Heart of England NHS
NHS Foundation Trust

Formal Meeting of the
Council of Governors Meeting
4.00 – 6.00pm on 22 January 2018
The Education Centre, Birmingham Heartlands Hospital

A G E N D A

		Presenter	
1.	**Apologies**	Jacqui Smith	
2.	**Declarations of Interest** (for any items on agenda for discussion)	Jacqui Smith	*(Oral)*
3.	**Minutes of previous meetings** –		
	3.1 23 October 2017	Jacqui Smith	*(Enclosure)*
	3.2 27 November 2017		*(Enclosure)*
4.	**Matters Arising**	Jacqui Smith	*(Oral)*
5.	**Chair's Update – Emerging Issues**	Jacqui Smith	*(Oral)*
6.	**Performance Report**	Kevin Bolger	*(Enclosure)*
7.	**Clinical Quality Report Q3**	David Rosser	*(Enclosure)*
8.	**Care Quality Report Q3** inc Infection Control Update	Julie Tunney	*(Enclosure)*
9.	**Finance Report Q3**	Julian Miller	*(Enclosure)*
10.	**Quality Account Update Q3**	David Rosser	*(Enclosure)*
11.	**Compliance and Assurance Report Q3**	David Burbridge	*(Enclosure)*
12.	**Report from CoG Sub-Groups**		
	12.1 Membership & Community Engagement Group	Albert Fletcher	
	12.1.1 4 October 2017 (Approved Minutes)		*(Enclosure)*
	12.1.2 12 January 2018		*(Oral)*
	12.2 Hospital Environment Group	Sue Hutchings	
	12.2.1 28 September 2017 (Approved Minutes)		*(Enclosure)*
	12.2.2 23 November 2017		*(Oral)*
	12.2.3 25 January 2018		*(Oral)*
	12.3 Patient Experience Group	Tony Cannon	
	12.3.1 15 September 2017(Approved Minutes)		*(Enclosure)*
	12.3.2 17 November 2017 (Approved Minutes)		*(Enclosure)*
	12.3.3 12 January 2018		*(Oral)*
13.	**Any Other Business Previously Advised to the Chair**		
	13.1 Chest Clinic – Concerns raised following Governor Drop-in		*(Oral)*
	13.2 Health Tourism – cost to HEFT		

14. Date of Next Meeting:
(Focus Meeting) Monday 19 February 2018, Room 2, Education Centre, Birmingham Heartlands Hospital

Minutes of a meeting of the
Council of Governors of Heart of England NHS Foundation Trust held
in Room 2, Education Centre, Birmingham Heartlands Hospital
on 23 October 2017 at 4.00 pm.

PRESENT:	Rt Hon. J Smith (Chair)	
	Mr S Baldwin	Mrs V Morgan
	Mr T Cannon	Mr G Moynihan
	Mr K Fielding	Mr B Orriss
	Mr A Fletcher	Mrs J Thomas
	Mr D Hoey	Mr D Treadwell
	Mrs S Hutchings	Mr T Webster
	Mr P Johnson	Mr L Williams
	Mrs A McGeever	
IN ATTENDANCE:	Mrs F Alexander	Dr M Kinski
	Mr D Burbridge	Ms K Kneller
	Mr K Bolger	Miss M Lalani
	Mr A Edwards	Mr J Miller
	Prof J Glasby	Dame J Moore
	Mrs J Hendley	Dr D Rosser
	Mrs A Hudson	Mrs T Watkins (Minutes)

17.089 APOLOGIES & WELCOME

The Chair welcomed everyone to the meeting.

Apologies for Governors had been received from Cllr M Mahmood, Mrs S Nicholl, Mrs L Passey, Cllr M Robinson and Mr M Trotter.

Apologies for Directors had been received from Mrs H Wyton.

17.090 DECLARATIONS OF INTEREST

There were no declarations noted for any items on the agenda.

17.091 MINUTES OF PREVIOUS MEETING

24 July 2017

The minutes of the meeting held on 24 July 2017 were considered and approved as a true record.

There was a request made for the minutes of the AGM to be circulated, particularly in relation to the private meeting of the Governors held immediately following the AGM. It was stated that an update had been made to the CoG Standing Orders and not the Constitution, to allow for proxy voting by Governors. Governors would be made aware of the options around voting should they be unable to attend a meeting to vote in person.

17.092 MATTERS ARISING

None

17.093 CHAIRS UPDATE

The Chair reported that the Board's proposed consideration of the Case for Change had been postponed as it had not been in a position to make a decision as it was waiting for a response to a letter sent by the UHB Board to NHSI seeking assurances regarding money, future liabilities and recompense for the cost of the transaction. Whilst progress had been made, not all assurances had been received.

In response to a question around the uncertainty felt by staff due to the delays in the merger process, the Chair reported that regular staff engagement sessions and updates had been undertaken and these would continue to take place on a regular basis.

It was confirmed that Governors would be given clear guidance on the proxy voting system. As previously reported, more than 50% of Governors would need to vote yes for the transaction to go ahead.

The 2nd Annual Building Healthier Lives Awards would be taking place in November.

Work had been carried out through the Birmingham Alliance to support the emergency department to work with young people who had been victims of violence. HEFT and UHB had entered into a partnership with Red Thread and had received a Health Foundation Grant to expand the service. The service would be introduced in 2018 and would include staff employed by Red Thread.

Resolved: to receive the report.

17.094 PERFORMANCE REPORT

The Governors considered the Performance Report presented by the interim Deputy CEO - Improvement that summarised the Trust's performance against targets and indicators in the Single Oversight Framework, contractual targets and internal targets. The A&E 4 hour standard had not been met and had remained a risk. Actions and initiatives had been implemented to support ED performance that included the conversion of two medical wards to medical short stay wards on the GHH and BHH sites with the aim to free up capacity in ED.

All cancer targets had been achieved.

The Trust's performance against dementia screening continued to decrease, individuals would now be held to account where screening was not undertaken.

Voluntary turnover rates had reduced. The new online exit monitoring tool had been implemented and this would continue to be monitored.

The Chair opened the floor to questions.

In response to a question raised regarding concerns that staff had been expected to work excessive shifts to enable MRIs to be carried out at weekends and evenings; it was reported that staff had volunteered to cover the shifts for the benefit of the patients.

In response to a question, it was reported it was that the number of vacancies had

risen due to an increase in the number of roles created.

Staff retention would be the topic for discussion at the next focus meeting.

Resolved: to accept the report

17.095 CLINICAL QUALITY MONITORING REPORT

The Governors considered the report presented by the interim Medical Director. The report provided assurance on clinical quality. Six Doctors were currently subject to investigation. The Trust's mortality rate had been within acceptable limits and there had been no overall concerns.

The Chair opened the floor to questions.

In response to a question, it was confirmed that the doctors referred to in the report were those reported at the July meeting the investigation had taken time due to the complexity of the cases.

The Chair reported that the report on the Paterson case would only be available after all patients had been informed. The report summarised the actions taken by the organisation to ensure that patients' physical and emotional care had been put back on track and the means by which patients had been communicated with. In order to avoid any similar cases like this in the future, all cases would be reviewed in property chaired MDT meetings including improved auditing processes.

Following the changes implemented, an increase in incidents had been reported and it was considered that staff now had more confidence that when an issue was raised, as part of a whistleblowing concern, it would be acted upon.

Resolved: to accept the report.

17.096 CARE QUALITY REPORT inc INFECTION CONTROL UPDATE

The Council of Governors considered the report presented by the acting Chief Nurse. There had been 1 case of MRSA bacteraemia and 21 cases of CDiff, three of which had been unavoidable due to inappropriate antibiotic prescribing. Work was being carried out with the divisions to address this. There had been 2 infection control outbreaks that had resulted from poor hand hygiene. Following an outbreak of flu on ward 19, a deep clean of the ward had been undertaken. The winter plan included a strategy should there be a further outbreak.

The flu campaign was underway with 40% of staff already having been vaccinated. The Trust's target was that 75% to be vaccinated by December.

A discussion took place regarding dementia screening and it was reported that the root cause was due to inconsistency and screening needed to be undertaken as part of the routine questions asked by doctors. Where dementia screening had not taken place individuals would now be held to account.

Parkinson's medication compliance had improved to 82.03% against the target of 90%. A change of practice had taken place, with the nurse dealing with the patient now held the bleep rather than the nurse in charge.

The performance rate for dealing with complaints had not improved as expected. There had been a peer review undertaken in partnership with UHB and HEFT processes had been changed to the reflect those used at UHB. It was reported that

the recording of complaints data, including outcomes had not previously been well documented and work was being undertaken to improve this.

There had been no areas of concern regarding nurse staffing and assurance had been given by Head Nurses that staffing had maintained safe levels in line with national guidelines. Twice daily telephone calls now took place to discuss staffing levels. A recruitment event would take place in December where interviews with candidate would be offered and undertaken on the day.

The Chair opened the floor to questions.

In response to a question as to whether community patients with pressure ulcers were scrutinised the same as inpatients it was reported that the same systems and processes were used in the community as used on the ward.

In response to a discussion regarding infections that were brought into hospital from outside and in particularly the use and availability of alcohol based hand gels, it was reported that hand gels were available inside the ward but had been removed from public areas due to incidents where it had been stolen to be ingested.

Resolved: to accept the report.

17.097 FINANCE REPORT

The Council of Governors considered the report presented by the interim Finance Director, who provided an update on the Trust's financial position for the period ended 30 September 2017 (Month 6). The Trust had agreed a planned deficit of (£7.5m) for 2017/18 in line with the control total set by NHSI. The plan included (£21.3m) of STF income subject to delivering the pre-STF position. 30% of the STF had also contingent on meeting the ED trajectory. The plan prior to STF had been a deficit of (£28.8m). For Month 6 the Trust had reported an actual deficit of (£5.8m) which was (£3.4m) above the pre-STF plan of (£2.4m). On a year to date basis the deficit would now be (£28.6m) against a pre-STF plan of (£14.5m) i.e. an adverse variance of (£14.1m). Because the deficit had been above plan, no STF had been assumed.

The main components of the variance included healthcare income at (£1.8m) in month / (£4.7m) YTD which was below seasonal plan. Day case & Electives were (£0.6m) in month / (£1.3m) YTD. The majority of the in-month shortfall had been at GHH due to cancellations / medical outliers. Compared to Sept 2016, GHH Electives were down 24% and day cases down by 10%. Outpatients were (£0.3m) in month / (£1.6m) YTD. September had shown a recovery against the previous month but was still below target.

The cash position was £16.4m, an increase of £4.0m in-month and remained £13.4m above plan this included the working capital loan of £9.8m.

The forecast showed the plan would not be achieved and the Trust had submitted a revised year end forecast of (£48.4m) to NHSI as part of the month 6 return, a (£19.6m) adverse to control total pre-STF. A response had yet to be received.

It had been reported that elective operations had been cancelled due to surgical beds occupied by medical outliers and as a result, income had reduced.

The Chair opened the floor to questions.

In response to a question on how HEFT finances would be affected if it were to be a

stand-alone organisation, it was reported that it would be need to re-engage in another financial recovery plan supported by NHSi.

ACAD would be funded by a long-term loan from the Department of Health.

Resolved: to accept the report.

17.098 QUALITY ACCOUNT UPDATE Q1 2017/18

The Council of Governors considered the report presented by the interim Medical Director that provided an update

The Board had approved the report at its meeting earlier that day and it would be published on the Trust website.

Resolved: to accept the report.

17.099 ANNUAL REPORT FROM CHAIR OF AUDIT COMMITTEE

The Council of Governors considered the report presented by the Chair of the Audit Committee. The opinion of the Audit Committee, based on the information set out in the report, was that considerable progress had been made in addressing the major weaknesses in the Trust's risk management, control and governance processes.

The Chair formally recorded a vote of thanks to the members of the Audit Committee for the work they had undertaken during the year.

Resolved: The report was received.

17.100 RE-APPOINTMENT OF EXTERNAL AUDITORS

The Council of Governors considered the report presented by the interim Director of Corporate Affairs.

It was the view of the Audit Committee that the auditors performed to a very satisfactory level and recommended that they would be re-appointed. The Council of Governors supported the recommendation.

Resolved: To reappoint the external auditors.

17.101 COMPLIANCE AND ASSURANCE REPORT

The Council of Governors considered the report presented by the interim Director of Corporate Affairs.

The final CQC report had been received and a response had been prepared to the requirement notices. One item was awaiting a response from the CQC regarding the security and access to the critical care area, as it was unclear what the concerns were.

It was reported that there had been 1148 NICE guidelines published to date. The Trust had implemented a new process to ensure compliance was undertaken.

An updated and approved External Agency Policy set out the process for appropriate coordination and evaluation of external recommendations arising out of

external agency visits, inspections, accreditations and peer review/assessments was now in place. Since Q2 20/6/17 there had been a total of 11 external visits. A PHE screening quality assurance visit had identified 6 high priority negative assurances, however these were quality related and did not have any patient risk associated with them.

Clinical audit had indicated that monitoring had taken place and action had been taken on the findings of the audit. Specialities had been required to provide a forward programme. The Audit Committee had questioned why the Trust had not been applicable to take part in the Cancer in Children, Teens and Young Adults study and the interim Director of Corporate Affairs had agreed to report back to the next meeting of the Audit Committee.

The Chair opened the floor to questions.

In response to a question, the Director of Corporate Affairs reported that CQC would be changing their inspection processes to inspect one core service on an annual basis, risks assessments would formulated on the results from data collated.

The Director of Corporate Affairs, in response to a question as to why there had been an increase in Freedom of Information (FOI) requests, reported that many of the requests were in relation to IT and commercial information from companies wanting data for tenders.

Resolved: The report was received.

17.102 REPORT FROM CoG SUB-GROUPS

17.102.1 MEMBERSHIP & COMMUNITY ENGAGEMENT GROUP

The Council of Governors considered the report presented by the Chair of the Membership & Community Engagement Group. The group had met on 4 October had discussed the new enlarged organisations membership boundaries and constituency work that had been undertaken by the UHB/HEFT Joint Working Group and it had been agreed that the boundaries would mirror council boundaries. There had been discussion and agreement on constituency names.

It was noted that the Governor's photo board had been put up at the Solihull and Heartlands sites and was due to be put up at GHH.

The Health seminars continued to be extremely popular with members.

There were concerns raised over the role of the sub committees when the merger took place and it had been reported that where sub-groups continued to operate, HEFT Governors would remain associate members and would continue to have a voice.

A response was still awaited as to whether a Governor would be a member on the new charity board.

19 May 2017

The minutes of the meeting held on 19 May 2017 were received.

Resolved: The report was received.

17.102.2 HOSPITAL ENVIRONMENT GROUP

The Council of Governors considered the report presented by the Chair of the Hospital Environment Group. The Group had met on 28 September and it had been reported that the planning application for ACAD had been submitted. The consultation meetings that had taken place had been poorly represented by local residents. The business case would be presented to the next Board Meeting.

Planning permission had been submitted for staff off-site car parking but a response was still awaited.

Work on the Richard Salt entrance was well underway. The work had not yet been carried out where funding was required and where the building needed to be vacated for work to proceed, progress would be reviewed at the next meeting.

Following the transaction the Hospital Environment Group would be absorbed into the new Patient Carer and Community Council group (PCCC) which would continue to monitor site inspections.

25 May 2017

The minutes of the meeting held on 25 May 2017 were received.

27 July 2017

The minutes of the meeting held on 27 July 2017 were received.

Resolved: The report was received.

17.102.3 PATIENT EXPERIENCE GROUP

The Council of Governors considered the report presented by the Chair of the Patient Experience Group. At its meeting on the 15 September it had been reported that the Governor drop-in programme had been well received by staff and had provided useful feedback.

The meeting had looked at the documentation which accompanied vulnerable patients when entering the Trust and it had been felt that it targeted a specific group and needed to have a more general format to include learning difficulties. This would be discussed with UHB colleagues.

The Chair acknowledged and recorded a vote of thanks and noted that this would probably be the last report given by the Patient Experience Group and commented on the quality of the members who had sat on the committees and that they, and the Council of Governors, had been very professional.

19 May 2017

The minutes of the meeting held on 19 May 2017 were received.

14 July 2017

The minutes of the meeting held on 14 July 2017 were received.

Resolved: The report was received.

17.103 ANY OTHER BUSINESS PREVIOUSLY ADVISED TO THE CHAIR

In response to a question, it was agreed that it would be clarified whether the 50th anniversary plaque at GHH referred to the Fothergill block or to Good Hope Hospital.

The next meeting Council of Governors (focus) meeting was scheduled for Monday 27 November 2017, in the Education Centre, Birmingham Heartlands Hospital.

.....
Chair

Minutes of a meeting of the Council of Governors of Heart of England NHS Foundation Trust held in Room 2, Education Centre, Birmingham Heartlands Hospital on 27 November 2017 at 4.00 pm.

PRESENT: Rt Hon. J Smith (Chair)

Mr S Baldwin
Mrs K Bell
Mr T Cannon
Mr K Fielding
Mr A Fletcher
Mr D Hoey
Mrs S Hutchings
Mr P Johnson
Mrs A McGeever
Mr G Moynihan
Mr B Orriss
Mrs J Teall
Mrs J Thomas
Mr D Treadwell
Mr T Webster
Mr L Williams

IN ATTENDANCE:

Mrs F Alexander
Mr K Bolger
Mr J Brotherton
Mr D Burbridge
Prof J Glasby
Mrs J Hendley
Mrs A Hudson
Dr M Kinski
Ms K Kneller
Miss M Lalani
Mr J Miller
Dame J Moore
Dr D Rosser
Prof M Sheppard
Mrs K Tongue
Mrs J Tunney
Mrs T Watkins (Minutes)

17.104 APOLOGIES & WELCOME

The Chair welcomed everyone to the meeting.

Apologies for Governors had been received from Mrs Doyle, Mrs Morgan, Mrs Nicholls, Mrs Passey and Cllr Robinson.

Apologies for Directors had been received from Mr Edwards.

17.105 DECLARATIONS OF INTEREST

There were no declarations noted for discussion.

17.106 MINUTES OF PREVIOUS MEETING

25 September 2017 - AGM

The minutes of the meeting held on 25 September 2017 were considered and approved as a true record.

17.107 MATTERS ARISING

None.

17.108 CHAIRS UPDATE

The Chair congratulated David Treadwell who had received his MBE honour from the Palace.

The Chair reported that she had opened the Safeguarding Conference at GHH which had been 1 of 3 held across the trust and had been very valuable.

The Governors had attended the Building Healthier Lives Awards which had been a good, heart-warming event.

The Governors had seen Phyllis' Story, which involved a theatre group that had spent time talking to patients, staff and partners and then produced a play. The production had been the idea of the Dame Julie Moore, CEO of the Sustainability and Transformation Partnership, to look at and understand how the elderly care pathway could be improved by all stakeholders.

Case for Change Update. There had been some progress made with NHSI on the assurances required by the UHB around the outstanding 'red line' queries including assurance around the security of STP funding for the next 2 years. The Trust had entered stage 2 of the process and the Chair had spoken with Andy Street, Mayor of the West Midlands who had agreed to raise the situation with No. 10 and the Treasury in order to seek resolution. The Chair had also briefed local MPs Liam Byrne, Rt Hon Caroline Spelman, Preet Gill and Rt Hon. Andrew Mitchell as well as Julian Knight on the current status in order to maximise any behind the scenes influence they had.

Back office work continued to be undertaken including staff consultation under TUPE and the process for the appointment of NEDs to the post-transaction Board.

It was hoped that the Board would be in a position to meet to take its decision on Monday 18 December which would be followed by a meeting of the CoG.

In answer to a question previously raised regarding a governor being included on the charity board, it was reported that there had been nothing further to report at present.

A question had been raised regarding ensuring that governors would be aware of how to make a proxy vote. It was reported that papers would be submitted 1 week in advance and it would be very clear on how to make a proxy vote.

