Notice is hereby given that a meeting of the Council of Governors
of Heart of England NHS Foundation Trust will be held at
the Harry Hollier Lecture Theatre, Partnership Learning Centre, Good Hope Hospital
on 8 July 2015 from 4.00 to 6.00pm

A G E N D A

		Timing (mins)
1.	Month 2 performance (Oral – J Brotherton/ D Cattell/ A Catto)	10
2.	CEO Recruitment update (Oral – Chair)	5
3.	Reports from CoG Cttee chairs:	
	a. Finance & Strategic Planning (21/05/15) (Enclosure – K Bell)	5
	b. Hospital Environment (07/05/15) (Enclosure – E Coulthard)	5
	c. Membership & Community Engagement (15/05/15) (Enclosure – A Fletcher)	5
	d. Patient & Staff Experience (15/05/15 – cancelled) (M Kelly)	5
	e. Quality & Risk (23/03/15, 12/05/15) (Enclosure & Oral – L Steventon)	
4.	Strategy update (M Cooke)	20
5.	Any other business previously advised to the Chair	2
6.	Governor Engagement workshop (A Catto/K Smith)	60

Next Meeting – 8 September 2015 – Colmore Gate, 6 Colmore Row, Birmingham

Refreshments will be available from 3.30pm

Kevin Smith
Company Secretary
30 June 2015

COUNCIL OF GOVERNORS
Finance and Performance Strategic Planning Committee
Of the Council of Governors of Heart of England NHS Foundation Trust
held on Thursday 21st May 2015, 10:00
in the Boardroom, Devon House, Heartlands Hospital

Present:	Mr Albert Fletcher Mrs Kath Bell Mr Michael Hutchby Mr Barry Orriss Mr Philip Johnson Dr Oliva Craig
In Attendance:	Mr Jonathan Gould Mrs Angeline Jones Mr Stephen Lewis Ms Hazel Gunter (p/t) Ms Jenny Hall (Minutes)
Partial Attendance	Professor Matthew Cooke Mr Simon Birley

1.	**APOLOGIES FOR ABSENCE** Apologies were received for: Mr M Trotter, Mrs J Hodgkiss, Mr R Hughes, Mr D Cattell, Mrs M Vaughan.
2.	**MINUTES OF THE MEETING HELD ON MONDAY 30TH MARCH 2015** The minutes of the meeting held on 30th March 2015 were accepted as an accurate record
3.	**MATTERS ARISING/ ACTION LOG** **Chairperson** Following recent discussions regarding Chairperson, Mrs Bell and Mr Trotter were nominated as new Chairperson. Following a vote, Mrs Bell was elected as Chairperson and Mr M Trotter will be invited to become Vice Chairman. **Fraud Policy for Finance Director Fraud** Mrs Jones is currently seeking advice from the Counter Fraud team regarding appropriate wording in this policy. Feedback will be provided at the next meeting. **Alternative venues for Council of Governor meetings** Meetings have now been rotated across the three sites as requested.
4.	**HR Staffing Processes and Controls** During previous meetings there have been issues raised in regards to overspend

	on bank and agency staff throughout the Trust and the effect use of agency has on staff morale and patient experience. Ms Gunter explained that there are currently problems throughout the region with recruiting Band 5 nurses in particular, and with retaining staff once recruited. In this Trust sickness and turnover are high. Approximately 26 nurses (1 per day) leave the trust and a paper has been sent to EMB and FPC setting a trajectory for recruitment in order to maintain existing staffing levels. In addition, Finance & Operations are completing capacity work to review the expected demand for beds over the next 12 months. This may mean that flexed capacity which has been staffed with temporary staffing will be given funding which will mean those posts become part of establishment and can be recruited to permanently. Ms Gunter presented the Workforce Delivery Unit Dashboard which illustrated the majority of bank and agency usage as a result of temporary capacity remaining open. Ms Gunter explained that the majority of leavers are staff within two years of completing their nurse training. This indicates that further work is required on leadership, maintaining educational support and personal support for newly qualified staff. All staff leaving the Trust are offered an exit interview or given the opportunity to complete an online exit survey. Results are then collated and any obvious concerns are managed appropriately. Mr Fletcher suggested that there may be lessons to be learnt from organisations such as the RAF and the Army. Nurses appear to be supported and sponsored throughout their training as well as on-going throughout their career. Mr Fletcher asked that this approach to sponsorship and recruitment is looked at with some veracity and that an update is provided in October from HR. **Action: Mr Birley – October meeting**. The Trust has recognised that more focus is required on staff engagement in order to improve morale. Andrew Foster has been involved in recent staff engagement events and is fully supportive of this approach. There have already been several staff engagement events throughout the Trust and there are more to follow. Specific sessions have been organised for Medics, Bands 1-4, Facilities and other Specialist staff groups. Andrew Foster chairs the staff engagement steering group where action plans for staff suggestions are generated and some of the quick wins are already being implemented, such as a hot air blanket for the main corridor and identifying a budget for new starters. . Reduction of sickness and improved staff survey results suggest that the feedback from staff engagement events has been positive. Ms Gunter will provide the committee with a video which shows how staff engagement has made positive changes throughout the Trust. **Action: Ms Gunter to forward to Mrs Vaughan for circulation with final minutes**.

	Mr Orriss raised a query that despite previous comments he still felt that there were too many staff in the Good Hope Treatment Centre. Mrs Jones advised that Theresa Price and the matron had previously attended the committee to explain the various roles the nurses complete. Mrs Gunter added that Nursing and HR are reviewing whether a band 4 nurse role can be developed where the band 4 will do some of what the band 5 nurses currently do. Other developments on staffing and culture included four values being agreed by the Board, a new appraisal system and new recruitment methods. Mr Birley explained the work being done in support to appointed staff in getting them into post and helping them to settle, such as accommodation, transport and mentoring support. Mrs bell was interested in how we were linking local universities, and Simon outlined how the lead nurse was in regular contact with the 89 students nurses appointed from Birmingham City University who will start in September. Mr Hutchby asked what impact the DoH proposals for 24/7 working would have on staffing and agency levels. Ms Gunter indicated the impact would be dependent on Trust strategy as not all services were required to be 24/7. **Action: Ms Gunter will provide an update on staffing numbers and staff retention in October 2015.**
5.	**Finance and Performance Month 12** **Month 12 figures** At mth12 the Trust had a COSR rating of level 4 (highest level) delivering a YTD deficit of £5.6m, as per the forecast The Service Improvement Efficiency Programme (SIEP) delivered £16.4m (68% of £24m target). Mth 12 delivered 75% of the in-month target. The cash balance is £9m above plan. This is due to capital spend being behind plan offset by overspends in income and expenditure. Total capital spend in the year was £20.5m. Carry forward expenditure of £20m to 2015/16 was approved by Finance and Performance Committee. 62% of CQUIN targets have been met. Therefore because the Trust will exceed the 60% target set by CCGs all CQUIN monies have been billed. Mr Orriss raised concern in regards to failing the Performance Standards in a number of areas. Mrs Jones explained that in the 2015/16 Plan additional investment had been allocated to spending on areas that would improve performance in these areas. Mr Gould outlined that the Integrated Improvement Plan (IIP) had been signed off by Trust Board, the CCG and Monitor and brought together all the action plans to achieve the performance targets in the future. Mr Johnson expressed concern that Mr Foster had indicated that a new building was the solution and that he felt this could encourage more attendances. Professor Cooke explained that the Trust needs better processes for treating patients in A&E but also better facilities were required.

	Mr Fletcher asked what was needed to get back on target. Professor Cooke commented on how we needed to hit the target sustainably and that the plan was to be at this point by November 2015, as the engagement and culture parts of this programme of work would take time to have an effect. Mr Orriss noted he had heard similar explanations before and wanted someone responsible for delivery of the targets and to come to the next meeting. **Action: Agreed to request Mr Catto to go through the IIP at the next meeting.**
6.	**"DRAFT" CORPORATE STRATEGY UPDATE** Professor Matthew Cooke attended to present the updated draft Corporate Strategy. It was clear from the recent staff engagement events that many staff were still not aware of the Trust's vision. Professor Cooke is coordinating the development of a new Trust Strategy. The Trust is currently engaging with staff, patients and other stakeholders of what the Trust vision should be. This includes considering whether we are 3 hospitals on a number of sites, whether we are a teaching hospital and/or an academic Trust and where are the areas we want to expand and what are we not going to do. The Strategy will be approved at September's Board. **Action: Professor Cooke to email electronic presentation to be attached with final minutes.** Professor Cooke outlined the strategic projects that are already happening: • Surgical reconfiguration will have a CCG led public consultation in September with a decision in December and first move in April 2016. • Solihull Urgent Centre (UCC) will go out to tender in the summer with changes taking effect from September 2016. • A Frail Elderly Care Strategy is being developed and a new deputy medical/director to specialise in this area has been appointed. Mr Johnson asked how the Trust was dealing with population changes such as more retired people and baby booms, as well as planned housing movements. Professor Cooke responded that these should be easy to predict and will be included in planning. Mr Orriss asked how we respond to the needs of non-frail elderly patients and Professor Cooke added that the elderly fit were an emerging patient class and that services such as trauma would be developed to cater for this. Dr Craig reiterated the importance of dementia planning in the strategy.

