Heart of England NHS
NHS Foundation Trust

Meeting of the Council of Governors
4.00 – 6.00pm on 26 March 2018
Room 2, The Education Centre,
Birmingham Heartlands Hospital

A G E N D A

		Indicative Timings (minutes)
1.	**Apologies**	1
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3.	**Matters Arising**	5
4.	**Chairs Report and Emerging Issues** (Oral –JS)	5
5.	**Performance Report Update (M11)** (Oral – KB)	15
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7.	**Financial Report Update (M11)** (Oral – JMi)	15
8.	**Quality Improvement Priorities for 2018/19** (Presentation – S Baker)	15
9.	**Chair of CoG Sub-Group Reports** **9.1** Patient Experience Group (TC) **9.1.1** 9 March 2018 - (Oral - TC) **9.1.2** 12 January 2018 (enc. Approved Minutes)	10
10.	**Any Other Business Previously Advised to the Chair**	10
11.	**Next Meeting (Formal – Q4)** – Monday 23 April 2018, Room 2, Education Centre, Birmingham Heartlands Hospital	

EXCLUSION OF THE PRESS AND PUBLIC

The Council of Governors resolved "That representatives of the press and other members of the public, Directors and Non- Executive Directors of the Trust be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted".

12.		10

Light refreshments will be available from 3.00pm when NEDs will be available to Governors

David Burbridge
Interim Director of Corporate Affairs
16 March 2018

Heart of England NHS
NHS Foundation Trust

Council of Governors

Minutes of a meeting of the Council of Governors of Heart of England NHS Foundation Trust held on 19 February 2018 at 4.00pm in the Education Centre, Birmingham Heartlands Hospital

PRESENT: Rt. Hon. J Smith (Chair)

Mr S Baldwin	Mrs V Morgan
Mrs K Bell	Mr G Moynihan
Mr T Cannon	Mr B Orriss
Mrs C Doyle	Cllr M Robinson
Mr A Fletcher	Mrs J Thomas
Mr D Hoey	Mr D Treadwell
Mrs S Hutchings	Mr T Webster
Mr P Johnson	Mr L Williams

IN ATTENDANCE:
Mr K Bolger, interim Deputy Chief Executive – Improvement
Mr D Burbridge, interim Director of Corporate Affairs
Mr A Edwards, Non-executive Director
Mrs M Garbett, acting Chief Nurse
Mrs J Hendley, Non-executive Director
Dr M Kinski, Non-executive Director
Miss K Kneller, Non-executive Director
Miss M Lalani, Non-executive Director
Mr J Miller, interim Finance Director
Dame J Moore, interim Chief Executive Officer
Dr D Rosser, interim Medical Director
Mr L Tallon, Director of Corporate Strategy, Planning & Performance, UHB
Mrs A Hudson, Senior Executive Assistant (Minutes)

18.015 WELCOME and APOLOGIES for ABSENCE

The Chair welcomed everyone to the meeting and in particular, Mr M Kershaw from the Kings Fund, who was observing the meeting,

Apologies for Governors had been received from Mr Fielding, Mrs Passey, Mrs McGeever and Mr Wallis.

Apologies for Directors had been received from Mrs Alexander, Prof Glasby and Prof Sheppard.

18.016 DECLARATIONS OF INTEREST

None

18.017 MINUTES OF PREVIOUS MEETINGS

22 January 2018

The minutes of the meeting held on 22 January 2018 were considered and the

following amendments noted:

18.013.1 Parking – It was the car parking machine at Good Hope, not Solihull, that would not accept payment by card.

18.013.2 Chest Clinic. The first line should read “The Chair of the Hospital Environment Group reported that….”

Subject to the above amendments the minutes were approved as a true record.

18.018 MATTERS ARISING

Charity Board. In response to a question, the Chair reported that, as advised at the last meeting, the Trust had been advised that the skill mix for the new Board of Trustees for the Charity had now been completed and there were three vacancies to be filled, one of which could be filled by a Governor fitting the skill criteria. The three highest ranked skills and expertise had been identified as NHS Knowledge, Media/PR and Medical Research Knowledge. It was agreed that details and requests for expressions of interest would be circulated.

Following further questions, the interim Chair and interim Director of Corporate Affairs advised that it was a decision for the Board of Trustees for the Charity to determine what skills were required. The Charity was an independent organisation and any decisions was a matter for the Charity and it was not up to this Trust to question their decision around what they decided was their required skill mix

18.019 CHAIRS REPORT & EMERGING ISSUES

The Chair reported on the Case for Change transaction process. A small amount of progress had been made but there were still some reassurances required around future finances.

18.020 PERFORMANCE REPORT

The Council of Governors considered the update given by the interim Deputy Chief Executive, Improvement. The report gave an update on the Trust’s performance targets and indicators in the Single Oversight Framework, contractual targets and internal targets.

Performance for the A&E 4 hour wait target had deteriorated in January to 73.99% compared with 76.80% in December 2017 with a decline across both GHH and BHH.

The recruitment of middle grade medical staff and nurses remained a significant issue for ED. The division was exploring recruitment of alternative speciality doctors eg Trauma & Medicine to fill the vacancy gap and provide specialty expertise at the front door to support patient flow. Following a nursing review, recruitment at GHH was now focussed on the right numbers and skill mix, with changes put in place from the beginning of February to assist with turnover.

Following a successful bid for primary care streaming funding, work to add an additional cubicle space and a nurse assessment station in Minors to support patient flow on the BHH site was underway, resulting in children no longer arriving through the adult ED entrance. Funding had also supported

improvements to GP streaming/navigation to create additional clinical assessment capacity on the GHH site that would be operational from 1st February.

18 Week Referral to Treatment incomplete pathway performance had not been achieved for the second consecutive month. There were 5 specialities that had failed to meet the target in month. The admitted backlog had increased further from last month mainly due to surgical day case and elective capacity constraints. Increased in-patient capacity was being utilised where available, with the use of the Private sector continuing for T&O.

The Trust met all national cancer targets in December 2017, with the exception of the 62 day national screening.

