Notice is hereby given that a meeting of the Council of Governors
of Heart of England NHS Foundation Trust will be held at
the Harry Hollier Lecture Theatre, Partnership Learning Centre, Good Hope Hospital
on 4 March 2015 from 4.00 to 6.00pm

A G E N D A

1. Introduction from Andrew Foster (Oral – A Foster)

2. Month 10 performance (Oral – A Catto)

3. Reports from CoG Cttee chairs:

    a. Finance & Strategic Planning (18.11.14, 14.01.15) (Enclosure & Oral – A Fletcher)
    b. Hospital Environment (08.01.15) (Enclosure & Oral – E Coulthard)
    c. Membership & Community Engagement (09.01.15) (Enclosure & Oral – A Fletcher)
    d. Patient Experience Committee (09.01.15) (Enclosure & Oral - M Kelly)
    e. Quality & Risk (07.08.14, 03.11.14, 26.01.15) (Enclosure & Oral – L Steventon)
    f. Kennedy Task Force (23.01.15) (Oral – M Pearson)

4. Report on the work of the Board Quality & Risk Cttee, plus Q&A (Oral – J Rao)

5. Surgery Reconfiguration and Solihull Urgent Care Centre – update (Oral - Chair)

6. Any other business previously advised to the Chair

7. Next Meeting – 14 April 2015 at St Johns Hotel, Solihull

Refreshments will be available from 3.30pm

Kevin Smith
Company Secretary
24 February 2015

COUNCIL OF GOVERNORS
FINANCE & PERFORMANCE & STRATEGIC PLANNING COMMITTEE

Minutes of the Finance & Strategic Planning Committee of the Council of Governors of Heart of England NHS Foundation Trust held in the Board Room - Heartlands Hospital on 18th November 2014

Present:	Mr A Fletcher (Deputy Chairman) Dr O Craig Mr R Hughes Mr M Hutchby Mr P Johnson Mr M Trotter Mr B Orriss Ms A Khan	
In attendance:	Ms J Hodgkiss Mrs A Jones Mrs M Vaughan	Head of Planning & Development Chief Financial Controller Personal Assistant (minutes)

1 APOLOGIES

Mr A Quinn.

2 MINUTES OF MEEETING HELD ON 8th SEPTEMBER 2014

The minutes of 8th September 2014 were accepted as an accurate record.

3 MATTERS ARISING / ACTION LOG

The following items were discussed under matters arising.

- Mr Fletcher asked again if any of the committee members wished to take on the role of chairman. Mr Fletcher agreed to continue chairing the committee until vacancy filled as no one had yet stepped forward.
- Mrs Jones to write to the Chairman for an update on 2 outstanding items (March '14) from action log as Mr Lawrence no longer attends meeting. **AJ**
- Mr Fletcher confirmed Committee Chairs had met to discuss Committees TOR and the verbal suggestions would be updated and Mr Smith would reissue TOR to all Committees for ratification. Mrs Jones asked to contact Mr Smith and request circulation in readiness for next meeting in January. **AJ**

4 CORPORATE STRATEGY/ RESHAPING HEFT UPDATE

Corporate Strategy

Ms Hodgkiss briefed on key areas where developments were happening within Professor Matthew Cooke's areas.

A decision had been made by Audit Committee/EMB/Trust Board that these areas would no longer be called Reshaping HEFT. A Clinical Strategy Board which covers all clinical developments which Les Lawrence is Chairperson has been set up. 1st Shadow board met last month to agree TOR and has a wider membership covering different organisations: Stroke services, Citizens assembly, Governors and staff representatives. HASU was launched on 30th October and a number of Governors had attended. Mr Orriss stated it was very impressive. Ms Hodgkiss confirmed 25 additional nurses had been appointed and HEFT had received its first patient on 7th November and had given positive feedback on their experience and had also been highlighted in the news. Patients from Solihull and GHH to be **JH**

transferred shortly. Issue presently with the ambulance service re activity cost pressure to a sum of £1.2 m. Ms Hodgkiss will be handing over to Operations as will become business as usual rather than strategic. Ms Hodgkiss will continue with the weekly programme meetings until December covering data, performance and patient experiences etc.

- Surgery Reconfiguration Consultation continuing as expected and extended to Lichfield and Tamworth as recommended by B Orriss.
- From 1st December a new piece of work on Frailty service was being undertaken initially on BHH site and then more medium to long term having a corporate approach. The Committee will be updated regularly. **JH**
- Mr Hughes asked for an update on 7 day services. Ms Hodgkiss stated HEFT was working collaboratively with a number of organisations to review gaps which may lead to a business case for additional investment.
- Mr Orriss asked whether the different systems of discharge were being assessed. Ms Hodgkiss advised that all 3 sites were being assessed. The Trust is now looking at an evaluation of these SID systems.
- Mr Fletcher asked what the Trust is doing about the wards 'stacking up' and the congestions. A discussion about more radical solutions and the suggestion of 'thinking outside the box' with ideas such as using hotel facilities started, and it was agreed this would be included as an agenda item for the January meeting. **AJ**
- Mr Hughes questioned whether the Trust had the capability to run the Sexual Health services it had tendered for. Mrs Jones explained this had been included in the tender and the trust would hear over the coming weeks whether it had been successful.

5. FINANCE & PERFORMANCE MONTH 6 UPDATE

Mrs Jones highlighted the following key points:

Month 6 Figures

At Month 6 (quarter 2) the Trust had a COSR rating 4 (highest rating) delivering a YTD deficit of £3.4m, largely in line with Plan.

- Operational budgets overspent by £9.7m primarily due to additional demand and activity to deliver targets and higher pay costs for temporary staffing usage. Includes medics of £4.3m and nursing £2.2m.
- 4 Divisions compiling detailed rectification plans for the Finance & Performance Committee in December
- Efficiency behind – delivered £5.3m of SIEP (formally CIP) YTD, 45% of target and month 6 delivered 60% of in month target. Forecast delivery of £18m, 75% of £24m target.
- October's Finance & Performance committee received a revised forecast. Original plan was a £2m surplus, the likely plan now is to break even. If Winter goes well could be a £3.3m surplus and if doesn't go well could be £3.2m deficit. Likely forecast of breakeven assumes the following:
    - Improve performance delivers £1.0m additional income
    - Resilience monies provides for cost to deliver RTT and winter (due partly to achieving 18 weeks target)
    - Modest delivery on rectification and SIEP. Mr Hughes did comment forecast extremely optimistic and delivering 60% not 75% as mentioned in previous report
    - Pay bill is effectively managed
    - Additional point to note: current decision regarding additional investment would change forecast. Discussions took place (previous week) suggesting further investment into the Trust for continued 18 weeks work in the private sector
- DOH Reporting – monthly return on revenue and capital actual and forecast now sent to Monitor monthly as part of consolidated NHS monthly report.
- Cash balance £95m, £8.6m above plan and Debtors £16.8m.
- Capital total expenditure budget for the year of £37.4m including £12.4m carry forwards along with good progress towards month 6, 85% of Plan threshold achieved year to date so reforecast not required by Monitor, forecast reduced to £29.9m.
- Mr Hughes requested further 'in between figures' to understand the assumptions arrived at to explain how there is a £9m YTD overspend and an under delivery on SIEP but the reduction in surplus is only £2m in forecast.
- Mr Hughes started a detailed discussion on temporary staffing. It was confirmed the overspend on nursing and medical in total was £6.5m and actual spend was in excess of £13m for the first 6

months of the year. Mr Trotter gave an overview of medics pay causing an over spend.

- Ms Hodgkiss explained there is a national issue with junior doctor shortages. A paper has been to EMB and is going to December's Trust Board for the creation of ACP (associated clinical practitioners). HEFT has had these posts in A&E departments for years and is recommending we recruit to scale by entering a detailed training plan which is linked to Warwick University (ie. Nurses, pharmacist, therapists) to be able to replace the loss of skills we are having in our junior medics workforce.
- Mr Johnson asked how were bureau staff being deployed following his experience in hospital and noting 2 bureau staff were not required on the ward and sent off somewhere else which does not give the impression of a controlled workforce position. Ms Hodgkiss stated there was an escalating process which covered ward managers, on call manager sign off and the medical workforce department for doctors. Mrs Jones stated the payroll and bank staff are managed by HR. Mr Fletcher suggested inviting Mrs Gunter to the March 2015 to discuss how the staffing process and controls work. **AJ**
- Mr Johnson asked what % above average wage do bank staff get paid and Mrs Vaughan agreed to send details and attach to minutes. **MV**
- On the overall financial position Mr Trotter stated he believed this was an important message to be communicated to Trust staff , especially after the departure of the CEO. Mrs Jones confirmed the total overspend was c3% of total spend, and that central reserves were included at budget setting and a review of this had taken place to arrive at the forecast.
- Mr Trotter asked for an update on the Chest Clinic. Mrs Jones stated the Trust did consider purchasing building but have decided not to as not viable for the Trust. Mr Trotter stated information not being communicated on the bigger strategy and although working in the Trust he does not know what's happening in the Trust. Mr Fletcher asked for the Chest Clinic to be added the full COG agenda and asked Mrs Jones to contact K Smith. **AJ**

<u>Performance</u>

- A&E 4 hour 95% target was missed in October and YTD position is 92.87%, C Difficile on target in month. Struggling to report the 18 Weeks target – this is partly due to issues with data transfer within the new PMS2 system. There is a cohort of 6 new staff working to rectify the issue and Monitor and CCGs are fully briefed with situation. Cancer targets are not being met although everyone is working to hit targets.
- Monitor Enforcement Undertaking was previously Section 106 which looked at A&E 4 hrs targets, following September's review Trust now Section 111 which has broadened a number of targets to also include 18 week RTT and 2 week cancer waits (breast and others). Monthly submissions of actions plans progress against trajectories and other information were required. In addition Deloittes undertook an internal audit governance review which had been distributed and included all Governors.

<u>Annual Plan</u>

- Monitor issued a new Annual Plan 'traffic light' system. The Trust scored an 'amber' which means "*The sensitisation of the projections identified that the foundation trust's sustainability may be marginal.. We therefore ask the trust to review its plans in light of our findings and to consider what improvements in strategic planning may be required".* In addition Monitor issued a toolkit consisting of 380 pages informing Trusts what they should be doing. Monitor has collaborated with a number of organisations compiling toolkit. Mrs Jones stated the Trust is continuing with the Plan timetable as stated in report.