7.	**ANY OTHER BUSINESS** • Mrs Bell requested that her previous queries be responded to and Mrs Jones agreed to speak after the meeting. • Professor Cooke to find out details in regards to dementia research funding received by the Trust. • Professor Cooke advised that the national audit figures for the newly implemented hyper acute stroke services show improved performance. The report to be circulated for information.	**A Jones** **Prof Cooke** **M Vaughan**
DATE AND TIME OF THE NEXT MEETING		
WEDNESDAY, 2ND SEPTEMBER @ 10.00a.m. SOLIHULL EDUCATION CENTRE, ROOM 3 *(please check plasmas on arrival as room can be moved at short notice)*		

Chairman ……..Dated .....

DRAFT

COUNCIL OF GOVERNORS
HOSPITAL ENVIRONMENT COMMITTEE

Minutes of a meeting of the Hospital Environment Committee of the Council of Governors, held at 2.00 p.m. on Thursday, 7 May 2015, at the Birmingham Chest Clinic, 151 Great Charles Street, Queensway, Birmingham, B3 3HX

PRESENT: Elaine Coulthard (Chair)
Andy Edwards
Ron Handsaker
Sue Hutchings
David O'Leary
David Treadwell
Arshad Begum
John Sellars

IN ATTENDANCE: Martin Dedicoat, Clinical Director, Chest Clinic
Pat Davis, Manager, Chest Clinic
Veronica Treadwell
Ann Harwood, Executive Assistant (minutes)

NOT PRESENT: Carol Doyle
Emma Hale

15.19 CHEST CLINIC WALKABOUT

Martin Dedicoat and Pat Davis accompanied the group on a walkabout the Chest Clinic, which included the reception area, consultation rooms and the x-ray facilities. The following points were noted/ discussed:

- The Chest Clinic was built in 1932 as a Chest hospital mainly for TB patients and patients requiring artificial lung treatment. The Trust has a 100-year lease with Birmingham City Council (BCC), which commenced in 1947 and costs the Trust approx £3k per year, to occupy the ground and first floors with x-ray facilities in the basement.
- The Trust installed a new fire protection system in 2014 and also carried out redecoration works, at a cost of £250k.
- BCC are responsible for the external envelope and structure of the building. There are a number of outstanding maintenance works which BCC are responsible for carrying out. The Trust has had a report prepared which outlines what work is required and this was sent to BCC, however to-date they have not carried out these works. Negotiations are currently underway with BCC via the Trust's solicitors and this issue is on the Asset Management Risk Register. The Trust has repaired all the windows in the area occupied by the Chest Clinic as there were some serious concerns regarding their condition. The invoice for these works has been forwarded to BCC.
- The location of the Chest Clinic in the City Centre is ideal for patients although there is limited parking available.
- Consultants are able to access patient's x-ray results immediately via the computer screens in their consultation rooms. The x-ray reports are prepared remotely at BHH with a turnaround time of approx 10 days for the reports to be produced. However serious abnormalities will be reported within 48 hours. Patients receive a copy of the letters sent to their GP. There is a walk-in GP service and GPs can refer patients directly to the Chest Clinic for chest x-rays.
- There are approx 500 patients diagnosed with TB across Birmingham every year and approx 200 of these patients will be managed at the Chest Clinic. Around 3,000 to 6,000 TB contacts are also

screened every year at the Chest Clinic. It was noted that approx 30% of patients acquire TB in the UK compared to 70% from overseas. The Chest Clinic works closely with the City Hospital and UHB.

- David O'Leary was concerned re wheelchair access to the building, particularly if the lift breaks down. This is a particular problem for motorised wheelchairs. It was noted that if there are access issues patients can be seen at BHH or GHH.
- Patients are generally very happy with the care they receive at the Chest Clinic and there are very few complaints received about the service.
- Staff are being encouraged to attend the Staff Engagement sessions being held across the Trust.
- Members thanked Martin Dedicoat and Pat Davis for the excellent walkabout and for the professional way in which they had explained the services provided at the Chest Clinic.

15.20 APOLOGIES

There were no apologies.

15.21 MINUTES OF THE MEETING HELD ON 5 MARCH 2015

The minutes of the meeting held on 5 March 2015 were approved as an accurate record.

15.22 ACTION SHEET FROM MEETING HELD ON 5 MARCH 2015

15.22.1 Parking at GHH

A drawing was circulated which shows plans developed by Mathew Trotter for dropping off and picking up patients from the Oncology Day Unit in the Sheldon Block at GHH. As well as allowing patients safe and easy access to and from the unit, the plans also include wider surrounding paths and a wider zebra crossing to allow easier mobility/ access for patients. There are a number of disabled parking spaces located nearby.

15.22.2 Terms of Reference

The Terms of Reference are still with Kevin Smith to give final approval and to ensure that they fit with all the other Council of Governors Committees' Terms of Reference.

15.22.3 RSU Entrance at GHH

The hand gel dispenser has now been relocated back to its original place in the RSU entrance.

15.22.4 Ward 3 at BHH

David O'Leary remains concerned about the temperature on ward 3 at BHH during the winter months. As this is an issue in the winter it was agreed to bring this item forward to the January meeting and John Sellars will review the ward temperature in October/ November/ December and bring the readings to the January meeting.

15.22.5 Maternity Project

This is an agenda item for John Sellars to give an update on the proposals for Maternity at BHH.

15.22.6 GHH A&E Entrance

It was noted that the revolving doors located at the GHH A&E entrance are currently being used as opening doors whilst work is being carried out on the sensors which are very sensitive. Dave Smith, Estates Manager at GHH, is arranging for the sensors to be painted yellow and a notice will be installed advising users to check the yellow sensors if the doors stop working.

15.22.7 Privacy Domes in A&E at GHH

- Microphones have been installed so that patients can talk to the reception staff. Elaine Coulthard was concerned that patients sitting in the waiting room can hear every conversation with the receptionists. JFS advised that the microphones had been installed because the receptionists had been unable to hear what patients were saying.

- David O'Leary felt that all privacy screens should be removed across the Trust and queried whether security guards could be stationed nearby instead, to prevent any attacks. John Sellars advised that this would be difficult within current security staffing levels as it would require a security officer to be stationed near the reception desks 24/7 to prevent staff being verbally and physically abused. A decision like this would need to be discussed at Executive level and a Board decision would be needed to remove these screens. Andy Edwards stated that the use of privacy screens is standard practice in hospitals and that as well as the safety aspect these screens also provide a physical barrier for staff from sick patients.

15.22.8 Restaurant at GHH

- Elaine Coulthard felt that although the restaurant at GHH has been refurbished it is still too far for staff to get to in their break times. John Sellars advised that the takings in the restaurant have doubled in March and April this year compared to the same months in 2014.
- Extended opening hours are being trialed in some of the coffee shops and restaurants to see when they are most needed.
- The Costa Coffee shops have now had chillers installed and provide salads.
- Elaine Coulthard advised that at the end of the day the Coffee Shop is disposing of any sandwiches remaining with that day's date on them. She felt that these sandwiches could be utilised in A&E. She was also concerned that the current choice of sandwiches is not suitable for A&E patients. John Sellars stated that the reason why there are currently no meat sandwiches being provided is that, following testing, some samples have been found to be contaminated with bacteria. The Trust has a zero tolerance and this is why all meat sandwiches have been removed for the time being. The Trust is about to trial preparing the sandwiches on site and the normal range of sandwiches will shortly be available. John Sellars agreed to discuss the possibility of A&E using the sandwiches from the Coffee Shop at the end of the day with Chris Davies, Head of Facilities.

15.22.9 Doctors Mess

David Treadwell was pleased that there is now a Doctors Mess at GHH and queried whether this facility is available at BHH and SH. John Sellars advised that the Doctors Mess at BHH is in Devon House and at SH is in the Mallory Block.

15.22.10 Faith Centre

Arshad Begum is working with Jamie Emery and Sarender Chana in looking at the female ablution space within the BHH Faith Centre. Visits are being arranged to Birmingham Childrens' Hospital and local mosques to get some ideas on washing facilities.

15.22.11 WRVS Signage at GHH

Elaine Coulthard was pleased with the new signage at GHH and agreed that the WRVS signage is now correct.

15.22.12 Main Corridor Roof Leak at GHH

There has been a leak in the main corridor roof where the new AMU is being built. Dave Smith, Estates Manager at GHH, will arrange for repairs to be carried out asap.

