Council of Governors

2 June 2015
4.00pm

Village Hotel,
The Green Business Park, Dog Kennel Lane,
Shirley, Solihull
**Council of Governors**

**June 2015**

<table>
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<tr>
<th>Agenda Item</th>
<th>Indicative Timings (minutes)</th>
<th>Presenter</th>
</tr>
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<tbody>
<tr>
<td>1. Welcome</td>
<td>2</td>
<td>Chair</td>
</tr>
<tr>
<td>2. Apologies</td>
<td>1</td>
<td>Kevin Smith</td>
</tr>
<tr>
<td>3. Declarations of Interest - Governors</td>
<td>2</td>
<td>Chair</td>
</tr>
<tr>
<td>- Directors</td>
<td></td>
<td>(Enclosure)</td>
</tr>
<tr>
<td><strong>Strategy</strong></td>
<td></td>
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<tr>
<td>4. Chief Executive’s Report</td>
<td>10</td>
<td>Andrew Foster</td>
</tr>
<tr>
<td><strong>Quality &amp; Performance</strong></td>
<td></td>
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<tr>
<td>5. Integrated Quality &amp; Performance Report, including Finance</td>
<td>20</td>
<td>Jonathan Brotherton/ Darren Cattell/ Andrew Catto/ Sam Foster</td>
</tr>
<tr>
<td><strong>Matters for Report</strong></td>
<td></td>
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<tr>
<td>6. Integrated Improvement Plan</td>
<td>10</td>
<td>Andrew Catto</td>
</tr>
<tr>
<td><strong>Governance &amp; Administration</strong></td>
<td></td>
<td></td>
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<tr>
<td>7. Dementia Strategy Presentation</td>
<td>20</td>
<td>Niall Fergusson/ Phil Hall</td>
</tr>
<tr>
<td><strong>For Information</strong></td>
<td></td>
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<tr>
<td>12. Chair’s Report</td>
<td>5</td>
<td>Chair</td>
</tr>
<tr>
<td>13. Any Other Business Previously Advised to the Chair</td>
<td></td>
<td></td>
</tr>
<tr>
<td>14. Date of Next Meeting</td>
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</tr>
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8 July 2015 – Harry Hollier Lecture Theatre, Good Hope Hospital, Sutton Coldfield

Refreshments will be available from 3.30pm
Welcome
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June 2015

Declarations of Interests
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### REGISTER OF INTERESTS

<table>
<thead>
<tr>
<th>NAME</th>
<th>INTEREST DECLARED</th>
<th>DATE DECLARED</th>
<th>DATE CEASED</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cllr Mohammed Aikhlaq</td>
<td>Awaiting information</td>
<td></td>
<td></td>
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<tr>
<td>Arshad Begum</td>
<td>Nothing to declare</td>
<td>21 Nov 2011</td>
<td></td>
</tr>
<tr>
<td>Kath Bell</td>
<td>Company Secretary - Succeed Services Ltd</td>
<td>21 Nov 2011</td>
<td></td>
</tr>
<tr>
<td>Nicola Burgess</td>
<td>Awaiting information</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Elaine Coulthard</td>
<td>Nothing to declare</td>
<td>21 Nov 2011</td>
<td></td>
</tr>
<tr>
<td>Dr Olivia Craig</td>
<td>No declaration received</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Carol Doyle</td>
<td>Awaiting information</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Helen Griffiths</td>
<td>Awaiting information</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emma Hale</td>
<td>Nothing to declare</td>
<td>27 May 2014</td>
<td></td>
</tr>
<tr>
<td></td>
<td>2. Director – 24/7 Industrial Services UK Ltd</td>
<td></td>
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</tr>
<tr>
<td>Albert Fletcher</td>
<td>Director – Aquarius (unpaid). A charity that specialises in helping and treating those with drink and/or drug issues.</td>
<td>28 May 2013</td>
<td></td>
</tr>
<tr>
<td></td>
<td>2. Chairman – Tamworth Credit Union Ltd</td>
<td></td>
<td>4 Mar 2014</td>
</tr>
<tr>
<td></td>
<td>4. Director – Tamworth Community Advice Network CIC</td>
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<tr>
<td></td>
<td>5. Chairman – Tamworth Talking Newspaper Ltd</td>
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<td></td>
<td>6. Trustee – Chairman – The Rawlett Trust</td>
<td>Amended 1 Sep 2013</td>
<td>23 Oct 2012</td>
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<tr>
<td></td>
<td>7. Vice Chairman – Standards Committee, Tamworth Borough Council</td>
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<td>8. Divisional President – St John’s Ambulance</td>
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<td></td>
<td>9. Member – Appeal Committee, St Giles Hospice</td>
<td></td>
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<tr>
<td></td>
<td>10. Retired CEO &amp; President Secretary, Tamworth Cooperative Society</td>
<td>Amended 23 Oct 2012</td>
<td>23 Oct 2012</td>
</tr>
<tr>
<td></td>
<td>11. Mr Hughes’ son holds a very senior managerial position with Barclays Bank</td>
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<tr>
<td></td>
<td>12. Chairman – Tamworth Community Advice Network CIC</td>
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<tr>
<td></td>
<td>13. Independent Member – Tamworth Borough Council Nominations Committee</td>
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<td>14. Member – Conservation Advisory Committee, Tamworth Borough Council</td>
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<td></td>
<td>15. President – Tamworth Male Voice Choir</td>
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<tr>
<td></td>
<td>16. Treasurer – St Andrew’s Methodist Church, Tamworth</td>
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<tr>
<td></td>
<td>19. Trustee – Spirit of Tamworth Trust</td>
<td>May 2014</td>
<td></td>
</tr>
<tr>
<td>Name</td>
<td>Declaration of Interests</td>
<td>Date</td>
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<tr>
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<td></td>
</tr>
<tr>
<td>Michael Hutchby</td>
<td>Nothing to declare</td>
<td>16 Aug 2013</td>
<td></td>
</tr>
<tr>
<td>Sue Hutchings</td>
<td>Shareholder in Lloyds TSB</td>
<td>19 Sept 2013</td>
<td></td>
</tr>
<tr>
<td>Phillip Johnson</td>
<td>Nothing to declare</td>
<td>21 Nov 2011</td>
<td></td>
</tr>
<tr>
<td>Michael Kelly</td>
<td>Nothing to declare</td>
<td>21 Nov 2011</td>
<td></td>
</tr>
<tr>
<td>Attiqa Khan</td>
<td>Nothing to declare</td>
<td>16 Aug 2013</td>
<td></td>
</tr>
</tbody>
</table>
| Heidi Lane         | 1. Member of Church – Renewal Christian Centre  
2. Husband is an Elder of the Church.  
3. Trust uses Christian Renewal Centre for conferences & meetings | 21 Nov 2011|
| Andrew Lydon       | Nothing to declare                                                                       | 16 Aug 2013|
| Anne McGeever      | 1. Registered with Therapy Bank in Worcestershire to provide services to BMI Droitwich Spa Hospital.  
2. Unite Professionals Limited (Occupational Therapists) – ad hoc employment. | 12 Sep 2014, 14 Apr 2015|
| Margaret Meixner   | Awaiting information                                                                     |            |
| Catherine Needham  | Nothing to declare                                                                       | 13 May 2014|
| Barry Orriss       | Nothing to declare                                                                       | 21 Nov 2011|
| Mark Pearson       | Member of Green Party                                                                    | 21 Jan 2015|
| Cllr Jim Ryan      | Archway Academy Ltd – Owner/MD  
Archway Community College - Owner/MD  
Archway Brimstone Security – Owner/MD  
Archway Renaissance LLP – Owner/MD  
Robert Ryan Housing Investments - Owner/MD | 15 July 2013|
| Liz Steventon      | Friends of Solihull Hospital                                                              | 21 Nov 2011|
| David Treadwell    | 1. Shareholder - Lloyds TSB  
2. Shareholder - STW  
| Matthew Trotter    | 1. HEFT Employee  
2. Director - Specialist Health Partnership  
3. Director - Specialist ENT Care Ltd | 12 Sep 13, 15 Dec 14|
## VOTING DIRECTORS

<table>
<thead>
<tr>
<th>NAME</th>
<th>DATE OF APPOINTMENT</th>
<th>INTEREST (if any)</th>
<th>DATE OF NOTIFICATION</th>
<th>DATE OF TERMINATION OF INTEREST</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mr Jonathan Brotherton</td>
<td>04.03.15</td>
<td>Nothing to declare</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| Dr Patrick Cadigan       | 01.07.13           | 1. Consultant cardiologist at Sandwell and West Birmingham Hospital Trust.  
                          |                     | 2. Registrar of the Royal College of Physicians of London.  
                          |                     | 3. Member of the clinical advisory group advising the Trust Special  
                          |                     | Administrators re the future of Mid Staffs NHS Trust.  
                          |                     | 4. Member of the clinical advisory group to NHS England on rare diseases.  
| Mr Darren Cattell        | 19.01.15           | Director & Shareholder - Mill Street Consultancy Limited.                       | Sept 2005            |                                 |
| Dr Andrew Catto          | 01.03.14           | (Interim CEO - 14.11.14 to 16.02.15)                                           |                      |                                 |
| Mr Andrew Edwards        | 01.10.14           | 1. Couch Perry & Wilkes. In receipt of annuity following business sale until  
                          |                     | May 2019.                                                                       |                      |                                 |
| Mr Andrew Foster         | 16.02.15           | Director of Wrightington Wigan & Leigh NHS Foundation Trust.                     |                      |                                 |
| Mrs Sam Foster           | 01.09.13           | Nothing to declare                                                               |                      |                                 |
| Ms Hazel Gunter          | 04.03.15           | Nothing to declare                                                               |                      |                                 |
| Mrs Karen Kneller        | 01.10.14           | 1. CEO of Criminal Cases Review Commission  
                          |                     | 2. Part time judge Social Entitlement Chamber Fitness to Practise  
                          |                     | 3. Member for General Dental Council  
                          |                     | 4. Director (unremunerated) of BRAP, an equalities think tank.                |                      |                                 |
## Declaration of Interests - Voting Directors

### Council of Governors

**June 2015**

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<thead>
<tr>
<th>NAME</th>
<th>DATE OF APPOINTMENT</th>
<th>INTEREST (if any)</th>
<th>DATE OF NOTIFICATION</th>
<th>DATE OF TERMINATION OF INTEREST</th>
</tr>
</thead>
</table>
| Mr Les Lawrence   | 01.04.12 (Chair – 01.06.14) | 1. Trustee for the National Institute for Conductive Education.  
2. Governor of City of Birmingham School.  
3. Director of Lindridge Enterprises Limited.  
4. Director (unremunerated) of Bordesley Birmingham Trust Limited (since 7 July 2011).  
6. Mr Lock’s wife, Dr Bernadette Gregory, is a medical doctor employed by Redditch and Bromsgrove Clinical Commissioning Group and is Clinical Lead for the Worcestershire Integrated Care Project.  
8. Receives instructions from the CQC.                                                                                                                                                                                                                                                                                                                                                                           | Mar 2013             | Mar 2015                      |
| Mr David Lock     | 01.07.13           | 1. Practising barrister and a member of Landmark chambers. Providing legal advice and representation to a wide range of individuals, NHS organisations, local authorities, charities and commercial organisations mainly on public law issues. These frequently involve issues concerning the rights of patients to NHS treatment as well as structural and management issues involving NHS bodies.  
2. Member of Amnesty International.  
3. Member of the BMA Ethics Committee (unremunerated).  
4. Member of the Labour Party and occasional legal advice to Labour Party and elected Members of Parliament on NHS policy issues.  
5. Mr Lock’s wife, Dr Bernadette Gregory, is a medical doctor employed by Redditch and Bromsgrove Clinical Commissioning Group and is Clinical Lead for the Worcestershire Integrated Care Project.  
6. Chairman of Innovation Birmingham Limited.  
8. Receives instructions from the CQC.                                                                                                                                                                                                                                                                                                                                                                           | Updated Jan 14      |                               |
| Ms Alison Lord    | 01.05.13           | 1. CEO and Shareholder of Allegra Ltd.  
2. Voluntary role as a business mentor for the Prince’s Trust.  
3. In her professional capacity as a ‘turnaround executive’ Ms Lord has relationships from time to time with major accountancy firms, legal firms, banks and venture capital providers.  
4. Company Secretary - Adente Limited (unremunerated).                                                                                                                                                                                                                                                                                                                                                     | 22.01.14             | 13.05.14                      |
<table>
<thead>
<tr>
<th>NAME</th>
<th>DATE OF APPOINTMENT</th>
<th>INTEREST (if any)</th>
<th>DATE OF NOTIFICATION</th>
<th>DATE OF TERMINATION OF INTEREST</th>
</tr>
</thead>
</table>
| Dr Jammi Rao        | 01.07.13            | 1. Sole director of Gorway Global Ltd. a private company and owning 50% of its share capital. A consulting company offering management support, training and bespoke public health analytical support to public sector organisations involved in health, well-being and health care.  
2. Board Director of Welcome CIC - a Community Interest Company supporting minority and disadvantaged communities by working with statutory and other agencies.  
3. Trustee of the Faculty of Public Health as an elected General Board Member. Term of office from 2010 to July 2013.  
4. Visiting Professorship in Public Health in the School of Health, Staffordshire University.                                                                                      | Jul 2013             |
| Prof Laura Serrant  | 01.04.12            | 1. Director of Research & Enterprise at University of Wolverhampton  
2. Non-executive director National Skills Academy for Health (unremunerated).                                                                                                                                                     | 01.04.12             | 23.01.14                        |
| Mr Adrian Stokes    | 01.07.08            | 1. Director of Heartlands Education Centre Ltd.  
2. Pfizer Virtual Customer programme.                                                                                                                                                                                            | 01.07.08             | 20.06.11                        |
Chief Executive's Report

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Introduction
I have now been in post for just over three months and it has been quite a journey. There have been several ups and downs but for the most part I think we can see signs of small improvements in performance and more significant advances in our systems of governance. Monitor tell us that they feel more assured that the Executive team is performing cohesively and, through the Integrated Improvement Plan, can demonstrate that we are tackling all of the major challenges we face. I hope that we can move from a position of being constantly on the back foot, responding to concerns from our Regulators and others, onto the front foot when we can agree a suite of strategies and plans in September.

By the time today’s HEFT Board meeting takes place, the WWL Board should have formally approved the extension of my interim period by a further 3 months, taking me through to mid-November 2015. This enables me to offer a little more stability and consistency of message which is very important to each of my three main priorities of Clarity, Staff Engagement and Quality Improvement.

Clarity
The two key areas of work are about how the Trust is managed and what are its plans for the future?

We have extended the structure charts to a third level (Appendix A) and published them internally. This means that everyone can see the main responsibilities and reporting lines for Executive Directors, each of their direct reports, and each next in line direct report. The plan is to continue this process until we have a full line of sight from Ward to Board.

The EMB has also held three discussions about the thorny issue of whether we manage by Site or by Service where currently we have an unhelpful hybrid of the two. The emerging view is that we should manage by Division. Thus the five Divisions include Heartlands and Good Hope as Sites, Solihull as a combined Site and Community, and Clinical Support and Women’s and Children’s as Cross-Site Divisions. The main principles of this should be that:

- We will operate a clinically-led, devolved system of management where the Trust Board sits above the Executive Management Board (EMB)
- The EMB comprises the Executive Directors, Associate Medical Directors and Heads of key departments
- AMDs will have direct line management of all staff in their Division through Clinical Directors
- The Clinical Support Division - stressing its role is indeed to support other Divisions and for CSS to reflect on possible future models of operation for example the equivalent of a Service Line Agreement
- In so far as possible, every member of staff should have a single line manager
- There will also be discussion with Clinical Directors (CD) on developing CDs with a Cross-Divisional responsibility. Their duty will not be to line manage other sites but to lead on collaboration between sites, professional standards and long term planning. There will also be work on the role of the clinical lead.

We will now consult with CDs and others to come up with a clear statement of how this will work in practice and the respective duties of a Divisional CD and a Cross-Divisional CD.
Matthew Cooke continues to make good progress on the suite of strategies. Two large Listening Events were well attended and produced enthusiastic initial feedback. The next major draft will be discussed in the second part of this meeting.

Staff Engagement
Hazel Gunter is reporting on progress in Part 2 of the meeting so I will not comment further here other than to thank the many hundreds of staff who have now actively participated in various events and Alex Covey’s team who are enthusiastically managing this complex and ambitious programme.

Quality Improvement
We held a Quality Summit on 27th April to celebrate four examples of excellence that are already happening in the Trust:

- Phil Hall, senior dementia nurse, gave a presentation on dementia care and we heard that the Trust has been selected as the acute pilot site for the Midlands to test a new Learning Needs Analysis (LNA) tool. This is part of the Skills for Health dementia innovation programme of work and its aim is to develop a national competency framework for staff working with people with dementia across healthcare organisations, social care, GP practices, care homes and voluntary organisations.
- Michelle Davies, resuscitation officer gave a presentation on the excellent work they are doing at Good Hope on anaphylaxis, making sure that the lifesaving adrenalin injection is administered correctly.
- Mr Haney Youssef talked us through the latest developments with peritoneal surgery and I had not previously known that HEFT is one of just three centres in England conducting this complex surgery. Mr Youssef is pioneering a new procedure called the “sugarbaker” which has spectacularly improved survival rates.
- Dr Das Pillay and Caroline Maries-Tillott gave a presentation about antibiotic initiatives in the Trust. They have helped electronic prescribing wards to increase antibiotic stop date performance which has gone up by 28% compared to the same period last year. IV antibiotic administration within one hour has improved in the past 2 years from 56% to 71%. A ‘live’ antibiotic dashboard (unique in the NHS) is available for wards to maintain vigilance to avert delays in STAT antibiotic dose administration. This involved the introduction of a medication dashboard which is part of a wider quality and safety improvement project to advance the Trust’s performance of indicating stop/review dates and administration of antibiotic doses.

A different kind of Quality Summit was held on 20 May when the CQC presented its findings following the unannounced inspection in December 2014. The final version of the report is due to be published on 1st June so we will arrange to have a full item about the report and our response at a future Trust Board meeting. In the meantime here are the headlines:

- The Trust will receive an overall rating of “Requires Improvement”. There are two higher ratings (Outstanding and Good ) and one lower (Inadequate)
- One department, Heartlands Emergency Services, was rated as Inadequate; Solihull Outpatients was rated as Good; all other departments were rated as Requires Improvement.
- The report cites five examples of outstanding practice: Heartlands AMU complaints resolution, leadership on five wards at Heartlands, the Practice Placement Team, Sexual Health Information and widespread observation of compassionate care across the Trust.
- It also cites numerous areas for improvement and 26 must-dos, many of which have already been done. The number one outstanding issue is safety in ED.
- We fully accepted the CQC report and recommendations and agreed to build them all into our Integrated Improvement Plan

**Other Matters**

As at the last Board, my contention is that we should accord most priority to the challenges described above but there is still a long list of other major issues that need attention:

- A&E performance and the controversial issue of what trajectory we can “commit” to
- 18 week performance (especially gastroenterology)
- Financial trading deficit last year and this
- Building and maintaining Monitor’s confidence
- Developing and mainstreaming the Integrated Improvement Plan
- The Deloitte Governance and IT reports
- The Kennedy report
- The Silverman report and excess mortality and harm
- Relationships with commissioners and the 15-16 contracts
- Staff shortages, especially nursing
- Surgical reconfiguration
- Solihull Urgent Care Centre
- Solihull Integration Plan
- Quality and capacity of senior and middle management

Andrew Foster
21 May 2015
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Deputy Director and Chief of Staff (Medical Director's Office)

- Medical Director’s Office Administration
- Medical Illustration and Multimedia Manager, Glenn Mannion
- Head of Communications, Kate Eccles
- Head of Review and Recall, Caroline Williams (Interim)
- Clinical Review – Specialist cases, Recall planning and delivery
- Internal Communications
  - External Communications
  - Intranet
  - Media
- Medical Illustration
  - Graphics Design
- Administration
  - Clinical Review
  - Specialist cases
  - Recall planning and delivery
  - Internal Communications
  - External Communications
  - Intranet
  - Media
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Note changes
Holier - now Phil Bright
Med Illustration - Richard Brown
Emergency Planning - Jonathan Brotherton
Med Leadership - DMD (Elderly)

Deputy Medical Director (Strategy and Transformation)
Matthew Cooke

Head of Innovation
Bethan Bishop

Innovation
Telhealth

Director of Research
Don Milligan

Research
MIDRU

Head of Clinical Services Strategy
Joanna Hodgkiss

Strategy Development
Strategy Deployment
Priority programmes
Specialised Services
Primary Care Integration

Strategy Development

Medical Director (Strategy and Transformation)
Matthew Cooke

Head of Innovation
Bethan Bishop

Innovation
Telhealth

Director of Research
Don Milligan

Research
MIDRU

Head of Clinical Services Strategy
Joanna Hodgkiss

Strategy Development
Strategy Deployment
Priority programmes
Specialised Services
Primary Care Integration
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Deputy Medical Director – Appraisal, Performance and Outcomes
Clive Ryder

Director of Medical Safety /Quality Improvement
Ann Keogh

Operations Manager (TBC)

Associate Medical Director Revalidation – Adedeji Okubadejo

Medical Revalidation Investigations
Caldicott Guardian

Quality Improvement
Mortality

Administration Support
Project Support

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Deputy Chief Nurse
Julie Tunney

Deputy Chief Nurse
Sue Hyland

Head Nurses
Children’s
BHH
GHH
Solihull

Head Nurse – Patient Experience

Corporate Nursing Team
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Deputy Director of Patient Experience

Richard Brown

Jamie Emery

Head of Patient Services & Engagement

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Finance Operations
Director of Finance Operations
Jonathan Gould

Chief Financial Controller
Angeline Jones

Procurement Director
Dave Coley

Head of Income & Contracting
Mike Archer

Project Support
Mona Taylor

Director of Finance Operations
Jonathan Gould

Finance Operations

Chief Executive's Report

May 2015

Director of Finance Operations
Jonathan Gould

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Performance

Head of Performance (Interim)
Diane Povey

Head of Clinical Coding
Stephen Cross

Project Manager Finance Staff Development
Sue Lyddon

Corporate Performance Manager
Dawn Carty

Head of Service Improvements
Vacancy

Operational Performance Delivery Manager
Claire Rymer

Head of Performance (Interim)
Diane Povey

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Operational Business Support

Deputy Finance Director
Aidan Quinn

Heartlands Hospital
Clair Young

Clinical Support Services
Claire Pooni

Women's & Children's
Jo-Anne John

Good Hope Hospital
Elena Edwards

Solihull Hospital
Adam Winstanley

Facilities & Corporate
Malcolm Clark

Richmond House
Richard Barratt

Head of Projects
Sue King

Malcolm Clark
Deputy Finance Director

Aidan Quinn
OPERATIONAL HR MANAGEMENT STRUCTURE

Deputy Director of Workforce/Head of Operational HR
(interim Kyriacos Kyriacou 6 months)
(Andrew McMenemy from 29.06.15)

Alison Money
Senior HR Business Partner
• BHH Site

Frieza Mahmood
HR Business Partner
• Solihull Site

Mark Tipton
HR Business Partner
• Good Hope Site

Jean Devenney
HR Business Partner
• Corporate & Facilities

Helen Barlow
HR Business Partner
• Policies & Projects

Sara Wood
• Work & Wellbeing

Julie Steward
• Workforce Planning

Leeanne Stokes
HR Business Consultant
BHH

Natalie Cooke
HR Business Consultant
W&C

Laura Graham
HR Business Consultant
CSS
OD TEAM PROPOSED STRUCTURE

Alex Covey
Head of OD

Danielle Goddard
Culture & Engagement Project Manager (interim 6 months)
- Programme manage Culture & Engagement Workstreams

Bill Nuttall
Leadership Specialist (interim 12 mths)
- Leadership Development Plans
- Appraisal
- Succession Planning

tbc
OD Manager Talent Management
- Programme leadership
- Appraisal
- Talent Management
- Succession Planning

Amy Passey
OD Manager Staff Engagement
- Engagement Programmes
- Staff Surveys

tbc
OD Manager Culture & Values
- Values development
- Behavioural frameworks
- Support implementation of Values & Behaviours into other working practices

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<td>Sickness</td>
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<td>Complaints</td>
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</table>
Performance Analysis

The main areas of concern for the Trust remain urgent care, RTT and diagnostics in particular in endoscopy.

Performance against the A&E 4 hour target for April was 86.25%. Despite the significant increase in attendances at Heartlands and Good Hope Hospital from April 2014 to April 2015, there has been an improvement in A&E 4 hour compliance. Overall emergency admissions have reduced over the same time period.

The urgent care pathway continued to experience further increase in demand during April. This placed both the Heartlands and Good Hope Hospitals under significant strain in terms of high bed occupancy, ED congestion and delays for large numbers of patients waiting for a bed to become available.

All three of the targets for referral to treatment were not achieved this month. However, both the admitted and non-admitted pathway have improved from March to April as shown in the heat map.

Trajectories for reducing the RTT admitted backlogs have been revised for 2015/16 and the overall backlog (1,271) is performing well against the in month target (1,322). From the capacity versus demand work undertaken it was found that to achieve the RTT targets the Trust will need to approximately undertake an additional 5100 cases compared to 2014/15. The increase in demand is predominantly due to urgent referrals, this is under discussion with the CCGs.

Gastroenterology (and more specifically the Endoscopy Service) continues to experience increased demand which significantly impacts on the overall admitted backlog and diagnostics compliance.

There has been a significant reduction in hospital led cancellations of elective surgery from the peak in January to March.

The validated cancer performance for two week waits and for breast symptomatic targets have failed in March 2015. There continues to be an above average in the number of referrals to two week wait clinics (including breast symptomatic). Performance against the 31 and 62 day cancer targets were met in March 2015, 99.41% and 86.24% respectively.

There have been no new cases of post 48 hour MRSA bacteraemia in April, there is a zero tolerance target for MRSA Bacteraemias in 2015/16. Clostridium difficile (C.diff) target was met in April with only 2 cases against a target of less than 6. The new C.diff trajectory for 2015/16 is more challenging this year, the year end target is less than 64 cases. The Trust continues to maintain good performance in falls and pressure ulcers despite an increase in frail and elderly patients.

Recruitment of staff especially nursing and medical staff continues to be challenging with turnover continuing to be above target. Staff sickness has improved this month and is below the new 2015/16 trajectory. The 85% target for mandatory training was achieved in March 2015 (data is one month in arrears). The appraisal’s target was not met this month, however there is an improved performance on 2014/15. Appraisal completion from April is now reported as a rolling 12 month position against a constant target of 85% across the whole Trust.
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**Integrated Quality and Performance Report**

### Emergency Care

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<tr>
<th>Hospital</th>
<th>A&amp;E 4 hour Performance: Apr 14 vs Apr 15</th>
</tr>
</thead>
<tbody>
<tr>
<td>Heartlands</td>
<td>Apr-14, 95.40%</td>
</tr>
<tr>
<td>Good Hope</td>
<td>Apr-14, 95.00%</td>
</tr>
<tr>
<td>Solihull</td>
<td>Apr-14, 95.00%</td>
</tr>
<tr>
<td>Trust wide (no WIC)</td>
<td>Apr-14, 93.40%</td>
</tr>
</tbody>
</table>

**Welcome**

The performance in April 2015 was 86.25%.

**Headlines**

- Increased Demand
- Breach & Capacity

**Performance Analysis**

1) Increased Demand

- The majority of breaches (52.35%) were due to awaiting a bed or no room in AMU. Capacity issues are also impacted by the increase in the average cycle time of patients in AMU areas who are later transferred to base wards.

2) Breach & Capacity

- The median time for patients in ED who are later admitted to hospital has also remained high. The increase has been as follows:
  - When BHH last achieved the 95% 4 Hour target (January 2014) median time in ED was 190 minutes. In contrast, during April 2015 the median time in BHH ED is significantly increased at 221 minutes.
  - Median time in GHH ED was 193 minutes in January 2011 (the last time GHH achieved the 4 hour target). Currently, median time in GHH ED is 271 minutes.

**Actions Taken**

- Launch of Drive for Discharge: This is an initiative to ensure availability of six AMU and two SAU spaces at key points during the day to improve flow to the assessment units. This has been implemented to create capacity and keep the EDs safe by reducing the number of breaches due to no space in AMU.

- When BHH last achieved the 95% 4 Hour target (January 2014) median time in ED was 190 minutes. In contrast, median time in GHH ED was 193 minutes in January 2011 (the last time GHH achieved the 4 hour target). Currently, median time in GHH ED is 271 minutes.

- 11 hours of private ambulance cover was provided to both GHH and BHH sites Monday to Friday to support patient discharge. Two new discharge lounges opened on each site to create early flow in the hospital.
### Integrated Quality and Performance Report, including Finance

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### Planned Care

#### Heat Map - 18 Weeks, Diagnostics, Operations

<table>
<thead>
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<th>Heat Map</th>
<th>Performance Improvement Apr 15</th>
<th>Trust Performance Apr 15</th>
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<tr>
<td></td>
<td></td>
<td>82.09%</td>
<td>93.10%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>89.61%</td>
<td>90.63%</td>
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</table>

### Integrated Performance Report - April

<table>
<thead>
<tr>
<th>Indicator</th>
<th>April 2015</th>
<th>April 2014</th>
<th>April 2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>AOS1 - Admitted Patients Treated within 18 Weeks of Referral (mia)</td>
<td>90.63%</td>
<td>89.83%</td>
<td>82.09%</td>
</tr>
<tr>
<td>AOS2 - Non-Admitted Patients Treated within 18 Weeks of Referral (mia)</td>
<td>88.99%</td>
<td>90.26%</td>
<td>82.09%</td>
</tr>
<tr>
<td>AOS3 - 18 week incomplete pathways (mia)</td>
<td>89.83%</td>
<td>92.26%</td>
<td>90.26%</td>
</tr>
<tr>
<td>Heat Map - 18 Weeks, Diagnostics, Operations</td>
<td>78.66%</td>
<td>83.69%</td>
<td>83.72%</td>
</tr>
</tbody>
</table>

### Dementia Strategy Presentation

- **MONITOR COMPLIANCE - RISK ASSESSMENT FRAMEWORK**
  - **TARGET**
    - ≥ 90%
    - ≥ 95%
    - ≥ 92%
    - ≥ 99%

- **CCG / Trust**
  - **AOS1**
    - Admitted Patients Treated within 18 Weeks of Referral (mia)
  - **AOS2**
    - Non-Admitted Patients Treated within 18 Weeks of Referral (mia)
  - **AOS3**
    - 18 week incomplete pathways (mia)
  - **Diagnostics waiting times less than 6 weeks**
    - ≥ 90%
    - ≥ 99%
  - **Cancelled operations not offered another date within 28 days**
    - ≥ 95%
  - **No urgent operation cancelled for the 2nd time**

### Integrated Quality and Performance Report - April

- **MONITOR COMPLIANCE - RISK ASSESSMENT FRAMEWORK**
  - **TARGET**
    - ≥ 90%
    - ≥ 95%
    - ≥ 92%
    - ≥ 99%

- **CCG / Trust**
  - **AOS1**
    - Admitted Patients Treated within 18 Weeks of Referral (mia)
  - **AOS2**
    - Non-Admitted Patients Treated within 18 Weeks of Referral (mia)
  - **AOS3**
    - 18 week incomplete pathways (mia)
  - **Diagnostics waiting times less than 6 weeks**
    - ≥ 90%
    - ≥ 99%
  - **Cancelled operations not offered another date within 28 days**
    - ≥ 95%
  - **No urgent operation cancelled for the 2nd time**

---

.46
18 Weeks - Referral to Treatment (RTT)

Headlines:
- April Admitted Performance: 82.09%
- April Non-Admitted Performance: 93.10%
- April Incomplete Performance: 89.61%

52 week breach position:
- There are 8 patients waiting more than 52 weeks on the incomplete pathway at the end of April. There were 59 patients breached the 52 week standard in April, all of these patients breached due to closure of legacy open clock pathways.

Performance Analysis:

Cancellation of Surgery (on & before the day of admission)
18 patients were cancelled in April, all were due to no beds available (BHH - 15, SOL - 2, GHH - 1). Relative to previous months, this is a small increase on March when 11 patients were cancelled.

One of these patients was on the cancer pathway requiring a critical care bed, the RCA has been completed and an action plan is in place.

Backlog:
The number of patients in the backlog at the end of April was 1,271 versus an expected backlog trajectory position of 1,322. All specialties with the exception of Urology and Gastroenterology achieved their predicted trajectory with Orthopaedics achieving by 76 patients.

The main specialties continuing to contribute to the backlog are as follows:
- Gastroenterology = 387, 30.4% of total backlog.
- Orthopaedic = 251, 19.7% of total backlog.
- General Surgery = 167, 13.1% of total backlog.
- Urology = 135, 10.6% of total backlog.

The overall backlog position for May is on target for delivery.

High Risk Specialties against the Overall RTT Performance (April 2015)

<table>
<thead>
<tr>
<th>Speciality</th>
<th>Admitted % seen within 18 weeks</th>
<th>Admitted % non seen within 18 weeks</th>
<th>Incomplete Pathways</th>
</tr>
</thead>
<tbody>
<tr>
<td>General Surgery</td>
<td>98.19%</td>
<td>2%</td>
<td>3%</td>
</tr>
<tr>
<td>Urology</td>
<td>98.37%</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>ENT</td>
<td>98.75%</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>MRI</td>
<td>98.72%</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>Ophthalmology</td>
<td>98.66%</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>Gastroenterology</td>
<td>98.69%</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>98.09%</strong></td>
<td><strong>0%</strong></td>
<td><strong>0%</strong></td>
</tr>
<tr>
<td>Planned breaches in total</td>
<td>252</td>
<td>256</td>
<td>1,110</td>
</tr>
</tbody>
</table>

18 weeks backlog

Legacy Open Clocks closure impact on pathways

Integrated Performance Report - April
Integrated Performance Report - April

Planed Care

18 Weeks - Open Clocks

Performance Analysis

Eight patients remain on an open clock pathway waiting 52 weeks or more. All but two patients are expected to have their pathway closed in May. These two patients are undergoing further diagnostic interventions following face to face consultation.

There is still a significant peak of patients on an open clock pathway between 19 and 25 weeks. The new Patient-targeted list (PTL) provides better visibility for teams to manage their patients on an open clock pathway.

Gastroenterology accounts for 24.18% of total patients with an open clock of more than 18 weeks and no planned future appointment. Other specialties that account for more than 10% of this group are:

- T&O - 11.10%
- Urology - 13.62%

Further Actions

- RCAs will be undertaken on both patients waiting longer than 52 weeks when their treatments are completed, this will include a review of harm.
- PTL will be monitored through the 18 week and Cancer meeting with all Divisions having internal procedures in place to ensure improved pathways management of patients.
Integrated Quality and Performance Report, including Finance

Council of Governors

June 2015

Headlines

Endoscopy and the related Gastroenterology service is considered to be the specialty of highest risk in Scheduled Care.

Performance Analysis

The number of patients on the Endoscopy admitted waiting list has increased significantly from 578 in October 2014 to 2,443 patients at the end of April with 360 waiting 18 weeks or more.

The Trust has failed its 6 week 99% diagnostic target since September 2014 due to the deterioration of performance within endoscopy.

Actions Taken

• An additional appointment bank for the service was inserted to the CCG activity to allow no waiting weeks of patients.

Endoscopy, and the related Gastroenterology service is considered to be the specialty of highest risk in Scheduled Care.

Performance Analysis

The number of patients on the Endoscopy admitted waiting list has increased significantly from 578 in October 2014 to 2,443 patients at the end of April with 360 waiting 18 weeks or more.

The Trust has failed its 6 week 99% diagnostic target since September 2014 due to the deterioration of performance within endoscopy.

Actions Taken

• An additional appointment bank for the service was inserted to the CCG activity to allow no waiting weeks of patients.

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Diagnostics Summary

<table>
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<tr>
<th>Test</th>
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<th>Target</th>
<th>Validated summary figures for April will be updated in next month's report</th>
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<td>Magnetic Resonance Imaging</td>
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<td>Computerized Tomography</td>
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<tr>
<td>Non-obstetric ultrasound</td>
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<td>Barium Enema</td>
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<td></td>
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<tr>
<td>DEXA Scan</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Urodynamics - pressures &amp; flows</td>
<td></td>
<td></td>
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<tr>
<td>Cystoscopy</td>
<td></td>
<td></td>
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<tr>
<td>Neurophysiology - peripheral neurophysiology</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diagnostics tests seen within 6 weeks</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MRI</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>CT</td>
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<tr>
<td>Cardiology - echocardiography</td>
<td></td>
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<td></td>
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<tr>
<td>Audiology Assessments</td>
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<td></td>
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<tr>
<td>Cardiology - electrophysiology</td>
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</tbody>
</table>

Planned Care

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<table>
<thead>
<tr>
<th>Test</th>
<th>Target</th>
<th>Validated summary figures for April will be updated in next month's report</th>
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<tr>
<td>Headlines</td>
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<tr>
<td>Performance Analysis</td>
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<tr>
<td>Actions Taken</td>
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</tbody>
</table>

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Planned Care

Cancelled Operations

Headlines

There were 75 hospital led cancelled operations on the day during April 15, a slight increase when compared with the previous month (72).

38 (51%) of the cancelled operations were at Good Hope, 21 (28%) at Heartlands and 16 (21%) at Solihull.

1 patient with cancer was cancelled on the day of their surgery due to no Critical Care bed.

In addition two patients had their ‘urgent’ operation cancelled for a second time at during April.

Performance Analysis

The following reasons account for 85% of the Hospital led cancelled operations on the day during April 2015; Ran out of time (28), Staff unavailable (11) and No bed (8).

- There were 28 (37%) cancelled operations due to a lack of time, 11 at Good Hope, 10 at Solihull and 7 at Heartlands. The operations were cancelled by Orthopaedics (8), Gynaecology (7), General Surgery (5), Ophthalmology (3), Urology (3) and Thoracic Surgery (2).
- 17 operations (23%) were cancelled due to staff members being unavailable, 14 of these were at Good Hope Hospital and 3 at Heartlands Hospital. 10 of the cancelled operations at Good Hope was due to no anaesthetist being available, this lead to Ophthalmology (9) and Cardiology (1) cancelling operations.
- 11 operations (15%) were cancelled due to equipment failure, 8 at Good Hope Hospital and 3 at Solihull Hospital.
- 8 (11%) operations were cancelled due to no bed, 7 were at Heartlands and 1 at Solihull.

