Notice is hereby given that a meeting of the
Council of Governors
of Heart of England NHS Foundation Trust will be held
at the Education Centre, Birmingham Heartlands Hospital
on 5th January 2015 at 4.00pm

A G E N D A

1. Leadership Support & Resilience Proposal and CQC update (Oral - Chair/A Catto)

2. Reports from CoG Cttee chairs:

    a. Finance & Strategic Planning (Oral – A Fletcher)
    b. Hospital Environment (Oral – E Coulthard)
    c. Membership & Community Engagement (Oral – A Fletcher)
    d. Patient & Workforce experience (Oral - M Kelly)
    e. Quality & Risk (Oral – L Steventon)
    f. Kennedy Task Force (Oral – M Pearson)

3. Report on work of Board Finance & Performance Cttee, plus Q&A (Oral – D Lock)

4. Proposal to extend PwC, external auditors, contract (Enclosure – A Quinn)

5. Quality Account & Report update (Enclosure - R Blackburn)

6. Solihull Urgent Care Centre – update (Oral - Chair/A Catto)

7. Surgery Reconfiguration – update (Oral - Chair/A Catto)

8. Any other business

9. Next Meeting – 3rd February 2015, St Johns Hotel, Solihull

Refreshments will be available from 3.30pm

Kevin Smith
Company Secretary
24 December 2014

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

External Auditor – Recommendation to extend contract

The appointment of the external auditor requires the approval of the Council of Governors (CoG), via a recommendation from the CoG Audit Appointments Committee, which in turn would follow a recommendation from the Audit Committee of the Board.

The Trust is required by Monitor's Audit Code to have an appointed external auditor at all times. The current contract for external audit services with PwC is a three year contract that runs from 1 April 2012 to 31 March 2015. The contract allowed the Trust to extend the contract by two years after beyond 31 March 2015.

There are three options available:

1. Extend the contract for two years.
2. Extend the contract for one year, by negotiation.
3. Run a procurement process for another three year contract.

Option one is not recommended because this would mean the external and internal audit contracts would end at the same time.

Option two is the preferred option because it gives stability at a time when there are other difficult issues for the Trust and the Audit Committee to address. In particular, PwC have gained great insight into how Monitor undertakings affect the audit opinion and it would be helpful to carry this insight into the 2015/16 year. A full procurement process would then be run in the autumn of 2015 to award the next three year contract.

PwC have indicated their willingness to agree terms for a one year extension.

The Audit Committee met on 26 November 2014 and recommended **option two** to the CoG Audit Appointments Committee. The COG Audit Appointments Committee unanimously resolved in December to recommend **option two** to the CoG.

If the CoG decides that it doesn't accept the CoG Audit Appointments Committee's recommendation, a sub-group of the Audit Committee would meet to set the criteria for the tender process in January leading to a fast track tender process and a recommendation to the CoG Audit Appointments Committee and on to the CoG in March 2015.

Recommendation

The CoG Audit Appointments Committee recommends **option two** to the CoG, to extend the contract with PwC for one year.

Alison Lord
Chair of CoG Audit Appointments Committee
24 December 2014

From: **Rachael Blackburn, Head of Corporate Risk & Compliance**

Title: **Quality Account & Report update to the Council of Governors**

Date: **December 2014**

Summary/Key Points:

- The Health Act 2009 required the publication of Quality Accounts by providers of NHS services from April 2010.

- Although final guidance is still awaited, it is anticipated Trusts will be required to publish their Quality Account for 2013/14 on the NHS Choices Website by 30th June 2015.

- The purpose of this paper is to provide the Council of Governors with an update on performance against the key priorities contained in the Quality Account & Report.

1. Introduction

The Health Act 2009 required the publication of Quality Accounts by providers of NHS services from April 2010. Quality Accounts are annual reports to the public from providers of healthcare services about the quality of the services they provide.

The Trust is still awaiting updated guidance as to the format of the new account as the National Quality Board has been discussing making changes. However, it is anticipated that Trusts will still be required to publish the Quality Account & Report for 2014/15 on the NHS Choices Website by 30th June 2015.

The purpose of this report is to update CoG regarding progress against the seven priorities identified for the current year.