15.22.13 Devon House

John Sellars advised that a bid has been submitted to install car parking barrier gates outside Devon House, with one key to fit all. These will replace the triangular barriers which have been damaged on several occasions by people driving over the locks and mechanisms.

15.22.14 GHH Multi Storey Car Park

This scheme is currently on hold until the Board of Directors has made a decision on the overall Trust Capital Plan.

15.23 MATERNITY PROJECT PRESENTATION

John Sellars gave an update on the Maternity and Neonates Options Appraisal as follows:

- It has been acknowledged that there is a need to increase capacity in the Maternity and Neonates department at BHH.
- The first 18 months of the programme has been taken up in reviewing changes that can be made in how the service is delivered.
- The second part of the programme has looked at what the building should look like to deliver this service. Four options have been presented to the Executive Management Board with the preferred option being the most expensive one. However the project is currently on hold while the Trust Capital Plan is being reviewed in line with the development of the new Medical Strategy. The Estates Strategy will be developed around the Medical Strategy and it is envisaged that the Capital Plan review will be complete in September/ October 2015.
- It was noted that the Trust has ring fenced £40m for Estates development over the next 12 months and in the short term £6.5m has been prioritised for maintenance projects including backlog maintenance. Allocation of the remaining funding has been put on hold until Trust priorities have been agreed. The Surgical Reconfiguration project will form part of the review.
- David O'Leary and Arshad Begum both supported the proposal for a new Maternity Unit as they felt that the existing unit is worn and tired looking.
- Andy Edwards advised that over the last 6 months the Trust has been under extreme scrutiny from Monitor and the CCGs. The Executive Directors are now driving the clinical process forward to agree the clinical strategy prior to the Estates strategy being developed. The Maternity project will form an essential part of this review.

15.24 CHC INSPECTION REPORTS

Sue Hutchings queried whether it was possible to have a copy of the schedule of CHC inspections and then receive a copy of the CHC reports. John Sellars advised that there are no schedules as the inspections are carried out on an unannounced basis. Ann Harwood provided a copy of all the CHC inspection reports for the last 12 months. Catherine Williams collates all the action plans from these reports.

15.25 PLACE INSPECTION UPDATE

John Sellars will update the Committee on the report from the National PLACE inspections once the reports have been released.

15.26 TERMS OF REFERENCE

Members have approved the updated Terms of Reference. Once these have been approved by Kevin Smith they will be brought back to the Committee as the final, approved version.

15.27 ANY OTHER BUSINESS

- David O'Leary was concerned that the Chest Clinic is not wheelchair friendly and that although patients and staff are happy with the building he felt that the service needs to move to a more appropriate building such as the Richmond Centre. Andy Edwards agreed that the building is not fit for purpose and advised that the Executive Directors and Non-Executive Directors had come to the same conclusion following a walkabout and that this has been reported back to the Board of Directors. Elaine Coulthard advised that any relocation would need to be in the City Centre and felt that the current location would last for at least another year. John Sellars advised that discussions have taken place with BCC and with the company who have bought the remainder of the block. This company has been advised that the Trust would be happy to move the Chest Clinic from its current location if they can provide a better alternative location at the same cost.
- David Treadwell requested that the Committee's comments be recorded and queried how the Committee's recommendations/ suggestions are carried through to the Board of Directors. John Sellars advised that any issues raised that can be actioned by the Asset Management Team immediately are picked up and addressed as outlined in the action sheets from the meetings. The

more major issues raised are outlined in the minutes and Elaine Coulthard reports back on these to the Council of Governors.

- David O'Leary queried what the current situation is with regard to the refurbishment of ward 5 at BHH. John Sellars advised that funding has been submitted for the refurbishment, the issue is with being able to provide decant arrangements so that the ward can be vacated for the refurbishment works to be carried out. This would need to be for a minimum of 6 weeks to a maximum of 13 weeks.
- Elaine Coulthard advised that the first meeting of the Friends of Good Hope Hospital had been arranged for the following Wednesday (13th May), at 4.00 p.m., in the Maternity Coffee Shop, anyone who wished to join the meeting would be welcome to attend.

- Elaine Coulthard thanked everyone for attending the meeting. Sue Hutchings asked for the Committee's thanks to be passed on to Martin Dedicoat and Pat Davis for their hospitality.
- Veronica Treadwell thanked members for allowing her to join the walkabout and meeting.
- David Treadwell highlighted how successful it had been to have a Non-Executive Director attend the meeting.

15.28 DATE OF NEXT MEETING

2.00 p.m. on Thursday, 9 July 2015, in Room 6, the Education Centre, Solihull Hospital

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Chairman

DRAFT MINUTES

MEMBERSHIP AND COMMUNITY ENGAGEMENT COMMITTEE OF THE COUNCIL OF GOVERNORS

Friday 15th May 2015 at 10:00
Boardroom, Devon House, Heartlands Hospital

Attendees
Arshad Begum
Elaine Coulthard
Albert Fletcher
Sue Hutchings
Jean Thomas
David Treadwell

Apologies
Anne McGeever

In Attendance
Bev Bellerby – minutes
Peter Colledge
Jamie Emery
Kevin Smith
Sandra White

Welcome and Apologies
Albert Fletcher welcomed everyone to the meeting and apologies were received from those mentioned above.

Sandra White advised the meeting that sadly David O'Leary died on 14th May, in hospital, following a recent accident.

Lisa Thomson has now left the Trust and the committee wanted to record its appreciation. Kevin Smith was in attendance as the Trust lead for the committee.

Minutes of the Last Meeting and Actions Arising
The minutes were agreed as a true record.
Arshad Begum apologised for not being able to attend any of the meetings at Good Hope.

Actions
Good Hope League of Friends has been retitled as Friends of Good Hope and met on 14th May. It sits within the Trust charity.

Media training dates went out. Jean asked if there were any other dates for those that missed the original dates. Kevin had picked that up from CoG and will see if it is feasible to rearrange another date. **Action 1**

Citizen Assembly minutes were sent out.

The meeting to discuss membership strategy did not go ahead due to sickness. It was an item on the agenda for discussion during the meeting.

Governors' posters were sent out.

Election of Vice-Chair

Albert Fletcher asked for nominations. Jean Thomas was put forward and all seconded the nomination. Jean Thomas is now officially the Vice-Chair.

Citizens' Assembly Update (including memorandum of understanding)

Jamie Emery advised that the last meeting was on 6th May; the minutes are not yet available but the April minutes were available, which had been sent out.

HEFT has 5 priorities – patient experience, time to first consult review, shift handovers, key services and quality improvement. It was still early days but the initial stages were going well, being a strategic partner for the organisation. There is a commitment from the team to liaise with the Citizens Assembly.

Volunteers have been asked from the Citizens Assembly to get involved with several hospital projects. The Citizens Assembly must differentiate itself from any other body. Jamie added that there were lots of patient groups doing different things which needed looking at to ensure there wasn't lots of overlap.

Jamie added that there are two Governors seats ring-fenced. Jean Thomas is one but Barry Clewer left a space for another Governor.

Kevin added that a Deloitte governance review was undertaken and one of their suggested work streams was to look at patient experience. Sam Foster's directorate encompassed patient experience since Lisa Thomson left. Citizens Assembly does not have a direct reporting line, as such, but Membership Committee is the dedicated meeting to discuss Citizens Assembly. Kevin Wright is the Chair of the Citizens Assembly and both Jamie and Jean liaise with him, regularly.

Meeting attendance is very high at the Citizens Assembly meetings; meetings have been held at Solihull and Good Hope. The members were recruited externally by Sharon Woodcock who were new to the hospital environment.

The Memorandum of Understanding has been accepted by Membership Committee and Jean Thomas will feed that back to the Citizens Assembly.

Albert asked that on the agenda for the next meeting should be that a Governor is required to sit on the Citizens Assembly. It does not have to be someone from the Membership Committee but it would be easier. The meetings are late afternoon/early evening and move across the region. **Action 2**

Albert was keen to do a joint meeting between Membership Committee and Citizens Assembly, once a year. No date was discussed but Albert asked everyone to give it some thought.

Jean Thomas said that there had been some really good presentations at the Citizens Assembly meetings and asked if anyone else wanted to see/hear them. Jean offered to send the presentation titles to Kevin and Jamie. **Action 3**

Jean advised that the original 30 members had gone down to around 20 and the Chair was keen to gain more numbers. The term is 2 years for each member so there will be a point when the members change. Jamie had liaised with Sandra White for ways to recruit new people.

Albert thanked Jean Thomas for the work she is doing with the Citizens Assembly.

Membership Strategy Update

Sandra did not have anything to report as there needed to be a pre-meet with Albert Fletcher, Jamie Emery and Sandra White.
Any comments on what could be included should be sent to Sandra.