In answer to a question that had been raised regarding what was holding back the financial assurances, it was reported that assurances had been required on four areas:
1. Certainty of receiving transferable funding - some progress had been made, but the final settlement needed to be signed off by the Treasury and this had been held up due to the timing of the Budget.
2. Support was required with capital works at HEFT – the Board had approved the business case for next stage of ACAD.
3. NHSI had agreed to fund the Case for Change business case - costs which were circa £3m and UHB required recompense; however funding was still to be received.
4. UHB required some protection against previous liabilities such as the cost of an enquiry eg Paterson case. Guarantees made by the Department of Heath had been agreed in principle but final agreement was still to be confirmed.

Resolved: to receive the report.

17.109 PERFORMANCE REPORT

The Governors considered the Performance Report presented by the interim Deputy CEO - Improvement that summarised the Trust's performance against targets and indicators in the Single Oversight Framework, contractual targets and internal targets. The A&E 4 hour standard had not been met and had remained a risk. Actions and initiatives had been implemented to support ED performance that included: -

All performance targets had been met except for ED. Overall performance had dipped in Oct. There had been an additional 50 beds opened on the GHH site, which had impacted surgical medical in order that ED took priority.

The Trust would now be including additional activity into ED performance data to include patients who attended walk-in centres and 'hot' clinics that were used to reduce the number of patients presenting at A&E. It was reported that many other trusts outside of the region had been using combined data for a considerable time. The Trust had not done so before as it had received mixed messages from NHSI on the subject.

In response to a question raised, it was reported that progress had been made on the junior doctor rota at GHH, but it was still challenging. The recruitment of substantive staff was a national problem.

All cancer targets had been met.

Ambulance targets had continued to improve and the Trust was working with the WMAS and HALO to improve it further.

DTOCs had reduced across all 3 sites.

57% of staff had received the Flu jab.

Resolved: to accept the report

17.110 FINANCE REPORT

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

The in-month position was a deficit of (£5.7m) against a planned deficit pre STF of (£2.4m), an adverse variance of (£3.3m). The year to date position at month 7 was a deficit of (£34.4m) against a planned deficit pre STF of (£16.9m), an adverse variance of (£17.5m). The reported position excluded the allocation of STF for the year to date due to the adverse financial position against the plan. A revised year end forecast of (£48.4m) had been submitted to NHSI.

The Trust's cash balance was £11.6m which included a working capital loan of £16.0m which equated to (£4.4m) in net terms. Should the transaction not go ahead on 1 January, it was likely that an increase for the borrowing requirement would be needed.

The main components to the variance were:

- Healthcare income was (£1.8m) in month / (£6.7m) YTD below seasonal plan. Of this day-cases & electives were (£0.6m) in month / (£3.5m) YTD. Day-cases were slightly up but electives were (146 spells) / (12.3%) below plan in month. The majority of the in-month shortfall was at GHH due to cancellations / medical outliers. Electives at GHH for Oct 2017 vs Oct 2016 a reduction of 26%. Emergency activity was (£0.6m) in month / (£1.9m) YTD, overall activity was strong with 155 spells above plan however income was down due to price variance. Work was ongoing to determine whether this was due to genuine case-mix issue or coding.
- CIP slippage (£0.5m) in month / (£3.1m) YTD.
- Financial Recovery Plan / Stretch (£0.1m) in month / (£4.5m) YTD.

The national Q2 results had been published on 17 November and in terms of the context, the overall provider sector was (£1.15bn) YTD vs a plan of (£1.0bn) i.e. (£143m) variance. There were 111 providers in deficit after STF including 79% of acute trusts. The forecast was (£623m) which even after STF phasing impact (£270m) was clearly unachievable and was more likely to be in the region of (£1.5bn) and (£2.0bn) dependent upon the impact of winter and technical adjustments. A number of providers had heavily back-ended their CIP and were hanging on to unrealistic forecasts.

There had been some extra funding announced in the budget that included £335m for winter 2017/18, £1.6bn revenue for 2018/19, £0.9bn revenue in 2019/20. All of which was non-recurrent and needed to plug the current gap rather than improve access.

In response to a question raised regarding what could be done to improve the financial situation, it was reported that we had been systematically underpaid for the level of ED work done at HEFT due to historical deals with the commissioner. The number of services provided across all sites would be looked at as well as staffing to see if services could be configured.

A discussion took place regarding a media article stating that the cost of thyroid treatment over the last 5 years had increased from £5 to £2500. It had been reported that there was a small number of drugs that could only be licenced by the manufacturer and this had been a European Regulation problem but was being looked into. It had not been reflective at the Trust as it only purchased the drug from one manufacturer.

In response to a question on how the merger would affect the 2008 base for ED income, it was reported that as part of the merger, the Trust would be looking to harmonise contracts. The current contract was due for renewal in 2019, and then it would be subject to re-negotiation.

In response to a question, the Director of Finance reported that, in terms of the effect in a rise in interest rates, the interest rate for the working capital loan had been set when the loan had been agreed. The interest rates associated with the ACAD loan had yet to be agreed. It would be possible that future borrowing would be at an increased rate of interest.

Resolved: to accept the report.

17.111 FOCUS ON STAFF RECRUITMENT & RETENTION

The Council of Governors received a presentation from the Director of Workforce on the work being undertaken around staff recruitment and retention. It was reported that there was a shortage of staff in the NHS nationally as a result of demographic changes over the years. The number of patients being admitted into hospital outweighed the number of staff available to nurse and care for them.

The number of people choosing to train in medical areas had decreased partially due to the pressures seen.

There had been a 23% decrease in nurse training as a result of the training bursary having been stopped. Brexit had also had an impact, as many nurses were employed from the EU.

A discussion took place where it was suggested that rather than there being a shortage of staff, staff were choosing to work for an agency rather than the Trust. It was reported that all staff employed, in a clinical role, were automatically registered to work on the Trust bank. Only in extreme circumstances was an outside staff agency used. Staff could, if they wished, work additional bank shifts on their days off, which were above and beyond their contracted hours.

In response to a question, as to what could be done nationally to help the lack of nursing staff, it was reported that the Band 4 Nurse Associates role had been approved which would see more nurses being employed.

A discussion on the standard of the English test being too high was held. It was noted that the text was a generic exam and not health focused, the NMC were to undertake a review.

A question on how nurses could return to nursing after taking time out to raise a family etc was raised and it was reported that individuals should contact the acting Chief Nurse in the first instance to discuss.

Resolved: to accept the report.

17.112 REPORT FROM CoG SUB-GROUPS

17.112.1 Hospital Environment Group

The Council of Governors considered the report presented by the Chair of the Hospital Environment Group.

28 September 2017

The minutes for the meeting on the 28 September had been agreed at the meeting held on 23 November and would be presented to the next meeting for information.

23 November 2017

The Chair reported that the group had met on 23 November 2017 and had received an update on the actions that were outstanding from site visits, these had been due to areas that required funding or needed to be vacated. Ward refurbishments had not been able to take place due to patients not being able to be relocated whilst works took place. It was reported that there would be the possibility that the discharge lounge could be relocated which would give the

opportunity for ward 5 to be relocated in order for it to be refurbished. It had been reported that funding issues would be included in the capital funding programme for next year.

A discussion had taken place regarding the relocation of the chest clinic and the potential costs of relocating to a new site.

The new speed bumps that had been installed outside the new outpatients department and the impact this had on patients being transported by ambulance had been discussed and was being investigated.

Resolved: The report was received.

17.112.2 Patient Experience Group

The Council of Governors considered the report presented by the Chair of the Patient Experience Group.

15 September 2017

The minutes of the meeting held on 15 September 2017 were received.

17 November 2017

The Chair reported that the group had met on 17 November 2017 and had received an update on the charges for prescriptions given in A&E; an update from the lead pharmacist had been requested. The Governor drop-in programme had commenced and continued to be well received. A discussion had taken place around the number of governors compared to the number of planned visits to wards and departments and it had been agreed to revisit the schedule post-merger, when planning for drop-ins.

There had been a presentation from Louise Passey who had recently visited Macclesfield General Hospital to look at the work they had undertaken with autistic patients. It had been reported that although there had been points to note, HEFT would be unable to do adopt the process as it was a much larger trust. It could however, be included as part of the patient passport programme. Discussions had taken place with HEFT and UHB to see how it could be implemented.

Resolved: The report was received.

17.113 ANY OTHER BUSINESS PREVIOUSLY ADVISED TO THE CHAIR

None.

The next Council of Governors (formal) meeting was scheduled for Monday 22 January 2018, in the Education Centre, Birmingham Heartlands Hospital.

.....
Chair

HEART OF ENGLAND NHS FOUNDATION TRUST

COUNCIL OF GOVERNORS

MONDAY 22nd JANUARY 2018

Title:	Performance Indicators Report
Responsible Director :	Kevin Bolger, Interim Deputy CEO – Improvement
Contact	Kevin Bolger, Interim Deputy CEO – Improvement 0121-424-0278

Purpose	To update the Council of Governors on the Trust's performance against targets and indicators in the Single Oversight Framework, contractual targets and internal targets.
Confidentiality Level & Reason	None
Annual Plan Ref	Not applicable
Key Issues Summary:	Exception reports have been provided where there are current or future risks to performance for targets and indicators included in the Single Oversight, national and contractual targets and internal indicators. A&E 4 hour performance remains a risk for the Trust.
Recommendations	The Council of Governors is requested to: **Accept** the report on progress made towards achieving performance targets and associated actions and risks.

Approved by:		

HEART OF ENGLAND NHS FOUNDATION TRUST

COUNCIL OF GOVERNORS

MONDAY 22ND JANUARY 2018

PERFORMANCE INDICATORS REPORT
PRESENTED BY THE INTERIM DEPUTY CEO – IMPROVEMENT

1. Purpose

This paper summarises the Trust's performance against national indicators and targets, including those in the NHSI Single Oversight Framework 6, as well as local priorities. Material risks to the Trust's Provider Licence, reputation or clinical quality resulting from performance against indicators are detailed below.

2. HEFT Performance Framework

The Trust has a suite of Key Performance Indicators that includes national targets set by NHS Improvement and the Department of Health (DH) and local indicators selected by the Trust as priority areas, some of which are jointly agreed with the Trust's commissioners. This report is intended to give a view of overall performance of the organisation in a concise format and highlight key risks particularly around national and contractual targets.

3. Material Risks

The DH sets out a number of national targets for the NHS each year which are priorities to improve quality and access to healthcare. NHS Improvement (NHSI) tracks the Trust's performance against a subset of these targets, enabling Trusts to access the Sustainability and Transformation Fund as long as agreed trajectories are achieved.

Table 1: Performance against National Contractual Requirements

Indicator	Threshold	Current Data Period	Performance
Single Oversight Framework			
18 week RTT - incomplete	92%	Dec-17	90.65%
A&E 4 hour access	95%	Dec-17	76.30%
Cancer 62 day - GP urgent referral	85%	Nov-17	85.94%
Cancer 62 day - national screening	90%	Nov-17	100.00%
6 weeks diagnostic test	99%	Dec-17	99.04%

Indicator	Threshold	Current Data Period	Performance
Other National Targets			
Cancer 2 week	93%	Nov-17	95.63%
Cancer breast - 2 week	93%	Nov-17	94.75%
Cancer 31 days- first treatment	96%	Nov-17	96.93%
Cancer 31 days- subsequent treatment -surgery	94%	Nov-17	95.89%
Cancer 31 days - subsequent treatment - drugs	98%	Nov-17	100.00%
Ambulance Handover ≥ 60 minutes	>0	Nov-17	99.8% (14)
12 hour Trolley waits A&E	0	Dec-17	0
52 week waits	0	Dec-17	0
Cancelled Ops rearranged 28 days	0	Dec-17	0
Urgent operation cancelled x 2	0	Dec-17	1
Sleeping Accommodation Breach	0	Dec-17	5
MRSA	0	Dec-17	0
C.difficile - (post 48 hours)	5	Dec-17	2
VTE risk assessment	95%	Dec-17	98.34%
Duty of Candour (2 months in arrears)	0	Oct-17	0
NHS Number acute	99%	Dec-17	99.59%
NHS Number A&E	95%	Dec-17	98.44%

3.1 Single Oversight Framework

3.1.1 A&E 4 Hour Waits

Performance for the A&E 4 hour wait target has declined slightly in December to 76.30% compared with 77.98% in November 2017.

Table 2: A&E Performance by Site November v December 2017

	Performance		Attendances		Daily Av	
	Nov-17	Dec-17	Nov-17	Dec-17	Nov-17	Dec-17
Heartlands	77.28%	75.68%	12,381	11,839	413	382
Good Hope	70.17%	68.34%	7,507	7,455	250	242
Solihull	98.62%	98.10%	3,263	3,056	109	99
Trust	**77.98%**	**76.30%**	**23,151**	**22,350**	**772**	**723**

Table 3: A&E Performance by Site December 2016 v 2017

	Performance		Attendances		Daily Av	
	Dec-16	**Dec-17**	**Dec-16**	**Dec-17**	**Dec-16**	**Dec-17**
Heartlands	79.43%	75.68%	11,513	11,839	371	382
Good Hope	77.12%	68.34%	7,337	7,455	237	242
Solihull	98.84%	98.10%	3,275	3,056	106	99
Trust	**81.54%**	**76.30%**	**22,125**	**22,350**	**714**	**723**

There were 22,350 attendances in December 2017 (an average of 723 patients per day). This compares to 22,125 attendances in December 2016 (an average of 714 patients per day).

The data demonstrates the decline in performance is on both the Heartlands and Good Hope Hospital site.

In a letter sent to Acute Trust Chief Executives in October 2017 from the Chief Executive of NHSI, Trusts were asked to review alternative pathways (diversion pathways) that were in existence created to divert attendances away from ED departments.

Examples of this include:-

- Direct admission to assessment unit
- Direct admissions to an in-patient ward on a specialty specific pathways
- Direct admission from out-patients.

In addition, the Trust is working collaboratively with the CCG to apportion Walk-In Centre (WIC) activity to Acute Trusts so that this can also be included within the Trust's ED dataset returns.

The table below demonstrates improvement in performance based inclusion of the activity outlined above for December 17.

Table 4: Additional ED Activity Inclusions

Current ED Performance	**Including WIC Activity**	**Including WIC Activity and Diversion Pathways**
76.30%	**84.09%**	**85.61%**

The whole of the NHS has been under significant pressure over the winter period. The Trust has implemented a comprehensive Winter Plan prepared in advance and a number of operational schemes have been enacted aimed at avoiding admissions, reducing length of stay and expanding capacity.

Since then additional national funding for winter schemes, announced in the Autumn Budget, was allocated by NHSE in the week before Christmas from which HEFT secured funding to implement further 'winter pressures' schemes.

Furthermore the National Emergency Pressures Panel (NEPP), chaired by Professor Sir Bruce Keogh, wrote to all providers on 19 December and 2 January outlining a number of actions that Trusts are required to take to improve emergency flow over the winter including:

a) Deferring all non-urgent inpatient elective care until 31 January. The panel reiterated that cancer operations and time-critical procedures should go ahead as planned
b) Also deferring day-case procedures and routine outpatient appointments where this will release clinical time for non-elective care
c) Implementing consultant triage at the front-door so patients are seen by a senior decision maker on arrival at the Emergency Department
d) Ensuring consultant availability for phone advice for GPs.
e) Maximising the usage of ambulatory care and hot clinic appointments as an alternative to Emergency Department attendance and/or hospital admissions
f) Increasing support from Allied Health Professionals, for example physios and therapists, for rehabilitation and discharge
g) Staffing additional inpatient beds
h) Ensuring twice daily review of all patients to facilitate discharge
i) Commissioners not enforcing sanctions for mixed sex accommodation breaches
j) Ensuring the vaccination for flu of frontline staff.

In summary the Trust has taken the following actions:

- Expanding ambulatory emergency care capacity to reduce the number of patients requiring admission
- Expanding the frailty service to help avoid the unnecessary admission of frail patients with complex needs
- Additional senior emergency medical staff in Emergency Departments to cope with increased patient acuity
- Additional senior acute physicians providing more senior input to patients at the 'front door' of the hospitals
- Additional medical staff at peak periods during evenings and overnight to manage increased acuity and volume of the medical admissions

- Making beds available earlier each day for new patients requiring admission through the earlier transfer of patients in assessment units to ward areas (Safer Patient Placement)
- Opening 78 additional inpatient beds at Good Hope Hospital and 18 beds at Solihull Hospital
- Significant reductions in inpatient elective activity to free up beds for non-elective patients
- Conversion of elective theatre lists to provide additional trauma and emergency theatre capacity in order to minimise the number of inpatients awaiting surgery.

The cancellation of elective activity has had a detrimental impact on elective performance, with the Trust failing the 18 week RTT target in December. Future RTT performance remains at risk given the ongoing volume of elective inpatient activity being cancelled. In order to mitigate the impact on long-waiting patients the Trust has secured the transfer of approximately 200 long-waiting elective patients to the independent sector via Inter-Provider Transfer arrangements. Day surgery capacity at Solihull is also being maximised. These actions have also reduced the risk of any 52 week breaches. There is also a risk to activity and income targets as elective activity paid at full tariff is displaced by emergency activity with a longer average length of stay which is only paid at 70% of tariff.

3.1.2 <u>18 Week Referral to Treatment (Incomplete Pathways)</u>

The incomplete pathway shows Trust performance did not achieve at aggregate level in December at 90.58%.

There are eight specialties that failed to meet the target in month as shown in the table below:

Table 5: 18 week RTT performance – specialties failing to meet the target in month

Specialty	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17
Neurology	96.55%	96.97%	93.23%	93.39%	92.55%	89.03%
Dermatology	93.97%	92.60%	91.54%	92.97%	92.42%	90.92%
T&O	85.60%	84.26%	83.62%	83.12%	81.16%	77.79%
ENT	92.15%	90.51%	90.31%	91.36%	91.39%	89.80%
Vascular	94.54%	94.60%	95.03%	93.43%	92.12%	90.97%
Urology	94.19%	95.78%	95.39%	92.86%	92.26%	90.50%
General Surgery	89.57%	89.47%	90.19%	90.47%	88.95%	87.77%
Breast	86.42%	90.41%	93.26%	88.06%	84.13%	88.61%

Within the category “other”, three specialties have failed to meet the target.

Table 6: 18 week RTT performance – category “other”

Specialty	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17
Other Therapy	95.59%	97.38%	91.79%	90.95%	92.89%	91.56%
Colorectal Surgery	93.98%	85.90%	91.86%	83.84%	84.21%	78.31%
Upper GI Surgery	61.00%	63.19%	60.68%	61.43%	62.09%	60.52%

December’s outpatient activity decreased from the expected level due to adverse weather conditions and people’s inability to attend hospital. Substantial bed pressures on all sites have resulted in a number of elective cancellations affecting surgical specialities which has increased the backlog of admitted RTT patients.

3.1.3 Cancer

The Trust met all national cancer targets in November 2017.

3.1.4. Cancer Long Waits

In November the Trust was accountable for 8 patients who have been treated in excess of 104 days from referral.

Three patients were referred to UHB for treatment. All patients had a complex diagnostic pathway prior to referral and led to late tertiary referrals to UHB. None of the patients could be treated within 24 days.

Three patients were treated at HEFT. Two required further investigation to assess metastatic disease and fitness assessment and one had to have treatment deferred due to a separate primary cancer being treated at UHB.

Two patients were referred to HEFT for treatment. Both patients were from Worcester and referred beyond 38 days. Neither could be treated within 24 days.

Following a clinically led review, it was determined that no patients came to avoidable harm as a result of any delays.

As of the 31st December – there were 3 patients who were over 104 days (1 Walsall and 2 from Hereford). All of these patients were lung, two referred for diagnostic investigations and one referred for treatment (unconfirmed cancer, but radiologically felt to be a cancer).

3.1.5 % patients waiting 6 weeks for 15 key diagnostic tests

The Trust met the target in December (99.04%) against the 99% target.

3.1.6 Urgent Operations Cancelled x 2

There was one urgent operation cancelled twice in December within Vascular surgery for a right below knee procedure cancelled due to other emergencies which was carried out 48 hours post last cancellation.

3.2 National Targets Monitored Locally Through CCG Contract

Of the 18 national targets that are not included as Operational Performance Metrics in the new Single Oversight Framework but are included in the CCG, contract the Trust is on target for 18.