2. CURRENT PRIORITIES

The Executive Management Board agreed in February 2014 that the all seven priorities from last year should continue. These are:

Priority 1: **FUNDAMENTALS OF CARE**	This priority looks at the fundamentals of care for patients to improve patient experience. This includes compliance with the national friends and family test, embedding the '6cs', and monitoring of pain management. This priority will be measured by various methods including reports to the Nursing Performance Committee, CQUINs and reports to the CCG.
Priority 2: **FALLS**	This priority aims to improve clinical outcomes from falls for patients. This will be measured through Trust wide developed scorecards which include metrics for assessments, falls per occupied bed days, and wards that have the highest number of falls.
Priority 3: **PRESSURE SORES**	This priority aims to reduce the prevalence of pressure ulcers across the Trust. This will be measured through Trust wide developed scorecards with metrics regarding assessments, tissue viability audits and incident numbers.
Priority 4: **FRACTURED NECK OF FEMUR**	This priority aims to improve clinical outcomes of patients with fractured neck of femur. This will be achieved by assessing clinical outcomes for the Trust from data submitted to the National Hip Fracture Database.
Priority 5: **STROKE**	This priority aims to improve clinical outcomes for patients suffering a stroke. The four priorities specifically identified from the stroke pathway include: • Number of acute stroke patients thrombolysed • Direct admission to stroke unit within 4 hours with a swallow assessment • The percentage of acute stroke patients who have received a swallow screen within 4 hours of arrival. • 90% of stay spent in a stroke unit
Priority 6: **DEMENTIA**	This priority aims to standardise the approach for dementia patients and hence lead to improvements in the care given.
Priority 7: **DISCHARGE ARRANGEMENTS**	This priority aims to improve communication relating to the discharge process for patients and is measured through a CQUIN.

PROGRESS TO DATE:

Priority 1: FUNDAMENTALS OF CARE

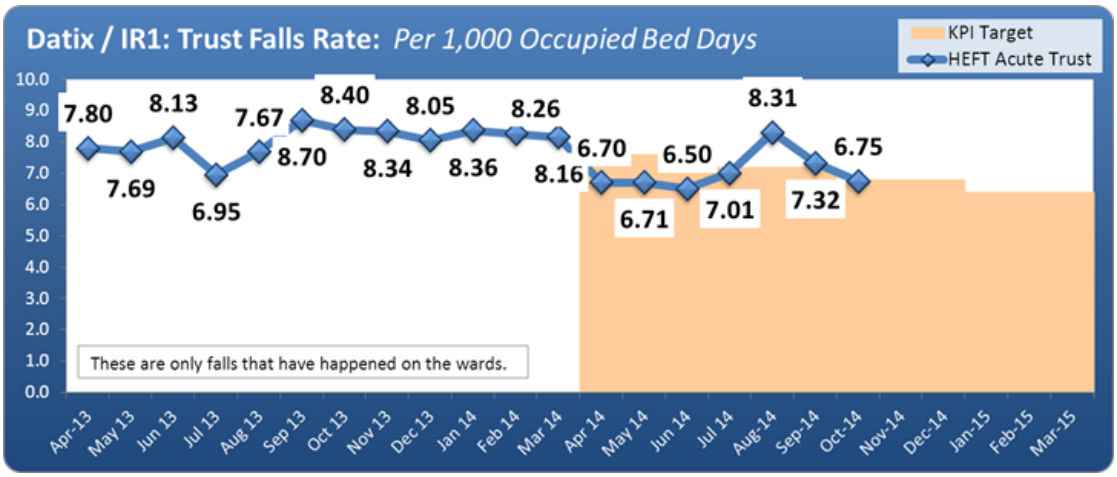
There are several strands to this priority which come under the heading of fundamentals of care:

What is the measure:	How is this priority measured:	What have we done to improve:	Future plans to improve compliance against the Trust targets include:
Compliance with the national friends and family test and achievement of the Trust friends and family (FFT) CQUIN.	The Patient Experience team collect and collate the data from the FFT cards and provide monthly reports which are presented at Trust Board. Monthly reporting at Nursing and Midwifery Performance meeting	A Trust wide initiative to increase numbers of FFT cards returned and the process of collection and collation of cards was streamlined. As an incentive, awards were given to best performing and most improved ward per site. In September the Trust achieved a return rate of 30% which is above the requirement for the FFT CQUIN. A thematic review of the comments is now being undertaken under the heading of the 6C's.	Ongoing discussion and support for Senior Ward Sisters. (SWS's) Quarterly thematic reviews. Awards for best performing and most improved wards per quarter. Aim to achieve CQUIN compliance of 40% in quarter 4.
Ongoing initiatives to embed the 6C's in the delivery of patient care.	This priority is measured through patient, carer and staff feedback, e.g. complaints, PALS, FFT narrative, staff forums and staff FFT and survey.	The Trust hosted a national 6C's conference in October 2014 with over 250 attendees and very positive feedback. A Restorative supervision project has been implemented at GHH to provide support for the SWS's and Matrons. The Trust has invested in the implementation of Schwartz rounds in the Trust. A focus group with carer representatives and members of the Alzheimer's association; Admiral Nurses, carers UK and end of life nurses has been set up.	The Trust has been asked by the National Council for Palliative Care to be the lead NHS pilot for their compassionate care project. The Trust are scoping the possibility of implementing sleep packs as disturbance at night has been highlighted as an issue on the wards.
Ongoing monthly monitoring of pain management through nursing metrics.	Monthly monitoring through the nursing metrics for reporting to Nursing and Midwifery Performance meeting.	A specific question on pain has been agreed by the CCG and added to the patient experience questions which are now on the FFT cards.	Ongoing monitoring via ward metrics and FFT feedback. Expert advice from the pain management team.