Kevin advised that it was good for this committee to comment on and said that he would also like to attend the meeting.
Jamie will ask Catherine Williams to set up the meeting. **Action 4**

How can we use Membership to greater effect?

Kevin Smith passed round a document created by Monitor 'Representing the interests of members and the public'.
Some actions from the review related to engagement. Kevin is leading on this work stream – utilising membership to greater effect.
Kevin sent out a questionnaire which was a significant part of the engagement exercise.
Membership is the appropriate committee to look at this element of the Monitor report.

The document does not set out what Governors should be doing to improve member relations but gives examples of what some other trusts have done.

There are already things that HEFT and Governors already do, including seminars and GP meetings. Some Governors are also members of CHC.

Elaine Coulthard advised there was a lot of apathy within the general public, even around emotive issues, such as Surgery Reconfiguration.

Kevin advised that there needs to be a clear message about what Governors want to do.

Arshad Begum advised that she took booklets about Surgery Reconfiguration and handed them out to family and friends to get the message across. She put her poster up in local libraries and leisure centres but had no response.

Sue Hutchings put her Governor poster up in her local health centre, as she is part of their PPG. Hall Green has thousands of patients but no one had contacted her at all, either.

Jean said that if everyone is serious about speaking to people, setting up a stand in the hospital reception area may work much better that putting up posters, which are easy to overlook.

Kevin agreed and said that only 2,000 email addresses are available out of 100,000 members so not many can be contacted that way. He also suggested giving Governors more space on

the newsletters. Sandra added that 2 pages used to be given to membership but that stopped a while ago.

On 30th May Solihull Hospital is hosting the Friends of Solihull Hospital Fete. Jean suggested setting up a stall with the posters on it to show a Governors presence.
Kevin added that there was also a Good Hope fete coming up soon, too.
Sandra will be in attendance at the fetes.

Sandra White lets everyone know the events and there are also stands at those. Acocks Green carnival and Small Heath carnival are both coming up in July.

Albert asked Kevin what the budget was for Governors. Kevin was not given a direct answer but if the committee needed to do anything, there could be some funding made available. Kevin is happy to ask Finance on behalf of the committee. There is a membership budget but most of it goes on the Heart and Soul magazine.

Albert suggested Kevin sending out a letter to all Governors and Board members, including NEDS, and staff, to ask them how they think the membership can be communicated to better. **Action 5**

Any Other Business

Governors Directories – Sandra advised that they were almost finished. Simon, Sandra and her team had worked hard to get them complete, to help the Governors. The lists are not exhaustive and things can be added to them, in the free space at the back.

When members sign up to the Trust they don't like their information going anywhere else so it is confidential. It does fall under the Data Protection Act. The information can only be held for the purpose it was collected. However, the members elect the Governors so there is a link between the two. Les Lawrence thinks that Governors should be a little like prospective politicians, going out to speak to their 'people'.
The magazine is posted to members so the Trust has access to these people to communicate with them.
Kevin to report back to the meeting about dos and don'ts. **Action 6**

David Treadwell asked about a GP Liaison Officer in the Trust. Jamie advised that various pieces of work are being done with the GPs.

David asked about having a membership badge with the Trust logo on, which could be sold for a pound each, to show support to the Trust and the NHS in general. Emma Hale thought that this could be done through the Fundraising office. Kevin will chase this up with Emma. **Action 7**

Leave on the agenda as standing items:

- Citizens Assembly
- Membership Strategy
- Utilising Membership to greater effect

Date and Time of the next meeting
Friday 10th July, 10:30 – Education Centre, Solihull

Action Log

Action No.	Date	Action	Action Owner	Date of Completion
1	15.05.15	Check if any more dates available for Governors' media training	Kevin Smith	Ongoing – feedback to next meeting
2	15.05.15	Add agenda item – 'Request for Governor to sit on Citizens Assembly'	Bev Bellerby	Add to agenda ready for next meeting
3	15.05.15	Send Citizens Assembly posters to Jamie Emery and Kevin Smith	Jean Thomas	Before next meeting
4	15.05.15	Meet re Membership Strategy. Ask Catherine Williams to organise the meeting	Jamie Emery, Albert Fletcher, Kevin Smith and Sandra White Jamie Emery	Before next meeting Immediately
5	15.05.15	Send a letter to all Governors and Board members, including NEDS, and staff, to ask them how they think the membership can be communicated to better	Kevin Smith	Before next meeting
6	15.05.15	Find out about Data Protection dos and don'ts	Kevin Smith	Report to next meeting
7	15.05.15	Speak to Emma Hale about an NHS fundraising badge that staff can buy to show support and raise money.	Kevin Smith	Report to next meeting

Approved

Minutes of a meeting of the

COUNCIL OF GOVERNORS

QUALITY AND RISK

Heart of England NHS Foundation Trust

Education Centre-Heartlands Hospital - Monday 23rd March 2015 at 10.30am

Present	Title	Initials
Liz Steventon	Chair & Public Governor	LS
Kath Bell	Public Governor	KB
Mark Pearson	Public Governor	MP
David Treadwell	Public Governor	DT
Jammi Rao	Non-Executive Director	JR
Nicola Burgess	Stakeholder Governor	NB

In attendance:	Title	
Louise Rudd	Head of Clinical Governance	LR
Ann Keogh	Director of Medical Safety	AK
Sam Foster	Chief Nurse	SF
Hazel Gunter	Director of Workforce	HG

1.Apologies for absence

Heidi Lane, Andrew Lydon, Barry Orris

2.Minutes of the previous meeting

The minutes were accepted as a true and accurate record.

KB requested minor amendments to the wording in Questions to JR Q19.

1st paragraph (change word effected to **affected**) 2nd paragraph change word over to **as**)

3.Actions from previous meetings

The committee members reviewed on-going actions and these have been updated.

4.Matters arising from minutes

LS informed the committee that Andrew Lydon has resigned from this committee.

5.Questions to Jammi Rao: Non-Exec Director

1. What does CRAB mean?

JR explained the Copeland Risk Adjusted Barometer **(CRAB)** is a measure of how services are very dependent on the quality of data.

In summary AK explained that there are 2 components of CRAB :

The first being a Surgical Component - which uses a risk adjustment tool called POSSUM using a lot of parameters for risk adjusting outcomes observed/expected also looks at complications.

The Second component is called Global Trigger Tool – this is a suite of 19 triggers within the medical records which may be associated with harm e.g. unexpected return to theatre; using Vitamin K to reverse Warfarin, sudden drop of Hb. AK also explained that the Trust proposes looking at speciality level rather than individual level, as this will lead to better coding and correct attribution, rather than looking at the underlying themes. The planning for the next 2 to 3 months is for a company to come in to talk to all the surgeons at a half-day audit and look at doing Grand Rounds.

JR felt that this family of aggregated outcome measures are based on routine data. The ultimate test of quality is case note review and good clinician involvement in day-to-day management.

MP added that he thought the unit of investigation should be with the Multiple Disciplinary Team (MDT). Pooling data introduces noise and the Trust needs to be able to identify the groups where it is going wrong.

SF said the Trust is looking to do some work with Ben Bridgewater, an individual consultant in performance.

JR commented that there were very good tools for specific speciality of operations but the biggest detriment of outcomes happens to be the pre-intervention condition of the patient but we do not have that information.

KB asked if the Trust could set up its own system? AK said that to a certain degree you can pick up the patient's pre-existing conditions i.e. stroke, respiratory etc but the difficulty is – just how sick is the patient and how can it be measured?

MP stated his view that the patient's pre-existing medical condition may not be the first point in their history

as the patient may be under a Consultant, MDT or GP when they re-present at A&E. In MP's view some patients may re-present because a Consultant has discharged them prematurely leading to complications.
MP is not pinning blame on individuals but is keen on blaming the system.
AK replied to say Consultants on the whole take full responsibility for the patient's care and that is why they are so sensitive about their data – they want good data.

2. Even when a patient's observations improve, should a suspected subarachnoid haemorrhage still be scanned, in case of some other cause? This appears to have led to a SUI, which seems to have been downgraded, i.e. not upheld – has this situation been reported as a SUI or not? Please (Also) see next question. In summary JR explained that this was a SUI**.** A patient came in with a migraine type headache**;** he improved after being given Sumatriptan (which is one of the treatments for migraine). The patient was discharged home and he re-attended 3 days later with a bleed.
AK said the lesson of the month was currently going through the Quality Assurance (QA) process and will be circulated. There is also some clear guidance coming out. JR added that there was a counterpart to this, saying that, had a Doctor decided not to do an MRI scan in the first instance, and the patient's condition deteriorated while still in the department, then that decision would have been reversed and an MRI given. Exactly the reverse happened in this case as the patient got better and asked to go home as he was not keen to have a scan. This shows the complexity of clinical decision-making.

