AGENDA

for a meeting of the Board of Directors of Heart of England NHS Foundation Trust to be held in the Harry Hollier Lecture Theatre, Good Hope Hospital on 11 May 2016 at 12.30pm

12.30 NOON – 2.10PM:		Indicative Timings (Minutes)	
1.	**APOLOGIES**	1	*(Oral)*
2.	**APPOINTMENT OF MEDICAL DIRECTOR – RATIFICATION** (JS)	1	*(Enclosure)*
3.	**DECLARATIONS OF INTEREST**	1	*(Enclosure)*
4.	**MINUTES** – 2 MARCH 2016	2	*(Enclosure)*
5.	**MATTERS ARISING** (KS)	2	*(Enclosure)*
6.	**CHAIR'S UPDATE** (JS)	5	*(Oral)*
7.	**CHIEF EXECUTIVE'S UPDATE** (DJM)	5	*(Oral)*
8.	**PERFORMANCE REPORT** (KB)	15	*(Enclosure)*
9.	**CLINICAL QUALITY REPORT** (DR)	10	*(Enclosure)*
10.	**CARE QUALITY REPORT, INCL. INFECTION CONTROL** (SF)	10	*(Enclosure)*
11.	**NURSE STAFFING REVIEWS** (SF)	5	*(Enclosure)*
12.	**2015 NATIONAL STAFF SURVEY RESULTS** (HG)	5	*(Enclosure)*
13.	**FINANCE REPORT, INCL. FINANCIAL RECOVERY PLAN** (JM)	10	*(Enclosure)*
14.	**CORPORATE IDENTITY** (FA)	5	*(Presentation)*
15.	**BOARD COMMITTEE MINUTES & REPORTS**	5	
	15.1 Audit Committee (6.05.16) (KK)		*(Oral)*
	15.2 Donated Funds Committee (21.04.16) (JS)		*(Enclosure)*
	15.3 Monitor Standing Committee (29.04.16) (JS)		*(Enclosure)*
16.	**MODERN SLAVERY ACT** (KS)	3	*(Enclosure)*
17.	**QUALITY COMMITTEE - TERMS OF REFERENCE – FOR APPROVAL** (JS)	2	*(Enclosure)*
18.	**BOARD BUSINESS PLAN 2016/17 – FOR APPROVAL** (JS)	3	*(Enclosure)*
19.	**ANY OTHER BUSINESS PREVIOUSLY ADVISED TO THE CHAIR**		

Date of next meeting – 6 July 2016 Education Centre, Birmingham Heartlands Hospital.

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

EXCLUSION OF THE PRESS AND PUBLIC

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

NED SURGERY WITH GOVERNORS	60	**3.00-4.00pm**
COUNCIL OF GOVERNORS	120	**4.00-6.00pm**

Title: Appointment of Medical Director - Ratification							**Attachments:**	0
From: Jacqui Smith, Chair				**To**: Board				
The Report is being provided for:								
Decision	Y	Discussion	Y	Assurance	N	Endorsement	Y	
The Board is being asked to:								
Ratify the appointment of David Rosser as interim Medical Director (a voting director position) and Responsible Officer with effect from 1 March 2016, in accordance with a recommendation from the Nominations Committee.								
Key points/Summary:								
The Nominations Committee met on 2 March and approved the appointment of David Rosser as interim Medical Director and Responsible Officer with effect from 1 March 2016 at the recommendation of the Chief Executive and resolved to recommend the ratification of that appointment to the Board.								
Recommendation(s):								
Ratify David Rosser's appointment as interim Medical Director (a voting director position) and Responsible Officer with effect from 1 March 2016.								
Assurance Implications:								
Strategic Risk Register		N		Performance KPIs year to date			N	
Resource/Assurance Implications (e.g. Financial/HR)		N		Information Exempt from Disclosure			N	
Identify any Equality & Diversity issues				N/A				
Outline how any Equality & Diversity risks are to be managed				N/A				
Which Committees has this paper been to? *(e.g. F&PC, QC, etc.)*								
Nominations Committee								

Jacqui Smith
Chair
29 April 2016

Minutes of a meeting of the Board of Directors of Heart of England NHS Foundation Trust held in the Harry Hollier Lecture Theatre, Partnership Learning Centre, Good Hope Hospital on 2 March 2016 at 12.00 noon

PRESENT:
J Smith, interim Chair
J Brotherton, Director of Operations
A Edwards, Non-executive Director
S Foster, Chief Nurse
J Glasby, Non-executive Director
H Gunter, Director of Workforce & OD
K Kneller, Non-executive Director
J Miller, interim Finance Director
J Moore, interim Chief Executive Officer
J Rao, Non-executive Director

IN ATTENDANCE:
F Alexander
M Cooke, Director of Strategy/ Deputy Medical Director
K Bolger, interim Deputy Chief Executive - Improvement
D Burbridge, interim Director of Corporate Affairs
R Cashman
A Hudson, Minutes
C Ryder, Deputy Medical Director
K Smith, Company Secretary

Governors
R Hughes
S Hutchings
J Thomas
D Treadwell

and members of the public.

16.026 APOLOGIES & WELCOME

The Chair welcomed everyone present to the meeting.

Apologies had been received from D Rosser.

The Chair noted the following changes:

- A Catto had been seconded to NHS England;
- A Lord and D Lock had resigned as Non-executive Directors due to an increase in their other business activities. The Chair recorded a vote of thanks for their commitment and attention especially during what had been a difficult period for the Trust and wished each of them well for the future.

The Chair welcomed David Burbridge as interim Director of Corporate Affairs.

16.027 APPOINTMENT OF FINANCE DIRECTOR - RATIFICATION

The Chair referred to the pre-circulated paper and advised that the Nominations Committee had met and approved the appointment Julian Miller as interim Finance Director (a voting director position) with effect from 3 February 2016. The Board ratified the appointment.

16.028 DECLARATIONS OF INTEREST

The Directors' Register of Interests was received.

16.029 MINUTES

The minutes of the meeting of 6 January 2016 were approved as a true record.

16.030 MATTERS ARISING & RECOMMENDATION TRACKING REPORT

There were no matters arising.

16.031 CHAIR'S UPDATE REPORT

J Smith gave an overview of the external meetings undertaken since the last meeting; these included attendance at the recent Birmingham & Solihull Overview and Scrutiny Committee with K Bolger and R Cashman where she had briefed councillors on the key performance and finance issues. The Chair had met with the Director of the Integrated Care and Support in Solihull to talk about the well-developed partnership work in the borough and had agreed to attend future meetings of the Leaders Board.

16.032 CHIEF EXECUTIVE'S REPORT

J Moore reported that the Government had identified an additional £8bn of funding which would be split into two allocations of £1.8bn, of which the Trust had been allocated £23.5m. The second tranche was subject to being part of the Sustainability & Transformation Plan (STP) which involved the local health economy working together in order to agree priorities; the agreed footprint for the trust included Birmingham and Solihull. Strict controls around how the funding could be spent would be applied. A considerable amount of work was being done with the Trust's partners and local authorities in this regard. The Trust had a lack of capital but was looking to generate savings of £15m - £17m internally to fund this; however more was required if the Trust was to upgrade essential buildings and equipment. J Moore had approached the Treasury direct and was optimistic that the Trust would obtain some funding from that source.

The Chair congratulated J Moore on being voted number two in the HSJ's list of top 50 Chief Executives nominated by their peers.

16.033 PERFORMANCE REPORT

K Bolger presented the report on the Trust's performance against national indicators and targets, including those in the Monitor Risk Assessment Framework, as well as local priorities. Material risks to the Trust's provider licence or governance ratings, finances, reputation or clinical quality resulting from performance against indicators were also reported, in order to give an overall view of the position of the Trust and set out the actions for those indicators that were failing to achieve compliance with targets.

Monitor Risk Assessment Framework (RAF)

Of the 14 indicators set out in the RAF ten were on target; the four targets missed comprised one cancer target, the 4-hour A&E wait target and the 18 week RTT incomplete pathway target and the in-month C.diff target. The Trust was working with key stakeholders to review and revise trajectories for four key national targets: A&E, 18 week RTT, diagnostics and cancer 62 day waits.

There had been a 17% increase in A&E growth that was peculiar to Birmingham. January's A&E 4-hour wait performance had been 84.3% against 83% in January 2015. The increase in attendance during January compared to the same month in 2015 had seen an average of 89 attendances more per day. Ambulance attendances were up by 10%; the Trust was working with CCGs to look at why the increase had occurred.

The 85% 62-day cancer referral target had been achieved in December at 85.36%; however maintaining the position was challenging with unvalidated performance at 76.5% for January. The 2 week wait from referral to appointment performance for December 2015 was 94.79% against the 93% target. The 2 week wait breast cancer target had been achieved for December.

Referral to Treatment time (RTT) had improved to 91.24%, which was ahead of trajectory, against the 92% target but it was proving difficult to achieve the last 0.5%. The Trust was working with the CCGs to ensure it was not agreeing to trajectories it was unable to deliver.

There had been 7 cases of C.diff in January against an in month target of 6. This was the second month in the current year that the Trust had exceeded its target.

National targets monitored through CCG contract

Of the 17 national targets not included in the RAF but included in the CCG contract the Trust had delivered ten with seven behind plan.

6 week diagnostics had improved to 96.88% against the 99% target; endoscopy continued to be the biggest problem with investment in equipment required in order to achieve and maintain targets.

The ambulance handover position was similar to that of December 2015; there had been a 10% increase in the number of ambulance attendances compared to January 2015.

There had been 2 confirmed cases of MRSA bacteraemia in January bringing the Trust total year to date count to 5; this compared to one case in 2014/15.

There had been two sleeping accommodation breaches affecting five patients; both events had occurred in HDU at BHH.

In January one urgent operation had been cancelled for the second time due to a lack of a critical care beds on both occasions; the patient had since been treated.

In response to a question from the Chair, K Bolger advised that recent discussions with the CCGs around growth, especially in respect of A&E attendances, had determined that options around managing the number of attendees were being explored that included looking to put in place a primary care facility at the front door, in order to move patients onto the right care pathway.

Activity would still be counted within the Trust's numbers. It would be important to ensure that finances were not adversely affected by such a change.

In response to a question from J Rao, K Bolger advised that the Trust had agreed to an audit of ED admissions to determine how patients were being treated; as the target made no allowance for acuity.

Local indicators – contract

There were a number of local contractual indicators that the Trust's performance was measured against; 22 were reported monthly, of these 16 were on target and six below target.

Breast feeding rates had dipped in January to 68.87% against the 72% target; an action plan to support delivery of the target was in place and had been discussed with the division at the recent Executive Performance Review Meeting. The Trust had achieved the target in February but sustainability was an issue.

Local indicators – internal

The Trust had a number of internal KPIs that were reviewed on a monthly basis under the headings of workforce and quality and safety. Those not being achieved included:

The January position against the workforce KPI's had shown no significant shift from the December position and continued to underperform in four areas; Staff in post versus budget establishment (excluding nurses); nursing staff in post vs budget established, average time to recruit – hiring manager and total time to recruit and voluntary turnover. The Trust was looking into measuring the targets that were in the Trust's control as opposed to those that were outside of the Trust's control.

The Trust continued to overspend, at 8.18% in January, against the Trust wide agency target spend of 3%; however, the Trust was complying with the Monitor rate caps. The overspend was due to activity levels and it was acknowledged that such an overspend was inevitable at times of high activity. There were around 160 nursing vacancies across Trust.

Delayed Transfers of Care (DTOCs) performance had improved slightly in January, by 0.51%, to 4.62%; cross-economy talks were being held with better support now in Birmingham. Staffordshire continued to be challenging. The number of DTOCs equated to a ward of patients at any one time.

There were 4 patients who had waited over 100 days for their first definitive cancer treatment; all of which were complex cases. The cancer team developed a forward look process to manage these complex patients better.

The Trust had cancelled 0.88% (71) operations at short notice in January against the target of 0.8%. There had been no breaches to the contractual target requiring patients to have surgery within 28 days of the cancellation of surgery since August 2015. **Action:** In response to a question from J Glasby, K Bolger agreed to undertake a review to ascertain whether there were any diversity issues for such patients (e.g. learning disabilities).

The target to record 90% of Admissions, Discharges and Transfers (ADTs) within 2 hours was missed in January at 77.01%. A review was underway to understand why compliance was so low; it was felt that the new organisation structure would have a positive impact on compliance.

Solihull community contract

The Trust contract with Solihull MBC focussed on performance of the Health Visiting Service managed by the Solihull Community Team. All the indicators were monitored quarterly and performance for Q3 showed that the Trust was only achieving 3 of the 9 indicators. The Chair noted her disappointment in the failure to achieve a better level of performance. K Bolger noted that the contract had not been integrated well by the Trust.

16.034 CLINICAL QUALITY REPORT

The Chair advised that D Rosser would be taking on the role of Interim Medical Director (and Responsible Officer) following A Catto's secondment to NHS England. C Ryder presented an overview of the report on behalf of D Rosser who was on leave.

Investigations into doctors' performance

There were currently thirteen medical practitioners within the formal review process; eleven cases predominantly related to conduct matters and two to capability matters. A robust process was being followed. The number of cases felt appropriate, given the size of the Trust. A training programme was being developed to generate a wider pool of investigators.

Mortality indicators

The Trust's April-October 2015 HSMR of 91.8 was below the average for Midland's trusts of 92.7 and had shown a favourable downward trend; the Trust was positioned at 45 of 135 trusts nationally. There was about to be major rebasing but it was expected that the Trust would broadly maintain its ranking.

The Trust's July 2014-June 2015 SHMI of 95 was respectable but was subject to the caveat previously reported on the historic corrupt data issue, which would take time to work its way out of the data set.

There had been six new CUSUM/ HSMR condition alerts, which were based on the number of re-occurring medical conditions seen at death; a review was underway and a report would be presented to a future meeting. A review of cases had already been undertaken with no concerns raised.

In response to a question from J Rao, C Ryder advised that the Trust had received a letter from the DoH clarifying what was required for the avoidable deaths review; it was expected that the new organisation structure would aid future reporting.

The Trust consistently ran at 0.4 -.05 in relation to its CRAB score, below 1 was considered good.

Board of Director's unannounced governance visits

The first of the new style Board visits had been to ward 15 at Solihull Hospital, an orthopaedic ward. The visit had been well received by the ward staff and appreciated by Directors too. There had been some previous concerns around ward 15 but a new nursing team and an enhanced medical team was now in place giving reassurance to the Board. The Chair advised that the March visit may need to be rescheduled due to lack of NED availability.

16.035 CARE QUALITY REPORT

S Foster referred to the pre-circulated report that summarised the Trust's performance against national quality indicators and targets, including those set out in Monitor's Risk Assessment Framework, and local priorities.

There had been five Trust apportioned MRSA bacteraemias and one outbreak of CPE. There was Trust wide focus on hand hygiene, to reduce contamination, and on screening.

In relation to C. Diff, the Trust was leading the way in faecal transplant treatment, where positive results were being seen.

Performance against the total numbers of avoidable hospital acquired pressure ulcers, for both grades 2 and 3, had improved compared to the same period in 2014-15. There was poor documentation to evidence good care and poor ward leadership in some areas, so the focus was now on the address these issues.

The falls rate had increased in month to 6.99 falls per 1,000 occupied bed days. This was the highest rate recorded so far during 2015-16 and meant that the Trust was now above the year end trajectory of 6.36. However, the January 2016 rate was 6.99 compared to the January 2015 rate of 7.26. The in-month increase was not expected to be an adverse trend.

There had been a negligible improvement in the recording of ADTs on the Trust IT system in January 2016, increasing from 79.09% to 79.5%. Staff training and cover was under review.

Nurse recruitment plans were on track. A tender was out with an agency to provide EU nurses with suitable English language skills; open days were also being held at Trust sites.

The number of re-opened complaints cases had fallen; the quality assurance process with divisional teams continued to have a positive impact. There was a view that there were too many ways to provide feedback on patient experience; the Trust was looking to review this in order to provide divisions with good, themed, information. NHS Elect was providing customer care training.

A review of open visiting had been undertaken; there had been a positive response overall. There had been some negative staff feedback around cleaning and protected meal times; in response to which a revised visiting code would be developed and cascaded.

There were some risks around CQUIN delivery; a performance review was being undertaken.

In response to a question from J Rao regarding duty of candour, S Foster advised that the Trust was looking at closing the loop by sending closure reports to patients.

In response to a question from J Glasby, S Foster advised that the Friends and Family Test (FTT) texting worked will in A&E and could in paediatrics but not everywhere. J Glasby advised that he had previous experience of an App used in conjunction with real time messaging displayed on public facing website. However, the current concern about possible over-reporting was noted.

16.036 FINANCE REPORT

J Miller presented the report for the period ending 31 January 2016 (M10). The Trust had reported an Income & Expenditure deficit of £4.6m during January, leading to a cumulative deficit of £56.0m for the year to date (YTD). As part of the financial recovery plan, short term measures (enhanced controls) had reduced the monthly run-rate from an average of £7.1m per month in Q2 to an average of around £5.0m per month since October. However the easy wins had now largely been delivered and a longer term plan would be required to tackle the residual deficit. The YTD position represented an adverse variance of £47.8m against the planned deficit of £8.2m YTD. The main adverse variances were medical pay (£11.2m YTD), nurse staffing (£9.2m YTD), private sector capacity (£3.2m YTD) and slippage against CIP (£23.2m YTD) that included £14.1m related to prior year targets. The current underlying year end forecast was projecting a deficit of between £60.0m and £63.0m dependent upon the delivery of recovery schemes and the impact of winter pressures over the next two months.

The Trust had recently been notified that it would receive £18.6m of additional income from DoH as

part of the national capital to revenue transfer (to improve the overall performance of the provider sector). This would reduce the reported deficit correspondingly but did not change the underlying position going into next year as it would go back out as PDC.

Emergency admissions remained high at 8% above plan in January (+1.4% YTD). Encouragingly Elective cases (and day cases) were 1.1% above plan in the month (+2.4% YTD) despite emergency pressures.

CIP delivery for the current year stood at 73% of target at month 10 (£5.4m slippage) but the YTD savings included £4.9m of non-recurrent schemes that would need to be re-addressed in 2016/17.

Cash had reduced to £41.6m, which was £23.5m below plan. The latest year end forecast for cash was £17.9m, which implied that the Trust would be run out of cash around by May or June at which time the Trust would need to apply to the DoH for distressed funding.

The focus was now on financial planning for 2016/17, including identification of CIP and working with EY to develop the longer term financial recovery plan, which needed to be submitted to Monitor on 11 April 2016. The plan set out a £69m best case deficit, the Trust had been offered £23.3m through the STF but had to agree to a maximum deficit, or control total, of £13.6m. In order to achieve this, the Trust needed to find an additional £32m of savings over CIP. Suspension of fines and penalties should result in £10m-£15m of benefit and QIPP was expected to be paid at a fair rate on work undertaken; these caveats had been made in the Trust's submission for the STF funding. There was a potential further allocation of £200m available from the STF but how this was to be accessed was unknown at the present time.

The Chair noted that the financial situation was a major concern to the Board and that the Board had spent considerable time, earlier in the day, considering the financial recovery plan with EY.

16.037 OPERATIONAL STRUCTURES

K Bolger delivered a presentation that set out the new operational structure that would come into effect from 1 April 2016. There was a focus on transparency and clarity. The new structure would allow stabilisation of the organisation over at least the next 18 months. J Brotherton was confirmed as Executive Director of Operations and would be supported by a Head of Operational Finance; Head of Operational Performance; Cancer Services Lead and Deputy Director of Operations, which would be a part time role but would provide continuity if the Director of Operations was not available. The current Associate Medical Directors would become Divisional Directors who would be professionally accountable to the Medical Director but operationally accountable to the Executive Director of Operations. There would be five divisions; an overview of each of the divisions was given. The Chief Executive's Group meeting would bring all of the divisions together with the corporate leads. Then new structure would force working together rather than silo working as had experienced in the past.

K Kneller welcomed the clarity that the revised operational structure should bring.

The Chair advised that similar work was underway on the corporate functions of the Trust.

16.038 BOARD ASSURANCE FRAMEWORK & RISK REGISTER

S Foster advised that she and D Burbridge had been reviewing the Board Assurance Framework and Risk Register in order to understand the baseline position; D Burbridge would be taking it forward.

16.039 BOARD COMMITTEE MINUTES AND REPORTS

Audit Committee

K Smith advised that the committee had met on 20 January when D Lock had chaired the meeting; the Committee had been updated on the 2015/16 year end process and reviewed the process for approving reference costs. The meeting had received reports from the internal auditors, Deloitte, most notably on Budgetary Controls, including budget setting & reporting, temporary staffing, third party capacity for clinical activity and waiting list initiatives. Overall there were 26 high, 15 medium and 9 low priority recommendations.

J Smith reported that K Kneller would be taking over as Committee chair following the resignation of A Lord.

Donated Funds Committee

The Chair advised that the Committee had met on the 29 January; she had attended but the Committee was chaired by Paul Hensel. There had been a useful report from Mike Hammond, CEO of QEHB Charity who had been appointed to undertake a review of the Trust's Charity. The report and its recommendations had been received with interest and subject to further clarification the Board should see improvements from a stronger focus on fundraising and fundholders' spending plans.

Monitor Standing Committee

The Committee had met on 29 January to approve the Monitor quarter 3 return; the minutes were received.

16.040 POLICIES FOR APPROVAL

The Celebrity & VIP Visitor Policy and the Consent Policy for Examination or Treatment Policy were both taken as read and duly approved.

16.041 DATE OF NEXT MEETING

The next meeting was scheduled for 11 May 2016, to be held in in the Harry Hollier Lecture Theatre, Partnership Learning Centre, Good Hope Hospital.

The Chair asked the governors or public present if there were any questions; none were received.

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

PART TWO

16.047 ANY OTHER BUSINESS

There being no further business the meeting closed.

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Chair

BOARD OF DIRECTORS

Matters Arising & Decisions/Recommendations Tracker

Date raised	Minute No	Detail	Action	Due	Status	Completed
7 Oct 2015	15.141	Report back on financial modelling for and progress with Priority Programme for Frailty.	IP/ RC	May 16		
6 Jan 2016	16.016	Bring Consultant and SAS job planning policy and procedure back to Board for approval after further review.	DR	Jul 16		
2 Mar 2016	16.033	In relation to cancelled operations; check whether there are any diversity issues (e.g. learning difficulties).	KB	May 16		

HEART OF ENGLAND NHS FOUNDATION TRUST

BOARD OF DIRECTORS

WEDNESDAY 11 MAY 2016

PERFORMANCE INDICATORS REPORT

PRESENTED BY INTERIM DEPUTY CEO - IMPROVEMENT

<table>
<tr><td colspan="6">Title: Performance Indicators Report</td><td colspan="2">Attachments:</td><td>1</td></tr>
<tr><td colspan="5">From: Kevin Bolger, Interim Deputy CEO - Improvement</td><td colspan="4">To: Board</td></tr>
<tr><td colspan="9">The Report is being provided for:</td></tr>
<tr><td>Decision</td><td>N</td><td>Discussion</td><td>Y</td><td>Assurance</td><td>Y</td><td>Endorsement</td><td colspan="2">Y</td></tr>
<tr><td colspan="9">The Committee is being asked to:</td></tr>
<tr><td colspan="9">Note the content of the report and note the action being taken to achieve compliance with the Trust's performance indicators.
Review the proposed internal KPIs for 2016/17</td></tr>
<tr><td colspan="9">Key points/Summary:</td></tr>
<tr><td colspan="9">Exception summaries have been provided where there are current or future risks to performance for targets and indicators included in Monitor's Risk Assessment Framework, national and contractual targets and internal indicators.

Two appendices are attached:

• Appendix 1 – provides an overview of contractual reporting requirements for 2016/17 and is provided for information
• Appendix 2- details changes to the Trust Internal Key Performance Indicators and is provided for agreement.</td></tr>
<tr><td colspan="9">Recommendation(s):</td></tr>
<tr><td colspan="9">The Board of Directors is requested to:

Accept the report on progress made towards achieving performance targets and associated actions and risks.

Agree to the revised internal KPIs for 2016/17</td></tr>
<tr><td colspan="9">Assurance Implications:</td></tr>
<tr><td colspan="3">Strategic Risk Register</td><td>N</td><td colspan="3">Performance KPIs year to date</td><td colspan="2">Y</td></tr>
<tr><td colspan="3">Resource/Assurance Implications (e.g. Financial/HR)</td><td>Y</td><td colspan="3">Information Exempt from Disclosure</td><td colspan="2">N</td></tr>
<tr><td colspan="4">Identify any Equality & Diversity issues</td><td colspan="5">None</td></tr>
<tr><td colspan="4">Outline how any Equality & Diversity risks are to be managed</td><td colspan="5"></td></tr>
<tr><td colspan="9"></td></tr>
<tr><td colspan="9">Which other Committees has this paper been to? (E.g. F & PC, QRC etc.)</td></tr>
<tr><td colspan="9">None</td></tr>
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HEART OF ENGLAND NHS FOUNDATION TRUST

BOARD OF DIRECTORS

WEDNESDAY 11 MAY 2016

PERFORMANCE INDICATORS REPORT

PRESENTED BY INTERIM DEPUTY CEO - IMPROVEMENT

1. Purpose

This paper summarises the Trust's performance against national indicators and targets, including those in Monitor's Risk Assessment Framework, as well as local priorities. Material risks to the Trust's Monitor Provider Licence or Governance Rating, finances, reputation or clinical quality resulting from performance against indicators are detailed below.

2. HEFT Key Performance Indicators

The Trust has a suite of Key Performance Indicators that includes national targets set by the Department of Health (DH) and local indicators selected by the Trust as priority areas, some of which are jointly agreed with the Trust's commissioners. This report is intended to give a view of overall performance of the organisation in a concise format and highlight key risks particularly around national and contractual targets as well as an overall indication of achievement of key objectives. The Trust currently rates indicators as either green – meeting the target or red - failing the target.

The report also contains a short overview of performance against the Solihull Community Contract.

In addition this month the report provides an overview of the contractual reporting requirements to be provided to the commissioners from the Trust.

The Trust internal KPI metrics have been revised for 2016/17 and these are provided for information and agreement in principle at Appendix 2.

3. Material Risks

The DH sets out a number of national targets for the NHS each year which are priorities to improve quality and access to healthcare. Monitor tracks the Trust's performance against a subset of these targets under its Risk Assessment Framework.

The remaining national targets that are part of the Everyone Counts document from the DH but not in Monitor's Risk Assessment Framework are included separately.

3.1 Monitor

Of the 14 indicators currently included in Monitor's Risk Assessment Framework (RAF), 12 were on target in the most recent month. The A&E 4 hour wait target and the in-month C.difficile target were not met.

3.1.1 A&E 4 Hour Waits

The Trust failed to meet the 95% patients waiting less than 4 hours in A&E target. March's performance is 85.1%, against 85.05% in February and 83% in March 2015.

(Please note that in the last report to the Clinical Quality Committee the A&E performance figure for February was incorrectly reported as 84.99%)

The number of attendances in March 2016 was 23,634 against 21,786 in March 2015. The Trust has seen on average 60 attendances more per day.

Table 1 - A&E attendances Mar 15 v Mar 16		
BHH - Avg per day	2015	10761
	2016	12332
	Var.	51
GHH - Avg per day	2015	7411
	2016	7691
	Var.	9
SH - Avg per day	2015	3614
	2016	3611
	Var.	0
Trust - Avg per day	2015	21786
	2016	23634
	Var.	**60**

There were no 12 hour trolley breaches in month.

3.1.2 Cancer Targets (month in arrears)

All Monitor Risk Assessment Framework Cancer targets were met in February, this is the first time the Trust has achieved this in over a year.

The cancer 2 week wait from urgent referral performance was 97.07% against a target of 93%, this indicator has now been met for the past 4 months

The 2 week wait for suspected breast cancer referral performance was 95.45% against a target of 93%; this indicator has been met for the second month in a row.

The 85% 62-day urgent GP referral standard was achieved in February 2016 with performance at 87.78% against a target of 85%. As part of the Transformation and Sustainability Funding the Trust has agreed a trajectory to deliver sustained performance against this indicator from the end of June 2016.

The Trust failed to meet the national contract indicator of treatment within 62 days of consultant upgrade achieving 74.58% against a target of 80%.

3.1.3 Referral to Treatment Time

Performance against the 92% incomplete 18 week referral to treatment target in March was 92.01%, just achieving the national target of 92%, for the second month in a row.

As part of the Transformation and Sustainability Funding the Trust has agreed a revised trajectory to deliver sustained performance against this indicator from the end of September 2016.

There were no 52 week breaches in March.

3.1.4 C.difficile

In March the Trust had 7 cases of C.difficile (4 at BHH and 3 at GHH) against an in-month target of 5. This is the fourth month the Trust has exceeded its in-month target.

The Trust however has not exceeded its year-end target of 64 cases, having had 61 cases in total.

All March cases have been reviewed with the CCG and 1 case has been determined as avoidable, bringing the year to date total to 14 avoidable cases.

3.2 National Targets Monitored Locally Through CCG Contract

Of the 17 national targets that are not included in Monitor's Risk Assessment Framework but are included in the CCG contract the Trust is on target for 11 and not delivering against 6.

3.2.1 6 Week Diagnostics

March performance was 99.31% against a target of 99%.

This is the second month in a row that the Trust has achieved this target.

As part of the Transformation and Sustainability Funding the Trust has agreed a revised trajectory to deliver sustained performance against this indicator from the end of September 2016.

3.2.2 Ambulance Handover - 30 and 60 minutes

307 patients waited longer than 30 minutes for handover from the ambulance, similar to February's performance. The number of patients waiting over 60 minutes for ambulance handover doubled in March to 14 from February's position of 7.

Table 2 below shows a 7% increase in the number of ambulance attendances at the Trust compared to January 2015

Table 2 - Ambulance attendances Mar 15 v Mar 16		
BHH - Avg per day	2015	3680
	2016	3875
	Var.	6
GHH - Avg per day	2015	2383
	2016	2588
	Var.	7
SH - Avg per day	2015	622
	2016	704
	Var.	3
Trust - Avg per day	2015	6685
	2016	7167
	Var.	**16**

3.2.4 Urgent Operations cancelled for the second time

There were 2 urgent operations cancelled for the second time in March. Both cancellations were in Trauma and Orthopaedics due to previous cases overrunning. Both patients have since been treated.

3.2.5 VTE assessment

The Trust failed to meet this contractual requirement for the first time since July with performance at 94.75% against a target of 95%. The main areas of non-compliance relate to short stay areas such as AMU.

A review of the Trust methodology for measuring this target is being undertaken to ascertain if any changes to the 'cohort's' of patients that can be block risk assessed, can be made.

4. Local Indicators – contract

There are a number of local contractual indicators that the Trust's performance is measured against; details of those indicators failing to meet their targets are provided below:

4.1 Breast feeding rates

Breast feeding performance improved in March to 70.21% from February (69.64%) against a target of 72%.

4.2 Maternity Screening Indicators

These indicators are reported a full quarter in arrears so this report is detailing performance against Q3 2015.

There are 12 maternity screening indicators in the contract of these 5 have not been met.

As a result of this performance the Division have reviewed their governance processes and have now included a review of performance against these targets in their monthly confirm and challenge meetings.

In addition it was identified that the two new indicators, detailed below, were discussed and agreed through the Maternity Local Implementation Group (LIG) meeting. From this point forward all discussions about performance, contracts and reporting indicators will be at the single Trust performance meeting and go through the directorate team.

The following indicators have not been met:

- Downs Screening – The proportion of laboratory request forms including complete data prior to screening analysis, submitted to the laboratory within the recommended timeframe of 10+ to 20+ weeks of gestation

  Performance was 94.07% against a target of 97%, this is the third quarter in a row that performance has deteriorated. There were 98 out of a total of 1652 forms that were incomplete.