3.2.1 MRSA Bacteraemia

There has been no post 48 hour MRSA bacteraemia reported in December 2017.

3.2.2 Clostridium difficile

Two cases of post-48-hour c.diff were reported. This is within the Trust monthly trajectory of six cases for the month. The total number of cases this year is 47 against a YTD trajectory of 47 cases and an annual trajectory of 64 cases.

3.2.3 Ambulance Handover

Since implementation of ECDS (Emergency Care Data Set) at the end of October, 30 minute breaches are currently only validated against CAD (Computer Aided Dispatch) data as the check field in Patient First (ED tracking system) to confirm handover time is currently unavailable due to the ECDS upgrade. Testing is in progress and it is anticipated that the check field will be back on line at the end of January. Therefore, reporting will recommence in February 2018.

There were 14 confirmed 60 minute breaches (99.8%) for November with the Trust achieving the required threshold of 99%.

3.2.4 Sleeping Accommodation breach

There was one sleeping accommodation breach reported in December 2017 that affected five patients.

The breach occurred in AMU at Good Hope Hospital and is deemed unavoidable based on the capacity issues that the site was facing at the time of the patient. Male and female patients were bedded in triage on trolleys overnight. Both the AMU co-ordinator and Site Manager were aware.

4. Local Indicators – acute contract

There are 67 local contractual indicators that the Trust's performance is measured against (31 are reported monthly, 32 of these are reported quarterly and the others either bi-annually or bi-monthly).

4.1 Delayed Transfers of Care (DTOC) for health and joint delays

The Trust did not achieve the target for December, achieving 1.42% against a target of 1.4%, the site and patient numbers waiting are shown in the tables below.

Table 7: DTOC HEFT and external NHS joint health delays – bed days occupied

	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17
BHH	354	462	252	219	311	340
GHH	153	345	242	163	250	113
SH	235	261	98	158	156	190
TRUST	**742**	**1068**	**592**	**540**	**717**	**643**

The tables below show performance for all delayed transfers of care and actual numbers i.e. those that are health and social delays.

Table 8: All DTOC delays - bed days occupied

	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17
BHH	825	999	688	672	795	677
GHH	365	719	466	440	599	358
SH	425	380	145	187	268	232
TRUST	**1615**	**2098**	**1299**	**1299**	**1662**	**1267**

Historically, DTOC figures increase during the month of January but additional support from all parties has been implemented to help reduce the overall impact.

4.2 Pressure Ulcer Reduction

One avoidable grade 3 hospital acquired pressure ulcer was reported in November 2017. A total of 8 avoidable grade 3 pressure ulcers have been reported year to date against an annual trajectory of 36.

Further detail can be found in the Care Quality Report.

4.3 Quarterly Maternity Screening Indicators

There are 14 maternity screening indicators, all reported a quarter in arrears, and therefore the current performance reported this quarter relates to Q2 (2017/18). Of the 14 indicators, the Trust has failed to meet 4.

These are:

- Laboratory request forms 10+0 to 20+0 weeks gestation – new validation process commenced in September with daily monitoring in place with an anticipated improvement for Q3
- Newborn Bloodspot – Avoidable Repeat Tests – additional training and new validation process instigated in September has contributed to an improved position and anticipated achievement for Q3
- Newborn hearing assessment referrals – performed under regional contract with Sandwell and West Birmingham Hospitals
- Newborn Hip Abnormality – performance missed by one case from a total number of referrals of three. Failure was due to communication issues. A new process is in place to prevent this recurring and an improved position for November is expected.

5. Internal Indicators – Performance

5.1 Dementia Screening

Trust performance against the dementia screening 'FIND' element of this metric shows a decrease in month to 80.34% in December. This indicator is still failing to meet the 90% target as shown in the chart and table below.

All Divisions have escalated issues and performance to their Divisional Directors and Clinical Leads and continue to review non-conforming areas to reinforce compliance. The Associate Head Nurses continue to send out daily reminders to the relevant named consultant.

5.2 Information Governance Training

Performance against the Information Governance Mandatory Training target of 95% has decreased slightly in month, with performance at 84.54% in December.

Divisional performance has improved for Divisions 1, 2 with a slight decrease in performance for Divisions 3, 4 & 5.

The significant reduction in performance for Facilities is due to the addition of the new G4S staff into the denominator, with the majority being out of date.

6. Local Indicators - Workforce

6.1 Mandatory Training

Mandatory Training performance remains above target (85%) and has decreased slightly this month to 91.25%, from 92.05% in December.

6.2 Appraisal

Appraisal completion rates have improved slightly in December to 87.18%, above the 85% CCG target. An internal target of 90% has been agreed and plans are being reviewed with Divisions to improve performance. Clinical Support Services Division remains the only Division above the internal target of 90%.

6.3 Recruitment

Time to Hire (recruitment) performance has reduced to 5.89 weeks against a target of 6 weeks. Divisional management time to hire in December has reduced to 2.68 weeks against a target of 3 weeks which is encouraging and reflects the proactive management of the recruitment process.

6.4 Voluntary Turnover

Trust turnover rates remained the same this month at 10.51%. The online exit monitoring tool has improved the quality of information obtained from leavers and year to date performance is 32.48%.

"Picker" has continued to be engaged to support staff retention through the provision of quality exit monitoring data.

6.5 Sickness Absence

Sickness absence rates for December are not available at the current time and an update will be provided at the meeting.

7. Acute CQUINs

For the Acute Contract, with the exception of STP and Sepsis all CQUINs were achieved in Quarter 2.

7.1 The reported Sepsis performance deteriorated in quarter 2, particularly in ED, where we failed to meet the minimum 50% payment threshold for both screening (ref 2a) and antibiotic administration. There has only been one audit undertaken in Q3. Issues are related to the process for completion of audit and expertise around paediatric cases which are being reviewed to improve completion rates. The monthly sample report is currently being updated to ensure that all paediatric patients

are sent to Division 2 for auditing. (2b) Inpatients fell short of the 90% target at 88.2% for indicator 2a, and 82.5% for 2b. There is currently a national dispute relating to the STP CQUIN performance, which is in abeyance until a resolution is reached.

7.2 Specialised Services/ NHS England CQUINs - Five of the seven Specialised Services CQUINs have been confirmed as fully achieved, the remaining two for Cystic Fibrosis and Optimising Palliative Chemotherapy were partially achieved and therefore only partial payment will be received. Full achievement and payment is expected Q3.

7.3 Public Health CQUINs - There are two CQUINs for Public Health, one Dental and one for AAA. The AAA CQUIN has just been agreed and will be varied into the contract; however Dental remains outstanding pending agreement of process and assurance of delivery.

7.4 Community Services - The Personalised Care and Support Planning CQUIN (the only one of three Community CQUINs with quarter 2 milestones) was achieved

8. Recommendations

The Council of Governors is requested to:

8.1 **Accept** the report on progress made towards achieving performance targets and associated actions and risks.

Kevin Bolger

Interim Deputy Chief Executive - Improvement

HEART OF ENGLAND NHS FOUNDATION TRUST

COUNCIL OF GOVERNORS

MONDAY 22ND JANUARY 2018

Title:	**Clinical Quality Monitoring Report**
Responsible Director :	David Rosser, Interim Executive Medical Director
Contact	Mark Garrick, Director of Medical Directors' Services

Purpose	**Purpose:** To provide assurance on clinical quality to the Council of Governors and detail the actions being taken following the Joint Clinical Quality Monitoring Group (JCQMG) in December 2017 and the HEFT Clinical Quality Monitoring Group (CQMG) in January 2018. To receive and note the contents of this report.
Confidentiality **Level & Reason**	NA
Annual Plan Ref	NA
Key Issues Summary:	The Council of Governors will consider: • Investigations into Doctors' performance currently underway • Mortality indicators: CUSUM, SHMI, CRAB and HSMR • Board of Directors' Unannounced Governance Visits
Recommendations	The Council of Governors is asked to receive the information set out in this report and accept the actions identified.

Approved by:	David Rosser, Interim Executive Medical Director	16/01/2018

1. Introduction

The aim of this paper is to provide assurance on clinical quality to the Council of Governors, detailing the actions being taken following the JCQMG and CQMG meetings. The Council of Governors is requested to discuss the contents of this report and accept the actions identified.

2. Update On Medical Staff Within The Remit Of Maintaining High Professional Standards (MHPS)

There are currently five Doctors subject to MHPS investigation. The investigations relate to four Consultant Grade Doctors and one Specialty Doctor.

3. Mortality – CUSUM

One CCS (Clinical Classification System) group had a higher than expected mortality but had not triggered a Care Qaulity Commission (CQC) mortality alert in September 2017. There were 37 observed mortalities for the group 'Pneumonia (except that caused by tuberculosis or sexually transmitted disease)' (122) with 31.74 expected.

A sample of fourteen patients was reviewed by a Deputy Medical Director and reported to the January 2018 CQMG meeting. All of the patients reviewed received appropriate care and none of the deaths were unexpected, with multiple comorbidities present in an elderly cohort. The Medical Examiner reviews for all 37 patients will be reported to a future CQMG meeting. Please see Figure 1 below.

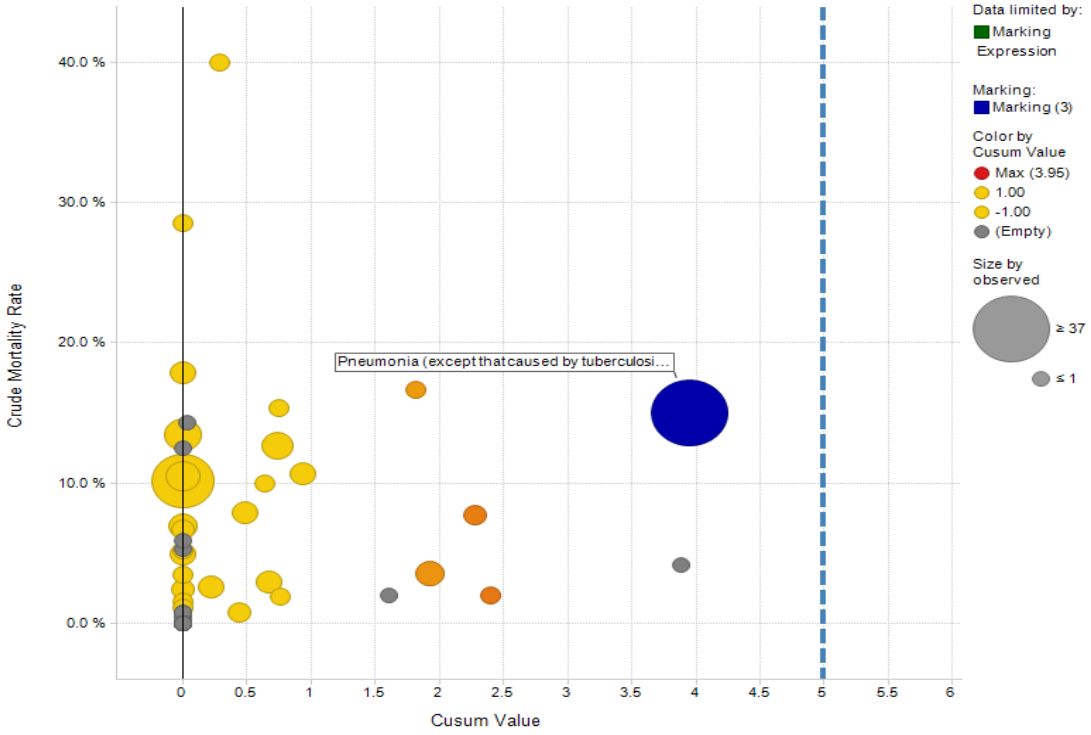


Figure 1: HEFT CUSUM in September 2017 for HSMR CCS Groups

The Trust's overall mortality rate as measured by the CUSUM for September 2017 is within acceptable limits as shown in Figure 2 below.

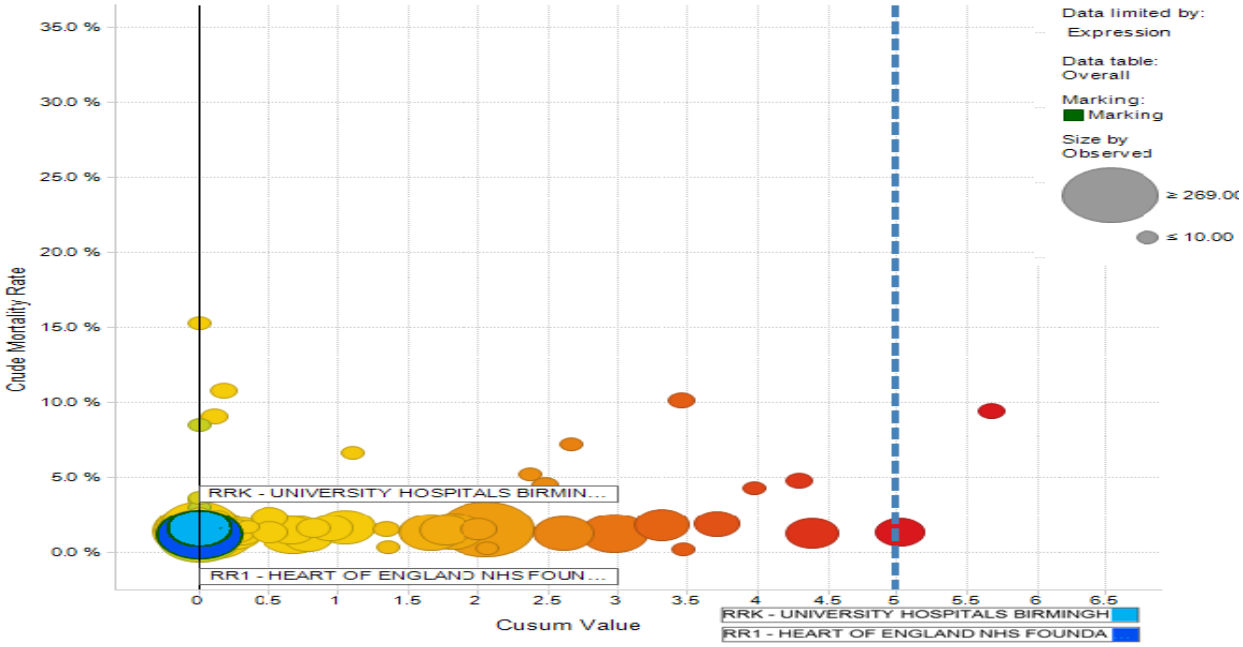
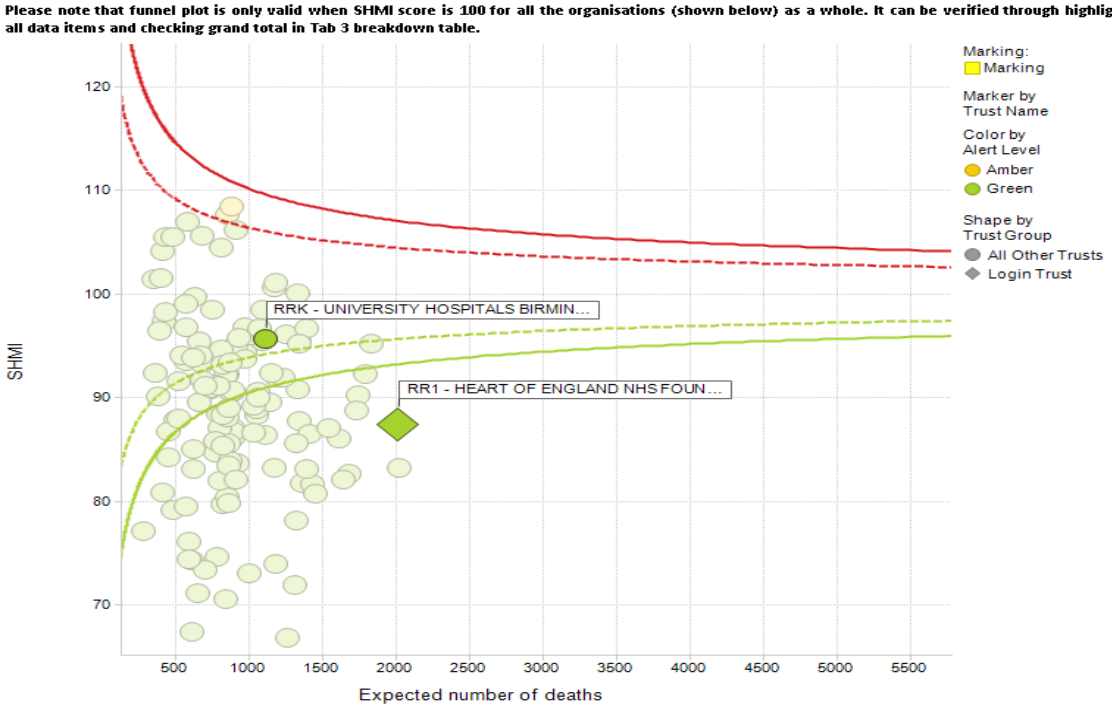


Figure 2: HEFT CUSUM in September 2017 at Trust level. UHB CUSUM included for benchmarking purposes.

4. Mortality – SHMI (Summary Hospital-Level Mortality Indicator)

The Trust's SHMI performance for April 2017 to August 2017 was 87. The Trust has had 1755 deaths compared with 2007 expected. The Trust is within the acceptable limits as shown in Figure 3 below.

Figure 3: HEFT SHMI April 2017 to August 2017. UHB SHMI included for benchmarking



purposes.

5. Mortality – HSMR (Hospital Standardised Mortality Radio)

The Trust's HSMR for the period April 2017 to September 2017 was 99 which is within acceptable limits. The Trust had 1276 deaths compared with 1289 expected (see Figure 4 below).

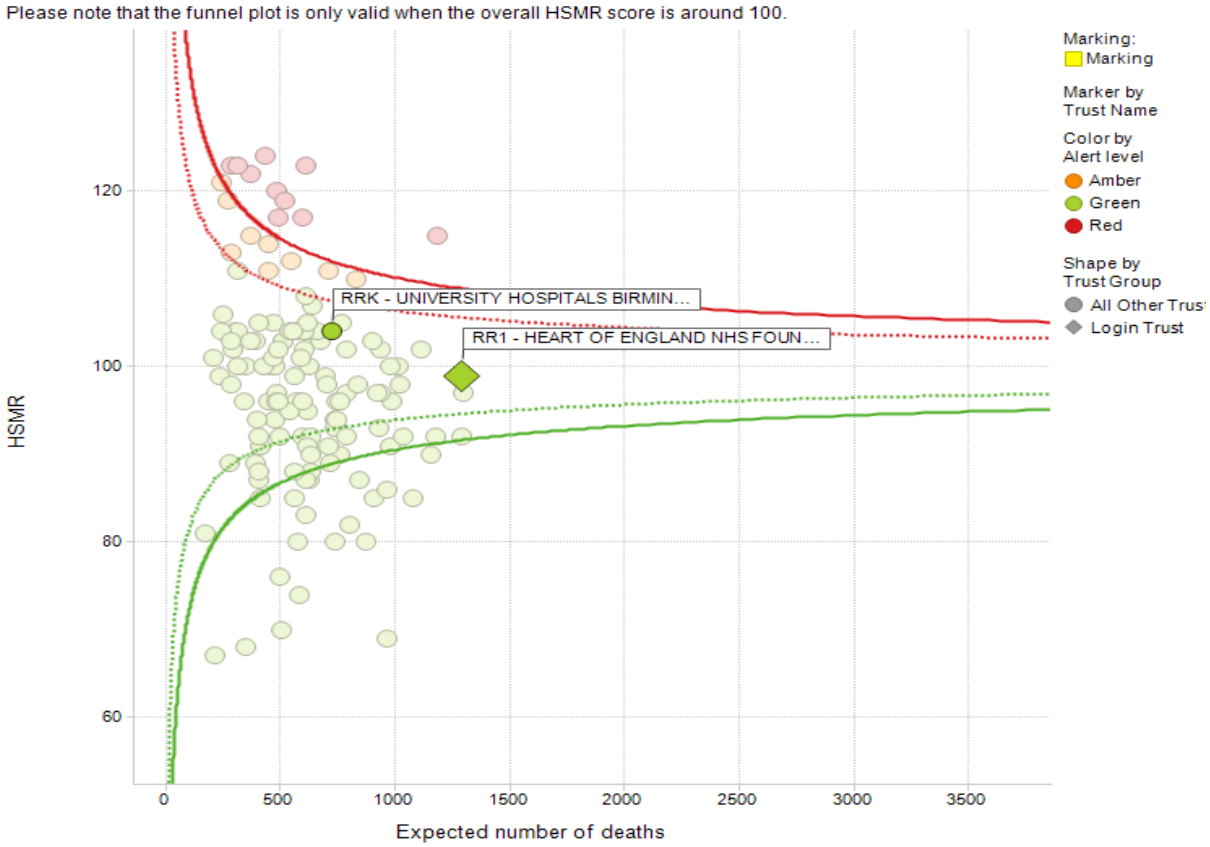


Figure 4: HEFT HSMR April 2017 to September 2017. UHB HSMR included for benchmarking purposes.

