PUBLIC

Board of Directors

6 May 2014

9.30am

St John's Hotel, Warwick Rd
Solihull

Apologies	Declaration of Interest	Minutes	Matters Arising	Chairman's Report	Council of Governors Report	Chief Executive's Report	Safety, Quality and Org. Dev.	Patient and Public Feedback	Finance and Performance	External and Strategic Review	Nursing, Midwifery care staffing capacity	Equality and Diversity

Board Assurance Framework	Transport Strategy	Board Committee Reports	Any Other Business	Part Two

Agenda

May 2014

PART ONE:

1.	**APOLOGIES**	
2.	**DECLARATIONS OF INTEREST**	*(Enclosure)*
3.	**MINUTES** – 4th March 2014	*(Enclosure)*
4.	**MATTERS ARISING**	*(Enclosure)*
5.	**CHAIRMAN'S REPORT**	*(Enclosure)*
6.	**COUNCIL OF GOVERNORS REPORT** (Chair)	*(Oral)*
7.	**CHIEF EXECUTIVE'S REPORT**	*(Enclosure)*
8.	**SAFETY, QUALITY AND ORGANISATIONAL DEVELOPMENT**	
	8.1 Quality and Risk Committee Report (JR/AK)	*(Oral & Enclosure)*
	8.2 Safety Sitrep Update (AK)	*(Enclosure)*
	8.3 Medical Revalidation Update (AC)	*(Oral)*
9.	**PATIENT AND PUBLIC FEEDBACK REPORT** (LT)	*(Enclosure)*
10.	**FINANCE AND PERFORMANCE**	
	10.1 Finance and Performance Report (LL/AQ)	*(Oral & Enclosure)*
	10.2 Update on capital spend programme (AQ)	*(Enclosure)*
	10.2 Flow and 4-hour target (AS)	*(Oral)*
11.	**EXTERNAL AND STRATEGIC REVIEW** (SH)	*(Enclosure)*
12.	**NURSING, MIDWIFERY & CARE STAFFING CAPACITY & CAPABILITY** (SF)	*(Enclosure)*
13.	**EQUALITY & DIVERSITY REPORT** (SF)	*(Enclosure)*
14.	**BOARD ASSURANCE FRAMEWORK – STRATEGIC RISK REGISTER** (LT)	*(Enclosure*
15.	**TRANSPORT STRATEGY** (JS)	*(Enclosure)*
16.	**BOARD COMMITTEE REPORTS**	
	16.1 Audit Committee (AL)	*(Enclosure)*
	16.2 Donated Funds Committee (LL)	*(Enclosure)*
	16.3 Monitor Standing Committee (Chairman)	*(Enclosure)*
17.	**ANY OTHER BUSINESS**	

Date and venue of next meeting – 3rd June 2014 – Venue to be confirmed

PRESS AND PUBLIC ARE WELCOME TO ATTEND THIS MEETING AS OBSERVERS ONLY

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Welcome

Apologies | Declaration of Interest | Minutes | Matters Arising | Chairman's Report | Council of Governors Report | Chief Executive's Report | Safety, Quality and Org. Dev. | Patient and Public Feedback | Finance and Performance | External and Strategic Review | Nursing, Midwifery care staffing capacity | Equality and Diversity

Board Assurance Framework | Transport Strategy | Board Committee Reports | Any Other Business | Part Two

Apologies

Declaration of Interests

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 Patrick Cadigan	01.07.13	1. Consultant cardiologist at Sandwell and West Birmingham Hospital Trust. 2. Registrar of the Royal College of Physicians of London. 3. Member of the clinical advisory group advising the Trust Special Administrators re the future of Mid Staffs NHS Trust 4. Member of the clinical advisory group to NHS England on rare diseases	 Mar 2014	 31.12.13 Mar 2014
Dr Andrew Catto	01.03.14	Nothing to declare.		
Mrs Sam Foster	01.09.13	Nothing to declare.		
Mr Simon Hackwell	01.03.07	1. 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. 2. Director on the interim board of the West Midlands Academic Health Science Network. 3. Governor at CTC Kingshurst Academy for term of 4 years.	09.10.09 10.10.12 12.03.13	26.06.12 Sep 2013
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,	 26.04.11 Jun 2011 Jun 2011 01.10.11 17.10.11	 17.08.11 03.07.12 03.07.12

		neither Lord nor Lady Hunt are involved in the arrangement and the value is approx £1,500pa 12. Patron/Ambassador of Saving Lives 13. Lord Hunt's wife, Selina Stewart, Vice Principle at Chamberlain Sixth Form College, is working with HEFT on a volunteer programme. 14. Son, Benjamin Hunt Stewart is a volunteer at HEFT. 15. President of GS1 UK. A remunerated office for a not for profit organisation dedicated to standardised processes in the procurement global bar coding standards for supply chains. 16. Patron of Speight of the Art – the Mark Speight Foundation	Nov 2011 03.01.12 12.11.13 05.11.13	03.07.12 31.07.13
Mr Les Lawrence	01.04.12	1. Trustee for the National Institute for Conductive Education 2. Governor of City of Birmingham School 3 Lindridge Enterprises Limited	Mar 2013 Mar 2013 Mar 2014	
Mr David Lock	01.07.13	1. Practising barrister and a member of Landmark chambers. Providing legal advice and representation to a wide range of individuals, NHS organisations, local authorities, charities and commercial organisations mainly on public law issues. These frequently involve issues concerning the rights of patients to NHS treatment as well as structural and management issues involving NHS bodies 2. Director of No5 Chambers Limited (management company running No5 chambers) 3. Member of Amnesty International 4. Trustee of Brook Young People Limited, the Sexual Health Charity for young people (unremunerated) 5. Member of the BMA Ethics Committee (unremunerated) 6. Member of the Labour Party and occasional legal advice to Labour Party and elected Members of Parliament on NHS policy issues 7. Chair of the West Midlands Labour Finance and Industry Group 8. Mr Lock's wife Dr Bernadette Gregory, is a medical doctor employed by Redditch and Bromsgrove Clinical Commissioning Group and is Clinical Lead for the Worcestershire Integrated Care Project. 9. Representing an NHS body in relation to Stafford Hospital 10. Chairman of Innovation Birmingham Limited 11. Representing NHS England in relation to specialised services	Updated Jan 14 10.09.13 05.11.13 06.01.14	 Mar 2014
Ms Alison Lord	01.05.13	1. CEO and Shareholder of Allegra Ltd. 2. Voluntary role as a business		

		mentor for the Prince's Trust. 3. In her professional capacity as a 'turnaround executive' Ms Lord has relationships from time to time with major accountancy firms, legal firms, banks and venture capital providers.	22.01.14	
Dr Mark Newbold	01.08.10	1. Member of Multidisciplinary Professional Advisory Panel of BabyLifeline (Charity) 2. Governor on the Council of Aston University 3. Chair of the NHS Confederation Hospital Forum 4. Member of the BMA Medical Manager Committee 5. Governor of Waverley School 6. Director on the West Midlands Academic Health Science Network	01.01.12 01.08.12 Oct 2012 Nov 2012 Nov 2012 Sep 2013	Mar 2014 01.04.14 01.04.14
Prof Edward Peck	01.04.12	1. Pro-Vice-Chancellor, Head of College of Social Science, University of Birmingham 2. Wife is the chair designate of the proposed organisation to deliver community health services in Gloucestershire 3. Councillor for Birmingham Chambers of Commerce 4. Vice-Chancellor Designate Nottingham Trent University (appointment effective 01.08.14)	Nov 2012 Mar 2014	
Dr Jammi Rao	01.07.13	1. Sole director of Gorway Global Ltd. a private company owning 50% of the share capital. A consulting company offering management support, training and bespoke public health analytical support to public sector organisations involved in health, well-being and health care. 2. Board Director of Welcome CIC - a Community Interest Company supporting minority and disadvantaged communities by working with statutory and other agencies. 3. Shareholder in GSK. 4. Trustee of the Faculty of Public Health as an elected General Board Member. Term of office from 2010 to July 2013. 5. Visiting Professorship in Public Health in the School of Health, Staffordshire University.		05.11.13
Prof Laura Serrant	01.04.12	1. Director of Research & Enterprise at University of Wolverhampton 2. Board member of MOSAIC – a registered charity. 3. Non-executive director (unremunerated) - National Skills Academy for Health	23.01.14	Mar 2014
Mr Adrian Stokes	01.07.08	1. Director of HECL 2. Pfizer Virtual Customer programme	01.07.08 20.06.11	

Ms Lisa Thomson	06.11.12	1. Non-executive Director of Multistory 2. Trustee of a charity - Redditch United Football In the Community	22.12.08 07.11.11	
Dr Sarah Woolley	07.05.07	Energy & Home Condition Surveys Ltd – Company Secretary	16.03.07	Jul 2008

REGISTER OF INTERESTS

NON VOTING TRUST BOARD MEMBERS

NAME	DATE OF APPOINTMENT	INTEREST (if any)	DATE OF NOTIFICATION	DATE OF TERMINATION OF INTEREST
Mrs Hazel Gunter	01.01.13	Nothing to declare	15.01.13	
Mr Andy Laverick		Nothing to declare	18.12.08	
Mr Richard Parker	03.02.14	No declaration received		
Mr Aidan Quinn	09.12.14	Nothing to declare		
Mr John Sellars	08.01.07	Nothing to declare	16.04.08	

Board of Directors

May 2014

Minutes

.10

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Minutes of a meeting of the
BOARD OF DIRECTORS
of Heart of England NHS Foundation Trust
held in St Johns Hotel, Warwick Road, Solihull
on 4 March 2014

PRESENT:
Lord P Hunt
Dr P Cadigan
Dr A Catto
Mrs S Foster
Mr S Hackwell
Mr L Lawrence
Mr D Lock
Ms A Lord
Dr M Newbold
Prof E Peck
Dr J Rao
Prof L Serrant
Mr A Stokes
Mrs L Thomson

IN ATTENDANCE:
Ms H Gunter (Director of Workforce)
Mrs A Hudson (Minutes)
Dr A Keogh (Director of Safety)
Mr K Smith (Company Secretary)

Members of the Public

14.029 APOLOGIES and WELCOME

The Chairman welcomed the Board and members of the public, and in particular welcomed Dr Catto who had joined the Trust as Medical Director from 1st March 2014. The Chairman recorded thanks to Dr Ryder for covering the post over the previous three months.

Dr Woolley was on leave and apologies had been received from Mr Quinn, Acting Finance Director, and Mr Sellars, Director of Asset Management.

14.030 DECLARATION OF INTEREST

The Declaration of Interests was received and the following items noted:

- Dr Cadigan had stepped down as Registrar of the Royal College of Physicians and was no longer a member of the clinical advisory group advising the Trust Special Administrators regarding the future of Mid Staffordshire NHS Trust. He had been appointed a member of the clinical advisory group to NHS England on rare diseases.
- Mr Lawrence had been appointed a director of Lindridge Enterprises Limited a start-up social enterprise organisation

- Mr Lock had resigned as a Director of No5 Chambers Limited.
- Dr Newbold no longer had an association with BabyLifeline.
- Prof Peck had been appointed as Vice-Chancellor Nottingham Trent

University from 1st August 2014.

- Prof Serrant was no longer a board member of MOSAIC.

14.031 MINUTES OF PREVIOUS MEETINGS

The minutes of the meeting held on 7th January 2014 were approved as a true record.

14.032 MATTERS ARISING

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

13.071.2 Mrs Foster advised that she and the Chair of Education at the University of Birmingham were in the final stages of agreeing the Distance Learning Strategy.

All other relevant matters would be addressed in the meeting.

14.033 CHAIRMAN'S REPORT

The Chairman referred to his report that was taken as read and drew attention to the following items:

The Chairman advised that he had raised concerns with the Foundation Trust Network (FTN) around the challenges faced by foundation trusts following the rationalisation of specialised services by NHS England; in particular the potential reduction in income and the detrimental impact on attracting specialised services clinicians and related research links.

The first meeting of the Kennedy Task Force had been held. Miss Ann Butler, Chair of the patient led Breast Cancer Support Group, and Dr Mark Pearson, Governor, had joined the Task Force. The meeting had considered the work of each of the ten work streams and the progress made to date.

The Chairman encouraged Board members to attend the NHS Confederation Annual Conference, 4 – 6 June 2014.

The Chairman had been invited to speak to the FTN Annual Conference the following week on how Governors worked at HEFT.

14.034 COUNCIL OF GOVERNORS REPORT

Lord Hunt gave an oral report, as follows.

The last meeting had been held on 20th January 2014 at which:

- The Chairman had commented on the Kennedy Report and the creation of the Task Force that would oversee the various work streams identified by the Board. A ballot by e-mail was initiated to identify the successful candidate from three volunteers for a Governor member of the Task Force; who was subsequently confirmed as Dr Mark Pearson.

- The Chief Executive had given an overview of the key themes for the Trust in 2014, being:
  - The emergency pathway
  - The Kennedy Report actions
  - The reconfiguration of the organisation to meet its financial challenges
- Mr Quinn reported on the year to date financial position, the year end forecast and the Trust's failure to achieve certain Monitor targets (A&E 4-hour wait, 62 day cancer target and C diff).
- Mr Stokes reported on the initiatives being taken to improve flow and achieve the A&E 4-hour target.
- The Governors had invited Lord Hunt to continue in post until 31st July to oversee the work of the Kennedy Review Task Force.
- Mr Hughes, Lead Governor, had given an update on the recruitment process for the new Chair.

14.035 CHIEF EXECUTIVE'S REPORT

Dr Newbold summarised his pre-circulated report and the following points were noted:

The CQC was due to publish its pilot ratings for three trusts, of which HEFT was one, on 6th March. The ratings grid set out the Trust's overall rating accompanied by ratings for each service at hospital level. The expected overall rating was 'requires improvement'; it was felt that this reflected the Trust at the time of the inspection. Good Hope Hospital (GHH) had undergone an unannounced follow-up visit by the CQC, which had gone well; the follow-up report was due to be received shortly and it was expected that the Improvement Notice would be removed in due course. The Trust could consider requesting a re-visit once its issues had been addressed.

In response to a question raised by Mr Lock about the 18-week rectification plan, Dr Newbold advised that private sector providers were selective in the cases they took and usually only undertook straightforward cases. The Trust had an additional action plan in place that would release additional in-house slots, which would reduce the backlog.

Mr Lock questioned whether Trust's mortality data was indicating any areas for concern; Dr Newbold advised that the Trust had undertaken an audit of case notes to understand why the spike had occurred and that it would continue to monitor and investigate as appropriate.

Dr Newbold had attended a half-day conference that marked the work of the Nuffield Trust on how the NHS had changed one year on from Francis. Dr Cadigan, Ms Diane Eltringham, Head Nurse for Birmingham Heartlands Hospital (BHH), and Louise Wood, Senior Ward Sister at BHH, had represented the acute trusts' perspective in a panel discussion.

14.036 SAFETY, GOVERNANCE AND RISK

14.036.01 QUALITY AND RISK COMMITTEE REPORT

Dr Rao reported that the Committee had met on 3rd February 2014 and the key items of discussion were as follows:

- The procurement process for electronic prescribing was likely to take longer than originally thought due to the complexity of some areas of prescribing. A survey of other trusts that already had electronic prescribing had shown that the system needed time to perfect.

- Dr Rao had accompanied the safety and quality team on their visits to theatres at GHH and BHH and was reassured that staff were aware of the 'SUIs at a glance' reports; however there were instances of safe practices not always being followed in 'the spirit' of WHO guidance by a minority of clinicians. Dr Rao assured the Board that the Quality & Risk Committee (Q&RC) would continue to follow this up, noting that the key to resolving it would lie with good clinical leadership.

- Ms Lord noted that it wasn't clear to her who was producing the 'Safety Sitrep' and its content wasn't always easy to decipher. Ms Lord requested feedback from Board colleagues as to how useful they found the report, so that she could take this into account in the Task Force Work Stream for 'Flow of information to the Board'.

14.036.02 SAFETY SITUATION REPORT

Dr Keogh presented the pre-circulated report and welcomed the discussion on its content initiated by Ms Lord; she suggested that material may be required on the CQC metrics and mortality rates.

The report revealed no new SUIs reported since the previous report, one red operational risk (Histopathology) had been closed but two new ones had been added (ED and Radiology); a further 13 were under review.

Dr Cadigan noted the February 2013 SUI where the early warning signs for a patient (including catastrophically low blood pressure) were not acted on effectively. Dr Keogh explained that the Trust's Medical Examiner had investigated and was satisfied that the actions taken that were described in the 'SUI at a glance report' were sufficient to avoid recurrence. In addition, the Deteriorating Patient Action Group was looking at escalation levels.

Dr Newbold confirmed that plans were in place to address the CQC actions and Mrs Foster confirmed that progress would be monitored using the CQC metrics, which would be monitored by the Q&RC.

Dr Keogh advised the meeting that the CQC had written to the Trust after it had received a letter from junior doctors raising concerns around bullying and workload at GHH. Dr Keogh and Dr Ryder had met with the junior doctors and

plans had been put in place to mitigate their concerns. The Chairman and Mr Lawrence proposed meeting with them to understand how they felt the Trust had dealt with their concerns.

14.036.03 MEDICAL REVALIDATION UPDATE

Dr Catto gave an oral update. Since April 2013 HEFT had made 166 revalidation recommendations. Of those 156 were positive recommendations for the GMC to revalidate; 10 were recommendations for the GMC to defer revalidation as the Responsible Officer did not have enough information to make a positive recommendation. Of the 166 recommendations made by HEFT none had been rejected by the GMC; 2 were still under review. There had been no formal recommendations of non-engagement made to the GMC. Out of the 18 doctors who had not completed their 2013 appraisals and who had received early concern notification from the GMC, 2 were yet to complete their appraisals. There was one doctor outstanding who was not one of the 18 reported, who had so far failed to undertake their 2013 appraisal.

14.037 PATIENT AND PUBLIC FEEDBACK REPORT

Mrs Thomson presented the pre-circulated report.

The Friends & Family Test (FFT) response rates and scores had continued to improve. The FFT was to be expanded to outpatients and day surgery by October 2014 and staff were to be surveyed quarterly by the end of June 2014. In response to a question from the Chairman, Mrs Thomson advised that low scoring ward areas could be identified and the data compared to nursing metrics. Where there was a difference in data the Trust would talk to patients and staff to understand and pinpoint areas of low score and use that information to guide improvements and action plans. The FFT feedback had been used to drive quality improvements.

The Board discussed the results set out in the report; in particular the work undertaken to improve patient discharges and the need to ensure that patients received adequate information about the side effects of medication, to allow informed decision making.

Mr Lawrence advised that the Cedarwood assisted discharge model had attracted national attention as an effective discharge method for frail elderly patients.

Mrs Thomson advised that she had seen a first cut of the BBC series ‘Protecting our parents’ that had been filmed over the past year at the Trust and in the local community. The stories were genuine and would highlight the challenges faced by frail and elderly patients and their families. The programmes were due to be aired in April - May; a preview of clips would be presented to the directors before the programmes aired.

The Spire Healthcare report on the review of the actions undertaken by Mr Paterson within the private sector was due to be released imminently.

14.038 FINANCE AND PERFORMANCE

14.038.01 Mr Lawrence noted that the Trust remained on track to achieve the projected £2m surplus for the year. There continued to be concern on the variability of staff turnover and high usage of bank/agency staff and locums with a high allocation of spend being attributed to bank coverage, especially to cover night shifts; Workforce had been tasked to look at this and develop a recovery plan to address the overspend. Efficiencies were being developed to achieve the £24m of savings required for the next financial year. The winter activities were being reviewed to identify successful and unsuccessful initiatives.

The 18-week backlog was being monitored on a weekly basis; although improvements had been seen three key areas were volatile. The 62 day cancer target was an area of concern. The urology and prostate cancer pathways were undergoing redesign.

Due to the financial challenge the operational capital plan would be cut back from £29m to £15-20m and would be re-assessed as the year developed. The plan was to end 2014-15 at break-even but without detriment to quality of patient care.

Dr Newbold was due to meet with the lead CCG for 2014-15 JMRA contract negotiations. If the offer remained low the JMRA would be in jeopardy and the Trust would consider reverting back to a tariff arrangement. Mr Stokes was confident of successful discussions with the Cross City CCG; discussions with the South Staffordshire CCG were more challenging but were still underway.

14.038.02 Patient Flow and 4-hour Target

Mr Stokes gave an oral update. Systems and processes put in place had continued to be monitored in order to sustain positive results. The Trust had achieved 95.3% in January, 91.6% in February and 93.4% in the quarter to date; the fall in performance seemed to be influenced by the changeover in the junior doctors and school holidays. A second 'Breaking the Cycle' week had been held at GHH that had reinforced the need for the 'SAFER bundle' to be undertaken every day on every ward. The next steps included real time recording of data via e-Jonah, work by IMAS to identify what works well elsewhere to improve discharges, a fortnightly Urgent Care Improvement Board, protected clinical time at the start of the day and a stronger 'gold command' structure at GHH. A 'Community' week was planned for week commencing 17th March with the emphasis on raising visibility with external partners.

The Board then had a robust and detailed discussion around the actions that needed to be taken to sustain the improvements including performance managing staff and the continuation of delivering performance following Mr Stokes returning to his substantive role.

14.039 EXTERNAL AND STRATEGIC REVIEW

14.039.01 *HEFT Strategic Plan/ Monitor Annual Plan*

Mr Hackwell presented an overview of the pre-circulated report and it was noted that:

- Monitor required the Trust to submit its 2014-15 Annual Plan, covering the next five years. The first two years of the Annual Plan were due for submission by the beginning of April 2014 with the following three years submitted by the end of June 2014. It was agreed that that the first submission would be presented to the Monitor Standing Committee for final approval.

- The Annual Plan would reflect the Trust's strategic plan that had been developed to reflect the challenges faced by the Trust over the years ahead. It recognised the radical transformation required to deliver a financially and clinically sustainable organisation. The plan would include financial assumptions and the revised capital plan.

- The Trust would be required to review its risk scores as part of the process. The scores were broken down into two categories Continuity of Services Risk (COSR) scoring 1-4, 4 being the highest score, and Governance Risk Rating (GRR) with 'traffic light' scoring.

- The Annual Plan commentary and values would be presented to the Council of Governors for consultation prior to final approval and submission to Monitor.

The Board had a robust and detailed discussion around the assumptions made in the Annual Plan and the status and relevance of the Plan in terms of Monitor holding the Trust to account. Dr Newbold confirmed that the Plan reflected where the Trust expected to be in terms of the outcome of its negotiations with the CCGs.

14.040 TRANSPORT STRATEGY

In the absence of Mr Sellars, this matter was deferred to the May meeting.

14.041 BOARD COMMITTEE REPORTS

14.041.01 Audit Committee Report

Ms Lord reported that the Committee had appointed Deliotte LLP as the new internal auditors succeeding KPMG LLP, who would handover at the end of March 2014. Ms Lord recorded her thanks to Mrs Jones, the Chief Financial Controller, and the procurement team for the work undertaken during the procurement process.

Mr Smith presented the revised Terms of Reference and Standing Orders which had previously been approved by the Audit Committee. The Board accepted and approved the revised Terms of Reference and Standing Orders as presented.

14.041.02 Donated Funds Committee

Mr Lawrence reported that the Committee had met on 17th January and received a presentation on investment approaches from its new investment manager, Investec, and agreed a revised Investment Policy. In addition the Committee had agreed a proposal for third party monitoring of Investec's performance against benchmark by the Charity's investment adviser, Marlborough.

The Charity had spent £95k more than income received in the first 9 months of the year but the plan had been for a £675k deficit, so a positive variance of £580k had been generated against plan. The value of investments had increased by £421k, resulting in an overall surplus YTD of £326k. The Charity held funds of around £9m at 31st December. The Committee continued to encourage fundholders to spend their funds.

No progress had been made on the independence of the Charitable Fund as the guidance had yet to be released by the DoH. In response to a question from Mr Stokes Mr Lawrence advised that the trust did not benchmark itself again other organisations.

14.041.03 Monitor Standing Committee Minutes

The pre-circulated minutes of the Committee meeting on 31st January 2014, at which the Monitor Quarter 3 return was approved, were taken as read.

14.042 ANY OTHER BUSINESS

There was none.

14.043 DATE OF NEXT MEETING

6th May 2014 at St Johns Hotel, Warwick Road, Solihull.

The Board resolved "That representatives of the press and other members of the public be excluded from the remainder of the meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest."

Matters Arising

BOARD OF DIRECTORS

Schedule of Matters Brought Forward and Action Points

Date raised	Minute No	Detail	Action	Due	Status	Completed
2 July 2013	13.064.02	Transport strategy – alternative methods review.	JS	May 2014	Agenda item 15	
	13.067.01	Identify any opportunities to increase private patient income.	AQ	Jun 2014		
10 Sep 2013	13.083.03	Review and report back on improved Board Assurance Framework and Risk Register process.	LT	May 2014	Agenda item 14	
4 Mar 2014	14.036.01	Give feedback to Alison Lord regarding usefulness of 'Safety Sitrep'.	All	May 2014		

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Chairman's Report

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CHAIRMAN'S REPORT to the BOARD of DIRECTORS – May 2014

Sir Ian Kennedy's Review

In this, my final Board Report, I felt it important that we continue to focus on Sir Ian Kennedy's Review of the Breast Care services at Solihull Hospital.

The Task Force has met three times and continues to review the progress to date against the work streams formed to address the recommendations in Sir Ian Kennedy's Review, encompassing:

1. Strengthening the Trust's approach to whistleblowing with a new policy and a process for ensuring that all staff feel able to raise concerns that are responded to and fed back with actions taken.

2. Professor Sir Muir Gray, Chief Knowledge Officer to the NHS, working with us to develop much further an open and patient-centred culture.

3. Board Quality and Risk Committee - reviewing the Terms of Reference in light of the recommendations in the Kennedy Review, including considering the information used by the Committee; reporting to the full Board; and, consideration of disciplinary and other staff issues that may impact on quality and safety.

4. The Non-executive Directors are taking an active role in implementing the recommendations:
   a. David Lock is leading on work to review and improve our procedures for agreeing consent with patients.
   b. Alison Lord is leading on a piece of work to look at information flows to the Board.
   c. Jammi Rao is leading the work regarding the Quality & Risk Committee.
   d. Les Lawrence is conducting a review into the patient environment and the information we provide to patients.

5. The Trust disciplinary and investigatory process is being reviewed.

6. A formal programme of clinical leadership development and support is being developed.

7. Formal values-based recruitment for medical staff is being developed.

8. The Task Force has agreed that the work stream looking at drawing up a 'recall protocol' which details how any future patient recall processes will be put on hold whilst work on widening the current patient recall is being developed.

As part of the overall programme of work a Patient/Stakeholder Engagement plan is being developed, this will support both the current work but will also identify any longer term patient/service user engagement which may be required as part of the continued development

and delivery of the work streams.

Information on each work stream is now live on the Trust website with the further updates planned including the publication of approved Task Force minutes.

Sir Ian Kennedy is planning to return to the Trust in late June 2014. Sir Ian does not expect that all work will have been completed by this time; his focus will be on the approach we are taking, the progress we have made to date and what work future work we have planned. He will wish to meet with the Board and the patient group.

Care Quality Commission (CQC) Update

As you will see from the Chief Executive's report we have received feedback form the CQC's recent visit, following the issuing of a Warning Notice for Good Hope Hospital last December. This was the result of the first round of the new CQC inspection process, for which the Trust volunteered. The CQC re-inspected to monitor compliance with the Notice on 27th February 2014 and *"found that the Trust was compliant in respect of the issues contained within the warning notice"*. Specifically the CQC reported that they *"found that systems and processes had been put in place to address the issues raised within A&E and Ward 20. Patients could be assured of a safer service due to these improvements."* The Trust has been informed that its CQC report has been updated to reflect this and we are now expecting this to be published imminently.

Charity Update

The Department of Health has now issued its guidance and supports the move toward the independence of 'NHS charities', which will require new, different, governance arrangements. The benefits of independence include enhancement of the ability to attract third party charitable support, self-sufficiency and efficiency. As previously expressed to the Board, I support the move toward independence and believe that the Trust should aim to be in the second 'wave' of NHS trusts pursuing this course, rather than one of the first implementers. This will enable the Trust to learn from the experiences of the three to four front runners.

A Steering Group under chairmanship of Paul Hensel has been established to take this forward and report back to the Board, in due course, with a clear proposal.

VISITS and MEETINGS

Since the last Board Meeting I have continued to go out and about, internally and externally, and these visits have included:

Patient Safety Visits

I am pleased that the programme of safety walk-rounds continues and I continue to be reassured by the feedback from staff. We have seen high levels of engagement in all areas of the Trust in improving safety for our patients and I would continue to encourage all of my Board colleagues to take part in the safety walk-rounds to support this vital agenda.

FTGA Development Day

I was invited to attend and had the pleasure of speaking at this recent event. The FTGA is the national representative body for foundation trust governors and the development days are an important opportunity for governors to learn, share and debate. It was an opportunity to spread the good work of our HEFT Governors who are dedicated to helping our trust improve, these are challenging times and sometimes governors play an integral role in their trusts.

Learning Disability Conference

I was invited to open and speak at this conference. The conference provides a range of speakers and subject matter that reflects the range of work being undertaken to support the health needs of people with learning disabilities in both acute and primary settings and was attended by a wide range of disciplines including GP's and practice staff, hospital doctors and nurses, commissioners and social services staff. Meeting the health needs of people with learning disabilities is important for the Trust and I am pleased to say that HEFT demonstrates this by supporting the acute liaison nursing team within its hospitals. Specialist learning disability health services are working alongside primary/acute health staff to improve the profile of people with learning disabilities accessing services, increase knowledge of staff in these area and ultimately improving the health outcomes for this client group.

Chairman's Governor Breakfast Seminars

The Chairman's Breakfast Seminars continue to prove to be very popular. Since the last meeting we have held two seminars and Aidan Quinn, Acting Finance Director, came to talk and answer governor questions on the current financial issues affecting the Trust. The second seminar saw Richard Parker, Interim Managing Director at Good Hope Hospital, present an update on the challenges faced and work underway at Good Hope Hospital.

Lord Philip Hunt of Kings Heath
Chairman

May 2014

Council of Governors Report

(Oral)

Apologies | Declaration of Interest | Minutes | Matters Arising | Chairman's Report | Council of Governors Report | Chief Executive's Report | Safety, Quality and Org. Dev. | Patient and Public Feedback | Finance and Performance | External and Strategic Review | Nursing, Midwifery care staffing capacity | Equality and Diversity

Board Assurance Framework | Transport Strategy | Board Committee Reports | Any Other Business | Part Two

Board of Directors

May 2014

Chief Executive's Report

Apologies | Declaration of Interest | Minutes | Matters Arising | Chairman's Report | Council of Governors Report | Chief Executive's Report | Safety, Quality and Org. Dev. | Patient and Public Feedback | Finance and Performance | External and Strategic Review | Nursing, Midwifery care staffing capacity | Equality and Diversity

Board Assurance Framework | Transport Strategy | Board Committee Reports | Any Other Business | Part Two

CHIEF EXECUTIVE'S REPORT to the BOARD of DIRECTORS – May 2014

Overview

As the Board will be aware, the Trust continues to face significant challenges. Whilst progress is being made, we are experiencing further impacts from increased activity in specific areas. We have plans in place to address all of the following and these are being closely monitored.

Performance Update

The quarter four (31 March 2014) the Monitor return highlights a continuity of service risk rating (COSSR) of 4. It is anticipated that the Trust will continue to maintain a COSSR of at least 3 over the next year.

For 2013/14 the Trust has declared a red governance risk rating due to the failure to achieve the four-hour A&E waiting target for seven consecutive quarters. The Trust is also declaring non-compliance with the C difficile target where the challenging full year target of 68 cases has been exceeded, with 82 cases. A review of C difficile cases at quarter three showed that 43 out of the 67 cases were unavoidable.

At this stage it is known that the Trust will not hit the quarter four two-week targets for both breast cancer and other cancers. There has been a significant increase in referrals to the breast cancer service following a national awareness campaign and to other areas due to lung and prostate cancer campaigns.

The Trust has failed to meet the 18-week admitted referral to treatment target (RTT) in line with a managed failure plan. The plan has been reassessed and the remaining backlog will result in a failure in quarter one 2014/15. This has already been shared with Monitor. A further planned failure of the 18-week admitted RTT in quarter one for a few remaining specialties has also been declared, to enable them to reduce backlogs. The aim of these measures is to prioritise those who have waited the longest for their operation.

In the fourth quarter of the financial year, the Trust has reported a deficit of £8.9m. This is £10.4m adverse to the planned surplus for the quarter. The full year deficit of £5.4m is £11.4m below the planned surplus. The outturn is after recording a fixed asset impairment charge of £4.8m and providing for costs arising out of the Kennedy review of £4.2m. If these one-off costs are excluded, the Trust is recording a normalised full year surplus of £3.6m; £2.4m below plan.

Contract discussions for 2014/15 are ongoing. The Trust is keen to continue with a Jointly Managed Risk Agreement (JMRA), which gives the Trust greater certainty over the vast majority of its income (and the wider health economy some certainty over its costs). This puts a real focus on demand management and indeed we have seen low levels of activity growth over the last two years as a result.

The recent increase in activity has had an impact on services. In quarter four, day case and elective activity saw a 7.9% increase in spells above plan in the quarter. This represents 1,524

more spells than planned. There is a combined over-performance of 4.1% or 3,143 spells year to date.

Non-Elective activity, which includes Emergency Admissions, Short Stay Assessment Areas and Maternity spells, in quarter four was below plan by 1.3%; 350 spells. Non-elective activity has underperformed by 2,862 or 2.8% year to date. Key areas for non-elective under-performance in quarter four are in Paediatrics, 769 spells, and Obstetrics & Gynaecology, 358 spells. There are over performances in Elderly, 209 spells; General Medicine, 127 spells and General Surgery, 127 spells.

Outpatient activity has over-performed in quarter four by 1,284 attendances, or 0.6%. There is an under-performance of 4,815 attendances or 0.6% year to date.

The Board will be aware that the agreed Mutually Agreed Resignation Scheme (MARS) has been launched and closed at the end of April 2014. I will keep the Board informed of progress on savings released as a result of this scheme.

A&E 4-hour performance

We continue to remain under close scrutiny from Monitor and commissioners for our performance against the 4-hour access target. Much improvement has been made but we have yet to consistently meet the 95% target. The Trust attended an escalation meeting with Monitor in April and remains under close scrutiny both from Monitor and the Area Team. On writing this report, I can confirm that for the weeks commencing the 13th and 20th April, the Trust met the 95% target, achieving 95.21% and 96.72% respectively. This is set against a backdrop of increased attendances at Heartlands Hospital, an average of 18 per day, with April this seeing a further increase.

HospitalSite	Jan	Feb	Mar	Apr	Total
BHH 2014	9,219	8,742	10,558	7,392	35911
BHH 2013	8,920	8,488	9,597	6,943	33948
Working Days	31	28	31	22	112
2014	297	312	341	336	321
2013	288	303	310	316	303
Var	10	9	31	20	18

Provisional quarterly publication of never events reported as occurring between 1 April 2013 and 31 March 2014

A report providing a provisional summary of never events that have occurred between 1 April 2013 and 31 March 2014 is now available from NHS England. A final annual report on Never Events in 2013/14 will be published in summer 2014. For the year commencing April 2014, provisional summaries of never events will be issued monthly, with each report updating earlier

data as incidents are locally investigated and more accurate information becomes available.

The Board will be aware that never events are classed as serious, largely preventable patient safety incidents that should not occur if existing national guidance or safety recommendations had been implemented by healthcare providers.

Never events for the NHS 1 April 2013 to 31 March 2014 by type PROVISIONAL DATA: SUBJECT TO CHANGE AS LOCAL INVESTIGATION COMPLETED

Type of never event	Number
Retained foreign object post procedure	123
Wrong site surgery	89
Wrong implant/prosthesis	49
Inappropriate administration of daily oral methotrexate	16
Misplaced naso or oro gastric tubes	14
Transfusion of ABO incompatible blood components	4
Air embolism	4
Wrong gas administered	3
Maladministration of insulin	3
Maladministration of a potassium containing solution	2
Escape of a transferred prisoner	1
Falls from unrestricted window	1
Overdose of midazolam during conscious sedation	1
Failure to monitor and respond to oxygen saturation	1
Maternal death due to post-partum haemorrhage after elective caesarean section	1
Total	**312**

The Board will know that during this period the Trust had two never events, one with regard to wrong site surgery and one with regard to wrong implant or prosthesis. To provide a reference point with regard to how the Trust compares to the rest of the NHS I have attached the interim report. This shows that whilst we recognise we can do more to improve we benchmark well against our peers.

Care Quality Commission (CQC) inspectors Visit

Following the CQC's comprehensive inspection of the Trust on 11-15 and 23 November 2013, the Board will be aware that a Warning Notice was issued with regard to Good Hope Hospital, as the inspection team identified areas of improvement. At this time, the CQC rated the hospital inadequate for Safe and Responsive in A&E and requires improvement within Safe in Medicine. The CQC undertook a focused inspection at the hospital on 27 February 2014, to check whether the hospital had made the necessary improvements to meet the issues highlighted in the warning notice. These included:

- The initial assessment of patients for treatment provided in the A&E department;
- Patient flow throughout the hospital to enable the A&E department to function effectively;
- Ensuring patients are cared for on appropriate wards and clinical areas, to ensure effective use of facilities;

- The safety of patients on the acute medical unit (Ward 20) by the creation of a ward team; and
- The security of medications on the acute medical unit (Ward 20).

At this visit, the CQC reviewed the above issues in A&E and Ward 20 and have reviewed the key questions of safe in A&E and Medicine and Responsive in A&E. The CQC has reviewed the above ratings and now find that the hospital is rated requires improvement in Safe and Responsive in A&E and Good in Safe within the Medicine section. At this inspection, inspectors found that the issues raised in the Warning Notice were met but we found that, although improvements had been made, there remained some improvements to be made. These included:

- Some patients were not being seen within 15 minutes of admission by a trained nurse or clinician;
- Documentation as to the patient's needs was not always completed as per protocol;
- Although triage arrangements had improved, further improvements were required to ensure the safety of patients; and
- The criteria of the CDU was not consistently implemented.

Whilst the hospital is now safer for patients, the CQC highlighted that improvements are required to ensure a good and appropriate service is provided. The team at Good Hope Hospital is continuing to work to further improve the systems, processes and care provided. This is being monitored closely via the Executive Management Board.

Executive Update

To support the need to focus on delivery in 2014/15, the Board will be aware that number of changes have been agreed to align executive portfolios with the business priorities and needs of the wider organisation. This builds on what we have learned from our approach to last winter and the need to improve delivery. Our poor staff survey results, especially concerning engagement and the staff recommender index, are of specific concern, as research highlights the relationship between these areas and outcomes data, including mortality. I believe the new structure will be more suited to current and future need.

It is best practice to review the needs and requirements of the organisation on a regular basis and in line with the Trust's delivery plan. What we have learned from the recent winter activity is that management across structures is in need of stream-lining and greater clarity is required and this is one of the key factors in what is seen externally as our generally weak performance. The future looks even more challenging. The new structure, which at its heart is the creation of a delivery unit, will enable the senior team to provide the clarity required to improve performance, deliver safety and quality improvements and provide the necessary cost savings to the Trust.

The new approach and structure:

- creates a more focused executive team; a team of seven all of whom are voting

directors;

- transfers the function of corporate governance to the Company Secretary with this role jointly reporting to the CEO and Chair;
- creates a delivery function via an executive triumvirate that mirrors those at divisional, site and directorate level;
- reduces the size of the Executive Management Board; and
- enhances the scope of the Medical Director, which will be supported by an additional two deputy medical director roles.

To support the proposals three interim positions will continue:

- Deputy CEO and Director of Delivery (for an additional period of 12 months)
- Director of Finance and Resources (for an additional period of 12 months)
- Managing Director GHH (for an additional period of 10 months).

Under this new arrangement, there are two posts which it is proposed will no longer exist, the Managing Director post at Solihull Division and the Director of Strategy post. In addition, at the end of the 12 month period the Managing Director post at Good Hope Hospital will also be disestablished. Local leadership at Solihull and Good Hope will continue, through the senior triumvirate of Associate Medical Director, Head of Operations, and Head of Nursing.

As part of these changes, I will take direct responsibility for cultural development and strategy. The Deputy CEO will also become the Director of Delivery and take joint responsibility for delivery (with the Chief Nurse and Medical Director); The Director of Corporate Affairs will become the Director of Patient Experience and External Affairs, responsible for internal and external communications and all external public and stakeholder management across the organisation and engagement. We will also shortly be going out to advert to recruit a permanent Chief Nurse.

VISITS and MEETINGS

Since the last Board Meeting I have continued to go out and about, internally and externally focusing on building awareness of the actions we are taking to support both our patients and our staff during the busy winter season. From these activities I would like to highlight specifically:

- On April 10 I gave a seminar on Raising Concerns along with Sir Ian Kennedy. This was to a group from across the West Midlands and the session was hosted by Health Education West Midlands
- On April 17 I met with Lorely Burt MP. We caught up on current health issues, and I picked up a number of points and concerns that constituents had raised with Lorely.
- On April 22 I attended the first meeting of the Expert Panel of the Dalton Review, which was commissioned by the Secretary of State to look at how hospital management teams can be supported. It has been widely publicised that the group will look at linkages ('chains') between hospitals as well as 'buddying' and other arrangements.
- On April 24 I was privileged to be invited to a meeting of the Solihull Breast Cancer Support Group, chaired by Ann Butler. We had a lively discussion looking particularly at the actions the Trust is taking following the Kennedy Review, as well as at a number of

developments we might make to improve breast services in the future.

- On April 29 I attended the first Provider Summit, convened by the Health Service Journal. I contributed to a seminar on 'The role of the Chief Executive' as well as listening to debates on topics such as integrated care, hospital finance, patient engagement, and nurse staffing levels.

Dr Mark Newbold
Chief Executive
May 2014

Provisional publication of never events reported as occurring between 1 April 2013 and 31 March 2014

NHS England INFORMATION READER BOX		
Directorate		
Medical	Operations	Patients and Information
Nursing	Policy	Commissioning Development
Finance	Human Resources	

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Provisional quarterly publication of never events reported as occurring between 1 April 2013 and 31 March 2014

This report provides a provisional summary of never events that have occurred between 1 April 2013 and 31 March 2014. A final annual report on Never Events in 2013/14 will be published in summer 2014.

For the year commencing April 2014, provisional summaries of never events will be issued monthly, with each report updating earlier data as incidents are locally investigated and more accurate information becomes available.

Never events

Never events are serious, largely preventable patient safety incidents that should not occur if existing national guidance or safety recommendations had been implemented by healthcare providers. For more detail on never events, see:

www.england.nhs.uk/ourwork/patientsafety/never-events/

Reconciliation of never events reported through different routes

In April 2013, NHS England became responsible for the never events policy framework. Never events data for 2013/14 to date has been collected from the National Reporting and Learning System (NRLS) and the Strategic Executive Information System (STEIS) by the NHS England Patient Safety Domain.

In prior years, although efforts were made at each year's end to identify the number of never events duplicate reported via both the NRLS and STEIS, an accurate assessment of overlap (and therefore the total number of never events reported to either or both systems) was difficult.

To avoid this, any possible never events reported via NRLS since April 2013 have been passed by NHS England to commissioners, who are asked to discuss with the relevant provider organisations and either confirm this is not a never event or to ensure the incident is reported as a never event on the STEIS system. This process means that (once this confirmation has been received) STEIS can be considered as the reliable and complete data source.

Additionally, the quality of reporting of never events made to the STEIS system is routinely reviewed. Where a Serious Incident is logged as a never event but does not appear to fit any definition of a never event on The *never events list 2013/14 update*, commissioners are asked to discuss with the provider organisation and either add extra detail to the STEIS system to confirm it is a never event or to take its never event designation off the STEIS system.

The detail of this reconciliation process is shown in the Appendix.

IMPORTANT NOTES on the provisional nature of these data

To support learning from never events, NHS England is committed to early publication. But because of the process of reconciliation described above, and because reports of apparent never events are made as soon as possible before local investigation is complete, all data are subject to change.

This provisional report is drawn from the STEIS system, and includes all Serious Incidents where the date of the incident was between 1 April 2013 and 31 March 2014 and where on 8 April 2014 they were designated by their reporters as never events.

Summary

At the time data for this report were extracted on 8 April 2014, 330 Serious Incidents on the STEIS system were designated by their reporters as never events with a reported incident date between 1 April 2013 and 31 March 2014. Of these 330 incidents:

- There were 312 Serious Incidents that appeared to meet the definitions of a never event in The *never events list 2013/14 update* and the date of incident was reported as occurring between 1 April 2013 and 31 March 2014. This number is subject to change as local investigation takes place.
- One appeared to meet the definitions of a never event but the actual date of incident was clearly prior to April 2013. This was an apparent retained foreign object recently discovered when the patient underwent further surgery.
- Seventeen additional Serious Incidents did not appear to describe circumstances that met any definition of a never event in The *never events list 2013/14 update*. The communication process described above is underway and updated information will be reflected in the final annual report on never event data for 2013/14 which will be published in summer 2014.

More detail is provided in the tables below.

TABLE ONE: Never events 1 April 2013 to 31 March 2014 by month

PROVISIONAL DATA: SUBJECT TO CHANGE AS LOCAL INVESTIGATION COMPLETED	
Month in which never event occurred	**Number**
April 2013	27
May 2013	30
June 2013	34
July 2013	27
August 2013	30
September 2013	19
October 2013	24
November 2013	28
December 20 13	18
January 2014	31
February 2014	21
March 2014	23
Total	**312**
Note as described above an additional 18 incidents either cannot be matched to a type of never event (17 incidents), or occurred prior to 1 April 2013 (1 incident).	

TABLE TWO: Never events 1 April 2013 to 31 March 2014 by type

PROVISIONAL DATA: SUBJECT TO CHANGE AS LOCAL INVESTIGATION COMPLETED	
Type of never event	**Number**
Retained foreign object post procedure	123
Wrong site surgery	89
Wrong implant/prosthesis	49
Inappropriate administration of daily oral methotrexate	16
Misplaced naso or oro gastric tubes	14
Transfusion of ABO incompatible blood components	4
Air embolism	4
Wrong gas administered	3
Maladministration of insulin	3
Maladministration of a potassium containing solution	2
Escape of a transferred prisoner	1
Falls from unrestricted window	1
Overdose of midazolam during conscious sedation	1
Failure to monitor and respond to oxygen saturation	1
Maternal death due to post-partum haemorrhage after elective caesarean section	1
Grand Total	**312**
Note as described above an additional 18 incidents either cannot be matched to a type of never event (17 incidents), or occurred prior to 1 April 2013 (1 incident).	

TABLE THREE: Serious Incidents that meet definitions of a never event and where actual date of incident fell between 1 April 2013 and 31 March 2014, with additional detail

PROVISIONAL DATA: SUBJECT TO CHANGE AS LOCAL INVESTIGATION COMPLETED	
Type *and brief description* **of never event**	**Number**
Retained foreign object post procedure	**123**
Vaginal swab	*30*
Surgical swab	*21*
Vaginal tampon	*15*
Throat pack	*4*
Central line guide wire	*4*
Throat swab	*4*
Arterial line guide wire	*3*
Drill bit	*2*
Femoral guide wire	*2*
Surgical glove	*2*
Surgical needle	*2*
Retrieval bag	*2*
Surgical forceps	*2*
Pedicle screw tab	*2*
Eye conformer	*1*
Fragment of blue plastic	*1*
Tip of hypodermic needle	*1*
Irrigation bulb syringe tip	*1*
Central line introducer	*1*
Laparoscopic port	*1*
Eye swab (German strip)	*1*
Microvascular clamp	*1*
Trial acetabular head	*1*
Not known	*1*
Vas cath guidewire	*1*
Vas cath guidewire introducer	*1*
Drill guide block	*1*
Vascular clamp	*1*
Teeth from Charnley retractor	*1*
Renal dialysis trocar	*1*
Chest drain guide wire	*1*
Retained specimen	*1*
Tracheostomy guide wire	*1*
Retrieval bag and specimen	*1*
Urethral introducer fragment	*1*
CVH guide wire	*1*
Guide plate for internal fixation	*1*
Suction guard	*1*
Humeral disc	*1*
Diathermy cleaning patch	*1*

PROVISIONAL DATA: SUBJECT TO CHANGE AS LOCAL INVESTIGATION COMPLETED	
Type *and brief description* **of never event**	**Number**
ACL guide wire	*1*
Pledget	*1*
Wrong site surgery	**89**
Wrong tooth removed	*18*
Wrong skin lesion	*9*
Wrong initial incision point	*4*
Wrong spinal level	*4*
Unnecessary procedure - wrong pathology	*3*
Wrong side chest drain	*3*
Unnecessary procedure - wrong documentation	*3*
Injection in wrong eye	*3*
Iridectomies rather than trabeculoplasty	*2*
Wrong hernia repair	*2*
Wrong finger	*2*
Wrong procedure - wrong skin lesion	*2*
Carpal tunnel rather than trigger finger release	*2*
Wrong level facet joint injection	*1*
Unnecessary procedure - lumbar puncture performed on wrong baby	*1*
Wrong side tumour biopsy	*1*
Wrong scar excised	*1*
Wrong side foraminectomy	*1*
Wrong organ removed - fallopian tube rather than appendix	*1*
Wrong side ureteroscopy	*1*
Blepheroplasty rather than canthal slings	*1*
Wrong side varicose veins	*1*
Cystoscopy rather than spinal injection	*1*
Wrong foot surgery (type of surgery not specified)	*1*
Wrong toes amputated	*1*
Angioplasty to wrong leg	*1*
Wrong side thoracostomy	*1*
Wrong vein harvested	*1*
Wrong eye procedure	*1*
Wrong femoral artery	*1*
Wrong nephrostomy tube replaced	*1*
Wrong procedure - not specified	*1*
Wrong fallopian tube removed	*1*
Wrong hernia repair	*1*
Wrong skin lesion	*1*
Wrong dental procedure	*1*
Wrong side meningocele cyst	*1*
Vasectomy rather than revision of scar tip of penis	*1*
Pilonidal sinus rather than abscess	*1*
Carpal tunnel rather than excision of skin lesion	*1*
Wrong side thoracoscopy	*1*
CT Arthrogram to wrong side	*1*

PROVISIONAL DATA: SUBJECT TO CHANGE AS LOCAL INVESTIGATION COMPLETED	
Type *and brief description* **of never event**	**Number**
Wrong testicle explored	*1*
Wrong scalp lesion	*1*
Wrong side pleuritc tap	*1*
Wrong implant/ prosthesis	**49**
Lens	*26*
Hip prosthesis	*9*
Knee prosthesis	*9*
Pacemaker	*1*
Cochlear implant	*1*
Wrong fixation plate	*1*
Grommet	*1*
Metal stent	*1*
Inappropriate administration of daily oral methotrexate	**16**
Wrong frequency	*14*
Wrong frequency and dose	*2*
Misplaced naso or oro gastric tubes	**14**
NG tube in lung	*13*
Possible NG tube in lung	*1*
Air embolism	**4**
Air injected into coronary artery	*2*
Radial arterial line flushed	*1*
Open line	*1*
Transfusion of ABO incompatible blood components	**4**
Wrong unit of blood	*4*
Maladministration of insulin	**3**
Insulin not given	*3*
Wrong gas administered	**3**
Air instead of oxygen	*2*
Oxygen instead of air	*1*
Maladministration of a potassium containing solution	**2**
Wrong route administration	*1*
Wrong dose	*1*
Escape of a transferred prisoner	**1**
Escaped during transfer from one area of hospital to another	*1*
Failure to monitor and respond to oxygen saturation	**1**
Volatile agent and ventilator not set correctly	*1*
Falls from unrestricted window	**1**
Unclear if window was restricted	*1*
Maternal death due to post-partum haemorrhage after elective caesarean section	**1**
Overdose of midazolam during conscious sedation	**1**
Full 5 mgs administered in one dose	*1*
Total	**312**
Note as described above an additional 18 incidents either cannot be matched to a type of never event (17 incidents), or occurred prior to 1 April 2013 (1 incident).	