  In order to improve compliance a new form was developed and implemented in mid-January 2016 with an associated training package for staff and validation of forms prior to them being sent to pathology, this also allows for immediate feed-back to staff, where there is non-compliance.

  This has already resulted a significant improvement in compliance; however it is unlikely that the target will be met in Q4. The Division have committed to meeting the target from Q1 2016/17.

- The percentage of babies from whom it is necessary to take a repeat blood sample due to an avoidable failure in the sampling process.

  Performance for this indicator was 3.48% (national average performance for Q2 was 4.4%) against a target of <2%, performance has deteriorated from Q2 to Q3. This relates to approximately 70 babies needing a repeat blood sample.

A robust performance recovery plan is in place to deal with the 2 main issues, not enough blood on the form and form completion. During March, any member of staff who has 2 or more blood spot failures is also required to complete the national on-line screening package. Provision for one to one training in the community is also now available.

A trajectory is in place aiming to hit the target in Q2 2016/17.

- The percentage of referred babies receiving audiological assessment within 4 weeks of the decision that referral for assessment is required or by 44 weeks gestational age.

  Performance dipped to just below the 90% target, with the Trust achieving 89.23%, down from 91.85% in Q2.

  This service is provided by City Hospital via an SLA, the target was missed by 1 patient. Of the 16 patients who breached the target 15 were DNA's or late cancellations by parents.

  Work is under way to review the information given to parents reinforcing the importance of these tests.

- Proportion of babies eligible for the newborn physical examination tested within 72 hours of birth

  This is a new metric reported for the first time in Q3 with the Trust achieving 79.66% against a 95% target.

  The Division has confirmed that every baby that leaves HEFT does have a 'newborn' baby check. However, they do not have a robust system in place for capturing this data. The Divisional team will work with the directorate to ensure data is available for Q1, and that a robust system is in place for reporting this prospectively.

- Proportion of babies who, as a result of possible hip abnormality detected at the newborn physical examination, have ultrasound assessment within 2 weeks of birth

  There is no system currently in place to report on this indicator. An audit of patient's notes suggests that we are not compliant with the 2 week timeframe. The divisional team will work with the directorate team to ensure a robust system is in place.

4.3 <u>Compliance with nursing care indicators (tissue viability/SSKIN bundle) – total score and repositioning frequency adhered to for 3 days</u>.

The Trust failed to meet the nursing care indicator relating to tissue viability compliance, this is a composite indicator made up of 3 sub-measures.

The overall compliance score was 94% against a target of 95%, the sub-measure that impacted most on the overall score was the metric to ensure

that repositioning frequency is adhered to for 3 days which only achieved 83% against a 90% target.

See Care Quality Report for more detail.

4.4 Falls Rate

In March the Trust falls rate was 6.58 against an in month and Q4 target of 6.35. The Trust year end position is 6.32.

The Care Quality Report provides more detail on this.

4.5 Pressure ulcers.

The Trust had 3 indicators relating to reductions in the number of pressure ulcers compared to last year. Despite good performance in Q4 all 3 indicators have failed their full year targets, mainly due to poor performance at the start of the year.

More detail is be provided in the Care Quality Report

4.6 Appraisal rates

The appraisal rate remains below the target of 85%, but has improved in March to 77.73%. This is in line with the Trust trajectory, to meet the target by June 2016, see table below:

	Jan	Feb	Mar	Apr	May	Jun
Performance	72%	75.65%	77.73%			
Revised trajectory	70%	73%	76%	79%	82%	85%

More regular monitoring and provision of information to Divisions is taking place to support the divisions with delivery of this target.

4.7 Medicines Management Indicators

There are 5 medicines management KPIs in the local contract which are reported bi-annually.

Of these the Trust has failed to meet the required standard for 1 of them:

- Reducing inappropriate use of piperacillin with tazobactam (“piptaz”) - 100 % have stop date/specified duration

There is a plan in place to address this performance which includes closer and more regular monitoring of compliance through the development of a live antibiotic stop date performance dashboard which will allow for the production of data per directorate per site to monitor individual trends in stop dates compliance.

In addition ward pharmacists will also be requested to escalate any problems related to stop dates.

5. Local Indicators - Internal

The Trust has a number of internal KPIs that it reviews on a monthly basis, these are classed under the headings of workforce and quality and safety

Details of those not being achieved are provided below:

5.1 Workforce KPIs

There are currently 13 workforce indicators included in the corporate KPIs; of these 8 are currently non-complaint

The March position against the workforce KPIs shows no significant shift from the February reported position with the following indicators continuing to underperform:

5.1.1 Staff in post v budget established

There are 3 metrics that relate to this overarching theme all indicators were missed in month, see table below:

Indicator	Target	**MAR-16**
Staff in post v budget established (excluding nursing)	<> 95% - 100%	92.17%
Qualified Nursing staff in post v budget established	<> 95% - 100%	89.81%
HCA Nursing staff in post v budget established	<> 95% - 100%	101.47%

There are still a number of qualified staff working in the Trust as HCA's whilst they await their NMC registration and are therefore not included in the qualified nursing figures. A further 90 qualified nurses have been offered posts and are due to start between April and June 2016.

The recruitment plan for nursing staff is continuing with the focus on attracting newly qualified nurses. There is also specific work being undertaken to recruit theatre nurses and staff to fill the vacancies in radiography.

5.1.2 Average time to recruit – hiring manager and total time

Both of these indicators missed their targets in March with time to recruit hiring manager deteriorating in month and the time to recruit total time improving slightly.

The focus remains on encouraging managers to improve time to shortlist and time to determine offer after interview, together with continuous process improvement of the pre-employment checks.

The Trust is a member of a regional streamlining group, which is looking to speed up NHS to NHS staff transfers.

5.1.3 Voluntary turnover

The level of turnover continues to decrease and is now reporting at 8.59% for March 2016. This is just short of the Trust target for March 2016 of 8.5%, and is an improvement against March 2015 where the turnover figure was 8.9%.

The operational HR team alongside local management teams continue to focus on areas that may be contributing to reasons for higher than average turnover.

There will be a number of changes across the Trust over the coming months whilst the new Operational Structure embeds. Change Management processes can have a potential impact on staff morale, sickness absence and turnover levels and these will be monitored closely

5.1.4 Trust wide Agency Spend

The Trust continues to overspend against its Trust wide Agency Spend indicator of 3%.

The March position is 7.35% an increase on February's position of 6.90%. Work to address this is being undertaken through the finance recovery programme.

5.3 Delayed Transfers of Care (DTOC)

Performance in March improved to 3.86% from February's position of 4.73%.

See Care Quality Report for more detail.

5.4 MRSA Emergency Screening Rates (% patients screened)

MRSA emergency screening performance remains below the 90% target at 85.66% in March.

There are a number of actions in place to address this and further information is provided in the Care Quality Report.

5.5 Patients receiving their first definitive treatment for cancer within 100 days of GP or dentist urgent referral for suspected cancer

In February there were 4 patients treated that waited over 100 days. The specialties with long waiting patients were Urology, Upper GI and Breast. RCAs are being undertaken for these patients in line with national requirements.

5.6 Operations cancelled on the day

The Trust cancelled 1.52% of operations at short notice in March (against a target of 0.8%), the worst performance of 2015/16. A total of 127 operations were cancelled an increase of 44 from February.

The main reason for cancellation in month was due to 'no bed', with 55 patients being cancelled for this reason, an increase of 30 on February.

The largest site increase was at GHH with 21 more breaches than the previous month, (31 in total) with an increase in cancellations due to no bed rising from 3 in February to 23 in March.

The specialties most impacted on due to these 'no bed' cancellations were T&O with 16 cancellations and General Surgery with 15.

There were no breaches of the contractual target requiring patients to have surgery within 28 days of cancellation of their operation.

5.7 Admissions, Discharges and Transfers (ADT) recorded within 2 hours

The Trust has a requirement for 90% of ADTs to be recorded within 2 hours performance in March was 79.70%. This is the best in-month performance for 2015/16.

See Care Quality Report for more detail.

5.8 Dementia CQUIN

In March the Trust performance against the dementia CQUIN indicator of the percentage of eligible patients aged over 75 asked the dementia question was 88.52%. The Trust has only achieved this target in two months year to date.

6. Solihull Community Contract

There were 3 Community Services CCG indicators that were not achieved during March and Quarter 4.

The Community Services 18 weeks RTT performance was 77.78% in March. The numbers on 18 week pathways for Solihull Community Services are small and there were 2 paediatric community breaches that resulted in the failure of the target. Both patients have since been seen.

There was a slight dip in performance for the End Of Life metric relating to the 'Number of patients on Gold Standard Framework who have a named nurse' – with performance at 89%, just below the 90% target. The Trust has been compliant for the rest of the year.

Appraisal performance is at 80.69% in March against a target of 85%

There was one exception reported on the CCG / SMBC KPI reports,

Breast feeding initiation achieved 65.78% below the 70% target. All other targets were met.

7. Solihull Metropolitan Borough Council (SMBC) Contract

The Trust has a contract with SMBC, which focuses on the performance of the Health Visiting Service managed by the Solihull Community Team.

All indicators are monitored quarterly; not all data is available for Q4, at the time of this report, but the current performance for Q4 shows that the Trust is only achieving 2 of the 6 indicators for which the data is available

Once the full quarterly position is known a more detailed review of these will be undertaken and an update on issues provided in the next Board report

8. CQUINS

The Trust is due to make its final submission on CQUIN performance to the CCGs at the end of April.

The total possible value of CQUINs for 2015/16 is £13,297,178, the Trust is forecast to achieve c82% of this value £10,903,686 well above initial forecasts.

Actions continue to maximise income and a final assessment of the financial outcome will be provided once final reports are compiled.

The CQUINs with risks to full achievement is as previously reported and detailed below:

- Acute kidney Injury
- Sepsis, Screening and Antibiotic Administration
- Dementia, Find , Assess, Refer
- COPD, discharge bundle and specialist review

9. Key Performance Indicators for 2016/17

The Trust is in the process of finalising the 2016/17 contractual performance indicators, for all of its contracted services:

- Acute
- Community Services
- Specialised Services
- Public Health
- Solihull Metropolitan Borough Council

Within the contract we are required to provide a significant amount of information to the CCG

Requirement	Approximate Number	Comments
Key Performance Indicators - National	30	Detailed in Appendix 1
Key Performance Indicators - Local	75	Examples in Appendix 1
Information Requirements	250	See examples in Appendix 1
Other requirements e.g. Service Development Improvement Plans/Data Quality Improvement Plans	20	All with multiple reporting requirements
CQUINs	15	All with multiple reporting requirements
TOTAL	390	

Please note that this information is subject to change until final contracts are signed.

The Trust also monitors a number of internally agreed performance indicators primarily related to workforce and quality and safety, these have been reviewed for 2016/17 and whilst these require further definition these are provided for information and agreement in principle at Appendix 2

10. Recommendations

The Board of Directors is requested to:

10.1 **Accept** the report on progress made towards achieving performance targets and associated actions and risks.
10.2 **Agree** to the revised internal key performance indicators for 2016/17

Kevin Bolger
Interim Deputy CEO – Improvement

Appendix 1

ACUTE CONTRACT KEY PERFORMANCE INDICATORS REQUIREMENTS 2016/17 - DRAFT

National Indicators	Target Type
A&E 4 hour access	National/Monitor
Ambulance Handover ≥ 30 minutes	National
Ambulance Handover ≥ 60 minutes	National
12 hour Trolley waits A&E	National
Cancer 31 days- first treatment	National/Monitor
Cancer 31 days - subsequent treatment - drugs	National/Monitor
Cancer 31 days- subsequent treatment -surgery	National/Monitor
Cancer 62 day - GP urgent referral	National/Monitor
Cancer 62 day - consultant screening	National/Monitor
Cancer 2 week	National/Monitor
Cancer breast - 2 week	National/Monitor
18 week RTT - incomplete	National/Monitor
6 weeks diagnostic test	National
52 week waits	National
Cancelled Ops rearranged 28 days	National
Urgent operation cancelled x 2	National
Sleeping Accommodation Breach	National
MRSA	National
C.difficile - (all cases)	National/Monitor
C.difficile - (avoidable cases)	National/Monitor
VTE risk assessment	National
Duty of Candour (2mia)	National
NHS Number acute	National
NHS Number A&E	National
Community Data Completeness - RTT information	National/Monitor
Community Data Completeness - referral information	National/Monitor
Community Data Completeness -treatment activity information	National/Monitor
Learning disabilities	National/Monitor
Implementation of e-Prescribing system for chemotherapy across all relevant clinical teams within the Provider (other than those dealing with children, teenagers and young adults) across all tumour sites	National

Local Contract Indicators	Target Type
Full maternity health and social risk assessment within first trimester (12+6 weeks of pregnancy)	Local Contract
Babies at risk of TB vaccinated	Local Contract
Mothers who have initiated breast feeding or babies who received expressed breast milk within 48 hrs. of delivery	Local Contract
CO monitoring recorded & documented in the antenatal notes of all mothers at booking.	Local Contract
Smokers who have stopped smoking in the last 2 weeks and those referred with a CO reading of >4ppm referred to Stop Smoking	Local Contract
The percentage of pregnant women eligible for ID screening tested for HIV, leading to a conclusive result	Local Contract
The percentage of pregnant women eligible for ID screening tested for Hepatitis B, leading to a conclusive result	Local Contract
The percentage of pregnant women eligible for ID screening tested for syphilis, leading to a conclusive result	
Proportion of pregnant women Hep B positive referred and seen by appropriate specialist within 6 weeks of identification	Local Contract
Proportion of lab request forms submitted to 10+0 to 20+0 weeks gestation	Local Contract
Proportion of pregnant women eligible for sickle cell and thalassemia screening for whom a conclusive screening result is available on	Local Contract
Proportion of pregnant women eligible for sickle cell and thalassemia screening for whom consent for or a blood test is undertaken by 10wks gestation	Local Contract
Proportion of sickle cell and thalassemia samples submitted that are supported by a Family Origin Questionnaire	Local Contract
Proportion of babies registered within the CCG eligible for blood spot screening with a conclusive result on CHIS by 17 days of age	Local Contract
Proportion of babies requiring repeat blood sample due to an avoidable failure in the sampling process	Local Contract
Proportion of babies eligible for hearing screening for whom process is complete by 4 weeks (hospital) or 5 weeks (community)	Local Contract
Proportion of referred babies receiving hearing assessment in 4 weeks of decision that assessment is required by 44 weeks gestational	Local Contract
Proportion of babies eligible for the newborn physical examination tested within 72 hours of birth	Local Contract
Proportion of babies who, as a result of possible hip abnormality detected at the newborn physical examination, have ultrasound assessment within 2 weeks of birth	Local Contract
Pressure Ulcer Reduction for avoidable grade 4 pressure ulcers	Local Contract
Pressure Ulcer Reduction for avoidable grade 3 pressure ulcers	Local Contract
Pressure Ulcer Reduction for avoidable grade 2 pressure ulcers	Local Contract
Reduction in overall falls rate	Local Contract
Compliance with Nursing Care Indicators - Tissue Viability metrics (Dashboard Overall Score)	Local Contract
Compliance with Nursing Care Indicators - Tissue Viability metric (Daily skin inspections)	Local Contract
Compliance with Nursing Care Indicators - Tissue Viability metric (Repositioning frequency documented)	Local Contract
Compliance with Nursing Care Indicators - Tissue Viability metric (Repositioning frequency adhered to 3 days)	Local Contract
Safeguarding supervision for appropriate frontline staff who work with children for those staff identified in Training Needs Analysis	Local Contract
Specialist Safeguarding supervision for Named Professional	Local Contract
Complaints made directly to commissioners. Initial Complaint responses from the Provider within 20 30 working days or Where complaints are complex timeframe agreed with complainant by Commisioner . CCG to act as advocate.	
Mandatory training	Local Contract
Staff receiving appraisal / PDR	Local Contract
All SIRIs to be notified by STEIS to the Commissioner within 2 working days of identification as a serious incident	Local Contract
Final RCA and action plan for SI's submitted within agreed timescales	
Following levels 1, 2, and 3 serious incident investigations, where queries are raised to obtain further assurances following submission of final report, providers will respond to the queries within 15 working days.	
Post Infection Review is undertaken on post 48 hour MRSA bacteraemia	Local Contract
C.diff Post Infection Review is undertaken internally within 30 days.	Local Contract
Medicines Management (1a) Reducing inappropriate use of piperacillin with tazobactam ("piptaz") - 100 % compliance with Trust antibiotic guideline	Local Contract
Medicines Management (1b) Reducing inappropriate use of piperacillin with tazobactam ("piptaz") - 100 % have stop date/specified duration	Local Contract
Medicines Management (4) The number of discharge summaries that include medication changes* and explanations for changes‡, or state "no change" where appropriate **2mia**	Local Contract
Delayed Transfers of Care (DTOC)	Local Contract
Stroke - Proportion of applicable patients who are assessed by a nurse within 24h AND at least one therapist within 24h AND all relevant therapists within 72h AND have rehab goals agreed within 5 days (BHH only due to Trust pathway)	Local Contract
Proportion of patients who **present with stroke** who spent at least 90% of their stay on stroke unit (all sites reported at trust level)	Local Contract
TIA - Proportion of patients **who present at A & E and are discharged** with a TIA that are scanned and treated within 24 hours	Local Contract
SSNAP Indicators (all sites)	Local Contract

ACUTE CONTRACT INFORMATION REQUIREMENTS 2016/17 - DRAFT	
In addition to the contractual key performance indicators the Trust is required to submit approximately 150 additional pieces of information (Monthly/quarterly/annually) relating to Trust performance under the Information Requirements section of the contract . This ranges from a single performance update against a particular service through to a full quality performance report. Some examples are provided below	
Early Pregnancy Assessment Unit – Initial scans within 48 hours	Trust to provide a report detailing the following: 1. Number of women entering the EPAU for whom an initial scan within 48 hours is clinically appropriate; and 2. The number of patients who waited longer than 48 hours and, of those, how many were for clinical reasons. 3. Information to be supplied by site. 4. Number of inappropriate referrals reported.
Information Governance	The Trust to provide a quarterly report of all Information Governance Incidents detailing type, trends and themes from incidents and detail of action being undertaken. This report should also provide detail of site of incident including a section on Solihull Community
Patient Experience and Complaints Report (Qualitative Analysis)	To include:- Number of complaints received by area Themes, trends, issues of complaints Risk grading of initial complaint Number upheld, partially upheld or not upheld Number and % responded to initially in 30 WD from receipt of complaint Number of complaints received with reference to Duty of Candour being breached. Themes of outcomes and learning identified Bi annual Evidence of how learning has been shared across the trust Number referred to PHSO and outcome Number and % of re-opened and criteria for re-opening Friends and Family Test broken down by inpatient, outpatient, maternity, day case, community, A&E MP complaints on behalf of patients, numbers themes , outcome (cannot supply individual details due to confidentiality) Thematic analysis of quantitative and qualitative research undertaken with regard to patient surveys Any relationship to service change In collaboration with commissioners agree top 5 key themes and to agree to focus on agreed theme 'STAFF ATTITUDE'. At end Q4 details to be provided of the outcomes and improvements on ' STAFF ATTITUDE' as a result of the work undertaken on the top 5.
Public Sector Equality Duties – Annual Equality Monitoring Report	Copy of published report to be shared with CCG

OTHER CONTRACT REQUIREMENTS 2016/17 - DRAFT
The Trust has contracts with a number of other organisations including the CCG, for the Community Services Contract, NHS England for the Specialised Services Contract, Solihull Metropolitan Borough Council for some other primary care services. For many of these contracts the national contract requirements map across as appropriate. However each individual contract has its own section of local key performance indicators and local information reporting requirements. It is estimated that once these contracts are all agreed that there will be an additional 25-30 key performance indicators to report on as well as a similar amount of local information requirements.

PROPOSED INTERNAL WORKFORCE INDICATORS FOR 16/17

KPI REF	WORKFORCE	Comments for 16/17
1	Staff in Post v Budget Established - Percentage (excluding Nursing)	Target changed to take account of financial recovery
2	Qualified Nursing Staff in Post v Budget Established - Percentage	No change
3	HCA Nursing Staff in Post v Budget Established - Percentage	No change
4	Average Time to Recruit - Hiring Manager	Plan to take out notice periods for which we have no control
5	Average Time to Recruit - Recruitment	No change
6	Average Time to Recruit - Total	Dependent on 4 above
7	Voluntary Turnover	No change
8	Sickness - in month position (YTD figure = MAA) **mia**	Decrease from target of 4.25% for 15/16
9	New Starters Attending Corporate Induction - Doctors only **mia**	No change
10	New Starters Attending Corporate Induction - Excluding Doctors **mia**	No change
11	Clinical Staff Undergoing Mandatory Training Cumulative Since Start of Programme **mia**	Stretched target 85-90% amber, 90-100% green
12	Number of Appraisals Completed	Stretched target 85-90% amber, 90-100% green
13	Trustwide Agency Spend	finance target

PROPOSED INTERNAL QUALITY AND SAFETY INDICATORS FOR 16/17

	QUALITY AND SAFETY	Comments for 16/17
1	Delayed Transfers of Care (TOTAL)	To be managed through the Length of Stay Workstream - may need to be Trust KPI due to national focus and stretched target
2	The number of patients who have waited over 104 days for treatment of cancer	This is included in the contract information requirements - important quality metric
3	The % of patients who have waited over 104 days for treatment of cancer that have had RCA completed	This is included in the contract information requirements - important quality metric
4	Nursing Metrics - Quality of Care	Specific metrics to be defined - dependent on local contract requirements but consideration to be given to pressure ulcers, falls, pain and observations
5	Nursing Metrics - Patient Experience	
6	30 day Emergency readmissions %	Trust KPI - target and methodology to be determined - UHB measure 28 day readmissions - both a quality metric and financial metric if fines apply next year
7	No. patients waiting ≥18 wks on IP Backlog **mia**	To be managed through the Scheduled Care Workstream - Board may want this as a Trust KPI - due to quality impact of long waiters
8	Total number of Never Events in month	Not included in CCG contractual reporting requirements but needs monitoring within the Trust
9	Friends & Family Index	Final metric to be defined
10	Mortality metrics	Final metric to be defined to ?include HSMR and SHMI
11	Incidents reviewed within 7 days	**All incidents should be reviewed within 7 days** (the review will include an assessment of correct grading etc. and also a view on whether further investigation is required (in some cases no investigation should be required in which case they can be closed there and then)
12	Incidents investigated and closed within 28 days	Where an investigation is required that those incidents are **investigated and closed within 28 days** (exception being SIs – where we have up to 60 days to investigate and close)
13	Serious Untoward Incidents closed with 60 days	New metric for 2016/17
14	Complaints turnaround	New metric for 2016/17
15	Omitted drugs - antibiotics	New metric for 2016/17
16	Omitted drugs -Parkinson's	New metric for 2016/17

HEART OF ENGLAND NHS FOUNDATION TRUST
BOARD OF DIRECTORS
WEDNESDAY 11th MAY 2016

Title: Clinical Quality Monitoring Report					**Appendices**		1
Presented by: Dr David Rosser, Interim Executive Medical Director Prepared by: Amy Fowlie, Project Assistant, Imogen Gray, Interim Head of Quality Development, and Dr Ann Keogh, Director of Medical Safety				**To**: Board of Directors			
The Report is being provided for:							
Decision	N	Discussion	Y	Assurance	Y	Endorsement	Y

Purpose

To provide assurance on clinical quality to the Board of Directors and detail the actions being taken following the first meeting of the Clinical Quality Monitoring Group (CQMG) in April 2016.
Receive and note the contents of this report.

Key points/Summary:

The Board of Directors will consider:

- Investigations into Doctors' performance currently underway
- Mortality indicators: CUSUM, SHMI, CRAB and HSMR
- Board of Directors' Unannounced Governance Visits
- Performance for timely delivery of antibiotic stat (one off) doses
- Summary table of Serious Incidents which are open or recently closed

Recommendation(s):

The Board of Directors is asked to

- Discuss the contents of this report and approve the actions identified.
- Agree that information will only be reported by exception in future reports following each Clinical Quality Monitoring Group meeting.

Assurance Implications:

Strategic Risk Register	Y	Performance KPIs year to date	Y
Resource/Assurance Implications (e.g. Financial/HR)	Y	Information Exempt from Disclosure	Y
Identify any Equality & Diversity issues		None identified.	
Outline how any Equality & Diversity risks are to be managed		None identified.	

Which other Committees has this paper been to? *(e.g. F&PC, QRC, etc.)*

N/A

HEART OF ENGLAND NHS FOUNDATION TRUST
BOARD OF DIRECTORS
WEDNESDAY 11th MAY 2016

CLINICAL QUALITY MONITORING REPORT
PRESENTED BY EXECUTIVE MEDICAL DIRECTOR

1. Introduction

The aim of this paper is to provide assurance of the clinical quality to the Board of Directors, detailing the actions being taken following the April 2016 Clinical Quality Monitoring Group (CQMG) meeting. The Board of Directors is requested to discuss the contents of this report and approve the actions identified. The Board of Directors, if suitably assured, is also asked to agree to receive information by exception in future reports following each Clinical Quality Monitoring Group.

2. Update On Medical Staff Within The Remit Of Maintaining High Professional Standards (MHPS)

2.1 At the time of reporting there are 11 medical practitioners within a formal process at the Trust, of which one is a Junior Doctor, four are SAS doctors and six are Consultants. There are two cases that deal predominantly with capability matters while the remaining nine cases are predominantly conduct matters. In three of the cases the practitioner is either excluded or has restrictions on their practice. Of these cases, there are four hearings that have been arranged. In two cases disciplinary sanctions have been proposed as part of the fast track process.

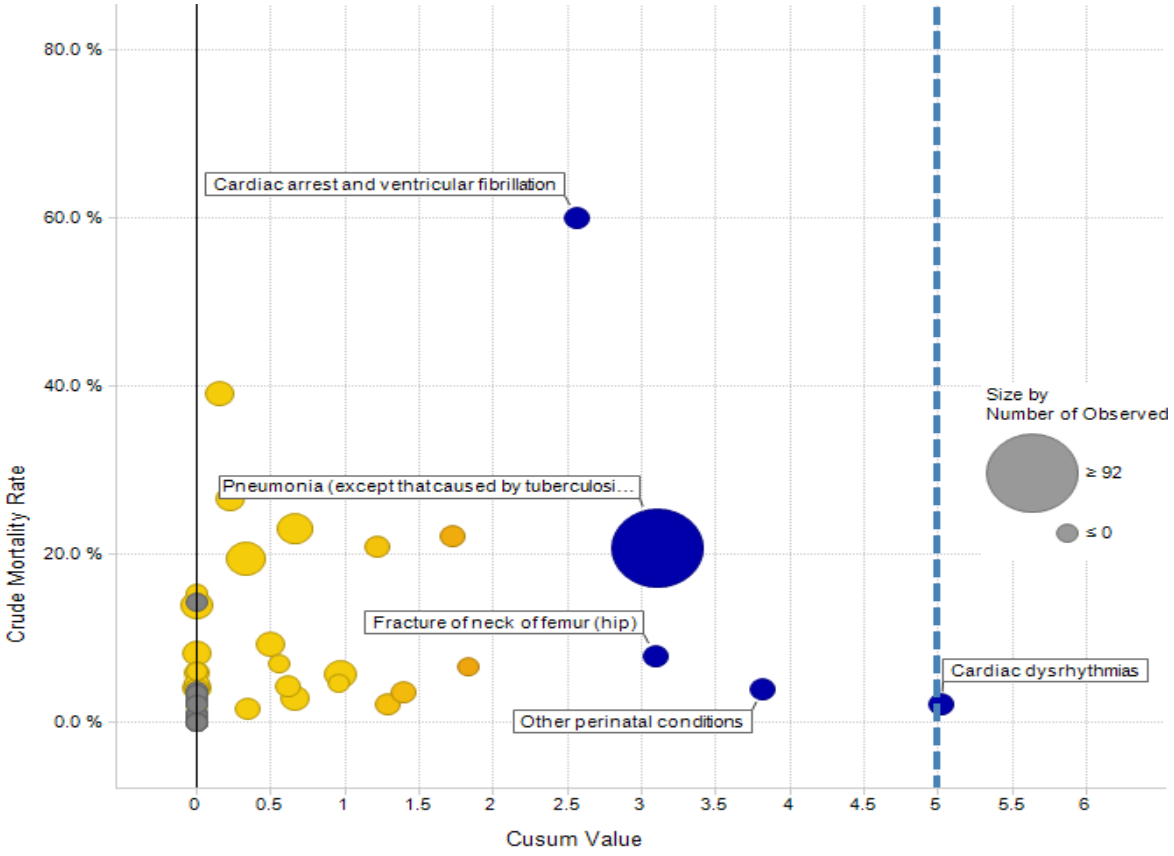
2.2 There are four investigations that have exceeded the expected timescale laid down within MHPS. However, these are being managed effectively by the Case Manager and plans are in place to receive completed reports. There are also two outstanding Employment Tribunals. One is associated with a doctor who has now left the Trust. The claim is for unlawful deduction of wages. There is a further claim made by a Doctor claiming Discrimination, Victimisation and Protective Disclosure.

2.3 In addition to the above, nominations from each division have been received for the Case Investigation Training and dates are being finalised.

3. Mortality – CUSUM

3.1 Mortality is reviewed in a number of ways including the 'CUSUM' Hospital Standardised Mortality Ratio (HSMR) methodology which is used by the Care Quality Commission. One CCS (Clinical Classification System) group has breached the mortality threshold in January 2016. The group is 'Cardiac dysthymias (106)'. The data from October 2015 to January 2016 (including January 2016 which triggered) shows that there were 23 observed deaths compared to 11.88 expected. The patient case list for this group was reviewed at the CQMG meeting in April 2016. No concerns were identified as the CCS group "Cardiac dysrhythmias" includes many elderly patients with multiple comorbidities. Please see Figure 1 below.

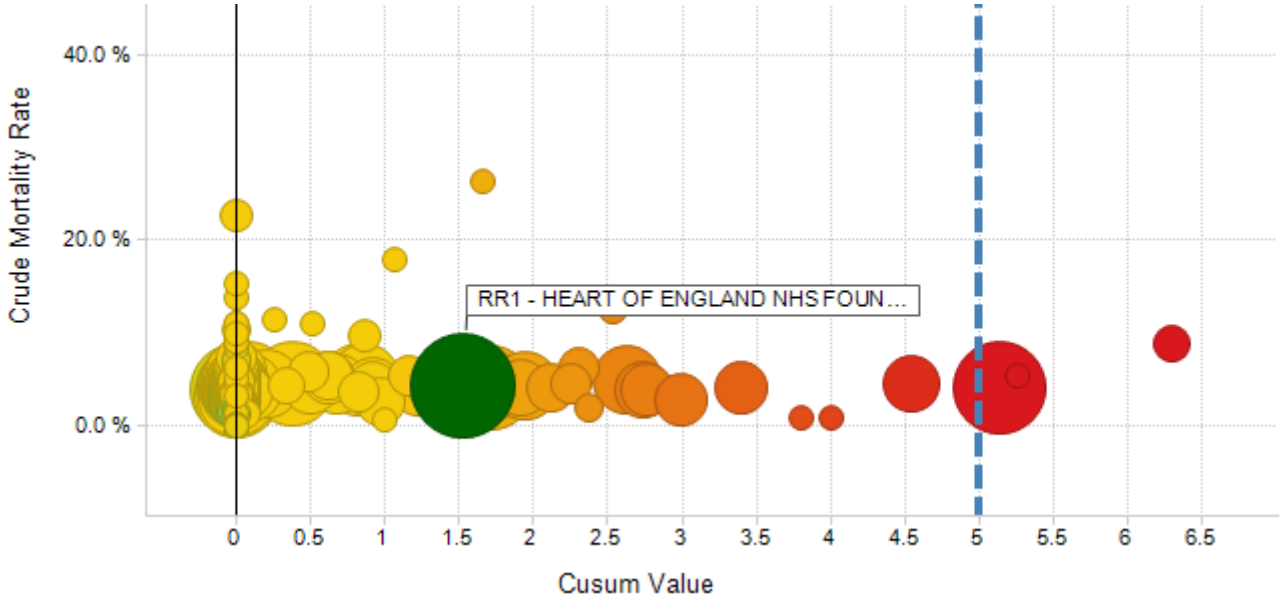
Figure 1: HEFT CUSUM in January 2016 for HSMR CCS Groups



3.2 Four CCS (Clinical Classification System) groups had higher than expected deaths in January 2016 but have not breached the mortality thresholds. The groups are 'Cardiac arrest and ventricular fibrillation (107)', 'Pneumonia except that caused by tuberculosis or sexually transmitted disease (122)', 'Other perinatal conditions (224)' and 'Fracture of the neck of femur (hip) (226)'. The patient case lists for these groups were reviewed at the CQMG meeting in April 2016. The caselist will now be reviewed in more detail to identify any patients who require a full case note review based on their age, length of stay or diagnosis codes.