3. **CR asks if SUI's should be counted if not upheld, and although the answer appears to be that the new "SIRIUS" Committee will look into and classify specific issues, does this mean that SUI's will not be counted/reported until SIRIUS has investigated them, meaning there will be a delay in reporting or not?** JR responded – All serious untoward incidents should all be counted and recorded. The Root Cause Analysis (RCA) and investigation information into the SUI will classify them. The investigation should determine if there were any contributory factors such as the quality of healthcare delivered. When there were no contributory factors**,** even when the right diagnosis and the right treatment was delivered to the right patient at the right time, it has to be acknowledged it carries a small risk. If there is an identifiable risk factor, whether a human factor or the system that has let the patient down, it should all be counted because they all have an important lesson for the Trust to ensure that any system factors are known.
LR commented that nationally it is not clear what constitutes what is or is not a SUI. The Trust perspective is that a SUI is something that has caused serious harm and above.
LS questioned whether SUI's are always counted or reported into a serious investigation?
LR confirmed that this happens after the SUI has been investigated.
AK advised that the Trust reports any severe harm and upwards onto a system called STEIS- *Strategic Executive Information System*, which is run by NHS England. The information is entered on their system and investigated but can then be downgraded if, after 72 hours, it is felt that the information does not fit the criteria and sometimes after the investigation the Trust can down grade the incident if required, but they are all reported initially as a serious incident.

4**. Issues around reportable or not reportable – different requirements such as, the Trust for learning and CCG's for assurance, but for patients' families and sensitivity (and I do understand sensitivity) - families would see a sensitively worded description of a SUI but if they insisted upon seeing the patient's notes and read descriptions of what the actual situation was, there could be an accusation of hiding the facts and lack of transparency. What is actually being said here?**

JR said we do not hide things especially with Duty of Candour. SF added that we share SUI reports with the family after the investigation, and confirmed that they see the same information, which is not edited.

5. **CQPG - Who or what has driven this new committee, as it sounds very similar to the new "SIRIUS" Committee?** LR said that the CQPG committee has not sat for a while as the question is, does it have a role in the new way going forward and that is not clear yet. CQPG was a sub group of the Q&R committee and the intention of it was to provide more operationally performance managed aspects of quality however, it struggled to do that and another mechanism has been put in place to do that more effectively.
SIRIUS – Serious Incident & Risks Under Scrutiny is a panel where the Deputy Chief Nurse & the Deputy Medical Director challenge the Quality Improvement Plans that are arising from SUI's and also where risks have not been resolved.

6. How can a "Continuing failure to publish" be green and what steps are being taken to resolve this? JR explained that this relates to the 18-week or 62**-**day target where, because of the transfer of

computer systems to PMS2, the new data system was unable to provide figures for the 18-week target. Technically to receive a green rating you have to either enter your data or admit you are unable to report. If a Trust sends in a blank return this will lead to an amber or red rating.

LS asked what is the Board doing to make sure that the Trust is at a stage where it is able to report?
JR explained that the Board has taken a very serious view of the PMS2 situation because the Trust 18-week performance cannot be monitored at the moment. It is an important Monitor standard, but more importantly patients are involved. The Trust now has a new Director of IT and a new IT committee that JR will sit on. The Trust is taking urgent steps and all patients on the waiting list have been identified & any open clocks are being managed. SF added that we have a detailed recovery plan that the Trust presents to Monitor on a monthly basis.

LS asked if we have a manual record of the patients we are breaching?
SF clarified that the Board is assured that the recovery plan is on track. The Board is aware there are technical issues with PMS 2 and they are waiting for the detailed recommendations to rectify the problems from the new interim IT Director. There is a very detailed recovery plan that has been approved and scrutinised by Monitor. A Napp Medical Director? has quality assured the process from a clinical risk perspective, looking into all the patients to which 'open clock' applied. (See attached response from Amanda Markall)

7. How do Appraisals identify Appraisers who need to be managed? What is this risk with doctors, and why are they not on our system? If bank doctors cannot be a RO, do we have enough of our own RO's to provide safe patient care?
JR explained RO is a Responsible Officer and we have one for each organisation. KB asked why are they saying Bank Doctors cannot be an RO? JR responded saying that Bank Doctors are not Trust employees and have their own RO and appraisal systems. Every Doctor has to have a link with a named RO.
AK added that the Trust Associate Medical Director is responsible for the appraisal & revalidation signing off of Trust doctors?
LR asked if the COG are asking the question of how the Trust is influencing, participating or being assured about the locum Doctors appraisal process? JR responded to say we will get a fuller answer.
MP added that some GP's were concerned that a few patients attend A&E and are then transferred to a ward where they are not under a consultant but a locum. AK explained that every patient is under a named Consultant.

8. This whole section seems to be a risk regarding Doctors Appraisals, Risks, people being confused about Appraisals, and Paragraph 4 is worrying with CR saying that "those that use the system will police themselves and those that did not use the system would not" – why are they not all using the system and why are they "policing" themselves?
JR explained that he thought Clive was acknowledging the inherent limitations of the appraisal system as a reassurance that we have good quality Doctors, which is universally recognised. Appraisals were brought in after Harold Shipman. The process is fundamentally confused as to the purpose it serves, as it is not to ensure that Consultants are continuously providing high quality care but is simply is a way of ensuring there is a mechanism in place by which poor practice can be identified.
There was a discussion on 360 appraisal process. LS asked who decides who does the 360?
JR said that it is decided by the appraisee. KB asked why are they not all using the system and JR explained that they all used the system although there are a certain number of staff that go through the process perfunctorily, going through the motions and ticking boxes, although some are doing it proactively and seeking out feedback. HEFT is ahead in terms of compliance with the system.
AK said Dr Adedeji OKUBADEJO, Associate Medical Director for Revalidation is due to bring a paper to the Board Quality & Risk Committee (Q&R) meeting in April.

HG explained that the current position of the Consultants within the Trust is 98% compliant compared with the rest of the staff within the Trust at 68%

9. HG's reply that Bank Staff are limited to the number of hours worked does not appear to answer the question of "Is there is a limit for Bank Staff"– and why do we not know how many hours staff were working per week? (See information in reply to question 10)

10. **HG's reply re staff signing declarations to work extra hours is a system that has been known since the Working Time Regulations came into force years ago and is a "get-out clause" to allow people to over-ride the system. Working outside the Trust should be declared, as it could be a patient safety risk for all staff. Working more than the 48 hours per week for nursing and medical**

staff can be a high patient safety risk, but 80 hours or more could be seen as the highest risk that can be attained for reducing patient safety.

JR we can monitor this but what is more reliable than regular monitoring of staff is when other staff on the ward become aware of this then bring it to our attention by complaining.
AK said she would argue that if a member of staff has been up all night with a poorly child and comes into work tired, it is very difficult. KB said it was more about their professional skill being affected by lack of sleep due to excessive hours either within the Trust or externally.

11. **Why is E-Rostering not monitored, and if some staff did work excessive hours then should this not only be handled by Ward Managers, but then referred onwards to either HR or the next highest nurse management tier for monitoring of safe patient care standards.**

Deferred to SF questions at next meeting

12. **Although Mandatory Training has been on the back burner at the moment due to the high attendance rate at the ED, if the CCG contract requires 85% compliancy, different types of Mandatory Training should not be an issue to attaining the 85%.(See information in reply to question 13)**

13. **There is a current HEFT booklet called Mandatory Matters 2014 – 2015 which sets out all of the Mandatory Training needs of all staff, is this now defunct, or are the committee members, in particular HR, just not aware of this booklet?**

HG explained that we have a system called Gold Command which means "all hands to the deck" over the winter period, where not only were staff not being released for training sessions, but because of the winter pressures Admin & Corporate staff were also helping out on the wards. The issue is that wards were not able to release staff to attend training, but also that training was stopped for six weeks. Mandatory Training is hitting the target at the moment but within that target a number of different subjects e.g Basic Life Support training, are lower than we would want them to be. The Resus team that deliver this training are putting a plan together which will be going to the next Q&R meeting.

14. **An 83 year old patient waiting for surgery being kept starved for 48 hours? I thought this stopped happening in hospitals years ago? Why is this a current feature of HEFT patient care?**
JR explained that most Dr's & nurses are aware of the importance of not starving patients for longer than the bare minimum so there must have been a failure of communication in several areas in this instance. This is totally unacceptable and JR hopes that the people involved have put steps in place to avoid situations of this nature happening again. NB asked why this wasn't declared a SUI?
AK explained that a SUI is a situation where severe harm or death has been caused to a patient, but for this scenario an investigation would be carried out to understand why this incident had occurred.
A SUI is the most severe form of investigation, but several other investigations are often performed when moderate harms have occurred to learn from them. This particular case required an understanding of what and why the situation had happened to aid understanding.
KB said that Lisa Thompson (formerly Director of Patient Experience) had discussed this as an example of a patient experience complaint.
MP asked what ward this was on? LS said that AMU, Ward 20 and then Ward 18 were all involved at various times.
MP asked if this data can be recorded as he will make sure that when he helps with the PLACE Inspections he will check to make sure that no-one else is being starved. He said that he is in favour of this type of information being accessible to the Governors.