6. Learning from Deaths Quarter 3 2017.

In line with national *Learning from Deaths* requirements. A summary of the all results of reviews of inpatient deaths during Quarter 3 2017/18 has been undertaken and appended (A). The report includes information for both UHB and HEFT for benchmarking purposes.

7. Board of Directors' Unannounced Governance Visits

The visit in December 2017 was to the Delivery Unit (Maternity) at Good Hope Hospital. Overall this was a positive visit to a clean and well organised ward with good feedback from both patients and staff. Sharps compliance was observed in all areas.

A Midwife Manager reported that significant work is being undertaken in the area to learn from incidents. The Senior Midwife has a robust plan for appraisal, which is reflected in compliance improvements. A Midwife Assistant commented that she had a positive

learning and development experience on the ward, which was enhanced by shadowing the same Midwife during the programme.

Staff expressed concerns in relation to prioritising emergent clinical needs and completing all appropriate documentation within two hours of birth. Staff reported that communication was strong between the multidisciplinary team and that respectful challenge was initiated as appropriate.
Equipment checks were in line with Trust standards. Although the notes trolley was locked by the staff base, there were two unlocked PCs.

Staff are aware of the importance of using the correct size baby security tag to avoid alarms being unnecessarily activated.

8. Recommendations

The Council of Governors is asked to:
Discuss the contents of this report.

David Rosser
Interim Executive Medical Director
16th January 2018

Heart of England NHS
NHS Foundation Trust

HEART OF ENGLAND NHS FOUNDATION TRUST
COUNCIL OF GOVERNORS MEETING
MONDAY 22ND JANUARY 2018

Title:	**Care Quality Board Report**	
Responsible Director:	Margaret Garbett, Interim Chief Nurse	
Contact:	Julie Tunney, Previous Interim Chief Nurse (ext. 4-1323)	
Purpose:	The purpose of this report is to provide an exception report of performance against the key performance indicators in the Single Oversight Framework, in addition to contractual and internal targets delivered in October and November 2017.	
Annual Plan Ref:	N/A	
Links to Trust Clinical Strategy		Yes
Links to Capacity/Demand and Annual Plan		Yes
Links to Quality/Safety		Yes
Other - Please Specify		N/A
Key Issues Summary:	Exception reports have been provided where there are current or future risks to performance against targets and indicators included in the Single Oversight Framework, national and contractual indicators and internal targets. **Infection Control** - Nine cases of post 48 hour Clostridium difficile were reported in November 2017. This is above the Trust monthly trajectory of five. The total number of cases this year is 45 against YTD trajectory of 41 cases and an annual trajectory of 64 cases. A community outbreak of measles was reported in November 2017. To date a total of 12 inpatients at Birmingham Heartlands Hospital have been identified with measles all of whom are community acquired cases. **Tissue Viability** - One avoidable grade 4 pressure ulcer was reported in October 2017. There were no avoidable grade 3 hospital acquired pressure ulcers. Five avoidable grade 2 pressure ulcers were reported in October 2017.	

	Dementia Screening - Performance in November 2017 currently outlines that the Trust remains non-compliant at 81.95% against a target of 90% **Parkinson's Medication** - Performance in November 2017 shows that the Trust is non-compliant at 76.71% against a target of 90%. **Admissions, Discharges and Transfers (ADT)** - Performance against this standard in November 2017 outlines that the Trust is currently non-compliant at 88.09% against a target of 95%. **Nurse Staffing** - There are no areas of concern for November 2017. Critical care and paediatrics, although rated red, were safely staffed as they are staffed based on acuity of patients which fluctuates throughout each day. **Vacancy Position** - Qualified vacancies are 334.58 WTE in November 2017, a reduction of 44.27 WTE in month and the third consecutive month where qualified vacancies have decreased. **Recruitment** - Joint discussions are planned between University Hospitals Birmingham and Heart of England NHS Foundation Trust to discuss possible options of overseas recruitment and further cohorts of Trainee Nursing Associates are being scoped for 2018 based on the funding support from Health Education England. **Complaints** - The current performance for October 2017 received complaints is 69%. This is a final validated figure and continues to show improvement in performance. **Friends and Family Test (FFT)** - During November 2017, the percentage of positive responders has increased in month at 95% for inpatients. For the Emergency Departments, the positive responder score remains static at 80% for November 2017. Response rates have increased by 5% in November 2017 to 36% for inpatients, compared to 31% in October 2017. The response rate for Emergency Departments has decreased slightly to 13%, compared to 14% in October 2017.		
Recommendations:	The Group is asked to consider the information set out in this report.		
Signed:	Margaret Garbett	**Date:**	15th January 2018

Heart of England NHS
NHS Foundation Trust

HEART OF ENGLAND NHS FOUNDATION TRUST
COUNCIL OF GOVERNORS MEETING
MONDAY 22ND JANUARY 2018

1. Purpose

This paper summarises the Trust's performance against national indicators and targets, including those in the new Single Oversight Framework which commenced on 1st October 2016 as well as local priorities.

2. Single Oversight Framework

NHS Improvement (NHSI) has introduced a new Single Oversight Framework (SOF) for both NHS Trusts and Foundation Trusts which replaced Monitor's Risk Assessment Framework (RAF) for Foundation Trusts on 1st October 2016.

There are five themes within the framework as follows:-

- **Quality of Care:** The CQCs rating for the Safe, Caring, Effective and Responsive domains, delivery of the four priority 7-day standards and in-year information.

- **Finance and use of Resources:** Financial efficiency and progress in meeting the financial control total.

- **Operational Performance:** Progress with improving and sustaining performance against NHS Constitution and other standards.

- **Strategic Change:** How well providers are delivering the strategic changes set out in the Five Year Forward View.

- **Leadership and Improvement Capability:** A shares system view with CQC on what good governance and leadership looks like, including organisations' ability to learn and improve, building on the joint CQC and NHSI well-led framework.

NHSI will use the information they collect on provider performance to identify where providers need support across these five themes. NHSI have identified an initial set of measures and triggers which will assist them to determine the level of support required and this report will focus on one of the five themes that is Quality of Care.

Specifically NHSI will use the quality indicators outlined in table 1 to supplement CQC information in order to identify where providers may need support under the theme of quality:-

Table 1 : Quality Performance Metrics

Measure	Frequency	Target
Mixed sex accommodation breaches	Monthly	0
Inpatient scores from Friends & Family Test - % positive	Monthly	≥95%
A&E scores from Friends and Family Test - % positive	Monthly	≥95%
Emergency C-Section Rate	Monthly	
Maternity scores from Friends & Family Test - % positive	Monthly	≥95%
VTE Risk Assessment	Quarterly	≥95%
Clostridium difficile - variance from plan	Monthly	≤5
Clostridium difficile - infection rate	Monthly	
MRSA bacteraemia	Monthly	0

Quality of Care

3. Infection Control

3.1 MRSA Bacteraemia

There have been no post-48 hour MRSA bacteraemia reported in November 2017. The total number of MRSA bacteraemia attributed to the Trust year to date is one.

3.2 Clostridium Difficile

Nine cases of post 48 hour Clostridium difficile were reported in November 2017. This is above the Trust monthly trajectory of five. The total number of cases this year is 45 against YTD trajectory of 41 cases and an annual trajectory of 64 cases.

Two wards experienced an increased incidence of Clostridium difficile (ward 2 and ward 29 at Birmingham Heartlands Hospital) due to two or more cases of post 48 hour Clostridium difficile on the ward within a 28 day period. Isolates have been sent for typing to determine if there has been transmission of Clostridium difficile between patients.

3.3 MRSA Screening

Compliance with MRSA screening was within the required target of 90% for the month with emergency screening achieving 92% compliance and elective screening achieving 95% compliance. This is an improvement from the previous month.

3.4 Outbreaks and Incidents

An outbreak of MRSA was declared on ward 8 at Solihull Hospital in November 2017. Three patients in the same bay were identified as having an indistinguishable strain of MRSA colonisation.

A community outbreak of measles was reported. To date a total of 12 inpatients at Birmingham Heartlands Hospital were identified with measles all of whom are community acquired cases. Ten children and one adult are epidemiologically linked all being from the Romanian community. The second adult has no links to the other cases.

4. Tissue Viability

4.1 Avoidable Grade 2 Pressure Ulcers

There were five avoidable grade 2 pressure ulcers reported in October 2017.

The Trust has reported a total of 51 avoidable grade 2 pressure ulcers year to date against a trajectory of no more than 102 for the year. The Trust is currently on target to achieve the required 10% reduction in avoidable Grade 2 pressure ulcers.

4.2 Avoidable Grade 3 Pressure Ulcers

There were no avoidable grade 3 hospital acquired pressure ulcers reported in October 2017.

A total of 7 avoidable grade 3 pressure ulcers have been reported year to date against an annual trajectory of 36. Two of the seven were reported by Community Services. The Trust is currently on target to achieve the required 10% reduction in avoidable grade 3 pressure ulcers.

4.3 Avoidable Grade 4 Pressure Ulcers

One avoidable grade 4 pressure ulcer was reported in October 2017 against a zero tolerance target. This is the only avoidable grade 4 pressure ulcer reported year to date.

The avoidable grade 4 pressure ulcer developed on Ward 18 at Birmingham Heartlands Hospital. The patient had a spinal fracture and was cared for on a normal mattress as requested by the Orthopaedic Doctors, to allow turning and stability of the fracture. The patient was reviewed by a Consultant Nurse from Oswestry who requested that the patient be nursed on a spinal bed. The bed was requested via the Clinical Equipment Resource Centre (CERC) at Birmingham Heartlands Hospital but there was no bed available for at least two days. This was not escalated to the Matron or the Head Nurse for the Division. In addition to this, the patient did not have all skin inspections completed as required.

In response to this unacceptable practice an action plan is in place on Ward 18 and the Tissue Viability Team have completed extensive training with the Ward staff. Performance notices have been issued to responsible staff and the Supervisory Ward Sister. The Matron will be responsible for ensuring the action plan is enacted and will report performance at the Divisional Quality meeting.

4.4 Care Quality Metrics - Tissue Viability Assessment

Tissue viability metrics were compliant at 98% in November 2017 with the metric for 'repositioning frequency adhered to' also compliant at 92%.

5. Dementia Screening

It is an expectation of the Trust that all patients over the age of 75 are screened for dementia. The Trust target for this indicator is 90% and performance for November 2017 currently shows that the Trust remains non-compliant at 81.95%

Performance by Division is as follows:-

	Jun17	Jul17	Aug17	Sep17	Oct17	Nov17
Division 1	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
Division 2	100.00%	50.00%	100.00%	N/A	100.00%	N/A
Division 3	89.37%	88.34%	84.31%	84.42%	84.56%	81.84%
Division 4	94.12%	93.22%	90.43%	86.67%	77.91%	77.03%
Division 5	82.98%	85.09%	85.71%	81.97%	92.40%	85.53%
TRUST	**88.76%**	**88.18%**	**85.00%**	**84.18%**	**85.53%**	**81.95%**

The actions to improve performance are:-

- **Division 3** - The Divisional Director has discussed current performance with the Clinical Directors for individual directorates. The dementia screening assessments are discussed at Jonah rounds along with support from the Matrons, Group Managers and Group Support Managers.

- **Division 4** - All patients that have not been screened are reviewed by the Head Nurse and Divisional Director. Any Consultants who are non-compliant with screening are escalated via the Clinical Director. All wards have a daily Dementia screening list which is reviewed by the Matrons, Supervisory Ward Sisters and General Managers.

- **Division 5** - The Divisional Director has spoken with Clinical Directors with regards to their responsibility in ensuring that the assessment is completed. The Division continues to send a daily email to consultants and Senior Sisters who have patients without a dementia screen.

Divisional performance is monitored through Trust wide Divisional Reviews where there will be an expectation to see an increase in improvement during the coming months.

6. Parkinson's Medication

It is an expectation that 90% of all Parkinson's medication is administered within 30 minutes. Compliance against this indicator has remained fairly static at around 80-82%.

Performance in November 2017 shows that the Trust is still non-compliant at 76.71%.

Performance by Division is as follows:-

	Jun17	Jul17	Aug17	Sep17	Oct17	Nov17
Division 1	100.00%	99.22%	96.88%	86.73%	100.00%	93.33%
Division 2	57.14%	54.55%	N/A	100.00%	57.14%	N/A
Division 3	81.13%	83.21%	75.90%	75.61%	76.65%	76.69%
Division 4	81.91%	84.50%	85.33%	86.61%	86.01%	76.84%
Division 5	80.19%	73.87%	69.21%	76.22%	73.31%	76.13%
TRUST	**81.58%**	**83.82%**	**80.10%**	**82.03%**	**80.02%**	**76.71%**

In addition to the actions taken during October 2017, the following has also taken place:-

- **Division 3** - Ward Managers are holding accountability conversations with individual Nurses when doses are missed. No patients have been reported as experiencing a Parkinsonian crisis and ongoing monitoring continues in relation to compliance.

- **Division 4** - The Parkinson's bleep is now carried by the nurse who is caring for the patient and not the Nurse in charge. This is following the best practice shared from Division 5 in October and the improvements in performance this has shown. The top three wards for non-compliance have been identified and performance is being reviewed.

- **Division 5** - The Head Nurse met with the Trust's Safety Learning Advisor on 11th December 2017 to discuss additional actions to improve performance. During October 2017, the Division trialled the nurse in charge of the patient with Parkinson's holding the bleep on one ward and this is now being rolled out to other wards in Division. Performance in this Division has improved by almost 3% in month.

7. Admissions, Discharges and Transfers (ADT)

Performance against this standard shows that the Trust is currently non-compliant at 88.09%, although this is an improvement in month.

Performance by Division is as follows:-

	Jun17	Jul17	Aug17	Sep17	Oct17	Nov17
Division 1	82.33%	80.11%	79.50%	78.93%	72.34%	84.81%
Division 2	92.78%	91.30%	92.05%	91.66%	90.37%	90.40%
Division 3	89.74%	88.99%	89.00%	86.91%	88.78%	88.51%
Division 4	83.53%	82.76%	82.16%	86.19%	82.77%	82.35%
Division 5	89.98%	90.61%	90.47%	89.88%	89.57%	90.81%
TRUST	**83.65%**	**88.32%**	**88.45%**	**87.87%**	**87.66%**	**88.09%**

Actions to continue to improve performance include:-

- **Division 3** - Acute Medical Units are trialling new Ward Clerk hours mapped against the peak times for activity.

- **Division 4** - Ongoing training is being provided to new starters. Staff continue to be allocated to complete ADTs after the Ward Clerk has left duty in the evening time and file notes have been issued to all staff who have failed to complete their ADT's according to the required standard.

- **Division 5** - Bespoke training days have been arranged at Birmingham Heartlands and Good Hope Hospitals for January 2018 to accommodate staff who have been unable to attend training due to difficulties being released from clinical duties.

8. Nurse Staffing

8.1 Compliance with UNIFY

The following table outlines compliance with UNIFY for November 2017:-

Divisional Area	Qualified Compliance	HCA Compliance
Division 1 Wards	98%	134%
Division 1 Critical Care	92%	85%
Division 2 Paediatrics	86%	108%
Division 2 Obs & Gynae	91%	91%
Division 3	95%	114%
Division 4	94%	126%
Division 5	91%	121%
Trust Overall	**92%**	**110%**

This is the second month that staffing compliance has been collected using the UNIFY report direct from the e-Roster. There is a picture of lower compliance during November 2017 with qualified staffing levels during the day and higher compliance overnight. There is also a high usage of HCAs, some of which is to compensate for nurse shortages.

Critical care and paediatrics although rated red were safely staffed as their areas are staffed based on acuity of patients which fluctuates throughout each day.

8.2 Vacancy Position

Qualified vacancies are a total of 334.58 WTE in November 2017, a reduction of 44.27 WTE in month and the third consecutive month where qualified vacancies have decreased. The projection is for a further 65 qualified starters across December 2017and January 2018.

8.3 Recruitment

Joint discussions are planned between University Hospitals Birmingham NHS Foundation Trust and Heart of England NHS Foundation Trust to discuss possible options of overseas recruitment and further cohorts of Trainee Nursing Associates are being scoped for 2018 based on the agreement to train at Band 2 and funding support from Health Education England.

9. Friends and Family Test (FFT)

During November 2017, the percentage of positive responders has increased in month at 95% for inpatients. For the Emergency Departments, the positive responder score remains static at 80% for November 2017.

Response rates have increased by 5% in November 2017 to 36% for inpatients, compared to 31% in October 2017. The response rate for Emergency Departments has decreased slightly to 13%, compared to 14% in October 2017.

Patient comments received via FFT are shared with Divisions and the themes evident for improvement are analysed and presented in a quarterly report.

10. Complaints

The current performance for October 2017 received complaints is 69%. This is a final validated figure and continues to show improvement in performance.

Therefore, the October 2017 Divisional performance is as follows:-

	Aug17	Sep17	Oct17
Division 1	70%	0%	100%
Division 2	33%	60%	46%
Division 3	52%	59%	54%
Division 4	39%	90%	93%
Division 5	65%	86%	73%
TRUST	**53%**	**75%**	**69%**

The total number of complaints received during October 2017 was 100 and the total number closed was 117.

All Divisions receive accurate and up to date listings of their live complaints to support progression of complaints responses within each Division.