Actions taken

- RCA undertaken to identify underlying cause for patient cancelled with cancer. Escalation process has been reviewed, reiterated and enhanced as a result.
- Weekly theatre scheduling meetings in place to facilitate a two week forward. This will identify potential issues with lists and improve efficiency. These meetings have started to improve session utilisation from 84.79% in March to 86.16% in April.
- The Theatre Utilisation Project commenced in April, the two core workstreams are pre-operative process and theatre scheduling.

In urgent operations cancelled for a second time:

<table>
<thead>
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<th></th>
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</tr>
</thead>
<tbody>
<tr>
<td>Urgent Ops 2nd Time</td>
<td>1</td>
<td>0</td>
<td>3</td>
<td>4</td>
<td>4</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>3</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>No bed 2nd Time</td>
<td>0</td>
<td>2</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>3</td>
<td>4</td>
<td>0</td>
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</tbody>
</table>
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**June 2015**

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- **Apologies**
- **Minutes**
- **Matters Arising**
- **Chairman's Report**
- **Chief Executive's Report**
- **Integrated Quality Report**
- **Integrated Improvement Plan**
- **Dementia Strategy Presentation**
- **Other Business**

### Integrated Quality and Performance Report, including Finance

#### Planned Care

<table>
<thead>
<tr>
<th>Heartlands Hospital</th>
<th>Good Hope Hospital</th>
<th>Solihull Hospital</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Heat Map - Cancers (mia)</strong></td>
<td></td>
<td></td>
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<td></td>
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<tr>
<td><strong>Last Month (Mar-15)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>AOS6</strong></td>
<td><strong>AOS12</strong></td>
<td><strong>AOS10</strong></td>
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<tr>
<td>Patients first seen by a specialist within two weeks when urgently referred by their GP or dentist with suspected cancer (mia) &gt; 93%</td>
<td>Patients receiving their first definitive treatment for cancer within two months (62 days) of GP or dentist urgent referral for suspected cancer (mia) &gt; 85%</td>
<td>Patients receiving subsequent treatment (surgery and drug treatment only) within one month (31 days) of a decision to treat - Surgery Modality (mia) &gt; 94%</td>
</tr>
</tbody>
</table>

#### QM/HEFT Risk Assessment Framework

<table>
<thead>
<tr>
<th>CGG / HEFT Ref.</th>
<th>Monitor Compliance</th>
</tr>
</thead>
<tbody>
<tr>
<td>A056</td>
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</tr>
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</tbody>
</table>

#### TARGET

| Q08 | Patients receiving their first definitive treatment for cancer within two months (62 days) of urgent referral for suspected cancer (mia) &gt; 90% |

### Performance Improvement - April

#### Heat Map - Cancers (mia)

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### Other Business

- **Governance and Governors’ responsibilities**
- **Attendance Record**
- **Chairman’s Report**
- **Any Other Business**
Planned Care

Cancers - Two week wait Performance

**Headlines**

Two week wait performance (Target 93%), March 91.4% (below trajectory).

Breast Symptomatic two week wait performance March 89.38% (slight decrease from 92.33% in February).

**Performance Analysis**

The volume of two week waits referrals continues to be above average. Additional capacity is being put into place but the rate of growth is exceeding what has been planned. This is likely to be exacerbated by the NICE guidance putting achievement of two week waits performance at risk.

The number of patients positively diagnosed with cancer reduced by 40 patients (2001 in 13/14 vs 1961 in 14/15). Dermatology, Gynaecology, Upper and Lower GI saw the most significant increase in referral rate and reduction in conversion rate.

Two week wait breaches (including Breast) have mostly been due to patient choice. The proportion of breaches due to patient choice has been significantly higher than capacity since October 2014.

**Actions Taken**

- HEFT representatives met Sandwell and City counterparts in April to discuss how they improved their performance, specifically in suspected and exhibited two week wait Breast referrals. A significant factor was transfer of services to one site. A multi-disciplinary group will discuss breast performance and agree further short and long term actions that will provide an improvement in the standard.

- The Trust is continuing to work with CCG on the appropriateness of two week wait referrals. This includes updating of referral forms in Dermatology neoplasms (in March) and Gynaecology neoplasms (in June). Further work to update referral forms for Lung and Urology is underway. An audit will commence in July 2015 to assess the impact of this change.

- Data and patient experiences regarding inappropriate referrals are being shared with CCGs and GPs.

**Conversion rate for Diagnosis of Cancer after 2 week wait clinic**

**Table 1: Two week waits/Breast Symptoms - percentage of patients seen in 2 weeks**

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</thead>
<tbody>
<tr>
<td>2 Week Wait (93%)</td>
<td>81.06%</td>
<td>77.91%</td>
<td>70.04%</td>
<td>80.11%</td>
<td>79.12%</td>
<td>78.75%</td>
<td>89.38%</td>
<td>90.36%</td>
<td>88.95%</td>
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<td>91.38%</td>
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<td>91.38%</td>
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<td>91.38%</td>
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<tr>
<td>2 Week Wait - (95%) Breast Symptoms</td>
<td>83.99%</td>
<td>87.36%</td>
<td>95.24%</td>
<td>92.64%</td>
<td>88.08%</td>
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<tr>
<td>Indicator</td>
<td>31 Day Target (96% target)</td>
<td>62 Day Target (85% target)</td>
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<td>62 Day National Screening Programme</td>
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<td>National Screening Programme</td>
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<tr>
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</table>

**Performance Analysis**

Quarterly performance of all 31 and 62 day standards was achieved with the exception of the 62 day national screening programme. The number of patients on 62 day national screening pathways were slightly lower compared to previous quarters due to the relative reduction in patients undergoing breast screening locally.

**Actions Taken**

- Workshops to further improve patient pathways in Lung and Urology will take place in May
- Focus is being applied at the weekly Cancer Patient Targeted List (PTL) meeting to ensure all patients are dated and issues escalated
- Meeting with CCG will take place in May regarding ‘pan-Birmingham’ management of patients referred late into their pathway and the impact this has on outcomes and performance
## Agenda

- **Welcome**
- **Declaration of Interest**
- **Apologies**
- **Minutes**
- **Matters Arising**
- **Chairman's Report**
- **Chief Executive's Report**
- **Integrated Quality Report**
- **Any Other Business**
- **Attendance Record**
- **Integrated Improvement Plan**
- **Dementia Strategy Presentation**
- **Governance and Governors' responsibilities**
- **Integrated Performance Report - April**

### Heat Map - Nursing Performance

<table>
<thead>
<tr>
<th>CCG</th>
<th>RISK ASSESSMENT FRAMEWORK</th>
</tr>
</thead>
<tbody>
<tr>
<td>ALQR2</td>
<td>AUCR2</td>
</tr>
<tr>
<td><em>Harm Free Care</em></td>
<td><em>Pressure User Reduction for avoidable grade 4 pressure users</em></td>
</tr>
<tr>
<td><strong>9%</strong></td>
<td>zero tolerance</td>
</tr>
<tr>
<td><strong>94.87%</strong></td>
<td>0</td>
</tr>
<tr>
<td><strong>94.00%</strong></td>
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<td><strong>93.75%</strong></td>
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<tr>
<td><strong>94.19%</strong></td>
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</tr>
<tr>
<td><strong>100.00%</strong></td>
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</tbody>
</table>

**Harm Free Care**
- Zero tolerance
- [ALQR2] 100.00%
- [ALQR2] 100.00%
- [ALQR2] 94.19%

**Pressure User Reduction**
- [ALQR2] 94.19%
- [ALQR2] 94.19%
- [ALQR2] 94.19%

**Pressure Ulcer Reduction**
- [ALQR2] 94.19%
- [ALQR2] 94.19%
- [ALQR2] 94.19%

**Injurious Falls**
- [ALQR2] 94.19%
- [ALQR2] 94.19%
- [ALQR2] 94.19%

### Quality & Risk

- **Heat Map - Nursing Performance**
- **MONITOR COMPLIANCE**
- **RISK ASSESSMENT FRAMEWORK**
- **TARGET**
- **In month trajectory**
- **Last Month**
- **Heartlands Hospital**
- **Good Hope Hospital**
- **Solihull Hospital**
- **Clinical Support Services**
- **Womens & Childrens Trust (Maj-15)**
- **Performance Improvement**
- **Performance**
- **Ref. 1**

### Integrated Performance Report - April
Quality & Risk

Headsline

The Falls assessment element of the nursing metrics achieved a score of 95% for Apr-15, the highest score since the Falls Bundle was first introduced in Jul-14. There is a year end target overall for 2015-16 of 95%, with each element of the falls bundle to achieve 90% by year end. There were no indicators scoring less than 90% for Apr-15. The Trust falls rate per 1,000 occupied bed days has fallen to 6.95 in Apr-15, its lowest rate since Jun-13. There is no official target for 2015/16 but the internal target is not to perform above the upper control limit (i.e. less than 8.80).

Performance Analysis

There were ten injurious falls in Apr-15:
- One on the Heartlands site (Ward 29)
- Five at Good Hope (Wards 11, 17, 18, 23 and Cedarwood)
- Four on the Solihull site (Wards 19, 20A, 20B and AMU Short Stay).

The themes from RCAs will be published on a quarterly basis.

The falls rate per 1,000 occupied beds days were split across the sites as follows:

- Heartlands, 2014/15 = 7.41, April 2015 = 6.70
- Good Hope, 2014/15 = 9.34, April 2015 = 8.02
- Solihull, 2014/15 = 7.26, April 2015 = 5.78

Actions taken

- Nursing Care indicators have been revised, therefore working to new metrics in 2015/16
- The new metric questions are now live
- Peer reviews/audits to be carried out by ward managers or senior sisters. This may have an initial negative impact on performance due to interpretation of the new questions.

Actions for Injurious Falls

- RCAs to be completed for recurrent fallers in Mar 2015.
- Themes to be identified and monitored over the next 12 months. This information will be used when developing targets in 2016/17.
**Quality & Risk**

**Pressure Ulcers**

**Headlines**

The Tissue Viability Assessment indicator of the nursing metrics achieved a score of 94% for Apr-15. A 95% year end target has been agreed for the three elements of the tissue viability metrics that were under-performing during 2014-15 (daily skin inspections, repositioning frequency completed, and repositioning frequency adhered to). These three elements were also the most commonly occurring themes from the RCAs resulting in pressure ulcers being classed as avoidable.

The Trust pressure ulcer point prevalence has remained below the average line for the past 14 consecutive months despite the small increase in month (from 3.51 to 3.77). The Trust also continues to sit well below the National average figure of 4.48%.

The number of avoidable pressure ulcers confirmed for Apr-15 were twelve grade 2, one grade 3, and one necrotic. However, there are still 48 pressure ulcers for Apr-15 still awaiting an outcome following RCA. Final figures for 2014-15 show the Trust has recorded 214 grade 2 avoidable pressure ulcers which is a 21% reduction on 2013-14 (271). Commissioners have set a further 20% reduction for 2015-16 in avoidable grade 2 pressure ulcers which would mean no more than 171 incidences across the Trust.

Point prevalence is no longer a CQUIN or KPI but is required as an information requirement (with no set target).

**Further Actions**

- Discussions with CCG regarding avoidable pressure ulcers and targets continues. A potential Trust target of 30% reduction is still to be agreed.
- Internal target set at 20% reduction across all sites (inc CSS) to be presented in May 2015.
- Site based trajectories set internally for the reduction of pressure ulcers to come into effect from May 2015.
Quality & Risk

Nursing Workforce

Workforce Headlines:

Overall there has been a reduction in Nursing sickness. There is a significant difference between sickness in qualified nursing and non-qualified nursing. Qualified nursing sickness alone is below the 4.65% target in April 2015.

Actions

- Raising high level of sickness of non-qualified nursing at site meetings, especially GHH and SOL.
- The split between qualified and non-qualified nursing sickness in 2014/15 to be detailed in May 2015 report.

National Staffing Return:

The UNIFY national staffing return showed that all sites and Womens services across April 2015 were compliant with staffing to their funded establishments (95% or over). This included the flex areas on each site. However there are a number of wards at BHH that have significant numbers of qualified vacancies (Wards 2, 3, 8, 9 and 24). These areas are heavily reliant on temporary staffing which is affecting the skill mix and continuity of care.

Actions

- Specific work being undertaken to measure quality of care wards with a significant number of qualified vacancies.
- Differentiating between bank and trust staff in terms of HCAs, to be available in May 2015. This is to determine whether there is any impact on ward safety.

Graph: % Sickness in Nursing at HEFT

Table: % Sickness in Nursing by Site April 2015

<table>
<thead>
<tr>
<th>Division</th>
<th>Qualified Nursing</th>
<th>Non-qualified Nursing</th>
</tr>
</thead>
<tbody>
<tr>
<td>BHH</td>
<td>4.87%</td>
<td>5.00%</td>
</tr>
<tr>
<td>GHH</td>
<td>4.00%</td>
<td>8.39%</td>
</tr>
<tr>
<td>SOL</td>
<td>3.08%</td>
<td>7.62%</td>
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<tr>
<td>CSS</td>
<td>4.87%</td>
<td>5.27%</td>
</tr>
<tr>
<td>W&amp;B</td>
<td>4.00%</td>
<td>6.28%</td>
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UNIFY Staffing Return

<table>
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<tr>
<th>Division</th>
<th>Qualified Compliance</th>
<th>HCA Compliance</th>
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<td>100%</td>
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<tr>
<td>GHH</td>
<td>96%</td>
<td>100%</td>
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<tr>
<td>SOL</td>
<td>105%</td>
<td>121%</td>
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<tr>
<td>O&amp;G</td>
<td>101%</td>
<td>99%</td>
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<tr>
<td>HEFT</td>
<td>99%</td>
<td>108%</td>
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Quality & Risk

Nursing Vacancies

Headlines
The key issue remains the shortage of registered nurses available to recruit and also the current turnover of staff. The introduction of new services and the provisional plan to substantively establish some of the flexible capacity beds is likely to have had a negative impact on the vacancy position.

Actions taken
- 86 posts have been offered over the last three months to nurses who qualify in September 2015.
- Local recruitment events have been held to target vacancies in specialist areas. This has been very successful in the Acute Medical Units on all three sites.
- Business case being prepared for the recruitment of nurses internationally as a result of the Recruitment and Retention paper presented to EMB.
- The Trust has invested in Nursing Times Group Access for every registered nurse across the Trust. This is aimed at slowing down attrition and encouraging new recruitment interest particularly from nurses with post registration experience.

Further Action
- HR and Nursing are working together to produce personal development and pastoral care incentives to make the Trust an employer of choice.
- Programme of local and national recruitment events planned throughout 2015.

Data not available at this time, due to be available for May 2015 Report

Graph: Qualified Nursing Vacancy Position April 2015
Graph: Qualified Nursing Vacancy Position April 2015 (A&E, CSS and W&C only)
Integrated Quality and Performance Report, including Finance

Council of Governors
June 2015

Quality & Risk

<table>
<thead>
<tr>
<th>Heat Map - Infection Control, VTE, Mortality</th>
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Integrated Performance Report - April

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<tr>
<td>ANQR2</td>
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</tr>
<tr>
<td>ANQR3</td>
<td>The number of avoidable Clostridium difficile</td>
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<td>ANQR1</td>
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MONITOR COMPLIANCE RISK ASSESSMENT FRAMEWORK

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<th>IN MONTH</th>
<th>LAST MONTH</th>
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<tbody>
<tr>
<td>Zero tolerance MRSA</td>
<td>≥ 90%</td>
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<td>≥ 90%</td>
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<tr>
<td>VTE risk assessment: all inpatient Service Users undergoing risk assessment for VTE, as defined in Contract Technical Guidance</td>
<td>≥ 95%</td>
<td>≥ 95%</td>
<td>≥ 95%</td>
</tr>
<tr>
<td>Mortality - HSMR</td>
<td>99.06%</td>
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</tr>
<tr>
<td>Mortality - SHMI</td>
<td>92.71%</td>
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<td>ANQR2</td>
<td>Minimise rates of Clostridium difficile</td>
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<td>ANQR3</td>
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<td>Mortality - SHMI</td>
<td>92.71%</td>
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</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>PRIMARY</th>
<th>MONITOR COMPLIANCE RISK ASSESSMENT FRAMEWORK</th>
</tr>
</thead>
<tbody>
<tr>
<td>ANQR2</td>
<td>Minimise rates of Clostridium difficile</td>
</tr>
<tr>
<td>ANQR3</td>
<td>The number of avoidable Clostridium difficile</td>
</tr>
<tr>
<td>ANQR1</td>
<td>Zero tolerance MRSA</td>
</tr>
</tbody>
</table>

MONITOR COMPLIANCE RISK ASSESSMENT FRAMEWORK

<table>
<thead>
<tr>
<th>TARGET</th>
<th>IN MONTH</th>
<th>LAST MONTH</th>
<th>TRUST (Mar-15)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Zero tolerance MRSA</td>
<td>≥ 90%</td>
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<td>≥ 90%</td>
</tr>
<tr>
<td>VTE risk assessment: all inpatient Service Users undergoing risk assessment for VTE, as defined in Contract Technical Guidance</td>
<td>≥ 95%</td>
<td>≥ 95%</td>
<td>≥ 95%</td>
</tr>
<tr>
<td>Mortality - HSMR</td>
<td>99.06%</td>
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</tr>
</tbody>
</table>
Quality & Risk

Infection Control

Headlines

There were no cases of post 48 hour MRSA bacteraemia reported in April. There is still a zero tolerance target for MRSA post 48 hour bacteraemia.

There have been two cases of post 48 hour toxin positive Clostridium Difficile (C.diff) in April against the month target of 6 or less. The 2015/16 year target is ≤ 64 cases (16 per quarter).

There was one new case of CPE identified in April. This was from a clinical specimen (sputum) from a child who has received healthcare in India.

There were two cases of suspected ebola in April. Both patients were returning healthcare workers who were low risk and low probability of ebola. In each case the patient was negative for ebola and was discharged within 24 hours.

Performance Analysis

- Four wards were closed during April due to outbreaks of diarrhoea and vomiting confirmed as Norovirus. These were BHH ward 6, GHH ward 14, GHH ward 16 and GHH ward 9.
- There was an outbreak declared of CPE on BHH ward 12 in April (all the patients were in hospital during March). The index patient had the organism identified from a clinical specimen of urine and two patient contacts were found to be positive on screening. Typing of the specimens identified that they were indistinguishable. All three patients had been discharged and screening of the remaining patients on the ward was negative.

Actions taken

- Deep cleaning was carried out on all norovirus outbreak wards prior to re-opening.
- An RCA was carried out for the CPE outbreak on BHH ward 12 and actions included deep cleaning of the entire ward, audit of practice, hand hygiene education and re-assessment of clinical staff for ANTT (aseptic non-touch technique).
- The ebola action group meets monthly and a debrief is carried out for all suspected cases.
- CPE screening has been implemented in adult inpatient and admission areas with the screening question being asked of all patients and included in electronic and paper documentation.
### Welcome Declaration of Interest Apologies Minutes Matters Arising

#### Heartlands Hospitals

<table>
<thead>
<tr>
<th>Performance Improvement</th>
<th>Trust Performance Apr-15</th>
<th>N/A</th>
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<th>11.4</th>
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<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>15.5</td>
<td>15.4</td>
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<tr>
<td>Integrated Plan</td>
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<td>16.7</td>
<td>16.6</td>
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#### Clinical Support Services

<table>
<thead>
<tr>
<th>Solihull Hospital</th>
<th>Good Hope Hospital</th>
<th>N/A</th>
<th>14.4</th>
<th>14.4</th>
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</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>15.5</td>
<td>15.5</td>
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<tr>
<td></td>
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<td>16.7</td>
<td>16.7</td>
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</table>

#### Women's & Children's

<table>
<thead>
<tr>
<th>N/A</th>
<th>14.4</th>
<th>11.4</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>15.5</td>
<td>15.4</td>
</tr>
<tr>
<td></td>
<td>16.7</td>
<td>16.6</td>
</tr>
</tbody>
</table>

#### Integrated Quality Report

- 85% rolling year
- No target set
- 85% rolling year

#### Any Other Business

- Vacancies
- Staff FFT
- N/A

#### Integrated Performance Report - April

<table>
<thead>
<tr>
<th>Ref.</th>
<th>W5</th>
<th>W6</th>
<th>W7</th>
<th>W12</th>
<th>W13</th>
</tr>
</thead>
<tbody>
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<td></td>
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</tbody>
</table>

#### Workforce & Well-being

<table>
<thead>
<tr>
<th>Ref.</th>
<th>CC/HEFT</th>
</tr>
</thead>
<tbody>
<tr>
<td>W5</td>
<td></td>
</tr>
<tr>
<td>W6</td>
<td></td>
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<tr>
<td>W7</td>
<td></td>
</tr>
<tr>
<td>W12</td>
<td></td>
</tr>
<tr>
<td>W13</td>
<td></td>
</tr>
</tbody>
</table>

#### Heat Map

- **MONITOR COMPLIANCE - RISK ASSESSMENT FRAMEWORK**
  - Average Time to Recruit from vacancy approval to start date - All Staff Groups
  - 8.5% by Mar-16
  - 9.01% by Mar-16
  - 4.33% by Mar-16
  - 3.93% by Mar-16
  - 3.93% by Mar-16
  - 85% rolling year
  - No target set
  - 85% rolling year

- **Heat Map - CCG / HEFT**
  - Monitor Compliance
  - Risk Assessment Framework
  - Target
  - In month trajectory
  - Last Month
  - Trust (Mar-15)
  - Heartlands Hospital
  - Good Hope Hospital
  - Solihull Hospital
  - Clinical Support Services
  - Women's & Children's
  - Clinical Support Services
  - Workforce & Well-being
  - Trustwide Agency Spend
  - Mandatory Training
  - 85% rolling year
  - No target set
  - 85% rolling year

#### Integrated Quality and Performance Report, including Finance

- Monitoring Review of Integrated Quality and Performance Report, including Finance
- Consent to publish

#### Council of Governors

- June 2015
- NHS
- Heart of England

#### Integrated Quality and Performance Report, including Finance
Workforce & Well-being

Appraisals

Headlines

There has been a change in the way appraisal completed data is published in 2015/16. The 2015/16 target is 85% over a rolling 12 months (rather than the trajectory used in 2014/15). The rolling 12 months in April 2015 is 73.29%. All data in this report is based on this new method of data collection.

HR Analysis

There has been gradual improvement through 2014/15 from 58.76% at the start of 2014/15 to 73.29% by April 2015.

The Directorates with staff numbers more than 50 which are most contributing to the performance being below target are:

<table>
<thead>
<tr>
<th>Heartlands</th>
<th>Acute Med</th>
<th>Elderly Med</th>
<th>T &amp; O</th>
<th>Out of Scope</th>
<th>Other &amp; Ops</th>
</tr>
</thead>
<tbody>
<tr>
<td>A&amp;E</td>
<td>61.22%</td>
<td>65.01%</td>
<td>50.39%</td>
<td>73.29%</td>
<td>55.53%</td>
</tr>
<tr>
<td>Acute Med</td>
<td>67.42%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Elderly Med</td>
<td>64.67%</td>
<td>66.39%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cardiology</td>
<td>61.00%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gastro</td>
<td>67.02%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Otolaryng</td>
<td>47.05%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Respiratory</td>
<td>62.77%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Clinical Supp | Critical Care | 57.12%

There were no major issues in Corporate and Facilities.

Actions

- There is further training for appraisers being provided centrally by HR.
- Improving and simplifying the appraisal process including investigating an online appraisal system.

% Appraisals completed by Division

<table>
<thead>
<tr>
<th>Division</th>
<th>March</th>
<th>April</th>
<th>2014/15</th>
</tr>
</thead>
<tbody>
<tr>
<td>BHH</td>
<td>61.17%</td>
<td>62.72%</td>
<td>0.00%</td>
</tr>
<tr>
<td>GHH</td>
<td>61.08%</td>
<td>60.09%</td>
<td>0.00%</td>
</tr>
<tr>
<td>SQA</td>
<td>73.05%</td>
<td>78.11%</td>
<td>0.00%</td>
</tr>
<tr>
<td>CSS</td>
<td>82.53%</td>
<td>80.92%</td>
<td>0.00%</td>
</tr>
<tr>
<td>WC</td>
<td>87.38%</td>
<td>66.05%</td>
<td>0.00%</td>
</tr>
<tr>
<td>COMP</td>
<td>92.15%</td>
<td>86.87%</td>
<td>0.00%</td>
</tr>
<tr>
<td>FAC</td>
<td>92.59%</td>
<td>89.02%</td>
<td>0.00%</td>
</tr>
<tr>
<td>HEFT</td>
<td>73.82%</td>
<td>73.29%</td>
<td>0.00%</td>
</tr>
</tbody>
</table>
Workforce & Well-being

Mandatory Training (MIA)

**Headlines**
The total figure for the year to March 2015 is 86.42% against a target of 85%.

**HR Analysis**
Despite achieving the overall training target, there are still areas where compliance can be improved:
- Resuscitation 61.33%
- Fire Safety 59.77%
- Blood Transfusion (administering) 59.7%

The release of staff is still a factor in non-delivery in the above areas. This is compounded by a number of vacancies in the resuscitation team which impacts on their ability to deliver the mandatory training.

All divisions have seen an increase from last month with the exception of Corporate Division (0.47% decrease). The Directorates with more than 50 staff and relatively low compliance include:

- Heartlands Elderly Med 72.26%
- CSS Lab Med 76.16%

**Actions Taken**
- Non-release of staff has been escalated to AMDs.
- Resuscitation staffing level review is currently in the process of being completed. Estimated 4 weeks
- Additional admin support confirmed for LMS.
- The three areas of concern were raised at the Risk Committee in April 2015.
  - DNA and Cancellation reports have been escalated to divisional level.

**Further Actions**
- New Learner Management System (LMS) being launched 1st June, graduated roll out will take 9 weeks.

### Integrated Quality and Performance Report, including Finance

**Mandatory Training (MIA)**

<table>
<thead>
<tr>
<th>Division</th>
<th>Feb 15</th>
<th>Mar 15</th>
<th>2015/16</th>
</tr>
</thead>
<tbody>
<tr>
<td>BHH</td>
<td>83.08%</td>
<td>89.62%</td>
<td>Not available at this time</td>
</tr>
<tr>
<td>GIM</td>
<td>83.61%</td>
<td>88.10%</td>
<td>Not available at this time</td>
</tr>
<tr>
<td>SOL</td>
<td>84.94%</td>
<td>85.50%</td>
<td>Not available at this time</td>
</tr>
<tr>
<td>CSS</td>
<td>83.39%</td>
<td>86.07%</td>
<td>Not available at this time</td>
</tr>
<tr>
<td>WC</td>
<td>83.83%</td>
<td>84.77%</td>
<td>Not available at this time</td>
</tr>
<tr>
<td>CORP</td>
<td>74.27%</td>
<td>75.40%</td>
<td>Not available at this time</td>
</tr>
<tr>
<td>FAC</td>
<td>76.27%</td>
<td>79.02%</td>
<td>Not available at this time</td>
</tr>
<tr>
<td>HEFT</td>
<td>85.86%</td>
<td>86.42%</td>
<td>Not available at this time</td>
</tr>
</tbody>
</table>
Headlines

Sickness for April was 4.32% across the Trust, a very slight reduction against the March figure of 4.33%. The moving annual average figure has stayed unchanged compared with last month so we are above target which is forecast as a month by month reduction over the year.

HR Analysis

Areas with significant staff numbers and the highest sickness levels for the month of April 15 were:

<table>
<thead>
<tr>
<th>Division</th>
<th>Area</th>
<th>April %</th>
</tr>
</thead>
<tbody>
<tr>
<td>SOL</td>
<td>Admission/Disch</td>
<td>13.43%</td>
</tr>
<tr>
<td>BHH</td>
<td>Admission/Disch</td>
<td>15.77%</td>
</tr>
<tr>
<td>Facil</td>
<td>Catering</td>
<td>9.57%</td>
</tr>
<tr>
<td>Facil</td>
<td>Hotel Services</td>
<td>9.99%</td>
</tr>
<tr>
<td>GHH</td>
<td>Acute Med</td>
<td>8.09%</td>
</tr>
<tr>
<td>GHH</td>
<td>General Surgery</td>
<td>7.49%</td>
</tr>
</tbody>
</table>

The areas with the highest sickness levels over a rolling 12-month period were:

<table>
<thead>
<tr>
<th>Division</th>
<th>Area</th>
<th>May14-Apr15</th>
</tr>
</thead>
<tbody>
<tr>
<td>BHH</td>
<td>Admission/Disch</td>
<td>7.12%</td>
</tr>
<tr>
<td>Facil</td>
<td>Catering</td>
<td>7.11%</td>
</tr>
<tr>
<td>GHH</td>
<td>Acute Med</td>
<td>2.01%</td>
</tr>
<tr>
<td>CSS</td>
<td>Sexual Health</td>
<td>2.09%</td>
</tr>
<tr>
<td>BHH</td>
<td>General Med</td>
<td>6.34%</td>
</tr>
<tr>
<td>Facil</td>
<td>Hotel Services</td>
<td>6.53%</td>
</tr>
<tr>
<td>BHH</td>
<td>Acute Med</td>
<td>6.47%</td>
</tr>
<tr>
<td>SOL</td>
<td>Elderly Med</td>
<td>6.01%</td>
</tr>
</tbody>
</table>

Actions

- HR continues to assist managers with the management of staff sickness.

Further Actions

- There is review of sickness policy under consultation with staff side which should help to improve processes for managing sickness. This is due to take place at the end of May.
- Continued development of staff engagement plan as part of overall trust plan. A working group will meet in May to consider incentives for staff achieving low sickness.
Integrated Performance Report - April

Workforce & Well-being

**Voluntary Turnover & Recruitment**

**Headlines**

**Voluntary Turnover**

Turnover was very slightly above the 9% target in April 2015 (9.01%). This has stabilised over the last few months.

**Turnover Analysis**

Despite being above target during April 2015, turnover is expected to reduce to 8.5% by the year end. Directorates with more than 50 staff and the highest levels of turnover are:

<table>
<thead>
<tr>
<th>Directorate</th>
<th>Mar-15</th>
<th>Apr-15</th>
<th>2015/16</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute Med</td>
<td>10.3%</td>
<td>11.6%</td>
<td>11.6%</td>
</tr>
<tr>
<td>Surgery</td>
<td>12.5%</td>
<td>12.9%</td>
<td>12.9%</td>
</tr>
<tr>
<td>Cardiology</td>
<td>17.9%</td>
<td>17.9%</td>
<td>17.9%</td>
</tr>
<tr>
<td>Overall</td>
<td>11.0%</td>
<td>11.0%</td>
<td>11.0%</td>
</tr>
</tbody>
</table>

**Recruitment - time to hire**

The target is 11 weeks consisting of 6.25 weeks for the Operational Management part of the process and 4.75 weeks for the central recruitment section. The actual position for April 2015 was 8.5 weeks and 5.5 weeks respectively, giving a total of 14 weeks.

**Recruitment Analysis**

The main reason for delays is the time taken to shortlist candidates and return a successful candidate form. The main areas with long timescales are:

**Actions Taken**

- A report is now sent monthly to each of the areas performing poorly.

Further Action

- Analysis into a potential link between the number of vacancies and long areas with longer recruitment times is being undertaken.
**Patient Experience**

**Metrics**

### Friends and Family Test (FFT)

This is no longer a CQUIN requirement but it is an important and useful metric. Currently, the targets are set at the Quarter 4 2014/15 position.

- The absolute number of responses to the FFT continues to grow.
- The number of positive responses for inpatients is below the regional score of 95%; however, this does vary month on month.

In the A&E data, the positive response rate is lower than that of inpatients, which indicates a lower level of satisfaction with our A&E service. There is also a larger difference between the A&E score for Heart of England and the regional score (87% in March, for Birmingham and Black Country region).

There is no regional benchmarking for negative responders, therefore we are unable to draw any comparisons. Comparison data for positive responses was not available at the time of writing.

**Disturbed by Noise at Night**

The noise at night question continues to be the poorest performing metric. On further analysis, it is difficult to target ward areas where there might be a particular issue due to a wide range of variance in the number of responses per ward.

### Further Actions

- Agreement to be reached on the thresholds for FFT for 2015/16
- Further work to improve the validity and comparability of the noise at night data is ongoing.
- Data from inpatient questionnaires is being made more readily available to nursing staff.

---

|-------------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|-----|--------
| Inpatients  | 86%    | 87%    | 87%    | 94%    | 94%    | 96%    | 96%    | 96%    | 96%    | 96%    | 96%    | 96%    | 96%    | 96% |
| A&E         | 14%    | 13%    | 13%    | 12%    | 12%    | 11%    | 11%    | 11%    | 11%    | 11%    | 11%    | 11%    | 11%    | 11% |

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</tr>
</thead>
<tbody>
<tr>
<td>Overall</td>
<td>723</td>
<td>779</td>
<td>831</td>
<td>1059</td>
<td>1006</td>
<td>1101</td>
<td>1140</td>
<td>1004</td>
<td>1143</td>
<td>1114</td>
<td>1143</td>
<td>1104</td>
<td>1114</td>
</tr>
<tr>
<td>Positive</td>
<td>654</td>
<td>705</td>
<td>780</td>
<td>1022</td>
<td>1006</td>
<td>1101</td>
<td>1140</td>
<td>1004</td>
<td>1143</td>
<td>1114</td>
<td>1143</td>
<td>1104</td>
<td>1114</td>
</tr>
<tr>
<td>Negative</td>
<td>69</td>
<td>74</td>
<td>51</td>
<td>37</td>
<td>37</td>
<td>37</td>
<td>37</td>
<td>37</td>
<td>37</td>
<td>37</td>
<td>37</td>
<td>37</td>
<td>37</td>
</tr>
</tbody>
</table>

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### Inpatients FFT 2014/15 Performance, Positive vs Negative responders

<table>
<thead>
<tr>
<th></th>
<th></th>
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<th></th>
<th></th>
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<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall</td>
<td>723</td>
<td>779</td>
<td>831</td>
<td>1059</td>
<td>1006</td>
<td>1101</td>
<td>1140</td>
<td>1004</td>
<td>1143</td>
<td>1114</td>
<td>1143</td>
<td>1104</td>
<td>1114</td>
</tr>
<tr>
<td>Positive</td>
<td>654</td>
<td>705</td>
<td>780</td>
<td>1022</td>
<td>1006</td>
<td>1101</td>
<td>1140</td>
<td>1004</td>
<td>1143</td>
<td>1114</td>
<td>1143</td>
<td>1104</td>
<td>1114</td>
</tr>
<tr>
<td>Negative</td>
<td>69</td>
<td>74</td>
<td>51</td>
<td>37</td>
<td>37</td>
<td>37</td>
<td>37</td>
<td>37</td>
<td>37</td>
<td>37</td>
<td>37</td>
<td>37</td>
<td>37</td>
</tr>
</tbody>
</table>

---

### Disturbed by noise at Night

On further analysis, it is difficult to target ward areas where there might be a particular issue due to a wide range of variance in the number of responses per ward.
### Integration Performance Report - April

**Integrated Quality and Performance Report, including Finance**

#### Council of Governors

**June 2015**

**Agenda**

* Welcome
* Declaration of Interest
* Apologies
* Minutes
* Matters Arising
* Chairman’s Report
* Chief Executive’s Report
* Integrated Quality Report
* Any Other Business
* Attendance Record
* Integrated Improvement Plan
* Dementia Strategy Presentation
* Governance and Governors’ Responsibilities

#### Integrated Quality and Performance Report

**Patient Experience**

**Complaints**

**New Complaints**

**Re-opened Complaints and Complaints referred to Ombudsman**

**Graph 2: Themes of New Complaints**

**Graph 1: % New Complainants as a proportion of Total Activity**

**Headlines**

The number of new complaints in April (93) increased slightly compared to March (89).

Validation of 2014/15 has been underway.

The number of complaints closed in year has improved from the previous year as has the number of complaints which have been re-opened:

<table>
<thead>
<tr>
<th>Complaints</th>
<th>2013/14</th>
<th>2014/15</th>
</tr>
</thead>
<tbody>
<tr>
<td>Re-opened</td>
<td>156</td>
<td>149</td>
</tr>
<tr>
<td>Closed</td>
<td>738</td>
<td>828</td>
</tr>
</tbody>
</table>

NB: These year end figures need to be validated.

**Themes Analysis**

The main themes for complaints show a similar picture across the quarters of 2014/15. Complaints are often complex and cover more than one issue. The biggest number of complaints by far in each quarter relate to delays and cancellations.

**Actions Taken**

- Information on delays and cancellations is currently being reported as part of the scheduled care programme.

**Further Actions**

- To counter the number of attitudes and behaviours complaints the Trust is currently developing a set of staff values and behaviours with a section on being patient centred.
FINANCE EXECUTIVE SUMMARY & KEY PERFORMANCE INDICATORS

Month 12 to 31st March 2015

The Report is being provided for: Trust Board and Council of Governors
Which other Committees has this paper been to?
Finance and Performance Committee, 24th April 2015

EXECUTIVE SUMMARY

We remain under Section 111 Monitor Enforcement.

Financially we ended the year as expected, key areas are illustrated below highlighting pressures, nurse bank rate and underlying pay control, as we enter the new financial year:

- Underlying pay bill showed a material movement, £0.4m, in month which Divisions need to address as a matter of urgency entering the new financial year.

- Divisions need to now implement exit strategies, outside of agreed new investment measures to deliver care, to mitigate financial risk in quarter 1.

- Divisions are required to close GAP on efficiency plans and implement early delivery 2015/16 to achieve 2015/16 plan.

- Divisions need to improve delivery and have consistent delivery against our finalised 2015/16 CQUIN’s.

- Cash balance at year end was £87.7m.

Performance remains our key area of concern with little improvement in the last month of the year. Improvement trajectories for A&E and RTT are currently being finalised prior to final submission to Monitor for the new year.

Finance

- Trust reforecast following additional measures investment (£5.6m)

- Year end income (£0.6m)

- Nurse bank rate impact (£0.8m)

- BCC rates impact (£1.0m)

- Year end stock, holiday accrual & provisions £1.6m

- Underlying March pay movement (0.4m)

- 2014/15 Year end (£5.6m)

The Report is being provided for Finance and Performance Committee, 24th April 2015.
• Capital expenditure for the year was £20.5m, including accruals which is £21.2m behind approved budget and £6.8m behind Monitor forecast.