In December, the Trust had been accountable for 6 patients who had been treated in excess of 104 days from referral; 3 patients had been late tertiary referrals, 2 patients had been referred late to another provider and 1 patient had to undergo multiple investigations due to difficulties in diagnosis.

The Trust met the target in January for patients waiting 6 weeks for 15 key diagnostic tests.

Of the 18 national targets not included as Operational Performance Metrics in the new Single Oversight Framework but which are included in the CCG contract, the Trust was on target to achieve all 18.

Ambulance Handover. The IT supplier, Ideagen, had been unable to meet the current deadline to re-establish the check field in Patient First (the ED tracking system), resulting in the ECDS “fix” being delayed until the first week of March, with reporting due to recommence from 7th March 18. There had been 32 confirmed 60 minute breaches (99.58%) for December, against a required threshold of 99%.

There had been 3 sleeping accommodation breaches reported in January that had affected 13 patients in AMU at GHH; decisions had been made in the best interest of the patients.

The Trust had achieved the DTOC target for January at 1.23% against a target of 1.4%.

Performance against the Information Governance Mandatory Training target of 95% had decreased in month, achieving 82.17% in January. All managers had been asked to agree dates for training with all non-compliant staff members.

Appraisal completion rates had improved slightly in January to 87.93%, which was above the 85% CCG target. An internal target of 90% had been agreed and plans were being reviewed with divisions to improve performance.

Trust turnover rates had reduced in January to 10.39%. Year to date performance for the completion of the online exit monitoring tool stood at 30.63%.

Sickness absence rates for December had risen to 5.59% which was higher than December 2016 (4.25%) and expect it to be higher in January too.

The Chair opened the floor to questions.

In response to a question whether patients who had their elective surgery cancelled would go to the back of the queue, the interim Deputy CEO-Improvement reported that this would not be the case. Any delay would unfortunately affect new patients rather than those who had their appointments cancelled.

There was a discussion regarding the information via the new BBC Tracker App where figures were available regionally and nationally. It had been noted that attendance went up in December and, in response to a question, it was reported that there were 724 attendances to ED at GHH compared to 717 last year. The ED at GHH had limited capacity due to its size. What had increased significantly was the acuity and the age demographic of patients with a rise in the number of patients over 75 and 85. In answer to whether the data compared volume, it was noted that each Trust would have different demographics.

In percentage terms, the number of agency middle grade doctors used by the Trust was approximately 50%.

In response to what work was happening to attract candidates to the Trust, it was reported that a considerable amount of work was being undertaken with the consultant teams trying to fill gaps as well as looking at recruiting international trainees

The Director of Corporate Strategy, Planning & Performance reported that the national A&E target had improved slightly in January and that the Trust was not going against the national trend for A&E attendances and performance.

The interim Deputy CEO - Improvement reported that the Trust had not cancelled all elective surgery, cancer operations had been protected.

In response to a question on staff sickness rates and how the Trust compared to other trusts within the region and whether there was any correlation between winter pressures and the use of bank staff to cover. It was reported that there was not however it was hard to fill bank shifts.

There had been 66 patients with confirmed influenza, which did not constitute an epidemic.

Resolved – the report was received.

18.021 CARE QUALITY REPORT

The Council of Governors considered the update given by the acting Chief Nurse.

The report provided an update on performance against the key indicators in the Single Oversight Framework, in addition to contractual and internal targets. There had been three cases of MRSA in month. There had been four cases of post 48 hour C.diff reported in January 2018. This was within the Trust monthly trajectory of six. The total number of cases reported this year was 51 against a YTD trajectory of 53 cases and an annual trajectory of 64 cases.

There had been an increased number of patients presenting with influenza, with the Trust having 66 patients with confirmed influenza.

There had been an outbreak of norovirus affecting one bay on the Day Case Unit at Good Hope Hospital.

There had been 11 avoidable grade 2 pressure ulcers reported in December 2017. The Trust had reported a total of 71 avoidable grade 2 pressure ulcers year to date against a trajectory of no more than 102 for the year. The Trust was currently on target to achieve the required 10% reduction in avoidable Grade 2 pressure ulcers.

There had been one avoidable grade 3 pressure ulcer which affected a patient within the community reported in December 2017. A total of nine avoidable grade 3 pressure ulcers had been reported year to date against an annual trajectory of 36. The Trust was currently on target to achieve the required 10% reduction in avoidable grade 3 pressure ulcers. There had been no grade 4 pressure ulcers in December.

Dementia screening performance for January 2018 was 82.26% against the Trust Target of 90%.

Compliance against the Parkinson's medication indicator had remained fairly static at around 80-82%. However, a decline had been seen over the last four months. Performance in January 2018 showed that the Trust was non-compliant at 70.55%. The CoG received a briefing on the findings of the review that had been undertaken and were reassured that there had been no harm to patients. The complexities involved in the prescribing system included the recording the data, reasons for late patient dosing included patient refusal, patients nil by mouth, as well as the impact on subsequent doses due to the initial dose being given late were explained

The Trust has not achieved the required 80% antibiotic STAT dose target for the third consecutive month. Performance showed that the Trust was non-compliant for January with 78.80% of Antibiotic STAT doses administered within one hour. The Trust was looking at the detail behind the data including how many patients it affected and if any harm had resulted.

UNIFY nurse staffing. Paediatrics was the only red rated division for qualified staffing. This had related to the Neonatal Units (NNU) at Birmingham Heartlands and Good Hope Hospitals, skill mix had been altered on a shift by shift basis to ensure safety was maintained at all times.

There had been 352 WTE qualified vacancies in December 2017 which had risen to 380 WTE in January 2018, an increase of 28 WTE.

Recruitment. There were 69 planned Band 5 qualified nurses due to start across February and March 2018. A Trust wide HCA recruitment event had been held on Saturday 17th February 2018, where interviews and offers made to 34 HCAs and 8 Band 5 positions. Recruitment was underway for the next cohort of 25 Trainee Nursing Associates to commence in April 2018. The Trust was looking at different ways to target recruitment into challenging areas such as Theatres and Elderly Care

The complaints performance for December 2017 was 78% of received complaints having a response within 30 working days. The final validated position for November 2017 was confirmed at 74%.