TABLE FOUR: Never events declared on STEIS at 8 April 2014, where reported date of incident is 1 April 2013 - 31 March 2014

PROVISIONAL DATA: SUBJECT TO CHANGE AS LOCAL INVESTIGATION COMPLETED Provider Organisation where never event (NE) occurred	Wrong site surgery (NE type 1)	Wrong implant or prosthesis (NE type 2)	Retained foreign object post-procedure (NE type 3)	NE types 4-25	TOTAL MATCHING ANY NE DEFINITION	*Additional Serious Incidents reported as NEs but CANNOT be matched to Never Event List types 1-25*	*Additional NEs detected since April 2013 but NE occurred at an earlier date*
5 Boroughs Partnership NHS Foundation Trust						*1*	
Aintree University Hospital NHS Foundation Trust			1		**1**		
Airedale NHS Foundation Trust	1				**1**		
Alder Hey Children's NHS Foundation Trust			1		**1**		
Barking Havering & Redbridge University Hospitals NHS Trust	1			1	**2**		
Barlborough NHS Treatment Centre						*1*	
Barnet & Chase Farm Hospitals NHS Trust				1	**1**		
Barts Health NHS Trust	4		3	1	**8**	*1*	
Basildon And Thurrock University Hospitals NHS Foundation Trust			1	1	**2**	*1*	
Birmingham Children's Hospital NHS Foundation Trust			1		**1**		
Birmingham Women's NHS Foundation Trust			1		**1**		
Blackpool Fylde & Wyre Hospitals NHS Foundation Trust				1	**1**		
BMI Highfield Hospital		1			**1**		
BMI Meriden Hospital		1			**1**		
BMI Saxon Clinic			1		**1**		
BMI Thornbury Hospital			1		**1**		
Bolton NHS Foundation Trust	1				**1**		
Bradford Hospitals NHS Foundation Trust	2				**2**		
Brighton and Sussex University Hospitals NHS Trust				1	**1**		
Buckinghamshire Healthcare NHS Trust			1		**1**	*2*	

PROVISIONAL DATA: SUBJECT TO CHANGE AS LOCAL INVESTIGATION COMPLETED Provider Organisation where never event (NE) occurred	Wrong site surgery (NE type 1)	Wrong implant or prosthesis (NE type 2)	Retained foreign object post-procedure (NE type 3)	NE types 4-25	TOTAL MATCHING ANY NE DEFINITION	*Additional Serious Incidents reported as NEs but CANNOT be matched to Never Event List types 1-25*	*Additional NEs detected since April 2013 but NE occurred at an earlier date*
Burton Hospitals Foundation Trust				1	**1**		
Cambridge University Hospitals NHS Foundation Trust			1		**1**		
Central Manchester University Hospitals NHS Foundation Trust			3		**3**		
Chelsea & Westminster Healthcare NHS Foundation Trust		1	2		**3**		
Chesterfield Royal Hospital NHS Foundation Trust			1	1	**2**		
City Hospital Sunderland NHS Foundation Trust	1				**1**		
Colchester Hospital University NHS Foundation Trust		1			**1**		
Co-operative Pharmacy				1	**1**		
Cornwall Partnership NHS Foundation Trust						*1*	
County Durham & Darlington NHS Foundation Trust						*1*	
Croydon Health Services NHS Trust			1		**1**		
DARTFORD AND GRAVESHAM NHS TRUST		1			**1**		
Derby Hospitals NHS Foundation Trust		1	1		**2**		
Doncaster & Bassetlaw Hospitals NHS Foundation Trust	2		1		**3**		
Dorset County Hospital NHS Foundation Trust			1		**1**		
Dorset Healthcare University NHS Foundation Trust	1				**1**		
East and North Hertfordshire NHS Trust	1				**1**		
East Kent Hospitals University NHS Foundation Trust	1		1	1	**3**		
East Lancashire Hospitals NHS Trust			1		**1**		
East London NHS Foundation Trust				1	**1**		
Epsom & St Helier NHS Trust			1		**1**		

PROVISIONAL DATA: SUBJECT TO CHANGE AS LOCAL INVESTIGATION COMPLETED Provider Organisation where never event (NE) occurred	Wrong site surgery (NE type 1)	Wrong implant or prosthesis (NE type 2)	Retained foreign object post-procedure (NE type 3)	NE types 4-25	TOTAL MATCHING ANY NE DEFINITION	*Additional Serious Incidents reported as NEs but CANNOT be matched to Never Event List types 1-25*	*Additional NEs detected since April 2013 but NE occurred at an earlier date*
Frimley Park Hospital NHS Foundation Trust			1		**1**		
George Eliot Hospital NHS Trust	3				**3**		
Gloucestershire Care Services NHS Trust	1				**1**		
Gloucestershire Hospitals NHS Foundation Trust		1	1		**2**	*1*	
Great Ormond Street Hospital for Children NHS Foundation Trust	1				**1**		
Great Western Hospitals NHS Foundation Trust			4		**4**		
Guy's & St Thomas' NHS Foundation Trust						*1*	
Hampshire Hospitals NHS Foundation Trust			1		**1**		
Harrogate and District NHS Foundation Trust		1			**1**		
Heart of England NHS Foundation Trust	1	1			**2**		
Heatherwood and Wexham Park Hospitals NHS Foundation Trust	1		1		**2**		
Homerton Hospital NHS Foundation Trust				1	**1**		
Horton Independent Surgical Treatment Centre	1				**1**		
Hull & East Yorkshire Hospitals NHS Trust	1		1		**2**		
Imperial College Healthcare NHS Trust	1				**1**		
Imperial College Healthcare NHS Trust				1	**1**		
InHealth Netcare	1				**1**		
Isle of Wight NHS Trust				1	**1**		
James Paget University Hospitals NHS Foundation Trust			2		**2**		
Kettering General Hospital NHS Foundation Trust			1		**1**		
King's College Hospital NHS Foundation Trust	2		3	1	**6**		

PROVISIONAL DATA: SUBJECT TO CHANGE AS LOCAL INVESTIGATION COMPLETED Provider Organisation where never event (NE) occurred	Wrong site surgery (NE type 1)	Wrong implant or prosthesis (NE type 2)	Retained foreign object post-procedure (NE type 3)	NE types 4-25	TOTAL MATCHING ANY NE DEFINITION	*Additional Serious Incidents reported as NEs but CANNOT be matched to Never Event List types 1-25*	*Additional NEs detected since April 2013 but NE occurred at an earlier date*
Kings College Hospital NHS Foundation Trust	1				**1**		
Kingston Hospital NHS Foundation Trust			1	1	**2**		
Lancashire Teaching Hospitals NHS Foundation Trust	2		1		**3**		
Leeds Teaching Hospitals NHS Trust		1	6	1	**8**		
Leighton Hospital - midwifery led unit			1		**1**		
Lewisham and Greenwich NHS Trust		1	2		**3**	*1*	
Liverpool Community Health NHS Trust	1				**1**		
Liverpool Heart and Chest NHS Foundation Trust	1		1		**2**		
Liverpool Women's Hospital NHS Foundation Trust				1	**1**		
Luton and Dunstable University Hospital NHS Foundation Trust	1			1	**2**	*1*	
Maidstone and Tunbridge Wells NHS Trust	1				**1**		
Mid Cheshire Hospitals NHS Foundation Trust			2	1	**3**		
Mid Essex Hospital Services NHS Trust	2			1	**3**		
Mid Yorkshire Hospitals NHS Trust			1	1	**2**		
Midlands Eye Care		1			**1**		
Moorfields Eye Hospital NHS Foundation Trust		1	1		**2**		
Newcastle Upon Tyne Hospitals NHS Foundation Trust	1	2	2		**5**		
Norfolk & Norwich University Hospitals NHS Foundation Trust	1		3		**4**		
North Bristol NHS Trust	2		2		**4**		
North Cumbria University Hospitals Trust	1		2		**3**		
North Tees & Hartlepool NHS Foundation Trust	1				**1**		

PROVISIONAL DATA: SUBJECT TO CHANGE AS LOCAL INVESTIGATION COMPLETED Provider Organisation where never event (NE) occurred	Wrong site surgery (NE type 1)	Wrong implant or prosthesis (NE type 2)	Retained foreign object post-procedure (NE type 3)	NE types 4-25	TOTAL MATCHING ANY NE DEFINITION	*Additional Serious Incidents reported as NEs but CANNOT be matched to Never Event List types 1-25*	*Additional NEs detected since April 2013 but NE occurred at an earlier date*
North West London Hospitals NHS Trust	1			3	**4**		
Northern Devon Healthcare NHS Trust			1	1	**2**		
Northern Lincolnshire & Goole NHS Foundation Trust		1	1		**2**		
Northumbria Healthcare NHS Foundation Trust	1			1	**2**		
Nottingham University Hospitals NHS Trust	1			1	**2**		
Nuffield Hospital Cambridge		1			**1**		
Oxford University Hospitals NHS Trust	1	1	1		**3**		
Papworth Hospital NHS Foundation Trust			1	1	**2**		
Peterborough and Stamford NHS Foundation Trust	1				**1**		
Plymouth Hospitals NHS Trust	1			1	**2**		
Poole Hospital NHS Foundation Trust	2		1		**3**		
Portsmouth Hospitals NHS Trust	2			1	**3**		
Queen Victoria Hospital NHS Foundation Trust	2				**2**		
Renacres Hospital		1			**1**		
Rochdale Ophthalmology Clinical Assessment & Treatment Service		1			**1**		
Rochdale Ophthalmology Clinical Assessment & Treatment Services		1			**1**		
Royal Berkshire NHS Foundation Trust		2	3	1	**6**		
Royal Brompton & Harefield NHS Foundation Trust			1	1	**2**		
Royal Cornwall Hospitals NHS Trust	2	1		1	**4**		
Royal Devon and Exeter NHS Foundation Trust	1			1	**2**		
Royal Free London NHS Foundation Trust	1			1	**2**		

PROVISIONAL DATA: SUBJECT TO CHANGE AS LOCAL INVESTIGATION COMPLETED Provider Organisation where never event (NE) occurred	Wrong site surgery (NE type 1)	Wrong implant or prosthesis (NE type 2)	Retained foreign object post-procedure (NE type 3)	NE types 4-25	TOTAL MATCHING ANY NE DEFINITION	*Additional Serious Incidents reported as NEs but CANNOT be matched to Never Event List types 1-25*	*Additional NEs detected since April 2013 but NE occurred at an earlier date*
Royal Liverpool & Broadgreen NHS Trust	2				**2**		
Royal Surrey County Hospital NHS Foundation Trust	2		1		**3**		
Salford Royal NHS Foundation Trust	2				**2**		
Sandwell and West Birmingham Hospitals NHS Trust	1	3			**4**		
Sedgeley House Hospital				1	**1**		
Sheffield Teaching Hospitals NHS Foundation Trust			3	1	**4**		
Sherwood Forest Hospitals NHS Foundation Trust				1	**1**	*1*	
South Devon Healthcare NHS Foundation Trust		2			**2**		
South London & Maudsley NHS Foundation Trust						*1*	
South Tees Hospitals NHS Foundation Trust			2	1	**3**		
South Warwickshire NHS Foundation Trust		1	2		**3**		
Southampton Treatment Centre	1				**1**		
Southend University Hospital NHS Foundation Trust				1	**1**		
Southport & Ormskirk Hospital NHS Trust			2		**2**		
Spire Cambridge Lea Hospital		1			**1**		
Spire Parkway Hospital		1			**1**		
Spire Tunbridge Wells Hospital			1		**1**		
Spire Wellesley Hospital		1			**1**		
St George's Healthcare NHS Trust	3		2		**5**		
St Helens & Knowsley Hospitals NHS Trust	1				**1**		
Staffordshire and Stoke on Trent Partnership Trust				1	**1**		
Stockport NHS Foundation Trust		1			**1**		

PROVISIONAL DATA: SUBJECT TO CHANGE AS LOCAL INVESTIGATION COMPLETED Provider Organisation where never event (NE) occurred	Wrong site surgery (NE type 1)	Wrong implant or prosthesis (NE type 2)	Retained foreign object post-procedure (NE type 3)	NE types 4-25	TOTAL MATCHING ANY NE DEFINITION	*Additional Serious Incidents reported as NEs but CANNOT be matched to Never Event List types 1-25*	*Additional NEs detected since April 2013 but NE occurred at an earlier date*
Surrey and Sussex Healthcare NHS Trust				1	**1**		
Tameside Hospital NHS Foundation Trust			1		**1**		
Taunton and Somerset NHS Foundation Trust	3				**3**		
The Dudley Group NHS Foundation Trust			1		**1**		
The Hillingdon Hospital NHS Foundation Trust			2		**2**		
The Ipswich Hospital NHS Trust	1				**1**		
THE PRINCESS ALEXANDRA HOSPITAL NHS TRUST			2		**2**		
The Rotherham NHS Foundation Trust	1				**1**		
The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust	1	1			**2**		
The Royal National Orthopaedic Hospital NHS Trust	2				**2**		
The Royal Wolverhampton NHS Trust	2		2		**4**		
The Walton Centre NHS Foundation Trust				1	**1**		
UKSH Emersons Green			1		**1**	*1*	
United Lincolnshire Hospitals NHS Trust			2		**2**		
University College London Hospitals NHS Foundation Trust	1		2	1	**4**		
University Hospital North Staffordshire			1		**1**		
University Hospital of South Manchester NHS Foundation Trust		1	1		**2**		
University Hospital Southampton NHS Foundation Trust			2		**2**		
University Hospitals Birmingham NHS Foundation Trust	2				**2**		
University Hospitals Bristol NHS Foundation Trust	1		1		**2**		
University Hospitals Coventry and Warwickshire NHS Trust		1	2		**3**		

PROVISIONAL DATA: SUBJECT TO CHANGE AS LOCAL INVESTIGATION COMPLETED Provider Organisation where never event (NE) occurred	Wrong site surgery (NE type 1)	Wrong implant or prosthesis (NE type 2)	Retained foreign object post-procedure (NE type 3)	NE types 4-25	TOTAL MATCHING ANY NE DEFINITION	*Additional Serious Incidents reported as NEs but CANNOT be matched to Never Event List types 1-25*	*Additional NEs detected since April 2013 but NE occurred at an earlier date*
University Hospitals of Leicester NHS Trust		2	1		**3**	*1*	
University Hospitals of Morecambe Bay NHS Foundation Trust	1	2			**3**	*1*	
Walsall Healthcare NHS Trust			1	1	**2**		
Warrington and Halton Hospitals NHS Foundation Trust		1		1	**2**		
West Hertfordshire Hospitals NHS Trust	1		1		**2**		
West Middlesex University NHS Trust			3	1	**4**		
West Suffolk NHS Foundation Trust		1	1		**2**		
Western Sussex Hospitals NHS Foundation Trust		1			**1**		
Weston Area Health NHS Trust	1		1		**2**		
Whittington Health NHS Trust			1		**1**		
Will Adams Treatment Centre		1			**1**		
Wirral University Teaching Hospital NHS Foundation Trust		1	1		**2**		*1*
Worcestershire Acute Hospitals NHS Trust		1		1	**2**		
Wrightington, Wigan and Leigh NHS Foundation Trust			1	1	**2**		
Wye Valley NHS Trust			2	1	**3**		
Yeovil District Hospital NHS Foundation Trust			1		**1**		
York Hospitals NHS Foundation Trust	1		2		**3**		
Yorkshire Clinic		2			**2**		
Totals (all organisations)	**89**	**49**	**123**	**51**	**312**	***17***	***1***

Appendix: technical process of reconciliation of NRLS & STEIS

The following steps are undertaken as incidents are reported and become available for review:

1. Ensuring all NRLS reports of never events are reported as never events via STEIS:

    a. Identifying possible or apparent never events in the NRLS:
        i. The NRLS is searched for all reports with the term 'never event' in the free text and reports where the field 'never event' has been reported as = Yes. These reports are reviewed by clinicians. Incidents that are clearly not never events are disregarded but all possible or apparent never events are flagged for reconciliation with STEIS
        ii. All incidents reported to the NRLS with an outcome of death or severe harm are reviewed by clinicians, and regardless of whether or not the term 'never event' is used, all possible or apparent never events are flagged for reconciliation with STEIS

    b. Matching apparent and possible never events reported via NRLS with STEIS:
        i. Where the provider organisation, date of incident and detail of incident (e.g. type of retained object) can be matched with a never event reported on STEIS no action is taken.
        ii. Where the provider organisation, date of incident and detail of incident (e.g. type of retained object) CANNOT be matched with a never event reported on STEIS, commissioners are contacted and asked to contact the relevant provider organisations and either confirm this is not a never event or to ensure the incident is not flagged in the never event field on the STEIS system.

2. Ensuring the quality and completeness of STEIS flagging of never events:

    a. Whilst the designation of an incident as a never event is the remit of the commissioning organisation, STEIS is routinely reviewed by clinicians with specialist expertise and where an incident does not appear to meet the definitions in The *never events list 2013/14 update* commissioners are asked to either add extra detail to confirm the type of never event, or to take its never event designation off the STEIS system.

    b. STEIS is searched for Serious Incidents including the free text term 'never event' but where the never event field on STEIS has not been completed as = Yes. Except where the use of the term is clearly not suggesting a never event (e.g. phrases like *'this is not a never event'*) commissioners are asked to contact the relevant provider organisations and either confirm this is not a never event or to ensure the incident is flagged in the never event field on the STEIS system.

    c. Some never events may only be detected at a later date (particularly retained objects found during further surgery). Where reports to STEIS clearly describe never events occurring prior to the date they are reported as occurring on STEIS, commissioners are asked to ensure incident date on STEIS reflects when the never event occurred, not when it was detected.

5 March 2014

Dr Mark Newbold
Chief Executive
Heart of England NHS Foundation Trust
Chief Executives Office
Birmingham Heartlands Hospital
Bordesley Green
Birmingham
West Midlands
B9 5SS

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Making the health sector work for patients

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Dear Mark,

Q3 2013/14 monitoring of NHS foundation trusts

Our analysis of Q3 is now complete. Based on this work, the Trust's current ratings are:

- Continuity of services risk rating - 4
- Governance risk rating - Red

The Trust is subject to formal enforcement action in the form of enforcement undertakings. In accordance with our Enforcement Guidance, such actions have also been published on our website.

I have attached a one page executive summary (Appendix 1) of your Trust's Q3 results for your information and a report on the aggregate performance of the NHS foundation trust sector will shortly be available on our website (in the ***News, events and publications*** section) which I hope you will find of interest.
For your information, we issued a press release on 21 February 2014 setting out a summary of the key findings across the NHS foundation trust sector from the Q3 monitoring cycle.

If you have any queries relating to the above, please contact me by telephone on 02037470053 or by email (Alexandra.Coull@Monitor.gov.uk).

Yours sincerely

Alexandra Coull
Senior Regional Manager

cc: Lord Philip Hunt, Chairman
Mr Aidan Quinn, Acting Finance Director

Heart of England NHS Foundation Trust
Q3 2013 - 14 Reporting Executive Summary

Monitor

Risk Ratings	Continuity of Service Risk Rating	
	13/14:	YTD Actual
		4

Governance Risk Rating:			
Declared risks at APR:	AETime	YTD Actual:	Red
Declared Risks in Year:	RTT, Cdiff		
Breaches for Current Period:	Cdiff, C62dGP, AETime		

- Monitor has taken regulatory action to address breaches of the A&E 4-hour wait target. There are a number of other governance concerns currently being considered by Monitor.
- The Trust has delivered CoSRR 4 in Quarter 3 2013/14. EBITDA of £25.9m is £2.3m behind plan. The variance is largely driven by miscellaneous expenditure (adverse variance of £7.2m).

Summary Income & Cash Flow vs Plan

£m	2013/14 Q3			2013/14 YTD		
	Plan	Actual	Variance	Plan	Actual	Variance
Op. Rev for EBITDA	156.3	159.6	3.3	467.9	473.6	5.7
Employee Expenses	(98.3)	(98.5)	(0.2)	(295.3)	(293.7)	1.6
PFI Op. expense	(0.2)	(0.2)	0.0	(0.7)	(0.7)	0.0
All other Op. costs	(47.7)	(54.0)	(6.3)	(143.7)	(153.3)	(9.6)
EBITDA	10.1	6.9	(3.2)	28.3	25.9	(2.3)
Surplus/(Deficit) pre exceptionals	4.3	1.3	(3.0)	11.0	9.0	(2.1)
Net Surplus/(Deficit)	2.2	(0.2)	(2.4)	4.5	3.5	(1.0)
EBITDA %	6.5%	4.3%	(2.1%)	6.0%	5.5%	(0.6%)
CapEx (Accruals Basis)	(9.6)	(6.7)	2.9	(23.7)	(19.9)	3.8
Net cash flow	(0.2)	(2.5)	(2.3)	10.4	10.9	0.5
Cash & Equiv	104.1	104.6	0.5	104.1	104.6	0.5
CoSRR Liquidity days	24.6	25.8	1.2	24.6	25.8	1.2
CIP % OpEx less PFI	3.6%	2.3%	(1.3%)	3.2%	2.2%	(1.0%)
Net current assets	47.7	50.8	3.1	47.7	50.8	3.1
Borrowing (excluding PFI)	0.0	0.0	0.0	0.0	0.0	0.0

Key risks	Action taken / committed	Gaps and residual concerns
Emergency performance • The Trust has failed the A&E 4-hour wait target for six consecutive quarters (Q2 2012/13-Q3 2013/14). • The Trust has had two +12 hour breaches up to Quarter 3 2013/14. • The Trust has declared a risk against achieving the Referral to Treatment (RTT) target in Quarter 4.	• The overall Trust position against the A&E 4-hour target has improved. The Trust implemented Gold Command and engaged with ECIST to run the perfect week at both sites during December. A second perfect week was also run in January 2014 at the Good Hope site. • In the longer term the Trust has commissioned McKinsey to assist in completing transformation of the Emergency Care Pathway before the winter of 2014/15. The Trust has recently appointed to fill medical vacancies. The Trust has a rectification plan in place to manage a fail of the RTT target in Quarter 4 and then return to compliance in Quarter 1 2014/15.	• There remains a risk that the Trust will not achieve the 95% target on a sustainable basis The overall performance against the 4-hour target at Good Hope continues to be worse than that at Heartlands and Solihull. • Patients may be waiting longer than planned for elective treatment due to the impact of the urgent care pressures. • There is a risk that the Urgent Care Transformation Plan could lack sufficient senior resources and robust engagement from clinicians to be delivered before 31 March 2014.
Quality governance • There are a number of indicators that have raised concerns regarding the quality of governance at the Trust. • The Sir Ian Kennedy report was published in Quarter 3 and the report raised a number of concerns regarding the previous leadership team at the Trust. • The Trust was subject to a CQC inspection in 2014. A number of areas of non compliance with regulations were raised and a Warning Notice was issued.	• Monitor outlined the nature of governance concerns in a letter to the Trust (dated 4 February 2014). The Trust has recently submitted a response to this letter. • The Trust has compiled an action plan to follow up on each issue raised in the Sir Ian Kennedy report. A task force has also been set up to oversee action taken in response to the recommendations. • A detailed action plan has also been compiled to address each issue raised in the CQC report as well as the Warning Notice.	• There is concern that leadership and governance arrangements require improvement. • Monitor will review the response to the governance letter and confirm any residual concerns in writing to the Trust.
Financial Performance • In Quarter 3 the Trust was behind the CIP plans by £4.4m and 34% of the CIPs were non recurrent. Delivery of 2014/15 and 2015/16 CIP targets will require transformational efficiencies. • The Trust continues to pay a premium for the use of agency staff. Miscellaneous costs have increased in Quarter 3 and are now £7.2m higher than planned.	• The Trust Board has commissioned external support (McKinsey) to develop and deliver transformation plans for 2014/15 and 2015/16. • The Trust has delivered an CoSRR 4 in Q3 13/14. • The Trust has continued to contract with its commissioners using a Joint Managed Risk Agreement, predicated on effective demand management. • The Trust confirmed that they have had a recruitment drive for nurses and continue to take action to improve staff retention.	• Failure to deliver 2013/14 CIPs on a recurrent basis will put further pressure on efficiency requirements in outer years. • There is a risk that further miscellaneous costs could further erode the surplus position.
Next steps	• **Monitor to consider the response from the Trust regarding governance concerns in light of the Enforcement Guidance and to confirm response in writing to the Trust.** • **Trust to confirm date that it will submit the draft Transformation Plan to Monitor (as per letter to the Trust dated 21 February 2014).**	

Apologies | Declaration of Interest | Minutes | Matters Arising | Chairman's Report | Council of Governors Report | Chief Executive's Report | Safety, Quality and Org. Dev. | Patient and Public Feedback | Finance and Performance | External and Strategic Review | Nursing, Midwifery care staffing capacity | Equality and Diversity

Board Assurance Framework | Transport Strategy | Board Committee Reports | Any Other Business | Part Two

Safety, Quality and Organisational Development

8.1	Governance and Risk Committee Report	(Oral and enclosure)
8.2	Safety SITREP Update	(Enclosure)
8.3	Medical Revalidation Update	(Oral)

These minutes are DRAFT until approved at the 31 March Quality & Risk Committee 2014

DRAFT Minutes of a meeting of the QUALITY AND RISK COMMITTEE of Heart of England NHS Foundation Trust held in the Board Room of Devon House at 0930 on 3 February 2014

	Name	Title
Present	**RAO, Jammi (JR)**	**Non-Executive Director/Chair**
	HUNT, Phil (PH)	Non-Executive Director and Trust Chairman
	LAWRENCE, Les (LL)	Non-Executive Director/Deputy Chair
In Attendance		
	BLACKBURN, Rachael (RB)	Head of Corporate Risk and Compliance
	FOSTER, Sam (SF)	Chief Nurse
	GUNTER, Hazel (HG)	Director of Workforce
	JONES, Alan (AJ)	Associate Medical Director
	KEOGH, Ann (AK)	Director of Medical Safety
	OKUBADEJO, Adedeji (AO)	Director of Medical Appraisal & Revalidation
	POLSON, Rex (RP)	Associate Medical Director
	RICHARDS EVERTON, Lisa (LRE)	Expert Patient Volunteer
	RYDER, Clive (CR)	Medical Director (Acting)
	RUDD, Louise (LR)	Head of Clinical Governance
	COVEY, Alex (AC)	Head of Organisational Development
	ABASSI, Ann (AA)	Redesigning Care Team (Part)
	CARUTHERS, Tania (TC)	Clinical Director, Pharmacy (Part)
	EWING, Joanne (JE)	Consultant Haematologist & Clinical Director Oncology/Haematology (Part)
Minutes	BRADSHAW, Sian	EA/Sarah Woolley

1. Apologies for absence

Apologies were received from Patrick Brooke, Patrick Cadigan, Sue Cordon, Raghuraman Govindan, David Lock, Sue Nicholls Laura Serrant Green, and Lisa Thomson.

2. Minutes of the meeting held on 2nd December / matters arising and standing agenda items

The minutes were taken as read.

3. Actions Arising

It was recognised that all were complete or underway.

MATTERS FOR DISCUSSION

4. Safety Sitrep

An additional red operational risk had been agreed since the report was published, concerning the impact of capacity and extended length of stay in ED. It was allocated a risk score of 15 for review after 6 months.

LR highlighted the new attachment 2b, a list of proposed risks scoring 15 and above for awareness of the risks currently being worked up by the organisation. Previously this has not been presented to QRC. There is also an emerging concerns report which goes direct from the risk forum to EMB which again is designed to increase the visibility of risks to the organisation

Medicines and Healthcare Products Regulatory Agency (MHRA) had made a critical finding on medical oversight and data integrity in trials being conducted by HEFT and the University of Birmingham. This is currently before a panel and HEFT will be informed of the outcome and any action against the Trust.

PH asked that the Board should consider whether the Kennedy Report, and expected implementation of the action plan, should be added as a strategic risk. RB confirmed that the strategic risk register was on the agenda for the next Board meeting.

Number of Never Events occurring in year was reducing but the number being reported was increasing, (as some were identified some time after they had occurred). We are working with the CCG's to develop Trust and regional initiatives to support learning from SUI's and Never Events including "Walk the walk events"

LL asked about the SUI Profiles and would like to see a reporting back method on the suggested actions and what has been done to learn from them. AK confirmed that a report on actions from SUI's was under development and would be submitted to this committee.

LR said the main purpose of the SUI at a glance reports was to easily share the learning from the event across the Trust. JR acknowledged that he had seen them in use to raise awareness and learning at a recent walk the walk

ACTION:
LESSONS LEARNED REPORT ON ACTION PLANS

5. Chemotherapy prescribing/administration in absence of EP

JE set out the background to the issue. This issue had been rated as a red risk for a considerable period of time. This paper was to demonstrate the attempts to mitigate the risk in the current situation whilst the IT package is being tendered for, built and implemented.

Procurement is complex and ongoing. It is likely to take longer than initially anticipated and it is estimated are that a supplier will be identified by October. To build the system over 400 oncology regimens that needed to be transcribed from paper to the electronic system.

At the moment a paper based system is being used. Data suggests that an electronic system can reduce mistakes in prescribing by up to 45%. The need for a new Chemotherapy EP system was identified in 2011 and a full business case (for a discrete Chemotherapy only EP system) was put forward in December 2011. On 12 Jan 2012 this was put on hold as it was a tender for a small system which may or may not integrate into a wider EP system which was also needed. As such, a tender was issued for an entire EP system across the Trust. As HEFT does not currently have EP, HEFT currently fails peer review in this area.

JR asked what was being done in the meantime to ensure patient safety and the current mitigation plans were explained with errors being identified as addressed as they occur.

At a recent Chief Pharmacists meeting, of the 17 Trusts present, 7 had EP and of those some said their systems were not the best. We will work with these Trusts to learn from their experience and see if improvements can be made. EP will not prevent all medication incidents are we will need to continue to review errors.

PH voiced concern that it was not reported to them that the business case was put on hold. AJ confirmed it had been a widening of the scope of the original proposal rather than an outright rejection. PH said he remained concerned about the issue.

LL said he would speak to Adrian Stokes to ensure that this is in the budget for 2014/5.

There was a discussion about how much of a requirement an EP system is and how much it could realistically reduce errors, including the restriction of over prescribing chemotherapy. CR said that it was another layer of safety but would still require correct data entry, correct dispensing and correct administration. AK said that we need to continue to review errors even with an EP system to highlight them.

.

6. High Risk Medications

The High Risk Medications paper highlighted actions taken to mitigate risks associated with high risk medications. Never Events were being reviewed as well as near misses, to identify trends to see if any further mitigation needs to be put into place.

LRE raised the point that when speaking to junior doctors some said they were not clear on how to report medication errors. LRE expressed the view that it wasn't focussed on enough in training.

AO suggested asking Junior Doctors about medication error reporting to see whether they had learned what to do and to adapt training from there.

ACTION: HOW TO REPORT INCIDENTS TO BE RAISED REGULARLY DURING RISKY BUSINESS FORA

7. Report on the current medical appraisal system and how it levers our corporate goals (including a verbal update on GMC referrals)

AO opened by explaining that the baseline was far from where we should be. Many colleagues saw appraisal and revalidation as a tick box/waste of time. He said appraisal was a way of ensuring and delivering quality and revalidation was a by-product of this.

Background

- In 2001 the Trust signed up to annual appraisals.
- Prior to 2012 the Appraisal rate was 25% of doctors had appraisals.
- AO's role began in 2012 and the first appraisal cycle commenced in 2013.
- The deferral rate earlier this year was 3%, is currently 5% and will be on 10% by the end of the year.

Role of the GMC

If a doctor is not engaging with the process, the GMC will be notified but at that point, no action is taken. If they then still fail to engage then a formal notice of lack of engagement is made to the GMC who can withdraw their license to practice. Of the 18 HEFT doctors who have failed to engage which represents the 3% mentioned above; 11 have now been appraised, 4 have still not engaged, 3 have started their appraisals. Of the four, about 50% are consultants.

LL asked whether CR had concerns over the four who had not engaged.

CR said that he said there were a number of reasons for non-engagement and that he was not particularly worried that they were 'behaving badly' but he said that it was getting to the stage that a strong message needs to be sent.

JR raised the theoretical situation that if a doctor who had not engaged with the appraisal process was involved in a major clinical incident and it could be shown that HEFT was aware of the doctor's failure to engage it would portray HEFT as not paying enough attention to patient safety. JR recognised that Revalidation and Appraisal were not a panacea.

AO said that failure to engage is a recognised risk. There was the risk that these doctors are not engaging with other systems as well as with appraisal.

HG said it was important to note that until AO got involved in appraisals, there was a low take up of appraisals. HG said that Workforce was linked in with AO regarding the 18 and was working closely with him.

AO said that the end of February is the last deadline for appraisals to be completed.

CR recommended that if the end of February deadline is not met then those who have failed to engage should not continue in the organisation.

HG said that whilst it is important that appraisals are conducted but there is a wider issue over raising concerns throughout the year.

SF said that a quarterly update on clinicians who have been referred/under sanction would give some level of assurance.

ACTION: EVERY OTHER MEETING UPDATE ON CLINICIANS REFERRED/UNDER SANCTION (CR/SF)

8. Quarterly Nursing Assurance report – encompassing nursing professional matters

NB. This section is a combination of an explanation of the Safety Thermometer (Agenda item 9) which forms page one of the Quarterly Nursing Report and then goes on to work through pages 2-4 of the Quarterly Nursing Assurance Report.

SF opened by explaining that the Safety Thermometer is a national tool which was brought out 18 months ago. It involves 100% inpatient data collection. The Safety Thermometer is available at a ward, site and board level which is the level that comes to the Quality and Risk Committee. There is a daily harm alert to all senior nurses which flags pressure ulcers/injurious fall. There is also a monthly harm document as well as injurious fall themes being shared across the organisation.

The first page concerns pressure ulcers (new or existing), Falls (fallen within last 72 hours), Catheters with UTI and those being treated for VTE.

N.B. It is important to note that the pre-conditions for a pressure ulcer may occur prior to admittance but may only develop once in hospital (usually within 72 hours).

Moving forward, there needs to be more of an integrated quality dashboard.
VTE needs to be shared with medics and pressure ulcers and falls are of interest to them.
The Safety Thermometer doesn't flag key areas of harm in Maternity and as such, Paediatrics and Maternity are looking at forming their own.

Points to note

- Pressure Ulcers - In critical care there has been a decrease of pressure ulcers form 30 down to 0 which has mainly been due to changes to the use of equipment in the department.
- Falls – There is a planned review around red slip socks for patients as well as the use of cohorting.
- Catheters – There is a flag against those with catheter passport which is a booklet to help patients going home with catheters. This is issued on discharge so this figure will only show those arriving with a catheter passport. Work with community nursing is showing very high levels of catheter passports do hopefully this should start to appear in the patients being admitted and the figure should increase.

The following text now refers solely to the Quarterly Nursing Report:

The second page covers ward level safety and this has proved to be an excellent local improvement tool. SF said that whilst the targets of 95% are high, this is an appropriate goal to aim for.

The third page covers workforce issues of workforce planning, sickness, turnover and recruitment.

SF said that the planned vs actual staffing statistics needed more work.

PH asked about sickness absence.

SF said that the overall Trust sickness is lower than last year but not yet at target. The highest levels are in HCAs. Last year HCA sickness was at 10%. This year it is at 7.5%. SF still worried about sickness and work is underway to discover why HCA sickness is high within the HCA role.

Turnover rates have dropped slightly and have now reached a plateau.

The fourth page covers Patient Experience. SF noted there was a discrepancy and she would look at this.

9. Presentation to explain the Safety Thermometer (for the benefit of new Non-Executive Directors)

As above

10. CQPG Minutes (November Meeting)

CR highlighted EP for Chemotherapy as the main issue to come from November's CQPG but felt that is had received robust scrutiny at this meeting.

When asked by the Chair which issues kept him awake at night, CR responded that under Trauma and Orthopaedics both Education and the 18 week target were particular concerns.

AK raised the issue of Site Governance given the current initiatives and there are now fortnightly meetings being held at Heartlands and at GH.

11. Supervisor of midwives report

SF confirmed that HEFT is not flagging as an outlier in this report.

CR said that the report's somewhat artificial split of GHH and Heartlands did not give the best

view. Heartlands has a higher acuity level. CR said that the C section rate is going up and work is underway to discover why.

JR said that there was a lot of media interest on midwife numbers.

SF and CR agreed that we are currently ahead of the curve on performance. We are now sitting mid-table but we should be aiming higher. This is the result of a three year plan. We currently have a proportion of 1:1 in established labour care – we are currently at mid 90% range.

PH asked whether HEFT needs more supervisors.

CR said that there is a requirement for balance around GHH from a managerial position. There is a plan to base the DH of Midwifery at GHH more often. There is also some balance needed on community midwives as there are plenty in Solihull which has a lower birthrate than Heartlands, where there are fewer.

There was a varied discussion around C section rates and the reason for this including choice, health factors, presence of consultants and a lower appetite for risk.

12. Team Stepps update

Ann Abassi updated on the work of Team Stepps. It was originally a US system that is being adapted to work in the UK. It works on training teams together and improving team working. The original Directorates targeted were Maternity and Theatres but this reduced to Maternity.

Within Maternity, two areas were identified; Strategic leadership and emergency C-section. The process is taking longer than originally thought. Improvements have been made and the two teams are working well together. The leadership angle is moving towards Project Pelican.

Currently Maternity, Upper GI and Colorectal are being supported through the process. The biggest problem being faced is finding time where the teams can be released together to go through the training together.

LL asked about the financial implications of this.

AA said that there needs to be scoping of where the project is going. Currently the funding is for AA's position and 2-3 days of a consultant per week.

There was a varied discussion over releasing staff for mandatory training and for scheduling of deep cleans, theatre shutdowns, audit days and other non operational days.

PH said there was a real conflict on the quality agenda and the funding available.

ACTION:JR ASKED AA AND CR TO CONSIDER CARRYING OUT AN EVALUATION OF TEAM STEPPS AND REPORT BACK

13. Infection control (Quarterly report)

SF asked that the paper be taken as read and highlighted a few areas.

SF said that they had a close relationship with their CCG as well as an excellent system in terms of peer review. Given that the targets have been halved and MRSA placed at zero each year, CCG remains confident in HEFT's activities. Whilst the statistics for C-diff and MRSA are within a very narrow range and is second highest in the region, HEFT is seen as doing well but continuing to look at infection control practices

Recent changes to the screening and typing processes have achieved a saving of £600,000.00 for HEFT. In terms of C-diff this is an area where the Commissioners have worked alongside us and HEFT is now getting to a point where a plateau is being reached. Conducting faecal transplants to assist patients with C-diff has certainly helped to improve the symptoms.

Following up on the Chairman's request from the last meeting regarding Infection Control, SF said that a meeting with CR would take place around this. SF reminded the meeting that there had been an Infection control summit with AMDs and the public perception around uniforms and consultants taking the lead, was discussed.

LL asked about Norovirus and whether it could be included in the reports.

SF said that the board had been updated 3 months ago on Norovirus and that it would be included in the next report.

PH asked about MRSA regarding the 6 cases which had placed Heartlands as an outlier.

SF said that when we were compared regionally, it was marginal (1 case).

AK said that more information would come back re the avoidable/unavoidable cases of MRSA.

SF said that we are where we are and that we need to continue to work on the issues which are raised.

AO suggested working through individual cases (6) and see if anything had been missed.

SF said that our current practise around infection control needs some level of wider discussion.

ACTION: SF AND CR TO MEET WITH AMDs AROUND INFECTION CONTROL AND REPORT BACK

14. Patient Experience Report

Taken as read. There were questions regarding the consistency of the data but these were not pursued in the absence of LT

ACTION: MEETING BETWEEN AK, SF AND LT TO DISCUSS DATA

15. Audit and effectiveness – Core Audit Report (Verbal)

The Clinical Audit and Effectiveness dashboard had not come back to this meeting yet as the Clinical Standards committee has not yet met. At the last meeting, LR raised the issue of progress as regards the national audits and is currently in the end stages of scrutinising these.

Aside from the national (statutorily required) audits, at the beginning of the year there were 161 core audits (non-statutory) which were required to be completed across the Trust. This has now been reduced to 150. Of these, only 10 have been completed. In previous years the number of audits required was in the thousands. Last year they were reduced to 161 and then to 150 to help departments pick out those audits which could best answer the questions they have/are most important to them and lead to improved delivery. The 150 were identified by the departments themselves.

LR's audit team has been approaching the directorates for progress. Initial feedback has indicated that gaps lie in engagement, choosing the right audit and Junior Doctor time and ability to do the audits. There are a few months remaining this year to improve the situation and to obtain a better picture of what could be delivered next year. There also needs to be

some work surrounding the sanctions and benefits of not completing/completing audits.

There was discussion of over what level of departmental buy in is required and historical situation of audit.

LR is not sure what the barriers are but work is ongoing to discover this. If these are going to be reinforced we need to be sure that we have identified the right audits.

ACTION: CLINICAL AUDIT AND EFFECTIVENESS DASHBOARD TO COME BACK TO QRC IN MARCH

ACTION: LR TO WORK WITH CSC TO GET A 2014 AUDIT PROGRAMME AGREED

16. CQC Update

RB updated that this was a high level report which naturally included a section on the significant inspection in November as well as a summary of quarterly assessment. Seven outcomes were identified as amber. Some of these reflect compliance actions from the recent inspection.

RB drew attention to outcome 16 which was self assessed as red to reflect that HEFT received a warning notice for GHH relating to that outcome. There is an action plan in place to address the issue. However, as there is a high risk that if the CQC came back today, HEFT would be non compliant, it is rated red. The CQC may come back any time after 21 Feb.

PH asked about level of confidence the Chair had regarding this issue.

RB mentioned that she had met with Sue Hyland and that a robust action plan is in place. External assessors to come in and run through action plan and the site team will check performance.

17. Internal Audit Reports

Two KPMG reports were presented. Both reports had been seen by the Committee before in different stages of readiness and both were graded as Significant Assurance. Both had now had a management response.

Site Based Quality Governance Report
This report was graded as Significant Assurance. There were 4-5 low importance actions to complete. Originally this report had not included any reference to Community Services of Women's and Children's. The report had been amended to include this.

SF was not happy with the add-on to the Site Based report for women's/community and felt that it did not go far enough.

Integrated Care Pathways
This report was graded as Significant Assurance.

ACTION: THESE TWO KPMG REPORTS WERE TO BE RAISED AT EMB AND TO RETURN TO QRC ONCE NEW AUDITORS IN PLACE (AK)

18. Integrated Audit Tracker

The format of the Audit tracker was discussed and it was felt that a different approach was required. This was to be taken up with Deloitte, the Trust's new Auditors for the period 2014-2017.

ACTION: AUDIT TRACKER TO BE RAISED WITH DELOITTE (LL)

19. Quality Report

RB updated that the paper supplied was presented for assurance. The Quality report is required to be published by the end of June but that this is integrated with the financial report. This work is well under way and the report is on track.

20. Assurance from Sub Committees

There was some discussion over the wide invitation and apology lists, as well as the number and frequency of meetings.

The following minutes/reports from sub committees were noted and taken as read.

- Trust Infection Prevention Committee - minutes 14.10.13
  Taken as read
- Clinical Standards Committee - minutes 10.10.13
  Taken as read
- Safety Committee - full report of 26.11.13
  Taken as read
- Safeguarding
  All taken as read
  This included the following documents on Adult safeguarding
    - Safeguarding Adults Steering group minutes 07.01.14
    - Quarter 3 Dashboard October – December 2013
    - Safeguarding Adults Steering group minutes 04.12.13
    - Safeguarding Adults Steering group minutes 02.10.13
    - Quarter 2 Dashboard July – September 2013
    - Safeguarding Adults Steering group minutes 31.07.13

  This included the following documents on Child safeguarding:
    - Quarter 2 Dashboard July – September 2013
    - Safeguarding Children Committee minutes 18.09.13
    - Safeguarding Children Committee minutes 23.07.13

- Consultative Health Council – minutes 13.12.13
  Taken as read
- HR Committee - minutes 18.12.13
  Taken as read
- Information Governance – minutes 26.11.13
- ***Taken as read***

21. AOB

Mortality
AK updated on the SHMI which came out last Wednesday. HEFT data for the period July 2012 - June 2013 is within expected parameters. The score was 1.08 having been 1.07 last time. HEFT is now 25th from the bottom of the table which is positive.

Date and Time of Next Meeting:
The next meeting will be on 31 March 2014 at 0930 in the Board Room of Devon House, BHH. Please send any apologies through to sian.bradshaw@heartofengland.nhs.uk

QUALITY & RISK COMMITTEE			
Ongoing Actions – February 2014			
February 2014	Future Sitrep to include a lessons learned section with action plans	March	SCC/LR
~~February 2014~~	~~How to report incidents to be raised regularly during risky business fora~~	~~March~~	~~AK/KB~~
~~February 2014~~	~~Every other meeting update on clinicians referred/under sanction from/to professional bodies~~	~~Ongoing~~	~~AC/SF~~
February 2014	JR asked AA to consider carrying out an evaluation of Team Stepps and report back	June	JS/SH
February 2014	SF and CR (AC) to meet with AMDs and report back on infection control issues	June	AC/SF
February 2014	Meeting to discuss data in Patient Experience report	March	AK/SF/LT
February 2014	Clinical audit and effectiveness dashboard to come back to QRC in March	March	LR
February 2014	LR to work with CSC to get a 2014 audit programme agreed	March	LR
February 2014	KPMG report (site based quality governance) to be raised at EMB with a view to being included in a re-audit in the 2014/5 audit programme	March	AK
February 2014	Format and usability of the audit tracker to be raised with Deloitte	June	AK/Deloitte
Date of Minutes	**Action**	**Target date**	**Owner**
July 2013	Meeting to be convened re pressure ulcers	December 2013	AK/SF
April 2013	Cross-discipline management of adverse events to be scheduled.	Before March 2014	CR/SF/AK/HG

These minutes are DRAFT until approved at the 2nd June Quality & Risk Committee 2014

DRAFT Minutes of a meeting of the QUALITY AND RISK COMMITTEE of Heart of England NHS Foundation Trust held in the Board Room of Devon House on 31st March

	Name	Title
Present	**RAO, Jammi (JR)**	**Non-Executive Director/Chair**
	CATTO, Andrew (ACA)	Trust Medical Director
	FOSTER, Sam (SF)	Chief Nurse
	LAWRENCE, Les (LL)	Non-Executive Director (Trust Chairman designate)
	SERRANT, Laura (LS)	Non-Executive Director
	THOMSON, Lisa (LT)	Executive Director and Acting Director Solihull
In Attendance		
	BLACKBURN, Rachael (RB)	Head of Corporate Risk and Compliance
	COVEY, Alex (AC)	Head of Organisational Development
	GUNTER, Hazel (HG)	Director of Workforce
	KEOGH, Ann (AK)	Director of Medical Safety
	POLSON, Rex (RP)	Associate Medical Director (SH)
	RAGHURAMAN, Govindan(GR)	Associate Medical Director (BHH)
	RICHARDS EVERTON, Lisa (LRE)	Expert Patient Volunteer
	ROSE, Arne (AR)	Associate Medical Director (GHH)
	RYDER, Clive (CR)	Associate Medical Director (W&C)
	RUDD, Louise (LR)	Head of Clinical Governance
	TURTON, Jenny (JT)	Deloitte
	BRIDGEWATER, Ben (BW)	Deloitte
Minutes	BRADSHAW, Sian	EA/Sarah Woolley

1. Apologies for absence

Apologies were received from Matthew Cooke, Lord Hunt, David Lock, Kevin Smith and Sarah Woolley.

2. Minutes of the meeting held on 3 February 2014 / matters arising and standing agenda items

JR suggested a different approach to the minuting of the meeting in that he would summarise the discussion at the end of each item. The relevant sections would also be sent out for approval to the presenters of the paper/item.

SF asked to clarify in the minutes that she was unhappy with the overall assurance provided by the site governance internal audit report, not just the added section about Women's and Children's services . The minutes were then taken as read.

3. Actions arising

JR ran through the outstanding actions:

Infection control: ACA and SF to meet to progress this. **Remains on action list**

Patient Experience Report: LT reported the meeting had taken place and the report is an evolving process **Action closed**

2014 Audit Programme: A different approach is being developed to focus on national audits and quality improvement projects instead of core audits. **Action closed**

Internal Audit tracker: Has been reformatted. **Action closed**

Meeting regarding Pressure ulcers: Resolved **Action closed**

Cross discipline management of adverse events: Going forward soon and also linking in to Kennedy workstream **Remains on action list**

4. Foundation Trust Network Quality Conference JAMMI RAO

JR reported that he attended this conference on 19th March. He referred the meeting to the enclosed paper, with specific reference to the culpability decision tree. AK highlighted the similarities between that and the incident decision tree which she circulated. AK said that the incident decision tree was in the process of being updated by the organisation which is the successor to the NPSA. Discussion of this led back to the cross discipline meeting in the actions list.

ACTION: JR requested to feedback once the multi-disciplinary meeting has taken place and a plan has been agreed (June) AK, SF, AC & HG

5. Safety SitRep LOUISE RUDD

LR went through the key points in the Safety SitRep:

Summary Risk Profile

- **Red operational risks** LR highlighted the current serious risks and commented that a further risk regarding IT systems in the sexual health services had just been agreed by the risk forum and would feature in future reports.
- There was a discussion about the proposed serious risks attachment. Generally, these are those risks that have been highlighted by the directorates, but not yet worked up or discussed at a risk forum yet.
- There was discussion over whether the risk profiles included in SitRep referred to the site risks by location or division. LR confirmed that it was by division but would look into providing the location profile as well as it was valuable information.

- **Mortality** A brief update was included but this was discussed in agenda item 14.

- **SUIs**
  - LR commented that there had been 2 additional SUI's since the report was produced bringing the total number of open SUI investigations to 4. JR raised the thrombosis case, outlined in the SUI at a glance report, and asked whether the policy which was one of the recommendations for the organisation, had been put in place. AK confirmed that a paper would come next meeting to clarify the position on how updates on learning from SUIs will come back to QRC.

- **CAS Report**
  - AK updated that HEFT will soon be compliant with the safety alert (spinal injections) as we have been awaiting agreement of the products required to support this standard.

- **Coroner's updates** – AK made the meeting aware that the new coroner was working through the backlog of cases quite quickly which means that this information will not always up to date/subject to change. The committee thought that the information on coroner's verdicts was useful and should remain in the report.

Attachment 2a

- LL raised the issue of proposed red risks on attachment 2a. LL was concerned that some risks were almost a year old and seemed to be showing little action taking place. LL was concerned that actions were not going forward or that the document was not being updated. He highlighted a risk dated 2011. LR acknowledged the problem, explaining that it was possible in Datix, to update the risk progress without updating the date of the risk. LR said that her team were working with the directorates to address this issue.

- LL also raised one particular risk #3359 Loss of Vascular Services. There was a round table discussion over the title, definition and assessment of the risk. RB responded that there was a lot of detailed information behind each of the entries and that it could be provided. There was a further discussion over the volume of information provided to the Committee and the variance between requiring a one page summary and requesting all information relating to a particular field.

Incident trends reporting

- JR raised the issue of tissue viability to confirm that almost all of the just under 4000 incidents were classified as harm incidents. LR confirmed that this was the nature of the incidents reported and the framework in place around tissue viability incidents. SF raised a concern that this was a snapshot in time and not necessarily a true trend over time. LR explained that the purpose of the report was to acknowledge the top themes in incident reports, signposting to other workstreams where they exist, like patient falls, tissue viability and medication, for further information and assurance. LR agreed that the presentation of this could be simplified and would liaise with SF and ACA to achieve this.
- Medication incidents – AK said that we had signed up to a KPI to increase medication incidents by 10%.

ACTION:

LR to work on a more intuitive Safety SitRep
LR to work with SF on Tissue Viability and Falls
LR to work with ACA on Medication and Ongoing care monitoring review
SUI action update paper to come to next meeting.
AK to bring an updated high level open risk profile and to show a worked through example risk.

6. CQPG Minutes ANDREW CATTO

JR welcomed ACA and noted that some of the sets of minutes pre-dated ACA's arrival. ACA said he would look to colleagues for assistance. ACA said he was looking for clarity around accountability in the very long list of actions. ACA said that he would use his settling in period to reflect upon what CQPG does.

HG said that there were discussions going on as to the purpose of various meetings.

JR said he would be happy to sit in on a CQPG meeting to gain an understanding of what it does.

ACTION: ACA to report back in 3 months on CQPG

7. SUI Action plan update ANN KEOGH

Deferred till next meeting.

ACTION: Add to June's agenda

8. NHS Quest update ANN KEOGH

AK updated the meeting on NHS Quest. HEFT joined NHS Quest in summer last year. We are hosting a peer site visit this summer. The enclosed (LP1 Late Paper 1) listed the workstreams in which we are involved with NHS Quest.

For Information only

9. Kennedy Taskforce LISA THOMSON AND JAMMI RAO

LT presented the paper, which had been presented in draft to the Taskforce. LT drew the Committees' attention to the breast recall section under the patient recall workstream. LT asked whether the Committee would like to have involvement in the breast recall workstream.

JR asked for a discussion over the Kennedy workstreams and outlined his key objective as involving the key clinical leaders when redrafting the Terms of Reference of the Quality and Risk Committee. JR asked for thoughts on how the wider engagement is achieved in the redesign of the Quality and Risk Committee.

SF said that problems occur where the infrastructure does not exist at supporting levels of a committee. AC asked about the flows of information and the attendees. JR accepted that involving clinical staff had obvious time pressures. AR said that we may need to look to allowing others to set the agenda so that they can feel they are getting something out of the meeting.

ACTION: Breast Recall report to be presented to the next QRC meeting.

10. Raising Concerns ALEX COVEY

AC presented her item on Raising Concerns, emphasising that the main focus of the work-stream is on supporting managers to create the right kind of environment, not solely on developing a policy. AC said she was looking for in principle ratification of the policy from the Committee. In developing the policy there was broad consultation, with the JLNC and Kennedy patient focus group still to be met with for their comments to be fed in. AC said she was not expecting further major changes. If there were, then the paper would come back to QRC in June.

AC outlined the main changes from the original whistleblowing policy;

- Broadened to include Raising Concerns of all kinds, not just those covered by whistle-blowing legislation.
- Minor amends to reflect legislative changes
- Made it more user-friendly, e.g. CEO introduction, employee flow-chart, examples of concerns.
- Inclusion of manager guidance – what to do if a concern is raised to you

- JR asked about acute concern raising and whether concerns are being appropriately dealt with in the moment. AC responded that the Raising Concerns course for managers will focus very much on communication. JR asked whether a section on the response to the concern raised should be added, along with some expectation management by e.g.

inserting a section to say that not all concerns can be addressed. After some discussion, it was agreed that section 7.5 of the policy was adequate for these purposes.

- LRE asked what Public Concern at Work (PCaW) do when concerns are reported to them. HG said that PCaW are there to advise the individual but do not contact the organisation. This caused questions on how concerns come back into the organisation.
- HG outlined the desire for a NED to be a named independent contact for employees, as an additional route to raise concerns. **It was agreed that this would be the Chair of QRC, Jammi Rao currently. This route will be added to the flow-chart on the Policy.**

- Following further discussion, 3 changes were agreed to the policy
  - Amend text Section 2 (Definitions) to make clear in that concerns about 'resources' includes 'staffing issues.'
  - Add text in Section 2 (Definitions) to make clear that concerns don't have to directly affect the individual, they could relate to things an individual sees / hears happening to others
  - Add text in Attachment 1 (Manager Guidance) to reflect that behaviour may be unacceptable, even though no harm has occurred. Add into each 'harm' level.

- **The "Raising Concerns, incorporating Whistle-blowing" Policy, with the changes outlined above, was ratified in principle by Quality & Risk Committee, and will only return if substantial changes occur following final consultations.**

- Further discussion took place relating to the behavioural / cultural changes required.
- HG outlined the additional work being undertaken on Consultant Recruitment and appraisal process all of which were supportive of bringing about change.
- LS asked whether there was a 'Manager Toolkit' or specific training on these matters.
- HG responded that they were developing a VITAL toolkit for managers.
- JR asked if we could speed the process up. HG said that we already have the processes to tackle bad behaviour, it is driving consistency.
- CR said that the Good Medical Practice Guidelines are all you need and it's about how you enforce them.

ACTION: AC to make agreed amends to Policy. Any substantial changes to be brought back in June.

11. Patient Experience Report: LISA THOMSON

LT presented the new format report patient experience report. LT highlighted that the new format made it easier to see any wards which were presenting particular problems and improved the read-across of the various parts of the patient experience data. LT highlighted ward 19 at Solihull as scoring in the red across various areas. This information could then be used to target action. The next iteration of the report will bring the highlight of this as well as what action is bring taken. It will also be used to bring out examples of good practice. AK asked for clarification around the diabetes nursing indicator as not clear in the executive summary

JR raised what he considered to be an excellent example of good practice, discovered on a recent patient safety walkabout, of a staff nurse speaking to relatives during visiting times to ask if they have any concerns. He felt that this helped to avoid complaints.

ACTION: LT to bring back the next version of the report to the June meeting.
LT to bring data on diabetes nursing indicator

12. Patient Safety Walkabouts: ANN KEOGH

The paper summarised top themes and showed examples of good practice.

- The programme of 20 walkabouts a year will continue.
- All board members would be expected to attend one per year as part of new CQUIN – leadership for harm free care.

ACTION: Patients Safety Walkabouts Reports to come to QRC three times a year

13. Audit and Effectiveness Dashboard: LOUISE RUDD

Of 34 national audits, 20 have been discussed so far at the Clinical Standards Committee. LR said that some of the information / discussions have resulted in the audit leads being asked for further clarity around some of the points identified, or where there is a more general lack of clarity of the interpretation of the results or intended improvement actions, invited back to the committee for confirm and challenge around the audit.

LR acknowledged that the core audit programme had not been successful this year despite efforts to engage and support the directorate clinical audit leads. LR suggested that the 2014 Core Audit programme be paused in favour of Quality Improvement Initiatives and focus on national audits ACA backed a focus on national audits driving improvement and less focus on core audits.

LR suggested that in future, the highlights from the CSC minutes and the headlines from this report could be combined into a single document.

JR asked for a summary of national audit reports to come to QRC when they are published and specifically to show where we stand in the rankings.

ACTION:
LR to produce a new report which combines CSC minutes and the audit and effectiveness dashboard and to include highlights of recently published National Audit reports.

14. Mortality: ANN KEOGH

AK reported a downward trend in HSMR figures but highlighted that the estimated rebased annual HSMR for 2103/14 was projected to be elevated The Heartlands site HSMR has higher HSMR than the other 2 sites and the Mortality group is looking into this.

HEFT has received two Dr Foster Unit alerts; one for therapeutic upper GI endoscopy and one for UTI. Genitourinary symptoms and composite HSMR indicators are also identified as an elevated risk in our CQC IMR.
It is important to note that our week day and weekend mortality rates are very close to each other. We also have raised levels of mortality across cardiology and haematology. Dr Foster are now producing a quarterly data summary report for us.