Standing Financial Instructions Update

A paper was presented to FPC that proposed the following changes to the SFIs to help provide clarity on responsibilities:

1. Amend the delegated authority levels to revised authority levels that reflected the Trust structure and set the operational managers as the dominant authoriser. For purchase orders and contracts the CEO can approve up to £250k.

2. Above the CEO level of £250k, purchase orders and contracts would be approved by Finance and Performance Committee. This had previously been noted in the SFIs as Trust Board, but this duty had been delegated to Finance and Performance Committee for a number of years. This change requires Trust Board approval as Finance and Performance Committee would now be performing a duty that was previously the responsibility of Trust Board.

3. For business cases where there is a request to spend new money, the case could be approved by EMB up to £500k, and above this would require Trust Board approval.

4. There were other several other procedural changes proposed including:
   - Self-approval of orders prohibited except for noted exceptions.
   - Exceptions to the authority levels for less usual transactions.

Recommendations

Agreed recommendations:

1. Division’s financial performance to be reported at Delivery Unit meetings.
2. Additional action to manage medical pay.
3. Executive led improvement in areas of poor performance.
4. Implement additional measures to improve performance.
5. Exit strategies to be in place for winter/additional measures above new investment decisions.
6. Close GAP on 2015/16 SIEP and begin early implementation.
7. Further review the decision regarding enhanced bank rates.
8. Conclude demand and capacity investment decisions when linked to 4, 5 and 7 above.
9. Accept revised SFI’s.
MARCH POSITION

The Trust had an I&E surplus in March.

The final outturn clinical income value for 2014/15 is £577.4m, £11.1m above plan for the year. Clinical income was £0.6m higher than expected at the end of the year compared to the forecast due to a combination of JMRA upside relating to fines and penalties, additional RTT funding and end of year specialised services challenges to drugs and devices expenditure.

The main areas of performance were Specialised Services £6.3m plus additional income recovered through Cancer Drugs Fund (CDF) of £4.7m.

The in month expenditure position showed a material movement in underlying pay bill of c£0.4m. Analysis shows this to be due to the following:

<table>
<thead>
<tr>
<th>Site</th>
<th>Headlines</th>
<th>£k</th>
</tr>
</thead>
<tbody>
<tr>
<td>Good Hope</td>
<td>Backlog claim of Waiting List Initiatives</td>
<td>133</td>
</tr>
<tr>
<td></td>
<td>Additional Capacity – Ward 3</td>
<td>34</td>
</tr>
<tr>
<td>Heartlands</td>
<td>Additional Locums (sickness / vacancy)</td>
<td>121</td>
</tr>
<tr>
<td>Solihull</td>
<td>New Waiting List Initiatives</td>
<td>15</td>
</tr>
<tr>
<td></td>
<td>Increased Winter / Thornbury</td>
<td>25</td>
</tr>
<tr>
<td>Trustwide</td>
<td>A&amp;E Nursing (sickness / vacancy)</td>
<td>52</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>380</td>
</tr>
</tbody>
</table>

The table below summarises our current Finance & Performance position:

<table>
<thead>
<tr>
<th>Category</th>
<th>Mar</th>
<th>Headlines</th>
</tr>
</thead>
<tbody>
<tr>
<td>Finance</td>
<td></td>
<td>Pay control</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Costs to delivery performance</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Efficiency (SIEP) delivery</td>
</tr>
<tr>
<td>Performance</td>
<td></td>
<td>A&amp;E 4 hour</td>
</tr>
<tr>
<td></td>
<td></td>
<td>18 week admitted RTT / non admitted RTT/ incomplete pathways</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Cancer 2 week wait / breast symptoms/ 62 day waits</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Diagnostics</td>
</tr>
<tr>
<td>Contracting</td>
<td></td>
<td>All contract risk for the JMRA has been covered in the year end contract settlement, including fines and CQUIN non delivery. Contract negotiations for 15/16 are still ongoing for both financial and non financial elements of the contract.</td>
</tr>
</tbody>
</table>
1. **FINANCE**

The Trust’s income and expenditure position in March was a £2.8m surplus and a £5.6m loss at year end.

The table below shows the key issues influencing the financial position:

<table>
<thead>
<tr>
<th>Category</th>
<th>Mar £m</th>
<th>Headlines</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical Staffing</td>
<td>(0.4)</td>
<td>Expenditure remains unaffordable</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Waiting List Initiatives spend of £0.4m</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Greatest pressures in BHH, SOL and GHH</td>
</tr>
<tr>
<td>Nursing &amp; Midwifery</td>
<td>(0.7)</td>
<td>Expenditure remains unaffordable</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Enhanced bank rates continue</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Greatest pressures in BHH and GHH</td>
</tr>
<tr>
<td>SIEP</td>
<td>(0.5)</td>
<td>Most significant shortfalls in BHH, SOL and W&amp;C’s</td>
</tr>
<tr>
<td>Overall Position</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

1.1 **SIEP** – Actual delivery in month was £1.4m (75% of target). The year end delivery for 2014/15 was £16.4m (68%) with the balance of plans being high risk. The focus now must be early implementation of 2015/16 plans.

1.4 **Cash Deposits** – The cash balance at the end of March 2015 was £87.7m. Barring some insignificant balances held in commercial accounts, this was all held in the Trust’s GBS accounts at the year end. Funds remaining in the GBS current accounts earn 25bp interest.

1.5 **Monitor Targets** – The Trust’s Continuity of Service Rating (COSR) at the end of March was 4. The COSR scale is 1 to 4 with 4 being the highest rating.

1.6 **Capital** – The total capital expenditure in the year was £20.5m, including accruals which is £21.2m behind the approved budget and £6.8m behind the forecast submitted to Monitor. A carry forward of £20.4m is being requested with the majority of this being due to slippage on cross site plans.
2 CONTRACTING

LDP meetings continue with HEFT service leads and the CCG. Key items for consideration currently are the underlying activity growth assumptions on both the Acute and Community contracts. Discussions are underway at FD level to agree these principles. Subgroup meetings to work up the detail of the KPI’s, CQUINs, SDIPs and other contractual content are continuing and an escalation document is currently being drawn up to identify the current gaps. This will support any required escalation and identify the risks preventing sign off.

3 ESCALATION PROCESS

The current escalation process will be revised in line with organisation needs at the start of the new financial year.

4 CURRENT ACTIONS

The below are the updated actions:

1. Division’s financial performance to be reported at Delivery Unit meetings.
2. Additional action to manage medical pay.
3. Executive led improvement in areas of poor performance.
4. Implement additional measures to improve performance.
5. Exit strategies to be in place for winter/additional measures above new investment decisions.
6. Close GAP on 2015/16 SIEP and begin early implementation.
7. Further review the decision regarding enhanced bank rates.
8. Conclude demand and capacity investment decisions when linked to 4, 5 and 7 above.

5 CONCLUSION

With investment in ongoing capacity clear exit strategies from winter and additional measures coupled with early delivery of service improvement efficiency plans will be essential to mitigating financial risk at the start of the new financial year. Additional investment and ongoing support needs to impact positively on performance, care and all standards in quarter 1 of 2015/16.

6 RECOMMENDATIONS

It is recommended the above actions are implemented.

Darren Cattell
Interim Director of Finance & Performance
March 2015
Heart of England NHS Foundation Trust
1. A&E Activity 2014/15

- There were 18,154 A&E attendances in Feb-15, 348 attendances, 2% above plan.
- In February 85.65% of patients were seen within 4 hours including walk-ins.
- At Heartlands 81.95% (1,626 breaches) of patients within 4 hours, 76.52% (1,437 breaches) at Good Hope site and 97.32% (81 breaches) at Solihull site.
- A&E activity excludes A&E outpatient attendances.
- Form TF2A

2. Emergency Activity 2014/15 excluding Paediatrics, Paediatric Surgery and Obstetrics

- The Emergency activity was above plan by 1% in February, 56 Spells.
- Heartlands 113 Spells, 4% and Solihull, 14 Spells, were above plan.
- Good Hope 39 Spells, 4% and Women & Childrens Spells, 15% were below plan in month.
- Following the implementation of PMS2 a potential patient classification issue has been identified. This is currently under a detailed review and any necessary retrospective realignment will be actioned.
- Form TF2A

3. Emergency Activity 2014/15, Paediatrics, Paediatric Surgery and Obstetrics

- The activity is above plan by 6%, 55 Spells in Feb-15.
- The activity YTD is above plan by 6%, 562.
- Following the implementation of PMS2 a potential patient classification issue has been identified. This is currently under review and any necessary retrospective realignment will be actioned.
**ACTIVITY / WAITING LIST PERFORMANCE**

### 4. AMU, MAU & SAU Activity 2014/15

- There were 1,938 spells during Feb-15, 246 Spells, 15% above plan.
- Good Hope 102 spells, 20%, Heartlands, 87, 15% an Solihull, 58, 9% were above plan in month.
- There were 4,813, 25% additional spells YTD.

![AMU,MAU & SAU Activity 2014/15](image)

In-Month Performance

### 5. Maternity Spells Activity 2014/15

- In February 2015, there were 816 Births Trustwide (5 at Heartlands, 294 at Good Hope, and 12 at Solihull) This compares to the plan of 852 (-4%). In February there were 3 planned homebirth (2 at Heartlands and at Good Hope).

![Maternity Spells Activity 2014/15](image)

In-Month Performance
6. Elective & Day Case Activity 2014/15

- The Day case and Elective activity was above plan by 3%, 220 Spells during Feb-15.
- Heartlands, 2%, 75 Spells and Women and Childrens, 32%, 146 Spells were below plan in month.
- Solihull Division, 25%, 318 Spells, Clinical Support. 5 Spells, 46% and Good Hope, 69 Spells, 11% were above plan in month.
- Following the implementation of PMS2 a potential patient classification issue has been identified. This is currently under a detailed review and any necessary retrospective realignment will be actioned.
- There were 186 patients treated by the private sector during February and 1,550 YTD. Ophthalmology (58 General Surgery (66), ENT (32), Orthopaedics (28), Urology (7), Vascular Surgery (4) and Gynaecology (3) had patients treated by the private sector in month.
- 122 patients were treated in the Vanguard Theatre in February and 897 patients since it opened in September.
- There were 24 cancelled sessions during February, 97.22% of the scheduled sessions were utilised. The following specialties cancelled sessions, General Surgery (8), Gynaecology (5), Orthopaedics (4), Thoracic Surgery (2), Urology (2), Vascular Surgery (2) and ENT (1).
- 75% (18) of the Theatre sessions were cancelled due to no surgeon in month.
- In addition 20 sessions were cancelled in the Vanguard Theatre during February.
- 121 operations were cancelled on the day during February, 51 (42%) of the cancelled operations were at Good Hope, 44 (36%) at Heartlands and 26 (21%) at Solihull.

7. Outpatient Activity 2014/15

- There were 64,935 Outpatient attendances during Feb-15, 719 atts, 1% attendances than planned.
- Good Hope 309 atts, 4%, Clinical Support, 123 atts, and Solihull, 922 atts, 4% were above plan in month.
- Heartlands (303 atts, 1%) and Women & Childrens (331 atts, 5%) were below plan in month.

Total DNA Rates (February-15):
- Good Hope 8.06% (2,166*)
- Heartlands 11.95% (3,780*)
- Solihull 7.45% (1,783*)

The DNA rate for first attendances was 14.16% (1,361*) at Heartlands site during Feb-15. Good Hope (8.30%) and Solihull (8.12%) achieved the target of less than 11%.

*No. of DNAs.

In-Month Performance
INCOME AND EXPENDITURE

8. Performance against Monitor Standards 2014/15

- The overall I&E deficit was £8.4m at the end of month 11.
- This deficit was £9.4m adverse to the Monitor plan and £2.8m adverse to the recent reforecast.
- Income was £14.9m favourable to plan while operating expenses were £28.5m adverse to the Monitor plan.
- PDC dividend expenditure was £1.2m favourable to plan, depreciation £3.0m favourable to plan.
- Continuity of Service Rating (COSR) was 4 for month 11, the highest rating.

In-month Performance

Cumulative I&E by Month 2014/15

9. Income 2014/15

NHS Contract Income (Category A)

- There was a trustwide over performance of £0.8m in month, £10.2m YTD.
- Specialised Services income was above plan by £0.4m in February, driven by drugs and vascular excluded devices.
- Income relating to the Cancer Drugs Fund was £0.4m in month.

In-month Performance

Over Performance YTD by Contract Type 2014/15

10. Income and Expenditure against Operational Budgets

- The Trust is (£12.5m) over spent at Month 11 of 2014/15.
- Pay is over spent by (£9.2m)
- Non Pay is over spent by (£6m)
- Other Operating Revenue £3.1m over recovered
- Form TF1

In-Month Performance
# INCOME AND EXPENDITURE

11. Operational Budgets 2014/15

<table>
<thead>
<tr>
<th>Hospital</th>
<th>Budgets</th>
<th>Equipment</th>
<th>Non Equipment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Heartlands Hospital (BHH)</td>
<td>Over spent by £(15.1m)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Income under recovery</td>
<td>(£0m)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pay over spend</td>
<td>(£5.9m)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non Pay over spend</td>
<td>(£9.2m)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clinical Support Services (CSS)</td>
<td>Under spent by £0.2m</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Income over recovery</td>
<td>£0.3m</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pay under spend</td>
<td>£1.5m</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non Pay over spend</td>
<td>(£1.6m)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Good Hope Hospital (GHH)</td>
<td>Over spent by £(7.2m)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Income over recovery</td>
<td>£0m</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pay over spend</td>
<td>(£4.6m)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non Pay over spend</td>
<td>(£2.6m)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Solihull Hospital (SOL)</td>
<td>Under spent by £(5.4m)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Income over recovery</td>
<td>£0.2m</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pay over spend</td>
<td>(£1m)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non Pay over spend</td>
<td>(£4.6m)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Womens and Childrens (WC)</td>
<td>Under spent by £(2.8m)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Income over recovery</td>
<td>£0.8m</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pay over spend</td>
<td>(£0.5m)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non Pay over spend</td>
<td>(£3.2m)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

In-month Performance: £1m

Corporate Directorates (CD) is under spent by £0.8m
- Income under recovery: (£0.1m)
- Pay under spend: £0.8m
- Non Pay under spend: £0m

Corporate Trust Wide (CTW) is under spent by £16.7m
- Income over recovery: £0.8m
- Pay over spend: (£0.2m)
- Non Pay under spend: £16m

Facilities (FAC) is under spent by £0.4m
- Income over recovery: £0m
- Pay under spend: £0.7m
- Non Pay over spend: (£0.3m)

Bad Debt provision included within the above: £1m
Council of Governors
June 2015

INCOME AND EXPENDITURE

12. Pay Expenditure
Pay Expenditure is over spent by (£9.2m) at Month 11 2014/15.

Material variances to operational budget relates to:
• Medical Staffing, which is over spent by (£7.5m),
• Nursing & Midwifery overspent by (£4.7m),
• Offset by other support staff underspend totaling £3.1m
• Form TF3

13. Non Pay Expenditure
Non Pay is over spent by (£6m) at Month 11 in 2014/15.

Material overspends against operational budgets are:
• 2014/15 SIEP shortfall (£7.1m)
• Clinical Supplies overspent (£5.2m)
• Drugs over performance benefit £2m
• Depreciation, Amortisation benefit £2.3m
• Miscellaneous Other Expenses £2m

Finance Executive Summary and Key Performance Indicators
## INCOME AND EXPENDITURE

### 14. Service Improvement Efficiency Plan 2014/15

<table>
<thead>
<tr>
<th>GROUPS</th>
<th>Feb - In Month</th>
<th>Year To Date</th>
<th>Forecast @ Month 11</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Target</td>
<td>Actual Rec</td>
<td>Actual Non Rec</td>
</tr>
<tr>
<td>heartlands hospital</td>
<td>625.0</td>
<td>285.6</td>
<td>43.6</td>
</tr>
<tr>
<td>good hope hospital</td>
<td>183.3</td>
<td>101.6</td>
<td>2.0</td>
</tr>
<tr>
<td>solihull</td>
<td>291.7</td>
<td>189.3</td>
<td>7.8</td>
</tr>
<tr>
<td>clinical support services</td>
<td>433.3</td>
<td>242.6</td>
<td>73.2</td>
</tr>
<tr>
<td>women's &amp; childrens</td>
<td>225.0</td>
<td>51.0</td>
<td>0.1</td>
</tr>
<tr>
<td>facilities</td>
<td>116.7</td>
<td>102.7</td>
<td>19.3</td>
</tr>
<tr>
<td>corporate directorates</td>
<td>125.0</td>
<td>136.0</td>
<td>6.8</td>
</tr>
<tr>
<td>corporate trustwide</td>
<td>0.0</td>
<td>166.7</td>
<td>0.0</td>
</tr>
<tr>
<td>TOTAL</td>
<td>2,000.0</td>
<td>1,275.5</td>
<td>152.6</td>
</tr>
</tbody>
</table>

- The Trust achieved £1.43m (71.4%) efficiency in Month 11.
- These results show a (£0.6m) shortfall against target at Month 11.

Based on Month 11 results the forecast out turn is £16.5m delivery of savings (68.9%).

**Analysis of forecast:**

- £16m in risk category 5 Delivered
- £0.2m in risk category 4 Planned with expected delivery
- £0.3m in risk category 3 Suggested plans

---

### In-month Performance

![In-month Performance Chart](chart.png)
15. Combined Capital Expenditure YTD 2014/15

YTD Expenditure was £17.8m, 77.0% of the reforecast YTD Monitor Plan (MP) and 42.9% of total Approved Budget (AB) £41.5m. Orders raised were £25.0m, 108.1% of YTD MP & 60.2% of AB.

- Operational was £6.6m, 73.9% of YTD MP, key spends on LAN & other IT projects
- Other was £6.6m, 78.7% of YTD MP, with spend on replacement MRI Scanner, Energy Sustainability, Document Scanning, Negative Pressure rooms.
- Site Strategy Investment expenditure was £4.4m, 79.3% of YTD MP, spend on Hybrid Theatres, Dermatology relocation, AMU refurb at GHH, the Chemotherapy and Rheumatology units
- HPA was £138k, 78.1% of YTD MP

YTD Performance

16. Capital Expenditure in Month 2014/15

M11 in-month expenditure was £2.4m:

- FAC / Site Strategy £2.1m- Hybrid Theatres, Dermatology relocation SOL, AMU refurbishment at GHH, Energy Sustainability, Ward 3 refurbishment at GHH.
- CD £162k- Corporate Community PC Replacement and iPads, Windows 7 compliance, LAN
- CSS £86k- Negative Pressure Isolation Rooms Ward 28 at BHH
- WC £36k- Obstetrics Capacity Risks project at BHH, Bladder Scanner at GHH, 2 Bipad Machines

In-month Performance

17. Creditors 2014/15

- Payment performance in February is about 70%. The volume of invoices paid in February is 13,535 in line with normal volumes.
- The continued poor payment performance is due to backlog clearing and processing delays following the Readsoft upgrades and will also impact on March performance and beyond.

Cumulative Performance
**Council of Governors**

**June 2015**

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**Council of Governors**

**June 2015**

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**Agenda**

- Welcome
- Declaration of Interest
- Apologies
- Minutes
- Matters Arising
- Chairperson’s Report
- Chief Executive’s Report
- Integrated Quality Report
- Integrated Improvement Plan
- Dementia Strategy Presentation
- Governance and Governors’ responsibilities
- Attendance Record
- Chairman’s Report
- Any Other Business

---

**BALANCE SHEET**

18. Debtors 2014/15

- Total debt reduced by £2.423m during February to £19.811m.
- Health Education England paid a training & education invoice for £5.156m during the month.
- There was a deterioration in the underpayment of the monthly SLA mandate invoices by £1.387m to a cumulative underpayment of £2.885m, in anticipation of expected contract penalties. Those underpaying include Birmingham Cross City CCG £1.664m and Solihull CCG £1.116m.
- Solihull CCG recalled a £2.000m advance on the February SLA mandate payment, but replaced it with a £0.550m advance of the March SLA mandate payment.
- A resilience funding invoice for £3.472m to Birmingham Cross City Clinical Commissioning Group remains outstanding and disputed. The invoice will be credited shortly and a replacement invoice for £2.129m will be issued.
- Ante natal maternity pathways activity debt for April 2013 to December 2014 increased to £3.525m, including £1.719m with Burton Hospitals, £0.860m with Sandwell & West Birmingham Hospitals, and £0.490m with Birmingham Women’s Hospital.
- Burton Hospitals Foundation Trust have debts of £2.337m, (including £1.719m for ante natal maternity pathways activity), and have recently placed the account on hold until this trust settle their debt for £0.595m.

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In-month Performance

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**CASHFLOW**


- The cash balance at the end of February 2015 was £101.6m, £18.6m above plan.
- Operating cash flows were £17.0m below plan. This was offset by favourable working capital movements of £14.6m. Capital expenditure in cash terms was £14.9m less than plan.
- The half yearly PDC dividend payment was processed in September and this was £1.7m less than planned including a rebate for the last financial year.
- All Trust funds remain in the GBS umbrella as a change in the rules on calculating PDC dividend means that it is currently financially unviable to invest in other commercial banks.
- £75m of funds have been reinvested in the National Loan Fund (NLF) for 6 months at a rate of 49bp. A further £9.0m was on deposit with NLF at the month end on a short term basis attracting interest rates of around 40bp.
- Funds in GBS attract 25bp.

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In-month Performance

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Finance Executive Summary and Key Performance Indicators

---

**In-context performance**

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.81
HEFT have now resumed reporting against the admitted patient pathway (clock stops), and achieved 79.34% against the 90% target for Jan15, with the aim to continue to see longer waits in order to help clear the backlog.

HEFT managed to see 85.91% of non-admitted patients within 18 weeks against the 95% target for Jan15.

The 95% target for A&E around 4 hour was not met in February with performance at 85.65%.

Total time in A&E

The 95% target for A&E around 4 hour was not met in February with performance at 85.65%.
Cancers: Reported 1 month in arrears

The Trust failed the 93% target for the 2 week GP cancer indicator in January at 91.24%, and also failed the 1 week Breast symptom 93% target, achieving 76.61%

The Trust achieved the 96% target for 31 day cancers in January, out-turning at 98.12% in month

The Trust met the 31 day anti-cancer drug target of 98% in January, achieving 100%

The Trust met the 31 day surgery modality cancer target of 94% in January, achieving 96.72%

The Trust achieved the 62 day cancer 85% target in January, achieving 86.22%

The Trust missed the 62 day national screening cancer 90% target in January, achieving 50%
Infection Control

The target for incidents of c-diff is no more than 6 in February, and in month the Trust reported 3 cases, with a total of 67 YTD.
## Trust Wide Income and Expenditure

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<tr>
<th>Year to Date</th>
<th>Full Year</th>
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## Key Performance Indicators (KPIs)

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<th>Full Year</th>
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<tr>
<td><strong>Annual Plan</strong></td>
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<td>Net I&amp;E Margin</td>
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<td>Revenue available for debt service (£m)</td>
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## Council of Governors

### June 2015

#### Minutes

### Matters

- **Welcome**
- **Apologies**
- **Declarations of Interest**
- **Chief Executive’s Report**
- **Integrated Quality Report**
- **Integrated Improvement Plan**
- **Dementia Strategy Presentation**
- **Matters Arising**
- **Governance and Governors’ responsibilities**
- **Attendance Record**
- **Chairman’s Report**
- **Any Other Business**

### Finance Executive Summary and Key Performance Indicators

#### Form TF1B

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### Key performance Indicators (KPIs)

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## Trust Wide Cash flow

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</table>

**Net cash inflow/outflow from operating activities:**

- **Net cash inflow/outflow from investing activities:**
  - Property, plant, and equipment acquisitions
  - Proceeds on disposal of property, plant and equipment
  - Purchase of investment property
  - Purchase of intangible assets
  - Proceeds on disposal of intangible assets
  - Other expenditure
  - Government grants received
  - Purchase of investments & deposits made
  - Proceeds on disposal of investments & withdrawals
  - Other cash flows from investing activities

- **Net cash inflow/outflow from financing activities:**
- **Net cash inflow/outflow before financing activities:**
- **Net cash inflow/outflow after financing:**

**Net increase / (decrease) in cash:**

- Public dividend distributable
- Public dividend capital
- Net increase in cash
- Closing cash balance

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**Council of Governors**

**June 2015**

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**Finance Executive Summary**

**and Key Performance Indicators**

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**Integrated Improvement Plan**

**Dementia Strategy**

**Integrated Quality Report**

**Minutes**

**Matters Arising**

**Governance and Governors’ responsibilities**

**Attendance Record**

**Chairman’s Report**

**Any Other Business**
**Finance Executive Summary and Key Performance Indicators**

### Council of Governors

**June 2015**

---

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**Weighted Average**

| 4.00 |

**Overriding rules**

| 4 |

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**Weighted Average**

| 4.00 |

**Overriding rules**

| 4 |

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**Weighted Average**

| 4.00 |

**Overriding rules**

| 4 |

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**Welcome**

**Apologies**

**Declaration of Interest**

**Chief Executive's Report**

**Integrated Improvement Plan**

**Dementia Strategy Presentation**

**Minutes**

**Matters Arising**

**Governance and Governors' responsibilities**

**Attendance Record**

**Chairman's Report**

**Any Other Business**

---

**Agenda**
Appendix 2

Standing Financial Instructions Update

1. Introduction

Due to various changes in the Trust over the last year it is necessary to amend the Trust Standing Financial Instructions (SFIs). This paper seeks approval from the Finance and Performance Committee to amend the SFIs in the following areas;

- Amend the delegated authority levels to revised values, new authority levels and to reflect the operational managers as the dominant authoriser.
- Confirm the reporting arrangements for orders and contracts above chief executive level.
- Make self-approval of orders prohibited except for noted exceptions.
- Detail the exceptions to the authority levels.
- Note the authorisation process for approval of business cases.
- Provide clarity on authority levels for contracts

This change will give clarity to the Trust on the relevant approval rights and will mean that controls can apply whilst decision making is speeded up.

2. Reason for change

The Trust is continually evolving and in March 2014 a change to SFIs was approved by Finance and Performance Committee to reflect the structure that was in place at that time. Since then a Delivery Unit structure has been established, new structures in the heartlands division have been set up and a number of corporate posts have been disestablished. Following the recent structure announcements it is now necessary to update the SFIs to make the authority limits workable with the new posts and to clarify responsibilities.

3. Authority Levels

In 2014 the values were updated to reflect the division/site structure with site Managing Directors that was in place at the time. Separate headings were set up to reflect that the structures within clinical areas were different to those in corporate and estates/facilities areas. In most cases these levels were applied into the Oracle system. The table below shows these values.
Table 1 Previous Authority Levels

<table>
<thead>
<tr>
<th>Role/ Title</th>
<th>Corporate</th>
<th>Estates</th>
<th>Clinical</th>
<th>Limit £</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ward Manager/ Community Services Manager</td>
<td></td>
<td>C</td>
<td></td>
<td>2,000</td>
</tr>
<tr>
<td>Corporate Department Manager, Executive Assistants</td>
<td>A</td>
<td></td>
<td></td>
<td>2,000</td>
</tr>
<tr>
<td>Estates Directorate Managers, Executive Assistants, Administrative Assistant.</td>
<td></td>
<td>E</td>
<td></td>
<td>2,000</td>
</tr>
<tr>
<td>Health and Safety Officer, Estates Managers, Hotel Services Managers</td>
<td></td>
<td>E</td>
<td></td>
<td>5,000</td>
</tr>
<tr>
<td>Corporate Head of Department</td>
<td>A</td>
<td></td>
<td></td>
<td>5,000</td>
</tr>
<tr>
<td>Matron / Community Services Equivalent</td>
<td></td>
<td>C</td>
<td></td>
<td>5,000</td>
</tr>
<tr>
<td>Operational Manager</td>
<td></td>
<td>C</td>
<td></td>
<td>5,000</td>
</tr>
<tr>
<td>Catering Manager</td>
<td></td>
<td>E</td>
<td></td>
<td>9,999</td>
</tr>
<tr>
<td>Corporate Senior Manager/ Business Consultant/ Business Partner</td>
<td>A</td>
<td></td>
<td></td>
<td>9,999</td>
</tr>
<tr>
<td>General Manager</td>
<td></td>
<td>C</td>
<td></td>
<td>9,999</td>
</tr>
<tr>
<td>Deputy Head of Hotel Services</td>
<td></td>
<td>E</td>
<td></td>
<td>10,000</td>
</tr>
<tr>
<td>Clinical Director</td>
<td></td>
<td>C</td>
<td></td>
<td>10,000</td>
</tr>
<tr>
<td>Programme Office Manager</td>
<td></td>
<td>E</td>
<td></td>
<td>64,999</td>
</tr>
<tr>
<td>Head of Hotel Services/ Head of Estates</td>
<td></td>
<td>E</td>
<td></td>
<td>64,999</td>
</tr>
<tr>
<td>Site Head of Operations</td>
<td></td>
<td>C</td>
<td></td>
<td>64,999</td>
</tr>
<tr>
<td>Deputy ED</td>
<td>A</td>
<td></td>
<td></td>
<td>64,999</td>
</tr>
<tr>
<td>Associate Medical Director</td>
<td></td>
<td>C</td>
<td></td>
<td>65,000</td>
</tr>
<tr>
<td>Site Managing Director</td>
<td></td>
<td>C</td>
<td></td>
<td>100,000</td>
</tr>
<tr>
<td>Trust Medical Director</td>
<td></td>
<td>C</td>
<td></td>
<td>100,000</td>
</tr>
<tr>
<td>Director of Asset Management</td>
<td></td>
<td>E</td>
<td></td>
<td>100,000</td>
</tr>
<tr>
<td>Corporate Executive Director</td>
<td>A</td>
<td></td>
<td></td>
<td>100,000</td>
</tr>
<tr>
<td>Finance Director</td>
<td></td>
<td>E</td>
<td></td>
<td>125,000</td>
</tr>
<tr>
<td>Deputy CEO</td>
<td>A</td>
<td></td>
<td>C</td>
<td>125,000</td>
</tr>
<tr>
<td>CEO</td>
<td>A</td>
<td>E</td>
<td>C</td>
<td>150,000</td>
</tr>
<tr>
<td>CEO &amp; Chair</td>
<td>A</td>
<td>E</td>
<td>C</td>
<td>250,000</td>
</tr>
<tr>
<td>Board</td>
<td>A</td>
<td>E</td>
<td>C</td>
<td>Over 250,000</td>
</tr>
</tbody>
</table>

A number of changes are suggested to the authority levels;

a) Increase the authority levels

An increase in the authority levels, particularly at the higher levels is proposed to reflect the expenditure level that is deemed appropriate for these senior posts. This reflects the increased costs over the last few years, the tendency to consolidate more business into
fewer supplier s and the raising of purchase orders for the total service rather than on an invoice by invoice basis.

b) Finance Director Level the same as all other Executive Directors and disestablishing Deputy Chief Executive as an approval level.

Previously the Finance Director has had a greater authority level than the other executive directors (ED) which has meant that for large orders they were required to be reviewed by the FD before it reached the Chief Executive. This had worked well when the Finance Director and the Deputy Chief Executive post were held by the same person. It is proposed that to provide clarity the Finance Director level is the same as all other ED levels so all orders over the value of an ED go the Chief Executive, and if the Chief Executive requires additional clarification, the requisition can be sent to the FD for review.

c) Operational lead the dominant authoriser

Previously the ordering for each cost centre has been through an operational manager who has had an authority level £1 lower than the clinician. In practice this has meant a delay in getting orders agreed as it requires the input of 2 senior people. Now that the triumvirate arrangements exist for each division and directorate, the proposal is that the operational lead will hold responsibility for approving the orders and where there is a query relating to a particular order will ensure that clinical and nursing colleagues are involved. This should streamline the approval process.

There will be some circumstances where a clinical director will be required to approve orders, such as is the case in pathology, and in these situations, they will be slotted into the managerial position in the hierarchy for that area.

d) Include an additional level for group reporting arrangements

In Heartlands and Solihull divisions there is a need for an additional level to be set up to reflect their structure of Group boards below the division. AN additional level of £25k is proposed for these areas.

The table below shows the proposed revised authority levels. Appendix 1 shows a mapping for the current levels to the proposed levels.

Table 2 proposed Authority levels

<table>
<thead>
<tr>
<th>Role/ Title</th>
<th>Revised limit £</th>
</tr>
</thead>
<tbody>
<tr>
<td>Originator level</td>
<td>£2,000</td>
</tr>
<tr>
<td>Manager</td>
<td>£5,000</td>
</tr>
<tr>
<td>Senior Manager</td>
<td>£10,000</td>
</tr>
<tr>
<td>Group Head (applicable in Heartlands and Solihull division only)</td>
<td>£25,000</td>
</tr>
<tr>
<td>Reporting to Executive Director</td>
<td>£65,000</td>
</tr>
<tr>
<td>Executive Director (non-voting)</td>
<td>£100,000</td>
</tr>
<tr>
<td>Executive Director (Voting)</td>
<td>£125,000</td>
</tr>
<tr>
<td>CEO</td>
<td>£250,000</td>
</tr>
<tr>
<td>Board</td>
<td>Over £250,000</td>
</tr>
</tbody>
</table>
4. **Reporting above Chief Executive Level**

Currently orders that are in excess of the level of Chief Executive are required to be reported to the Board according to SFIs. However, practice over a number of years has meant that these are reported to the monthly Finance and Performance Committee. It is proposed that the SFIs are amended so that approval of the purchase orders is the responsibility of Finance and Performance Committee. This will include all orders.

5. **Prohibiting self-approval**

A review by the Trust’s counter fraud team has found that there have been instances where the person raising the requisition has also approved that order, known as self-approval. The SFIs will need to explicitly state that this is prohibited unless this has been agreed in advance for that service (e.g. renal), code or where exceptional circumstances that have been approved by the manager mean that this is absolutely necessary. This will mean that if an individual is found to be self-approving they can be advised that is not permitted by SFIs.

6. **Exceptions to the authority levels**

There are a number of exceptions where the authority levels set out for a role are insufficient on a particular cost line for a role that manager is doing. The exceptions that are current practice are set out in the table below and are required to be approved by the Committee. As any new exception requirements are identified they will be added to the exceptions list in the SFIs.

**Table 3 Variations to approval levels**

<table>
<thead>
<tr>
<th>Reason</th>
<th>Responsible Manager</th>
<th>Variation to normal levels</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trust wide leased car arrangements</td>
<td>Employee services manager</td>
<td>Normal authority level £10k, needs £25k for leased car lines across whole Trust.</td>
</tr>
<tr>
<td>NHS logistics invoices</td>
<td>Financial Controller</td>
<td>Normal authority level £5k, approves invoices of up to £100k (all items have been previously approved by the budget holder vi i-proc, this is the payment of the consolidated invoice).</td>
</tr>
<tr>
<td>Pathology consumables ordering under the Abbots contract</td>
<td>Pathology Manager</td>
<td>Normal approval level would be £25k, needs £65k for this contract)</td>
</tr>
<tr>
<td>Mobile telephones and travel consolidated invoices</td>
<td>Chief Financial Controller</td>
<td>No change in approval level required, but approving invoices on Trust wide cost lines. Consolidated invoice, expenditure is already approved via manager at the point of agreeing to have the phone or booking travel.</td>
</tr>
</tbody>
</table>
7. **Business Cases and Contracts**

There are three elements to incurring spend in the Trust.

![Diagram: Business Case -> Contract -> Purchase Order]

When a new area of expenditure is identified in the Trust a business case is required. A business case approval process has been set out and recently agreed at an executive directors meeting. This is included in appendix 2. This shows that the SFI levels for approving a business case follow the board meetings/committees at the same levels as the individual roles except at the executive management board (EMB) where the board approval level is £500k, whereas the Chief Executive level is £250k.

A contract is required once a business case has been approved or when a contract for existing services has expired. The levels set out in table 1 above apply to signing of contracts as well as for raising purchase orders. Therefore, if a contract is required for several years the total value of that contract needs to be calculated and the contract signed by the relevant approving manager. This may result in the contract being approved by a higher approval level than is required for the annual purchase order for that service. For example, a three year contract at £40k per year will require sign off by the ED at £120k, but the purchase order can be approved by the person reporting into that ED.

These rules around business cases and contracts will need to be made explicit in the SFIs.

8. **Next Steps**

Once these revisions have been agreed the next steps are as in the table below.

<table>
<thead>
<tr>
<th>Task</th>
<th>Responsibility</th>
<th>Due Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Communicate revised approval levels to managers</td>
<td>Angeline Jones</td>
<td>End of May</td>
</tr>
<tr>
<td>Confirm structures</td>
<td>OBS Finance team</td>
<td>End of Apr</td>
</tr>
<tr>
<td>Set up roles and responsibilities in Oracle system</td>
<td>Adrian James, Systems Manager</td>
<td>Mid May</td>
</tr>
<tr>
<td>Update SFI document with these changes, ratify at FPC, put on website</td>
<td>Angeline Jones</td>
<td>June FPC</td>
</tr>
<tr>
<td>Run a communications programme to make all managers aware of the requirements in SFIs</td>
<td>Angeline Jones</td>
<td>August</td>
</tr>
</tbody>
</table>
9. Recommendation

The Finance and performance Committee is requested to approve the following changes to Standing Financial Instructions:

- Approve the proposed changes in authority levels
- Approve making self-approval of orders prohibited except for noted exceptions.
- Approve the exceptions to the authority levels.