The Chair opened the floor to questions.

In response to a question as to what the strategy and plan was to ensure that

Parkinson medication was given on time, the acting Chief Nurse reported that all medication should be given in a timely manner, not just Parkinson medication. New e-prescribing technology would assist in this, as would ensuring that all agency staff were appropriately trained.

It was confirmed that wards had appropriate stocks of medicines available.

The acting Chief Nurse reported that the Associate Head Nurse in Corporate Nursing was responsible for the management of the career stand at recruitment events. In response to whether it would be appropriate for a Governor to attend, it was confirmed that all offers were gratefully accepted and the Lead Governor and acting Chief Nurse would meet to discuss outside of the meeting.

In response to a question on the proportion and grades of staff leaving, the acting Chief Nurse reported that division 3 had the highest number of leavers with 3 from ED at GHH and 3 in AMU at Solihull. Where bank staffing were used to fill vacancies, if the right grade of staff was not available then wards would use the grade nearest the vacancy to fill the post, but remuneration would only be paid at the grade that was filled, ie where a grade 6 member of staff covered a grade 5 vacancy they would be paid as a grade 5.

The acting Chief Nurse, in answer to a question as to whether the Trust was monitoring the reasons for leaving, confirmed that it did. The main themes were promotion, relocation, education. How the Trust could improve retention was been considered as part of education strategy.

Resolved the report was received.

18.022 FINANCE REPORT

The Council of Governors considered the update given by the interim Director of Finance. The Trust had agreed a planned deficit of (£28.8m) pre Sustainability and Transformation Funding (STF) for the 2017/18 financial year. The full STF allocation for the Trust was £21.3m subject to financial performance. Of this, 30% (£6.4m) was tied to A&E performance. Including the full STF, the Trust had a planned deficit of (£7.5m) for the year in line with the control total required by NHSI.

The in-month position was a deficit of (£6.0m) against a planned deficit pre STF of (£2.4m), an adverse variance of (£3.6m) that was around (£1.0m) worse than recent months due to the cancellation of all routine elective surgery during January. The year to date position at month 10 was a deficit of (£49.0m) against a planned deficit pre-STF of (£24.1m), an adverse variance of (£24.9m). The reported position excluded the allocation of STF for the year to date due to the adverse financial position against the plan. A revised year end forecast of (£48.4m) had been submitted and accepted by NHSI at Q2.

In December 2017, the Trust received confirmation that it would receive £4.2m of non-recurrent winter funding. Of this, £2.2m was to meet existing winter costs, with the expectation that the forecast improved 2m was to cover existing winter costs and therefore the forecast has reduced to (£46.2m). The other £2.0m was for additional service provision to improve performance against the 4 hour target. However the funding had yet to be received.

The year to date position included £2.0m of winter funding. The year-end position would be worse than forecast due to the under-performance against Healthcare

Income targets, largely as a result of operational pressures.

Given the year to date position, the revised forecast was very unlikely to be achieved. This was due to the deterioration in activity driven healthcare income which was (£12.8m) below plan YTD. The forecast had been produced at M5 when it was only (£2.5m) and made explicit the assumption that it would recover in line with plan. Outpatient income was £0.1m in month / £1.9m YTD a recovery from the December dip. CIP slippage was (£0.5m) in month / (£3.1m) YTD. The Financial Recovery Plan / Stretch was (£0.1m) in month / (£4.5m) YTD.

The Trust's cash balance was £8.2m which included a working capital loan of £22.4m. Capital expenditure was £10.3m against a YTD plan of £16.6m; a further £2m of orders had been raised at 31 January. The finance and Use of resources rating remained a 4 in month as the Trust was now slightly above its agency cap due to winter costs.

The interim Director of Finance reported that in terms of context, although Q3 results had yet to be released there had been some significant deficits announced in the last 3 weeks including Portsmouth with a £47m deterioration; Mid Essex reporting a £36m deterioration / (£55m deficit) on £310m turnover (18%); Norfolk and Norwich a £30m deterioration and Kings with a potential (£150m) deficit / (£223m) in year borrowing requirement.

The Chair opened the floor to questions.

In response to a question whether, the poor performance at GHH been due to staff fatigue, it was reported that this was not the case but rather the acuity of patients attending.

In response to the impact on the Trust's financial situation and whether it would receive recompense for the income lost due to the instruction by NHSI to cancel all elective surgery, the interim CEO reported that it was still not known.

The CoG congratulated the Board and noted the progress made by the Trust in its financial recovery since the leadership intervention. The interim Director of Finance reported that the current financial position had been due to the increase in winter pressures and the loss of income from the cancellation of elective work rather than spending.

The interim CEO reported that the Trust could have taken a slower trajectory to achieve financial balance but it would still have reached the current situation. The CoG was reminded that the Trust had achieved a 2.2% efficiency saving this year.

In answer to whether all winter flexed beds had been opened across each of the Trust sites, and whether the Trust had received any additional income for the additional capacity, it was confirmed that all available beds were open on each of the sites. The Trust received income for additional emergency work at 70% of normal tariff rate; as well as income for excess bed days but it was conditional.

Resolved the report was received.

18.022.1 DRAFT FINANCIAL PLAN 2018/19

The Council of Governors received an update from the interim Director of Finance on discussion that had taken place at the Board meeting earlier that day

around the work being undertaken on the draft financial plan and control totals for 2018/19. NHSI had issued the planning guidance for 2018/19 in February 2018 setting out that providers were required to refresh year 2 of the previous 2 year plans and submit an updated draft plan for 2018/19 by 8 March and a final Board certified plan by 30 April.

