDT review for discharge planning	Percentage of patients	Yes/No													
Post op DVT/PE	Percentage of patients	NPSA													
Incident forms	Number of falls	Local													
Hosptial acquired															
pressure ulcer grade 2 or over	Percentage of patients	<4%													
Incidence of HAI is below trust target	Number of patients	local													
Discharge/LOS															
Criteria based discharge	Percentage of patients	95%													
Readmissions within 28 days	Number of patients	Local													
Discharged to original place of residence	within 19 days (spell)	Local													
Discharged to original place of residence	within 25 days (superspell)	Local													
Inappropriate transfer of care in acute setting	Percentage of patients	10%													
in hospital mortality	Percentage of patients	Local													
Service Overview															
Complaints	Number	Local													
Staff sickness	Percentage	Local													
Vacancy	Percentage	Local													

NOTES:
Where a measure is indicated as **Local** this requires the Trust to establish a current baseline for each specified measure

Key	
Target achieved this week	G
Just missed	A
Target failed this week	R
Data source not provided	

prototype

Trademarked

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TO	**TRUST BOARD**
FROM	**DIRECTOR OF HR & OD (ACTING)**
DATE	**MARCH 2012**

Title	**Quarterly OD & HR Reporting to Executive Directors**

The purpose of this report is to present to Executive Directors the quarterly OD & HR report.

Decision	**N**	**Discussion**	Y
Assurance	Y	**Endorsement**	Y

SUMMARY/KEY POINTS:

To set out the challenges ahead for the next 3-5 years under the themes:

- Leadership, culture & staff engagement
- Workforce Planning
- Workforce Development -
- Pay, productivity and health

The paper outlines current issues and forward look.

STRATEGIC RISK REGISTER	*PERFORMANCE KPIS YEAR TO DATE*
• Leadership, Culture • Workforce redesign and planning	As per report

RESOURCE IMPLICATIONS (E.G. FINANCIAL, HR)

ASSURANCE IMPLICATIONS

Information Exempt from Disclosure:

1.0 PURPOSE

The purpose of this report is to present to the Trust Board the quarterly OD & HR report

2.0 BACKGROUND

In August 2010, Trust Board received a report 'Strategic Workforce Challenges' that set out the challenges ahead for the next 3-5 years under the following themes:

- Leadership, culture and staff engagement
- Workforce planning
- Workforce development
- Pay, productivity and health

Trust Board agreed to receive quarterly updates around these issues commencing in October 2010. The quarterly update would provide an overview of current progress, forward look for the next 3-6 months and present a suite of KPIs and data for each theme.

Attached to this report is the update for EMB and the Board.

3.0 CURRENT ISSUES AND FORWARD LOOK

Organisational Development & Work & Wellbeing

- ***Work and Wellbeing***

The current service internally remains fairly traditional, delivering core OH services. However, there is a desire to really deliver on the staff wellbeing agenda to promote health and prevent absence. This requires a level of both support from the Trust Board and investment. It is proposed that a Staff Health and Wellbeing Steering Group be established to give this the right level of drive and support with individual wards piloting the scheme with backing from the CEO. . The income target within Work and Wellbeing remains extremely challenging and given the current climate is becoming more difficult to achieve. The HR Strategy Committee, has requested a paper which focuses on how the OH department can more proactively support absence prevention and reduction. This paper will also be presented to EMB in March.

- ***Changing Culture, improving morale and performance***

A paper was presented to the HR Strategy Committee in January which outlined work that had so far been undertaken around improving the performance culture. This has so far focused on two key work strands:

- Improving selection processes to ensure we recruit the right people, with the right behaviours
- Enhancing the appraisal process, including a succession planning process for leaders

The work will be presented to EMB in March.

A guide for managers has been developed and the CEO has asked that we develop proposals around supporting directorates to really focus on how they work with their staff, change their culture and improve morale, to enhance engagement, involvement, reduce absence, improve overall wellbeing, and reduce stress.

Measurement of engagement moving forward will be conducted as follows:

- Annually, via local engagement questions in the National Staff Survey
- Bi-annually, at directorate level, through an internal pulse survey approach

The development of this process is being undertaken currently, and it is envisaged that we will ask directorates to run a pulse survey in April and October each year.

This will reduce costs to the Trust and also ensure that this process is owned locally by directorate leaders.

Engagement rates will become a key part of the leaders appraisals.

- ***Clinical Director Review***

This work was completed earlier in 2011 and the Medical Director is now moving the recommendations forward.

- ***Ward Manager Review***

The review undertaken last year culminated in a Challenge Event in November and has resulted in the development of a business case to support ward leaders become supervisory to support improved quality of care. This is being led by Sam Foster, Deputy Chief Nurse.

- ***National Staff Survey***

The National Staff Survey ran between October and December. We achieved a 45% response rate, a 3% increase on the previous year. Results will be received in Spring.

- ***Appraisals***

We have achieved target of 8000 appraisals being undertaken in 2011/12. We will be reviewing the target for 2012/13 and are in the process of improving the documentation further. Training is available and dates are on the HR website.

- ***Leadership Development***

The Faculty and OD have been working collaboratively around leadership development proposals. We are working with stakeholders to ensure our development programmes are fit for purpose and support achievement of the Trust's goals and vision.

This will include the launch of a VITAL for managers e-learning package. Modules are currently in development, as well as a 'menu' of development options for leaders which will be tailored to individual need and also include some role specific elements. There will be a strong focus on experiential learning.

Shared Services

As part of the Improving Performance Culture project, we are currently working on the pilot stages of the new values based recruitment and selection process. The pilot phase concentrates on three staff groups; Head Nurses, GrODS and GMDs/CDs. The pilot will commence in March 2012.

Ongoing monitoring and compliance of tightened controls for bank usage are in place with weekly reporting to Dep Chief Nurse and monthly reporting to Finance Sub Committee. Other measures include EVCP still in place and as of January stats 52% of vacancies presented approved, 30% approved with restrictions and 18% declined/held.

Access to children retrospective CRB audit 92% completed and on target to be fully completed by end of Q4. Community Services retro audit will commence in April with prep and implementation work being completed in March.

- New payroll contract won for Birmingham & Solihull NHS Cluster. The payroll contract will generate c£25K profit per annum for the Trust and goes live in April 2012.

HR Consultancy

- ***Sickness Absence***

Sickness absence is reducing compared to 2010/11 across all sites. This is demonstrable by the rolling year figure for 2010 of 4.05% compared with 3.92% for the rolling year to December 2011. In order to ensure continuous improvement, we have renewed our focus on providing targeted support for managers which include refresher training and coaching. We are also currently developing an options appraisal with additional targeted actions for consideration by the Executive Board, to further reduce the costs of sickness absence.

Employee Relations

- ***Case Management***

We are currently managing a significant number of complex cases, including performance and disciplinary issues, involving for e.g. consultant staff, which are subject to external scrutiny by the National Clinical Assessment Authority (NCAS) and the General Medical Council (GMC).

Overall, the vast majority of cases are being handled successfully without recourse to employment tribunals.

- ***Consultations***

The consultation has been launched for Phase 1 of the organistional restructure. Phase 1 affects senior teams and, once they are in place, we will plan Phase 2 with input from those appointed to positions in Phase 1. The Trust is currently undertaking a significant number of other consultations to support its wide-ranging change and organisation development agenda. These include a number of service reconfigurations in critical care, diabetes and sexual health.

- ***NHS Pension Scheme***

As the Board are aware, the Government, in response to the Hutton Review, has made recommendations on the long-term structural reform for all public service pensions.

In response to the proposed changes, the Trades Unions co-ordinated industrial action which culminated in a day of action on 30 November 2011, across the public sector. The Trust's contingency plan worked well with minimal disruption to services on the day. Although the National negotiations are still ongoing, the Trust has re-rated this risk from red to amber as agreement has not been reached as yet. We will continue to review and update the risk register.

- ***On Call Review***

The national protection for current on-call schemes ended in March 2011. In its place, Trusts are required to develop a single new local scheme which applies to all staff within a particular Trust. The Trust established a multi-disciplinary project team, in partnership with staffside to review all current on-call arrangements for all staff groups. Following a significant amount of work, a draft framework has been developed and presented to the Executive Committee in February. The planned implementation date is 1 April 2012.

- ***Pay and Reward***

Following a review in 2010, to establish approaches for pay and reward reform to be adopted by the Trust, a detailed Project Initiation Document (PID) has been developed to take forward the key recommendations. The PID was reviewed by the Executive Board on 20 December 2011, and a decision was made to focus on delivery of the sickness absence element and performance management. A further report focussing on sickness will be presented to EMB.

Faculty of Education/Learning & Development

Quality and core compliance

The Faculty successfully achieved the objectives set by the NHLSA assessor in October in relation to enhancing mandatory training processes. However, maintaining data quality using the OLM system (learning management system linked to ESR) remains an on-going and resource intensive issue. A review is currently being undertaken, in collaboration with ICT, to identify a new system that will allow individuals and managers to view there own training data. The new system would secure enhanced data quality and reduce the current administrative burden. Once options are fully appraised recommendations will be submitted for consideration by the Executive team.

Workforce design

The Faculty now have a *workforce diagnostic and design service* that will support Directorates and Groups in designing and planning their workforce in line with identified service delivery plans.

Widening participation (work experience and apprenticeships)

The Faculty and Corporate Affairs team work with local schools and colleges in a variety of ways to offer young people the opportunity to experience healthcare. This has three key aims: to support the school curriculum; to promote health; and to provide exposure to careers in healthcare. The Faculty has facilitated the following work experience placements over the last three years:

Year	Staffing	Placements
2009	Band 8a f/t Year in Industry f/t (fixed term)	**397**
2010	Band 8a f/t Year in Industry f/t (fixed terms)	**344**
2011	Band 6 f/t (fixed term)	**626**

However, despite the increase in capacity in 2011 there were an additional **628** unsuccessful applicants that we were unable to accommodate due to a lack of suitable placements. In addition to this requests from schools and future medical students (who require experience for their University application) have increased significantly. Each placement requires significant investment to ensure that the learner is placed safely, in line with all Trust policies, and that placements are of the right level of quality to achieve the placement learning outcomes. For the last three years dedicated income has been used to resource this activity and this funding has now ended; there is no core funding for this.

An options paper is currently being drafted for the Executive Board in order that it can consider a strategy for this work in the broader frame of the Trust's community engagement and corporate citizenship priorities.

The HCDU continues to deliver successfully on the Trust's ambitious apprenticeship agenda and, in November, won the HSJ award for workforce development for the Trust's steps for work programme.

Professional Education

The VITAL programme continues with VITAL for Midwives and Paediatrics due to launch before April. VITAL for managers is in progress, with launch planned for spring. VITAL for nurses won the Nursing Times patient safety award in November.

A bid has been submitted to the Health Foundation shared purpose programme to fund the roll out of VITAL, as a mode of learning and assessment, across the Trust (400k over 3 years). We await a decision on this application.

A pilot is currently being developed called VITAL STEPS for Junior Doctors. This programme will offer enhanced transitional support for FY1 doctors and includes the use of VITAL Doctors and a set of personal metrics that will enable tracking of individual safe practice and progression. A bid is being submitted to Medical Education England to support this pilot (100k over 1 year).

We have successfully won a bid from the Workforce Locality Board to develop the i skills library (80k over 1 year).

We are currently out to tender for academic accreditation of our further and higher education programmes. The first year of using this approach reduced the unit costs for education modules by, on average, 50% as compared with direct commissioning with traditional education providers. There has been a high level of interest from regional education providers.

Workforce Planning

In response to feedback from recent planning cycles a more co-ordinated approach to workforce planning has been agreed. This will form part of HEFT's 2012-13 Business Planning process lead by the Commercial Directorate.

This year strategic, business, finance and workforce plans will be brought together, to support those with responsibility for completing the plans and those with responsibility for quality assuring the plans. It is also anticipated that in addition to key trust wide initiatives it will also enable the trust to shape and react to the level of change in the wider health economy from national or local changes in policy.

The cycle will commence in February 2012 with a series of workshops and be concluded in June 2012 with the submission of HEFT's workforce plan to the Cluster and SHA.

Hazel M Gunter
Acting Director of HR and OD

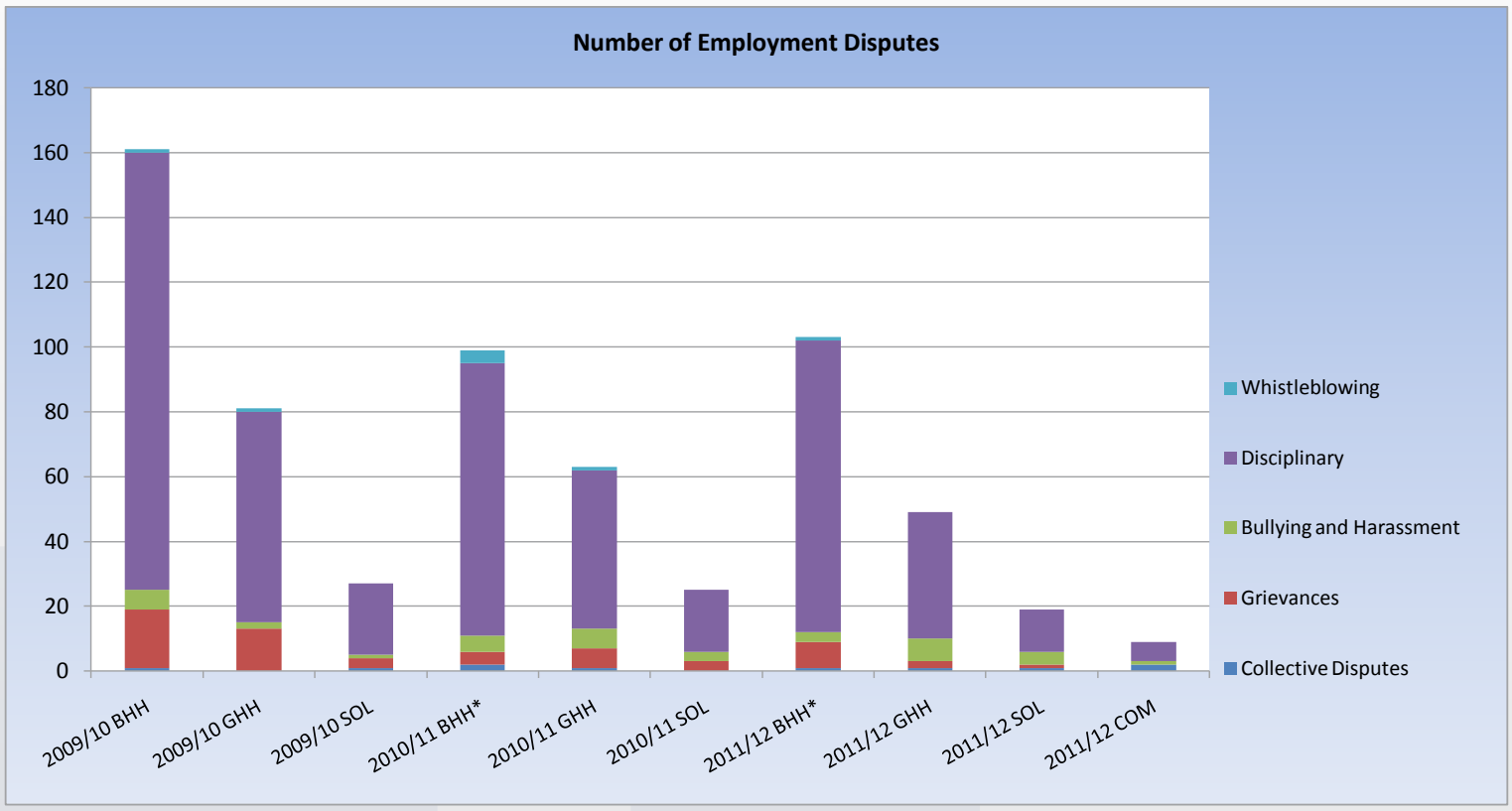
OD & HR EXECUTIVE SUMMARY MARCH 2012 TRUST BOARD

Strategic OD/HR issues * = Trust strategic risk	CURRENT	FORWARD LOOK NEXT 6 MONTHS	MEASURES
LEADERSHIP & CULTURE *	➢ Local staff survey shows engagement increasing by 5% across the Trust ➢Responding to themes in Local Staff Survey	➢ 'VITAL' for managers and leaders ➢Enhanced appraisal processes ➢Improved selection processes to include behaviour	➢ **Staff Survey** ➢ **360 Feedback** ➢ **Staff engagement rate** ➢ **Staff turnover**
WORKFORCE PLANS *	➢ Dedicated resourcing for redeployment programme	➢Workforce redesign issues considered as part of Trust service redesign planning	➢ **KPIs – time to hire** ➢ **Staff in post, temporary staffing** NEW Measures: ❖ Redeployment success ❖ Redundancies
WORKFORCE DEVELOPMENT	➢ Consultation on 'Developing the Healthcare Workforce completed ➢VITAL and apprenticeship programmes	➢ Influence regional skills networks and Deanery functions ➢Determine future models for the Faculty of Education ➢Leadership and management development across the workforce	➢ **Learning KPIs** ➢ **Appraisal take up** ➢ **Induction attendance** ➢**Mandatory Training**
PAY, PRODUCTIVITY & HEALTH	➢ Pensions Choices exercise and planning for future changes ➢Beginning work on additional pay savings in partnership with staff side ➢Develop controls for containing pay in consistent manner	➢ Develop proposals for future pay and rewards package for HEFT ➢Develop proposals to support directorates to enhance engagement	➢ **Sickness absence** ➢ **Staff engagement** NEW Measures e.g: ❖ Skill mix ❖ Average pay

PERFORMANCE

Dec-11

1. EMPLOYMENT DISPUTES



NB: 2011/12 Figures are April-November only.