3.3 The Trust's overall mortality rate as measured by the CUSUM is within acceptable limits (see Figure 2 on the following page).

Figure 2: HEFT CUSUM in January 2016 at Trust level



3.4 Previous CQC Mortality Outlier Alert

Patients admitted with a diagnosis of GI haemorrhage were the subject of a CQC mortality outlier alert following a run of higher than expected mortality from December 2014 to April 2015. A response was sent to CQC at the end of November 2015. The CQC responded in March 2016 to request some further information which was provided. The Trust has received a further letter requesting more information on the following two areas and the information has been provided:

3.4.1 Self-assessment checklist against the NCEPOD GI haemorrhage recommendations

The Trust stated that integrated management of both upper and lower gastrointestinal bleeding by gastroenterology was "unlikely to be deliverable due to the current infrastructure." The CQC has asked if there are any plans to modify the current infrastructure within this context.

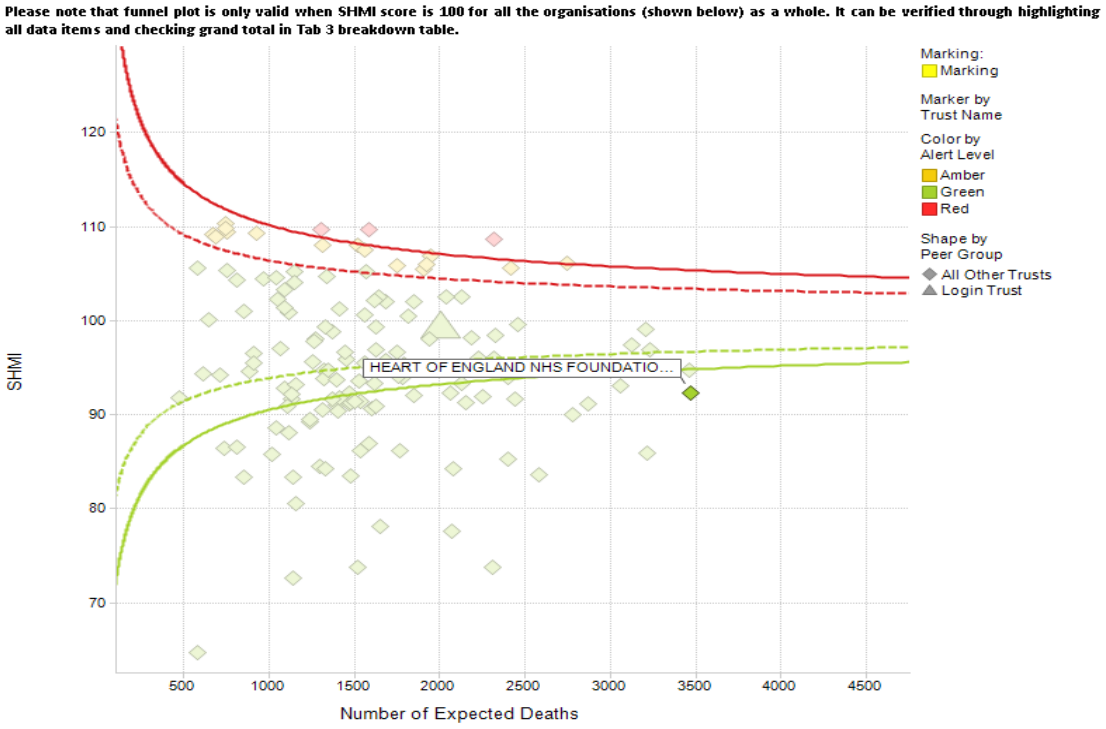
3.4.2 Provision of interventional radiology

The CQC has asked for documentation to describe the new arrangements for the interventional radiology service with University Hospital Birmingham providing 24/7 out of hours cover, in addition to the Interventional Radiology lists provided 9am-5pm Monday to Friday at Birmingham Heartlands Hospital and Good Hope Hospital.

4. Mortality – SHMI (Summary Hospital-Level Mortality Indicator)

4.1 The Trust's SHMI performance from April 2015 to December 2015 is 92.29. The Trust has had 3,200 deaths compared with 3,467 expected. The Trust is within the acceptable limits as shown in Figure 3 below.

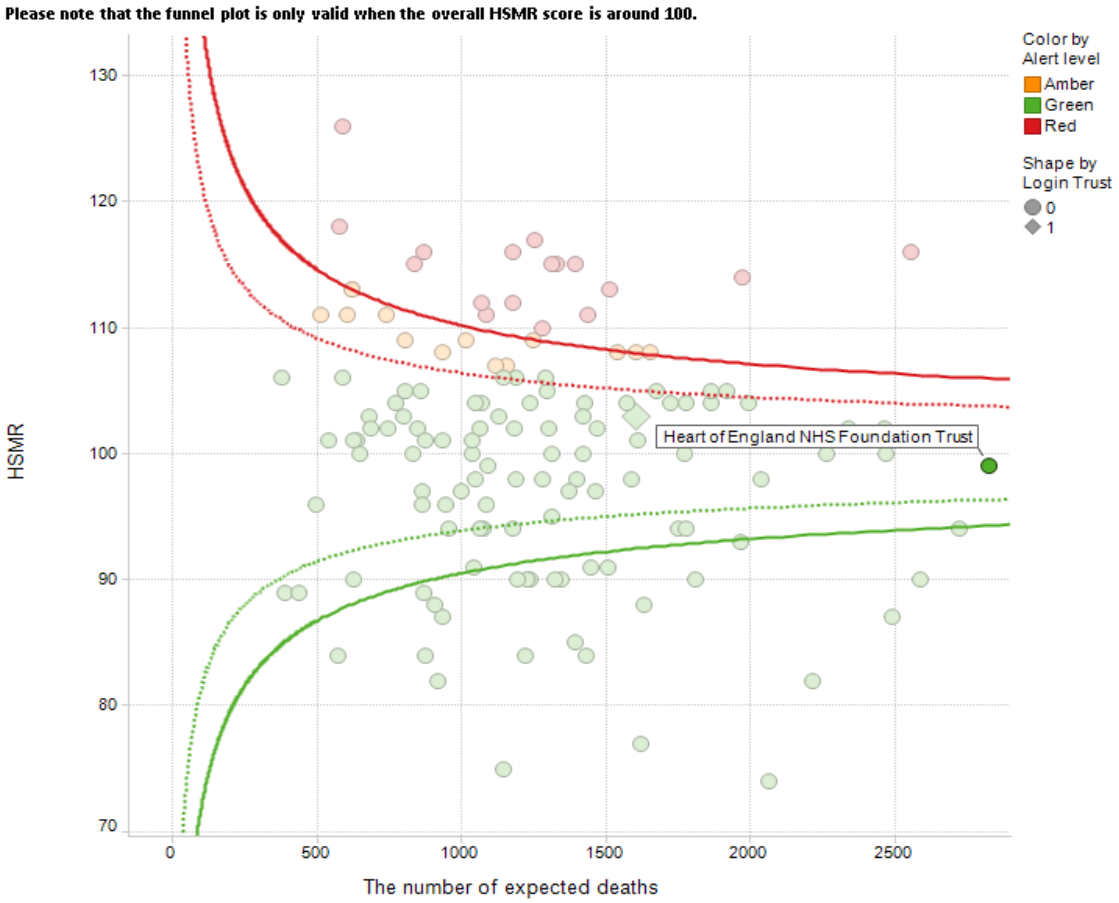
Figure 3: HEFT SHMI



5. Mortality – HSMR (Hospital Standardised Mortality Radio)

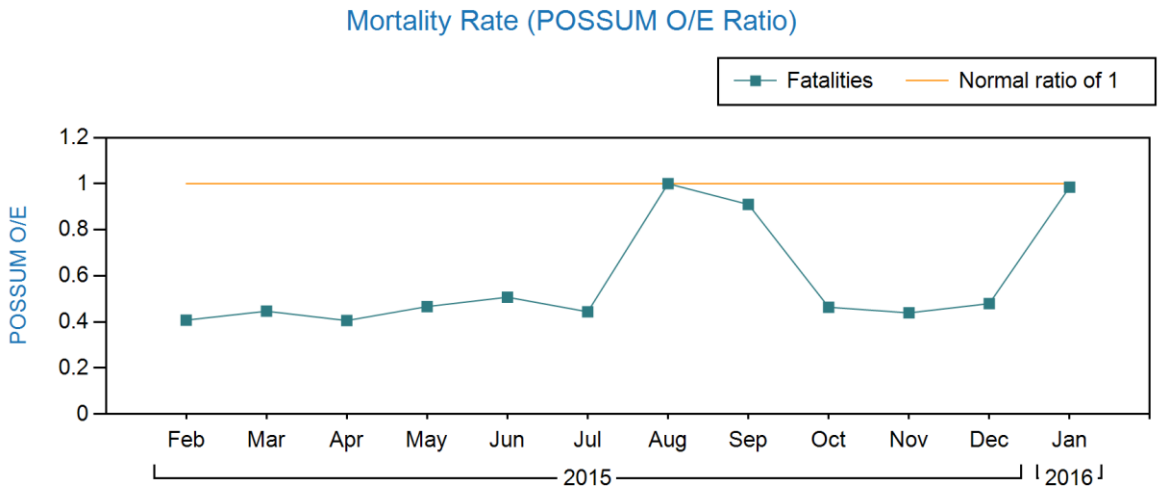
The Trust's HSMR in 2015/16 (April-January) is 98.8 which is slightly lower than expected. The Trust had 2,790 deaths compared with 2,823 expected (see Figure 4 below).

Figure 4: HEFT HSMR



6. CRAB (Copeland Risk Adjusted Barometer) surgical 30 day risk adjusted mortality ratio to January 2016.

The Trust's CRAB 30 day surgical mortality O/E (outcome versus expected) ratio continues to show a level below or equal to the average of 1.



7. Board of Directors' Unannounced Governance Visits

A programme of monthly Board of Directors' Unannounced Governance Visits involving Non-Executive Directors and Executives commenced in December 2015. The March 2016 Board of Directors' Unannounced Governance Visit did not take place due to Non-Executive Directors not being able to attend. The most recent visit took place 15 April 2016 and was to ward 14 (Trauma & Orthopaedics) at Good Hope Hospital. The visit was very positive and the action plan is currently being finalised and will shared with the Divisional Management Team shortly. The action plan will be included in the next paper to the Clinical Quality Committee.

8. Timely Delivery of Antibiotic Stat Doses

8.1 The project to increase the timeliness of administration of antibiotic stat (one off) doses began in June 2013 with the aim of improving outcomes for patients with sepsis. The administration of the stat dose is time critical and a target of one hour from prescription to administration was therefore set. To further assist in the timely administration of stat doses, pagers have been deployed to wards throughout the Trust. These pagers bleep to inform the nurse that a stat dose has been prescribed, and continue to bleep at 15 minute intervals until the stat dose is administered or the time to administer the dose has lapsed. Performance relating to the timely delivery of the stat dose is measured at Trust, site, ward and administrator level.

8.2 The bleep system was initially implemented at Birmingham Heartlands Hospital (BHH) in January 2015 on Wards AMU and 11 and rolled out to all BHH wards in December 2015. The bleep system was initially implemented at Good Hope Hospital (GHH) in May 2015 on AMU and rolled out to all GHH wards in March 2016. The bleep system was implemented at Solihull Hospital (SH) in January 2015 on AMU and rolled out to all SH wards in February 2016.

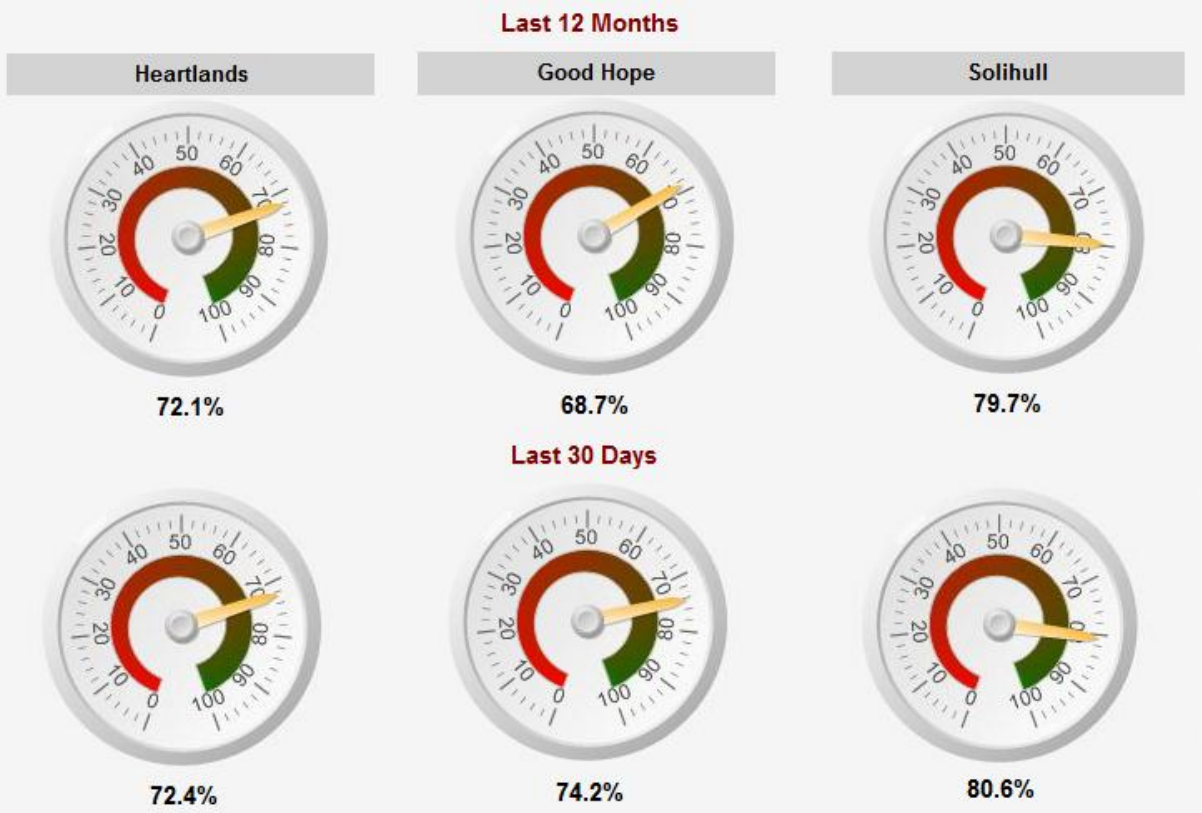
8.3 HEFT was 75.2% compliant with the one hour target in the last 30 days compared with 72.9% in the last twelve months. The information contained in this report was collated 28/04/2016. Please see Figure 5 below.

8.4 The following actions were identified:

8.4.1 The worst performing ward from each site will be invited to the next available Executive Root Cause Analysis (RCA) Care Omissions meeting, along with the best performing ward(s) to review performance and identify improvement actions.

8.4.2 Modification of the dashboard to include individual prescribers' information so that Junior Doctors' performance can be reviewed.

Figure 5: Delivery of antibiotic stat performance by site 28/04/2016.



9. Open and Recently Closed Serious Incidents (SIs)

Table 1 below provides a summary of open and recently closed serious incident investigations at the Trust. Progress and themes will be monitored at the Clinical Quality Monitoring Group with a summary reported to each Board of Directors meeting.

Table 1: Open and Recently Closed Serious Incidents (SIs)

Site	Division	Speciality	Date of incident	Submission Date	STEIS Description	Status	Level of harm
BHH	Surgery	Trauma and Orthopaedics	**27/12/15**	**24/03/16**	STEIS 2016/82 Wrong Site Surgery – hip aspiration	DOC – awaiting feedback to family Report submitted to CCG	No harm – patient discharged
BHH	Medicine	Acute Medicine	**21/01/16**	**18/04/16**	STEIS 2016/2094 Sub optimal care of a deteriorating patient – concerns due to escalation	DOC - awaiting feedback to family Report submitted to CCG	Patient has died
BHH	Respiratory	Respiratory	**01/02/16**	**03/05/16**	STEIS 2016/3398 Sub optimal care of a deteriorating patient – suction to tracheostomy failed	DOC – letter confirmed Report – Draft completed	Temporary Harm
BHH	Medicine	Acute Medicine	**01/12/15**	**03/05/16**	STEIS 2016/3403 Blood product incident	Report – Draft completed	No harm
BHH	Women's and Children	Obstetrics	**30/12/15**	**06/05/16**	STEIS 2016/4145 Unexpected admission to ITU post delivery	DOC – letter confirmed Report - Draft	Low harm

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BOARD OF DIRECTORS
WEDNESDAY 11th MAY 2016

Site	Division	Speciality	Date of incident	Submission Date	STEIS Description	Status	Level of harm
SHH	Theatres	Theatres	**03/02/16**	**06/05/16**	STEIS 2015/4166 Medication error – atacurium rather than normal saline flushed into cannula	DOC – letter confirmed Report – complete awaiting exec sign off	No harm
BHH	Women's and Children's	Paediatrics		**01/06/16**	Multi-Agency (early cardiology involvement)	Birmingham Children's Hospitals fulfilling DoC.	Patient has died
BHH	Women's and Children's	Gynaecology	**08/02/16**	**25/05/16**	STEIS 2016/5543 Retained VAC sponge	DoC – letter confirmed Report - pending	Temporary harm now resolved
BHH	Surgery	General surgery	**28/02/16**	**25/05/16**	STEIS 2016/6014 Retained VAC sponge	DoC – letter confirmed Report - pending	Temporary harm now resolved
BHH	Women's and Children's	Obstetrics	**29/11/15**	**07/06/16**	STEIS 2016/7284 Misinterpretation of pathological Cardiotocography (CTG)	DoC – letter confirmed Report - Draft	Neonate death Mother – no harm
BHH	Clinical Support Service	Anaesthetics	**04/03/16**	**03/06/16**	STEIS 2016/6355 Never Event Wrong site nerve block	Doc – letter confirmed Report - Draft	No harm

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BOARD OF DIRECTORS
WEDNESDAY 11th MAY 2016

Site	Division	Speciality	Date of incident	Submission Date	STEIS Description	Status	Level of harm
BHH	Women's and Children's	Obstetrics	**11/03/16**	**09/06/16**	STEIS 2016/7571 issues with Cardiotocography (CTG)	DOC – letter confirmed Report pending	Neonate – poor condition at birth now self-ventilating Mother – no harm
BHH	Emergency Care	Emergency Department	**04/03/16**	**14/06/16**	STEIS 2016/8017 Delay in review leading to acute kidney injury	DoC – letter confirmed	No harm
BHH	Women's and Children's	Obstetrics	**19/03/16**	**27/06/16**	STEIS 2016/8696 Sub-optimal care of the deteriorating patient causing pulmonary oedema.	DoC – letter confirmed	No harm
BHH	Women's and Children's	Obstetrics	**02/04/16**	**10/06/16**	STEIS 2016/9320 Unexpected admission to the intensive care unit.	DoC – letter confirmed Report pending	No harm
BHH	Emergency Care	Acute Medicine	**08/04/16**	**12/07/16**	STEIS 2016/10249 No senior review of deteriorating patient.	DoC – letter pending Report – pending	Patient died
BHH	General Surgery	Theatres	**04/04/16**	**12/07/16**	STEIS 2016/10275 Unidentified plastic found in patient's pelvic cavity	DoC – letter confirmed	No harm

Site	Division	Speciality	Date of incident	Submission Date	STEIS Description	Status	Level of harm
BHH	Women's and Children's	Obstetrics	**14/04/16**	**12/07/16**	STEIS 2016/10244 Unexpected neonatal death	DoC – letter confirmed Report - pending	Neonate died Mother – no harm

10. Recommendations

The Board of Directors is asked to:

- Discuss the contents of this report and approve the actions identified.
- Agree that information will only be reported by exception in future reports following each Clinical Quality Monitoring Group meeting.

Dr David Rosser
Executive Medical Director
29th April 2016

HEART OF ENGLAND NHS FOUNDATION TRUST
TRUST BOARD

WEDNESDAY 11TH MAY 2016
PRESENTED BY THE CHIEF NURSE

Title: Care Quality Report						**Attachments:**	
From: Sam Foster				**To**: Board			
The Report is being provided for:							
Decision	N	Discussion	Y	Assurance	Y	Endorsement	N
The Committee is being asked to:							
Note the content of the report and the required onward actions.							
Key points/Summary:							

1. **Infection Control-** There have been no cases of post 48 hour MRSA bacteraemia in March.
   The overall Trust compliance for MRSA screening for March saw an improvement at 86%.
   There were three wards closed during March due to outbreaks of norovirus. These were
   Rowan ward and ward 29 at Heartlands Hospital, and ward 11 at Good Hope Hospital.
2. **Pressure ulcers-** Current performance at the end of March 2016 for avoidable grade 3 and necrotic pressure ulcers is 51 reported against a target of no more than 29 for the year, breaching the Trust trajectory for 2015-16. Prevalence against grade 2 pressure ulcers equate to 190 against a target of no more than 187 for the year. This has breached the 10% reduction target. However, there has been an overall reduction in the total numbers of hospital acquired pressure ulcers in year with a 12% reduction in pressure ulcers grade 3 and an 8.6% reduction for pressure ulcers grade 2.
3. **Falls-** The Trust achieved its 10% reduction in overall falls rate per 1,000 occupied bed days with a year to date position of 6.32 against a target of 6.36, with only two months (January and March 2016) falling outside of the trajectory.
4. **Nurse Staffing and Recruitment-** All divisions were compliant with nurse staffing with the unify system with the exception of Maternity for both Midwives and Support Workers. For midwives Maple Ward was rated red for one week and was mitigated with assurance from the Associate Head Nurse. For Support Workers there was an 88% compliance and recruitment to vacant posts remains live. The current number of vacancies is 158wte, in addition there are 34 EU and 20 newly qualified Registered nurse awaiting PIN numbers, once in post this will then reduce the position by 54wte. For specialty areas Theatres have a total of 30 vacancies, paediatrics have 6, critical have none and the Emergency Department have made significant in roads, are currently awaiting new starters and are still utilising temporary staff to cover these shifts.
5. **Nurse Staffing Reviews** -There is a schedule of nursing workforce reviews across all areas and specialties that evidence compliance with a section of the NHS Standard Contract. The March workforce review indicates safe staffing across AMU and SAU. For inpatient wards there is a recommendation to uplift the establishment on ward 26 and to further review wards 24 and 12 at the Heartland

site. For the Emergency Departments there is currently no national tool to measure compliance and both departments were 93 and 94% compliant against staffing in March.

6**. Complaints-** Month on month the numbers of complaints being closed off are increasing and have done so progressively since December 2015 when 40 were closed, to more than twice that number, 90, in March. The Trust is now very close to having more complaints closed in month than being received.

7. **Friends and Family Test-** for In patients the FFT positive responder score dropped to 92% in March 2016. This is 3% behind both the national and regional scores (95%). The participation rate increased to usual levels at 37%, 13% ahead of the national participation rate. For the Emergency Departments (ED) the percentage positive responder score decreased in March by 6% to 73%. Regionally and nationally the score was 85% (one month in arrears).The participation rate was 5% ahead of the regional rate (14%) and 1% ahead of the national participation rate. There is a continuous piece of work being undertaken to improve the patients experience in the ED.
8. **National In Patient Survey-**The results of the National Inpatient Survey 2015 saw a response rate of 43.6%, which was an improvement of 7.6% in the response rate of the 2014 survey. The findings outlined that the organisation was in the top 20% of Trusts for one question and in the bottom 20% of Trusts for 19 questions. Various work streams are in place addressing each of the concerns for the bottom 20% of responses.
9. **Adult Safeguarding –** There has been an increase in the number of both safeguarding and DOLS referrals during the last year. Safeguarding referrals have increased by 130 and Dols have increased by 45. The reasons for this increase are due to the Cheshire West Judgement, an increased staff knowledge and awareness and widened access to training for other staff groups.
10. **Admissions Discharges and transfers-** The Trust overall performance for March 2016 has demonstrated an improvement to 81.19% compared with 80.65% for February, however it remains it remains in breach trajectory of 90%. There have been some pockets of improvement, noticeably transfer; all sites achieved above 85% with Solihull for the second consecutive month achieving above 95% for ensuring transfers are completed within two hours.
11. **Revised Ward to Board reporting-** The launch of five new divisions in April 2016 had provided an opportunity to revise the local framework for ward to board reporting. This revised framework will focus on bringing the ward even closer to the board whilst evidencing assurance of clinical quality across the organisation. The revised framework will commence from May 2016 and will focus on performance in April. The revised report will be presented at the Care Quality Report in June 2012.
12. **CQUIN-** For 2016/17 there are 15 proposed CQUINs: three national acute, four local acute, six Specialised Services, and two Public Health CQUINs.

Assurance Implications:

Strategic Risk Register	Y/N	Performance KPIs year to date	Y/N
Resource/Assurance Implications (e.g. Financial/HR)	Y/N	Information Exempt from Disclosure	Y/N
Identify any Equality & Diversity issues			
Outline how any Equality & Diversity risks are to be managed			

Which other Committees has this paper been to?

None

HEART OF ENGLAND NHS FOUNDATION TRUST
TRUST BOARD

WEDNESDAY 11TH MAY 2016
PRESENTED BY THE CHIEF NURSE

1. Purpose

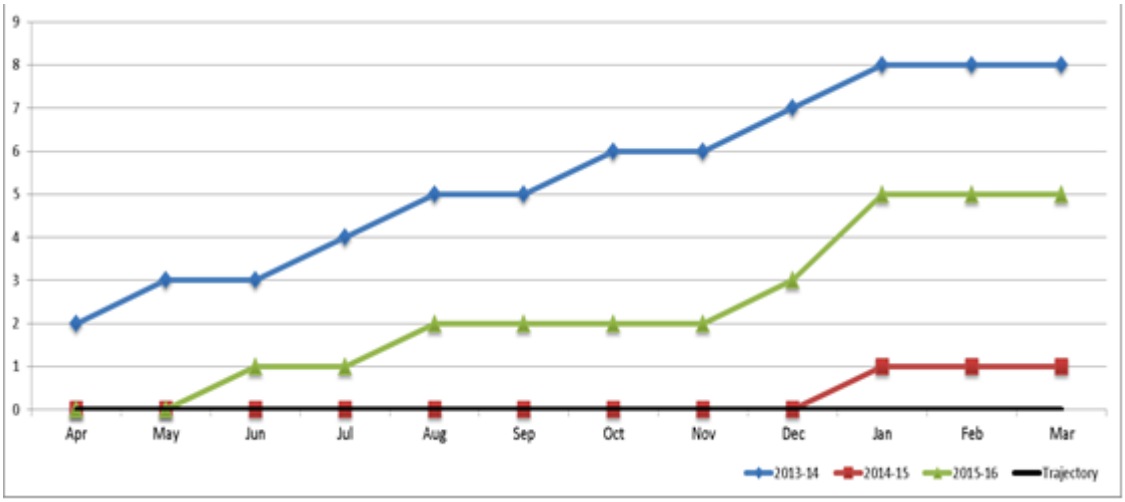
This paper summarises the Trust's performance against national quality indicators and targets including those in Monitor's Risk Assessment Framework as well as local priorities.

It outlines the current position with performance and actions required in key areas to build on the care provided to patients in our hospitals.

2. Infection Control

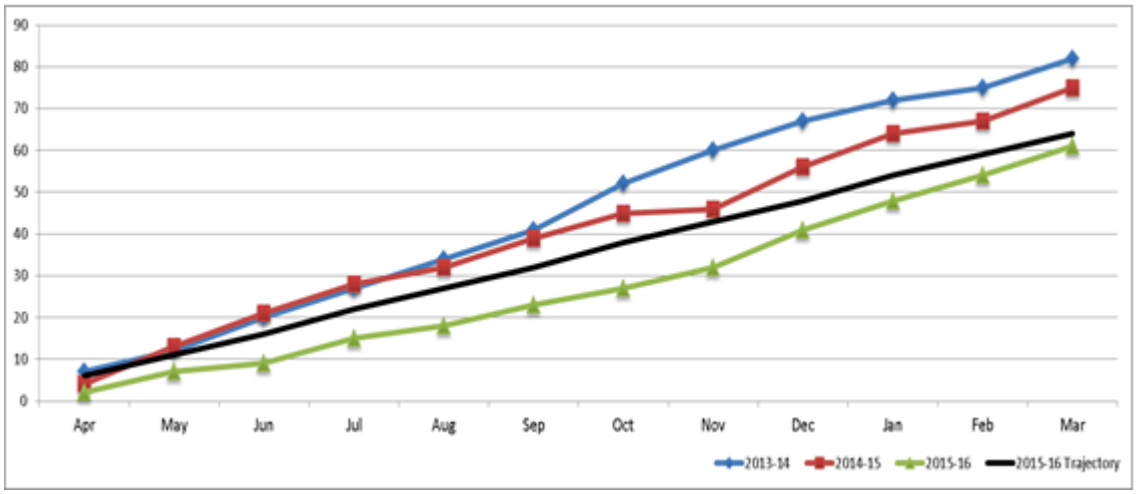
2.1 Methicillin Resistant *Staphylococcus aureus* (MRSA) bacteraemia

There have been no cases of post 48 hour MRSA bacteraemia in March. The total number of Trust attributable cases for 2015-16 is five. Four MRSA bacteraemia were post 48 hour cases and one was attributed to the Trust depsite being a pre 48 hour case. This was due to transmission of MRSA on the ward which was confirmed following ribotyping of MRSA isolates.



HEFT Attributable MRSA bacteraemia cases for April 2015 to March 2016, with the annual threshold shown

2.2 Post 48 hour toxin positive Clostridium Difficile



HEFT *C. difficile* toxin-positive post-48 hour cases from April 2015 to March 2016 with the annual threshold shown

2.3 MRSA Emergency Screening

There has been gradual improvement with MRSA emergency screening compliance since August 2015 when the new dual screening swab was introduced. The overall Trust compliance for March was 86% although Good Hope Hospital achieved 90% compliance for the third consecutive month.

2.4 Outbreaks

There were three wards closed during March due to outbreaks of norovirus. These were Rowan ward and ward 29 at Heartlands Hospital, and ward 11 at Good Hope Hospital.

3. Tissue Viability

3.1 Avoidable Hospital Acquired Pressure Ulcers

The priority for HEFT is to reduce the overall number of patients who acquire avoidable pressure ulcers whilst in Hospital. During the 2015-16 financial year, the agreed reduction trajectory for HEFT set with the Commissioners was to achieve a 10% reduction for avoidable hospital acquired grade 2 pressure ulcers, and a 50% reduction for avoidable hospital acquired grade 3 and necrotic ulcers, based on the Trusts overal performance in these areas for 2014-15.