We are also trialling another mortality and morbidity analysis tool, CRAB. The consultant's initial response was that they did not trust the data CRAB was producing. Work is going on to understand the methodology behind CRAB's data analysis and increase organisational faith in it.

JR commented on the correlation, or lack of, between mortality and CQC compliance and cautioned on overreliance on mortality data as a measure of safety.
ACTION: None

15. TOR change for safety committee: ANN KEOGH

Safety Committee oversees a number of regulatory areas. The main changes to the Terms or Reference are outlined in the summary sheet; including reducing the frequency of the meeting from monthly to bi-monthly.

ACTION: None

16. Internal Audit tracker ANN KEOGH

This was the reformatted document which tracks the key recommendations and actions.

ACTION: None

17. CQC and IMR update RACHAEL BLACKBURN

CQC Update

RB updated the meeting to provide assurance that detailed action plans have been produced.

RB assured that those plans are being updated monthly and are being reported regularly to EMB. The follow up CQC inspection happened on 27 February but the report has not yet been received. The initial indications were positive and it is expected that the warning notice will be lifted.

SF asked whether the ED action from the CQC inspection could be included in future reports to monitor effectiveness in the light of the vulnerability of the department to overwhelming surge in patients.

JR raised the issue of a discussion around an aspiration to stop using agency staff and rely solely on bank staff in order to meet the CIP. There was an active discussion around the risks and challenges this would present. CR raised the issue of staff attrition. HG said that it would be very difficult to get rid of agency staff. The incoming chairman reiterated that quality and safety is the top line.

IMR report

This is a new report, replacing the Quality and Risk profile (QRP) which give a list of risks and elevated risks. Prior to HEFT's inspection we were cited as Band 1 which is the least well performing band (1-6). RB said that since our inspection HEFT would not be banded anymore but would get a list of risks and elevated risks via the IMR. ACA said that these risks needed to be taken contextually. RB said that what sits below the indicators can be tricky to find out.

ACTION: RB to bring Quarterly updates

18. Site Governance Framework (status update)

Deferred

LR updated that this was a broad brush status report on the resilience of site and divisional governance arrangements which would come to the next meeting. Heartlands is on track. Good Hope is progressing towards being back on track.

ACTION: None

Assurance from Sub Committees

Trust Infection Prevention Committee ***Minutes noted***

Clinical Standards Committee ***Minutes noted***
JR asked for clarification on the area prescribing committee. CR said that there were some queries over jurisdiction.

Safety Committee ***Minutes noted***
AK noted that on the subject of emergency planning – some tests had to be cancelled.
Manual handling – the low amount of devices being purchased was being investigated.

Safeguarding ***Minutes noted***
SF said that she intended to meet CR around these issues.

Consultative Health Council ***Minutes noted***

HR Committee ***Minutes noted***

Information Governance ***Minutes noted***
We will be reporting a strong level 2 with level 3 on some areas, where as last year we scraped a level 2.

19. AOB and next meeting

There was no other business.

Date and Time of Next Meeting:
The next meeting will be on Monday 2nd June 14.00 in the Board Room of Devon House, BHH.
Please send any apologies through to sian.bradshaw@heartofengland.nhs.uk

Date of Minutes	Actions from 31 March meeting	Target date	Owner
March 14	Feedback regarding the agreed plan from multi-disciplinary meeting (meeting is in June) AK, SF, AC & HG	July 14	AK, SF, ACA & HG
March 14	LR to work on a more intuitive Safety SitRep	June 14	LR
March 14	LR to work with SF on Tissue Viability and Falls	June 14	LR/SF
March 14	LR to work with ACA on Medication and Ongoing care monitoring review	June 14	LR/ACA
March 14	SUI action update paper to come to next meeting.	June 14	AK
March 14	AK to bring an updated high level open risk profile and to show a worked through example risk.	June 14	AK
March 14	ACA to report back in 3 months on CQPG	July 14	ACA
March 14	Breast Recall report to be presented to the next QRC meeting.	June 14	LT
March 14	AC to make agreed amends to Raising Concerns Policy. Any substantial changes to be brought back in June.	June 14	AC
March 14	LT to bring back the next version of the patient experience report	June 14	LT
March 2014	LT to bring data on diabetes nursing indicator	June 2014	LT
March 14	LR to produce a new report which combines CSC minutes and the audit and effectiveness dashboard and to include highlights of recently published National Audit reports.	June 14	LR
Date of Minutes	**Actions from previous meetings**	**Target date**	**Owner**
February 2014	Future SitRep to include a lessons learned section with action plans	March	SCC/LR
February 14	JR asked Anna Abbassi to consider carrying out an evaluation of Team Stepps and report back	June	JS/SH
February 14	SF and CR (AC) to meet with AMDs and report back on infection control issues **Update** 31.03.14 meeting scheduled	June	AC/SF

Safety Situation Report

Everyone in our organisation is aware of and learns from local and national safety events, themes and best practice

April 2014

	ED	Status
Strategic risks (Updated Apr 14)	LT	Regular reports provided to Board to discuss Strategic Risks
Corporate governance (Updated Jan 14)	LT	Adverse outcome from CQC visit assessing us as non compliant with outcome 16 in some GHH services. Feedback from follow up visit awaited.
Red (≥ 15) operational risks.	SW	One red operational risk (IT system for Sexual Health) has been added to SitRep.
SUIs and incidents	SW	Three new SUI's (Unexpected harm following endoscopy, Delay in antibiotics, Patient Suicide) since the last report. Quarterly action plan update under development for Q&R
Lesson of the Month	SW	Reducing harm from omitted and delayed medicines
SUI@A Glance	SW	No new SUI at a glance reports
Mortality	AK	SHMI: As expected but deteriorating position HMSR: "not rebased" figures returned to within normal range. Estimated 13/14 re-based =111
IMR (March 2014)		Currently 7 risks and 6 elevated risks highlighted through "intelligent monitoring report"

Summary risk profile

STRATEGIC RISKS-Monitoring by EMB, GRC & TB (as at Apr 2014)
Summary & score
Future tariff efficiency: 15% CIP across the NHS (↔ 16)
Patient flow (↔ 16)
Re-shaping HEFT (↔ 12)
Workforce transformation (↔12)
Staff Engagement (↔ 12)
Winter planning (↔ 16)
GHH Site Management (*NEW*)
18 Weeks (*NEW*)
Breast Recall (*NEW*)

RED OPERATIONAL RISKS-Monitoring by sites / division. Escalated to CQPG GRC and TB (April 2014)

Risk Summary: Red	Site	Division	Date^	Initial Score	Current Score *
Implementation of IT system for Sexual Health - Lillie	BHH	**CSSD**	Mar14	**16**	***NEW***
Loss of vascular service	BHH	**BHH**	Mar14	16	***NEW***
Plain film reporting backlog	All	**CSSD**	Feb14	16	**16**
Impact of extended stay in ED. *(Related to sustainability of improvements at BHH and need for improvements at GHH)*	GHH BHH	**BHH**	Jan14	15	**15**
Chemotherapy prescribing / administration in absence of EP)	BHH		Oct13	15	15

OPERATIONAL RISKS ≥12 - Monitoring by Site, Group and CQPG. (March 2014)

Division	
BHH	59
GHH	5
SH	12
CSSD	16
W&C	9
Total	**101**

Divisional risk profile (March 2014)

Division	R(v)	R(p)	A	Y	G
BHH	3	6	86	27	0
GHH	0	0	11	8	0
SH	0	0	34	2	0
CSSD	1	0	42	26	1
W&C		1	19	5	0
Total	**4**	**7**	**192**	**68**	**1**

^Date risk rated as red (≥15) and agreed at Risk Forum

*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).

- W&C – Women's and Children's Services
- CSS – Clinical Support Services

(v) Red risk that has been validated through risk forum

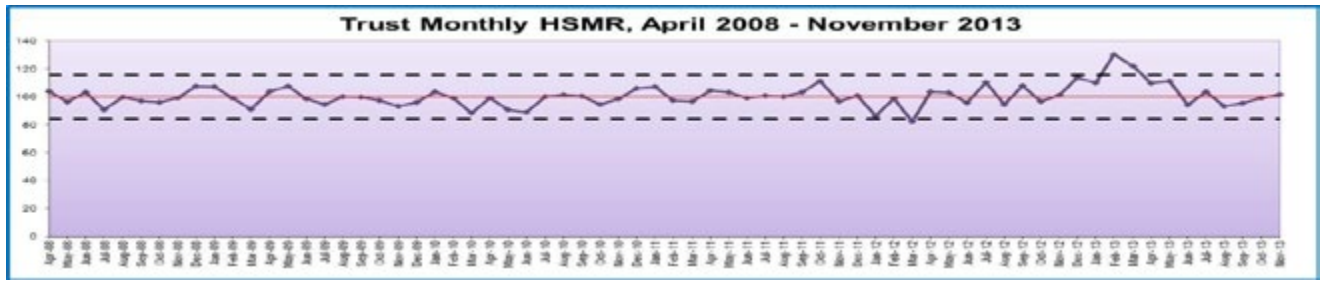
(p) Red risk that has been proposed and awaits further info / review

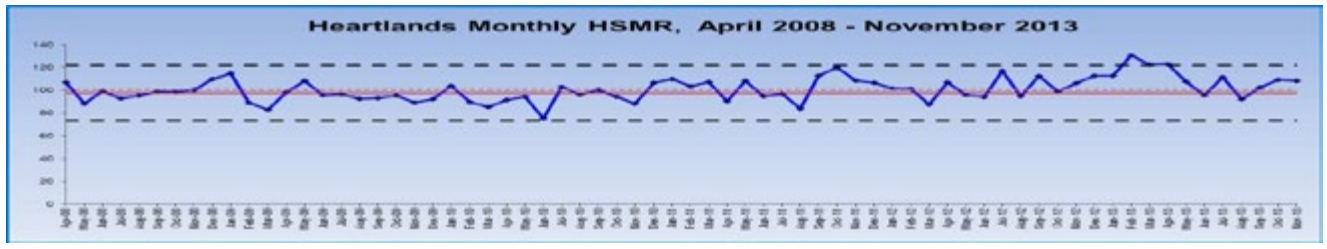
Profiles may have changed since created 13 January

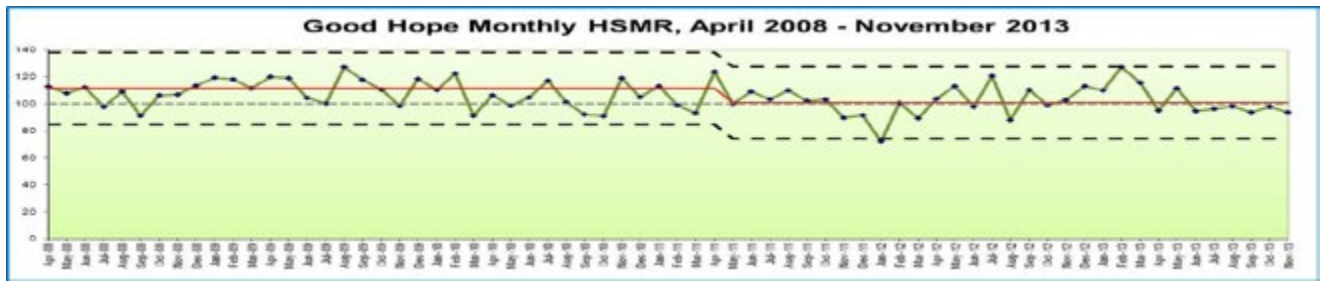
Apologies | Declaration of Interest | Minutes | Matters Arising | Chairman's Report | Council of Governors Report | Chief Executive's Report | Safety, Quality and Org. Dev. | Patient and Public Feedback | Finance and Performance | External and Strategic Review | Nursing, Midwifery care staffing capacity | Equality and Diversity

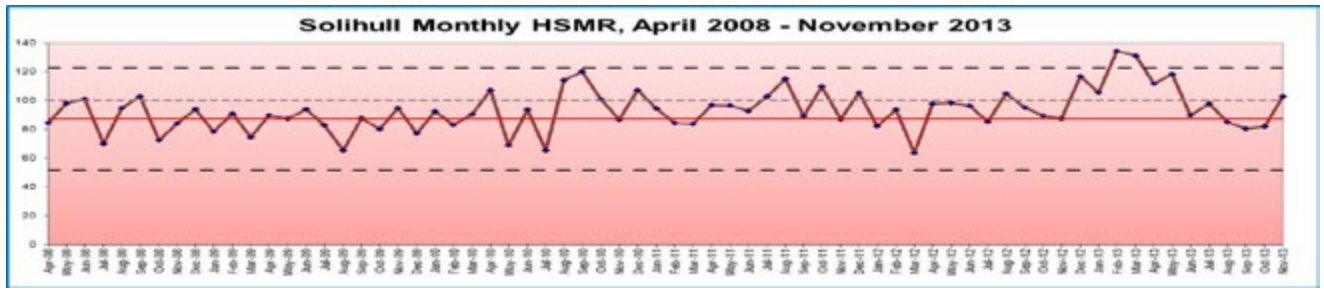
Board Assurance Framework | Transport Strategy | Board Committee Reports | Any Other Business | Part Two

Mortality overview









Recent Alerts

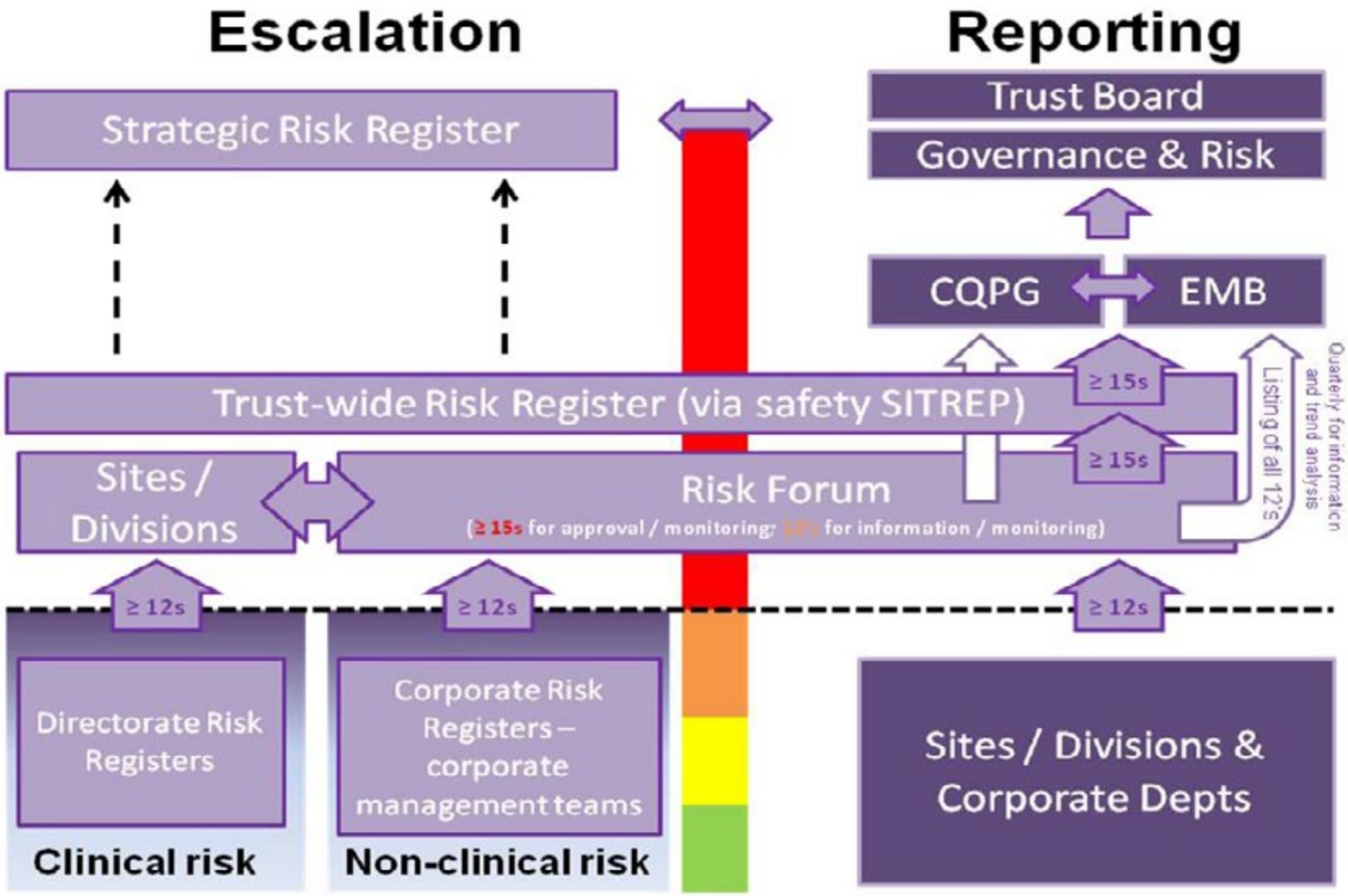
Alert Type: CQC
Subject : AMI
Status: Response sent: No significant patterns of concern but areas for improvement identified
Action plan: Under development

Alert Type: Dr Foster Unit
Subject : UTI
Status: Data review for November 2013 underway. Outcome expected May 2014
Action plan: N/A

SHMI

Period: Jan 12-Dec 12 **Measure**=103.0 Band 2: As expected
Period: Apr 12 -Mar 13 **Measure**=107.9 Band 2: As expected
Period: Jul 12- Jun 13 **Measure**=108.55 Band 2: As expected

Risk Escalation Process (Risk Management Policy Attachment 4



Apologies	Declaration of Interest	Minutes	Matters Arising	Chairman's Report	Council of Governors Report	Chief Executive's Report	Safety, Quality and Org. Dev.	Patient and Public Feedback	Finance and Performance	External and Strategic Review	Nursing, Midwifery care staffing capacity	Equality and Diversity
				Board Assurance Framework	Transport Strategy	Board Committee Reports	Any Other Business	Part Two				

Summary SUI profile April 2014

OPEN SUI INVESTIGATIONS (as at 08/04/2014)					
Site / Division*		Directorate	Date	(N = Never Event; P = Prevented Never Event	Status
	CSS	Pathology	Oct 13	Histopathology backlog (delayed diagnoses)	**Open**
BHH	W&C	Obstetrics	Feb 14	Unexpected neonatal death	Open
BHH		Gastro	Mar14	Unexpected harm following endoscopy	Open
BHH		Renal	Mar14	Delay in receiving antibiotics	Open
BHH		Gen Surg	Apr14	Patient Suicide	Open

SUI profile by management team (as at 08/043/2014)

Site/Div	10/11	11 / 12	12/ 13	13/14	14/15
BHH	5	5	3 (1x N)	9 (2xN)	1
GHH	0	2 (2xN)	2 (1xN)	3 (2xN; 1xPN)	0
SHH	1 (1xN)	2(2xN)	1	1 (1xN)	0
W&C	5	3(2xN)	5 (1xN)	1	0
CSS	2(1xN)	5	0	1	0
Never Events	2 of 14	6 of 17	3 of 11	6 of 15	1

SUI profile by location (as at 08/04/2014)

Site	10/11	11 / 12	12/ 13	13/14	14/15
BHH	8	11	7 (2x N)	7 (1xN)	1
GHH	5	1	3 (1xN)	4 (2xN; 1xPN)	0
SHH	0	5	1	3 (2xN)	0
Other / n/a				1	0
Total	14	17	11	15	1

Never events in 2012/13 relate to:
1 wrong site surgery (General Surgery)
1 Inappropriate administration of daily oral methotrexate (T&O)
1 retained tampon (O&G)

Never events in 2013/14 relate to:
2 wrong implant (T&O / Theatres and Ophthalm / Theatres)
2 retained foreign objects (Gen Surg / Theatres and T&O / theatres)
Prevented : Opioid overdose of opioid naive patient (Elderly)
1 wrong site surgery (General Surgery)

Summary "Severe Harm" incident March 2014

SEVERE HARM INCIDENTS Top 10 directorates Severity may be subject to change after review of incident		
Specialty	**13/14 YTD Reported (as at 14/03/2014)**	
	Total	Filtered*
Accident and Emergency (ED)	49	19
Obstetrics	13	13
Elderly (BHH)	12	1
Acute Medicine (BHH)	12	3
T&O	11	6
Acute Medicine (GHH)	11	1
Respiratory Medicine	10	2
Acute Medicine (SH)	10	5
Elderly (GHH)	10	1
SCS – Out of Hospital Services	10	2
Other (all other areas)	44	23
Total	192	76

SEVERE HARM INCIDENTS by location		
Site	**13/14 YTD Reported (as at 14/03/2014)**	
	Total	Filtered*
Heartlands Hospital Site	56	32
Good Hope Hospital Site	50	23
Solihull Hospital Site	21	9
Home / Residence	62	10
Public Place	2	2
Other Hospital	1	0
Total	192	76

•Filtered to exclude Tissue viability incidents, falls with fractures and HCAI incidents
•^ Data collated for January CQPG. Due update for March CQPG

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Summary: Other risk information March 2014

Schedule 5 Section 7 (formerly Rule 43) / Coroner's concerns

Outcome from recent Inquests:

•Inquest on 20 Feb touching upon the death of a patient who received anticoagulation therapy after elective orthopaedic surgery and, following CT scan after collapse, identified to have acute on chronic subdual bleed. **Verdict: Narrative verdict with no criticism of Trust**

•Inquest on 3 March into the death of patient where care concerns over the management of the deteriorating patient had been subject to SUI investigation. **Verdict: Narrative verdict with no criticism of Trust**

•Inquest (rescheduled to 26 March) touching upon the death of a 16 year old who attended ED with headaches, was diagnosed with migraine and discharged home with analgesia. Sadly she was found dead in bed the following day. **Verdict: Natural Causes**

•Inquest on 28 March touching upon the death of a patient who was transferred to Bruce Burns Unit (BSHMHT) from Solihull AMU. **Verdict: Narrative verdict with no criticism of Trust**

Hot topics

Issues arising from surgical practice of a breast surgeon employed by the Trust. External independent review, commissioned by the Trust has now been published and Trust has issued response. Action plans are in place and progress is being monitored

MHRA

The University of Birmingham had a routine GCP inspection by the MHRA on the 16th Dec 2013. In preparation HEFT audited studies which we co-sponsor with the University which identified a serious breach of procedure (for randomisation of patients and transfer of blood samples to the university without consent) which was reported to the MHRA on the 13th December.

All of the individual's other studies were put on hold pending further audits which identified similar breaches on two further studies which have been reported to the MHRA.

The MHRA haven confirmed that both the Trust and the University of Birmingham will have a triggered inspection of these studies on 21st-23rd January 2014.

Forward look: Potential for adverse inquest verdicts

•Inquest on 6 May touching upon the death of a surgical patient. Care concerns over escalation of the deteriorating patient had previously been identified and subject to SUI investigation.

•Inquest on 6 May touching upon the death of a patient at UHB following surgery. The patient had previously had the wrong adrenal gland removed at HEFT. Concerns had been subject to SUI investigation

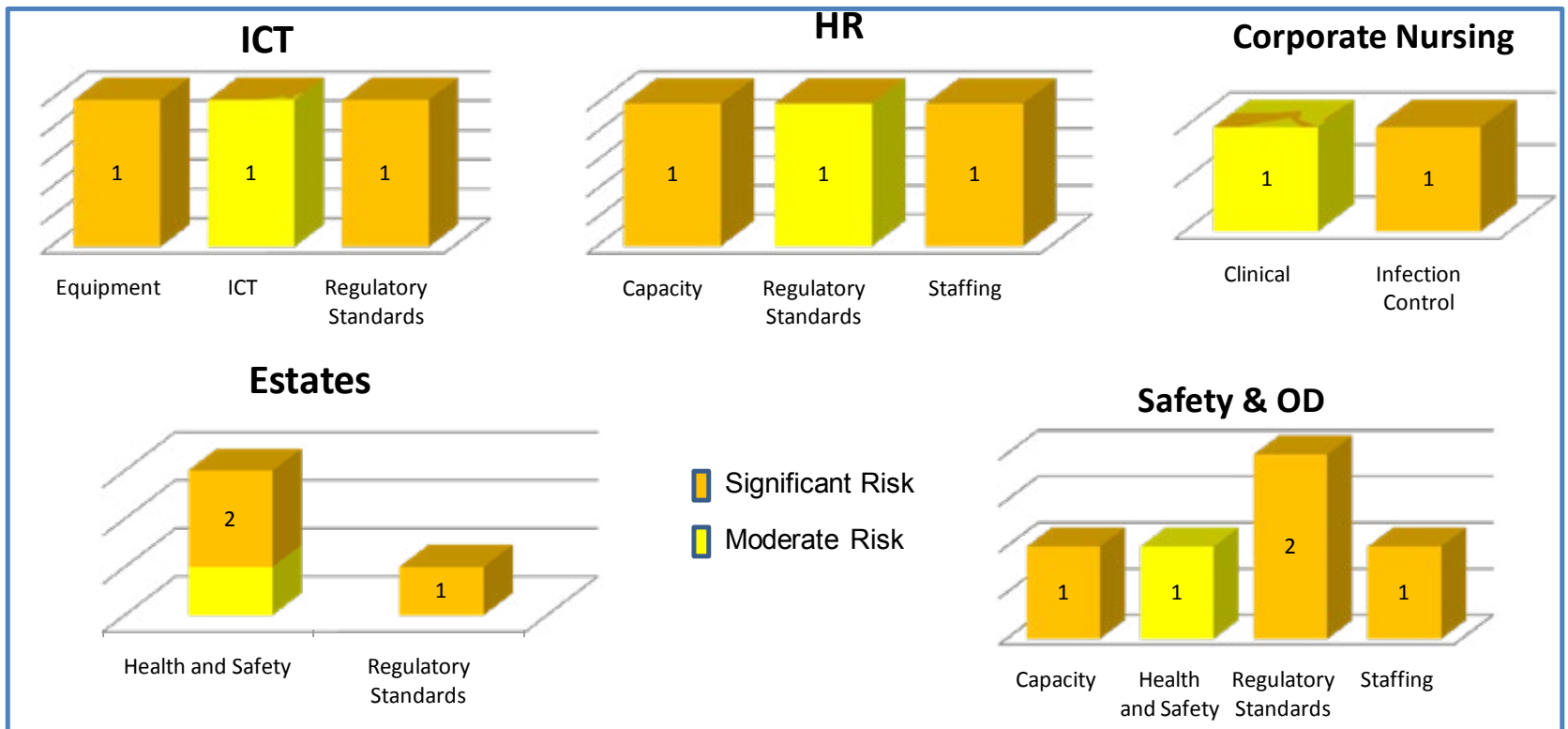
Summary incident themes profile

THEMES FROM SUIS / (TIER 3 Investigations) October 2012-September 2013	
Theme	**Trust Actions**
Documentation	•Surgical safety checklist / audit •Nursing Metrics •Trust-wide documentation audit •Safety thermometer
Medication	•Safe Medication Practice Group •Medication Matters newsletters •Refinement of anticoagulation chart •Oxygen prescribing working groups •Roll out of medicines management programme •Revised EP codes for omitted/delayed medication •Quality improvement project: delayed/omitted IV antibiotics
Communication	•Simulation resources-team steps •Nursing safety manuals •Safety walkarounds and responsive safety review processes •Risky business forum for junior doctors •Lesson of the month •HEFT apps developed to guide safe practice •SUI at a glance report
Deteriorating patient	Nursing metrics Sharing of learning identified in SUI reports Fluid balance improvement programme and toolkit Revised ALERT course commenced Sept 2013
Safer Surgery	•Review of WHO safer surgery checklists •Sharing the learning from theatre related Never Events. •Knowing the risk. Perioperative risk assessment / communication tool

Summary profile for corporate functions: January 2014

CORPORATE RED RISKS: There are no validated red risks for non clinical areas.

Corporate Risk profile (*)



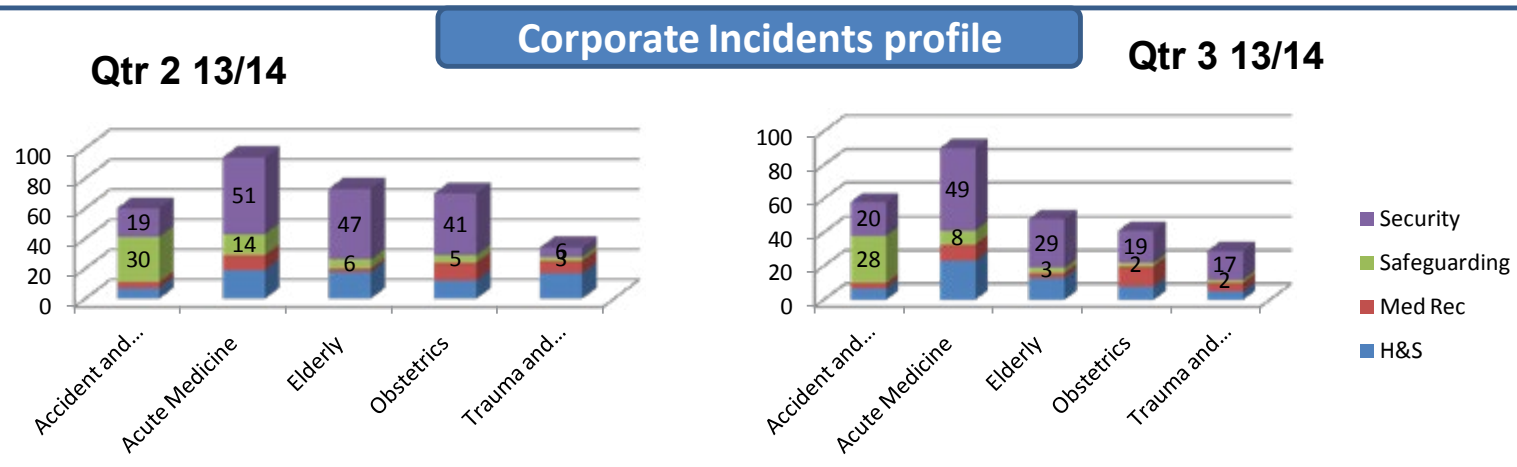
(*): Currently no risks approved for Corporate Affairs

Statutory compliance issues

•No assurance from the PCT or their Landlords, that their buildings are compliant with statutory requirements. An audit to assess the scale of the issue has been commissioned

• Lack of evidence to provide assurance that waste management training is being provided as detailed in the Waste Management Policy. There is a risk of the trust being subjected to prosecution by the Environment Agency.

Corporate Incidents profile



The above graph details the Directorates reporting the highest number of the top 5 corporate categories of incidents.
"Security" is the highest category of corporate incidents being reported. The number of security incidents report in Obstetrics has significantly increased in Q2 13/14. A majority of the security incidents reported in obstetrics relate to unavailable or faulty baby tag system.

OPEN Non-clinical Severe Incidents

Directorate	Date	Description (N = Never Event)	Status
None.			

Trust wide regulatory issues

Quality Account - Work has began on the Quality Account for 2013/14 incorporating 7 priorities for the Trust. We are waiting for national guidance to be released as to what the final account should look like now it is under the remit of NHS England.

CAS Alerts –

A total of 46 new alerts were received during quarter 3 (October – December 2013)

7 alerts remained open within the deadline for completion date at the end of December 2013. These will be progressed during 2014.

2 Alerts NPSA/2009/PSA004B and NPSA/2011/PSA001 continue to remain open past the deadline for completion date. Mitigating action is in place and the Medical Devices Manager continues to monitor the situation and is awaiting the release of National guidance.

Update on other external inspections: March 2014

CQC The Trust was part of the first wave of Acute Trusts undergoing the new CQC inspection regime and the Trust was inspected – under the new framework – between the 11th and 15th November 2013. The final report has been published with the warning notice relating to regulation 10 on the Good Hope site. The CQC re-visited Good Hope Hospital on the 27th February and found that significant improvements had been made. The draft report is still awaited.

CCG – The Solihull CCG visited Solihull Phlebotomy Clinic on the 17th December. The full report was received with minor recommendations which are being completed. The action plan is being monitored through the Solihull Site Clinical Governance Forum.
Solihull CCG as co-ordinating commissioner, in collaboration with Birmingham Cross City CCG and South East Staff and Seissdon CCG and Heart of

England Foundation Trust undertook a themed review of pressure ulcer prevention, management and reporting in February 2014. They identified a number of examples of good practice, specifically in relation to individual members of staff, the leadership on GHH ward 9 and Solihull ward 18. However, they did identify across the sites that the documentation in regards to assessments and evaluation of care was confusing and often incomplete. The Trust is awaiting the full report.
Cross city CCG did a falls themed visit to Ward 11 GHH in February.

Cancer Peer review – There have been no recent cancer peer reviews.
Education West Midlands – There have been no recent visits from the Deanery.
WMQRS – There are no inspections by WMQRS planned.

CQC IMR March

Elevated risk	Dr Foster Intelligence: Composite of Hospital Standardised Mortality Ratio indicators
Elevated risk	Composite indicator: In-hospital mortality - Genito-urinary conditions
Elevated risk	PROMs EQ-5D score: Hip Replacement (PRIMARY)
Elevated risk	Monitor - Governance risk rating
Elevated risk	NHS Staff Survey - Percentage of staff receiving health and safety training in last 12 months
Elevated risk	Whistleblowing alerts
Risk	Never Event incidence
Risk	Proportion of patients risk assessed for Venous Thromboembolism (VTE)
Risk	Composite indicator: In-hospital mortality - Cardiological conditions and procedures
Risk	Composite indicator: In-hospital mortality - Haematological conditions
Risk	Maternity Survey 2013 C12 "Did the staff treating and examining you introduce themselves?" (Score out of 10)
Risk	Composite indicator: A&E waiting times more than 4 hours
Risk	GMC - Enhanced monitoring

March 2014

Reducing harm from omitted and delayed medicines

Delays and omissions of medicines can cause harm and impact on clinical outcomes

These are just three examples of reported incidents at HEFT, where patients suffered harm from medicines being delayed or omitted.

- A patient with epilepsy, did not have their regular anticonvulsant medication prescribed. 24 hrs after admission the patient suffered three seizures over a period of 30 minutes.
- A patient on regular bisoprolol (beta blocker) did not have this medication prescribed whilst on the ward. Two days after admission the patient became tachycardic, requiring an ECG, IV fluids and STAT doses of bisoprolol.
- Over a five day period a patient with Parkinson's disease and vascular dementia was refusing to take his regular anti Parkinson medicines, and a number of doses were missed. This resulted in the patient developing problems with mobility and swallowing. A SALT assessment deemed swallowing unsafe and the patient was made NBM.

Timely administration of medications is crucial. In some cases delays and omissions can be catastrophic.

Lesson of the month

Actions for prescribers

Think...When admitting a patient, establish accurately and as quickly as possible ALL the medicines that they are taking by carrying out a medicines' reconciliation. ★

Think..... Do you know what the medication is for? Will a delay or omission in prescribing have serious implications for the patient?

✓ ACT... Ensure that medicines are prescribed without delay.

✓ ACT... If you prescribe a 'STAT' dose, make sure you inform a nurse immediately that this drug is to be administered within 1 hour or administer it yourself.

Actions for Pharmacy staff

✓ ACT... Prioritise work to ensure urgent requests are dealt with promptly to avoid delayed or omitted doses.

✓ ACT... Ensure you are involved in the patient's medicines reconciliation as soon as possible after admission to help prevent medication errors.

✓ ACT... Use the EP missed dose report to check for omitted doses and liaise with the appropriate MDT to decrease future omitted doses.

Report any omissions or delays in prescribing, dispensing or administration of medicines to ensure learning and avoidance of repeated incidents.

Actions for Nurses

Think... Do you know what the medication is for? Will a delay or omission have serious implications for the patient?
E.g. Parkinsons meds, diabetic medication,

Think... If the patient is NBM or has refused their medication do you need to ask the Doctor for a review. The medication may need to be prescribed via an alternative route. e.g. NG ,buccal, IV, rectal or transdermal.

✓ ACT (in hours)... If the drug is not stocked on the ward, urgently contact your ward based pharmacist or pharmacy department.

✓ ACT (out of hours)...
Check if the patient has brought in their own medication.
Check if the medication is available on a neighbouring ward to borrow by accessing ward stock lists *via pharmacy home page: Following the procedure as per section 5.12 of the medicines policy.*
If not available contact the1st on sister who will see if medication is stocked in the emergency cupboard and if required will contact the on-call pharmacist to dispense.

✓ ACT... Alert the prescriber or patient team at the earliest opportunity if there are any missed or delayed doses.

Further information and guidance :
pharmacy home page medicines information service HEFT
medicines management service HEFT
★ NICE NPSA medicines reconciliation

SUI:At a glance

Key learning for Trust staff:

•Does your Directorate have a standardised approach to VTE risk assessment and thromboprophylaxis?
•Have all your patients had their VTE risk assessment completed?

Information regarding VTE can be found on the Trust intranet under 'Policies'.

Incident Theme(s):

•Non adherence to Trust Policy
•Communication

Situation

A 30 year old man, was admitted to Heartlands Hospital for bilateral varicose vein surgery. During his admission no VTE risk assessment was undertaken and he did not receive any prophylactic low molecular weight heparin. He was discharged two days later. Whilst still on hospital grounds he collapsed. He was taken to ED where he suffered a cardio-respiratory arrest and died at 1545hrs. Cause of death following HMC post mortem examination was listed as pulmonary embolism.

Background

The patient was placed on the elective list for bilateral varicose vein surgery following review in the vascular clinic in September. He had a past medical history of high BMI, hypertension, and varicose veins for which he had previously received foam sclerotherapy. He was seen in the pre op assessment clinic in October. Following assessment the staff nurse made a decision to change the patient to an overnight stay patient instead of a day case. She also deferred the surgery and referred him back to his GP for blood pressure optimisation. No VTE risk assessment was completed during the pre op assessment as the surgery had been deferred. The surgeon contacted the GP and the anaesthetist and following discussion a decision was made to continue with the original surgery date.

The patient was admitted but no VTE risk assessment was performed. The WHO theatre safety checklist was completed and the check for VTE prophylaxis was ticked. At the end of the surgery the patient was prescribed analgesia on the EP system. No VTE risk assessment was completed at this time. The patient was admitted to the ward post operatively.

The next day, the patient was reviewed on the ward round. It was noted that he should receive clexane and have an out patients appointment in 6-8 weeks. He stayed in hospital until the following day and had his bandages removed. It is unknown why he stayed in hospital a further night.

The patient was seen by a consultant who days after surgery and discharged home. He made his own way to the front entrance of the hospital. The patient had a collapse within hospital grounds and was transported to ED by WMAS. He suffered a cardiac arrest and despite full resuscitation efforts died at 1545 hours.

Assessment

•The patient did not have a VTE risk assessment in line with Trust policy and did not receive pharmacological prophylaxis.
•Had the VTE risk assessment been completed it would have indicated that the patient should have been considered for thromboprophylaxis.
•There were a number of missed opportunities to complete the VTE risk assessment; pre op assessment, pre operatively on the Surgical Admission Unit, and when the patient was admitted onto the EP system.
•It was identified that it was possible to prescribe on EP, in hours, without completing the VTE risk assessment.
•Following review on his first post operative day a request was made for clexane to be prescribed and this did not happen. It is not known why this did not happen.
•There is no standardised protocol or practice across the vascular directorate for the use and timing of thromboprophylaxis in varicose vein surgery.
•Paper charts and EP were both used in the surgical admissions unit at the time of the incident.

Recommendations

•A directorate policy should be formulated on the use of thromboprophylaxis in varicose vein surgery to standardise practice.
•To undertake a review of the EP system to identify if it is possible for the VTE risk assessment prompt to always be shown.
•Regardless of the route of admission the Directorate should ensure a robust system is in place so that all required pre-op assessments are completed including VTE risk assessment.
•All paper drug charts should be removed from the surgical admissions lounge and EP used for all patients.

SUI at a Glance

Trust wide key learning points:

•Do you know the Policy and Procedure that should be followed in the event of a retained swab?
•Do you know what is expected regarding documentation in the patients medical records following an adverse event in line with Duty of Candour?
This information can be found in the Policies section of the Trust intranet

Incident Theme(s):
• Retained foreign object – NEVER EVENT
•Adherence to Trust Policy and Procedure
•Documentation

Situation
A 74 year old man was admitted to Solihull Hospital in October for an elective total right hip replacement. The patient was discharged home on an enhanced recovery programme 6 days later. He was referred back to Trauma and Orthopaedics due to increasing pain in his left hip 9 months later. The patient was seen in the out patient clinic and the x-rays from previous follow up appointments were reviewed. This review revealed a thread like foreign body within the cement mantle of the right femoral canal. This has been identified as part of the ribbon gauze used to clean the femoral canal.

Background
During a right total hip replacement operation at Solihull Hospital, a piece of ribbon gauze was retained in the right femoral canal. It was standard practice to dry the femoral canal, using ribbon gauze, prior to the insertion of the femoral component and cement.
The operation was completed and a post operative x-ray was reported as satisfactory in the medical notes. The patient was discharged home on an enhanced recovery programme on 6 days later.
An artefact was noted on the post-operative pelvic x-ray but no immediate action was taken as it was believed that this was x-ray artefact rather than a retained object.
A repeat x-ray was taken in December at a routine physiotherapy appointment. It was documented as satisfactory with no reference made to previous artefact seen.
The patient was then reviewed in the out patients clinic in February and was found to be making good progress. The x-ray taken in December was reviewed and it was confirmed the artefact was likely to represent a retained piece of ribbon gauze. It is likely that this sheared off whilst drying the femoral canal. The patient was verbally informed of the retained piece of ribbon gauze and a decision was made to treat conservatively. This conversation was not documented in the patient's medical records. The patient was then discharged from the clinic.
The following September the patient attended the orthopaedic clinic for consideration of a left total hip replacement. It was at this appointment that the retained ribbon gauze was identified and escalated as a never event.
The patient attended the out patient clinic two months later for further explanation of the retained piece of ribbon gauze. He was shown his sequential pelvic x-rays and it was explained that the femoral component of his right hip replacement had tilted and sunk. It was explained that it was possible that this was due to the prosthesis finding its own natural position, but also possible that the femoral component was tilting due to the retained piece of gauze. He was given the option of either right hip revision surgery and the removal of the piece of ribbon gauze or conservative management. The patient decided on conservative treatment and expressed a wish to proceed with a left total hip replacement.

Assessment
Following an elective right total hip replacement a retained piece of ribbon gauze was identified on a pelvis x-ray. A retrospective x-ray report describes the appearance in keeping with a foreign body and most probably a swab.
The piece of ribbon gauze was initially confirmed in February but was not escalated as a Never Event [redacted] as the surgeon was unsure of what action to take.
There is no documentation in the notes to support the verbal discussion where the patient had been informed of the retained piece of ribbon gauze in line with Duty of Candour and Being Open.
The surgeon discussed the incident with orthopaedic colleagues. Two other colleagues have experienced ribbon gauze shearing whilst drying the femoral canal. On each of these occasions the shortened length of ribbon was noted prior to the introduction of the femoral prosthesis and cement. It appears that neither of the two surgeons who had had this experience escalated it to anyone else.

Recommendations
Review of alternative methods for the process of drying the femoral canal or identifying robust methods to check the length of the tape to ensure it remains intact.
Dissemination of the updated Never Event List [redacted] to consultant colleagues across the trust in order to improve the awareness and reporting of such events.
Presentation of this case at the Directorate meeting to ensure that information and learning from this event and the importance of reporting incidents such as breakage of ribbon gauze is reinforced.

Patient and Public Feedback Report

PATIENT and PUBLIC FEEDBACK REPORT

This document provides an update on the Trust's Patient and Public Experience activity, an update on the current position with the Parliamentary Health Service Ombudsman and a site-level complaints overview.

Summary/Key Points:

The Trust employs three quality indicators to monitor patient experience. The Patient Metrics Programme which collects views from patients whilst they are in hospital. The Nursing Care Indicators which audits a ward on a number of key safety measures and the Friends and Family Test. The points below are a summary of the main findings:

Trust inpatient metrics highlight 9 of the 15 measures reached target satisfaction levels of 95%. Highest satisfaction was for support eating meals, single sex bays and hand hygiene**.** The lowest scores were informing patients about their discharge date, talking about the side effects of medication and call buzzer response.

Annual nursing indicators show 6 of the 10 indicators scored 95% or higher. Pain Management and Resus Trolley were the highest; while the lowest were Diabetes and Tissue Viability.

The Trust's inpatient score for the Friends and Family Test (FFT) was 69 points in March, four points below the Birmingham and Black Country region also that of the national score for England (February scores, March not available). The score however was one point higher than the previous month.

The Emergency Department score in March was 24, compared with the regional ED score of 49 and a national score of 55 (February scores, March not available). Trust wide response rate for the FFT was 18.4% in March. The CQUIN requirement was a 20% response rate by the end of March 2014.

The Head of Patient Engagement is working closely with Heads of Nursing to boost response rates for the year ahead, initially through in house card collection methods. We are also looking to outside providers to support us in this for the year ahead.

The FFT is to be expanded to outpatients and day surgery by October 2014 and staff are to be surveyed quarterly by the end of June 2014.

Community Services returns the highest FFT scores in the Trust and the score for March was 75.

Site analysis shows similar patient and nursing metrics scores across the three main hospitals, average scores for each measure are as follows:

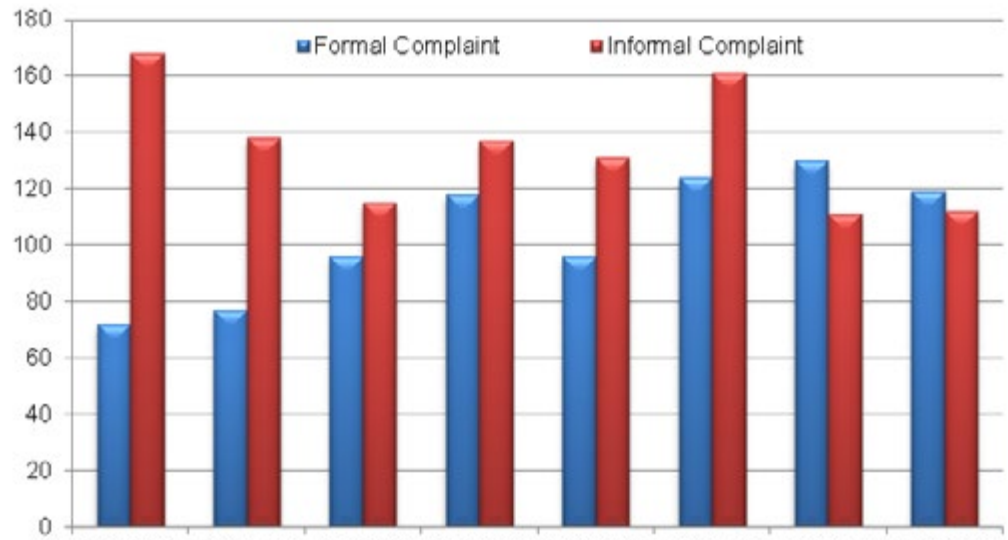
1. Solihull Hospital, Nursing Indicator = 95%, Patient Metrics = 95%
2. Heartlands Hospital, Nursing Indicator = 95%, Patient Metrics = 94%
3. Good Hope Hospital, Nursing Indicator = 95%, Patient Metrics = 93%

Overview of Complaints

Comparison Complaints Data

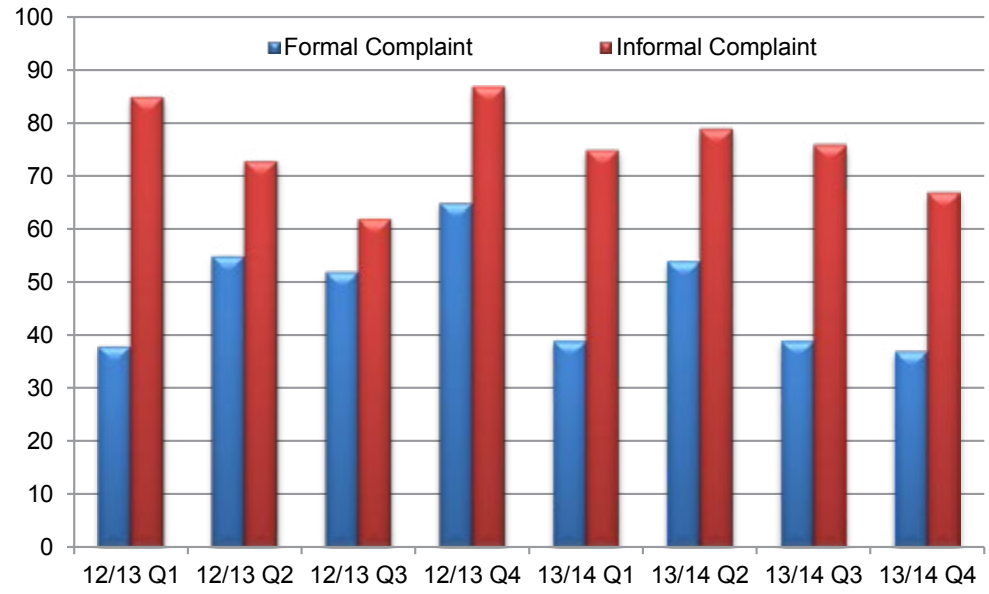
Although complaints seem to remain fairly consistent, the number of concerns that are raised and dealt with and resolved at an early stage has increased, reducing the number of potential formal complaints to the Trust. The data for formal complaints and informal is used in conjunction with each other to identify themes and trends across the Trust.

Formal complaints and Concerns raised for Birmingham Heartlands Site



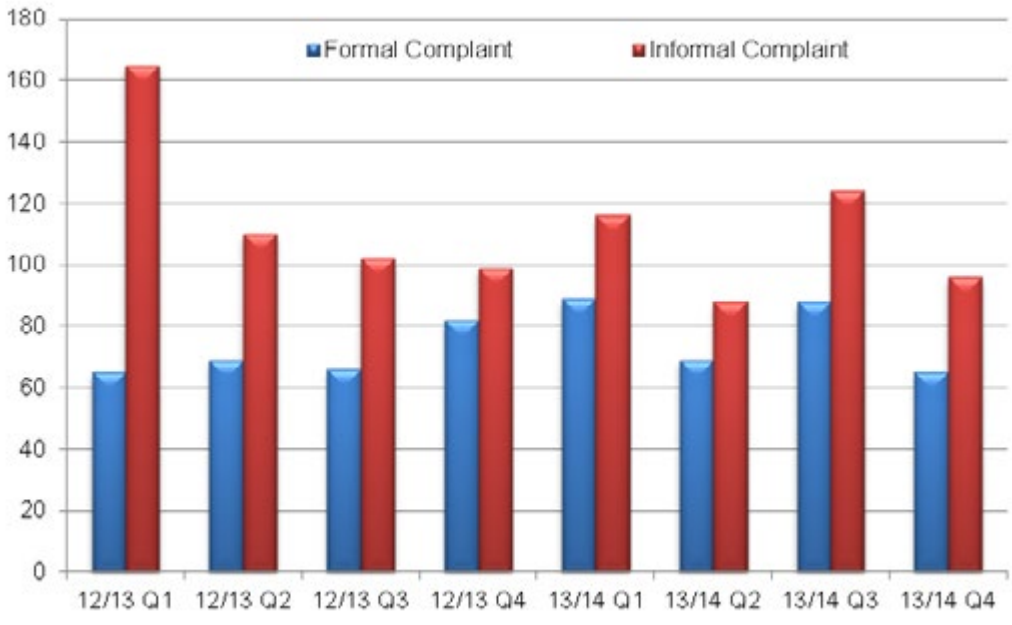
	12/13 Q1	12/13 Q2	12/13 Q3	12/13 Q4	13/14 Q1	13/14 Q2	13/14 Q3	13/14 Q4	Total
Formal Complaint	72	77	96	118	96	124	130	119	797
Informal Complaint	168	138	115	137	131	161	111	112	1073
Totals:	240	215	211	255	227	285	241	231	1870

Formal complaints and concerns raised for Solihull Hospital Site



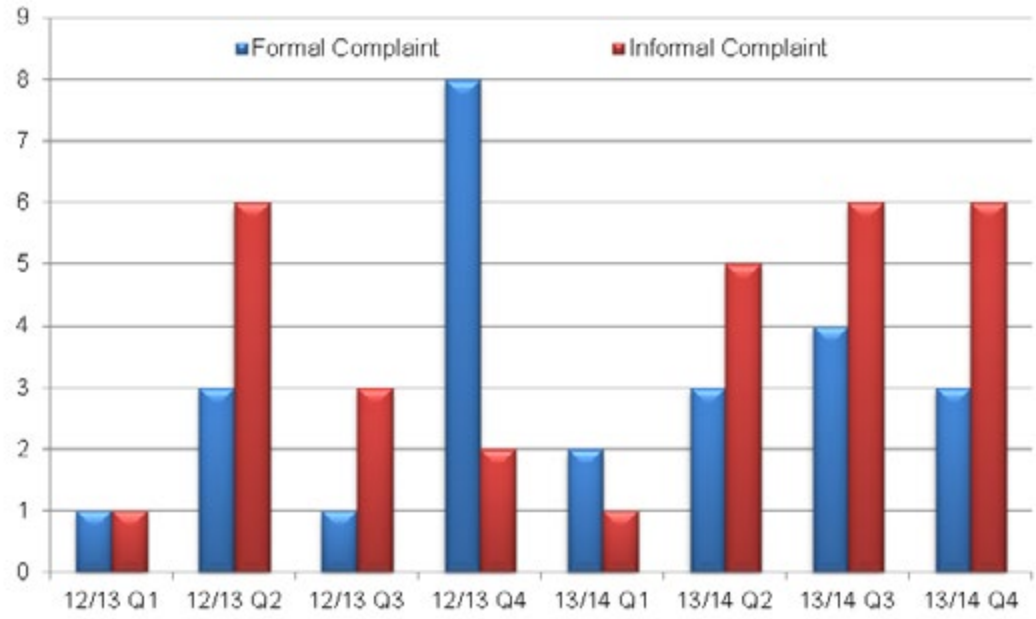
	12/13 Q1	12/13 Q2	12/13 Q3	12/13 Q4	13/14 Q1	13/14 Q2	13/14 Q3	13/14 Q4	Total
Formal Complaint	38	55	52	65	39	54	39	37	368
Informal Complaint	85	73	62	87	75	79	76	67	604
Totals:	123	128	114	152	114	133	115	104	972

Formal complaints and concerns raised for Good Hope Hospital Site



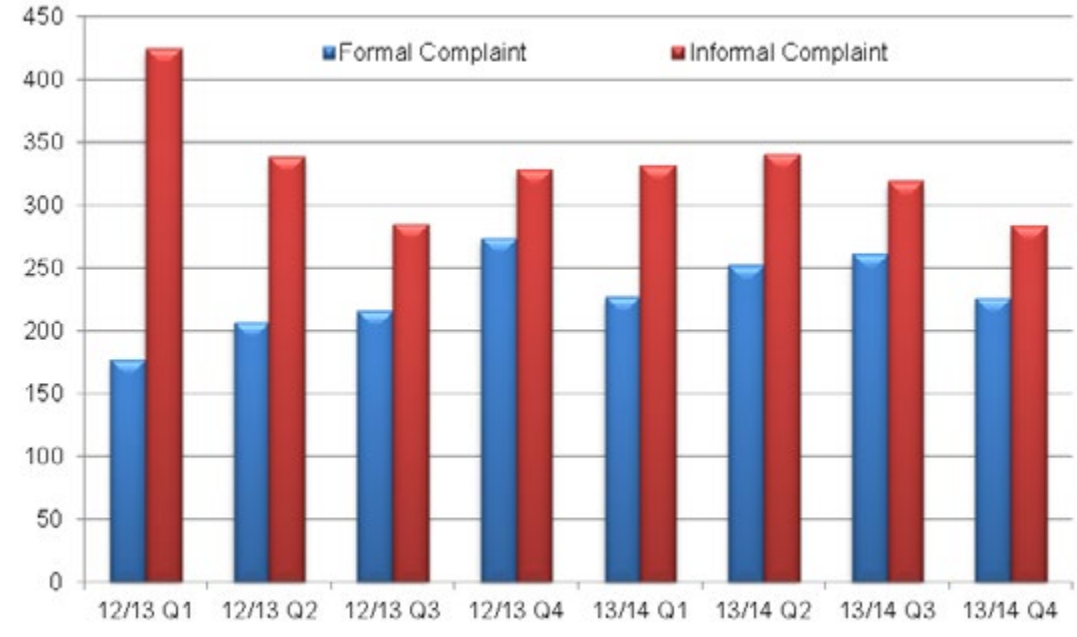
	12/13 Q1	12/13 Q2	12/13 Q3	12/13 Q4	13/14 Q1	13/14 Q2	13/14 Q3	13/14 Q4	Total
Formal Complaint	65	69	66	82	89	69	88	65	581
Informal Complaint	165	110	102	99	116	88	124	96	899
Totals:	230	179	168	181	205	157	212	161	1480

Formal Complaints and concerns raised for Community Services



	12/13 Q1	12/13 Q2	12/13 Q3	12/13 Q4	13/14 Q1	13/14 Q2	13/14 Q3	13/14 Q4	Total
Formal Complaint	1	3	1	8	2	3	4	3	25
Informal Complaint	1	6	3	2	1	5	6	6	30
Totals:	2	9	4	10	3	8	10	9	55

Complaints and Concerns raised for all sites April 2012 – January 2014



	12/13 Q1	12/13 Q2	12/13 Q3	12/13 Q4	13/14 Q1	13/14 Q2	13/14 Q3	13/14 Q4	Total
Formal Complaint	178	207	216	274	227	252	261	226	1782
Informal Complaint	425	339	285	329	332	341	319	284	2653
Totals:	603	546	501	603	559	593	580	510	4435

Parliamentary Health Service Ombudsman

Further improvement has been maintained with the number of complaints being forwarded to the Parliamentary Health Service Ombudsman (PHSO) reducing for the second year, continuing with the good work involving Directorates and Patient Services to achieve a satisfactory outcome with the complainants. Changes to the way PHSO investigate their current case load has changed and having a key person working within the organisation providing a link person to review cases such as those requiring investigation from the PHSO has improved considerably.