Priority 2: FALLS

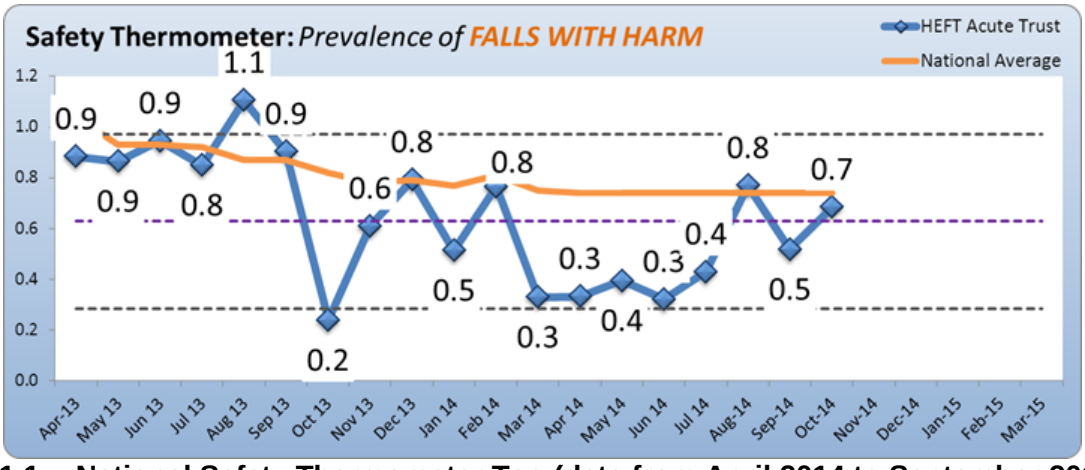
'Patient falls' account for the largest number of adverse events reported within the Trust and therefore a priority for all healthcare professionals in preventing harm to patients. Falls prevention has executive board support in its challenge to achieve 'harm free care' to our patients.

Currently the falls rate is measured as the number of falls per 1000 occupied bed days and a projected reduction in the overall fall rate is currently a key performance indicator with our commissioning partners. The trust performance is currently on a downward trajectory following sustained efforts with the clinical teams to focus on falls preventative strategies at ward level.



In addition to the planned reduction in the falls rate, reporting also commenced in July 2014 with compliance of the level 1 local falls care bundle of 95% by March 2015. Current performance stands at 85 % - it is anticipated that with additional training and education to high risk clinical areas the compliance of 95% will be achieved.

The NHS Safety Thermometer national audit is a point prevalence audit undertaken every month to look at how organisations are delivering harm free care. It provides a quick and simple method for surveying patient harms and analyzing results to measure and monitor local improvement and over time.



1.1 National Safety Thermometer Too (data from April 2014 to September 2014)

The trust falls steering committee provides a forum for a regular review of falls data at trust, site and ward level. This clinical forum ensures that a robust and coordinated approach is used to

standardise clinical practices, focusing on preventative strategies and clinical interventions to reduce the incidence of harm to those patients at risk of falling in hospital.

Clinical outcomes are measured monthly through trust-wide developed scorecards which include metrics regarding assessments; falls per occupied bed days; and the clinical areas demonstrating a high number of patient falls.

Improvements currently in place include:

- **Policy -** The annual review of the Trust's' Falls Prevention' policy has incorporated recommendations from the National Institute of Clinical Excellence (NICE) – assessing patient risk of falling in the Accident and Emergency department (A&E) right through to their discharge from hospital.

- **Education** – A range of educational programmes are in place to support new starters/nurses/medical staff and allied health care professionals. In addition, there is bespoke training for clinical areas demonstrating a high incidence of patient falls.

- **Staff Engagement** – Awareness is raised for all staff groups through a range of mediums such as 'Safety' lesson of the month, newsletters, clinical forums and learning lessons events. A trust wide 'falls' learning event took place in October 2014 for clinical teams to share strategies/tips on how to care for patients with challenging and complex behaviours – this proved a successful approach and will be repeated again for junior clinical teams.

- **Multidisciplinary Approach** to risks/care planning takes place, including the re-launch of the Trust's falls group with extended membership to include acute/primary care partners.

- **Clinical Review of all adverse incidents** related to falls – implementation of clinical forums to review adverse incidents and learn lessons which is then disseminated across the 3 hospital sites. This approach has now been extended to a senior clinical review of all serious falls and learning to be shared across clinical teams.