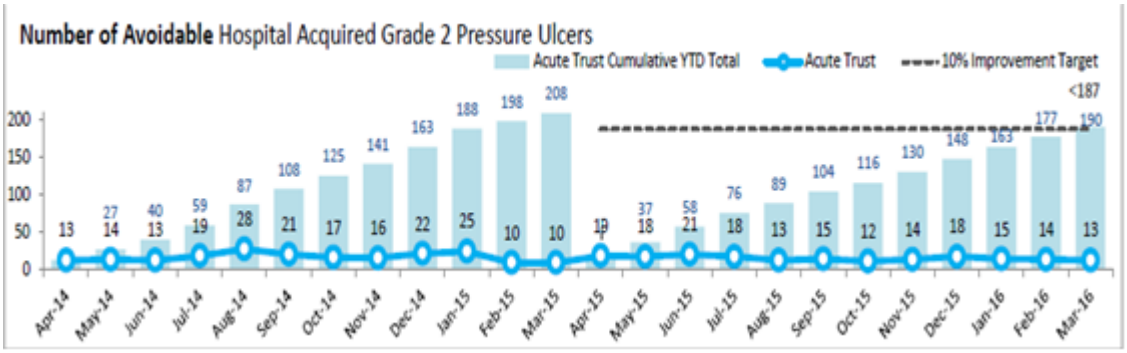
In addition to this, the following three Key Performance Indicators (KPIs) are outlined within the contract: Documented repositioning; Actual repositioning; and Daily skin inspection, all of which are to achieve compliance of 90% by the end of Quarter 2, and 95% overall by the end of Quarter 4.

Whilst it is important to achieve the target, the priority is to ensure that incidence of patient harm caused by pressure ulcers is minimised through robust root cause anyalysis and shared learning.

3.2 Grade 2 Avoidable Hospital Acquired Pressure Ulcers

Current performance as at the end of March 2016 for avoidable hospital acquired grade 2 pressure ulcers equate to 190 against a target of no more than 187 for the year. This has breached the 10% reduction target.

Performance has improved for 2015/16 compared to the previous year when 208 avoidable grade 2 pressure ulcers had been reported up to the end of March 2015, against a total number of 190 in March 2016. This is an improvement of 8.6%.

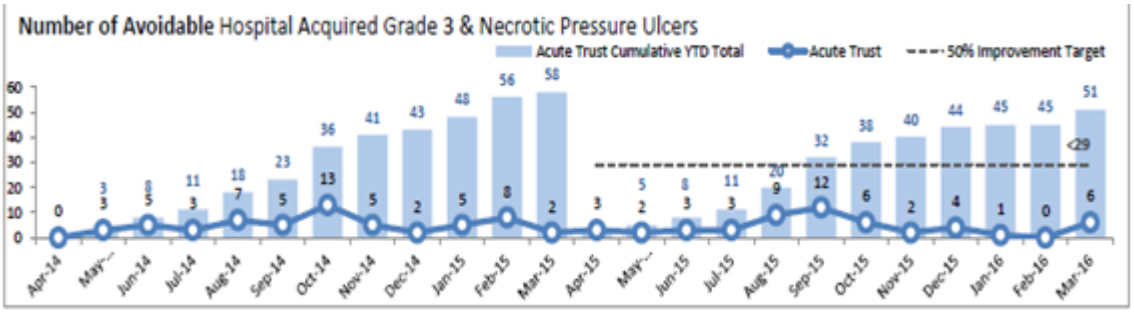


Number of avoidable hospital acquired grade 2 pressure ulcers

3.3 Grade 3 and Necrotic Avoidable Pressure Ulcers

Performance for avoidable grade 3 and necrotic pressure ulcers is 51 reported against a strategic target of no more than 29 for the year, breaching the Trust trajectory for 2015-16. There have been 6 new grade 3 avoidable pressure ulcers during March 2016.

Performance has improved during 2015/16 compared to the previous year when 58 grade 3 and necrotic pressure ulcers had been reported up to the end of March 2015, against a total of 51 in March 2016 which is an improvement of 12%.



Number of avoidable hospital acquired grade 3 and necrotic pressure ulcers

3.4 Tissue Viability Key Performance Indicators (KPIs)

There are three tissue viability KPIs that are measured:

- Documentation of repositioning;
- Documentation of frequency of repositioning adhered to;
- Daily skin inspections adhered to.

Performance against the repositioning of patients adhered to has remained static in March 2016 at 83%. Performance against all KPIs continues to be monitored through the Trust Wide Tissue Viability Steering Group, with revised remedial action plans in place for each of the wards. Performance against the two remaining KPIs in month is within trajectory. Documented repositioning is at 95% and daily skin inspection has improved and is at 92%. Overall the KPI score for tissue viability is compliant at 94%.

3.5 Action Plan

One of the main aims across all Divisions is to minimise patient harm, to reduce the deterioration of existing pressure ulcers, the incidence of device related pressure ulcers and a reduction in the incidence of avoidable pressure ulcers. These work streams form part of the actions from the Sign up to Safety Campaign.

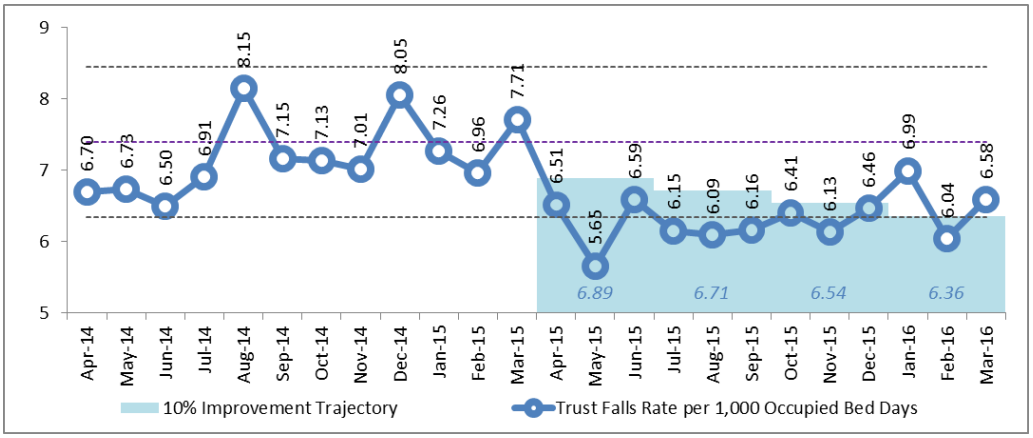
As a result of the Sign up to Safety Campaign, a group of wards of concern across all sites are receiving a package of intense support over a four week period, with a view to reducing harm.

The first ward to complete intensive support is ward 8 at Heartlands and has improved in the prevalence of numbers of pressure ulcers and performance against KPIs. This work will continue across wards along with the launch of a brilliant basics campaign focusing on reducing harm in May 2016.

4. Falls

The Trust achieved its 10% reduction in overall falls rate per 1,000 occupied bed days with a year to date position of 6.32 against a target of 6.36, with only two months (January and March 2016) falling outside of the trajectory.

The increase in falls during March 2016 was due to an overall increase on the Heartlands site. Whilst this cannot be attributed to additional capacity as this has not changed from the previous month, the acuity of patients remains high.



Falls rate per 1,000 occupied bed days

The Falls Assessment indicator in the Nursing Metrics (KPI) has achieved all elements in March 2016 with overall score at 97%.

5. Nurse Staffing

5.1 UNIFY Staffing Return

The Trust measures its compliance with safe staffing levels through weekly surveillance and submission of the monthly UNIFY return to NHS England. These monthly mandated reviews include staffing for all inpatient areas across all specialities. They include Supervisory Ward Sisters' hours and any resource needed for one to one nursing as per the UNIFY criteria. Compliance is measured by comparing funded staffing hours to actual staffing hours.

SITE / DIVISION	QUALIFIED COMPLIANCE	HCA COMPLIANCE
BHH	99%	108%
GHH	96%	105%
SOL	99%	119%
O&G	92%	88%
TRUST	95%	101%

UNIFY staffing data for March 2016

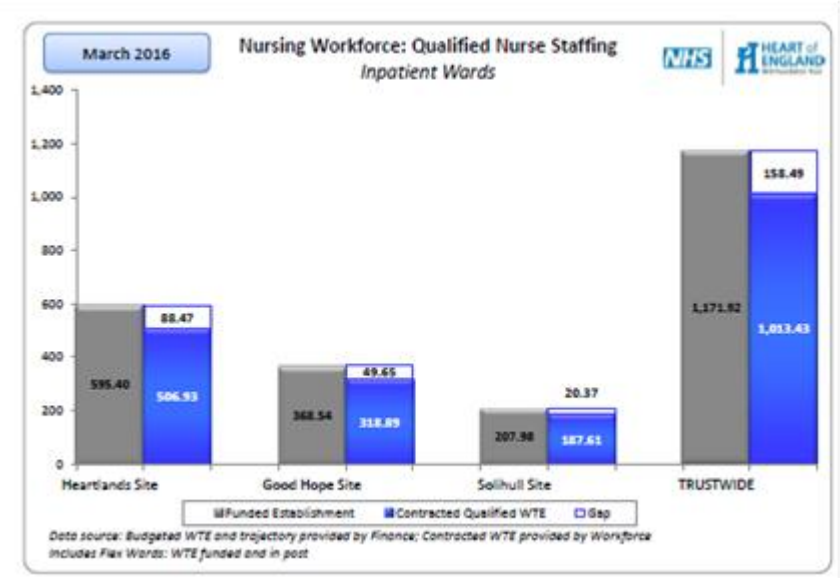
Areas of non–compliance where actual qualified staffing levels fell below 90% of their agreed safe staffing levels and mitigating actions:

5. **Ward 8 GHH** Diabetes **–** planned new starters will take the ward up to establishment. Ward safety maintained by Supervisory Ward Sister working clinical shifts and staff movement from other areas.
6. **23 HASU BHH, ITU BHH, ITU GHH, NIV BHH, 4 HDU BHH** – all of these areas flex staffing according to patient acuity and adhere to the national staffing levels for level 2 and 3 acuity at all times. On occasions this will require more than their funded establishment and sometimes less, hence the variation in staffing day to day.
7. **Ward 23 GHH** Cardiology **–** staffed as one unit with CCU with a combined qualified compliance of 93%. Associate Head Nurse assurance that safety was maintained across all shifts.
8. **Ward 23 ASU BHH –** ward has a number of qualified vacancies. Ward staffed to meet patient dependency and staffing shared across HASU and ASU.
9. **Maternity Support Worker's (MSWs) across Maternity** – 88% compliance with MSW staffing. Compliance improved from February 2016. MSW recruitment campaign remains live.
10. **Maple Ward BHH** Maternity **–** red rated compliance for one week in March. Full mitigation detail provided by Associate Head Nurse with assurance that the ward was safe

The Trust has a robust mechanism to assess and assure safe staffing levels and can provide actions and risk mitigation where actual staffing levels fall below established numbers.

5.2 Qualified Nursing Vacancies

There were 158 WTE qualified nursing vacancies across the adult inpatient wards and AMUs in March 2016. This includes the qualified establishment for Rowan Ward at Heartlands.



Qualified nurse staffing by site

Currently there are 34 EU nurses awaiting PIN numbers. In addition there were 20 newly qualified nurses who commenced post in March 2016 some of which are also awaiting their PIN numbers. The NMC continue to have a backlog of applications for PIN numbers. When all PIN numbers are received this will reduce the current vacancy position by a further 54 WTE.

5.2.1 Planned Starters

- 35 qualified nurses across the adult inpatient wards and AMU's in April 2016.
- 17 qualified nurses across the adult inpatient wards and AMU's in May 2016.
- 11 qualified nurses are planned to start in theatres across April and May 2016.
- 32 offers made at the generic recruitment event on the 2nd April 2016 to commence in September 2016

5.2.2 Planned Recruitment Events

- Dublin Jobs Fair on the 27th April 2016
- BCU Jobs Fair on the 27th April 2016
- Commencing SKYPE interviews for EU nurses in May 2016
- Commenced planning for recruitment event in Romania at the end of July 2016

5.3 Current Position and Actions to Date

The Trust currently has a vacancy position of 158 WTE qualified nurses across the adult wards and AMU's. This includes the establishment for Rowan Ward which is a newly funded area with a qualified establishment of 16 WTE. The vacancy position for these areas (excluding Rowan) in October 2015 was 209 WTE showing a reduction in vacancies of circa 30%. There are 52 qualified nurses planned to start in April and May 2016 and, to date, the Trust has offered 32 posts to nurses qualifying in September 2016. In addition to this there are circa 40 WTE qualified nurses awaiting their PIN numbers from the NMC (predominantly EU nurses). Once these are received the Trust will see a further reduction in the qualified vacancy gap.

The main body of qualified vacancies is at Heartlands and work will be undertaken with the new divisional Head Nurses to address a number of 'hotspot' areas.

Theatres have 11 qualified nurses starting over April and May 2016 and continue to have a vacancy of around 30 WTE. Recruiting to theatres remains a national problem and a difficult challenge to address.

Paediatrics has circa 6 WTE qualified nursing vacancies however they have a very significant problem with the level of maternity leave. The Head Nurse for the division has presented a proposal both to the Chief Nurse and the divisional triumvirate to introduce an over establishment model to help to mitigate the risk presented by maternity leave.

Critical care have no qualified vacancies and the Emergency Departments have made significant inroads into recruiting to their vacancies, however the majority of these new recruits have not yet started in post and the departments are reliant upon a significant amount of temporary staffing including agency nurses. Once the Division the Head Nurse is in post work will be undertaken to improve nurse vacancy reporting from the ED's.

5.4 Compliance with NHS Standard Contract 5.2.4

Undertake a detailed review of staffing requirements every 6 months to ensure that the Provider remains able to meet the requirements set out in GC5.2.1.

There is a schedule of nursing workforce reviews across all areas and specialties that evidence compliance with this section of the NHS Standard Contract:

5.4.1 Acute Medical Unit and Surgical Assessment Unit workforce review

The last workforce review was presented at the Public Trust Board meeting in September 2015 and was included in the Quarter Two workforce report. A review has now been completed as planned for AMU and SAU at Good Hope following service redesign and potential changes in patient acuity. This review will be presented at the public Trust Board meeting in May 2016 and indicates that staffing is safe across both of these areas. All AMUs and SAUs across all sites will be reviewed again in Autumn 2016.

5.4.2 Adult Inpatient Workforce Review

The multiple methodologies used for this review are compliant with the NICE guidelines for safe staffing for nursing in adult inpatient wards in acute hospitals (2014). The review incorporates clinical outcomes associated with harm free care to fully triangulate the situation on each ward area.

The last adult inpatient workforce review was presented at the Public Trust Board meeting in September 2015 and was included in the Quarter Two workforce report. Data collection was planned to commence again in February 2016 across areas where there have been service changes or concerns raised about the acuity of patients when compared to the funded skill mix. The review has now been completed and the wards included were; wards 2, 3, 8, 9, 12, 24, 26 and Rowan at Heartlands; Wards 8, 19 and 20B at Solihull, and Wards 9, 11, 12 and 21 at Good Hope. This review will be presented at the public Trust Board meeting in May 2016 and indicates that staffing is safe across both of these areas. Recommendations will include:

- An uplift in the staffing on Ward 26 BHH which is the Cystic Fibrosis unit. Patient acuity has risen due to the longer life expectancy of these patients and the acuity of their care needs when they have an inpatient stay. Often these patients can be at acuity level 2 which is comparable with a high dependency unit. A recommendation will be given to Board for an uplift of 5.16 WTE Band 5 nurses which equates to an additional qualified nurse on each shift.

- A further review of the staffing on Ward 24 BHH which is the Respiratory Unit. The challenge in this area is to ensure adequate staffing for NIV patients who are acuity level 2 in terms of their care needs. The numbers of NIV patients at any one time varies significantly and the challenge is to be able to flex staffing up and down accordingly. The Divisional Head Nurse will lead this piece of work.

- Ward 12 BHH which is colorectal surgery. There are a significant number of qualified vacancies on the ward together with increased acuity. A recommendation will be given to the Board for an uplift of 2.3 WTE Band 5 nurses and a requirement for the Divisional Head Nurse to establish a robust recruitment plan to decrease the number of qualified vacancies.

5.4.3 Emergency Department Workforce Review

There remains no nationally recommended tool for measuring patient acuity and workforce requirements in emergency department areas. The ED at Heartlands and Good Hope both have escalation procedures to enable staffing to be increased when patient volume rises above the level that can be safely staffed by the funded establishment. Bed capacity updates also show a RAG score for

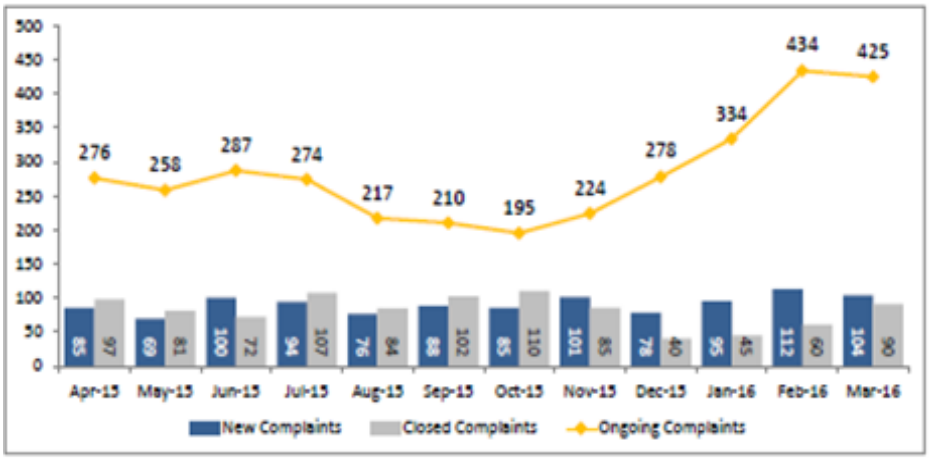
activity in each ED to enable escalation to be implemented with minimal delay.

The table below shows the percentage compliance of actual qualified staffing in the two emergency departments across Quarter Four

Area	% qualified staffing compliance Quarter Four -2015/2016
Emergency Department BHH	94%
Emergency Department GHH	93%

6. Complaints

The graph below shows the number of complaints received and the number closed. Month on month the numbers of complaints being closed off are increasing and have done so progressively since December 2015 when 40 were closed, to more than twice that number, 90, in March. The Trust is now very close to having more complaints closed in month than being received.



Number of new complaints received; and number of closed complaints

There are still over 400 live complaints in the system, however this has reduced for the first time since the new processes were introduced.

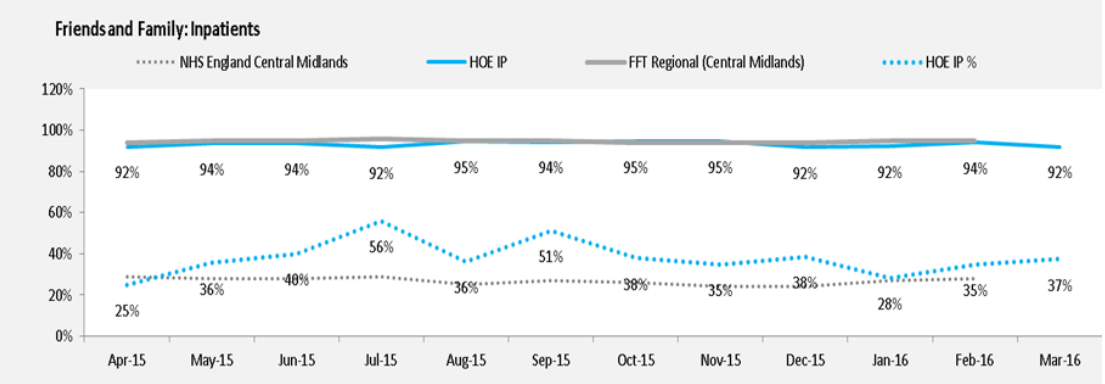
There are still significant numbers of complaints in the system which are overdue, and these are escalated to new divisional leads each week. In terms of trajectory, whist a backlog does still exist, the progress with complaint closure in line with updated quality assurance arrangements is evident.

7. Friends & Family Test (FFT)

7.1 Adult Inpatient FFT

The FFT positive responder score dropped to 92% in March 2016. This is 3% behind both the national and regional scores (95%).

The participation rate increased to usual levels at 37%, 13% ahead of the national participation rate.

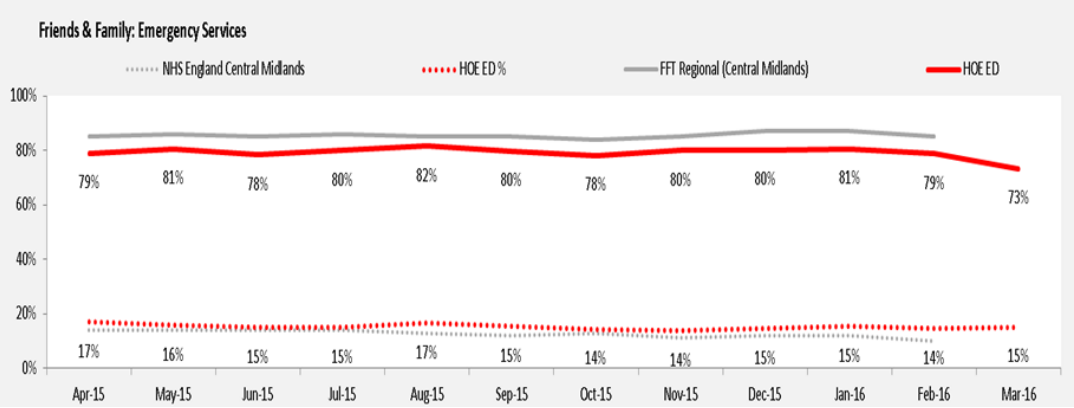


Adult Inpatients FFT

7.2 Emergency Departments FFT

The percentage positive responder score decreased in March by 6% to 73%. Regionally and nationally the score was 85% (one month in arrears).

The participation rate was 5% ahead of the regional rate (14%) and 1% ahead of the national participation rate.



Emergency Departments FFT

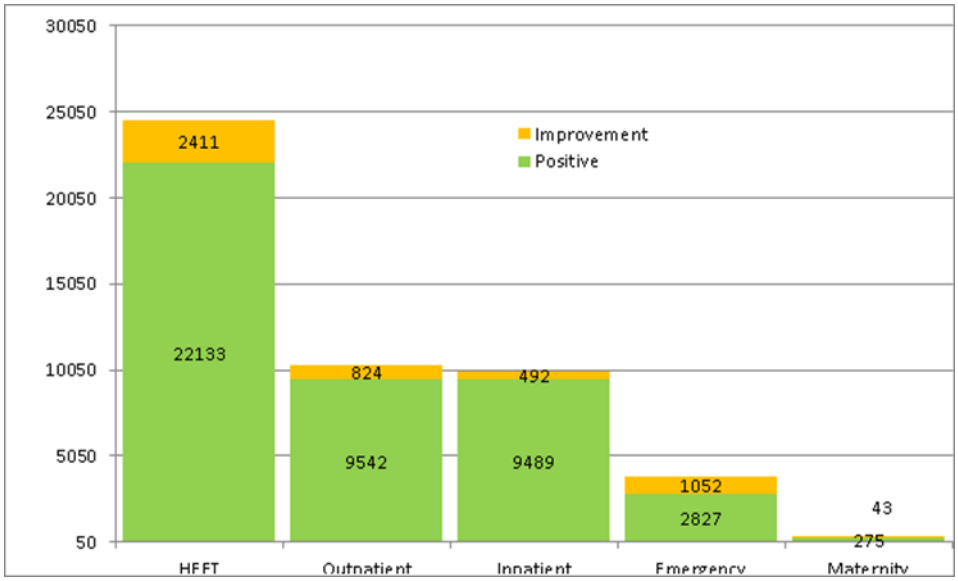
The table below shows that the largest decrease in positive responders occurred at the Heartlands site (9%). The qualitative / text comments are being analysed to establish reasons from the patients' perspectives as to why the Trust experienced this dip; the task and finish group chaired by the Head Nurse are meeting to discuss FFT feedback and actions required.

Emergency FFT Metric	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16
NHS England	88%	88%	88%	88%	88%	88%	87%	87%	87%	86%	85%	
FFT Regional (Central Midlands)	85%	86%	85%	86%	85%	85%	84%	85%	87%	87%	85%	
Good Hope	79%	82%	81%	81%	83%	81%	80%	79%	82%	83%	80%	79%
Heartlands	76%	76%	72%	76%	76%	77%	71%	78%	75%	74%	72%	63%
Solihull	83%	85%	82%	84%	88%	83%	86%	86%	85%	89%	87%	85%
HOE ED	**79%**	**81%**	**78%**	**80%**	**82%**	**80%**	**78%**	**80%**	**80%**	**81%**	**79%**	**73%**
Target	87%	87%	87%	87%	87%	87%	87%	87%	87%	87%	87%	87%

Emergency Departments FFT – Positive Responder Score by Site

7.3 FFT Themes for Quarter 4 2015/16

FFT qualitative feedback (patient comments) were analysed as shown below.



FFT Number of Positive and Improvement Comments for Service Group – Quarter 4 2015/16

90% of comments were positive, an increase of 7% against quarter 3. The remaining 9% suggested areas for improvement as shown in the table below:

HEFT Service	Top 3 Improvement Themes	Q4	%
Outpatient	Staff attitude	349	3%
	Environment	248	3%
	Waiting time	216	2%
Emergency	Staff attitude	359	5%
	Environment	281	4%
	Waiting time	279	4%
Inpatient	Staff attitude	37	2%
	Implementation of care	30	2%
	Environment	24	1%
*Maternity	attitude	22	5%
	Environment	18	4%
	Implementation of care	12	3%

FFT Top Improvement Themes – Quarter 4 2015/16

7.4 Actions Taken

- Recording of a relative's story (as a result of a complaint) in a 'goldfish bowl' environment, to be used with all ward staff and in wider training as a case study.
- Engagement of Patient Community Panels in supporting Trust objectives concerning Learning Disabilities, Maternity and ED.
- Quality review in conjunction with Patient Community Panel (PCP) members
- PCP member review of draft mental health policy.
- Planning of patient experience study of Cystic Fibrosis patients' experiences.
- Further environment inspections in tandem with lay representatives (PLACE).

7.5 Actions Planned

- MacMillan Therapy team pilot study of patient experience
- Consultations and discussion with PCP regarding Visual Impaired Policy
- PCP assistance with maternity patient interviews
- Further local staff training to be provided by FFT contracted provider in use of data and themes from the online FFT platform
- HoN meeting with EDs to discuss FFT and approaches to patient experience.
- Further quality reviews engaging members of PCPs
- Wards and departments with low quality scores to submit rectification plans with agreed improvement trajectory via quarterly divisional nursing and midwifery assurance board.

8. National Inpatient Survey

8.1 Overall Results

The results of the National Inpatient Survey 2015 saw a response rate of 43.6% which was an improvement of 7.6% on the response rate of the 2014 survey. The findings outlined that the organisation was in the top 20% of Trusts for one question and in the bottom 20% of Trusts for 19 questions (see Appendix One).

The following tables outline the percentage reduction or improvement of responses to questions:

Year	Greater Improvement in Score	No of Questions
2015	5%	7

Year	Greater Reduction in Score	No of Questions
2015	5%	5

In addition to this, three questions showed a satisfactory significant improvement and two questions showed a statistically significant reduction in the score. The results dashboard (see Appendix One) outlines an overall improvement, compared to the results in 2014, of 1.2%.

8.2 Analysis of Results

The organisation sits in the top 20% of Trusts for ensuring patients are cared for in same sex accommodation.

The organisation sits in the bottom 20% of Trust for the following themes:

- Patients were bothered by noise at night;
- Concerns with overall communication with Doctors and Nurses in relation to providing information, including them in conversation, information provided as to whom to contact on discharge and including patient views about their care;
- Patients feeling threatened by other patients / visitors;

- Concerns with discharge arrangements, including medicines and side effects, equipment requirements and services after discharge;
- Patients were concerned that they did not get enough help with meals.

Those responses that scored significantly better include:
- Patients waiting for a bed;
- Being cared for in same sex accommodation;
- Delayed discharge.

Those responses significantly worse include:
- Printed discharge provided before leaving hospital;
- Receiving information explaining how to complain about care that you received.

8.3 Actions Taken

As a result of the overall scores and findings of the National Inpatient Survey 2015 the following actions have been put into place:

- A task and finish group has commenced focusing on a reduction in noise at night. Actions already taken include quality reviews and night visits by senior teams, silent closing bins and a lights out before midnight pledge.
- For concerns about discharge there has been a series of actions put into place to address this and includes the opening of discharge lounges on all sites, the re-issuing of discharge leaflets and REACT team working in partnership with frailty specialities.
- The Trust wide complaints leaflet has been updated and issued to all wards and feedback has been sought from patient community panels.
- Friends & Family Test (FFT) written comments are now available via the Quality Dashboard at ward level.

8.4 Next Steps

The following work streams to improve patient experience are currently in progress and include:

- Revision of the Quality Dashboard;
- Revision of the Governance Dashboard;
- Cases of concern presented at Chief Executives RCA Forum for action;
- Good Hope site review of the quality and process of discharge plans.

In addition to this there are 2 areas of concern that require further action and are:

- Action plans and themes of patient feedback to be implemented and monitored by each division;
- Patient feedback to be embedded into staff training.

9. Adult Safeguarding

9.1 Deprivation of Liberty (DOLS) applications:

There has been a steady increase in the number of applications over the year. Detailed reports are completed quarterly and circulated to the

members of the Safeguarding Steering Group, Head Nurses and champions. Copies are also uploaded onto safeguarding Intranet page.

The following table outlines the total numbers of Deprivation of Liberty Applications (Dols) for 2014-15 and 2015-16

DOLS applications	2014 - 2015	2015 - 2016
Q1	29	44
Q2	35	48
Q3	47	49
Q4	47	62
Totals	**158**	**203**

This increase as anticipated is due to Cheshire West Judgement and in addition the awareness and understanding across the organisation has developed over the last two years. Also a number of bespoke training packages have also been delivered to consultants in the Emergency Department, Dermatology and groups of Allied health Professionals. Audits of compliance have also been undertaken and results discussed at the Safeguarding and Dols Steering Groups.

9.2 Lessons learnt

A Lack of consistency was identified across the organisation with the applications; staff did not always inform the senior nurse in safeguarding of referrals which resulted in Supervisory body contacting the Lead nurse to coordinate each of the cases. This has been addressed. There is now evidence of good practice within a number of the wards and staff now follow the process and complete applications correctly

9.3 Adult Safeguarding Incident data

In total **1047** safeguarding adult concerns were reported this was an increase of 130 from last year when there were 917 reported

This increase could be due to a number of reasons, awareness has grown across the organisation and referrals are received form all grades/professional bodies from administration staff to consultants. The training packages that are in place for all levels and are in have various forms (face to face, moodle, e-learning, leaflets, newsletters etc.)

The Trust has also invested in the Safeguarding Team and has increased its establishment, that has enabled a stronger site presence and accessibility to the team.