2. TRUST PERFORMANCE ON HR INDICATORS 2011/12

WORKFORCE	TARGET	Oct-11	Nov-11	Dec-11	TRUST YTD	
Staff in Post v Budget Established - Percentage	<> 95% - 100%	96.86%	97.31%	97.38%	97.38%	
Staff in Post v Budget Established - WTE Vacancies		278.97	238.15	231.97	231.97	
Nursing Requests Filled by Bank/Agency	> 80%	89.00%	90.00%	88.00%	87.33%	
Nursing Requests: No. of Requests		6,269	6,034	5,287	66,383	
Nursing Requests: Total No. Filled		5,601	5,401	4,631	57,894	
Nursing Requests Filled by Bank Proportion of all Filled Requests	> 85%	93.00%	94.00%	96.00%	90.67%	
Medical Requests Filled by Bank/Agency	> 90%	99.00%	100.00%	98.00%	98.56%	
Medical Requests: No. of Requests		611	480	525	7,277	
Medical Requests: Total No. Filled		604	478	516	7,164	
Medical Requests Filled by Bank Proportion of all Filled Requests	≥ 34%	58.00%	55.00%	49.00%	46.67%	
Average Time to Recruit in Weeks - All Staff Groups	≤ 11 Weeks	11.00	11.00	11.00	11.00	
Voluntary Turnover	<7.32 Dec 11%	6.27%	6.10%	6.12%	6.12%	
Sickness - YTD Moving Annual Average	<3.93 Dec 11	3.85%	4.30%	3.82%	3.92%	
New Starters Attending Corporate Induction - Doctors only **MONTH IN ARREARS**	90%	91.0%	89.0%	mia	91.63%	
New Starters Attending Corporate Induction - Excluding Doctors **MONTH IN ARREARS**	98%	100.0%	100.0%	mia	99.88%	
Clinical Staff Undergoing Mandatory Training Cumulative Since Start of Programme	1200 By Nov	193	175	130	1,466	
Number of Appraisals Completed	8000 By october	**1,784**	**329**	**108**	**7,864**	

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PAY, PRODUCTIVITY & HEALTH

Dec-11

ITEM	2009/10	2010/11	2011/12	Bench Mk*
Sickness Absence Rolling yr to Dec 11	4.30%	4.05%	3.92%	3.76%
Pay cost of sickness absence**	£12,295,269	£12,127,602	£12,132,979	
Staff Engagment	55%	60%	60%	
Average Pay (Sep 2011)		£32,700	£34,200	£33,200

*Based on West Mids Acute Units averge pay at Sep 2011

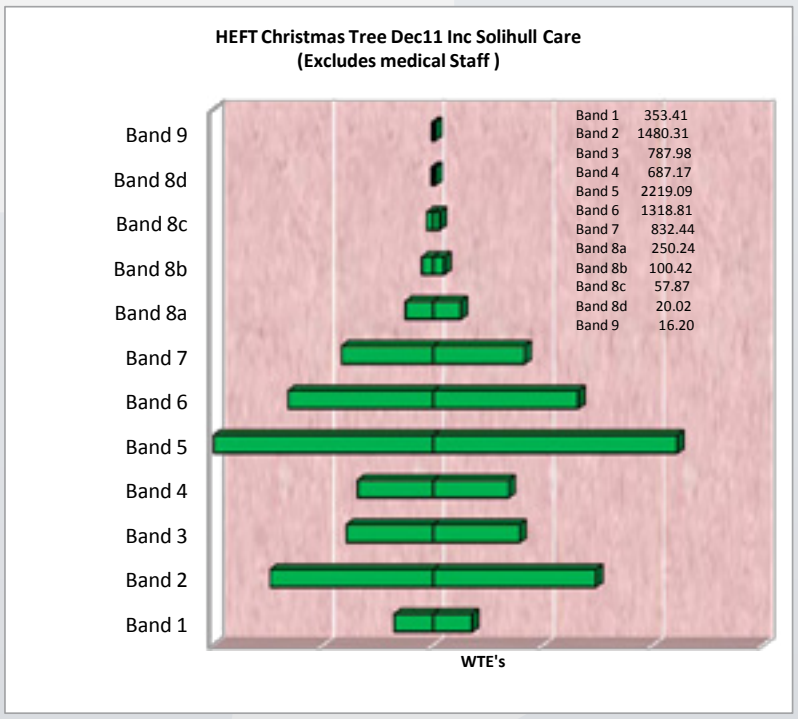
**2011/12 sickness % and cost now includes Sol Comm

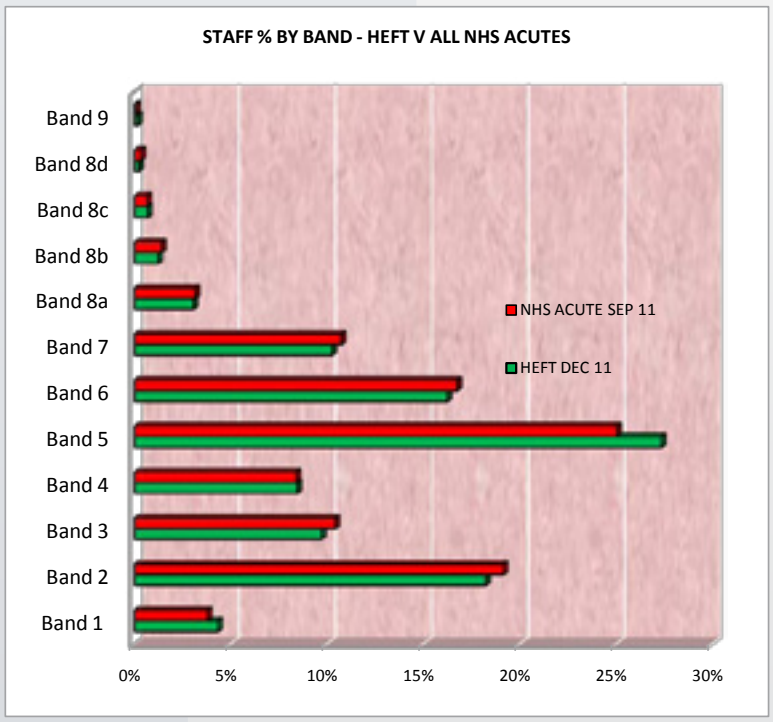
SICKNESS % BY SITE	2009/10	2010/11	2011/12 Dec
Heartlands(+Sol 9/10 and 10/11	4.03%	3.23%	3.69%
Solihull			4.39%
Good Hope	4.78%	4.54%	4.37%
Solihull Comm			3.43%
Trustwide	4.30%	4.05%	3.92%

Heartlands/Solihull sites separated from April 2011.

Dec 11 target is 3.93%

BAND MIX

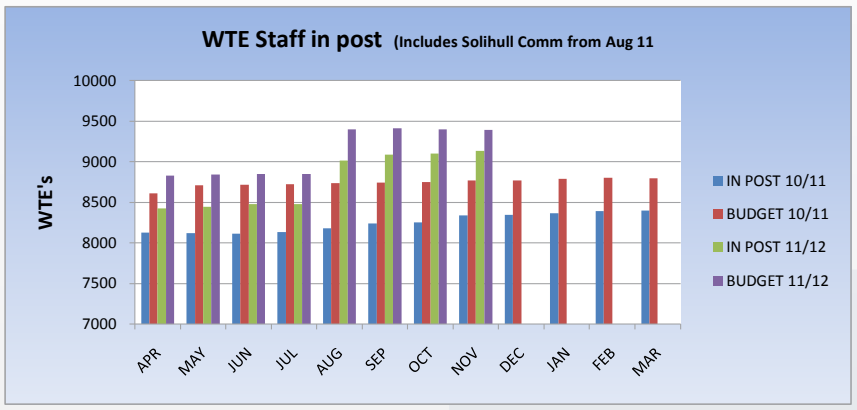


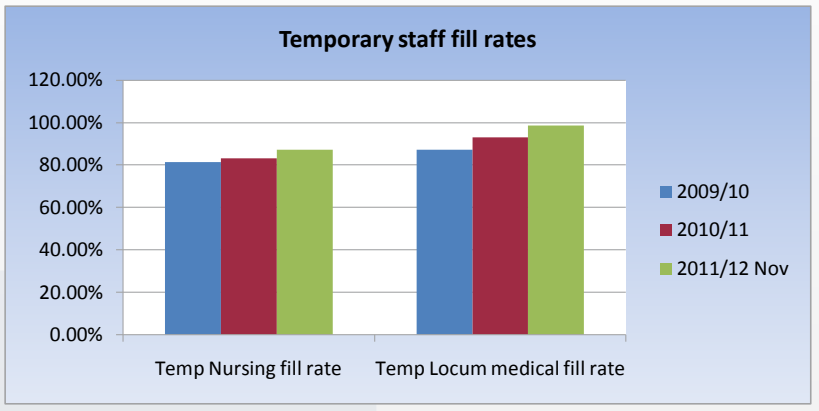


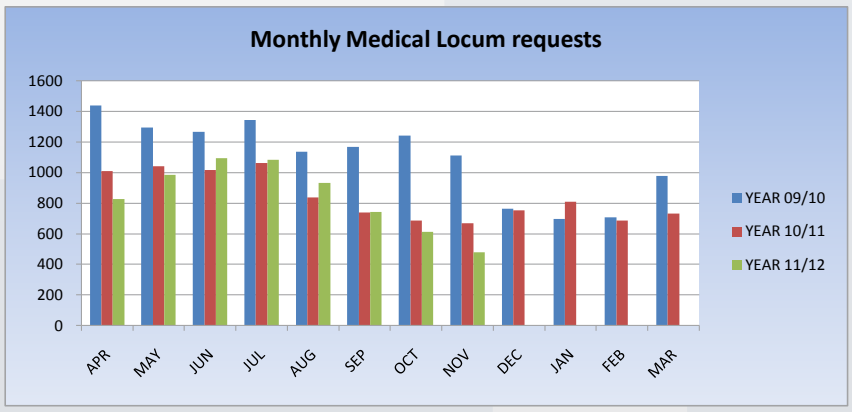
AGENDA
Apologies .01
Declaration of interest .02
Minutes from previous meeting .03
Matters Arising .04
Chairmans report .05
Chief Executives report .06
Quality and Performance Monitoring .07
Board Committee Reports .08
Trust News and External Environment .09
Governing Body and Membership .10
Corporate Governance .11
Any Other Business .12

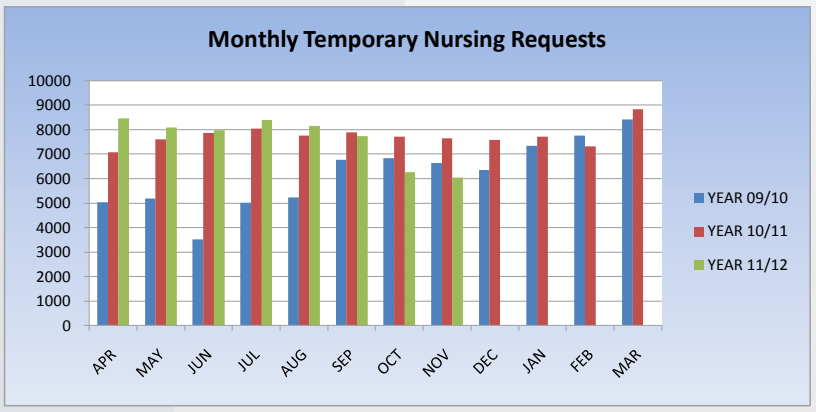
WORKFORCE PLANNING

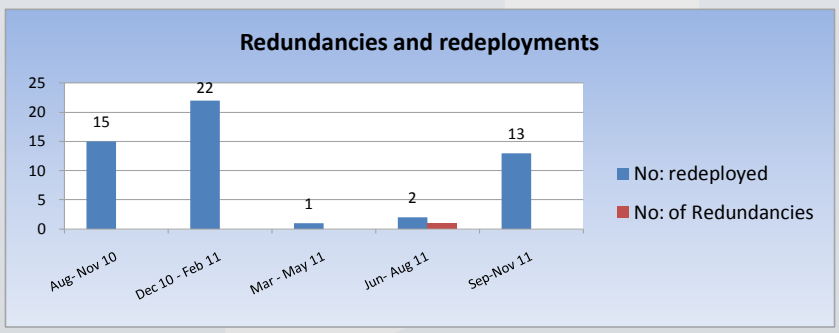
Dec-11











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From: John Sellars

Title: Ambulatory Care & Diagnostics Project (ACAD)

This report sets out the key changes in circumstances that have resulted in the proposal to cancel the ACAD building project.

The report is provided to the Board for:

Discussion: Approx 10 mins)

Endorsement: (Approx 5 mins)

The Board of Directors is asked to endorse the Executive Management Board decision to cancel the ACAD building project.

Summary/Key Points:

- Since the original X Site Programme was set up in 2008 a number of investment options into Outpatient facilities have been considered. Most recently an outline business case was completed with instruction to develop the full and final case based on an Ambulatory Care and Diagnostics based facility
- The NHS operates in an ever changing environment, since that decision was taken the Trust has identified other more high priority areas for development, it has also been identified that approximately 80% of the Business Change projects can now be delivered in the existing premises with minimal changes. The Re-shaping HEFT work confirmed the Trusts' strategy to seek ways in which it can devolve a number of it's outpatient clinics into the community
- In recognising the need to realign expenditure with current spending plans the EMB agreed to cancel the ACAD building project and redistribute the funding to other more pressing issues but to continue the Business Change projects. It was also agreed that a project to redecorate and make minor amendments to the Outpatients Department should be undertaken.

Strategic Risk Register:

SR3 – IMPACT OF WHITE PAPER
SR1 – FUTURE TARIFF EFFICIENCY

Performance KPIs year to date:

NONE IDENTIFIED AT THIS STAGE

Resource Implications (e.g. Financial, HR):

- Resources are existing capitalised costs currently reconciled to the business case for the ACAD project.

Assurance Implications:

NONE IDENTIFIED AT THIS STAGE

Information Exempt from Disclosure:

- Nil

1. Background

The Trust launched its X Site Strategy Programme in 2008 in support of its 10 year vision for the organisation. The programme consisted at the time of a number of small, medium and large property projects at each of HEFT's three principal hospitals. The total value of the programme was based on an initial capital budget of £190m.

During the development of the programme plan various changes were made to the projects. This included the alignment of the investment into property, to business outcomes needed by the Trust to meet its aims. This in turn introduced business change projects to the programme, to sit alongside the existing property projects. Change to the size and scale of the property project to service a greater number of clinical services, combined with the introduction of business change projects; has led to the proposal to invest in the Heartlands ACAD (Ambulatory Care & Diagnostics) project, the subject of this paper.

Through the development of the business case, a number of options were created and analysed to find the best solution to meet the business need. The principal options developed by the team were:

- £10m refurbishment of the existing Outpatients facility only - February 2008
- Do nothing, refurbishment options or new building for Outpatients plus 6 new wards - November 2008
- An ambulatory care and diagnostics centre based on an initial cost of circa £38m - March 2009 to August 2009
- The Board recommended that the ACAD project proceed to Full Business Case - April 2011.

2. EMB Recommendation

- At its meeting in December 2011 the EMB took the decision (subject to Board approval) to cancel the ACAD building project. This decision was taken following a presentation on the project, which outlined the current progress of the project and a discussion around its standing against other key strategic imperatives. The ACAD project had been included as a Phase 1 project in the original X-Site Strategy and it was agreed that since that decision had been made the environment within which HEFT was now operating had now changed considerably.
- During the period of detailed development of this project other strategic imperatives such as a provision of Maternity/Neo-natal facilities and ITU facilities on the Heartlands site had now become a greater risk to the Trust. Additionally the work carried out as part of the Re-shaping HEFT identified other operational priorities that will need to be addressed as part of that development as well as a commitment to identify ways in which a number of clinics can be relocated into the community.
- EMB accepted that the proposed building satisfied the brief and that the work carried out was to a high standard, however it also accepted that given the other now more pressing demands on the capital budget it was not now the highest priority project in which to invest. It was therefore agreed that the project should be cancelled and the allocated budget redistributed via the Trust's capital budgeting process. It was also agreed that the problem areas which were to have been resolved via the ACAD new build: endoscopy, central decontamination and day surgery would be reviewed in light of this decision and that a budget of approx £3m would be identified for a cosmetic remodelling and redecorating of the existing outpatient area.
- The EMB was assured that despite this decision the business change projects that are redesigning our outpatient clinics will continue and will be implemented within the existing space of the Outpatients Department, which it is now estimated will provide 80% of the benefits that would have been achieved from this work if the new ACAD had been built.

3. Recommendation

The Board of Directors is asked to endorse the EMB decision to cancel the ACAD building project.

Jonathan Gould March 2012

12/13 Contracting Update for Trust Board

Executive Summary

This paper discusses the benefits and risks of moving away from a cost and volume contract to a Jointly Managed Risk Agreement (JMRA) for 2012/13. The JMRA will set a financial envelope for 2012/13 based on 2011/12 outturn plus funding for an agreed level of growth. The key benefits of agreeing a financial envelope are; that HEFT will receive upfront funding for growth, that HEFT is now incentivised to mange demand, and that the financial risk of not achieving KPI targets will be contained. The key risk is that funding allows for 3% growth, and although there has been flat growth during last year and there are internal and external initiatives to contain growth further, the risk remains. This proposal requires a culture change in the organisation and recognises that it will have to be closely managed. Both the cost and volume approach and a Jointly Managed Risk Agreement carry a level of risk, however on balance it is recommended that the JMRA is used because it carries less uncertainty and risk for HEFT.

1. A change in contracting principles

Historically, to support the Nicholson challenge in the local health economy, commissioners and providers have used a contracting approach which results in there being a difference in expectations and objectives between the two.

Commissioners would expect providers to reduce activity as well as deliver the efficiencies in Tariff.

Providers however, would struggle to see how this could be delivered in a financially sustainable way, because a drop in income could not necessarily be offset by cost reduction on top of delivering the efficiencies in tariff. In reality though, the activity reductions have failed to materialise.

The table below, taken from the 2009 Financial Preparedness report submitted to Monitor in response the announcement of the Nicholson Challenge, shows the significance of the financial impact that was being projected.

Financial projections £m	10/11	11/12	12/13	**total**
Income reduction from reduced demand	-20	-30	-20	**-70**
Cost reduction due to falling demand (75% of Tariff)	15	22.5	15	**52.5**
Reduction in Tariff prices	-23	-32	-32	**-87**
Total reduction in resources	**28**	**39.5**	**37**	**104.5**

(Financial Preparedness – HEFT Trust Board – Sept 2009)

In turn, this had lead to protracted contracting and coding disputes throughout the year which have had to be resolved by a financial compromise having to be made right at the end of the year. Unfortunately, this approach increases uncertainty for commissioners and providers, which they typically mitigate by setting higher internal efficiency targets.

For 12/13, the proposal is to adopt contracting principles using a Jointly Managed Risk Agreement (JMRA) that aligns commissioner and provider objectives from the outset by agreeing the overall impact of the operating framework, PBR guidance and changes in demand for services across the local health economy. For the majority of the 12/13 contracts it is proposed that a JMRA is used to agree financial envelope, based on 11/12 outturn plus growth, and set up a jointly managed risk pool of funds to cover the risk of any issues arising during the contract period.

These proposed contracting principles represents a significant change in the approach for the Trust and the Cluster, and is not without risk. However, using the JMRA where possible, is considered less of a financial risk for organisations across the local health economy than continuing with the historical approach of cost and volume and disputes.

2. <u>Jointly Managed Risk Agreement (JMRA)</u>

The JMRA will fix the financial envelope for 12/13 based on 11/12 outturn plus growth. The growth will be determined by the 12/13 operating framework. The operating framework will reduce tariff by 1.5%, increase CQUIN payments by 1% and increase the funding to PCTs by 2.8%. With the JMRA the commissioners will use 1% of their 2.8% uplift to fund activity growth in HEFT.

12/13 Tariff reduction		-1.5%
CQUIN increase	1%	
PCT growth	1%	
Funding for activity growth		2%
Growth on 11/12 outturn		**0.5%**

The table above shows how the JMRA secures a 2% increase to fund activity growth, which offsets the tariff reduction of 1.5% to give a 0.5% growth on 11/12 outturn.