15. GR asks what can be done as it is very frustrating. The patient was mistakenly cancelled, but did the ward take any steps to inform theatres of the hours that this patient had been starved or did they not know that the patient had been starved for 48 hours? There seems to have been several areas of queries, starting in theatres and then following on by the ward? - So what is being done about this?
KB said that Richard Brown (Deputy Director of Patient Experience) had attended a Governors Patient Experience Committee meeting to explain how information about Patient Experience is being collated and used but it seemed to be more about numbers.
MP said it was a safety issue as well as a patient experience issue.

16. **If issues were around a surgeon's operating procedure then why is he being allowed to operate**

at all? If there are legally agreed procedures and these are being ignored then what is being done to correct this?
JR confirmed that this Consultant has been formally excluded.

17. JR felt that the Silverman Mortality Review was a hard-hitting report – when will the report be forwarded to this governors committee, as was agreed at the Governors Quality and Safety meeting of 26th January 2015? Liz Steventon sent out the action plan in February but we still have not received a copy of the report, how can we seek assurance if we do not know what was in the original report?
JR confirmed that we now have the report and he circulated it to the committee.

18. What is the concern regarding Stroke and why are there no responses from the Stroke Team and also the T & O to the committee? AK is to send out the report detailing this and JR will follow it up to ensure they are reporting. LS said Trauma & Orthopaedics (T&O) and Stroke did not complete the data.
KB asked if that was being followed up? LR said she will find out.

19. Re the SUI dated as February 2015, reference number 2014/36858

a) **Why was this classed as a Deteriorating Patient?**
b) **Why was the SUI classed as being a SUI from the ED/AMU and not the Endoscopy Department?**
c) **Why was the SUI classed as a Failed Endoscopy Procedure?**
d) **Was there no evidence of perforation of the oesophagus, such as visual noting, haemorrhage, dyspnoea or other symptoms of mechanical failure noted during the procedure or even in the recovery period immediately following the procedure, given the fact that they presented in ED only 2 hours post procedure?**
e) **How long are patients kept in the Endoscopy Department before being judges fit to be discharged?**
f) **How much experience had the practitioner had before this patient, i.e. upon how many patients had they performed this procedure previously?**
g) **Was the oesophagus perforated by the endoscopy practitioner?**
h) **How many experienced staff, either doctors or endoscopy trained nurses were in the department when this patient was undergoing the procedure?**

JR said that as there was only the two hour gap between going home and coming back again, the patient should have been kept in longer. His expectation of the investigation into that SUI was along the lines that it should be carried out under the BIG guidelines. There is a recognised risk when endoscopies are being performed, which an experienced endoscopist recognises as a complication.
LS asked if we have changed the process now?
LR explained that actions were immediately put into place, and there were concerns surrounding management, the more complicated cases stay in recovery longer and the diagnostic cases are more prone to complications. She also confirmed that this is being brought back to SIRIUS.

20. **As there is a new Chief Executive, Board, Management Structure and Strategy the questions I had intended asking now need to be put on hold to give the new plans a chance to evolve and become embedded in the implementation of the new systems.**
This does not however, reduce the need to put in place some of the measures recommended by the Deloitte Report, the Kennedy Review and the Silverman Mortality Review, each of which point to lack of accountability, best practice, performance management, poor implementation of action plans, staff engagement, cultural issues and a myriad of other issues.
Hopefully the new Trust-wide Engagement Events and Quality Champions will have a positive effect for the future of the Trust.

HG explained that we have had a successful Monitor meeting, where Monitor agreed to the Trust's proposal of one master plan which is currently being worked up to capture everything and will be presented to the Trust forums in the next couple of weeks. The Trust has a new Project Management Office which is central to chasing people. The Deloitte action plan is incorporated into the master plan.
The group discussed that it will help make things clearer and also whether it should be presented to the COG rather than the COG Q&S Committee. HG commented that Andrew Foster (AF), Interim Chief Executive, had organised many events and was listening to staff. The Trust Board will now have the 3 top

items as the agenda structure at all the meetings.
Many meetings will be held behind the scenes to make sure that it is working well.

21. **Can you tell us does anyone know whether Silverman was able to identify whether mortality was affected when flex wards were being used.**
Flex wards which are used during times over patient over flow are wards largely for sub-acute patients but requiring acute ward staffing, and therefore draw doctors and nurses off the acute wards with acute patients.
They seem to me to be a short term fix that is both uneconomic and probably affect quality - whether Silverman was able to identify it or not.

JR said this wasn't the brief as such and that it identified pressure, flow, and demand as the main drivers of mortality. LS said essentially it wasn't part of his brief so we would not have expected the question to be answered.

22. The committee is still concerned as to the manner in which the governors are given access to reports such as the Silverman report and the Kennedy 6 Month review and asked if a system can be set up to ensure that we are given the reports when they are available and secondly how do we ensure that the governors are receiving all the relevant information?
HG explained that Andrew Foster has come in and defined his 3 priorities – Clarity, Quality and staff engagement – on the clarity issue he has really defined what each of the Executives Directors portfolio will entail. The COG will see improvements and be assured.

23. **CR's answer to CR4 only addresses recall and not when we inform patients that the consultant they are seeing is under investigation. Can you answer the same question? "In the light of Kennedy when should patients be informed that a consultant they are under is under investigation?"**
We understand it is a difficult issue and we wondered if it could be resolved by having a register of Professional Misconduct Investigations, which patients and governors can consult if they wish. There will be quite a few consultants on it, mostly for matters which are not serious clinical concerns, but patients cannot give informed consent if they are not informed of these and we have a "Duty of Candour" to our patients.

Mark has informed us that he was once under investigation, following bizarre complaints from patients which were never substantiated but he would have wanted an open process, so he has an understanding of the problem of openness being misleading and defamatory, as well as informative.
If the Trust had told patients earlier about Patterson most would have opted to go to someone else and a lot of suffering would have been avoided. A system of a register and routine informing is costly but both essential and ethical when patient's lives and health depend on making informed decisions. He would like the new CEO to discuss this with the new Board. The Governors understand that it is an issue for the Trust Board to decide, but we need to know this issue is being discussed as we think it represents a major change in culture where we put patients first by allowing them to make their own decisions about who they trust.
LS stated that the committee had received an explanation from CR on this at the last meeting and the group had a further discussion.

24. How do other NHS Foundation trusts inform patients about doctors they are seeing who are still practicing clinically, whilst under investigation for professional misconduct? A register is only one solution and may not be the best.
HG explained that she produces a report for the Quality & Risk committee called Workforce Compliance Report and said that she will now include Doctors under Investigation and categorize the reasons, e.g the impact on patient safety. AK added that the Trust has internal systems which build patient risk and would not allow that person to continue whilst under investigation. MP said there is also a duty regarding protection of staff against malicious and malevolent complaints, but patients can't make an informed opinion and consent if they don't know the information context when a consultant is under investigation. The group discussed that a public register of such things and that hiding information is not acting ethically and The Trust could possibly be sued by patients. By creating a register and putting doctors under suspicion on such a public register, we would be 'externalising the problem'. JR acknowledged that there is a powerful argument for creating a register, but what would be the threshold and how would it be done? A specific case discussed was the example of the cultural sea-change and the speed & approach in dealing with professional misconduct since the Kennedy Report. There was further discussion that now is the time to do this and all changes that are needed.

25. **How many SUI's actually occur in the ED and CDU/AMU? Does the board consider it is good use of capital to fix the front end when for years we have been being told that the problem has been lack of beds to move patients out of the ED? Did this get answered? SF to respond at May Meeting**

6. Dementia Feedback following the Membership Information Evening

Andrew Lydon has resigned from this committee therefore this subject will be discussed at the Dementia Strategy Group (DSG). (See Attached Minutes of DSG)

7. Board Q&R minutes (Jan & Feb)
Due to time constraints taken as read.

8. Safety Sit Rep
Due to time constraints taken as read.

9. Quality Accounts by SF
SF informed the committee that Rachel Blackburn is putting together the draft areas for discussion by Governors for the Quality Account Report 15/16. The areas governors would want to choose are up for debate.
The Trust has historically chosen 7 separate quality indicators is now thought to be a bit too ambitious and this year 4 indicators have been chosen to put forward.
These are are:

- Reduction of Grade 2 hospital acquired pressure ulcers.
- Reduction of incidents of patients that have multiple falls (these are two areas we believe we can make further improvements)
- There are two more up for debate. Last year these were Stroke, Dementia & Fracture Neck of Femur.