During Q2 & Q4 audits were undertaken to assess staff knowledge and understanding and actions taken as a result have provided the opportunity to raise awareness and improve practice

The following table outlines the total number of safeguarding referrals for 2014-15 and 2015-16

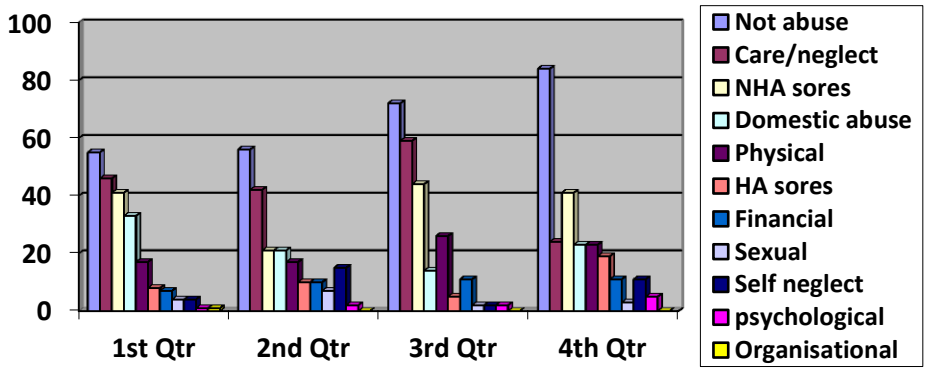
Category	Q1 – Q4 2014 – 2015	Q1 – Q4 2015-2016
Actual	494	570
Potential	225	154
Not	198	323
Totals	**917**	**1047**

The following table breaks this into referrals by site for the same periods.

Site Specific	Q1 – Q4 2014 - 2015	Q1 – Q4 2015 - 2016
Solihull reported	141	176
Heartlands reported	511	554
Good Hope reported	265	317

9.4 Themes and Lessons Learnt

The high proportion of the reported safeguarding alerts were as a result of care/neglect, physical abuse, financial, non-hospital acquired pressure ulcers. Monthly Site specific reports have been developed and these are copied to the Head Nurses for them to share with Matrons and Sisters for discussion at the quality and safety meetings. Lessons learnt are then reported back to the monthly Safeguarding Steering Group.



10. Admissions, Discharges, and Transfers (ADTs) Recorded Within Two Hours

The Trust overall performance for March 2016 has demonstrated a small improvement to 81.19% compared with 80.65% for February, however it remains it remains off the agreed trajectory of 90%. There have been some pockets of improvement, noticeably transfer; all sites achieved above 85% with Solihull for the second consecutive month achieving above 95% for ensuring transfers are completed within two hours.

Site	Admissions %		Discharges %		Transfer %		Overall Performance%		
	Feb	March	Feb	March	Feb	March	Feb	March	YTD
BHH	79.6	79.0	73.8	76.7	86.7	88.1	78.5	79.8	76.8
GHH	82.2	79.5	69.9	69.9	86.0	85.1	77.9	76.7	75.0
SOL	81.9	87.0	74.5	82.4	96.3	95.8	80.6	86.3	82.0
Trustwide	82.6	82.1	72.8	75.90	86.7	85.6	80.7	81.2	78.4

Activity within agreed two hours

The ICT Trainers continue to provide frontline staff with updates within the clinical area and classroom based training for any new starters. To support ward activity, particularly out of hours, nights, and weekends, all clinical areas had to identify their minimum number of staff who could undertake ADTs.

Site	Admissions %		Discharge %		Transfer %		Overall Performance%		
	Feb	March	Feb	March	Feb	March	Feb	March	YTD
BHH	71.7	72	71.7	71.3	54	53.8	68.4	68.3	67.7
GHH	78	79.5	77.9	69.9	62.8	85.1	75.1	76	78.2
SOL	85.4	83.8	77.8	75.9	58.4	56.1	78.5	76.5	77.4
Trustwide	78.36	78.43	75.8	72.3	58.4	65	74	73.6	74.4

Activity within core business hours (07:00 to 18:00hrs)

Core hours have been defined as being from 07:00 to 18:00hrs as many clinical areas have admin support across this time span. The agreed standard is for at least two members of staff to be ADT competent. During core hours this may include the ward clerk / administrator.

All three sites continue to have high activity outside core hours with Good Hope having 30% of discharges occurring outside of core hours which may be contributing to the poor performance in managing. The new divisional leads are to ensure the timelessness of ADTs. This remains high profile for the teams who continue to monitor performance through their divisional meeting structures.

11. New Ward to Board Reporting Process

The launch of five new divisions in April 2016 had provided an opportunity to revise the local framework for ward to board reporting. This revised framework will focus on bringing the ward even closer to the board whilst evidencing assurance of clinical quality across the organisation.

As board members are responsible for making major decisions about patient care it is important that the information they receive is closest to the patient and is owned at ward and divisional level. In addition to this, board members are responsible for gaining assurance for all clinical performance and are confident that the management / divisions understand this at ward and department level (Good Governance Institute 2015). The revised framework provides this opportunity.

The framework follows a process whereby performance against a set of quality indicators is reported by exception closest to the patient, by ward in the first instance and then by division. This information will be collated into one overarching Care Quality Board Report (see Appendix Two). Each divisional report will be available to view as appendices to this report.

The revised framework will commence from May 2016 and will focus on performance in April. The revised report will be presented at the Care Quality Report in June 2016 (Appendix Two)

12. CQUINs 2016/17

For 2016/17 there are 15 proposed CQUINs: three national acute, four local acute, six Specialised Services, and two Public Health CQUINs. These are as follows:

Level	Contract	Ref	Indicator
National	Acute	1a	**Improving Health and Well-being of NHS Staff:** Introduction of staff health and well-being initiatives (staff survey)
National	Acute	1b	**Improving Health & Well-being of NHS Staff:** Introduction of staff health and well-being initiatives (implementation plan)
National	Acute	1c	**Improving Health & Well-being of NHS Staff:** Health food in the NHS
National	Acute	1d	**Improving Health & Well-being of NHS Staff:** Flu vaccine update
National	Acute	2a	**Sepsis:** Timely identification and treatment for sepsis in Emergency Departments
National	Acute	2b	**Sepsis:** Timely identification and treatment for sepsis in inpatient settings
National	Acute	5a	**Antimicrobial Resistance:** Reduction in antibiotic consumption per 1,000 admissions
National	Acute	5b	**Antimicrobial Resistance:** Empiric review of antibiotic prescriptions
Local	Acute		**VTE:** To improve the management of patients who present with a VTE within 90 days of being discharged
Local	Acute		**Transfer of Care Plan:** To improve the transition of care from inpatient hospital setting to community
Local	Acute		**Clinical Utilisation Review**
Local	Acute		**MDT Review of Perinatal Deaths**
Local	Specialised Services		**Neonatal Unit Admissions:** Reducing the number of avoidable admissions of term babies
National	Specialised Services		**Cardiac Surgery Optimal Device:** To ensure cardiac device selection for patients remains consistent
National	Specialised Services		**Adult Critical Care Timely Discharge:** To reduce delayed discharges from Adult Critical Care to ward level care by improving bed management

National	Specialised Services		**Renal Failure:** For Cystic Fibrosis the development of a system to measure skills, knowledge and confidence needed to self-manage long term conditions
Public Health		1(i)	**AAA Screening:** Improving access and uptake through Patient & Public Engagement (PPE)
Public Health		1(ii)	**AAA Screening:** Working with specified priority group to improve access to screening
Public Health		2(i)	**Health Visiting Developmental Checks:** Achievement of antenatal visit target
Public Health		2(ii)	**Health Visiting Developmental Checks:** Achievement of 2/2.5 year review target

Proposed CQUINs for 2016/17

The above list of CQUINs has not yet received final sign off by the Trust, and therefore is subject to change.

For further detail, please see Appendix Three of this report.

APPENDIX ONE

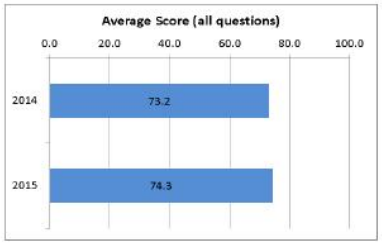
National Inpatient Survey 2015

1

Summary

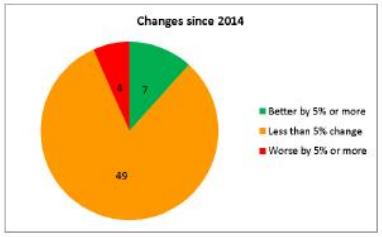
- Response rate of 43.6% - improvement on the 2014 survey.
- In the top 20% of Trusts on 1 question
- In bottom 20% of Trusts on 19 questions.
- Since 2014 survey
  - 5% or greater **improvement** in score on 7 questions
  - 5% or greater **reduction** in score on 4 questions
  - 3 questions showed a statistically significant **improvement**
  - 2 questions a statistically significant **reduction** in score.
- 642 written comments

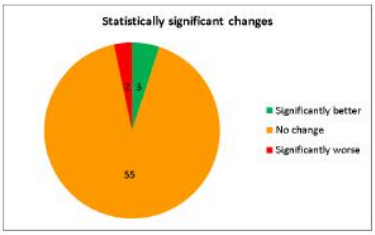
2

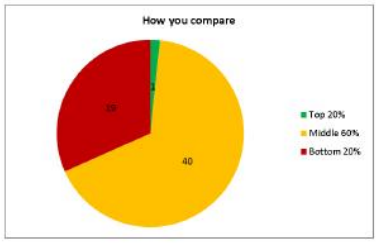


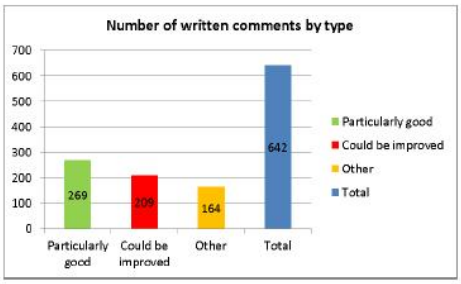
Results Dashboard

Overall improvement since 2014 - 1.2%









3

Top 20% of Trusts

Q13 After moving ward, was it to a mixed-sex room or bay?

Bottom 20% of Trusts

Q8 Was specialist you saw given all condition/illness information by person referring you?
Q16 Ever bothered by noise at night from staff?
Q19 Did you ever feel threatened by other patients/visitors?
Q23 Enough help from staff to eat your meals?
Q26 Did doctors talk in front of you as if you weren't there?
Q29 Did nurses talk in front of you as if you weren't there?
Q37 Do you feel you got enough emotional support from staff?
Q44 Before op., did staff explain the risks and benefits of the operation?
Q49 Before op., did anaesthetist explain understandably how they would control any pain?
Q59 Before leaving, were you given written or printed discharge information?
Q61 Were the side-effects of medicines to watch for when home explained?
Q64 Were you told about any danger signals to watch for when you went home?
Q65 Did staff take your family/home situation into account when planning your discharge?
Q66 Did doctors/nurses give family/friend all information needed to help care for you?
Q67 Did staff tell you told who to contact if worried about condition/treatment once home?
Q68 Did staff discuss whether you may need any equipment/adaptations in your home?
Q69 Did staff discuss whether you may need further health/social care services after leaving?
Q73 During your stay, were you ever asked views on quality of care?
Q74 Did you see/were you given any information explaining how to complain about care received?

4

Significantly better than in 2014

Q9 From time you arrived, did you feel long wait to get a bed on a ward? (+7)

Q14 Did you ever share mixed-sex bathroom or shower areas? (+6)

Q53 Was your discharge delayed? (+8)

Significantly worse than in 2014

Q59 Before leaving, were you given written or printed discharge information? (-10)

Q74 Did you see/were you given any information explaining how to complain about care received? (-6)

5

Next Steps and Actions

Done:

- ✓ SH - Task and finish group, re noise
- ✓ BHH Soft closing rubbish bins in situ
- ✓ Lights turned off before midnight and doors closed or pulled to minimise disruption
- ✓ Staff sitting just outside bays –allows patient observation without disturbing if issues of care require discussion
- ✓ GHH - doors greased , no longer noisy
- ✓ GHH - Quality reviews, in depth review of noise at night
- ✓ Grouping of confused patients - nursed safely in a bay, minimise disruption and noise for other patients
- ✓ Night visits undertaken by senior nursing team.
- ✓ SH - Re issuing of discharge home leaflets at Solihull
- ✓ SWS - daily round to discuss discharge home and support required
- ✓ GHH - REACT team assist with discharge planning for patients on frailty ward
- ✓ GHH - ticket home project launched , ward 9
- ✓ GHH Discharge Lounge
- ✓ Significant uplift in delayed discharge score (Vs. NIS 2014)
- ✓ Reprint of complaints information leaflet and creation of shortened version
- ✓ Simplification access to provide feedback via the website involving Patient Community Panels
- ✓ All written comments provided via FFT (c500 per month) are available via the nursing quality dashboard live at ward level

6

Next Steps and Actions

In progress:

- Ward quality reviews
- GHH Reviewing of discharge plans - below normal standard reported to the Head Nurse
- Nursing quality dashboard
- Governance dashboard – under construction
- Cases presented at (CEO committee)
- Head Nurse monthly meetings
- Quality committee – new title(to discuss themes and actions)

To do:

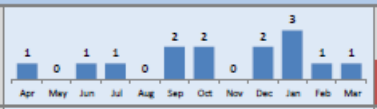
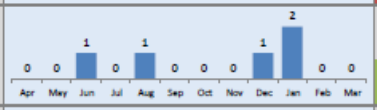
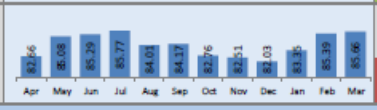
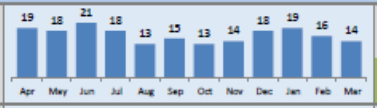
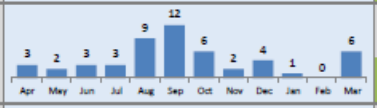
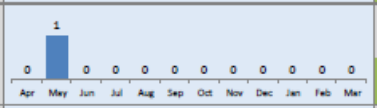
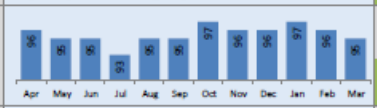
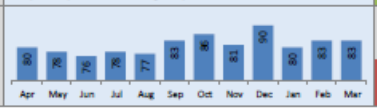
- Action plans for themes from patient experience data by site division and ward / department to be compiled and implemented and monitored
- Discus with Department of Education to see how patient feedback can be embedded in staff training

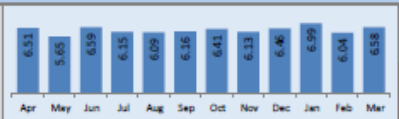
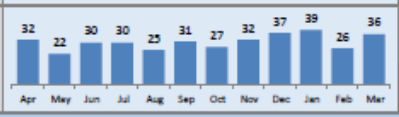
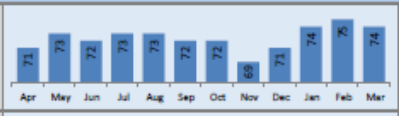
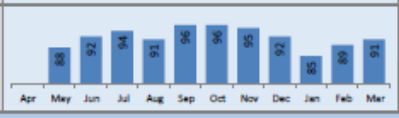
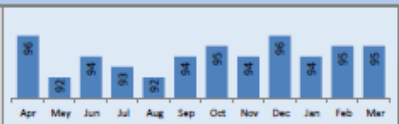
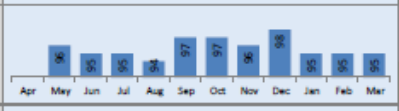
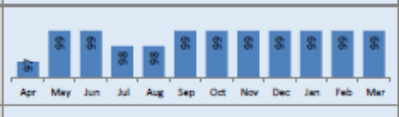
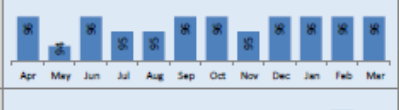
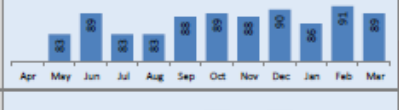
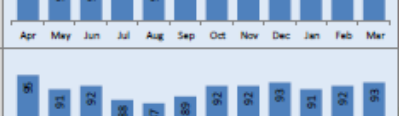
7

APPENDIX TWO - Ward to Board Assurance Reporting Template

Nursing & Midwifery
Ward to Board Assurance Report

NHS | HEART of ENGLAND NHS Foundation Trust
ACUTE TRUST

Ref	Indicator Name	Target	Performance		Wards / Areas Not Achieving Target	Position	Action
	Infection Control						
1	Clostridium Difficile *Number of avoidable cases*	*0*		In Month Position Mar-16 1	2 BHH (2), 19 BHH (1), 24 BHH (1), 22 HDU / ITU GHH (1), 24 GHH (1), AMU SS GHH (1)	For all sections, need to tell a brief story about themes and trends and local governance processes, i.e., discussed at Quality Board, etc.	This needs to be either: 1) Assurance of improvement; or 2) Reassurance of a plan to improve and an expected date that you will be evidencing this.
2	MRSA *Number of cases*	*0*		In Month Position Mar-16 0			
3	MRSA Screening (Emergency) *% of patients screened*	≥90%		In Month Position Mar-16 85.66%			
	Tissue Viability						
4	Avoidable Grade 2 Pressure Ulcers *Number of avoidable cases*	*<171 at year end*		In Month Position Mar-16 14	9 BHH (2), 19 SH (2), 6 CCU BHH (1), 20 AMU 1 BHH (1), 29 BHH (1), Rowan BHH (1), 11 GHH (1), 14 GHH (1), 15 GHH (1), 15 SH (1), 17 SH (1), 20B SH (1)		
5	Avoidable Grade 3 & Necrotic Pressure Ulcers *Number of avoidable cases*	*<43 at year end*		In Month Position Mar-16 6	9 GHH (2), 9 BHH (1), 19 SH (1), 20B SH (1)		
6	Avoidable Grade 4 Pressure Ulcers *Number of avoidable cases*	*0*		In Month Position Mar-16 0			
7	SSKIN Bundle: Daily skin inspection *A daily skin inspection is recorded if the patient is identified as being at risk*	≥90%		In Month Position Mar-16 92%			
8	SSKIN Bundle: Repositioning frequency completed *The repositioning frequency has been completed*	≥90%		In Month Position Mar-16 95%			
9	SSKIN Bundle: Repositioning frequency adhered to *The repositioning frequency has been adhered to for the past three days*	≥90%		In Month Position Mar-16 83%			

Ref	Indicator Name	Target	Performance		Wards / Areas Not Achieving Target	Position	Action
	Inpatient Falls						
10	**Falls Rate** *Falls rate per 1,000 occupied bed days*	≤6.3		In Month Position Mar-16 6.58	Wards with the highest number of falls in month: 24 BHH (17), 29 BHH (13), 3 BHH (12), 12 GHH (12), 4 BHH (10), 7 BHH (10), 9 GHH (10), 8 SH (10), AMU SS SH (10) 8 BHH (9), 30 BHH (9), Rowan BHH (9), 10 GHH (9), 15 GHH (8), 24 GHH (8)		
11	**Recurrent Fallers** *Number of patients falling twice or more during the same admission*	<311 at year end		In Month Position Mar-16 36			
	Medication						
12	**Antibiotic STAT Doses** *% of antibiotic STAT doses administered within 1 hour*			In Month Position Mar-16 74%			
13	**Medication Assessment: Secure medicines / cupboard** *Medicines are secured and medicines cupboards are locked*	90%		In Month Position Mar-16 91%			
	Care Quality Metrics						
14	**Overall Clinical Score** *% compliance with overall care quality metrics*	≥95%		In Month Position Mar-16 95%	7 GHH (72%), 26 BHH (79%), 23 ASU BHH (88%), 29 BHH (89%), Rowan BHH (89%), 7 BHH (91%), 30 BHH (91%), 9 GHH (91%), 2 BHH (92%), 10 BHH (93%), 21 ECAU BHH (93%), 16 GHH (93%), North Team (93%), 12 BHH (94%), 22 AMU 2 BHH (94%), ED GHH (94%)		
15	**Environment** *% compliance with environment indicators*	≥90%		In Month Position Mar-16 95%	26 BHH (69%), 23 ASU BHH (75%), 7 GHH (75%), 9 GHH (81%), 30 BHH (87%), Rowan BHH (87%), 29 BHH (88%), 15 GHH (88%)		
16	**Patient Safety & Dignity** *% compliance with patient safety and dignity indicators*	≥90%		In Month Position Mar-16 99%			
17	**Observations** *% compliance with observations indicators*	≥90%		In Month Position Mar-16 96%	PAU BHH (80%), 26 BHH (83%), 7 GHH (83%), 9 GHH (83%), 23 ASU BHH (88%)		
18	**Fluid Balance** *% compliance with fluid balance indicators*	≥90%		In Month Position Mar-16 89%	21 ECAU BHH (50%), 30 BHH (53%), 7 BHH (75%), 2 BHH (76%), 4 BHH (80%), 17 GHH (80%), 28 BHH (82%), 9 GHH (82%), 3 BHH (83%), 10 BHH (87%), AMU SS SH (83%), 10 GHH (88%), 12 BHH (89%), 12 GHH (88%), AMU SS GHH (88%), 27 BHH (89%)		
19	**Tissue Viability** *% compliance with tissue viability indicators*	≥95%		In Month Position Mar-16 94%	26 BHH (65%), 7 GHH (67%), North Team (67%), 23 ASU BHH (76%), 16 GHH (80%), 7 BHH (83%), 15 SH (83%), AMU SS GHH (87%), 12 BHH (88%), 22 AMU 2 BHH (88%), SCBU GHH (88%), 9 BHH (89%), 6 BHH (90%), 2 BHH (91%), 29 BHH (92%), Rowan BHH (92%), 22 HDU / ITU GHH (92%), Recovery at Home GHH (93%), 17 SH (93%), 19 SH (93%), 16 BHH (93%), 19 BHH (94%), 9 GHH (94%), 17 GHH (94%), 20B SH (94%)		
20	**Nutritional Assessment** *% compliance with nutritional assessment indicators*	≥90%		In Month Position Mar-16 93%	7 GHH (50%), Rowan BHH (75%), 9 GHH (84%), 2 BHH (83%), 10 BHH (83%), 16 GHH (83%), AMU GHH (83%), AMU SS SH (83%), 26 BHH (86%), 15 GHH (86%), 20 AMU 1 BHH (88%), 23 ASU BHH (88%), 29 BHH (88%), 30 BHH (89%), 20B SH (89%)		

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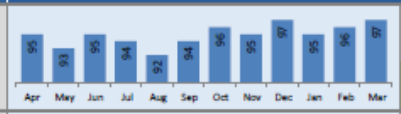
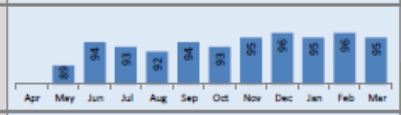
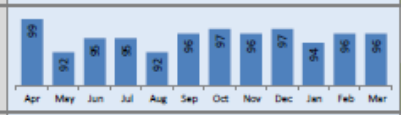
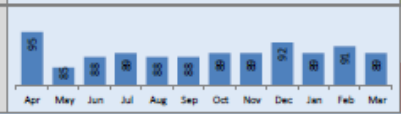
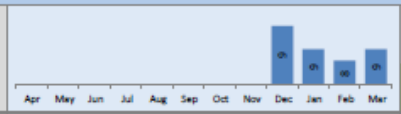
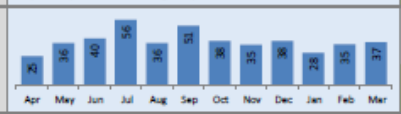
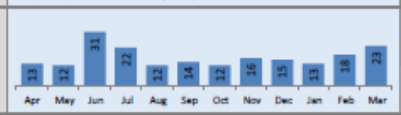
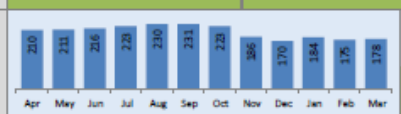
21	**Falls Assessment** *% compliance with falls assessment indicators*	≥90%		In Month Position Mar-16 97%	26 BHH (0%), 7 GHH (73%), Rowan BHH (79%), 17 GHH (79%), Dialysis Unit BHH (80%), 2 BHH (84%)		
22	**Manual Handling** *% compliance with manual handling indicators*	≥90%		In Month Position Mar-16 95%	7 GHH (42%), 26 BHH (54%), 29 BHH (66%), 30 BHH (86%), 12 GHH (87%), 23 ASU BHH (88%)		
23	**Continence Assessment** *% compliance with continence assessment indicators*	≥90%		In Month Position Mar-16 96%	7 GHH (75%), 30 BHH (84%), 22 AMU 2 BHH (87%), 8 GHH (87%), 19 BHH (88%), 24 BHH (89%), HDU BHH (89%)		
23	**Blood Glucose Monitoring** *% compliance with blood glucose monitoring indicators*	≥90%		In Month Position Mar-16 89%	7 GHH (0%), 10 BHH (33%), 9 BHH (50%), Rowan BHH (67%), 7 BHH 19 SH (67%), (71%), 29 BHH (73%), 17 GHH (75%), 21 GHH (75%), 24 BHH (80%), 15 SH (80%), 12 BHH (82%), 2 BHH (83%), 8 BHH (85%), 26 BHH (85%), 22 AMU 2 BHH (89%)		
	Safety Thermometer						
24	**Safety Thermometer: Harm Free Care** *% of patients receiving harm free care*	≥95%		In Month Position Mar-16 92%	9 GHH (70%), 30 BHH (82%), 4 HDU BHH (83%), 8 BHH (87%), 28 BHH (87%), 12 GHH (88%), 29 BHH (89%), 21 ECAU BHH (92%), 7 GHH (92%), 10 GHH (92%), 15 GHH (92%), 4 BHH (93%), 8 GHH (93%), 11 GHH (93%), 21 GHH (93%), AMU GHH (93%), 2 BHH (94%)		
	Patient Experience						
25	**Patient Experience Survey** *Overall Rating*	≥7.8		In Month Position Mar-16 8.5	7 BHH (5.6), 8 SH (6.4), 9 BHH (7.3), 15 GHH (7.4), 29 BHH (7.5) 28 BHH (7.6)		
26	**Friends & Family Test** *% response rate*	≥30%		In Month Position Mar-16 37			
27	**Nursing Complaints** *Number of new nursing complaints*			In Month Position Mar-16 23	Top themes in month are: Clinical treatment, Information / communication, Bereavement issue, Verbal communication, Medication administration, Medication error		
	Nurse Staffing						
28	**UNIFY Compliance** *Overall compliance in month*	≥90%	Qualified Compliance: 95% HCA Compliance: 101%		Hot spot areas: 4 HDU BHH, 5 BHH, 7 BHH, 23 ASU BHH, 23 HASU BHH, 24 NIV BHH, 8 GHH, 11 GHH, 16 GHH, 23 CCU GHH, 15 SH, 17 SH, 19 SH, 20A SH, ITU BHH, 22 HDU / ITU GHH, 1 BHH, Aspen BHH, Cedar BHH, Maple BHH, 4 GHH, NNU BHH		
29	**Vacancy Position** *Number of WTE Vacancies*			In Month Position Mar-16 37			
30	**Care Hours per Patient Day** *Number of care hours per patient day*			In Month Position Mar-16			

APPENDIX THREE

Proposed CQUINs for 2016/17

Level	Contract	Indicator Name	Description	Owner
National	Acute	**Improving health and wellbeing of NHS Staff**	**1a: Introduction of staff health & wellbeing initiatives (<u>OPTION A)</u>** Achieve an improvement of 5% compared to 2015 staff survey results for three questions in the NHS Annual Staff survey: 1. Does your organisation take positive action on health and well-being? 2. In the last 12 months have you experienced musculoskeletal problems (MSK) as a result of work activities? 3. During the last 12 months have you felt unwell as a result of work related stress?	Executive Lead: **Hazel Gunter** Clinical / Ops Lead: TBC
			1a: Introduction of staff health & wellbeing initiatives (<u>OPTION B)</u> Providers to develop a plan and ensure the implementation against three areas; a) Introducing a range of physical activity schemes for staff (promoting active travel, building physical activity into working hours and reducing sedentary behaviour) b) Improving access to physiotherapy services for staff (fast track physiotherapy service for staff suffering from musculoskeletal (MSK) issues to ensure staff who are referred via GPs or Occupational Health) c) Introducing a range of mental health initiatives for staff (stress management, line management, mindfulness courses, counselling services, sleep counselling and mental health first aid training)	
			1b: Health Food in the NHS <u>PART A</u> Achieve a step-change in the health of the food offered on their premises in 2016/17: a. The banning of price promotions on sugary drinks and foods with HFSS b. The banning of advertisement on NHS premises of sugary drinks and foods HFSS c. The banning of sugary drinks and foods HFSS from checkouts d. Ensuring that healthy options are available at any point including night shifts <u>PART B</u>	

Level	Contract	Indicator Name	Description	Owner
			Provider to submit national data collection by July based on existing contracts with food and drink suppliers. To cover any contracts - restaurants, cafés, shops, food trolleys and vending machines or any other outlet that serves food and drink. The data will include the following; the name of the franchise holder, food supplier, type of outlet, start and end dates of existing contracts, remaining length of time on existing contract, value of contract and any other relevant contract clauses. It should also include any available data on sales volumes of sugar sweetened beverages (SSBs).	
			1c: Flu vaccination Update Achieving an uptake of flu vaccinations by frontline clinical staff of 75%	
National	Acute	**Sepsis**	**2a. Timely identification and treatment for sepsis in emergency department** There are two parts to this indicator: i. The percentage of patients who met the criteria for sepsis screening and were screened for sepsis ii. The percentage of patients who present with severe sepsis, Red Flag Sepsis or septic shock and were administered intravenous antibiotics within the appropriate timeframe and had an empiric review within three days of the prescribing of antibiotics. The two indicators apply to adults and child patients arriving in the hospital via the Emergency Department (ED) or by direct emergency admission to any other unit (e.g. Medical Assessment Unit) or acute ward.	Executive Lead: **Sam Foster** Clinical / Ops Lead: **Mr Rangaraju Ragunathan**

Level	Contract	Indicator Name	Description	Owner
			2b. Timely identification and treatment for sepsis in inpatient settings There are two parts to this indicator: i. The percentage of patients who met the criteria for sepsis screening and were screened for sepsis ii. The percentage of patients who present with severe sepsis, Red Flag Sepsis or septic shock and were administered intravenous antibiotics within the appropriate timeframe and had an empiric review within three days of the prescribing of antibiotics. The two indicators apply to adults and child patients who are acute hospital inpatients	
National	Acute	**Antimicrobial Resistance**	**5a. Reduction in antibiotic consumption per 1,000 admissions** Reduce total antibiotic consumption measured as defined daily doses (DDDs) per 1000 admissions as well as to obtain evidence of antibiotic review within 72 hours of commencing an antibiotic. The CQUIN has two parts, the first aimed at reducing total antibiotic consumption and certain broad-spectrum antibiotics and the second focussed on antimicrobial stewardship and ensuring antibiotic review within 72 hours. **5b. Empiric review of antibiotic prescriptions** Percentage of antibiotic prescriptions reviewed within 72 hours	Executive Lead: **Sam Foster** Clinical / Ops Lead **Dr Abid Hussain**
Local	Acute	**VTE**	To improve the management of patients who present with a VTE within 90 days of being discharged. Monitor, review and action plan all VTE occurrences up to 90 days post discharge, aiming to reduce VTE occurrence	Executive Lead: **Dr David Rosser** Clinical / Ops Lead **Dr Vijayan Suresh**