The table below shows the number of Ombudsman's contacts direct to the organisation relating to concerns raised for a specific patient reflective over a 4 year period:

PHSO profile by management team for FY 13/14				
Site/Division	**10/11**	**11/12**	**12/13**	**13/14**
BHH	12	27	6	6
GHH	10	16	11	4
SH	6	5	1	3
W&C	6	3	1	0
CSSD	1	4	1	3
Community	0	0	1	0
Corporate	0	1	0	0
Total	**35**	**56**	**21**	**16**

PHSO Profile by outcomes (YTD 31.1.14)				
	10/11	**11/12**	**12/13**	**13/14**
Upheld	6	5	0	0
Partially Upheld	5	1	1	1
Not Upheld	1	2	1	2
Not Investigated	23	48	17	2
Ongoing	0	0	2	12
Total	**35**	**56**	**21**	**17**

PHSO profile by Findings FY 13/14				
Findings	**10/11**	**11/12**	**12/13**	**13/14**
Service failure	10	5	0	0
Maladministration	4	2	1	1

PHSO Profile by compensation paid FY 13/14				
	10/11	**11/12**	**12/13**	**13/14**
Total	£24,779	**£10,000**	**£250.00**	**£0.00**

Received	Total number of enquiries received by PHSO	Advice and Support given on where or how to complain	Number of complaints PHSO accepted	Number of complaints that they Upheld	Number of complaints they partially upheld	Number of complaints they were not upheld
2010/2011	171	0	12	6	5	1
2011/2012	124	7	8	5	1	2
2012/2013	111	28	9	4	3	2

Real Time Feedback and Family and Friends Test (FFT)

The most robust local patient feedback programme was introduced four years ago to collect and report 'real time' feedback; which currently surveys 9,000 patients annually. The results are integral part of our patient experience drive with monthly satisfaction reports presented towards and areas to help drive improvements. This work allows wards and departments to understand the key issues affecting patients. The table below shows our range of scores for the inpatient survey, it is organised into colour coded sections, the highest scores (green) are on the left and the lowest are on the right (red).

Inpatient Experience Metrics (April 2013 – March 2014)

The summary tables below show the first benchmarks average scores for each question or indicator over a 12 month period. The second shows the monthly trend of overall scores, the target for the Trust is 95%.

Help eating meals	Mixed sex bay	Hand hygiene	Respect & dignity	Cleanliness	Felt cared for	Regularly checks if comfortable	Privacy discussing condition	Pain control	Discuss worries or concerns	Would recommend ward to others	Involved in treatment decisions	Call buzzer response	Medication side effects	Informed about going home
100%	99%	99%	98%	98%	97%	97%	97%	97%	94%	93%	92%	86%	84%	68%

Trend Analysis	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-13
Score	94%	94%	94%	94%	94%	94%	96%	91%	89%	93%	93%	93%

We have dedicated a lot of time ensuring the FFT is fully implemented for Inpatients, the Emergency Department and more recently Maternity Services. In real terms, for this measure alone we have increased the number of patients who gave feedback from 12,000 in 2012 to over 44,000 throughout 2013/14. Currently the Trust achieving a response rate of 18.4% (inpatient and ED only) in March; our target for March 2014 was 20% (see table below for monthly trend).

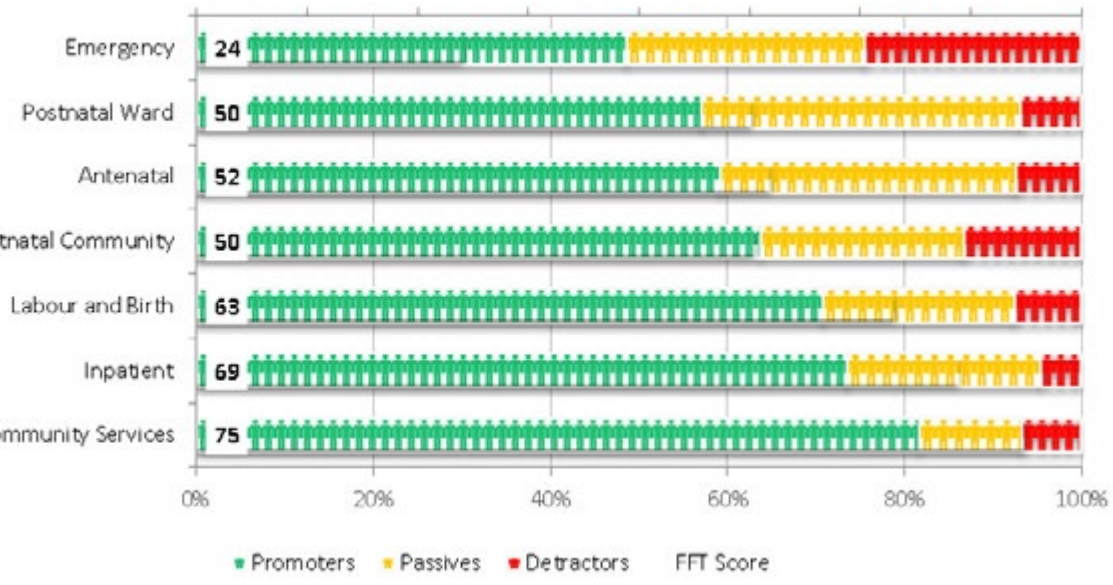
FFT Survey (April 2013 – March 2014)

FFT Response Rate	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14
Trust	11%	6%	16%	15%	16%	17%	15%	19%	16%	17%	19%	16%
Inpatient	26%	18%	18%	13%	19%	20%	18%	21%	13%	13%	23%	11%
Emergency	4%	1%	15%	16%	15%	16%	14%	18%	18%	19%	18%	18%
Maternity							13%	15%	22%	17%	16%	23%

20% or above	15% to 19%	Below 15%

The table below shows the average scores for each area participating in the FFT.

FFT Scores (April 2013 – March 2014)



FFT Scores – Maternity (October 2013 – March 2014)

Maternity	Service	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14
Antenatal	BHH	8%	0%	6%	3%	3%	1%
Antenatal	GHH	63%	16%	4%	13%	3%	9%
Antenatal	SOL	3%	1%	1%	1%	0%	1%
Labour/Birth	BHH	7%	32%	33%	20%	19%	21%
Labour/Birth	GHH	8%	18%	53%	47%	32%	54%
Labour/Birth	SOL	71%	81%	100%	45%	29%	45%
Postnatal Ward	BHH	14%	22%	23%	16%	19%	15%
Postnatal Ward	GHH	16%	17%	46%	24%	37%	67%
Postnatal Ward	SH						50%
Postnatal Community	Trust	13%	10%	11%	12%	12%	20%

The following details a pilot to benchmark results from three quality measures (see below) over a 12 month period:

- Patient Experience Metrics (February 2013 to January 2014 - views from 9000 patients and relatives)
- Nursing Care Indicators (February 2013 to January 2014 - 8,000 ward level safety audits)
- Friends and Family Test (April 2013 to January – views from 25,000 patients and relatives)

To qualify the ward or department must have submitted at least five months of data in the last 12 months. The only exception to this rule was data collected from Therapies team who carry out their metrics survey each quarter.

The average scores for the entire year were calculated and then used percentiles to show dispersion within that particular range of data. A percentiles measure is used in statistics to designate a value (or score) where a percentage of the observations may be found. For example, the 50th percentile is the value (or score) which the median or average can be found, the 20th percentile is the bottom 20% and the 80th percentile is the top 20% of scores. The scores in each measure were ranked from highest and colour coded as follows:

Green section relates to the top 20% of highest scores
Red section relates to the bottom 20% of lowest scores
Orange section represents the range of scores within the remaining 60% of scores

The table below shows how the range of data is organised into three colour coded sections, the highest scores are on the left of the table and the lowest are on the right.

Nursing Indicators (April 2013 – March 2014)

Pain Management	Resus Trolley	Medication Storage and Custody	Falls Assessment	Infection Control & Privacy & Dignity	Continence Assessment	Patient Observations	Nutritional Assessment	Tissue Viability	Diabetes
98%	97%	97%	97%	95%	95%	94%	93%	90%	89%

Trend Analysis	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14
Total	94%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	96%

Renal Survey (July 2014 – April 2014)

Hand hygiene	Felt cared for	Respect & dignity	Recommend ward to family or friends	Call buzzer response	Assured by staff	Discuss worries or concerns	Pain control	Involved in treatment	[illegible] effects	Privacy discussing condition	Cleanliness
100%	99%	99%	99%	99%	98%	97%	94%	84%	81%	78%	66%

Trend Score	Oct-11	Jan-12	Apr-12	Jul-12	Oct-12	Jan-13	Apr-13	Jul-13	Oct-13	Jan-14	Apr-14
	93%	88%	90%	88%	92%	94%	89%	87%	92%	92%	92%

IP Therapies Survey (June 2013 – April 2014)

Recommend ward to family or friends	Respect & dignity	Felt cared for	Privacy discussing condition	Treatment helpful to wellbeing	Waiting time for therapy in hospital	Discuss worries or concerns	Hand hygiene	Explanation of treatment	Involved in treatment decisions	Discussing next steps
98%	97%	95%	94%	93%	93%	92%	91%	91%	91%	87%

Trend	Jan-12	Apr-12	Jul-12	Oct-12	Jan-13	Apr-13	Jul-13	Oct-13	Jan-14	Apr-14
Inpatient Therapy Score	85%	93%	92%	92%	93%	92%	91%	94%	95%	93%

Community Services Survey (April 2013 – March 2014)

Length of time spent with staff	Involvement in decisions	Overall care rating	Information about treatment	Hand Hygiene	Appointment convenience	Privacy and dignity	Additional general health advice	Appointment waiting	Impact on daily life
98%	98%	98%	97%	96%	95%	93%	92%	91%	90%

Trend Analysis	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14
Score	94%	94%	93%	93%	95%	96%	95%	96%	96%	97%	97 %	96 %

Quality Improvement

This feedback has been used to drive quality improvements and the following outlines some of the work undertaken:

2012 Concern	HEFT Action / Response	2013 Outcome	March 2014 update
15% decline in the number of patients always given help to eat meals	**Keeping nourished scorecard and exception report** presented monthly at Nursing and Midwifery Performance Committee which were scrutinised to ensure, where necessary, patients are always given help to eat meals. Where appropriate trained volunteers and relatives now assist with feeding.	12% increase in the number of patients always given help to eat meals (National Inpatient Survey 2013). Internal patient metrics programme has attained target satisfaction levels of 95% or higher for last 12 months.	**Inpatient metrics indicate 100% compliance from patients asked if they received the assistance they needed throughout the whole of 2013/14**
9 in 10 patients were not asked to give their views while in hospital	600 patients surveyed each month on the wards asking them to rate the care they receive, results reported to Trust Board every two months. Successful launch of 'The Friends and Family Test' in April 2013 for Inpatients and Emergency patients, Maternity Services commenced in October 2013. The Trust is currently achieving CQUIN baseline target of a 15% response rate.	6% increase in the number of patients who said they were asked to give views whilst in hospital (National Inpatient Survey 2012-13)	**Over 44,000 patients carers and relatives have participated in the FFT during 2013/14 (Inpatient, ED, Maternity)**

1 in 2 patients not informed when they would be discharged from hospital (Inpatient Survey 2012-13). Patient Metrics show 60% of patients said staff did not talk about when they would go home	The Jonah Programme has been integrated across the Trust. A key feature has been visual management to ensure the planned patient journey is visible, along with their progress. There is a heavy emphasis on coaching to develop leadership, improvement and problem solving skills at ward level. At ward level it focuses on individual patients and engages the multidisciplinary team in setting and delivering a Planned Date of Discharge (PDD). The focus is on defining clear plans for the patient's stay on the ward.	Solihull hospital patient metrics show a 9% increase in the number of patients who were informed about their discharge date from 68% in the first quarter to 77% in quarter 3. Good Hope increased the number of patients by 15% between April and October, similarly, Heartlands increased by 10% in the same period. However, the results for November and December show a decline which is being monitored.	**Across the 3 main sites a decline in this standard in evident in in the inpatient metrics. This standard will be picked up as part of the development of how we monitor this going forward. The standards will be discussed with patients through the collection of the nursing indicators and tracked for improvement.**
12% decline in patients who knew how to complain about care received	Information campaign throughout the Trust, new leaflets and posters were designed that detailed the number of ways patients and relatives can escalate concerns and complaints. Posters are displayed in corridors, wards and outpatient clinics. The leaflets are in display boards and the information is also included in the Trust bedside folders.	5% increase in the number of patients who said they were given information about how to complain about their care (Inpatient Survey 2013)	**No further update, inpatient survey for 2014 as yet not undertaken. However publicity and information about how to complaint has been developed since patients took part in the 2013 survey.**
2 in 3 patients not told about side effects of medication	The CEO Safety Project focused on medication safety supported by a 'message of the month'.	The Trust set a target of 50% of patients completely told about the side effects of medication. It is monitored through the Key Performance Indicators (KPI). Results from quarter 3 show 47% of patients were told about side effects of medication, an increase of 15% since the previous quarter.	**Evidence from inpatient metrics shows that this standard has improved significantly. The May, June, July 2013 average was 84.7%. The average for Q4 2014 was 94.7%.**

NHS Choices

The NHS Choices and Patient Opinion websites allow Trust users and visitors to post their feedback on-line.

In total 30 patients/visitors gave feedback during March 2014. The tables below give a summary of activity on each site during March.

Heartlands: NHS Choices & Patient Opinion Feedback

- 9 stories in – 8 were positive and 1 was a mixture of positive and negative.

Some of the comments include:

What was Good?

I had 2 procedures done by Theresa (Radiologist). I was feeling nervous but she was wonderful and made the experience so much easier. I would not feel so nervous if I had to go back to Theresa again.

I was placed in Respiratory Medicine Ward 24 for 11 days. The staff were very good, helpful and very kind. Nothing was too much trouble, the treatment was good and the staff looked after me from morning till night. Not one bad person out of all the staff. The food was also great.

What could be improved?

After seeing such a great team of staff on Ward 1, I was really upset with the way I was treated when waiting in the Discharge Lounge. My prescription was not there when I arrived and it took ages but the woman didn't seem bothered. I waited over an hour with my family waiting in the expensive car park to collect me. By the time it arrived I was so upset and in pain (I needed my painkillers) that I left alone and carrying my heavy bags as I could not wait any longer.

Good Hope: NHS Choices & Patient Opinion Feedback

- 15 stories in – 11 were positive, 3 were negative and 1 was a mix of positive and negative.

Some of the comments include:

What was Good?

We were made very welcome in the Plaster Room. The 2 male plasterers were fantastic. They chatted to my 6 year old, made him laugh, reassured him when his plaster was taken off his wrist and talked him through what he would see when the plaster was off. They showed him the screws in his wrist and again came down to his level and reassured him that all was fine.

I would like to record my heartfelt thanks to the Urology team, appointment staff and after care in recovery. I have been under their care for the past 6 years and am probably still alive today due to their dedicated care.

What could be improved?

My daughter was supposed to have an urgent appointment. Details were faxed to Good Hope with a send receipt. Now they have lost the message! How can an organisation run like this!

The midwife involved in my care was very unsupportive. She was un attentive to my care and I was left on my own with my partner for long periods of time. I had a normal pregnancy and normal labour with no complications until I entered the hospital. The midwife kept shouting at me to stay on the bed and not move and had me on continuous monitoring. I had an emergency c-section in the end and there was no consultant cover. The junior doctors were not competent enough and they have botched up the surgery. Horrible experience.

Solihull: NHS Choices & Patient Opinion Feedback

- 6 stories in – 3 were positive and 3 were negative.

Some of the comments include:

What was Good?

Gallbladder patient – helpful staff and put up with a moaner like me! Arrived at 8.00 am and left 9.00 pm the same day. Well taken care of and would have no fear about going again.

I recently attended the Eye Clinic for a cataract operation and was treated like Royalty and as if I was in private care. The staff were professional, friendly and caring. The surgeon explained in great detail as to what would happen to me, very reassuring before the operation and all went well. Three weeks on I had reason to attend A&E due to a fall and once again receptionists very kind explaining the waiting time, due to many patients, but I was kept informed at regular intervals.

What could be improved?

Arrived early for my nine o clock appointment and should have been second to be seen. However, as other patients arrived for the same clinic, their files were put on top of mine contributing to my waiting time of 45 minutes. It looked like the consultant took my file and then decided to have a meeting with his secretary before seeing me!
When I saw a consultant, he would not let me speak unless I was answering his questions. He decided that, as I already had some health conditions, my latest problems were obviously down to them!
I feel that I was dismissed by this health professional and made to feel like I was wasting his time!

I have to visit the hospital frequently and am very worried about the number of people who walk in the road and do not use the footpath when entering or leaving. This causes vehicles to drive in the middle of the road to avoid them and I have witnessed several near misses, especially when there is a vehicle driving in the opposite direction.

NHS Choices comparison of HEFT versus other local Trusts

The table below shows for each local NHS Trust how many patient/visitors have rated the hospital to date and scores given. This information has been taken from the NHS Choices Website.

Hospital	No. of patients/ visitors who have rated the hospital	Cleanliness rating (out of 5)	Staff co-operation (out of 5)	Dignity & respect (out of 5)	Involvement in Decisions (out of 5)	Same sex accomm. (out of 5)	Overall rating (would recommend the hospital) (out of 5)
Stafford Hospital	85	4.5	4.5	4.5	4.5	4.5	4.5
Warwick Hospital	205	4.5	4.5	3.5	4.5	4.5	4.5
City Hospital	22	4	3.5	4	3.5	3.5	3.5
George Eliot Hospital	53	4	4	4	4.5	4.5	4
Heartlands Hospital	110	4	4	4	4.5	4.5	4
New Cross Hospital	102	4	4	4	3.5	4	3.5
Queen Elizabeth Hospital (UHB)	88	4.5	4	4	4	4	4
Solihull Hospital	60	4	4	4	4	4	4
University Hospital – North Staffs	64	4	4	4	3.5	4	3.5
Good Hope Hospital	152	4	4	4	4	4	3.5
University Hospital – Coventry	79	4	3.5	3.5	3.5	4	3.5

Media Update

The communications team generated **99** pieces of positive coverage during March 2014 – this is **15** more pieces than in March 2013.

Coverage included print, broadcast and online media, both regionally and nationally.

Key highlights for the month:

The collaborative approach to rehabilitating patients taken by Good Hope Hospital and partners through the new Cedarwood service featured in articles in The Guardian, Care Home Management and the Birmingham Post.

The Birmingham Mail, Sutton Coldfield Observer, Solihull News, Tamworth Herald and Lichfield Mercury published articles about 'Come Dine with Me' taster sessions that took place at Heartlands Hospital, Good Hope Hospital and Solihull Hospital. These sessions were held to enable staff and visitors to sample some of the 40 new dishes that have been introduced to the menu for patients at the Trust.

A good news story about baby, Harvey Sutton, who received life-saving treatment at Heartlands Hospital's maternity unit by sleeping on a cooling bed featured in the Express and in the Birmingham Mail.

Articles raising awareness about Ovarian Cancer featuring comment from consultant gynaecologist, Mr Raj Saha were published in The Tamworth Herald, Sutton Coldfield Observer and Solihull News, as well as an interview with the consultant featuring on Heart FM.

Good Hope Hospital features in ITV1 series 'Student Nurses: Bedpans to Bandages', which follows the lives of trainee nurses and how they deal with the challenges they face on the wards. The Guardian, The Times and The Independent included the programme within their TV listings.

An advice column on stopping smoking appeared in The Asian Today and Shoparound Magazine, a local Bordesley Green and Sparkhill publication.

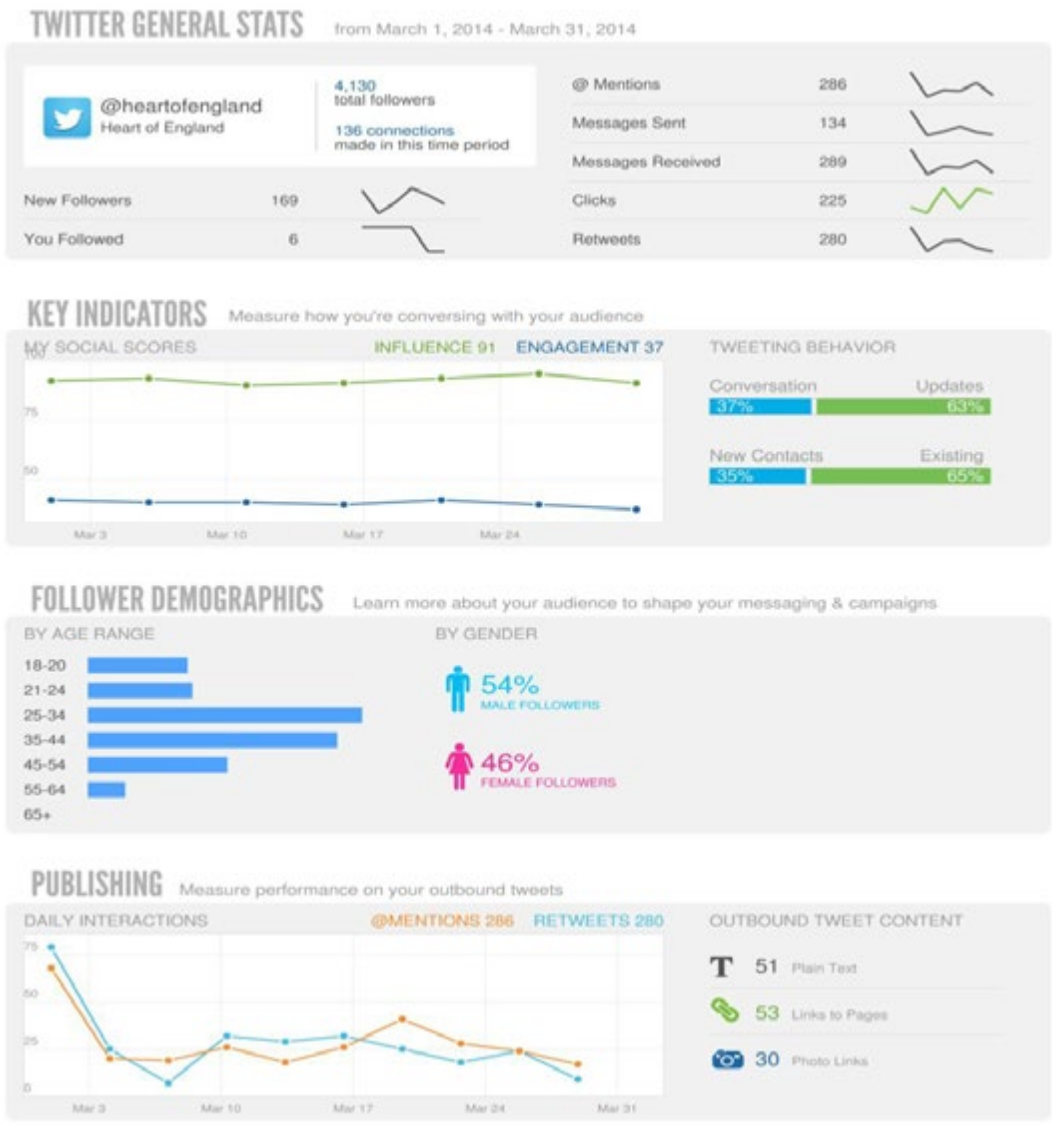
Key highlights for trade press are as follows:

- The collaborative partnership between Good Hope Hospital and third agency organisations to provide a rehabilitation service for patients was the focus of an article in Care Home Management magazine.
- Medical News Today and Diabetes.co.uk ran articles on a newly launched licensed treatment for Type 2 Diabetes, featuring the Trust.
- MIDIRS Midwifery Digest ran an article on the day in the life of a Trust bereavement maternity support worker.
- Professor Geoff Hackett gave an expert opinion for an article on safe therapies for erectile dysfunction.

The Trust on Twitter:

The top Twitter highlights include:

- The Trust's account has a total of **4,130** followers. We have gained **136** new followers this month.
- We were mentioned **286** times, retweeted **280** times and the various links posted gained **225** click-throughs.



Filming:

There were **5** sets of filming across the sites during March:

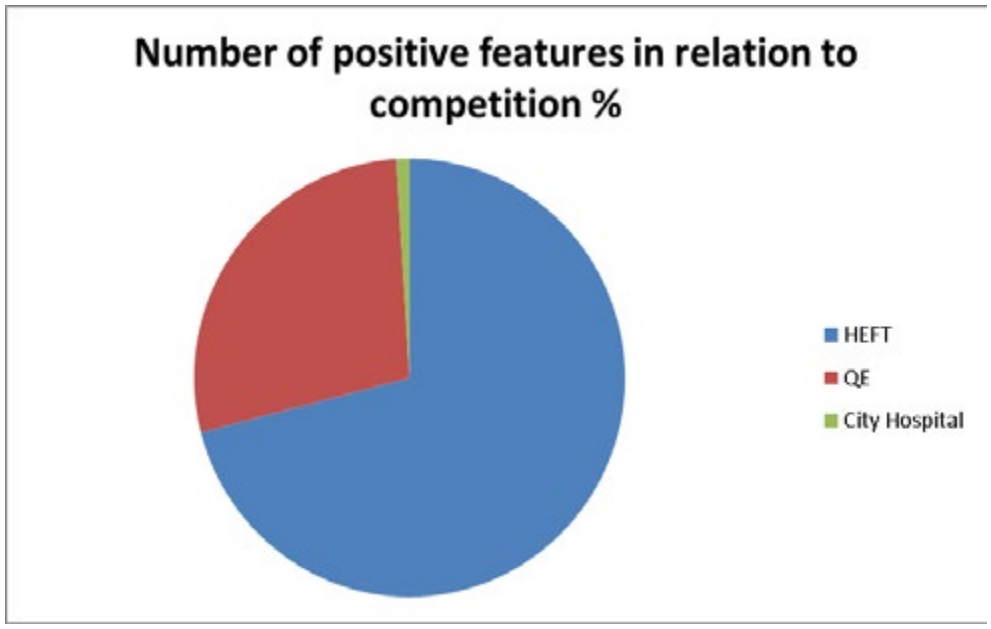
- Good Hope Hospital features in three episodes of the ITV1 series: 'Student Nurses: Bedpans to Bandages', during March which follows the lives of trainee nurses and how they deal with the challenges they face on the wards.
- Improvements made at the Trust following the CQC Inspection are detailed on BBC Midlands Today.
- Lord Philip Hunt is interviewed on BBC Midlands Today about the future of emergency care.
- The 3DOM Soundbeam Music Project, enabling Trust stroke patients to produce their own music was highlighted on BBC Midlands Today.
- Tuberculosis (TB) expert, Dr Martin Dedicoat was interviewed on BBC Midlands Today during world TB day.

If the Trust were to purchase the positive coverage for March as advertising space (AVE) it would cost: **£153,244.**

Press statements:

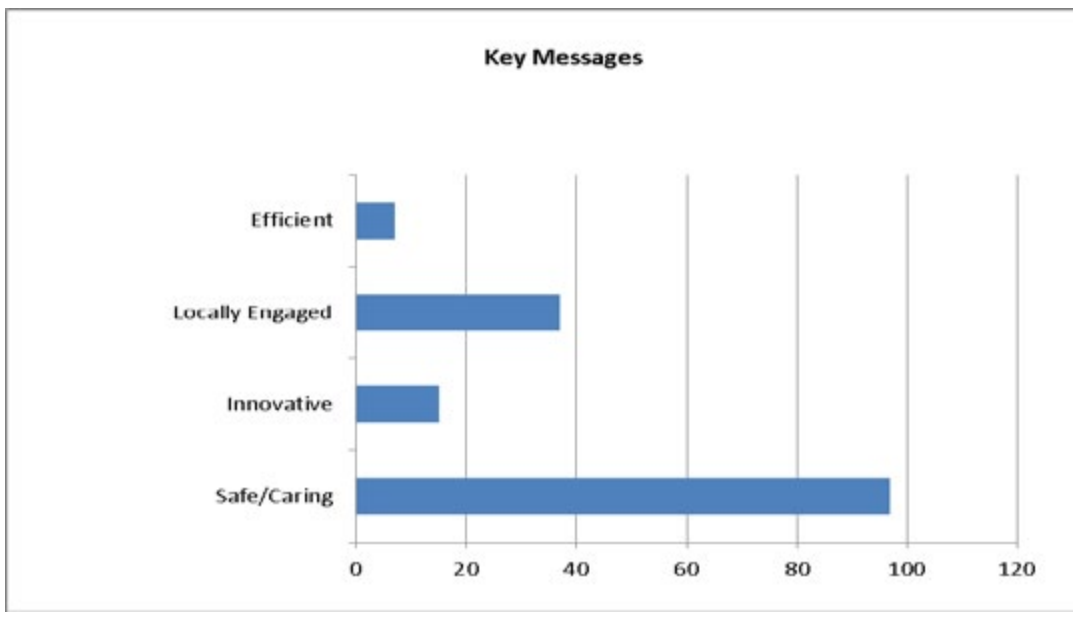
The team issued press statements on 3 separate subjects during March. These statements were around:

- Postponement of the Good Hope Hospital public meeting
- The Chris White patient case
- Fears that the dementia ward will close at Solihull Hospital.



*Meltwater media monitoring services.**

**This chart was calculated using Precise and*



The communications team aims to get at least one of the following key messages in every press release issued each month. This is to promote certain values that the Trust is associated with.

Trust blog:

Throughout March 2014, the Trust blog was visited 125 times.

There were 4 blog posts published in March:

- How to stay healthy in the workplace.
- Stop smoking advice.
- Nutrition and Hydration Week.
- Breaking Barriers for Patients.

The Heart of England NHS Foundation Trust gained more online coverage than City Hospital and the University Hospitals Birmingham NHS Foundation Trust in the first three weeks of March. In an unannounced inspection, the CQC found HEFT had made improvements in the services and facilities provided for patients and much of this coverage was about this topic.

The fourth and final week in March saw the University Hospitals Birmingham NHS Foundation Trust gain more online coverage compared to HEFT and City Hospital. This was due to a deaf woman given hearing after 39 years of silence. Joanne Milne was treated by audiology specialists at Queen Elizabeth Hospital.

Negative coverage:

In total, the Trust received **51** pieces of negative coverage in March. The majority of negative coverage the Trust received focused on breast care services provided by Solihull Hospital surgeon, Ian Paterson. BBC radio stations (BBC Radio 2, BBC Radio 4, BBC Coventry and Warwickshire and BBC Hereford and Worcester) and regional papers included stories on 'opportunities missed to take action against surgeon'.

Plans to axe ward 10 at Solihull Hospital also received negative coverage from the Solihull newspapers (Solihull News and Solihull Observer).

RECOMMENDATION

The Board is asked to:

- note the contents of this report and the work being undertaken to continue improving the reports bringing together three sets of data.
- note the on-going progress and low number of queries with the Parliamentary Health Service Ombudsman.
- note that work is on-going to improve response rates to the FFT with new work commencing in the new year to collect and report on staff data quarterly.

Lisa Thomson

May 2014

Finance and Performance

10.1 Finance & Performance Report	(Oral & Enclosure)
10.2 Update on capital spend programme	(Enclosure)
10.2 Flow and 4-hour target	(Oral)

FINANCE EXECUTIVE SUMMARY & KEY PERFORMANCE INDICATORS

Month 12 to 31st March 2014

Aidan Quinn, Acting Finance Director

EXECUTIVE SUMMARY

Finance

From a financial perspective we ended the year, prior to the revaluation of our estate and year end provision movement, as expected.

This year the statutory accounts will report, for the first time, the consolidated results of the Trust and the Charity due to a change in the reporting guidance issued by Monitor. The consolidated result for the year shows a deficit of £6.0m.

Recurrently we begin 2014/15 with a c£6.0m loss prior to the new efficiency challenge and this remains our key financial area of concern.

Performance

In line with the Monitor Risk Assessment Framework performance is monitored against delivery in previous quarters.

The Trust remains under a series of enforcement undertakings imposed by Monitor due to sustained failure to deliver the A&E 4 hour performance target.

The plan to manage a planned failure of the 18 week target in Q4 to clear the backlog did not deliver and Monitor has been informed.

2 week cancer and breast symptomatic targets have failed in month, primarily due to an increase in referrals. The Q4 position remains a risk.

Performance in Q4 against A&E, 18 weeks and cancer will roll forward and will be considered as part of any governance concerns raised by Monitor at the start of 2014/15.

Conclusion and Recommendations to Trust Board:

- Continuity of Services Rating 4 achieved
- Red Governance Risk Rating (A&E 4 hour performance target)
- Level of high risk efficiency plans suggests slow start to delivery in 2014/15
- Continue to negotiate remainder of 2014/15 Contracts
- Submission of annual accounts to Monitor
- Approval of new purchase orders and contract awards
- Approval of £12.5m capital carry forward into 2014/15
- Approval of Monitor annual plan 3 to 5 year assumptions - £2m surplus per year, £24m CIP per year, c0.5% activity/income growth per year

Aidan Quinn
Acting Finance Director, March 2014
Heart of England NHS Foundation Trust

Minutes of the Finance & Performance Committee meeting held on 21st February 2014 at 9.30hrs, In the Boardroom, Devon House, Heartlands Hospital

Present:	Lord Phillip Hunt	Chairman	PH
	Mrs Hazel Gunter	Director of Workforce	HG
	Mr Les Lawrence	Non Executive Director (Chair)	LL
	Mr Richard Parker	Interim Managing Director – GHH	RP
	Mr Aidan Quinn	Acting Finance Director	AQ
	Dr Clive Ryder	Acting Medical Director	CR
	Mrs Lisa Thomson	Managing Director – SOL	LT
In Attendance:	Mr Malcolm Clark	Business Consultant – Corporate	MC
	Mr Jonathan Gould	Finance Operations Director	JG
	Mr Carl Holland	Head of Operations - BHH	CH
	Ms Sue Hyland	Deputy Chief Nurse	SH
	Miss Jo-Anne John	Business Accountant - BHH	JJ
	Mrs Angeline Jones	Chief Financial Controller	AJ
	Mrs Sue King	Head of Performance	SK
	Ms Erica Loftus	Head of Operations - CSS	EL
	Dr Govindan Raghuraman	Associate Medical Director - BHH	GR
	Miss Louise Jenkins	Personal Assistant (Minutes)	LJ

1. APOLOGIES FOR ABSENCE

Apologies were received for; Mrs Sam Foster & Prof. Edward Peck

2. MINUTES OF THE MEETING HELD ON 21st JANUARY 2014

The minutes of the meeting held on 21st January 2014 were accepted as an accurate record.

3. MATTERS ARISING

All matters arising were identified for action in either this, or a future agenda.

Lord Hunt advised for Procurement a Non Executive Director (NED) had been nominated to lead and to be added as an agenda item for the next meeting.

4. FINANCE POSITION UPDATE

4.1 Finance and Performance Directors Report – Month 10

Mr Quinn opened with a overview of Month 10. January delivered a small loss in month as expected and the Trust remains on track (depending on review of year end provisions) to deliver a £2m surplus at year end. Mr Quinn advised Month 11 would show a significant loss as February is very low income month.

Underlying position going into 2014/15 remains c£6m deficit prior to the new CIP challenge of £24m. The efficiency challenge remains our key area of concern. It is imperative that the Trust starts the year by addressing the following in quarter 1.

- A managed exit from winter
- Early implementation of efficiency plans
- Reduction in pay costs through better controls on medical and nursing spend

From a performance perspective whilst A&E improved in month we remain under Monitor undertakings and need to see continued improvement. Our 18 weeks plan requires attention within certain directorates as well as 62 day cancers.

Mrs Thomson provided an update on the Family and Friends Test (FFT). The results are reviewed regularly and a full report is submitted to the Quality and Safety Committee outlining the top 5 areas of concern. This is also presented to the Patient Experience meeting

The test can provide a high level indication of a problem with a ward, particularly when triangulated with other patient experience metrics and complaints which may need a 'deep dive' to investigate the causes for the poor scores.

The NRI score for inpatient for Q3 was 69.5 against a national average of 71. It is recognised that more work needs to be done to improve the A&E FFT score.

The NRI scores have fallen for 3 out of 4 maternity indicators in January.

Mrs King advised the national CQUIN doesn't measure NRI score but percentage response rates which should meet 20% by the end of the current financial year. The rate increases to 30% by next year end the FFT rolls out to out-patients and day surgery from October.

Mrs Thomson advised some patients have been reluctant to provide their feedback immediately and the text back system is working well. We need however to think about how we capture the elderly and dementia patients.

A meeting is being held in March to review how this can be taken forward alongside the need to introduce the staff Friends and Family Test from April.

Mr Lawrence noted January's A&E performance had ended well but that it was slipping for February.

Mr Parker stated for GHH more patients were brought in by ambulance and were converted to bed patients and there was need to increase discharges, especially at weekends in order to achieve the 95%.

Mr Holland added for BHH there had been an exceptionally busy weekend, which resulted in no beds on Monday. The daily ward rounds are happening, but the timing has slipped lately and we need to get back to doing these at 8am.Dr Ryder added on
.108 Wednesday there is a Clinical Directors meeting where it will be reinforced what time

wards rounds start, but there was also a need to recognise that not everything can be done at 8am as clinicians have other priorities to deliver. A high level discussion took place on ward rounds, discharges, TTO's, booking patients for operations and outliers.

5. CURRENT MATTERS

5.1 Q4 18 Weeks Plan Update

Mr Lawrence opened the discussion by stating a clear accountability framework needed to be established and clarity was needed on this for the next Executive Management Group (EMG)

Ms Loftus advised the backlog has remained static since the last update in January, circa 1400 patients. The Trust will have achieved an 84% RTT in line with the Monitor plan and 60 of the longest waiters had been treated too.

The main cause for concern was the ongoing additions to the backlog, prior to the implementation of the plan these were averaging 320 long a month, but had increased to 560 for January.

Activity has been sent to the private sector, but they are rejecting about 50% of the referred patients.

There is a new management team for General Surgery, and T&O are largely on target. ENT and Ophthalmology plans need to be more robust and we need further rectification plans. We need to date a further 1400 patients. We have capacity to do 1800 patients, a proportion of which will be allocated to urgent operations.

No patient waiting less than 12 weeks and classed as routine should be added to the list unless agreed with a Clinical Director. Clinical Directors and Operations Managers currently review all short waiters dated and remove these along with routine and replace these with long waiters. Dr Ryder has agreed reluctantly to cancel the theatre audits in February and March but this will be the 4th one in a row. In addition we need to maximise theatre usage – currently utilising 85%, smaller cases are to be added to the lists.

It was asked if we have enough theatre capacity – or are we always going to have a backlog. Ms Loftus continued, in totality we have enough capacity. One or two specialities might be under/lower. ECIST are following up work from earlier in the year and undertaken demand and capacity work in a number of surgical specialties this will help us identify areas of concern.

Dr Raghuraman advised there has been no face to face communication about centralised bookings and Consultants are booking their own lists. The current structure doesn't fit well and we have surgical specialities reporting to different sites. The Surgical Medical Director is meant to oversee the aspect of services. A high level discussion took place on theatre capacity/theatre staff/scheduling. Dr Raghuraman continued patients want their Consultant to complete their operations. We are struggling to get engagement from the Consultants on centralised booking and we need a communications plan. Dr Raghuraman wanted to raise staffing as an issue and morale is low. A discussion took

place about running theatre capacity at 85%, scheduled and additional lists. Mr Holland added nationally there is an issue with theatre staff.

Ms Loftus reiterated that we should not be placing short routine waiters onto lists. Specialties need to identify the proportion of the lists they need to hold for urgent cases then give the remainder to centralised booking who will then book the long waiters. Dr Raghuraman has given commitment to get the Consultants on board for centralised booking. A discuss then followed on routine operations, short and long term waiters. Mr Quinn stated people are not following the process which is causing the plan to fail.

Dr Raghuraman wanted assurance of theatre capacity if surgeons change their views of scheduling. Ms Loftus said we need to ensure we have surgeons available to complete the operations. There are more sessions cancelled due to lack of surgeon coverage than theatre staff shortages. Mr Holland added emergency surgery rates had increased and is currently running at 20% which means we need to move elective surgery around. Ms Loftus stated we need more emergency capacity at BHH. Patients had been approached to see if they were willing to have their elective surgery on an alternative Trust site, but many are reluctant to do so.

Mrs King continued we have an issue with outpatients being added to the back log as they are in the system; they have been waiting for example for 14 weeks which means we only have 4 weeks to treat them.

Mrs Thomson gave a high level of overview of plastics and ophthalmology. ENT is looking for support and centralised booking would greatly benefit them.

Ms Loftus continued we have offered and completed training sessions – with limited clinician attendees. Dr Ryder added it helped when the waiting list coordinator attended directorate meetings to discuss the management of waiting lists and what centralisation will look like.

Mrs Jones stated we advised Monitor that we would plan to fail 18 weeks as we knew we had safety issue with long waiters and to get them treated we would fail the target in Q4. As progress hasn't been as quick as originally planned we need to decide at what point we inform Monitor of the position.

Mr Lawrence ended with we need to confirm the right accountability framework is in place and give the committee assurance. EMG must exercise constant oversight to ensure all are playing the part. Mr Lawrence advised this will be discussed at the next Board meeting.

EL/Mar 2014 – Updated 18 Weeks Report including the accountability framework
Provide a weekly report to PH and LL on weekly 18 weeks meetings

5.2 Open Pathways Update

An update was provided to the Committee re: the open pathways still on the outpatient system; Mr Lawrence questioned when this will be concluded.

Ms Loftus stated numbers had not been included in the paper due to fluctuation in numbers, however there are still tens of thousands of pathways to be closed. A lot relies on an interim IT solution for intermediate closure of some pathways, but resources in IT to manage this are limited.

Several thousand records had been manually reviewed and as yet there has been no patient harm issues identified.

From a resource respective – the biggest risk is the availability of the IT team to support the project alongside implementing PMS2.

The staff at Lyndon Place are undertaking a significant amount of work relating to manual validation and closing pathways. However this may not be enough to clear all the open pathways by the end of March.

Mrs King stated if we do not close the clocks by 31 March, we will need to publish our performance against the out-patient RTT including these patients, as a commitment had been given to ECIST that the locally agreed 15 week rule would not be used after that date. This could significantly affect our 18 week position.

5.3 Cancer Update

Mr Lawrence questioned if the exception report was fit for purpose. The targets dates are not updated and doesn't give proper assurance.

Mr Holland advised the issue only arose in October, and we only failed 62 days in October and November, we achieved December and January.

There has been a change in management in the cancer team and it is believed that what was needed is a process change and rectification plan for Urology, which is the directorate having most difficulty in delivering this target. Mrs King felt that we needed a clear position statement on the prostate one stop clinic, as if it was not going to be deliverable there needs to be an alternative solution identified.

The Trust has failed the 2 week cancer target in January, alongside the 2 week breast symptomatic target; performance in February is indicating that the target may fail in month.

There has been a significant rise in referrals to this service following a national cancer campaign and because of the 2 week nature of this service it is difficult to 'flex up' capacity, particularly when clinics need radiology input, at very short notice.

CR/CH/RG/Mar 2014 – present report on Urology and Breast cancer, commentary and feedback to F&PC

5.4 CIP 2013/14 & 2014/15 Update

Mr Lawrence expressed concerns the report presented contained recommendations with no dates and referred to a Division Level Plan B. Mr Clark stated Plan B referred to a recommendation/action from February CIP Board whereby Divisions were asked for

suggestions as to how the gap could be closed. Mr Quinn finalised with we need to focus on next year and moving schemes to low risks and progressing plans.

5.5 Financial Challenge – Plan A

Mr Quinn gave a overview of the £3m efficiency plan gap including progress update on Plan A:

- 5% target is proportioned equally against budget envelope
- MARS was agreed on 20th February and will launch on 24th February
- Dis-investment – peer to peer meetings in progress
- Winter 'delivery'moved to Plan A
- John Sellars is presenting a paper to future EMG on a Trust PMO

It is imperative that:

- Divsions close gap and implement savings plans without delay
- Divisions CIP plans from high risks to low risk.

It was noted the Trust is disputing the £15m QIPP with the CCG. Some progress has been made (they have reduced this by half) but discussions are ongoing.

5.6 Quarterly Workforce Update

Mrs Gunter advised the main concern regarding workforce was our attrition rates. Turnover increased in January – up to 9.67% Trustwide and GHH has now increased to 10.5%. A discussion took place with regard to reasons for leaving and Mrs Gunter is keen we regard turnover as a priority area to address. In particular, nurse attrition is high. Some of this is due to the fact across the region there is a shortage of circa 400 nurses. This provides opportunities for nurses to move around easily within the region which is having an impact.

The workforce summit meets bi monthly and has been focused mainly on sickness, including support from Occupational Health. Each division is now focusing also on attrition. Plans will be submitted from each division at the next meeting on what is being done to address turnover in specific hot spots. Sickness absence is at 3.85% which is lower than last year with an end of year target of 3.75%. HCA sickness is particularly high, at circa 7% ad there is a project plan drawn up to address this, which will be discussed through EMB.

Although nurse bank requests reduced during November and December, bank requests increased by 700 in January and we are reviewing the increase. Mr Holland added requests were to assist with 4 hours, theatre lists and extra clinics. Also time to hire has increased so this may increase bank request. Mr lawrence requested a breakdown of where requests come from. Ms Loftus queried whether all of the sickness had been captured in the report. HG to look into this and feedback to EL.

We are continuing to run a qualified nursing recruitment campaign, working with the head nurses. There has always been a 20% uplift in budget to cover absence for the nursing establishment. These absences include sickness, maternity, etc. The actual absences are higher than 20% and, therefore, more recently it was decided that we

would recruit to 114% of establishment. We are currently over established at 109%. Therefore recruitment remains a priority, although we recognise the need to work in conjunction with workforce plans and the Corporate Strategy. Mrs Gunter finished with attrition was our main concern and we need corporate focus on this area.

5.7 Supervisory Ward Managers and Nurse Pay Update

Mrs Hyland advised this was the first update since its implementation in September 2013. The report provides the base line performance. The model rested on the recruitment of 50 band 5's which were slow to recruit to. All 50 wards are up and running. Majority of wards looking at a reduction in falls rate for KPI 10. Progress is being made on all 3 sites for sickness in conjunction with HR. Discharge and staffing levels will be reported in Q2.

Mrs Hyland asked the committee to approve the delivery plan and quarterly reporting. Mr Lawrence requested monthly reporting due to £1.4m non recurrent funding and for complete assurance

Sam Foster – Monthly reports including trajectories and timescales for delivery

5.8 Winter Update

The winter plan update was deferred until next month due to the absence of Mr Clements. Mr Lawrence expressed concerns at the content of the report and asked that future updates contain clarity on

- Funding (National and Local)
- Performance
- Detailed assurance
- Division specific
- Exit strategy
- Plan for after 1st April
- Conclusion and Recommendations

Mrs Gunter advised 32% of staff received the flu vaccine which is our highest rate ever with 68% of corporate staff receiving it. Mrs Hyland stated we need to start the vaccination process sooner next year to increase the uptake. A high level discussion followed on why staff don't want the vaccine.

AC/Mar 2014 – Provide updated winter report and forward to PH & LL before being presented to the committee.

5.9 2014/15 Contracting Position Update

The report was taken as read

5.10 Capital Plan Update

Mr Lawrence confirmed the report outlined the proposed allocations of capital spend for

the 2014/15 financial year. Mrs Jones explained that because of the risk of under-delivery on CIP and the need to preserve cash, the capital plan for the year had been reduced to £30m. A proposal of allocations was agreed and the further detail required for the schemes to be included in the "other" category would be brought to a future F&PC meeting. The committee approved the spend of £7.55m for operational spend and £1.65m for phase 2 of the energy sustainability project.

5.11 Trust Wide Budget Setting Update - 2014/15 Startpoints

Mr Lawrence asked the committee to note the sensible construction of Trust Wide reserves with particular reference to Keogh and Francis.Mr Clark provided a high level overview and key points. It was noted the Trust Planned surplus for 2014/15 is £2m. The recommendation and next steps were approved. Mr Clark concluded by advising that divisional start point budget updates would be presented to March meeting

MC/Mar 2014 – Present Divisional envelopes and budgets

5.12 5 Year Plan For Monitor

Mr Gould presented a paper showing the financial planning assumptions and summary income statement. Mr Lawrence advised the paper should also highlight the stake holder's participation. Mr Quinn added divisions are progressing with providing more detail to support the plan will feed into this into the corporate strategy.

All/ASAP – feedback any comments to Mrs Jones

5.13 Update on BHH Main Entrance – viability of purchasing

Mr Gould advised there have been several meetings with Assura to discuss different options for reconfiguring the main entrance at BHH and their viability.

In terms of food provision in main entrance of BHH for patient, visitors and staff, the communications team are preparing surveys to gather the feedback. More details of the survey and would be provided in the March meeting.

JG/Mar 2014 – Provide an updated BHH main entrance report

5.14 Purchase Orders & Contract Awards

All Purchase Orders and Contracts Awards were agreed.

6. RECTIFICATION REPORTS

6.1 Financial Rectification Plans (BHH/GHH/SOL/W&C/FAC/CORP)

All rectification plans were taken as read.

7. FOR INFORMATION

All items marked for information were noted and no further comments were made.

8. AOB

JG advised PMS2 live date – internal date of 7 April. Communication to Trust states April only

DATE AND TIME OF THE NEXT MEETING

The next meeting is scheduled to take place on 21st March 2014 at 9.30am in the Board Room, Devon House, Heartlands Hospital.

.....
Chairman

.....
Dated

Minutes of the Finance & Performance Committee meeting held on 21st March 2014 at 9.30hrs, in the Boardroom, Devon House, Heartlands Hospital

Present:	Dr Andrew Catto	Medical Director	ACa
	Mrs Hazel Gunter	Director of Workforce	LL
	Mr Les Lawrence	Non Executive Director (Chair)	HG
	Mr Aidan Quinn	Acting Finance Director	AQ
	Mr Richard Parker	Managing Director – GHH (interim)	RP
	Mrs Lisa Thomson	Managing Director – SOL	LT
In Attendance:	Mr Richard Barratt	Business Consultant - BHH	RB
	Mr Malcolm Clark	Business Consultant - Corporate	MC
	Mr Andrew Clements	Business Consultant - SOL (from 10am)	ACl
	Mrs Sam Foster	Acting Chief Nurse	SF
	Mr Jonathan Gould	Finance Operations Director	JG
	Mr Carl Holland	Head of Operations - BHH	CH
	Mrs Angeline Jones	Chief Financial Officer (from 10.35am)	AJ
	Mrs Sue King	Head of Performance	SK
	Ms Erica Loftus	Head of Operations - CSS	EL
	Dr Govindan Raghuraman	Associate Medical Director - BHH	GR
	Mr Mike Taylor	Head of Estates (from 11.35am)	MT
	Miss Louise Jenkins	Personal Assistant (Minutes)	LJ

1. APOLOGIES FOR ABSENCE

Apologies were received for: Lord Hunt, Prof Edward Peck and Dr Jammi Rao.

2. MINUTES OF THE MEETING HELD ON 21st FEBRUARY 2014

The minutes of the meeting held on 21st February 2014 were accepted as an accurate record.

3. MATTERS ARISING

All matters arising were identified for action in either this, or a future meeting agenda.
Mr Lawrence introduced and welcome Dr Andrew Catto to the meeting

4. FINANCE POSITION UPDATE

4.1 Finance and Performance Directors Report – Month 11

Mr Quinn opened with an overview of month 11. He advised that February was a low income month, with a bottom line loss of £2.8m in month in line with forecast. The year to date surplus is now £430k and we remain on track for a £2m year end surplus prior to revaluation and any year end provision movement.
The Trust underlying position remains a £6m loss at the start of the new financial year.

Mr Quinn advised that Divisions need to deliver early implementation of their efficiency plans for 2014/15. We are still negotiating the contracts with commissioners although CQUINs and KPIs have been signed off. A&E performance remains a concern and we are still under a series of enforcement undertakings from Monitor. The 18 week target is also still a concern and for 2 weeks breast cancer a course of action is required.

Mr Lawrence advised we are pleased the spend for Nursing and Midwifery this month was reducing. He then questioned the ambulance handover performance.

Mr Holland answered that the numbers have increased significantly over the last 6-8 weeks. Mr Lawrence asked how we are notified of the number coming into the Trust. Mr Holland advised that West Midlands Ambulance Service (WMAS) log these electronically and that reports can be requested from WMAS. Mr Lawrence advised that it would be worthwhile establishing whether WMAS were biased towards certain Trusts and this could from the basis of a discussion with them. Mr Holland stated that Mr Matthew Cooke is looking to meet with WMAS as it is time to look at boundaries and disproportionate numbers between local Trusts.

Mr Lawrence advised that we need to look at the number of attendances for January to March, a difference of circa 12%. We cannot discharge to the level of the numbers coming in and this makes it difficult for A&E to manage. Mr Holland advised that a number of audits were completed last week and A&E remain insufficiently robust. UHB are monitoring ambulance handover closely as they are not under JMRA and are therefore at risk of fines. Mr Parker advised that we need a strategic approach to such issues going forward.