The key headlines in the guidance were that £650m of the £1.6bn new revenue had been allocated to providers. There was no separate winter money allocation in 2018/19 resulting in £335m being removed and added to existing STF rather than fed back into prices. The STF has been renamed Provider Sustainability Fund (PSF). The same rules around performance applied i.e 30% based on ED with 90% rising to 95% by end of March 2018. RTT – there was an expectation that the total waiting list at March 2019 would not exceed that in March 2018. There would be closer STP working. There would be an alignment of commissioner and provider activity and income plans, not just contracts. HEFT's PSF had increased by £8.7m to £30m. In order to earn this the Trust had to deliver a control total surplus of £9.4m (up £8.8m from the original £0.6m surplus).

NHSI had written to the Trust setting out the revised financial control totals for 2018/19 plan that resulted in a maximum deficit before STF of (£20.6m). The Trust had responded to that letter on 9 February, but to date no feedback had yet been received.

The interim Director of Finance reported that the overall position projected a deficit of (£63.5m) vs (£58.3m) forecast for 2017/18, a gap of £42.9m to control total which would result in a total efficiency of £58.5m / 8.4% of turnover to hit the control total.

It was apparent that control totals had been set nationally with no regard for current performance. This would be a huge problem for any provider who was currently not meeting their control total on a recurrent basis, including Kings, Barts, Oxford, HEFT, Portsmouth, North Midlands, Worcester, Mid Essex, Norfolk, etc.

The Trust had begun work on the draft plan that was required to be submitted by the 8 March with a further final plan submission on 30 April.

The CoG was informed that the planning exercise had been based on HEFT continuing as a standalone organisation and as a result it was likely that an additional working capital of £60m would be required in 2018/19 due to the ongoing deficit.

The draft capital plan 2018/19 was £16m before ACAD, with an expected spend of £17.3m the total value was proposed at £33.3m, £16m of which was internally funded capital. There was £9.3m currently prioritised for spending.

The Board had held an in-depth discussion at its meeting earlier that day on whether it accepted the proposed control total for 2018/19, the impact of declining the proposed control total and the caveats required to accept the control total. There had been acknowledgment of the progress made in respect of its performance, and that it was achieving all of its targets with the exception of the A&E target.

Should the Trust decide to decline the proposed control total, it would be subject to financial penalisation eg higher interest charges for the additional working

capital borrowing, it would have no access to PSF funding, commissioner fines regimes would be fully applied and it would have restricted access to discretional capital allocations and potential regulatory impacts.

The Chair opened the floor to questions.

It was considered that the government was setting trusts up to fail and it was questioned whether the general public understood the problems that the NHS was facing in its financial challenges. The interim Chair believed that the public did understand some of the pressures that the NHS faced. She went on to state that she sat on the Chairs Advisory Board for NHSI who were also of the view that the control total regime did not function properly.

Following an observation, the interim CEO stated that one of the reasons for not being wanting to sign up to the 8% savings proposed was the impact that it would have on patient safety.

The interim Chair and interim CEO reported that they would be meeting with the Chair and CEO from NHSI to gain further clarification and discuss the situation and affect the proposals would have on the proposed transaction.

The Chair summed up the discussion and noted that the Board had concluded that there seemed little alternative to accept the control totals 2018/19, if it did not agree to sign up to the plan it would be heavily penalised. It would however heavily caveat the acceptance of the proposed control totals for 2018/19

Resolved the report was received.

18.023 QUALITY ACCOUNT PRIORITIES FOR 2018/19

The Council of Governors considered and discussed the presentation given by the Quality Support Manager, Samantha Baker. It was noted that the Quality Account was part of the Trust annual report. The HEFT 2016/17 Quality Account was subject to internal review, external consultation and assurance from KPMG, the External Auditors, who were required to provide limited assurance on two mandated indictors: A&E – 4 hour waiting times and SHMI – a measure of mortality rate, however these were still tentative and subject to change.

The report's content was subject to national guidance. The External Auditors were required to provide a private report to the Board and CoG on one local indicator that had been proposed by the Trust and discussed and agreed by the CoG.

The focus of the audit for the local indicator would be Data Quality and it was recommended that, for maximum value, it should be a genuine marker of high quality care or patient experience, and affected a large number of patients. The 2016/17 audit had been "Stat dose of IV antibiotics".

Following discussions held with executive colleagues including the interim Medical Director and the acting Chief Nurse, it was proposed that the new indicator for audit for 2017/18 should be:

- Number of pressure ulcers that are
  - Grade 2
  - Hospital-acquired
  - Non-device related

– avoidable

The reasoning behind the proposed indicator was that pressure ulcers could affect patients from all specialities, impact on quality of life and affect a patient's length of stay. By choosing grade 2 pressure ulcers as a priority it would reduce the incidence of grade 3 and 4 ulcers.

It had been agreed that both HEFT and UHB would audit the same local indicator which would allow staff to compare processes.

It was reported that the Quality Improvement Priorities for 2018/19 were still under discussion and proposals would be presented to the March meeting of the CoG.

The Chair opened the floor to discussion and questions.

It was confirmed that the same recommendation for local indicator audit would be presented to the UHB CoG later that week.

There was concern expressed around the level of expertise and quality of the external auditors (KPMG) given the recent media reports around Carillion. The interim Director of Finance reported that Governors were able to register any concerns they may have. The meeting was reminded that the current external auditors had been appointed through a rigorous appointments process by the CoG Audit Appointments Committee. Mrs Hendley, NED and ex-Partner of KPMG reported that investigations undertaken had now found anything against them. It was more a question of how they conducted their due diligence and what questions were asked.

Following due consideration and discussion, the Council of Governors agreed the proposed recommendation.

Resolved: to receive the presentation
To agree Grade 2 pressure ulcers be selected for audit.

18.024 AUDIT COMMITTEE TERMS OF REFERENCE

The Council of Governors considered the report presented by the interim Director of Corporate Affairs. In line with best practice, the Audit Committee has undertaken an annual review of its Terms of Reference and these have been updated to reflect changes in some Directors job titles and any references to 'Monitor' have been replaced with 'NHSI'. There has been no change in the FT Code of Governance (last updated in July 2014) which would necessitate a further change to the Terms of Reference.