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Local	Acute	**Transfer of Care Plan**	This CQUIN aims to improve the transition between inpatient hospital settings and community, care homes or any NHS provider for adults over 65, improving patient, carer and staff experience of transfer and discharge from hospital by better coordination of health and social care services.	Executive Lead: **Jonathan Brotherton** Clinical / Ops Lead: **Dr Vijayan Suresh**
Local	Acute	**Clinical Utilisation Review (CUR)**	Clinical Utilisation Review (CUR) - Installation and Implementation; reduction in inappropriate hospital utilisation; reporting of results. The second year CQUIN payment needs to fund an achieved reduction in the proportion of emergency admissions and bed-days for patients that do not meet the CUR criteria beyond the baseline reached in year one. The scope of CUR, in terms of the number of beds covered, must be equal or greater than what was implemented in year one.	Executive Lead: **Jonathan Brotherton** Clinical / Ops Lead: **Andrew Clements**
Local	Acute	**MDT Review of Perinatal Deaths**	This CQUIN will measure the Trust's implementation of a robust MDT review to identify themes and trends of all perinatal deaths that fall within the following criteria: >22 weeks gestation >500g in weight >Do not have a lethal congenital condition (i.e. corrected perinatal mortality criteria) The CQUIN will aim to identify themes and trends with any identified lessons to be highlighted and flagged to Commissioners	Executive Lead: **Sam Foster** Clinical / Ops Lead **Dr Liz Howland**
Local Specialised Services		**Neonatal Unit Admissions**	Reducing the number of avoidable admissions of term babies. All babies who are admitted to a neonatal unit for medical care at term (≥37weeks gestation) a thorough and joint clinical review is undertaken by the maternity and neonatal service within one month of the admission. The review should aim to identify the learning points to improve care provision and service design.	Executive Lead: **Sam Foster** Clinical / Ops Lead **Dr Liz Howland**

Level	Contract	Indicator Name	Description	Owner
National Specialised Services		**Cardiac Surgery - Optimal Device**	To ensure cardiac device selection for patients remains consistent whilst the new national procurement and supply chain arrangements are put in place. Optimisation of device usage during the year will measure the number of medium specification High Cost Tariff Excluded cardiac devices to ensure: 1. Enhancement and maintenance of local systems to assure compliance with national policies and specifications; 2. Development of local policies to optimise cost effective device usage and ensuring quality outcomes for patients; 3. Improved compliance with policies and specifications will result in improved outcomes.	Executive Lead: **Jonathan Brotherton/ Julian Miller** Clinical / Ops Lead **Mr Richard Steyn**
National Specialised Services		**Adult Critical Care Timely Discharge**	To reduce delayed discharges from Adult Critical Care (ACC) to ward level care by improving bed management in ward based care, thus removing delays and improving flow. This is to support Trusts with the Year Two QIPP scheme referenced above – to remove delayed discharges of 4 hours or more within daytime hours.	Executive Lead: **Dr David Rosser** Clinical / Ops Lead **Alan Jones**
National Specialised Services		**Clinical Utilisation Review (CUR)**	Clinical Utilisation Review (CUR) - Installation and Implementation; reduction in inappropriate hospital utilisation; reporting of results. The second year CQUIN payment needs to fund an achieved reduction in the proportion of emergency admissions and bed-days for patients that do not meet the CUR criteria beyond the baseline reached in year one. The scope of CUR, in terms of the number of beds covered, must be equal or greater than what was implemented in year one.	Executive Lead: **Jonathan Brotherton** Clinical / Ops Lead **Dr Vijayan Suresh**
National Specialised Services		**Renal Failure**	Preventing or delaying the need for patients to start dialysis through laboratory monitoring of eGFR being flagged to Primary Care providers. Supporting Primary Care Clinicians to manage this group of patients.	Executive Lead: **Dr David Rosser** Clinical / Ops Lead **Dr Vijayan Suresh**

Level	Contract	Indicator Name	Description	Owner
National Specialised Services		**Activation System for Patients with Long Term Conditions (LTCs)**	For Cystic Fibrosis the development of a system to measure skills, knowledge and confidence needed to self-manage long term conditions, and with that information to support adherence to medication and treatment and to improve patients outcomes and experience.	Executive Lead **Dr David Rosser**
Public Health		**AAA Screening**	**1. Improving access and uptake through Patient & Public Engagement (PPE)** Establish reasons for participation and/or non-participation in a screening programme, through direct engagement with patients and the general public. A core set of questions will be supplied by the screening manager. Method of data collection is left to the provider to devise the best way to engage with patients and public. **3. Working with specified priority group to improve access to screening** Working with eligible people in a specified priority group to improve access to screening (e.g. geographical and/or specific characteristics/deprived). N.B. The focus group will be agreed between the service and the PHE screening manager.	Executive Lead: **Dr David Rosser** Clinical Lead: **Mark Gannon**
Public Health		**HV Developmental Checks**	**1. Achievement of antenatal visit target (= 70%)** 70% of mothers to receive first face to face antenatal contact with a Health Visitor at 28 weeks or above, during quarter 4 **2. Achievement of 2/2.5 year review target (= 95%)** 95% of children who turned 2.5 years in the fourth quarter who received a 2-2.5 year review, by the age of 2.5 years of age	Executive Lead: Clinical Lead:

Title: Adult inpatient acuity and dependency workforce review April 2016						**Attachments:**	0
From: Sam Foster, Chief Nurse			**To**: Board				
The Report is being provided for:							
Decision	N	Discussion	N	Assurance	Y	Endorsement	Y
The Committee is being asked to:							
Endorse the findings and recommendations from the Nursing Workforce Review April 2016.							
Key points/Summary:							
• In June 2015 the Board endorsed the plan to undertake a repeat review of areas that were a point of concern from the workforce review completed in May 2015, and also new patient areas or areas where there had been a service reconfiguration • This review has been completed and included seventeen clinical areas across the divisions • The review indicates that the current staffing levels on fourteen out of the seventeen areas are at a safe level • Three areas are of concern; Ward 12 BHH- Division 5; Ward 24 BHH and Ward 26 BHH – Division 3 • The results of this review need to be considered in conjunction with the current vacancy rate of circa 150wte qualified nurses and the continued reliance on temporary staffing from internal and external sources							
Recommendation(s):							
• The Board accepts the findings of the Adult Inpatient Workforce Review April 2016 • The Board endorses the requirement for uplift in qualified nursing establishments for Wards 12 BHH and Ward 26 BHH – This will be progressed by the divisional team via either a business case or funded from within budget envelope.							

Assurance Implications:			
Strategic Risk Register	Y	Performance KPIs year to date	Y
Resource/Assurance Implications (e.g. Financial/HR)	Y	Information Exempt from Disclosure	N
Which other Committees has this paper been to? *(e.g. F & PC, QRC, etc.)*			
Circulated through Operations Committee.			

1. SUMMARY

This report focuses on the workforce review for the adult inpatient areas and AMU's/ SAU's across the divisions where there has been some concerns around the current funded staffing establishments and also where there has been service reconfiguration. The multiple methodologies used are compliant with the NICE guidelines for safe staffing for nursing in adult inpatient wards in acute hospitals (2014).The review has incorporated clinical outcomes associated with harm free care to fully triangulate the situation on each clinical area. The review indicates that fourteen out of the seventeen areas of focus have safe levels of staffing. Three areas are of concern; Ward 12 BHH- Division 5; Ward 24 BHH and Ward 26 BHH- Division 3.

Ward 12 BHH requires uplift in their qualified funding establishment of 2.34wte Band 5 nurses and Ward 26 BHH requires an uplift of 5.16wte Band 5 nurses. The cost of this investment is circa £263,250, which will be funded either through business case process or within existing budget envelope. Ward 24 requires a further in depth review to identify how staffing can be flexed at short notice to deliver care safely to fluctuating numbers of NIV patients.

2. BACKGROUND

The National Quality Board expectations set out in their guide to nursing, midwifery and care staffing capacity and capability (2014) states that Boards take full responsibility for the quality and care provided to patients, and as a key determinant of quality, take full and collective responsibility for nursing, midwifery and care staffing capacity and capability. As part of the Trust's standard requirements of the NHS contract, workforce reviews must be undertaken bi-annually and the results and recommendations taken through the Public Trust Board.

This report focuses on the workforce review for the adult inpatient areas and AMU's/ SAU's across the divisions where there has been a concern around the current funded staffing establishments and also where there has been service reconfiguration. The multiple methodologies used are compliant with the NICE guidelines for safe staffing for nursing in adult inpatient wards in acute hospitals (2014).

The areas included in the review and the reason for selection are shown in Table One

Table One

Clinical area	Division	Reason for inclusion
AMU GHH	Three	New unit opened
SAU GHH	Five	Consideration of change in skill mix overnight
Ward 9 GHH	Four	Change in skill mix
Ward 11 GHH	Four	Change in skill mix
Ward 12 GHH	Four	New ward
Ward 21 GHH	Four	New ward
Ward 8 Solihull	Three	Concerns around metrics scores and patient harm
Ward 19 Solihull	Three	Concerns around metrics and patient harm
Ward 20B Solihull	Three	New Ward
Ward 2 BHH	Five	On-going concerns around acuity and staffing levels
Ward 3 BHH	Four	On-going concerns around acuity and staffing levels
Ward 8 BHH	Five	On-going concerns around acuity and staffing levels
Ward 9 BHH	Five	On-going concerns around acuity and staffing levels
Ward 12 BHH	Five	Concerns around clinical care and acuity
Ward 24 and NIV BHH	Three	Concerns around clinical care and acuity
Ward 26 BHH	Three	Concerns around clinical care and acuity
Rowan Ward BHH	Four	New ward

3. ACTION

A full breakdown of the results of the review and associated actions are shown in Appendix One. These have all been approved by the Divisional Head Nurses. The review indicates that current staffing levels by ward/ clinical area are at a safe level for fourteen out of the seventeen areas reviewed.

The required uplift for Ward 12 and Ward 26 at BHH is currently being progressed by the divisions. The further review of Ward 24 staffing associated with the care of NIV patients will be led by the Divisional Head Nurse.

There is a vacancy rate for qualified nurses of around 150wte across the base wards and AMU's. The Trust's intensive recruitment campaign will continue through 2016/2017 with a focus on EU and local UK recruitment and a campaign in Dublin. This vacancy rate results in the need for a significant amount of temporary staff both internal and external and the associated risks to the continuity of patient care that this brings.

4. RECOMMENDATION(S)

Fourteen out of the seventeen clinical areas included in the review have safe levels of staffing. Ward 12 BHH requires an uplift in their qualified funding establishment of 2.34wte Band 5 nurses and Ward 26 BHH requires an uplift of 5.16wte Band 5 nurses. The cost of this investment is circa £263,250. Ward 24 requires a further in depth review to identify how staffing can be flexed at short notice to deliver care safely to fluctuating numbers of NIV patients. This review will be led by the Divisional Head Nurse

It is recommended that the Board accept the findings of the Adult Inpatient Workforce Review and the recommendation to fund the uplift in establishment for Ward 12 BHH and Ward 26 BHH.

5. NEXT STEPS

All adult inpatient areas and AMU's/ SAU's will be reviewed in September 2016.

Appendix One – Results and actions by ward/ clinical area

Clinical Area	RAG rating	Agreed actions
AMU GHH		Safe staffing levels, review again in September 2016
SAU GHH		Safe staffing levels for up to 10 patients, division aware of need to escalate staffing if numbers in SAU exceed 10
Ward 9 GHH		Division need to review skill mix changes in relation to patient harm
Ward 11 GHH		Safe staffing levels, review again in September 2016
Ward 12 GHH		Safe staffing levels, review again in September 2016
Ward 21 GHH		Safe staffing levels, review again in September 2016
Ward 8 Solihull		Safe staffing levels, review again in September 2016
Ward 19 Solihull		Staffing levels remain borderline in relation to acuity, review again in September 2016
Ward 20B Solihull		Ward is currently reviewing patient admission criteria, review again in September 2016
Ward 2 BHH		Safe staffing establishment but significant vacancies, review again in September 2016
Ward 3 BHH		Patient acuity variable, prioritise for SafeCare implementation and review again in September 2016
Ward 8 BHH		Safe staffing establishment but significant vacancies, review again in September 2016
Ward 9 BHH		Safe staffing levels, review again in September 2016
Ward 12 BHH		Deficit between funded establishment and patient acuity. Requires an uplift of 2.34wte Band 5 nurses
Ward 24 BHH		Current inability to flex staffing to cover fluctuating numbers of NIV patients. Divisional Head Nurse to review
Ward 26 BHH		Deficit between funded establishment and patient acuity. Requires an uplift of 5.16wte Band 5 nurses
Rowan Ward BHH		Safe staffing establishment but significant vacancies, review again in September 2016

HEART OF ENGLAND NHS FOUNDATION TRUST

BOARD OF DIRECTORS

WEDNESDAY 11 MAY 2016

NATIONAL STAFF SURVEY REPORT

PRESENTED BY DIRECTOR OF WORKFORCE

Title : 2015 National Staff Survey Results				**Attachments**		1	
From : Hazel Gunter, Director of Workforce				**To :** Board			
The report is being provided for:							
Decision		Discussion	Yes	Assurance		Endorsement	

The Board is being asked to:
Take consideration of the main findings from the 2015 National Staff Survey and agree the next steps in order that the Trust is appropriately managing the outcome of the survey and implementing actions that support the feedback provided.

Key points/Summary

- National Staff Survey results have improved from 2014 – from 3.53 to 3.63;
- The Trust remains in the bottom 20% of Acute Trusts – 97th/99 Acute Trusts;
- This latest score is the highest attained since data collecting in 2009;
- The survey showed an improvement in 9 Key Findings and no change in a further 10 key findings;
- A full census was undertaken and 29% of staff responded (circa 3000 staff)

Assurance Implications

Strategic Risk Register		Performance KPIs year to date	
Resource/Assurance Implications (e.g. Financial/HR)		Information Exempt from Disclosure	

The National Staff Survey ran from October to December 2015 and included a full census of staff at HEFT. It achieved a 29% response rate (circa 3,000), a decrease from 39% in 2014.

The results show that across the 32 Key Findings, there was an improvement with our overall engagement score of **3.63** compared to **3.53** in 2014. This is a metric score out of 5, with the Acute Trust average being 3.79.

However, we remain in the bottom 20% of Acute Trusts nationally (ranked 97th out of 99 on overall engagement indicator score, compared to 128th out of 138 Trusts in 2014). However, this latest score is the highest score attained since data collected in 2009.

The results for each of the 32 Key Findings, of which the National Staff Survey is comprised, are shown in the enclosed attachment. This includes whether there was any significant change from 2014. In 2015 some of the Key Findings were either new or had changed slightly, meaning that not all of the data was comparable to 2014 results.

Across the 32 Key Findings:

- **9 had improved since 2014:**
    - Staff recommending the organisation as a place to work;
    - Staff motivation at work;
    - Staff satisfaction with the level of responsibility & involvement;
    - Support from immediate line managers;
    - % appraised in last 12 months;
    - Reduction in % feeling pressure in last 3 months to attend work when unwell;
    - % reporting good communication between senior management and staff;
    - Reduction in % witnessing potential harmful errors, near misses or incidents in last month;
    - Effective use of patient/service user feedback.

- **2 were worse than 2014:**
    - % Working extra hours;
    - % experiencing harassment, bullying or abuse from staff in last 12 months.

- **10 saw no change in the scoring.**

There were also 10 new findings that did not allow for a comparison to take place.

Conclusions and Next Steps

Although there were improvements indicated from 2014 to 2015, on the whole the feedback generated from the Staff Survey highlights that further work is required to improve the perception and feeling of staff at HEFT. There is an opportunity to build on the improvements and directly support those areas that have worsened, such as staff experiencing bullying.

Divisions are developing action plans to address the main issues presented by staff and work in partnership with HR representatives to highlight positive changes.

Staff satisfaction will be monitored through the new divisional structures going forward and the results of the 2015/16 NSS will feed into those new Divisions.

Hazel M Gunter
Director of Workforce

Heart of England
National Staff Survey 2015 – results

Agree | Disagree | Ranking against other Acute Trusts | Compared to 2014

During Oct - Dec 2015, 2825 of you took part in the annual National Staff Survey.
Our results are slightly better than 2014, however, we still remain in the bottom 20% of Acute Trusts.

Staff Pledge 1 - To provide all staff with clear roles, responsibilites and rewarding jobs

	Agree	Disagree	Ranking against other Acute Trusts	Compared to 2014
1. Staff recommendation of the organisation as a place to work or receive treatment	69%	31%	Bottom 20%	Improved
2. Staff satisfaction with the quality of work and patient care they are able to deliver	78%	22%	Below Average	NEW
3. % agreeing that their role makes a difference to patients / service users	90%	10%	Below Average	NEW
4. Staff motivation at work	76%	24%	Bottom 20%	Improved
5. Recognition and value of staff by managers and the organisation	66%	34%	Bottom 20%	NEW
8. Staff satisfaction with level of responsibility and involvement	77%	23%	Bottom 20%	Improved
9. Effective team working	73%	27%	Bottom 20%	NEW
14. Staff satisfaction with resourcing and support	65%	35%	Below Average	NEW

Staff Pledge 2 – To provide all staff with personal development, access to appropriate education and training for their jobs, and line management support to enable them to fulfil their potential.

	Agree	Disagree	Ranking against other Acute Trusts	Compared to 2014
10. Support from immediate managers	73%	27%	Below Average	Improved
11. % appraised in last 12 mths	85%	15%	Average	Improved
12. Quality of appraisals	59%	41%	Below Average	NEW
13. Quality of non-mandatory training, learning or development	80%	20%	Average	NEW

Staff Pledge 3 - To provide support and opportunities for staff to maintain their health, well-being and safety.

	Agree	Disagree	Ranking against other Acute Trusts	Compared to 2014
15. % of staff satisfied with the opportunities for flexible working patterns	47%	53%	Below Average	NEW
16. % working extra hours	72%	28%	Average	Worse
17. % suffering work related stress in last 12 mths	38%	62%	Below Average	No Change
18. % feeling pressure in last 3 mths to attend work when feeling unwell	61%	39%	Below Average	Improved
19. Org and mgmt interest in and action on health / wellbeing	69%	31%	Bottom 20%	NEW
22. % experiencing physical violence from patients, relatives or the public in last 12 mths	15%	85%	Average	No Change
23. % experiencing physical violence from staff in last 12 mths	2%	98%	Below Average	No Change
24. % reporting most recent experience of violence	52%	48%	Average	No Change
25. % experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 mths	28%	72%	Average	No Change
26. % experiencing harassment, bullying or abuse from staff in last 12 mths	27%	73%	Below Average	Worse
27. % reporting most recent experience of harassment, bullying or abuse	38%	62%	Average	No Change

Staff Pledge 4 To engage staff in decisions that affect them, the services they provide and empower them to put forward ways to deliver better and safer services.

	Agree	Disagree	Ranking against other Acute Trusts	Compared to 2014
6. % reporting good communication between senior management and staff	26%	74%	Below Average	Improved
7. % able to contribute towards improvements at work	65%	35%	Bottom 20%	No Change

Equality & Diversity

	Agree	Disagree	Ranking against other Acute Trusts	Compared to 2014
20. % experiencing discrimination at work in last 12 mths	13%	87%	Bottom 20%	No Change
21. % believing the organisation provides equal opportunities for career progression / promotion	80%	20%	Bottom 20%	No change

Errors & Incidents

	Agree	Disagree	Ranking against other Acute Trusts	Compared to 2014
28. % witnessing potentially harmful errors, nearmisses or incidents in last mth	29%	71%	Top 20%	Improved
29. % reporting errors, near misses or incidents witnessed in the last mth	87%	13%	Bottom 20%	No Change
30. Fairness and effectiveness of procedures for reporting errors, near misses and incidents	71%	29%	Bottom 20%	NEW
31. Staff confidence and security in reporting unsafe clinical practice	69%	31%	Bottom 20%	No Change

Patient Experience Measures

	Agree	Disagree	Ranking against other Acute Trusts	Compared to 2014
32. Effective use of patient / service user feedback	70%	30%	Bottom 20%	Improved

HEART OF ENGLAND NHS FOUNDATION TRUST

BOARD OF DIRECTORS

WEDNESDAY 11 MAY 2016

Title: Finance Report to 31 March 2016						**Attachments:**	0
From: Interim Director of Finance				**To**: Board of Directors (11 May 2016)			
The Report is being provided for:							
Decision	N	Discussion	Y	Assurance	Y	Endorsement	N

The Committee is being asked to:

Receive the Finance Report for the period ending 31 March 2016.

Key points/Summary:

- The Trust has reported an I&E deficit of (£3.8m) after net impairment gains of £0.9m in month 12 (March 2016) of the 2015/16 financial year.
- Year to date the Trust has reported an overall deficit of (£46.1m), leading to an underlying deficit at the year-end (excluding impairment gains of £0.9m and capital to revenue transfer of £18.6m) of (£65.6m) which is (£55.7m) above plan.
- The cash balance is £31.5m at 31 March 2016.
- The Financial Sustainability Risk Rating remains at 1.

Recommendation(s):

The Board of Directors is requested to:

- Receive the contents of this report.
-

Assurance Implications:

Strategic Risk Register	Y	Performance KPIs year to date	Y
Resource/Assurance Implications (e.g. Financial/HR)	Y	Information Exempt from Disclosure	N
Identify any Equality & Diversity issues		N/A	
Outline how any Equality & Diversity risks are to be managed		N/A	

Which other Committees has this paper been to? *(e.g. F & PC, QRC etc)*

None

HEART OF ENGLAND NHS FOUNDATION TRUST

BOARD OF DIRECTORS

WEDNESDAY 11 MAY 2016

FINANCE REPORT FOR THE PERIOD ENDING 31 MARCH 2016

PRESENTED BY THE INTERIM DIRECTOR OF FINANCE

1. Introduction

This report covers the 2015/16 financial year (1 April 2015 to 31 March 2016). The report summarises the Trust's financial performance and includes information on healthcare activity, expenditure variances and Cost Improvement Programme (CIP) delivery.

During March 2016, the Trust benefited from an impairment gain of £0.9m which led to a (£3.8m) deficit in month, taking the year to date overall deficit to (£46.1m). This is after the non-recurrent capital to revenue adjustment of £18.6m made during month 11.

The Trust has reported an underlying run rate deficit of (£65.6m) for the financial year, after excluding the benefits of £18.6m for the capital to revenue adjustment and £0.9m for impairment gains. This represents an adverse variance of (£55.7m) against the plan at the year end. The adverse variance is partially driven by Medical staffing (£12.2m) and Nursing staffing (£11.1m), reflecting expenditure linked to additional capacity to meet the growth in activity and premium rate cover for vacancies. Other key drivers of the adverse variance are the use of Private Sector capacity (£3.4m) and slippage against CIP delivery (£27.3m) which includes under delivery in both the current year and prior years.

The year-end cash position is £31.5m against a plan of £49.1m, an adverse movement of (£17.6m) although an improvement on previous forecasts by circa £14.0m.

2. Income & Expenditure

2.1 Year to Date Summary

The Trust's year to date underlying income and expenditure position as at the end of March is a (£65.6m) deficit against a plan of (£9.9m), an adverse variance of (£55.7m).

Table 1 below details the actual income and expenditure deficit compared to the planned trajectory produced at the start of the year.

Table 1: I&E – Normalised Actual vs Plan

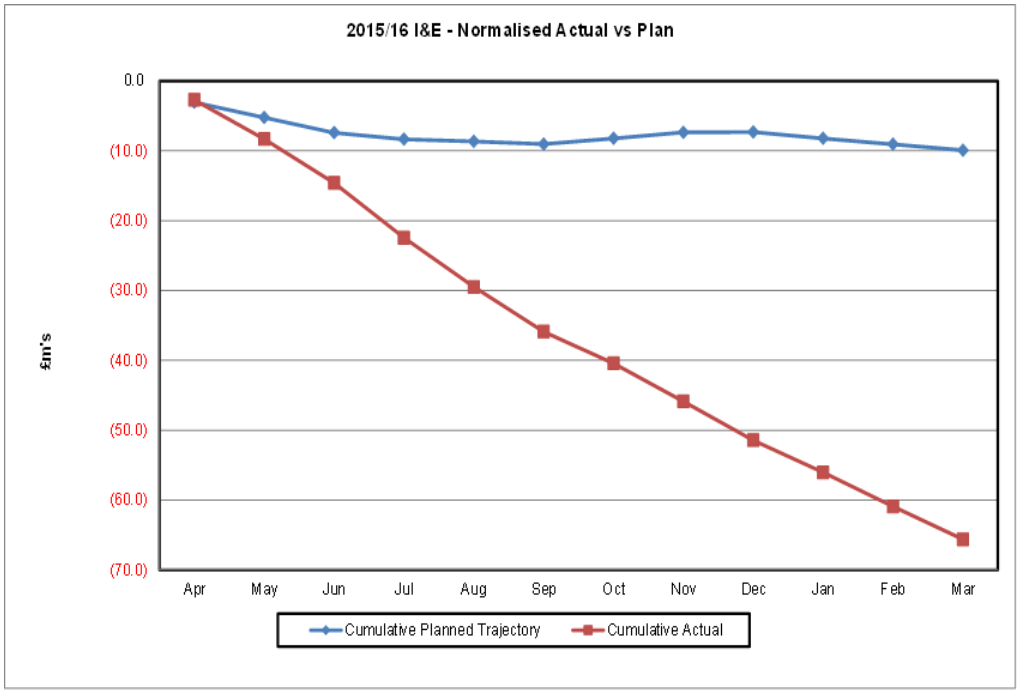


Table 2 below summarises the Trust's income and expenditure position at the end of March with analysis of expenditure from section 2.3 and operating revenue from section 2.6 below.

It should be noted that the operating revenue variance included in table 2 includes the non-recurrent capital to revenue transfer of £18.6m.

Table 2: YTD Income and Expenditure Plan vs Actual

	YTD Plan Mar £m	YTD Actual Mar £m	Variance £m
Operating Revenue	633.6	672.4	38.8
Operating Expenses	(619.2)	(695.3)	(76.0)
EBITDA	**14.3**	**(22.9)**	**(37.2)**
Depreciation	(17.1)	(17.3)	(0.2)
Interest Receivable	0.3	0.2	(0.1)
Interest Payable	(0.3)	(0.2)	0.0
PDC Dividend	(6.9)	(6.6)	0.3
Other Finance Costs	(0.0)	(0.0)	(0.0)
Surplus/(Deficit)	**(9.7)**	**(46.8)**	**(37.2)**
Gain/(Loss) on Asset Disposal	(0.3)	(0.1)	0.1
Total Surplus/(Deficit) Before Impairments	**(9.9)**	**(47.0)**	**(37.1)**
Impairment (Losses) / Reversals	0.0	0.9	0.9
Surplus / (Deficit) After Impairments	**(9.9)**	**(46.1)**	**(36.2)**

2.2 Impairment/Revaluation Adjustments

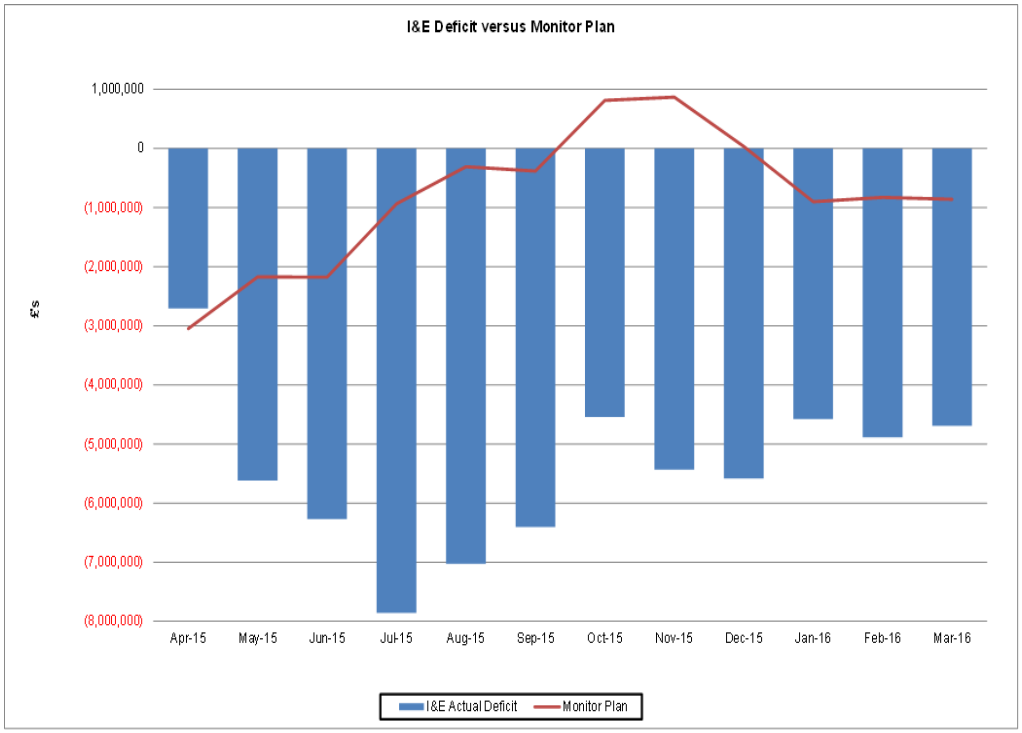
The total trust revaluation resulted in a net upward revaluation of the Trust's assets of £11.4m. This has resulted in a revaluation reserve increase of £10.5m and a £0.9m benefit to the income and expenditure.

The £0.9m benefit to the I&E represents a £10.5m reversal of previous impairment charges to the I&E, less a (£9.6m) new impairment for which a revaluation reserve does not exist.

2.3 Monthly Run Rate

The normalised monthly deficit from the start of the financial year is demonstrated in table 3 below.

Table 3: Normalised Deficit by Month Compared to Plan



The March period deficit of (£3.8m) represents an improvement of £1.1m against February performance predominantly due to the impairment gains of £0.9m. In overall terms, the normalised deficit of (£4.7m) reflects an improvement on previous monthly average deficits which have been an average of (£5.5m) in months 1 to 11.

2.3.1 Financial Recovery Plan

The first phase of the support provided by Ernst and Young (EY) was in identifying easy to implement, short term actions to deliver in year savings for the recovery process. These schemes delivered recovery of £16.1m for the 2015/16 financial year.

The second phase of the EY support focuses on the longer term actions which will return the Trust to financial stability. A first draft of the Financial Recovery Plan (FRP) was submitted to NHS Improvement on 21 April 2016 with the final report due mid May, which details the challenge over the coming years. The movements from 2015/16 outturn to 2016/17 plan are summarised as follows:

2015/16 normalised deficit -	(£65.6m)
Net impact in 2016/17 of tariff vs inflation -	(£12.7m)
New cost pressures in 2016/17 -	(£4.0m)
Sustainability and Transformation Fund -	£23.3m
Benefit from suspension of fines -	£15.2m
Efficiency target (including local CIP and FRP delivery) -	£30.2m
2016/17 required control deficit -	(£13.6m)

The FRP outlines productivity opportunities in the following areas to deliver the required efficiencies in 2016/17 and close the longer term financial deficit:-

- Patient flow and average length of stay.
- Operating theatres.
- Outpatients.
- Diagnostics.
- Workforce productivity.
- Non-pay expenditure.
- Estates and facilities.
- Depth of coding and income.
- Corporate.

2.4 Operating Expenditure Analysis

The adverse operating expenditure variance of (£76.0m) against plan can be broken down as detailed in table 4 below.

Table 4: Breakdown of Variance Against Plan

	YTD Plan Mar £m	YTD Actual Mar £m	Variance £m
PAY			
Medical Staff	113.7	125.9	(12.2)
Nursing	161.7	172.8	(11.1)
Scientific & Technical	57.8	59.1	(1.3)
Other	78.1	81.0	(2.9)
Total Pay	**411.3**	**438.8**	**(27.5)**
NON PAY			
Drugs	71.5	68.3	3.2
Clinical Supplies & Services	66.2	70.7	(4.5)
Unidentified CIP	(27.3)	0.0	(27.3)
Private Sector Usage	6.0	9.4	(3.4)
Other	91.6	108.1	(16.5)
Total Non Pay	**207.9**	**256.5**	**(48.5)**
GRAND TOTAL	**619.2**	**695.3**	**(76.0)**

The main areas of pay and non-pay variance are explored further in sections 2.5 and 2.6 below.