6. TERMS OF REFERENCE

To be discussed at January's meeting**.**

9 ANY OTHER BUSINESS

Mrs Jones confirmed 'fraud' will be included in the Governors training scheduled in December and presented by Lorna Barry and David Fletcher from Deloittes. In addition Deloittes prepare an annual report of work under taken during 14/15 and the plan for 15/16 which is reported through to the Audit Committee. Mr Fletcher asked that fraud be included in the updated TOR reference update in January. **AJ**

Mr Trotter asked about changes in the senior leaders. Ms Hodgkiss informed that Andrew Catto is acting as Chief Executive and Clive Ryder as Medical Director and that Adrian Stokes is currently on leave.

Mr Hughes' apologies noted for January's meeting.

10 DATE OF NEXT MEETING

WEDNESDAY, 14th JANUARY 2015 @ 10.00a.m. SOLIHULL EDUCATION CENTRE.

Followed by an additional meeting of all Governors in Room 6, Solihull Education Centre @ 12.15p.m.

Committee Chairman

COUNCIL OF GOVERNORS
FINANCE & PERFORMANCE & STRATEGIC PLANNING COMMITTEE
DRAFT

Minutes of the Finance & Strategic Planning Committee

of the Council of Governors of Heart of England NHS Foundation Trust

held Solihull Education Centre, on Wednesday, 14th January 2015

Present:	Mr M Hutchby	
	Mr P Johnson	
In attendance:	Mr A Quinn *(Chairman for Meeting)*	Acting Director Finance
	Mrs A Jones	Chief Financial Controller
	Mr M Cooke (p/t)	Deputy Medical Director Strategy & Transformation
	Mrs M Ross (p/t)	Clinical Director of Therapy Services
	Mrs M Vaughan	Personal Assistant (minutes)

1 APOLOGIES

Mr A Fletcher; Mr R Hughes; Mr M Trotter; Mr B Orriss; Ms A Khan; Ms J Hodgkiss.

Dr O Craig was not in attendance.

2 MINUTES OF MEEETING HELD ON 8th SEPTEMBER 2014

Mr Quinn agreed to chair the meeting in the absence of Mr Fletcher. Mrs Jones asked it to be minuted the meeting was not quorate and did not believe any decisions were required at the meeting but if a decision was required suggested a written resolution would be tabled at the next meeting or if urgent response required the Committee members would be emailed. Mr Quinn noted the low attendance and asked the Committee to discuss and appoint a chairperson.

The minutes of 18th November 2014 were accepted as an accurate record.

3 MATTERS ARISING / ACTION LOG

The following items were discussed under matters arising.

- Mr Johnson asked if there was an incentive to staff to give up their substantive post and work on the bank for more money. Professor Cooke stated there were shortages in certain areas i.e. A&E, theatres but not across the board. A discussion continued on changes within the workforce especially more part time hours been undertaken both male and female to accommodate work life balance. Mr Johnson confirmed the communication regarding bank shifts was no longer required as question answered in earlier discussion.

- Mrs Jones had written to the Chairman for an update on item 2 &3 on the action log. Item 2 policy charging of information from solicitors remained outstanding and an update would be sent to next meeting. Mr Lawrence confirmed item 3, the ambulance retendering of transporting discharged patients was being discussed as part of the whole surgery reconfiguration and no longer a specific action so should be removed from action log. **LL**

4. DISCHARGE PROVISIONS

Ms Ross stated she was asked to update the committee re the discharging of patients to free up beds, what was being done and what options were being reviewed to address issue one example suggested was moving medically fit patients into hotels to free up beds.

Ms Ross clarified the meaning of 'medically fit' being a patient was fit to leave the medical acute environment but requiring on-going care and if moved to a Travel Lodge or other hotel there would be no provision of care present.

Ms Ross explained in detail the discharge to assess process. At any one time there are 300 people who meet the criteria for medical fit for discharge and need on-going care from other partners. This is at a normal expected level for an acute trust at 20-25% of our 1200 beds. This is ok as along as it's not the same 300 patients every day. If it is it and these patients are in the "clearing house" where the team work out why they are there and are there any routes for them and how long they are there for.

Ms Ross stated the Trust is working on the big project 'discharge to assess' model with partners and the goal is to have the model agreed. Model includes the nursing home model and currently HEFT has access to 200 nursing home beds which is differentiated by who is paying for the patients i.e. what is postcode /who GP is/ need for rehabilitation beds. She is working with CCG, Barbara King, CCG not taking the time to understand the true meaning of the problem.

Ms Ross mentioned South Staffs support is very low which has an impact on GHH. Birmingham City Council provides a lot of beds compared to South Staffs. Overall there are enough out of hospital beds; the Trust needs to understand how to access them all.

Ms Ross had written the 'Discharge to Assess' paper which has been distributed and now needs to become part of the Trust's Strategy. Mr Quinn stated it does fit into the Strategy.

Mr Johnson noted that from a governor's point of view was looking at alternative accommodation that was not as expensive as a hospital bed.

Ms Ross stated the whole Better Care Fund is about pooling money to do this although the many financial flows are making it harder to access even before reaching clinical need. Professor Cooke stated Better Care Fund does address but very fragmented as so many projects and needs to be considered as one whole project. Professor Cooke and Dr Catto sit on the Better Care Fund Boards for Solihull and Birmingham.

Ms Ross stated HEFT works well when a patient gets into the 'clearing house' system. Using the JONA system the wards need to identify the people who need this help which presently we are not good at doing this in a timely manner. Professor Cooke said it's a cultural change required by wards and clinicians.

Ms Ross stated beds not all means tested and are free for 6 weeks as it is a City Council bed and requires a signature to state if patient requires bed longer than 6 weeks then payment will be required. If patient going into a continuing health bed it is paid for by CCG which means CCG are careful to assess these patients. MV

Mr Johnson confirmed Ms Ross had answered the Governors question fully. Ms Ross' discussion paper to be circulated with minutes. Mr Quinn confirmed the discharge to assess would be included in the Clinical Strategy.

4 CORPORATE STRATEGY/ RESHAPING HEFT UPDATE

<u>Corporate Strategy</u>

Professor Cooke explained the Trust hadn't had a clinical strategy before only a corporate strategy. He is now developing the Clinical Strategy.

One of the criticisms received from CCGs and Monitor was that various Trust documents were not as coherent as they could be i.e. Trust priorities varied between documents. Professor Cooke explained he would like to discuss 3 particular slides of his presentation: Timetable; Our Mission, Vision & Values and Priorities.

Professor Cooke outlined the slides on mission, vision and values. The statement of intent is very important *'we work together to deliver the right care for our patients, our people and the communities we serve'.* A lot of work going on with Values and the listed values on slide may change as this area being reviewed by Lisa Thompson and Hazel Gunter with staff and the public. Professor Cooke expanded that one of the most important slides is the one setting out the Trust's Priorities. Mr Hutchby noted it was important the priorities also included Community as at the moment they do not feel part of the strategy. Mr Johnson commented on how important it was to improve the culture. He also asked what the Trust was doing about equality of care at the weekend.

Professor Cooke explained the annual cycle. It was very tight between now and April because of the Monitor imposed deadlines, and this would be a rapid production of the strategy based on last year and be top down. In April '15 the Strategy would be launched and a consultation with all directorates would take place to develop a fuller strategy for next year. This will mean each directorate has a plan that aligns to the Trust's needs. The process will be iterative.

5. FINANCE & PERFORMANCE MONTH 8 UPDATE

Mrs Jones highlighted the following key points:

Month 8 Figures

- At Month 8 the Trust had a COSR rating 4 (highest rating) delivering a YTD deficit of £5m, £3m adverse to Monitor Plan. Compared to last year we were on plan but fell behind at Q4. Mr Quinn explained the biggest variance is due to the independent sector and the additional measures the Trust putting into place to deliver waiting list and our performance issues. Mrs Jones looking at the variance on income lines and stated our income was higher than plan showing we are doing more activity than originally planned for. £17m worse off than plan from an expenditure point of view due to demand. A discussion took place around the Trust's staffing costs.

  Mr Quinn stated Trust Board had signed off up to c£7m additional measures the bulk being independent /private sector work to deliver 18 weeks and other performance targets/additional care.

- Efficiency delivered £10.2m of SIEP (service improvement efficiency plans, formally CIP) YTD, 63% of target and month 8 delivered 83% of in month target. Forecast to deliver £17.2m which is 72% of £24m target. Mrs Jones hoped this addressed Mr Hughes' concern regarding 70% of the target and if only at 60% ytd
  - Mr Quinn stated the £24m is the target and current forecast provides for low risk currently. Importantly need to do more transformation and redesign as we cannot rely on traditional schemes and key risk is now 2015/16.
- Forecast of c£6m deficit is the likely position which was submitted to Monitor in December.
- Mr Johnson asked what it meant when the forecast excluded disputed rates charges. Mrs Jones explained BCC had raised BHH rates with additional backdated charges which had been paid as statutory. The charges are being disputed. This amount was not included in the forecast.
- Cash balance £102m, £17m above plan with the majority includes capital not spent. Debtors were £26m which is higher than previously reported. Mrs Jones stated there were 3 main reasons:

  1) £5m invoice to Health Education which included a duplicate error of £20k which has since been repaid.

2) Additional winter measures. Trust billed CCGs end November with payment plans in place for Jan – Mar '15.
3) Maternity pathways which has been escalated at FD level.

- Capital total expenditure budget for the year of £37m including £12.m carry forwards. Month 8 spend £12m, 715 of Plan. Forecast reduced to £28m in submission made to Monitor in December.

Performance

- A&E 4 hour 95% target was missed in November and YTD position is 92.72% and 18 weeks target also not hit. Mr Quinn stated Trust has a response plan for A&E which is being implemented and will take time to see the benefits. HEFT's performance signals some improvement against national 'pack' and plan to improve further in the new year.
- Mr Johnson asked why Solihull achieves targets when GHH/BHH does not. Mrs Jones explained Solihull not a trauma A&E and patients are taken to BHH as covers all acute conditions whereas Solihull attendees of more of a minor injuries and Solihull has the 'walk in centre' which includes statistics in Solihull's performance .
- Mr Johnson suggested charging £15 for each visit to A&E which would help reduce A&E figures by 10% and alleviate some of the pressure on the NHS as a whole. If a visit was drink/drug related charge £45. Mrs Jones pointed out if charges were to be imposed a National agreement would be required. Mr Johnson also stated with the elderly living longer will have a huge impact in the future on the NHS.
- Cancer targets remain difficult but are on trajectory for the March delivery.