CH – Request ambulance data (over a 3-4 week period) and forward to Mr Lawrence and Mrs King

Mr Lawrence advised that the recommendations contained within the report were approved.

5. CURRENT MATTERS

5.1 18 Weeks Update

Ms Loftus stated at the last meeting we reported the peak of the backlog at 1,476 and needed put in place some remedial action plans. At the time of writing the report the backlog was at circa 1,270. The trajectory is 1,200 for the end of March and we are on target to meet this. We have reduced the backlog by circa 250 and in mainly the 26 weeks waiters so we are targeting the longer waiters.

We are still sending patient to the private sector. General Surgery and Urology have made the greatest improvements with intervention from Dr Raghuraman and a new management structure.

For:

- Breast surgery, there is an ongoing review for the types of procedures completed.
- Gynaecology, there is a mismatch with capacity and demand across the sites and there has been limited success with transferring patients/surgery to manage this. Mr Holland advised there is a meeting on Monday to discuss
- ENT and Ophthalmology plans rely on the private sector and extra capacity
- T&O, the backlog has increased
- Smaller specialities, the backlog has reduced

The trajectory will achieve a reduction to 1,200 by the end of March, but is off track from December's plan. Monitor has asked how we will proceed for quarter one (Q1).

Ms Loftus advised the governance structure had been identified and summarised her report by stating:

- We are not achieving the original plan
- Remedial plan has had some limited effect
- Robust plans are needed for ENT, Ophthalmology and T&O
- That the Committee needed to agree the next steps for informing the Commissioners and Monitor.

Mr Lawrence advised that there was a meeting with Monitor on 10th April and plans will need to be submitted prior to this.

EL/4 April 2014 – Provide full details of plan and trajectory for 18 weeks

Mr Lawrence asked how we change the culture in T&O and Ophthalmology.

Dr Polson said that there is an over reliance on waiting list initiatives. He felt that we now had better buy in with clinicians to support delivery but believed that they would still struggle to complete in Q1. Mr Lawrence asked if we open theatres 8am to 10pm could this clear the backlog. Ms Loftus advised we don't have sufficient theatre staff to do this and we currently have a 30% vacancy. We are interviewing 24 Italian nurses on Monday which has taken a long time to get to this point. Mrs Thomson advised if we added one more case to the list each day this would solve the issue in Ophthalmology. Plastics will achieve their medium term plan.

Ms Loftus continued there is a surge in new referrals, not necessarily new operations and we are referring these back out. We need referrals to be reviewed by Consultants and decide on treatment. We need to think about the medium and long term plans. Mrs King added we need to be following process and not listing patients as urgent when they are not.

Dr Raghuraman stated the issues are with generic procedures. There should be adequate middle skilled doctors who should help solve the issue. A discussion followed on middle grade doctors.

Ms Loftus stated that to clear the backlog we will need to fail the indicator in Q1. Mr Lawrence stated Monitor will want to see positive actions and attitude to achieve the plan on the 10th April. Mr Quinn continued we need to see the revised plans before we can decide if we plan to fail Q1 and we need to ensure trajectories submitted are real. We need to ensure that any plan submitted to Monitor is both realistic and deliverable. We need to ensure that plans will deliver sustainable solutions e.g. clinical engagement and managing the front door to see patients earlier in the pathway

Mr Lawrence said for the Monitor meeting on the 10th of April, for which all papers should be forwarded by the 4th, to include:

- What we are doing with the front door
- For each speciality what procedures and improvement have changed
- The degree of engagement of all staff
- Submission by sub speciality – T&O – Hip/shoulder/knee etc
- Trajectory plan for April to July

Mr Quinn stated the divisions need to produce their plans by close of play Friday 28th March so we can review and ensure they are robust, fit for purpose, and include both governance arrangements and vigour. Mrs King advised we will tell Monitor today and they will receive our plans by the 8th April.

Mrs King and Ms Loftus will forward a proforma template for today so all plans are the same.

The plan should be forwarded to Mr Adrian Stokes and Dr Catto to review by the 4th April after initial scrutiny by SK and EL.

LJ/EL – 18 weeks to be a standard monthly agenda item

5.2 Cancer Update – Urology & Breast

Mr Lawrence stated the report presented provided no timelines or trajectories. This will be needed for the Monitor meeting on the 10th.

Mr Holland stated Urology is delivering but breast referrals are continuing to increase.

An interim surgical manager has been appointed who will focus on the delivery of both breast and urology and a detailed plan is currently being developed.

SK/CH – Look at conversions rate of referrals to diagnosis
SK – Explore results and feedback to CCG
CH - 4 April 2014 - Action plan, timelines, trajectories to be provided for Monitor meeting
LJ/CH – Cancer to be a standard monthly agenda item

5.3 Financial Challenge

There has been some small incremental progress with CIP development; however there is concern that 50% of plans remain rated as high risk. It is essential that all areas implement promptly to ensure delivery in Q1.

A summary of progress against Plan A:

- MARS project in place and planning for circa £1m efficiency
- Review of dis-investments – decisions need to be made by Sites
- Winter review to be completed in new year
- Additional pay cost opportunities – still need full and robust Gate 1's from leads

The first two years of the Monitor Plan have been signed off with a planned £2m annual surplus.

Mr Lawrence asked Mrs Foster to outline the current issues with E-Rostering compliance. Mrs Foster advised that analysis has identified some avoidable costs which we need to address. Plans need to be worked up and we will ask the E-Rostering company to come back in and support.

Mrs Loftus questioned the projected savings contained within the report. Mr Quinn advised that a process has been undertaken to eliminate double counting between these figures and local plans.

CH/LT/RP/EL –4 April 2014 Sites to respond regarding disinvestment opportunities

5.4 Medical Workforce

Mrs Gunter opened with the report which was requested from the January committee and will also be presented to the Executive Management Board (EMB) through the Trustwide KPI update. Finance had previously reported we had a lot of medical vacancies. HR have reviewed this information and provided an update.

It was reported that there are 30 vacancies, of which 17 are live – advertising, short listing etc and 30 have been offered and due to start throughout March – June.

For the long term locums we need to decide whether they should be recruited to. Ms Loftus stated that the issue is vacancies cannot be filled, they are advertised and re-advertised and this is the reason locums are used. Mrs Gunter confirmed that a workforce report will come to April Committee with details of the long term locum use, including whether recruitment has been attempted. In addition, we have 20 vacancies not being actively recruited to. Workforce Management team are meeting with the AMDs and Andrew Catto to confirm whether recruitment needs to commence for these posts. Mr Quinn requested that this was detailed to show individual posts.

Dr Raghuraman added that the issue started in 2007 and we are left with a hole in middle grade doctors. A discussion followed on middle grade doctors, advance practitioners and responsibilities for training. Mr Lawrence added we need to complete a job fair and create a reputation for HEFT. Mrs Gunter continued this is a two-prong approach – (1) what do we need to recruit to and (2) long term locums used.

HG/April 2014 – Provide a further update to the committee
HG – Provide a report to EMB on long term locums and the next steps through the Trustwide KPI update.

5.5 Workforce KPIs

Mrs Gunter provided an overview of the report. The proposed new KPIs are broken down by area and the scorecard attached is an example rather than actual figures. The proposals were accepted.

Mrs Foster added that a piece of work is being completed around E-Rostering. Dr Catto stated we also need to also look this from a medical perspective. Mrs Foster continued the new E-Rostering license has been re-signed so gives the opportunity to review and junior doctors are included. There is still some work to do and we need clear definitions and accuracy of establishments and funding matched.

Mr Lawrence confirmed Mrs Gunter to now develop these KPIs further, use monthly, process after payroll and include narrative.

5.6 Sickness Update

Mrs Gunter advised that the report follows on from last month's meetings and addresses the questions as to whether all sickness data is being captured.

There is a difference in data due to information being submitted after ER has been closed and ESR is rejecting sickness which spans two different months. This then has to be clarified with the managers, causing a delay in the data or it not being captured. There is an approximate 0.4% difference; however bank and agency usage is correct.

HG – Future reports to be tabled at the committee in order to allow latest data to be presented
HG – Present report to EMB on sickness reporting

5.7 Supervisory Ward Sisters Update

Mrs Foster provided an overview of the report including the scorecard. The Supervisory KPIs will be monitored at the Nursing and Midwifery Performance Committee. There are nine standard KPIs monitored at Trust level, with one local to sisters. Mrs Foster concluded there is a risk against funding if we do not deliver, as Supervisory Nursing was funded on a trial basis.

SF/April 2014 – Provide an updated report
SF/July 2014 – Provide an evaluation process report, including return on Investment
SF/Sept 2014 – Provide presentation to the Board

5.8 Winter Update

Mr Lawrence stated this report now clearly states the exit plans, which will be need to be delivered, and why certain schemes were not fully implemented. The questions that will still need answering are why some of the failing services weren't discontinued earlier, and at what point did we recognise they were failing. All are to note the contents of the report, which will form the basis of the post winter review paper being developed with the Executives.

LT/CH/RP – to provide granular detail for review

5.9 Main Entrance Update

Mr Lawrence advised the report was noted and deferred until the Out of Hours food provisions work was completed

The Communications team are carrying out surveys regarding the out of hours food provision during April. Feedback from the surveys and next steps will be discussed at F&P in May.

JG/May 2014 - provide feedback from Out Of Hours food survey

5.10 Procurement

Mr Gould provided an overview of the report including details of the Trust performance in delivering non pay savings, and plans for the Trust to continue delivering non-pay savings over the next three years.

The main areas of focus to deliver savings are:

- Continuing to develop our systems and procurement expertise to deliver value each time a contract is to be renewed
- Continuing to work through the list of strategic outsourcing opportunities to assess their potential and prioritise resources to deliver savings
- Work on much closer collaboration with other trusts beyond project work
- Move to pooling of e-procurement systems and resources.

The DoH is implementing a framework to assess the effectiveness of the procurement function across the NHS. These centers on assessing each trust using a set of common KPIs, and requests that a Non-Executive Director from each trust assumes responsibility to keep the board informed of procurement effectiveness.

We will continue to reside at Lyndon Place and we have now secured a better deal.

JG – address non-pay savings queries from Divisional Directors via BCs.

5.11 Purchase Orders and Contract Awards

All purchase orders were approved

5.12 Asbestos Report

Mrs Jones provided an overview of the report with Mr Taylor. A provision was made last year and for audit reasons it is important to make sure the board was included in discussions for this year.

The total cost of removing all asbestos in the Trust would cost £18.7m. However, not all asbestos will need to be removed and for the areas where work will need to be undertaken and therefore are most at risk it will cost £6.5m, and the Trust has committed to do this over a 5 year work programme.

It is proposed that a provision for £6.5m is made which includes dispersal, removal fees and follow up. A discussion then followed on ward upgrades, changes and what happens on a ward refurbishment. The Committee agreed to the provision value of £6.5m.

5.13 Capital Plan

Mrs Jones advised this is a follow up report following on from last month and gave an overview of the report. Since last month we have reviewed the £25m split and approval was requested for the remaining schemes included in the “other” category, leaving £1m unallocated.

Business cases will be processed via the Capital Prioritisation Group (CPG) and HEFT Operational Management Board (HOMB), with larger cases processed through EMB. The four estates schemes scoring 25 did not need business cases.

The Report was approved

5.14 Divisional Startpoint Budgets

Mr Barratt advised that start point budgets have been derived for divisions in line with the Trust Budget Setting Policy previously agreed at Finance & Performance Committee.

Divisional budgets are inclusive of cost pressures, service developments, pension auto-enrolment, non pay inflation, non-JMRA growth and CIP targets.

Pay inflation, incremental drift, and clinical excellence awards are held centrally and will be released post-start point in line with cost.

The Trust will be required to agree a more affordable winter plan, for which £2.5m is held in central reserves at start point.

Acute JMRA growth has also been held centrally and will be released to Divisions at month one following conclusion of the LDP round.

The divisions acknowledged the report, and the Committee recognised the next steps presented.

RB - June 2014 – provide an update report

5.15 Quality Impact Assessment Letter

The letter from Dr Catto and Mrs Foster was noted by the Committee. Quality Impact Assessments are required for all CIP schemes.

CH/LT/RP/EL – QIA's to be produced for all schemes.

5.16 Patient Communication / Discharge Escalation

Mrs Thomson advised that the greatest concern with patient satisfaction scores related to failure to discuss discharge dates. Through the JONAH programme we will see a significant improvement in this. More work is needed on this issue at Heartlands, Good Hope has tailed off but Solihull has improved.

From April the Friends and Family Test (FFT) for staff will need to be included and in the report.

5.17 Standing Financial Instruction – Policy Ratification

Mrs Jones provided an overview of why the policy was being revised, including licence changing from Monitor, updated wording and revised approval limits following discussions with Finance. The revised approval limits were discussed.

The policy was approved.

6. FOR INFORMATION

All items marked for information were noted and no further comments were made.

7. AOB

No further items were raised under any other business.

DATE AND TIME OF THE NEXT MEETING

The next meeting is scheduled to take place on 25th April 2014 at 9.30am in the Board Room, Devon House, Heartlands Hospital.

.....
Chairman

.....
Dated

Capital Plan 2014/15

Overview

This paper updates Trust Board on the capital expenditure plan for 2014/15 following a query from a Governor over the removal of the Good Hope restaurant scheme from the capital plan. The capital planning process started in September 2013 was working towards £40m of capital expenditure for 2014/15 which was in line with the previously expected capital plan. However the financial challenge the Trust faces in the future has meant that the budget has been revised to £25m for 2014/15.

Revised Plan

The table below shows the original plan against the revised plan.

	Original Plan £m	Revised Plan £m	(Decrease) £m
Operational	7.6	7.6	-
Cross Site Strategy	17.7	10.0	(7.7)
Other	14.8	7.5	(7.3)
TOTAL	**40.0**	**25.0**	**(15.0)**

Key reasons for change

The key reasons for the change in the capital plan are;

- To maintain a small recurrent surplus, c£2.0m.
- To maintain a Monitor COSR rating of 3 or above.
- To provide an affordable capital programme.
- To mitigate risk associated with required efficiency programme.

Decision process

The following meetings have been involved in the process of setting this plan.

- Proposal for reduction to £25m agreed at March Finance and Performance Committee (F&PC) and individual schemes confirmed in April F&PC.
- Revised plan endorsed by Executive Management Board.
- Capital plan for 2013/14 and 2014/15 discussed at March Finance, Performance and Strategic Planning Governors' Committee and March Council of Governors.
- Confirmed at March Monitor Standing Committee before submitting Plan to Monitor.

Cross Site Strategy

The Cross Site Strategy part of the programme has been reviewed in detail. The Cross Site Strategy Programme was reviewed in February to reduce the overall size of the plan. The Director of Asset Management presented a revised list of projects at the CEO weekly meeting on 24th February 2014.

The total forecast cost of the projects remaining in the programme was in excess of the budget allocated of £20m over the next two years. Therefore it was agreed that each project would be subject to further challenge to review scope, standards of build, and procurement methods to identify cost reductions. Because this review included the principle that only clinically driven or payback schemes were to be pursued schemes such as the Good Hope restaurant and the Solihull front entrance plan were removed from the plan.

Other

This value was reduced to fit within with the affordability envelope of £25m. The schemes included in this are a mixture of

- Specifically approved schemes to cover higher risk large estates schemes,
- A number of previously committed to Trust wide schemes such as energy sustainability, car parking and ward refurbishment,
- Earmarked schemes that will be subject to a business case.

All of these schemes are subject to review by Capital Prioritisation Group.

Conclusion

The Trust Board is requested to agree the methodology that has been applied by Finance and Performance Committee in setting the Capital budget for 2014/15.

Aidan Quinn
Acting Finance Director, May 2014
Heart of England NHS Foundation Trust

External and Strategic Review

11.1 HEFT Strategic Plan - Monitor Plan (Enclosure)

EXTERNAL AND STRATEGIC REVIEW – 6th May 2014

1. Better Care Fund submissions

In 2013, the Government announced the creation of a £3.8 billion integration transformation fund for 2014/15 and 2015/16 – now referred to as the Better care fund (BCF). This fund has been created from existing health and social care budgets and is not new funding. It transfers £2 billion directly from the NHS budget in 2015/16 to put in to "a single pooled budget for health and social care services to work more closely together in local areas." First drafts of the local BCF plans led by CCGs and Health and Wellbeing Boards have been submitted to NHS England for assurance. Each plan has to identify how patients will benefit from changes to service delivery and how the local area will meet this funding challenge.

Birmingham BCF – A proposed fund of £82m has been identified for 2015/16 (£26m in the current year). The objective of the BCF is to:

"Create locally integrated community teams based around primary care with sufficient capacity and empowerment to change the way care is delivered locally, to be more proactive and reduce dependence on acute hospital provision."

A number of workstreams are being established to support delivery of the programme. All providers are encouraged to participate in these.

The Health and Well Being Board retains responsibility for the BCF supported by a Birmingham Adult Unplanned Care Integration Board which should have CEO / Medical Director representation.

In terms of direct impact on providers, the specific implications are not clear. However, there is a clear direction of travel around significant bed acute bed reductions. This is in line with HEFT's own strategy. A sticking point remains around who funds alternative models of care.

The Birmingham plan has been assessed by NHS England and given a 'red' rating, with particular concerns raised around the overall affordability of the plan and the level of support / buy in from local provider organisations.

Solihull BCF - A proposed fund of £15m has been identified for 2015/16 (£7m in the current year). The objectives of the Solihull BCF are based around the ICASS programme with urgent care, dementia and Frailty as first priorities.

Again there is little specific information on the impact on providers, although this would be worked through the ICASS programme.

The Solihull BCF has also been red rated by NHS England with concerns around affordability and level of buy-in from providers. Additionally NHS England has also given a red rating around confidence that the plan is deliverable.

Implications for HEFT

While the BCF plans at this stage are light on detail there are some important considerations for the Trust.

The BCF plans set out to achieve a smaller provision of acute services across their areas. This is in line with HEFT's short stay strategy and plans around alternative models of care which we recently submitted to Monitor. However, it is not yet clear whether the scale of change proposed in the BCF is congruent with how HEFT sees the next two years.

In addition it remains unclear where the resources allocated for the BCF will come from in both the Birmingham and Solihull health economies. Importantly the Birmingham BCF talks about a potential pooled budget of up to £600m. Monitor now projects that the gap between costs and revenues will increase from 3.1% in 2014/15 to 6.6% in 2015/16 partly as a result of the affordability challenge posed by the BCF. Unbundling tariff seems one clear option for commissioners, which will obviously have implications for the Trust. Allied to this is the confusion over who has responsibility for funding alternative (to hospital) models of care.

The role of community services is clearly crucial in the BCF plans. It would be fair to say there are different views on who should provide these services in the medium to long-term. One argument is that they should (in Birmingham) be integrated with secondary care to optimise the chances of achieving transformational change and reduce organisational barriers.

In Solihull, much hangs on the success or otherwise of the ICASS programme and the CCG is facing significant financial challenges.

Potentially, the BCF programmes could herald important changes in both the Birmingham and Solihull health and social care economies, with both opportunities and threats for providers. Transferring funds between sectors at the pace required under the BCF creates risks to service delivery unless commissioners, local authorities and providers work closely together to ensure that the activities funded from the BCF offset the risks caused by the transfer of funds.

It is critical, therefore, that HEFT is fully engaged with both the Birmingham and Solihull BCF programmes.

2. *Sexual Health tender*

Work continues in preparing our bid for the Birmingham sexual health tender. We have submitted the Pre Qualification Questionnaire and expect to be invited to participate in the bidding process by the end of May.

HEFT is part of a formal alliance with Brooke, the Terence Higgins Trust, a local pharmacy network and a number of local GPs.

I will elaborate on the position at the meeting.

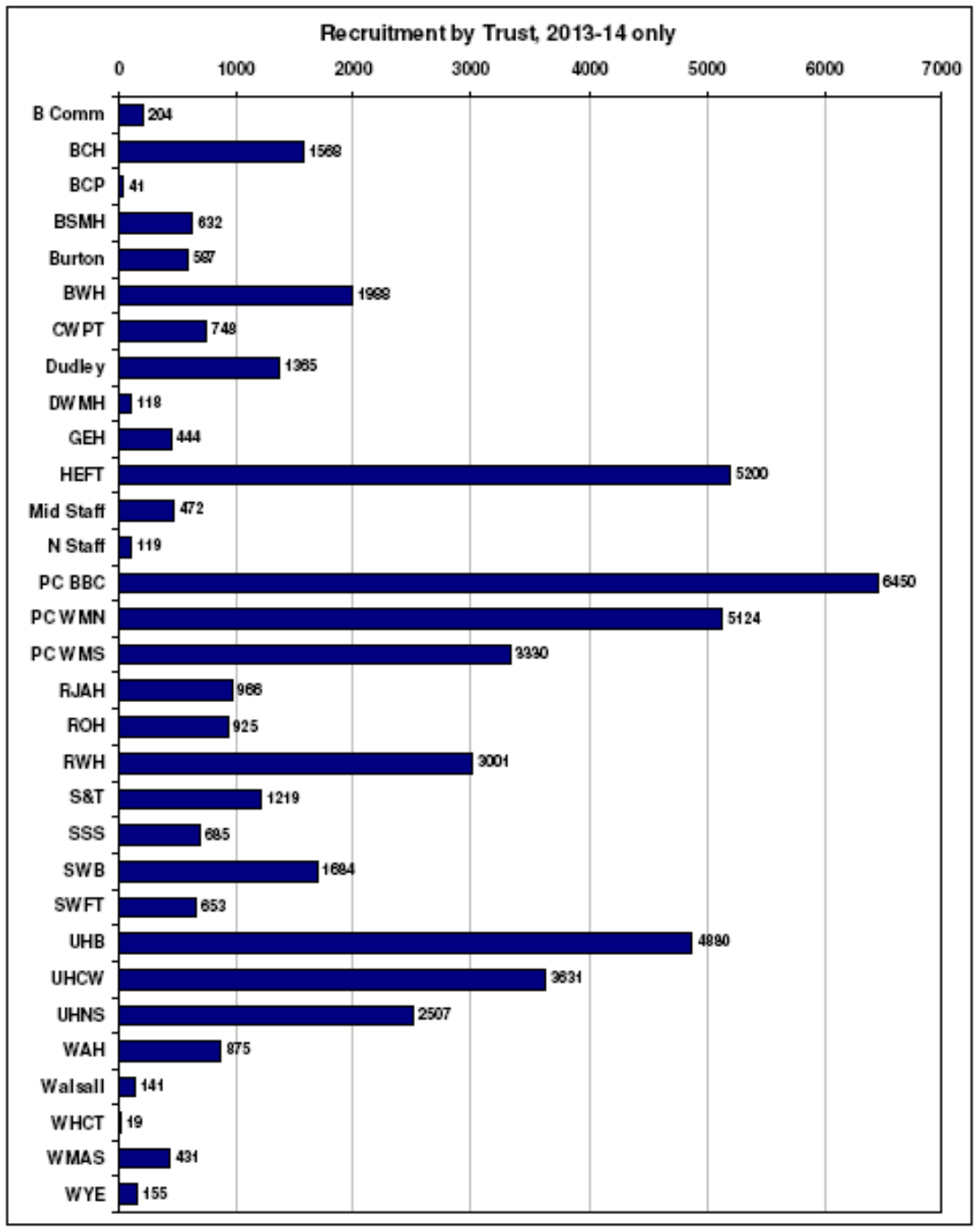
3. *Diabetic Retinopathy services*

Following the recent successful tender to run the service for Solihull, Birmingham and the Black Country (£20m, 5 year contract and largest of its kind in the NHS), the Trust has recently formed an alliance to bid for another service.

The screening service for Coventry, Warwickshire, Worcestershire and Herefordshire is out to tender and HEFT (as lead bidder) is submitting a bid with University Hospital Coventry and Warwickshire. The invitation to tender is expected in June.

4. Research

Following the investment made by the Board into research it is pleasing to note that the Trust has now become the highest recruiter of patients to clinical trials in the region by a single Trust. The Board will recall that a key part of HEFT's strategy was to focus on trials and this has been successful under the leadership of Prof Don Milligan. A report on R&D will be presented to the Board in due course.



Simon Hackwell
Commercial & Strategy Director

Board of Directors

May 2014

Nursing, Midwifery and Care staffing capacity and capability

.130

Apologies | Declaration of Interest | Minutes | Matters Arising | Chairman's Report | Council of Governors Report | Chief Executive's Report | Safety, Quality and Org. Dev. | Patient and Public Feedback | Finance and Performance | External and Strategic Review | Nursing, Midwifery care staffing capacity | Equality and Diversity

Board Assurance Framework | Transport Strategy | Board Committee Reports | Any Other Business | Part Two

From: Sam Foster – Chief Nurse

Title: Hard Truths – Commitments Regarding the publishing of Staffing Data

The report is provided to the Board for:

Decision: Y

Discussion: Y

Assurance: Y

Endorsement: Y

Summary/Key Points:

On March 31st 2014- a joint letter from the CQC and NHS England was issued to all CEOs of Trusts with in-patient areas. The letter followed guidance from the NHS Quality Board to "Optimise Nursing." Research has demonstrated that staffing levels are linked to the safety of care, and that staffing shortfalls increase the risks of patient harm and poor quality care. It stated that Patients have the right to know how the hospitals that they are paying for are run, in light of this, the Government have made a number of commitments in the document *"Hard Truths – The Journey to putting patients first"* The letter and associated documents gives Trust Boards clear guidance on the delivery of "Hard Truths" commitments associated with publishing staffing data regarding nursing, midwifery and care staff.

The guidance sets out ten expectations of commissioners and providers, to ensure compliance with the NHSQB paper *"How to ensure the right people, with the right skills, are in the right place at the right time."* This paper details in table form the trust position and key actions in place to enable the Public and the Trust Board to be informed as directed. The key priority areas include agreement of future reporting and production of a robust recruitment and retention plan for nurses and midwives. It is suggested that the Director of workforce co-ordinates this with the site teams and this is presented to Trust board in June as part of the on-going updates required.

Strategic Risk Register:

N/A

Performance KPIs year to date:

Nursing and Midwifery workforce data is submitted as a contractual requirement under section 5.2 of the NHS Contract – the attached table has been cross-referenced with these requirements. It is likely that the CQC/NHS England guidance will supersede section 5.2

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

Nil Identified

Assurance Implications:

The Trust is currently compliant with the CQC standards around staffing – the Trust highlighted to the CQC that one of our key challenges is our planned vs. actual nursing and midwifery staffing levels. The Trust Board have been regularly appraised by the Chief Nurse of our current planned staffing levels and our

actions to monitor and mitigate ensuring that our actual staffing levels meets our case mix need. There is however further stretches in the expectations attached – Is recommended by the CQC & NHS England that the Trust Board receive and number of updates from June on a monthly and six monthly basis. This position paper and discussion at Trust board aims to approve future plans for reporting. The CQC/NHS England team plan to take two stock takes of progress- the 1st of those stock takes have been requested and submitted by the Chief Nurse.

Information Exempt from Disclosure:

None – There is a requirement for the Trust to upload the monthly report onto the Trust website and link/upload the report to the relevant hospital (s) NHS Choices webpage.

Reccomendations:

- Trust Board are appraised of requirements
- Trust Board discuss the current position
- Trust Board accept the timescales for the next staffing review
- From June onwards – the Trust Board receive a short exception report on a monthly basis using the format suggested for recording or both workforce data and staffing breach data.
- Trust board accept the 6 monthly reviews required by the CQC/NHSQB.

HEFT Position April 2014 against: Expectations relating to nursing, midwifery and care staffing capacity and capability:

National Quality Board Guidance Cross referenced with NHS Standard Contract section 5.2	Heart of England Position April 2014	Lead	Actions/progress
Expectation 1: **Boards take full responsibility for the quality of care provided to patients, and key determinant of quality, take full and collective responsibility for nursing, midwifery and care staffing capacity and capability.** **Board reports:** • Draw on expert professional opinion and insight into local clinical need and context • Makes recommendations to the Board which are considered and discussed • Is presented to and discussed at the public Board meeting • Prompts agreement of actions which are recorded and followed up on. • Is posted on the Trust's public website along with all the other public Trust Board papers	CIP quality assurance process currently in place	Medical Director and Chief Nurse	Process initiated via F&PC – All divisions are planned for CIP QIA during May/June 2014
	Monthly Workforce performance report currently presented to – Trust Governance & Risk Committee. – Detailing nursing manpower, vacancies, sickness and attrition rates. This dataset needs to be revised to ensure robust assurance by site can be given- refreshed dataset requested form workforce team, – to include; Data set 1: Run rate by site/(Broken down by registered and non-registered) • Month on month trend of live vacancies • Month on month filled vacancies • Month on month total vacancies - i.e. Combined of the above as these staff are yet to be in post. • Month on month attrition • A trajectory of recruitment to enable us to assess if we are on track prospectively – this should be moving towards the 120%	New monthly report to be presented by Chief Nurse at Trust Board – this month report is suggested to report the exceptions against the revised workforce data sets and staffing breach reports- including actions and mitigations. Revised dataset to be produced by workforce information team/performance team	Draft Revised dataset in appendix 1-3

	target Data set 2: Run rate by site and Month on month Registered nurse/midwife sickness • Month on month non registered sickness • Month on month maternity leave. • A trajectory for sickness towards trust level.		
Expectation 2 **NHS Standard - 5.2.1. And 5.2.3.1.** **Processes are in place to enable staffing establishments to be met on a shift-to-shift basis.** The Trust: • Reviews the actual versus planned staffing on a shift by shift basis • Responds to address gaps or shortages where these are identified • Uses systems and processes such as e-rostering and escalation and contingency plans to make the most of resources and optimise care	E Rostering policy and systems in place to support all clinical teams.	Chief Nurse	In place
	E Rostering rules supports setting of agreed skill sets to support clinical requirements on a shift-by-shift basis.	Chief Nurse	In place
	Daily monitoring of staffing levels/ - planned versus actual. Trust wide Staffing breach performance reports starting May 2014	Chief Nurse	Suggested reporting to be tabled
	Escalation processes in place to support mitigation of shortfalls	Chief Nurse	In place
	Unplanned capacity /staffing requirements fully risk assessed to maintain safe care. Escalated to Site boards to determine mitigation of risks.	Site Head Nurses	In place
	Temporary staffing skill set under review by HR/Faculty	Director of Workforce	Requested
Expectation 3 **NHS Standard - 5.2.2 5.2.4** **Evidence-based tools are used to inform nursing, midwifery and care staffing capacity and capability.**	Next - Annual Nursing Staffing review scheduled for July 2014. To include; • Safer Nursing Care Tool – Shelford Group • Acuity/Dependency scoring tools. • RCN Guidance • Benchmarking • Safe Staffing Alliance - 1: 8 ratio's • Acuity / dependency tools • Birth-rate Plus (Maternity Tool) • Professional judgement and scrutiny. • Triangulation of results. • This year's review to undertake time allocated to IT technology and training provision.	Chief Nurse	Next workforce review scheduled for July 2014
Expectation 4 **Clinical and managerial leaders foster a culture of professionalism and responsiveness, where staff feel able to raise concerns.**	Development of enhanced 'Raising concerns' policy Open door and reporting culture/forums. Face to face Ward Managers/Matrons meetings x 2 monthly Datix reporting staffing shortfalls. Transparency – Intranet displaying staffing levels daily.	Head Nurses/Workforce/ OD	For discussion/wider review
Expectation 5 **A multi-professional approach is taken when setting nursing, midwifery and care staffing establishments.**	Annual nursing establishment review involving key stakeholders – Operational colleagues/Finance director/HR and clinical teams. In addition reviews undertaken when pathways changed, ward numbers, acuity changes planned.	Chief Nurse	Next workforce review scheduled for July 2014

Expectation 6 **Nurses, midwives and care staff have sufficient time to fulfil responsibilities that are additional to their direct caring duties.**	• Supervisory Ward Sister status commenced October 2013. • Nursing performance against 10 KPI's reported to Finance / Performance Committee. • Annual workforce review to take account of equity between wards in relation to administrative support, Housekeepers and other ancillary staff groups. • Annual workforce review to include mandatory training requirements	Chief Nurse	
Expectation 7 **Boards receive monthly updates on workforce information, and staffing capacity and capability is discussed at a public Board meeting at least every six months on the basis of a full nursing and midwifery establishment review.** The Board: • Receives an update containing details and summary of planned and actual staffing on a shift-by-shift basis • Is advised about those wards where staffing falls short of what is required to provide quality care, the reasons for the gap, the impact and the actions being taken to address the gap • Evaluates risks associated with staffing issues • Seeks assurances regarding contingency planning, mitigating actions and incident reporting • Ensures that the Executive Team is supported to take decisive action to protect patient safety and experience • Publishes the report in a form accessible to patients and the public on their Trust website (which could be supplemented by a dedicated patient friendly 'safe staffing' area on a Trust website).	Monthly Nursing Workforce data will be presented to board as previously described above, and published publically as required	Chief Nurse/Director of external affairs	

The Trust will ensure that the published monthly update report specified in Row C [i.e. the Board paper on expected and actual staffing] is available to the public via not only the Trust's website but also the relevant hospital(s) profiles on NHS Choices. The latter can be achieved either by placing a link to the report that is hosted on the Trust website on the relevant hospital(s)' newsfeed on their NHS Choices webpage or by uploading the relevant document to the relevant hospital(s)' NHS Choices newsfeed. For Trusts with multiple hospital sites that have their own NHS Choices webpages, this will require the separate posting of the Trust Board report to each hospital newsfeed. However, this is likely to reach more patients given that patients tend to review hospital, not Trust, NHS Choices webpages. This approach will also allow you to highlight hospital-specific plans and achievements, which may be of particular interest to a public audience. Given these requirements, the update reports should be written in a form that is accessible and understandable to patients and the public. This is likely to include ensuring that the information on staffing is not embedded within hundreds of pages of other board papers. Your own NHS Choices web editor(s), who already provide your Trust and hospital-specific content to NHS Choices, will be able to advise you further on their preferred mechanism for making these documents available on NHS Choices – either via a link or by uploading a .pdf of the Board paper. NHS Choices will also be liaising directly with each Trust's web editors with further information.			

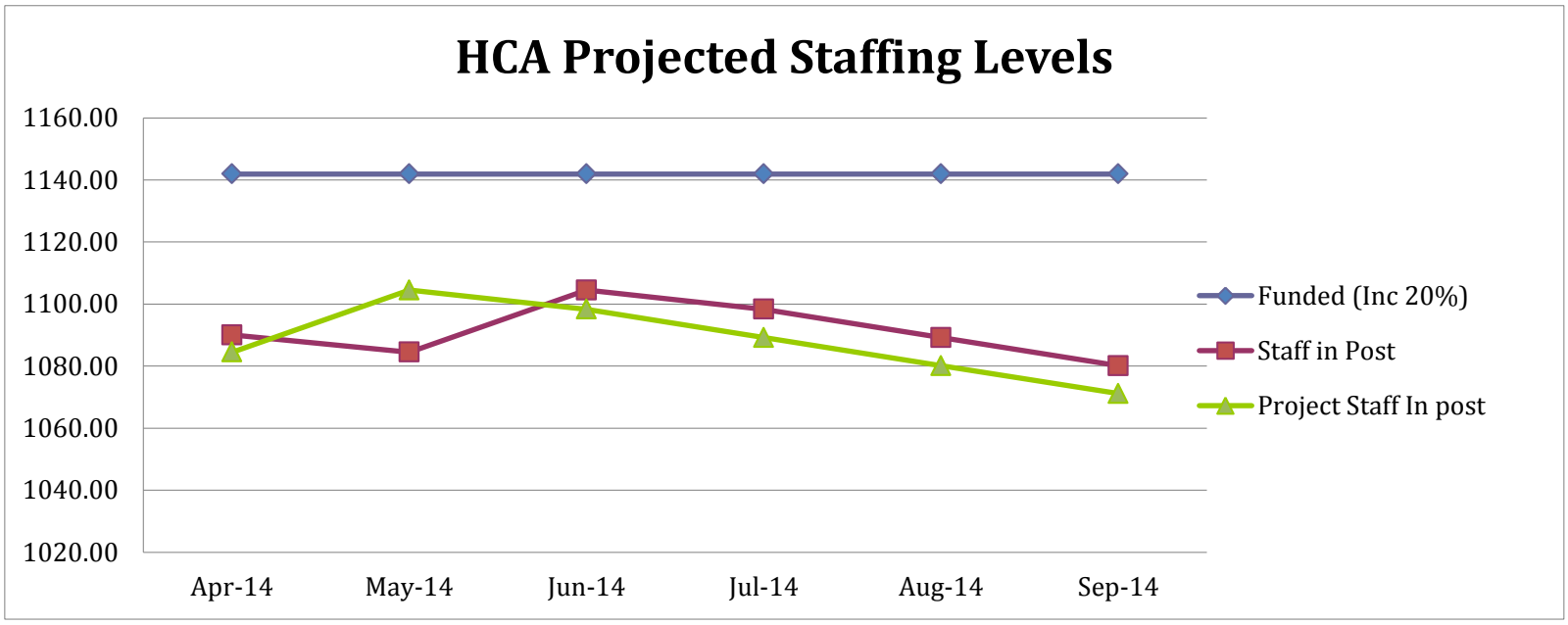
Expectation 8 **NHS providers clearly display information about the nurses, midwives and care staff present on each ward, clinical setting, department or service on each shift.** The Trust clearly displays information about the nurses, midwives and care staff present and planned in each clinical setting on each shift. This should be visible, clear and accurate, and it should include the full range of patient care support staff (HCA and band 4 staff) available in the area during each shift. It may be helpful to outline additional information that is held locally, such as the significance of different uniforms and titles used. To summarize, the displays should: • Be in an area within the clinical area that is accessible to patients, their families and carers • Explain the planned and actual numbers of staff for each shift (registered and non-registered) • Detail who is in charge of the shift • Describe what each member of the team's role is • Be accurate	• All inpatient wards now displaying daily staff numbers and Nurse in Charge details.	Ward Sisters	In place – Head nurses to agree audit programme to ensure this is in place robustly.
Expectation 9 **Providers of NHS services take an active role in securing staff in line with their workforce requirements.**	• Robust recruitment plans aligned to site-specific service charges are not formally written/approved • Evidence required of robust recruitment and retention strategies are required to be written up / approved • Trust Workforce plans reflect current/long term forecast/reconfigurations/local/national assumptions	Director of Workforce to co-ordiante with site teams for update to June Trust Board as part of Chief Nurse monthly report. Director of Workforce to co-ordinate	For update and inclusion in June Trust board paper For update and inclusion in June Trust board paper
Expectation 10 **Commissioners actively seek assurance that the right people, with the right skills, are in the right place at the right time within the providers with whom they contract.**	• Electronic Rostering tool applied to all inpatient areas. Contains skill set functionality to match skills required or shift/against staff in post. • Faculty/Education strategies/provision are driven by the needs of service /patient requirements. • Performance team to support agreement with CCG of how to report information shared with Trust board.	Chief Nurse/Director of Workforce Director of Workforce	Skill mix review requested from temporary staffing dept. TNA and LBR assumptions requested from Faculty of Education

NB. Revalidation (NHS CONTRACT 5.3.1)– Need to include timescales and process for revalidation of Nursing staff.

Appendix 1 – Data set 1 : Non- Registered nursing staff:

HCA

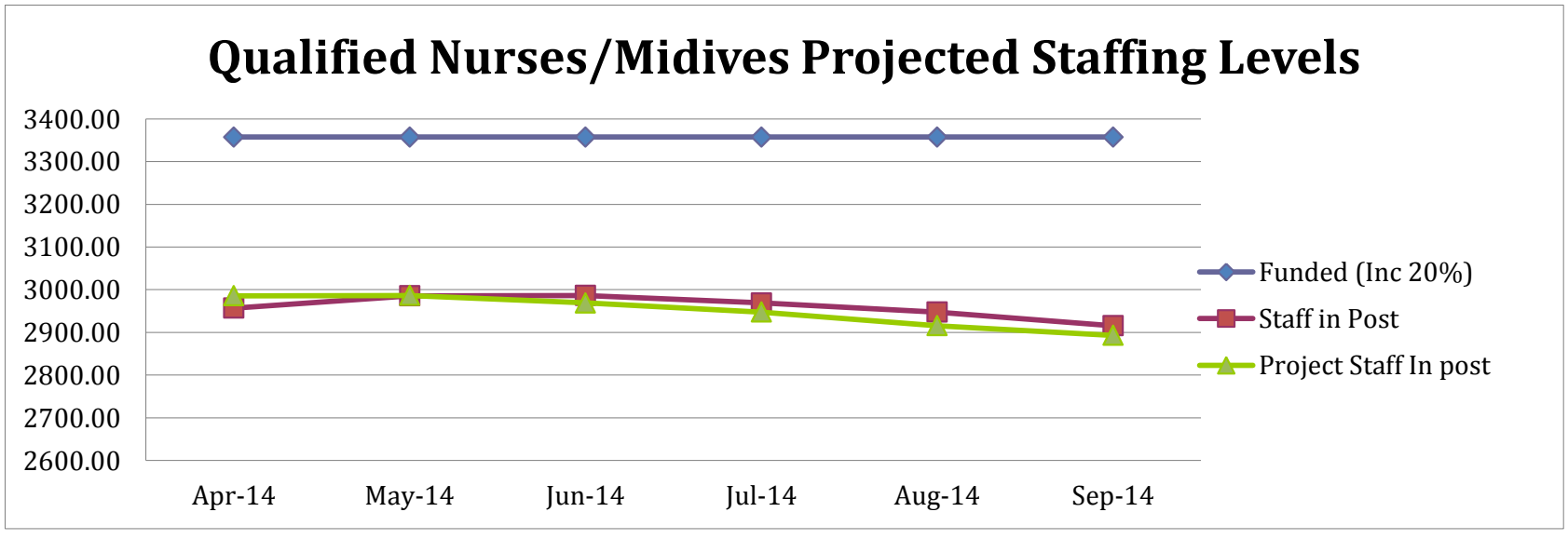
Month	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14
Funded (Inc. 20%)	1141.94	1141.94	1141.94	1141.94	1141.94	1141.94
Staff in Post	1090.06	1084.50	1104.49	1098.31	1089.18	1080.13
Variance	51.88	57.44	37.45	43.63	52.76	61.81
Starters Offered Post	5.00	26.00	3.00	0.00	0.00	0.00
Forecast Starters	0.00	3.00	0.00	0.00	0.00	0.00
Estimated Leavers	10.56	9.01	9.18	9.13	9.05	8.97
Project Staff In post	1084.50	1104.49	1098.31	1089.18	1080.13	1071.16



Appendix 2: Data set 1 : Registered nurses/midwives:

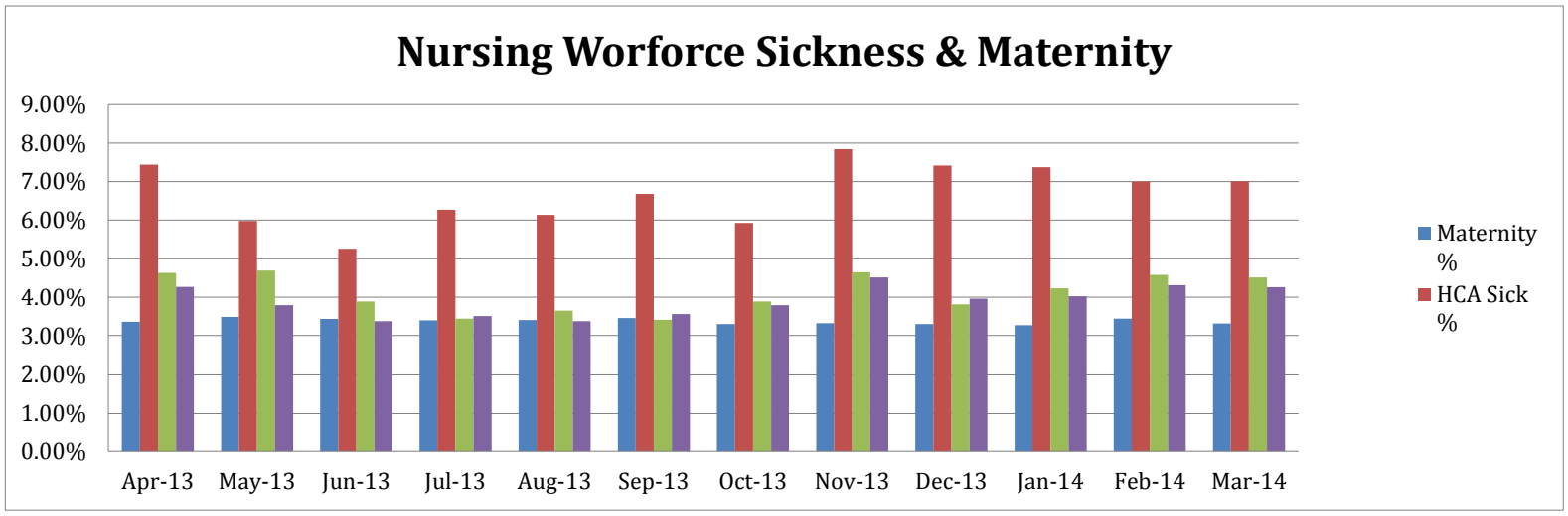
Qualified Nurses/Midwives

Month	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14
Funded (Inc. 20%)	3357.60	3357.60	3357.60	3357.60	3357.60	3357.60
Staff in Post	2957.03	2985.80	2986.39	2968.97	2947.76	2915.80
Variance	400.57	371.80	371.21	388.63	409.84	441.80
Starters Offered Post	69.00	31.00	8.00	1.00	3.00	12.00
Forecast Starters	0.00	5.00	10.00	13.00	0.00	0.00
Estimated Leavers	40.23	35.41	35.42	35.21	34.96	34.58
Project Staff In post	2985.80	2986.39	2968.97	2947.76	2915.80	2893.22



Appendix 3

Moth	Maternity %	HCA Sick %	Qualified Sick %	Trust wide Sick %
Apr-13	3.35%	7.44%	4.63%	4.27%
May-13	3.48%	5.98%	4.69%	3.79%
Jun-13	3.43%	5.26%	3.89%	3.37%
Jul-13	3.39%	6.27%	3.44%	3.51%
Aug-13	3.41%	6.14%	3.65%	3.37%
Sep-13	3.45%	6.68%	3.41%	3.56%
Oct-13	3.30%	5.93%	3.89%	3.79%
Nov-13	3.32%	7.84%	4.65%	4.51%
Dec-13	3.30%	7.42%	3.81%	3.96%
Jan-14	3.27%	7.37%	4.23%	4.02%
Feb-14	3.44%	7.00%	4.58%	4.31%
Mar-14	3.32%	7.01%	4.51%	4.26%



Board of Directors

May 2014

Equality and Diversity report

.140

Apologies	Declaration of Interest	Minutes	Matters Arising	Chairman's Report	Council of Governors Report	Chief Executive's Report	Safety, Quality and Org. Dev.	Patient and Public Feedback	Finance and Performance	External and Strategic Review	Nursing, Midwifery care staffing capacity	Equality and Diversity

Board Assurance Framework	Transport Strategy	Board Committee Reports	Any Other Business	Part Two

From: Sam Foster – Chief Nurse

Title: Public Sector Equality Duty – Annual Workforce Equality Monitoring Report – April 2014

The report is provided to the Board for:

Decision: N

Discussion: Y

Assurance: Y

Endorsement: Y

Summary/Key Points:

Situation:

Whilst recognising the efforts internally in respect of equality and diversity, the Trust Board is keen to obtain an external objective view in relation to our workforce equality and diversity performance. In doing so the Trust Board are also seeking to take into account "noise in the system" surrounding workforce equality and diversity in the NHS and external research relating to NHS workforce equality such as "Discrimination by Appointment – How Black and Minority Ethnic Applicants are Disadvantaged in NHS Staff Recruitment" (R Kline, 2013).

Background

The Equality Act 2010 came into force on the 1st October 2010, replacing the previous anti-discrimination legislation in the UK. Public sector organisations have specific responsibilities under the Act, namely the Public Sector Equality Duty (PSED) that came into force on the 6th April 2011. It consists of a general duty comprising 3 main aims, and specific duties. The purpose of the Equality Duty is to embed equality considerations into the day-to-day work of public bodies.

The Equality Duty covers the following protected characteristics:

- Age
- Disability
- Gender Reassignment
- Pregnancy and maternity
- Race (includes ethnic or national origins, colour or nationality)
- Religion or belief (includes no belief)
- Sex
- Sexual orientation

Marriage and civil partnerships are protected characteristics under the Act however under the Duty organisations only have to have due regard to the need to eliminate discrimination.

The General Duty

Under the General Duty public bodies are required to have due regard to the need to:

- Eliminate unlawful discrimination, harassment and victimisation and other conduct prohibited by the Equality Act 2010.
- Advance equality of opportunity between people from different groups
- Foster good relations between people from different groups
- Public sector organisations have a duty to meet the needs of people with protected characteristics and reduce or eliminate the disadvantage that such groups may suffer.

The Specific Duties

- These duties require public bodies to set specific, measurable equality objectives and to publish information regarding their performance on equality. The information that needs to be published is as follows:
- Equality objectives, at least every four years
- Information to demonstrate compliance with the equality duty, at least annually

Assessment

The report contains the progress of the actions agreed in 2012/13. The 2014 Workforce Equality Report has been used as the basis for assessing the current position in relation to Workforce Equality and Diversity. Workforce equality monitoring data is collected when an individual commences employment at HEFT, although staff can opt out of this. The workforce profile is based on The Trust's staff in post data as at January 2014. The reference period for recruitment, employee relations and training data is July 2013 – December 2013. In addition,

- Staff survey information is based on the 2013 NHS Staff Survey analysis.
- Population data is based on the 2011 Census.
- Where available, data is compared to that produced for the previous year.
- A useful summary of results table is included on page 29/30

Recommendations:

Following discussion with the Trust Convenor, it is proposed that a trust wide staff diversity group is set up – Chaired by the Trust convenor, supported by the Director of workforce. Based on an initial analysis of the data it is suggested that the following areas are considered and a report is presented back to Trust Board in 6 months.

- Consideration of an external review of workforce equality and diversity.
- Consideration of the current internal resources allocated to equality and diversity.
- Participation in the RCN programme to support BME Nurses through formal employment processes including disciplinary and grievance.

How best to meet CCG contractual information requirements regarding:

- Training applications submitted and approved and how flexible working requests submitted and approved
- Further analysis of the recruitment and selection process in relation to ethnicity and disability. (Reference to Discrimination by Employment – How Black and Minority Ethnic applicants are disadvantaged in NHS Staff Recruitment)
- Further analysis of employee relations data, particularly for BME staff.
  -To include analysis of referrals to professional bodies
- Improving the number of BME staff and women in senior leadership positions – leadership and mentoring.
- Improvement of recorded data for protected characteristics, particularly disability, religion and belief and sexual orientation.
  -Also to scope ways of better engaging and understanding the needs of these groups.
- Decide which aspects of the staff survey will be reviewed in detail, based on the differences highlighted for different protected characteristics, particularly disabled staff.
- Review of other information sources such as Exit Questionnaire

Strategic Risk Register:

N/A

Performance KPIs year to date:

The Trust does have contractual information requirements to submit.

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

None

Assurance Implications:

Nil

Information Exempt from Disclosure:

Nil

Public Sector Equality Duty

Annual Workforce Equality Monitoring Report

Heart of England NHS Foundation Trust

April 2014

Apologies | Declaration of Interest | Minutes | Matters Arising | Chairman's Report | Council of Governors Report | Chief Executive's Report | Safety, Quality and Org. Dev. | Patient and Public Feedback | Finance and Performance | External and Strategic Review | Nursing, Midwifery care staffing capacity | Equality and Diversity

Board Assurance Framework | Transport Strategy | Board Committee Reports | Any Other Business | Part Two

Executive Summary

Each public sector body is required by the specific requirements of the Public Sector Equality Duty to publish data annually to show it is compliant with the general aims of the duty. To ensure we are compliant with the duty equality reports are produced in relation to both workforce and service users.

Aims of the Report

This report covers the main aspects of workforce data including workforce demographics, recruitment and selection, NHS Staff Survey, employee relations (disciplinary and grievance), mandatory training and development (appraisals) across the protected groups, where this data is available. The report helps us to identify potential disadvantages for any protected groups and to support the development of further actions.

The report is collated by the Trust's Workforce Information and Analysis Team and presented to the Equality and Diversity Steering Group and HR Committee for review. The report will also be scrutinised at Trust Board with a view to agreeing an updated set of workforce equality objectives.

Review of 2013/14 Actions

Action – Step into Work and Apprenticeships

Continuation of the Step into Work and Apprenticeship programmes through the Faculty of Education.

Progress:

For 2013/14 there were 4 planned cohorts for Step into Work, with anticipated recruitment of 45 trainees. As at March 2014 4 cohorts had commenced and 43 trainees recruited. Projected recruitment for 2014/15 is a further 45 trainees.

60 apprenticeships were planned for 2013/14, a reduction from 157 in 2013/13 due to changes to funding streams. As at March 2014 124 members of staff had commenced, or were due to commence an apprenticeship.

Projected apprenticeships for 2014/15 are 100 (subject to final confirmation of funding).

Action – Inclusion of equality and diversity in VITAL

Further development of an on line module to support equality and diversity capability.

Progress

Completed in October 2013.

A standalone Equality and Diversity module was created on the MOODLE platform and mandated for all staff groups. As at April 2014 2480 staff had completed this training.

Action – Development of Succession Planning

Development of succession planning and embedding of processes to establish a cohort of emerging leaders.

Progress:

Following the re-alignment of Organisational Development, this action was deferred until 2014.

Action – Development of Leadership Programmes

Development of leadership programmes to address leadership gaps.

Progress

Following the re-alignment of Organisational Development, this action was deferred until 2014.

The Nursing Directorate and Faculty of Education developed a specific programme “Leading from the Front” in conjunction with Keele University. It was designed to support the introduction of supervisory Senior Sisters in the organisation, recognising that people management and leadership would form the major part of their role and be subject to key performance indicators. . As at March 2014 77 Senior Sisters had commenced the programme and 31 had completed, with a further 23 due to complete in April 2014. Evaluation of the introduction of this role is on going.

Further development opportunities have been made available across Nursing including funding from Birmingham University for a Masters in Research and Scholarships through the Florence Nightingale Foundation.

The Faculty of Education also delivered 2 cohorts of the ILM level 5 and 7 Leadership and Management programme through an external provider for Clinical Scientists and other non-clinical staff.

Action – Disciplinary Cases

Understanding the reasons for the high proportion of disciplinary cases relating to BME staff.

Progress

The initial review of information highlighted some data validation queries. This has been addressed by the development of a Case Management Tracker that will improve the management information relating to all case management within the HR Operations Team.

Action – Recruitment and Selection

Identifying reasons for the variation between the proportion of Applicants and Appointments from different ethnic groups.

Progress

An analysis of NHS Jobs vacancy data between April 2012 and March 2013 has highlighted across all staff groups (with the exception of Medics) that White applicants are more likely to be appointed than their BME counterparts (see Graphs 3-6).

Action - Ageing Workforce

Keep under review the impact of retaining an ageing workforce.

Progress

An initial report was presented to the Live Well Work Well group in July 2012. Whilst no further action was considered necessary in view of current policies, the age profile of our workforce will be monitored on an annual basis.

Action – Collaboration with Equality and Diversity Department

To explore opportunities for working in partnership with the Equality and Diversity department.