Appendix 1 – Tracker from current levels to proposed levels

<table>
<thead>
<tr>
<th>Role/ Title</th>
<th>Previous Limit £</th>
<th>Change</th>
<th>Revised limit £</th>
</tr>
</thead>
<tbody>
<tr>
<td>Originator level</td>
<td>0</td>
<td>New level</td>
<td>£2,000</td>
</tr>
<tr>
<td>Ward Manager/ Community Services Manager</td>
<td>2,000</td>
<td>Move to generic originator level</td>
<td>0</td>
</tr>
<tr>
<td>Corporate Department Manager, Executive Assistants</td>
<td>2,000</td>
<td>Move to generic originator level</td>
<td>0</td>
</tr>
<tr>
<td>Estates Directorate Managers, Executive Assistants, Administrative Assistant</td>
<td>2,000</td>
<td>Move to generic originator level</td>
<td>0</td>
</tr>
<tr>
<td>Manager</td>
<td>0</td>
<td>New level</td>
<td>£5,000</td>
</tr>
<tr>
<td>Health and Safety Officer, Estates Managers, Hotel Services Managers</td>
<td>5,000</td>
<td>Move to generic manager level</td>
<td>0</td>
</tr>
<tr>
<td>Corporate Head of Department</td>
<td>5,000</td>
<td>Move to generic manager level</td>
<td>0</td>
</tr>
<tr>
<td>Matron / Community Services Equivalent</td>
<td>5,000</td>
<td>Move to generic manager level</td>
<td>0</td>
</tr>
<tr>
<td>Operational Manager</td>
<td>5,000</td>
<td>Move to generic manager level</td>
<td>0</td>
</tr>
<tr>
<td>Catering Manager</td>
<td>9,999</td>
<td>Move to generic senior manager level</td>
<td>0</td>
</tr>
<tr>
<td>Corporate Senior Manager/ Business Consultant/ Business Partner</td>
<td>9,999</td>
<td>Move to generic senior manager level</td>
<td>0</td>
</tr>
<tr>
<td>General Manager</td>
<td>9,999</td>
<td>Move to generic senior manager level</td>
<td>0</td>
</tr>
<tr>
<td>Senior Manager</td>
<td>0</td>
<td>New level</td>
<td>£10,000</td>
</tr>
<tr>
<td>Deputy Head of Hotel Services</td>
<td>10,000</td>
<td>Move to generic senior manager level</td>
<td></td>
</tr>
<tr>
<td>Clinical Director</td>
<td>10,000</td>
<td>Move to generic senior manager level</td>
<td></td>
</tr>
<tr>
<td>Group Head (applicable in heartlands and Solihull division only)</td>
<td>0</td>
<td>New level</td>
<td>£25,000</td>
</tr>
<tr>
<td>Reporting to Executive Director</td>
<td>0</td>
<td>New level</td>
<td>£65,000</td>
</tr>
<tr>
<td>Programme Office Manager</td>
<td>64,999</td>
<td>Move to generic reporting to executive director category</td>
<td>0</td>
</tr>
<tr>
<td>Head of Hotel Services/ Head of Estates</td>
<td>64,999</td>
<td>Move to generic reporting to executive director category</td>
<td>0</td>
</tr>
</tbody>
</table>
### Finance Executive Summary and Key Performance Indicators

<table>
<thead>
<tr>
<th>Position</th>
<th>Salary</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Site Head of Operations</td>
<td>64,999</td>
<td>Move to generic reporting to executive director category</td>
</tr>
<tr>
<td>Deputy ED</td>
<td>64,999</td>
<td>Move to generic reporting to executive director category</td>
</tr>
<tr>
<td>Associate Medical Director</td>
<td>65,000</td>
<td>Move to generic reporting to executive director category</td>
</tr>
<tr>
<td>Site Managing Director</td>
<td>100,000</td>
<td>Move to generic executive director (non-voting) category</td>
</tr>
<tr>
<td>Trust Medical Director</td>
<td>100,000</td>
<td>Move to executive director (voting) category</td>
</tr>
<tr>
<td>Director of Asset Management</td>
<td>100,000</td>
<td>Move to generic executive director (non-voting) category</td>
</tr>
<tr>
<td>Executive Director (non-voting)</td>
<td>0</td>
<td>New level</td>
</tr>
<tr>
<td>Corporate Executive Director</td>
<td>100,000</td>
<td>Split between executive director Noting and non-voting categories</td>
</tr>
<tr>
<td>Finance Director</td>
<td>125,000</td>
<td>Remove additional level, same authority as all EDs</td>
</tr>
<tr>
<td>Executive Director (Voting)</td>
<td>0</td>
<td>New level</td>
</tr>
<tr>
<td>Deputy CEO</td>
<td>125,000</td>
<td>Remove level</td>
</tr>
<tr>
<td>CEO</td>
<td>150,000</td>
<td>Increase level</td>
</tr>
<tr>
<td>CEO &amp; Chair</td>
<td>250,000</td>
<td>Remove level</td>
</tr>
<tr>
<td>Board</td>
<td>Over 250,000</td>
<td>Remove level</td>
</tr>
</tbody>
</table>

Angeline Jones  
Chief Financial Controller  
April 2015
FINANCE EXECUTIVE SUMMARY & KEY PERFORMANCE INDICATORS

Month 1 to 30\textsuperscript{th} April 2015

Darren Cattell, Interim Director of Finance & Performance

EXECUTIVE SUMMARY

We remain under Section 111 Monitor Enforcement.

APRIL POSITION

The Trust had a larger I&E loss in April than planned.

April delivered a £2.7m loss when compared to the planned figure of £2.5m.

All 2015/16 contracts are still currently in negotiation for both the financial and non financial elements. Income is therefore prudently estimated based on activity under JMRA principles.

1. FINANCE

The Trust’s income and expenditure position in April was a £2.7m loss versus a planned loss of £2.5m.

The table below shows the key issues influencing the financial position, in terms of actuals but also in terms of plan:

<table>
<thead>
<tr>
<th>Category</th>
<th>Plan £m</th>
<th>Apr £m</th>
<th>Variance £m</th>
<th>Headlines</th>
</tr>
</thead>
<tbody>
<tr>
<td>NHS Clinical Income</td>
<td>49.7</td>
<td>49.7</td>
<td>-</td>
<td></td>
</tr>
</tbody>
</table>
| Medical Staffing       | (9.6)   | (10.4) | (0.8)       | Expenditure remains unaffordable  
Underlying pay controls  
Waiting List Initiatives spend of £0.4m  
Greatest pressures in BHH, SOL and GHH |
| Nursing & Midwifery   | (13.6)  | (14.1) | (0.5)       | Expenditure remains unaffordable  
Underlying pay controls  
Enhanced bank rates continue  
Greatest pressures in BHH and GHH |
| SIEP                   | 0.6     | 0.4    | (0.2)       | Most significant shortfalls in BHH, CSS, W&C’s and SOL                               |
| Other                  | (28.4)  | (27.5) | 1.3         | Recognition of investment reserves                                                  |

Overall Position        | (2.5)   | (2.7)  | (0.2)       |                                                                                   |
1.1 Medical Staffing – Total medical expenditure remains unaffordable at £10.4m in month compared to a budget of £9.6m. Divisions need to address this as part of their efficiency plans going forwards, where not resolved as part of rebasing capacity.

1.2 Nursing & Midwifery – Nursing expenditure remains unaffordable at £14.1m in month compared to a budget of £13.6m. Divisions need to address this as part of their efficiency plans going forwards, where not resolved as part of rebasing capacity.

1.3 SIEP – Actual delivery in month was £0.4m. Further action is required to close the early gap and deliver early implementation to mitigate risk in 2015/16.

1.4 Cash Deposits – The cash balance at the end of April 2015 was £84.0m, slightly ahead of plan. £65m was held on short term deposits with the National Loans Fund at the end of the month attracting rates of around 40bp. Funds remaining in the main GBS current accounts earn 25bp interest.

1.5 Monitor Targets – The Trust’s Continuity of Service Rating (COSR) at the end of April was 3 in line with the quarter one plan. The COSR scale is 1 to 4 with 4 being the highest rating.

1.6 Capital – The total planned capital expenditure in the year is £50.4m, including carry forwards. Spend year to date was £1.0m against a plan of £2.2m but did not include any accruals as the year end position was still being finalised.

2 CONTRACTING

Contract negotiations have not yet concluded, the main areas yet to be resolved are CQUINs and Finance. Subgroup meetings are continuing in order to support the delivery of the final contract package, FD meetings are also ongoing with a focus on the underlying activity assumptions. This is pivotal to supporting the choice of contract type (i.e. JMRA) that best supports the Trust strategy in 2015/16.

3 CONCLUSION

The previously highlighted risk with regards to efficiency planning has resulted in a low level of delivery in April, this coupled with underlying pay controls requires an immediate response to mitigate risk in quarter 1 of the new financial year.
4 RECOMMENDATIONS

The below actions are recommended:

1. Escalate level of risk in relation to efficiency delivery with Executive led response to reduce gap, improve delivery and current forecast.
2. Divisions to commence pay controls as part of controls focus of SIEP planning.
3. Release reserves to fund Q1 Enhanced Bank Rate costs pending further review the decision regarding enhanced nurse bank rates.
4. Finalise demand and capacity decisions to release reserves into Operational Budgets.

Darren Cattell
Interim Director of Finance & Performance
April 2015
Heart of England NHS Foundation Trust
1. A&E Activity 2015/16
- There were 21,507 A&E attendances in Apr-15, 836 attendances, 4% above Apr-14.
- In April 86.25% of patients were seen within 4 hours excluding walk ins.
- At Heartlands 86.45% (1,438 breaches) of patients within 4 hours, 80.23% (1,443 breaches) at Good Hope site and 97.82% (79 breaches) at Solihull site.
- A&E activity excludes A&E outpatient attendances.
- Form TF2A

2. Emergency Activity 2015/16 excluding Paediatrics, Paediatric Surgery and Obstetrics
- The Emergency activity was below April 2014 by 4%, 181 Spells.
- Heartlands 61, 2%, Good Hope, 112, 11% and Women & Children, 37, 11% were below Apr-14.
- Clinical Support 7, 15% and Solihull, 22, 4% were above Apr-14.
- Following the implementation of PMS2 a potential patient classification issue was identified. This remains under ongoing review and any necessary retrospective realignment will be actioned if applicable.
- Form TF2A

3. Emergency Activity 2015/16, Paediatrics, Paediatric Surgery and Obstetrics
- The activity is above Apr-14 by 3%, 24 Spells in Apr-15.
- Following the implementation of PMS2 a potential patient classification issue was identified. This remains under ongoing review and any necessary retrospective realignment will be actioned if applicable.
4. AMU, MAU & SAU Activity 2015/16

- There were 2,225 spells during Apr-15, 28 Spells, 1% above Apr-14.
- Good Hope Hospital 38 spells, 6%, Heartlands Hospital, 57, 7% were above April-14 outturn.
- Solihull Hospital was below Apr-14 by 68 Spells, 9%.

5. Maternity Spells Activity 2015/16

- In April 2015, there were 842 Births Trustwide (532 at Heartlands, 295 at Good Hope, and 15 at Solihull). This compares to 854 in April 2014 (-1%). In April there were 8 planned homebirth (4 at Good Hope, 2 at Heartlands and 2 at Solihull).
6. Elective & Day Case Activity 2015/16

- There were 6,458 Day case and Elective spells during Apr-15, this was 5%, 373 Spells below Apr-14 outturn.
- Heartlands, 9%, 354 Spells, Women and Childrens, 22%, 91 Spells were below Apr-14 in month.
- Solihull Division, 1%, 11 Spells, Clinical Support, 27 Spells, 18% and Good Hope, 34 Spells, 5% were above Apr-14 in month.
- Following the implementation of PMS2 a potential patient classification issue was identified. This remains under ongoing review and any necessary retrospective realignment will be actioned if applicable.
- There were 26 sessions cancelled during Apr-15, 96.96% of the scheduled sessions were utilised. The following specialties cancelled sessions, General Surgery (17), Gynaecology (4), Orthopaedics (2), Thoracic Surgery (2) and Urology (1).
- 92% (24) of the Theatre sessions were cancelled due to no surgeon in month.
- In addition to this, 22 sessions were cancelled in the Vanguard Theatre during April, 59% of the scheduled lists were utilised.
- 90 patients were treated in the Vanguard Theatre during April.
- There were 202 patients treated by the private sector during April. Ophthalmology (54), General Surgery (48), Orthopaedics (25), ENT (22), Urology (19), Gastroenterology (18), Gynaecology (14), Vascular Surgery (2) had patients treated by the private sector in month.
- There were 75 hospital led cancelled operations on the day during April-15. 38 (51%) of the cancelled operations were at Good Hope, 21 (28%) at Heartlands and 16 (21%) at Solihull.

In-Month Performance

7. Outpatient Activity 2015/16

- There were 68,391 Outpatient attendances during Apr-15, 1,639 atts, 2% additional attendances than Apr-14.
- Clinical Support Services, 505 atts, 11%, Good Hope, 436 atts, 6%, Heartlands 119 atts and Solihull, 708 atts, 3% were above Apr-14 outturn.
- Women & Childrens, 129 atts were below Apr-14 outturn.

Total DNA Rates (Apr-15):

- Good Hope Hospital 8.17% (2,381*)
- Heartlands Hospital 12.62% (4,379*)
- Solihull Hospital 8.70% (2,038*)

The DNA rate for first attendances was 12.91% (1,438*) at Heartlands site during Apr-15. Good Hope (7.52%) and Solihull (7.90%) achieved the target of less than 11%.

*No. of DNAs.
INCOME AND EXPENDITURE

8. Performance against Monitor Standards 2015/16
- The overall I&E deficit was £2.7m at the end of month 1.
- The Monitor plan has not yet been set and we expect to be reporting against this in month 2.
- Continuity of Service Rating (COSR) is estimated at 3 (2.5 rounded up) at this early stage of the financial year. The Trust has the lowest score on the capital service cover measure due to recording a negative EBITDA in month 1.

9. Income 2015/16
NHS Contract Income (Category A)
For the month of April there was trust wide clinical income of £49.7m.
There is no graph showing an analysis of over performance as LDPs have not yet been finalized with commissioners.

10. Income and Expenditure against Operational Budgets
- The Trust is (£4.2m) over spent at Month 1 of 2015/16.
- Pay is over spent by (£2.1m)
- Non Pay is over spent by (£3.3m)
- Other Operating Revenue £1.2m over recovered
- Form TF1
INCOME AND EXPENDITURE

11. Operational Budgets 2015/16

Heartlands Hospital (BHH) is over spent by (£3.8m)
- Income under recovery (£0.1m)
- Pay over spend (£1.2m)
- Non Pay over spend (£2.5m)

Clinical Support Services (CSS) is over spent by (£0.5m)
- Income under recovery (£0m)
- Pay under spend £0.1m
- Non Pay over spend (£0.6m)

Good Hope Hospital (GHH) is over spent by (£1.5m)
- Income under recovery (£0m)
- Pay over spend (£0.8m)
- Non Pay over spend (£0.7m)

Solihull Hospital (SOL) is over spent by (£1.1m)
- Income under recovery (£0m)
- Pay over spend (£0.3m)
- Non Pay over spend (£0.7m)

Womens and Childrens (WC) is over spent by (£0.6m)
- Income over recovery (£0.1m)
- Pay under spend £0m
- Non Pay over spend (£0.7m)

Corporate Directorates (CD) is under spent by £0m
- Income over recovery £0m
- Pay under spend £0.1m
- Non Pay over spend (£0m)

Corporate Trust Wide (CTW) is under spent by £3.3m
- Income over recovery £1.2m
- Pay over spend (£0m)
- Non Pay under spend £2.1m

Facilities (FAC) is over spent by (£0.1m)
- Income under recovery (£0m)
- Pay under spend £0.1m
- Non Pay over spend (£0.1m)

Bad Debt provision included within the above: £0.1m
12. Pay Expenditure

Pay Expenditure is over spent by (£2.1m) at Month 1 2015/16.

Material variances to operational budget relates to:

- Medical Staffing, which is over spent by (£1.1m)
- Nursing & Midwifery overspent by (£0.9m)
- Professional Bank and Agency (£0.1m)
- Agency other (£0.2m)
- Form TF3

13. Non pay Expenditure

Non Pay is over spent by (£3.3m) at Month 1 of 2015/16.

Material overspends against operational budgets are:

- Prior and current year SIEP (£3.2m)
- Clinical Supplies (£0.8m)

Form TF4
The Trust achieved £0.4m (20.9%) efficiency in Month 1.
These results show a (£1.6m) shortfall against target at Month 1.
Based on Month 1 results the year end out turn is £12.7m delivery of savings (53%).

Analysis of Forecast:
- £1.4m in risk category 5 Delivered
- £2.0m in risk category 4 Expected Delivery.
- £9.3m in risk category 3 Suggested Plans.

Divisions have to date completed 68 Quality Impact Assessments for 2015/16. A further 209 are in progress.
15. Combined Capital Expenditure YTD 2015/16

Expenditure YTD to month 1 was £975k, 45.2% of the YTD Monitor Plan (MP) and 1.9% of total Approved Budget (AB) £50.6m. Orders raised were £9.1m, 422.6% of YTD MP & 18.0% of AB.

- Other was £442k, 45.3% of MP; with spend various estates projects
- Operational was £357k, 36.6% of MP, key spends on SAN, Windows 7 Compliance project, Ultrasound Machine, LAN
- Site Strategy Investment expenditure was £176k, 18.0% of MP, spend on Dermatology relocation, Endoscopy BHH

YTD Performance

16. Capital Expenditure in Month 2015/16

M1 In-month expenditure was £975k:

- FAC / Site Strategy £509k- Various estates projects
- CD £346k- SAN, Document Scanning, Windows 7 Compliance project, LAN
- BHH £75k- Ultrasound Machine, Profiling Beds, ECG
- SOL £36k- Day Room upgrade, 2 Flexible Nasendoscope
- WC £9k- Ambulatory Blood Pressure Monitors, Capacity Risks project for Obstetrics at BHH
- CSS £1k- Histopathology Archive Provision, BHH Mortuary Fridge refurbishment

In-month Performance

17. Creditors 2015/16

- Payment performance in April is about 69%. The volume of invoices paid in April is 15,818. This is a little higher than normal volumes and around 5,400 invoices higher than April 2014.
- The continued poor payment performance is due to backlog clearing and processing delays following the Readsoft upgrades and will also impact on performance into month 2 and 3.
- A special project team is being set up to tackle the backlog of old year invoices and from next month we should be able to report project and business as usual performance separately.

Cumulative Performance
18. Debtors 2015/16

- Total debt reduced by £2.043m during April to £22.360m.
- NHS England paid several large value invoices in the month, including £0.684m for public health, £0.393m for cancer drugs recharges and £0.361m for clinical excellence awards.
- Health Education England paid a training & education invoice for £0.577m during April.
- A high volume of smaller value invoices issued during March to both NHS and Non NHS customers were also paid during April.
- There are still underpayments of £2.372m against the 2014-15 SLA mandate invoices, including £0.944m by Solihull Clinical Commissioning Group and £1.349m by Birmingham Cross City Clinical Commissioning Group, who have also underpaid the April 2015 SLA mandate invoice by £0.505m, although this was for an estimated value only.
- There are four April 2015 SLA mandate invoices totalling £0.966m still outstanding with NHS England. These were issued late in the month and are expected to be paid shortly.
- Ante natal maternity pathways activity debt for April 2013 to March 2015 increased slightly to £3.724m, including £1.957m with Burton Hospitals, £0.617m with Sandwell & West Birmingham Hospitals, and £0.643m with Birmingham Womens Hospital.
- A specialised services over-performance invoice for £3.145m issued to NHS England in March remains outstanding, as does an RTT funding invoice for £1.100m to Solihull Commissioning Group.

CASHFLOW

19. Monthly Closing Cash Balance vs Plan 2015/16

- The cash balance at the end of April 2015 was £84.0m.
- The Monitor plan has not yet been set and we expect to report against this in month 2.
- All Trust funds remain in the GBS umbrella as a change in the rules on calculating PDC dividend means that it is currently financially unviable to invest in other commercial banks.
- £65m was held on short term NLF deposits at the month end attracting rates of about 40bp.
- Funds in GBS attract 25bp.
MONITOR - RISK ASSESSMENT FRAMEWORK KPIs

18 weeks: Reported 1 month in arrears

HEFT have now resumed reporting against the admitted patient pathway (clock stops), and achieved 82.09% against the 90% target for April, with the aim to continue to see longer waits in order to help clear the backlog.

HEFT managed to see 91.02% of non-admitted patients within 18 weeks against the 95% target for April.

Incomplete Pathways

HEFT have now resumed reporting against the incomplete pathways, and achieved 89.61% against the 92% target for April.

A&E

Total time in A&E

The 95% target for A&E around 4 hour was not met in April with performance at 86.25%.
The Trust failed the 93% target for the 2 week cancer indicator in March at 90.96%, and also failed the 2 week Breast symptom 93% target, achieving 88.41%.

The Trust achieved the 96% target for 31 day cancers in March, out-turning at 98.48% in month. March data is unvalidated.

The Trust met the 31 day anti-cancer drug target of 98% in March, achieving 100%.

The Trust met the 31 day surgery modality cancer target of 94% in March, achieving 96.97%.

The Trust achieved the 62 day cancer 85% target in March, achieving 84.40%.

The Trust missed the 62 day national screening cancer 90% target in March, achieving 62.50%. March data is unvalidated.
Infection Control

In month the Trust reported 2 cases of C-diff, with a total of 2 YTD.
### Trust Wide Income and Expenditure

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<thead>
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<th>Year to Date</th>
<th>Full Year</th>
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<tr>
<td><strong>Annual Plan</strong></td>
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### Key Performance Indicators (KPIs)

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<th>Year to Date</th>
<th>Full Year</th>
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## Council of Governors
### June 2015

### Trust Wide Balance Sheet

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<th>Variance to Plan</th>
<th>Annual Plan</th>
<th>Forecast</th>
<th>Variance from Plan</th>
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### Other Receivables

- Inventories: £8,634
- Trade Receivables, current, gross: £28,360
- Non NHS Trade Receivables, current, gross: £4,582
- Other Related Party Receivables: £0.244
- Other Receivables: £1.533
- Impairment of receivables for bad and doubtful debts, current: £8,396
- Accrued Income: £2.539
- Prepayments: £10.841
- Cash and Cash Equivalents: £84,019

### Current Assets

- Total Assets: £379,118
- Trade Payables: £8,272
- Other Payables: £15,149
- Capital Payables: £3,179
- Accruals: £52,778
- Finance Leases / PFI Leases, Current: £0.480
- PDC Dividend Payable: £0.573
- Provisions, current: £8,066
- Deferred Income: £6,430

### Current Liabilities

- Total Current Liabilities: £38,267
- Provisions, non current: £7,531
- Finance Leases, non current: £1,598
- PFI Leases, non current: £2,360

### Liabilities, Non Current

- Total Liabilities, Non Current: £10,733
- Public Dividend Capital: £215,309
- Retained Earnings / (Accumulated Losses): £16,724
- Revaluation Reserve: £44,408

### Total Taxpayers Equity

- Total Taxpayers Equity: £278,880

### Key performance Indicators (KPIs)

- Net Return After Financing: NaN
- Liquidity: NaN

### Notes

- Full Year figures are as reported by the Integrated Quality Report.
## Finance Executive Summary

### Welcome

- **Actual Plan Variance to Plan Annual Plan Forecast**
  - **Opening cash balance:** 87,671
  - **Net increase / (decrease) in cash -**
  - **Net cash inflow/(outflow) from financing activities, Total:** -

### Trust Wide Cash flow

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Safety SitRep – April 2015
## Safety Situation Report

### April 2015

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<th></th>
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<tr>
<td><strong>Strategic risks (Updated April 15)</strong></td>
<td>• Regular reports provided to Board and EMB to discuss Strategic Risks.</td>
</tr>
</tbody>
</table>
| **Red (≥ 15) operational risks.**   | • There are eleven operational red risks currently open. Seven have been validated in 2014/15 and four remain open from 2013/14  
• One new red risk (March 2015) relating to loss of JAG accreditation for Endoscopy units across HEFT |
| **SUIs and incidents** | • There has been one new SUI’s declared since the last report. Missed diagnosis of pneumothorax.  
• Two SUI reports have been closed since last report “Suboptimal care of deteriorating patient” and “Missed diagnosis of pneumothorax” |
| **Mortality**   | • The Trust is still unable to measure mortality reliably using HSMR.  
• Crude mortality shows a peak and decline in number of inpatient emergency deaths.  
• The latest Summary Hospital-level Mortality Indicator (SHMI) score for Jul 13 to Jun 14 is 109, this is within the HSCIC ‘as expected’ banding. |
| **IMR (December 2014)** | • Currently 9 risks and 6 elevated risks highlighted through the December 14 “intelligent monitoring report” (was 11 and 5 in draft version issued in October 14)  
• Was 9 risks and 7 elevated risks in previous (June IMR) |
**Council of Governors**

**June 2015**

**Minutes**

**Matters**

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**Safety Sitrep - April 2015**

**Welcome**

**Apologies**

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**Summary risk profile**

<table>
<thead>
<tr>
<th>RED OPERATIONAL RISKS-Monitoring by sites / division.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Risk Summary: Red</strong></td>
</tr>
<tr>
<td><strong>Site</strong></td>
</tr>
<tr>
<td>----------</td>
</tr>
<tr>
<td>Loss of JAG Accreditation across HEFT - NEW</td>
</tr>
</tbody>
</table>

The Joint Advisory Group (JAG) offers a voluntary quality accreditation system for endoscopy units in England. Although it is a voluntary scheme it is accepted as the service standard. There are 2 elements of the process; firstly a site visit every 5 years and secondly electronic submissions every 6 months. HEFT last made a submission in September 2014 and was advised that, as our waiting times exceeded 5 weeks, our accreditation was deferred. Another submission is to be made at the end of April and should the waiting times still exceed 5 weeks then accreditation would be removed. Based on the current back log within endoscopy, with a projected return to 5 week diagnostic times not expected until Q3 2015, it is highly unlikely that accreditation will be granted as this is a core measure of the service. If we do not hold JAG accreditation then the National bowel screening programme will be withdrawn from HEFT and no consideration will be given to host the bowel scope programme.

**Staffing the A&E Service at SHH**

| **SH** | **BHH** | **Feb 15** | **15** | **15** |

Provision of 24 hour A&E service is dependent on adequate staffing with appropriate skill mix. Almost all medical shifts at Solihull are now covered by locums. Nursing-wise, received funding for an additional assessment nurse in response to our last CQC assessment but unable to recruit. ENP-wise the proposed changes to the service at Solihull have created anxiety about job security and many staff are reviewing their options for the future. ENPs are a highly desirable group of staff both for other EDs and for primary care. In terms of safety we are unable to guarantee quality standards around assessment. Unable to always ensure locums have up to date training / competencies. This is compounded if the nursing staff / ENPs working with them are bank staff and is set within a hospital site that has little on-site back up for unwell cases. It is becoming increasingly difficult to obtain adequate numbers of staff in all groups of an appropriate calibre to provide a safe quality service.

**Implications of Solihull CCG ERG proposals**

| **All** | **SH** | **Feb 15** | **16** | **16** |

In June 2014 Solihull CCG published plans developed through their Effectiveness Review Group (ERG). HEFT services affected by the ERG proposals are: (1) Non-renewal: Virtual Wards; Heart Failure; Hospital Liaison Nursing; Nutrition Service; Castle Practice Dietetics and Podiatry; plus Balsall Common Practice ENT; (2) Activity threshold: MSK; Podiatry; (3) Contract renegotiation: Diabetes; SALT (Children); OT (Paediatric). It is important to highlight that there are implications of ERG on wider care pathways utilized by patients cared for by HEFT. HEFT are currently in formal negotiations regarding ERG proposals. As part of these negotiations information regarding the CCG impact assessment of ERG proposals has been requested.

**Delay in diagnostic Endoscopy tests**

| **All** | **BHH** | **Oct 14** | **15** | **20** |

The endoscopy service is not meeting required timescales for diagnostic endoscopy testing of out-patient (2 week wait endoscopy requests, urgent requests) and in-patient requests (especially upper GI bleed which should be completed within 24 hours). GP two week wait cancer referrals are being completed within timesframes. Urgent endoscopy requests currently within 4 - 6 weeks (should be 2). **Update:** A further 600 patients have been identified that were not on the waiting list system which has increased the overall waiting list to 1580 patients. The additional backlog now means that the number of patients waiting more than 18 weeks stands at 155 with projected return to 5 week diagnostic time not expected until Q3 2015/16. There have been an increasing number of clinically significant cases with delayed diagnosis.

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**STRATEGIC RISKS-Monitoring by EMB, QR&C & TB (as at April 15)**

<table>
<thead>
<tr>
<th><strong>Summary &amp; score</strong></th>
<th><strong>Future financial risk</strong></th>
<th><strong>Patient flow</strong></th>
<th><strong>Ability of the Trust to undertake strategic configuration</strong></th>
<th><strong>Staff Morale</strong></th>
<th><strong>18 Weeks</strong></th>
<th><strong>Breast Recall</strong></th>
<th><strong>Mortality</strong></th>
<th><strong>Enforcement Action</strong></th>
<th><strong>PMS2</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>(⇒ 16)</td>
<td></td>
<td></td>
<td>(⇒ 12)</td>
<td></td>
<td></td>
<td>(⇒ 12)</td>
<td></td>
<td>(⇒ 16)</td>
</tr>
</tbody>
</table>

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*W&C – Women’s and Children’s Services 
<33 – Clinical Support Services

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

*Score with mitigation in place: mitigating action to reduce the risk needs to take place within one month in order to reduce the risk to acceptable level (i.e. Amber).
RED OPERATIONAL RISKS-Monitoring by sites / division.

<table>
<thead>
<tr>
<th>Risk Summary: Red</th>
<th>Site</th>
<th>Division</th>
<th>Date^</th>
<th>Initial^</th>
<th>Current *</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sexual Health IT system unable to meet statutory reporting</td>
<td>BHH</td>
<td>CSS</td>
<td>Jul14</td>
<td>6</td>
<td>16</td>
</tr>
</tbody>
</table>

The Telecare system currently used to record attendance and drug treatment is unable to meet mandatory data requirements for Public Health England, HIV and AIDS Reporting System (HARS). As well as the reputational impact this may have on commissioning decisions, organisational non compliance may result in a 10% fine (equates to approximately £400k for 14/15 contract value). The department opted to implement a new (HARS compliant) IT system. Climate–HIV but technical difficulties in the IT systems / interfaces with other Trust systems means that they remain unable to comply with these statutory reporting requirements. **Update:** Predicted “Go live” date is March 2015. Risk score to be reviewed.

| Impact of unacceptable delay for backlog of cases requiring complex endovascular aneurysm repair (EVAR) | BHH | BHH | July14 | 15 | 16 |

The death of a patient from a ruptured thoracic aneurysm whilst waiting for a date for treatment at HEFT identified a potential 92 patients on the EVAR pathway without an operation date who were not recorded as part of the HEFT waiting list. Following validation the backlog is 41 patients who are currently listed for surgery (with another potential 24 patients who may filter into the system as the decision is taken to treat). The oldest case is 38 weeks from decision to admit. 38 additional lists are required to address the backlog. **Update:** Plan to clear backlog by end of March 15 is on track, some delays in receiving complex grafts but negotiation is ongoing to expedite this.

| Emergency Rescue from Lifts at BHH and RSU | BHH/GHH | Corp | Aug 14 | 16 | 16 |

In the event of a lift failing and passengers being trapped, estates staff are trained annually to hand wind the lift to the next floor. This year the trainer deemed it unsafe to undertake this task/provide training for the lifts in the main ward block at BHH and RSU at GHH (due to the loading and effort required to hand wind the lift). The lifts in main ward block (BHH) fail approximately 1/month and the lifts in RSU approximately 2/month. Therefore estates staff will have to perform this task, despite their training having expired. A safe system of work for the release of passengers from these lifts is being developed as an interim measure.

### Remaining Red Risks from 2013/14

<table>
<thead>
<tr>
<th>Implementation of IT system for Sexual Health – Lillie</th>
<th>BHH</th>
<th>CSSD</th>
<th>Mar14</th>
<th>16</th>
<th>16</th>
</tr>
</thead>
</table>

Potential loss of vascular service (if unable to provide hybrid theatre and loss of commissioning of these services)

**Hybrid theatre build now underway – risk remains at 16.**

| Impact of extended stay in ED. Reviewed Jan 2015 – risk upgraded to 20 | GHH | BHH | Jan14 | 15 | 20 |

| Chemotherapy prescribing / administration in absence of EP | BHH | BHH | Oct13 | 15 | 15 |
Mortality Headlines

- The confirmed rebased 2013/14 HSMR is 107.9, which is an outlier for that year.
- Due to issues with PMS2 and input error, HSMR data from July onwards is not reliable for mortality measurements but will be published by Dr Foster. The latest HSMR as provided by Dr Foster for November is 91.3.
- Crude numbers of deaths of deaths are being monitored until the issue is resolved.
- There was a marked rise in the weekly number of deaths over December which peaked at the end of December/beginning of January. This was associated with increased congestion in patient flow and also mirrors the Flu A spike – this is in line with the findings of the Public Health England (PHE) report into seasonal flu. There was a decline in crude numbers of deaths throughout January which has stabilised at a slightly higher number than the pre-winter level, possibly associated with a minor rise in Flu B positive cases since the start of February.
- The latest Summary Hospital-level Mortality Indicator (SHMI) score for Jul 13 to Jun 14 is slightly higher than last quarter at 109, this is within the HSCIC ‘as expected’ banding.

Graph: Trust Monthly HSMR, April 2008 - November 2014

Graph: Number of trust weekly adult emergency deaths, April 2007 - Sunday 27th April 2015

CQC mortality outlier alerts
- No new or open CQC mortality outlier alerts.

Graph showing three weekly average number of deaths and +ve flu tests

<table>
<thead>
<tr>
<th>Site</th>
<th>2010/11 (government)</th>
<th>2011/12 (government)</th>
<th>2012/13 (rebased)</th>
<th>2013/14 (government)</th>
<th>2014/15 (government)</th>
</tr>
</thead>
<tbody>
<tr>
<td>TrustWals</td>
<td>99.6</td>
<td>99.5</td>
<td>100.9</td>
<td>99.3</td>
<td>99.3</td>
</tr>
<tr>
<td>Mortlake Hospital</td>
<td>97.7</td>
<td>101.2</td>
<td>100.8</td>
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<td>97.0</td>
</tr>
<tr>
<td>Good Hope Hospital</td>
<td>100.2</td>
<td>99.5</td>
<td>100.4</td>
<td>98.5</td>
<td>97.8</td>
</tr>
<tr>
<td>South East London</td>
<td>95.0</td>
<td>95.1</td>
<td>104.7</td>
<td>103.6</td>
<td>95.6</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Site</th>
<th>2010/11 (government)</th>
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<th>2012/13 (rebased)</th>
<th>2013/14 (government)</th>
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<td>104.7</td>
<td>103.6</td>
<td>95.6</td>
</tr>
</tbody>
</table>
Site HSMR April 2008- November 2014
Dr Foster provided HSMR data to be used with caution from July onwards due to PMS2 input errors with respect to type of admission
Summary SUI profile April 2015

OPEN SUI INVESTIGATIONS (as at 09/04/15)

<table>
<thead>
<tr>
<th>Site / Division*</th>
<th>Directorate</th>
<th>Date</th>
<th>(N = Never Event; P = Prevented Never Event)</th>
</tr>
</thead>
<tbody>
<tr>
<td>BHH</td>
<td>BHH</td>
<td>Multiple</td>
<td>Salmonella Outbreak (May /June) 2014/18537 Draft report received and QA process commenced</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>BHH</td>
<td>BHH</td>
<td>Cardiology</td>
<td>Delay in Diagnosis of Breast Cancer 2014/41308 Patient diagnosed with metastatic breast cancer in December 14 after having an abnormality noted on CT scan in 2011, whilst under the care of the cardiology team (coincidental finding). A recommendation was made within the CT scan report to refer to Breast Service, which does not appear to have been actioned.</td>
</tr>
<tr>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>BHH</td>
<td>BHH</td>
<td>Gastro</td>
<td>Delayed diagnosis 2015/1430 Patient referred to gastroenterology in June 2014, following results of an abnormal abdominal ultrasound scan and CT scan. The referral was marked as urgent. The patient's first outpatient appointment was in Sept 2014, a delay of approx 3 months from point of referral to first outpatient attendance. Between September and December 2014 the patient underwent further diagnostic investigations and was given a diagnosis of multifocal hepaticoma on a background of cirrhosis at the beginning of January 2014. The patient has been given a limited prognosis and is receiving palliative care.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>BHH</td>
<td>BHH</td>
<td>Gastro</td>
<td>Delayed Diagnosis 2015/1435 In October 2013, an urgent GP referral was sent to the Trust regarding a patient with a 6 month history of upper abdominal pain and weight loss. Referral was received early November 2013, and marked “for pancreatic clinic soon”. The patient had a complex history of impacted common bile duct stone which required treatment in 2009 (multiple ERCP’s and unsuccessful surgery). This urgent referral is recorded as being received on ICARE in Jan 2014. The patient was first seen in outpatients in April 2014 and subsequently underwent diagnostic investigations and MDT discussions. In June 2014 the patient was given a diagnosis of metastatic colon cancer and was referred to oncology team for further management. The patient died in October 2014.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>BHH</td>
<td>BHH</td>
<td>Gastro</td>
<td>Service Failure 2015/1438 During late December 2014, an increase in the backlog of patients waiting for diagnostic investigations was identified, this position was reviewed and clarified early January 2015, with an additional 600 patients confirmed as not being on the gastroenterology diagnostic waiting list, some dating back to September 2014. In June 2014, a corporate risk was raised relating to a backlog in gastroenterology for diagnostic investigations and a plan was agreed and put into place to manage the backlog.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>GHH</td>
<td>GHH</td>
<td>Mortuary</td>
<td>Wrong body release 2015/6047 Patient A died at GHH and was transferred to an offsite mortuary. Deceased patient B with a similar name was also transferred from a different to the same offsite mortuary. Due to a decision change for patient A to be cremated not buried, it was necessary for patient A to be transferred back to GHH for amendments of required paperwork. In error patient B was transferred to GHH instead of patient A. Patient B was then released for cremation instead of patient A. The error was noted when the pathology laboratory routinely rang the off site mortuary to see if they had any outstanding deceased patients for GHH. Patient A was identified as still being at the offsite mortuary.</td>
</tr>
</tbody>
</table>

NB: Linked to “Delay in diagnostic Endoscopy tests” Risk
OPEN SUI INVESTIGATIONS (as at 09/04/15)

<table>
<thead>
<tr>
<th>Site / Division*</th>
<th>Directorate</th>
<th>Date</th>
<th>(N = Never Event; P = Prevented Never Event)</th>
</tr>
</thead>
<tbody>
<tr>
<td>BHH</td>
<td>BHH</td>
<td>ED</td>
<td>Feb 15 Suboptimal care of deteriorating patient 2015/6003 Patient admitted with a history of chest pain. Whilst being clerked the patient suffered a cardiac arrest. The patient was successfully resuscitated but found to have a potassium of 9.1mmols. Appropriate treatment was given to lower the potassium however; the patient suffered a further two cardiac arrests and despite prolonged resuscitation the patient died. The patient’s potassium at this point was 8.4mmols. It would appear that for a period of six hours the patient did not have a repeat potassium check or receive any treatment for hyperkalaemia. Open</td>
</tr>
<tr>
<td>SOL</td>
<td>SOL</td>
<td>Acute Med/AMU</td>
<td>Mar 15 Missed diagnosis of pneumothorax 2015/10303 Patient referred at the weekend via GP with a history of breathlessness, chest pain, asthma and reduced air entry on left side of the chest. After examination and investigations the clinicians reviewed the patients’ CXR which identified the presence of a possible lung mass or abscess. After several hours the patients symptoms had settled and the observations were within normal parameters. The patient was discharged home with a management plan for an urgent CT, bronchoscopy, and follow up with the respiratory team to exclude lung mass or abscess which were arranged. The CXR was routinely reviewed 3 days later by a radiologist who identified a large pneumothorax with collapsed lung. There were several attempts by clinicians to contact the patient, however it was found that they had flown abroad on holiday. Once contact was made they were advised to attend hospital The patient was treated successfully abroad and returned to the UK three weeks later. Other aspects of clinical management under review. NEW</td>
</tr>
</tbody>
</table>
Summary SUI profile: Recently closed

Recently Closed SUI INVESTIGATIONS (as at 09/04/15)

<table>
<thead>
<tr>
<th>Site / Division</th>
<th>Specialty</th>
<th>Date</th>
<th>Event Description</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>SH</td>
<td>Ophthalmology</td>
<td>Dec14</td>
<td>Insertion of incorrect lens (Never Event) 2014/41293 Patient underwent cataract surgery in her left eye in January 2014 with successful outcome. Patient then underwent surgery on right eye in July 2014. Both of the lenses chosen for her surgeries were based upon biometry she underwent in November 2013. In December 2014, it was identified that an incorrect lens had been inserted into her right eye and as a result she had poor refractory outcomes and required further surgery. Initial investigation has identified that the wrong biometry was in the patient's electronic Medisoft record that was used to select the lens required.</td>
<td>Closed</td>
</tr>
<tr>
<td>BHH</td>
<td>BHH</td>
<td>Feb 15</td>
<td>Deteriorating patient 2014/36858 A patient was discharged home following a failed endoscopy procedure. The patient presented in ED 2 hours post procedure with difficulty in breathing and marked surgical emphysema. A CT scan confirmed a perforated oesophagus and the patient was transferred to AMU. The following morning the patient suffered a cardiorespiratory arrest and died. Concerns have been raised regarding the management of the patient's care.</td>
<td>Closed</td>
</tr>
</tbody>
</table>

Opthalmology should develop a standard operating procedure for the timely escalation of patients in the event of poor surgical outcomes.
Opthalmology should consider purchasing software which allows the storage of the IOLMaster biometry data and printout within the Medisoft system, so all biometry is available electronically.
Lead biometrist should explore with Medisoft if they are able to facilitate a lock down of data within the system with any further information being added as an addendum.
Opthalmology should review the competencies of all clinical nurse specialists and offer further training regarding refractive outcomes and lens choice if required.
Opthalmology should mandate that all the surgeons and scrub nurses are aware of the previous lens choice when they are operating on a second eye.