Annual Plan

- Monitor issued Annual Plan guidance on 24th December stating that only a one year plan (15/16) required and not a 5 year plan as previously requested. Draft numbers to be submitted on 28th February which will be reviewed by Monitor and feedback to the Trust in readiness for resubmission of 10th April. Mrs Jones mentioned the timetable had slightly changed to reflect new requirements.

6. TERMS OF REFERENCE

Mrs Jones was asked to present the updated TOR of the committee following verbal updates received previously from a full Governors meetings via Mr Smith the Company Secretary.

Mrs Jones highlighted the differences below and asked for the TOR be circulated and amendments, if any to be raised at the next meeting.

- Title to include the word 'performance' - takes into account performance & targets.
- Point 4 Frequency of Meetings: Originally monthly meetings now to be held bi-monthly to fall in line with full COG meetings. Revised dates to be issued in due course.
- Point 7 – Duties:
  - Review the process for preparation of the Trust's *Planning documents required to be sent to Monitor* and to review the final documents on behalf of the CoG prior to submission to Monitor
  - Agree the principles for the Monitor *Plan,* including high level financial assumptions
  - Review *divisional/site* planning for service delivery and strategy to support the Plan
  - Review performance against the *Monitor* Plan throughout the year
  - Added: *Review the Trust's activity and performance relating to fraud. This was agreed at a previous meeting to keep the governors updated and the 15/16 annual fraud plan would be also presented at the point of agreement with internal audit.*

Mr Johnson asked when Fraud would be presented to the governors. Mrs Jones mentioned Lorna Barry from Deloittes had attended the Governors training in December informing how fraud was dealt within the Trust and in the NHS generally. Agreed the slides presented in December would be circulated along with the Trust's Fraud policy to the Committee. **MV**

9 ANY OTHER BUSINESS

Mr Quinn informed the committee of changes at Trust level. Mr Darren Cattell Interim Finance Director was now in post and would be attending the committee thereafter and he would be returning to post of Deputy Finance Director.

Mr Johnson informed the committee he had recently under gone a gall bladder day case procedure at GHH and asked that it be minuted the care and whole experience was fantastic. The appointed nurses were excellent and he had written to Mrs Hudson to pass on his comments.

10 DATES OF 2015 MEETINGS

Due to the change of the full COG meetings the future dates of this committee have changed and agreed with Darren Cattell, Interim Finance Director.

Monday, 30th March '15 @ 10.00a.m. – 12.00p.m. BHH Education Centre, Room 4
Thursday, 28th May '15 @ 10.00a.m. – 12.00p.m. BHH Education Centre, Room 1
Wednesday, 26th August '15 @ 10.00a.m. – 12.00p.m. BHH Education Centre, Room 1
Wednesday, 21st October '15 @ 10.00a.m. – 12.00p.m. – BHH Education Centre, Room 7
Monday, 21st December '15 @ 10.00a.m. – 12.00p.m. – BHH Education Centre, Room 1

Committee Chairman

COUNCIL OF GOVERNORS
HOSPITAL ENVIRONMENT COMMITTEE

Minutes of a meeting of the Hospital Environment Committee of the Council of Governors, held at 2.00 p.m. on Thursday, 8 January 2015, in Meeting Room 1, Estates Offices, Heartlands Hospital

PRESENT: Elaine Coulthard (Chair)
Sue Hutchings
David O'Leary
John Sellars

IN ATTENDANCE: Rob Bovill, Estates Officer, Solihull Hospital
Mark Piggott, Programme Manager
Ann Harwood, Executive Assistant to Director of Asset Management (minutes)

NOT PRESENT: Arshad Begum
Carol Doyle

15.1 VISIT TO NEW TEMPORARY PHLEBOTOMY UNIT (WARD 10)

Rob Bovill, Estates Officer at Solihull Hospital, accompanied members on a visit to the area on ward 10 where the temporary Phlebotomy Unit is being created. The following points were noted/ discussed:

- There will be 6 bays where the blood samples will be taken and a waiting area with a ticket system to manage patients so that they are seen in the order they arrive in the department.
- Works to the temporary Phlebotomy Unit will be complete by the end of January 2015.
- David O'Leary queried whether the blood samples taken at SH are tested in the Pathology department on site or whether they are transported to BHH for testing. Following discussion it was agreed that John Sellars would invite a representative from Pathology to attend the next meeting on 5 March to confirm the process followed for blood testing at BHH, GHH and SH, and also to give an overview of how they see the service in the future.

15.2 APOLOGIES

Apologies were received from Barry Clewer, Ron Handsaker, David Treadwell and Emma Hale.

It was noted that Joy Townsend had resigned as governor with effect from 31 August 2014. It was agreed that the meeting would go ahead although it was not quorate.

15.3 MINUTES OF THE MEETING HELD ON 9 OCTOBER 2014

The minutes of the meeting held on 9 October 2014 were approved as an accurate record with a note re item 14.26, that Mike Kelly is Chair of the Patient Experience Committee rather than Lisa Thomson.

15.4 ACTION SHEET FROM MEETING HELD ON 9 OCTOBER 2014

15.4.1 Remit of Group

- Elaine Coulthard confirmed that the remit of the Committee does include clinical areas in relation to the environment, but that the title of Hospital Environment Committee will remain the same. However it was noted that there are some clinical areas where members would not be expected to visit e.g. the mortuary and theatres

- Elaine Coulthard has also contacted Kevin Smith, Company Secretary, regarding the Terms of Reference and confirmed that the Hospital Environment Committee meetings will now take place bi-monthly. Arrangements for these meetings in 2015/ 16 have since been circulated.
- The Terms of Reference have also been amended to reflect the fact that the length of time of Committee membership has been brought in line with the length of term for governors i.e. 3 years.
- Mike Kelly has agreed that the Patient Experience Committee minutes can be circulated to Hospital Environment Committee members. A copy of the minutes from the Patient Experience Committee meeting held on 7 November 2014 was circulated to members for information.

15.4.2 Treatment Centre at GHH

At the last meeting Ron Handsaker had raised concern regarding the Health & Safety issues relating to the bend in the road outside the Treatment Centre at GHH. Dave Smith, Estates Manager at GHH, had arranged for a risk assessment to be undertaken in this area. A copy of the risk assessment and the resultant actions identified was circulated to members. The following actions have been agreed:

- To remove a section of shrubbery and widen the roadway (bend in the road) outside the entrance area to the Treatment Centre, adding road markings (central lines) to the centre of the bend in the road.
- To remove the shrubbery along the side of the Treatment Centre to lengthen/ widen the roadway to create additional visitor drop-off points.

An order has been placed with the contractor and these works will be completed by the end of February 2015.

15.4.3 Catering Issues/ Concerns

John Sellars confirmed that sweeteners are provided to patients in sachets on the advice of Infection Control. Elaine Coulthard felt that this is contradictory as sugar is provided to patients in pots. John Sellars advised that any further concerns relating to this issue should be raised at the Patient Experience Committee.

15.4.4 Terms of Reference

The Terms of Reference have been amended to state that appointment to the Committee shall be for 3 years from the date of the Governor's respective appointment to the CoG, and also that the Hospital Environment Committee meetings will take place bi-monthly. As the meeting was not quorate the Terms of Reference will be circulated again for approval at the next meeting on 5 March 2015.

15.4.5 RSU Entrance, GHH

- Chris Davies has spoken to Sandria Brown, Housekeeping Manager at GHH, to ensure that the hand gel dispensers in corridors and common areas are refilled. Supervisors have been asked to check this on a daily basis.
- John Sellars agreed to speak to Infection Control and ask them if they can put a hand hygiene poster up adjacent to the hand gel dispenser in the RSU entrance.

15.4.6 Ward Refurbishments

- John Sellars confirmed that there had been no wards closed on the BHH site during the summer period.
- David O'Leary queried whether anything can be done to resolve the heating issues on ward 3 at BHH. He advised that the heaters on the ward are inefficient and that the ward areas by the windows in particular are very cold. Ward staff are wearing cardigans/ jackets which is against infection control procedures. John Sellars was not aware of this as a particular problem and agreed to arrange for the heating system on ward 3 to be inspected. He advised that the heating in wards/ departments is checked on a regular basis in the location of the sensor points. It was noted that there is an item on the Capital Plan to renew the heating and infrastructure to the Tower Blocks at BHH and GHH but there is no funding allocated for these works. £75m has been

allocated to other projects which the Trust feels are of a higher priority e.g. Maternity, Endoscopy. The Board of Directors will be reviewing the Capital Plan again shortly.

- Funding has been allocated to refurbish ward 5 at BHH over a period of 8 weeks but it has not yet been possible to vacate the ward to carry out these works. Members queried whether it would be possible to erect a temporary ward on the BHH site to provide some decant space. However It was noted that it would cost approx £3.5m for one temporary ward. John Sellars advised that there are other Trusts in the same situation. Elaine Coulthard and Sue Hutchings agreed to raise this issue at the next Governors Breakfast meeting.

15.5 DERMATOLOGY AND RHEUMATOLOGY/ ONCOLOGY PROJECTS

Mark Piggott, Programme Manager, circulated an overview of the plans for the Dermatology and Oncology/ Rheumatology projects at Solihull Hospital, which were discussed as follows:

Dermatology

- The new Dermatology department will be located where ward 21 had previously been sited, on the first floor above the Bruce Burns Unit, near the South entrance to the hospital.
- The investment drivers include the fact that the current facility is at the end of its economic life and the new facility will provide a quality improvement in terms of the building and service.
- The new scheme will provide improved theatre facilities with 3 new theatres to replace the existing 2 theatres, which will provide increased surgical capacity to meet increasing demands.
- Activity figures have been reviewed to-date and projected going forward, to provide a facility which has been future proofed.
- The new location is ideally located near an entrance and the works will have minimal impact on the building envelope.
- Some decant works had been required where some areas on ward 21 had been occupied by admin staff and also a storage area.
- The biggest challenge is in relation to the Bruce Burns Unit (Mental Health unit) situated below ward 21, which is operational 24/7. Regular meetings are taking place with the Mental Health unit staff to keep them informed.
- Meetings had taken place with users and the Programme Management office to look at NHS guidance, patient flows and capacity, to develop an appropriate schedule of accommodation and workflow. The Reception area will be central to the patient pathway.
- There will be minimal impact on the building elevation with 2 small dormers which provide louvres for ventilation for the plant to the unit
- The project cost is £3.63m with completion planned in August 2015. The project is currently running to programme with all critical success factors currently being achieved.