Progress

Regular meetings took place during 2013, working towards the achievement of CCG requirements. The Head of Equality and Diversity retired in February 2014 and working arrangements are currently being agreed with the new Head of Equality and Diversity and Head Nurse Patient Experience/Clinical Dean for Nursing

Action – Protected Characteristics

To discuss the remaining protected characteristics under the equality duty and agree appropriate actions

Progress

A further review of data has taken place so that information concerning Religion or Belief and Sexual Orientation are included within this report.

NHS Employers Equality and Diversity Audit Tool

In addition to the above actions the Head of Equality and Diversity completed the NHS Employers Equality and Diversity Audit Tool in December 2013. The survey results are included in Appendix A.

Recommendations for 2014/15

The information contained within this report will be used to inform further discussion and agreement of an updated set of workforce related equality objectives at Trust Board in May 2014.

Whilst recognising the efforts internally in respect of equality and diversity, the Trust Board are keen to obtain an external objective view in relation to our internal performance, taking into account emerging information and external research relating to NHS workforce equality such as “Discrimination by Appointment – How Black and Minority Ethnic Applicants are Disadvantaged in NHS Staff Recruitment” (R Kline, 2013).

Based on an initial analysis of the data it is suggested that the proposed Trust Diversity Group considers the following areas:

- Consideration of an external review of workforce equality and diversity.
- Consideration of the current internal resources allocated to equality and diversity.
- Participation in the RCN programme to support BME Nurses through formal employment processes including disciplinary and grievance.
- How best to meet CCG contractual information requirements regarding:
  -training applications submitted and approved
  -flexible working requests submitted and approved
- Further analysis of the recruitment and selection process in relation to ethnicity and disability.
  -reference to Discrimination by Employment – How Black and Minority Ethnic applicants are disadvantaged in NHS Staff Recruitment
- Further analysis of employee relations data, particularly for BME staff.
  -To include analysis of referrals to professional bodies
- Improving the number of BME staff and women in senior leadership positions – leadership and mentoring.
- Improvement of recorded data for protected characteristics, particularly disability, religion and belief and sexual orientation.
  -Also to scope ways of better engaging and understanding the needs of these groups.
- Decide which aspects of the staff survey will be reviewed in detail, based on the differences highlighted for different protected characteristics, particularly disabled staff.

Review of other information sources such as the Exit Questionnaire.

1 Equality Duty and Public Sector Equality Duty

1.1 Background

The Equality Act 2010 came into force on the 1st October 2010, replacing the previous anti-discrimination legislation in the UK.

Public sector organisations have specific responsibilities under the Act, namely the Public Sector Equality Duty (PSED) that came into force on the 6th April 2011. It consists of a general duty comprising 3 main aims, and specific duties.

The purpose of the Equality Duty is to embed equality considerations into the day-to-day work of public bodies.

The Equality Duty covers the following protected characteristics:

- Age
- Disability
- Gender Reassignment
- Pregnancy and maternity
- Race (includes ethnic or national origins, colour or nationality)
- Religion or belief (includes no belief)
- Sex
- Sexual orientation
- Marriage and civil partnerships are protected characteristics under the Act however under the Duty organisations only have to have due regard to the need to eliminate discrimination.

The General Duty

Under the General Duty public bodies are required to have due regard to the need to:

- Eliminate unlawful discrimination, harassment and victimisation and other conduct prohibited by the Equality Act 2010.
- Advance equality of opportunity between people from different groups
- Foster good relations between people from different groups
- Public sector organisations have a duty to meet the needs of people with protected characteristics and reduce or eliminate the disadvantage that such groups may suffer.

The Specific Duties

These duties require public bodies to set specific, measurable equality objectives and to publish information regarding their performance on equality. The information that needs to be published is as follows:

- Equality objectives, at least every four years
- Information to demonstrate compliance with the equality duty, at least annually.

1.2: Workforce Monitoring and Information:

The Equality Act requires employers with 150 plus employees to produce and monitor data on their workforce to demonstrate that they can show compliance with the Public Sector Equality Duty. Workforce equality monitoring data is collected when an individual commences employment at HEFT, although staff can opt out of this. The workforce profile is based on The Trust's staff in post data as at January 2014. The reference period for recruitment, employee relations and training data is July 2013 – December 2013. Staff survey information is based on the 2013 NHS Staff Survey analysis. Population data is based on the 2011 Census. Where available, data is compared to that produced for the previous year. Selected data has been included within this report to illustrate each protected characteristic. Further data is in the accompanying workforce profiles (Age, Disability, Ethnicity, Gender, Sexual Orientation and Religious Belief).

2.0 Ethnicity Profile

Note regarding calculations: Approximately 8% of staff did not provided details of ethnicity. Therefore the internal percentage figures have been recalculated to exclude them and enable direct comparisons with the local population.

2.1 Ethnicity Profile against the local population

Table 1 - Ethnicity Profile of HEFT against the local population

	Local Population*	Staff in post Jan '13	Staff in post Jan '14
White	71%	74.7%	74.2%
BME	29%	25.3%	25.8%

Table 2 – Ethnicity Profile of Heartlands Hospital against the local population.

Heartlands	Local Population*	Staff in Post Jan '14
BME	52%	30%
White	48%	70%

Table 3 – Ethnicity Profile of Solihull Hospital against the local population

Solihull	Local Population*	Staff in Post Jan '14
BME	11%	18%
White	89%	82%

Table 4 – Ethnicity Profile of Good Hope Hospital against the local population		
Good Hope	Local Population*	Staff in Post Jan '14
BME	18%	20%
White	82%	80%

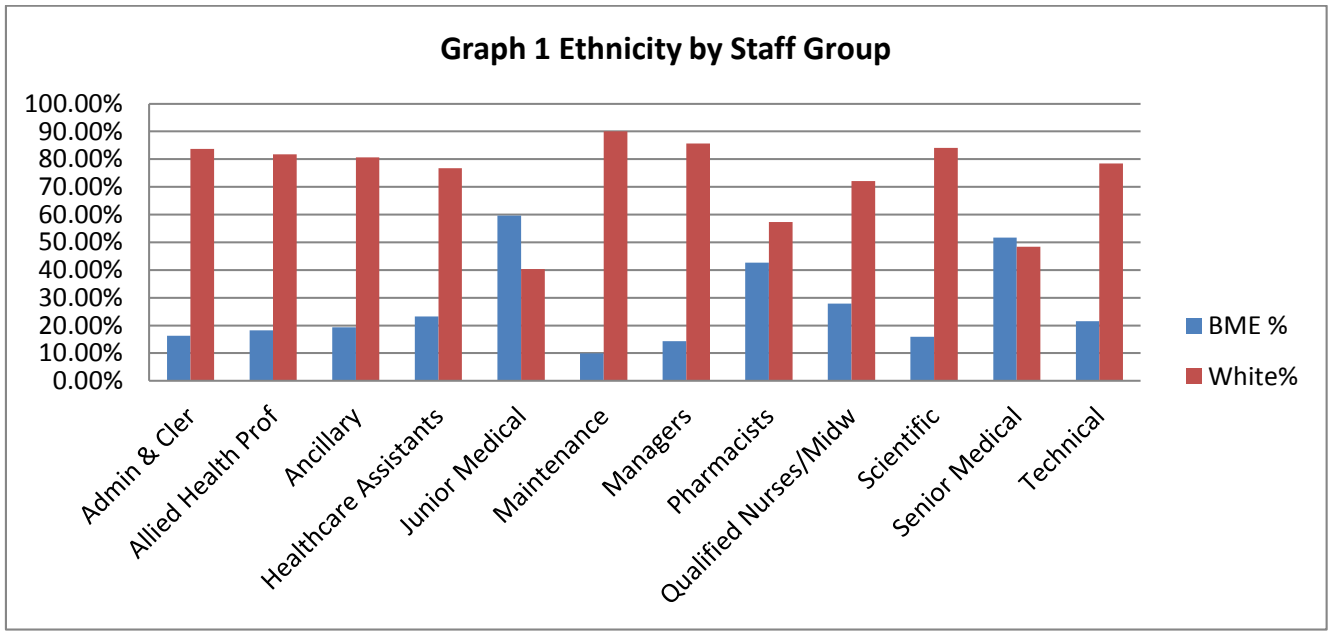
*Source 2011 Census. Approximately 11% of the local population surrounding Solihull Hospital and 18% surrounding Good Hope Hospital is from black and minority ethnic backgrounds (BME). For the Heartlands area the local BME population is around 52%. When combined proportionately for the Trust, the overall BME population is calculated as 29%.

Table 1 demonstrates that the percentage of staff from BME groups is 25.8%, a 0.5% increase from January 2013.However the BME workforce is under represented compared to the local population of 29%

Table 2 demonstrates that the BME workforce % at Heartlands Hospital is considerably lower than for the local population.

Table 3 demonstrates that the BME workforce at Solihull Hospital is proportionately higher than that of the local population

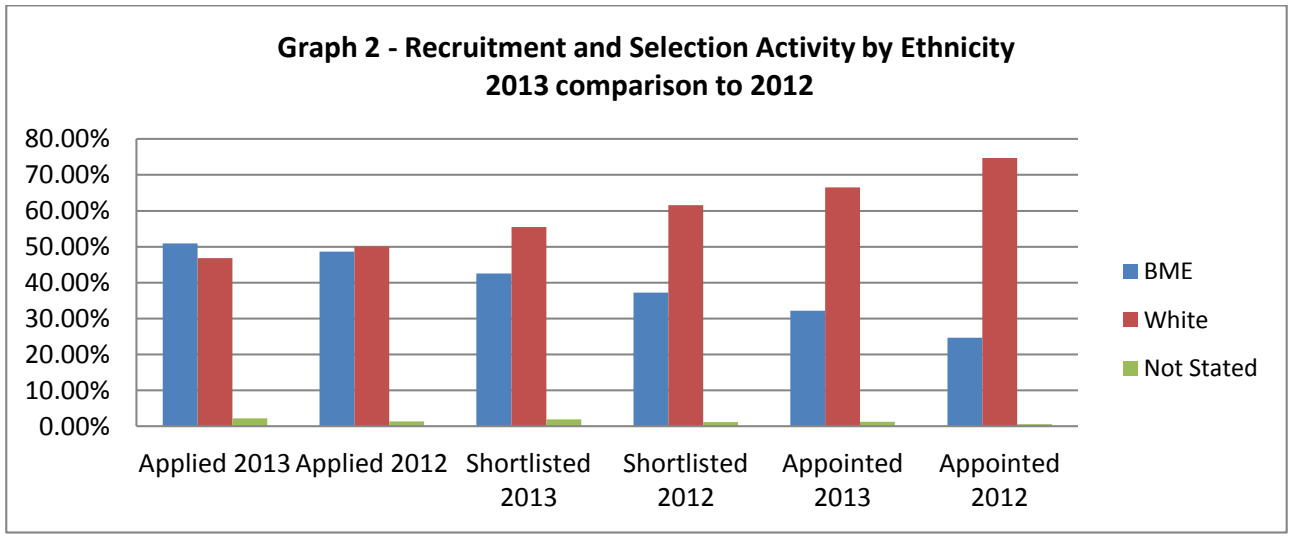
Table 4 demonstrates that at Good Hope the BME workforce % exceeds that of the local population.



Graph 1 shows that there are still some groups in which BME representation is very high across the Trust such as Medics (Junior Medics 60%, Senior Medics 52%) and Pharmacists (43%), but there are also areas of relatively low representation such as Maintenance (10%).

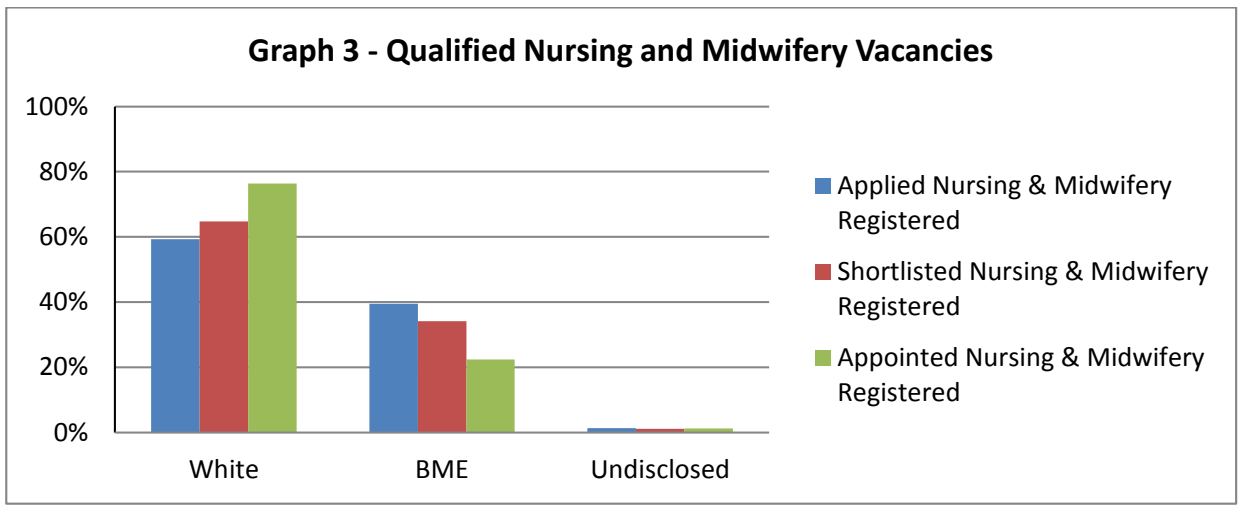
In addition the BME Administrative and Clerical staff (6%) and Managers (6%) at Good Hope, and the proportion of Pakistani staff at Heartlands (4%) remain low in comparison with the local population. This reflects a similar position to 2013.

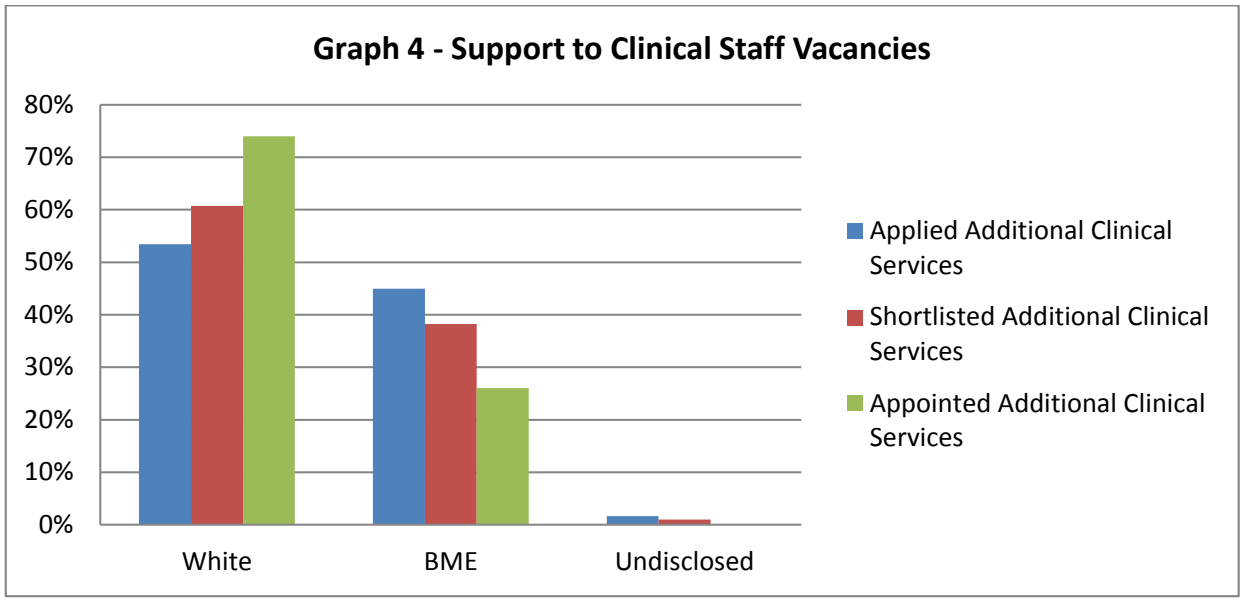
2.2 Recruitment and Selection analysis by Ethnicity

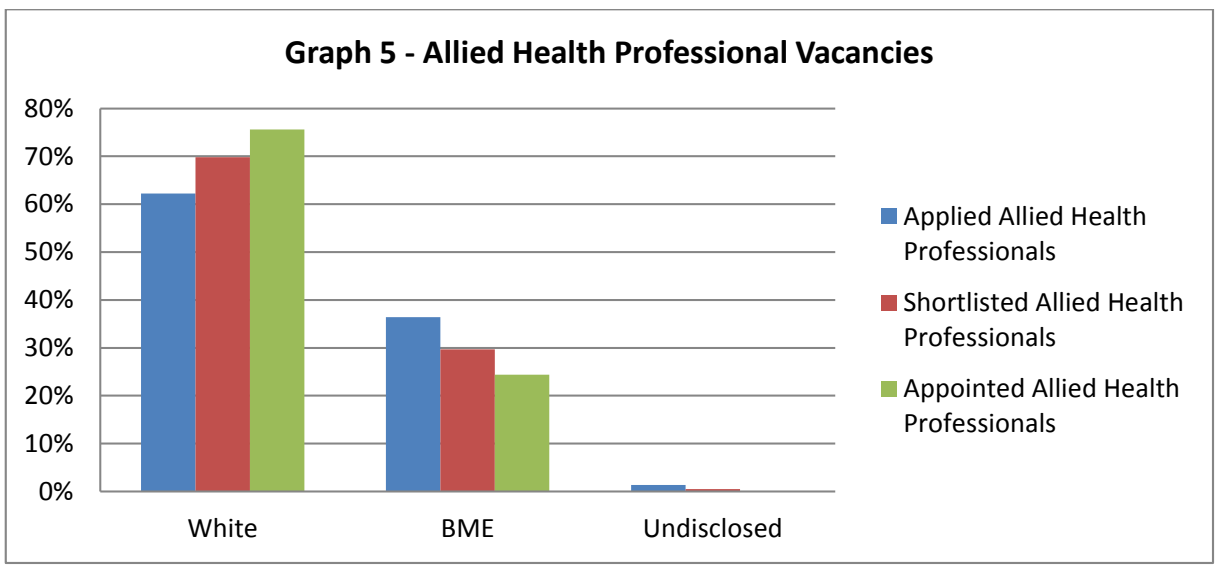


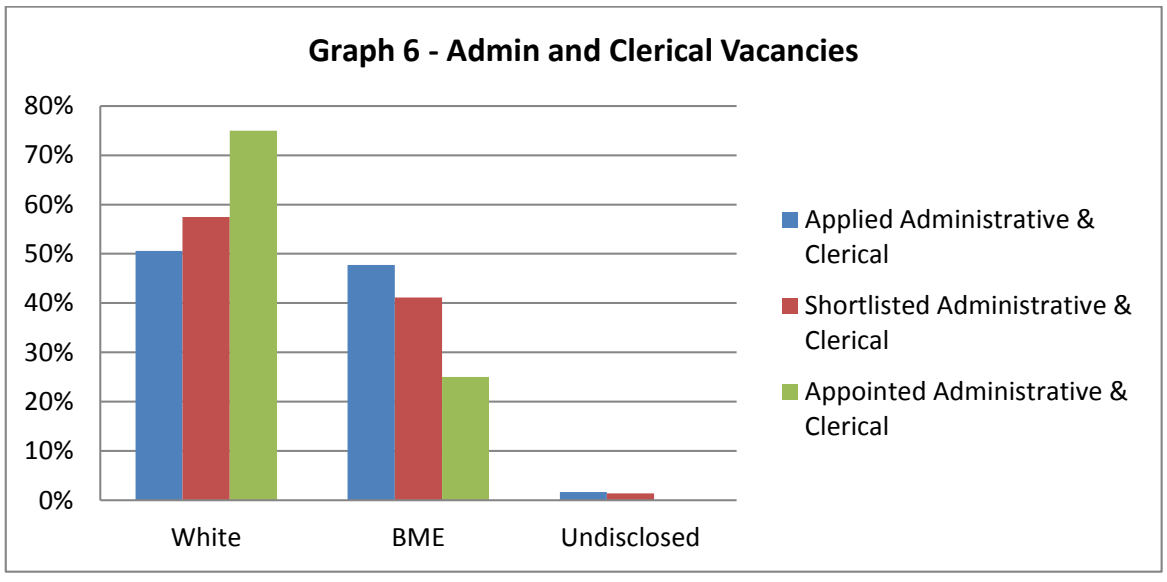
Graph 2 demonstrates a comparison of recruitment and selection activity for the period August – December 2012 and 2013. During 2013 there was an increase in BME applications to 51% (was 49%), shortlisted candidates 43% (was 38%) and appointed staff 32% (was 25%). Whilst this represents an overall improvement, the disparity between applications from BME candidates and appointments remains.

A further analysis of recruitment and selection data between April 2012 and March 2013 by vacancy type indicated that white applicants were more likely to be appointed than their BME counterparts (no data for medical staff was available). Graphs 3 – 6 highlight this information for a selection of vacancies.



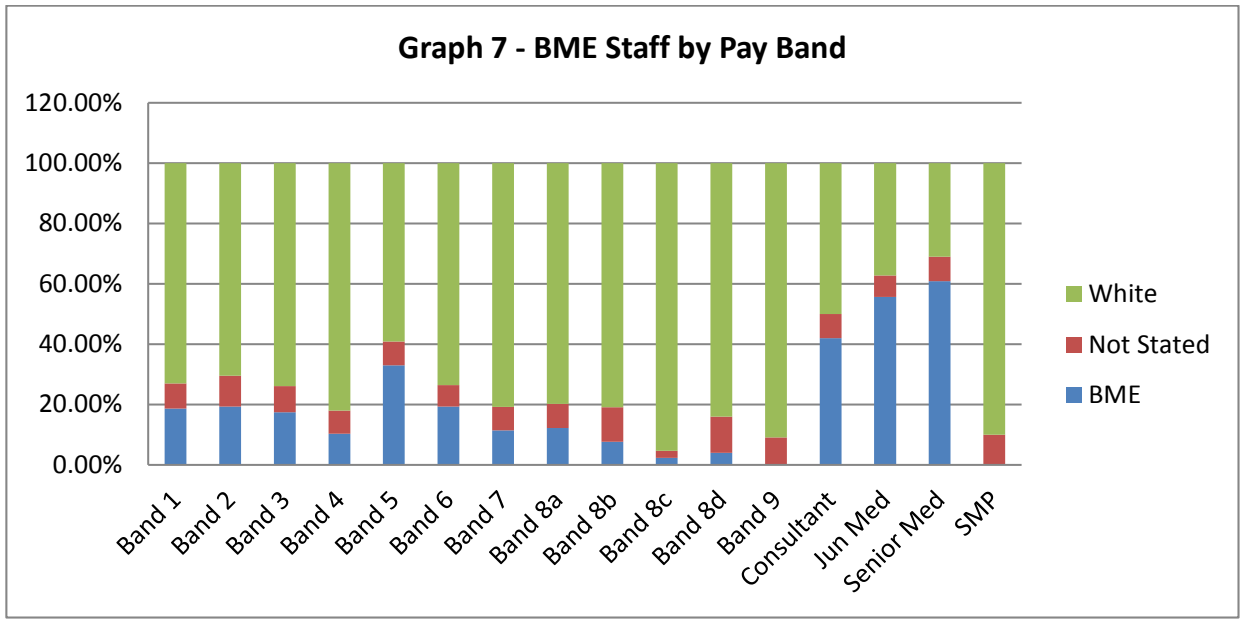

Graph 4 - Support to Clinical Staff Vacancies
80%
70%
60%
50%
40%
30%
20%
10%
0%
White
BME
Undisclosed
Applied Additional Clinical Services
Shortlisted Additional Clinical Services
Appointed Additional Clinical Services


Graph 5 - Allied Health Professional Vacancies
80%
70%
60%
50%
40%
30%
20%
10%
0%
White
BME
Undisclosed
Applied Allied Health Professionals
Shortlisted Allied Health Professionals
Appointed Allied Health Professionals


Graph 6 - Admin and Clerical Vacancies
80%
70%
60%
50%
40%
30%
20%
10%
0%
White
BME
Undisclosed
Applied Administrative & Clerical
Shortlisted Administrative & Clerical
Appointed Administrative & Clerical

It is recognised that the analysis of recruitment data is complex with different variations impacting on the outcome of the recruitment process; further investigation will be required to arrive at firm conclusions.

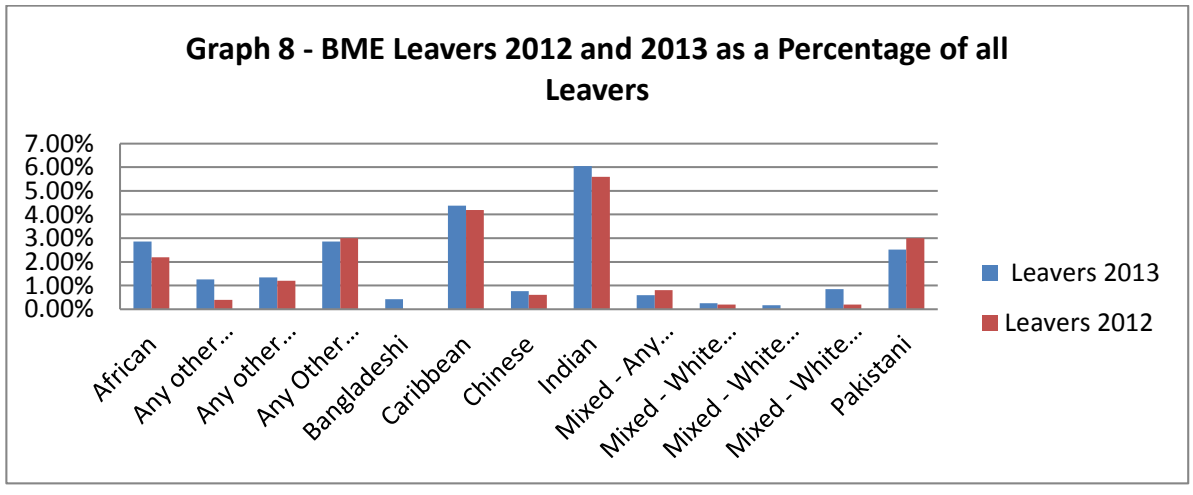
2.3 Pay Band by Ethnicity



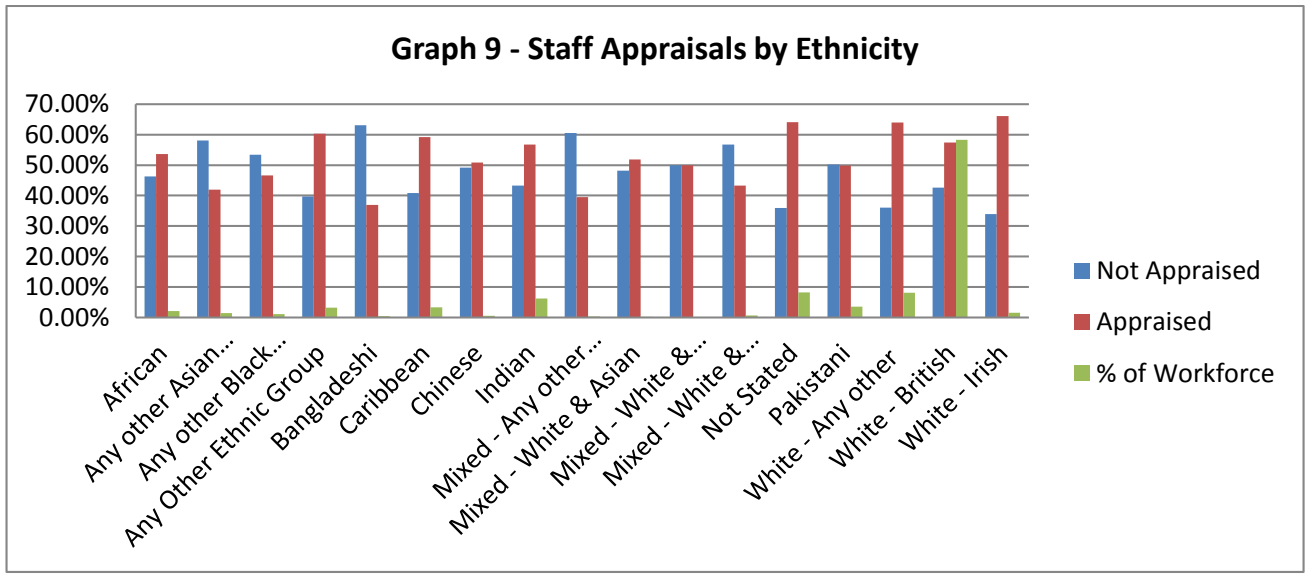
Graph 7 shows the percentage of BME staff by pay band. BME staff are over represented at Band 5 and throughout the Medical grades when compared to the average employment rate of that ethnic group. For all other pay bands BME staff are under–represented. Reviewing promotions during the period August 2013 to January 2014, approximately 22% of promotions were to staff from BME groups, an increase from the last report where 16% of promotions were to staff from BME groups.

2.4 Leavers

24% of all leavers during the period August 2013 to January 2014 were from BME groups. Whilst this is slightly lower than the BME workforce, it represents an increase of 3% from the last report.



2.5 Appraisals



Graph 9 shows the percentage of staff appraised by ethnicity during 2013. No clear inference can be drawn from the data.

Clinical Excellence Awards

At present, only doctors receive an element of pay based on assessed performance and this relates to Clinical Excellence Awards, Optional Points and Discretionary Points. For 2014 some 46% of staff eligible for these awards were from a BME background and 48% of these awards were granted to BME staff, a slight increase on last year.

2.6 Employee Relations Indicators

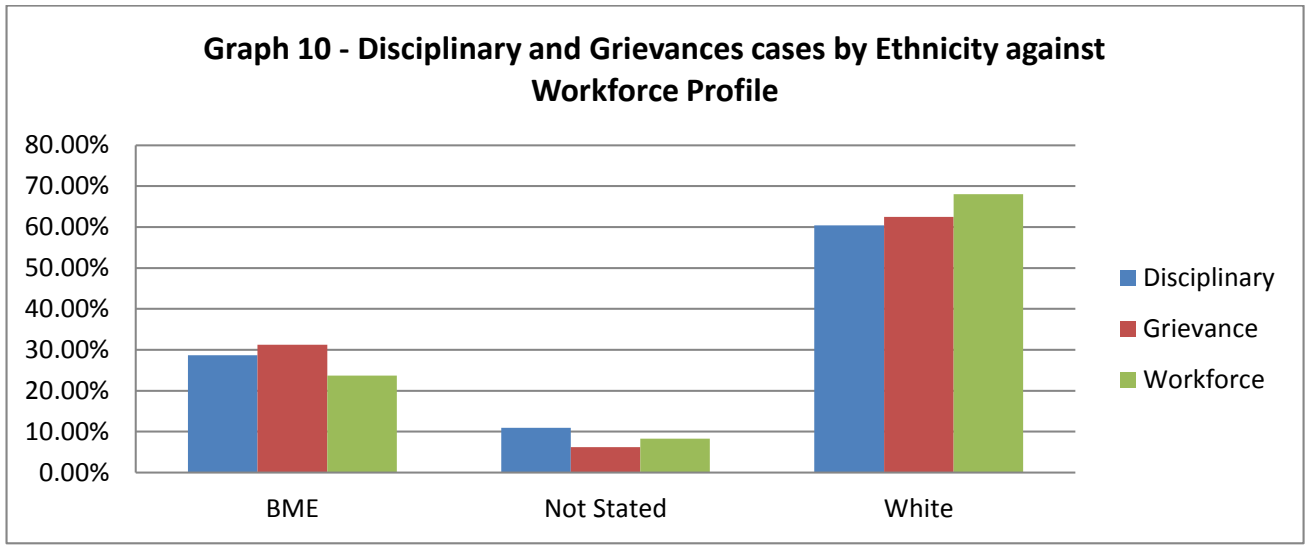


Table 4 - Number of Disciplinary and Grievance Cases by Ethnicity July – Dec 2013				
Ethnicity	Disciplinary	Grievance	Grand Total	Workforce
BME	55	5	60	2447
Ethnicity not Stated	21	1	22	854
White	116	10	126	7035
Grand Total	192	16	208	10336

Graph 10 and Table 4 shows the proportion of disciplinary and grievance cases by ethnicity. Both disciplinary and grievance case numbers are higher than would be expected based on BME representation in the workforce.

It is expected that data quality in relation to employee relations data will improve during the course of 2014, following the introduction of a case management tracker within the Workforce Directorate.

2.7 Staff Survey

In response to the questions broken down by ethnicity in the 2013 Staff Survey, the most notable differences between White and BME colleagues were:

- 90% of BME staff responded that they had received job-relevant training, learning or development in the last 12 months, compared to 78% of White staff.
- 51% of BME staff responded that they had a well-structured appraisal in the last 12 months, compared to 37% of White staff.
- 24% of BME staff said they had suffered work related stress in the last 12 months compared to 40% of White staff.
- 20% of BME staff responded to feeling pressure in the last 3 months to attend work when unwell, compared to 37% of White staff.
- 56% of BME staff responded that they believed the Trust provides equal opportunities for career progression or promotion, compared to 87% of White staff.

2.8 Ethnicity Observations

Overall the picture on ethnicity gives some mixed outcomes:

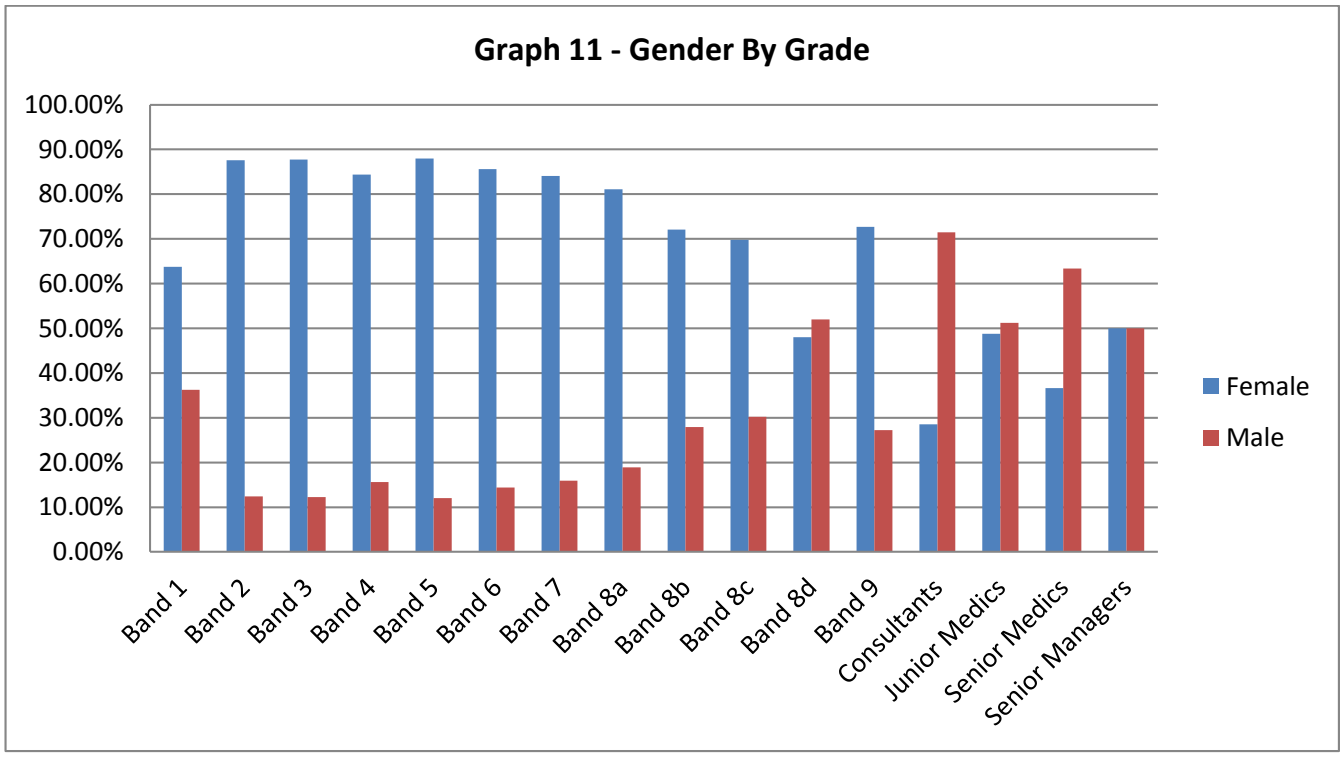
- The overall level of BME staff in post is below expectations when compared to the local population. This position has not changed significantly since the last report.
- BME staff are under-represented in most pay bands, apart from Band 5 and Medical grades. This is reflected across staff groups with the exception of Medical, Qualified

Nursing and Midwifery and Pharmacists.

- The number of BME doctors receiving awards is in line with the proportion of BME doctors in post.
- The proportion of disciplinary and grievance cases relating to BME staff is quite high in relation to the overall number of BME staff in post.
- BME staff responded more positively to several staff survey questions, however responded less positively to whether the Trust provides equal opportunities for career progression.

3.0 GENDER PROFILE

3.1 Staff in post



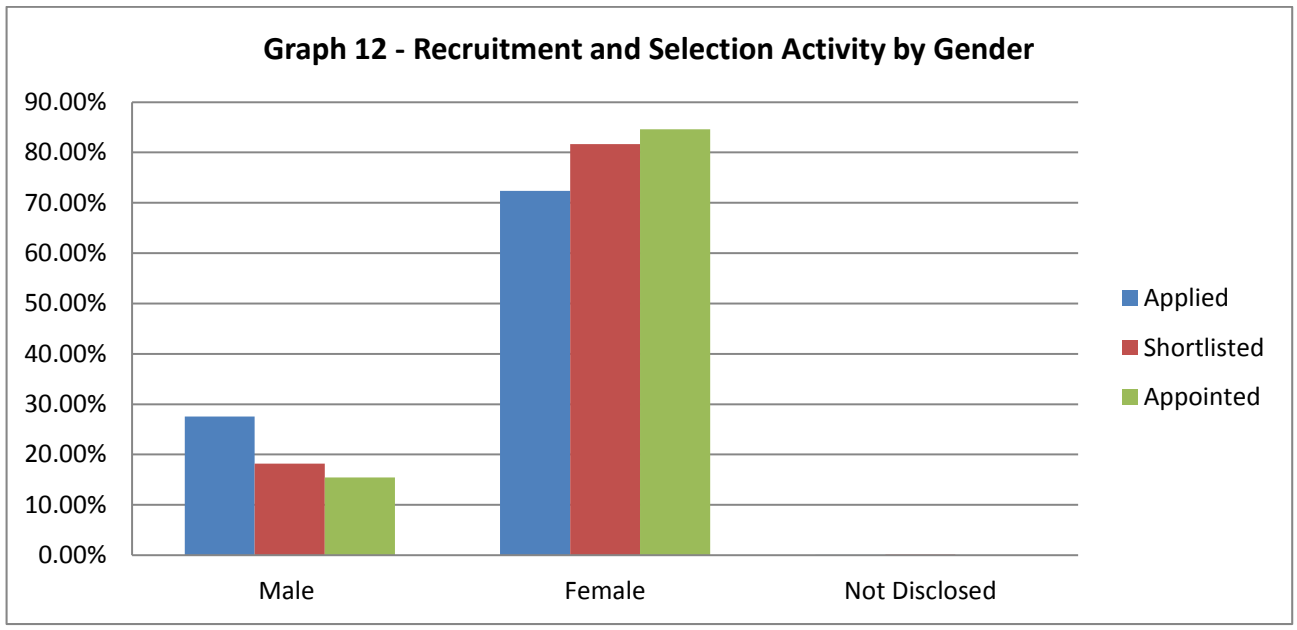
Graph 11 shows an updated gender analysis by grade. Overall there are 80% female staff and 20% male staff within the Trust, which represents no change over the last 2 years.

For Bands 8c – 9 the proportion of females has remained at 64% during the year.

The picture for medical staff remains similar to last year. At Junior Medical level there is almost an equal proportion of females employed, at 49%. Whilst at Consultant level females make up 29% of the workforce.

A brief analysis of Executive Directors shows that 50% of this group are female.

3.2 Recruitment



Graph 12 shows recruitment activity by gender during the period August to December 2013.

During the period approximately 72% of applicants and 85% of appointments were female, thus maintaining the high proportion of female staff within the Trust. During the period the data suggests that male applicants overall were less likely to be appointed than female applicants; however this would require further investigation.

3.3 Promotions

During the period August 2013 to December 2013 some 83% of promotions were to female staff, which is a little higher than last year and slightly higher than the proportions in post.

3.4 Flexible Working

An analysis of male and female staff working flexibly on a part-time basis shows that 47% of female and 15% of male staff work part-time. An analysis of staff groups shows that the staff group with the highest proportion of part-time staff is Ancillary and with the lowest is Maintenance. 21% of the Senior Medical workforce is employed on a part-time basis and 43% of the Qualified Nursing and Midwifery workforce is employed on a part-time basis.

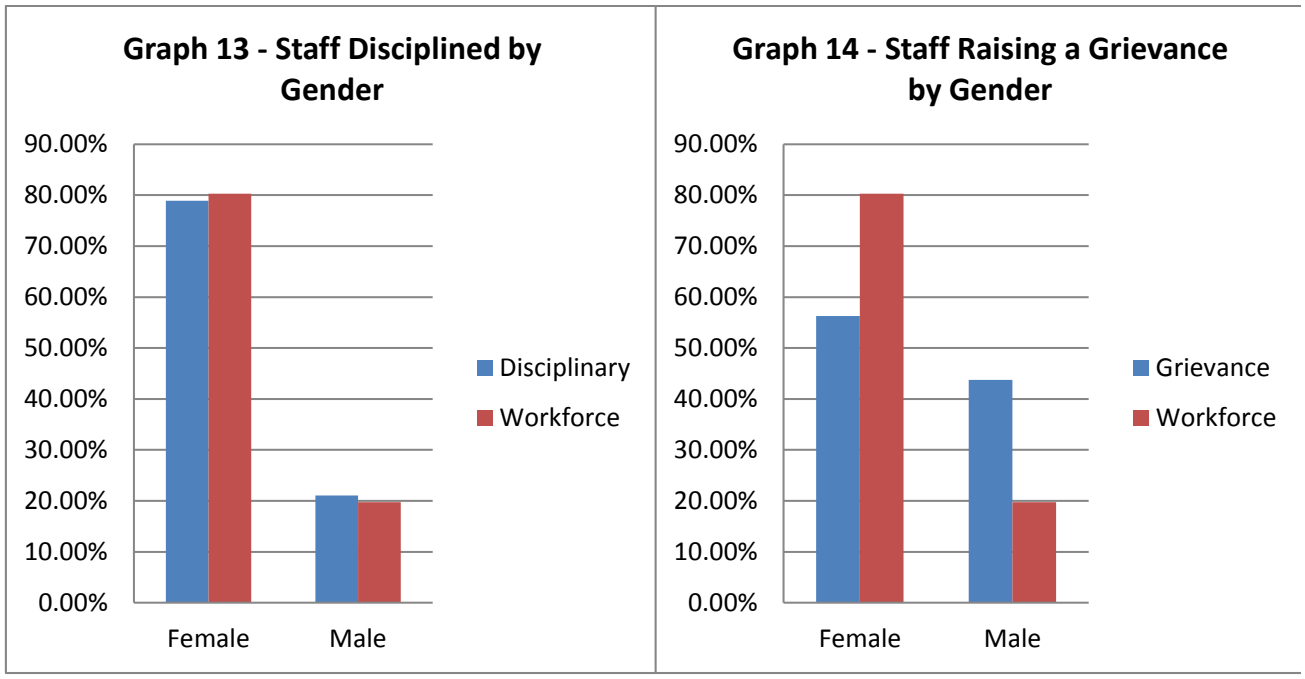
3.5 Leavers

83% of leavers during the period August 2013 – December 2013 were female. This is slightly higher than in the previous year but more or less matches the proportion of staff in post.

3.6 Assessment

As with ethnicity, this section relates only to doctors who are eligible to receive Clinical Excellence Awards, Optional Points and Discretionary Points. For 201329% of staff eligible for these awards were female and there was a further increase in the percentage of awards granted to female staff from 19% to 22%.

3.7 Employee Relations Indicators



Graphs 13 and 14 show the percentage of disciplinary and grievance cases by gender for the period August 2013 to December 2013. The most notable difference relates to what appears to be a disproportionate number of male staff raising a grievance, however the numbers are so low (16 cases) that it is difficult to say whether this is statistically significant.

3.7 Staff Survey

The main differences between male and female responses within the 2013 staff survey included:

- 28% of males indicated they suffered work related stress in the last 12 months compared to 40% of females, which is broadly consistent with the 2012 survey.
- 19% of males felt pressure in the last 3 months to attend work when feeling unwell compared to 36% of females. Both figures have risen since the 2012 survey.
- Compared to 2012, 67% (was 56%) of males said they were able to contribute towards improvements at work compared to 63% (was 72%) of females.
- 76% of males said they believed the trust provides equal opportunities for career progression or promotion compared to 81% of females, which is broadly consistent with the 2012 report.

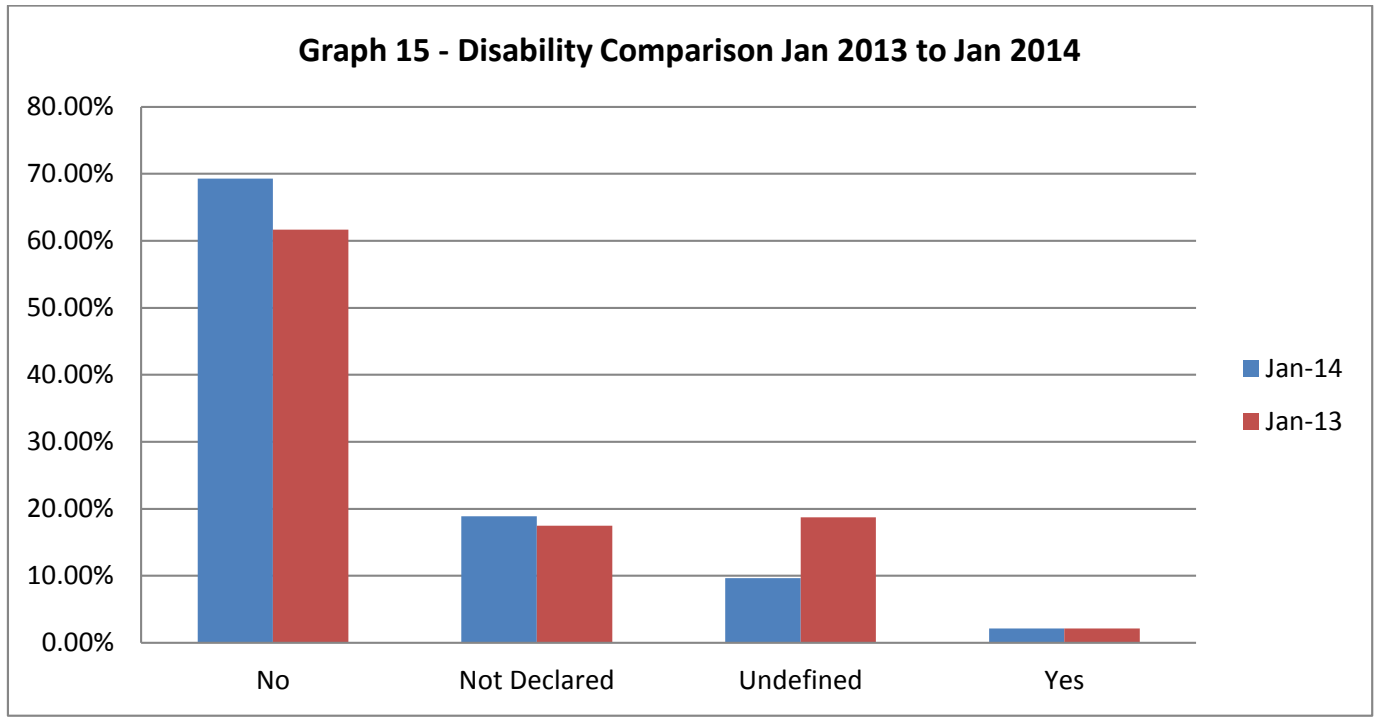
3.8 Gender - Observations

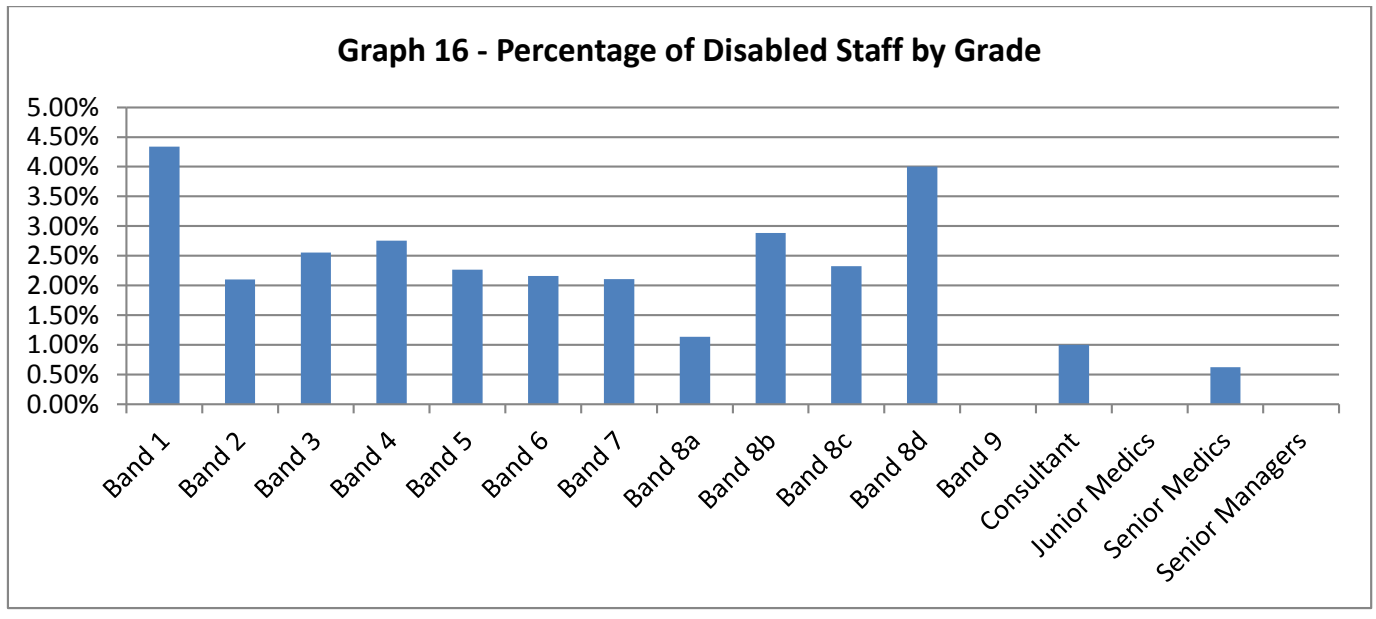
A reduced representation of women in senior management posts above Band 8a and in senior medic grades. Whilst the NHS has a predominantly female workforce, the male workforce remains at or around 20%, compared to our nearest Acute Trust UHB with a male workforce of 28%. To discuss what action may be required to address the differences between male and female responses within the staff survey, particularly around stress.

4.0 Disability

4.1 Staff Profile

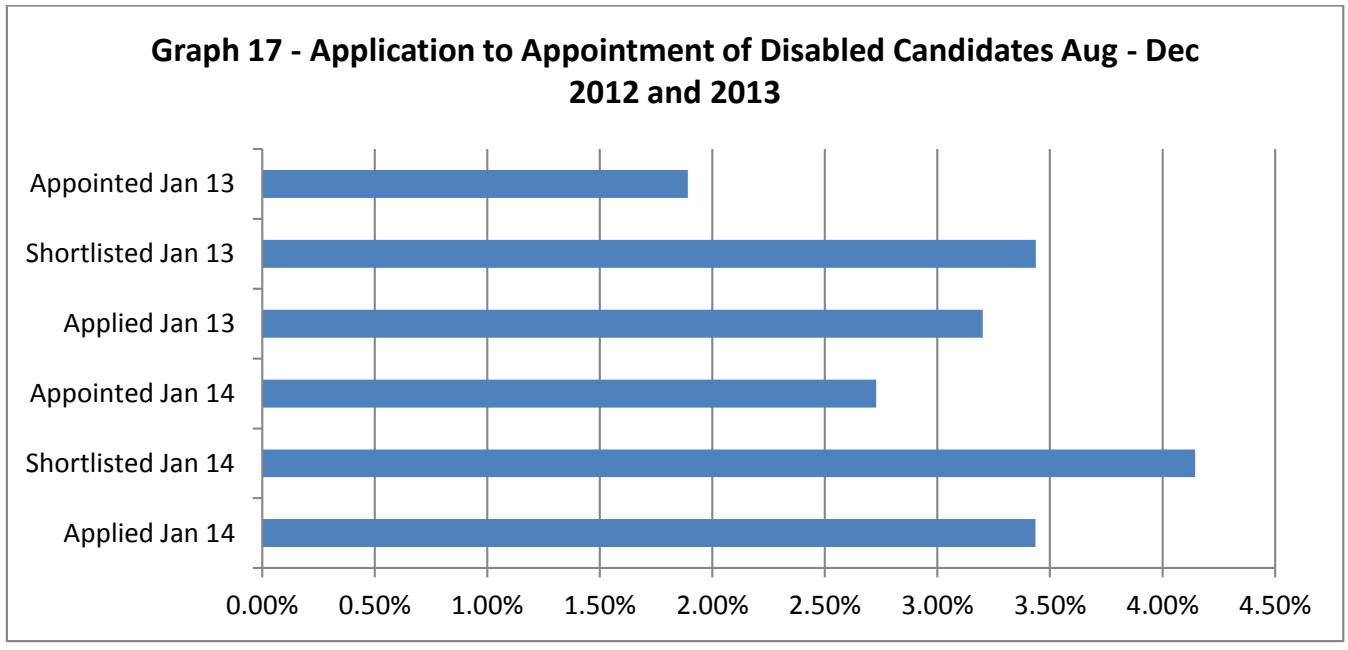
The Office for National Statistics has produced data showing that in the West Midlands 19.4% of 16-64 year olds have disabilities. Graph 15 shows that just over 2% of staff (223) have stated that they have a disability. However there remains a high percentage of staff (29%) where disability status is unknown or not declared. Information from the 2013 Staff Survey shows that 20% of respondents indicated that they have a disability, suggesting that more staff have a disability that we have recorded.





Graph 16 shows the percentage of staff recorded as having a disability by grade. Excluding Band 9 and Executives, where overall staff numbers are low, disabled staff are least represented in the medical grades.

4.2 Recruitment and Selection



Graph 17 shows the passage of disabled candidates from application to appointment for the 6 months following August 2012 and August 2013. Around 3.4% of applicants declared a disability compared to 3.2% last year. However despite disabled applicants representing 4.2% of those shortlisted, just 2.73% of appointments were made to applicants declaring a disability.

4.3 Training and Appraisals

Of those that completed mandatory training in 2013/14, 2.16% were recorded as having a disability. This is in line with the recorded disabled workforce.

The 2013 staff survey highlights some differences between disabled and non-disabled staff in relation to personal development:

- 65% of disabled staff responded to receiving job-relevant training, learning or development in the last 12 months compared to 83% of non-disabled colleagues.

- 25% of disabled staff responded to having a well-structured appraisal in the last 12 months compared to 42% of non-disabled colleagues.