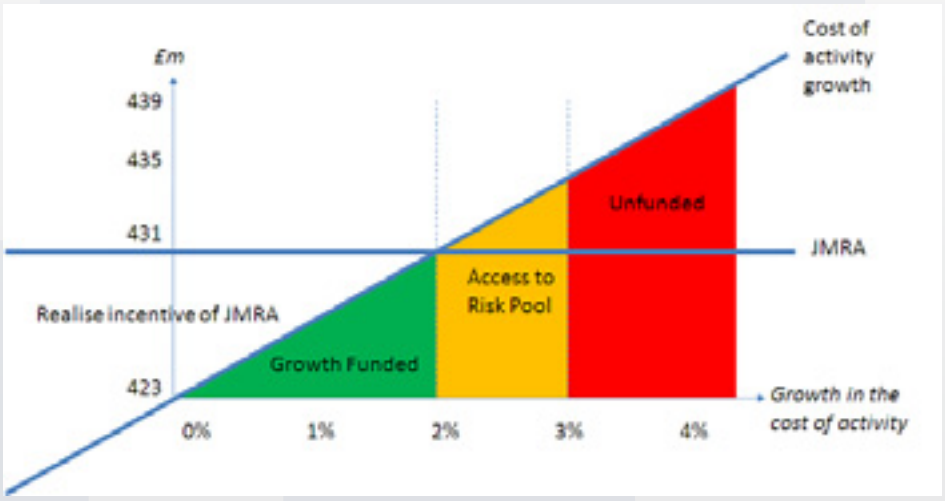
3. <u>JMRA benefits, risk and sensitivity</u>

The key benefits of the JMRA are that; HEFT is now incentivised to reduce activity because income will remain the same irrespective of how activity changes, the financial risk of not achieving performance targets is contained with a JMRA and finally, for the first time HEFT will receive funding for activity growth upfront.

The key risk of the JMRA for HEFT is that the cost of activity growth exceeds the financial envelope agreed with the commissioner. The graph below shows that the cost of activity growth in 12/13 can

be up to as much as 3% of the 11/12 financial outturn before the cost of growth becomes a financial risk.

The JMRA sets the financial envelope for 12/13 at £431m which includes 2% growth. If activity growth in 12/13 remains below 2%, HEFT will benefit from the financial envelope being fixed at £431m. If activity growth in 12/13 is between 2% and 3%, then HEFT will not benefit from having a fixed financial envelope and will look to access the risk pool to recover the cost of this activity. If activity growth is above 3%, it is unlikely that the cost of delivering growth above 3% will be funded.



4. Managing the risk of activity growth

In addition to several local health economy initiatives and several HEFT specific initiatives, shown in the table below, the overall trend of demand is supporting a reduction. It has been reducing since 8/9 down to a level of -1% in 11/12. This trend driven by a reduction in Emergency activity but also reflects our focus on initiatives such as reducing New to follow up rates, implementing the Policy for procedures of limited clinical value (PLCV) and having Geriatricians at the front door.

Additional measures to manage demand in 12/13 include....	
Across the Local Health economy	**Specific to HEFT**
Enhance the pathway to care for Frail Elderly	Increase the cover of Geriatricians at the Front door
Extend the RAID service	Early supported discharge eg. IV@home
Extend PLCV	Implement the Respiratory hub
Enhance the pathway for End of Life care	Move day case to out patient
Monthly performance monitoring at the Joint Clinical Contracting Group	Implement referral reporting at GP practice level, supported by HEFT Clinician intervention where outliers are identified
	All services to develop demand reduction plans to be managed as part of the CIP delivery process

5. Contracting summary

The table below shows that there will be 3 types of contract for 12/13: Jointly Managed Risk Agreement, Block, Cost and volume. Over 80% of income will be under a JMRA. The block contracts for Solihull Community and HOB sexual health will continue as Block and Specialise Services will continue as a cost and volume contract.

Commissioner	Contract type	12/13 £m est.	Funding Growth on 11/12
Cluster	JMRA	367	0.5%
12 Associate PCTS	JMRA	25	0% - 0.5%
South Staffs	JMRA	39	0% - 0.5%
Solihull Community	Block	28	-0.5% - 0%
HOB Sexual Health	Block	4	-0.5% - 0%
Specialised Services	Cost and Volume	66	-/+2%
Other	Cost and Volume	5	-/+2%
		534	**0.3+%**

6. Payment by results (PBR) continues

Although the proposal is to change the contracting principles for 12/13, PBR principles will continue to underpin contracting.

- The financial envelop has been determined using the operating framework and tariff rules.
- The standard NHS contract for acute services is being used to ensure contract management and that clear escalation procedures remain in place.
- The contract will include a full set of performance KPIs and CQUINS
- The risk pool provides a mechanism where HEFT can be financially penalised for not achieving contracted performance levels.
- Full financial reconciliations will be carried out each month to maintain transparency of activity and its value.

7. Conclusion

This type of contracting will create a culture shift in the organisation where the incentive is to reduce activity and start to manage an organisation with flat cash in the medium term.

There is no guarantee as to what will actually happen to activity in 2012/13 and even though this year looks to have demonstrated a drop from last year, quarter 4 activity seems to be growing again.

The decision is based on a balance of risk and the creation of a different relationship with our commissioners.

8. Recommendations

a. Detail communication plan in recognition of this culture change
b. Risk register to reflect the risk of growth and set aside funding in the 12/13 budget to cover the cost of any growth
c. All services/sites to develop demand reduction plans
d. Close scrutiny of activity growth and reductions at Finance and Performance Committee
e. Review the contracting approach at Month 6
f. Accept this contracting proposal

Board of Directors

March 2012

Reports from Board Committees

Donated Funds Committee Report (PHe)	(ORAL)
Finance and Performance Committee Report (RH)	(ORAL)
Finance and Performance Committee Minutes (301/12)(30/1/12)	(ENCLOSURE)
Governance and Risk Committee Report (AE / SW)	(ORAL)
HR Strategic Committee Report (PH)	(ORAL)
HR Strategic Committee Minutes (9/1/12)	(ENCLOSURE)
IM&T Committee Report (PHe)	(ORAL)
IM&T Committee Minutes (10/2/12)	(ENCLOSURE)
Monitor Standing Committee Minutes (30/1/12)	(ENCLOSURE)

.08

Minutes of the Finance & Performance Committee meeting held on 30th January 2012 at 09.00hrs, in Committee Room 2, Devon House at Heartlands Hospital

Present:	Mr Aresh Anwar	Medical Director	AA
	Mrs Hazel Gunter	Acting Director of HR and OD	HG
	Mr Richard Harris	Non Executive Director (Chair)	RH
	Lord Phillip Hunt	Chairman	PH
	Mr Adrian Stokes	Finance & Performance Director	AS
	Mr Richard Samuda	Non-executive Director	RS
In Attendance:	Mr Jonathan Gould	Finance Operations Director	JG
	Mrs Angeline Jones	Chief Financial Controller	AJ
	Mrs Sue King	Head of Performance	SK
	Mr Aidan Quinn	Deputy Finance Director	AQ
	Mrs Claire Walker	Executive Assistant (Minutes)	CW

1. APOLOGIES FOR ABSENCE — **ACTION**

Apologies were received from Mrs Sue Moore.

2. MINUTES OF THE MEETING HELD ON 19 DECEMBER 2011

The minutes of the meeting held on 19th December 2011 were accepted as a correct record and agreed.

3. MATTERS ARISING

No items were discussed under Matters Arising.

4. CURRENT MATTERS

4.1 Procurement Presentation (Pharmacy and Facilities)

Mr Dave Coley the Procurement Director and Mr Gurjinda Bhella the Head of Pharmacy attended the meeting to give a presentation around estates and pharmacy, Lord Hunt asked to review this at a future meeting in the new financial year. — **DC/BG**

A copy of the slides presented at the meeting are attached for information.

4.2 Write Off Schedules

Mrs Jones reassured members of the Committee that these debts had been rigorously chased and have proved difficult to recover. It was therefore agreed to write off the total of £71,673.16 to enable a tidy-up of the debtor's ledger.

4.3 Capital Planning Process

The paper summarised the capital planning process within the Trust, the Committee discussed this in detail and agreed the following budgets:

- Medical Equipment - £3m
- ICT - £3m
- Estates - £629k
- Contingency - £995k

Mr Harris asked Mr Stokes to come back to a future meeting with strategic estates capital after consideration of reshaping HEFT and the need to maintain some flexibility. **AS**

4.4 Treasury Management Minutes

The minutes of the Treasury Management Committee meeting held on 12th December 2011 were presented and were agreed.

4.5 Jointly Managed Risk Agreement for 2012/13

Mr Gould presented the paper and discussed the key benefits of increased certainty, supporting demand management and the development of a stronger long term relationship with commissioners.

The Committee also discussed the risks around growth and demand and the view of various external stakeholders.

Lord Hunt expressed the need to change culture within our Clinicians and Dr Anwar thought that this was a process that had already begun and would continue to be worked on throughout the next year.

The Committee were supportive of the approach, subject to residual risk around CQUIN and fines being resolved.

5 FINANCE POSITION UPDATE

5.1 Finance and Performance Directors Report Month 9

Mr Stokes presented the paper and the following points were noted:

- The December position was confirmed as a surplus of £2.7m
- New to follow up fines have been resolved in month leading to benefit in the December position.
- Pay controls are remaining strong but it is recognised that significant improvement is needed going into next year.

The Trust is still forecasting a likely surplus of £7m year end with only valuation and commissioner income being significant variables.

Mr Stokes described current budget setting process and agreed to discuss this more widely at next Finance & Performance Committee. **AS**

6 RECTIFICATION REPORTS

6.1 18 Weeks Update

Dr Anwar described the current approach to 18 weeks and acknowledged that whilst the Trust has stopped the rise in the back log we have yet to see a decrease. Dr Anwar recognised that the key object is to treat patients in sequence and would continue to update the Committee. **AA**

6.2 Maternity CQUIN Update

Dr Anwar agreed that he would keep a close eye on this area but the Committee recognised that this is predominantly a target around the recording of data.

7 AOB

There were no other items discussed under any other business.

DATE AND TIME OF THE NEXT MEETING

The next meeting is scheduled to take place on 27th February 2012 at 9.00am in Committee Room 2, Devon House, Heartlands Hospital.

.....
Chairman

.....
Dated

H R STRATEGY COMMITTEE

Minutes of the meeting held on Monday 9th January, 2012 at 9.30 am
In Committee Room 2, Devon House, Heartlands Hospital

PRESENT	Lord Philip Hunt (Chairman) Mrs. Lisa Thomson, Director of Corporate Affairs Dr. Aresh Anwar, Medical Director Mr. Richard Harris, Non Executive Director Mrs. Najma Hafeez, Non Executive Director
IN ATTENDANCE	Ms. Sara Brown, Head of OD and Work & Wellbeing Mrs. Margaret Ward (Minutes)

1. APOLOGIES

Apologies were received from Mrs. Hazel Gunter, Acting Director of HR & OD and Ms. Mandie Sunderland, Chief Nurse.

2. MINUTES OF THE MEETING HELD ON MONDAY 17TH OCTOBER 2011 AND ACTION POINTS

The minutes were agreed as a correct record, action points to be covered as agenda items.

3. TRUSTWIDE HR KPIs

Sara Brown presented the HR KPIs reported in November 2011 the majority being green with two showing red. Those reported as red are sickness year to date at 3.96% against a target of 3.94% and appraisal just below the 8,000 target.

The Chairman discussed the recent visit by Carol Black and the interesting debate in terms of more interaction with occupational health services to input into sickness absence, particularly being more proactive and offering support for front line supervisors to allow managers immediate referral of staff.

Sara Brown confirmed that Occupational Health has been rebranded in the last 12 months as Work & Wellbeing, the Department itself has to balance the occupation health service it delivers to staff alongside achieving its income target of £800K pa with a limited budget.

Sara is preparing a paper with a number of options on how we take the department forward.

The Chairman requested that proposals are brought to the next meeting for discussion and that it should also include comparisions of where the Trust sits with other Trusts.

Sara reported on a recent meeting she and Hazel Gunter had had with the CEO to move forward on the Health & Wellbeing agenda and discussions around taking a structured approach around staff engagement and wellbeing rather than just managing sickness absence.

Lisa Thompson suggested that a paper on these proposals is presented to the executive team at EMB as they will need to consider any financial implications and ensure it is tied into a business plan to balance costs against reduction in sickness absence, and that the HR Strategy Committee should have an opportunity to discuss the proposals.

In terms of other KPIs; the Chairman enquired about attendance of doctors at induction. It was confirmed that doctors who commence rotation in August (95%) go through a rigourous induction process both corporate and locally as well as at the Deanery, there are a number of doctors who start at odd times throughout the year and these doctors are dealt with adhoc.

An executive vacancy control panel is now in place which oversees all vacancies. This group has been set up to 'double check' requests to recruit and since this has been in place (September 2011) reductions have been seen in the pay bill. It was confirmed that although we are reviewing requests patient needs and safety rather than cost savings are a priority and that vital posts (i.e. B5 and B2 nursing staff) do not need to be considered through this additional control.

It was requested that for the next meeting a discussion should take place on proposed targets for 2012/13.

Sara Brown advised that the executive vacancy panel is setting the tone for stringent targets and we have to ensure we can maintain this for the future.

The Committee had a short discussion on the time to recruit, which stands at 11 weeks and has been improved as a result of the implementation of the electronic CRB checking system (previously 12-14 weeks). The aim is to get this as low as possible to ensure we are meeting vacancies and limiting the use of bank and agency staff to fill gaps. It was agreed to review the target for 2012/13 at the next meeting.

4. PAY AND REWARD

The Committee was advised that a report was submitted to EMB in December 2011 identifying a range of options for pay and reward. There were a number of key areas proposed and the EMB selected two to progress further:-

- Sickpay (requiring negotiations with staffside)
- Performance

The HR Strategy committee discussed the issue of pay and reward in terms of where HEFT would stand and what proposals might be put forward by the Government/NHS in terms of future pay arrangements.

Within the current system there is a view of unfairness in terms of performance/pay and underperforming staff not being managed well enough. We now have an opportunity to review this which will allow us to address these issues.

The Chairman advised that he would like the Board to be involved in this and reflect on where people think the NHS is going. A focus on pay and reward needs to address poor performance whilst rewarding excellent performance.

Sara Brown indicated that Hazel Gunter wanted to ensure HR Strategy Committee is aware of discussions taking place and the views of EMB. EMB will be making decisions on pay and performance in terms of reshaping HEFT and we will use this as an opportunity to get a high quality workforce in place. In addition it was noted that intiaitives have already started to reward staff by improving facilities and providing better equipment.

There has also been a discussion with the CEO around community staff and bringing them into line with the Trust. HEFT has an opportunity to make changes and become a leader in this.

5. APPRAISALS AND PERFORMANCE MANAGEMENT UPDATE

Sara Brown advised the Committee of key areas within the report on improving the performance culture. She advised that the report had been prepared following discussions with many staff groups including Operational Managers and Matrons the group had identified performance management as negative in some areas. It was important that the performance management culture includes how we approach people and provide feedback at appraisal.

The group picked out two priorities to be addressed:

- A complete review of recruitment and selection process, focusing on the establishment of a consistent approach to selection – core competency questions, clear scoring mechanisms and consistent methods for selection for each 'job family'.

- A review of the current appraisal system to include a more effective way of measuring performance, using some form of 'rating system so that the process is less subjective'. This will also be linked to the succession planning toolkit that has recently been distributed.

In addition further steps are underway to develop VITAL for Managers which will encompass technical skills; identification of leadership development for our future leaders; a focus on mentoring/coaching/secondment opportunities; and guidance for managers on the performance process.

The Committee were advised that the CEO and Board are keen to implement processes to ensure a shift from the 'blame culture' that has existed in some areas in the past. Lisa Thompson advised that historically there have been issues and this

has been used as a mechanism to kick back. The Board is clear on setting the standards expected from our employees. We have to ensure that our senior managers and leaders approach this in the right way and that we have prepared them to deal with this.

In addition, a review of HR policies will be undertaken to ensure processes are clear and precise. The Trust is looking to implement a mediation process before any grievances are made and reviewing the policy. Mediation can deal with many of the issues we currently have and may enable us to make savings in time and resources.

Najma Hafeez strongly supported this paper as a way forward, she felt that it was a transparent and clear process and will provide good support, guidance and standards for leaders and managers to follow.

The group supported the proposals and also suggested a review of contracts to ensure the Trust's expectations are clearly set out.

The Trust has to be clear from the outset at interview/job offer stage on its expectations and this has been achieved in the Step in to Work programme set up by the Faculty.

6. EMPLOYEE ENGAGEMENT

The HR Strategy Committee discussed the staff engagement results and proposals to have monthly engagement data. Sara Brown felt that providing the information monthly would not show any significant change and proposed that this be done either 6 monthly or annually.

Sara Brown reported that a focus group has met to identify core areas for development against the Trust's Leadership Charter which will include supporting Wellbeing and Engagement.

The Trust currently captures engagement annually through the national survey in which it can add 'local' engagement questions, however, the national survey is only sent to a sample 850 staff; and our return rate is around 45%. The local surveys we undertake are costly and as a result it has been suggested that we run our own local survey as the internal 'pulse' survey undertaken in 2010 gave us some good results in terms of response but does require managers to take ownership.

The recommendation is that we

- use the national survey to capture staff engagement annually by adding our local engagement questions;
- potentially run an additional Trustwide local survey every 3 years with a focus on engagement and wellbeing;
- every directorate undertakes a local survey twice yearly using a few core questions;
- work with 'hot spot' directorates to tackle their key issues which are impacting on stress and engagement levels;
- make engagement rates a key part of leaders/managers appraisal to ensure it is seen as a key priority.

7. SUCCESSION PLANNING

Sara Brown advised that the Trust has, in the past, employed an external organisation to do work on this process which has been costly. As a result a similar process has been developed internally along the lines of a '9 box' model for succession planning for Managers which will be linked into the appraisal process. Managers will be asked to assess staff using this model against performance, reports and ratings, and will allow them to plot where individual staff are in terms of performance and skill requirements.

Initially it is intended that this is undertaken by senior managers/leaders but there is no reason why it could not be used throughout the organisation. This process will allow us to corporately map leadership progression and identify gaps.

8. WORKFORCE PLANNING

The report presented at EMB was discussed at HR Strategy Committee.

Sara Brown advised that the purpose of workforce planning is to establish a 5 year forecast and allows us to identify any significant gaps and monitor any service changes. The report highlighted inconsistencies between the Trust's public workforce plan and the workforce plans produced during 2011. This related to a number of variances including creation of a top down workforce plan in 2010.

The report recommended a number of options including the necessity to bring workforce planning into the financial and business planning arena to ensure consistency. In addition there is a need to reach agreement on the Trust's stance in relation to the 2012 workforce plan submission to Birmingham & Solihull Cluster and NHS Midlands and East.

The workforce planning process should be driven and controlled by the budget setting process all senior managers should have input into the process for their specific areas. In terms of Medics numbers are Deanery led but all budget holders should play a part in the process. We have to ensure our service is fit for purpose.

In terms of inaccuracy of numbers the Trust has a turnover of around 400 staff pa which is managable.

By incorporating the process into business and financial planning we should be able to predict future workforce requirements.

The Chairman advised that the Board would be keen to be involved and informed of progress and that the Governors at some stage will need to see the report.

9. ANY OTHER BUSINESS

There was no further business to discuss.

10. DATE AND TIME OF NEXT MEETING

Monday 19th March, 2012. At 9.30 am in Committee Room 2, Devon House, BHH.