Oncology/ Rheumatology

- There are currently limited Oncology services provided at SH and the BHH Oncology services are running at capacity. Having a new unit at SH will provide local services for local people and also reduce the pressure on services at BHH.
- The scheme will provide shared facilities for Oncology and Rheumatology with an infusion suite for cytotoxic drugs, providing 15 chairs for patient treatment.
- The workforce will be used flexibly between Oncology and Rheumatology. It was noted that there are some challenges with providing a combined unit.
- The new unit will be located near a hospital entrance and directly beneath live operating theatres.
- There are a number of decants to be completed prior to works commencing, including moving the District Nurses, Phlebotomy and Waiting List Co-ordinators.
- The report included a floor plan showing the layout of the new unit which is centred around the waiting area and infusion day unit, with support services provided around the waiting area e.g. therapies, pharmacy, drug preparation etc.
- The scheme includes a small single storey extension which will be located in the space currently occupied by 2 quadrants. This will allow for a 2nd storey to be created at a later date if required.

- The project cost is £3.6m. Works are planned to commence in March 2015 with completion planned for December 2015.
- The critical success factors and project deliverables are on target to be delivered.

Elaine Coulthard thanked Mark Piggott for his presentation.

- David O'Leary queried whether there are any plans at BHH to increase the size of the corridor adjacent to ENT/ Ophthalmology. John Sellars advised that there are currently no plans for this area which is not on the list of critical projects. He acknowledged that there are major issues with OPD and A&E at BHH but there is no funding to resolve these issues. There is funding in the Capital Plan to carry out some minor refurbishment/ decoration works in OPD.
- Elaine Coulthard was concerned that the new revolving doors are in place in the GHH A&E entrance but are not yet operational. John Sellars agreed to pick this up with Dave Smith and also to check whether the asbestos issue in the toilets has been resolved.

15.6 PLACE INSPECTION RESULTS: UPDATED ACTION PLANS

- A copy of the PLACE inspection reports for all 3 sites was circulated, showing the actions taken for all of the Estates and Facilities issues raised, and with the nursing/ clinical issues shaded out. John Sellars advised that these reports will be reviewed again at the next Statutory Compliance meeting to ensure that there are no further issues to be addressed.
- David O'Leary queried whether it would be possible for any of the Hospital Environment Committee members to visit any of the wards to review the areas highlighted in the reports. John Sellars stated that the CHC also carry out regular inspections of wards and departments on each site. Reports from these inspections are circulated for the actions to be picked up. All non-urgent Estates actions will be picked up during the next maintenance round. David O'Leary queried why the CHC members never receive any feedback on the actions taken. John Sellars agreed to pick this up with Catherine Williams, from the Patient and Public Involvement Directorate, who manages the CHC reports.

15.7 GOOD HOPE HOSPITAL ISSUES

15.7.1 Privacy Dome in A&E

Dave Smith, Estates Manager at GHH, has arranged for a contractor to visit the site to discuss the requirements with the A&E staff, a quotation is being prepared. It is envisaged that this work will be complete by the end of February 2015.

15.7.2 Multi-Storey Car Park

John Sellars circulated a Car Parking Update report which was discussed as follows:

- Birmingham City Council have agreed to the proposals subject to a final review of the plans.
- Mark Piggott advised that the initial proposal was for a 600 space, standalone car park at the rear of the existing HQ building. The scope of the scheme then grew to include the demolition of the HQ building, construction of a multi-deck car park to provide an additional 365 parking spaces with the capacity to further extend, realignment of the roadways and a minor upgrade and refurbishment of the RSU Entrance.
- The Board of Directors will need to decide on whether to proceed with the decked car park alone at a cost of £6m or the entire sequence of works at a cost of circa £12.5m. However it was noted that there won't be the same end result with the standalone scheme as to locate the decked car park as close to the RSU as possible will entail demolishing the HQ building. The other option is to locate the car park near to the Bedford Road entrance which may upset the residents living opposite.
- Elaine Coulthard queried whether the car park could be located immediately outside the Treatment Centre, however John Sellars advised that this land is owned by Birmingham City Council.

- The timescale to complete the car park is approx 21 months for the standalone scheme, which includes the design and procurement process. The full scheme will take an additional 12 months.
- John Sellars confirmed that the car park will pay for itself over a period of 15 years, funded from car parking income received.
- The paper will be presented to the Executive Management Board (EMB) in January and if approved to the Board of Directors in February 2015.
- John Sellars advised that he is working with the Chairman and West Midlands Transport on the provision of a bus service between the 3 sites, looking at times, costs etc. It was noted that at GHH the bus will need to enter the site from Rectory Road and exit the site on to Bedford Road.

15.7.3 Restaurant/ Coffee Shop: Food Change

John Sellars advised that a chilled unit for the Costa Coffee shop has been ordered which will sell fresh food, salads etc. He agreed to confirm the timescales at the next meeting on 5 March 2015.

15.8 ANY OTHER BUSINESS

There was no other business.

15.9 DATE OF NEXT MEETING

2.00 p.m. on Thursday, 5 March 2015, in Meeting Room 1, Estates Offices, Heartlands Hospital

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Chairman

Draft

MEMBERSHIP AND COMMUNITY ENGAGEMENT COMMITTEE OF THE COUNCIL OF GOVERNORS

Friday 9th January 2015 at 10:30
Harry Hollier Lecture Theatre, Good Hope Hospital

Attendees
Elaine Coulthard
Albert Fletcher – Chair
Sue Hutchings
Jean Thomas
David Treadwell

Apologies
Barry Clewer
Ann McGeever
Lisa Thomson

In Attendance
Richard Brown
Peter Colledge
Jamie Emery
Sandra White
Sharon Woodcock

Bev Bellerby – minutes

Welcome and Apologies
Albert Fletcher welcomed everyone to the meeting.
Apologies were given by those shown above.

Minutes of the Last Meeting and Actions Arising
The minutes were agreed as a true record.

All actions were complete, with the exception of setting up the League of Friends. Some work had been done; it would remain on actions, as it was still work in progress. **Action 1**

Citizen Assembly Update
Sharon Woodcock advised the group what the Citizens' Assembly was – it was set up to look as strategic developments within the Trust.
Sharon would leave the project at the end of January but the Assembly was set up and secure. Sharon had been working with Jamie to ensure the group's sustainability. The Trust would only be asked for room bookings; the team would do their own meeting minutes.
Jean Thomas and Barry Clewer had both been involved, as Governors. Jean went to two meetings and was also involved in the visit from the Bristol hospital team. Matthew Cooke and Jo Hodgkiss were also strongly linked to the Assembly. The group had developed a memorandum of understanding and would send it through to the CoG Membership meeting to agree, if appropriate, and pass up to the Trust Board. It could then be agreed, officially, as a Trust committee.

The group would look into the Patients' Charter during the next 6 months. They also had the opportunity to have social media training. Sharon had found someone, internally, to help with Twitter training and would send out the dates for the training sessions. **Action 2**

Sharon wanted to thank the Trust, as a whole, for agreeing to the setup of the committee. David Treadwell thanked Sharon for her work in setting up the Assembly and this was acknowledged by the meeting, with an official vote of thanks given to Sharon.

Jamie would liaise with the Assembly and their meeting minutes would come to the Membership Committee and be a regular meeting agenda item. Albert asked to see the minutes before the Membership meeting. **Action 3**

All public organisations were encouraged to have Citizens' Assemblies and Sharon had set up similar committees, elsewhere. However, they were not a statutory requirement. At team from a Bristol hospital visited HEFT to look at working together and they were impressed how well HEFT's Citizens' Assembly was set up and were looking to do something similar at their hospital. Trusts and local authorities formed the assemblies if they choose to; it was not mandatory. Richard Brown added that Bristol staff were surprised at the senior team's willingness to engage, compared to their organisation.

By linking them to the Membership Committee, the Citizens' Assembly would have more influence. The HEFT strategic team had a good relationship with the Assembly. Healthwatch also had 3 seats on the Assembly.

Jamie added that it took a lot of time to set up the Assembly so it was wise to listen to the citizens involved.
Sharon said that Surgery Reconfiguration linked in with the Citizens Assembly and other outside bodies were really happy with the engagement.
HEFT was seen as a progressive trust, especially because of its large membership.
The Trust would continue the good work that Sharon has started. Jean Thomas commented that all of the members were diverse so lots of care would be needed to keep the Assembly on track. They would need, and want, the support of the Trust. As the responsibility grew, some members could decide to leave so it would need promoting externally by everyone that was able to do that.
Albert added that the Chairman's Breakfast attendees were concerned at what would happen when Sharon left. Jamie added that lots of things had already become sustainable, but Jamie would always be around to support the group. The minute-taker would be given a nominal fee for doing the role and Jamie would be the official link person. The Chair was a rotational post. One of the hospital volunteers had offered to change his role to will help Jamie with the Assembly.

Membership Strategy

Jamie liaised with other trusts to see what their membership strategy but not many other trusts had the high membership that HEFT did.
A group of Governors would be asked to get together to look at a functioning membership strategy, going forward.
Surgery Reconfiguration would in early February, so that would be a good date to get the Governors together to look at the strategy.

In the first instance, Albert, Sandra and Jamie agreed to get together to discuss strategy further. All at the meeting agreed for this to be the way forward. **Action 4**

Sandra White would be giving a Dementia presentation on 21st January and leaflets had been produced.
She would roll out the programme, as it was in the previous year. The youth forum would continue in Solihull and the aim was to roll it out into schools around the Heartlands catchment area.

There was no youth involvement in the Citizen Assembly. Sharon thought it was better for Sandra to include the children in her forums, only, due the guidelines around children not being allowed in such assemblies.