Since the composition and remit of the Audit Committee had remained the same, the Audit Committee had considered and approved the changes at its meeting on 22 January 2018 and they were then presented to the Board for their consideration and they duly approved them at their meeting 22 January.

The Council of Governors were asked to receive the approved Audit Committee Terms of Reference.

Resolved: To receive the approved Audit Committee Terms of Reference.

18.025 REPORT FROM CoG SUB-GROUPS

18.025.1 HOSPITAL ENVIRONMENT GROUP

The Council of Governors considered the report presented by the Chair of the Hospital Environment Group. The Group had met on the 25 January 2018 at GHH where they had undertaken visits to the Treatment Centre and the Orchard Restaurant. It was reported that the roof of the building behind the restaurant had now been cleared of growth, but the restaurant roof was still to be cleared.

The walkaround of the Treatment centre had found some concerns including patient feedback that signage to the 'pods' needed improvement and the water dispenser drip trays needed regular emptying. Following feedback, these had been actioned.

Following the visit to the Chest Clinic, regular weekly meetings were being held with the estates teams to address the log of outstanding issues.

The outstanding PLACE inspections would recommence in March. There had been concern raised on how the HEG could monitor progress against actions raised by the previous inspections and the Director of Asset Management had agreed to provide a list of works requiring capital funding. It had also being agreed that when estates were undertaking maintenance works the PLACE log would be reviewed to see if any outstanding works could be undertaken at the same time. The HEG continued to consider how it could progress and monitor actions and the Deputy CEO – Improvement agreed to meet with the Chair of HEG outside of the meeting to discuss.

The Chair opened the floor to questions.

Governors were pleased to hear that the growth from the roof of the building behind the orchard restaurant had been cleared.

The Deputy CEO – Improvement's intervention in ensuring works were progressed was appreciated.

23 November 2017

The minutes of the meeting held on 23 November were received.

Resolved: The report was received.

18.026 ANY OTHER BUSINESS PREVIOUSLY ADVISED TO THE CHAIR

18.026.1 **HR Processes for new starters.** This question was raised following an issue at Worcester when a surgeon had been employed on the understanding that they had undertaken operations and who had, in fact, had no experience of doing so. The question was raised as to who checked credentials for new recruits and what the procedure for doing so was. The interim Medical Director reported that the Trust did not check on the number of operations undertaken as Consultants were normally signed off when they were competent. The consultant concerned had lied about operations he had done.

All job offers were conditional on references. References followed a structured procedure with referees receiving specific details of the post offered. At consultant level, references would also be obtained from the Medical Director of

the candidates' current organisation plus three additional references.

The fact that patients came to harm showed a failure in the governance processes at the trust concerned, including induction, supervision and training as well as intervention.

HEFT followed a structured process for all patients who were listed for surgery including multiple disciplinary team meetings, as well assurance in the level of supervision and surveillance of new consultants. Where there was any doubt in a Consultants capability, they would be removed from operating with immediate effect.

18.026.2 **Mike Kinski NED.** The Chair reported that Dr Kinski, NED would be leaving the Trust on 28 February and formally recorded a vote of thanks for his contribution during his term of office.

17.027 DATE OF THE NEXT MEETING

The next meeting (focus) was scheduled for 26 March 2018 in the Education Centre, Birmingham Heartlands Hospital.

There being no further business the meeting closed at 5.50pm.

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Chair

Heart of England NHS
NHS Foundation Trust

Minutes of a meeting of the
Patient & Staff Experience Group of the Council of Governors
of Heart of England NHS Foundation Trust
held on Friday 12th January 2018 at 12.30pm
in the Boardroom, Devon House, Birmingham Heartlands Hospital

PRESENT:	**CANNON, Antony (AC)**	**Chair (and Chair of the GHH PCP)**
	BALDWIN, Stan (SB)	Governor
	CHAPLIN, Dawn (DC)	Head Nurse, Patient Experience
	FIELDING, Keith (KF)	Governor
	GARBETT, Margaret (MG)	Interim Chief Nurse
	HUTCHINGS, Susan (SH)	Governor
	KNELLER, Karen (KK)	Associated NED
	THOMAS, Jean (JT)	Governor
	WEBSTER, Thomas (TW)	Governor
IN ATTENDANCE:	BALDWIN, Alan (AB)	Matron for Outpatients
	EMERY, Jamie (JE)	Head of Patient Services & Engagement
	EVANS, Helen (HE)	Group Manager for Outpatients - Access Booking & Choice
	GREENWAY, Sandra (SG)	Information Governance Officer
	HOBDAY, Fiona (FH)	Information Governance Lead
	RUDGE, Kevin (KR)	Chair of the SH PCP
MINUTES:	HIGGINS, Vickie (VFH)	Executive Assistant

18.001 Welcome

AC welcomed everyone to today's meeting. Introductions were made around the table and MG introduced herself as HEFT's new Interim Chief Nurse, replacing Julie Tunney.

18.002 Apologies for Absence

Apologies were received from Louise Passey.

18.003 Minutes of the Previous Meeting

After two minor amendments, the minutes of the meeting held on Friday 17th November 2017 were agreed as an accurate record and have been forwarded onto Angela Hudson.

18.004 Matters Arising

Patient Passport:-

AC gave a brief background. Drafts had been approved and were sent to UHB to produce. However, UHB has a similar document for patients with learning disabilities at QEHB. This will be picked up at the next meeting. **Action : MG and DC to discuss.**

Incident at BHH:-

JE advised there was CCTV footage, so this was now a police matter and was being followed-up.

Drop-In at Birmingham Chest Clinic:-

With regard to paperwork, this was usually brought to the pre-meet by the Lead, who had all the facts and data. After the walkabout, they would regroup to discuss the issues and a report and action plan was circulated afterwards, which was sent to the ward.

At Birmingham Chest Clinic, JE felt staff and team morale was good but they were under severe pressure to maintain the service while the building renovations were carried out. This had been picked up by AC/SH and escalated to John Sellars, Kevin Bolger and MG. SH, as Chair of the CoG Environment Committee, stated she was still waiting for a reply from John Sellars.