AGENDA
Apologies .01
Declaration of interest .02
Minutes from previous meeting .03
Matters Arising .04
Chairmans report .05
Chief Executives report .06
Quality and Performance Monitoring .07
Board Committee Reports .08
Trust News and External Environment .09
Governing Body and Membership .10
Corporate Governance .11
Any Other Business .12

H R STRATEGY COMMITTEE 9.1.12

Schedule of Matters Brought Forward and Action Points

Minute Date		Item	Who	When	Status	Completed
October 2011	.	Terms of Reference to be updated in line with discussions, i.e. item 7.2 to read "Shaping Employment Policy and Standards"	MW	Jan 2012	Done	
October 2011		• Performance Management update	HG	Jan 2012	Report submitted January 2012	
October 2011		• Pay and Rewards paper to be brought to HR Strategy Committee for discussion and debate	HG	Jan 2012	Discussion held 9.1.12	
October 2011		• Employee Engagement update and discussion in terms of actions from staff survey	HG	Jan 2012	Report submitted January 2012	
October 2011		• Workforce Planning and Role Change update progress	HG	Jan 2012	Report submitted January 2012	
January 2012		• Options paper for Occupational Health Services. Proposals brought to the next meeting for discussion and to be presented to EMB for discussion. • Review of income target for 2012/13	HG/SB Agenda MW	HR Strategy Committee March 2012 & EMB		
January 2012		• KPIs. Further discussion on KPIs and proposals for 2012/13 targets • Discussion about the target for 2012/13 for time to recruit	HG Agenda MW	HR Strategy Committee March 2012 & EMB		
January 2012		• Pay and Reward. Further update on ED proposals • Information on what other Trusts are planning in terms of pay and reward	HG Agenda MW	HR Strategy Committee March 2012 & EMB		
January 2012		• Workforce Planning. Board keen to be involved and informed on discussions/progress. • To be discussed with Governors at some point in the future.		HR Strategy Committee March 2012 & EMB		

IM&T Committee

Minutes of the meeting held on Friday February 10th 2012 at 11am, Bordesley House, BHH

PRESENT:

Paul Hensel	Non Executive Director (Chairman)	PH
Andy Laverick	Director of ICT/Chief Information Officer	AL
Sam Foster	Deputy Chief Nurse	SF
Alan Jones	Clinical Director	AJ

IN ATTENDANCE:

Winsome Annakie Notes

1.	**APOLOGIES** Aresh Anwar, Adrian Stokes	**ACTION**
2.	Notes from the last meeting were accepted as a true record.	
3.	**Capital 2012/13** AL updated the group on the current bids for next financial year (2012/13), against current £1million block. He highlighted major schemes that are on-going and that have been approved against this original £1million block. Increased investment is required and AL advised he hoped to secure a further £2 million. AL proposed approx. £1million should be made available to the Clinical IT Group, with spend subject to approval by AL and the IM&T Exec Committee, and other £1million to support ICT infrastructure, storage, servers, Citrix, etc.	
4. **a.**	**Clinical IT** <u>EPR- Concerto</u> AJ stated importance of clear communication strategy for deliverables. AL proposed a potential Concerto go live date of 1st April 2012, based around initial benefits of Single Sign On, Work lists, greater system integration, secure clinical messaging, central reporting and Theatre integration. Future features will include electronic Observations, Labs and EP integration which would support Decision Support, Alerts, Results sign	

	off, Notifications. Clinical IT Group will give direction on priorities of future features and the required changes in working practice.	**AJ**
b.	<u>Ward Pilot of Hardware/Software/Processes</u> ADT's(Admission-Discharge-Transfer) are important factor in any pilot. SF/AJ to be identify ward areas for pilot of additional hardware and assess impact of clinical processes to ensure efficient use of systems. SF has met with Phil Lyddon, Ali Bahron and Dave Hextell to look at roll out a plan and was due to meet with Phil Lydon and AJ to progress further.	**SF/AJ**
c.	<u>Medical Records Scanning</u> AL explained that ICT had met with a number of consultants individually and from the outcome of the meetings, there have been lots of progress. AL is arranging to meet with Roger Stedman to discuss plans for rationalisation of paper and indexing of 'skinny notes'. AL stated that no records have been destroyed yet but EDM are now proposing to commence destruction. AL showed the group a demonstration of the proposed new viewer. AL also added that colour scans of records were being assessed, with the plan to introduce soon, to aid consultant navigation of the scanned records.	**AL**
d.	<u>EP(Electronic Prescribing) Update</u> The paper to recommend the Trust assess the market place for a new EP system was agreed and will now go to the Clinical IT meeting, for discussion and review then forwarded to the Executive Management Board for approval.	**AL**
5. **a.**	**Trust Wide ICT update** <u>Community & GP</u> AL announced that Citrix will be available to Solihull Care Community by the end of February. AL also stated that he is working with a GP practice in Solihull for them to submit on line referrals directly to the Trust. This is in its early stages. AL will inform the group on progress. AL/PH discussed potential to bring in house the services currently delivered by an SLA held with the Cluster.	**AL**

b.	<u>New in patient system (ADT's, Waiting Lists, Clinical Coding, Theatres, PMS2 (Pathway Management System)</u> AL reported that work with the finance team in re-writing ADT modules, Clinical coding, Waiting Lists and Theatres was progressing, with an aim to replace current HISS functionality and offer greater reporting of In-Patient episode activity. ADT's are key to this and AL advised his developers are committed to completing their elements of the work by April 2012. Updates will be fed back to the Clinical IT group. AJ drew attention on how bar coding could possibly be used on the wards for ADT's. AL to review use of barcodes, but highlighted that it is important processes are also analysed to ensure timely ADT's.	**AL/AJ**
c.	<u>Nursing Initiatives</u> SF informed the group that the implementations of Patient Status at a Glance at screens are now installed at GHH and Solihull. The Jonah system and Patients Status at a Glance will be totally integrated applications to support nursing staff on the wards. AJ commented that Ann Keogh is keen to see the process for raising alerts. AJ suggested that alerts should appear on the Patient Status at Glance. SF agreed, but stated a risk assessment and a pilot needs to be done. Clinical IT Group to discuss alerts.	**SF** **AJ**
6.	**There was no AOB**	
7.	**DATE OF NEXT MEETING** **TBA**	

Minutes of a meeting of the STANDING COMMITTEE of the Board of Heart of England NHS Foundation Trust held in the Chairman's Office, Devon House, Heartlands Hospital on 30 January 2012

PRESENT:	Lord P Hunt	*(Chairman)*
	Mrs A East	
	Mr R Harris	
	Dr M Newbold	
	Mr A Stokes	
IN ATTENDANCE:	Mr M Pye	

12.1 APOLOGIES

There were no apologies.

12.2 MINUTES OF THE MEETING HELD ON 21 October 2011

The minutes of the meeting held on 21 October 2011 were approved by the Committee and signed by the Chairman.

12.3 SCHEDULE OF MATTERS BROUGHT FORWARD

There were no Matters Arising that would not be covered during the course of the meeting.

12.4 APPROVAL OF MONITOR QUARTER 3 RETURN

Mr Stokes confirmed that Monitor Q3 Return has been completed in accordance with the Compliance Framework.

The meeting reviewed in detail the papers circulated prior to the meeting.

The following points were noted

- The unadjusted Governance rating is red because of the overshoot on MRSA and CDiff year-to-date targets and some minor outstanding actions following a recent unannounced CQC visit but it was anticipated that Monitor would use its discretion to adjust to Amber/Red. This is essentially the same position as for Q2. Six cancer targets are still to be validated. No substantive issues were expected to be raised by Monitor. Mr Harris specifically raised the issue of the unadjusted red governance rating but Mr Stokes confirmed that this declaration was necessarily a direct consequence of the MRSA & CDiff targets. The meeting went on to consider the likely outturn for the full year and concluded that it was content with current progress. It was concluded that a Governance Declaration of 2 was appropriate.

- A financial risk rating (frr) of 3 was considered in light of the anticipated year end outturn of a surplus of £7m. This frr was approved, leading to a Financial Declaration of 1.

- The Action Plan following the CQC visit in August 2011 was reviewed but the outstanding items were considered to result from normal operational, day to day issues with none thought to be of major concern. Mr Stokes confirmed that all appropriate actions were being taken.

- A Quality Declaration of 1 was approved.

Following due consideration, the Committee approved the Q3 Return for immediate signature by either Dr Newbold or Mr Stokes and submission to Monitor.

12.5. ANY OTHER BUSINESS

The Company Secretary was asked to consider if this Committee's work might reasonably be incorporated into that of the Finance & Performance Committee.

12.6 DATE OF NEXT COMMITTEE MEETINGS

27 April 2012
27 July 2012
26 October 2012
28 January 2013

.....
Chairman

Board of Directors

March 2012

Trust News and External Environment

Communications Update (LT)	(ENCLOSURE)
Patient Engagement Report (LT)	(ENCLOSURE)

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Press coverage and evaluation | January 2012

Media report summary –January 2012

The Communications team generated **92** pieces of positive coverage in January; this is twenty three more than in December. Coverage included print, broadcast and online media, both regionally and nationally.

Key highlights included:

Come dine with me – patient meal experience events across all sites featured positively in Birmingham Mail, Sutton Coldfield Observer, and Solihull News along with several regional papers, helping to change the perception of hospital meals.

HIV consultant Steve Taylor featured as an expert on BRMB's evening programme, The Sanctuary, raising awareness of STDs and the importance of regular health checks.

Birmingham Mail, Solihull News and Solihull Observer covered the introduction of free stop-smoking clinics provided by Solihull Community Services.

The £1.1m facelift for Good Hope Hospital's special care baby unit appeared in the Birmingham Mail, Sutton Coldfield Observer and Coleshill, Atherstone and Tamworth Heralds.

Trade media, including the Guardian's Government Computing Blog, reported an innovative contract with the EDM group that will digitise the patients' records across the Trust.

Twitter highlights:

Trust's Twitter account reached **1,100** followers in January. @heartofengland has successfully supported the Patient Safety First campaign throughout the month featuring updates on iskills and 'come dine with us' - the patient meal experience.

Top tweets @heartofengland:

- Nutritious meals can also be tasty! Patient meal experience proved just that at **#Solihull** earlier today.
- Nutrition and hydration tip of the day: some foods also count as liquids-this includes soup, custard and jelly.
- **#Carers** UK are coming to Good Hope Hospital with free drop in sessions starting from today, join us from 2 till 4 every Tuesday on ward 24

Key highlights for trade press articles about the Trust during January included:

- The Guardian Government Computing Blog- *Heart of England Trust to digitise millions of patient records*

These calculations are industry standard and are used by the CIPR

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Press coverage and evaluation | January 2012

- Royal College of Midwives – *For the record (digitisation of records)*
- E-Health Insider - *Heart of England digitises records*
- The New England Journal of Medicine - *Lung Herniation after Cough-Induced Rupture of Intercostal Muscle*
- Hospital Imaging & Radiology Europe - *Good Hope Hospital upgrades ultrasound systems*

Health columns during January in the local press included:

- Asian Today, advice written by Dr Dyer, explaining the symptons of kidney disease.

Filming across the sites included:

- University of Birmingham- *Internal interview with Dr Kiri Elliot on diabetes and obesity.*
- Embarrassing Bodies- Filming *of colonoscopic polypectomy.*
- ITV Tonight programme- *The growing obesity epidemic- an interview with Dr Taheri, including a patient's case study.*

If the Trust were to purchase the positive print coverage for January as advertising space (AVE) it would cost **£146,595.**

The team issued press statements on **10** separate incidents/news stories throughout January.

These statements were around:

- Parking issues at Good Hope Hospital
- Medicines audit
- Stroke services at Solihull Hospital
- Cost of patient meals
- A ruling in the case of a TB patient - Ms Smith
- Mr Ian Paterson
- Flesh eating bug
- Gastric band operation cancellation
- Ambulance turn-around times

In total, the Trust received **20** pieces of negative coverage for the month.

These calculations are industry standard and are used by the CIPR

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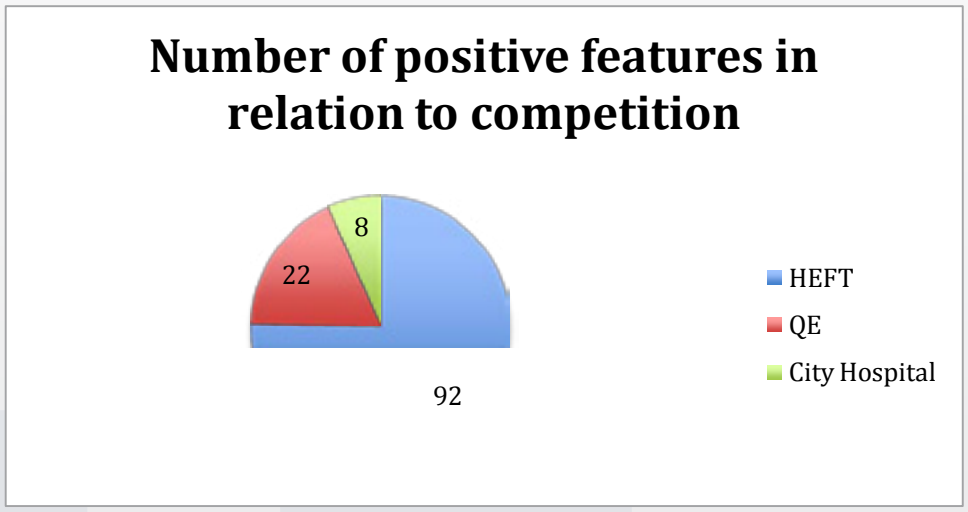
Press coverage and evaluation | January 2012

Compared to local competitors, University Hospitals Birmingham and City Hospital, the Trust received a higher proportion of positive local newspaper coverage.



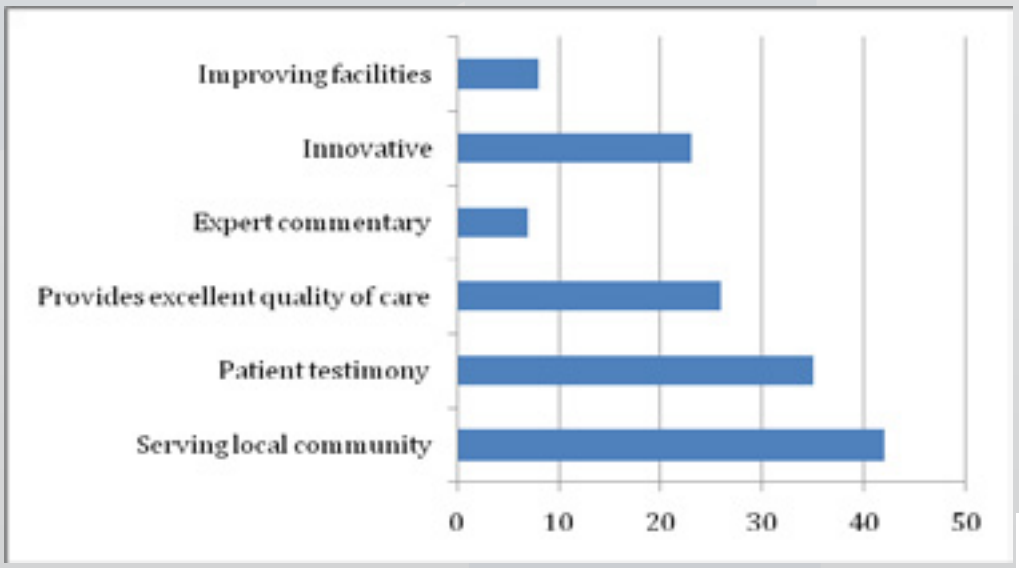
This chart was calculated using Precise and Meltwater media monitoring services.

The total opportunities to see (OTS) for newspaper, online and broadcast coverage - the number of people estimated to have read or seen the positive coverage for Heart of England is **12,201,051.**

To see all the coverage in detail, please see appendix 2**.**

Key Messages

The communications team aim to get at least one key message in every press release issued. This is to promote certain values that the Trust is associated with.



These calculations are industry standard and are used by the CIPR

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Press coverage and evaluation | January 2012

Appendix 1

Sutton Coldfield Observer – 20 January

Innovative dementia scheme to be rolled out at Good Hope

By Amy Bowen
News Reporter

A SERVICE aimed at A&E departments dealing with dementia patients and those with psychiatric needs is to be rolled out to Good Hope Hospital this month, saving hundreds of pounds.

The Rapid Assessment, Interface and Discharge (RAID) service will ensure that such patients will be assessed within an hour of arriving at A&E, or within 24 hours if on a ward, then referred on to the relevant service.

It is thought the introduction of RAID could save the hospital thousands of pounds a year, based on saving of £245 per bed day.

Professor George Tadros, a consultant in old age liaison psychiatry and lead clinician at Birmingham's City Hospital, helped develop the scheme.

He said: "This is excellent news for patients now that other major hospitals are following our lead, after seeing what we have achieved at City.

"It is exciting as RAID potentially could become a national model which has the ability to save the NHS a colossal amount of money by improving quality instead of cutting essential services.

A new scheme will be rolled at Good Hope will help people with dementia and psychiatric needs.

"RAID is an innovative mental health model which has significantly improved quality of care in acute hospital for patients with mental illness and alcohol problems and especially for older people with dementia."

The scheme was established in December 2009 and was the first service of its kind to work with an acute partner to improve patient outcomes, streamline care and, in the process, make significant savings to the public purse.

It was originally set up as an 18-month pilot scheme, but was extended in March 2011 after additional funds were secured from local commissioners to plug a £600,000 funding gap.

RAID will initially operate seven days a week between 8am and 8pm at Good Hope, but this is expected to become a round-the-clock service at the hospital later in the year.

These calculations are industry standard and are used by the CIPR

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Press coverage and evaluation | January 2012

Birmingham Mail – 21 January

Baby unit to get £1m upgrade

A Midland hospital's unit for babies needing special care is being given a £1.1million facelift.

Work at Good Hope Hospital in Sutton Coldfield is due to start on Wednesday.

An environment promoting family-centred care will be created that will provide much needed extra space for more cots.

The special care baby unit will move to a nearby ward in the hospital's Fothergill building. Danielle Lloyd, the fiancé of Wolves midfielder Jamie O'Hara, gave birth to second son Harry at the hospital last year.

Head nurse for children's services Jackie Edwards said: "This is an exciting project which will dramatically improve the facilities, helping us to continue to provide the best possible care for our tiny babies and their families."

These calculations are industry standard and are used by the CIPR

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Press coverage and evaluation | January 2012

Solihull Observer – 26 January

Maternity unit receives some welcome additions

VITAL equipment has been donated to the maternity unit at Solihull Hospital as part of a first wave of fund-raising.

Charity Baby Lifeline pledged to raise £250,000 to spend on maternity equipment for the Heartlands NHS Trust hospitals.

On Tuesday staff at the hospital were given the first equipment bought with funds raised through the campaign, which included £360 from Balsall Common Lions for a fetal Doppler - a device which monitors the unborn baby's heart rate.

Other equipment included 12 baby weighing scales which will be used in hospitals and the community.

Over 11,000 babies are delivered every year in the region and the charity is hoping to buy equipment ranging from hand-held fetal monitors to more complex hospital-based monitoring for both mothers and babies.

Judy Ledger, founder of Baby Lifeline, said she is delighted with the generosity shown by the Balsall Common Lions and is looking for more volunteers to get involved with the campaign.

Visit www.babylifeline.org.uk for more information.

Lord Phillip Hunt, chairman of Heart of England NHS Trust, Emma and Jude Harrison, Marie-Louise Marsden, president of Balsall Common Lions, and Judy Ledger, founder and chief executive of Baby Lifeline. 04.012.38.sol.nc1.

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Press coverage and evaluation | January 2012

Sutton Coldfield Observer – 27 January

Tasty hospital grub is what the doctor ordered at Good Hope

Food glorious food is not a term you always think of when hospitals are mentioned. CHRIS PHILPOTTS finds out if that is about to change

WHEN I was first asked to taste hospital food this week, I initially thought I was being threatened.