Sandra advised that it was difficult getting the youth involved in the first place. Sandra went into the schools to speak to children to get them interested. Solihull had been very keen to be involved and the school heads were keen to work with the Trust. Sandra was also liaising with Birmingham Youth Parliament and Solihull Youth Council.
Sue Hutchings and David Treadwell both attended the recent youth conference. Saira Begum was recently elected as a young Governor and was really keen to be a youth health advocate. Chairman, Les Lawrence was keen to make it a formal role. Saira could not be involved as a full time Governor, as she was at college, but she should be invited to Governors' meetings and maybe be given a task that she could own, develop and feed back to a future meeting.

Any Other Business

David Treadwell requested A4 Governor posters. Sandra White would send them to David. **Action 5**

Sue Hutchings queried the meeting venue for 10th July as it appeared to have changed. Bev confirmed that the Membership meeting and the Patient Experience meeting had moved to Solihull on that date, as they would follow on from the Chairman's Breakfast meeting, which was being held on that site.

Date and Time of the next meeting
Friday 13th March, 12:00 noon, Education Centre, Heartlands Hospital.

Action Log

Action No.	Date	Action	Action Owner	Date of Completion
1.	07.11.14	Set up Good Hope League of Friends	Elaine Coulthard and Emma Hale	Ongoing
2.	09.01.15	Send out dates of social media training	Sharon Woodcock	Immediately
3.	09.01.15	Send minutes of Citizen Assembly meeting to Albert Fletcher	Jamie Emery	Before next Membership meeting being held on 13.03.15
4.	09.01.15	Meet to discuss membership strategy, further	Jamie Emery, Albert Fletcher and Sandra White	Before next Membership meeting being held on 13.03.15
5.	09.01.15	Send A4 Governor posters to David Treadwell	Sandra White	Immediately

Draft

PATIENT EXPERIENCE
COMMITTEE OF THE COUNCIL OF GOVERNORS
MEETING
Friday 9th January 2015 at 12:30
Harry Hollier Lecture Theatre, Good Hope Hospital

Attendees

Elaine Coulthard
Sue Hutchings
Mike Kelly – Chair
Margaret Meixner
David Treadwell

Apologies

Kath Bell
Sam Foster
Lisa Thomson

In Attendance

Richard Brown
Peter Colledge
Jamie Emery
Frances Linn
Elaine Tandy
Tom Webster
Sandra White

Bev Bellerby - minutes

Welcome and Apologies

All were welcomed to the meeting. Apologies were received from Kath Bell, Sam Foster and Lisa Thomson.

Minutes of Previous Meeting and Actions Arising

The minutes were agreed as a true record, except the item regarding FFT scores in A&E which Jamie Emery would correct, for the minutes. **Action 1**

The types of wards against ward numbers had been circulated to all attendees, as requested.

Quality Accounts

Elaine Tandy advised that Rachael Blackburn presented Quality Accounts to Council of Governors earlier in the week.
Elaine Tandy had given a six-monthly update to Audit Committee in November 2014, listing the Trust's progress.
2015/16 would see a change in the 7 priorities. They had been kept the same, to date, to be able to show history, which was a recommendation.
There would be new guidance shortly and changes would be made and the first draft would be done by March 2015.

Frances Linn advised that the press had reported that HEFT had high numbers of pressure sores. Elaine advised that the Trust's target was under 159 for a year; HEFT were 93 at the half-year point, which was slightly above target, at that point. The Trust was always very open about its results.
Elaine would like to improve benchmarking against similar trusts, to give an idea where Heart of England was nationally.
Frances Linn commented that many patients spent long hours in bed so it would be easy for them to develop pressure sores. Margaret Meixner added that all patients were risk-assessed for sores. They are categorised as hospital-acquired or community-acquired. Elaine concentrated on hospital-acquired ones, as they were the ones that could be prevented, but any patients coming in with sores were reported accordingly, for information.

Elaine Tandy recapped all 7 of the priorities.

'Fractured neck of femur' results were not available at the time of the meeting. A working party would be set up to look at the pathway and would be speaking to staff and patients. Jamie invited them to the patient group meetings that he attended.

The new stroke ward had opened with 16 beds.

A lot of work was being done around dementia and there would be a launch, soon.

The next step was to await external guidance, regarding changes. Elaine would do more stakeholder engagement work and use Patient Experience Committee and Council of Governors to do that. She was also working with the CCGs to ensure they were happy with the Trust's progress.
Elaine would start the draft report shortly and keep the meeting attendees up to date, throughout the year.

Changing Quality Accounts did not mean that work stopped in certain clinical areas. All 7 would not change but 1 or 2 might. HEFT needed to declare why they changed.
The EDs were engaged with Quality Accounts and Andrew Catto was involved with them at his old trust.
Tom Webster was keen to ensure that the statistics were used for patients' benefit, especially regarding information gathered on falls.

David Treadwell stated that many of the Quality Accounts items were covered by Quality and Safety Committee. Elaine advised that she used to take QA to Quality and Safety but since coming under Lisa, it went to Patient Experience. Elaine currently reports to Kevin Smith and he is keen to still bring it to Patient Experience, rather than Quality and Safety.
David was keen for a clarification of roles. Mike Kelly offered to discuss it with Liz Steventon (Chair of Quality and Safety Committee). **Action 2**

Elaine Coulthard mentioned the Hospital Environment Committee which only had 7 members. People sometimes did not attend but did not send apologies, either. The last meeting had only 3 attendees.

Update on Patient Experience – all sites

Richard Brown wanted to update the meeting on recent successes in Patient Experience. The Trust had a lot of rich intelligence and data and Richard was looking at the best ways to present it to the site teams.

Richard's team had produced 5 reports; a HEFT global view and each site had an individual report, including Community Services.

The reports were meaningful and showed the individual teams what was going well and not so well. Included in the report were Family and Friends, including numbers of responses and the quality scoring. The Net Promoter Score had changed which is good as it had been misleading; Positive Responders were used instead, which was more accurate. This was done by ward so that all areas knew what their responses were. Targets were set externally and were rated red, amber and green.

Frances Linn asked if the reports could go on the ward walls. Richard advised that it was the next step. Jamie added that some wards displayed the data already, but others did not. Frances asked to see the bed numbers and bed numbers currently in use, to show patients and visitors the pressure on the areas.

Elaine Tandy did a '15 steps' on each ward and community clinics to get a feel of what happens as soon as someone walked into an area. There was a large difference between the data on different wards. There needed to be a poster showing the staffing levels and the senior nurses on each ward. Not all wards had up to date information. Wards were encouraged to update the data, daily. If the information was quarterly, it needed to say so, otherwise visitors would think data was out of date.

Richard advised that much of the information was held electronically so there should be quick ways of getting the information out there. Staff often did not have time to print items off for display. Deloitte had previously made comments about how data was displayed. Richard mentioned Listening, Looking, Learning and posters would be displayed around the clinical areas. Good results needed promoting as well as tackling the poor results.

Tom Webster's mentioned a scenario; his wife was resident in a nursing home and was admitted to Heartlands on Christmas Day. Patients were on trolleys in open corridors that were freezing cold. There were no support services around to keep the hospital warm. The doors opened quickly and often stayed open if anyone was near the door. The temperature dropped quickly. Tom had been there from 4.00pm until midnight and was freezing cold when he got home. Tom complained and estates staff did check the doors but they still closed incredibly slowly.

David Treadwell advised that a warm barrier curtain was due to be fitted so that warm air blew over the doors but this had never been done. Elaine Coulthard added that she had raised it with John Sellars 4 years ago.

All discussed that the red doors in the main corridor at BHH could not be closed as the area was used to take patients to and from Theatres. They only closed when a fire alarm was triggered as the doors then acted as fire doors. Richard Brown would have a look at the minutes of the meeting where it had been discussed previously and arrange to meet John Sellars. **Action 3**

Richard advised that all complaints categories were monitored and solutions sought and fed back.

Elaine Coulthard said that wards were too cold. A Governor has been an inpatient on Ward 3 and was freezing cold for several days. It was fed back to John Sellars but he did not think that the ward was not warm enough.

Richard advised that all departments received their complaints but would not necessarily have the whole story. There were plans to change the way complaints were fed back.

Environment Committee issues did not always feed back to the correct areas of concern. The reports did go back to the Board and any issues that were raised from ward visits went to the Sister and they acted on the concerns.
Nursing Patient Experience metrics were also included in Richard's team's reports. Any issues were fed back and also Governance and Risk staff were contacted to see if there were any bigger problems for certain wards or areas.
Work was ongoing and issues needed to be picked up quickly; Catherine Williams followed up issues to ensure that work was done, where necessary.
CHC reports were not discussed at Governors' meetings
Richard would take a fuller report to Patient Experience meetings, as requested.

Update on FFT Progress and Complaints

Jamie gave recent scores – 88% inpatient positive responses for November; awaiting December's results. The Trust was slightly behind the national picture.
BHH 86%
GHH 94%
SoH 89%

March last year was 11% response, now 40%. Jamie was happy that the responses had increased as had the positive responses.

During April 2014 the methodology changed. It used to be face-to-face but cards were now handed out to patients. Scores then dropped which CQC picked up on as an elevated risk. Responses increased from 300 per month to 1500 per month.
Richard and Jamie were much happier with the current feedback and results.
The ward staff have really helped in collecting the cards and they are rewarded for good work. Richard wanted to officially thank the staff.

A&E – the change in reporting looked better for HEFT. September 2014 score was 7. In November 2014 was 76% positive compared to the region, which was 80%.
A&E used cards, automated calls, voice calls and texts to collect the feedback.
BHH 68%
GHH 78%
SoH % positive

The new Deputy Chief Nurse, Julie Tunney will look after patient quality. Jamie and she will meet soon and she will be invited to the next meeting. **Action 4**

Feedback will be advertised by posters etc., and the team were looking at ways to involve non-English speakers, etc.
OPD Clinics will be included in FFT and maternity have already been included.

The Quarter 2 complaints report had been produced and could be circulated.
The complaints review was ongoing and Richard and Jamie were talking to many stakeholders to see what they would like to see from a complaints function.

Complaints have been reviewed – My expectation for raising concerns and complaints – report. Jamie to send to BB to distribute. **Action 5**

A discussion was had around hospital inpatient food with an agreement that it had been good quality, of late.

Jamie said that 3.79 per thousand people had complained last quarter, which had increased to 3.95 per thousand in the current quarter.