- There are no notable differences between the percentage of disabled and non-disabled staff recorded as having an appraisal in 2013/14, based against their respective workforce profiles.

4.4 Staff Survey

Some notable differences between disabled staff and their non-disabled colleagues within the 2013 staff survey:

- 53% of disabled staff indicated they had suffered work related stress during the past 12 months compared to 35% of their non-disabled colleagues. This represents an increase on the 2012 survey.

- Disabled staff were the most likely amongst any demographic group to say they had experienced harassment, bullying or abuse from patients, relatives, the public or staff in the last 12 months. This is consistent with the 2012 survey.
- 22% of disabled staff compared to 9% of non-disabled staff said that they had experienced discrimination at work in the last 12 months, the same response as 2012.
- 53% of disabled staff reported feeling pressure to attend work when feeling unwell compared to their non-disabled colleagues at 28%.

4.5 Disability - Observations

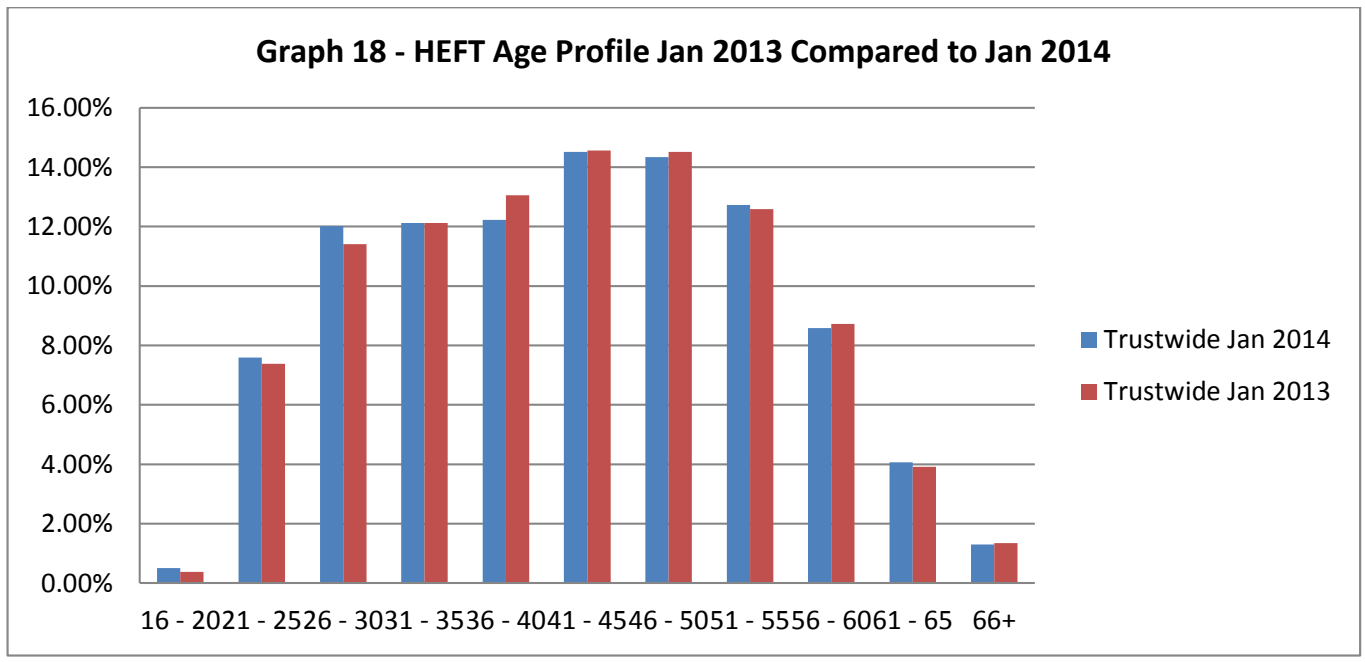
Workforce comparison against local population suggests under reporting of disabilities.

Further investigation is required into the relatively low proportion of disabled recruits.

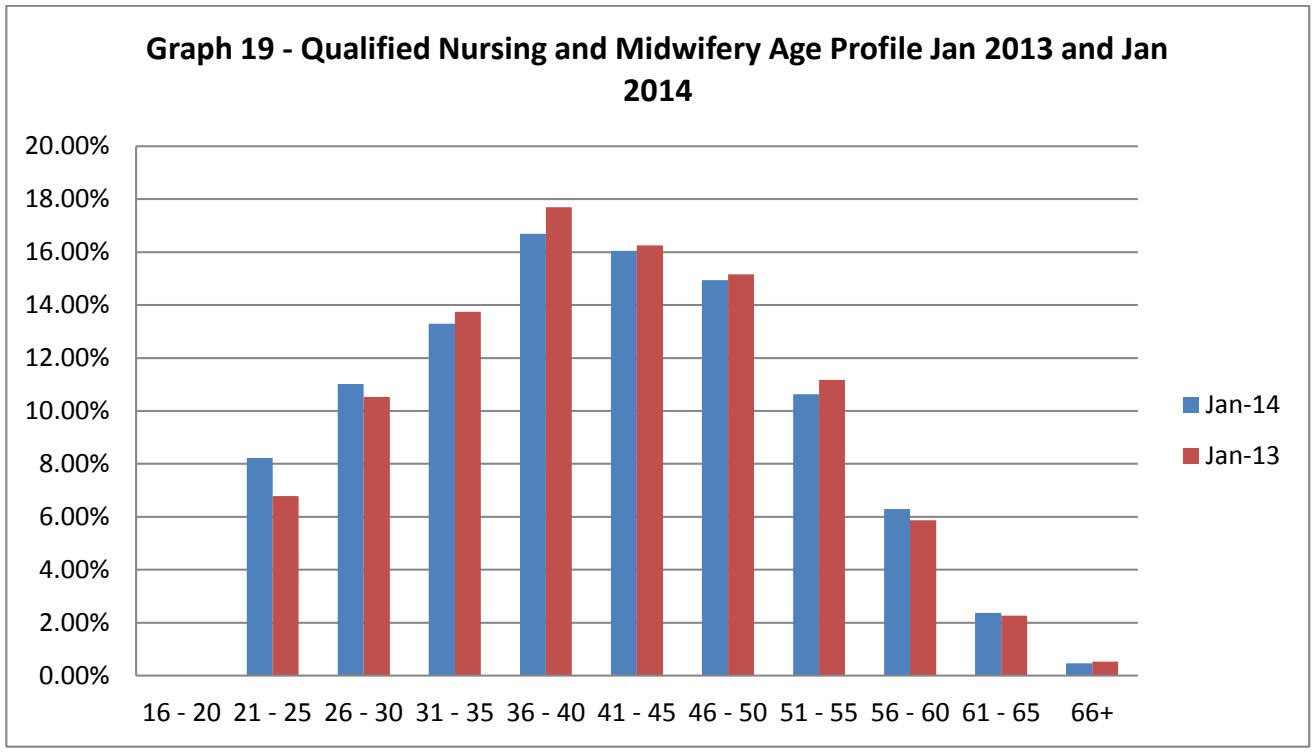
There are some notable differences within the 2012 and 2013 staff survey, warranting further investigation.

5.0 Age

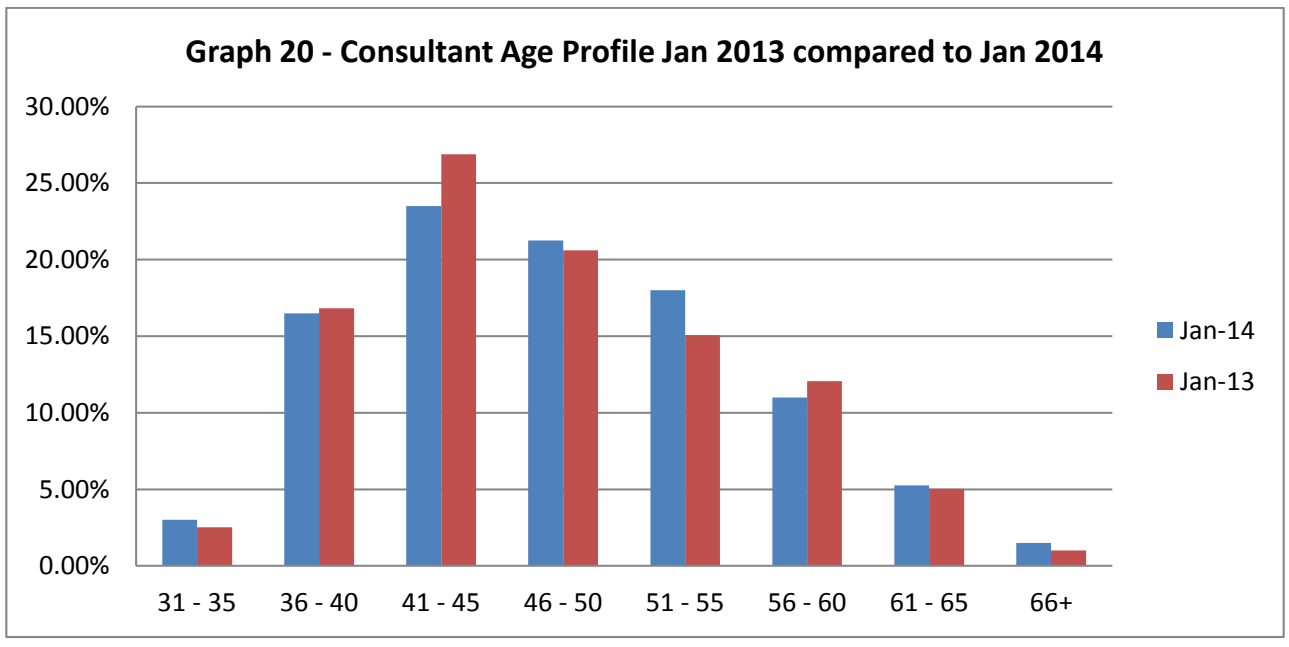
5.1 Age Profile



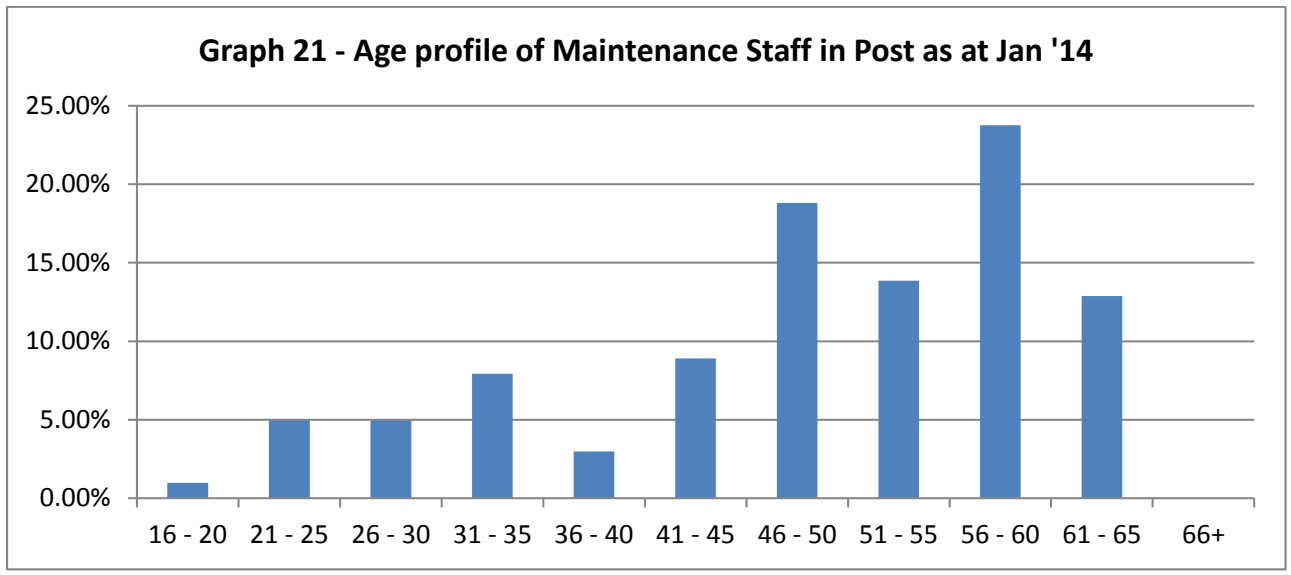
Graph 18 shows a comparison of age profiles across the Trust between January 2013 and January 2014.The overall profile for the Trust remains largely unchanged from last year with more than two thirds of staff within the age range 26-50.



Graph 19 - around 20% of Qualified Nursing and Midwifery staff are over 50 with 9.1% over 55. This is a slight increase for the fifth successive year and does suggest a trend. Given the changing social position with regard to retirement this may be expected.

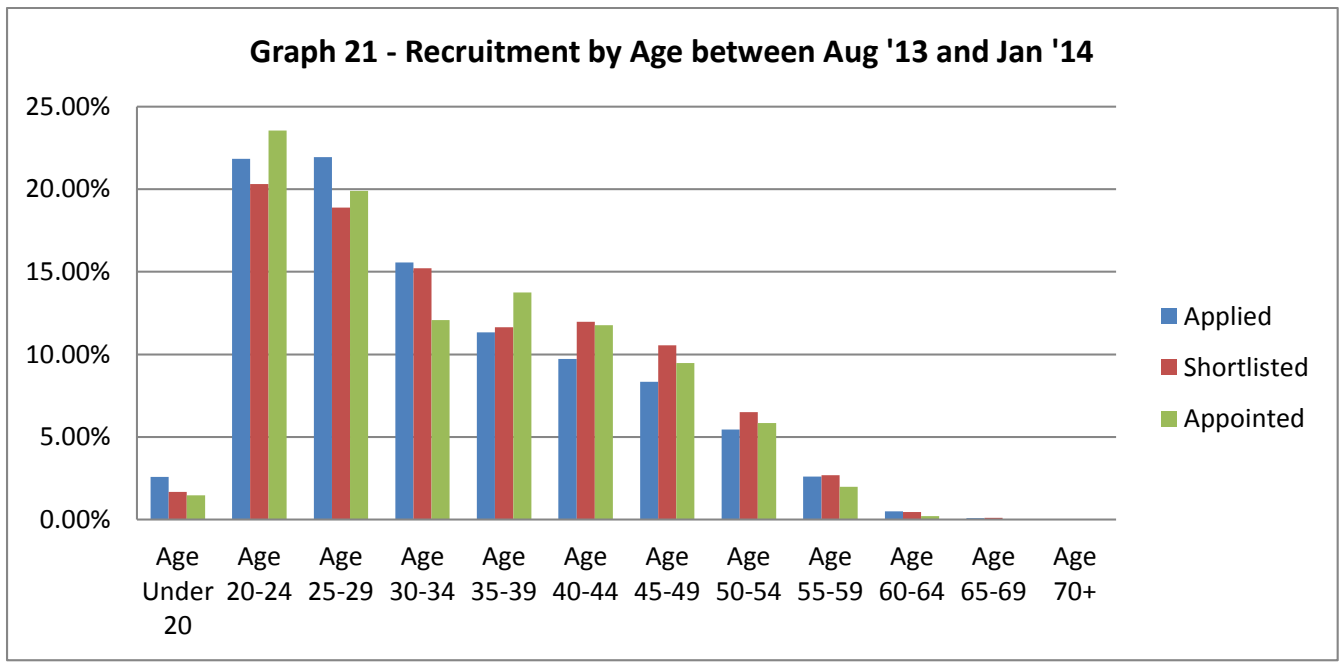


Graph 20 - around 18% of Consultants are over 55 (no change from the previous two years). Again this may be expected as mentioned above for Nurses.



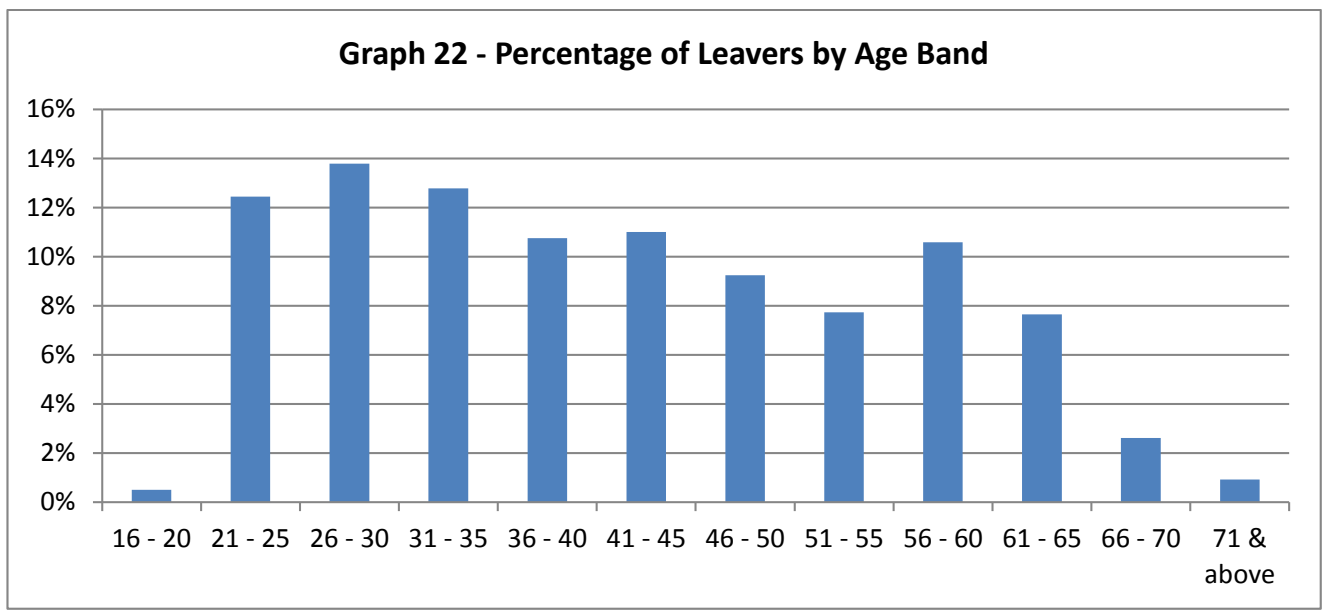
Graph 21 shows that 50% of maintenance staff are over 50. Whilst there are no current issues recruiting into these roles, pro-active management within this area, supporting development opportunities for current staff to acquire new skills means that staff are better placed to apply for future roles when they become available. Consideration is also being given to a Modern Apprenticeship scheme.

5.2 Recruitment



Graph 21 shows the recruitment percentages by age. Initial analysis indicates that applicants aged between 20-24 and 35-39 were more likely to be appointed overall. More detailed analysis would be necessary to arrive at any firm conclusions.

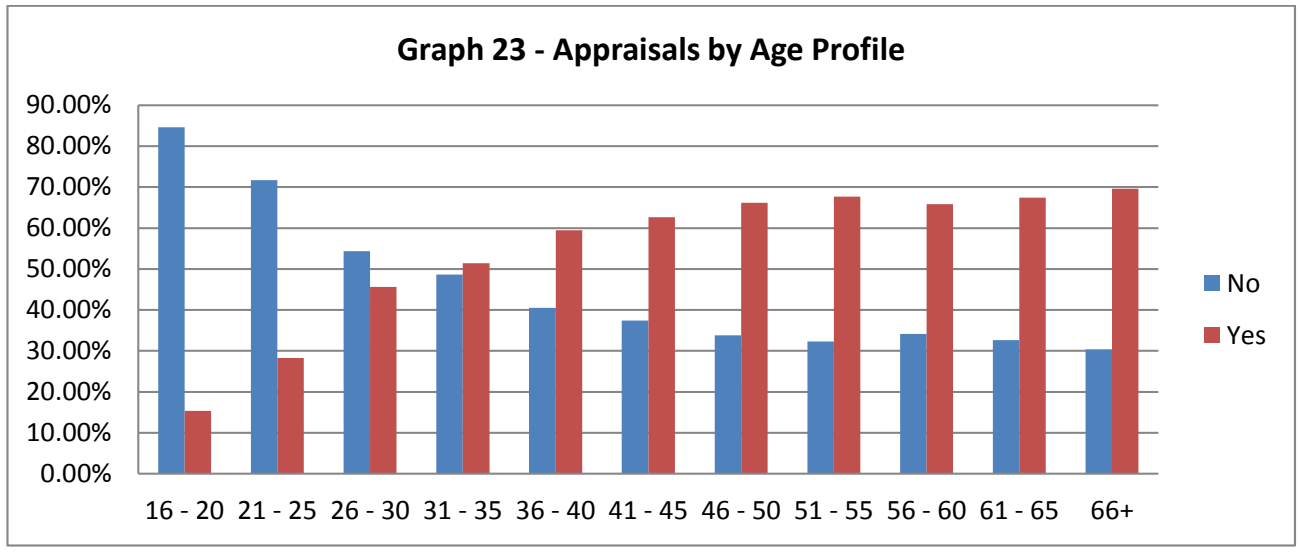
5.3 Leavers



Graph 22 shows the percentage of leavers by age band. 27% of leavers were under 30 during the period January to December 2013.

5.4 Training and Appraisals

The mandatory training profile by age indicates that staff in the 21-30-age band are the least likely to have completed their mandatory training.



Graph 23 also indicates that staff under the age of 30 appear less likely to have completed an appraisal. It is unclear why this variation exists and further investigation would be required.

5.2 Staff Survey

Some notable differences based on age within the 2013 staff survey included:

- Responses to appraisals differed quite considerably between age bands with 56% of staff aged 16-30 agreeing they had had a well structured appraisal compared to staff aged 31-40 at 31%.
- Responses to being able to contribute at work differed quite considerably between age bands with 76% of staff aged 31-40 agreeing they were able to contribute to improvements at work compared to 56% of staff aged over 51.

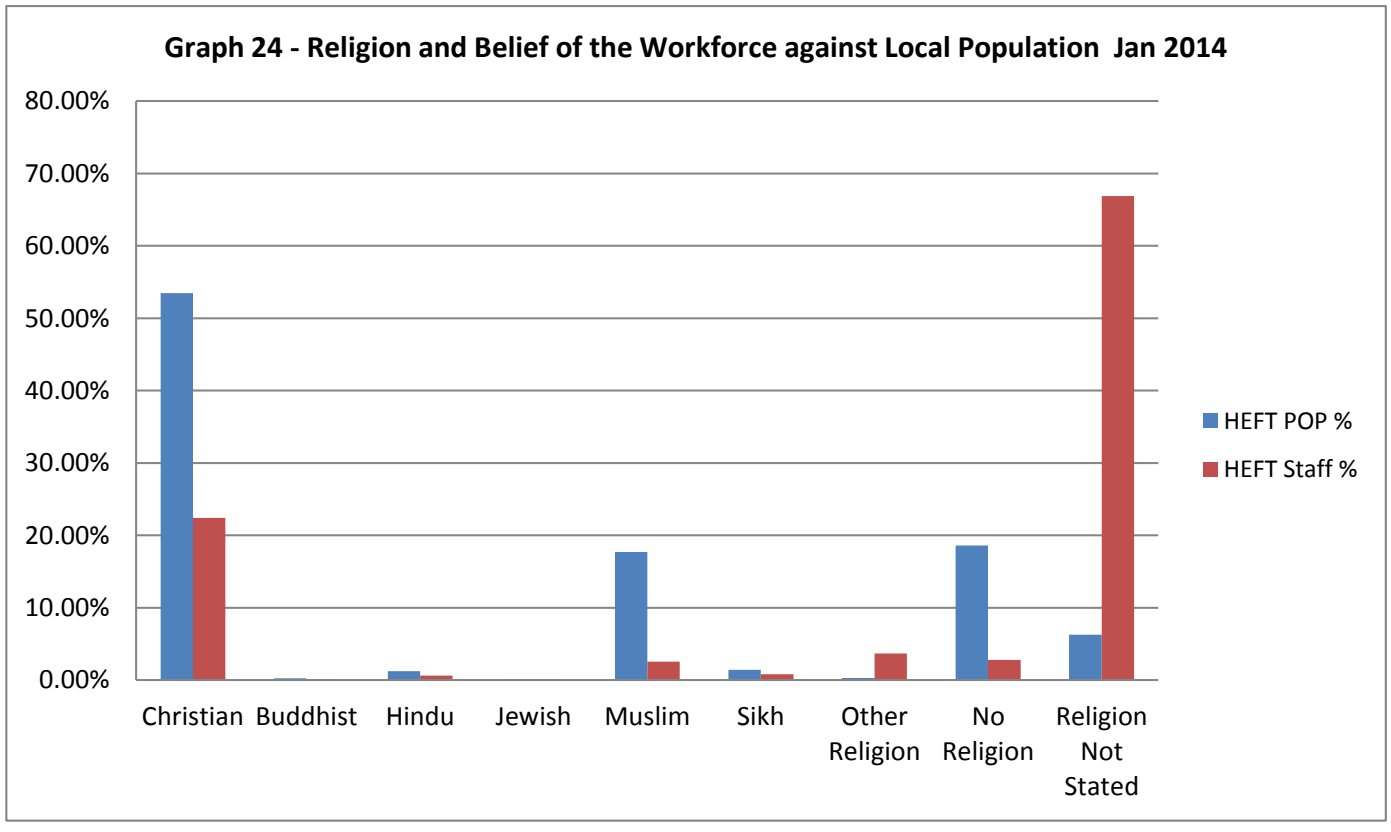
5.3 Age – Observations

With the change in the law relating to age in employment it may be that more staff will choose to work longer. The Trust needs to be aware of this and to plan accordingly.

To better understand the apparent variation in completion of mandatory training and appraisals for staff under 30, and to take account of the responses to the staff survey and to understand what action may be necessary as a result of these.

6.0 Religion and Belief

6.1 Staff Profile



Graph 24 shows the profile of the workforce by religion and belief as at January 2014. As can be seen, the data held for this protected characteristic is poor with 67% of staff not stating their religion or belief. Improvements in reporting will be required to gain a better understanding of this group. In 2014 – the Telegraph reported that 176,632 identified themselves as Jedi Knights- making it the most popular faith in Other religions on the census and the 7th most popular faith overall.

6.2:Religion and Belief – Observations

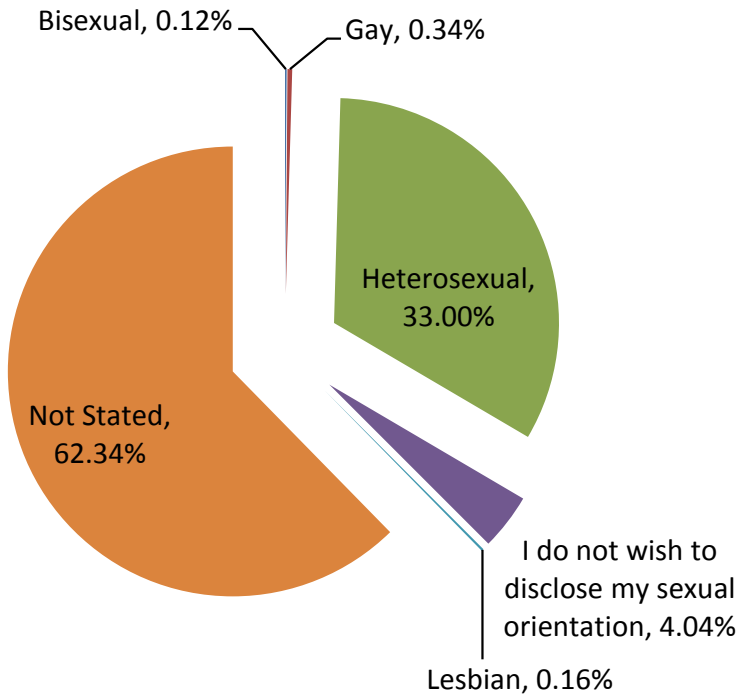
Due to the current under-reporting of staff on declared religion and belief it is not possible at present to undertake a further analysis of key workforce data.

Currently the NHS Staff Survey does not present analysis on Religion and Belief.

7.0 Sexual Orientation

7.1 Staff Profile

Graph 25 - Sexual Orientation at Jan 2014



Graph 25 shows the reporting of sexual orientation across the workforce. As can be seen, the data held for this protected characteristic is poor with 62% of staff not stating their sexual orientation. Improvements in reporting will be required in order to gain a better understanding of this group.

7.2 Sexual Orientation – Observations

Due to the current under-reporting of staff on sexual orientation it is not possible at present to undertake a further analysis of key workforce data.

Currently the NHS Staff Survey does not present analysis on Sexual Orientation.

Appendix A

NHS EMPLOYERS EQUALITY AND DIVERSITY AUDIT TOOL RESULTS – DECEMBER 2013

Survey Results for: **Embedding equality and diversity**

the business case:

There seems to be a well-established ethos within your organisation which recognises the business benefits of diversity. This is however an area which is still developing, and there is ongoing research which you might be interested in to help you further fine tune your approach. See:
CIPD, Work Foundation and NHS Employers E&D Partners

Engagement:

You seem to be doing some good things – but there is room for improvement.

See our staff engagement pages for the latest research and information on staff engagement, making the most of the staff survey and case studies that show what other trusts are doing in this area.

The Improving Working Lives Framework will help you to address the needs of your staff and put their suggestions into action.

Organisational commitment:

You seem to have the basics in place to build on but you need to continue to keep your board and senior managers engaged and involved in your agenda, if you are going to progress. Regular reports and updates on developments in the equality and diversity field are critical in this respect. You therefore should make sure that you are signed up to the NHS Employers Workforce Bulletin which contains regular articles and legal updates.

JANUARY 2014 ASSESSMENT

CATEGORY	ITEM	TARGET	ACTUAL	CHANGE	NOTES
ETHNICITY	Employees BME %	29%	25%	⟺	The local BME population surrounding Heartlands is 52%, Solihull 11% and Good Hope 18%. Proportionately this gives us an overall expected population of 29%. Actual staff in post are currently 25.8% which is slightly below the population and represents minimal change from 2013.
	Last 6 mths Appointments BME %	29%	32%	⇧	Recent appointments from BME groups improved from 25% last year to 32%.
	Last 6 months Promotions BME %	25%	22%	⇧	The proportion of promotions amongst BME staff has improved from 16% last year to 22%.
	Leavers BME %	25%	24%	⇧	% Of Leavers from BME groups is a little lower than the proportion of staff in post, however has increased since last year
	Grievance BME %	25%	31%	⇩	There were 5 grievance cases from BME staff in the reporting period, representing a reduction from 16-reported last year.
	Disciplinary BME %	25%	29%	⇩	There were 55 disciplinary cases from BME staff in the reporting period, slightly less than the 61 cases reported last year.
	Assessment (Doctors awards) BME %	45%	48%	⇧	The proportion of awards to doctors from BME groups remains higher than the comparative numbers in post and has increased slightly from last year.
GENDER	Employees Female %		80%	⇔	The proportion of female staff in post remains at 80%. At band 8c-9 the proportion of female staff in post remains at 64%.
	Consultants Female %		29%	⇧	The proportion of female consultants has increased slightly to 29% from 28% last year.
	Last 6 mths Appointments female %		85%	⇧	Recent appointments continue to reflect the high proportion of females who join the organisation.
	Last 6 months Promotions female %	80%	83%	⇧	Recent promotions for female staff are a slightly higher than the proportions in post.
	Leavers Female %	80%	83%	⇧	The proportion of female leavers is slightly above the % in post.
	Grievance Female %	80%	56%	⇩	Grievances from female staff have decreased from last year and are well below the proportionate levels in the workforce.

	Disciplinary Female %	80%	72%	⇧	Female disciplinary cases are proportionately lower than the levels in the workforce, although have increased proportionately in the last year.
	Assessment (Doctors awards) BME %	29%	22%	⇧	Awards to female doctors are less than the proportions in post, however have increased again from 19% to 22%.
DISABILTY	Employees with a disability recorded No.		223	⇧	Slightly up from 218 last year.
	Last 6 mths Appointments Staff with a disability No.		26	⇧	26 appointees (3%) declared a disability this year compared with 9 for the same period last year
AGE	Qual Nursing Staff aged 55+ %		9%	⟺	The proportion of Qualified Nursing staff aged 55+ remains the same as last year.
	Consultants aged 55+ %		18%	⟺	The proportion of Consultants aged 55+ remains the same as last year.
RELIGION AND BELIEF	% Staff with recorded religion or belief		33%	N/A	33% of staff have a recorded religion or belief (including no belief) as at January 2014
SEXUAL ORIENTATIO N	% Staff with recorded sexual orientation		38%	N/A	38% of staff have a recorded sexual orientation as at January 2014

Apologies | Declaration of Interest | Minutes | Matters Arising | Chairman's Report | Council of Governors Report | Chief Executive's Report | Safety, Quality and Org. Dev. | Patient and Public Feedback | Finance and Performance | External and Strategic Review | Nursing, Midwifery care staffing capacity | Equality and Diversity

Board Assurance Framework | Transport Strategy | Board Committee Reports | Any Other Business | Part Two

Board Assurance Framework- Strategic Risk Register

Apologies | Declaration of Interest | Minutes | Matters Arising | Chairman's Report | Council of Governors Report | Chief Executive's Report | Safety, Quality and Org. Dev. | Patient and Public Feedback | Finance and Performance | External and Strategic Review | Nursing, Midwifery care staffing capacity | Equality and Diversity

Board Assurance Framework | Transport Strategy | Board Committee Reports | Any Other Business | Part Two

From: Director of Corporate Affairs
Date: May 2014

Title: Strategic Risk Register

Purpose:
The purpose of this report is to provide the Board with an update on the Trust's Strategic Risk Register. The Annual Governance Statement requires that the Strategic Risk Register is presented to the Board each quarter for review.

Recommendation:

The Board is asked to:

- **Review** the current Strategic Risk Register and provide feedback on any changes required;
- **Approve** the next steps and further actions in relation to the future development of the Strategic Risk Register / Board Assurance Framework.

1. Introduction

The Board Assurance Framework provides a structure and process that enables the Trust to focus on those risks that might compromise it achieving its strategic objectives and to map out the controls and assurances 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 Trust's strategic objectives or its continued existence.

2. Current position

The Strategic Risk Register has continued to be reviewed quarterly during 2013/14 with all Executive Directors and updates have been reported quarterly to the Executive Management Board (EMB) and the Board. It is also presented to Audit Committee 6 monthly - in line with the Annual Governance Statement.

The current version (Quarter 4) of the Strategic Risk Register, which was presented to Executive Management Board in April 2014, is included in **Attachment 1.**

There are currently 9 risks on the Strategic Risk Register, as follows:

Risk ID	Risk Title	Current Score
SR1	Future Tariff efficiency	16
SR2	Patient Flow	16
SR8	Reshaping HEFT	12
SR10	Workforce Transformation	12
SR13	Staff Engagement	12
SR14	Winter Planning	16
SR15	18 Week RTT	16
SR16	Breast Recall Programme	16
SR17	Good Hope site management	12

Attachment 1 provides further detail regarding the controls and assurances for each risk along with any gaps and required action.

The following changes have been made to the register since the Q3 review:

- EMB agreed the addition of three **NEW** risks - 18 week RTT, Breast recall programme and Good Hope Hospital site management and governance arrangements.

These changes are reflected in **Attachment 1.**

3. Strategic Risk Register review

At its meeting in September 2013, the Board requested that a review of the existing Strategic Risk Register should be completed to include revising the format of the document as well as reviewing the process required for its development and review.

Following a review of the registers in other large NHS organisations, a revised format for the Strategic Risk Register was presented to EMB in January and April 2014. This is reflected in Attachment 1.
This second part of this work is still to be completed. This was to focus on reviewing the process of updating and collating the Strategic Risk Register and it was agreed that this should be delayed until the Trust's new Internal Auditors had commenced.

One of the main priorities will be a risk awareness session with the full Board to: Provide an understanding of the role of the Board Assurance Framework in the Trust's governance framework and the responsibilities of the Board in managing it; Review in detail the existing risks on the Strategic Risk Register to ensure that they fully reflect the real risk to delivering the Trust's corporate objectives; Discuss the current process and develop proposals for the way forward. This discussion will be facilitated by the Internal Auditors.

A proposal will then be presented to the Board and to the Audit Committee.

4. Recommendation

- **Review** the current Strategic Risk Register and provide feedback on any changes required;
- **Approve** the next steps and further actions in relation to the future development of the Strategic Risk Register / Board Assurance Framework.

Lisa Thomson
Director of Corporate Affairs

Chronology of Strategic Risk Register scores

Risk ID.	Risk Description	2011/12				2012/13				2013/14			
		Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
SR1	Tariff efficiency	16	16	12	12	16	20	20	20	20	20	20	16
SR2	Patient flow	20	20	12	12	12	16	16	20	12	16	16	16
	18 week wait			12	12	12	12	12					
SR8	Reshaping HEFT			15	15	15	15	12	12	12	12	12	12
SR10	Workforce transformation				12	12	12	12	12	12	12	12	12
	CCGs				6	9	9	9					
SR13	Staff Engagement									12	12	12	12
SR14	Winter Planning									16	16	12	16
SR15	18 Weeks												16
SR16	Breast recall programme												16
SR17	Good Hope governance and Management arrangements												12

Heart of England NHS Foundation Trust - Board Assurance Framework

Risk Number and Title:	SR1 FUTURE TARIFF EFFICIENCY					Executive Lead:	Aidan Quinn		
Strategic Priority:	Efficient					Date first raised:	April 2011		
Description of Risk	Initial Score (C*L)	**What are we doing about it?** *(What are the key controls that we have implemented to assist in the delivery of this objective?)*	Current score (C*L)	**How do we know we are doing it?** *(Key assurances of the controls - include relevant reports considered by the Board or a relevant committee whereby the Board is given evidence that the controls are being effective)*	Assurance (RAG)	**What are we not doing?** *(Gaps in controls and assurances that have been identified)*	**What else can we do?** *(Include actions required to address any current gaps in controls and assurances)*	Timeframe	Target score
The NHS is required to make 5% year on year savings. There is a risk that the required savings will be too big to respond to appropriately without an impact on existing services. Without careful management this could cause a risk to the quality and safety of services provided.	4*4 = 16	Relationship building with external partners including Birmingham City Council and CCGs	4*4=16	Jointly managed risk agreement. Monthly updates to Finance and Performance committee and Trust Board		No gaps identified	No actions required	Ongoing	3*3 = 9
		CIP Board		Monthly updates to Finance and Performance committee, HOMB and Trust Board. Monthly discussions at CIP board and Finance and Performance Committee		CIP slow to start in year. Directorates not accepting the scale of the challenge	Earlier planning and longer term planning	Ongoing	
		Pay controls		Monthly updates to finance and Performance committee.		Resistance to review key medical and nursing staff groups	Trust led initiatives across medical and nursing staff groups	Ongoing	
		Escalation process - directorate to site to Chief Executive and Director of finance		Monthly updates to finance and performance committee		No gaps identified	No actions required	Ongoing	
		Finance and performance sub-committee of Trust Board		Monthly meetings		No gaps identified	No actions required	Ongoing	
		Transformation parter for reshaping HEFT / corporate strategy		Commercial Director monthly updates to trust Board		See Strategic risk 8	See Strategic risk 8	Ongoing	
		Development of CIP plans earlier in the financial year including QIA		Confirm and challenge meetings with Directorates lead by the Director of Finance, Chief Nurse and Medical Director		Lack of adherance to the timetable for planning and implementation of CIP plans	Reinforce message and facilitate workshops for managers	Ongoing	

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Risk Number and Title:	SR2 - PATIENT FLOW					Executive Lead:	Adrian Stokes		
Strategic Priority:	Efficient, safe, caring					Date first raised:	April 2011		
Description of Risk	Initial Score (C*L)	**What are we doing about it?** *(What are the key controls that we have implemented to assist in the delivery of this objective?)*	Current score (C*L)	**How do we know we are doing it?** *(Key assurances of the controls - include relevant reports considered by the Board or a relevant committee whereby the Board is given evidence that the controls are being effective)*	Assurance (RAG)	**What are we not doing?** *(Gaps in controls and assurances that have been identified)*	**What else can we do?** *(Include actions required to address any current gaps in controls and assurances)*	Timeframe	Target score
Failure to successfully address discharge planning arrangements resulting in poor patient flow and unecessary delays to admissions, transfers and discharges. Leading to an increase in risk to the urgent care pathway, including significant impact upon the capacity in A&E and the use of additional flex capacity. There is a risk to the corporate objective 'safe and caring'	4*3 = 12	Discharge Hub	4*4 = 16	KPIs reviewed by Finance and Performance Committee		The discharge hus is not co-located - which can cause unecessary delays and inefficiencies	Plan to colocate the discharge hub services	Jun-14	3*2 = 6
		SAFER		Daily reports and monitoring by the site team Urgent care improvement board		S of safer - daily ward rounds at 8am	Job planning letter for consultants	Jan-14	
						E of safer - early discharge	Early discharge prize @ BHH	Feb-14	
		External Capacity		Tracked through discharge hub		No gaps identified	Further discussions with commissioners and other stakeholders e.g. Monitor	Ongoing	
		Additional actions		Monthly updates to Trust Board Trust wide implemntation group chaired by emergency pathway transformation lead		Medical staff vacancies	Appointments to key vacancies	Ongoing	
						Standard operating procedures not evident	Improve standard operating procedures and stronger performance management	Ongoing	
					⇧	Bottle neck in AMU resulting in a backlog arising in A&E and poor performance despite having a lower overall occupancy	Perfect week in AMU assessment areas	Complete	
						Perfect week showed that there are some examples of poor practices amongst the supernumary ward sisters	Supernumary ward sisters - additional training from corporate nursing	Aug-14	
						Staffing	Ensure staffing levels are adequate - to be monitored as a risk through site operational risk registers	Ongoing	
		Protected clinical time				No gaps identified	No actions required	Ongoing	
		Breaking the barriers (with local council and community partners)				No gaps identified	No actions required	Complete	
		Monitor undertaking		Gold command - reports to CEO daily and Trust Board monthly		No gaps identified	No actions required	Ongoing	
		CQC Warning notice - Good Hope Hospital		Action plan developed. Review by site team and demonstration of compliance by 21st February. Followup visit completed by CQC 27th February	⇧	No gaps identified	No actions required	Complete	

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Risk Number and Title	SR8 - Ability of the Trust to undertake strategic reconfiguration and develop new business models for services								
Strategic Priority	Efficient, locally engaged								
Date first raised	December 2011		Executive Lead:		Simon Hackwell				
Description of Risk	Initial Score (C*L)	**What are we doing about it?** *(What are the key controls that we have implemented to assist in the delivery of this objective?)*	Current score (C*L)	**How do we know we are doing it?** *(Key assurances of the controls - include relevant reports considered by the Board or a relevant committee whereby the Board is given evidence that the controls are being effective)*	Assurance (RAG)	**What are we not doing?** *(Gaps in controls and assurances that have been identified)*	**What else can we do?** *(Include actions required to address any current gaps in controls and assurances)*	Timeframe	Target score
Key Challenges around quality, resources and demography mean that current configuration and delivery models of some services are not sustainable in the future. The Trust has developed a clinical transformation strategy (reshaping HEFT) to address this. There is a risk that such a large scale change programme will not be fully delivered within the required timescales due to the complexity of the work involved and the organisational focus on short term operational issues	3*5 = 15	Clinical Transformation Programme Board	3*4=12	Monthly progress reports to EMB		Reshaping HEFT Board is not meeting every month, as scheduled	Greater use of Trust programme management office. Proposals have been developed to help assess resources available.	Jan/Feb 2014	2*3 = 6
				Report to Finance and Performance Committee (September 2013)		Operational resources are slow to be released for transformation work (e.g. Surgery)	TBC	Ongoing	
				Trust Board away day (June 2013)	↓	Plan for the management of the external politics relating to the proposed changes to services			
		Transformation partner		Appointed November 2013. Work to commence January 2014		No gaps identified	No actions required	Complete	

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Risk Number and Title	SR10 WORKFORCE TRANSFORMATION					Executive Lead:	Hazel Gunter		
Strategic Priority	Efficient, safe					Date first raised:	March 2012		
Description of Risk	Initial Score (C*L)	**What are we doing about it?** *(What are the key controls that we have implemented to assist in the delivery of this objective?)*	Current score (C*L)	**How do we know we are doing it?** *(Key assurances of the controls - include relevant reports considered by the Board or a relevant committee whereby the Board is given evidence that the controls are being effective)*	Assurance (RAG)	**What are we not doing?** *(Gaps in controls and assurances that have been identified)*	**What else can we do?** *(Include actions required to address any current gaps in controls and assurances)*	Timeframe	Target score
The proposed service changes, including reshaping HEFT, requires redesign of the current workforce - specifically in terms of appropriate skill mix. There is a risk that this is not happening fast enough to deliver the level of operational transformation that is required.	3*4 = 12	Workforce plans	3*4=12	Due to be submitted to Monitor on 31st March		No gaps identified	No actions required	Mar-14	2*3 = 6
		Workforce Transformation committee		Meets and reports monthly		No gaps identified	No actions required	Ongoing	
		Project 1: Upskilling of Band 4 nurses				Confirmed March 2014 that this project will be suspended	COMPLETE	Mar-14	
		Project 2: Supernumary ward sisters programme		Supernumary ward sisters in place with effect from October 2013		No gaps identified	COMPLETE	Complete	
		Project 3: Integration of acute and community staff to ensure flexibility of services		Monthly updates to workforce transformation committee. March update identified a number of streams of work that are progressing	⇧	No gaps identified	No actions required	Apr-14	
		Project 4: Maternity (midwifery assistants)		Maternity assistants commenced in post 31st March 2014. Maternity support workers project ongoing - initial cohort are in post and jst completing their classroom based training.	⇧	Metrics and audits to be developed	Meeting arranged with Claire Whittle to discuss	Apr-14	
		Physicians associates		6 placements confirmed and individuals to commence in post May 2014. placements have been offered verbally by HEFT. Verbal confirmation received asking that the associates be employed at the Trust after their two year placement	⇧	No gaps identified	No actions required	May-14	

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Risk Number and Title	SR13 STAFF ENGAGEMENT					Executive Lead:	Mark Newbold		
Strategic Priority	Safe, caring					Date first raised	April 2013		
Description of Risk	Initial Score (C*L)	**What are we doing about it?** *(What are the key controls that we have implemented to assist in the delivery of this objective?)*	Current score (C*L)	**How do we know we are doing it?** *(Key assurances of the controls - include relevant reports considered by the Board or a relevant committee whereby the Board is given evidence that the controls are being effective)*	Assurance (RAG)	**What are we not doing?** *(Gaps in controls and assurances that have been identified)*	**What else can we do?** *(Include actions required to address any current gaps in controls and assurances)*	Timeframe	Target score
Results from the staff survey indicates that the Trusts overall performance in terms of staff satisfaction and engagement is below the national average. There is a risk that staff may experience a reduced level of well being leading to increased staff turnover and an organisational inability to attract and retain the workforce we need to deliver our services	3*4 = 12	Emergency care pathway work	3*4 = 12	See SR2		See SR2	See SR2	Apr-14	2*2 = 4
		Trust Organisational Development plan		Monthly updates to live well work well committee		Some directorates not fully engaged with the process and slow to deliver action plans	Targetted work by OD team to work with these directorates	Jun-14	
		Kennedy project 8: Development of a clinical leader support and development programme – to help clinicians who take on these challenging roles		Monthly updates to Kennedy Task force			Terms of reference to be confirmed	Jun-14	
		Leadership role modelling		Monthly updates of Trust OD plan		No gaps identified	No actions required	Aug-14	
		Restorative clinical supervision		Monthly updates of Trust OD plan		No gaps identified	No actions required	TBC	
		E&D Workstream		Monthly updates of Trust OD plan		No gaps identified	No actions required	TBC	
		Consultant engagement activities		Monthly updates of Trust OD plan		No gaps identified	No actions required	May-14	
		Kennedy Project 9: Implementation of 'values-based' consultant recruitment – to ensure values, team working skills and behaviours are assessed, and to implement a 'compact' to describe expected behaviours		Monthly updates to Kennedy Task force		No gaps identified	Terms of reference to be confirmed	Jun-14	
		Kennedy Project 2: Further development of a Patient-Centred approach in the Trust - culture work with Sir Muir Gray		Monthly updates to Kennedy Task force		No gaps identified	Terms of reference to be confirmed	Jun-14	

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Risk Number and Title:	SR14 WINTER PLANNING					Executive Lead:	TBC		
Strategic Priority:	Safe, effective					Date first raised:	April 2013		
Description of Risk	Initial Score (C*L)	**What are we doing about it?** *(What are the key controls that we have implemented to assist in the delivery of this objective?)*	Current score (C*L)	**How do we know we are doing it?** *(Key assurances of the controls - include relevant reports considered by the Board or a relevant committee whereby the Board is given evidence that the controls are being effective)*	Assurance (RAG)	**What are we not doing?** *(Gaps in controls and assurances that have been identified)*	**What else can we do?** *(Include actions required to address any current gaps in controls and assurances)*	Timeframe	Target score
Although HEFT implemented arrangements to provide extra capacity for winter, there is a risk that the wider health economy winter planning arrangements is not sufficient to meet the demands for the coming winter, impacting on patient flow and staff engagement	4*4 = 16	Trust wide winter plans	4*4 = 16	Scrutiny and challenge events for site winter plans		Fully articulated and funded capacity plans still not in place	TBC	Aug-14	2*3 = 6
		SAFER		See SR2		See SR2	See SR2	Ongoing	
		Discussions with community and primary care partners		Reports from stakeholder meetings		Robust plans not evident from partners within the wider health economy	No actions required	Aug-14	
		Breaking the barriers with local authority and community colleagues		See SR2		See SR2	See SR2	Ongoing	

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Risk Number and Title:	SR16 BREAST RECALL PROGRAMME					Executive Lead:	Andrew Catto		
Strategic Priority:	Effective, caring					Date first raised:	April 2014		
Description of Risk	Initial Score (C*L)	**What are we doing about it?** *(What are the key controls that we have implemented to assist in the delivery of this objective?)*	Current score (C*L)	**How do we know we are doing it?** *(Key assurances of the controls - include relevant reports considered by the Board or a relevant committee whereby the Board is given evidence that the controls are being effective)*	Assurance (RAG)	**What are we not doing?** *(Gaps in controls and assurances that have been identified)*	**What else can we do?** *(Include actions required to address any current gaps in controls and assurances)*	Timeframe	Target score
A review is currently being under taken of the recall programme of breast care patients under the care of Mr Ian Patterson. There is a risk that this review will identify patient safety, reputation and financial risk for the Trust	4*4 = 16	Review of individual cases included in the previous recall programme	4*4 = 16	Weekly updates from project manager to breast recall project group and monthly updates to Executive Oversight Group. Monthly updates to Trust Board.		No gaps identified at this stage	Ensure that all relevant groups of patients have been identified	May-14	3*3 = 9
		Review of individual cases not included in the previous recall programme - to ensure that appropriate advice / treatment plans have been identified and communicated.		Weekly updates from project manager to breast recall project group and monthly updates to Executive Oversight Group. Monthly updates to Trust Board.		No gaps identified at this stage	Ensure that all relevant groups of patients have been identified	May-14	
		Implementation of robust governance arrangements to identify, escalate and manage the programme of work including an Executive Oversight Group and weekly project group		Weekly updates from project manager to breast recall project group and monthly updates to Executive Oversight Group. Monthly updates to Trust Board.		No gaps identified at this stage	No actions required	Complete	
		Communications plan developed to ensure that all relevant stakeholders are updated on progress with the programme of work						Ongoing	
		Project team in place		Weekly updates to project group from project manager		Project team needs to be adequately resourceed and the level of resource reviewed as the programme of work increases	Review existing resource and future requirements	May-14	
		Patients support group established and ongoing communications meetings in place		Weekly updates from project manager to breast recall project group and monthly updates to Executive Oversight Group. Monthly updates to Trust Board.		No gaps identified at this stage	Ensure that regular, ongoing communication is maintained and that all relevant information is communicated to the group in a timely manner	Ongoing	
		Formal reporting route established into Trust Board		Standing agenda item on monthly Trust Board meetings		No gaps identified at this stage	No actions required	Complete	

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Risk Number and Title:	SR17 GOOD HOPE HOSPITAL SITE MANAGEMENT AND GOVERNANCE AR					Executive Lead:	Richard Parker		
Strategic Priority:	Effective, safe, efficient					Date first raised:	April 2014		
Description of Risk	Initial Score (C*L)	**What are we doing about it?** *(What are the key controls that we have implemented to assist in the delivery of this objective?)*	Current score (C*L)	**How do we know we are doing it?** *(Key assurances of the controls - include relevant reports considered by the Board or a relevant committee whereby the Board is given evidence that the controls are being effective)*	Assurance (RAG)	**What are we not doing?** *(Gaps in controls and assurances that have been identified)*	**What else can we do?** *(Include actions required to address any current gaps in controls and assurances)*	Timeframe	Target score
There is a risk that the current management and governance arrangements on the Good Hope site are not sufficiently robust to proactively identify emerging performance issues on the site.	3*4 = 12	Monthly site performance and efficiency meetings	3*4 = 12	Monthly reports to site board		Meetings need to be embedded and performance dashboards developed to ensure all relevant information is being captured, escalated and managed appropriately	Review terms of reference for this group. Develop a meeting and reporting schedule and communicate to relevant stakeholders. Identify exceptions to site board for action	Jun-14	2*2 = 4
		Monthly site Quality and Safety meetings		Monthly reports to site board		Meetings need to be embedded and performance dashboards developed to ensure all relevant information is being captured, escalated and managed appropriately	Review terms of reference for this group. Develop a meeting and reporting schedule and communicate to relevant stakeholders. Identify exceptions to site board for action	Jun-14	
		Monthly site board meeting				No gaps identified	Review terms of reference and reporting schedule for this meeting		

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Risk Number and Title:	SR15 18 WEEK WAITS					Executive Lead:	TBC		
Strategic Priority:	Effective, caring					Date first raised:	April 2014		
Description of Risk	Initial Score (C*L)	**What are we doing about it?** *(What are the key controls that we have implemented to assist in the delivery of this objective?)*	Current score (C*L)	**How do we know we are doing it?** *(Key assurances of the controls - include relevant reports considered by the Board or a relevant committee whereby the Board is given evidence that the controls are being effective)*	Assurance (RAG)	**What are we not doing?** *(Gaps in controls and assurances that have been identified)*	**What else can we do?** *(Include actions required to address any current gaps in controls and assurances)*	Timeframe	Target score
Risk of failure to achieve and sustain 18 week target (90% admitted, 95% non admitted and 92% open pathways) leading to action from regulators, patient safety concerns and poor reputation	4*4 = 16	Trust 18 week plan	4*4 = 16	Monthly updates to Finance and Performance Committee		Specialty backlog plans require further development and scrutiny	TBC	TBC	TBC
						Delivery and implementation of PMS2 to address open clock issues	TBC	May-14	
						Standard procedures for scheduling of patients on admitted pathways	TBC	TBC	
						Addressing extra capacity issues relating to clearing the identified backlogs	TBC	TBC	
						Lack of operational engagement to address and manage the backlogs	TBC	TBC	
						Weekly performance updates against backlog action plans from specialities	TBC	TBC	
		18 week plan for Monitor		Submission of plan to Monitor		No gaps identified	No actions required	Apr-14	
		ECIST review and report regarding the 18 week pathway							

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Transport Strategy

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To: Board of Directors
From: John Sellars, Director of Asset Management
Date : May 2014

Title : Transport Strategy

The purpose of this report is to inform the Board of the transport strategy for the Trust which outlines current initiatives and policies which support patients, staff and visitors who work and attend our hospitals. It also outlines areas for improvement and development going forward

Summary/Key Points:

- Outlines the schemes and initiatives currently available to staff which support environmentally friendly travel and transport
- References other key policies and services which support patients, staff and visitors travel to/from hospital sites
- Identifies opportunities for areas of improvement in terms current sustainable travel schemes & initiatives
- Identifies potential schemes and initiatives for further development in respect of sustainable travel

The Board of Directors is asked to:

- Endorse and support the strategy

Resource Implications (eg. Financial, HR)

- Requires ‘buy in’ from line managers, departmental heads and staff side representatives
- Additional resources maybe required dependant on what initiatives are to be pursued

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1. AIM OF THE STRATEGY

The aim of this strategy is to outline a range of transportation methods and initiatives currently available to patients, staff and visitors who work on and attend our sites. The strategy also identifies other initiatives that could be explored in order that Trust can demonstrate its commitment to sustainability and improving the environment.