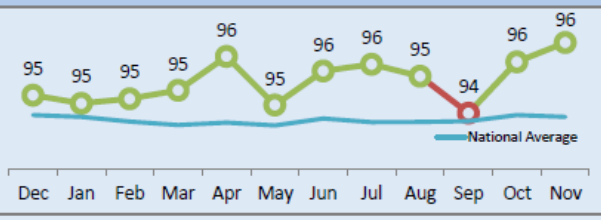
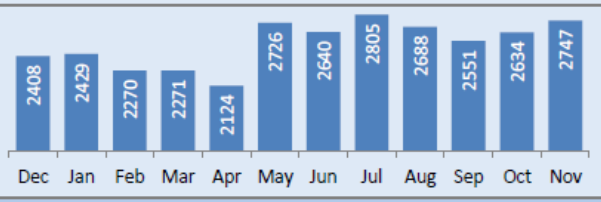
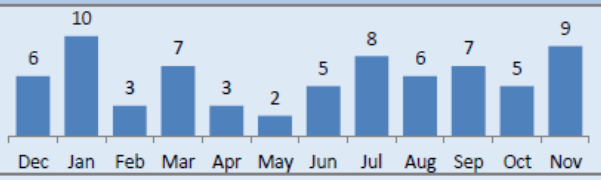
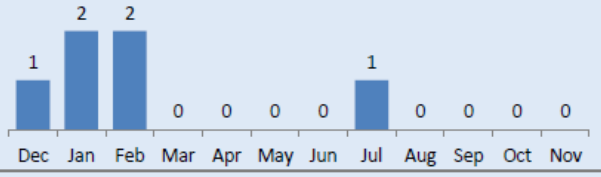
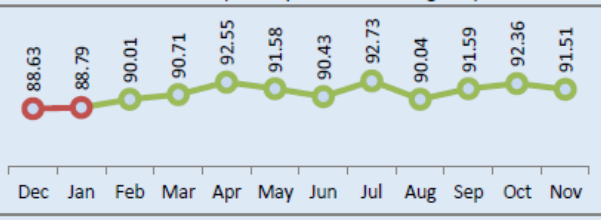
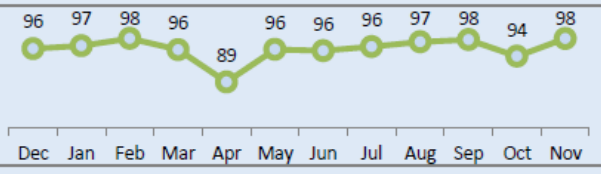
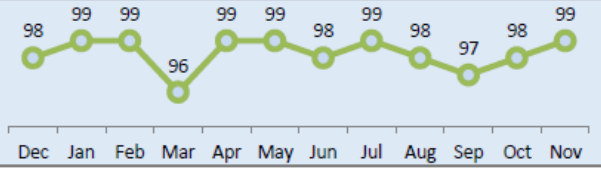
Appendix
Ward to Board Report - November 2017

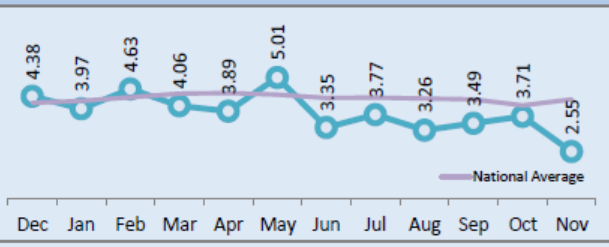
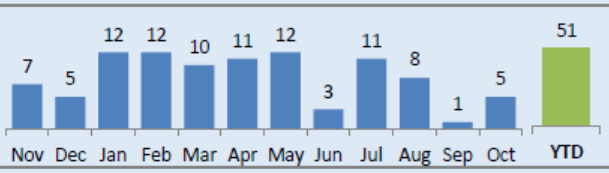
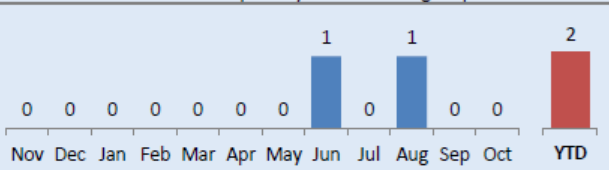
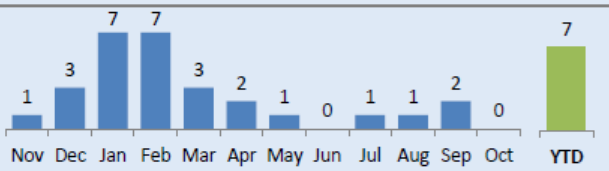
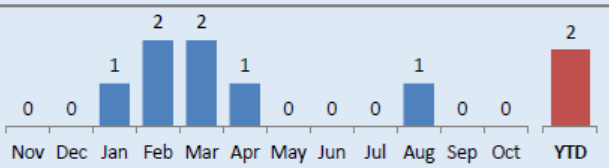
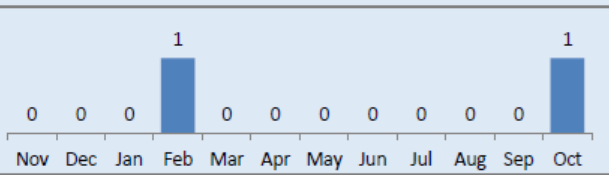
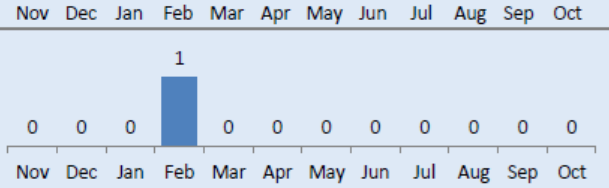
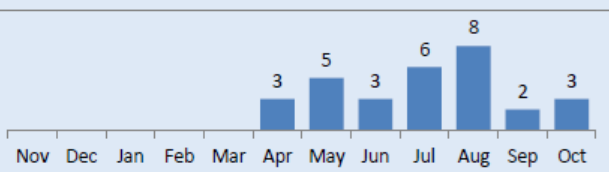
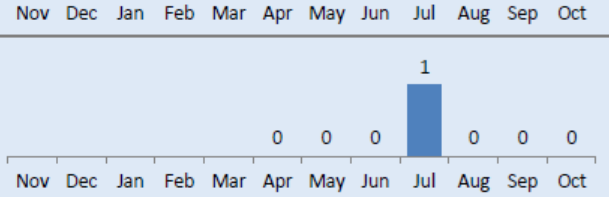
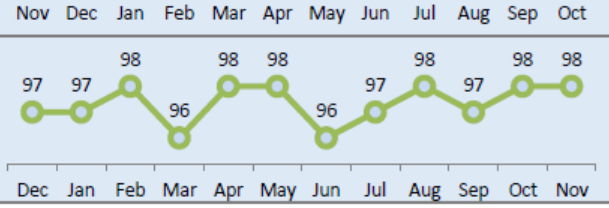
Nursing & Midwifery Ward to Board Assurance Report

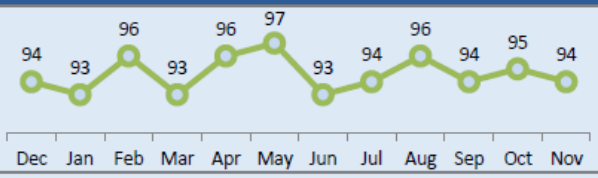
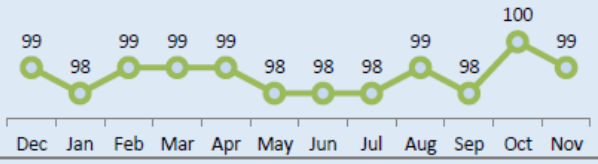
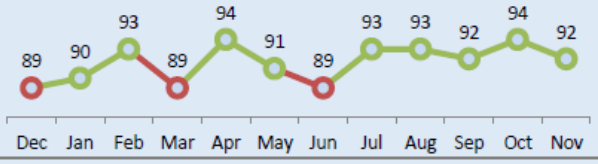
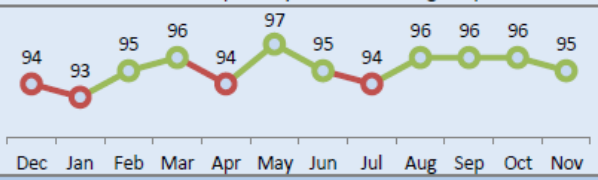
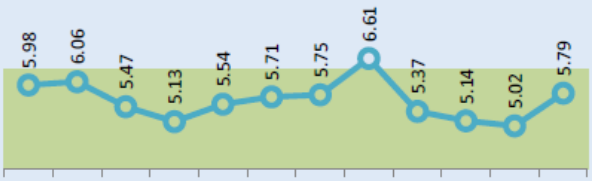
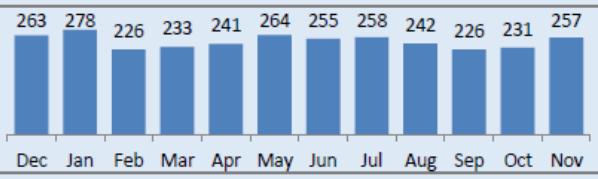
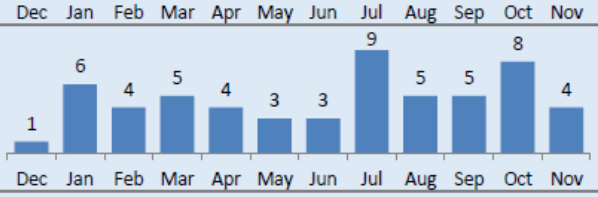
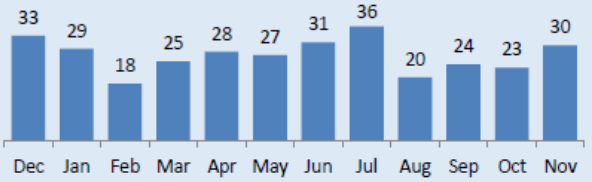
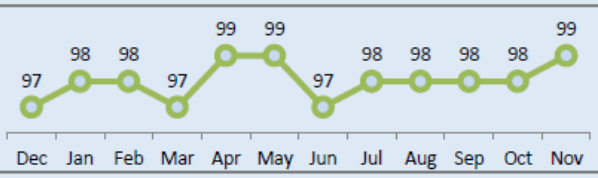
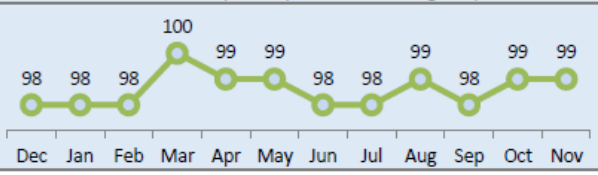
Building healthier lives

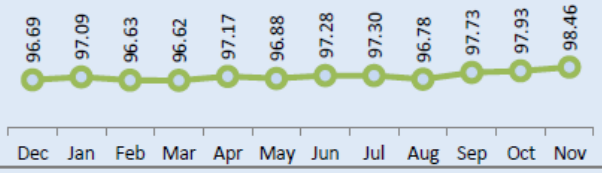
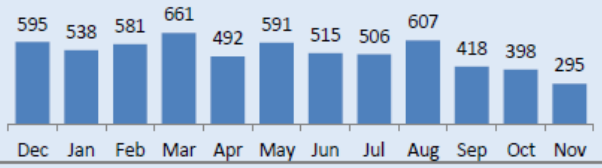
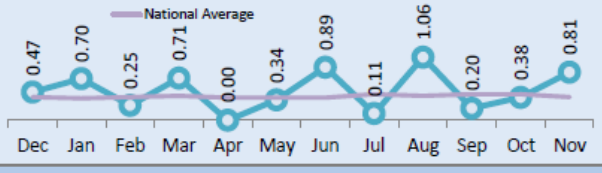
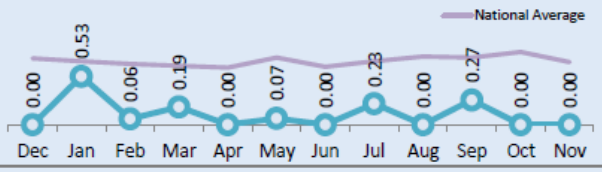
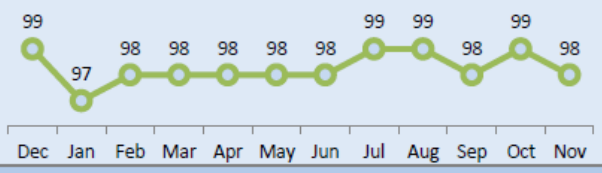
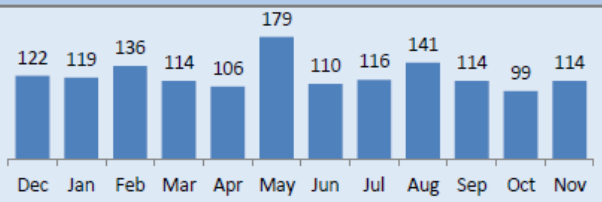
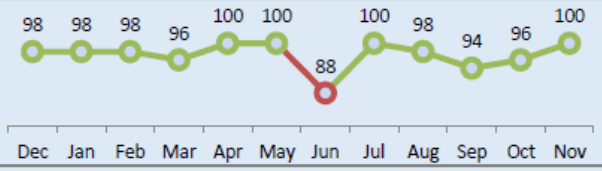
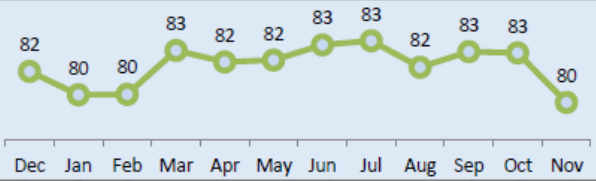
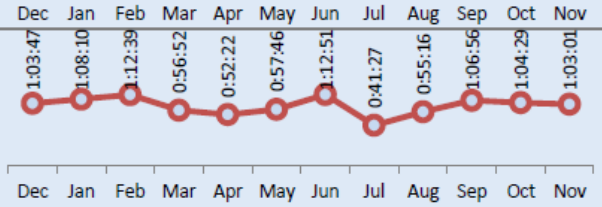
Heart of England NHS
NHS Foundation Trust

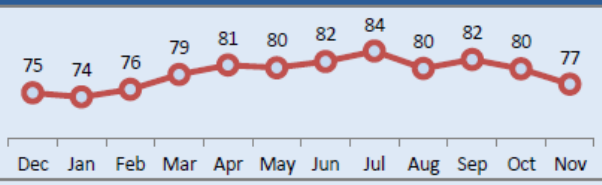
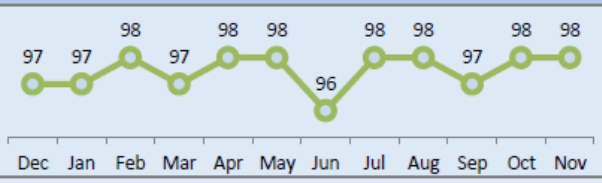
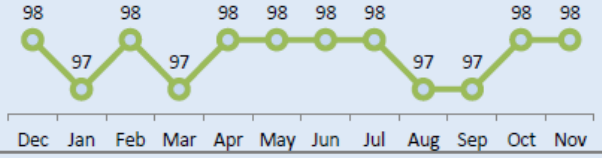
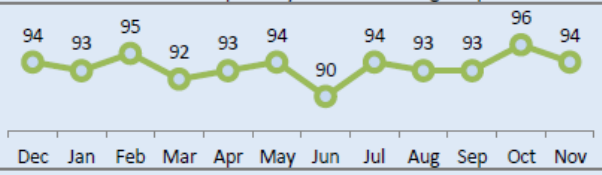
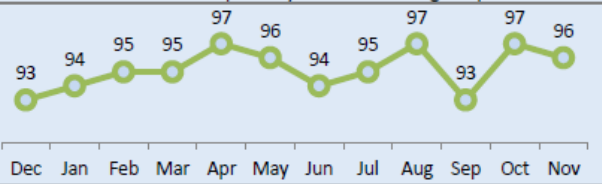
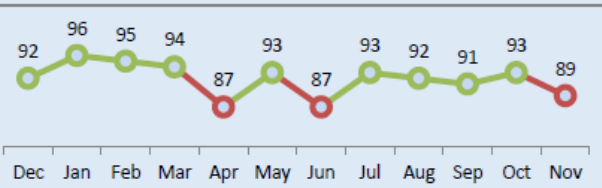
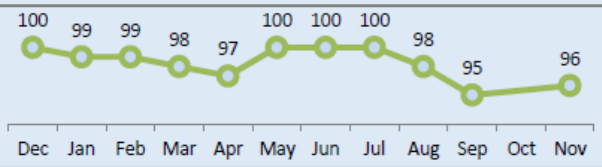
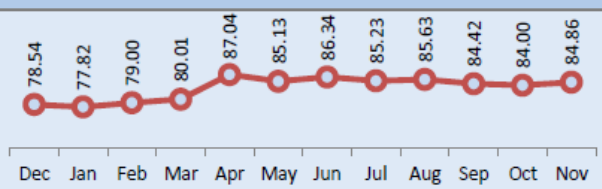
TRUST LEVEL OVERVIEW

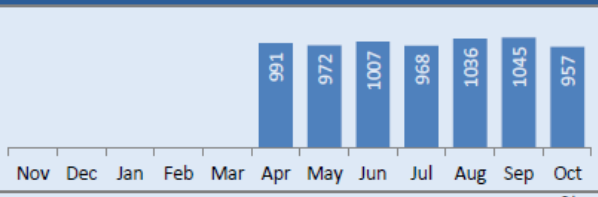
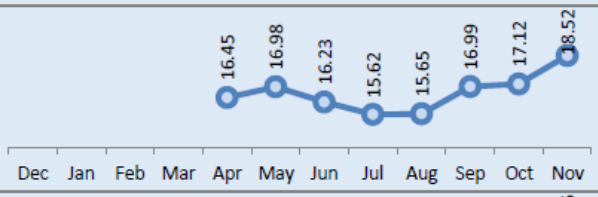
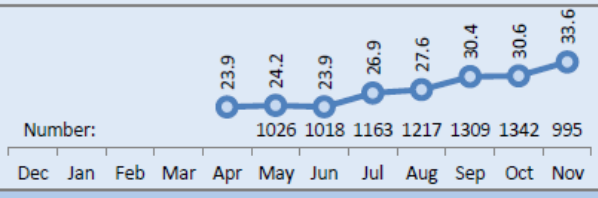
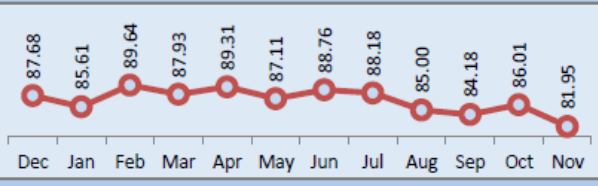
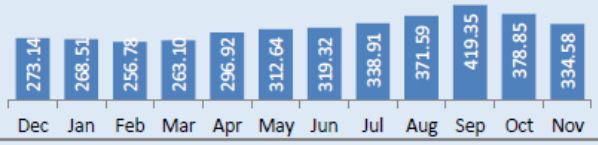
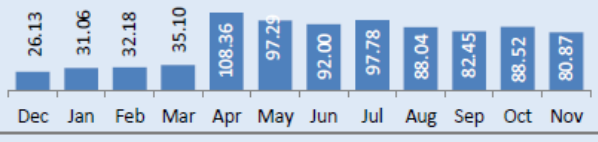
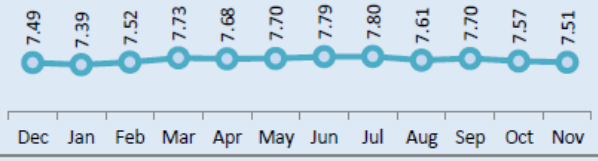
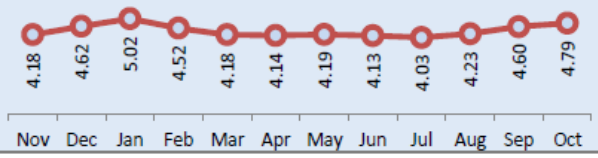
Ref	Indicator Name	Target	Performance	In Month Position Nov-17
	Harm Free Care			
1	Harm Free Care *% of patients receiving harm free care recorded via NHS Safety Thermometer*	≥95%		96%
2	Incidents Reported *Number of incidents reported*			2747
	Infection Control			
3	Clostridium Difficile *Number of avoidable cases*	≤5		9
4	MRSA *Number of cases*	*0*		0
5	MRSA Screening (Emergency) *% of patients screened*	≥90%		91.51%
6	Hand Hygiene Compliance *% compliance with hand hygiene*	≥85%		98%
7	Care Quality Metrics: Environment Score *% compliance with environment indicators*	≥90%		99%