AOB

Mike asked for an update on DNAs before he visited Lyndon Place. Richard advised that HEFT was meeting its 10% target but as it was a large trust, it equated to a lot of actual people.
Richard to get data and will pass it on to Lisa to pass on to Mike before next Patient Experience meeting. **Action 6**

Date of Next Meeting

The next meeting will be held on Friday 13th March, at 14:00, in the Education Centre at Heartlands Hospital.

Action Log

Action No.	Date	Action	Person responsible	Completion Date
1.	07.11.14	The minutes were agreed as a true record, except the item regarding FFT in A&E which Jamie Emery would correct, for the minutes.	Jamie Emery	Immediately
2.	09.01.15	Discuss clarity of roles with Liz Steventon (Chair of Quality and Safety Committee).	Mike Kelly	Before next Patient Experience meeting on 13th March 2015
3.	09.01.15	Check minutes from Environment Committee meeting regarding item on heat blowers over external hospital doors and arrange to meet John Sellars.	Richard Brown	
4.	09.01.15	Meet the new Deputy Chief Nurse, Julie Tunney to discuss patient quality and invite her to the next meeting.	Jamie Emery	Before next Patient Experience meeting
5.	09.01.15	Send 'my expectation for raising concerns and complaints' report to BB to distribute.	Jamie Emery	Immediately
6.	09.01.15	Get data on DNAs and pass it on to Lisa to pass on to Mike before next Patient Experience meeting.	Richard Brown	Immediately

Final Version

Minutes of a meeting of the
COUNCIL OF GOVERNORS
SAFETY AND CLINICAL EFFECTIVENESS
Heart of England NHS Foundation Trust, Education Centre, Heartlands Hospital
7 August 2014, 10.00, Room 1

Present	Title	Initials
BELL, Kath	Deputy Chair & Public Governor	KB
KHAN, Attiqa	Public Governor	AK
LYDON, Andrew	Public Governor	AL
PEARSON, Mark	Public Governor	MP
ORRIS, Barry	Public Governor	BO
TREADWELL, David	Public Governor	DT
LANE, Heidi	Staff Governor	HL
In attendance		
CARR-CAVE, Sarah	Head of Investigations	SCC
RUDD, Louise	Head of Clinical Governance	LR
BRADSHAW, Siân	EA/Minutes	SB
BLACKBURN, Rachael	Head of Corporate Risk and Compliance	RB

1. Apologies for absence

Apologies were received from Liz Steventon, Sarah Woolley and Ann Keogh.

2. Minutes of the previous meeting

The minutes of 5 June were discussed and are a true record.

KB stepped in at a day's notice to chair the meeting but was not in receipt of an update from the Chair.

AL asked about the late return of the minutes and LR responded that sick leave and annual leave had caused a delay.

KB asked about the legal status about the Raising Concerns (whistleblowing). LR responded that the policy incorporated the legal section which is referred to as "Whistle Blowing" and has legal duties attached to it but that the wider policy is about dealing with concerns at source so that they do not need to reach that level of escalation .

KB asked about MP's comment about how challenges are raised and who is required to answer the challenges. MP and LR clarified that the pathway is that they ask their issues of their chair who then escalates to the chair of Quality and Risk (Jammi Rao) and receives the answer and reports it back.

LR suggested that the minutes contain a list of questions be formulated and passed to Jammi Rao (Chair of Quality and Risk).

LR reported than as of 31st August Sarah Woolley will have resigned and that from the end of this month Andrew Catto (Trust medical Director) will be in charge of Safety. Andrew will attend the meetings from time to time.

Actions. It was noted that a glossary had not been sent out with the minutes from the last meeting.
All other actions are complete or scheduled to occur at the next meeting.

Matters Arising

AL said he had queries with some of the Quality Account priorities. AL said he had concern over the dementia priority and the 90% target requirement to diagnose. AL raised concerns that a dementia diagnosis can mask or prevent treatment of other symptoms. RB agreed that it was a CQUIN (**C**ommissioning for **Qu**ality and **In**novation) and that there was work to do on the dementia pathway but that early identification of dementia was a key area for development. RB said that further targets would be developed in the coming years once the target of identification of dementia had bedded in. LR explained the impact of the dementia screening tool and the benefit it brings the patient. AL asked about the next phase. RB said that if this priority is carried forward to next year then it will be developed further and beyond the current 90% identification target.

AL raised the issue of discharge and falls and the contributory factor of iron deficiency.

AL asked about pressure ulcers and whether these get passed to a dermatologist as he believed B12 deficiency could cause some of them. HL explained the role of Tissue Viability Nurses and how skin lesions are looked at. LR suggested raising awareness around B12 deficiency.

MP raised the issue of applying labels to patients which can adversely affect how they are perceived. LR said that whilst labels can be disadvantageous they are required to enable treatment.

DT asked about targets, what they do and how they are changed. RB explained how they are reported and monitored and how they change.

ACTION:
Sue Hyland (Deputy Chief Nurse) to be asked about anaemia and falls.
Refer awareness raising on B12 in the context of falls and tissue viability.
AL's comments to be passed to the dementia strategy group
Check with Lisa's Thompson's team about Governor press communications which seem to have ceased.
TORs of Safety and Clinical effectiveness to be reviewed

Post meeting minute: The deputy chairperson noted that the Terms of Reference had been postponed since November 2013

3. Care Quality Commission (CQC) Inspection and Quality Account Priorities

RB updated on the CQC plans. There were 5 action plans.

The first was the warning notice at GHH. CQC revisited and warning notice has been lifted and what had been put in place to address the gaps had been implemented.

The other 4 plans; Reconfiguration at Solihull (Urgent care services vs A and E), Staffing levels, Supporting staff (mandatory training) and an Other Issues action plan.

Plans have been reported monthly to the Executive Management Board, also to Monitor and CQC. RB said she met with CQC to update and in August an updated plan will be available. Most actions are complete but some are underway.

One issue that was escalated was signage at Heartlands and progress, to date, has been limited. The Executive team will be nominating a lead to take this forward.

MP asked for more information on staffing levels. RB said that it related to nurse levels and that we are now recruiting to 120%. LR said that was work going forward to look at long term shortages and how to look at changing certain roles.

MP asked what we could do to make the jobs more attractive. LR said that there were a number of approaches to this. MP reported feedback from a GP was that most complaints they received were around

- night staff and low numbers,
- patients not feeling safe at night
- noise from other patients

HL explained the acuity assessment which is carried out monthly which allows reassessment of staff numbers against the complexity/nature of the ward.

BO raised the issue to stroke continuing to be a priority. RB said that the priority has remained but that what is being measured is changing. Fractured Neck Of Femur has been ongoing as well and that performance needs to improve.

4. Staff recommender Index update

LR updated that there is currently work on going around the staff recommender index and that this will come back next meeting – Alex Covey and Amy Passey to come to next meeting.

RB mentioned the Wirral's turnaround of their FFT (Friends and Family Test)

KB repeated a previous request to invite Mike Kelly, Chair of Governors Patient Experience Committee (PEC), to attend the Safety and Clinical Effectiveness Committee meetings and also stated that she wondered why permission from KS or JR for this was required when Mr Kelly is at liberty to, and frequently does, invite anyone that he wishes to attend his PEC Committee

ACTION: Invite Mike Kelly to update the meeting on patient experience

5. Kennedy taskforce Update

MP said that Sir Ian Kennedy returned and MP attended the feedback meeting. MP said that HEFT have set aside £6m to deal with the aftermath of the Ian Patterson matter. Sir Ian stated that changing the policies was important but that this does not necessarily change the culture and that listening to the patients is an important first step. MP said that the Taskforce had extended the remit of the taskforce for another 3 months.

KB asked about the Patient safety researchers mentioned in the QRC (Quality and Risk Committee) minutes. LR explained what they will do. MP said that there was more emphasis on listening to patients as well as the work going on around consent.

KB raised whether this committee should be informed of consultants under investigation. MP said that informing a patient that a consultant is under investigation may cause undue concern and undue pressures in workload elsewhere. LR suggested that this is a question to ask Jammi Rao. BO suggested that an update simply give numbers and status. LR said that there are a number of pathways open to the Trust (supervised practice, suspension and other pathways).

LR said that Clive Ryder has been appointed Deputy Medical Director who covers revalidation and reports regularly to QRC.

6. Safety Sitrep

BO asked about sustainability of endoscopy services and what the current position is. LR said that we are not on track to keep the endoscopy service. The issue will be whether when the JAG accreditation will be retained. LR stated that was why it has been raised it as a risk. BO was concerned about the financial implications around losing the service. The problem was identified as being specifically about the location of the service; size, space, infection control and the physical nature of the building. The plan is that the new unit will be located where Beach and Rowan currently are.

KB asked about the plain film and radiology backlogs. LR explained that the demand and complexity has increased and that the backlog is being addressed. LR said that the backlog is being reduced.

BO asked about the 2 week cancer risk. LR said that they are reliant on clinicians to raise risks with them.

LR presented the ideas around the new safety sitrep and who uses it. LR outlined the balance of detail versus easily consumable information and the changes that have taken place since it started in 2011. LR also covered the accessibility and level of being able to drill down. LR said that it will be site based and triangulated with patient experience. LR said her target was to produce something that is useful to the sites to allow them to produce action plans and to escalate upwards to the site management.

BO asked whether it could be triangulated with Monitor standards. MP asked how another Patterson-like case would feature on here and whether recurrence rates are looked at.

There was a discussion over where services take place and whether they are unsafe.

7. Discussion of QRC minutes

KB raised the issue of the Junior Doctors' concerns at Good Hope. LR said that a number of the issues had been addressed and that there was an action plan in place to increase the involvement that they have.

KB asked what Keith Struthers concerns raised with MB

KB asked what mortality issues were. LR gave the headlines. Our SHMI was deteriorating as it was a 12 month rolling average and took account of the winter spike. The HSMR was in a reasonable position. When we are rebased (against regional and national picture) we expect to be higher than it currently is. LR said that Stan Silverman will be conducting a review which will clarify our position.

QUESTIONS FOR JAMMI RAO

It was agreed that going forward a section of questions to put to Jammi Rao should be included. LR offered to help phrase these questions and circulate to the chair for confirmation.

Q.	Question	**Update**
QFJ 1	What doctor/consultant investigations are out there and how are patients protected. How do we put the patients at the centre. What can we know?	See proposed questions at end of minutes
QFJ2	What is stopping the endoscopy service and the vascular services ending?	