18.005 Update : Recovery of Prescription Charges

Unfortunately, Shahzad Razaq did not attend today's meeting. VFH has emailed him (and copied in Tania Carruthers, Pharmacy Clinical Director) to ask why but he has not yet responded.

18.006 Appointments System & Text Reminder Service

SH had recently read a newspaper article stating there were over 8 million missed appointments last year. However, when people called in about their appointment, they could be told they were "32nd in the queue", then "31st in the queue", then "24th in the queue" and so on - people did not want to wait and hung up.

Helen Evans (Group Manager for Outpatients Access Booking & Choice) and Alan Baldwin (Matron for Outpatients) joined the meeting.

HE gave a background of the appointments system, where appointments were made either by GP manual referral, electronically via NHS.NET or electronic referral services (DBS Choose and Book). However, since October 2017, the only route was via the electronic referral system where the GP or patient could go online to book their own appointment and appointment centre - i.e. date, time and site. This should alleviate DNAs and they were working with NHS England and NHSI.

HE advised clinics were planned six weeks ahead and appointment letters sent out.at four weeks. At this point clinics should be fixed but could be changed due to sickness, compassionate leave, Coroners meetings, weather, etc. Letters concerning changes were sent out to patients, who could respond either via email, posting back the slip attached to the letter or via telephone.

Their offices at Lyndon Place had recently moved to Yardley Green Road (during Christmas), which had taken two weeks and they were now in a different environment and were adjusting to their new surroundings. Since Christmas, call waits had dropped and were being closely monitored. KPIs were set and they could add extra staff, if required.

HE advised patients were reminded of their appointment two weeks before by telephone - either by staff or an automated service. If they wished to cancel, there was a number to press to call to rearrange. HEFT does not have a text reminder service but UHB does, so they were working with them to introduce it here. HEFT's DNAs were currently at 10.2% and BHH was the highest. A recent audit showed this was not always due to the patient - i.e. no car parking on the day, etc.

They were looking at a project for off-site letter printing - i.e. for letters sent by 6.00pm, there was a guaranteed delivery of two working days, tracked and via second class, in an "NHS" envelope to alert patients. Lots of work was being done and they were also looking at opening Saturday mornings. They currently work to 5.30pm on a Friday but receive lots of calls after this time, so most are not called back until Monday morning. They receive around 4,500 to 5,000 calls per week.

HE advised, for urgent appointments, they could not leave a message due to data protection. They had to leave a generic message stating the call was regarding an appointment. For cancer patients, they received a text asking them to contact us to confirm their appointment.

MG felt if a patient heard they were 32nd in the queue, they would not wait and suggested they alter the automated message. AC suggested advising of the current approximate waiting time - i.e. five minutes was better than being 32nd in the queue. HE will investigate this.

KF asked about referrals only being online and via the doctor or patient and asked about those without access. HE advised the GP could make appointments online or there was a national telephone number. MG advised initial referrals arrived online via GPs and HE advised this was more efficient for the patient and, when called, they had the choice of site, date and time.

KK asked about four-week follow-ups, with the annual leave of a doctor coming before the patient. HE advised they would look at annual leave and move appointments forwards or backwards to the next available appointment, which was why letters were only sent out four weeks before the appointment.

AC felt if a patient could not make an appointment, they would try to reschedule, only to be told the Clinician was fully booked. HE would expect patients to be rescheduled at the time, but the next appointment could be three or four months ahead - at which point, some patients would try to keep their original appointment.

SB asked why they could not say they were from the NHS when they called a patient and HE advised this was due to data protection and Information Governance. They had to confirm who they were speaking to, but they could also gain the patient's consent to speak to someone else.

KK asked if BHH's DNAs were higher due to demographics. HE discussed the region's ethnicity and patients at GHH and SH being more affluent and better at keeping appointments but older. BHH also had interpretation issues. KK discussed cultural issues and HE felt BHH's paediatric patients' DNA was due to the child getting better.

MG asked about specific clinics and HE agreed some had higher DNA rates - i.e. patients with chronic conditions (renal and diabetes) and being ill on the day. The DNA policy stated if this was the first DNA, they could discharge the patient back to the GP only if it was safe to do so and after reviewing the notes. For follow-ups, it was the Clinicians' decision whether another appointment was made.

JT asked about DNAs affecting other appointments and the financial implications. HE advised they did not make patients pay and often overbooked clinics to ensure they were full on the day. However, if, for example, there were four DNAs in the middle of the day, the Consultant could be left waiting. It had been suggested they put the cost of DNAs in the letter. Also, they had previously put posters in clinical areas advising of the cost of DNAs and what this could have paid for - i.e. extra nurses. They could also put posters in GP surgeries.

JT asked how patients cancelled appointments and HE advised there is a yellow box at the top of the letter with details of how to do this - i.e. via telephone, fax or returning the slip at the bottom. They could benefit from being able to go via the Internet but not all patients had access. They tried to ensure appointments were communicated well and gave reasonable notice and felt they could not do any more. Patients who DNA could be discharged back to their GP (after reviewing their notes), so the GP would then need to contact the patient.

HE discussed UltraGenda and they were looking at centralising the systems for all areas. HEFT was better than other areas, with DNAs currently at 10% (previously, this was 14.75%). December 2017 had gone down to 9.83%, possibly due to the snow. There were around 900,000 outpatient appointments each year, across the three sites and BCC. SH was at 9.5% and GHH at 8.8%. SB asked if they had a percentage of how many appointments were cancelled by the Trust, but HE did not have this information.

Day Surgery was discussed and the policy of having all patients report at 8:00am. AC stated (from personal experience) that patients would arrive at 8.00am, wait all morning and then go home in frustration when told they were last on the list. Would this show as a DNA? HE advised it would not as the patient had been admitted. They are looking at staggering their admissions in line with what is done at UHB and the new ACAD building will also help.

18.007 Feedback / Verbal Reports from PCP Meetings

SH - KR advised their recent meeting was cancelled due to low attendance.