2.5 Pay Analysis

The drivers behind the pay variance are predominantly Medical and Nursing staffing.

2.5.1 Medical Staffing

Tables 5.1 and 5.2 below detail the monthly expenditure for medical staff split between consultant and non-consultant posts respectively.

Total medical expenditure in March was £10.3m, an adverse movement of (£0.3m) against the expenditure in February but an improvement of £0.2m on the average monthly expenditure from April to February.

Table 5.1: Senior Medical Expenditure per Month

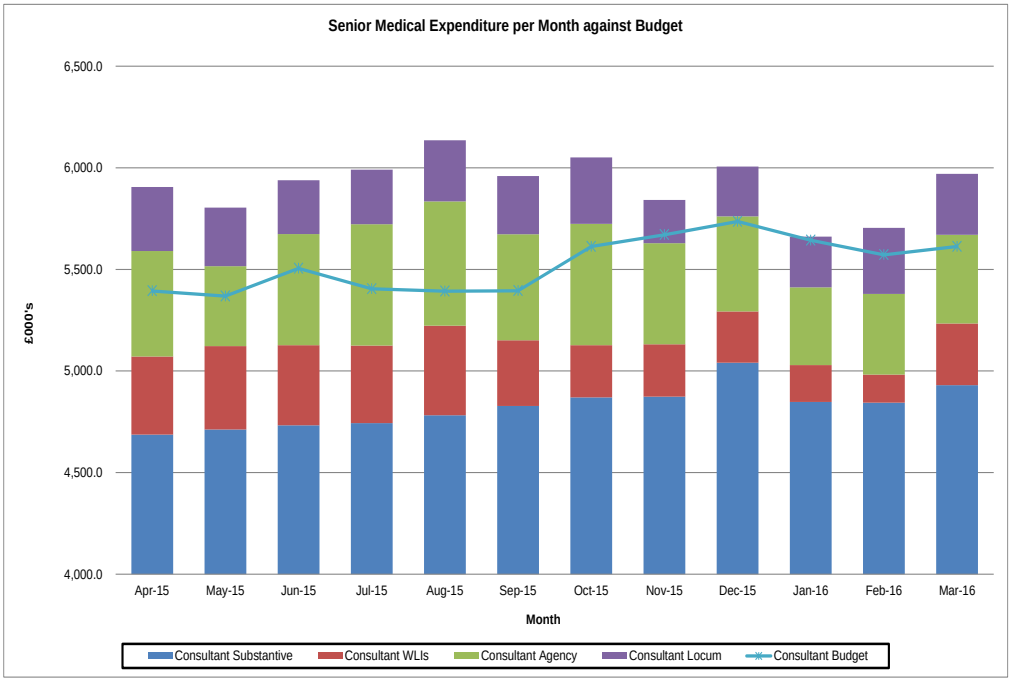
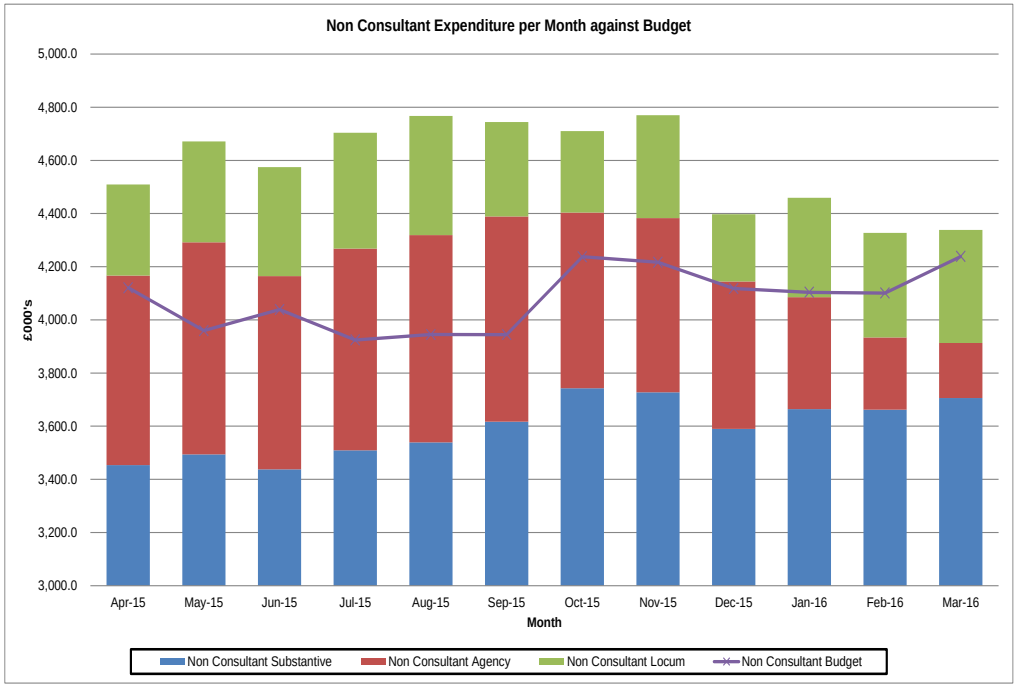


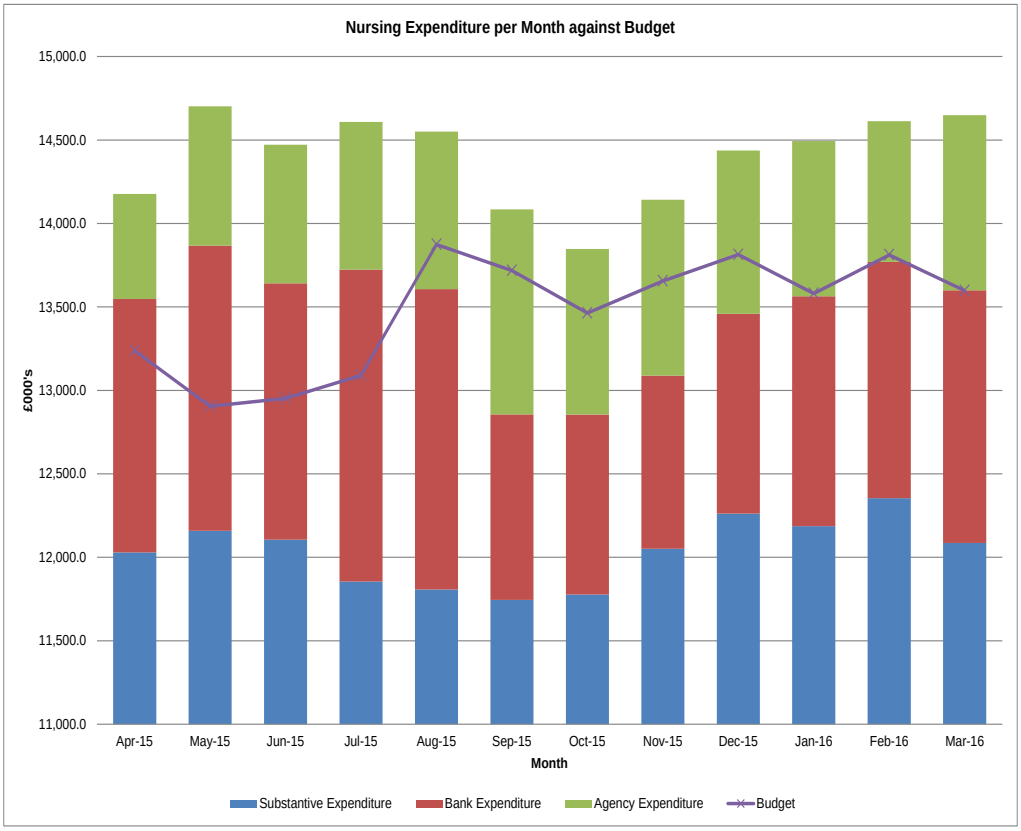
Table 5.2: Non-Consultant Medical Expenditure per Month



2.5.2 Nursing

Table 6 below details the monthly expenditure on nursing compared to the budget.

Table 6: Monthly Nursing Expenditure



Total nursing expenditure in March was £14.6m in line with the expenditure in February and an adverse variance of (£0.3m) on the average expenditure over the first 11 months.

2.6 Non Pay Expenditure

2.6.1 CIP Delivery

Table 7 below details the breakdown of the undelivered CIP target.

Table 7: Breakdown of Unidentified CIP

	Mth 12 In Month	Mth 12 YTD
	£m	£m
Unachieved CIP 2015/16	(0.2)	(6.1)
Cash Releasing Run Rate Reductions 2015/16	(0.4)	(4.4)
Unachieved CIP Prior Years	(1.4)	(16.9)
Grand Total	**(2.0)**	**(27.3)**

The CIP delivery and year end forecast will be analysed further in section 3 below.

2.6.2 Clinical Supplies and Services

The deficit on clinical supplies is largely driven by increased activity levels.

2.6.3 Private Sector Usage

The use of the private sector has now been eliminated in all areas with the exception of a couple of cases per week within Urology. These cases are expected to continue until alternative capacity can be identified for this patient cohort.

2.7 Income Analysis

2.7.1 Total Operating Income

Total operating income is £38.8m above plan at the end of March as shown in table 8 below.

Table 8 – Income against Plan

	YTD Plan Mar £m	YTD Actual Mar £m	YTD Variance £m
Clinical - NHS	(568.5)	(591.6)	23.1
Clinical - Non NHS	(10.6)	(10.5)	(0.1)
Other	(54.5)	(70.3)	15.9
TOTAL	**(633.6)**	**(672.4)**	**38.8**

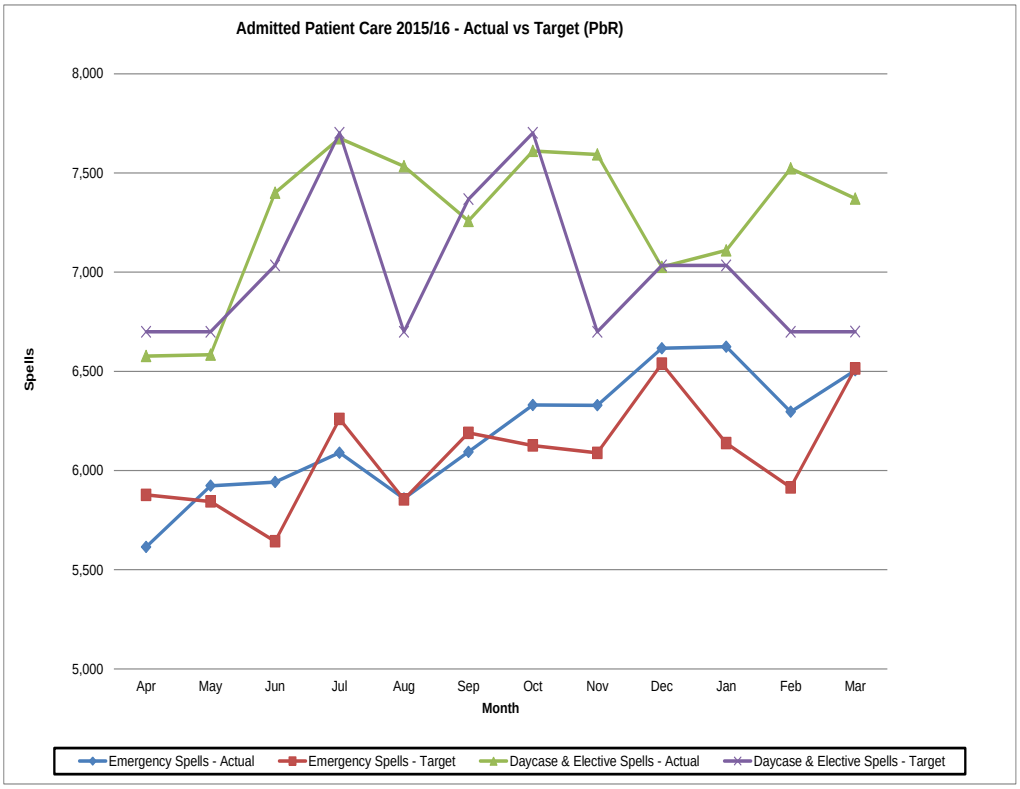
NHS Clinical Income is £23.3m above plan for the year to date, however, this is offset by payment challenges from commissioners. Although the Trust disputes the majority of the challenges, a bad debt provision has been made where appropriate.

Other Income includes the impact of the £18.6m capital to revenue transfer actioned in February.

2.7.2 NHS Clinical Income/Activity - Inpatients

Table 9.1 below details the monthly admitted patient care (APC) spells against target to the end of March.

Table 9.1: Trust Inpatient Activity



The March in-month activity position reflects a (0.1%) under-performance in emergency pathways (9 spells), taking the year to date over-performance to 1.7% (1,233 spells).

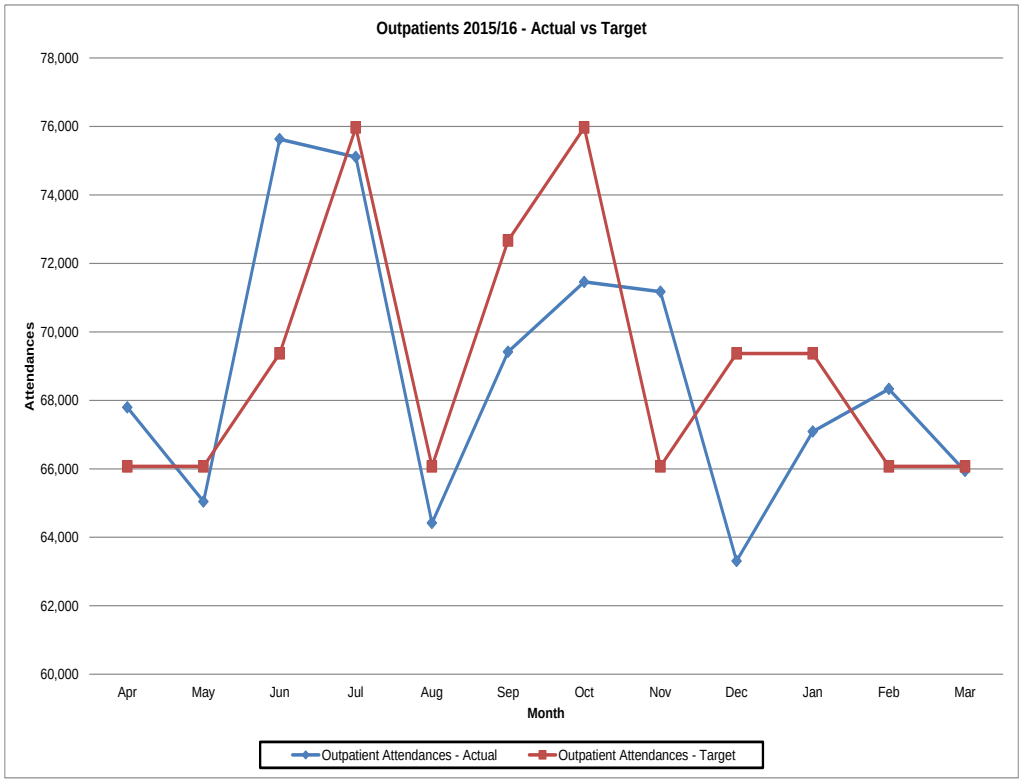
This is being driven by an increase in A&E activity which has shown 3.1% over-performance in March (733 attendances) bringing the year to date performance to 2.2% above plan (5,537 attendances).

The in-month planned elective and daycase activity was 10.0% above plan (671 cases) and 3.8% above the annual plan (3,193 cases).

2.7.3 NHS Clinical Income/Activity – Outpatients

Table 9.2 below details the monthly outpatient attendances compared to target to the end of March.

Table 9.2: Trust Outpatient Activity



Outpatient activity in month is (0.2%) below plan (136 attendances) which takes the annual performance to (0.5%) below plan (4,435 attendances).

3. Cost Improvement Programmes

3.1 Current Year CIP Programme

The current year CIP performance by Division is detailed in table 10 below.

Table 10: CIP Delivery by Division

	March - In Month				Year to Date				Year End Forecast		
Division	Target £000's	Actual Recurrent £000's	Actual Non Recurrent £000's	Variance £000's	Target £000's	Actual Recurrent £000's	Actual Non Recurrent £000's	Variance £000's	Annual Target £000's	Forecast Actual £000's	Variance £000's
Heartlands Hospital	623.8	374.9	197.4	(51.5)	7,485.0	3,106.9	2,239.6	(2,138.5)	7,485.0	5,346.5	(2,138.5)
Corporate Directorate	117.3	55.9	17.0	(44.4)	1,407.0	635.6	98.1	(673.3)	1,407.0	733.7	(673.3)
Clinical Support Services	436.5	204.3	171.3	(60.9)	5,237.5	2,055.9	2,417.7	(763.9)	5,237.5	4,473.6	(763.9)
Trustwide Education Services	7.8	7.8	0.0	0.0	93.0	93.0	0.0	0.0	93.0	93.0	0.0
Facilities	116.7	121.2	2.1	6.6	1,400.0	1,375.0	25.0	0.0	1,400.0	1,400.0	0.0
Good Hope Hospital	183.3	194.3	0.0	11.0	2,200.0	1,346.4	5.9	(847.7)	2,200.0	1,352.2	(847.8)
Solihull Hospital	289.8	255.9	141.8	107.9	3,477.5	2,662.7	853.8	39.0	3,477.5	3,516.5	39.0
Womens & Childrens	225.0	46.1	21.9	(157.0)	2,700.0	781.2	232.3	(1,686.5)	2,700.0	1,013.5	(1,686.5)
GRAND TOTAL	**2,000.2**	**1,260.4**	**551.5**	**(188.3)**	**24,000.0**	**12,056.7**	**5,872.4**	**(6,070.9)**	**24,000.0**	**17,929.0**	**(6,071.0)**

The 2015/16 target for CIPs is £24.0m against which £17.9m of schemes have been delivered (74.7%). Of this delivery (£5.8m) is non-recurrent for which recurrent alternatives need to be identified going into 2016/17.

The delivery in the period of March shows under-performance against target of (£0.2m).

3.2 Cash Releasing Run Rate Reductions

As detailed in table 8 above, circa £4.4m of the CIP target has been allocated to this type of reduction. These schemes are those that have delivered a reduction in unbudgeted expenditure.

The challenge with this type of scheme is in identifying where the funding will be allocated from in order to offset the negative budgeted CIP target.

4. Statement of Financial Position

The Statement of Financial Position (Balance Sheet) shows the value of the Trust's assets and liabilities. The upper part of the statement shows the net assets after deducting short and long term liabilities with the lower part identifying sources of finance. Table 11 below summarises the Trust's Statement of Financial Position as at 31 March 2016.

Table 11: Statement of Financial Position

		Audited Mar-15 £m	Actual Mar-16 £m	Plan Mar-16 £m	Annual Plan Mar-16 £m
Non Current Assets:					
	Property, Plant and Equipment	245.3	260.1	266.4	266.4
	Intangible Assets	3.6	2.8	12.9	12.9
	Trade and Other Receivables	1.1	1.3	1.1	1.1
	Other Assets	4.2	4.0	4.0	4.0
	Total Non Current Assets	**254.2**	**268.2**	**284.4**	**284.4**
Current Assets:					
	Inventories	8.5	9.1	8.5	8.5
	Trade and Other Receivables	23.5	20.8	21.9	21.9
	Other Financial Assets	0.0	0.0	0.0	0.0
	Other Current Assets	8.5	11.0	8.5	8.5
	Cash	87.7	31.5	49.1	49.1
	Total Current Assets	**128.2**	**72.4**	**88.0**	**88.0**
Current Liabilities:					
	Trade and Other Payables	(73.7)	(89.4)	(79.1)	(79.1)
	Borrowings	(0.5)	(0.5)	(0.5)	(0.5)
	Provisions	(8.7)	(6.0)	(7.0)	(7.0)
	Tax Payable	0.0	0.0	0.0	0.0
	Other Liabilities	(6.5)	(7.0)	(6.5)	(6.5)
	Total Current Liabilities	**(89.4)**	**(102.9)**	**(93.1)**	**(93.1)**
Non Current Liabilities:					
	Borrowings	(4.0)	(3.7)	(3.5)	(3.5)
	Provisions	(6.7)	(5.9)	(6.7)	(6.7)
	Other Liabilities	0.0	0.0	0.0	0.0
	Total Non Current Liabilities	**(10.7)**	**(9.6)**	**(10.3)**	**(10.3)**
TOTAL ASSETS EMPLOYED		**282.3**	**228.1**	**269.1**	**269.1**
Financed by:					
	Public Dividend Capital	215.3	196.7	215.3	215.3
	Income and Expenditure Reserve	19.4	(24.4)	11.8	11.8
	Donated Asset Reserve	(0.2)	(0.2)	(0.2)	(0.2)
	Revaluation Reserve	47.7	56.0	42.1	42.1
	Merger Reserve	0.0	0.0	0.0	0.0
TOTAL TAXPAYERS EQUITY		**282.3**	**228.1**	**269.1**	**269.1**

5. Capital Expenditure (Non-Current Assets)

The approved capital plan for the 2015/16 year is £50.4m which includes £20.4m of schemes brought forward from 2014/15. The capital forecast was revised as part of the financial recovery to £19.3m.

The expenditure in March 2016 was £2.7m, to take it to £19.2m at the year-end broadly in line with the reforecast plan. Main in month spend was around IT (hardware and software) of £0.9m and expenditure on buildings of £0.9m.

6. Current Assets

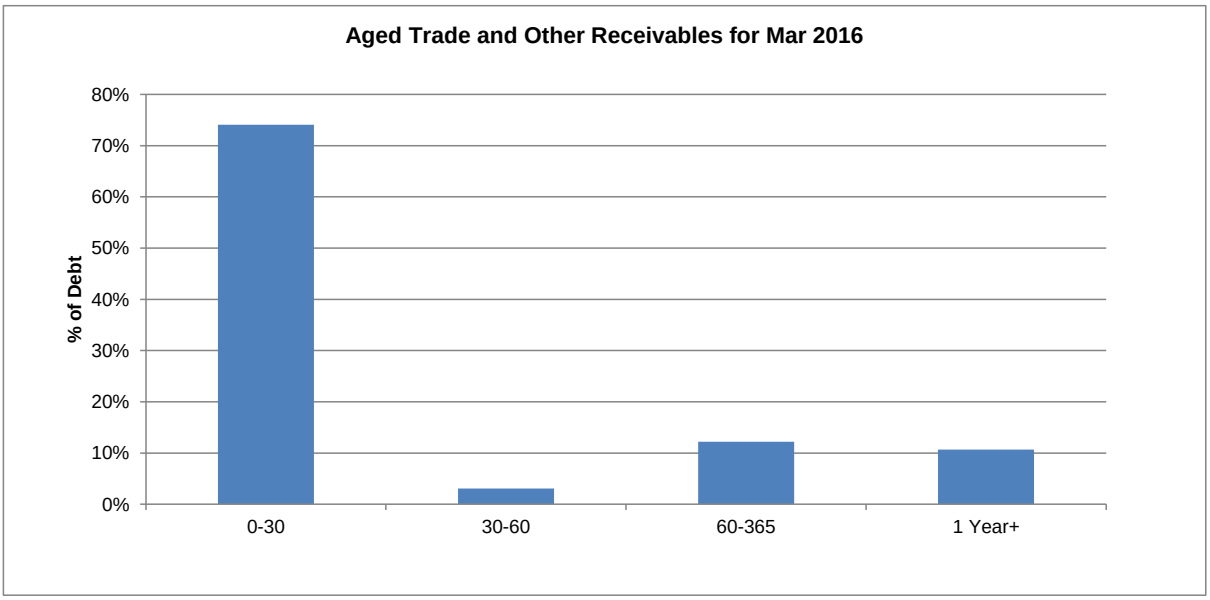
The Trust's total current assets (excluding cash and inventories) amount to £31.8m at 31 March 2016, (£1.4m) higher than plan.

Table 12: Analysis of Current Assets (excluding Inventories and Cash)

	YTD Actual March 2016 £m	YTD Forecast March 2016 £m
Trade Receivables	35.8	28.0
Bad Debt Provision	(16.5)	(8.4)
Other Receivables	1.5	2.3
Trade and Other Receivables	**20.8**	**21.9**
Accrued Income	2.6	2.5
Other Financial Assets	**2.6**	**2.5**
Prepayments	8.3	6.0
Other Current Assets	**8.3**	**6.0**
TOTAL	**31.8**	**30.4**

Analysis of the age profile of Trade Receivables (unpaid invoices issued by the Trust) is summarised in table 13 below.

Table 13: Aged Debt Analysis



The main movement during March has been the invoicing of the over-performance to commissioners.

An update on the 3 main debts analysed throughout 2015/16 is detailed below:

- Burton Hospitals Foundation Trust (£2.1m > 30 days, £2.6m total) – this has increased by (£0.4m) in month due to new maternity charges.

- Sandwell and West Birmingham Trust (£0.1m > 30 days, £0.6m total) – this has reduced by £1.0m in month as agreement has been reached with regards the maternity pathways.
- University Hospitals Birmingham (£1.1m > 30 days, £1.5m total) – the over 30 days has reduced in month with a payment of £0.4m for 2015/16 maxillofacial services. A further (£0.1m) has been raised in month for 2015/16 ministry of defence HIV services. These accounts continue to be discussed in order to reach a settlement.

7. Cash Flow

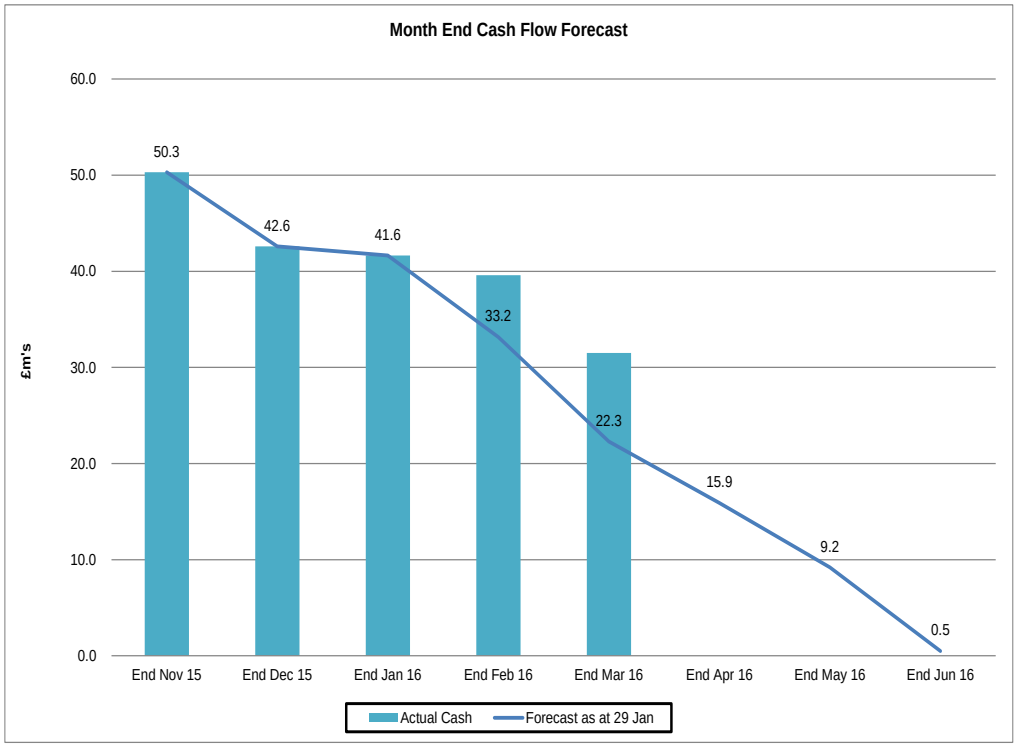
7.1 Current Position

The cash balance at the end of March 2016 was £31.5m, a decrease of (£8.1m) in month. The variance to plan is (£17.6m) which is a £1.7m improvement on the February variance.

7.2 Year End Cash Balance

This year end cash balance is a little better than forecast earlier in the year as detailed in table 14 below. However, additional financing is still expected to be required from June/July 2016.

Table 14: Cashflow Forecast



8. Monitor Financial Sustainability Risk Rating

Monitor has replaced the previous Continuity of Services Risk Rating with a new Financial Sustainability Risk Rating (FSRR) from August 2015. The four criteria evaluated, the weighting placed on each of them and the scoring rationale is detailed in table 15 below.

Table 15: Scoring Mechanism for FSRR

		FSRR			
Metric	**Weight**	**4**	**3**	**2**	**1**
Capital Service Cover	25%	2.50	1.75	1.25	<1.25
Liquidity	25%	0.0	(7.0)	(14.0)	<(14.0)
I&E Margin	25%	1%	0%	(1%)	<(1%)
I&E Margin Variance	25%	0%	(1%)	(2%)	<(2%)

The Trust planned to achieve an FSRR of 2 as at month 12. However due to the large income and expenditure deficit, three of the four criteria are rated as 1 bringing the actual FSRR at month 11 down to a weighted average of 1.

This FSRR is not expected to improve by the end of the year due to the continued deterioration in the Trust's net current liability position.

9. Conclusion

The Trust delivered an overall year end deficit of (£46.1m) following a non-recurrent technical adjustment for capital to revenue transfer of £18.6m actioned in month 11 and impairment gains of £0.9m received in month 12. This is an underlying deficit of (£65.6m) for the 2015/16 financial year, representing a (£55.7m) adverse variance against the Monitor plan of (£9.9m) deficit.

The Trust's cash balance as at 31 March 2016 is £31.5m which is (£17.6m) below the planned cash balance at this point in the year.

10. Recommendations

The Board of Directors is requested to:

- Receive the contents of this report.

Julian Miller
Interim Director of Finance
3 May 2016

Minutes of a meeting of the Donated Funds Committee of Heart of England NHS Foundation Trust held in the Board Room, Devon House, Birmingham Heartlands Hospital on 21 April 2016

PRESENT:	P Hensel (Chair) A Jones J Smith K Smith
IN ATTENDANCE:	A Hudson (Minutes) R Manon (Marlborough) Items 8 & 9 G Soggi (Marlborough) Items 8 & 9 M Turner (Investec) Items 8 & 9 R Yardley

16.011 APOLOGIES AND WELCOME

Apologies had been received from A Fletcher.

E Hale remained absent on sick leave.

16.012 MINUTES OF PREVIOUS MEETING

The minutes of the meeting held on 29 January 2016 were approved as a true record.

16.013 MATTERS ARISING

15.003 Trust-wide communication exercise. Carried forward **(Action: EH)**.

16.007 Check Marlborough's terms of engagement and extension or renewal options - K Smith advised that Marlborough's engagement expired on 31 March 2016 and that he had written and had received a response advising that they were happy to extend but not terms had been discussed to date.

16.007 Check with M Hammond what QEHB Charity does in terms of investment adviser and scrutiny of investment managers - P Hensel reported that he had spoken with M Hammond who advised that QEHB Charity did not have independent scrutiny of the charity as their trustees undertook that function.

16.008 Start scoping exercise for appropriate substantive dedicated person in post running the Charity. This would be addressed under the next item of business.

16.008 Organise meeting to consider final version of M Hammond Report – the report had not yet been finalised pending management feedback.

16.014 FUNDRAISING REPORT

It was noted that there was no Fundraising Report due to E Hale's absence.

It was noted that at the present time there were two staff employed within the Fundraising Team, David Liberati, Marketing Manager, and another member of staff who was current on maternity leave; the Finance Team had been supporting D Liberati where it could. K Smith explained that S Foster had recently advised that managerial responsibility for the Fundraising Team was transferring to F Alexander. J Smith reported that she would be meeting with F Alexander, A Jones and K Smith in order to discuss how HEFT wished to move forward with the fundraising function **(Action JS/KS)**.