ONGOING ACTIONS

Date of Meeting	Action/Person responsible	Due
April 2014	Invite Lisa Thomson to update on the staff recommender index Alex/Amy next meeting	October 2014
April 2014	JR to consider the QRC TORS and membership	October 2014
June 2014	LS to clarify with KS: • The issue of 'direct access' to NEDs by Governors. • The issue of Governors receiving internal communications in advance or following media storms 'patient found dead in bed'. • Whistleblowing LS to raise nurse staffing with Hazel Gunter	October 2014
June 2014	AK to raise the inclusion of Theatres in the Teamstepps programme and report back.	October 2014

8. AOB and Date of next meeting

The date of the next meeting is . Tea and coffee will be provided on arrival as will lunch at 12.00. Please send any apologies and dietary requirements to Vickie Higgins Victoria.Higgins@heartofengland.nhs.uk or call 0121 424 2438. Parking is booked at Devon House on a first come, first served basis and 6 spaces have been reserved. Please let Vickie Higgins know if you require a parking space.

Future Meeting Dates for 2014 - All are in the Education Centre and begin at 0930 for 10.00

- Another date is to be identified in October (3rd October not possible)
- Thursday 11th December

POST MEETING NOTE:

Suggested questions for JR from the meeting (Subject to agreement of chair)

1) The governors would like to ask the following questions of the dementia steering group
    a. How have we considered the issues of B12 deficiency / Depression / Over medication do not get overlooked for people considered to have dementia
    b. Learning the lessons from other areas ... how have we considered the unintended consequences of applying the dementia label (through the increased assessment focus)

2) How is B12 deficiency factored into falls and tissue viability strategies. Is there a potential for a lesson of the month to raise awareness of it?

3) How is ward 19 doing after Matt Fowler has left? Is it sustaining the improvement that had been made

4) How are we improving how safe patients feel at night / are able to sleep at night

5) What are the barriers to allowing us to make progress with the endoscopy unit (and therefore risking non compliance at a future JAG accreditation)

6) Other professional practice issues (applying the learning from the Kennedy Report)
    a. What information can you give us to assure us that these are being managed safely and that the patient is at the heart of the investigation.

7) What incentives have we considered for staff. What plans are in place to address the shortages that are coming down the line (e.g. increased requirement for advanced practitioner roles)

Minutes of a meeting of the
COUNCIL OF GOVERNORS
SAFETY AND CLINICAL EFFECTIVENESS
Heart of England NHS Foundation Trust, Education Centre, Devon House, Heartlands Hospital
03 November 2014, 09.00

Present	Title	Initials
STEVENTON Liz	Chair & Public Governor	LS
LYDON, Andrew	Public Governor	AL
PEARSON, Mark	Public Governor	MP
ORRIS, Barry	Public Governor	BO
TREADWELL, David	Public Governor	DT
LANE Heidi	Staff Governor	HL
In attendance		
RUDD, Louise	Head of Clinical Governance	LR
KEOGH Ann	Director of Medical Safety	AK
HOLLANDS Zoe	Minutes	ZH

1. Apologies for absence

Apologies were received from KB and AK.

NB: Several members informed the meeting attending a meeting at this time of day had been challenging due to increased traffic and the impact on travel time for this meeting, it was therefore agreed that future meetings would be held with a start time after 10am wherever possible.

2. Minutes of the previous meeting

LS acknowledged that the minutes from the last meeting were unfortunately very late and explained that since the last meeting, a process had been proposed to ensure that meeting minutes were produced in a more timely manner, with meetings scheduled between LS (Chair), KB (deputy chair) and LR (secretary) to agree the draft minutes and circulate to committee members within two weeks of the meeting.

Page 1: Meeting took place at Heartlands not Solihull and HL did attend the meeting.

AL & MP both commented on the grammatical quality of the minutes in the Trust and with this in mind MP requested that his update on the Kennedy Task Force (page 3 section 5) be slightly amended to say:

.. MP said that HEFT has set aside £6m to deal with the aftermath of the Ian Patterson matter. Sir Ian stated that changing the policies was important but that this does not necessarily change the culture .....

Page 3: It was noted that the minute asking whether this committee should be informed of consultants under investigation had been included into Q6 of those posed to Jammi Rao

LS encouraged the members to forward any comments on factual accuracy of the minutes to the Chair of the group and secretary within a week of receipt so that they could be acted upon and the final set of minutes just agreed at future meetings.

Subject to the above amendments, the minutes were agreed as a true and accurate record.

ACTIONS

a) Minutes of the previous meeting of the 7th August to be revised and amended and the revised versions to be sent out to Committee Members. (LS/LR/KB/ZH).
b) LS/LR/KB to meet to agree draft minutes of the meeting held on the 3rd November.
c) LS/LR/ZH to ensure that the first draft of the minutes from the 3rd November go out to Committee

Members within three weeks of the meeting taking place.

Matters Arising

BO asked about the current situation in Endoscopy with regards to JAG accreditation which had been highlighted through SitRep at the previous meeting. He was informed that there had not been any change since the last meeting as JAG had not yet visited the Trust to renew or remove the accreditation. AK advised that she had already requested an update on this serious risk from the local leads.

3. Questions to Jammi Rao

JR said that he was delighted to be invited to the meeting and share what he knows from his role as a HEFT NED and chair of the Trust's Quality and Risk Committee. He noted that having sufficient visibility of the whole hospital (even a modest one, let alone one as large as HEFT) was a constant challenge.

JR confirmed that the Quality and Risk Committee had five non executive members including the Trust chairman who regularly attended.

JR explained his view that quality and safety ultimately depended upon staff doing the right things 24/7 and that this cannot be realistically policed or supervised being instead very dependent on high quality staff. The Board's role therefore was to provide the right infrastructure to let staff do this.

JR explained that the patient safety walkabouts that he was involved in allowed him to visit frontline areas and listen to staff. Whilst the specific content of the discussions in each area may be different, the general themes seemed to be around: excessive workload; rapid change and throughput of patients; shortage / continuity of staff and team working.

He explained that the board had agreed that improvements would not be refused purely on financial grounds, if a case is well made, the executive team would support it. JR said that they would prioritise by risk using the risk registers to get a sense of these priorities.

BO asked if JR was confident that there were systems in place to allow any staff concerns to be raised.

JR responded that he would never be perfectly happy with such a system but was reassured that HEFT now had a much better system. He explained that the Board had recently signed off the "Raising Concerns Framework" and that he had a role as the last "internal" point of reference that staff could use before going to external agencies such as Care Quality Commission (CQC) or the media. JR commented that he had already had a concern raised with him via this route which was promptly followed up.

JR concluded that he hoped the staff felt able and knew that they had a duty to raise issues with their line manager (or suitable alternative if they felt unable to raise such issues with their line manager).

HL commented that this message had reached ward level and that we are still empowering staff to feel able to raise concerns about colleagues and also safeguarding concerns. She also commented that the change in the name from whistle blowing to raising concerns was a positive move.

There was a broader discussion about the framework and training that had been put in place to enable managers to respond appropriately to staff who raise concerns and help staff understand what they should expect when they do and what alternative routes are available to them if their expectations are not met.

Action: AK agreed to send out the flow chart to members for their information

3.1: Questions about dementia and B12

a. How have we considered the issues of B12 deficiency / Depression / Over medication do not get overlooked for people considered to have dementia
b. Learning the lessons from other areas ... how have we considered the unintended consequences of applying the dementia label (through the increased assessment focus)

c. How is B12 deficiency factored into falls and tissue viability strategies. Is there a potential for a lesson of the month to raise awareness of it?

In response to the questions raised about dementia JR expressed his view that the dementia strategy was important, needed to happen but would depend upon time, clinical staff and training.

There was further discussion about the dissatisfaction of the current dementia targets which are focussed upon diagnosing dementia and not necessarily management.

JR commented that the dementia strategy aimed to raise awareness of dementia and was dependent upon GP's, consultants and other health professionals as well as the clinical guidelines and evidence that was currently available on management / treatment. JR said he would be surprised if a diagnosis of dementia was the end of the road from a clinician's perspective but he did highlight that the identification was not only an important step to ensure suitable clinical treatment of the condition (albeit the treatment options are not that effective yet) but also to prevent chasing other false leads (and potentially avoid multiple unnecessary community and secondary investigations)

As part of a broad discussion the key points were:

- A&E may not be best placed for identifying chronic problems like dementia and that other services, (such as a memory clinic) may be more suitable.
- A check list might be useful to support the management of patients identified to have dementia (including co morbidities common to this patient group)
- This was a wider health economy issue and training was required for GP/ practice nurses as well as our own staff
- Ask pathology would the routine FBC counts that many patients get at HEFT be used to identify B12 deficiency (LR)
- There was a brief discussion about what role the group should have in this issue and it was agreed that the Trust dementia lead would be invited to hold a future workshop for the Governors to further understand this issue. (LS)

It was acknowledged that the Committee would like to function along the lines of a parliamentary sub-committee, enabling the committee members to be primed on the key quality and safety issues before the meeting but still able to provide the lay challenge on behalf of the Trust members and holding the Non-Executives Directors to account (primarily JR for this Committee).

The group requested key documents (strategy / guidelines) prior to the workshop with the Trust representative for Dementia.

ACTION: Ask Dementia lead to consider whether a checklist could be developed (LR)
ACTION: Ask Pathology lead if routine FBC are used to identify B12 deficiency (LR)
ACTION: Invite Dementia lead to future workshop circulating key documents before meeting (LS/LR)

Post meeting note: Following the meeting AL wrote to the Chair to summarise his concern to be:
"My main issue was that when people are labelled as having dementia, it means that lots of doctors tend to see most decline in the patients as the dementia getting worse, rather than another separate problem intruding. This can obviously lead to late diagnosis of a range of problems such as over-active thyroid, and anaemias (both iron deficiency, and B12 deficiency) and the often more dramatic Urinary Tract Infections. All of which have behavioral symptoms that then get entangled in dementia. And 20-40 % of patients in acute hospitals are vulnerable to this"

3.2: Question about Ward 19

d. How is ward 19 doing after Matt Fowler has left? Is it sustaining the improvement that had been

made

This area had not recently been subject to a patient safety walkabout and therefore JR was not in a position to comment. It was agreed that it would be more suitable to ask the Chief Nurse this question at a future meeting.