2. NHS NATIONAL CONTEXT

The NHS accounts for 5% of all road traffic in England and travel is responsible for 18% of the NHS carbon footprint in England. The Department for Transport has forecast that 'business as usual' transport related emissions in the UK will rise by 35% by 2030 and that NHS transport related emissions will match this trend unless action is taken now. The NHS SDU (Sustainable Development Unit) responsible for setting national policy in this area state that NHS organisation should be exemplar in leading the population-wide shift from sedentary travel to more active travel such as walking and cycling. The SDU go onto say that NHS organisations should explore every opportunity to reduce the time and distance travelled in scenarios whereby staff do not need to travel in the course of their duties.

3. TRUST CONTEXT

The Trust has in place a range of policies and initiatives that support the way in which patient, staff and visitors travel and access the hospital sites and were possible reduce and/or avoid travel.

The policies include:

- Trust Workplace Transport Policy
- Trust Car Parking Management Policy
- Transport Standard Operating Procedures

4. CURRENT TRANSPORT INITIATIVES & SCHEMES

This section of the Transport Strategy outlines current initiatives, schemes and support mechanisms in place within the Trust that support patients and visitors accessing hospital sites and staff who have to travel to/from their place of work throughout the course of their duties.

Car Parking

The Trust Car Parking Management policy outlines how car parking is managed across the Trust for patients, staff and visitors. Initiatives to reduce travel and promote sustainability include:

- Car sharing arrangements with an associated reduction in costs to staff of £12.50, currently there are 62 staff who have signed up for this permit
- An exclusion zone for staff who live within 2 miles of Good Hope site, i.e. such staff are not eligible for a permit
- Yardley Green Multi Storey Car park, this is to promote staff parking off the main site with the aim of reducing on site congestion at Heartlands

Public transport

The 3 hospital sites are served by a range of bus services majority of which stop on main roads immediately adjacent to hospital entrances, local train stations for Solihull and Good Hope Hospitals are within a short walking distance. Appendix C provides details of the buses

that serve the hospitals. It should be noted that Heartlands Hospital is not well serviced in terms of bus routes when comparing to Solihull and Good Hope.

The Trust web site provides a range of information for patients and visitors on how to access the sites by car and public transport and provides links to journey planning websites, local transport authority and national coach provider's websites. Local authority website also includes information on walking and cycling routes.

Inter site shuttle bus service

The Trust operates a regular shuttle bus service connecting all 3 hospital sites which runs 6 days per week, which reduces the need for staff to use their car between sites were possible. Shuttle bus times are published on the Trust intranet site and at the various drop/pick up locations around the sites, appendix A shows details of the current service.

Cycle to work scheme

The Trust operates a 'Cycle to work' scheme which provides savings to staff who wish to purchase accessories and bikes through salary sacrifice. Currently there are 97 staff that have loans being deducted from their salary and 304 bikes have been purchased by staff through the scheme since April 2010. Secure cycle compounds are also provided on all 3 hospital sites for use by both staff and visitors. A dedicated website page providing advice to staff on cycling is also available on the Trust intranet site.

Corporate travel pass scheme

A corporate travel scheme is available to all staff within the Trust which allows the purchase of annual travel passes for use on both bus and trains to be purchased by staff through payroll deduction and offers a 5% discount. There are 228 staff currently signed up to this scheme, details of the scheme are shown in appendix B.

Vehicle fleet management

The Transport Manager in Facilities regularly reviews the commercial vehicle fleet to ensure that the number of vehicles required to deliver Trust transport services are kept to a minimum. Vehicle delivery routes between sites and other healthcare organisations are also regularly reviewed to ensure that mileage is kept to a minimum.

At the 3 hospital sites electric vehicles are used by the portering teams to move goods around site and for the removal of waste thus reducing carbon emissions.

5. FUTURE INITIATIVES AND DEVELOPMENTS

This section outlines concepts and initiatives that are being developed and areas which need to be considered for improvement in terms of reducing carbon footprint relating to transport.

Car sharing

The Trust could promote car sharing further via a purpose built website which securely matches staff's location to another user as the current car sharing notice board is not well used.

Capital developments

As part of future capital development schemes there is a need to review the availability of facilities for staff who cycle to work such as changing and shower facilities.

Exclusion zones – Car Parking permit allocation

The Car parking policy could be reviewed and consideration given to implementing a 2 mile exclusion zone around Heartlands and Solihull sites which would reduce the number of staff eligible for a car parking permit relieving congestion on site.

Commercial fleet management

The Trust commercial vehicles used in the provision of transport services within the Trust is of an age whereby it has become uneconomical to repair and does not meet emissions level requirements. The fleet needs to be reviewed and lease option arrangement considered so that vehicles of both a 3 and 5 year life cycle can be replaced keeping up to date with the most environmentally friendly vehicles possible.

Remote working

Options for staff who could work remotely from other locations or from home could be promoted further as long as it supports the needs of the service. This could reduce unnecessary traffic and congestion on the hospitals resulting from staff who do not always need to be on site to fulfil their role.

Grey fleet management

An incentive scheme could be explored whereby the Trust cease's to reimburse staff mileage expenses for larger engines size's at the normal standard or regular user rate and could introduce a lower rate of reimbursement for those staff who wish to use a vehicle with a larger engine size. This would need to be pursued through the Trust management and staff consultation structure.

Future changes to public transport services

West Midlands Transport Authority as a matter of course consult the Trust on any potential changes to public transport when they are proposing changes however the Trust does not have an active voice or representation at such Transport committee's. It is therefore proposed that Facilities request the opportunity to be represented at forthcoming committees so that the Trust can influence the Transport agenda in the areas surrounding the Hospital sites.

Appendix A

Alterations to the Intersite Shuttle Service, Passenger collection point

As from Monday the 20th January 2014, the Intersite shuttle buses no longer collect passengers from outside the Pathology building. This improvement to the service will reduce the risk to passengers waiting to travel; all passengers wishing to travel between sites will be required to wait **inside the Outpatients building next to the WRVS shop**. This area benefits from being inside a warm building with seating, toilets and coffee shop.

Monday to Friday

BHH to GHH	GHH to BHH	BHH to SH	SH to BHH
7.20	6.45	6.15	6.45
9.30	8.00	7.15	7.45
11.00	10.15	9.30	10.15
12.30	11.45	11.00	11.45
14.00	13.15	12.30	13.15
16.00	14.45	14.00	14.45
17.30	16.45	16.00	16.45
19.00	18.15	19.15	19.45
	19.45		

Saturdays

BHH to GHH	GHH to BHH	BHH to SH	SH to BHH
6.45	7.45	6.45	7.45
8.30	9.15	8.30	9.15
10.00	10.45	10.00	10.45
11.30	12.15	11.30	12.15

Please note: the shuttle service does not run on Sundays and Bank Holidays.

Departure/Arrival Points:

- BHH - Outpatients
- GHH - Fothergill Entrance Canopy
- SH - South Entrance (staff car park/stores)

APPENDIX B: CORPORATE TRAVEL SCHEME PRICE UPDATE 2014

Joining the **Centro Corporate Travel Scheme** offers you great savings and convenience.

Save time – your ticket will last for 52 weeks, so no more queuing at ticket office each week to get your ticket

Save money – we offer great savings compared to monthly station purchased tickets

Hassle free – tickets are posted or issued at your workplace the week before they start saving you time and hassle

Bus and Rail – nNetwork ticket

The **nNetwork** ticket season ticket provides you with the flexibility to travel on virtually any bus, train (within your chosen zone) and Metro (if purchasing a zone 1-3 ticket or more) across the Network.

Zones	Annual Cost	Normal 4 Week Price
Zone 1	£ 745.00	£ 74.00
Zone 1-2	£ 790.00	£ 78.50
Zone 1-3	£ 900.00	£ 90.00
Zone 1-4	£ 945.00	£ 95.50
Zone 1-5	£1,015.00	£ 101.00
Zone 2-5	£ 900.00	£ 90.00
1st Class 1-5	£ 424.12	£ 45.00

TRAIN only – nTrain ticket

The nTrain ticket allows you to travel on all trains within the Network West Midlands rail Zones.

Tickets valid in Zones 5 are also valid to travel as far as Rugeley (Town and Trent Valley).

Zones	**Annual Cost**	**Normal 4 Week Price**
Zone 1	£355.00	£37.00
Zone 1-2	£380.00	£41.50
Zone 1-3	£624.00	£63.50
Zone 1-4	£712.00	£79.50
Zone 1-5	£770.00	£132.00
1st Class 1-5	£1,267.50	£142.00
Zone 2-5	£624.00	£63.50
Pre 09:30	£385.00	£63.50

If you travel from outside the West Midlands- for example from Redditch, Lichfield, Worcester plus many more destinations, then we can supply Cross Boundary tickets to meet your individual requirements. Contact the sales team at directsales@centro.org.uk **or** 0121 214 7550 for more information.

Appendix C

Bus Services for Main Trust Sites

Frequency of Bus Service Heartlands Services

Bus #	Mon - Fri Morning	Mon - Fri Daytime	Mon - Fri Evening	Sat AM	Sat Daytime	Sat Evening	Sunday AM	Sunday Daytime
73	30	30	30	30	30	30	NA	NA
28	20	20	Var	Var	20	Var	Var	Var
97	7	10	30	10	10	30	30	10
97A	8	10	30	Var	10	30	Var	20

73 Bus Service - Birmingham Centre - Heartlands - Yew Tree - Solihull
28 Bus Service - Heartlands - Erdington - Great Barr
97 Bus Service - Birmingham Centre - Heartlands Hospital - Chelmsley Wood
97A - Bus Service - Birmingham Centre - Heartlands - NEC

Frequency of Bus Service Solihull Hospital

Bus #	Mon - Fri Morning	Mon - Fri Daytime	Mon - Fri Evening	Sat AM	Sat Daytime	Sat Evening	Sunday AM	Sunday Daytime
966	30	30	60	30	30	60	60	60
957	10	15	30	20	15	30	30	20
72	30	30	Var	20	30	Var	NA	NA
71	20	20	Var	30	20	Var	NA	NA
58	15	15	NA	30	15	NA	NA	20

966 Bus Service - Solihull Hospital - NEC - Airport - Erdington
957 Bus Service - Birmingham Centre - Yardley - Sheldon - Lode Lane - Solihull Hospital
72 Bus Service - Solihull Hospital - Marston Green - Chelmsley Wood - Birmingham
71 Bus Service - Solihull Hospital - Garretts Green - Castle Vale - Good Hope Hospital
58 Bus Service - Birmingham - Yardley (Swan) - Lyndon - Solihull Hospital

Frequency of Bus Service Good Hope Hospital

Bus #	Mon - Fri Morning	Mon - Fri Daytime	Mon - Fri Evening	Sat AM	Sat Daytime	Sat Evening	Sunday AM	Sunday Daytime
914	30	30	60	30	30	60	Var	30
904	30	30	60	30	30	60	NA	60
115	30	30	NA	30	30	NA	NA	NA
71	20	20	Var	30	20	Var	NA	NA

914 Bus Service - Birmingham Centre - Pype Hayes - Good Hope Hospital
904 Bus Service - Birmingham Centre - Erdington - Good Hope Hospital
115 Bus Service - Birmingham Centre - Erdington - Good Hope Hospital
71 Bus Service - Solihull Hospital - Garretts Green - Castle Vale - Good Hope Hospital

Board Committee Reports

16.1 Audit Committee	(Enclosure)
16.2 Donated Funds Committee	(Enclosure)
16.3 Monitor Standing Committee	(Enclosure)

Audit Committee

The Audit Committee minutes of the meetings held on 27 January and 24 March 2014 have been included in the Board pack for information.

The proceedings of the January meeting were reported on by Alison Lord at the Board meeting held on 4 March 2014.

A key focus of the March meeting was preparation for the 2013/14 year end, the external audit process and preparation of the Annual Report & Accounts.

The next meeting of the Audit Committee is scheduled for 30 April 2014.

Kevin Smith
29 April 2014

AUDIT COMMITTEE

Minutes of a meeting of the Audit Committee held in the Board Room, Devon House, Heartlands Hospital on 27 January 2014

PRESENT:
Ms A Lord (Chair)
Dr J Rao
Prof L Serrant-Green

IN ATTENDANCE:
Mr R Bacon (PwC)
Ms R Blackburn (Head of Corporate Risk and Compliance)
Mr A Bostock (KPMG)
Mr S Cross (Head of Clinical Coding) (part meeting)
Mrs A Jones (Chief Financial Controller)
Dr A Keogh (Director of Medical Safety)
Ms S Richards (Head of Communications) (part meeting)
Mrs C Rymer (Operational Performance & Delivery Mgr) (part meeting)
Mr J Sellars (Director of Asset Management) (part meeting)
Mr D Sharif (KPMG)
Mr K Smith (Company Secretary)
Mrs L Thomson (Director of Public Affairs)
Mrs A Hudson (Minutes)

14.001 APOLOGIES AND QUORUM

Apologies were received from Mr Lock, Prof Peck, Mr Quinn and Dr Woolley.

14.002 MINUTES OF PREVIOUS MEETINGS

The minutes of the meeting held on 25 November 2013 were approved as a true record.

14.003 MATTERS ARISING

The Schedule of Matters Brought Forward was reviewed.

13.040 HR policy Mrs Jones advised that work was progressing with HR in relation to this matter.

13.051 Mrs Jones advised that she was working toward evidencing resolution of the outstanding IA recommendation regarding unannounced safety visits. A report to include a full updated schedule of safety visits would be presented to the Quality & Risk Committee (Q&RC). It was agreed that the Q&RC would monitor this going forward; this item could therefore be treated as discharged.

13.052 – Mr Smith advised that Mr Wootton had produced a timeframe for completion of the IT Security Audit and an Information Security Manager had been appointed who was due to commence in March. It was agreed that this item should be treated as discharged.

13.054. Mr Smith advised that he was still waiting to receive the Re-shaping

HEFT plan from Mr Hackwell, who was in the process of updating it. It was agreed that the original document was required not an updated version.

Prof Serrant-Green noted the resignation of Prof Peck and asked if plans were in hand to replace him. Mr Smith noted that the quorum for the Committee was two Non-executive Directors (NEDs), so there would be sufficient members to enable the Committee to function effectively without Prof Peck but noted that the Governors would be reviewing the need to appoint new NEDs in due course.

Internal audit tender process. Ms Lord advised that interviews had now taken place and Deloitte had been appointed subject to contract. KPMG would therefore be standing down from the end of March 2014; however there would be some overlap in order to ensure a smooth handover of outstanding items. Ms Lord extended her thanks to everyone involved in the tender process.

It was noted that all other matters brought forward would be addressed in the meeting.

Actions:

13.051 to be discharged	**KS**
13.052 to be discharged	**KS**
10.54 Mr Smith to obtain original version of HEFT Re-shaping Plan and circulate to the 'new' NEDS	**KS**

14.004 FINANCE DIRECTOR'S REPORT

Mrs Jones presented the report and it was noted that:

Monitor had released its Annual Reporting Manual which confirmed the major change for 2013/14 was consolidation of the Charitable Fund into the Trust's accounts. A meeting had taken place with PwC to discuss the Trust's approach and the key points had been agreed.

The timetable for submission would, as expected, be tight with the final submission for the Annual Report and Accounts including the Quality Account and all auditor statements and certificates being Friday 30 May 2014.

GVA had been commissioned to undertake a small revaluation exercise on the large capital build projects that had been completed during the year. There had been a transfer of circa £700k of PPE balances for community services assets from Solihull CCG.

Mr Bacon advised there were two areas that required particular attention, being the requirement to ensure that the redundancy and asbestos provisions were appropriate.

It was noted that most of the accounting policies were listed in the appendix to the report. Mrs Jones advised that further work on the accounting policies was required as a result of the need for inclusion of a policy on consolidation due to the changes associated with consolidation of the Charitable Fund; an update would be presented to the March meeting. In response to a question from Ms Lord, Mrs Jones confirmed that she had no concerns with the accounting policies.

Ms Richards was overseeing the Annual Report & Accounts (AR&A) project; a series of project meetings had been set up to ensure the document would be delivered on time.

Ms Lord noted the reduction in the number of Internal Audit recommendations completed. Mrs Jones advised that this had been as result of the additional work required for the Kennedy Review, the CQC visit and the 'Perfect Week'. Business finance consultants had been reminded to chase outstanding actions at directorate meetings. Mr Bostock advised that KPMG would be attending the Executive Management Board to push for progress on outstanding recommendations.

Ms Lord asked how the transition of outstanding actions from KPMG to Deloitte would be carried out. Mrs Jones advised that all outstanding actions would be transferred to the new database. Dr Keogh advised that the Q&RC had requested a clinical audit tracker too.

Ms Richards presented her proposal for the AR&A that was taken as read. It was noted that it had been a challenging year for the organisation and this would be reflected in the AR&A. The key topics would include the CQC inspection, the Kennedy Review and the Corporate Strategy, including the transformation work. Ms Lord and Dr Rao noted that the report sounded very negative around the challenges the Trust faced and a more balanced outlook was required including a focus on innovation. Ms Lord noted there were no contact details for members of the Executive team or NEDs. Ms Richards advised that Trust email addresses for all NEDs were currently being set up and would be published in the AR&A. Dr Keogh noted that more information on safety was required in the document.

14.005 EXTERNAL AUDITORS REPORT

Mr Bacon presented the update report that was taken as read. It was noted that the audit fees for 2013/14 had been agreed. The total fee was £84,400 a reduction of £10,000 from the previous year based on the expectation of a smoother process for the Quality Account.

14.006 INTERNAL AUDIT

14.006.1 Progress Report

Mr Sharif presented the progress report that was taken as read.

The Re-shaping HEFT Terms of Reference had been agreed and the review programme had been agreed with Simon Hackwell.

The final reports had been issued for Core Financial Systems and Charitable Funds Income with significant assurance opinions; both reports were included within the pack.

The Recruitment and Selection report had recently been issued with a limited assurance opinion and would be presented to the March meeting.

The management response was outstanding on the IT General Controls review;

the draft report carried a limited assurance opinion.

Ms Lord advised that any delays by management in accepting reports needed to be escalated to the Committee

Lack of reference to a review of Winter Plans was noted. Mr Bostock advised that it was intended be a retrospective review. Ms Lord questioned whether this would be undertaken before the end of March. Mr Bostock advised that agreement would be required as to whether this review should be undertaken by KPMG or Deloitte.

Ms Lord noted the amount of work scheduled to be undertaken before the end of March and it was agreed that Mrs Jones, Dr Keogh and Mr Bostock would discuss the content of the programme and the split of work between KPMG and Deloitte outside of the meeting.

Mr Sharif advised that there were 74 IA recommendations outstanding of which 38 had passed their due date. A discussion was held to consider how assurance could be gained that recommendations were completed and evidenced; it was agreed that going forward terms of reference should set out evidence requirements for closure of recommendations.

It was suggested that it may be better for high impact recommendations to be developed into action plans.

The Q&RC was overseeing progress of the recommendations on clinical reviews pending the arrival of Dr Catto, the new Medical Director.

Mr Bacon advised that PwC would be evaluating the recommendations on IT General Controls as part of its external audit work.

Ms Richards left the meeting

Action:

Discuss the content of the programme and the split of work between KPMG and Deloitte outside of the meeting.	**AJ/AK/ KPMG**
Consider including evidence requirements for closure of recommendations in future IA reports and action plans for high impact recommendations	**AJ/AK/ KPMG**

14.006.2 Waste Management Review

Mr Sellars joined the meeting for this item of business only.

Mr Sellars explained that the Trust had received a critical report from the Environment Agency in 2009 and subsequently asked for an IA review; he went on to provide an overview of the work that had been done over the last three years to improve and implement the Environment Agency action plan.

There were five basic recommendations in the IA report; these had been accepted and actions were underway to address them. Recommendations 1 and 2 were already complete with the recommendation 3 set to complete by the end of April 2014. Mr Sellars explained that he had requested mandatory waste management training and that the Infection Control Team was now mentioning this subject as part of its training package. Monthly waste audits were being

undertaken with results being fed back to wards. Any areas with a red rating would be audited on a weekly basis until they became compliant.

Ms Lord suggested that maybe waste management should to be part of the Ward Manager role. Mrs Thomson explained that Ward Managers nominated 'safety champions' who could pick up this agenda. Dr Rao noted that putting waste in the correct bags was also likely to save the Trust money.

It was agreed there was no requirement for further updates on this matter to be brought to the Committee.

14.006.3 Charitable Funds Review

Mr Sharif presented the report that had been issued with a significant assurance opinion. Good progress had been made against the seven recommendations set out in the 2012/13 report; four had been completed, two were partially completed and one was yet to be implemented but plans were in place to ensure completion prior to the due date.

The two recommendations for 2013/14 review were being addressed. Ongoing reviews of low value and dormant funds (and larger funds) were already being undertaken through the Donated Funds Operations Committee with account holders contacted and encouraged to use the funds they control.

It was agreed there was no requirement for further updates on this matter to be brought to the Committee.

14.006.4 Core Financial Systems Review

Mr Sharif presented the report that had been issued with a significant assurance opinion and noted that there were five recommendations, of which two were medium priority and three were low priority.

14.006.5 Recent Publications

Ms Lord referred to FT Strategic and Operational Planning Guidance and asked whether the Board should seek assurance by use of the self assessment tool to assess the quality of HEFT's strategic plans. Mrs Jones advised that the timeline from the issue of the guidance to submission of the Annual Plan was very tight but the F&PC would be reviewing a self-assessment of the Annual Plan.

Ms Lord referred to KPMG's benchmarking exercise (conducted as part of the Financial Systems Review) of the September 2013 Board Finance Report against 'Raising the Standard of Performance Reporting in the NHS: A Guide to Best Practice in Performance Reporting to NHS Boards' published by HfMA and CIMA in the context of the Trust's very brief Finance Reports to the Board. Mr Bostock explained that the guidance revolved around high level numbers for non-accountants. Mrs Jones explained that practice on Board reporting in the Trust had moved back and forth over a number of years in terms of the level of detail but that the current view was that the F&PC had visibility of much greater detail and could therefore provide assurance to the Board.

14.007 IA TERMS OF REFERENCE - RE-SHAPING HEFT REVIEW

Mr Sharif summarised the proposed updated terms of reference for this review. The four projects from the Reshaping HEFT portfolio of 13 projects would be selected to determine the strengths and weaknesses of the approaches taken and the progress made.

Ms Lord asked for greater understanding of the work streams and Prof Serrant-Green asked for clarification of how the work streams were linked.

Action:
Report back on Re-shaping HEFT work streams subject to review and their linkage. **KPMG**

14.008 COUNTER FRAUD PROGRESS REPORT

The report was presented and taken as read. Mr Sharif advised that the team had received one additional referral since the report was prepared and was liaising with Mrs Jones on how to take this forward. .

Ms Lord referred to HEFT 038 and asked for clarification of the issue as, on face value, this seemed to be a normal HR issue.

Action:
HEFT 038 Provide greater clarity of the issue and why it was reported. **KPMG**

14.009 CLINICAL CODING – PROGRESS REPORT

Mr Steve Cross and Mrs Claire Rymer joined the meeting for this item of business only.

The report set out the position in relation to Information Governance Requirement 505 regarding Clinical Coding. The Trust was currently achieving level 2 and working toward level 3. All coders were assessed to ensure they were achieving satisfactory standards and were performance managed where necessary. It was noted how important it was to ensure that patient notes were well written in order to improve coding and clinicians and nursing staff needed to own the data in order to improve coding. Ms Lord noted the marked improvement overall in clinical coding and that Q&RC would be monitoring progress going forward.

It was agreed there was no requirement for further updates on this matter to be brought to the Committee.

14.010 COMMUNITY SERVICES INTEGRATION REPORT –PROGRESS REVIEW

Mrs Thomson presented an overview of her report that was taken as read and it was noted that:

Therapies and the management team were now fully integrated. Ambulatory care and the frail elderly work had seen slow progress but work was progressing. A re-design of the clinical services was underway in order to match the estate and

service requirements. The offices in Union Road had been vacated. Judith Davis's role had expanded to support and to improve Community Services across all three hospital sites and she now reported to Simon Hackwell, Director of Strategy. The next steps included understanding and developing the Urgent Care Model at Solihull Hospital. Solihull was beginning a three month pilot to trial seven-day working across all services. It was noted that funding for the Dementia Ward would cease at the end of March and work was underway to design a new service model to better suit the needs of patients.

Prof Serrant-Green asked if a full evaluation of all models (e.g. GHH hospital at home) had been undertaken; Mrs Thomson advised that a review was underway and this would help inform future developments for the Trust going forward with the findings being presented to the F&PC for further consideration. Prof Serrant-Green was keen that sight wasn't lost of the overall impact and noted the importance of patient experience.

14.011 INFORMATION GOVERNANCE REVIEW - UPDATE

Mr Smith presented the paper updating the Committee on action that had been taken relating to Information Governance since the last meeting in order to provide assurance that the process and controls were robust and advised that KMPG were due to commence an IA review of IG shortly.

14.012 KENNEDY REVIEW – ACTIONS

Mr Smith presented the paper that was taken as read and it was noted that following the launch of the Kennedy Report in December 2013 the Board had committed to respond to the recommendations set out in the Report and identified ten director led actions to respond to the principal recommendations. The Trust had appointed a dedicated Project Manager, Richard Brown, who would report monthly on progress to the Task Force, chaired by Lord Hunt. The next steps included drawing up detailed plans for each of the action work streams.

It was agreed that Mr Brown should report to the Committee and provide evidence of progress for each of the work streams.

Action:
Arrange for Richard Brown to report progress to future Committee meetings. **KS**

14.013 ANY OTHER BUSINESS

Ms Lord advised that she had asked each of the Chairs of the Board Committees to present an annual update in order that the Audit Committee could gain assurance on the work of those committees.

Dr Rao had agreed to present a report for the Q&RC and he circulated a paper setting out the work and priorities for the Q&RC that were broken down into four categories (1) Patient Safety, Harm and Risk, (2) Effective Care, (3) Professional regulation and (4) Regulatory compliance. Dr Keogh advised that the Terms of Reference for the Q&RC were also to be reviewed.

Prof Serrant-Green was concerned that the HR Committee had been disbanded

and questioned how assurance could be gained that HR matters (e.g. Equality & Diversity) were being picked up within the existing committee structure. Mrs Jones advised that standard HR reports were now picked reported through the F&PC and the Q&RC. Mrs Thomson agreed to take this concern away and report back to a future meeting.

Action:
Bring back a report on reporting lines for HR matters (including E&D). **LT**

14.014 PROPOSED MEETING DATES

Mr Smith presented the schedule of proposed meeting dates for 2014/15 which were agreed with the exception of the March meeting which would take place on Monday 24th March at 10am.

Action:
Re-arrange the March meeting date, book venue and circulate details. **KS/AH**

14.015 DATE OF NEXT MEETING

24th March 2014, 10.00am Boardroom, Devon House, Birmingham Heartlands Hospital.

.....
Chairman

AUDIT COMMITTEE

Minutes of a meeting of the Audit Committee held in the Board Room, Devon House, Heartlands Hospital on 24 March 2014 at 10.00am

PRESENT:
Ms A Lord (Chair)
Mr D Lock
Dr J Rao
Prof L Serrant-Green

IN ATTENDANCE:
Mr R Brown (Kennedy Task Force)
Ms R Blackburn (Head of Corporate Risk and Compliance)
Mrs S Bradshaw (Minutes)
Mrs A Jones (Chief Financial Controller)
Dr A Keogh (Director of Medical Safety)
Ms S Richards (Head of Communications) (part meeting)
Mr D Sharif (KPMG)
Mr J Sawyers (KPMG)
Mr J Howse (KPMG)
Mr K Smith (Company Secretary)

Mr T Jones (Finance Graduate – observer)

14.016 APOLOGIES AND QUORUM

Apologies were received from Mr R Bacon, Mr A Bostock, Prof E Peck, Mr A Quinn, Mrs L Thomson and Dr S Woolley.

14.017 MINUTES OF PREVIOUS MEETINGS

The minutes of the meeting held on 27th January 2014 were approved as a true record.

14.018 MATTERS ARISING

The Schedule of Matters Brought Forward was reviewed.

13.040 Mrs Jones reported that the HR policy was being reviewed and a further update would be given at the next meeting. Ms Lord reminded the Committee that the reason the request for a change had come about was a subordinate signing off a more senior member of staff's time sheet and that the Committee simply required assurance that a suitable change had been made to the policy to stop any recurrence.

Action: Confirm suitable change has been made or HR to attend meeting with explanation (AJ)

13.048 Ms Richards reported that the next draft of the Annual Report together with the draft Quality Account would be circulated to the Non-executive Directors shortly, once the Executive Directors had reviewed the content.
13.049 Dr Rao explained that he had previously reported back on the performance monitoring and data quality assurance that would be considered by the Q&RC for the Quality Account. Ms Lord emphasised the need for verification of the Quality Account content. The action was closed.

13.054 The reshaping HEFT document had been circulated.

13.057 This action would transfer from KPMG to Deloitte.

14.006.1 Mrs Jones had met with Deloitte to discuss the split of work between KPMG and Deloitte. Deloitte would come to the next meeting with a draft plan of reviews to progress immediately and a full work plan would follow later in the year. All outstanding clinical reviews were underway except the review relating to mortality. Ms Lord reminded KPMG that they should carefully consider what evidence was required for closure of recommendations in new reports.

Mrs Jones reported that compatibility tests were currently being conducted between the two IA databases; the plan was to switch to the Deloitte database at the end of April.

14.007 The report on re-shaping HEFT would come to the next meeting.

14.008 A useful e-mail had been received regarding HEFT 038; this issue was now closed.

14.013 Ms Lord asked that a senior HR representative be invited to address the question of reporting lines for HR matters at the next meeting.

Action: Invite H Gunter to next mtg (KS)

14.019 FINANCE DIRECTOR'S REPORT

Mrs Jones referred to the pre-circulated report and commented on the status of the annual accounts. The accounts were on track with the initial FTC and accounts submission due on 23rd April and the final submission due 30th May.

Mrs Jones highlighted the following:

- The new consolidation accounting requirements had been reviewed with PwC; no particular problems were anticipated.
- An increase in the asbestos provision was proposed from £1.5m to £6.5m based on external review.
- There would be a MAR scheme provision; the scheme had been opened for a limited period.

There was discussion around the appropriateness of re-opening the MAR scheme given current clinical staff shortages. Mrs Jones noted that the scheme was generally aimed at non-clinical areas and that each case had to be supported by a 'business case' for re-organisation and a reduction in headcount. Mr Lock noted that the NHS had not been good at ensuring that staff reductions weren't subsequently backfilled. Dr Rao outlined the checks and balances, being removal of budget for the leaver and no scope to fill the position unless a fresh business case was presented. Mrs Jones pointed out that the Trust's EVAS system did not allow overspend on substantive staff; however, overspend was possible with agency staff and locums. Ms Lord asked that Ms Gunter be invited to the next meeting to provide assurance that MARS exits weren't subsequently being backfilled and to describe what

Action: H Gunter to be asked to provide assurance on MARS issues (KS)

controls were in place and audits undertaken to ensure this didn't happen.

Ms Richards referred to the pre-circulated first draft of the 'front end' of the Annual Report and undertook to provide a cover sheet with future drafts to explain what was being asked of the Committee. As the 'front end' currently contained significantly more copy than the previous year some editing would be required. Ms Richards acknowledged that assurance would be required for the data in the final version of the document.

Mr Lock expressed the view that whilst the copy provided was the basis for a good document he would prefer that the themes were laid out more clearly and a strong focus on the Trust's strategy, given the changes and challenges the Trust was facing; he suggested that a section called 'The Board's Vision' be developed to cover the high level message that the Trust was going to change radically over the next two-to-three years and pick up the 'big picture' around the health economy, commitment to best care for patients and structural change. Ms Richards acknowledged this and confirmed that this would likely come from the work that she would be doing on the document with Dr Newbold.

Mr Lock questioned the value of the article explaining the process design team's work and noted that it provided too much detail. Ms Richards explained that the contributors had been given the 'key messages' but not a style guide which may explain this. This led to a discussion around the document's audience; namely Parliament, the DoH, Regulators, CCGs, MPs, Councillors, Governors, patients, the public and potential future employees, and the suggestion that the copy needed to be more externally facing. Ms Lord noted that the document should be engaging for staff too. The Trust also needed to be conscious of how the press might re-package and communicate the content.

Ms Lord asked that the jargon be explained and the promised actions be examined to ensure that they were deliverable, so that expectations were not raised unreasonably.

Prof Serrant commented that she found the report 'dry'. She felt that it didn't demonstrate the level of engagement provided by the NEDs and portrayed them as only attending Board meetings; she suggested that the part-time nature of the NED's role should also be explained and contrasted with the EDs role.

Prof Serrant added that there was little information about equality and diversity. Mr Lock observed that the Trust's staff survey results were not good.

Dr Keogh observed that the most up to date position on the CQC visit and the Trust's mortality spike should be included to provide a balanced view. Ms Lord commented that, in particular, the Good Hope section didn't appear to mention the CQC Warning Notice.

Dr Rao felt that the report should contain shorter, punchier messages to keep the attention of the reader but acknowledged the need to cover statutory content. He suggested considering the use of some patient stories with relevant pictures.

It was acknowledged that time constraints may make it impossible to cater for all of the foregoing suggestions.

14.020 QUALITY ACCOUNT - UPDATE

It was agreed that this had effectively been covered in the previous item. Ms Blackburn would circulate the draft Quality Account shortly and be grateful for high level constructive feedback.

14.021 EXTERNAL AUDITORS REPORT

This pre-circulated paper provided a progress report on the year end work.

Mr Howse outlined the key points:

- The interim audit in February had progressed well with no significant issues to report.
- PwC was developing its audit approach; including provision for the use of computer assisted audit tools, its approach to testing accruals, year-end adjustments and management estimates.
- Consideration was being given to regulatory matters (Monitor Undertakings and CQC reports) but no significant issues had been identified yet in relation to their impact on the audit. Mrs Jones acknowledged that a Monitor breach could affect the audit position.

In response to a question from Mr Lock regarding the testing of income samples, Mr Howse explained that these related to both the JMRA and other income sources.

Ms Lord referred to the issue of the commissioning of £50,000 work from the auditors, without prior approval of the Committee. Mrs Jones clarified that this related to work authorised by the Committee in the previous year but carried out in the current year.

14.022 INTERNAL AUDIT

Progress Report

Mr Sharif confirmed that the five outstanding reviews were expected to be completed in the next few weeks and reported to the next meeting.

There were 77 outstanding recommendations at 11 March, 35 of which were passed their due dates.

In relation to the two outstanding high priority recommendations, Mrs Jones reported that (1) a significant amount of evidence had been received from Mrs Thomson regarding completion of the community services integration action but this needed to be reviewed, and (2) Deloitte would be providing risk management training to the Board during the summer.

Dr Rao questioned one of the oldest yet to be completed recommendations regarding clinical outcomes and whether the action might have become irrelevant with the passage of time, also whether the owners even understood what was required to complete them. Mr Sharif offered to send Dr Rao the report with the original recommendations. Mrs Jones noted that there had been two changes of Medical Director since the recommendation was raised.

IT General controls audit

Mr Sharif said that several of the recommendations had been identified in previous reviews. Ms Lord questioned whether KPMG were happy with the responses received from management as they seemed to lack rigour.

Mr Lock was concerned by the possibility of ex-employees still having access to Trust IT systems.

Ms Lord requested that Mr Laverick be invited to the next meeting to discuss the report.

Action: Invite A Laverick to next mtg (KS)

Risk management

Ms Lord explained that she felt that the report concentrated too much on the use of Datix and failed to focus on whether the Board was looking at the right risks. The revised BAF had not yet been seen by the Board and would need to take into account the Trust's new strategic objectives, to identify the key risks. This area would be subject to an early re-review by the new internal auditors.

Ms Lord acknowledged that a Board session on risk would be very useful.

Mr Sharif noted that the implementation of Datix had been helpful. Dr Keogh acknowledged, as a user, that Datix was a powerful tool.

Recruitment and Selection review

Deferred until next meeting when Ms Gunter would be present.

Action: Invite H Gunter to next mtg (KS)

14.023 KENNEDY REVIEW

Mr Brown outlined the ten Kennedy Work Streams, which had each assigned a Board level lead and executive support. The timescale of 5-6 months had been set to achieve solid progress that could subsequently be built upon. The Board was keen to demonstrate achievable outcomes and real progress.

The Kennedy Task Force overseeing the Work Streams was currently being chaired by Lord Hunt who agreed to remain longer with the Trust than previously planned for this purpose. The overall approach is to ensure that the Work Streams have clear objectives.

The ten Work Streams were:

- Whistleblowing policy
- Patient centred culture
- A review of the Terms of Reference for Quality and Risk Committee
- Consent policy
- Flows of information to the Board
- Improving the patient environment
- Disciplinary policy
- Leader support
- Values based recruitment (reviewing consultant recruitment)

- Development of a protocol for a patient centred recall

Mr Brown explained that there were issues around resource, especially in relation to the Work Streams led by NEDs. Some Work Streams were making better progress than others.

The Breast Cancer Support Group formed in the wake of the Ian Patterson issue were working with the Trust on some of the Work Streams.

Mr Brown would share his reports to the Task Force with the Audit Committee going forward.

14.024 ANY OTHER BUSINESS

None.

14.015 DATE OF NEXT MEETING

30th April 2014, 10.00am Board Room, Devon House, Birmingham Heartlands Hospital.

.....
Chairman

Donated Funds Committee

The Donated Funds Committee minutes of the meeting held on 17 January 2014 have been included in the Board pack for information.

The proceedings of the January meeting were reported on by Les Lawrence at the Board meeting held on 4 March 2014.

The next meeting of the Donated Funds Committee is scheduled for 23 May 2014.

Kevin Smith
29 April 2014

Minutes of a meeting of the Donated Funds Committee of Heart of England NHS Foundation Trust held in the Boardroom, Devon House, Birmingham Heartlands Hospital on 17th January 2014

PRESENT: Mr P Hensel (Chairman)
Mr A Fletcher
Mr L Lawrence

IN ATTENDANCE: Ms A Evans
Mrs E Hale
Mrs A Jones
Mr D Richardson (part mtg) (Investec)
Mr K Smith (Secretary)
Mr M Turner (part mtg) (Investec)

14.001 APOLOGIES

Apologies had been received from Mr Quinn and Mrs Thomson.

14.002 MINUTES OF PREVIOUS MEETING & MATTERS ARISING

The minutes of the meeting held on 18th October 2013 were approved as a true record.

The only matter brought forward but not otherwise covered by the agenda was 13.043.1, in relation to which, Mrs Hale confirmed that letters had been sent to staff involved in arranging for stall holders to visit sites.

14.003 INVESTMENT MANAGER PRESENTATION

Mr Richardson and Mr Turner joined the meeting for this item of business only and presented the pre-circulated Investec Wealth & Investment Limited (Investec) report.

It was noted the longer term nature of the Charity's objectives allowed for a medium risk strategy to achieve a desired return over the longer term. Particular attention was drawn to the different strategy options (numbered 1-6) and asset class ranges. It was noted that Investec recommended option 4 if there was flexibility to accept a greater proportion of equities than the original brief given in the procurement exercise (30%); this would offer an initial income yield of 3% plus capital growth. Bonds included gilts and investment grade corporate bonds, which Investec recommended holding as a dampener against the equity volatility risk.

Investec was comfortable to cap the combined holding of UK and overseas equities at 65%.

Investec's remuneration was calculated as a percentage of the value of the assets under management and was not linked to transaction levels.

Measurement of performance against bespoke benchmarks based around the proposed asset allocation was discussed, together with a longer term view of performance against inflation.

14.004 INVESTMENT ADVISOR PROPOSAL

The pre-circulated proposal for performance monitoring and portfolio analysis from Marlborough Investment Management Limited (Marlborough) was considered.

The proposal was approved subject to agreement by Marlborough to a fixed fee of £2,800 for an initial term of one year with an option for the Charity to renew thereafter for a further year. Any one member of the Committee or the Secretary were authorised to negotiate and conclude these terms with Marlborough.

14.005 INVESTMENT POLICY

The Committee considered the recommendations made by Investec earlier in the meeting and discussed the risk/reward appetite of the Committee together with the longer term objective of achieving a reasonable return compared to the return on UK equities whilst not subjecting the assets under management to an excessively high level of volatility. The importance of achieving a level of income yield that covered the Charity's administrative costs was also noted.

After careful consideration it was resolved to instruct Investec to invest the assets with the objective of seeking a balanced return between income and capital growth, in accordance with Option 4 as set out in on page 9 in Investec's presentation, subject to the ranges set out on slide 10 with an absolute cap of 65% on all equities and a targeted yield of 3% (£200,000), for budgetary purposes, plus capital growth. Furthermore, Investec should not knowingly invest in companies whose business was based directly on tobacco and/or tobacco related products.

It was also agreed that Investec should be asked to propose appropriate benchmarks, based on this investment strategy, which would be reviewed with Marlborough prior to presentation to the Committee.

14.006 FUNDRAISING REPORT

Mrs Hale presented the pre-circulated fundraising report and noted that the function was now almost back to a full complement of staff. Whilst performance was behind plan, it was catching up and legacies, grants and fundraising year-to-date were ahead of the previous year's positions. Grant income was expected to perform significantly better in the following year.

Project Pelican had not progressed but the Executive Management Board had asked for options to be brought forward.

A new agency community fundraiser was in post and having a significant positive impact. There was generally a positive feeling in the team.

There were currently seven live appeals; Mrs Hale wished to increase this number to give potential funders more choices.

14.007 FINANCIAL REPORT

Mrs Jones referred to the pre-circulated report and noted that total income of £1,149k year to date was £314k behind plan but expenditure of £1,244k year to date was £894k behind plan, therefore the Charity had spent £95k more than income received but this had generated a £580k positive variance against plan.

A gain on the revaluation of investments of £421k had been recorded.

£1.5m was held in the RBS deposit account, for liquidity, currently bearing interest at 0.92% p.a. Total funds (including cash deposits) at 31st December 2013 amounted to £8,906k.

A large legacy of £140k had been received from the estate of Jeremy Winchcombe for Good Hope General Purpose Fund.

A review with the key fundholders confirmed that they all had plans in place. It was agreed that there was no need for the Committee to review proposals from the three site General Donated Funds below the £100k threshold but fundholders could seek guidance from the DFOC on proposals if they wished to.

Mrs Jones undertook to clarify a request for expenditure from the Leukaemia and Cancer Research Fund regarding commitments for a Researcher and a Nurse Educator over a two-year period, although the proposal was approved in principle.

A KPMG Internal Audit review confirmed significant assurance on the charitable funds finance function. There were two new recommendations that had been accepted. Three recommendations from the previous review were outstanding but two were near completion.

Mrs Jones had undertaken to share HEFT's capital planning schedule to highlight items that the Charity might fund.

Mrs Hale reported that the Donated Organs team had requested support to fund organ prolonging equipment that would cost around £80k; the proposal was for the charity to fund £40k across the three site general purpose funds, matching the £40k that would be funded from the ITU fund. The proposal was approved.

14.008 OPERATIONS COMMITTEE REPORT

Mr Smith reported that the Operations Committee had met informally on 6th December 2013 and 10th January 2014 and the related Actions Log was noted.

14.009 RISK REGISTER

The pre-circulated paper was noted. Risks 6 and 7 had been added as non-financial risks. Risks 4 and 5 could now be removed following the decisions regarding investment policy that had been taken during the meeting.

14.010 INDEPENDENCE UPDATE

Mr Hensel reported that the DoH still hadn't issued its guidance although it was expected soon.

It was noted that the Steering Group meeting had been deferred to March but that it could meet to consider 'back office' issues even if the DoH guidance wasn't available.

14.011 ANY OTHER BUSINESS

There was none.

14.012 DATE OF NEXT MEETING

23rd May 2014

.....
Chairman

Monitor Standing Committee

The Monitor Standing Committee minutes of the meetings held on 31 March and 25 April 2014 have been included in the Board pack for information.

The March meeting considered and approved the Operational Plan (2014/15-2015/16) for release to Monitor.

The April meeting considered and approved the Quarter 4 Return for release to Monitor.

The next routine meeting of the Monitor Standing Committee is scheduled for 25 July 2014.

Kevin Smith
29 April 2014

Minutes of a meeting of the Monitor Standing Committee of the Board of Heart of England NHS Foundation Trust held in the Board Room, Devon House, Heartlands Hospital on 31st March 2014

PRESENT:	Lord Hunt	*(Chairman)*
	Mr L Lawrence	
	Dr M Newbold	
	Dr J Rao	
	Mrs L Thomson	
IN ATTENDANCE:	Mr K Smith	*(Company Secretary)*
	Mr J Gould	*(Operations Director - Finance)*
	Mr S Hackwell	*(Commercial & Strategy Director)*
	Dr A Keogh	*(Director of Safety)*

14.06 APOLOGIES & WELCOME

Apologies were received from Mr A Quinn; Dr Woolley was on leave.

The Chairman welcomed Mr Hackwell and Mr Gould who had been invited to present the Operational Plan 2014-16 (the Operational Plan).

14.07 MINUTES OF THE MEETING HELD ON 31 JANUARY 2014 & MATTERS ARISING

The minutes of the meeting held on 31 January 2014 were approved as a true record. There were no matters arising.

14.08 APPROVAL OF MONITOR OPERATIONAL PLAN

It was noted that the Operational Plan was required to be submitted to Monitor by 4th April 2014 and that an additional submission of the Strategic Plan for years 3-5 was required by 30th June 2014.

The Board and the Council of Governors had previously considered the Trust's updated strategic plan and its underlying assumptions, which were reflected in the Operational Plan. The Committee had been convened to give final approval to the Operational Plan prior to submission to Monitor.

The pre-circulated papers were then considered.

The Trust's five year strategy had concentrated on the acute models of care and run alongside other work streams that had been included in the Re-shaping HEFT programme that had been running for several years. The strategy recognised that radical transformation was needed to deliver a clinically and financially sustainable organisation. The key themes of the strategy were:

- Transforming acute care
- Investing in out of hospital services
- Becoming recognised as providing outstanding services
- Developing a more distinct identity for the Trust's hospitals
- Creating a truly patient centred culture

These plans would ultimately develop a reduced acute footprint, a reconfigured surgical service, an integrated health and social system in Solihull and an 'outstanding' CQC rating. By improving the way services were delivered, efficiencies would be achieved leading to cost reductions to support the Trust's financial security. Plans had already been put in place to start the transformation programme.

The Trust also had plans to address some key aspects of quality and safety of care that had been highlighted by the CQC visit in November 2013, the Kennedy Report in December 2013 and the patient flow issues identified as part of the Monitor Undertakings in January 2014.

The financial plan was deliver a small surplus (£2m) each year, which reflected a combination of small income growth and a challenging efficiency programme. The Trust would continue to invest in a significant capital programme to support the strategy. The Trust would maintain a COSR rating of at least 3 across the Operational Plan period.

In response to a question from the Chairman, Dr Newbold confirmed that whilst contract terms for 2014-15 had not yet been agreed with all of the CCGs, the Operational Plan reflected management's expectation of the outcome of negotiations. Clearly this represented a risk, so it was agreed that Mr Gould would add language in the submission explaining the assumptions made.

Dr Rao expressed surprise regarding the plan to eliminate agency/bank staff costs; Mr Lawrence explained this was a necessary part of reducing staff costs.

Mr Hackwell undertook to add some language around Better Care Fund initiatives.

Mr Lawrence drew attention to the 'place holder' for words to be added regarding CQUINS.

It was agreed that Mr Gould should add more to the Executive Summary regarding the messaging around the need for reductions in capacity within the hospital environment.

A small number of typographical corrections were noted.

After due and careful consideration, subject to the revisions outlined above, the Operational Plan was approved for submission to Monitor.

14.09 ANY OTHER BUSINESS

There was none.

14.10 DATE OF NEXT COMMITTEE MEETING

25th April 2014

.....
Chairman

Minutes of a meeting of the Monitor Standing Committee of the Board of Heart of England NHS Foundation Trust held in the Boardroom, Devon House, Heartlands Hospital on 25 April 2014

PRESENT:	Lord Hunt	*(Chairman)*
	Mr L Lawrence	
	Dr M Newbold	
	Mr A Quinn	
	Dr J Rao	
	Mrs L Thomson	
IN ATTENDANCE:	Mr K Smith	*(Company Secretary)*
	Dr A Keogh	*(Director of Safety)*

14.11 APOLOGIES

There were none.

14.12 MINUTES OF THE MEETING HELD ON 31 MARCH 2014 & MATTERS ARISING

The minutes of the meeting held on 31st March 2014 were approved as a true record. There were no matters arising.

14.13 APPROVAL OF MONITOR QUARTER 4 RETURN

Mr Quinn confirmed that the Monitor Q4 Return had been completed in accordance with the Compliance Framework.

The meeting reviewed the pre-circulated papers and the following points were noted.

Finance

In quarter 4 a COSSR of 4 was reported:

- In the fourth quarter of the financial year the Trust had reported a deficit of £8.9m. This was £10.4m adverse to the planned surplus for the quarter. The full year deficit of £5.4m was £11.4m below the planned surplus. The outturn was after recording a fixed asset impairment charge of £4.8m and providing for costs arising out of the Kennedy Review of £4.2m. If these one off costs were excluded the Trust was recording a normalised full year surplus of £3.6m, £2.4m below plan.

- The Trust had continued to contract with its commissioners using a Jointly Managed Risk Agreement (JMRA). The JMRA gave the Trust greater certainty over the vast majority of its income (and the wider health economy some certainty over its costs). This puts a real focus on demand management and the control of operating costs to improve margins and bring costs into planned levels during this financial year.

- In quarter 4 overall operating income was £7.2m favourable to the plan. This was offset by operating costs £15.8m over plan. For the full year the favourable operating income variance of £13.2m was offset by operating costs £23.8m over plan.

- This adverse operating variance was offset by a significant underspend on depreciation and PDC dividends as a result of capital underspends and downward revaluations of the Trust's fixed asset base. Depreciation was below plan by

£5.0m for the quarter and the year to date. Non-operating expenses were below plan £2.1m for the quarter, £3.1m for the year to date due to the underspend on PDC dividends as a result of lower than expected capital balances and due to change in PDC calculation rules.

- The Trust's liquidity remained strong. Cash and investment balances of £86.7m were ahead of plan by £5.0m. Due to the change in PDC rules the Trust no longer invested cash outside the Government Banking Service (GBS) umbrella. This had resulted in a sharp reduction in interest receivable (just £0.4m compared to an outturn of £1.9m in FY2013) though this had been planned for. This was offset by the reduction in PDC payable.

- While some of the operating cost overspend was due to higher than planned activity levels, the Trust continued to recognise that there was a significant challenge that needed to be addressed due to increased medical and nurse staffing expenditure and delays in delivering agreed CIP plans. Extra costs were being incurred in maintaining extra capacity and addressing A&E waiting targets whilst the Trust took steps to improve patient flow across all three sites.

- The Trust had recently submitted the initial part of the Annual Plan for 2014/15 and 2015/16 wherein a surplus of £2m was forecast in 2014/15.

Governance

The Trust was declaring a red governance risk rating due to the failure to achieve the four hour A&E waiting target for seven consecutive quarters.

The Trust was also declaring non-compliance with the C difficile target where the challenging full year target of 68 cases has been exceeded with 82 cases. Work continued to deliver improvement and a quarterly review of all cases was undertaken with CCG colleagues, which had been able to identify that a number of the cases had been unavoidable. At quarter 3, 43 of the 67 cases were unavoidable. The Q4 review was currently being undertaken.

In line with national reporting deadlines, the Trust's performance against cancer targets had not yet been fully validated for the quarter. The results in the return were provisional and fully validated results would be notified in May. At this stage it was known that the Trust would not hit the two week targets for both breast cancer and other cancers. There had been a significant increase in referrals to the breast cancer service following a national awareness campaign and to lung and prostate cancer services due to awareness campaigns.

The Trust had failed to meet the 18 week admitted referral to treatment target in line with a managed failure plan. The plan had been reassessed and the remaining backlog would result in a failure in Q1 2014/15. This had already been shared with Monitor.

The Trust also provided supplementary Governance Information which included three new SUIs, four HMC cases with the potential for an adverse verdict, two information Governance breaches and information on an unannounced CQC inspection at Good Hope Hospital in February 2014. Dr Keogh explained that the Four HMC cases had subsequently gone through without issue.

The Board was expected to sign a new combined governance statement. This would confirm three things:

The Board anticipated that the Trust will continue to maintain a Continuity of Service Risk Rating of at least 3 over the next 12 months;

the Board was satisfied that plans in place were sufficient to ensure: ongoing compliance with all existing targets (after the application of thresholds) as set out in Appendix A of the Risk Assessment Framework; and a commitment to comply with all known targets going forwards; and

the Board would confirm that there were no matters arising in the quarter requiring an exception report to Monitor (per the Risk Assessment Framework page 21, Diagram 6) which had not already been reported.

The Board would have to highlight in the governance statement any exceptions to the confirmations noted. As noted above, disclosure would be required of the further planned failure of the 18 week admitted RTT in Q1 2014/15.

Dr Keogh undertook to provide additional content regarding the lifting of the CQC Warning Notice in respect of Good Hope Hospital and a NHRA investigation into the conduct of trials where there had been two critical findings.

Mr Quinn was also asked to make it clearer in the covering letter to Monitor where the Trust was missing the 18 week targets and that the Trust had plans in place to rectify the situation by quarter 2 2014/15.

Following due consideration of the requirements for signing the compliance statement, the Committee approved the Q4 Return, subject the matters described above.

14.14 ANY OTHER BUSINESS

There was none.

14.15 DATE OF NEXT COMMITTEE MEETING

25th July 2014

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Chairman

Apologies	**Declaration of Interest**	**Minutes**	**Matters Arising**	**Chairman's Report**	**Council of Governors Report**	**Chief Executive's Report**	**Safety, Quality and Org. Dev.**	**Patient and Public Feedback**	**Finance and Performance**	**External and Strategic Review**	**Nursing, Midwifery care staffing capacity**	**Equality and Diversity**

Board Assurance Framework	**Transport Strategy**	**Board Committee Reports**	**Any Other Business**	**Part Two**

Any Other Business

Board of Directors

May 2014

PART TWO

Reports from Committees

The Board will be asked to resolve

"That representatives of the press and other members of the public be excluded from the remainder of the meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest"

Date and Venue of next meeting

3 June
Venue to be advised

Apologies | Declaration of Interest | Minutes | Matters Arising | Chairman's Report | Council of Governors Report | Chief Executive's Report | Safety, Quality and Org. Dev. | Patient and Public Feedback | Finance and Performance | External and Strategic Review | Nursing, Midwifery care staffing capacity | Equality and Diversity

Board Assurance Framework | Transport Strategy | Board Committee Reports | Any Other Business | Part Two

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