- **Patient/Carer Support** – Development of patient literature and patient falls notification forms enhances communication and delivers a joined approach to falls prevention.

- **Recruitment of a dedicated 'Falls' team** – recruitment of two clinical 'falls' practitioners is underway to support site teams in providing education and support with complex patient needs.

Priority 3: PRESSURE ULCERS

What is the measure:

The Trust is committed to reducing harm caused to patients and strives to achieve zero hospital acquired pressure ulcers.

How is this priority measured:

- Daily
- Weekly
- Monthly National Safety Thermometer Audit
- Monthly Nurse Care Indicators Monthly Local Forums
- Site Forum Meetings

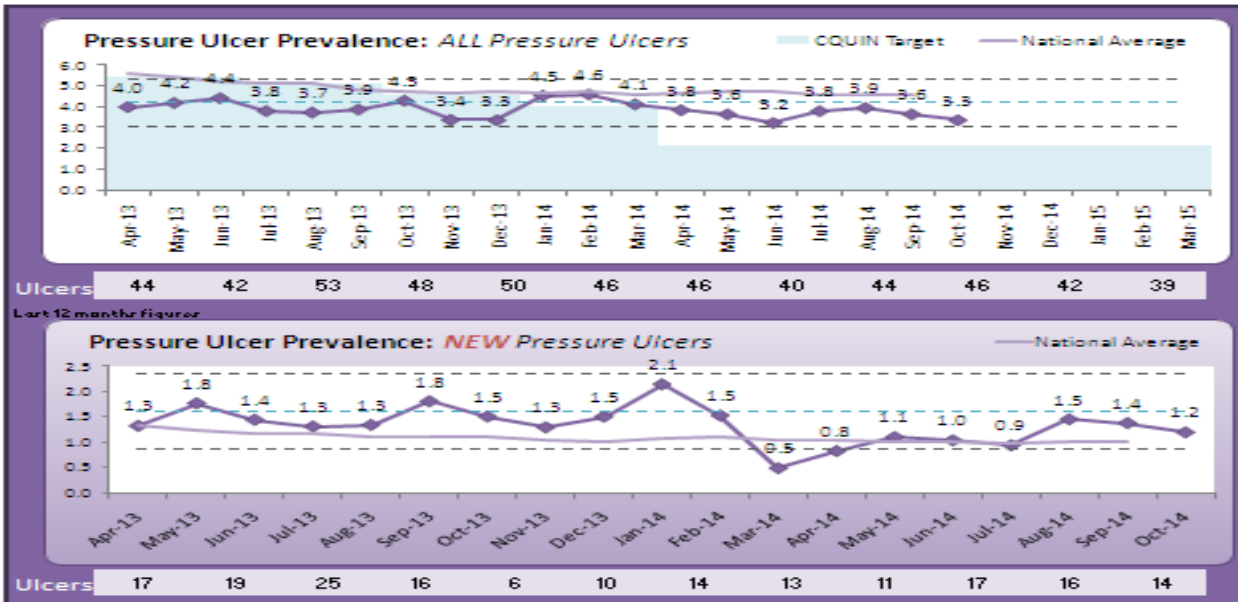


Figure 1

What have we done to improve:

- Although there is lots ongoing work to improve the reduction in all pressure ulcers, the Trust overall does report avoidable grade 3 pressure ulcers Year To Date=8. Grade 2 avoidable pressure ulcers the Trust has a yearend target of no more than 159 avoidable pressure ulcers, to date we are currently at 93 at the end of quarter 2
- In August a new Integrated Tissue Viability Policy was launched across the Trust. The Trust Tissue Viability team are now site based in order to provide a stronger site presence and to work directly under the remit of the site Head Nurse to address site issues as they become apparent.

Future plans to improve compliance against the Trust targets include:

- To work to reduce the number of avoidable pressure ulcers across the organisation by learning from previous action plans.
- To continue to roll out improvement practice across Maternity and Emergency Departments.
- November is 'Stop the Pressure' month. The NHS England Patient Safety Domain and NHS England Midlands and East will work collaboratively in the planning and delivery of the month. Support has also been gained from the Nursing Times, Royal College of Nursing, Tissue Viability Society.
- The Trust will be supporting and holding events to support the World-wide stop the pressure day is November 20th 2014.

Priority 4: FRACTURED NECK OF FEMUR

No return has been received from the indicator lead

Priority 5: STROKE

The Trust is responsible for providing a stroke service to 3 sites.

Currently Birmingham Heartlands Hospital (BHH) receives all the out of office hours Hyper Acute Stroke patients and provides a 24/7 service. It has a Hyper Acute Stroke Unit (HASU) and an Acute

Stroke Unit (ASU). Solihull Hospital (SH) and Good Hope Hospital (GHH) provide an 'office hours' Hyper Acute Stroke service and there is a Stroke Unit on each site.