When it was explained to me that it would be for a feature for the *Herald*, I still did.

That is because, like school dinners and aeroplane food, hospital grub has a certain stigma attached to it.

But Good Hope Hospital is looking to change that.

So confident are they that – as part of a nutrition and dehydration awareness week – they have put their money where their mouth is, so to speak, and given the stuff away.

And on Tuesday I was invited to the Rectory Road site to try it out for myself.

Anne O'Brien, head of catering at the hospital, explained: "We tackle what is needed in terms of nutrients, with a quality which means the patient enjoys it."

One of the first things I noticed was the choice on offer: shepherd's pie, liver and onions, curry, vegetables, crumbles... more than I could ever have imagined.

But then again, living up as part of a three-week cycle in terms of menu, there had to be.

For Anne, aiming for quality as well as quantity is what it is all about.

"Our menus are worked out between the dietetic department and ourselves," she said. "After that it is up to us to create the dishes that meet the required nutrients, sugars etc.

"We are in communication with the nurses and the dietetic departments to ensure we are giving the patients what they need.

"And I can say I'm proud of the job we do when it comes to the food we produce.

"We want the food to be nice for the patients to eat, and we are confident to say to people 'come and have a taste'."

She added: "This is not the only time we do this type of thing.

"For us it is important to show that hospital food is not like the reputation."

With that endorsement, I could not wait to get tucked in and see what the fuss was about.

A healthy portion of shepherd's pie and creamy mashed potato was my choice.

After only a few mouthfuls I knew something was wrong, not in terms of what I was eating, but in terms of what I had been told.

Fine dining it was not, but passable for sale it was, providing a tasty meal that left me feeling full.

And for Ruth Spealding, one of the corporate nurses at Good Hope, that is just the kind of thing they are looking for.

She said: "There is a lot of hearsay about the quality of hospital food and all we are trying to do is show people what we are providing.

"Nothing that was prepared and given away on the day is any different to what is given to patients on the ward."

Good Hope may not be a five-star, celebrity-endorsed Michelin restaurant, but it certainly provides patients with all the nutritional and tasty goodness they need to see them well on the road to recovery.

And that's definitely what the doctor ordered.

Chris samples the food.

Catering manager Ann O'Brien with the food selection.

These calculations are industry standard and are used by the CIPR

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Press coverage and evaluation | January 2012

Great Barr Observer- 27 January

Hospital's scheme to digitalise patient files 'will increase security'

By Nick Horner
News Reporter

A MULTI-MILLION pound scheme to digitise patients' medical records at Good Hope Hospital will increase security and reduce costs, the health trust assured this week.

The Heart of England NHS Foundation Trust has signed a £7 million contract with EDM Group to digitise 360 million archive images and thousands of daily files over a five-year period.

The files will be tracked, transported, captured and scanned by the information management firm which is using a large team of trained "preparation staff".

State-of-the-art software and scanners are used to capture the medical records with the info and transferred on to HEFT's secure system which allows authorised clinicians instant access.

Andy Laverick, IT director for Heart of England NHS Foundation Trust, said: "As one of the largest Trusts in England, the digitisation of records is part of our ongoing commitment to drive up standards, putting patient care and safety at the heart of everything we do.

"Not only will using this system enhance the overall efficiency of the Trust, it will also help to reduce costs and increase the security of our patient files."

Documents will be collected daily from Good Hope, Heartlands and Solihull hospitals, with barcodes on packs of files to help pinpoint their location.

With urgent admissions there will be a rapid response service where records are retrieved and scanned and made accessible within two hours if the need arises.

Sam Ferguson, CEO of EDM Group, said: "The company has vast experience of working with NHS Trusts so we are therefore delighted to be awarded this contract.

"We believe our success was, in part, due to our capacity to meet the time scale as well as the quality of our solution which addressed all compliance issues at a competitive cost."

Patient records at Good Hope are being digitalised.

These calculations are industry standard and are used by the CIPR

Finding a Way
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Appendix 2

Evaluation - January 2012

Trust Wide coverage

POSITIVE COVERAGE

Date	Publication	Article	AVE	Circulation	OTS
05/01/2012	Birmingham Mail	Steven talks at support group	£340	48,660	145,980
13/01/2012	Solihull News	Walk and toddle set to raise health trust cash	£980	84,602	253,806
17/01/2012	The Business Desk	Healthy contract win for EDM	£450		
17/01/2012	Insider News Midlands	EDM Group wins £7m NHS deal	£846		
17/01/2012	Birmingham Post	EDM Group wins £7m NHS contract to digitise patients' records	£560	11,935	35,805
17/01/2012	The Guardian (Technology blog)	Heart of England trust to digitise millions of patient records	£15,340	262,937	788,811
18/01/2012	Public Technology	Heart of England makes big digitisation push	£50		
18/01/2012	I4U News	Heart of England NHS begins massive digitisation plan	£100		
17/01/2012	Midlands Business Week	The Heart of England NHS Foundation Trust Signs £7 Million Contract with EDM Group	£27		
18/01/2012	PJ Online	Trajenta looks set to buck renal trend	£50		
25/01/2012	Birmingham Mail	Baby wards in appeal boost	£530	48,660	145,980

These calculations are industry – standard and are used by the CIPR

Press coverage and evaluation | January 2012

27/01/2012	Solihull Observer	Baby lifeline	£640	53,796	161,388
19/01/2012	NewsRx	Research on Heart Attack Reported by Scientists at Heart of England NHS Foundation Trust	£187	11,849	35,546
20/01/2012	Express&Star	EDM wins patients contract worth £7m	£104	12,548	37,644
21/01/2012	Royal College of Midwives	For the record	£1,904	49,000	147,000
26/01/2012	E-Health Insider	Heart of England digitises records	£128		
27/01/2012	Great Barr Observer	Hospital's scheme to digitalise patient files will increase security	£325	25,276	75,828
		Total	£22,561	609,263	1,827,788

NEGATIVE COVERAGE

Date	Publication	Article
06/01/2012	Birmingham Mail	138 miss out in hospital bed rush
14/01/2012	Birmingham Mail	Breast cancer mum tells of surgery ordeal
06/01/2012	Birmingham Mail	Hospitals still hit by bed blocking problem
20/01/2012	Solihull News	Cleavage sparing surgery won't spare Sharon's pain
21/01/2012	Birmingham Mail	City stroke units facing downscale
23/01/2012	Birmingham Mail	A&E Delay crisis could cost lives
23/01/2012	Birmingham Mail	Patients do not need words- they need sorting
31/01/2012	Daily Mail	Bedsores now kill hundreds of patients on NHS wards every year..
30/01/2012	Birmingham Mail	This was her last chance. Without op, she could die.

These calculations are industry – standard and are used by the CIPR

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Press coverage and evaluation | January 2012

19/01/2012	Solihull Observer	Cancer patient's anger at surgery
27/01/2012	Orange news	UK Hospitals Breach Drug Storage Security
27/01/2012	Real Radio	UK Hospitals Breach Drug Storage Security
27/01/2012	Sky News	Drugs Security: Hospitals Named And Shamed
30/01/2012	Daily Mail	They're playing with my life': 25-stone woman fears she will die after gastric bypass op is cancelled for the second time
01/01/2012	Daily Mail	NHS loses billions over the no-show patients

These calculations are industry – standard and are used by the CIPR

Heartlands coverage

POSITIVE COVERAGE

Date	Publication	Article	AVE	Circulation	OTS
02/01/2012	Birmingham Mail	Sam's bundle of New Year's Joy	£5,400	48,660	145,980
03/01/2012	Birmingham Mail	My problem wasn't getting pregnant… I just couldn't stay pregnant	£7,894	48,660	145,980
06/01/2012	Solihull News	Samuel's a New Year surprise	£980	84,602	253,806
07/01/2012	Birmingham Mail	Desert bug is eating brave troops	£9,080	48,660	145,980
14/01/2012	Birmingham Mail	Hospital Plan	£540	48,660	145,980
03/01/2012	Birmingham Mail	Woman on miscarriage trial in Birmingham celebrates birth of baby	£10,230	48,660	145,980
11/01/2012	Bromsgrove Advertiser	Wheely good effort by students	£200		
11/01/2012	Redditch Advertiser	Wheely good effort by students	£200		
19/01/2012	BRMB- The Sanctuary	Steve Taylor on STD's	20,480	52,000	156,000
27/01/2012	Solihull News	Store donates trees to women's unit	£566	84,602	253,806
27/01/2012	Birmingham Mail	Just what the doctor ordered?	£8,760	48,660	145,980
27/01/2012	Birmingham Mail	Thanks to Heartlands (letter)	£530	48,660	145,980
29/01/2012	Sunday Mercury	Deadly TB Bug could hit UK	£560	43,610	130,830
19/01/2012	BBC News	Blood bikers Midlands Freewheelers appeal for	£8,978		135,000

These calculations are industry – standard and are used by the CIPR

		volunteers		45,000	
25/01/2012	Coventry Telegraph	Supermarket staff set for charity swim	£473	35,180	105,540
27/01/2012	Express&Star (Sandwell)	Demand puts team on the road to bigger things	£206	12,548	37,644
27/01/2012	Express&Star (Wolverhampton)	Demand puts team on the road to bigger things	£199	30,226	90,678
27/01/2012	Express&Star (Dudley)	Demand puts team on the road to bigger things	£106	58,676	176,028
		Total	£75,382	787,064	2,361,192

NEGATIVE COVERAGE

Date	Publication	Article
24/01/2012	Birmignham Mail	As soon as I had the epidural I knew something was wrong. I lost all feeling on one side of my body..
30/01/2012	Birmignham Mail	Gran's death sentence after op Is canelled
27/01/2012	Daily Mail	Don't worry, it's just tennis elbow! Woman falls into coma and almost dies after doctors fail to spot flesh-eating bug

MISC COVERAGE

Date	Publication	Article
18/01/2012	Birmingham Mail	£60,000 fine after driver breaks neck

These calculations are industry – standard and are used by the CIPR

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Good Hope coverage

POSITIVE COVERAGE

Date	Publication	Article	AVE	Circulation	OTS
05/01/2012	Tamworth Herald	Doctor highlights walk-in to reduce waiting times at A&E	£870	9,996	29,988
05/01/2012	Tamworth Herald	Double dose of thanks are due	£230	9,996	29,988
05/01/2012	Tamworth Herald	Babies make start of year perfect for new parents	£1,320	9,996	29,988
05/01/2012	Tamworth Herald	George family 'thrilled' as Thomas Michael enters world for 2012	£980	9,996	29,988
11/01/2012	Birmingham Mail	Who is mysterious Good Hope angel?	£8,900	48,660	145,980
06/01/2012	Sutton Coldfield Observer	Help swell bra banks to back cancer cause	£300	51,008	153,024
06/01/2012	Sutton Coldfield Observer	Ex-reporter makes delightful news	£560	51,008	153,024
06/01/2012	Sutton Coldfield Observer	Breast Friends say thanks	£130	51,008	153,024
01/01/2012	Journal Magazine	What is bugging you?	£2,140	28,381	85,143
13/01/2012	Sutton Coldfield Observer	Think Twice	£450	51,008	153,024
13/01/2012	Sutton Coldfield Observer	Caring for the carers	£190	51,008	153,024
13/01/2012	Sutton Coldfield Observer	Sponsored walk to help Good Hope patients	£540	51,008	153,024

These calculations are industry – standard and are used by the CIPR

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05/01/2012	The New England Journal pf Medicine	Lung Herniation after Cough-Induced Rupture of Intercostal Muscle	£1,200	18,000	54,000
06/01/2012	Sutton Coldfield Observer	Ex-Villa boss is knighted for charity dedication	£640	51,008	153,024
13/01/2012	Tamworth Herald	Help is at hand to care for the carers	£430	9,996	29,988
21/01/2012	Birmingham Mail	Revamp for baby care unit	£760	48,660	145,980
20/01/2012	Sutton Coldfield Observer	Good Hope to host skin sessions	£130	51,008	153,024
20/01/2012	Sutton Coldfield Observer	Innovative dementia scheme to be rolled out at Good Hope	£625	51,008	153,024
20/01/2012	Sutton Coldfield Observer	Monthly meeting to help with breathing	£60	51,008	153,024
20/01/2012	Sutton Coldfield Observer	Plan to digitise Good Hope medical records 'safer and cheaper'	£349	51,008	153,024
27/01/2012	Sutton Coldfield Observer	Million-pound baby unit revamp will help town's tiniest residents	£389	51,008	153,024
26/01/2012	Tamworth Herald	Questions answered on skin conditions	£82	9,996	29,988
26/01/2012	Tamworth Herald	Rapid assessment speeds into operation at Good Hope	£173	9,996	29,988
26/01/2012	Tamworth Herald	Extra space to care for newborn babies	£102	9,996	29,988
26/01/2012	Tamworth Herald	Tasty hospital grub is what the doctor ordered at Good Hope	£1,395	9,996	29,988
19/01/2012	Lichfield Mercury	New dementia treatment at Good Hope	£261	35,180	105,540
21/01/2012	BBC WM	Good Hope parking debate	£12,450	280,000	840,000
21/01/2012	Express&Star	Baby unit to make £1m upgrage	£250		90,678

These calculations are industry – standard and are used by the CIPR

				30,226	
26/01/2012	Coleshill Herald	Questions answered on skin conditions	£61	23,238	69,714
26/01/2012	Coleshill Herald	Rapid assessment speeds into operation at Good Hope	£136	23,238	69,714
26/01/2012	Coleshill Herald	Extra space to care for newborn babies	£79	23,238	69,714
26/01/2012	Coleshill Herald	Tasty hospital grub is what the doctor ordered at Good Hope	£1,187	23,238	69,714
26/01/2012	Atherstone Herald	Questions answered on skin conditions	£61	23,238	69,714
26/01/2012	Atherstone Herald	Rapid assessment speeds into operation at Good Hope	£153	23,238	69,714
26/01/2012	Atherstone Herald	Extra space to care for newborn babies	£77	23,238	69,714
26/01/2012	Atherstone Herald	Tasty hospital grub is what the doctor ordered at Good Hope	£1,204	23,238	69,714
27/01/2012	Hospital Imaging & Radiology Europe	Good Hope Hospital upgrades ultrasound systems	£221		
27/01/2012	PharmiWeb	Good Hope Hospital chooses SonoSite's M-Turbo	£90	7,803	23,410
31/01/2012	Tamworth Blog	Baby Lifeline appeal tips the scales	£200		
27/01/2012	Sutton Coldfield Observer	Tasty hospital grub is what the doctor ordered at Good Hope	£659	51,008	153,024
27/01/2012	Sutton Coldfield Observer	Former Good Hope nurse is all heart	£600	51,008	153,024
27/01/2012	Great Barr Observer	Tasty hospital grub is what the doctor ordered at Good Hope	£803	25,276	75,828
		Total	£41,437	1,512,166	4,536,499

These calculations are industry – standard and are used by the CIPR

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Press coverage and evaluation | January 2012

NEGATIVE COVERAGE

Date	Publication	Article
27/01/2012	Sutton Coldfield Observer	Hospital staff parking in nearby side streets angers local residents

MISC COVERAGE

Date	Publication	Article
04/01/2012	Birmingham Mail	Lichfield dad tells how baby son died on his first day at nursery
06/01/2012	Daily Mail	The woman who coughed OUT her own lung: 40-year-old's violent hacking caused hernia to burst through her rib cage

These calculations are industry – standard and are used by the CIPR

Press coverage and evaluation | January 2012

Solihull coverage

POSITIVE COVERAGE

Date	Publication	Article	AVE	Circulation	OTS
06/01/2012	Solihull News	Don't go to A&E if it isn't an emergency	£980	84,602	253,806
06/01/2012	Solihull News	Screening extended	£540	84,602	253,806
06/01/2012	Solihull News	Doctors fly out to fight blindness	£129	84,602	253,806
06/01/2012	Solihull News	Counting the cost of diabetes	£234	84,602	253,806
13/01/2012	Solihull News	Drinkers totally unaware of strengh of alcohol	£940	84,602	253,806
20/01/2012	Solihull News	Put the patients before paperwork	£340	84,602	253,806
20/01/2012	Solihull News	X-PERT diabetes advice available	£863	84,602	253,806
20/01/2012	Solihull News	Brilliant care	£250	84,602	253,806
20/01/2012	Solihull News	Dedicated staff	£250	84,602	253,806
12/01/2012	Solihull Observer	Put your best foot forward for charity walk	£136	53,796	161,388
21/01/2012	Birmingham Mail	Smokers free quitting clinic	£487	48,660	145,980
27/01/2012	Solihull Observer	Stop smoking clinic	£234	53,796	161,388
27/01/2012	Birmingham Mail	Kind Donations	£760	48,660	145,980
27/01/2012	Solihull News	Meal costs defended	£271	84,602	253,806
19/01/2012	Solihull Observer	Team to speed up mental health care	£159	53,796	161,388
26/01/2012	Solihull Observer	Maternity unit receives some welcome additions	£642	53,796	161,388
		Total	£7,215	1,158,524	3,475,572

NEGATIVE COVERAGE

Date	Publication	Article
07/01/2012	Mail Online	Save a breast, or a woman's life? It's a simple choice,' says breast cancer surgeon Lester Barr

These calculations are industry – standard and are used by the CIPR

Press coverage and evaluation | January 2012

These calculations are industry – standard and are used by the CIPR

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AGENDA	Apologies .01	Declaration of interest .02	Minutes from previous meeting .03	Matters Arising .04	Chairmans report .05	Chief Executives report .06	Quality and Performance Monitoring .07	Board Committee Reports .08	Trust News and External Environment .09	Governing Body and Membership .10	Corporate Governance .11	Any Other Business .12

PATIENT ENGAGEMENT REPORT FEBRUARY 2012

AGENDA .1
Apologies .01
Declaration of interest .02
Minutes from previous meeting .03
Matters Arising .04
Chairmans report .05
Chief Executives report .06
Quality and Performance Monitoring .07
Board Committee Reports .08
Trust News and External Environment .09
Governing Body and Membership .10
Corporate Governance .11
Any Other Business .12
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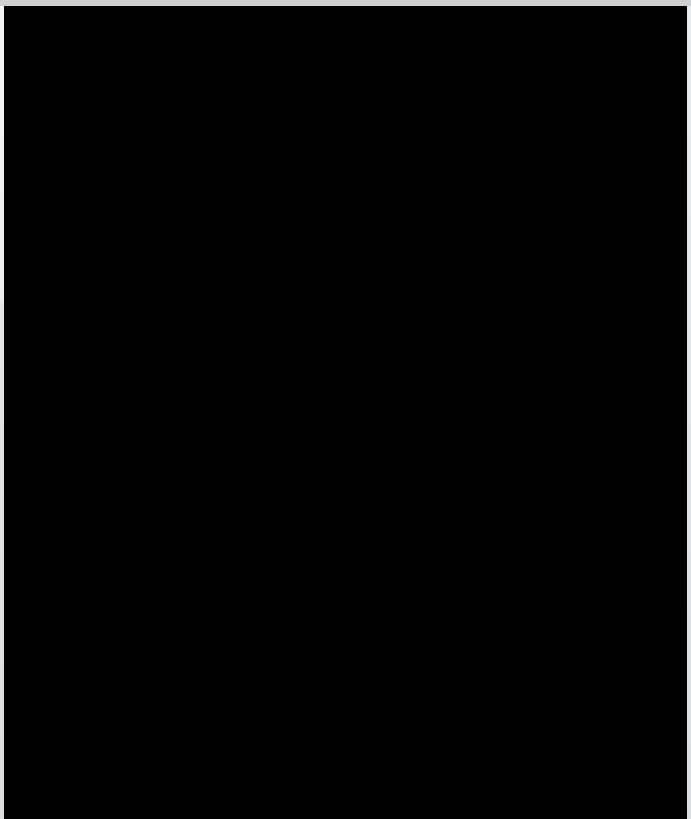
EXECUTIVE SUMMARY

- 98% of inpatient wards areas were surveyed in January 2012 (614 patients and 10 visitors)
- All of the CQUIN targets were met in January 2012
- Improvement in the majority of A&E (patient metrics) measures
- January complaints most common themes were **clinical care, nursing care** and **communication / information problem**
- ***Patient metrics threshold will increase in March 2012 to align with nursing metrics**

JANUARY COMPLIANTS



PATIENT METRICS SUMMARY

Overall Satisfaction	YTD
BHH	90%
GHH	92%
SOL	89%
Gp1	89%
Gp2	91%
Gp3	88%
Gp4	93%
Gp5	86%
Inpatient	91%
AE	82%
Renal	88%
Therapies	93%
Elderly	90%
Acute Med	88%
Cardiology	89%
T&O	92%
Gen Surg	91%
Resp	92%

High Ward Satisfaction	Score
BHH - Radiology	98%
GHH - Radiology	97%
GHH AMU	96%
BHH 26 - Respiratory	96%
SOL 15 - T&O	96%
GHH 24 - Elderly Care	95%
BHH 28 - Infectious Diseases	95%
BHH 14 - Paeds	95%

Low Ward Satisfaction	Score
GHH - A&E	85%
BHH - NNU	85%
BHH Dialysis Unit	84%
BHH - Phlebotomy	83%
BHH - A&E	80%
BHH - Aspen	79%
GHH - NNU	74%
SOL - A&E	72%

Inpatient Experience Risks	
Call buzzer	88%
Discharge date	51%

TRUSTWIDE: NHS CHOICES & PATIENT OPINION FEEDBACK

January Online Summary

- 13 stories
- 7 positive, 3 negative
- 4 stories - mixture of positive and negative

- YTD: 112 patients rated the hospital (60% Would recommend hospital)

What was Good?