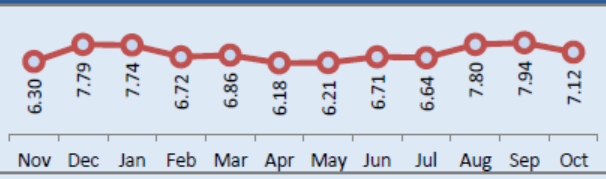
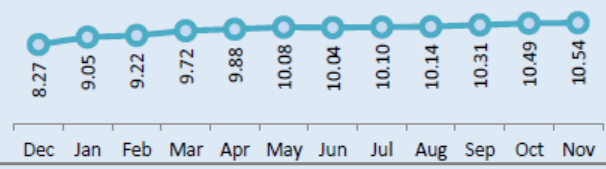
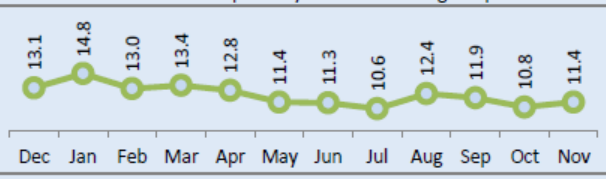
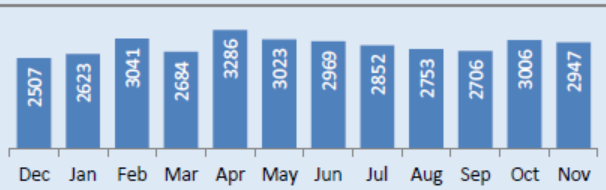
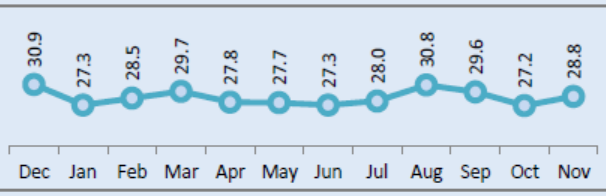
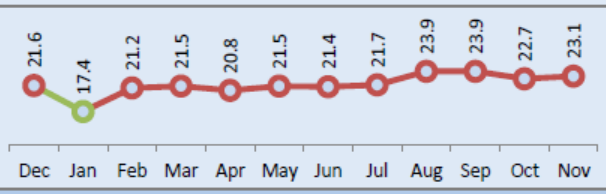
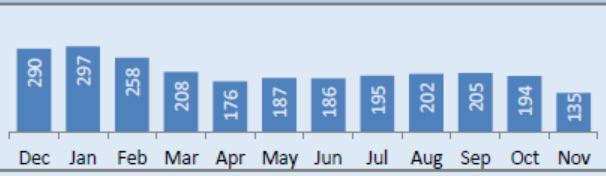
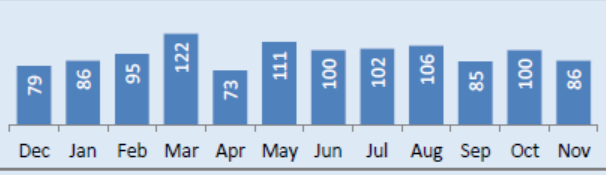
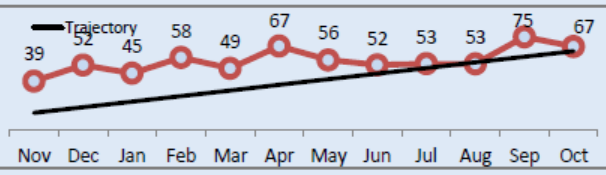
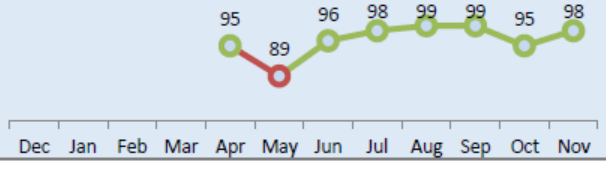
Ref	Indicator Name	Target	Performance	
	Tissue Viability			
8	Pressure Ulcer Prevalence *% of patients with a pressure ulcer (old and new) reported via NHS Safety Thermometer*			In Month Position Nov-17 2.55%
9a	Avoidable Grade 2 Pressure Ulcers *Number of avoidable cases*	*<102 at year end*		In Month Position Oct-17 5
9b	Avoidable Grade 2 Pressure Ulcers (Community) *Number of avoidable cases*	*<4 at year end*		In Month Position Oct-17 0
10a	Avoidable Grade 3 Pressure Ulcers *Number of avoidable cases*	*<36 at year end*		In Month Position Oct-17 0
10b	Avoidable Grade 3 Pressure Ulcers (Community) *Number of avoidable cases*	*<7 at year end*		In Month Position Oct-17 0
11a	Avoidable Grade 4 Pressure Ulcers *Number of avoidable cases*	*0*		In Month Position Oct-17 1
11b	Avoidable Grade 4 Pressure Ulcers (Community) *Number of avoidable cases*	*0*		In Month Position Oct-17 0
12a	Avoidable Suspected Deep Tissue Injury (SDTI) Pressure Ulcers *Number of avoidable cases*			In Month Position Oct-17 3
12b	Avoidable Suspected Deep Tissue Injury (SDTI) Pressure Ulcers (Community) *Number of avoidable cases*			In Month Position Oct-17 0
13	Care Quality Metrics: Tissue Viability *% compliance with tissue viability indicators*	*≥95%*		In Month Position Nov-17 98%

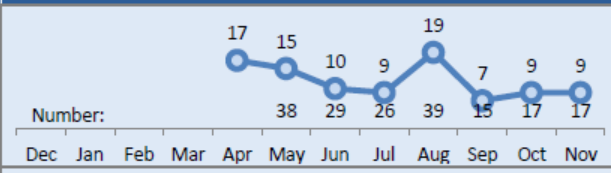
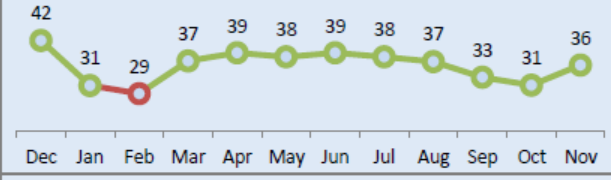
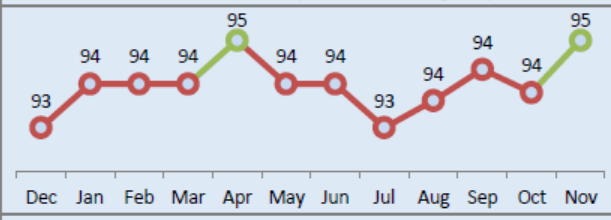
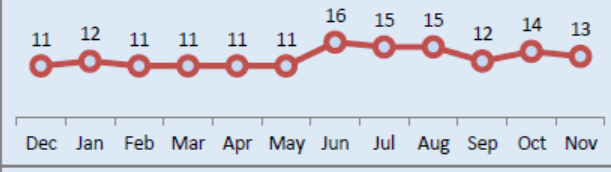
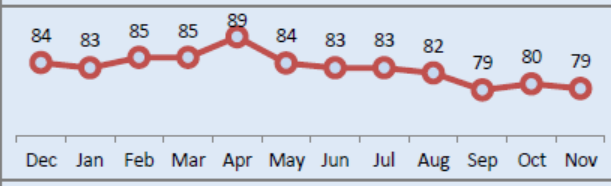
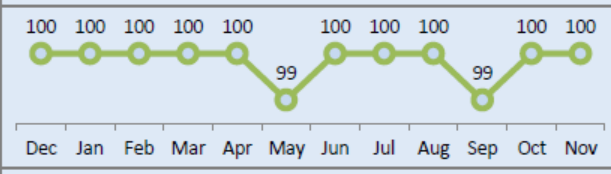
Ref	Indicator Name	Target	Performance	
14	Care Quality Metrics: SSKIN Bundle - Daily skin inspection *A daily skin inspection is recorded if the patient is identified as being at risk*	≥90%		In Month Position Nov-17 94%
15	Care Quality Metrics: SSKIN Bundle - Repositioning frequency completed *The repositioning frequency has been completed*	≥90%		In Month Position Nov-17 99%
16	Care Quality Metrics: SSKIN Bundle - Repositioning frequency adhered to *The repositioning frequency has been adhered to for the past three days*	≥90%		In Month Position Nov-17 92%
17	Matrons Assurance: Overall Tissue Viability Score *% compliance with matrons assurance metrics for tissue viability*	≥95%		In Month Position Nov-17 95%
	Inpatient Falls			
18	Falls Rate *Falls rate per 1,000 occupied bed days*	≤6.36		In Month Position Nov-17 5.79
19	Falls Incidence *Number of inpatient falls*			In Month Position Nov-17 257
20	Injurious Falls *Number of falls resulting in a fracture or head injury*			In Month Position Nov-17 4
21	Recurrent Fallers *Number of patients falling twice or more during the same admission*			In Month Position Nov-17 30
22	Care Quality Metrics: Falls Assessment *% compliance with overall falls assessment indicator*	≥90%		In Month Position Nov-17 99%
23	Care Quality Metrics: Manual Handling *% compliance with overall manual handling indicator*	≥90%		In Month Position Nov-17 99%

Ref	Indicator Name	Target	Performance	In Month Position Nov-17
	VTE			
24	VTE Screening *% of patients screened for VTE*	≥95%		98.46%
25	VTE Screening *Number of patients NOT screened*			295
26	Prevalence of New VTE *% of patients with a new (hospital acquired) VTE reported via NHS Safety Thermometer*			0.81%
	UTI			
27	Ca-UTI *% of catheterised patients with a UTI reported via NHS Safety Thermometer*			0.00%
28	Care Quality Metrics: Continence Assessment *% compliance with overall continence assessment indicator*	≥90%		98%
	Medication			
29	Medication Incidents *Number of medication incidents reported via Datix*			114
30	Care Quality Metrics: Medication - Secure Medicines / Cupboard *% compliance with indicator*	90%		100%
31	Antibiotic STAT Doses *% of antibiotic STAT doses administered within 1 hour*	≥80%		80%
32	Antibiotic STAT Doses *Average time taken for doses administered AFTER 1 hour*	≤1 hour		1:03:01

Ref	Indicator Name	Target	Performance	In Month Position Nov-17
33	Parkinsons Medication *% of Parkinsons medication administered within 30 minutes*	≥90%		77%
34	Guardrails © Medication Safety Software (for IV systems) *% compliance with use of Guardrails © medication safety software*			
	Care Quality Metrics			
35	**Care Quality Metrics: Overall Clinical Score** *% compliance with overall care quality metrics*	≥95%		98%
36	Care Quality Metrics: Observations *% compliance with observations indicator*	≥90%		98%
37	Care Quality Metrics: Fluid Balance *% compliance with fluid balance indicator*	≥90%		94%
38	Care Quality Metrics: Nutritional Assessment *% compliance with nutritional assessment indicator*	≥90%		96%
39	Care Quality Metrics: Blood Glucose Monitoring *% compliance with blood glucose monitoring indicator*	≥90%		89%
40	**Care Quality Metrics: Community Services Overall Score** *% compliance with overall care quality metrics*	≥95%		96%
	Patient Flow			
41	ADTs *% of discharges completed within 2 hours*	≥95%		84.86%

Ref	Indicator Name	Target	Performance	
42	Readmissions: 28 days *Number of patients readmitted within 28 days of discharge* Data One Month in Arrears			In Month Position Oct-17 957
43	Discharges before 12pm *% of patients discharged before 12 o'clock midday*			In Month Position Nov-17 18.52%
44	Discharge Lounge Utilisation *% of patients utilising the discharge lounge*			In Month Position Nov-17 33.6%
	Dementia			
45	Dementia Screening *% of eligible patients screened for dementia*	≥90%		In Month Position Nov-17 81.95%
	Nurse Staffing			
46	UNIFY Compliance *Overall compliance in month*	≥90%	Qualified Compliance: 98% HCA Compliance: 134%	
47a	Registered Vacancy Position *Number of WTE Vacancies for registered nursing staff*			In Month Position Nov-17 334.58
47b	Unregistered Vacancy Position *Number of WTE Vacancies for unregistered nursing staff*			In Month Position Nov-17 80.87
48	Care Hours per Patient Day *Number of care hours per patient day*			In Month Position Nov-17 7.51
49a	Sickness: Registered Staff *% of nursing & midwifery sickness in month*	≤4%		In Month Position Oct-17 4.79%

Ref	Indicator Name	Target	Performance	
49b	Sickness: Unregistered Staff *% of nursing & midwifery sickness in month*	≤4%		In Month Position Oct-17 7.12%
50	Turnover *% of staff turnover*			In Month Position Nov-17 10.54%
51	e-Rostering KPI: Unfilled Duties *% of planned duty hours that were left unfilled*	<30%		In Month Position Nov-17 11.4%
52	e-Rostering KPI: Additional Duties *Number of duties rostered in addition to planned staffing levels*	*0*		In Month Position Nov-17 2947
53	e-Rostering KPI: Unavailability *% of leave and unavailability*			In Month Position Nov-17 28.8%
54	e-Rostering KPI: Temporary Staffing *% of duties filled by bank and agency staff*	<20%		In Month Position Nov-17 23.1%
	Patient Experience			
55	Live / Open / Active Complaints *Number of active complaints*			In Month Position Nov-17 135
56	New Complaints Received *Number of new complaints received in month*			In Month Position Nov-17 86
57	Complaints Response Rate *% of complaints responded to within 30 days or less* Data One Month in Arrears	≥80%		In Month Position Oct-17 67%
58	Complaints KPI: Complaints Sent to Divisions *% of complaints sent to Divisions / Operational Teams within one working day*	≥90%		In Month Position Nov-17 98%

Ref	Indicator Name	Target	Performance	In Month Position Nov-17
59	Complaints KPI: Complaints Older than 50 Days *% of complaints older than 50 days without a response*			9%
60	Friends & Family Test: Inpatients *% response rate*	≥30%		36%
61	Friends & Family Test: Inpatients *P ositive responder score*	≥95%		95%
62	Friends & Family Test: Emergency Departments *% response rate*	≥20%		13%
63	Friends & Family Test: Emergency Departments *P ositive responder score*	≥95%		79%
64	Care Quality Metrics: Patient Safety & Dignity *% compliance with patient safety and dignity indicator*	≥90%		100%
65	Compliments *TBC*			

HEART OF ENGLAND NHS FOUNDATION TRUST

COUNCIL OF GOVERNORS

MONDAY 22 JANUARY 2018

Title:	Finance Report to 31 December 2017
Responsible Director :	Julian Miller, Interim Director of Finance
Contact	Ext. 40411

Purpose	To provide an update on the Trust's finances for the period ending 31 December 2017 (Month 9 2017/18).
Confidentiality Level & Reason	Confidential
Annual Plan Ref	
Key Issues Summary:	• The Trust has a planned deficit of (£28.8m) pre Sustainability and Transformation Funding (STF) for the 2017/18 financial year. • The full STF allocation for the Trust is £21.3m subject to financial performance. Of this, 30% (£6.4m) is also tied to A&E performance. • Including full STF, the Trust has a planned deficit of (£7.5m) for the year in line with the control total required by NHSI. • The in-month position is a deficit of (£4.9m) against a planned deficit pre STF of (£2.4m), an adverse variance of (£2.5m). • The year to date position at month 9 is a deficit of (£43.0m) against a planned deficit pre STF of (£21.7m), an adverse variance of (£21.3m). • The reported position excludes the allocation of STF for the year to date due to the adverse financial position against the plan. • A revised year-end forecast was submitted to NHS Improvement at Q2 indicating a likely deficit of circa (£48.4m) compared to a pre-STF planned deficit of (£28.8m) i.e. an adverse variance of (£19.6m). This was predicated on NHS clinical income returning to plan. • In December 2017, the Trust received confirmation that it will receive £4.2m of non-recurrent winter funding. Of this, £2.2m is to meet existing winter costs, with the expectation that the forecast improves by an equivalent amount. The other £2.0m is for additional service provision to improve performance against the 4 hour target. • The month 9 position includes £0.9m of winter funding. • The year-end position is now likely to be worse than

	forecast due to the continued deterioration in Healthcare Income. • The cash balance is £16.9m at 31 December 2017, including (£22.4m) of interim revenue support (working capital loan). • The Use of Resources Metric (UoR) is a now 4 due the increase in agency expenditure during December.
Recommendations	The Council of Governors is requested to: • Receive the contents of this report.

Approved by:	Julian Miller	16 January 2018

HEART OF ENGLAND NHS FOUNDATION TRUST

COUNCIL OF GOVERNORS

MONDAY 22 JANUARY 2018

FINANCE REPORT FOR THE PERIOD ENDING 31 DECEMBER 2017

PRESENTED BY THE INTERIM DIRECTOR OF FINANCE

1. Introduction

This report covers the first nine months of the 2017/18 financial year, for April to December 2017. The report summarises the Trust's financial performance and includes information on healthcare activity, expenditure variances and Cost Improvement Programme (CIP) delivery.

The Financial Plan agreed by the Board of Directors on 23 January 2017 included a pre Sustainability and Transformation Fund (STF) deficit of (£28.8m) for 2017/18. The Trust's STF allocation is £21.3m which if received in full would reduce the Trust's plan deficit to (£7.5m) in line with the control total mandated by NHS Improvement (NHSI).

The Trust has reported an actual deficit of (£4.9m) for December 2017 (month 9) compared to a pre STF planned deficit of (£2.4m), an adverse variance of (£2.5m). This moves the year to date deficit to (£43.0m) against a planned deficit pre STF of (£21.7m), an adverse variance of (£21.3m).

The key variances against the plan year to date include:

- Under-performance against clinical income targets (£10.3m);
- Under-delivery against CIP targets (£2.1m) – of which (£0.4m) is a gap in the programme, (£0.8m) relates to phasing and (£0.9m) relates to slippage against planned delivery; and
- Under-delivery against FRP/stretch savings target (£6.8m) – of which (£4.6m) is a gap in the programme, (£0.3m) relates to phasing and (£1.9m) relates to slippage.
- Inability to replace 2016/17 non-recurrent benefits of (£5.1m).

As a result of the adverse financial performance, the allocation of STF year to date (£3.3m in quarter 1, £4.2m quarter 2, £6.4m quarter 3) totalling £13.9m, has not been recognised and this forms part of the (£43.0m) year to date deficit.

A revised year end forecast was submitted to NHSI at Q2 indicating a likely deficit of circa (£48.4m) by the end of the year, compared to the original pre-STF deficit of (£28.8m), an adverse variance of (£19.6m). Following receipt of additional funding in December 2017, there is an expectation that there will be a corresponding improvement in the reported Month 7 forecast outturn financial position. However, the year-end position is likely to be worse than forecast due to the continued deterioration in Healthcare Income Further details are set out in section 2.7.

The cash balance at the end of December is £16.9m against the plan of £3.0m at this point, a favourable movement of £13.9m. However, this includes a £22.4m working capital loan.

2. Income & Expenditure

2.1 Summary Position

The Trust's income and expenditure position as at the end of December is a (£43.0m) deficit against the planned deficit pre STF of (£21.3m).

Table 1 below details the actual income and expenditure deficit compared to the planned trajectory submitted to NHS Improvement both pre and post STF allocation.

Table 1: I&E – Actual vs Plan

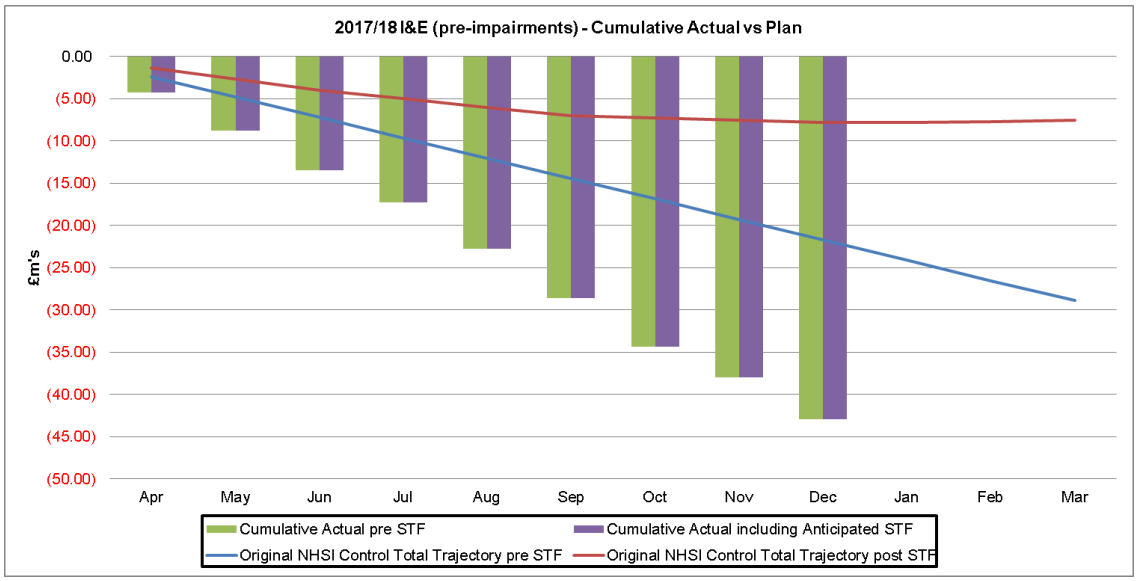


Table 2 below summarises the Trust's income and expenditure position at the end of December with analysis of expenditure from section 2.2 and operating revenue from section 2.6 below.