JE advised meetings were cancelled due to site pressures. AC advised of two generic emails he and other PCP members had received, stating nonessential meetings were to be cancelled. AC felt saying “nonessential” was not good practice. DC agreed to discuss this further with JE.

18.008 Patient Experience Dashboard

Unfortunately, the dashboard was unavailable for today’s meeting.

18.009 Update : Information Governance

FH and SG introduced themselves to the Group and FH advised she was Head of Information Governance (“IG”) at HEFT, covering all sites but based at BHH. They were to discuss the document; “Fair Processing Notice for Patients : Data Protection and Confidentiality” (tabled).

FH advised IG had lots of engagement with staff in relation to patient information around IG and dealt with internal training, security and safeguarding personal data. HEFT is legally obligated to supply information about what it does with personal data - i.e. where it is stored, shared, etc. This document is a legal requirement outlining who we are, what is our purpose, where the data is used, etc. This is known as a Fair Processing Notice. The current notice dated March 2017 is on the Trust website and needs to be reviewed in three/four months’ time due to new Data Protection legislation, which increases requirements.

FH advised a new draft was being drawn up via national guidance and the new document will be circulated through relevant groups for their view and input. It is important the document makes sense and is accessible to patients. FH asked whether it would be appropriate to circulate the new version through this Group and is looking for suggestions on how it can be improved or made more user-friendly. This is difficult as it is a legal document and HEFT is mandated to include certain information but the language should be as accessible as possible.

FH felt the document was not currently as accessible or publicised as it could be. Clinics should be printing it out from PAID and giving it to their patients. It should also be printed and left on reception desks in outpatient areas. FH advised she is looking into a way where our systems automatically send it out when a patient is referred or has a new episode of care, so we are being open. It could go out with the initial appointment contact letter and also appear on the website and was being reviewed in collaboration with UHB's IG Team due to the merger plans but this would also enable the message to be consistent across a large part of the region. FH asked if the Group had any thoughts, ideas or suggestions as to how to improve patient engagement.

KF asked a question in relation to GDPR and if we had to be fully compliant by 1st May 2018. FH advised some elements of GDPR were easy for the NHS as we already had to do them - i.e. reporting data breaches - but other areas required a lot of work. FH advised her view, based on attendance at conferences and ICO guidance, was that HEFT must ensure it has an action plan in place, be working toward compliance and show it was being proactive but it was not unreasonable to recognise that work would continue after May 2018. The ICO is generally very pragmatic and likely to accept it was ongoing, subject to the previous information. There is also a UK DP Bill, which will sit alongside GDPR and is going through the House of Lords, so there is a lot of change coming this year.

SB advised it needed to be easy to read and recommended the 'Plain English Organisation' (www.plainenglish.co.uk). KK agreed it needed an 'easy read' approach.

AC discussed primary care, information sharing, opting out and holding personal data for commercial purpose and queried if this document should contain an 'opt out' or 'opt in' for patients attending hospital. FH advised that consent was not the only legal basis for using personal data and, for provision of direct care/medical purposes, consent is not needed, for example, patients coming through the Emergency Department, data will be shared to treat them. ED staff did not have to reply on explicit consent. With the GDPR, this legal basis was now clearer. We offer choice where consent is the legal basis but not when there was a direct care purpose as we cannot treat people without information.

AC asked about the definition of personal data and clinical data and the degree of sharing data. FH advised the general principle with information sharing was to share the minimal amount of information necessary for staff to do their job but it depends on the purpose and legal basis. This was a very clear principle, even when dealing with the police. FH provided a police example - i.e. the victim - on a case-by-case basis with consent where possible and the offender - i.e. if there were burns and the case was around arson may be released without consent; it depends. Where necessary, cases are reviewed by a clinical member of staff and only minimal information given - i.e. a name and address - and not clinical information - i.e. if the patient is in a coma. The Clinician looks at what is minimal and what is necessary on a case-by-case assessment, being clear on what data needs to be shared to fulfil the purpose. Clinical staff do this every day as part of decision making and will have a good approach to this.

AC felt the document was currently too complex, it was appropriate to be brought to this Group and suggested the PCPs may also like to review and comment.

FH advised legislation stated what is or could be identified from the data was classed as personal identifiable. If the patient can or possibly be identified, then it was personal data. The new definition also includes new areas such as IP addresses.

18.010 Any Other Business

18.010.1 Newspaper Article - "Birmingham Mail", Wednesday 10th January 2018

SH showed the Group a recent press article (see Appendix), complimenting various staff at BHH. DC agreed to forward this on.

JT asked who any future articles should be sent to and DC advised it was herself or MG. AC agreed these should be circulated and would be appreciated by the patients.

18.011 Confirmation of the Next Meeting

The next meeting will take place on Friday 9th March 2018 at 10.30am in the Boardroom, Devon House, Birmingham Heartlands Hospital.

Heart of England NHS
NHS Foundation Trust

PATIENT & STAFF EXPERIENCE GROUP OF THE COUNCIL OF GOVERNORS

Schedule of Matters Brought Forward and Action Points

Date Raised	Minute Number	Detail	Action	Due	Status	Completed
14Jul17	17.039	Dawn Chaplin to arrange meeting with Shropshire Community Health NHS Trust and obtain more copies of the "Observe & Act Course Handbook".	DC	09Mar18	Ongoing - met on 06Dec17 and currently discussing with UHB.	
15Sep17	17.048	Shahzad Razaq to be invited to attend future meeting to give an update on the recovery of prescription charges.	VFH	12Jan18	Invited to attend the next meeting. Did not attend. VFH to chase.	
15Sep17	17.052	Dawn Chaplin to action amendments to the Governor Drop-In Survey Form.	DC	27Sep17	Ongoing.	
17Nov17	17.064	Helen Evans and/or Alan Baldwin to be invited to attend the next meeting to discuss the appointments system.	VFH	12Jan18		**12Jan18**
17Nov17	17.065	Antony Cannon to talk to Mike Hammond, QEHB Charity, with regard to a possible trial of lockers in dementia wards.	AC	09Mar18	Ongoing.	
12Jan18	18.004	Margaret Garbett and Dawn Chaplin to discuss the Patient Passport document.	MG/DC	09Mar18		

Appendix

birminghammail.co.uk PEC 18.010.1 (Tabled)
WEDNESDAY, JANUARY 10, 2018 BIRMINGHAM MAIL 5

News

Brilliant A&E staff saved Ellie after measles struck

By JOSH LAYTON
News Reporter
jchlayton@birdymirror.com

A BIRMINGHAM mum has praised Heartlands Hospital for quickly treating a rare case of measles that left her daughter so poorly she feared she would die.