16.015 FINANCE REPORT

A Jones outlined the key financial information for the 12 months to 31 March 2016 stating that total income received was £1,376k, £424k below plan; expenditure was £2,084k, there was a loss on revaluation of £366k, resulting in a net deficit of £1,074k. The value of the fund at 31 March was £7,362k.

A whole fund review had taken place that had resulted in receipt of spending plans from all fund holders.

2015/16 had been a challenging year that had resulted in more pressure to use funds. Fundraising staffing issues had impacted on funds raised. Changes in the Finance team had also increased costs. A Jones now reviewed all requests to spend funds. The spending plan for 2016/17 was circa £1.5m, if the Charity continued to spend as it had in 2015/16, in the absence of increased receipts, it would begin to reduce its reserves.

A Jones reported that the Charity would over the coming months require cash and proposed that Investec be instructed to liquidate £1m, as follows:

- £300k within next 14 days
- £200k by the end of May.
- £500k over the next 6 months.

There had been two potential fraud investigations; one related to cash handling by a member of the Fundraising Team – following investigation no fraud was found but poor adherence to procedures had been identified. Corrective action had been taken and appropriate records were now being kept and cash now went straight to the cashiers for banking.

The second incident had been in relation to an online donation and subsequent request for a part refund to different account. The full donation was refunded to its source.

There had been two late requests for spend over £10k:

1. Funding for a cancer nurse consultant on trial basis to ease the patient pathway; the business had been backed by the fund holder and Operations Manager, the cost of the trial was £58k; sufficient funds were available in the Leukaemia Cancer fund to support the cost. The Committee approved the proposal.

2. Request for the transfer of £15k from the Ministry of Defence charity fund to the University of Warwick to follow the work that had been transferred from HEFT. The Committee approved the proposal.

A Jones described a proposal to spend £98,500 from the Good Hood General Purpose fund to refurbish the tunnel that connected Fothergill Block to the main hospital building. There was enough money in the fund, subject to anticipated receipt of a legacy, to accommodate the proposal. The Committee debated the use of funds and considered that the proposal was one that HEFT would not be able to fund at the present time and that it constituted an appropriate use of charitable funds as it would improve patient experience. The Committee approved the proposal.

K Smith asked whether the Charity had received funds from Sutton Municipal Fund following the successful £200k grant application, A Jones advised that due to operational issues the money had not been drawn down. A Jones undertook to escalate the matter to J Brotherton and D Rosser, as appropriate **(Action AJ)**.

16.016 ANNUAL REPORT & ACCOUNTS 2015/16

The meeting received the draft Annual Report & Accounts 2015/16. A vote of thanks was recorded to D Liberati and R Yardley for the work they had done in producing the document; P Hensel agreed to write a letter of thanks **(Action PH)**. Any amendments would be made over the next few days, following which the audit would take place and the final draft would be presented to the 20 May meeting for sign off and recommendation to the Audit Committee and the Board.

16.017 CHARITABLE FUNDS USED FOR STAFF BENEFIT

K Smith reported that the Association of NHS Charities had recently written to all trusts to remind them of the guidance in relation to charitable funds spent on staff matters, following an increase in press scrutiny. There was a discussion on the use of funds for staff with linkages to patient benefits including the principle purpose of the charity. It was agreed that the DFOC would consider the guidance and bring back an update to a future meeting **(Action KS/AJ)**.

16.018 OPERATIONS COMMITTEE

K Smith commented on the Operations Committee Actions Log and noted that the new maternity scanning image equipment was still to be commissioned; the delay had been due to lack of staff within the Fundraising Team. In the meantime, the Charity was still receiving income from the sale of scam images under the previous arrangement.

A £2k payment had now been received from the 'independent' Good Hope League of Friends. The meeting received an update on the newly established Friends of Good Hope Hospital; initially it had been agreed that the group would be set up to operate under the HEFT Charity umbrella, however the group had subsequently registered itself separately and set up its own bank account and requested that money was transferred from the Charity to the account. A Jones and members of the Finance Team had also received several challenging emails from the group. It was agreed that K Smith and A Jones would meet with the members of the group to encourage their fundraising initiatives and explain the correct procedures. An update would be presented to the next meeting **(Action KS)**.

16.019 INVESTEC INVESTMENT REPORT S

M Turner (Investec), G Soggi and R Manon (Marlborough) joined the meeting for the next two items of business.

M Turner referred to the pre-circulated papers and reported on Investec's performance against the benchmark for the 12 months to 31 March 2016.

	Q2 2015	Q3 2015	Q4 2015	Q1 2016	Total %
HEFT Charity	-1.2%	-3.4%	3.5%	-0.6%	-1.8%
Benchmark	-2.2%	-2.4%	3.3%	+1.8%	+0.5%

The market commentary was noted.

M Turner explained that Q1 had seen a disappointing performance that effectively negated the positive returns against benchmark seen earlier in the year.

Q4 performance was discussed in detail. Bonds had been adversely affected by the lack of an anticipated US interest rate increase and central banks imposing negative rates. The recent volatility in UK equities and move away from traditional dependable stocks (e.g. mining), together with the funds restriction on investments in tobacco products had been unhelpful; although it was felt that this wouldn't be a problem over the longer term. Investec was overweight in smaller companies that had also underperformed during the quarter. The Absolute Return assets were concentrated on hedge funds that had been adversely impacted by the weaker US Dollar.

It was noted that, since inception in April 2014, Although Investec (6.5%) had underperformed against the benchmark (11.8%), they had performed well against the RPI (2.2%).

Looking forward, Sterling was weak due to uncertainty around the EU Referendum and possible Brexit; Investec thought this may result in further weakening to come. The US elections had introduced political risk. Russia reasserting itself was unhelpful. The Chinese slowdown had continued to impact on investments. However, Investec still believed they were well positioned going forward. They might invest more in long dated Bonds if the US continued to deteriorate.

A Jones advised that the Charity was looking to disinvest £1m; £300k within the next two weeks a further £200k over next five or six weeks, followed by an additional £500k over coming 12 months. A Jones agreed to liaise with M Turner outside of the meeting to agree the precise timeline and mechanics **(Action: AJ)**.

16.020 MARLBOROUGH REPORT

G Soggi tabled a report setting out an overview of the portfolio performance by Investec. The portfolio had been invested in line with the objectives and restrictions outlined by the Trust. Performance had been somewhat disappointing; however Marlborough felt that it remained relatively early in the relationship with Investec to fully judge the investment returns. They held the view that it remained in the best interests of the Trust to continue to engage the services of Investec.

M Turner, G Soggi and R Manon left the meeting at this point.

The meeting discussed whether the Charity required Marlborough to continue to provide independent scrutiny of Investec's performance and decided that it did not. K Smith undertook to write to Marlborough and advise them that the Trust would not be renewing the arrangement. **(Action KS)**.

It was noted that should the strategic status of the Charity or its investments change significantly, further consideration could be given to independent scrutiny in the future.

16.021 ANY OTHER BUSINESS

There was none.

16.022 DATE OF NEXT MEETING

20 May 2016 in the Board Room, Devon House, Birmingham Heartlands Hospital.

.....

Chairman

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, Birmingham Heartlands Hospital on 29 April 2016 at 8.00am

PRESENT:	J Smith	*(Chair)*
	D Burbridge	
	S Foster	
	J Moore	
	J Rao (by phone)	
IN ATTENDANCE:	K Smith	*(Company Secretary)*
	J Gould	

16.06 APOLOGIES

Apologies were received on behalf of J Brotherton, K Kneller and J Miller (J Gould was in attendance on his behalf); the meeting was therefore quorate.

16.07 MINUTES OF PREVIOUS MEETING

The minutes of the meeting of 29 January 2016 were approved as a true record.

16.08 APPROVAL OF MONITOR QUARTER 4 RETURN

J Gould confirmed that the Monitor quarter 4 return had been completed in accordance with the Risk Assessment Framework and commented at a high-level on the current financial position of the Trust in terms of the deficit and the failure to achieve certain performance targets, all as previously advised to the Board.

The meeting considered the pre-circulated papers.

The Board was expected to sign the combined Governance Statement. This would confirm, or otherwise, four things:

For finance, that:

- The Board anticipates that the Trust will continue to maintain a financial sustainability risk rating of at least 3 over the next 12 months.
- The Board anticipates that the Trust's capital expenditure for the remainder of the financial year will not materially differ from the amended forecast in this financial return.

For governance, that:

- The Board is satisfied that plans in place are 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.

Otherwise:

- The Board confirms that there are no matters arising in the quarter requiring an exception report to Monitor (per the Risk Assessment Framework, Table 3) which have not already been reported.

The Board would therefore have to highlight in the governance statement the

exceptions to the confirmations noted.

Governance

The Trust had failed to achieve the four hour A&E waiting target for the fifteenth consecutive quarter. The Trust had agreed a system wide trajectory to achieve the target on a quarterly basis by quarter 1 2016/17. With increased demand on the urgent care pathway this trajectory will not be met. A revised stretch trajectory had been developed as part of the S&TF with the Trust planning to return to performance of 92% by March 2017.

It was noted that, 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, however, it was expected that the Trust had returned to compliance for both 2 week cancer wait targets in quarter four.

With regard to the 62 day cancer target, the Trust had remained non-compliant in quarter 4. A revised trajectory had been developed as part of the S&TF with the Trust agreeing to deliver sustained performance against this metric from the end of June 2016.

Also as previously disclosed the Trust failed to hit the 18 week RTT target in the quarter, although it did meet the 92% target in both February and March. A revised trajectory had been developed as part of the S&TF with the Trust agreeing to deliver ongoing sustained performance against this target from the end of September 2016.

The Trust also provided supplementary Governance Information to Monitor. Amongst other things it included information on serious untoward incidents (SUIs), contacts with the CQC, information governance breaches, dealings with the Coroner and exchanges with other regulatory organisations such as the Health and Safety Executive (HSE).

Finance

The Trust was subject to Monitor enforcement undertakings under sections 106 and 111 HSCA. The Trust had been working hard over the last several months to improve operational performance with trajectories, agreed with its stakeholders, to measure this improvement. The Trust had made many improvements in performance. This had come at a financial cost much greater than planned as significant investment in services has been made to meet these trajectory targets and improve clinical quality. The Trust was now in a financial recovery process with the support of Ernst and Young.

Urgent work continued in order for the Trust to re-establish a sustainable financial position while maintaining improvements in operational performance. The Trust had produced and delivered a short term financial recovery plan for 2015/16 and must produce and deliver a longer term financial sustainability plan for 2016/17 and beyond.

In the final quarter of the financial year the Trust had reported a surplus of £5.3m, £7.9m favourable to the plan. The full year deficit of £46.1m was £36.2m adverse to the plan. The final quarter's performance included two significant one-off items: £18.6m of income as part of an agreed capital to revenue transfer and a net impairment charge reversal of £0.9m following an Estate revaluation. If the impact of these items was excluded, the underlying deficit of £14.1m for the quarter, £65.6m for the full year was adverse to the original plan by £11.5m and £55.7m respectively.

The deficit was £0.4m under the month 11 reforecast.

The Trust's Financial Sustainability Risk Rating was 1. While there has been some improvement in financial performance in the quarter continuing significant operating losses mean that the Trust's liquidity had continued to decline sharply.

In quarter 4, overall operating income of £164.6m (excluding the capital to revenue transfer) was £9.2m favourable to the plan, full year income of £653.8m was £20.2m above plan. NHS Clinical Income of £150.0m outperformed the Monitor plan by £10.7m. The clinical income outturn of £591.6m outperformed plan by £23.1m (this included an off plan switch of £3.8m of retinopathy income from miscellaneous other operating income). In 2015/16 the Trust was recognising income under full Payment by Results (PbR) terms and conditions using the Enhanced Tariff Option (ETO). An impairment charge of £10.1m year to date was included in the position relating to ongoing payment queries from the CCGs and risks associated with moving to PbR.

The favourable variance on operating income was offset by an overspend of £19.6m on operating expenses of £175.8m in the quarter. At the full year, operating expenses of £711.7m were £75.4m over plan. Notable full year overspends against plan were recorded on employee expenses £25.5m (unfilled vacancies, enhanced bank rates, additional WLI work, high levels of agency nurses and locum doctors), drugs, including pass through expenses £10.0m, clinical supplies £7.5m, non-clinical supplies £5.7m (extra capacity still open impacting on laundry, cleaning and security), consultancy £3.9m (including E&Y costs and project management office), impairment of receivables £10.1m (unplanned switch to PbR terms and conditions) and miscellaneous other operating expenses £15.1m (including extra internal audit and governance costs and unrealised planned savings). A small overspend of £0.2m on depreciation was offset by the net £0.9m impairment credit as a result of the Estate revaluation.

The Estate revaluation resulted in a reappraisal of the PDC dividend charge; the expense of £2.0m was £0.3m over plan, full year the charge of £6.6m was £0.3m under plan with lower than planned capital expenditure and a small unplanned repayment of PDC dividend in relation to the prior year.

There had been a further reduction in the Trust's liquidity. Cash and investment balances of £31.5m were below plan by £17.7m. Lower than planned operational performance had resulted in adverse to plan cash flows of £48.2m for the year after stripping out the artificial impact of the £18.6m capital to revenue transfer. Changes in working capital balances were £4.1m better than planned for the year. Cash capital additions were £25.9m below plan for the full year to date. The tightening of the reins on capital expenditure and the more assertive cash preservation measures actively managing working capital, in place during the second half of the year, had resulted in a stabilisation in cash balances despite the continued, significant operating losses being recorded

I was noted that A Edwards had questioned the narrative in the Executive Summary for the Board that set out what the Board was expected to sign up to in the governance statement but this was only an explanation of the aspirational standard required and that the Trust's governance statement would be qualified to reflect the Trust's actual position.

In response to a question from J Smith, D Burbridge explained that all of the Serious Incidents being reported in the return either had been or would be reported to the Board in the Clinical Quality Report presented by the Medical Director.

After due consideration and subject to the foregoing the quarter 4 return was

approved and any one or two directors, as applicable, were authorised to sign the relevant documents on behalf of the Trust.

16.09 ANY OTHER BUSINESS

There was none.

16.10 DATE OF NEXT COMMITTEE MEETING

29 July 2016.

……
Chair

Title: The Modern Slavery Act 2015						**Attachments:**	0
From: Kevin smith, Company Secretary			**To**: Board				
The Report is being provided for							
Decision	Y	Discussion	Y	Assurance	N	Endorsement	Y
The Board is being asked to:							
Approve an action plan and statement pursuant to the Modern Slavery Act 2015.							
Key points/Summary:							
The Modern Slavery Act was passed by Parliament in March 2015. The provisions of the Act came into effect in October 2015. The Act consolidated slavery and trafficking offences, strengthened powers of enforcement and introduced tougher penalties. It also included a transparency clause requiring all UK based organisations with a turnover of over £36m to make an annual statement on the steps it has taken in the previous financial year to ensure its business and supply chains are free from Modern Slavery, which the Act defines as slavery, servitude, forced or compulsory labour and human trafficking. The statement should be Board approved, signed by a director and must be published on an organisation's website. The Trust is obliged to publish a statement under the Act. In common with many organisations in the UK, the Trust has just started work to address the issue and the draft statement reflects the progress during 2015/16 and includes an action plan to take this forward in 2016/17.							
Recommendation(s):							
To approve the Modern Slavery Action Plan for 2016/17 and to approve the Modern Slavery Statement for 2015/16 for publication on the Trust's website.							
Assurance Implications:							
Strategic Risk Register	N	Performance KPIs year to date	N				
Resource/Assurance Implications (e.g. Financial/HR)	N	Information Exempt from Disclosure	N				
Identify any Equality & Diversity issues		None					
Outline how any Equality & Diversity risks are to be managed		N/A					
Which Committees has this paper been to? *(e.g. F&PC, QC, etc.)*							
None							

Introduction

The Modern Slavery Act was passed by Parliament in March 2015 and its provisions came into effect in October 2015. The Act consolidated slavery and trafficking offences, strengthened powers of enforcement and introduced tougher penalties.

In addition, Clause 6 of the Act: "Transparency in Supply Chains" requires businesses of a certain size to publish annually a slavery and human trafficking statement that summarises the steps taken during the previous financial year to ensure that slavery and human trafficking is not taking place in any part of its own business or its supply chains. The

disclosure statement must be published regardless of whether any steps have been taken or not.

If the Trust fails to make a statement for any financial year the Secretary of State can seek an injunction and if the Trust fails to act on the injunction it is in contempt of court, which is punishable by an unlimited fine. Although Monitor has remained silent on the issue to date, it is likely that the obligation will be subject to regulatory enforcement. In addition, failure to comply may also damage the reputation of the organisation.

Background

Modern Slavery is a term used to encapsulate the two offences included in the Act:

- slavery (i.e. where ownership exercised over a person), servitude (i.e. which involves an obligation to provide services and is imposed by coercion) and forced or compulsory labour (i.e. work or service exacted from any person under the menace of a penalty and for which the person has not offered himself voluntarily); and
- human trafficking, which concerns arranging or facilitating the travel of another with a view to exploiting them.

Modern Slavery is increasingly common:

- The 2014 Global Slavery Index estimates 35.8 million people are living in some form of modern slavery globally and 61% are estimated to live in 5 countries: India, China, Pakistan, Uzbekistan and Russia.
- According to the International Labour Organisation, illegal profits from forced labour amounted to more than $150 billion a year.
- In the UK, 1746 cases of slavery were reported in 2013; however, the Home Office estimated there were between 10-13,000 victims of Modern Slavery in the UK in the same year.

There is no expectation in the Act that any eligible organisation can *guarantee* there is no Modern Slavery in their business or supply chain, rather that reasonable steps have been taken to make them free of Modern Slavery. Whilst Modern Slavery is illegal in every country in the world, it still occurs in every country. It is acknowledged that many suppliers are either wilfully blind or will go to extreme lengths to hide the fact that Modern Slavery is in use. Assurances from legislation, codes of practice or conduct and audit are useful but from recent evidence cannot be used as absolute assurance.

The nature of global supply chains for goods and services is increasingly complex. Modern Slavery can be found anywhere in the chain but it tends to be much worse further down the value chain, where there is little visibility and the poorest and most vulnerable workers are engaged. That is why the disclosure requirement is challenging. A survey published in October 2015, found that 72% of supply chain professionals admit to having no visibility of their supply chain below the second tier (Chartered Institute of Procurement and Supply).

Procurement of goods and services within the NHS is equally complex and may occur by direct supply to end-users, or through a number of local, regional or national procurement hubs.

Current position

As a corporate body that carries out a business in the UK supplying goods and services with a turnover in excess of the £36m threshold and with a year-end of 31 March 2016, the Trust is obliged under the Act to make a statement for financial year 2015/16 and annually thereafter.

The Act permits an organisation to make a disclosure that no steps have been taken in the previous year. However, whilst this may be acceptable for this year there are likely to be reputational and regulatory consequences if no action is taken going forwards. It is anticipated that the issue will attract increased public scrutiny, especially for public sector organisations.

In common with a significant proportion of eligible UK businesses, the Trust is able to report it has made limited progress for 2015/16 i.e. it is starting to act on the issue and has an outline action plan to take the work forward during 2016/17 – see **Appendix 1** - with the intention to consolidate and build upon this in future years.

The statement
The Act does not prescribe a template for the disclosure statement but suggests the following for inclusion:

- an outline of the Trust's structure, business and supply chains
- policies in relation to Modern Slavery
- due diligence processes in relation to Modern Slavery in its business and supply chains
- the parts of its business and supply chains where there is a risk of Modern Slavery and steps it has taken to assess and manage that risk
- the effectiveness in ensuring the Modern Slavery is not taking place in its business or supply chains
- staff training concerning Modern Slavery

The statement must be approved by the Board and signed by a director.

It must be published on the Trust's website and include a link to the statement in a prominent place on the website's home page. As a public facing document it should be written in plain English but consideration should be given to providing the statement in other languages.

The draft 2015/16 Statement on Modern Slavery is attached as **Appendix 2**.

Recommendation
The Board is asked to approve the Modern Slavery Action Plan for 2016/17 and to approve the Modern Slavery Statement for 2015/16 for publication on the Trust's website.

Appendix 1

Modern Slavery Action Plan 2016/17

Action	Notes	Timeline	Lead
Board paper, draft action plan 2016/17 and draft 2015/16 statement to Board.	Limited steps taken in 2015/16 following introduction of Act provisions in Oct 2015.	11.05.16	KS
Agree governance and oversight.	Discuss at CEG and agree Executive lead and senior management owner.	24.05.16	KS
Include short commentary in 2015/16 Annual Report.	Link to statement on website.	25.05.16	FA
Publish 2015/16 statement.	Subject to Board approval, publish on website with prominent link from front page of website.	25.05.16	FA
Agree working group with ToR, actions, deadline and reporting for MSA project (including project plan).	Review and amend action plan, as appropriate. Identify work streams with agreed deadlines and performance management arrangements. Consider the resource implications of the project plan and, if necessary, make a business case for additional resource.	30.06.16	Exec lead
Develop Trust response to associated national initiatives, as appropriate.	It is anticipated that further guidance, amended standard contracts, relevant regulations, etc. will be issued by Home Office, DH, NHSE, NHS Improvement, specialist bodies such as NHS Employers, NHS Supplies and professional bodies such as Chartered Institute of Purchasing and Supply (CIPS) from 31 March 2016 onward.	Ongoing	Exec lead

Appendix 2

Modern Slavery Statement 2015/16

In accordance with the Modern Slavery Act 2015, Heart of England NHS Foundation Trust ("HEFT") makes the following statement regarding the steps it has taken in the financial year 2015/16 to ensure that Modern Slavery (i.e. slavery and human trafficking), is not taking place in any part of its own business or any of its supply chains.

About the Trust
HEFT serves around 1.2m people in Birmingham East and North, Solihull, Sutton Coldfield and South Staffordshire.

We have a workforce of around 11,000 and we operate three local hospitals (Birmingham Heartlands, Good Hope and Solihull) with nearly 1,500 beds in total and community services in Solihull. The nationally-renowned Birmingham Chest Clinic is also an important part of the Trust and we operate a number of satellite units that treat patients as near to their homes and families as possible.

We are a medically led organisation with, medically qualified, Divisional Directors who are focused on running their Divisions; they are supported by Head Nurses and Heads of Operations.

The Trust is recognised as a national leader in the treatment of MRSA and other infectious diseases. We also specialise in treating a range of illnesses and conditions including heart and kidney disease, cancer, HIV and cystic fibrosis and we have specialised expertise in premature baby care, bone marrow transplants and thoracic surgery.

In the 2014-15 year our staff:
- Treated 248,069 people in accident and emergency departments
- Delivered 79,844 elective and day case procedures
- Fulfilled 819,446 outpatient appointments
- Supported 10,721 births

The Trust's income in 2014-15 was £647m.

Like many other large, complex organisations our supply chain arrangements are complex in parts.

Action taken during 2015/16
The Trust is aware of the key issues around the Modern Slavery Act. A briefing paper on Modern Slavery and the implications of the 2015 Act was prepared, together with an action plan for 2016/17, both of which were considered by the Board at its meeting on 11 May 2016.

The Board approved this statement for publication on its website and approved a Modern Slavery Action Plan for 2016/17 (*hyperlink to Action Plan*) to ensure Modern Slavery is not taking place in any part of its own business or any of its supply chains.

Rt. Hon. Jacqui Smith
Chair
Heart of England NHS Foundation Trust
11 May 2016

QUALITY COMMITTEE Terms of Reference

Approved by the Board: 11th May 2016

Review Date: April 2017

All powers and authorities exercisable by the Board, together with any delegation of such powers or authorities to any Committee or individual, are subject to any limitations imposed by the Constitution or by Monitor or by the National Health Service Act 2006. Due regard will also be had to any Code of Governance issued from time to time by Monitor.

Any reference to "Director" shall be to formally appointed Directors of the Trust Board of Directors and, unless otherwise specified, not to personnel who carry the word "Director" as part of their title.

Purpose

The purpose of the Committee is to support, and provide continuity for the Board in relation to the Board's responsibility for ensuring that the care provided by the Trust meets or exceeds the requirements of the Trust's clinical quality policy.

Membership

Only members of the Committee have the right to attend Committee meetings. However, other individuals, including external advisers, may be invited to attend for all or part of any meeting as and when appropriate.

The Committee shall be appointed by the Board from amongst the Directors of the Trust and shall consist of not less than five Non-executive Directors (of which one shall be the Chair of the Trust) and four Executive Directors, being the Chief Executive, the Medical Director, the Chief Nurse and the Director of Operations. The Chair of the Trust shall be the Chair of the Committee.

Other members of the Board may attend any meeting of the Committee. Other Trust staff, including Executive Directors, may be invited to attend to present and/or discuss particular items on the Agenda.

Secretary

The Company Secretary, or their nominee, shall be Secretary to the Committee and shall attend all meetings and provide appropriate support to the Chair and Committee members.

The Secretary's duties will include:-

- Agreement of the agenda with the Chair, collation and circulation of papers.
- Minuting the proceedings and resolutions of all meetings of the Committee, including recording the names of those present and in attendance.
- Keeping a record of matters arising and issues to be carried forward.
- Advising the Committee on pertinent areas.
- Arranging for the Committee to receive legal or other professional advice, if required.

Quorum

The quorum necessary for the transaction of business shall be five, three of whom must be independent Non-Executive Directors, including the Chair or Deputy Chair. A duly convened meeting of the Committee, at which a quorum is present, shall be competent to exercise all or any of the authorities, powers and discretions vested in or exercisable by the Committee.

Where the Chair has approved their attendance, deputies will have full delegated authority and count in the quorum.

Frequency of Meetings

The Committee shall meet not less than four times a year.

Notice of Meetings

Meetings of the Committee shall be summoned by the Secretary of the Committee at the request of the Chair of the Committee.

Unless otherwise agreed, notice of each meeting confirming the venue, time and date shall be forwarded to each member of the Committee and any other person required to attend, no later than ten working days before the date of the meeting.

The Agenda and supporting papers shall be sent to Committee members and to other attendees no later than five working days before the date of the meeting.

Minutes of Meetings

The Secretary shall minute the proceedings of all meetings of the Committee, including recording the names of those present and in attendance.

The Secretary shall ascertain, at the beginning of each meeting, the existence of any conflicts of interest and minute them accordingly.

Draft minutes of Committee meetings shall be circulated promptly to all members of the Committee. Once approved, minutes should be circulated to all other members of the Board, unless it would be inappropriate to do so in the opinion of the Committee Chair.

Approved minutes shall be retained and stored by the Secretary in accordance with statutory requirements.

Annual Members Meeting

The Chair of the Committee shall attend the Trust Annual Members' Meeting prepared to respond to any questions on the Committee's activities.

Duties

The duties of the Committee are to monitor the performance of the Trust against the requirements of the clinical quality strategy, including:

- Reviewing, and monitoring action taken in relation to managing, exceptions;
- Notifying the Board should any irregularity be identified;
- Overseeing compliance with external and internal care standards;

- Receiving quantitative and qualitative analyses reflecting all aspects of clinical governance, including complaints, claims, inquests and clinical incidents;
- Ensuring that lessons are learned from complaints, litigation, adverse incident reports and trends, and service enquiries and review;
- Overseeing the Trust's responses to all relevant external assessment reports and the progress of their implementation (e.g. Care Quality Commission, NAO, Monitor, NHSLA, NICE guidelines, external and internal audit reports);
- Assuring itself that participation in clinical audit and relevant research and development activity by individuals and multi-professional teams is encouraged and supported as integral to the provision of high quality clinical care;
- Overseeing the development of the annual Quality Report and Quality Account;
- Scrutinising assurance on the performance of the Divisions against the Quality Framework that includes the relevant Strategic Objectives and the priorities set out in the Quality Account;
- Initiating and monitoring investigation of areas of serious concern as necessary and ensure resulting action plans are implemented; and
- Monitoring the key performance indicators relevant to areas of clinical quality.

Accountability and Reporting

The Committee Chair shall report formally to the Board and, where appropriate, the Council of Governors, on its proceedings after each meeting on all matters within its duties and responsibilities.

The Committee will make whatever recommendations to the Board it deems appropriate on any area within its remit, where action or improvement is needed.

Reporting from the Committee to the Board shall be configured to meet the requirements of the Trust's Board Assurance Framework and such responsibilities as are delegated by the Board therein.

Reporting to the Board shall be comprised of the Chair's Report and Committee minutes.

Authority

The Committee is invested with the delegated authority to act on behalf of the Board in all matters concerning the Trust's clinical quality strategy. The limit of such delegated authority is restricted to the areas outlined in the Duties of the Committee contained within these Terms of Reference and subject to the provisions on Accountability and Reporting, as described above.

The Committee is authorised to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee.

The Committee may require any employee of the Trust or any other person involved in the delivery of clinical or patient care services on behalf of the Trust to attend any meeting and to produce the required information for the Committee.

The Committee is authorised by the Board to obtain legal or other professional advice and support to enable it to discharge its duties.

Other Matters

The Committee shall, at least once a year, review its own Terms of Reference to ensure it is operating at maximum effectiveness and recommend any changes it considers necessary to the Board for approval.

The Committee shall have access to sufficient resources in order to carry out its duties, including access to the Company Secretary for assistance as required, and shall be provided with appropriate and timely training, both in the form of an induction programme for new members and on an ongoing basis for all members.

Board Business Programme 2015/16	Lead	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Apologies for Absence	KS		✓		✓		✓		✓		✓		✓
Declarations of Interest	KS		✓		✓		✓		✓		✓		✓
Minutes of previous meetings	KS		✓		✓		✓		✓		✓		✓
Matters arising	KS		✓		✓		✓		✓		✓		✓
Chair's Report, incl. Quality Committee Report and Governor feedback	JS		✓		✓		✓		✓		✓		✓
Chief Executive's Report	DJM		✓		✓		✓		✓		✓		✓
Performance Indicators Report	KB/JB		✓		✓		✓		✓		✓		✓
Clinical Quality Report, incl. Serious Untoward Incidents and Medical revalidation	DR/CR		✓		✓		✓		✓		✓		✓
Care Quality Report, incl. Infection Control Updates	SF/JT		✓		✓		✓		✓		✓		✓
Nurse Safe Staffing reports	SF/JT		✓				✓						✓
Infection Control Annual Report	SF/AH								✓				
Safeguarding Annual Reports	SF/MK										✓		
Finance Report, incl. Monitor Qtly Feedback letters	JM		✓		✓		✓		✓		✓		✓
Final Operational Plan	JM	✓											
Draft Operational Plan	JM										✓		
HEFT Annual Report and Accounts	DJM		✓										
Donated Funds Annual Report and Accounts	JS		✓										
Staff Survey results	HG		✓										
Board Assurance Framework and Risk Register	DB		✓				✓				✓		
Audit Committee Report	KK		✓		✓		✓		✓		✓		✓
Audit Committee Minutes	KK		✓		✓		✓		✓		✓		✓
Donated Funds Committee Report	JS		✓		✓		✓		✓		✓		✓
Donated Funds Committee Minutes	JS		✓		✓		✓		✓		✓		✓
Monitor Standing Committee Report	JS		✓				✓				✓		✓
Monitor Standing Committee Minutes	JS			✓			✓				✓		✓
Organ Donation Committee Annual Report	JS								✓				
Carbon Footprint Annual Report	KB/JSe								✓				
Site Strategy Annual Report	KB/JSe								✓				
Review Committees' Performance and Terms of Reference	JS				✓								
Review of Board Performance and Director Appraisals	JS				✓								
Review Constitution, Schedule of Matters Reserved to the Board, Standing Orders, SFIs, etc.	KS				✓								
Set Board Business Plan for next year	KS												✓