There should be agreement amongst ENT, thoracic, Upper GI surgeons and Gastroenterology for “Suspected Perforated Oesophageal Pathway” in terms of clear ownership, management supported by the Trust to agree a solution, especially out of hours. To be put on the trust Upper GI surgical risk register.
There should be careful consideration of HDU admission for all patients with surgical emphysema secondary to oesophageal perforation, discussed with and reviewed in person by the critical care team.
All patients with a suspected perforation on admission in working hours should be reviewed by an appropriate specialty registrar in person, must be discussed with their consultant on call. ENT should be involved for cervical level oesophageal perforation and Upper GI surgeons or thoracic for below cervical level perforations.
Staff should be reminded not to rely solely on MEWS as the indicator of severity of illness. If an overall assessment of concern is present it should be escalated to medics as appropriate.
Staff should be reminded of the criteria to invoke the Sepsis 6 Pathway and the implementation of the bundle.
Council of Governors
June 2015

Agenda

Welcome

Declaration of Interest

Apologies

Minutes

Matters Arising

Chairman’s Report

Chief Executive’s Report

Integrated Quality Report

Any Other Business

Attendance Record

Integrated Improvement Plan

Dementia Strategy Presentation

Governance and Governors’ responsibilities

SUI: August 2013 GHH Care of Elderly Opiate overdose in opioid naive patient – Prevented Never Event
Themes: Communication/non adherence to policy

SUI: September 2013 SHH T&O Theatres Retained ribbon gauze following THR – Never Event
Themes: Communication/ non adherence to policy/poor awareness of duty of candour

SUI: September 2013 SHH Urology/ED Delay in timely intervention and escalation of the deteriorating patient
Themes: Communication/Non escalation of clinical concerns.

SUI: October 2013 Vascular Surgery BHH Unexpected death following surgery
Themes: Non adherence to VTE policy/ communication/documentation

SUI: October 2013 Pathology BHH Delay reporting pathology specimens
Themes: Under efficiency, lack of capacity, poor organisation

SUI: October 2013 General Surgery BHH Wrong Site Surgery – Never Event
Themes: Documentation/communication

SUI: July 2013 SHH ED Unexpected Infant Death
Theme: Documentation/Communication

SUI: July 2013 SHH Ophthalmology Wrong lens insertion– Never Event
Themes: Theatre checking procedures/communication

SUI: September 2013 Gastroenterology BHH Injury during liver biopsy
Themes: Communication

SUI: September 2013 Gastroenterology Surgery BHH Delay in escalating deteriorating patient to consultant level/poor recognition of the deteriorating patient
Themes: Delay in escalating patient to consultant level

Communication

• Vital and skills resources
• Nursing safety manuals
• Safety walkarounds and responsive safety review processes
• Risky business forum for junior doctors

Documentation

• Surgical safety checklist / audit
• Nursing Metrics
• Annual Trust-wide documentation audit
• Safety thermometer
• NG tube policy and guideline

Medication

• Safe Medication Practice Group
• Medication Matters newsletters
• Improvement to EP system
• New Medicines Group for reviewing all severe harm incidents from medication incidents
• New RCA for all severe harm medication incidents
• Patient Safety Team developed tool for live information relating to missed dose anti-biotics.

Deteriorating Patient

Re-established Deteriorating Patient Recognition Group
Vital and Skills resources
Mews audit
Nursing metrics
Lessons of the month
SUI at a glance report
Action cards being produced for issue to surgical registrars mandating the circumstances where they must contact their consultant

Learning tools

• SUI at a glance reports and cascade system
• Mortality digest
• Safety lesson of the month
• Weekly Quality and Safety Meetings
• Developing Dare to Share Meetings

Serious Untoward Incident Themes /Never Events July 2013 – April 2014

Common themes from SUIs and associated work-streams

Communication

Documentation

Medication

Safer Surgery

Deteriorating Patient

Learning tools
Serious Untoward Incident Themes /Never Events April 2014 – October 2014

SUI Themes (Root causes and contributory factors) and Schedule 5 letters received by HEFT

- **SUI: April 2014 – Surgery BHH**
  - Unexpected patient death
  - Themes: Patient Suicide

- **SUI: August 2014 – Paediatrics BHH**
  - Unexpected Death of a child
  - Themes: Ownership of patients by paediatric team regardless of speciality patient is under.

- **SUI: May 2014 – Gastroenterology BHH**
  - Delay in escalation of deteriorating patient
  - Themes: Poor recognition of deteriorating patient /delay in escalating patient to consultant level

- **SUI: August 2014 – Paediatrics BHH**
  - Intrapartum Stillbirth
  - Themes: Lack of aneurysm pathway coordinator.

- **SUI: June 2014 – Paediatrics GHH**
  - Delay in recognition and escalation of a sick child.
  - Themes: Communication/ delay in recognition and escalation

- **SUI: July 2014 – ED BHH**
  - Delay in diagnosis of sub arachnoid haemorrhage
  - Themes: Lack of communication

- **SUI: July 2014 – Cardiology BHH**
  - Delay in recognition of sick patient
  - Themes: Communication/recognition and intervention following change in telemetry

Common themes from SUIs and associated work-streams

- **Communication**
  - Vital and iskills resources
  - Nursing safety manuals
  - Safety walkarounds and responsive safety review processes

- **Documentation**
  - Surgical safety checklist / audit
  - Nursing Metrics
  - Annual Trust-wide documentation audit
  - Safety thermometer
  - Consent Policy

- **Medication**
  - Safe Medication Practice Group
  - Medication Matters newsletters

- **Safer Surgery**
  - Sharing the learning from theatre related Never Events
  - Knowing the risk. Perioperative risk assessment / communication tool
  - Safety walk about in all theatres across sites
  - No Mark – No Go Campaign for safer surgery

- **Deteriorating Patient**
  - Re-established Deteriorating Patient Recognition Group
  - Vital and iSkills resources
  - Mews audit
  - Lessons of the month
  - SUI at a glance report
  - Deteriorating patient campaign
  - Sepsis pilot in AMU on all three sites to improve treatment for sepsis

- **Learning tools**
  - SUI at a glance reports and cascade system
  - Mortality digest
  - Safety lesson of the month
  - Weekly Quality and Safety Meetings
  - Patient safety and learning lessons boards piloted in AMU BHH
## Summary SUI profile March 2015 and inquest update

**SUI profile by management team (as at 09/04/15)**

<table>
<thead>
<tr>
<th>Site/Div</th>
<th>10/11</th>
<th>11/12</th>
<th>12/13</th>
<th>13/14</th>
<th>14/15</th>
</tr>
</thead>
<tbody>
<tr>
<td>BHH</td>
<td>5</td>
<td>5</td>
<td>3 (1x N)</td>
<td>9 (2xN)</td>
<td>15</td>
</tr>
<tr>
<td>GHH</td>
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<td>2 (2xN)</td>
<td>2 (1xN)</td>
<td>3 (2xN; 1xPN)</td>
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<td>2 (1xN)</td>
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<td>W&amp;C</td>
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<td>5 (1xN)</td>
<td>1</td>
<td>6 (1xPN)</td>
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<td>2</td>
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<td>Never (or PN) Events</td>
<td>2 of 14</td>
<td>6 of 17</td>
<td>3 of 11</td>
<td>6 of 15</td>
<td>2 of 25</td>
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</table>

**SUI profile by location (as at 09/04/15)**

<table>
<thead>
<tr>
<th>Site</th>
<th>10/11</th>
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### Never events in 2012/13 relate to:
- 1 wrong site surgery (General Surgery)
- 1 Inappropriate administration of daily oral methotrexate (T&O)
- 1 retained tampon (O&G)

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

### Never events in 2014/15 relate to:
- Prevented: 1 Opioid overdoes of opioid naive patient (Paediatrics)
- 1x wrong implant (Ophthalmology)

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

Inquest scheduled for 16th March 2015 associated with an incident being investigated through the Trust SUI process as “deteriorating patient”. **STEIS 2014/36858**

Narrative conclusion – Patient died from recognised complication of an investigative endoscopy. No schedule 5 section 7

### Forward look: Potential for adverse inquest conclusion

Inquest scheduled for 25 March 2015 associated with delay in recognition of change in telemetry monitoring which was formerly investigated through the Trust’s SUI process **STEIS 2014/22609** Inquest adjourned rescheduled to 22nd May 2015
### CQC IMR December

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<td>Risk</td>
<td>Diagnostics waiting times: patients waiting over 8 weeks for a diagnostic test (01-Jul-14 to 31-Jul-14)</td>
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<td>Inpatients response percentage rate from NHS England Friends and Family Test (01-Aug-13 to 31-Jul-14)</td>
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Integrated Improvement Plan
Title: HEFT Integrated Improvement Plan (IIP)  

From: Dr Andrew Catto, Deputy CEO & Executive Medical Director  
To: Board of Directors and Council of Governors

The Report is being provided for:

<table>
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<th>Decision</th>
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<th>Endorsement</th>
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The BoD is being asked to:

Review the IIP and consider if the IIP reaches the standard of an effective recovery plan given the current operational and regulatory context of the Trust.

Key points/Summary:

The IIP:
- Describes the HEFT programme management methodology
- Describes the next 30 / 60 / 90 days and the action HEFT will take
- Provides a framework around the assurance process HEFT will use
- Describes the programme structure and the governance arrangements in the six constituent IIP programmes
- Recognises certain risks and constraints to delivery
- Describes a range of programme metrics to inform progress against the HEFT improvement journey

Recommendation(s):

That the IIP is implemented in full and that the Executive Management Board manages and monitors the implementation of the IIP using the IIP Programme Board.

The BoD and External Stakeholder Engagement Group will be updated on progress with the IIP.

Assurance Implications:

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<th>Strategic Risk Register</th>
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Which other Committees has this paper been to? (e.g. F&PC, QRC, etc.)

- Executive Management Board and Board of Directors Forum in draft format.
- Stakeholder Engagement Group 20th May 2015
HEART OF ENGLAND NHS FOUNDATION TRUST
INTEGRATED IMPROVEMENT PLAN
RECOVERY PLAN
Document Control

Change history

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<td>6th Draft - comments from Execs and Board + Executive summary &amp; revised Comms plan</td>
<td>18/5/15</td>
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Document approvals - this document requires the following approvals

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<th>Name</th>
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<th>Version and Date</th>
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<td>Interim Chief Executive</td>
<td>May 2015 - V0.6</td>
</tr>
<tr>
<td>Andrew Catto</td>
<td>Deputy Chief Executive and Medical Director &amp; SRO</td>
<td>May 2015 - V0.6</td>
</tr>
<tr>
<td>Darren Cattell</td>
<td>Interim Director of Finance</td>
<td>May 2015 - V0.6</td>
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<tr>
<td>Sam Foster</td>
<td>Chief Nurse</td>
<td>May 2015 - V0.6</td>
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<td>Jonathan Brotherton</td>
<td>Director of Operations</td>
<td>May 2015 - V0.6</td>
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<tr>
<td>Hazel Gunter</td>
<td>Director of Workforce</td>
<td>May 2015 - V0.6</td>
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<tr>
<td>Monitor</td>
<td>Regional representative</td>
<td>May 2015 - V0.6</td>
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Distribution

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<th>Name</th>
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This document will remain in DRAFT Format until formal agreement and acceptance by Monitor and the Trust Board as the definitive description of the IIP, it's constituent programmes and the methodology and approach that will be used to deliver the IIP.
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1. Executive Summary

Heart of England NHS Foundation Trust (HEFT) is a multi site acute and community services provider with locations at Heartlands Hospital, Good Hope Hospital and Solihull Hospital, employing approximately 11000 staff across the three sites.

During the twelve months preceding the publication of this document HEFT have been the subject to a number of reviews, the subsequent reports have not cast HEFT in a positive light in a number of areas which includes both clinical and managerial disciplines.

This has had direct and indirect consequences for HEFT, including major leadership changes with the highly publicised resignation in November 2014 of Dr Mark Newbold as the Chief Executive Officer. This followed the relatively recent change in the Chair, Mr. Les Lawrence was appointed as the new Chairman succeeding Lord Hunt. in July 2014.

Further changes in the executive leadership team followed which understandably created a certain amount of instability and concern amongst those remaining in the leadership team and HEFT staff alike.

Running in parallel to some of these events was the enforcement action that Monitor accepted under section 106 of the Health and Social Care Act ("the Act") and was compelled to impose upon HEFT on 20 December 2013 in relation to the Licensee’s governance arrangements for urgent care. Amendments were accepted to those undertakings on 21 October 2014, following breaches of additional access and outcome performance indicators.

As a consequence of these collective actions Monitor appointed an Improvement Director to work with HEFT to support a number of improvement initiatives.

Following the resignation of Dr Mark Newbold the Medical Director, Dr Andrew Catto was appointed as the Interim Chief Executive Officer to immediately fill the void and bring some stability to the Trust. Dr Catto set about constructing a number of plans and initiatives designed to improve clinical services, safeguard the reputation of HEFT, improve the leadership team and fill the gaps left by departing Executives - appointing an Interim Director of Finance and Director of Information Management & Technology (IM&T).

Dr Catto led the development of an integrated leadership support and resilience programme (LSRP) between December 2014 and February 2015. The key programmes in the LSRP, which was presented to Monitor, key stakeholders and national clinical leaders, comprised the 7 work streams of governance, mortality / congestion, culture / engagement, safe staffing, IM&T/PMS2, performance and executive leadership, which have latterly become known as the Integrated Improvement Plan (the IIP).

Further refinement has seen the IIP change, evolve and expand to include a number of Trust wide improvement programmes such as Urgent Care and Scheduled care whilst other smaller programmes have merged with others to form larger programmes. The IIP now consists of six primary change programmes see Fig 1 below:
However whilst there was a common intention to run these programmes as an Integrated programme the reality was that the programme management arrangements needed to support this approach were not in place at the time of conception, not even in an embryonic form.

HEFT established a Programme Management Office (PMO) in January 2015 and engaged a small number of Interim resources to support the delivery of the IIP.

Following the appointment of Mr Andrew Foster on the 16th of February the LSRP evolved into the Pyramid of Priorities, developed by Mr Andrew Foster which is based on a six phases of the delivery model as described in Fig 2 below:

As the last quarter of 2014/15 passed and the year end approached the Executive Management Board (EMB) and subsequently Monitor started to voice concern about the lack of clarity and intent surrounding the IIP. concerns were also raised about the quality and format of the reporting. There was confusion about the metrics and how meaningful they were/are not and the ambiguity that some of the reporting formats seemed to indicate.

In March 2015 the Interim Director of Finance (DoF) and the Chief Nurse moved to engage additional interim support to deliver a Governance recovery programme based on the findings and recommendations of the Deloitte report commissioned by Monitor, who decided to share the report with the EMB to help them understand the breadth and depth of the challenges facing HEFT.

1 This is explained in more detail in Item 2.2 of the main body of the document
In April 2015, a new stakeholder group was established comprising the HEFT executive team, NHS England, Lead Clinical Commissioning Groups (CCG’s), Monitor and the Care Quality Commission (CQC). This innovative approach, supported by the Monitor Director of Improvement replaced the Quality Steering Group (QSG).

The implementation of the Governance recovery programme and subsequent analysis by the Interim DoF and Chief Nurse, coupled with the outputs of the first stakeholder meeting in April, heightened awareness within the EMB that the IIP PMO was not functioning as efficiently as desired or at the level required. Immediate action was taken with the appointment of Dr Andrew Catto as the Senior Responsible Owner (SRO) for the whole of the IIP and the transfer from the Governance recovery programme of one of the interim resources to lead the IIP as Programme Director. To lead the reform and restructure of the PMO this task also included the development and publication of this IIP recovery document.

The plans and processes described in this document are built around a tried and tested methodology with an identified recovery timeline based on a 30/60/90 day phasing which aligns perfectly with Mr Andrew Foster’s six delivery phrases.

Note: One of the biggest challenges facing HEFT is the current structure of the divisions and the directorate structures which are diverse in both their management and governance processes; as well as their cultures which present a number of issues in their own right. This recovery plan does not seek to address the divisional structure as part of the IIP at this point in time. It is felt that evolution rather than revolution is all that we can really hope to achieve within the life cycle of the IIP.

In the third week of April a decision was made to restructure the PMO see Fig 3 below, with administration and governance moving under the Interim DoF and Strategic direction and delivery moving to Dr Andrew Catto.

Since this decision was made there have been a number of movements within the PMO itself with additional specialist resources being added to bolster the skills and expertise needed to ensure and assure delivery.
Essentially each programme within the IIP will have a dedicated programme/project manager to provide support around change management techniques and processes and to provide support and rigour around the reporting requirements. The majority of these positions have been filled with existing personnel but we have also recruited a small number of additional subject matter experts to provide the necessary PMO management and leadership that is required. An additional Programme manager has been engaged to support the Governance programme and provide additional support to the PMO. A new Head of PMO will join the Trust on Thursday 21st of May. The following table provides detail on the current and near future manning arrangements available to the PMO:

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<tbody>
<tr>
<td>Stuart A Brown</td>
<td>IIP Programme Director</td>
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<td>James Weller - joins 21/5</td>
<td>Head of PMO</td>
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</tr>
<tr>
<td>Phill Wilson</td>
<td>Project manager</td>
<td>IIP Programme &amp; Governance</td>
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<td></td>
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<td>Paul Arford</td>
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<td>Urgent Care Programme</td>
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<td>Lara Williams - joining date tbc</td>
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<td>Vacant</td>
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<td>IM&amp;T</td>
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<td>Danielle Goddard</td>
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<tr>
<td>Nick Varney</td>
<td>Head of PMO and IIP</td>
<td>IIP Programmes</td>
<td>Moves to Surgical reconfiguration</td>
</tr>
<tr>
<td>Keith Hawley</td>
<td>Project manager</td>
<td>Governance programme support and ad-hoc support as directed by Head of PMO</td>
<td>Will leave the Trust on 11th of June or sooner if mutually agreeable</td>
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Work commenced on the development of the narrative that describes the IIP and the delivery methodology on the 24th of April, in the form of a document Mind Map setting out the structure and content of the document. This was approved by the Deputy CEO and Interim DoF on the same day. The first draft of the narrative document was received at EMB the following week and then presented for discussion at the Trust Board on the 5th of May.
The recovery plan is based on a 30/60/90 day plan, the following graphic Figure 4 describes the current status against that plan:

The 30/60/90 phases are described in full detail in the main body of the document in section 9.

The programme gateway process has already begun with the support of Deloitte undertaking a programme delivery status assessment during the week commencing 11th of May 2015. The outcome of the assessment was in line with the internal assessments made by the SRO’s for the individual programmes.

HEFT faces a significant set of challenges which it must overcome if we are to deliver the IIP on-time and within an agreed financial window. However there are a number of factors that bode well for the Trust in it’s quest to deliver the IIP:

- The Executive Leadership Team are totally committed to the delivery of the IIP and the determination to embed quality at every level of the organisation and make it a natural part of the “day job”;
- Engaging our staff, patients, commissioners and the wider health economy is at the center of our delivery strategy;
- We have a willing staff body who want to see change that genuinely improves patient care and staff wellbeing and want to play their part in delivering it;
- We have tangible hands on support from our regulator - they have provided access to best practice examples of “the way to do it” they have worked with us to engage constructively and beneficially with Deloitte’s and they have provided us with an Improvement Director who makes a positive contribution to our endeavors;
• We believe that the recent changes we have made to the structure and operating model of the PMO will now give us the drive and rigor that we need to deliver the IIP;

In conclusion, this is our plan and this is the journey we are committed to, we know we have a long way to go but we know we will achieve the desired outcomes and we know that patient care will be significantly improved as a result of HEFT completing this journey.

Andrew Foster - Interim CEO

Dr Andrew Catto - Deputy CEO
At the *Heart* of it……

**Integrated Improvement Plan**

**SECTION 2 - INTRODUCTION**
Integrated Improvement Plan
Council of Governors
June 2015

2. INTRODUCTION

HEFT has been striving to drive a number of improvement programmes across the Trust in the areas of: Unscheduled care, Planned care, Governance - including performance, Mortality, Culture and engagement and IM&T. The set of programmes is the Integrated Improvement Plan (IIP).

Having established a Programme Management Office (PMO) in January 2015 the Trust has made progress but it has lacked pace. Monitor, the Trust CEO and Executive Management Board (EMB) have expressed concerns about the format and quality of IIP reporting.

Following a recent performance review with Monitor the Trust was asked to provide a comprehensive plan to get the IIP back on track as quickly as possible. The finalised plan will be presented to Monitor prior to May 20th 2015.

2.1. PURPOSE OF THIS DOCUMENT

This document details the narrative, proposed IIP plans, governance arrangements and programme and high level project interdependencies for the recovery of the portfolio of programmes comprising HEFT's Integrated Improvement Programme – the IIP. (see Figure 5 below). The IIP articulates six specific programmes of work that are required to ensure the programme(s) are on track and maintaining traction and pace at a time of significant pressure for HEFT.

The ultimate aim of the IIP is to deliver sustained change, by an engaged workforce, committed to improving high quality embedded care delivery.

Fig 5 - The Integrated Improvement Programme (IIP)

The purpose of this document is to provide the Board of Directors, Regulators and stakeholders with the assurance on delivery. Assurance by clearly articulating the detail of the HEFT improvement plans, improvement metrics and the timeline for delivery.
This document:
- describes the corporate Programme and Project Management (PPM) function, its role, responsibilities and relationships. PPM will be used extensively to support operational and corporate teams with delivery and also serve as robust assurance function. It is important to acknowledge that operational teams are responsible for the delivery of the IIP, not the PMO;
- lays firm foundations for multi programme delivery, communication, assurance and future reviews; and
- provides the basis for developing more detailed plans, and for considering how other initiatives relate to corporate PPM, so that current and future activities across HEFT can be aligned to maximum effect to support the delivery of HEFT’s strategic objectives. Ultimately this plan will be aligned to the Trust’s suite of strategies in September 2015.

2.2. CONTEXT

2.2.1. Heart of England NHS Foundation Trust (HEFT)

Heart of England NHS Foundation Trust (HEFT) regulatory and quality chronology

In July 2013 the Care Quality Commission announced that HEFT would be one of the 18 first wave Trusts to be inspected by a more robust new style inspection. At that time, HEFT was considered neither low nor high risk but a ‘variety of risk points’ [Ref: http://www.cqc.org.uk/content/cqc%E2%80%99s-new-hospital-inspection-programme-start-tomorrow]. However, HEFT had been subject to registration conditions by the CQC when in April 2010 the regulator registered HEFT on condition it made improvements to three essential standards of care when it introduced a new registration system for all health and adult social care services.

Two conditions were removed in October 2010 and the final condition in February 2011. HEFT underwent a further unannounced 3 day inspection in December 2014, the findings from which have now been received from the CQC and published on the CQC website2. The current overall status of HEFT as assessed by the CQC is: Requires improvement. [ref: http://www.cqc.org.uk/provider/RR1]

In December 2013 HEFT was one of thirteen hospital trusts named by Dr Foster Intelligence (DFI) as having higher than expected higher mortality indicator scores for the period April 2012 to March 2013 in their Hospital Guide 2013.[4] although based on the Health and Social Care Information Centre (HSCIC)[ref http://www.hscic.gov.uk/] HEFT mortality was at the upper limit of expected. The principle reason for the difference being the statistical methodology adopted by DFI and HSCIC.

In June 2014 Mr. Les Lawrence was appointed as the new Chairman succeeding Lord Hunt. In July 2014, NHSE in discussion with key Trust stakeholders, held a risk summit that focussed on key quality risks and performance concerns. The resulting action plan

2 The resultant action plans do not form part of this narrative at this point in time but will do in future iterations
was monitored by the unusual step of HEFT attending meetings of the NHSE quality summit. HEFT was represented by the Chief Nurse and Executive Medical Director, ensuring that a strong focus on quality was maintained.

Dr Mark Newbold resigned as Chief Executive in November 2014 after HEFT had a condition placed on its license by Monitor on 21 October 2014 relating to performance, governance and mortality. Dr Andrew Catto was appointed interim Chief Executive until 16th February 2015 when he was succeeded by Mr Andrew Foster as Interim Chief Executive. Following Dr Newbold’s resignation, a number of changes were made at Executive Director level with the appointment of external interim Directors of Finance and IM&T. The Director of Patient Experience and External Affairs left HEFT in March 2015.

The then interim CEO Dr Catto, with the support of the Board of Directors, developed an integrated leadership support and resilience programme (LSRP) between December 2014 and February 2015. The key programmes in the LSRP, which was presented to Monitor, key stakeholders and national clinical leaders, comprised the 7 work streams of governance, mortality / congestion, culture / engagement, safe staffing, IM&T / PMS2, performance and executive leadership.

The LSRP evolved into the current pyramid of priorities (see Fig 6 below) developed by Mr Andrew Foster.

---

### The Pyramid of Priorities

Recovery

1. Clarity (Governance & Strategy)
2. Quality Improvement
3. Staff Engagement
4. Safe Staffing
5. ICT Investment
6. Estates Investment
7. Mortality Reduction
8. Deloitte Governance Plan
9. Monitor Enforcement Undertakings
10. A&E
11. RTT
12. Scheduled Care
13. Cancer
14. CQC Recommendations
15. Kennedy Report
16. Silverman Report

---

**Safe** | **Effective** | **Caring** | **Responsive** | **Well led**
Fig 6

The CEO Andrew Foster and executive team are focussed on 3 high level deliverables see Figure 7 below:

- **CLARITY**
- **CULTURE & ENGAGEMENT**
- **QUALITY**

Fig 7 - High level deliverables

In April 2015, a new stakeholder group was established comprising the HEFT executive team, NHS England, Lead CCGs, Monitor and the CQC. This innovative approach, supported by the Monitor Director of Improvement replaced the QSG.

2.2.2 The IIP in the context of the National Picture

The healthcare system is facing very significant care delivery changes and enduring financial pressures. With an ageing population, people are living longer with more complex health needs and often multi-morbidity, therefore the need for services will continue to grow faster than funding, meaning that the NHS and social care must innovate and transform service delivery, within the resources available, ensuring that patients, and their needs, are always put first.

The planning guidance establishes key criteria:

- Strategic plans covering a five year period, with first two years at operating plan level
- An outcomes focused approach, with stretching local ambitions expected of commissioners, alongside credible and costed plans to deliver them
- Citizen inclusion and empowerment to focus on what patients want and need
- More integration between providers and commissioners
- More integration with social care – cooperation with Local Authorities on Better Care Fund planning
- Plans must be explicit in dealing with the financial gap and risk and mitigation strategies. - **No change not an option**

It should also be noted that Acute Service providers have been under significant operational pressures for sustained periods of time, in some case providers have not seen the expected seasonal drops in emergency activity since the Winter of 2011/14. This has resulted in adverse publicity for some Trusts and for the wider NHS as a whole.

Also at the time of writing and publication of this document the General Election is fast approaching so focus and publicity around the NHS is at a heightened level.
2.2.3. NHS Outcomes Framework


- Preventing people from dying prematurely
- Enhancing quality of life for people with long-term conditions
- Helping people to recover from episodes of ill health or following injury
- Ensuring that people have a positive experience of care
- Treating and caring for people in a safe environment and protecting them from avoidable harm

These 5 outcomes are aligned to the development of the HEFT clinical strategy.

2.2.4. The IIP in the context of the Local Health Economy

HEFT serves a diverse range of communities in Birmingham East and North, Solihull, Sutton Coldfield and South Staffordshire, with up to 1.2 million people visiting HEFT every year and a base commissioning population of over 1 million people. A number of these populations have significantly challenging health needs. All CCG’s are supported by and provided with extensive access to a number of tools to inform their planning and commissioning intentions - PHE CCG Outcomes benchmarking support packs [http://www.england.nhs.uk/la-ccg-data/#ccg-info].

HEFT predominantly serves three Clinical Commissioning Groups (CCG’s) : Birmingham Cross City, Sandwell and West Birmingham CCG and Solihull CCG, with a combined population catchment area of circa 1 400 000. However all in all there are 10 commissioning bodies that purchase services from HEFT at the following levels:

- NHS Birmingham Cross City CCG £231.5M
- NHS Birmingham South and Central CCG £14.7M
- NHS Sandwell and West Birmingham CCG £8.0M
- NHS Solihull CCG £134.6M
- NHS South East Staffs and Seisdon Peninsular CCG £33.5M
- NHS Walsall CCG £6.2M
- NHS Warwickshire North CCG £6.3M
- Birmingham and the Black Country Area Team £112.6M
- Health Education England £23M
- Birmingham City Council £7.0M
### Five year key priorities for each the lead CCGs are as follows:

<table>
<thead>
<tr>
<th>Key Priorities</th>
<th>Solihull CCG</th>
<th>Birmingham Cross City CCG</th>
<th>Sandwell and West Birmingham CCG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preventing illness, Improving Health Programme</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>High quality primary care</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Better community provision</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Whole system approach - i.e. Your Care Connected (Joint commissioning)</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Commissioning elective care based on achieving better outcomes from interventions</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Urgent Care</td>
<td>X</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Hospital transformation/Outpatient transformation</td>
<td>X</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Mental Health - high quality and responsive</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Children's and maternity services</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Preventing readmissions</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Long term conditions</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Intermediate care</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stroke services</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pathway management</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Effectiveness review</td>
<td>X</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

HEFT has developed an excellent working relationship with commissioners and local authority partners in the delivery of the Better Care Funds (BCF) in Birmingham and Solihull with senior executive representation on BCF Boards.

Regular dialogue between HEFT and Solihull / Birmingham Cross City CCGs established as an action of the quality summit ensures close dialogue between the very senior leaders.
2.2.5. The IIP in the context of The Divisional Landscape

The following points provide a high level summary of the Divisional position in relation to the IIP:

- The clinical services are delivered through 5 clinical divisions (3 site based, 2 specialty based) supported by 27 directorates.
- The management teams at division and directorate level are formed by a triumvirate model (doctor, nurse and manager).
- A mixture of site specific and cross site specialties/directorates.
- The Trust is failing across a range of key performance indicators and is under scrutiny by the regulators.
- Significant additional corporate management support recently introduced to improve performance.
- An Executive view that HEFT needs to become a highly devolved clinical led, organisation.

So this poses the question - What should good look like in a clinically led, management supported devolved division?

- They should have a written plan setting out service priorities, key objectives, timescales and leads;
- A clear structure supported with roles and responsibilities;
- Clear decision making arrangements with responsibilities and authority set out. As a minimum a formal divisional board with recorded agreements;
- Performance management framework at team and individual level;
- Intelligent use of KPI’s supported with improvement/change capabilities;
- Staff comms and engagement processes;
- High quality leadership distributed and every level (ward to board);
- Effective relationships with key stakeholders (executives, other divisions and CCG’s);
- A distinctive culture characterised by positive behaviors, clinical leadership, drive for quality and a common purpose.

Why would you need good clinical leadership?

Good hospitals are run by good strong clinical leadership which empowers clinicians but also makes them accountable (See Fig 8 - Driving clinical leadership) and HEFT is no different in their aspiration to become a “beacon” for clinical leadership. However HEFT also recognises that we are have some way to go before we can be recognised as having that characteristic.

The current divisional and directorate structure presents a number of complex challenges for the senior management team of HEFT which question the long term viability of the
The current model which is based on site primacy. Many of the directorates operate with different management models which increases the level of complexity.

Fig 8 - Driving clinical leadership

The Executive team have recognised the need to make some tactical changes in order to bring about some improvements in the current operating model (COM), now is not the time for a radical restructuring of the COM and it may be some time before the optimum conditions for radical restructuring exist. They have also recognised that the COM represents a not inconsiderable risk to the overall delivery of the IIP.

Some of the characteristics of the COM are manifest in some of the things that have been observed during a recent piece of work that was commissioned by Andrew Foster:

- Divisions believe they have lost the right to manage their own business (eg interim support, PMO, improvement boards etc):
  - There is a lack of clarity on roles responsibilities boundaries and accountability across sites and specialities;
  - General/Senior Management -sufficient capacity was observed at appropriate grade mix with varying capability;
  - Managers at all tiers were working at levels below what was required;
  - Varying degrees of clinical leadership is in place;
  - The divisions do not have meaningful engagement with each other;
  - There appears to be a lack of synergy between divisions in the pursuit of corporate objectives (strong silo working);
  - There are significant differences in the way the divisions operate but there is a lot of problem processing and blaming others and not enough drive for change and improvement;
  - Bidding for resources to solve problems is the starting point;
  - Getting to the reality has been a challenge.
As mentioned above there needs to be some tactical changes to the COM and as we said this means that the issues identified in this analysis are key to delivery and is underpinned by a combination of cultural, process and structural issues.

The recent clarity that the Associate Medical Director (AMD) is the divisional accountable officer is an important starting point. In addition to the engagement events held with staff, the next key engagement opportunity is for EMB (attended by all AMDs) to receive the analysis and agree a shared way forwards. This will be held on 5th May 2015.

2.2.6. The IIP in the context of individual HEFT staff members - Staff Engagement

The staff at HEFT are our biggest and most valuable asset. Without a strong, committed and well-motivated workforce we will not, despite our best intentions, deliver the level of service that we aspire to or the patient experience and level of care that our patients deserve. Furthermore, it has long been recognised that engagement of employees with their work and organisation is a factor in their job performance, but the research evidence has been steadily increasing over recent years. West and colleagues have carefully studied the relationship between employee engagement and a variety of individual and organisational outcome measures, including staff absenteeism and turnover, patient satisfaction and mortality, and safety measures, including infection rates. [Ref West http://www.kingsfund.org.uk/sites/files/kf/employee-engagement-nhs-performance-west-dawson-leadership-review2012-paper.pdf]

Culture and Engagement is a crucial, pivotal IIP programme in the IIP Portfolio. For the Culture & Engagement programme, the objectives are to develop a working environment in which staff feel significantly more engaged, and to reap the benefits of the associated improvements in performance and patient outcomes. This will be achieved by introducing a more structured approach to staff engagement, including senior team led large scale listening events, strong governance around how feedback is turned into action, and the introduction of the more locally focused Engaging Teams Programme, to build sustainable skills and capability across our teams.

A programme of Listening Events has commenced across the 3 main sites and ‘you said – we did’ feedback to staff is evident throughout the Trust. Focussed listening sessions have been held in high clinical risk areas such as the Emergency Department (ED).

2.3. BACKGROUND

The need to develop and deliver a robust well managed IIP spans a period of least three years during which a number of reviews and interventions have highlighted a number of quality, performance, engagement and governance concerns about HEFT.

The concerns are not specific to one site or HEFT department, as they sit across a broad range of clinical services, subject matter and impact on all sites. In addition, the Deloitte review of governance identified the absence of Programme Management methodology throughout HEFT as a major shortcoming. A PMO at HEFT was developed using interim staff in late January 2015 and additional expertise was identified in early April 2015 to
facilitate the development of the PMO into supporting the delivery a robust IIP methodology.

Expert subject reviews by the Emergency Care Intensive Support Team (ECIST), Mr Stan Silverman FRCS, Deloitte - CQC as part of their previous standard inspection regime and more latterly under the new CQC Enhanced inspection regime. This led, in part, to further Monitor intervention and the issuing of Monitor Undertakings.

The Silverman report, commissioned by the Executive Medical Director (delivered 29th September 2014) reached the following important conclusions:

The Board of the Heart of England FT receive only partial assurance in regard to mortality as reports are based largely on information derived from coding data. The Board is uninformed about the potential shortfalls in care that might be revealed through structured review of all deaths.