This is due to change over the next few months as the Trust wide Stroke Reconfiguration takes shape. The entire Hyper Acute Stroke service will be provided by BHH by the end of the year and all suspected stroke patients will be admitted here before repatriation to their local hospital if further acute care is required.

Four specific measures have been chosen from the acute stroke pathway because they are considered good indicators of the quality of care received by patients. They are the same measures as previously reported.

1. Acute Stroke Patients Thrombolysed

What is the measure:

Target ≥ 10% + SSNAP eligibility ≥ 90%

How is the priority measured:

This measure is collected as part of hyper acute stroke service measured nationally and reported through the Sentinel Stroke National Audit Programme (SSNAP). This measure is reviewed weekly in the Thrombolysis Governance meeting at BHH.

	Percentage of patients who received thrombolysis				
		Q3 13/14	**Q4 13/14**	**Q1 14/15**	**Q2 14/15**
Heartlands (BHH)		6.0%	9.3%	4.4%	13.3%
Good Hope (GHH)		2.6%	5.3%	0.0%	2.9%
Solihull (SH)		7.6%	2.2%	10.8%	6.5%
Trust		**5.4%**	**5.6%**	**5.1%**	**7.6%**
Nationally		11.3%	11.5%	12.2%	unknown

Currently the performance varies greatly between the sites and overall the trust performance is below the suggested national figure. BHH which admits the most stroke patients is currently the best performing site and is now exceeding the target of 10%.

SSNAP data also records thrombolysis performance with the added marker that is related to percentage of eligible patients who received thrombolysis of 90%. This is an important addition as it indicates good practice. For Q1 the Trust achieved 91.65% and Q2 the Trust achieved 95.83%.

This indicates that the vast majority of patients who are eligible do receive thrombolysis; however the number of patients who are eligible across the trust is below the national average.

What have we done to improve:

The out of hours service moving to BHH has recently shown an increase in the numbers of patients thrombolysed. This has been supported by the Stroke Specialist Nurse (SSN) team responding within 5 minutes 24/7 and introduction of a supporting medical bleep holder responding within 15 mins 24/7.

There is a weekly Thrombolysis governance meeting that scrutinises the process to ensure that opportunities to thrombolyse patients are not missed and that thrombolysis practice is safe.

2. Direct Admission to Stroke Unit within 4 hours

What is the measure:

This measure is monitored closely by the performance department and reviewed bimonthly at the Stroke Sub-Directorate meeting. This is possibly the single most evidence based intervention for stroke patients. An early admission to a stroke unit generally means early assessment by specialists and less variation in treatment and care.

How is the priority measured:

This measure is reported through best practice tariff (BPT) and nationally through SSNAP.

Target 50%

Percentage of Patients Directly Admitted to Stroke Unit within 4 hours					
	Q2 13/14	**Q3 13/14**	**Q4 13/14**	**Q1 14/15**	**Q2 14/15**
Heartlands (BHH)	68%	64%	73%	50.5%	53.8%
Good Hope (GHH)	58%	38%	47%	46%	48.8%
Solihull (SH)	30%	38%	44%	21.4%	35.5%
Trust	**36.4%**	**45.1%**	**51.4%**	**43.3%**	**49.3%**

Performance for this measure is quite variable. Attendance in ED and capacity throughout the 3 sites remains very challenging and this has a large impact on direct admissions. The Stroke bed capacity on all three sites is sufficient, but many these beds are occupied for long periods by non-stroke patients. This makes it difficult for patients to move through ED into a Stroke bed within 4 hours.

SH site performance is particularly poor, however there are unique issues with the ED located in an Acute Medical Unit (AMU) which affects the urgency to move to a Stroke specific bed and is likely to distort these figures.

What have we done to improve:

The strengthened SSN team and medical bleep holder at BHH 24/7 provides support for the ED and attempts to pull the patient through in an efficient manner. BHH site has maintained performance above 50% during an incredibly difficult period in terms of overall bed capacity.

3. Swallow Assessment for Stroke patients within 4 hours

What is the measure:

This measure is monitored closely by the performance department and reviewed bimonthly at the Stroke Sub-Directorate meeting. There are plans to make this meeting monthly once Stroke becomes a directorate.

How is the priority measured:

This measure is part of our contracts and is reported as a Key Performance Indicator (KPI) to the commissioners. It is also measured nationally through SSNAP.

Target Q1 84% Q2 86% Q3 88% Q4 90%

Percentage of Stroke Patients with a Swallow Assessment Completed within 4 hours					
	Q2 13/14	**Q3 13/14**	**Q4 13/14**	**Q1 14/15**	**Q2 14/15**
Heartlands (BHH)	61.4%	72.7%	84.6%	86%	94.3%
Good Hope (GHH)	84.9%	75.0%	59.3%	65.1%	82.9%
Solihull (SH)	64.4%	78.2%	81.0%	72.7%	72.4%
Trust	**74.2%**	**75.6%**	**75.9%**	**75.1%**	**86.4%**

This is a very good marker for the level and speed of initial specialist assessment. Swallow screens have to be taught as a competency and are usually only performed by stroke specialist / competent nurses.