Treatment Centre modern and comfortable
Your staff, particularly one doctor was excellent (A&E)
Thanks to Nurses on Ward 1
Ward 12 staff were lovely and friendly
Staff efficient and polite (Ophthalmology)
Received top quality care (Maxillofacial Dept)
Staff on day of my labour were very nice

What could be improved?

Seating in waiting area for CT scans cramped and intrusive
Patient called in Treatment Centre but couldn't hear
Gridlock in visitor car park on 16 January
Toilets in main entrance unclean
Not enough eye drops prescribed following surgery
Not given antibiotics doctor wanted patients to have (A&E)

METRICS SUMMARY TABLES

Inpatient Ward Summary	Apr-11	May-11	Jun-11	Jul-11	Aug-11	Sep-11	Oct-11	Nov-11	Dec-11	Jan-12
Did staff wash or clean their hands between touching patients?	96%	95%	98%	97%	98%	99%	98%	97%	98%	99%
Do you feel informed about potential medication side effects?	77%	80%	85%	90%	91%	90%	90%	87%	90%	94%
Do you feel involved in decisions about treatment/care?	84%	87%	89%	89%	90%	91%	91%	90%	90%	93%
Have you been treated with respect and dignity?	95%	96%	97%	98%	98%	98%	99%	97%	98%	99%
Have you had enough privacy discussing treatment?	92%	93%	94%	94%	95%	95%	96%	94%	95%	97%
Do you get enough help from staff with eating your meals?	96%	97%	98%	98%	98%	99%	99%	90%	99%	99%
Do you think staff do everything they can to control you pain?	91%	94%	95%	95%	96%	98%	97%	96%	96%	98%
Has a patient of the opposite sex slept in this area overnight?	96%	98%	99%	99%	98%	99%	99%	99%	99%	100%
Have staff been around to discuss concerns or worries?	88%	90%	93%	94%	96%	96%	96%	96%	96%	99%
Have staff talked to you about going home?	40%	39%	46%	42%	58%	50%	54%	52%	51%	51%
How clean is the ward (including toilets)?	94%	95%	96%	97%	97%	97%	98%	96%	97%	97%
If you use the call buzzer is it answered promptly?	78%	84%	85%	85%	83%	86%	88%	85%	86%	88%
Did nurses/midwives regularly check patients?										
Would you recommend this hospital to family or friends?	96%	97%	98%	98%	98%	99%	98%	98%	97%	99%
Overall Month	86%	88%	90%	90%	92%	93%	92%	90%	91%	93%
% of wards surveyed	**94%**	**98%**	**97%**	**95%**	**91%**	**91%**	**92%**	**92%**	**97%**	

Key:			
Patient Experience Metrics	0% -79%	80% - 89%	90% - 100%
Nursing Metrics	0% – 84%	85% - 94%	95% - 100%
CQUIN questions			

Inpatient CQUIN (Commission Quality and Innovation Targets)	Apr-11	May-11	Jun-11	Jul-11	Aug-11	Sep-11	Oct-11	Nov-11	Dec-11	Jan-12
Involved in decisions about your treatment	84%	87%	89%	89%	90%	91%	91%	90%	90%	93%
Able to discuss worries with staff	88%	90%	93%	94%	96%	96%	96%	96%	96%	99%
Given enough privacy discussing treatment	92%	93%	94%	94%	95%	95%	96%	94%	95%	97%
Told about side effects of medication	77%	80%	85%	90%	91%	90%	90%	87%	90%	94%

Accident & Emergency	Apr-11	May-11	Jun-11	Jul-11	Aug-11	Sep-11	Oct-11	Nov-11	Dec-11	Jan-12
Did staff wash or clean their hands between touching patients?	100%	92%	87%	92%	95%	91%	89%	77%	84%	84%
Staff were polite, courteous and professional	83%	100%	92%	87%	87%	95%	88%	94%	84%	90%
Feel involved in decisions about assessment, treatment/care?	83%	80%	78%	83%	85%	88%	81%	82%	78%	85%
Have you been treated with respect and dignity?	83%	90%	92%	85%	87%	95%	84%	87%	83%	89%
Have you had enough privacy discussing treatment?	67%	60%	60%	50%	54%	54%	59%	56%	53%	59%
Did hospital staff do everything to help control your pain?	83%	80%	80%	78%	87%	80%	77%	72%	81%	70%
Staff been available to talk to about any worries / concerns?	83%	80%	70%	74%	83%	84%	81%	77%	79%	85%
Staff talked to you about your discharge from hospital?	100%	30%	66%	72%	72%	72%	69%	74%	74%	75%
Been given information about any medication?	100%	100%	82%	85%	88%	85%	81%	78%	84%	84%
How clean is the ward (including toilets)?	80%	86%	74%	83%	89%	86%	84%	82%	82%	84%
How would you rate your overall visit to A&E (ED)?	80%	86%	74%	77%	81%	85%	78%	75%	75%	78%
When you asked for assistance was this given?	100%	100%	82%	79%	93%	95%	83%	87%	82%	79%
What was your experience of reception in A&E?	90%	80%	76%	82%	79%	80%	79%	75%	77%	81%
Would you recommend this hospital to family or friends?	100%	100%	96%	83%	93%	86%	91%	90%	86%	87%
TOTAL	88%	83%	79%	79%	84%	84%	80%	79%	78%	81%

Renal Dialysis Units	Apr-11	May-11	Jun-11	Jul-11	Aug-11	Sep-11	Oct-11	Nov-11	Dec-11	Jan-12
Staff wash/clean hands between touching patients	88%	100%		97%	97%			100%	100%	96%
Felt reassured by staff when receiving your treatment	90%	90%		100%	93%			100%	100%	93%
Involved in decisions about your treatment and care	80%	83%		70%	77%			87%	100%	79%
Treated with respect and dignity	97%	93%		100%	80%			97%	100%	93%
Well informed about side effects of treatment (inc' dialysis)	80%	87%		60%	67%			73%	93%	79%
Staff do everything they can to help control your pain	93%	97%		100%	77%			97%	100%	86%
Staff available to talk about any worries or concerns	93%	100%		87%	77%			97%	100%	82%
Cleanliness of Dialysis Unit (including toilets)	86%	94%		90%	79%			84%	87%	71%
Enough privacy discussing your condition or treatment	80%	67%		63%	70%			93%	89%	75%
When you use the call buzzer is it answered?	85%	83%		83%	81%			88%	100%	83%
Would you recommend this hospital to family or friends?	93%	100%		100%	80%			80%	86%	86%
TOTAL	88%	90%		87%	80%			91%	96%	84%

Therapies Summary	Jun-11	Jul-11	Aug-11	Sep-11	Oct-11	Nov-11	Dec-11	Jan-12
Informed next steps in your care/going home	69%	73%	80%	83%	78%	68%	44%	64%
Informed next steps in care/continuing treatment	94%	85%	81%	89%	90%	82%	92%	59%
Therapist wash/clean their hands between patients	93%	94%	100%	94%	90%	94%	100%	97%
Therapist explained treatment they were providing	95%	90%	97%	94%	92%	97%	97%	96%
Involved in decisions about your therapy	89%	81%	96%	94%	90%	90%	93%	91%
Treated with respect and dignity	98%	97%	99%	98%	96%	98%	99%	97%
Enough privacy discussing your condition / treatment	94%	90%	93%	92%	91%	92%	97%	97%
Able to talk about worries / concerns	87%	85%	94%	82%	84%	89%	96%	93%
Satisfied with the referral length of time	92%	92%	92%	93%	89%	89%	93%	92%
Therapist checked you had pain relief	88%	90%	85%	87%	89%	93%	85%	94%
Would recommend this hospital for therapy	98%	100%	100%	100%	99%	99%	97%	100%
TOTAL	92%	89%	93%	92%	90%	91%	94%	91%

Nursing Metrics	Apr-11	May-11	Jun-11	Jul-11	Aug-11	Sep-11	Oct-11	Nov-11	Dec-11	Jan-12
Medication Storage and Custody	91%	94%	93%	90%	94%	96%	97%	98%	97%	97%
Infection Control and Privacy & Dignity	94%	93%	94%	95%	93%	95%	95%	94%	95%	94%
Patient Observations	91%	91%	91%	91%	93%	93%	91%	92%	92%	92%
Pain Management	96%	96%	94%	95%	96%	96%	95%	97%	98%	96%
Tissue Viability	93%	91%	93%	92%	93%	94%	92%	94%	91%	93%
Nutritional Assessment	89%	91%	91%	89%	92%	91%	90%	92%	89%	93%
Falls Assessment	92%	90%	92%	92%	95%	96%	93%	95%	93%	94%
Continence Assessment	87%	86%	91%	90%	91%	93%	89%	94%	91%	93%
Diabetes	76%	75%	81%	86%	81%	83%	77%	87%	87%	88%
TOTAL	**92%**	**91%**	**92%**	**92%**	**93%**	**94%**	**92%**	**94%**	**93%**	**94%**

Key:			
Patient Experience Metrics	0% -79%	80% - 89%	90% - 100%
Nursing Metrics	0% – 84%	85% - 94%	95% - 100%
CQUIN questions			

PATIENT METRICS GROUP TABLES

Group 1 (Emergency Medicine)	Apr-11	May-11	Jun-11	Jul-11	Aug-11	Sep-11	Oct-11	Nov-11	Dec-11	Jan-12	№	Nurse Metric
BHH 2 - Elderly Medicine	75%	82%	86%	80%	84%	93%	94%	85%	91%	95%	*11*	97%
BHH 3 - Renal	74%	85%	91%	88%	90%	92%	95%	90%	92%	93%	*5*	97%
BHH 6 - CCU	82%	81%	88%	87%	93%	89%	97%	87%	87%	94%	*12*	91%
BHH 8 - Acute Med	82%	76%	81%	90%	94%	91%	90%	83%	88%	93%	*14*	92%
BHH 9 – Acute Med	82%	82%	83%	80%	93%	91%	91%	76%	91%	94%	*12*	89%
BHH 20 - Acute Med	84%		94%	93%	91%	94%	96%	93%	92%	93%	*15*	88%
BHH 21 - Elderly Care	78%	73%	83%	92%	92%	93%	83%	92%	100%		*0*	94%
BHH 22 - Elderly Care	77%	79%	80%	93%	89%	93%	93%		91%	92%	*5*	
BHH 23 - Elderly Care	91%	91%	92%	94%	91%	89%	93%	94%	93%	93%	*12*	93%
BHH 30 - Elderly Care	88%	90%	93%	92%	91%	91%	92%	90%	91%	91%	*15*	96%
BHH - A&E	91%		72%	78%	76%	80%	80%	77%	78%	80%	*53*	
GHH 24 - Elderly Care	91%	94%	90%			89%	94%	93%	95%	95%	*16*	96%
GHH 10 - Elderly Care	91%	92%	93%	89%	91%	92%	92%	92%	93%	90%	*15*	89%
GHH 11 - Elderly Care	90%	94%	94%	92%	92%	93%	83%	94%	94%	93%	*16*	93%
GHH 17 - Acute Med	93%	92%	94%	93%	93%	94%	94%	92%	93%	91%	*15*	96%
GHH 18 - Acute Med	93%	92%	94%	94%	93%	93%	94%	92%	91%	93%	*15*	95%
GHH 9 - Elderly Care	89%	91%	92%	91%	95%	92%	91%	88%	92%	94%	*13*	92%
GHH AMU	89%	91%	93%	93%	89%	92%	92%	92%	92%	96%	*15*	96%
GHH 23 CCU - Cardiology	92%	90%	94%	92%	95%	94%	92%	93%	94%	94%	*15*	98%
GHH 26 – (was SNU)	89%	92%	90%	91%	84%	91%	90%	91%	89%	92%	*15*	88%
GHH - A&E			88%		97%	88%	81%			85%	*7*	
SOL 8 - Elderly Care	82%	90%	83%		100%	91%	93%	88%	93%	95%	*9*	85%
SOL 17 - (Cardiology & CCU*)	82%	84%	89%	85%	81%	91%	91%	88%	92%	94%	*8*	91%
SOL 18 - Acute Med	75%	81%	81%	76%	91%	88%	91%	91%	93%	92%	*12*	97%
SOL AMU – Acute Med	74%	84%	92%	90%	89%	93%	94%	93%	88%	94%	*15*	95%
SOL AMU SSU		84%	79%	84%	90%	89%		84%	74%	86%	*9*	93%
SOL 20A - Acute Med	79%	76%	91%		92%	88%	93%	86%	90%	95%	*5*	93%
SOL 12 - Elderly Care	77%	79%	80%	93%	89%	93%	93%	91%	89%	93%	*14*	0%
SOL - A&E	84%	81%	82%	83%	80%	83%	76%	87%	80%	72%	*2*	
Therapies			92%	89%	93%	92%	90%	91%	94%	92%	*64*	
Total (Group 1)	***84%***	***86%***	***88%***	***89%***	***90%***	***91%***	***91%***	***89%***	***90%***	***92%***	***85%***	***89%***

Key:			
Patient Experience Metrics	0% -79%	80% - 89%	90% - 100%
Nursing Metrics	0% – 84%	85% - 94%	95% - 100%
*Area not included in metrics programme			

Group 2 (Planned Inpatient Care)	Apr-11	May-11	Jun-11	Jul-11	Aug-11	Sep-11	Oct-11	Nov-11	Dec-11	Jan-12	№	Nurse Metric
BHH Rowan - T&O	90%	91%	92%	91%	91%	92%	95%	91%	94%	92%	*15*	98%
BHH Beech - T&O	90%	94%	92%	91%	90%	92%	92%	92%	91%	91%	*15*	96%
BHH 4 - Thoracic	85%	87%	82%	94%	94%	93%	92%	89%	93%	91%	*16*	90%
BHH 10 - Urology	86%	77%	91%	93%	96%	95%	96%	92%	93%	91%	*14*	99%
BHH 11 - General Surgery	93%	90%	92%	93%	96%	92%	94%	92%	95%	92%	*19*	95%
BHH 12 - General Surgery	74%	91%	81%	90%	91%	86%	88%	81%	85%	92%	*14*	94%
BHH 19 - Oncology	85%	84%	90%	94%	91%	92%	98%	87%	93%	95%	*6*	94%
BHH 24 - Respiratory	91%	93%	94%	94%	92%	93%	95%	90%	91%	92%	*15*	89%
BHH 26 - Respiratory			0.92	95%	92%	93%	92%	96%	90%	96%	*15*	94%
GHH 7 - General Surgery	94%	94%	93%	93%	94%	93%	93%	93%	94%	91%	*15*	98%
GHH 8 - Respiratory	92%	91%	93%	94%	93%	93%	93%	95%	94%	94%	*16*	98%
GHH 14 - T&O	88%	95%	94%	95%	93%	92%	93%	92%	94%	93%	*15*	95%
GHH 15 - T&O	91%	88%	94%	91%	93%	94%	93%	89%	90%	92%	*15*	99%
GHH 16 – Gen Surgery	92%	91%	92%	93%	91%	93%	91%	92%	94%	94%	*15*	98%
SOL 14 - General Surgery	84%	89%	91%	88%		97%	95%	97%	93%	94%	*14*	96%
SOL 15 - T&O	88%	84%	95%	84%	91%	92%	94%	96%	95%	96%	*15*	95%
SOL 19 – Respiratory	82%	89%	91%	80%	88%	93%	89%	91%	93%	93%	*11*	93%
Total (Group 2)	***88%***	***89%***	***91%***	***91%***	***92%***	***93%***	***93%***	***91%***	***92%***	***93%***	***96%***	***95%***

Group 3 (Ambulatory Care)	Apr-11	May-11	Jun-11	Jul-11	Aug-11	Sep-11	Oct-11	Nov-11	Dec-11	Jan-12	№	Nurse Metric
BHH 5 - ENT			84%	86%	94%	89%	90%	89%	94%	97%	*14*	97%
BHH Outpatients												
SOL Outpatients												
BHH Diabetes												
BHH ENT OPD												
BHH Dialysis Unit	88%	90%		87%	80%			91%	96%	84%	*14*	
BHH Ophthalmology												
GHH Ophthalmology												
SOL Ophthalmology												
SOL Rheumatology												
SOL Dermatology												
Total (Group 3)	***88%***	***90%***	***84%***	***87%***	***87%***	***89%***	***90%***	***90%***	***95%***	***91%***	***17%***	***97%***

Key:			
Patient Experience Metrics	0% -79%	80% - 89%	90% - 100%
Nursing Metrics	0% – 84%	85% - 94%	95% - 100%
*Area not included in metrics programme			

Group 4 (Clinical Support)	Apr-11	May-11	Jun-11	Jul-11	Aug-11	Sep-11	Oct-11	Nov-11	Dec-11	Jan-12	№	Nursing Metrics
BHH 27 - Infectious Diseases	93%	94%	92%	92%	93%	92%	94%	93%	95%	94%	*5*	95%
BHH 28 - Infectious Diseases	86%	90%	93%	91%	92%	94%	95%	96%	94%	95%	*15*	91%
BHH - Phlebotomy	96%	94%	82%	84%	97%	90%	83%	80%	94%	83%	*18*	
GHH - Phlebotomy	99%	97%	90%	97%	97%	98%	98%				*0*	
SOL - Phlebotomy	86%	86%	96%	93%	91%	93%	94%		96%	94%	*13*	
BHH - Radiology	92%	94%	95%	96%	95%	98%	98%	97%	99%	98%	*15*	
GHH - Radiology	94%	97%	97%	98%	95%			94%	99%	97%	*15*	
SOL - Radiology	92%	91%	91%	87%	93%	99%	89%	96%	95%	98%	*14*	
Total (Group 4)	***92%***	***93%***	***92%***	***92%***	***94%***	***95%***	***93%***	***93%***	***96%***	***94%***	***79%***	***93%***

Group 5 (Women's & Children's)	Apr-11	May-11	Jun-11	Jul-11	Aug-11	Sep-11	Oct-11	Nov-11	Dec-11	Jan-12	№	Nurse Metric
GHH - Antenatal												96%
BHH -Antenatal												61%
SOL - Antenatal												80%
BHH - NNU			81%		95%	95%	89%		94%	85%	*2*	97%
GHH - NNU			86%	81%	88%	88%		88%	93%	74%	*9*	97%
BHH 14 - Paeds	81%	81%	91%	83%	82%	82%	92%	92%	87%	95%	*15*	97%
BHH - Aspen								93%		79%	*30*	97%
BHH - Cedar												86%
BHH - Maple												91%
GHH 4 – Maternity												98%
GHH 5 - Maternity												99%
GHH 2 - Gynaecology	78%				71%	71%	91%	97%	91%		*0*	
BHH 1 - Gynaecology					84%	84%	85%	91%	96%	96%	*10*	98%
Total (Group 5)	***80%***	***81%***	***86%***	***82%***	***84%***	***84%***	***89%***	***92%***	***92%***	***86%***	***34%***	***91%***

METRICS COVERAGE TABLE

The table below details total of patient and nursing metrics for this financial year. The grey shaded area shows the total number of respondents surveyed; the second table shows the patient and visitor total for last three months.