There is potential to vastly increase knowledge about safety and risk through the incident reporting system which currently appears to be suboptimal.

There is a lack of compliance with guidance on best clinical practice in HEFT.

Clinical staff are under severe pressure, morale is poor, and engagement is poor.

Multidisciplinary working and good team working are poorly developed. Silo working is widespread.

Clinical congestion is likely to be the biggest factor in causing raised mortality indicators. This can be addressed to a large extent by transforming clinical practice. The HEFT executive has focused on clinical congestion as the greatest threat to the delivery of safe care in the Emergency Department and this IIP has a strong focus on this key quality risk.

We have triangulated these outcomes with other expert reviews and reports such as IST/ECIST, and the Deloitte Governance Review. Whilst they carry specific recommendations on leadership, board assurance and risk management, there is a common narrative considering they have been conducted independently.

2.3.1. Monitor Undertakings

As HEFT’s regulator Monitor have a duty to provide assurance to the Secretary of State (SoS) for Health about the safety and financial viability of HEFT. The following undertakings represent the action that Monitor have agreed to take in order to provide that assurance. What is obvious from the timelines against the specific actions and milestones is that HEFT have not been able to meet Monitors expectations and assurance given to the SoS. This is further evidence of the need for this recovery plan.

BACKGROUND: PREVIOUS AND CURRENT REGULATORY ACTION

Monitor accepted enforcement undertakings under section 106 of the Health and Social Care Act ("the Act") from the Licensee on 20 December 2013 in relation to the Licensee’s governance arrangements for urgent care. Monitor then accepted amendments to those undertakings on 21 October 2014, which were made following breaches of additional access and outcome performance indicators. These are referred to collectively as the
"existing undertakings". The undertakings (detailed in the Appendices) relate to breaches of the additional licence condition imposed under section 111 of the Act on 21 October 2014 ("the additional condition") and the broader governance conditions of the licence, and are without prejudice to the existing undertakings. The additional condition requires the Licensee to ensure that it has in place sufficient and effective Board, management and clinical leadership capacity and capability, as well as appropriate governance systems and processes.

Full details of the Monitor Undertakings are contained in the appendices in Appendix V.

2.4. SPONSORSHIP OF THE INTEGRATED IMPROVEMENT PORTFOLIO
Ownership and strategic direction of the IIP sits with the Deputy Chief Executive, and the collective responsibility for the delivery and the sustainability of the changes arising from this programme resides with the Executive Management Board and the Board of Directors.

Monitor and The Care Quality Commission (CQC) will receive assurance from HEFT on the progress of IIP via the monthly external stakeholder group and secure evidence that HEFT remains financially viable and delivering safe care throughout the period of change implementation and beyond.

2.5. KEY PRIORITIES AND TIMELINES
There are six stages to the development and delivery of the IIP, Fig 9 below describes the six stage maturity model. (also appears in the Exec Summary)
Monitor have formally expressed concerns regarding progress to date on the IIP. (Andrew Foster has received a formal letter from Monitor expressing their concern around the progress of the IIP and its reporting architecture). There is specific concern that the presentation and content of the IIP thus far requires further development. This is acknowledged by the executive team and this document, along with other decisive action, will add traction to the delivery of the IIP and support the implementation of stage 5 of this process namely that the IIP is perceived as centre stage.

The first iteration of this document and the high level plan metrics were received at EMB on 29th April and the first meeting of the IIP programme board was held on 29th April 2015.

The draft IIP and metrics will be received at the Board of Directors on 5th May 2015.

It is stressed that the IIP is a live document that will continue to evolve up to the stakeholder meeting when the final definitive version 1.0 will be published.

2.6. THE 30 DAY CHALLENGE – GETTING BACK ON TRACK

The next 30 days are a critical period for HEFT, a period where we have to demonstrate to the BoD, Monitor and the commissioners that the IIP has the required traction and pace to provide the required level of assurance.

During this period we will be implementing the following actions:

- Additional skilled resources will be added to the PMO to provide additional support to the programmes that sit on the critical path;
- All programmes will be scheduled to undergo a rigorous Gateway review to assess their capability to deliver against the current agreed timelines.

If it is determined that the delivery schedule is at risk a recovery action plan will be developed and implemented;
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SECTION 3- VISION & OBJECTIVES
3. Vision and Objectives

3.1. Vision

The HEFT 2020 Vision consists of the clinical strategy, quality strategy, quality improvement strategy and corporate strategy, supported by strategies for IT, HR and business. Each of the divisions will subsequently produce a strategic portfolio adding local detail to the Vision and their strategic deployment plans.

3.2. Objectives

Our key objectives are to:

- Improve the quality of care, including the outcomes, the safety and the experience for all;
- Engage with patients, carers, staff, our community, stakeholders and partners to redesign our services to provide improved access to services at the right time in the right place;
- Innovate and research new treatments and new ways of delivering care.

In five years time

Heartlands will be the centre for complex and emergency care. Based in the heart of the East Birmingham community it has facilities which mean we can provide leading edge clinical services, some of which have a national reputation. By concentrating some specialist care we will provide the best outcomes and care.

Good Hope will continue to provide a full acute and emergency medical service. The recent investment in the new A&E department means it has a strong and sustainable future to manage this workload to high standards. Over time the hospital will undertake less emergency surgery but will be home to some surgical specialties, many of which serve a regional population.

Solihull Hospital and Community Services will become the centre of an integrated care system. For patients this means that their health and social care services will be aligned and integrated around their individual needs. This is important since many of the patients at Solihull are elderly and the hospital care is often only one part of an overall package of care and support they are receiving.

It is planned that Solihull will have an urgent care facility which will be closely linked to primary care. The Hospital will continue to provide acute care but closely linked to the specialist centre at Heartlands.

Heart of England run community services in Solihull providing a wide range of support to people of all ages.

In Solihull we are already developing plans to bring together a wide range of public sector services. This will include “one stop shops” where people can seek help relating not just to their health but also for their overall well being, including leisure services, local safety, finance and council services.

In the future we will deliver more care in peoples’ homes and in community facilities across all of our catchment area and will work more closely with partners so that our patients and their carers see all their care needs are joined up with less handovers between individuals and organisations.

Fig 10 - 5 Year aspiration
At the **Heart** of it......

**Integrated Improvement Plan**

**SECTION 4-PROGRAMME MANAGEMENT AND PMO**
4. PROGRAMME MANAGEMENT & PMO

HEFT made a conscious decision in the third quarter to adopt a programme management approach and establish a fully functioning effective programme management office (PMO). The effectiveness and influence of the PMO to date has been variable. Confidence in the delivery of the programmes that make up the IIP now needs to move to the next level in order to provide Monitor, The Board and Commissioners with the level of assurance that they require. Based on this analysis HEFT is recruiting additional resources with an enhanced level of capability to provide the necessary skill mix and capacity to provide the drive delivery and provide the assurance required.

4.1. STRUCTURE OF THE IIP

Managing the interdependencies within a programme of this size and complexity is challenging, with plenty of opportunities for silo working and duplication of effort. Individual Programme Directors and Work Stream leads will need to work effectively to mitigate any risk of this happening.
The programme directors for each of the constituent IIP programmes will meet regularly with the IIP Programme Director, weekly for the next 30 days and fortnightly thereafter to review progress and resolve any interdependency issues.

4.1.2. Personnel

In the third week of April a decision was made to restructure the PMO see Fig 12 below, with administration and governance moving under the Interim DoF and Strategic direction and delivery moving to Dr Andrew Catto.

Since this decision was made there have been a number of movements within the PMO itself with additional specialist resources being added to bolster the skills and expertise needed to ensure and assure delivery.

The following table describes the current manning levels of the PMO, this may be subject to change and additions as the requirements become clearer over the coming weeks.

<table>
<thead>
<tr>
<th>Name</th>
<th>Title</th>
<th>Area of responsibility</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stuart A Brown</td>
<td>IIP Programme Director</td>
<td>IIP Programme</td>
</tr>
<tr>
<td>James Weller - joins 21/5</td>
<td>Head of PMO</td>
<td>IIP PMO</td>
</tr>
<tr>
<td>Phill Wilson</td>
<td>Project Manager</td>
<td>IIP Programme &amp; Governance programme</td>
</tr>
<tr>
<td>Paul Arford</td>
<td>Programme Manager</td>
<td>Urgent Care Programme</td>
</tr>
<tr>
<td>Lara Williams - joining date tbc</td>
<td>Project manager</td>
<td>Mortality and Congestion</td>
</tr>
<tr>
<td>Vacant</td>
<td>Project manager</td>
<td>IM&amp;T</td>
</tr>
<tr>
<td>Danielle Goddard</td>
<td>Project manager</td>
<td>Culture and Engagement</td>
</tr>
</tbody>
</table>

The following table details the movements out of the PMO:
4.1.3. Corporate Fit

The PMO is directly accountable to the Deputy Chief Executive for the full scope of the IIP and is also accountable to the Director of Finance for the performance and finance element of all programmes.

4.2. APPROACH

4.2.1. Assurance role

A programme assurance role is a very different model to the delivery driver model and requires different skill mixes and styles. The assurance roles is to all intents and purposes a very light touch review and report type approach and is not designed to provide intense challenge or roll your sleeves up support. The skill mix for an assurance PMO is generally fulfilled by staff that do not necessarily have subject matter expertise but do have the necessary programme management process knowledge and capability.

4.2.2. Delivery Driver

This role is much more focussed on tangible support to the projects and work streams and is usually staffed by personnel with a mixture of programme management skills and subject matter knowledge and capability in order to provide hands on support to projects and where necessary to offer leadership expertise to help remove blockages if required.

4.3. METHODOLOGY

The PMO will follow the standard Managing Successful Programmes (MSP) framework and the Prince2 frameworks originally developed by the Office of Government Commerce (OGC). This will ensure that we are following a consistent approach to programmes and projects and that an assurance regime is naturally embedded in the process.

![Diagram](Fig 13 - Managing Successful Programmes)
4.4. PMO TOOLS

4.4.1. New Programme and Project Development

Each time a new programme or project is required it will follow a clearly defined development process, that addresses the key stages of a project - a copy of these stages can be found in the appendices in Appendix II.

4.4.2. Software

The PMO is currently using a combination of Microsoft office applications to track and manage the IIP and constituent programmes which is both clunky and does not provide the opportunity for “real time” management and update - it also makes version control somewhat more challenging.

A number of web based products are available such as Share point, PM3, Smartsheet, Basecamp - at very competitive prices. Packages.

A brief review process will be undertaken as part of the “The 30 day challenge” to select the most suitable and user friendly package to provide a constructive and un-intrusive PMO tool that is capable of delivering the appropriate level of reporting direct to the relevant recipients i.e members of the Executive Management Board (EMB), Programme Directors, etc, etc.

4.4.3. Lean/Kaizen

Lean and Kaizen are proven methodologies for designing, developing and implementing change.

Where appropriate we will use Lean methodology to effect and deliver change and we will use Kaizen events to implement those changes.

4.4.4. PMO Templates

The PMO will be introducing additional/replacement templates into the PMO suite of documents that are designed to streamline the processes and improve efficiency whilst at the same time reducing the level of complexity and time required to complete the various documents.

The document suite will include the following standard templates:

Programme/Project/Work stream Unique Identification Number (UIN) Reference table

Because of the number of different reviews and reports that inform the IIP we currently have a plethora of different cross references within the various programmes. From the 1st of May we will initiate a revised Programme UIN system - this will be a HEFT generated UIN system.

---

3 Samples of which can be found in the appendices
So that we do not lose the various threads of the individual reviews and reports from Deloitte, Silverman, Monitor, CQC, etc we will produce a PMO document that cross references the links from the IIP UIN system and these reports/reviews. This will be known as the Book of Reference (BR)

Project status report (PSR)
A one side of A4 that describes the progress against predetermined milestones and timelines, reports risk status, reports any issues and describes the activity for the next period;

Highlight report
A more detailed report that can be used to appraise EMB of progress and outcomes to date.

Master Risk register & Programme risk registers
Records risks, issues, opportunities, actions, dependencies, decisions and lessons learned. The IIP Master Risk log will feed into the Trust Strategic Risk Register/Log

Exception report
Describes a situation where the programme or project has deviated against time, cost, resource or quality tolerances. The exception report asks the Programme Board to:

- Approve or reject the situation;
- Defer making a decision until later;
- Request more information;
- Make a concession for the project manager to proceed without the need for any corrective action;
- Instruct the project manager to resolve the problem;
- Give advice and guidance to the project manager;
- Request an exception plan based on one of the options (theirs or the project manager’s);
- Seek advice and guidance from corporate or programme management; or
- Instruct that the project be prematurely closed.

Change control form
A change request is a formal proposal for an alteration to some product or system relating to the programme or individual project/work stream. The IIP Change Control Form is aligned to the process described in Fig 14 below.

It is the work stream lead’s responsibility to raise a change form as soon as it becomes evident that a deviation from scope is required and/or inevitable.

Scope changes must follow the agreed change process so programme directors must ensure that the work stream leads act in a timely manner.
4.5. MANAGING INTERDEPENDENCIES

Managing interdependencies is a critical success factor for both the individual programmes and projects and the overarching IIP itself. As part of the Gateway review process a thorough analysis of the interdependencies will be undertaken using a workshop environment. Once we have clarity on the links and the potential impacts they will be managed via the matrix working arrangements described in 4.1.1.

We will also consider using a technique called Outcome relationship mapping. Outcome Relationship Mapping is a simple but powerful technique for exploring complex changes by identifying and analysing the potential impacts in other areas that would be affected by the change(s) which any organisation is seeking to implement - both internal and external to the organisation. Outcome relationship mapping can also be used to help:

- Clarify policy/strategy effects, gaps, overlaps & contradictions
- Strategic scoping & prioritisation
- Planning and the setting up of portfolios, programmes and projects
- Look for strategic risks (barriers, problems of success and associated risks)
- Evaluation, identification of measures and targets & learning lessons
- Communicate the vision
4.6 BENEFITS MANAGEMENT AND REALISATION

Each work stream must develop a benefits map and a benefits management and realisation plan.

A benefit profile must contain as a minimum:
- Benefit owner;
- Description of the benefit;
- Related issues and risks to the full realisation of the benefit;
- Financial profile of the benefit;
- Any dependencies on other programmes or projects outside the boundary of the parent programme that the benefit realisation relies on;
- Details of the beneficiary i.e. Patient, Staff, Infrastructure, Quality & Safety;
- Evidence that demonstrates when the benefit has been realised;
- Other benefits that this benefit contributes to.

4.7 WHAT DOES GOOD LOOK LIKE?

This defines what a successful PMO and Programme management function looks like, so we will measure the success of the PMO and Programme Director on the following key criteria:
- On time performance of all constituent programmes and projects;
- Delivery of programmes and projects within the agreed budgets;
- On time performance of reporting timescales;
- BRAG ratings are performing as expected;
- Programme temperature - EMB, Trust Board and Monitor have confidence in the PMO and Programme Director that the IIP is maintaining the desired momentum or exceeding expectations.
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SECTION 5- METRICS
5.1. Metrics

Individual programmes have a newly developed, in collaboration with Deloitte’s, set of metrics that will measure their progress against their key milestones and objectives. The specific metrics which have been developed for each individual IIP programme are contained in a separate document - IIP Dashboard. An image of the dashboard is contained in the appendices of this document in Appendix IV.

The PMO will also provide reports against standard PMO disciplines.

5.2. Reporting Timetable

Each work stream will be required to complete a weekly PSR for the PMO and a comprehensive monthly Highlight report.

Programme level reports will be required in accordance with the table shown below in 4.3.1

5.3. Reporting To Who

5.3.1. Monitor

<table>
<thead>
<tr>
<th>IIP Reporting Timeline - Monthly</th>
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<tbody>
<tr>
<td>Individual IIP programme updates to be provided by 5th working day</td>
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<tr>
<td>May 08 - May</td>
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<td>June 05 - June</td>
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<td>July 07 - July</td>
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<td>Sept 07 - Sept</td>
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* the latest copy of each PSR will be made available for the fortnightly EMB meetings
5.3.2. NHSE, CCG’s and Local authorities

Should the CCG’s and Local Authorities require formal reporting of HEFT’s IIP then the reports will be provided in accordance with the Monitor reporting timeline as shown in 4.3.1

5.3.3. Internal

See 4.2 and 4.3.1

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<tr>
<td>Nov</td>
<td>06 - Oct</td>
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At the Heart of it......

Integrated Improvement Plan

SECTION 6- PROGRAMME PROFILES
6. PROGRAMME PROFILES

6.1. GOVERNANCE RECOVERY PROGRAMME

Background:
In 2014 Deloitte were commissioned to undertake an independent review of Governance arrangements at Heart of England NHS Foundation Trust against Monitors’ well-led framework for governance reviews. The final report was published in October 2014. Throughout the review a number of significant governance concerns were noted:

- Lack of plans to support the implementation of the trust wide strategy – such as a quality strategy;
- A need to significantly strengthen risk management arrangements within the trust including oversight from board level;
- Significant concerns around the culture of the trust;
- A complex structure lacking in clarity in accountability;
- A weak governance structure.

Deloitte recognised that the governance arrangements in the trust did not meet the requirements of a Foundation Trust, and identified a number of material areas where progress improvements were required:

- Organisational Development;
- Strategic Focus;
- Board Leadership and cohesion;
- Board Oversight;
- Risk management and Board Assurance Framework.

The final report was grouped under the four themed areas outlined within the Monitor well-led framework.

- Strategy and Planning;
- Capability and Culture;
- Process and Structures;
- Measurement;

Mr Andrew Foster was appointed to HEFT in February 2015 as interim CEO. He revised the executive portfolios to include Governance within the portfolio of the Chief Nurse.

The Chief Nurse has worked with the executive team and the PMO to develop the Trust Governance Recovery programme (GRP) in response to the Deloitte 2014 Governance review. As Senior Responsible Officer (SRO) for the GRP, the Chief Nurse will:
• Be accountable for ensuring that the GRP meets its objectives and delivers the projected benefits within the agreed IIP Programme framework;
• Ensure that the executive team is fully aware of their roles in delivery of the programme and that the programme is sufficiently resourced;
• Ensure that the change process maintains its business focus, has clear authority and that the overall context including risk is actively managed;
• Be the visible owner of the programme reporting to the IIP Board and Trust Board.

Resources:
The Executive Team have appointed four senior experienced interims to support key internal staff to deliver the GRP; this is a critical component of the IIP.

The programme will deliver the recommendations from the Deloitte Governance review, in addition to both the implementation of a revised performance management framework and a refreshed Trust Assurance Framework.

The Trust are also engaged with Deloitte to scope support with the delivery of a training programme, and consultation with the site and divisional teams to enable the development of an integrated quality governance dashboard and supporting processes regarding assurance and performance across a range of indicators and data sources. The proposal will include the opportunity for Deloitte subject experts to take up short-term secondments in the trust. Deloitte are also engaged with the Trust to refresh the trusts’ BAF.

The Executive Team will revise alignment of the internal audit programme in line with the integrated plan.

The Executive Team will also quality assure the GRP with external stakeholders such as Monitor, CCGs, NHSE and the patients association for the elements relating to patient experience.

Monitoring successful delivery of the GRP will be seen through the key metrics under the IIP as agreed with Monitor. The Governance Programme Board, and IIP Programme Board will oversee this delivery.

The SRO/Exec lead - Sam Foster - Chief Nurse

My role as the Executive lead (SRO) for this programme is to ensure that we maintain grip, pace and focus and that the programme delivers on it’s objectives, that we provide the requisite level of assurance to the Trust Board and to Monitor that we can and will achieve a greatly improved approach and understanding of our strategic risks and how they relate to our operational performance and our public reputation.

Sam Foster - Chief Nurse
6.2. URGENT CARE PROGRAMME

To deliver a consistent and efficient patient pathway for patients presenting into the Trust’s urgent care systems.

Impact of the programme

As a result of reducing variability within our processes, flow through patient processes will be improved. Consequently, delays for patients at the beginning of their pathway will be reduced and clinical risk reduced. Improvements urgent care pathway will also reduce the interference that urgent care demand creates within the elective inpatient pathways due to competition for bed capacity. Accordingly there will be positive impact on patient quality, overall costs and Trust performance against both the 4 hour emergency and 18 week admitted standards.

Elements of the Programme

The Programme addresses all stages in the care of a patient, from first attendance through to discharge from the Hospital’s Services. Each of the three sites have specific plans to address both local constraints to delivery and common threads across all sites.

The main elements being addressed are:
• Flow within the Emergency Departments (ED) themselves;
• Physical and staffing capacity;
• Coordination and balancing of operational capacity within the ED to match the needs of patients;
• Internal Professional Standards and escalation processes to ensure appropriate responses within ED and to requests from ED for support;
• Bringing specialist opinion and decision making to the ‘front door’;
• Ambulatory Care - presenting an alternative route for advice and treatment for ambulant patients;
• Reducing demand on both ED and admission capacity;
• Ensuring that capacity for Ambulatory Care patients is sufficient and is available to times of peak demand 7 days per week;
• Reviews of the type of patient which can be managed through this route;
• Promotion of ‘pull’ model from the A&E;
• Developing existing links with GPs for direct referral;
• Short Stay – many medical patients do not require a traditional specialist bed and can be managed within acute medicine on a reduced Length of Stay;
• Sizing of acute medical short stay capacity to match presenting demand, 7 days per week;
• Reviewing and updating guidance to ensure that appropriate patients are managed with Short Stay;
• Promoting and investing in a Frailty Service such that these patients receive a rapid assessment and are signposted to an appropriate service. In many cases this can avoid the patient losing the capability to manage in their usual place of residence;
• Delivering a model of care focussed of regular senior review of patients to ensure a rapid turnaround;

Discharge and external capacity;
• Redesigning clinical coordination within each ward’s daily routine such that each patient’s Length of Stay is appropriate;
• Identifying and removing blocks to rapid discharge once a patient becomes Medically Suitable for Discharge, 7 days per week;
• Redesigning how each Hospital Site coordinates internal flow to ensure delays and variability are reduced or eliminated;
• Planning for known period of increased demand to ensure the Trust responds in a planned, predictable and effective manner.

Trust and site capacity and demand matching
• Review of physical capacity to ensure appropriate use of existing, or commissioning of additional, based upon demand.

The SRO/Exec Lead - Jonathan Brotherton Director of Operations

“The Urgent Care Improvement Programme is a key element of the overall Improvement Plan for the Trust; ensuring that all unplanned patients are quickly assessed and appropriately treated. This programme involves the vast majority of our clinical services and so it is appropriate that, as Director of Operations, I act as its Senior Responsible Owner. I have an engaged clinical and managerial team working with me to deliver the significant changes that are required. I believe that together we will lift our performance and reduce, to the lowest possible level, the clinical risk to our patients”

Jonathan Brotherton - Director of Operations
6.3.IM&T PROGRAMME

Our focus is on the opportunities and innovation that Information Management & Technology (IM&T) can offer to the Trust and sets out how the Trust can deal with rapid changes both in respect of the internal and potentially external health economies.

The IM&T (IIP) element is based on the outcomes of the audits undertaken by Deloitte and Ideal.

These outcomes of collective observations and recommendations have been documented and form the benchmark for the readiness activities which are currently being actively monitored via the IIP.

The planning is also expanded into three sub-level plans for:

- Quick Wins - Benchmark Project Closure Readiness
- Stabilisation - Benchmark Business as Usual Readiness
- Exploitation - Improvement Planning to Realise Benefits

The detailed sub-level plans are monitored on a daily basis and for further assurance a detailed project plan is currently under development.

Our planning identifies requirements to drive and support innovation, improved access to Trust, Community, GP and Patient Services via robust and resilient technology and infrastructure.

We are working toward improved data quality and reporting as we must ensure that the use of Trust information improves our patients’ safety and experience.

Moving forward, the IIP will ensure improve Trust communications, engagement, more effective and co-ordinated planning to assist with closing service gaps that will ultimately prepare us for any future challenges.

SRO/Exec Lead - Jonathan Rex - Director of IM&T

Appointed in an interim capacity to initially stabilise the IT function as well as some key project recovery and then review, with some carefully selected 3rd party consultancy, the capability and capacity of the department. In parallel there was a need to re-engage the IT function with the clinical and corporate functions and bring all that together in to an IT Strategy which aligned and underpinned the emerging corporate strategy.

Jon - Director of IM&T
6.4. CULTURES AND ENGAGEMENT

The aim of the Culture and Engagement work stream is to:

- Systematically improve LEADERSHIP capability across the Trust
- Step change Staff ENGAGEMENT across all areas of the workforce
- Strengthen VALUES led culture

Within LEADERSHIP,

The objectives are to develop the Board and senior leadership team in order that the Trust is able to operate effectively, and to develop a strong pipeline of future leaders so that the Trust is able to implement its strategy effectively. The first steps within this are to provide a clear analysis of the current leadership position, as relates to both individuals and development provision, and to work with the Board and senior leaders to agree both the current and future need in terms of leadership and to develop a practical plan that supports the long term development whilst prioritising immediate need with pace. Systems will be put in place to effectively monitor, review and take appropriate actions at both individual and Trust level.

Visible outcomes will be an agreed HEFT Leadership Development Framework, Succession Plans for senior roles and a bespoke Leadership Development Programme.

Within staff ENGAGEMENT,

The objectives are to develop a working environment in which staff feel significantly more engaged, and to reap the benefits of the associated improvements in performance and patient outcomes. This will be achieved by introducing a more structure approach to staff engagement, including senior team led large scale listening events, strong governance around how feedback is turned into action, and the introduction of the more locally focused Engaging Teams Programme, to built sustainable skills and capability across our teams.

Visible outcomes will be improved engagement within local teams; and across the Trust, as measured by the Staff Survey.

Within VALUES,

The objectives are to develop and strengthen a Trust culture where Values are key, and how we are with each other and our patients is a defining factor. The first steps are to develop a set of staff-generated Trust Values and associated behavioural frameworks. To launch the Values in a way which engages and motivates staff to embed them into local working practices, and to build sustainability by incorporating the Values into infrastructure such as appraisals, recruitment, leadership development programmes and induction.
Visible outcomes will be a set of Trusts Values, a behavioural framework, Values base to the bespoke leadership development programme and a Board and senior team appraisal process in place.

**The SRO - Hazel Gunter - Director of Workforce**

“My personal role is to lead the development of this programme to ensure it delivers on the outcomes and assuring the Board on this project, whilst also supporting the senior executives in their part of the culture and engagement programme”

Hazel Gunter

6.4.1.Key Milestones

**Engagement:**
- Preparation of new quarterly Pulse Staff Engagement Survey based on WWL model;
- Implement Workforce Committee chaired by NED and a Staff Engagement Steering Committee chaired by Chief Executive;
- Implement senior led Staff Engagement Events reporting to the Staff Engagement Steering Committee;
- Roll out Pulse Staff Engagement Survey across 25% of the workforce per quarter;
- Implement “Engaging Teams” programme for first cohort;
- Undertake analysis of first quarterly Pulse Staff Engagement Survey results at Trust level;
- Agree baselines for all nine categories of the quarterly Pulse Staff Engagement Survey and forecast targets for the 3 key enablers.

**Values:**
- Develop and agree Trust values through Trust wide consultation for Board approval and sign off;
- Develop a locally led Trust values implementation plan;
- Identify and recruit appropriate resource accountable for delivery of the values implementation plan and appraisal process;
- Define and develop permanent culture metric once values are agreed;
- Launch value based appraisal process for Board and complete full appraisal cycle.

**Leadership:**
- Provide clear analysis of current leadership development offering within the Trust;
- Define current and future leadership needs;
- Conduct a gap analysis between defined needs and current status;
- Develop and implement a practical plan to improve leadership across the Trust;
Agenda

Welcome

Declaration of Interest

Apologies

Minutes

Matters Arising

Chairman's Report

Chief Executive's Report

Integrated Quality Report

Integrated Improvement Plan

Dementia Strategy Presentation

Attendance Record

Governance and Governors' responsibilities

Integrated Improvement Plan

Safe
Effective
Caring
Responsive
Well led

- Agree a bespoke Leadership Development Framework and then implement a bespoke Leadership Development Programme;
- Implement a system to monitor and track delivery of the Leadership Development Programme;
- Implement succession plan for all executive board members.
6.5 SCHEDULED CARE

To ensure that patient waiting times are minimised at all stages of the scheduled care patient pathway based upon joint trust and CCG patient access standards.

Impact of the programme

As a result of implementing a programme of robust development and management of performance against trajectories, along with identification of underlying factors that influence our ability to consistently ensure patients are treated as quickly as possible within each milestone of their pathway, the scheduled care programme will deliver a return to the 18 week and cancer performance standards. The work streams identified therefore focus both on the “here and now” as well schemes that will transform the way in which services are delivered to ensure sustainable change and improvement. Joint working with our partners to achieve success is key and is reflected within the programme and supporting structures which ensure performance is monitored, scrutinised, root causes understood and associated actions developed.

Elements of the programme

The programme addresses all elements of scheduled care and key milestones within the patient pathway, from referral through to follow up and including the diagnostic and therapeutic elements of the patient journey. Whilst there is 1 overall plan, this is supported by specialty level trajectories and where necessary, specific recovery plans for those specialties identified as a “red risk”. The main elements of the programme are:

Planned care/RTT:

- Reduce the backlog of patients >18 weeks to a level where RTT targets are achieved and maintained;
- Monitor performance and manage any deviations against specialty specific trajectories;
- Manage closely patients on open clock pathways to further reduce risk to patients breaching the 52 week standard;
- Improve data quality by applying a multi-faceted approach that includes input from operational, IT, finance and performance teams;
- Provide a single waiting list that is clean and through which teams have full visibility of their patients and their pathway position and status;
- Centralise waiting list management functions to reduce risk and ensure equity of patient waiting times across all sites for the same procedure;
- Publish and launch a Patient Access Policy that has been developed in conjunction with the IST and CCG colleagues and supports teams in better managing patients in line with DoH and local RTT rules;
- Provide greater certainty to our most vulnerable patients by ensuring that no category 1 patient is cancelled due to “no bed” being available;
• Ensure that all cancer target are achieved, most critically the 2ww target for cancer and breast symptomatic achievement of which is challenging due to multiple factors including increase in referrals, high median wait times, patients not being aware of their reason for referral and high numbers of patients choice breaches;

• Work with other Trusts and CCG’s to revise specialty specific referral forms for 2ww that provide greater guidance to GPs at the point of referral;

• Implement new best practice pathways in our specialties that have a higher proportion of 62 day breaches due to their complexity, most notably Lung and Urology;

• Forward look and plan for changes in demand as a result of revised guidance from NICE and publicity campaigns;

• Provide a workforce and resource capacity for the whole of scheduled care that enables delivery and creates further capacity;

• Provide a governance structure and clear roles and responsibilities for scheduled care that support service improvements as well as the ability to monitor and manage performance of the position.

SRO/Exec Lead - Jonathan Brotherton - Director of Operations

“My role as the SRO for this programme is to drive improvements in patient flow right across the whole of HEFT, so identifying the links between this programme and the Urgent Care Programme and then managing those interdependencies is critical to the successful delivery of both programmes and the realisation of the full range of benefits for patients and staff alike”

Jonathan Brotherton
### 6.6. Mortality

**Key objectives of the programme:**

There should be a Trust wide policy that all deaths will be reviewed. This should be with the intent of looking for suboptimal clinical care rather than to determine whether or not the death was avoidable or inevitable.

The outputs of these reviews should be fed to the Mortality and Morbidity Performance Group for triangulation across specialities and with the outcomes of reviews of incident reports, patient experience, complaints and other data sources such as Trainee survey reports.

Messages about hospital mortality should regularly go out to staff so that they are aware of the situation and know what they can do to improve matters.

There should be a review of the incident reporting system in order to encourage incident reporting and make best use of the reports including near misses to improve safety.

Improving flow through the Trust should be a high priority. Rather than a "magic bullet" approach, it would be best to focus on the impact of accumulation of marginal differences. These should include:

- Better working between the ED and the specialities to get specialists as close to the "front door" as possible;
- Considering using the recommendations of the Royal College of Physicians Future Hospital Programme;
- A system of specialities “pulling” patients from ED;
- Increasing the range and scope of ambulatory emergency clinics and making their operational policies explicit;
- Use of ward round checklists and adhering to the Royal College of Physicians and Royal College of Nursing guidance on ward rounds;
- Reviewing the processes for prescribing and dispensing TTO drugs;
- Daily (7 days a week) senior review of all patients including all outliers;
- Reviewing compliance with the 10 standards for 7 day working by undertaking the self-assessment exercise on the NHS IQ website and developing an action plan;
- Aim to achieve the same numbers of discharges per day at weekends as on weekdays;
- Reduce non-medically indicated ward transfers; consider a policy of requiring all such transfers to be discussed with the responsible consultant first.

All clinical directorates should agree pathways and standards for care of non-elective admissions and undertake regular audits of compliance with results reported back to clinicians.
Consider the use of an electronic track and trigger system for detection of deteriorating patients and escalation of care.

A programme to improve staff engagement, multidisciplinary team working and empowerment (such as Listening into Action) should be considered as a matter of urgency. This should be prioritised to those clinical teams where poor engagement and team working are well known.

Review the interactions between consultants and coders to help improve the quality of medical notes and the way diagnoses are recorded. Consider using appraisal as a lever to improve consultant recording of diagnoses and engagement with the coding process.

When these outcomes are triangulated with other reviews and reports such as the IST reviews and the Deloitte Governance Review, which carries very specific recommendations on Leadership, Board Assurance and Risk management, they all tell as similar story and make similar recommendations, albeit the reviews are approaching things from different angles, based on different criteria and carried out independently of each other.

**Key milestones:**

Mortality process:
- Review current Mortality and Morbidity Performance Group, including ToR, membership, roles and responsibilities and agree reporting governance;
- Agree pro forma and screening method for mortality case review;
- Identify resources to support pilots;
- Pilot redefined Trust process with AMU and Cardiology;
- Submit proposal to Trust Board outlining the governance and reporting arrangements for MMPG within the Trust BAF;
- Pilot analysis and full Trust roll out of compulsory process to all Clinical Groups or Directorates;
- Define mechanism to identify and approve Quality Improvement schemes and governance to support improvement monitoring.

Education:
- Draft and agree education materials;
- Develop schedule and timetable of engagement events;
- Delivered all engagement as a mixture of open event or targeted events by Directorate.

Coding:
- Scope and develop clinical coding work stream to improve clinical engagement in coding;
- Complete visits to each directorate to increase clinical engagement in coding.

Future Information Requirements:
• Undertake visits to exemplar organisations with regards to advance mortality / morbidity analytics;
• Draft Business Case for Trust Board approval for development of Trust advanced mortality / morbidity analytics capability.

“My role as the Director of Medical Safety (Clive Ryder is SRO for this programme) is very clear to me, to ensure that the programme is properly managed and resourced. To ensure that the Trust develops and implements robust policies and processes that enable us to fully understand the reasons that underpin our mortality rates and provide opportunities to improve our survival rates”

Dr Ann Keogh - Director of Medical Safety
At the Heart of it......

Integrated Improvement Plan

SECTION 7- PROGRAMME COSTING
7. Programme Costing

7.1. Programme Management Costs

The following tables describe the running costs for the PMO for the next twelve months and for IIP Programme resources that might work within the services themselves but are still deemed as supernumerary or interim.

Each of the IIP Programmes is responsible for managing its own budget and recruitment of substantive and interim resources.

The PMO has got a mixture of resources working out of the PMO itself although they don’t necessarily have reporting lines directly into the PMO. This will be reviewed over the coming weeks to ensure the most effective and efficient structure to support the delivery of the IIP programmes.

An interim governance process (see Fig 15 below) is also being introduced to ensure that we have control over recruitment and the on boarding processes.

Interim Support Engagement process

![Diagram showing the process]

* Appointment of Additional Temporary Resource Form

Fig 15 - Interim Governance process for Interim/temporary support to the IIP

* Samples of PMO reporting and other process templates can be found in the Appendices
Programme Costs 2015-16 - Approximate (Manpower)

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| TOTAL COSTS PMO & GOVERNANCE | £254,974 | £254,974 | £254,974 | £254,974 |

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| TOTAL PERSONNEL COST | £114,510 | £114,510 | £114,510 | £114,510 |

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Council of Governors
June 2015

At the **Heart** of it……

Integrated Improvement Plan

SECTION 8- STAKEHOLDERS
8. STAKEHOLDERS

8.1. STAKEHOLDERS PROFILES

Understanding our stakeholders will help us manage their expectations and their levels of influence and interest in the IIP. Although it is sometimes an uncomfortable analysis to share publicly it is an essential part of programme management, there are numerous examples of large scale change programmes and projects that have failed because organisation did not understand their stakeholders, their level of expectation and their power to derail the programme or project. Therefore we will undertake a detailed profiling exercise to ensure that we don’t fall into the same trap. So we will be asking ourselves some or all of the following questions and reviewing them on a quarterly basis:

- What financial or emotional interest do they have in the outcome of our work? Is it positive or negative?
- What motivates them most of all?
- What information do they want from us?
- How do they want to receive information from us? What is the best way of communicating our message to them?
- What is their current opinion of our work? Is it based on good information?
- Who influences their opinions generally, and who influences their opinion of us? Do some of these influencers therefore become important stakeholders in their own right?
- If they are not likely to be positive, what will win them around to support our programmes and projects?
- If we don’t think we will be able to win them around, how will we manage their opposition?
- Who else might be influenced by their opinions? Do these people become stakeholders in their own right?

The outcome of the profiling exercise (the profiles) will be shared with the SRO’s.

8.2. STAKEHOLDER MAPPING & MANAGEMENT

How and when we communicate with our various stakeholders is critical to the success of the programme, so coupled with the IPP Communications Strategy we will pro-actively manage our stakeholder communications to ensure that our stakeholders are kept informed about the progress of the IPP and its constituent programmes.

The following diagram (Fig 16) representative of how we will map our stakeholders and define the type and level of communications with them. As the IPP progresses through the various stages of Definition, Development Delivery and Assurance individual stakeholders will move up and down the grid depending on their level of interest and influence in the programme at a given point in time.
Fig 16 - Stakeholder map

We will centralise communications with our key stakeholders through the communication team. Developing a core database of our stakeholders and tracking our interaction with them will ensure we are communicating consistently and effectively. The trust stakeholder communications plan is currently being updated, and will then be further developed using the feedback from the stakeholder review, currently being carried out on behalf of the trust by Deloitte.
At the Heart of it……

Integrated Improvement Plan

SECTION 9- SCHEDULING & MILESTONES
9. Scheduling/Milestones

9.1. Thirty Days (0+30)

The next 30 days will be focused on ensuring that we have stabilised the IIP and its constituent programmes, as stated in 13.1 - Gateway Schedule. The following schematic (Fig 17) describes other PMO focussed activities that will take place during the next 30 days.