Table 2: Income and Expenditure Plan vs Actual

	In Month Plan £m	In Month Actual £m	In Month Variance £m	YTD Plan December £m	YTD Actual December £m	Variance £m
Control Total Items						
Operating Revenue (excluding STF)	58.5	55.7	(2.8)	526.2	511.7	(14.5)
Operating Expenses	(59.0)	(59.2)	(0.2)	(530.5)	(540.9)	(10.4)
EBITDA	**(0.5)**	**(3.5)**	**(3.0)**	**(4.4)**	**(29.2)**	**(24.8)**
Depreciation	(1.3)	(1.0)	0.3	(12.0)	(9.5)	2.4
Interest Receivable	0.0	0.0	0.0	0.0	0.0	0.0
Interest Payable	(0.0)	(0.0)	0.0	(0.2)	(0.1)	0.0
PDC Dividend	(0.5)	(0.4)	0.1	(4.7)	(3.8)	0.9
Other Finance Costs	(0.1)	(0.0)	0.0	(0.5)	(0.1)	0.4
Control Total Surplus/(Deficit) (pre STF)	**(2.4)**	**(5.0)**	**(2.6)**	**(21.7)**	**(42.8)**	**(21.0)**
STF Income	2.1	0.0	(2.1)	13.9	0.0	(13.9)
Control Total Surplus/(Deficit) (post STF)	**(0.3)**	**(5.0)**	**(4.7)**	**(7.9)**	**(42.8)**	**(34.9)**
Gain/(Loss) on Asset Disposal	0.0	(0.0)	(0.0)	0.0	(0.1)	(0.1)
Donations and Grants Received	0.0	0.1	0.1	0.0	0.2	0.2
Depreciation on Donated Assets	0.0	(0.0)	(0.0)	0.0	(0.3)	(0.3)
Total Surplus/(Deficit) Before Impairments	**(0.3)**	**(4.9)**	**(4.6)**	**(7.9)**	**(43.0)**	**(35.1)**
Impairment (Losses) / Reversals	0.0	0.0	0.0	0.0	0.0	0.0
Surplus / (Deficit) After Impairments	**(0.3)**	**(4.9)**	**(4.6)**	**(7.9)**	**(43.0)**	**(35.1)**

2.2 Operating Expenditure Analysis

The adverse operating expenditure variance of (£0.3m) in month and (£10.4m) year to date can be broken down as detailed in table 3 below.

Table 3: Breakdown of Variance against Plan

	In Mth Plan £m	In Mth Actual £m	Variance £m	YTD Plan £m	YTD Actual £m	Variance £m
PAY						
Medical Staff	10.8	11.5	(0.7)	94.9	100.9	(6.0)
Nursing	15.2	15.6	(0.4)	132.6	138.8	(6.2)
Other	11.5	12.3	(0.8)	109.6	106.1	3.5
Total Pay	**37.5**	**39.3**	**(1.9)**	**337.1**	**345.8**	**(8.7)**
NON PAY						
Drugs	6.2	5.6	0.6	55.9	56.3	(0.4)
Clinical Supplies & Services	4.5	6.3	(1.9)	52.4	54.2	(1.8)
Other	10.9	7.9	2.9	85.2	84.6	0.5
Total Non Pay	**21.5**	**19.9**	**1.6**	**193.4**	**195.1**	**(1.7)**
GRAND TOTAL	**58.9**	**59.2**	**(0.3)**	**530.5**	**540.9**	**(10.4)**

The main areas of pay and non-pay variance are explored further in sections 2.3 and 2.4 below.

2.3 Pay Analysis

Table 4 below details the average monthly pay expenditure each quarter through 2016/17 (adjusted for 2017/18 pay inflation) in comparison to the quarter averages in 2017/18 and month 9 expenditure.

Table 4: Quarterly Average Monthly Pay Expenditure

	2016/17				2017/18			
	Qtr 1 Avg	Qtr 2 Avg	Qtr 3 Avg	Qtr 4 Avg	Qtr 1 Avg	Qtr 2 Avg	Qtr 3 Avg	Month 9
MEDICAL & DENTAL	10.5	10.5	11.0	11.0	10.9	11.3	11.4	11.5
NURSING & MIDWIFERY	15.3	14.9	15.1	15.5	15.5	15.4	15.4	15.6
OTHER SUPPORT STAFF	4.8	5.0	4.8	4.8	4.8	4.8	5.2	5.4
PAMS	2.2	2.2	2.2	2.2	2.2	2.3	2.3	2.4
PROFESSIONAL & TECHNICAL (PTB)	2.3	2.2	2.3	2.3	2.4	2.3	2.4	2.3
SCIENTIFIC & PROFESSIONAL	0.6	0.7	0.6	0.6	0.6	0.6	0.6	0.6
TRUST BOARD	1.8	1.7	1.6	1.5	1.6	1.6	1.6	1.5
Pay Total	**37.4**	**37.3**	**37.7**	**37.9**	**38.0**	**38.3**	**38.9**	**39.3**

The quarter 3 monthly average is higher than quarter 2 but circa £1.6m of this increase relates to the insourcing the G4S contract. Excluding this adjustment the expenditure remains (£0.8m) higher than quarter 3 of last year with the main areas of increase (after inflation adjustment) relating to Medical staffing (increase of £0.4m) and Nurse staffing (increase of £0.4m). The month 9 pay costs of £39.3m are higher than the previous quarter due to winter staffing and the G4S contract.

2.3.1 Medical Staffing

Tables 5.1 and 5.2 below detail the monthly expenditure for medical staff split between consultant and non-consultant posts respectively.

Total medical expenditure was £11.5m in December, which is (£0.1m) higher than the expenditure in November and is (£0.4m) higher than the rolling twelve month average (adjusted for pay inflation) overall.

The December expenditure on consultant medical staff was £6.4m which is £0.1m lower than in November. December expenditure on non-consultant staff was £5.1m which is (£0.2m) higher than in November.

Table 5.1: Senior Medical Expenditure per Month

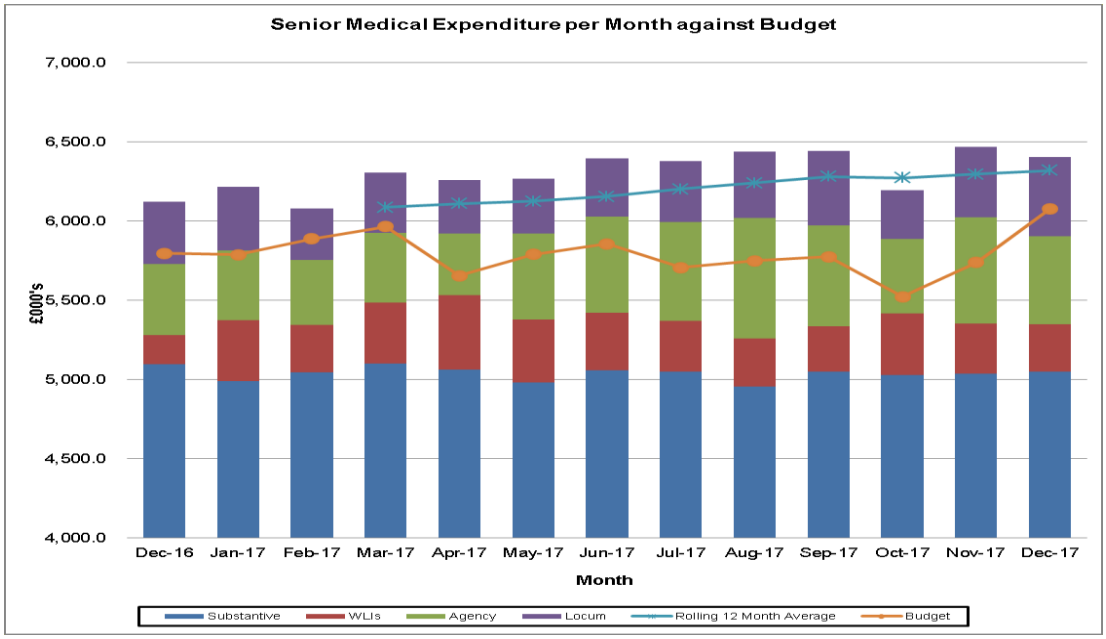
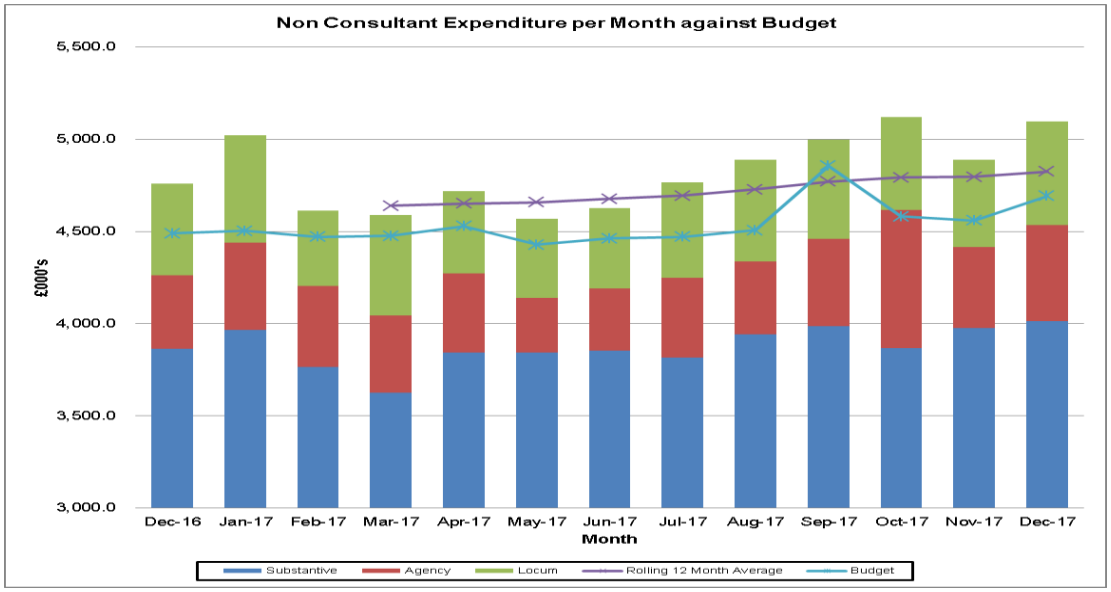


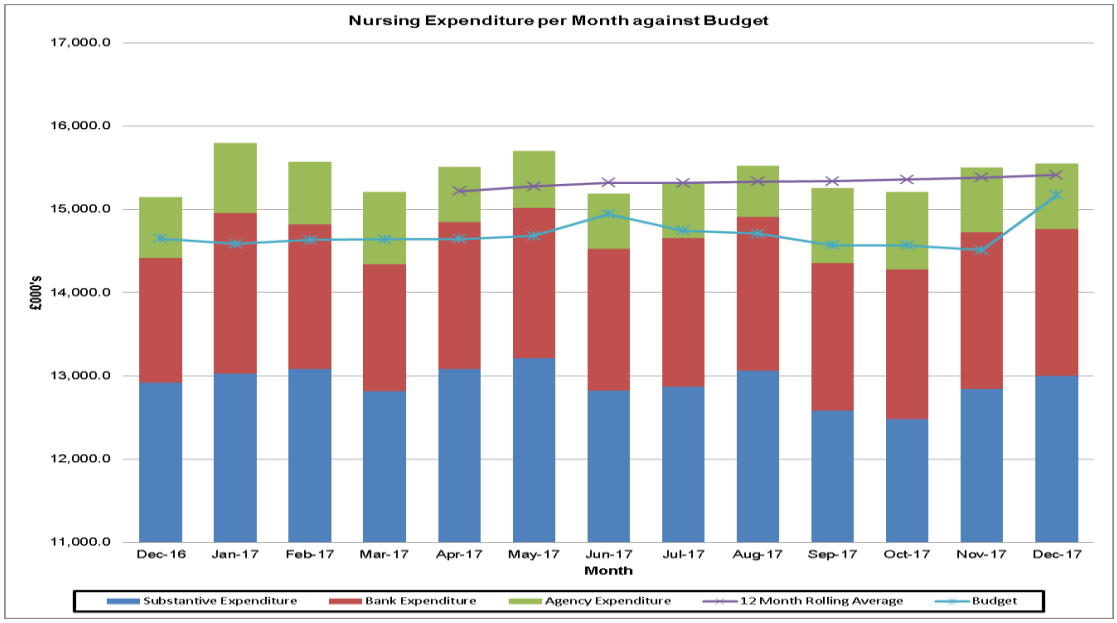
Table 5.2: Non-Consultant Medical Expenditure per Month



2.3.2 Nursing

Table 6 below details the monthly expenditure on nursing compared to the previous twelve months (adjusted for pay inflation).

Table 6: Monthly Nursing Expenditure



Total nursing expenditure in December was £15.6m which is broadly in line with the previous month and is (£0.1m) higher than the rolling 12 month average (adjusted for pay inflation).

2.4 Non Pay Expenditure

Table 7 below details the average monthly non pay spend each quarter by expenditure group through 2016/17 in comparison to the quarters 1, 2 and 3 averages as well as month 9 in 2017/18.

Table 7: Non Pay Spend by Expenditure Group

	2016/17				2017/18			
	Qtr 1 Avg	Qtr 2 Avg	Qtr 3 Avg	Qtr 4 Avg	Qtr 1 Avg	Qtr 2 Avg	Qtr 3 Avg	Mth 9
Clinical Supplies	5.8	5.7	5.9	6.2	6.0	6.1	5.9	6.3
Drugs	5.8	6.1	6.0	6.3	6.2	6.3	6.2	5.6
Less: Pass Through Items	(5.9)	(6.5)	(6.5)	(6.6)	(6.2)	(6.5)	(6.4)	(5.5)
Clinical Supplies and Drugs Subtotal	**5.6**	**5.4**	**5.5**	**5.8**	**6.0**	**6.0**	**5.8**	**6.4**
Non-Clinical Supplies	1.6	1.6	1.6	1.7	1.6	1.6	1.2	1.0
Premises	2.5	2.5	2.6	2.8	2.6	2.8	2.6	2.4
Purchase of Healthcare Services NHS	0.7	0.7	0.6	0.5	0.6	0.7	0.6	0.4
Purchase of Healthcare Services Non NHS	0.6	0.6	0.4	0.4	0.6	0.6	0.6	0.5
Other	5.2	3.7	3.1	3.4	4.2	3.0	3.8	3.6
Grand Total	**16.2**	**14.5**	**13.8**	**14.7**	**15.5**	**14.6**	**14.6**	**14.3**

2.4.1 Drugs and Clinical Supplies and Services

The expenditure on drugs and clinical supplies increased to (£11.9m) in December, an increase of (£0.2m), which was primarily driven by a return to normal run rates following a favourable stock adjustment in November. This expenditure includes a reduction in cost per case drugs and devices of (£1.5m) for which additional healthcare income will be received. This is attributed to the reduction in elective and outpatient activity. The quarterly averages in table 7 above show that the costs of clinical supplies and drugs which are within tariff, increasing this month in comparison to both quarters 1 and 2, and the 2016/17 quarter 3 average.

2.4.2 Non-Clinical Supplies

The continued reduction of £0.2m in month 9 primarily relates to the insourcing of the G4S contract.

2.5 <u>Divisional Performance</u>

Table 8 below details the budgetary variance by Division split by expense type. The “Income” expense type refers to Category C income such as SLA income from other organisations; it does not refer to NHS Clinical Income, which is detailed in section 2.6 below.

Table 8: Variance Breakdown by Division

Division	ExpenseGroupDesc	In Month Budget - £000's	In Month Actual - £000's	In Month Variance - £000's	YTD Budget - £000's	YTD Actual - £000's	YTD Variance - £000's
D1	INCOME	(396.9)	(394.4)	(2.4)	(3,954.3)	(3,864.7)	(89.6)
	NON PAY EXPENDITURE	2,382.9	2,633.9	(251.1)	22,524.1	25,575.6	(3,051.4)
	PAY EXPENDITURE	7,772.8	8,108.4	(335.6)	70,837.7	72,430.5	(1,592.9)
D1 Total		**9,758.8**	**10,347.9**	**(589.1)**	**89,407.5**	**94,141.4**	**(4,733.9)**
D2	INCOME	(437.3)	(310.0)	(127.2)	(3,905.0)	(3,544.9)	(360.2)
	NON PAY EXPENDITURE	990.3	946.2	44.1	9,382.4	10,392.9	(1,010.5)
	PAY EXPENDITURE	4,656.1	4,714.0	(57.9)	42,754.2	42,822.2	(68.0)
D2 Total		**5,209.1**	**5,350.2**	**(141.1)**	**48,231.6**	**49,670.3**	**(1,438.7)**
D3	INCOME	(322.7)	(301.0)	(21.7)	(2,886.6)	(2,815.3)	(71.3)
	NON PAY EXPENDITURE	2,509.1	2,598.8	(89.6)	22,766.6	24,016.7	(1,250.0)
	PAY EXPENDITURE	8,066.2	8,457.7	(391.5)	67,846.9	72,746.4	(4,899.5)
D3 Total		**10,252.6**	**10,755.5**	**(502.9)**	**87,727.0**	**93,947.7**	**(6,220.8)**
D4	INCOME	(196.0)	(218.4)	22.4	(1,787.4)	(2,034.9)	247.5
	NON PAY EXPENDITURE	4,116.5	4,543.6	(427.1)	38,562.0	42,054.9	(3,492.9)
	PAY EXPENDITURE	6,907.8	6,828.2	79.6	58,283.0	60,471.6	(2,188.6)
D4 Total		**10,828.2**	**11,153.4**	**(325.2)**	**95,057.6**	**100,491.7**	**(5,434.1)**
D5	INCOME	(141.5)	(163.5)	22.1	(1,273.1)	(1,254.9)	(18.2)
	NON PAY EXPENDITURE	3,343.6	3,509.8	(166.1)	32,526.1	31,784.6	741.5
	PAY EXPENDITURE	5,376.4	5,964.1	(587.7)	48,875.7	53,589.2	(4,713.5)
D5 Total		**8,578.6**	**9,310.3**	**(731.8)**	**80,128.6**	**84,118.9**	**(3,990.3)**
Grand Total		**44,627.2**	**46,917.3**	**(2,290.0)**	**400,552.3**	**422,370.0**	**(21,817.7)**

The main areas of variance in month for each Division are as follows:

- Division 1 (CSS) - Radiology underlying over-spend of (£229k) non pay predominantly on clinical supplies and outsourcing of reporting, (£155k) pay primarily on Radiographer bank and agency premium rate cover. Theatres pay of (£22k) on nursing and professional and technical staffing and non-pay (£40k) despite reduced activity levels.

- Division 2 (W&C) - (£85k) overspend across medical staffing in the division due to unfunded International Fellows and Medical Training Initiative Doctors as well as WLI, partly offset by an under spend in nursing. Income under performance of (£112k) predominantly due to reduced Maternity PbR income from other organisations. Continued shortfall in CIP identification also causes a pressure of (£130k) in the month but this is offset by the release of £227k accrual for inter maternity provider treatment relating to 2016/17.

- Division 3 (Emergency) - Nursing overspends of (£416k) across the division with (£204k) in Accident and Emergency and (£106k) in Acute Medicine. Medics overspend with Accident and Emergency presenting the biggest pressure at (£166k). Unmet CIP targets across the division in non-pay with Acute Medicine and Respiratory being the biggest pressure points in this area.

- Division 4 (Medicine) - Overspends on Clinical Supplies and Drugs within Clinical Haematology and Renal Medicine account for (299k) and (£75k) of the overspend with unmet CIP targets in non-pay across the causing the remainder of the pressure in this area. Nursing overspends of (£170k) driven by Elderly Care (£92k) before receipt of winter funding. Medic overspends of (£93k) with the biggest pressure within Diabetes and Clinical Haematology (£17k) overspent each.