Measure	Apr-11	May-11	Jun-11	Jul-11	Aug-11	Sep-11	Oct-11	Nov-11	Dec-11	Jan-12	Total (YTD)
Metrics : Care Indicators	507	556	519	537	523	524	492	508	479		4645
Metrics : Care Ind's- Assurance	12	10	11	10	3	2	2	1		0	51
Metrics : Care Ind's - Critical Care	12	9	11	9	10	12	8	9	10	3	93
Metrics : Care Ind's - Discharge	18	137	29	27	164	26	6	141	6	6	560
Metrics : Care Ind's - Endoscopy	21	31	50	11	40	30	30	30	31	32	306
Metrics : Care Ind's - Neonatal	20	20	20	20	20	18	20	20	20	20	198
Metrics : Care Ind's - OPD	31	35	34	42	23	55	10	57	30	30	347
Metrics : Care Ind's - Paeds	29	32	31	43	37	29	26	27	26	29	309
Metrics : Care Ind's - Theatres	19	19	30	30	30	29	21	29	20	30	257
Metrics : Patient Experience	634	659	704	630	652	645	623	639	642	587	6415
Metrics : Patient Exp – A&E	3	5	25	23	27	28	90	39	58	62	360
Metrics : Patient Exp - Day Unit											0
Metrics : Patient Exp - OPD			10								10
Metrics : Patient Exp - Phleb	50	48	45	37	54	59	51	20	52	31	447
Grand Total	**1356**	**1561**	**1519**	**1419**	**1583**	**1457**	**1379**	**1520**	**1374**	**830**	**13998**

Inpatient metrics analysed by patient visitor count	Sep-11		Oct-11		Nov-11		Dec-11		Jan-12	
	Patient	Visitor	Patient	Visitor	Patient	Visitor	Patient	Visitor	Patient	Visitor
Metrics: Patient Experience	673	5	648	7	663	10	672	9	614	10
Total	678		655		673		681		624	

PATIENT QUALITY INITIALTIVES (PQI)

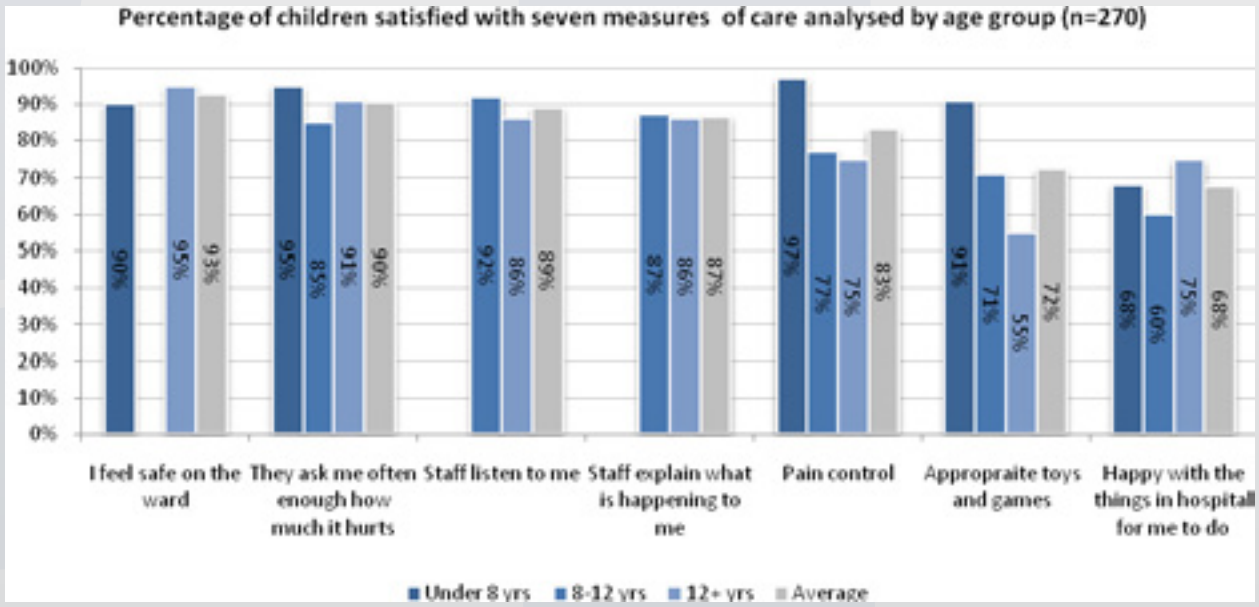
The table below shows areas that have reported quality initiatives to improve patient experience since August 2011. All are featured in detail each month and staff are encouraged to share all changes/service improvements made as a result of patient feedback / concerns in the future.

August 2011	September 2011	October 2011
Ward 24 (GH) Emergency Department Diabetes Centre (BHH)		Ward 21 (BHH) Ward 24 (GHH)
November 2011	**December 2011**	**January 2012**
Gynaecology (BHH)	AEU (GHH) Outpatients (SOL) Cardiac Rehabilitation (BHH & SOL)	

PAEDIATRICS SURVEY 2011-2012

This is a short summary of the results of an on-line Paediatrics survey at Heart of England Foundation Trust (HEFT). The National Patient Toolkit (NPT) designed a unique, hand held survey tool which uses animated questionnaires incorporating the character Fabio the Frog® to capture the opinions and experiences of children and young people.

Four wards at Heartlands hospital **(Wards 14, 15, 16 and PHDU)** and one ward at Good Hope **(Harvey Ward)** took part in the programme. Participation was entirely voluntary. In total, 270 children and young people took part in the study and gave feedback about their experiences between May 2011 and January 2012.



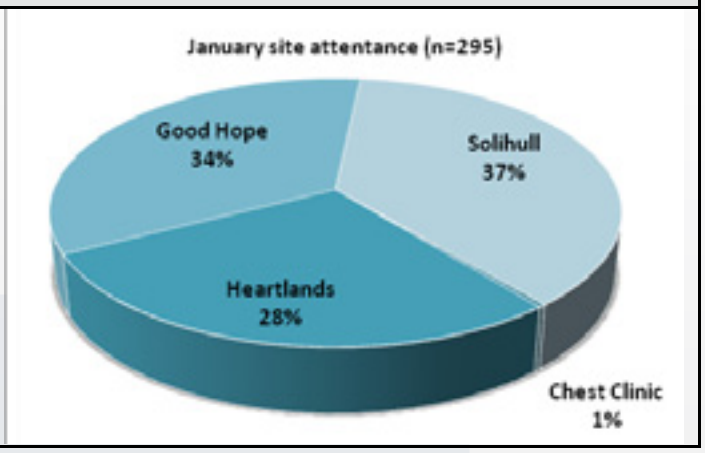
- 9 in 10 children 'felt safe' on the ward
- 9 in 10 were happy with the way staff communicate
- 3 in 10 children were not happy with the things to do in hospital
- 1 in 4 patients were not satisfied with pain control
- 1 in 2 young people (12+ years) were not satisfied with toys and games

The department intend to collect data on a monthly basis using Fabio which will be incorporated into the patient metrics programme; once a methodology has been agreed by the Clinical Director / Matrons and their teams.

OUTPATIENTS WEEKLY SURVEY

Each month the Survey Team send out 800 surveys to a random selection of outpatients who have been cared for at one of HEFTs hospitals.

Outpatient Survey Demographics			
Survey Month	**Respondent Count**	**Specialty Count**	
Nov	103	*Department*	*n*
Dec	239	Cardiology	98
Jan	295	Dermatology	82
Feb		Gynaecology	58
Mar		Ophthalmology	158
Apr		Orthopaedics	132
May		Urology	76
Total	**637**	**Total**	**604**



Five questions about appointments, waiting times and overall care have been selected to report each month. The two tables below show monthly data for each question and overall results for each speciality. Cardiology, Dermatology, Gynaecology, Ophthalmology, Orthopaedics and Urology will be sent questionnaires until April 2012, after this period another six specialties will be selected for feedback.

Outpatient weekly survey	***Target***	**Nov-11**	**Dec-11**	**Jan-12**	**Feb-12**	**Mar-12**	**Apr-12**
Would rate appointment letter as 'good'	*80%*	82%	78%	79%			
Outpatient appointment unchanged by hospital	*90%*	78%	80%	82%			
Waited 15 mins or less for appointment	*90%*	66%	72%	67%			
Waited 20 mins or less for medication	*90%*	66%	67%	46%			
Overall would rate care as 'excellent' or 'good'	*90%*	96%	92%	94%			

YTD results analysed by speciality	**App'nt letter**	**Appoint unchanged by hospital**	**Appoint waiting (<15 mins)**	**Pharmacy waiting**	**Overall care**
Cardiology	80%	73%	73%	56%	95%
Dermatology	91%	86%	85%	37%	99%
Gynaecology	81%	93%	59%	70%	98%
Ophthalmology	76%	71%	62%	60%	92%
Orthopaedics	73%	82%	66%	52%	88%
Urology	88%	91%	73%	73%	97%
Target	*80%*	*90%*	*90%*	*90%*	*90%*

NHS CHOICES & PATIENT OPINION WEBSITES

The NHS Choices and Patient Opinion websites allow Trust users and visitors to post their feedback on-line. In total 13 patients/visitors gave feedback during January 2012. Trust wide 62% of respondents said they would recommend the hospital. The tables below give a summary of activity on each site during January 2012. A full copy of the report is available from Catherine Williams (Patient Engagement Office & Project Manager).

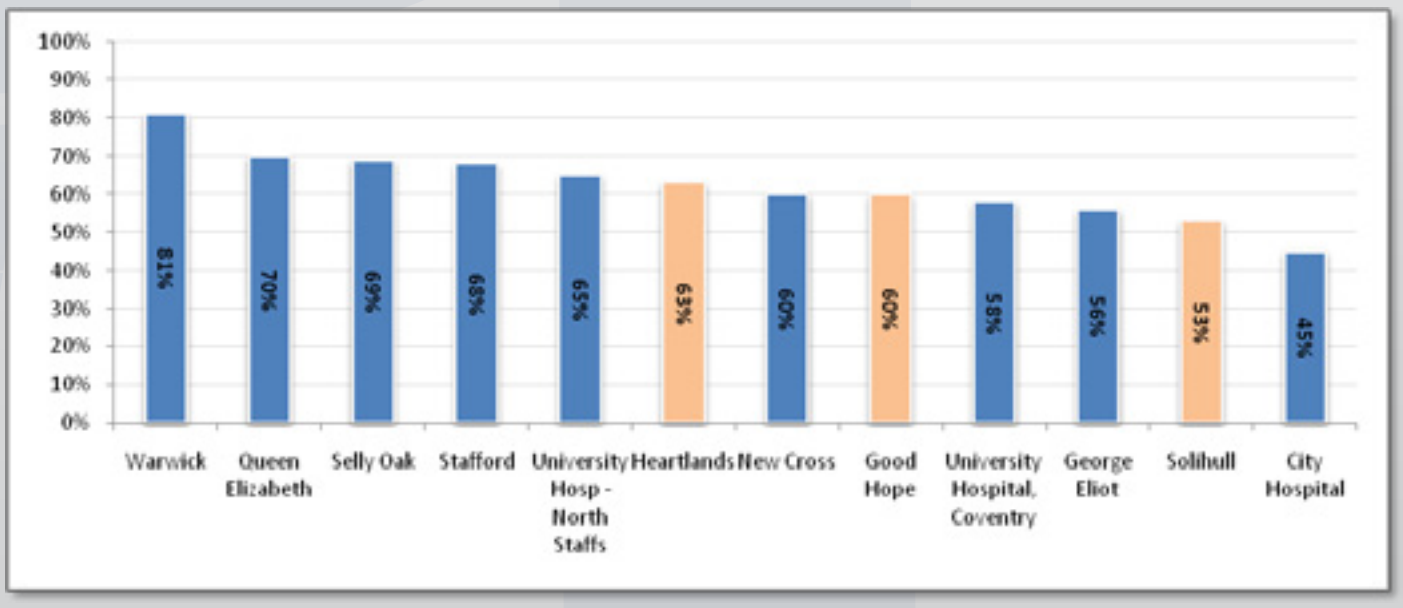
Heartlands: NHS Choices & Patient Opinion Feedback	Good Hope: NHS Choices & Patient Opinion Feedback	Solihull: NHS Choices & Patient Opinion Feedback
• 4 stories • 2 positive, 1 negative • 2 mixture of positive and negative • 31 patients rated the hospital • 64% Recommend hospital	• 4 stories • 2 positive • 2 - mixture of positive and negative • 66 patients rated the hospital • 62% Recommend hospital	• 5 stories • 3 positive, 2 negative • 15 patients rated the hospital • 53% Recommend hospital
Some of the comments include:	**Some of the comments include:**	**Some of the comments include:**
What was Good?	**What was Good?**	**What was Good?**
Thanks to Nurses on Ward 1 Ward 12 staff were lovely and friendly	Treatment Centre modern and comfortable Your staff, particularly one doctor was excellent (A&E)	Staff efficient and polite (Ophthalmology) Received top quality care (Maxillofacial Dept) Staff on day of my labour were very nice
What could be improved?	**What could be improved?**	**What could be improved?**
Gridlock in visitor car park on 16 January Toilets in main entrance unclean	Seating in waiting area for CT scans cramped and intrusive Patient called in Treatment Centre but couldn't hear	Not enough eye drops prescribed following surgery Not given antibiotics doctor wanted patients to have (A&E)

NHS Choices Comparison with Local Trusts

The table below shows each local NHS Trust and how many patient/visitors have rated the hospital to date and out of those how many would recommend the hospital to a friend or relative. This information has been taken from the NHS Choices Website.

Hospital	No. of patients/visitors who would recommend hospital to a friend or relative	Percentage who would recommend the hospital
Warwick	39 out of 48	81%
Queen Elizabeth	12 out of 17	70%
Selly Oak	9 out of 13	69%
Stafford	30 out of 44	68%
University Hosp - North Staffs	19 out of 29	65%
Heartlands	**19 out of 30**	**63%**
New Cross	17 out of 28	60%
Good Hope	**39 out of 64**	**60%**
University Hospital, Coventry	20 out of 34	58%
George Eliot	9 out of 16	56%
Solihull	**8 out of 15**	**53%**
City Hospital	9 out of 20	45%

The graph below shows the percentage of patients/visitors who have rated local NHS Trusts to date who would recommend the hospital to friends or family.



COMPLAINTS SUMMARY

The table below provides a summary of all 56 formal complaints received during January 2011. These have been itemised by clinical group and specialty. The top five themes for January include:

- **Clinical Care**
- **Nursing Care**
- **Communication problem / information problem**
- **Staff Attitude**

January complaints for clinical group analysed by theme	Number
Group 1: Emergency Services	**14**
All aspects of clinical treatment	2
Buzzer - slow/no response	1
Decision regarding treatment	1
Delay/Cancellation – OPD appointment	1
Information/communication - verbal	1
Lack of assistance with hygiene needs	1
Misdiagnosis	1
Nutrition assessment/care	1
Patient dignity - general	1
Patient fall and fracture	1
Problem with discharge	1
Query over medication	1
Rudeness of staff	1
Group 2: Planned Inpatient Care	**29**
All aspects of clinical treatment	21
Buzzer - out of reach	1
Information/communication - written	4
Other	1
Pain assessment/care	1
Patient observations	1
Group 3: Ambulatory Care	**1**
Complication of surgery	1
Group 4: Clinical Support	1
All aspects of clinical treatment	1
Group 5: Women & Children	**10**
All aspects of clinical treatment	9
Rough handling	1
Solihull Community Services	1
All aspects of clinical treatment	1
Grand Total	**56**

January complaints for clinical group analysed by specialty	Number
Group 1: Emergency Services	**14**
Accident and Emergency	2
Acute Medicine - Heartlands Hospital	5
Cardiology	2
Elderly	5
Group 2: Planned Inpatient Care	**29**
Gastroenterology	2
General Surgery	17
Respiratory Medicine	2
Trauma and Orthopaedics	6
Urology	2
Group 3: Ambulatory Care	**1**
Ophthalmology	1
Group 4: Clinical Support	1
Infectious Diseases	1
Group 5: Women & Children	**10**
Gynaecology	3
Neonatal	1
Obstetrics	3
Paediatrics	3
Solihull Community Services	**1**
Child Health	1
Grand Total	**56**

APPENDIX

Complaints data table

ID	Clin. Group	Specialty	Location (exact)	Description	Subject (primary)	Sub-subject (primary)	Unit
9949	Group 1: Emergency Services	Acute Medicine - Heartlands Hospital	Heartlands Ward 20 (AMU)	Concerns regarding treatment on Ward 20 prior to her death on ITU.	Clinical care	Decision regarding treatment	BHH
9990	Group 2: Planned Inpatient Care	General Surgery	Operating Theatre (General)	CSM	Clinical care	All aspects of clinical treatment	SH
9841	Group 2: Planned Inpatient Care	Trauma and Orthopaedics	Operating Theatre (General)	Patient had a TKR in May 2008 and suffered pain for years afterwards.	Clinical care	All aspects of clinical treatment	GHH
9912	Group 5: Women & Children	Paediatrics	Heartlands Ward 16	Parents have raised several areas of concern regarding the medical treatment and nursing care of their son, together with issues surrounding staff attitude and lack of communication. please note 'media interest' - 13.2.12	Clinical care	All aspects of clinical treatment	BHH
10003	Group 1: Emergency Services	Elderly	Good Hope Ward 10	Concerns regarding condition in which the patient was discharged. She was subsequently admitted to Walsall Manor Hospital + diagnosed with MRSA.	Admission, discharge and transfer arrangements	Problem with discharge	GHH
9927	Group 2: Planned Inpatient Care	General Surgery	Operating Theatre (General)	Breast complaint	Clinical care	All aspects of clinical treatment	SH
9886	Group 2: Planned Inpatient Care	Trauma and Orthopaedics	Main Outpatients Department	Patient not happy with the consultants attitude and she is still experiencing pain in her hand	Staff attitude	Other	GHH
9885	Group 1: Emergency Services	Acute Medicine - Heartlands Hospital	Heartlands Ward 08 (Acute Medicine)	Concerns regarding alleged poor standard of nursing care on Ward 8 at BHH	Nursing Care	Buzzer - slow/no response	BHH
9896	Group 5: Women & Children	Gynaecology	Operating Theatre (General)	Patient was left with retained products for 34 months	Clinical care	All aspects of clinical treatment	GHH