The trust are keen that Improving Emergency Care is one of the proposals and will be doing a piece of work to improve the response rates and improve the overall scores of FFT (Friends & Family Test) in the ED dept. We are also keen to have Improvement around Stroke, Matthew Cooke is going to provide a specific and care orientated proposal.

KB said this now goes to the CoG Patient Experience Committee. At the last meeting Elaine Tandy attended and asked members which priority, out of the list of 7, they would wanted to be followed up. They voted for Dementia. SF responded that it is for the full CoG to be consulted and have that wider discussion before a decision is reached. As there is a dementia strategy group we need to be more specific within the five key areas that I flagged. We need to take the opportunity to include something about the environment that is measureable or provides training. LS asked if the governors could do something that is meaningful and not just a paper exercise? SF said it will be brought to the wider COG and whether we choose 4 or 5 is irrelevant. Our quality account needs to be aligned with CQUIN. As a Trust we want to focus on 4 or 5 key improvement areas and line the resources up behind them so it can have a real impact. SF to send the paper to explain the proposals then we will be looking for a recommendation from this committee to influence the wider CoG.

LS asked about Dementia, where the Trust is with the Dementia Strategy SF explained there was a discussion outside Board with a couple of the NED's around the Strategy and the five key work streams is something CoG could all support. The strategy around next steps has been sent out and is aimed at giving executive oversight and ensure we get that Board to Ward feedback. SF is looking to strengthen this in the coming months. LS asked SF if Nial Ferguson could to come to the full CoG and that LS would write to Kevin Smith.

There was a general discussion regarding the minutes and questions. LS suggested questions to JR/ Board members should be in email form to reduce time spent on these during the meetings. The committee agreed they would be happy with highlighting one or two headline questions for each meeting and receiving emailed answers to any broader questions they might individually have.

10. **HG update on HR's response to Ian Kennedy report & initial follow up**

HG said out of the 10 Kennedy Work streams 3 fell under HG and these are the Raising Concerns Policy, Values Based Recruitment and the Disciplinary Policy.

HG reviewed the Raising Concerns Policy using the Patient Focus Groups and explained that it was important that managers recognised when a concern was being raised and HR has trained all the managers on the policy. Human Resources (HR) have also been out to staff to encourage them to raise anything they think they want to question.

There are currently 10 consultants being investigated and this means that the policy is working. The Trust has been working with the breast patients for input into the Disciplinary Policy and the first question is "Was there any harm to the patient?" Things should not be put on hold whilst disciplinary procedures are going on. Although employment law cannot be changed, the first part is all about the patient. Recruitment for consultants is now behaviour-based. HR went out to patient, nurse, AHP's & other staff groups then presented the findings to the Clinical Director Forum to provide them with the feedback. We then used this information to build up a personality profile of the type of consultant we want to appoint.

HR have trained two cohorts of people who are now experts at pulling out the questions and answers at a two stage interview encompassing skills & personality traits which is fed back to the interview panel. The plan is to train more cohorts and roll it out to other staff groups, while recognising that this will require a huge resource.

An Organisational Development Team, which is about culture, values and behaviours in the organisation, is now back with HR and AF really believes that engagement is key to our success. We have had a number of Engagement events which all of the board members have attended. KB asked if ground level staff have attended and HG responded to say it was an open invitation to all and every comment has been captured and that is a piece of work we are doing now. As information comes from Staff Engagement Events it would be interesting to see the breakdown of bands/grades who attended. HG to provide feedback to this Question when info is available.

The Trust is changing the way we communicate, changing the induction and engagement plan, and is about doing diagnostics in departments so during every quarter 25% of the organisation will receive a survey.

At the engagement event staff were asked via a questionnaire what values they thought were important. These were narrowed down to 11 words but research shows that most people cannot remember more than three. Three words will be shortlisted and these values will be measured in the appraisal system next year.

LS asked when the Interim Chief Executive leaves the Trust after 6 months will the changes he has implemented stay in place? JR answered to say AF has already changed the basic infrastructure and HG added that this was not the first time this question has been asked. HG reported that AF responded to this question by saying he didn't know what was going to happen in six months' time but the board is behind him and the agenda is not going to change.

LS commented that there had been a lot of change in management recently and could she clarify who the voting board members are?
HG explained that all the board directors are voting directors now and they are: Andrew Foster, Darren Cattell, Jonathan Brotherton, Sam Foster, Andrew Catto, Hazel Gunter

AOB

DT asked if there was a set level of accountability in the NHS? JR responded there is accountability, but this depends upon what are you measured. We are accountable for financial expenditure balance and meeting targets. Monitor regulates the Trust, as they are looking into stock level measures. Individual patient safety has always been difficult to measure & monitor. There is a need to identify clear markers for post-operative infections, MRSA rates, CDIFF rates and re-admission rates etc as these are all crudely measured. Data needs to be used sensibly & intelligently and interpreted in the light of other knowledge.

DT asked who is a consultant accountable to? JR responded to say ultimately he is accountable to the patient in terms of quality of care because of Duty of Candour. DT stated in his opinion that the patient does not have any authority to question the consultant. AK replied we are accountable upwards, clinical directorate to medical directorate and there is revalidation.

DT asked if a visitor could read the patients notes at the bottom of the bed. JR responded no.
MP asked whose property the notes are? LR said they are the property of HEFT.

MP asked what does treatment starting mean with regards to 18 weeks, is it 18 weeks from the Trust receiving the referral letter to treatment? AK responded that it is the start of positive treatment, which could

be surgery or drugs, this must happen within 18 weeks of receiving the referral letter

MP asked how do we record the 18 weeks? SF responded saying that the Trust has an IT system that monitors the patient pathway and when a patient's referral letter is received the clock starts.

MP stated that he believes the IT system does not work. This maybe because the Trust does not agree about what is meant by the start of treatment. SF explained that migrating from the old system to the new system has raised data quality issues. SF advised that there will be assurance in the delivery unit report of where the Trust is with the 18 week target and that SF will bring the report to the next COG meeting.

MP asked whether all patients have to start treatment within 18 weeks?
LR replied yes, but JR explained that all targets and policies can have unintended consequences, as he felt that patients may be rushed into surgery far too soon due to the 18 week target, as many conditions get better on their own. Patients could be informed that they have other options, e.g. if a patient has a painful shoulder they may choose to have physiotherapy and wait to see if the condition improves rather than undergo key hole surgery, (which has a one in a hundred complication rate), therefore many people might decide to wait and try it out, but because of the 18 week target, Consultants are not encouraged to give them this option. JR said that because of the target people are on a kind of treadmill, and admitted that he did not know what the answer was, but he believed that having an operation foisted on them could potentially harm some patients.

DT asked if we have difficulty communicating with primary care providers, the Trust IT system is Windows 7 and some primary care providers are working on other systems so GP practices can't access i-care. AK responded that the responsibility is now on the GP surgeries to upgrade to Windows 7, the minimum recommended standard by NHS England.

DT asked about a Trust structure of who is responsible. AK responded by saying currently there is a huge mapping process of all the committee structures and how they all work all the way up to board. DT asked how does COG influence HEFT policies. LS said our minutes are circulated to the COG, we have an Executive Board Director, SF and Non-Executive Director, JR attending our meetings. This means that anything discussed here should be going to board through SF or JR.

11. Action log

Date of minutes	ACTIONS FROM PREVIOUS MEETINGS	Target date	Owner
Dec 14	Update on current & possible risks and sustainability of associated services at the Chest Clinic		**CR**
Dec 14	Investigate Risks over maintaining the Chest Clinic – awaiting an update from the Estates team who are completing a risk assessment. LR updated the committee on the risk assessment carried out by the Estates team regarding the Chest Clinic building which is currently scored 12. LR will circulate the assessment to the committee members. LR to ask the question Is it fit for the service.	May 15	**LR**
Dec 14	Questions to JR: rolling review members of staff under investigation	May 15	**LS/JR**
Dec 14	This committee to receive feedback that was given to Trust following the CQC visit as soon as possible- update Jan – delay with report as the person completing the surgical part is unwell SF confirmed the Trust still have not received a report following a responsive CQC visit and went on to explain that she and Andrew meet with CQC monthly – and as CQC have a number of staff off sick they could not complete their report but went on to say it is in the QA process now.LS to write to Tim.	May 15	**JR/LL** **LS**
Dec 14	Report back on SUI referring to transfer of neo-natal patient from GHH to BHH-To bring sui at a glance to May meeting	May 15	**AK**
Dec 14	Confirm area where we are bottom of matrix for Patient Experience (page 3 Q&RC minutes) LR emailed committee	May 15	**LR**
Jan 15	LS ask Trust Chairman to invite presentation of Dementia Strategy at future COG and inform KS of proposed Governor representation Dementia Strategy Steering Group dates are: 2nd Tuesday of each month - meetings are 1st Tuesday of every month. David Seaman emailing LS & AL of DSSG details	June'15 CoG	**LS**
Jan 15	SF to inform KB of further dates re: night ward visits	May'15	**SF**
Mar 15	SF to bring Delivery unit report (that was presented to EMB) to the next Meeting	May 15	**SF**
Mar 15	SF to invite Nial Ferguson to full COG	June'15 COG	**SF/LS**
Mar 15	Pt experience group & linking in with incidents information and safety matters – to schedule a combined meeting to have a debate on how to present reports to COG (integrated reporting)	July 15	**SF**
Mar 15	Why is E-Rostering not monitored, and if some staff did work excessive hours then should this not only be handled by Ward Managers, but then referred onwards to either HR or the next highest nurse management tier for monitoring of safe patient care standards?	May'15	**SF**
Mar 15	KB asked if ground level staff have attended Staff Engagement Events – HG to provide further information when info available	May'15	**HG**
Mar 15	From Board Q&R Minutes Nov '14 Report to be circulated to this committee regarding response to Q18.(No response from T&O & Stroke. Has this been followed up as per minutes)	May '15	**AK/LR**
Mar 15	How many SUI's actually occur in the ED and CDU/AMU? Does the board consider it is good use of capital to fix the front end when for years we have been being told that the problem has been lack of beds to move patients out of the ED?	May '15	**SF**