Debbie Roscoe drove Ellie to A&E after her temperature soared to 39°C in what they later discovered was a rare case of the highly infectious illness.

Mum Debbie claims her local GP surgery in Harborne twice misdiagnosed Ellie's symptoms as chicken pox after she began to fall ill early last week.

The 23-year-old was eventually diagnosed at Heartlands and transferred to an infectious diseases ward, where she is thought to have become one of 21 people in the Midlands treated for the viral illness over the past 12 months.

Debbie, a telemarketer, said: "When Ellie came out in a rash we first went to our GP in Harborne, who thought it was chicken pox and gave her antibiotics.

"Her temperature continued to go up so we went back and another GP also said it was chicken pox.

"I phoned 999 on Wednesday evening and was told it would be a two- to four-hour wait for someone to come out.

"We decided to trust the GPs at that stage and sit it out.

"Then, by Thursday evening, her temperature was around the 39°C mark and she was really, really ill.

"I thought I was going to lose her, so we got in the car and I drove her to A&E."

Charity administrator Ellie was swiftly diagnosed at the hospital.

"A nurse took one look and immediately got a consultant who took her temperature and sent her on for X-rays which were taken within five minutes of them seeing her," Debbie said.

"They sent off the blood tests and put her into isolation.

"At this stage I thought it might have been pneumonia or meningitis, but they came back and said it was measles.

"After she was put into isolation, another consultant from infectious diseases told us it was a really infectious illness which should have been wiped out with inoculations.

"If it hadn't been for the team at Heartlands, I don't even want to think about what could have happened.

"They were absolutely fantastic."

Ellie was discharged on Sunday evening after three nights at the hospital in Bordesley Green East.

She had had one set of MMR inoculations as a child but Debbie wants other families to be aware that measles has not been eradicated and the full course is needed.

Ellie added: "The team at Heartlands were absolutely fantastic. I ended up with mild hepatitis on my liver and part of my lungs were slightly affected by it. I had viral meningitis two years ago and this felt like a walk in the park by comparison.

"I didn't know where it was going to end."

Mum and daughter want to praise nurse Mustafa, consultant Christopher Green and consultant Dr Aiden Macnamara.

Ellie before and after the measles struck her down

FACTFILE

- Measles is uncommon in the UK because of the effectiveness of vaccinations, according to the NHS.
- But a total of 70 cases were confirmed in five areas of England - including Birmingham - in December.
- None of the patients had received two doses of the MMR vaccine.
- Symptoms of measles, which can sometimes lead to serious complications, can resemble a cold and also include sore, red eyes and high temperature. For more information visit www.nhs.uk/conditions/measles/

Birdsong, trees and sky can boost mental health in our cities

BEING exposed to nature can boost a person's mental wellbeing in cities, experts have said.

Even short-term exposure to birdsong, trees and the sky can have a measurable impact on how a person feels, the study found.

Researchers from King's College London studied the relationship between nature in urban places and mental wellbeing in real time using smart-phone technology.

The study, published in the journal BioScience, saw more than 100 participants input data into an app called Urban Mind.

During the one week trial, the 108 participants completed 3,013 assessments about their mood and environment.

The app also used tracked their exact location.

The study, in collaboration with landscape architects J and L Gibbons and art foundation Nomad Projects, found there were both immediate and "time lagged" associations with mental wellbeing for several natural features including trees, the sky and birdsong.

These associations were still evident several hours after exposure had taken place, the authors found.

Dr Andrea Mechelli, of the Institute of Psychiatry, Psychology and Neuroscience at King's College London, said: "These findings suggest that short-term exposure to nature has a measurable beneficial impact on mental wellbeing.

"From a clinical perspective, we hope this line of research will lead to the development of low-cost interventions aimed at promoting mental health in urban populations."

GLOSSARY

Abbreviation	Definition
A&E	Accident & Emergency
ACAD	Ambulatory Care and Diagnostics Centre
BCC	Birmingham Chest Clinic
BCU	Birmingham City University
BHH	Birmingham Heartlands Hospital
CMA	Competition and Markets Authority
COG	Council Of Governors
COPD	Chronic Obstructive Pulmonary Disease
CQC	Care Quality Commission
CQMG	Clinical Quality Monitoring Group
CQUIN	Commissioning for Quality and Innovation
DNA	Did Not Attend
DoH	Department of Health
ED	Emergency Department
FFT	Friends & Family Test
FLR	Follow-Up Request
GHH	Good Hope Hospital
HCA	Healthcare Assistants
HEFT	Heart of England NHS Foundation Trust
IR1	Incident Reporting Form (Datix)
ITU	Intensive Therapy Unit
KPI	Key Performance Indicators
LOS	Length Of Stay
MFFD	Medically Fit For Discharge
MRSA	Methicillin-Resistant Staphylococcus Aureus
NHSI	NHS Improvement
NOK	Next Of Kin
NPS	National Patient Survey
PCP	Patient Community Panel
PHSO	Parliamentary & Health Service Ombudsman
PLACE	Patient-Led Assessments of the Care Environment
QA	Quality Assurance
QEHB	Queen Elizabeth Hospital Birmingham
RAG	Red Amber Green
RTT	Referral To Treatment
SH	Solihull Hospital
TBA	To Be Agreed
UHB	University Hospitals Birmingham NHS Foundation Trust