This performance at BHH has improved significantly since the introduction of the 24/7 specialist nurse team in June 2013. This is by far the best performing site and provides treatment for the most patients. The performance on the other sites is variable and this affects the overall trust figure. However as a Trust we have exceeded the target for Q2.

What have we done to improve:

Out of hours service moving to BHH has shown improvements in the numbers of patients seen at the site where performance is best managed out of hours.
GHH have had a transition in specialist nursing and this had caused a drop in performance. Two new posts are now in place and are covering 7 days. This has secured an improvement in performance at GHH.

In addition to this the teams on all sites have been informed that rapid assessment of stroke patients in the ED, which will include swallow screens, is a priority.

4. 90% of Stay Spent in a Stroke Unit

What is the measure:
This measure is monitored closely by the performance department and reviewed bimonthly at the Stroke Sub-Directorate meeting. There are plans to make this meeting monthly once stroke becomes a directorate.

How is the priority measured:

This measure is part of our contracts and is reported as a KPI to the commissioners. It is also measured nationally through SSNAP.

Target 80% of patients

Capacity throughout the 3 sites remains challenging which at times directly impacts on the performance to meet this target. Each site needs to continue to focus on keeping specialist capacity free to allow this performance to continue to improve.

Percentage of Patients Spending 90% of stay in a Stroke Unit					
	Q2 13/14	**Q3 13/14**	**Q4 13/14**	**Q1 14/15**	**Q2 14/15**
Heartlands (BHH)	90.0%	91.7%	86.0%	84.9%	84.9%
Good Hope (GHH)	89.6%	85.0%	78.4%	79.8%	76.5%
Solihull (SH)	83.9%	76.2%	79.6%	81.8%	82.9%
Trust	**88.3%**	**83.7%**	**82.2%**	**82.4%**	**81.5%**

These are consistently stable figures that are reasonable but the Trust is aiming for 90% compliance. This is closely associated to the direct admission metric as anyone who has a short length of stay who is not initially admitted to a stroke unit is likely to fail this metric. As previously discussed the current performance on direct admission to a Stroke Unit is poor and this will reduce the figures above. We have managed to maintain performance as a Trust above the target despite an incredibly difficult period in terms of overall bed capacity.

What have we done to improve:

All three sites are aware of the importance of flow from HASU to ASU and looking after stroke patients at all stages of the pathway in stroke specific beds. There have been many initiatives within the Trust to improve patient flow and facilitate discharge for all patients. Engagement with both social services and community health services has helped to reduce the length of stay across the trust for stroke patients to 12.5 days. All this work has improved access to stroke specific beds and ensured that the performance has been maintained.

Future plans to improve compliance against the Trust targets include:

All Hyper Acute Stroke services moving to BHH from SH and GHH with the increased specialist workforce across medicine and nursing is expected to improve the efficiency of the pathway and the quality of treatment received within the first 72 hours. This concentration of expertise should lead to a greater proportion of people being eligible for thrombolysis and it will also ensure that everyone eligible receives the thrombolysis treatment.

BHH is currently the best performance site (due to the 24/7 SSN team) and the performance of GHH and SH will improve as they will need to directly admit very few patients. The new designated HASU will increase capacity in real terms from 12 beds across the three sites to 16 beds at BHH. With the enhanced bed protection policy that will run alongside this, performance must improve.
The Trust reconfiguration will also incorporate timely repatriation and efficient discharge planning using enhanced supported discharge to optimise patient flow and improve the access to Stroke specific beds.

In addition telemedicine will be available very shortly at BHH which will allow the SSN team and consultant on-call to interact with each other more efficiently and effectively.

We are also in the process of separating Stroke on the three sites into a single directorate. One of the intentions of this will be to have absolute control over Stroke bed capacity as a whole.

Finally, the stroke reconfiguration will support efficient discharge planning using a strengthened enhanced supported discharge team to optimise patient flow.

Priority 6: DEMENTIA

What is the measure?

There has been a change in measurement standards for this year's submission, namely;

- S2: Every patient with newly diagnosed dementia to have communication with primary care teams *(changed from every patient with potential dementia to have communication with primary care teams)*.
- S3: 'This is me' tool in nursing notes to be completed by family / carer for every patient with known or newly diagnosed dementia *(changed from joint elderly care medicine and old age psychiatry expertise to be routinely available on all three sites for older people in need)*.