9993	Group 5: Women & Children	Obstetrics	Maternity Assessment Centre	Patient would like to know why was vasa-previa no identified during her 36 week scan.	Clinical care	All aspects of clinical treatment	GHH
9869	Group 2: Planned Inpatient Care	General Surgery	Heartlands Ward 12	Patient has raised several areas of concern during her stay, regarding her medical and nursing care.	Clinical care	All aspects of clinical treatment	BHH
9971	Group 1: Emergency Services	Cardiology	Heartlands Ward 07	Query regarding medication, condition of ward 7 and staffing levels.	Clinical care	Query over medication	BHH
9860	Group 2: Planned Inpatient Care	Gastroenterology	Heartlands Ward 12	Family have raised several areas of concern regarding poor communication, management, lack of general common sense and inconsistent care for the patient	Communication problem / information problem	Information/communication - written	BHH
9931	Group 3: Ambulatory Care	Ophthalmology	Operating Theatre (General)	Concerns regarding treatment under ophthalmology.	Clinical care	Complication of surgery	SH
9928	Group 2: Planned Inpatient Care	Respiratory Medicine	Heartlands Ward 24	Family have raised concerns regarding the medical treatment of their father and his medication	Clinical care	All aspects of clinical treatment	BHH
9876	Group 2: Planned Inpatient Care	General Surgery	Operating Theatre (General)	CSM	Clinical care	All aspects of clinical treatment	SH
9926	Group 1: Emergency Services	Acute Medicine - Heartlands Hospital	Heartlands Ward 08 (AMU2)	Concern regarding care management. NOTE: INQUEST REF C2011.449	Clinical care	All aspects of clinical treatment	BHH
9929	Group 2: Planned Inpatient Care	General Surgery	Operating Theatre (General)	CSM	Clinical care	All aspects of clinical treatment	SH
9917	Group 2: Planned Inpatient Care	General Surgery	Operating Theatre (General)	CSM	Clinical care	All aspects of clinical treatment	SH
9880	Group 2: Planned Inpatient Care	General Surgery	Operating Theatre (General)	Breast case.	Clinical care	All aspects of clinical treatment	BHH
9954	Group 2: Planned Inpatient Care	Trauma and Orthopaedics	Fracture Clinic	Complainant has raised several areas of concern regarding the medical treatment of his son. Why has it taken so long to have his leg straightened, however the patient has been left with a large hole in this leg and is receiving	Clinical care	All aspects of clinical treatment	SH

				district nurse input 4 months post injury and will have a scar on his leg for life.			
9967	Group 1: Emergency Services	Elderly	Good Hope Ward 10	Concerns regarding treatment on Ward 10 GHH. Also concerns GHH ED + Bereavement Office. *CQC *	Nursing Care	Patient dignity - general	GHH
9875	Group 2: Planned Inpatient Care	General Surgery	Heartlands Ward 07 (HDU)	Family have raised several areas of concern regarding the medical treatment and nursing care of the patient	Clinical care	All aspects of clinical treatment	BHH
9874	Group 1: Emergency Services	Cardiology	Main Outpatients Department	Concerns re delays in treatment	Appointments, delay or cancellation (OPD)	Delay/Cancellation - outpatient appointment	SH
9992	Group 2: Planned Inpatient Care	General Surgery	Solihull Ward 14	Family have raised several areas of concern regarding the medical treatment of their father, the lack of communication with the family and that there was a lack of nursing entries in the patient's medical records.	Clinical care	All aspects of clinical treatment	SH
9863	Group 1: Emergency Services	Elderly	Heartlands Ward 30	Concerns re poor communication + implementation of end of life care	Clinical care	All aspects of clinical treatment	BHH
9878	Group 2: Planned Inpatient Care	General Surgery	Other Hospital	Patient is not happy that her colonoscopy was cancelled twice and with the attitude of the Matron	Clinical care	All aspects of clinical treatment	OTHHOS
9897	Group 5: Women & Children	Obstetrics	Accident & Emergency	Patient suffered a miscarriage (just under 3 months) and was not happy with care and treatment or the cleanliness in A&E and not being able to get a EPAU appointment.	Clinical care	All aspects of clinical treatment	GHH
9865	Group 4: Clinical Support	Infectious Diseases	Heartlands Ward 28	Concerns re standard of care given on Ward 28 BHH	Clinical care	All aspects of clinical treatment	BHH
9906	Group 5: Women & Children	Obstetrics	Labour Ward/Delivery Room	Complainant has raised several areas of concern regarding medical and nursing treatment after her daughter gave birth on 30.11.2011.	Clinical care	All aspects of clinical treatment	GHH

14

9870	Group 2: Planned Inpatient Care	Trauma and Orthopaedics	Operating Theatre (General)	Patient has raised several areas of concern regarding her medical treatment and break down of communication. In addition consultant has advised her that her initial surgery was carried out incorrectly - POTENTIAL LEGAL	Clinical care	All aspects of clinical treatment	GHH
9977	Group 2: Planned Inpatient Care	General Surgery	Operating Theatre (General)	Patient feels the removal of his testicle was result of his first operation going wrong.	Clinical care	All aspects of clinical treatment	BHH
10020	Group 1: Emergency Services	Accident and Emergency	Accident & Emergency	Alleged failure to fully investigate cause of back pain in GHH ED.	Clinical care	Misdiagnosis	GHH
9998	Group 5: Women & Children	Gynaecology	Heartlands Ward 01 GAU	Delay in diagnosing the patient had an ectopic pregnancy and queries regarding the decision for her treatment.	Clinical care	All aspects of clinical treatment	BHH
9859	Group 5: Women & Children	Paediatrics	Good Hope Ward 06 (Harvey)	Mother is not happy with the medical treatment of her son, or with the delay of him receiving medication. In addition he was discharged and later diagnosed with a chest infection which required antibiotics.	Clinical care	All aspects of clinical treatment	GHH
9914	Group 1: Emergency Services	Acute Medicine - Heartlands Hospital	Heartlands Ward 22	Concerns with standard of nursing care on Ward 22 BHH *Complaint rec'd via Governor*	Nursing Care	Lack of assistance with hygiene needs	BHH
10005	Group 5: Women & Children	Paediatrics	Heartlands Ward 15	Mother unhappy with the way her baby was handled and the way the nurse forced the tube down her nose.	Clinical care	Rough handling	BHH
9909	Group 2: Planned Inpatient Care	Urology	Main Outpatients Department	Patient not happy that the only way of communicating with the Trust is via telephone, he does not have access to one.	Communication problem / information problem	Information/communication - written	BHH
9925	Group 2: Planned Inpatient Care	Trauma and Orthopaedics	Good Hope Ward 15	Patient's buzzer was out of reach when nurse did arrive as another patient called her, the nurse refused to attend to the patient.	Nursing Care	Buzzer - out of reach	GHH
9973	Group 2: Planned Inpatient Care	General Surgery	Heartlands Ward 10	Wife has raised several areas of concern regarding the nursing treatment of her late husband issues in relation to a meeting that was held	Nursing Care	Pain assessment/care	BHH

				on the ward.			
10059	Solihull Community Services	Child Health	Kingshurst Clinic	Family have several areas of concerning regarding the decisions made of the future of their sons treatment.	Clinical care	All aspects of clinical treatment	COMM
9996	Group 2: Planned Inpatient Care	Respiratory Medicine	Heartlands Ward 24	Daughter has raised areas of concern regarding the nursing care of her mother, she also suffered a fall, but unfortunately passed away	Nursing Care	Patient observations	BHH
9862	Group 2: Planned Inpatient Care	Trauma and Orthopaedics	Main Outpatients Department	Patient has advised that he ws not given any information regarding DVT's following his arthroscopy operation, he developed a DVT and now may have to take warfarin for the rest of his life. He has also been advised that POTENTIAL LEGAL	Communication problem / information problem	Information/communication - written	BHH
9976	Group 2: Planned Inpatient Care	Gastroenterology	Main Outpatients Department	Pt not happy that as a result of a delay in him receiving further tests, he went privately as suggested by his GP. He also cancelled an appointment at GHH only to be sent an appointment to attend BHH.	Communication problem / information problem	Information/communication - written	GHH
10024	Group 5: Women & Children	Gynaecology	Good Hope Ward 02	Patient has raised several areas of concern regarding her nursing and medical treatment.	Clinical care	All aspects of clinical treatment	GHH
9868	Group 2: Planned Inpatient Care	General Surgery	Operating Theatre (General)	Breast complaint / ?CSM	Clinical care	All aspects of clinical treatment	SH
9877	Group 1: Emergency Services	Elderly	Good Hope Ward 10	Alleged poor communication on Ward 10 at GHH	Staff attitude	Rudeness of staff	GHH
9867	Group 2: Planned Inpatient Care	General Surgery	Operating Theatre (General)	CSM case	Clinical care	All aspects of clinical treatment	SH
9887	Group 1: Emergency Services	Elderly	Heartlands Ward 30	Concerns re alleged poor standard of care on Ward 30	Nursing Care	Information/communication - verbal	BHH
9910	Group 2: Planned Inpatient Care	General Surgery	Operating Theatre (General)	Breast complaint	Clinical care	All aspects of clinical treatment	SH

9932	Group 1: Emergency Services	Acute Medicine - Heartlands Hospital	Heartlands Ward 09	Concerns regarding nurse on Ward 9 BHH.	Nursing Care	Nutrition assessment/care	BHH
9913	Group 2: Planned Inpatient Care	General Surgery	Operating Theatre (General)	CSM	Clinical care	All aspects of clinical treatment	SH
9916	Group 2: Planned Inpatient Care	General Surgery	Operating Theatre (General)	Husband feels that his late wife underwent an unnecessary mastectomy and the Trust did not detect that she had overwhelming cancer in her lungs, liver and bones	Clinical care	All aspects of clinical treatment	SH
9915	Group 1: Emergency Services	Accident and Emergency	Accident & Emergency	Fall from trolley in GHH ED resulting in fracture.	Nursing Care	Patient fall and fracture	GHH
9930	Group 2: Planned Inpatient Care	Urology	Laboratory - Vascular	Patient has been waiting to have a prostrate operation and it has not been explained as to why his urine is cloudy.	Clinical care	All aspects of clinical treatment	GHH
10016	Group 5: Women & Children	Neonatal	Birthing Unit	Mother has advised that her baby had dislocated hips at birth; however this was not picked up prior to her discharge.	Clinical care	All aspects of clinical treatment	SH

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Board of Directors

March 2012

Council of Governors and Membership

Update (PH / LD)	(ORAL)
Council of Governors Meeting (16/1/12)	(ORAL)

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Board of Directors

March 2012

Corporate Governance

Schedule of Matters Reserved to the Board (ENCLOSURE)

Monitor Standing Committee Membership (ENCLOSURE)

.11

BOARD MEETING 6 March 2012

Agenda Item 34

Schedule of Matters Reserved to the Board

Following the discussion at the Board meeting on 3 January 2012, this document is now presented for approval.

Malcolm Pye
Company Secretary
March 2012

Heart of England NHS
NHS Foundation Trust

SCHEDULE OF MATTERS RESERVED TO THE BOARD

(Approved by the Board on [DATE])

The following is a Schedule of Matters that the Board of Directors reserves to itself. Any matter not so reserved is, de facto, delegated to the Chief Executive.

All powers and authorities exercisable by the Board together with any delegation of such powers or authorities to any committee or individual are subject to any limitations imposed by the Constitution or by Monitor or by the National Health Service Act 2006. Due regard will also be had to any Code of Governance issued from time to time by Monitor.

Any reference to "Director" shall be to formally appointed directors of the Trust Board and, unless otherwise specified, not to personnel who carry the word "Director" as part of their title.

1. GENERAL

Notwithstanding the list set out below and the delegation of any powers or authority to the Chief Executive or any other person or body, the Board may determine in full session any matter within its powers.

2. REGULATION AND CONTROL

2.1 This Schedule of Matters Reserved to the Board.

2.2 Approval, suspension, variation or amendment of:

- Standing Orders
- Standing Financial Instructions

2.3 Requiring and receiving the declaration of Directors' interests which may conflict with those of the Trust. Determining the extent to which that Director may remain involved with the matter under consideration.

2.4 Requiring and receiving the declaration of interests from senior management which may conflict with those of the Trust.

2.5 Disciplining Directors who are in breach of statutory requirements or Standing Orders, Standing Financial Instructions or any of any other requirement placed upon them.

2.6 The organisational structure at Board Director level.

2.7 The appointment and dissolution of Board committees and Board sub-committees and the approval of terms of reference and reporting arrangements of all Board committees and Board sub-committees.

2.8 Receipt of reports from committees and to take appropriate action thereon.

2.9 Approval of arrangements relating to the discharge of the Trust's responsibilities as a corporate trustee for funds held on trust.

2.10 Ratification of any urgent decisions taken in accordance with Standing Order 4.2 Emergency Powers (or any replacement thereof).

3. STRATEGY AND MANAGEMENT

3.1 Responsibility for the overall management of the Trust.

3.2 Approval of the Trust's long term objectives and strategies.

3.3 Approval of the annual operating and capital expenditure budgets and any material changes to them.

3.4 Oversight of the Trust's operations ensuring:

- Competent and prudent management
- Sound planning
- An adequate system of internal control and risk management
- Adequate accounting and other records
- Compliance with statutory and regulatory obligations

3.5 Review of performance in the light of the Trust's strategy, objectives, business plans and budgets and ensuring that any necessary corrective action is taken.

3.6 Extension of the Trust's activities into new business or geographic areas.

3.7 Any decision to cease to operate all or any material part of the Trust's activities.

3.8 The division of responsibilities between the Chairman and the Chief Executive, which should be in writing.

4. STRUCTURE AND CAPITAL

4.1 Changes relating to the Trust's capital structure.

4.2 Major changes to the Trust's corporate structure.

4.3 Changes to the Trust's management and control structure.

5. FINANCIAL REPORTING AND CONTROLS

5.1 Approval of the annual report and accounts, including all required attachments/appendices.

5.2 Approval of the payment of any dividend.

5.3 Approval of any significant changes in accounting policies or practices.

5.4 Approval of treasury policies.

5.5 Approval of the opening or closing of any bank account.

5.6 Approval of the Annual Report and Accounts, including all required attachments/appendices, for funds held on Trust.

6. INTERNAL CONTROLS

6.1 Ensuring maintenance of a sound system of internal control and risk management including:

- Receiving reports on, and reviewing the effectiveness of, the Trust's risk and control processes to support its strategy and objectives
- Undertaking an annual assessment of these processes
- Approving an appropriate Statement on Internal Controls for inclusion in the annual report

6.2 Approval and monitoring of the Trust's policies and procedures for the management of risk.

7. CONTRACTS

7.1 Major capital projects involving investments of more than £500,000.

7.2 Individual contracts (including NHS Service Agreements but excluding Consultant appointment) whether of a capital or revenue nature or which are otherwise material strategically, entered into in the ordinary course of business, amounting to, or likely to amount to £500,000 over a three year period or the period of the contract if longer, or acquisitions or disposals of fixed assets above £500,000..

7.3 Contracts not in the ordinary course of business, for example loans and repayments above £250,000; foreign currency transactions above £100,000.

7.4 Consideration of Outline and Final Business Cases with an estimated capital and/or revenue impact value in excess of £500,000.

7.5 The acquisition, disposal or change of use of land and/or buildings (except the taking on of any lease commitment of less than 12 months duration).

7.6 The introduction or discontinuance of any activity or operation having a gross annual income or expenditure (that is before any set off) in excess of £100,000.

7.7 The approval of individual cases for the write-off of losses or making of special payments above £100,000.

7.8 Any proposal involving Protected Assets (as defined by Monitor).

7.9 Any PFI proposals.

8. BOARD MEMBERSHIP AND OTHER APPOINTMENTS

8.1 Changes to the structure, size and composition of the Board.

8.2 Ensuring adequate succession planning for the Board and senior management.

8.3 Subject to the provisions of the Constitution, the appointment, appraisal, disciplining and dismissal of the Chief Executive and Executive Directors.

8.4 Selection of Chief Executive, subject to approval of the Council of Governors.

8.5 Appointment of the Deputy Chairman and/or Senior Independent Director.

8.6 Membership and Chairmanship of Board committees.

8.7 Continuation in office of any Director at any time, including the suspension or termination of service of an Executive Director as an employee subject to the law and their service contract.

8.8 Appointment or removal of the Company Secretary.

8.9 A recommendation to appointment, reappoint or remove the External Auditor that is to be put to the Council of Governors for approval, following the recommendation of the Audit Committee.

8.10 Appointment of any Director as representative of any outside body or organisation.

9. REMUNERATION

9.1 Determining the remuneration policy for the Executive Directors and Company Secretary.

10. CORPORATE GOVERNANCE MATTERS

10.1 Undertaking a formal and rigorous review annually of its own performance, that of its committees and individual Directors.

10.2 Determining the independence of Directors.

10.3 Review of the Trust's overall corporate governance arrangements.

10.4 Any proposal to apply to Monitor for any amendment to the:

10.4.1 Authorisation

10.4.2 Constitution

11. POLICIES

11.1 Approval of policies, including (but not limited to):

- Risk Management Strategy, Policy and Procedures
- Code of Conduct
- Health and Safety Policy
- Environmental Policy
- Communications Policy
- Corporate Social Responsibility Policy

12. OTHER

12.1 The making of political donations.

12.2 Approval of the appointment of the Trust's principal professional advisers.

12.3 Prosecution, defence or settlement of litigation involving above £500,000 or being otherwise material to the interests of the Trust.

12.4 Approval of the overall levels of insurance for the Trust, including Directors' and Officers' Liability insurance and indemnification of Directors.

12.5 Approval of periodic returns and declarations to Monitor and the Care Quality Commission.

12.6 Approval of the use of the Seal.

Matters which the Board considers suitable for delegation are contained in the terms of reference of its Committees.

In addition, the Board will receive reports and recommendations from time to time on any matter which it considers significant to the Trust.

BOARD MEETING 6 March 2012

Agenda Item 35

Monitor Standing Committee Membership

Approval is sought for Richard Harris, in his capacity as Chair of the Board Finance & Performance Committee, to join the Monitor Standing Committee.

Malcolm Pye
Company Secretary
March 2012

Board of Directors

March 2012

Any Other Business

Date of next meeting:

Tuesday 1 May 2012
Birmingham Heartlands Hospital

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Medical Illustration

AGENDA