It is evident that the IIP has lost some of its earlier momentum and grip so it is vital that we reinvigorate the programme as quickly as we can whilst at the same time increasing staff awareness of the programme and its objectives.

We will need to overcome what is often referred to as "change fatigue" and the perception in some areas that they are being "done to" and that HEFT is placing too much emphasis on interim support and programme boards.

As we will be making some changes to processes and documentation the next thirty days are likely to be punctuated with periods of frenetic intensive activity so that we do not lose any further momentum.

One of the key features of 0+30 will be the Programme gateway reviews.

Fig 17 - The next 30 days
9.2. **Sixty Days (0+60)**

By the time we reach the end of the first thirty days of the recovery phase we will have a clear understanding of which of the IIP programmes are performing to the required standard and which require support and intervention.

So during 0+60 (see Fig 18 below) we will be undertaking “deep dives” on the full range of constituent projects and work streams to carry out similar analysis. During this period we will also be reviewing the BRAG reporting format to ensure that we are meeting Monitors expectations and providing the desired level of assurance - should we conclude that we are not we will establish a small task and finish group to deliver a remedial action plan.

We will also be initiating a series of “re-ignition” events for the IIP to ensure that we regain the early momentum and engagement. These will be based on the “European Cafe” format where different groups of staff from all levels of the organisation come together for short sharp high intensity workshops/briefing events.

![Fig 18 - The next 60 days](image)

9.3. **Ninety Days**

We intend to gain momentum very quickly over the next 30 and 60 days so we fully expect that a number of challenging but nevertheless important milestones will need to be achieved during this period. The following diagram (Figure 19) describes the next 90 days in the life cycle of the rejuvenated IIP and PMO. This diagram identifies a selection of some of those milestones.
A selection of Milestones that are due to be delivered in the next 90+ days

Governance
- When succession planning system is in place
- When the Kennedy Training Programme is complete
- When the Governor engagement exercise is complete
- When the Programme Framework is implemented across Organisation
- When the patient metrics are in place

Board and Engagement
- When the Trust values and behaviours are introduced
- When the Senior Leaders have implemented a systematic and effective cascade process
- When the Engaging Leadership Programme starts

Mortality
- When the new Mortality Policy is implemented across Directorate

Organ Care
- When AEC is the default for emergency medical referrals
- When an effective recruitment strategy for senior staff is implemented
- When a written policy for the management of outliers is implemented
- When the Medical redesign for Consultants across SHU is in place
- When the redesign of back-up and incident investigations for major events is implemented
- When the Rapid Assessment and Treatment process for major cases is implemented

Finance Care
- When the Implementation Plan to be developed to deliver the Reconfiguration is complete
- When the Trust achieves avoidance of all breaches of the 52 week standard
- When the processes for management of patients on an Open Clock Pathway are embedded
- When the patient metrics are in place

Figure 19 - The next 90 days
At the *Heart* of it......

**Integrated Improvement Plan**

**SECTION 10- RISK**
10. Risks

10.1. Managing Risks Within The Portfolio

As the IPP is going to follow MSP methodology it makes sense to use a recognised Risk management methodology, Management of Risk (M_o_R) that aligns to MSP. We will be managing risk and issues not just recording them. We will use a standard 5x5 scoring matrix for likelihood and impact as depicted in Fig 20 below:

```
<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>5</td>
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<td>4</td>
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<tr>
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<td>20</td>
<td>25</td>
<td>25</td>
<td>25</td>
<td>25</td>
</tr>
</tbody>
</table>
```

Risk = Likelihood x Impact

EG - Likelihood 3 x Impact 3 = Risk score 9 = Amber

Each programme within the IIP will be required to maintain its own Risk Register that feeds into the main IIP risk register. Each project/Work stream will be expected to feed into the programme risk register and to manage risk effectively, escalating risks to the Programme Director if particular risk(s) start to increase in likelihood and impact.

Risk management must become a business as usual discipline within HEFT, and reform of the approach to risk management is a major work stream within the Governance programme. The IIP programme has the resources and expertise to provide wide ranging in-house training on risk management practices and methodologies.

The PMO will support a number of risk awareness and management training events as part of the work around the implementation of the new BAF.

Each programme and constituent project and work stream will undertake a risk workshop in May 2015, recognising that this is a retrospective exercise we believe that it is an essential step to confirm that we have captured all the risks, developed robust mitigation plans and made the links to other programmes and projects. The following diagram (Figure 21) describes the minimum information that will be required for the risk registers:
10.2. Links to Strategic Risks

One of the main work streams in the Governance programme is the redesign and implementation of a much more robust risk management framework for the Trust. This is due to be in place by early September 2015 - in the run up to that implementation the PMO will work collaboratively with the Governance programme to ensure that programme risks are fully analysed and mitigation plans fully developed and recorded in the strategic risk register if the risk is deemed to be of such magnitude that it constitutes a strategic risk to HEFT.
At the *Heart of it*……

Integrated Improvement Plan

**SECTION 11 - CONSTRAINTS**
11. CONSTRAINTS

11.1. TYPES OF CONSTRAINTS

11.2. External
At the time of writing of this plan the Country is officially in Purdah, which places obvious constraints on HEFT and indeed Monitor from making announcements about major reconfigurations in public services.

The General Election itself provides uncertainty and constraints for all public sector bodies, especially this general election due to the complete uncertainty of the outcome.

Certain outcomes of the election may provide an endorsement of HEFT's plans whilst other outcomes may not and may initiate other demands on HEFT's reconfiguration plans or even more radical intervention.

11.3. Internal
The main internal constraints that are likely to impact the delivery of the IIP are related to resource, insufficient capacity may slow down the programme, insufficient capability could threaten delivery overall.

11.4. POTENTIAL IMPACT
The internal constraints are likely to slow down the delivery in the first instance, prolonged resource starvation will of course introduce change fatigue and resent across the front line staff body initially i.e “we have heard it all before” and then there is a risk that this will potentially spread upwards through the senior management ranks and possibly even to Executive level.

The external constraints have to a degree receded at the point when this final draft has been published. The outcome of the General election is now known and to all intents and purposes we can say with some confidence that the direction of travel will likely remain the same as it was pre-election.

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Footnote:

Purdah is the pre-election period in the United Kingdom, specifically the time between an announced election and the final election results. The time period prevents central and local government from making announcements about any new or controversial government initiatives (such as modernisation initiatives or administrative and legislative changes) which could be seen to be advantageous to any candidates or parties in the forthcoming election. Where actual advantage to candidates is proven in law based on precedent cases to have been given this amounts to a breach of Section 2 of the Local Government Act 199
At the *Heart* of it......

Integrated Improvement Plan

**SECTION 12-**

**COMMUNICATIONS**
**12. COMMUNICATIONS**

**12.1. TACTICAL APPROACH FOR THE IIP**

Effective, clear and engaging communication is critical to the success of any major programme of change; HEFT’s IIP is no different. It is our intention to pursue a proactive communications approach to ensure that our messages are focussed and unambiguous.

Our approach will be proportionate, driven, not least by the need to safeguard the reputations of HEFT and our partner organisations whilst at the same time providing transparency around progress and processes.

The delivery of the communications and engagement strategy will be the responsibility of the IIP PMO and Heart of England’s communication team.

**12.2. OBJECTIVES**

To ensure that staff and stakeholders understand the changes that are taking place, and feel engaged and supported throughout the process by keeping them updated, using effective channels of communications including sufficient opportunities for feedback.

We will work across all IIP programme areas to support delivery of the key objectives:

- Improving the quality of care, including the outcomes, the safety and the experience for all;
- Engaging with patients, carers, staff, our community, stakeholders and partners to redesign our services to provide improved access to services at the right time in the right place; and
- Innovating and researching new treatments and new ways of delivering care.

The key work streams for the communications team are broadly defined below.

**12.3. SUPPORTING THE IIP IMPLEMENTATION**

Clearly set out the overall programme’s strategy that will be used to communicate with key stakeholders and partners over the life cycle of the programme.

We will:

- Ensure that we communicate programme information in a timely and accurate manner which is open and transparent;
- Establish tailored local and cross CCG Borders stakeholder engagement processes;
- Ensure a process for strategic coordination across the participating organisations to ensure consistent messages and timelines;
- Help staff to understand the vision for the delivery of the IIP;
- Build awareness and involvement in the transition process;
- Build trust and confidence in the process;
• Ensure staff can raise and share their concerns, thoughts and ideas;
• Help staff to feel enthused and motivated to be part of the new arrangements;
• Support the HR processes around the transformation processes; and
• Ensure key external stakeholders are kept informed and involved – particularly EMB, Trust Board, Monitor, Staff Forums & Patients and their friends and families.

12.4. CLINICAL COMMUNICATION
Increasing knowledge about safety and risk and improving patient flow, patient quality, and trust performance against all clinical targets.

We will:
• Work closely with clinicians to improve the way we communicate with our front line staff, through face to face regular meetings;
• Explore the tools that are most effective for engaging out internal audience through research;
• Develop a handbook (hard copy and online) which all front line staff can access easily and which can be readily updated, which contains information on our targets and current status;
• Produce a series of guides which clearly explains to all staff our processes and procedures;
• Develop specific communications packages around Mortality, Urgent Care and Scheduled Care improvement plans;
• Continue to work closely with the IT team to support implantation of all IM&T systems and help with communicating any planned changes to staff effectively.

12.5. GOVERNANCE
Sufficient and effective Board, management and clinical leadership capacity and capability, as well as appropriate governance systems and processes.

We will:
• Support the organisation in the development and delivery of its strategic objectives;
• Support the implementation of new systems and processes;
• Communicate changes to any governance effectively;
• Promote a trust wide understanding of the need for improving governance.

12.6. CULTURE AND ENGAGEMENT
Develop a working environment in which staff feel significantly more engaged, and to reap the benefits of the associated improvements in performance and patient outcomes.

We will:
• Improve communications with governors and stakeholders, working in consultation to streamline and target our message and delivery channels;
• Clearly define our stakeholders through mapping;
• Have a clear plan which addresses the issues raised in the Deloitte stakeholder review;
• Fully support the patient engagement work stream by developing a plan to support effective communications with patients about how to give feedback to the trust;
• Fully supporting the Staff Engagement programme with the introduction of the values, quality champions.

We will achieve this by clearly identifying our internal channels, facilitating engagement across teams and promoting synergy.

We will provide structure and guidelines for clear communications within a vast organisation where responsibility is devolved in order to empower teams to communicate with their audience and we will offer support where necessary.

Ultimately we will provide a strong sustainable framework for effectively communicating with our staff, stakeholders and the media, which is fit for purpose and enhances the reputation of the trust both regionally and nationally.

12.7. Resources

Currently the trust’s communications resources are disparate and need to work more effectively together. Corporate services functions such as events, web design, intranet management, graphic design, multimedia, and GP communications are not controlled within the communications team.

As a team of five the focus has historically been on reactive external communications so has needed some reorganisation. In order to fully support the implementation of the IIP we are in the process of reorganising the current communications team and are taking on 3 new members of staff. Of these three one will primarily support the overall IPP delivery, one will support the culture and staff engagement agenda. The existing internal communications officer will lead on clinical communications. The Head of Communications will support the team, attend relevant meetings and specifically support governance and stakeholder work alongside patient experience.

The other team members will focus on external communication and have a strong focus on becoming a proactive rather than reactive public relations function. Our external communications strategy will be broadly aligned to the internal communications strategy with subtle changes in messaging as appropriate to the audience(s) being targeted.

Managing the interdependencies of the communications requirements within a programme of this size and complexity is challenging, we have chosen to work on the communication as a close group within one team to try to minimise the risk of silo working and duplication of effort.

There is currently no budget allocation for communication to support the implementation of the IIP other than funding for one post. This needs to be resolved.
12.8. IMPLEMENTATION

Over the next 30 days we will have the resource in place to produce a clear strategy and timeline to support the IIP. This will outline deliverables for each key communications work stream within the IIP. Implementation of the IIP Communications Strategy will take place during the latter half of May 2015 and will be fully embedded by the end of June.

Each IIP Programme will be expected to allocate sufficient resource to manage the communications plan for their programme. They will be expected to work closely with the HEFT communications team and the Organisational Development senior management team to ensure that outgoing messaging is well thought out and appropriately targeted.

The plan will support a go live date of September 2015 (we will try to bring this forward). It will also include details on how this will be measured and evaluated and sustained in the future.
At the Heart of it……

Integrated Improvement Plan

SECTION 13-GATEWAY REVIEWS
13. Gateway Reviews

Although the original OGC Gateway review process has now ceased to be a service offered by Central Government the process and logical review stages still have merit and still add valuable oversight and assurance to public sector programmes.

**Figure 22 - Gateway review process**

We will compliment the Gateway process with the self assessment processes and challenges that P3M3 provides around:

- Management Control;
- Benefits Management;
- Financial Management;
- Stakeholder Engagement;
- Risk Management;
- Organizational Governance;
- Resource Management.

Each programme will undergo a retrospective Gateway 0 review to assure the decision and/or identify any flaws or gaps in the strategic assessment that supported the decision to initiate the programme in the first instance.

Individual projects and work streams will be subject to a set of reviews during the life cycle of the project as shown in Fig 22 above.

*Further details of which can be found in the Appendices*
13.1. **SCHEDULE OF REVIEWS**

The formal review schedule, which commenced in May 2015 utilising Deloitte, Programmes will be further reviewed by the Gateway panel (see 12.3) in the first instance in June 2015 and quarterly thereafter. Projects will be reviewed monthly and will be required to submit a monthly highlight report and weekly project status report (PSR). For the purposes of scheduling each project will be assigned a unique identification number (UIN) - for example a Governance project will could have the following UIN - IIP-GV-01. The following tables sets out the timetable for May, subsequent schedules are contained in the appendices.

<table>
<thead>
<tr>
<th>Programme</th>
<th>W/C 25/5</th>
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<th>W/C 8/6</th>
<th>W/C 15/6</th>
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<tr>
<td>Urgent Care</td>
<td></td>
<td></td>
<td>X - GW-0</td>
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</tr>
<tr>
<td>Scheduled Care</td>
<td></td>
<td>X - GW-0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mortality</td>
<td></td>
<td></td>
<td>X-GW-0</td>
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</tr>
<tr>
<td>Governance</td>
<td></td>
<td></td>
<td>X-GW-0</td>
<td></td>
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<tr>
<td>IM&amp;T</td>
<td></td>
<td></td>
<td>X - GW-0</td>
<td></td>
</tr>
<tr>
<td>Culture and Engagement</td>
<td></td>
<td></td>
<td>X - GW-0</td>
<td></td>
</tr>
</tbody>
</table>

*UIN used for the Gateway process will be aligned to the UIN numbering system being implemented for Programme workbooks and other reporting architecture.
**13.2. DESCRIPTION OF REVIEW**

Each review will be a structured review with a set agenda circulated in advance and will centre on check and challenge around the key themes identified above from the P3M3 project assurance methodology.

**13.3. GOVERNANCE AND RESOURCES FOR THE REVIEWS**

The Gateway review process will be accountable to Trust EMB and will report monthly to them.9

The review panel will work on a “Star Chamber” approach10 - (“a court or other group that meets privately and makes judgements that can be severe”) with standing panel members and individual SRO’s required to attend as necessary. The standing members of the panel will be:

- Deputy Chief Executive and Medical Director (or delegated Deputy);
- IIP Programme Director;
- Finance representative;
- Head of PMO.

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9 This may be by way of a verbal update or a written brief depending on the length of the Board agenda

10 This approach can also be adopted for the CIP Programme(s) if and when it comes into the IIP
At the *Heart* of it......

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SECTION 14-APPENDICES
14. APPENDICES

14.1. APPENDIX I – CCG “UNIT OF PLANNING”

Fig 23 - Unit of planning
14.2. APPENDIX II – PMO SAMPLE TEMPLATES

Fig 24 - Project exception report

Fig 25 - Project exception report
Fig 26 - Highlight report
Agenda

Welcome

Declaration of Interest

Apologies

Minutes

Matters Arising

Chairman's Report

Chief Executive's Report

Integrated Quality Report

Integrated Improvement Report

Dementia Strategy Presentation

Governance and Governors' responsibilities

Attendance Record

Chairman's Report

Any Other Business

Safe
Effective
Caring
Responsive
Well led

Doc. Owner: Stuart A Brown
Doc. Status: V0.6

Fig 27 - Sample project closure and review report

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Council of Governors

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Integrated Improvement Plan

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June 2015

Fig 28 - Project stages
14.3. APPENDIX III – SAMPLE OF AN OUTCOME RELATIONSHIP MAP

Figure 28 - Outcome relationship map
14.4 APPENDIX IV - MAIN IIP DASHBOARD

Figure 29 - Screenshot of IIP Metrics Dashboard - Sample data
14.5. **APPENDIX V – MONITOR UNDERTAKINGS**

On the basis of the grounds set out below, and having regard to its Enforcement Guidance, Monitor has decided to accept from the Licensee the enforcement undertakings specified below pursuant to its powers under section 106 of the Act.

**Monitor has agreed to accept and the Licensee has agreed to give the following undertakings, pursuant to section 106 of the Act:**

**Improvement programme:**

- The Licensee is developing an Integrated Leadership Support and Resilience Programme (‘the improvement programme’) in response to leadership, clinical and governance concerns including those identified in the mortality review and the governance review;
- The Licensee will provide Monitor with its improvement programme covering the period from 1 January 2015 to 31 March 2015 by 23 January 2015, or such day to be subsequently agreed;
- The Licensee will provide Monitor with its improvement programme covering the period from 1 April 2015 to 31 July 2015 by 13 February 2015, or such day to be subsequently agreed;
- The Licensee will agree with Monitor:
  - milestones for the delivery of each major element of the improvement programme and;
  - success measures to monitor the delivery of the programme.

For the period between 1 January 2015 and 31 March 2015 by 31 January 2015, or such day to be subsequently agreed, and for the period between 1 April 2015 and 31 July 2015 by 27 February 2015, or such day to be subsequently agreed.

- The Licensee will implement the improvement programme according to the milestones agreed with Monitor;
- The Licensee will monitor its performance against the improvement programme and will send Monitor written monthly updates summarising its performance. The monthly updates will:
  - include actual performance against the actions outlined in the improvement programme;
  - include any failures to deliver or risks to the delivery of actions in line with the milestones agreed for the improvement programme;
  - include details of any mitigations to the identified failures to deliver or risks to delivery;
  - include actual performance against the success measures agreed with Monitor;
  - be sent to Monitor for the first time in respect of February 2015;
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Council of Governors

June 2015

- Safe
- Effective
- Caring
- Responsive
- Well led

- be sent to Monitor within fourteen working days of the end of the month to which the written update relates; and
- be sent to Monitor until such time as Monitor agrees that the improvement programme has been delivered in full or the monthly updates are no longer require;

- The Licensee will implement comprehensive and effective management and governance arrangements to enable the delivery of the improvement programme. Such arrangements will as a minimum enable the Licensee’s Board to:
  - Obtain clear oversight over the progress in delivering the improvement programme;
  - Obtain an understanding of any risks to the successful achievement of the improvement programme; and
  - Hold individuals to account for the delivery of its actions.

Improvement Director

- The Licensee must cooperate with an Improvement Director appointed by Monitor for the purpose of monitoring the work of the Licensee’s Board and overseeing the implementation of the Licensee’s improvement programme. In particular the Licensee must;
  - Invite the Improvement Director to attend meetings of the Board, and permit the Director’s participation at such meetings;
  - Allow the Improvement Director reasonable access to the Licensee’s premises; and
  - Provide such information, and allow such access to documents or records, as the Improvement Director may reasonably request.
14.6. APPENDIX VI – INTERIM GOVERNANCE ON BOARDING FORM

**Integrated Improvement Plan**

**Council of Governors**

**June 2015**

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**Interim Process for Appointment of Additional Temporary Resource to Support IP Activities (23 April 2015)**

<table>
<thead>
<tr>
<th>Specification of Requirement</th>
<th>Interim Programme Manager</th>
</tr>
</thead>
<tbody>
<tr>
<td>Specific work to be undertaken</td>
<td>Provide summary job description including required outputs</td>
</tr>
<tr>
<td>Period of appointment</td>
<td>Start date:</td>
</tr>
<tr>
<td>Formal specifications</td>
<td>Full time / part time</td>
</tr>
<tr>
<td>Job grade</td>
<td>Provide summary of key skills and attributes required</td>
</tr>
</tbody>
</table>

**Appendix VI - Interim Governance On-Boarding Form**

**Figure 30 - Temporary resource on-boarding form**

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# Integrated Improvement Programme Dashboard

<table>
<thead>
<tr>
<th>What will we deliver?</th>
<th>How will we measure success?</th>
<th>Outturn</th>
<th>Target</th>
<th>2015/16 YTD</th>
<th>Actual</th>
<th>2015/16 FOT</th>
</tr>
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<tbody>
<tr>
<td>Review of competence and capability of the ICT Function to support the Trust’s needs and subsequent remediation of issues identified</td>
<td>PMS2 Recovery</td>
<td>Median Time to Treatment in ED (Minutes)</td>
<td>63.00</td>
<td>52.00</td>
<td>60.00</td>
<td></td>
</tr>
<tr>
<td>Develop and roll out education programme to improve Executive and Clinical understanding with regards to mortality analytics</td>
<td>Mortality Governance Process</td>
<td>Mortality Education</td>
<td>Refine and implement revised governance process and supporting mechanisms to capture and review mortality data with supporting analytics</td>
<td></td>
<td></td>
<td></td>
</tr>
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<td></td>
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<td>Develop a Trust-wide staff engagement programme</td>
<td>Staff Engagement Survey</td>
<td>Fatalities per Week</td>
<td>98.00</td>
<td>53.00</td>
<td>TBC</td>
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<td>Develop a Trust-wide staff engagement programme</td>
<td>Staff Engagement Survey</td>
<td>SQP Mean Score</td>
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<td>3.40</td>
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<td>Develop Trust strategy and establish a Data Quality Strategy and Stakeholder Engagement Survey</td>
<td>Strategy Development and Planning:</td>
<td>Assess residual work and transfer to PMO; determine executive lead and map in to action plan</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Implement a Performance Management Framework, associated reporting data quality and governance strategies and processes</td>
<td>Strategy Development and Planning:</td>
<td>Assess residual work and transfer to PMO; determine executive lead and map in to action plan</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>To assess, refresh and implement governor engagement arrangements</td>
<td>Governor Engagement:</td>
<td>A refreshed patient experience dashboard and systems to ensure learning and remediation are in place</td>
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<tr>
<td>Review of competence and capability of the ICT Function to support the Trust’s needs and subsequent remediation of issues identified</td>
<td>PMS2 Recovery</td>
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<td>Strategy Development and Planning:</td>
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<td>Governor Engagement:</td>
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### Medians wait time for 2 week cancer wait

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**Welcome**

**Apologies**

**Declaration of Interest**

**Chief Executive's Report**

**Integrated Quality Report**

**Integrated Improvement Plan**

**Dementia Strategy Presentation**

**Minutes**

**Matters Arising**

**Governance and Governers' responsibilities**

**Attendance Record**

**Chairman's Report**

**Any Other Business**

---

**Agenda**
TBC case agreement of values and delivery of values implementation plan.

Permanent Culture Metric

Indicator to be developed by 31/08/2015

Permanent Culture Metric

Metric provider: Alex Covey

Last provided: n/a

Next expected date: September 2015

Executive Board Members roles with an approved Succession Plan

Staggered delivery of 1+1 Succession Plans commencing from Q1 2016/17

Staggered delivery of 1+1 Succession Plans

Last provided: n/a

Next expected date: July 2015

Detailed Measures

EXECUTIVE ENGAGEMENT

Executive Board Succession Plan:

Last provided: n/a

Next expected date: July 2015

Board Engagement Survey:

Last provided: n/a

Next expected date: July 2015

Survey accomplished. Score out of five. Typical range for a high score is 3.8 and low score is 3.6.

Implementation:

Delegation of key roles and accountability for the delivery of the values implementation plan and approval process.

Deliver value starting plan with values in place in place for the implementation of the values.

Delegation of key roles and accountability for the delivery of the values implementation plan.

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Council of Governors

June 2015

Target Dates scheduled for 3 x workshops at BHH, GHH and Sol.
Review of PMS2 to ensure fit for purpose and reliable and subsequent remediation of issues identified. 100% On target
70% On target

3 Minutes
Meetings commenced. Deloitte to develop ICT strategy.

Target

Matters

PMS2 User Group established to exploit lessons learned and action plan as per Business As Usual.
CCIO resource confirmed. Interim Director of ICT to advise confirmation to proceed.
IM&T Steering Committee established and operational. Chaired by the relevant NED.
Review of competence and capability of the ICT Function to support the Trust’s needs and subsequent remediation.

Heart of England NHS Foundation Trust Culture and Engagement Dashboard

No. of Anomalies

<table>
<thead>
<tr>
<th>2,000</th>
<th>3,000</th>
<th>4,000</th>
<th>5,000</th>
<th>6,000</th>
<th>7,000</th>
<th>8,000</th>
<th>9,000</th>
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</table>

Overall how satisfied are you with the service you received?

Overall ICT Satisfaction Score

This is based on a monthly survey requesting feedback and measuring overall satisfaction for the ICT team. The percentage of respondents who were satisfied overall is measured each month by this means.

Next expected date: 14th June 2015

Metric provider: Jonathan Rex
Last provided: 14th May 2015

Service desk calls resolved in SLA

<table>
<thead>
<tr>
<th>0%</th>
<th>20%</th>
<th>40%</th>
<th>60%</th>
<th>80%</th>
<th>100%</th>
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<tbody>
<tr>
<td>Oct-14</td>
<td>Nov-14</td>
<td>Dec-14</td>
<td>Jan-15</td>
<td>Feb-15</td>
<td>Mar-15</td>
</tr>
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Service desk calls resolved in SLA

The percentage of calls resolved within agreed Service Level Agreements by the ICT helpdesk.

Metric provider: Jonathan Rex
Last provided: 14th May 2015

Thank you for your presentation and feedback, best wishes (CB)
**Minutes of Council of Governors Meeting**

**June 2015**

- **Develop a clear set of values and behaviours for the Trust and improve board cohesion**
- **Planned Improvement (Primary)**
- **Actual**
- **Total Complaints**
- **Planned Improvement (Primary)**
- **Actual**
- **Planned Improvement**

**HEFT IIP Dashboards 18 05 2015.xlsx**

**GOVERNANCE RECOVERY**

- **10%**
- **25%**
- **5%**

**2014/15 May Jul Sep Nov Jan Mar**

**200**

**300**

**50**

**60%**

**20%**

**40%**

**60%**

**0%**

**100**

**160**

**180**

**60%**

**20**

**60**

**0**

**15**

**25**

**35**

**Q1 2014/15 Q2 2014/15 Q3 2014/15 Q4 2014/15 Q1 2015/16 Q2 2015/16**

**Governor Engagement**

To assess, refresh and implement governor engagement arrangements

- **62%**
- **30/07/2015**
- **On target**

**Development**

Implement an Organisation Development Plan

**Culture and Values**

A refreshed patient experience dashboard and systems to ensure learning and remediation are in place

- **29%**
- **30/06/2015**
- **On target**

**Strategy Development and Patient Experience**

**KEY PERFORMANCE TRACKER**

**SENIOR RESPONSIBLE OFFICER:**

**PROGRAMME DIRECTOR:**

**ANGELA HOPPER**

**GOVERNANCE RECOVERY**

**Project Key Output % Complete Date Due Assessment**

**KEY MILESTONE TRACKER**

**Top three areas of formal complaints**

**Issue 1 - Staff Attitude and Behaviour**

- **38 33 24 29**
- **Jul-12**
- **38 33 24 29**
- **Jul-13**
- **38 33 24 29**
- **Jul-14**
- **38 33 24 29**
- **Jul-15**
- **38 33 24 29**

**Issue 2 - Delays and Cancellations**

- **20 60 0 0**
- **Nov-12**
- **20 60 0 0**
- **Jan-13**
- **20 60 0 0**
- **Jul-13**
- **20 60 0 0**
- **Nov-13**
- **20 60 0 0**

**Issue 3 - Query Appropriate Treatment**

- **160 180 150 120**
- **Apr-12**
- **160 180 150 120**
- **Oct-12**
- **160 180 150 120**
- **Apr-13**
- **160 180 150 120**
- **Oct-13**
- **160 180 150 120**

The trust is developing complaints handling which is aligned to national guidance and regulatory compliance, anticipated to implement July 2015.

**Informed by national and local guidance and**

This will provide robust complaint handling data, by issue, at Trust Board level and at a Clinical Institute level.

The number of medicine or drug incidents, which could have led to an avoidable adverse outcome.

- **0%**
- **100%**
- **20%**
- **40%**

The number of medication related incidents and systems to ensure learning and remediation are in place.

**IMPROVING PERFORMANCE**

**MANAGEMENT OF RISK AND BAF**

**PATIENT EXPERIENCE**

**Report date:**

- **Last provided:** 28th April 2015

**IIP PMO**

**Director and Director of Nursing as workstream lead:**

**Metric provider:** Richard Brown

**Last provided:** 13th May 2015

**IIP PMO**

**Director and Director of Nursing as workstream lead:**

**Metric provider:**  Richard Brown

**Last provided:** 28th April 2015

**IIP PMO**

**Director and Director of Nursing as workstream lead:**

**Metric provider:**  Richard Brown

**Last provided:** 13th May 2015

**Integrated Improvement Plan**

**Ministry of Health and Social Care**

**National Health Service Improvement Plan (NHSIP)**

- **To comply with new statutory requirements**
- **To be delivered by December 2015**
- **To be developed by October 2015**

**Top three areas of formal complaints**

**Issue 1 - Staff Attitude and Behaviour**

- **9%**
- **30/09/2015**
- **On target**

**Issue 2 - Delays and Cancellations**

- **88**
- **Aug-13**
- **123**
- **Jan-15**
- **123**
- **Jan-16**
- **123**
- **Jan-17**
- **123**

**Issue 3 - Query Appropriate Treatment**

- **247**
- **Aug-13**
- **247**
- **Feb-14**
- **247**
- **Mar-14**
- **247**
- **Apr-15**
- **247**

**Number of patients falling twice or more during the same admission**

- **Sept-14**
- **20**
- **31.05.2015**
- **80**
- **Jan-15**
- **9%**
- **30/09/2015**
- **On target**

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- **Jan-15**
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- **30/09/2015**
- **On target**
Target date for policy refresh is 15/06/2015 (June EMB BAU Matters Workshop planned for 15/7/15)

Dashboard progressing in line with strategy
Dependent on outcome of workshop
Linked to BAF & PMF workstreams
Workshop booked
First draft complete
Finance provided summary status and next steps to Planned for 8/9/15
Questionnaire issued and responses starting to arrive.
Not yet started

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Any Other Business

Agenda
Admitted Pathways Backlog Trajectory

This indicator demonstrates the expected reduction in backlog of patients waiting more than 62 days for first OP appointment for those patients who have had a first appointment. The data measures the time from their referral into the Trust, up until the date of first attendance.

Achieving the expected reduction in backlog will enable the 90% Admitted RTT standard to be achieved.

National submission of RTT data occurs on the 10th working day of each month. Performance for April is expected to be ahead of trajectory and will be available on the 22/5/15.

Median wait time for two week cancer waits

This indicator demonstrates the expected reduction in median wait times for patients on a 2 week wait pathway, from GP referrals being seen in an outpatient clinic, or for ‘Upper and Lower’ endoscopy diagnostic procedures.

Achieving the standard of 80% will provide greater certainty that patient pathways (both Admitted and Non - Admitted) will be completed within 18 weeks and will offer a greater time to undertake necessary diagnostic and therapeutic procedures.

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**Key Milestone Tracker**

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<tr>
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<th>Key</th>
<th>Target Date</th>
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**DRAFT FOR DISCUSSION ONLY**

**Welcome**

**Council of Governors**

**HEFT IIP Dashboards**

June 2015

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**Patient length of stay of 14 days or more**

This indicator demonstrates the number of patients who require admission to an acute bed. The target for the Trust is to have no patients remaining in hospital beyond four hours. Achieving and maintaining this level of performance will be a result of the improvement work across the ED, AMU and Hospital Flow projects.

**Time in the Emergency Department - Admitted**

This indicator demonstrates the average length of time patients will wait in the Emergency Department, following their initial delay experienced by a patient once they meet the criteria for an ED admission. This indicator is used to improve the current breach profile to meet and exceed the national emergency care standard.

**Time in the Emergency Department - Non-admitted**

This indicator demonstrates the average length of time patients will wait, who require admission to an acute bed. The target for the Trust is to have no patients remaining in hospital beyond four hours. Achieving and maintaining this level of performance will be a result of the improvement work across the ED, AMU and Hospital Flow projects.
**Council of Governors**

June 2015

---

**Key Milestones**

- **Coding**
  - Complete visits to each directorate to increase clinical engagement in coding
  - Scope and develop clinical coding work stream to improve clinical engagement in coding
  - Delivered engagement as a mixture of open event or targeted events by Directorate
  - Draft and agree education materials
  - Define mechanism to identify and approve Quality Improvement schemes and governance to support improvement monitoring
  - Mechanism defined conceptually. Documentation and consultation to be
  - Submit proposal to Trust Board outlining the governance and reporting arrangements for MMPG within the Trust BAF.

- **Mortality Governance Process**
  - Review current Mortality and Morbidity Performance Group, including ToR, membership, roles and responsibilities and agree reporting governance

**Key Output**

**Detailed Milestones**

- **Coding**
  - Improve clinical engagement and understanding of clinical coding
  - 30% completed

**Future Information Requirements**

- **Mortality Governance Process**
  - Refine and implement revised process and supporting mechanisms to capture and review mortality data with wider stakeholders

**Project Key Output % Complete Date Due Assessment**

- 10% 31/07/2015 On target
- 30% 31/05/2015 On target
- 70% 31/01/2015 On target

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**SRENIOR RESPONSIBLE OFFICER:**

- SHMI Ratio
- 105
- 110
- 120
- 130
- 140

- HSMR Ratio
- 95
- 105
- 115
- 120

**PROGRAMME DIRECTOR:**

- Deaths per day at the trust
- Deaths per day at the trust

**MORALITY**

- Mortality by Month of Death (Shmi):
  - Deaths per Week

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**Declaration**

- ‘as expected’ banding.

**Report**

- **Chief Executive’s Report**
  - Arising

**Any Other Business**

- Agenda
Dementia Strategy Presentation
Minutes of Meeting
held on 14 Apr and 5 May 2015
COUNCIL OF GOVERNORS

Minutes of a meeting of the Council of Governors of Heart of England NHS Foundation Trust held in St Johns Hotel, Warwick Road, Solihull on 14 April 2015

PRESENT: Mr Les Lawrence (Chairman)
Mrs A Begum
Mrs K Bell
Mrs E Coulthard
Dr O Craig
Mr R Handsaker
Mr R Hughes
Mr M Hutchby
Mrs S Hutchings
Mr P Johnson
Mr M Kelly
Ms A Khan
Mrs H Lane
Mr A Lydon
Mrs A McGeever
Mrs M Meixner
Mr O’Leary
Dr M Pearson
Mrs J Thomas
Mr D Treadwell
Dr M Trotter

In attendance:
Mr D Cattell
Dr A Catto
Mr A Edwards
Mrs A Hudson (Minutes)
Ms K Kneller
Mrs S Foster
Mr K Smith (Company Secretary)

15.031 APOologies AND WELCOME

Mr Lawrence welcomed everyone to the meeting and apologised for the absence of the Chair’s Report, this had been due to IT issues; a full report would be submitted to the next meeting.

The Chair welcomed Ms Natalie Shaw, of PwC, who was in attendance to present item 10.

Mr O’Leary apologised for missing the last meeting as he had been in hospital at the time.

Apologies for Governors had been received from Cllr Aikhlaq, Dr Burgess, Mr Fletcher, Mr Orriss, Dr Needham and Mrs Steventon.

Apologies for Directors had been received from Mr Brotherton, Dr Cadigan, Mr Lock, Ms Lord and Dr Rao.

15.032 DECLARATION OF INTEREST – Governors

The Chair referred to the Register of Interests and asked that Governors notify the Company Secretary of any changes so that the Register could be updated accordingly.

15.033 DECLARATION OF INTEREST – Directors

The Register of Interests for Voting Directors was noted.
15.034 CHIEF EXECUTIVE’S REPORT

The pre-circulated report was taken as read; Mr Foster reiterated he was continuing to focus on the three main priorities of Clarity, Quality and Engagement and it was noted that:

Clarity - work had commenced on reporting lines and developing the Strategy for the organisation.

Quality - the main concern was around the Emergency Departments and safety issues that resulted when it became congested. Plans were in place to consider the short, medium and long term priorities. Mr Foster was working towards a more celebrated approach to quality that included encouraging staff to become Quality Champions, an initiative that had proved successful at Wightington, Wigan and Leigh NHS Foundation Trust (WWL).

Engagement - there had been 8 staff engagement events held to date with future events planned; feedback so far had been positive.

The Trust had been on a difficult journey especially over the last year and Mr Foster believed the Board’s acceptance of the Deloitte Governance Report had been a critical point and catalyst to make improvements. Mr Foster formally thanked Dr Catto and the Board for supporting the changes required.

Dr Pearson referred to the Deloitte Governance Report and was concerned to know whether Governors were at fault for the poor systems in governance it highlighted and questioned why Nursing was now responsible for Governance. Mr Foster responded that Mrs Foster had been appointed to lead on Governance as part of the realignment of roles in the executive team and added that in most foundation trusts Governance sat within the remit of Nursing. He went on to say that Mrs Foster was developing a document setting out the roles and responsibilities for everyone in the organisation and this would be circulated upon completion. Mrs Foster advised that she was pleased to be taking on the added responsibilities that included Governance and Patient Experience and advised that she had appointed a Governance Support Team to move work forward and agreed to prepare a briefing paper for the next meeting.