- S4: All elective surgical patients will have dementia screening and where positive delirium information provided *(changed from care of delirium will be standardised and improved).*

After review of the quality account by the dementia strategy steering group the consensus was that the current account would no longer reflect quality of care and therefore changes were made to what was being measured. It was acknowledged that the standards chosen reflected the initial phases of introducing good dementia care. The trust strategy has moved on and these measures will be met as a default. It was therefore felt appropriate to change the standards to better reflect care quality. The changes, particularly the new standard 3, involve measuring activities known to improve dementia care.

Standard	Previous Position	Current Position	Future Aims
S1: Every unplanned admission for a patient aged over 75 to result in querying dementia as a known diagnosis within 72 hours following admission **Target 90%**	In March of 2014, the percentage of all patients aged over 75 years who had been screened following admission to hospital using the dementia screening tool was 69.5%. **Actual 90%**	At present the trust wide performance for dementia screening within 72 hours is at 90% This is now a mandatory requirement at the time of prescribing medication. A robust performance dashboard is in use to monitor performance down to a lead medic level to ensure that this can be pursued where necessary.	Continuation of work with the faculty of education so that all staffs understand the importance of this work in the provision of quality care for patients. Further development of a clear bundle / pathway Further development of ward based metrics system for ward management
S2: Every patient with newly diagnosed dementia to have communication with primary care teams	Standardised advice being given on how to communicate this. It was identified that further work was needed to develop robust data to measure compliance with this target.	Work has been underway to look at integration of Mental Health and acute trust records	Integrate local IT system so information collected or patients with dementia or suspected dementia is automatically passed to primary care Need to improve consultant cover at Solihull site (0.5 wte initially)
S3: 'This is me' tool in nursing notes to be completed by family / carer for every patient with known or newly diagnosed dementia	Sporadic performance mainly driven by relatives and pockets of good practice	A standard document has been developed. This is known to improve the care of patients with dementia. This will be incorporated into the dementia care bundle. The initial completion target will be 90%, 95% after 6 months and then 100%	This is Me to be IT based, travelling with the patient between healthcare providers
S4: All elective	Not done	This is currently not	To use this as a template

surgical patients will have dementia case finding and where positive delirium information provided		done as it is not required of us. It will improve patient care, in particular recognising the risk of worsening cognitive impairment after surgery	for case finding in all patients

How is this priority measured?

S1: Every unplanned admission for a patient aged over 75 to result in querying dementia as a known diagnosis within 72 hours following admission is measured by a dashboard that is able to drill down to specific patient / consultant level for highlighting off track areas. The target is 90% and the current performance is 90%. This has significantly improved since this was made mandatory. This data is discussed at the monthly Dementia Trust Steering Group Meeting.

S2: Every patient with newly diagnosed dementia to have communication with primary care teams is measured by the presence of printed communication in the electronic record. This is currently not measured. The initial target will be 80%, then 90% after 6 months. The measurement will be based on a 3 monthly review of 10% of qualifying notes. The current position is relatively high but this data sits with Birmingham & Solihull Mental Health Trust and cannot be readily measured.

S3: 'This is me' tool in nursing notes to be completed by family / carer for every patient with known or newly diagnosed dementia. Measurement methods will require discussion in the patient pathway work stream of the dementia strategy and the strategy steering group. The initial and six monthly targets are set out above.

S4: All elective surgical patients will have dementia screening and where positive delirium information provided is measured by the extension of current data\ capture tools to elective admissions, reported electronically. Initially the target will be set at 70% with a view to achieving 90% after 6 months.

What have we done to improve:

The case finding standard (S1) is now mandated compulsory and reported both weekly and in real time via IT. The standards of dementia care have been formalised as a trust strategy which has been accepted by the Board. Involving third sector partners, patients and carers there is now a trust standard this is me document.

Future plans for improvement:

The compliance of S1 on the Good Hope site still requires improvement. This is being led by the Associate Medical Director for the Good Hope site. The dementia strategy has been developed into a project brief and work streams, leading to full implementation by 2016.

The main method of improving care and compliance is thought to be staff education. An intensive education plan is being formulated and delivery is in the early stages. This is linked to a number of research projects to ensure the highest quality possible.

Now that the strategy has been agreed by EMB the strategy group will have more time to focus on the targets set out in this plan. This will allow bi-monthly discussions of all targets and robust planning to implement improvement plans.

Priority 7: DISCHARGE

What is the measure: To improve communication relating to discharge arrangements for patients and relatives

What have we done to improve: The Trust has developed an electronic system, called e-Jonah to help staff manage and improve the patient discharge process. This identifies key teams involved in the discharge process for any particular patient and highlights delays or issues leading to unnecessary delays to discharge. The benefits are:

- Improve patient safety and patient experience;
- Timely clinically appropriate discharge;
- Reduced length of stay and readmissions;
- Systematic approach to reducing causes of delay;
- Improved cross boundary communication;
- Improved internal communication;
- Visual management of the pathway;
- Clear escalation process; and
- Bedside to board information identifying constraints.