ACTION: Forward question d) to Chief Nurse prior to next meeting (LR)

3.3: Question about patient experience at night

e. How are we improving how safe patients feel at night / are able to sleep at night

JR expressed his sympathy with patients and acknowledged that the design and nature or hospitals did not really allow patients to sleep well.

There was a general discussion about:

- staffing numbers affecting how safe patients felt at night. JR assured the group that the Board were aware of the current staffing issues but that they had not necessarily solved it yet.
- challenge posed by confused patients calling repeatedly for help from staff at night, both in terms of the impact this has on the staff but also other patients and their confidence that their calls will be answered.
- use of side rooms to help with the management of this issue, e.g. to cohort confused patients with dedicated nurse in that area to maintain high visibility.
- patient safety walkabout where call bell was constantly ringing because staff did not have the time to answer it due to lack of resources and the impact of increasing acuity of patients.
- need to incentivize night time shifts to ensure consistent provision of good staff at night.
- additional space, time and resources that could be available to enable better sleep if patients who did not need an acute bed could be promptly provided with a suitable alternative.

One perceived source of night time noise was noted to be “staff chatter” and it was agreed that this would be a question posed to the Chief Nurse along with the Trust’s approach to ensuring safe staffing at nights.

A brief discussion followed about joined up working within wider health delivery and the challenges posed by there being no where else for the patients to go. JR explained that this was being addressed by the “Better Care Fund” and LR explained some of the other pathways that Good Hope Hospital was trying to support (with Cedarwood Unit and Recovery at Home Service)

It was acknowledged that over the years the needs of the patients had significantly changed, particularly those with long term conditions, however the service had not changed fast enough to support these yet.

ACTION: Ask Chief Nurse about “staff chatter” as a perceived source of night time noise (LR).
ACTION: Ask Chief Nurse about Trust’s approach to ensuring safe staffing at nights (LR).

3.4: Question about Endoscopy unit and JAG accreditation

f. What are the barriers to allowing us to make progress with the endoscopy unit (and therefore risking non compliance at a future JAG accreditation)

The group were advised that the Trust was still waiting for an update about the JAG accreditation. BO commented that he felt this to be indicative of the way that the Trust seemed to deal with problems, i.e. seemingly quite relaxed about the problem and then suddenly subject to enforcement action.

JR assured the group that there had been a discussion on how to move beyond the current position and that the Board were not taking the issue lightly.

3.5: Question about professional practice issues

g. Other professional practice issues (applying the learning from the Kennedy Report)

h. What information can you give us to assure us that these are being managed safely and that the patient is at the heart of the investigation.

JR confirmed that there was a strong view at the Board that the Trust must put patients at the heart of the management of such professional practice issues. JR outlined a case example where rapid action had been taken to appropriately protect patients, there had been good liaison with other affected organisations and an internal investigation had been promptly undertaken and actions implemented. He also explained the Trust had a duty of care to staff, both those who raised or were otherwise affected by such issues and that it can take 6-12 months to fully resolve such issues.

There was a general discussion about the challenge of giving patients sufficient information, in relation to members of staff under investigation regarding professional practice issues, in order for them to make an informed choice. A scenario was posed questioning how patients may feel if the clinician they were seeing in an outpatient setting had been stopped from other areas of their practice and when, how and if they should be informed. JR agreed to raise this discussion with his colleagues and feedback to this Committee.

Following a discussion about doctors challenging each other and poly-pharmacy (using the experience that some members of the group had with the impact of multiple medications for multiples issues) it was agreed that the Medical Director would be asked what our approach to this issue is.

ACTION: Feedback from JR about discussions with colleagues
ACTION: Ask Medical Director about Trust's approach to addressing this issue (and poly-pharmacy)

3.6: Question about staffing

i. What incentives have we considered for staff. What plans are in place to address the shortages that are coming down the line (e.g. increased requirement for advanced practitioner roles)

It was agreed that the Chief Nurse and the Medical Director, along with the HR would be better placed to comment on the trusts strategy to staff recruitment and role changes, including those to support increasing emergency care throughput.

There was a general discussion about recruitment challenges with key points being:

- National shortage in some roles and therefore reliant on short term fix to attract workforce from other countries.
- Impact of bad publicity on recruitment drives and need to do something to turn around the reputation of the Trust and challenges highlighted by last staff survey.
- Need to promote some of our areas of good practice more such as: bariatrics; thoracics; diabetes and clinical research.
- Need for leadership to challenge the press when media articles are misleading or biased.
- Good Culture and leadership with attract good staff through word of mouth and networking.
- Most front line staff's view of the Trust if influenced by the quality of their local manager and teams, therefore need to invest more in these front lines managers.
- Publicise what we do well through regular intranet / poster updates that are simple and easy to read and share local good experiences.
- It was suggested that the NED's may want to write letters to the local press highlighting good practice and good news stories

ACTION: Ask Chief Nur.se and Medical Director about Trust's strategy on staff recruitment and role changes

4. Quality & Risk Minutes

There was a general consensus that the minutes alone did not enable the group to fully understand the business from the Quality and Safety Committee. It was agreed that in future an executive summary of the minutes would be circulated as well.

4.1: Mortality Statistics

MP sought confirmation that the Hospital Standardised Mortality Ratio (HSMR) implied that the Trust was slightly worse than other organisations. AK explained that the mortality data is best considered to be "smoke alarms" that suggest you are different to other organisations and should be looked into to understand why. She explained that even thought the Trust had improved, other organisations have improved more which means that HEFT will soon be confirmed as a national outlier (although regionally it varies month to month). AK explained that the Silverman Mortality Review had looked at flow, capacity and care bundles and the way that the Trust improves and learns from it's mortality information.

There was a further discussion about Mortality information, in summary the key points were:

- the need to link public health issues into the way that mortality data is looked at rather than just focus on case reviews and the local learning that we can extract from these.
- national debate over the best methodology used to calculate mortality statistics and the sensitivity on the way that information is coded (for example palliative care coding) means that it is often not clear what the statistics mean.
- ethnic coding not sufficient yet at a national and local level to enable analysis of mortality by ethnic grouping.
- the need to ask what deaths are avoidable by acts of commission of omission and focus on learning from these.
- difference of approach between UHB and HEFT and the need (from public interest perspective) to challenge media which may be misleading.

4.2: Internal Audit Reports

BO asked if internal auditors were instructed to tell it "as it is" and then allow officers to respond. AK confirmed that this is what happens. BO confirmed that he was reassured by this and AK further commented that the internal auditors also had a professional framework / code of ethics that they had to work within.

There was some further discussion to clarify some of the terminology within the minutes as well as some of the changes of roles within the clinical management teams.

MP commented that he was confident that the Medical Director seems to be getting the job done and not afraid to be perceived as unpopular when needed.

5. Sit Report

AK explained the evolution and future of SitRep including the development of a "Heatmap" as a way of capturing and triangulating some of the more qualitative information and local intelligence from areas.

It was suggested that the name could be changed to "SafeRep" and that the contents and format were beginning to become familiar to the governors.

In response to one of the risks (closure of ward 10 at Solihull) there was a general discussion about the provision of dementia care in Solihull and how the contract was awarded to Ardenlea in the light of a media article which suggested that the Star & Garter was the best provider of this service.

LS explained that Ward 10 had gradually become full of patients with dementia who did not need acute beds rather than a ward for patients who needed acute beds and had dementia.

The group asked for the following questions to be raised with the Solihull Management team and the Chief Nurse.

- What are the arrangements with Ardenlea and what is the role of our staff in this unit.
- How was the decision made to move the service and how had funding been withdrawn.

ACTION: Ask Chief Nurse and Solihull Management team about decisions, arrangements and staffing at Arden Lea.

6. AOB/Terms of Reference

LS read out an email from KB which raised concerns over the removal of the word "Quality" from the terms of reference and asked who or which governors committee would look at Quality of Care. The email expressed KB's opinion that this was not putting patients at the heart of the matter.

LS confirmed that the name change had come from structural changes within the Board of Directors to reflect the sub groups of the Trust Board and portfolios of the associated Executive Directors.
LR suggested that the group may want to consider calling the group "Quality (Safety and Effectiveness)" if this was preferred.

BO agreed with the sentiments of KB and following wider discussion it was recommended that the group should mirror the name of the Board Sub Committee (Governors Quality and Risk Committee) accepting that the name of this is also likely to change in the near future.

MP commented that he was not sure that splitting patients experience from this group was a good idea, however, going forward just needed to ensure cross liaison between the groups. It was requested that both group's terms of reference include a reciprocal arrangement under the duties section to advise and receive advice from the other committee.

It was requested that the statement about other members should to moved to the "membership section" rather than the "quorate section"

There was a general discussion about the role of the Council of Governors as a place to share the findings of both the Patient Safety and Patient Experience Committees. Comments were made that the current schedule did not enable this to happen and Chairs of the sub committees were not getting sufficient opportunity to raise fully the concerns from their meetings. It was confirmed that the Trust chairman was aware of these issues and was seeking to address them.

ACTION: Request inclusion of reciprocal arrangement in Committees; Terms of Reference (LR/LS)
ACTION: Update membership and quorate section of Terms of Reference (LR)

7. Proposed Questions for Chief Nurse (to be answered at next meeting).

LS asked if there were any other questions that Committee members would like to put to the Chief Nurse at the next meeting

DT asked about how the work of the community services teams at Solihull was considered by this group and were they confident that the services were integrated in the Trust, supported and accountable and what were the transformation plans regarding these services. It was agreed that the chief nurse (and the deputy medical director (transformation) would be asked this question.

BO asked was the Trust confident that nurses were able to work effectively and being respected by the rest of the multidisciplinary team as these were issues that he had noted from patient safety walkabouts. It was agreed that this would be put to the Chief Nurse.

ACTION: Ask Chief Nurse about integration of Community Services
ACTION: Ask Chief Nurse about integrated working within the MDT

8. Date of Next Meeting

LS informed the meeting that LS/LR/KB would be meeting to go through the minutes on Friday 14th November 2014.

There was a further meeting planned for the Monday 17th November 2014,which ZH was in the process of arranging.

LS proposed that future meetings started at a later time (she proposed 10.30am, and include lunch), so that members could have more chance of attending.

ACTION: ZH to schedule meeting for 2015