Dr Trotter referred to recently circulated structures and questioned some of the changes, including that of Director of Medical Safety. Dr Catto advised that as a result of the realignment Clinical Effectiveness and Quality Improvement formed part of his portfolio and changes in structures and reporting were in transition, the role of the Director of Medical Strategy had changed and was now the responsibility of the Deputy Medical Director - Quality & Safety. Both Dr Catto and Mrs Foster emphasised that the structures in the organisation were in transition but it was clear that the Medical and Nursing teams needed to work closely together going forward.

In response to a question from Mr Lydon, Mr Foster confirmed that many of the new structures of responsibility were based on those in place at WWL.

Mr Lydon advised that he had resigned as a member of the CoG Quality and Risk Committee as it was his opinion that the committee was dysfunctional and seldom received minutes and reports in a timely fashion. He asked whether there was a similar issue with the Board Quality and Risk Committee in particularly citing the lack of information within the Safety Sitrep Report around the spike in mortality in 2012/13 and asked why this had not been highlighted to Governors. The Chair advised it had not been raised with Governors as the Board had been satisfied that there was no significant issue at that time.
Mr Foster noted that as part of the work on clarity, each of his direct reports had been reviewed and each layer in turn would be doing the same. The Emergency Departments had a high impact on quality and safety and thus was the number one issue to be addressed. Dr Catto advised that heightened mortality had been raised as a risk in January 2015.

The meeting discussed the earlier reference to Governance and the statutory duties of Governors. It was agreed that Mr Smith would produce a short paper setting out the distinctions between Governors’ responsibilities and Governance. (Action: KS)

**15.035 INTEGRATED QUALITY & PERFORMANCE REPORT, INCLUDING FINANCE**

Dr Catto presented an overview of the report. Mr Brotherton had sent apologies as he was attending the Systems Resilience Group meeting with the CCG. There were three areas of focus; 18 week RTT target, cancer targets and Emergency Departments (EDs). Work continued to address poor performance which including longstanding issues and the need to learn from shortcomings in previous strategies and a lack of modelling; rectification work included capacity modelling led by Mr Cattell and staff engagement being undertaken as part of Mr Foster’s work.

The 18 week RTT target had not been achieved due to a series of issues that included, amongst other things, hidden waiting lists and IT issues. The hidden waiting lists mainly consisted of Gastroenterology patients that had come to light as a result of inefficient practices. Other factors had included higher cancellation rates for elective procedures due to the number of acute patients occupying surgical beds. The Board had, that morning, discussed and agreed to extra investment to improve the situation. April had seen a return to full reporting of RTT performance; an enormous amount of work had been undertaken over the last 6 months to close open clocks, together with reviews to ensure no significant harm to patients.

Cancer performance had improved despite a continued increase in demand. There had been a dip in the 62 day target in March but following improvements the Trust was back on trajectory.

Urgent care continued to experience an increase in demand and flow was slow but work was underway to address this. There had been a surge in the number of 999 calls with the Trust seeing up to 10 ambulances arriving at EDs within 30 minute timeframes that resulted in unsafe EDs. Teams were demoralised as a result of the constant pressure and non-delivery of A&E standards over the last 10 quarters. The report set out a list of actions that had been put in place to help address the issues; however feedback from ED colleagues had been that they did not feel the benefit from those actions, as a result ad hoc ED listening events had taken place and steps had been taken to overhaul the escalation management system; some success had been seen including earlier ward discharges and patients movement from AMU to wards, however ED still remained the greatest operational and safety risk.

**Finance and Performance**

Mr Cattell advised that the Trust continued to spend money in a planned manner on patient care including ED and outplacement of surgical patients. The Trust had not previously planned for the right level of patient activity and this had resulted in unplanned flex which was inefficient and costly to run. It was also noted that:

- Capital spend was a little behind plan due to a pause whilst the Board considered a Strategic Plan;
- The Trust was on track to deliver the forecasted year end position;
- COSR rating was 4;
• The Trust remained in a strong cash position;
• Contracting discussions continued in order to agree the right levels of activity for 2015/16. It was important that the Trust managed its risk in relation to excess planned activity.

Mrs Foster reported that the corporate nursing team continued to monitor staffing levels. Ward 3 at GHH had been re-commissioned. Following a visit to WWL Quality Champion work had begun.

Dr Catto, Mrs Foster and the Governance Recovery Team had begun investigative work around SUIs and how the Trust could take learning forward.

Staff sickness was at its lowest for six months.

Fall rates had shown a downward trend over the last three months.

The report on the Salmonella outbreak at the Trust been received and had been complimentary on how the Trust had handled the situation.

Open visiting had commenced across all sites from the 1 April 2015 and had multiple benefits for patients and carers; the greatest benefits were for dementia and end of life patients.

Following several questions from the Governors, including Messrs Hughes and Treadwell, on open visiting Mrs Foster agreed to circulate the Trust Visitor Code to Governors; it set out how the Trust would manage open visiting including night time visits. Mrs Foster added that ward sisters had the authority to manage visitors locally in order to keep the ward environment safe. Overall the benefits were expected to outweigh the burdens. (Action: SF/KS)

Mr Hughes congratulated Mrs Foster and the team for initiating open visiting. He went on to ask about staff recruitment and noted that he had never seen any advertisements in the local papers for staff. Mrs Foster advised that the Trust successfully recruited regionally, nationally and worldwide. All trusts, including HEFT, used NHS Jobs to advertise for staff; HEFT also attended university open days, etc. Ms Gunter added that the Trust had just held a very successful recruitment event and several others were planned but it needed to keep in mind that recruitment and retention remained a constant challenge.

Mrs McGeever noted the great work underway to improve patient flow and in response to several points Dr Catto advised that the Trust now had a long list of actions that needed to be taken to achieve effective discharges, including TTO planning. Discharge lounges had been reinstated on all sites and this had resulted in a positive impact.

In response to a question from Dr Pearson about complaints analysis and in particular those related to cancelled operations, Dr Catto advised that urgent care did sometimes take precedence over elective surgery; he and Mrs Foster, who was now responsible for complaints, had arranged for the Complaints Manager from Airedale to review the Trust’s complaints processes.

Mr Lydon referred to discharges and explained that he believed that Social Services had a responsibility to help get patients out of hospital and, from his own experience, knew how long this could take. He felt that the Trust needed to challenge Social Services to improve.

Mr Lydon asked for an update on falls that included what type of patients experience falls. Mrs Foster advised that she would be attending the next Governors Breakfast
Meeting, in May, to talk about falls and invited Governors to forward questions via Mr Smith prior to the meeting in order that she could provide answers to detailed questions.

The Chair suggested that Mary Ross, Clinical Director for Therapies, should also attend a Breakfast Meeting to give an update on the SiDs work she had implemented to reduce the re-admittance of elderly patients. (Action: KS)

15.036 RECOMMENDATION FOR RE-APPOINTMENT OF PROF LAURA SERRANT

The Chair referred to the pre-circulated paper setting out the recommendation for re-appointment of Prof Laura Serrant to the role of Non-executive Director.

The Council of Governors approved the proposal and re-appointed Prof Serrant for a second three year term with retrospective effect from 1 April 2015.

15.037 NED APPRAISALS

The Chair advised that he had carried out the annual appraisal of the longer serving Non-executive Directors (NEDs) that had included discussions around the output from the 360 degree reviews, their strengths and weaknesses and he had agreed objectives with each NED for the coming year.

Although appraisals had not been undertaken for the most recently appointed NEDs, Mr Edwards and Ms Kneller, their objectives had been agreed for the coming year.

15.038 CHAIR’S APPRAISAL

Mr Lawrence left the room and Mr Smith took the chair for this item of business.

Mr Hughes advised that he and Mr Lock, Senior Independent Director, had undertaken the Chair’s appraisal in line with previous years, using the same process as the NED appraisals, including a 360 degree review, to which the responses had been exemplary. Some improvement was required around managing the Chair’s frustration with poor performance. Five objectives had been set:

- Working towards the removal of the Monitor enforcement undertakings by 1 January 2016;
- Taking reasonable steps to appoint a substantive Executive Team by 1 January 2016;
- Leading the Board to work in a cohesive manner;
- Engagement with key external stakeholders;
- Demonstrating culture change, including winning the trust of staff.

Mr Lydon questioned how and when the range of responses had been gained; Mr Hughes advised the questionnaire had been completed in September and had included tick box answers and spaces for comments. Mr Lydon noted that Lord Hunt, the previous chair, had been appraised as ‘extremely satisfied’ and that the Trust had been in a difficult place ever since. He suggested that the questions asked were not critical enough and that narrative answers, rather than tick boxes, should be used. Mr Hughes agreed to take on board these comments, reiterating that no major weaknesses had been raised as part of Mr Lawrence’s appraisal process.

Mr Lawrence returned to the room and resumed the chair.

15.039 Quality Account & Report Update
Mrs Foster presented an overview of the progress made on the 2014/15 Quality Account and the setting of objectives for 2015/16. It was noted that the Quality Account was an annual report to the public from providers of NHS services. Its primary purpose was to encourage boards and leaders of NHS organisations to assess the quality of services provided. The HEFT 2014/15 Quality Account was subject to internal review, external consultation and assurance from PwC, the Auditors, and needed to be compliant with the Monitor Annual Reporting Manual requirements.

The report had been submitted to the Overview and Scrutiny Committee for comment; feedback had included the need for more benchmarking data, narrative and less jargon. The draft report would be circulated to Governors as part of the consultation process.

The priorities for 2015/16 were:
- Reduction of grade 2 pressure sores;
- Improving clinical outcomes for stroke;
- Reduction of incidence of multiple falls;
- Friends and family test response rates in ED.

In response to question from Mr Lydon, Mrs Foster advised that the priorities were new and replaced those set out in the 2014/15 Quality Account.

The next step was the assurance review by PwC. The Trust’s performance on 18 week RTT and cancer waiting targets would be considered as part of this review.

Dr Pearson questioned whether the Trust would have the means to be able to spot another ‘Paterson’ type event. Dr Catto and Mrs Foster advised that discussions with Deloitte were ongoing regarding the development of a dashboard to track underperformance and, although it was absolute impossible to give absolute assurance, current systems were much better at picking up irregularities.

In response to a question from Mr Hughes, Dr Catto advised that operations were not observed unless a specific concern had been raised but could be videoed with the relevant consent.

In response to a question from Mr Lydon, Dr Catto explained he didn’t regard the number of SUI’s and never events as a problem for the organisation, given its size; he would be more concerned if he thought there was under-reporting. Dr Catto preferred a culture where all incidents were reported and then downgraded, if appropriate, as this built trust and confidence with stakeholders.

Mr Foster added that ‘Paterson’ had been a shocking case and one where several people within the organisation had known of the practice but felt unable to do anything about it. Going forward it was about a changing that type of culture and empowering people to raise concerns.

15.040 EXTERNAL AUDITOR UPDATE

Ms Shaw advised that the external audit of systems and controls was underway and would continue over the next 6-7 weeks at the end of which PwC would produce its opinion on the Annual Report and Accounts for 2014/15. To date no significant issues or material weakness on financial controls and systems had been identified.

In respect of economy, efficiency and effectiveness, it was expected that a modified opinion would be issued as a result of the Monitor enforcements undertakings.
15.041 MINUTES OF PREVIOUS MEETINGS

The minutes of the meetings held on 3 February 2015 and 4 March 2015 were approved as a true record.

15.042 MATTERS ARISING

14.080 Decision not to purchase Chest Clinic building – Mr Cattell advised that the Trust leased the building used by the Chest Clinic from Birmingham City Council at a very low rent and the cost to purchase and refurbish would be very high; therefore it had been agreed not to purchase but to continue to lease. Mr O’Leary questioned whether it might be appropriate for the Chest Clinic to move to more suitable premises; Mr Cattell indicated that this might also be more expensive than the current arrangement but that it would be kept under review.

14.080 Overseas patients – Mr Smith advised that this had been fully reported at the March 2014 meeting and undertook to circulate the report on this subject from that meeting. (Action: KS)

In response to a question from Mr Treadwell on whether attendees at A&E should be asked for sight of their passports, Mr Cattell advised that a vast amount of work was underway nationally on managing overseas visitors accessing the NHS and a report on how these changes would affect the Trust would be presented when these were understood.

14.080 Progress of decked car park for Good Hope – the Chair explained that a report on capital prioritisation, which would address this subject, would be brought in due course.

14.082.2 Substantive chair for F&SP – discussions were ongoing.

14.082.3 Progress of hospital environment projects and attendance of Mr Sellars – The Chair had discussed this with Mr Sellars and he would routinely be attending future meetings when possible to report on such issues.

14.082.6 Consider the need to strengthen administrative support to CoG committees – the pre-circulated paper describing committee membership and support was noted.

14.084 Report on CIP/SIEP and pay bill overspend rectifications. Mr Cattell noted that this had been covered within the finance section of the Integrated Performance Report

15.017 Investigate heating issues in BHH Tower Block and report back. Mr Mike Taylor, Head of Estates, reported that an energy efficiency survey had been undertaken on the whole of the block and showed that the 40 year old heating coil system within the ceiling was outdated; however rectification work had already been undertaken to mitigate the issues, this included installation of more valves, additional insulation and installation of computerised systems to monitor temperature variances. Maintenance teams would be looking to carry-out further works including draft proofing windows in readiness for the coming winter. A full report on the planned works would be submitted to the Hospital Environment Committee.

15.043 ATTENDANCE RECORD - Governors

The report was noted.
The Chair advised that attendance records for CoG sub-committees were also being developed.

15.044 CHAIR’S REPORT

As advised at the beginning of the meeting a full report would be presented to the next ‘formal’ meeting.

15.045 ANY OTHER BUSINESS

Mr Treadwell had submitted the following items:

- Acronyms should be avoided in Board and CoG reports and where they are used a key should be provided – noted.

- Implementation of an attendance register for members of the public to sign in when attending Public Board and CoG meetings - noted.

Mr Lydon noted that the Trust’s AGM did not see much public attendance compared to the UHB AGM and questioned whether the Trust would consider a central venue and increased publicity for the event. He also advised that UHB did not rotate its meetings between different venues. The Chair noted that UHB only had one site whereas the Trust had three main sites; therefore rotation was appropriate for the Trust. The Chair agreed to consider the suggestion of a central venue and increased publicity for the forthcoming AGM. (Action: Chair/KS)

15.046 DATE OF NEXT MEETING

5 May 2015 at the Harry Hollier Lecture Theatre, Good Hope Hospital, Sutton Coldfield.

There being no further business the meeting closed.

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Chairman
COUNCIL OF GOVERNORS

Minutes of a meeting of the Council of Governors of Heart of England NHS Foundation Trust held in the Partnership Learning Centre, Good Hope Hospital, Sutton Coldfield on 5 May 2015

PRESENT:
Mr L Lawrence (Chair)
Mrs K Bell
Dr Burgess
Mrs E Coulthard
Dr O Craig
Mr A Fletcher
Prof H Griffiths
Mr M Hutchby
Mrs S Hutchings
Mr P Johnson

In attendance:
Mrs S Bradshaw (Minutes)
Mr D Cattell
Dr A Catto
Prof M Cooke
Mr A Foster
Mrs S Foster
Mrs H Gunter

Members of the public

15.047 APOLOGIES AND WELCOME

Apologies for Governors had been received from Mrs Begum, Mr Hughes, Mrs Lane, Mrs McGeever, Mrs Meixner and Dr Needham.

Apologies for Directors had been received from Mr Brotherton, Dr Cadigan, Dr Rao, Mr Edwards and Prof Serrant.

15.048 MONTH 12 PERFORMANCE REPORT

Dr Catto presented the on behalf of Mr Brotherton. The themes in the report were similar to the previous month’s report. The main areas of concern were urgent care, referral to treatment (RTT), 62 day cancer targets, diagnostic support (in particular endoscopy) and Gastroenterology. The increased demand in urgent care in March was noted resulting in high bed occupancy and congestion in Emergency Departments (EDs). The RTT targets had not been met in the month but RTT reporting had re-commenced and there was an improvement in the RTT admitted backlog. There had been a strong focus on Gastroenterology, where additional capacity had been agreed. There had been improvement in the 2 week wait and breast symptomatic targets. Performance against the 31 day cancer target had been good but there was a shortfall against the 62 day cancer targets.

Mrs Foster presented on quality and safety issues. The biggest risks were around the emergency pathway and safe staffing. Recruitment within Europe had proved less and less successful and therefore other countries, outside Europe, were being looked at. The
Philippines was being looked at for nurses and the University of Islamabad for doctors. The Trust’s vacancy rate remained static and there was an overreliance on agency staff. Harms continued below the national averages (pressure ulcers and falls). A review of complaints and SUI (Serious Untoward Incidents) processes was underway.

The draft CQC report from the visit in December 2014 has been received to check for factual accuracy; it contained no surprises. The final report would follow.

Mrs Bell asked about recruitment from Greece; Mrs Foster explained that the Trust had sent three nurses to Greece on a recruitment campaign but only managed to recruit two nurses.

In response to a question from Mr Orriss regarding the lengthy delay of the CQC report, Dr Catto explained that there were two main reasons (1) a key member of CQC staff had been on lengthy sick leave, and (2) there had been much internal discussion at CQC about ratings. It was still not clear whether or not CQC would state an overall rating in the final report.

Mrs Steventon asked whether the Trust came out better in this inspection than the last. Dr Catto explained that the Trust remained rated the same; mainly yellow (‘needs improvement’) with some green and some red. Dr Catto believed it was an accurate picture of how the Trust stood in December 2014.

Mrs Thomas asked if the CQC would do an interim assessment before they published the final report, given the delay. Dr Catto stated that there would be no reassessment despite the delay and the fact that the Trust had made progress in some areas since the inspection.

Mr Treadwell asked if the Foreign Office had been approached to assist with the overseas recruitment. Mrs Foster replied that the Home Office set the policy on the visa regime which dictated where the Trust could recruit from, also that neither the Home Office nor the Foreign Office would act as recruitment agency on the Trust’s behalf.

Mrs Foster outlined a new practice that had been introduced to reduce congestion in Emergency Departments (ED). The new scheme was ‘safer placement on wards’ and placed a limited number of ED patients awaiting discharge and transfer on wards related to their condition. These patients were nursed beside the nurses’ station. In practice this had meant one extra patient on eight separate wards in Good Hope. This approach had good clinical engagement. Dr Catto explained that this was a measure that had been carefully thought through; he referred to research which indicated that patients preferred to be placed on a ward, pending discharge, rather than in ED.

Mrs Coulthard asked whether the reinstated discharge lounge at Good Hope was helping. Mrs Foster replied that it had six beds and 19 chairs and was working well so far. Mrs Coulthard noted that there had been no beds on A&E majors available at Good Hope after 8.00pm the previous Saturday evening. Dr Catto explained that when patients arrive at A&E the Trust does whatever it can to provide appropriate treatment.

Dr Pearson questioned the use of flawed mortality rates (such as HSMR) given the understanding that congestion drives mortality. Dr Catto explained that due to the problems with the introduction of the new patient administration system (PMS2), HSMR would be an unreliable mortality indicator for the Trust for a while; however the Trust was monitoring crude mortality and undertaking a review of each death to ensure that trends and spikes were understood. Dr Catto noted that mortality spikes and the flu did seem to correlate over the winter.
Mr Kelly explained that he and the late Gerry Robinson campaigned against the closure of the discharge lounges and he was therefore pleased to see them reinstated. Mrs Foster explained that the original discharge lounge on the ground floor had not been large enough to take beds and a number of the patients awaiting discharge were bed bound, so this arrangement did not work. The new lounge could take both beds and chairs.

Mr Orriss asked about parking at Good Hope in the context of discharging ED cases from wards which would require more pick up time for relatives and carers. Mr Sellars explained that the 30 minute free tariff applied across all sites. The Chair asked Mr Sellars to discuss this further at the next Hospital Environment Committee meeting.

Mr Lydon asked about mortality spike in 2013/14. Dr Catto explained that mortality spikes in ED were usually a surrogate for the entire hospital and that being clinically unwell in ED was not good for patients who were exposed to greater risk in that environment.

Mr Webster congratulated the Trust on moving people that were awaiting discharge or transfer from ED to wards. He went on to note that the general consensus was that the Trust was in trouble but that not enough was being done to publicise the good things that the Trust was doing. He was also concerned about the possible inappropriate use of hospitals for patients near the end of their lives. His experience with his wife, who was terminally ill, had been that she had been sent to A&E several times, against his wishes, by her nursing home. He felt that the nursing home didn’t want his wife to die in their care although her demise was expected. Dr Catto acknowledged the dilemma of care and nursing homes tending to transfer end of life patients to hospital when little or nothing could be done to prolong their lives.

15.049 REPORTS FROM COG COMMITTEE CHAIRS

Finance and Strategic Planning

Mr Fletcher presented the minutes and reported that there had been problems over some dates being changed and that the meetings had been less well attended as a result. Mr Cattell apologised and confirmed that this was being looked into. Mr Fletcher reported that Mr Johnson has chaired the March meeting, which had been a good meeting, and that the committee was looking to appoint a new chair. Mrs Bell would chair the next meeting.

Hospital Environment Committee

Mrs Coulthard presented the minutes and highlighted that Good Hope’s fete would take place on 18 July 2015. Mrs Coulthard reminded the meeting that the A&E canopy was being installed at Good Hope and that it was hoped that it would be finished by end month. The next meeting would be at the Chest Clinic and interested Governors were invited to attend. The new signage for Good Hope had arrived but had taken seven years to organise! The privacy domes and speakers for A&E had taken four years to organise! Mrs Coulthard also raised the issue of the Good Hope Multi-storey car park which was thought to have been ‘written off’ in the capital prioritisation programme. Mr Foster said that a multi-storey car park for Good Hope could be considered in the ten year capital strategy but it would be competing against other projects for prioritisation.

Mr Treadwell reported he had raised the issue of a Doctor’s mess and was pleased to note that there now was one at Good Hope.

Mrs Steventon asked about parking concessions for foster carers. Mr Sellars responded that the special rate of £10 for 20 visits was available for all patients and their carers at the relevant Ward Managers’ discretion.
Mrs Coulthard raised the issue of there being nowhere for medical staff to eat after 3.00pm. Mr Cattell noted that F&SP was looking into this and would ask Mr Gould to prepare a report for the Hospital Environment Committee. (Action: D Cattell)

Mr Orriss explained that the Good Hope car park had been approved three years previous by the Board and that he couldn’t understand why it hadn’t been built by now. Mr Fletcher noted that car parks for both Good Hope and Heartlands had been discussed for the last three or four years and he was disappointed that there had been little communication back to the Governors regarding any change of plan. Mrs Coulthard explained that Mr Sellars had described two options for the Good Hope car park to the Hospital Environment Committee a few months previous and that there had been no suggestion of the project being abandoned at that point.

The Chair asked Mr Cattell and Mr Sellars to prepare a full paper on the car park history and situation for the next ‘formal’ meeting. (Action: D Cattell/ J Sellars)

Membership and Community Engagement
Mr Fletcher explained that the last meeting had been cancelled.

Patient and Staff Experience
Mr Kelly explained that DNAs had continued to decrease from 90,000 to 80,000 and the friends and family test response rate was sitting at Heartlands 44%, Solihull 45% and Good Hope 20%. Complaints were running at less than 1% of patients with the key areas being: delays and cancellations, attitudes and behaviour, appropriate treatments, poor information and medication issues.

Thee PLACE inspections had showed some examples of poor conditions for staff.

Dr Pearson suggested that benchmarking the complaints rate against other Trust to see how the Trust’s performance compared.

Mr Orriss asked whether patients were being texted reminders as he had not been when recently attending appointments at Good Hope. Mrs Foster confirmed that patients were generally texted reminders and that this should be considered further by the Patient and staff Experience Committee.

Quality and Risk
Mrs Steventon asked that the minutes from the 26 January meeting be taken as read and reported that the committee had changed its strategy to drilling down into the work of the Board Quality and Risk Committee. The issue of cross-over with the Patient and Staff Experience Committee was being considered again. Mrs Gunter had given an update on the work done by the Kennedy Task Force. Mrs Foster was coming to the next meeting on 12 May.

Mr Lydon reported that he had resigned from the committee as he was not happy with the accuracy and lack of timeliness of the minutes. He felt that the executives supporting the committee were lacking grip and would have preferred more regular un-minuted meetings with quarterly formal meetings.

Mrs Steventon reported that having reviewed the minutes the previous week with the minute taker, it was discovered that the draft minutes were being held up in the management chain. Mr Fletcher suggested that minutes should be sent to committee chairs within seven days. The Chair emphasised that it was important that there be no interference by Trust officers and that the draft committee minutes should go directly to the committee chairs for review. Mrs Foster said that she would resolve the issue of a suitable minute taker for committee.
Kennedy Task Force
Dr Pearson reported that he had no update on the Kennedy Task Force and that the continuing work arising from the Kennedy Report was expected to be completed through routine channels but that there might be an alternative scrutiny arrangement. It was agreed that Dr Pearson should continue to represent the CoG in relation to any new scrutiny arrangement.

15.050 REPORT ON THE WORK OF THE BOARD AUDIT COMMITTEE

Ms Lord introduced herself; she had been a Non-executive Director since May 2013 and chair of the Audit Committee since July 2013.

Every foundation trust has to have an Audit Committee. The Board must put in place governance processes and systems of control. The Audit Committee reviews these and is an assurance committee - not an operational committee. Ms Lord explained that ‘reassurance’ is when someone asks if everything is okay and is told ‘yes’; by contrast ‘assurance’ is when someone asks to see that everything is okay and is shown an evidence base that demonstrates everything is okay.

The Committee only Non-executive Directors as members, to ensure its independence from management, but is supported by Internal Audit, External Audit, finance and other subject experts. It should be chaired by a qualified accountant, which Ms Lord is.

The Committee initiates reviews of systems and controls and looks at the outcome of those reviews, the recommendations made and the actions taken. Most of the reviews are done by Internal Audit. Internal Audit is outsourced, currently to Deloitte, in common with many large organisations.

Since Ms Lord took the chair certain governance failings had been noted within the Trust, including the Board Assurance Framework. Ms Lord was a strong supporter of the Deloitte Governance Review and welcomed the huge amount of work currently being done on the improvement programme, especially that led by Mrs Foster. Under Ms Lord’s chairmanship, the Committee reviewed the work of the then current internal auditor (KPMG), went out to tender and appointed Deloitte. The new auditors provide more rigorous and advice. Each year Internal Audit undertake a series of core internal control reviews which generally give substantial assurance. This year Deloitte had carried out three reviews where moderate assurance was received (1) CQC compliance, (2) IT controls, and (3) Procurement, and a limited assurance review of the Board Assurance Framework and Strategic Risk Register.

From the programme of reviews a series of recommendations are created. There were over 100 overdue responses when Ms Lord became chair; there were now only four. Ms Lord acknowledged the hard work of Mrs Angeline Jones, Chief Financial Controller, and her team in chasing responses. The results of the reviews in 2014/15 had led to the Head of Internal Audit’s Opinion being graded as one of ‘Limited Assurance’.

Ms Lord also explained the work of the Local Counter Fraud Service (LCFS), conducted by Deloitte, which proactively works to deter and prosecute fraud against the Trust. This year there had been 23 referrals; as a result four dismissals and two potential prosecutions had been progressed.

The Audit Committee also considers the external auditors’ reports (PwC) in relation to the Annual Report and Accounts, including the Quality Account. For the year 2014/15 it is likely that the Trust would receive a modified conclusion on economy, efficiency and effectiveness as a result of the Monitor enforcement action. PwC test three indicators in the Quality Account; one is the 18 week RTT performance, which the Trust would be unable to report on for 2015/16, so an alternative would be reviewed instead.
Mr Lydon stated that an important issue for the coming year would be the tender for the external auditors’ service. He thought that PwC would have had to provide a modified opinion regarding economy, efficiency and effectiveness in relation to 2013/14. Ms Lord explained that they had taken expert technical advice at that time and concluded that this was not the case.

Ms Lord clarified what the external audit function could and could not do. Mr Lydon asked whether the external auditors were responsible for flagging issues and whether they did. Ms Lord explained that there was an agreed process for this and confirmed that the external auditors view was absolutely objective.

Mrs Steventon asked what the Head of Internal Audit’s Opinion was for 2014/15. Ms Lord replied that the outgoing auditors reported no concerns at that time. Mr Kelly asked about the performance of the previous internal auditors; Ms Lord compared it to the banking crisis in that the problems were not seen until after the event.

Mr Kelly asked whether the Audit Committee dealt with debtors. Ms Lord explained that the Audit Committee looks at whether debtors are accurately recorded and the process for their management but not with specific reference to individual debtors.

Mr Lydon asked whether Monitor could recommend good audit firms; Ms Lord explained that this was not something that Monitor did and explained that reputable audit firms had a checklist approach to audit and were all independent of their client organisations.

Dr Pearson asked whether clinical audit was covered by the Audit Committee. Ms Lord outlined that Audit Committee sees the structure of clinical reviews but the reviews would be considered by the Quality and Risk Committee from a clinical perspective. Dr Pearson asked what Ms Lord would do if she felt that she did not have sufficient assurance. Ms Lord replied that she would raise it with the full Board; Dr Pearson suggested that such issues be raised with the Governors too.

15.051 2015/6 ANNUAL PLAN

Mr Cattell referred to the report included in the pack. The Annual Plan Return (APR) was due for submission to Monitor by 14 May and it will have its final sign off by Board Monitor Standing Committee but Mr Cattell would also take a summary of the final form plan to the F&SP.

The Trust would be striving to improve its performance and governance over coming months and had developed an Integrated Improvement Plan to help to achieve this; it would also require the development of a suite of strategies. All of this would be referred to in the narrative of the APR.

The plan recognised that the Trust expected to spend £10m more than it received in income to help fix the things that were broken, including performance against national targets such as 4-hour A&E, 18 week RTT and 2 week waits.

Mrs Coulthard asked if the funds were in place for Surgery Reconfiguration. Mr Cattell confirmed that there was a general allowance for this but noted that the Trust wouldn’t know exactly what was required until the public consultation exercise being run by the CCGs was completed.

Mr Lydon asked whether investment in sub-acute beds was a priority. Mr Cattell confirmed that this was still on the Trust’s agenda as it clearly related to flow but at this stage it was not clear what was required, or when.
Mr Treadwell asked about emergency evacuation of patients. Mr Foster confirmed that the Trust has an emergency plan and that in the event of a full scale emergency it is normal to rely on neighbouring hospitals.

15.052 ANY OTHER BUSINESS

Mrs Steventon reminded the meeting that the Friends of Solihull Hospital would be running the Solihull fete on 30 May.

Mr Treadwell asked if the trust was aware of the ‘Hug in a Hospital’ event; Mr Foster confirmed that the Trust was aware.

In response to a question from Mrs Thomas, the Chair confirmed that the staff engagement events were going well and that the latest events had considered the outline strategy for the Trust.

15.053 DATE OF NEXT MEETING

2 June 2015 at The Village Hotel, The Green Business Park, Dog Kennel Lane, Shirley, Solihull B90 4GW.

There being no further business the meeting closed.

..........................
Chairman
Matters Arising
## COUNCIL OF GOVERNORS

### Matters Arising & Decisions/Recommendations Tracker

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<tr>
<th>Date raised</th>
<th>Minute No</th>
<th>Detail</th>
<th>Action by</th>
<th>Due</th>
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<td>24 Nov 2014</td>
<td>14.080</td>
<td>Report to go to F&amp;SP Cttee regarding decision not to purchase Chest Clinic building.</td>
<td>DC</td>
<td>Feb 2014</td>
<td>Oral update given to CoG.</td>
<td>14 Apr 15</td>
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<td>14.080</td>
<td>Receive full briefing from AQ/AJ on overseas patient income.</td>
<td>Chair</td>
<td>Feb 2014</td>
<td>Report presented at March 2014 meeting to be circulated by e-mail - KS.</td>
<td>18 May 15</td>
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<td>14.080</td>
<td>Report on progress of decked car park for Good Hope.</td>
<td>AC</td>
<td>Feb 2014</td>
<td>Report on capital prioritisation to be brought to the CoG in due course.</td>
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<td>14.082.3</td>
<td>Consider issues raised by E Coulthard regarding lack of focus, grip and pace regarding hospital environment projects.</td>
<td>AC</td>
<td>Feb 2014</td>
<td>J Sellars to routinely attend future CoG meetings to report on such issues.</td>
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<td>14.082.6</td>
<td>Consider the need to strengthen administrative support for CoG Cttees</td>
<td>Chair</td>
<td>Feb 2014</td>
<td>Report on resource given to CoG.</td>
<td>14 Apr 15</td>
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<td>14.084</td>
<td>Report to CoG on CIP/SIEP and pay bill overspend/ rectification status</td>
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<td>Report given to CoG.</td>
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<td>14.087</td>
<td>Consider with Lead Governor and CoG Cttee chairs whether an oversight and scrutiny Cttee might be appropriate.</td>
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<td>3 Feb 2015</td>
<td>15.012</td>
<td>Consider Governor attendance at CoG and Committees with Lead Governor</td>
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<td>Investigate heating issues in BHH Tower Block and report back.</td>
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<td>Oral report given to CoG.</td>
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<td>14 Apr 2015</td>
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<td>Produce paper setting out the distinctions between Governance and Governors’ responsibilities.</td>
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<td>Jun 2015</td>
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<td>Circulate Trust Visitor Code to Governors.</td>
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<td>15.035</td>
<td>Invite Mary Ross, Clinical Director for Therapies, to a Breakfast Meeting to give an update on SIDs work.</td>
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### Matters Arising

**Council of Governors**

**June 2015**

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<td>5 May 2015</td>
<td>15.045</td>
<td>Chair agreed to consider a central venue and increased publicity for the 2015 AGM.</td>
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<td>5 May 2015</td>
<td>15.049</td>
<td>Ask J Gould to prepare report for HEC on solution for clinical staff not being able to get a hot meal after 3.00pm (based on F&amp;SP deliberations).</td>
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<td>Prepare a full paper on the car park history and situation (BHH and GHH) for the next ‘formal’ meeting.</td>
<td>DC/JS</td>
<td>Jun 2015</td>
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Governance and Governors' responsibilities
Governance and Governors’ responsibilities

Governance

The Board has a duty to promote the success of the Trust so as to maximise the benefits for the members of the Trust as a whole and for the public who will be treated by the Trust.

Governance is the means by which the Board leads and directs the organisation so that decision-making is effective and the right outcomes are delivered.

Good governance incorporates, amongst other things, corporate governance and quality governance. Robust corporate and quality governance arrangements complement and reinforce one another. Other important aspects of governance include, for example, finance governance and research governance.

Governance arrangements delegate responsibility from the Board down to the operating levels in the organisation. In the case of quality, this means that although individuals and clinical teams are at the frontline and responsible for delivering quality care, it is the responsibility of the Board to create a culture within the organisation that enables clinicians and clinical teams to work at their best, and to have in place arrangements for measuring and monitoring quality and for escalating issues, including, where needed, to the Board. The same applies equally to other aspects of governance.

Some important features of good governance are strong leadership capability and capacity, clear strategies, robust structures (e.g. Board, clinical and operational committees which meet regularly and have appropriate terms of reference), clear lines of accountability, robust and timely flows of information, appropriate policies and procedures, etc.

Governors’ responsibilities

Governors have an important role to play in making the Trust publicly accountable for the services it provides. They should do this by exercising their statutory powers and responsibilities; these come from the National Health Service Act 2006 and the Health and Social Care Act 2012 and can be summarised as:

- Hold the Non-executive Directors, individually and collectively, to account for the performance of the Board.
- Represent the interests of the members of the Trust as a whole and the interests of the public.
- Approve “significant transactions”.
- Approve an application by the Trust to enter into a merger, acquisition, separation or dissolution.
- Decide whether the Trust’s non-NHS work would significantly interfere with its principal purpose, which is to provide goods and services for the health service in England, or performing its other functions.
- Approve amendments to the Trust’s constitution.
- Appoint and, if appropriate, remove the Chair.
- Appoint and, if appropriate, remove the other Non-executive Directors.
- Decide the remuneration and allowances and other terms and conditions of office of the Chair and the other Non-executive Directors.
- Approve (or not) any new appointment of a Chief Executive.
- Appoint and, if appropriate, remove the Trust’s auditor.
- Receive the Trust’s annual accounts, any report of the auditor on them, and the annual report at a general meeting of the Council of Governors.
Governors should be committed to encouraging improvements in governance on a continuing basis by exercising their powers and responsibilities, such as holding the Non-executive Directors to account for the performance of the Board, but ultimately the legal responsibility for good governance sits with the Board.

Kevin Smith
Company Secretary
18 May 2015
Attendance Record
## Council of Governors

### June 2015

#### Agenda

- Welcome
- Declaration of Interest
- Apologies
- Minutes
- Matters Arising
- Chairman's Report
- Chief Executive's Report
- Integrated Quality Report
- Integrated Improvement Plan
- Dementia Strategy Presentation
- Minutes
- Governance and Governors' responsibilities
- Attendance Record
- Chairman's Report
- Any Other Business

## 2014/15

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N.B. J Ryan went to St John's Hotel, Solihull for 23 July meeting (per front cover of pack) so claims attendance.

Key:
- Ap 1 = No reason stated
- Ap 2 = Sickness
- Ap 3 = Holiday
- Ap 4 = Care Cover Obligations (Child/Elderly/Relatives etc)
- Ap 5 = Bereavement
- Ap 6 = Unavailable due to change of meeting date
- Ap 7 = Other (prior engagement etc)
- Ab = Absent (no apology received)
### Agenda

- **Welcome**
- **Declaration of Interest**
- **Apologies**
- **Minutes**
- **Matters Arising**
- **Chairman’s Report**
- **Chief Executive’s Report**
- **Integrated Quality Report**
- **Integrated Improvement Plan**
- **Dementia Strategy Presentation**
- **Any Other Business**
- **Attendance Record**
- **Governance and Governors’ responsibilities**

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**Key:**
- **Ap 1** = No reason stated
- **Ap 2** = Sickness
- **Ap 3** = Holiday
- **Ap 4** = Care Cover Obligations (Child/Elderly/Relatives etc)
- **Ap 5** = Bereavement
- **Ap 6** = Unavailable due to change of meeting date
- **Ap 7** = Other (prior engagement etc)
- **Ab** = Absent (no apology received)
Chair's Report
Any Other Business

Dates of Future Meetings

8 July 2015

Harry Hollier Lecture Theatre, Good Hope Hospital, Sutton Coldfield

Refreshments will be available from 3.30pm
Produced by the Company Secretary’s Office