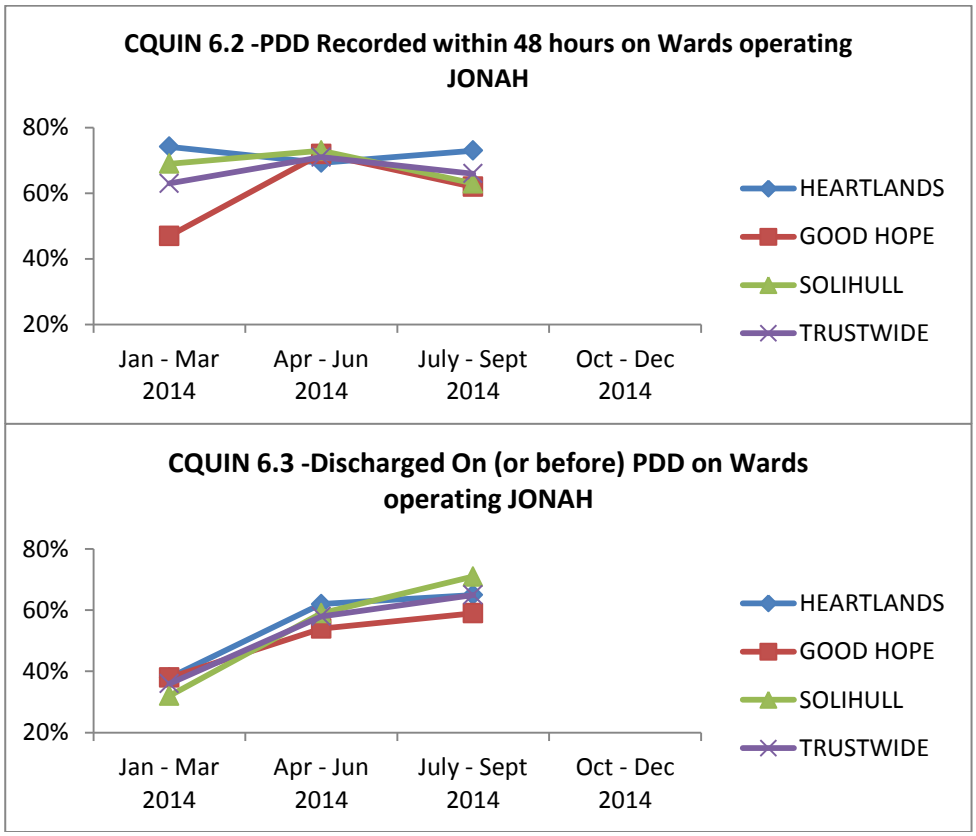
The system is now established across the inpatient areas (excluding paediatrics, maternity and gynaecology) at Birmingham Heartlands Hospital, Good Hope Hospital and Solihull Hospital. Maternity is also currently looking to implement the system at Good Hope Hospital.

How is the priority being measured: This initiative is being monitored by our commissioners through a related CQUIN.

What improvements have been put in place:

- 100% of identified wards across the Trust are utilising the electronic monitoring system;
- % of patients across the Trust who received a PDD (predicted date of discharge) within 48 hours of admission was 47% at the start of the project – current Trust performance is 66%, a slight decrease from Q1- PDD is discussed at site meetings. Reduced compliance was seen at GHH & SH, with a slight increase at BHH. This needs to be re-embedded with ward teams.
- % of patients who went home before or on their D4D (date for discharge) was 19% - current Trust performance is 65%- this is a significant improvement from Q1 of 58%. All 3 sites have seen improvement, with the most improved site being Solihull.
- The Trust made significant investment in to Supervisory Ward Sister status in Oct 2013- 100% compliance of D4D is one of the 10 KPI's, which audit the impact of this role.

The Trust monitors progress against the numbers of patients given a predicted date of discharge within 48 hours of admission and the numbers of patients who go home on or before their date for discharge.



Performance against these indicators reflects that the Trust rolled the system out in a methodical way by site and that the sites were at different stages of embedding the process.

Future plans for improvement:

A significant amount of work has taken place on all 3 sites following a decrease in performance in Q1, which has resulted in all sites now achieving over 80% of patients being spoken to about expected date of discharge. This was achieved by use of SAFER, daily Board rounds, planned discharges for following day, robust site meetings where discharges later in the week are discussed & planned and increased engagement from clinicians & community teams.

A discharge hub is now in place on all 3 sites, where complex discharges are discussed & planned with Multi Disciplinary Team & family, this has had a positive impact on patient & family experience.

Future plans to roll out a 'ticket home system' are currently being discussed.