HEFT STRATEGIC DIRECTION JUNE 2015

OUR 2020 Vision

CLINICAL.STRATEGY@HEARTOFENGLAND.NHS.UK

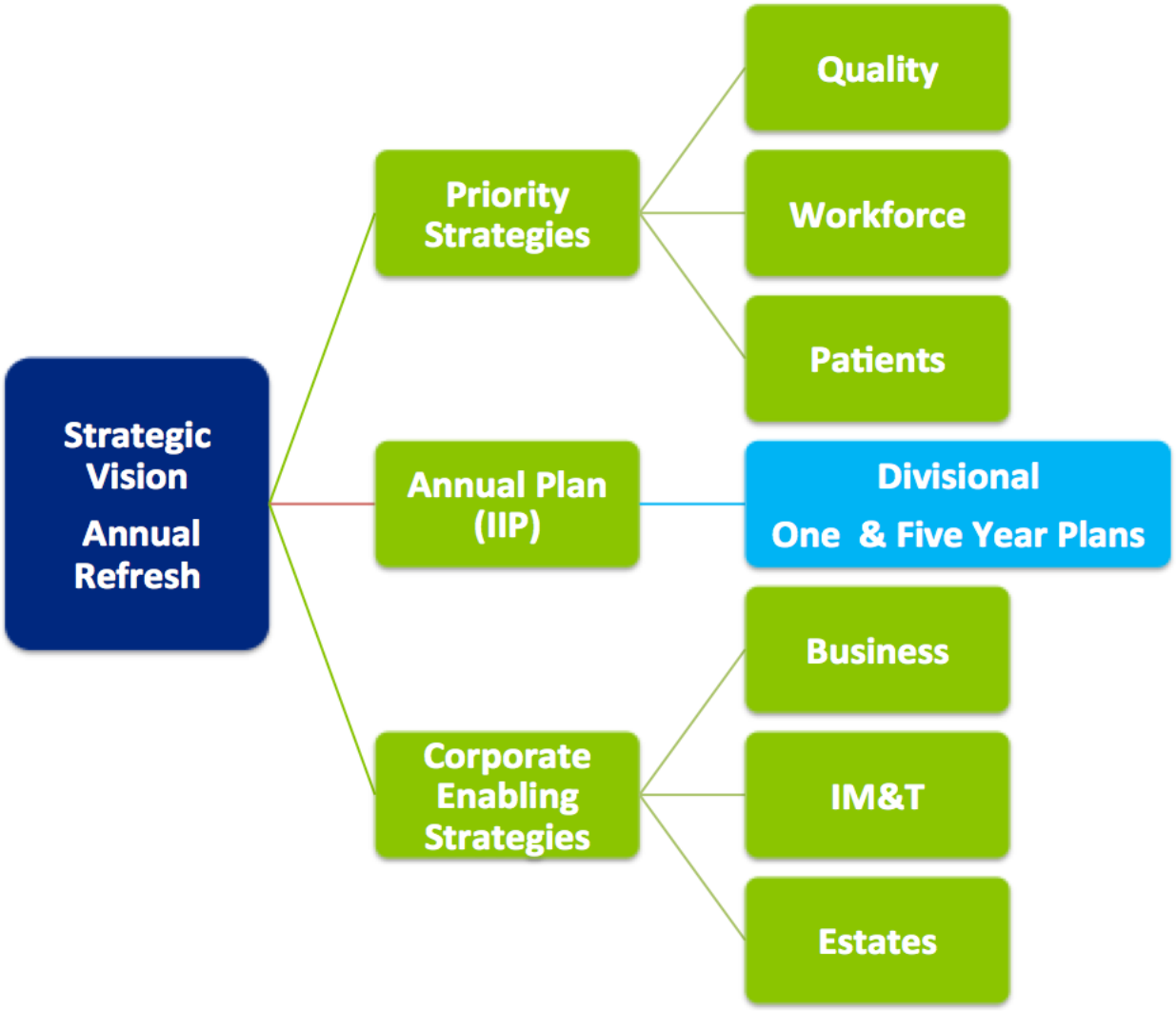
UPDATE TO STAFF

In April 2015 two engagement events were held to gather views on the draft strategy with over 250 staff members attending.

Following the engagement events and other feedback opportunities, please find the updated strategy over the following slides.

In particular more focus has been included on staff and patients; the strategic principles have been redesigned, and more positive language has been used wherever possible.

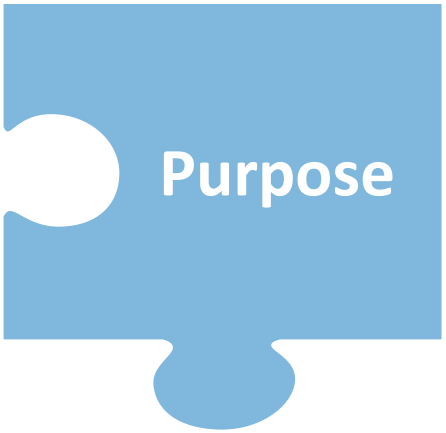
WHERE DOES THE STRATEGY FIT IN?



OUR 2020 VISION AND PURPOSE

" In the next five years, we will be a successful, patient centred organisation that is internationally recognised for **placing quality, safety and innovative thinking at the centre of service provision**.

We will build on our strengths in specialised services, research and teaching; offer faster access to high quality care, expand our 'out of hospital' offering and develop our workforce and improve patient experience."



To provide high quality services that inspire ***confidence***, ***trust*** and ***pride*** within the communities we serve and within our workforce.

QUALITY, WORKFORCE AND PATIENTS

- Quality is paramount
- People are our greatest asset
- Patients are at the centre of all our decisions

OUR STRATEGIC PRINCIPLES

WHAT HEFT WILL LOOK LIKE IN 2020

1. **Centralise where necessary, localise when possible**
2. **Always encourage collaboration and integration where feasible**
3. **We will clarify and communicate what services are available on all sites**
4. **Agile and responsive to challenges and the changing environment**

THE 10 DIFFERENCES IN 2020

In five years' time, Heart of England NHS Foundation Trust will:

Focus on quality by having patient safety, outcomes and experience at the centre of all our decision making

Improve efficiency and so be able to deal with greater demands, by improving our resilience, reducing variation and duplication, using IT to its full capability and innovating.

Improve scheduled care by improving planning, flow of patients through theatres and by undertaking more pre and post-operative care in the community.

Improve the urgent care system by introducing consistent earlier senior assessment, increased seven day services and better systems of operations management.

Have a well-trained and engaged workforce ensuring the delivery of high quality care, with improved workforce resilience.

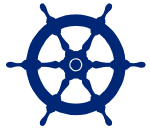
THE 10 DIFFERENCES IN 2020

In five years' time, Heart of England NHS Foundation Trust will:

Make every contact count in improving public health and supporting healthy lifestyles and wellbeing.

Focus specialist work (service and research) in those areas that most benefit our community and where we can demonstrate excellence.

The organisation will work in less silos.



Improving the working environment and operational aspects of staff's jobs are core to the way we will work.

Have an easily accessible reliable IT system sharing information across organisational boundaries to facilitate seamless integrated care.

NEXT STEPS

Jun – Sep 2015	Significant internal and external engagement programme; data analysis
Jun – Sep 2015	Enabling strategy development
Sep 2015	Final 2020 Vision document produced
Oct 2015	Embedding the strategy

What are your thoughts?

clinical.strategy@heartofengland.nhs.uk