- Division 5 (Surgery) - Medical overspends of (£473k) with the biggest pressures in Trauma and Orthopaedics (£170k) and Gastroenterology

(£128k) in the month, as well as nursing overspends of (£119k). This is despite lower activity.

2.6 Income Analysis

2.6.1 Total Operating Income

Total operating income (excluding STF) is (£2.8m) below plan in December taking the year to date under-performance to (£14.5m) as shown in table 9 below.

Table 9 – Income against Plan

	In Mth Plan December £m	In Mth Actual December £m	Variance £m	YTD Plan December £m	YTD Actual December £m	Variance £m
Clinical - NHS	(52.7)	(50.7)	(2.0)	(474.5)	(466.9)	(7.5)
Clinical - Non NHS	(0.8)	(0.6)	(0.1)	(7.0)	(6.6)	(0.4)
Other	(5.0)	(4.3)	(0.6)	(44.8)	(38.2)	(6.6)
TOTAL	**(58.5)**	**(55.7)**	**(2.8)**	**(526.2)**	**(511.7)**	**(14.5)**

NHS Clinical Income is a further (£2.0m) below plan in December moving the year to date under-performance to (£7.5m). Excluded drugs and devices were (£0.6m) below plan in December with over-performance of £2.9m for the year to date.

The adverse variances against the seasonally adjusted plan for healthcare income are (£1.9m) in month and (£10.3m) year to date with the main areas of variance during December and year to date detailed in table 10 below:

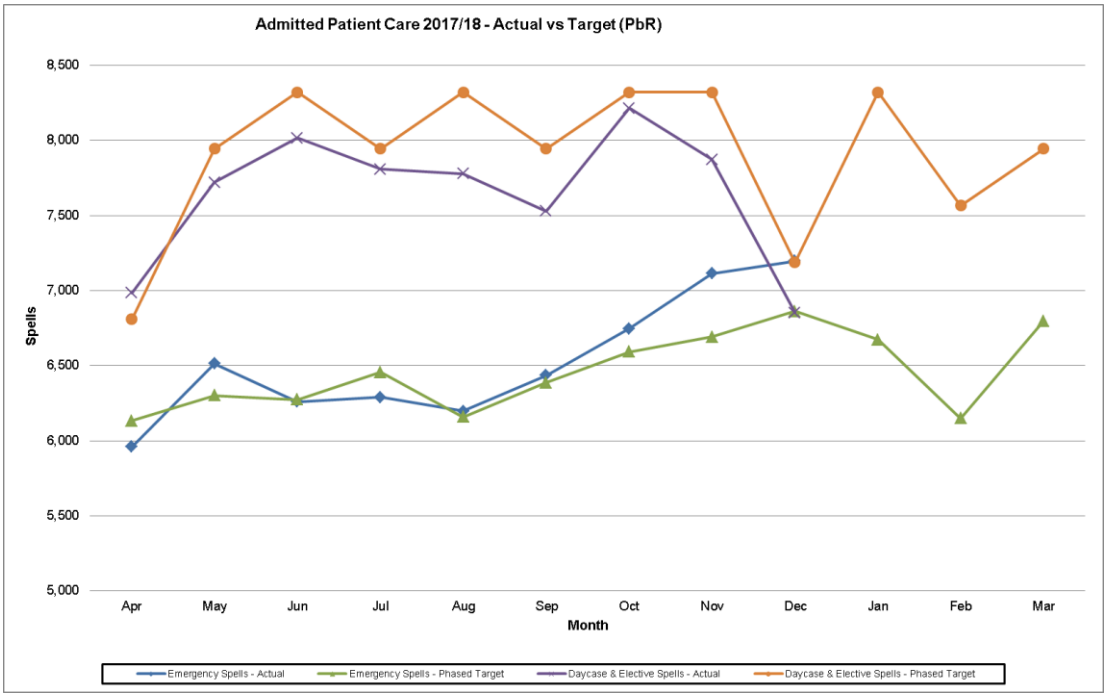
Table 10 – Healthcare Income Variances by Point of Delivery

	In Month Variance	YTD Variance
Maternity Spells/Pathways	0.0	(1.4)
Ambulatory Emergency Activity	0.2	1.4
Emergency Spells	(0.3)	(2.9)
Accident and Emergency	(0.1)	0.2
Elective/Daycase Spells	(0.5)	(5.0)
Outpatients	(1.1)	(2.0)
Other	(0.3)	(0.7)
Grand Total	**(1.9)**	**(10.3)**

2.6.2 NHS Clinical Income/Activity - Inpatients

Table 11.1 below details the monthly admitted patient care (APC) spells against the seasonally phased targets in December.

Table 11.1: Trust Inpatient Activity



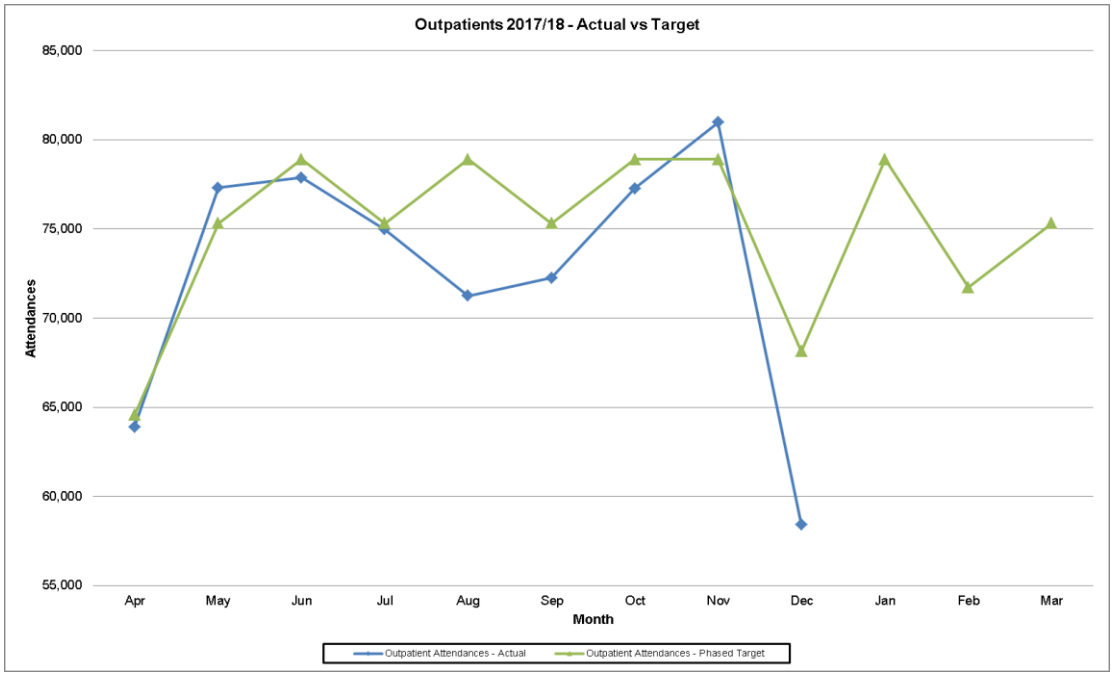
The December in-month activity position shows a 4.9% over-performance in emergency spells (335 spells) against the seasonally phased plan, resulting in year to date over-performance against the seasonal plan of 1.5% (860 spells). The increase in emergency spells is slightly out of step with A&E activity which shows a 0.8% under-performance in December (177 attendances) moving the year to date performance to 1.1% over-performance, (2,270 attendances).

Combined elective and daycase activity was (4.7%) below plan in December (335 spells) taking the year to date under-performance to (3.3%) (2,339 spells).

2.6.3 NHS Clinical Income/Activity – Outpatients

Table 11.2 below details the monthly outpatient attendances compared to the seasonally phased targets in December.

Table 11.2: Trust Outpatient Activity



Outpatient activity in month has under-performed by 14.3% in December (9,713 attendances) meaning the year to date position is now under-performance of (3.0%) or 20,028 attendances. The in-month shortfall is partially attributable to a reduction in attendances at the start of the month due to the heavy snow. The largest areas of under-performance in the month relate to Neurology (430 attendances, 49.4%), ENT (888 attendances, 26.2%), Rheumatology (355 attendances, 23.9%) and Ophthalmology (1,385 attendances, 20.9%). The main areas of over-performance in the month include Acute Medicine (683 attendances, 6.3%) and Gastroenterology (149 attendances, 5.9%).

2.6.4 Divisional Performance

Table 12 below details the variance against the year to date seasonally phased plan, split by Division and point of delivery but excluding performance on Excluded Drugs and Devices.

Table 12: Healthcare Income Variance vs Seasonally Phased Plan

	Point of Delivery			
Division	**IP - £000's**	**OP - £000's**	**Other - £000's**	**Total - £000's**
1 - CSS	471	(152)	(657)	**(338)**
2 - W&C	(353)	(339)	(1,792)	**(2,484)**
3 - Emergency	(1,554)	822	(483)	**(1,214)**
4 - Medicine	(1,251)	(1,105)	603	**(1,754)**
5 - Surgery	(4,361)	(1,182)	370	**(5,173)**
Central Risks	0	0	643	**643**
Total	**(7,048)**	**(1,955)**	**(1,317)**	**(10,320)**

2.6.5 Other Miscellaneous Operating Revenue

The adverse variance of (£0.6m) against the planned other operating revenue in December is £0.2m better than in November but broadly in line with earlier months and is predominantly driven by shortfalls RTA income and Research Income.

2.7 Year End Forecast

The Trust submitted a revised forecast within the month 6 return to NHS Improvement indicating a likely year end deficit of (£48.4m). This was calculated based on the following assumptions:

- Healthcare income (exc. cost per case) recovers back in line with plan
- CIP planned phasing delivers as anticipated
- Recovery schemes deliver in line with divisional projections
- International fellows and ACP programme deliver anticipated savings
- Costs increase for winter in line with previous years trends
- Vacancy and sickness rates do not materially change

As a result of the adverse movement to the Trust's forecast, NHS Improvement attended the Trust on 11 October 2017 for an assurance visit. They challenged the assumptions made in the forecasting process, assessed the expenditure controls and interviewed operational divisions about the robustness of the Trust's governance processes associated with the identification and delivery of efficiency savings. Verbal feedback received following this visit was positive with regard to the controls in place and there was an acknowledgement of the scale of the challenge facing the Trust. No formal written response has been received by the Trust, however the published quarter 2 provider monitoring confirms that the revised forecast of (£48.4m) was accepted.

In December 2017, the Trust received confirmation that it will receive £4.2m of non-recurrent winter funding. £2.2m of this is to be offset against existing costs with the expectation that the revised forecast improves by the same amount.

Performance against Healthcare Income (excluding EDD) has deteriorated since the forecast was produced and is now (£10.3m) below plan for the year to date. This is contrary to the assumptions made above and it is therefore likely that the current forecast will be missed, but this is entirely due to the drop off in Healthcare Income.

.

3. Efficiency Savings

The financial plan for 2017/18 relies on delivering a total efficiency of £33.2m (4.7% of income). Forecast delivery overall currently stands at £15.3m or 2.2% of total income.

3.1 Cost Improvement Programme

The 2017/18 identified schemes by Division, together with delivery against them both in December and year to date, is detailed in table 13 below.

Table 13: CIP Delivery by Division

Division	In Month 12ths Target	In Month Delivery	In Month Variance	YTD 12ths Target	YTD Delivery	YTD Variance	Annual Target	Forecast Delivery
CORPORATE	130.8	35.7	(95.1)	1,177.2	1,180.8	3.6	1,569.6	1,476.7
FACILITIES	146.4	27.8	(118.6)	1,317.6	691.3	(626.3)	1,756.7	1,260.6
TRUSTWIDE EDUCATION SERVICES	33.6	94.4	60.7	302.6	481.4	178.8	403.5	911.5
RESEARCH & INNOVATION	8.1	0.0	(8.1)	72.7	0.0	(72.7)	96.9	0.0
CSS	209.7	170.0	(39.7)	1,887.5	1,167.0	(720.5)	2,516.7	2,111.4
WOMENS & CHILDRENS	106.3	41.0	(65.3)	956.5	337.0	(619.5)	1,275.3	511.0
EMERGENCY CARE	185.3	846.5	661.3	1,667.5	1,792.2	124.7	2,223.3	2,166.1
MEDICINE	202.9	333.4	130.5	1,826.1	1,436.4	(389.7)	2,434.8	2,139.2
SURGERY	171.5	494.9	323.4	1,543.5	1,530.5	(13.0)	2,058.0	2,358.3
TOTAL	**1,194.6**	**2,043.8**	**849.2**	**10,751.1**	**8,616.6**	**(2,134.5)**	**14,334.8**	**12,934.8**

The (£2.1m) variance against the year to date target reflects a combination of slippage on schemes planned to deliver year to date (£0.9m), planned phasing adjustments (£0.8m) and target with schemes unidentified (£0.4m).

3.2 Financial Recovery Plan

Year 2 of the Trust's Financial Recovery Plan for 2017/18 included agreed cross cutting schemes with saving opportunities of £5.0m, the delivery against which is detailed in table 14 below.

Table 14: Year 2 Cross Cutting Schemes

		Month 9					
Workstream / Project	Scheme Start	In Mth Target	In Mth Actual	YTD Target	YTD Actual	Full Year Target	Full Year Forecast
Length of Stay	Apr-17	104	0	729	0	1,042	0
Theatre Productivity	Apr-17	44	0	391	346	524	479
Diagnostics	Apr-17	8	8	75	33	100	58
Procurement: National & Local Standardisation	Apr-17	2	2	35	35	41	41
Procurement: UHB Alignment	Aug-17	68		340		544	
Procurement: Direct Source Pricing	Aug-17	17		83		133	
Procurement: GHX Renewal	Oct-17	19	(74)	57	313	114	418
Procurement: Review 111 Other Contracts	Oct-17	19		57		114	
Procurement: Mobile Phones	Apr-17	2	2	16	16	22	22
Medical: International Fellows	Apr-17	0	0	0	0	0	0
Medical: Business Case Pipeline	Jun-17	28	0	253	0	338	0
Medical: E-rostering & Compliance with Policies	Jul-17	0	0	0	0	0	0
Nursing: Matron Review	Apr-17	9	9	83	83	111	111
Nursing: E-rostering & Compliance with Policies	Jul-17	83	0	505	0	755	125
Nursing: ACP	Sep-17	57	61	254	158	426	387
Corporate: Updated Communications	Apr-17	2	2	19	19	25	25
A&C: Balance to full year effect of restructures	Apr-17	66	66	547	547	745	745
Grand Total		**529**	**76**	**3,445**	**1,551**	**5,033**	**2,410**
Balance to find from original FRP following validation				*902*		*1,203*	
Balance to find from stretch targets				*3,675*		*4,900*	
Total						**11,136**	

As with the CIP targets the total FRP/stretch savings target has been posted in the ledger in 12ths. Overall there is circa (£1.9m) slippage on the planned delivery to date and (£0.3m) of under-delivery in the position which relates to

the planned phasing of the schemes. A further (£4.6m) relates to the unidentified balance of the FRP and the additional stretch savings target.

The current year end forecast delivery is £2.4m against the overall additional savings target of £11.1m, slippage of circa (£8.7m).

3.3 2016/17 Non Recurrent Benefits

Within the reported position for 2016/17, circa £7.7m was delivered non-recurrently either through one off savings or through release of balance sheet flexibility. Therefore in order to achieve the plan as set for 2017/18, additional savings are required in order to recurrently achieve this cost reduction.

To date, this is contributing an adverse variance of (£5.1m) in comparison to the Trust's planned position.

4. Statement of Financial Position

The Statement of Financial Position (Balance Sheet) shows the value of the Trust's assets and liabilities. The upper part of the statement shows the net assets after deducting short and long term liabilities with the lower part identifying sources of finance. Table 15 below summarises the Trust's Statement of Financial Position as at 31 December 2017.

Table 15: Statement of Financial Position

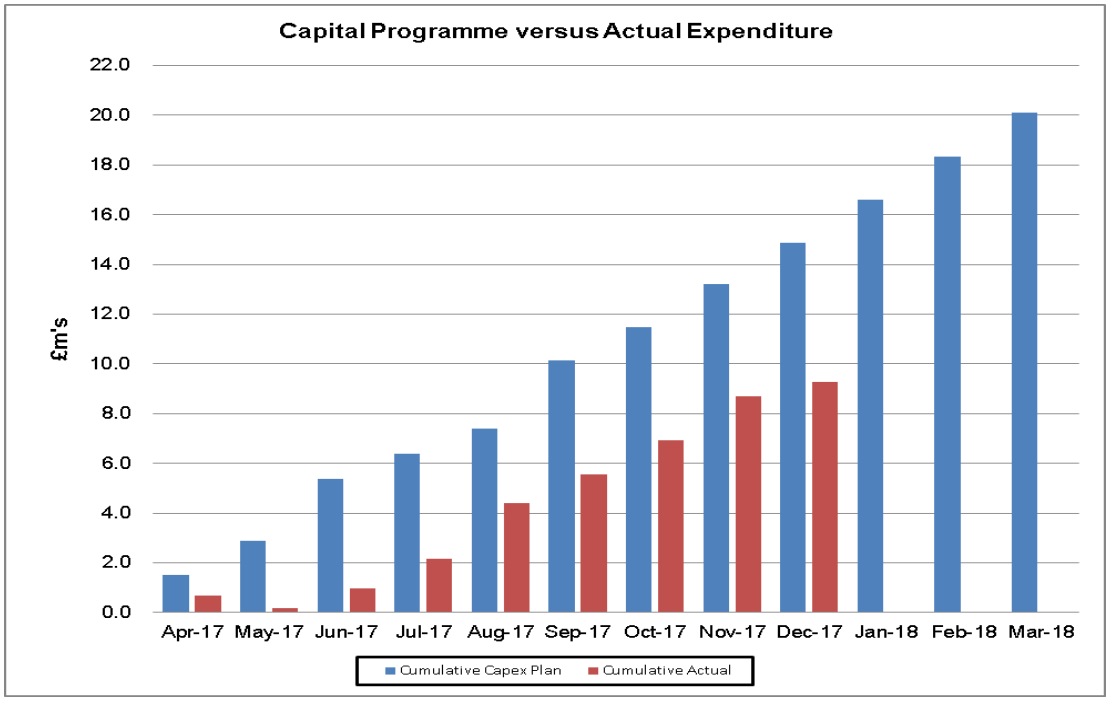
		Actual Mar-17 £m	Actual Dec-17 £m	Plan Dec-17 £m	Annual Plan Mar-18 £m
Non Current Assets:					
	Property, Plant and Equipment	248.1	247.5	258.5	259.8
	Intangible Assets	2.0	2.1	9.2	9.1
	Trade and Other Receivables	1.0	1.1	1.6	1.6
	Other Assets	3.8	3.7	3.6	3.6
	Total Non Current Assets	**254.8**	**254.4**	**272.9**	**274.0**
Current Assets:					
	Inventories	10.7	11.8	10.0	10.0
	Trade and Other Receivables	40.6	35.6	50.6	43.8
	Cash	19.2	16.9	3.0	3.0
	Total Current Assets	**70.6**	**64.3**	**63.6**	**56.8**
Current Liabilities:					
	Trade and Other Payables	(102.4)	(115.2)	(98.5)	(98.8)
	Borrowings	(0.5)	(0.5)	(0.5)	(0.5)
	Working Capital Loan	0.0	(22.4)	(9.5)	(3.5)
	Provisions	(3.2)	(3.1)	(2.6)	(2.4)
	Tax Payable	0.0	0.0	0.0	0.0
	Other Liabilities	(6.3)	(6.2)	(6.5)	(6.5)
	Total Current Liabilities	**(112.4)**	**(147.4)**	**(117.6)**	**(111.6)**
Non Current Liabilities:					
	Borrowings	(3.3)	(3.0)	(3.0)	(6.0)
	Provisions	(6.2)	(6.2)	(5.8)	(5.8)
	Other Liabilities	0.0	(1.6)	(3.1)	0.0
	Total Non Current Liabilities	**(9.5)**	**(10.8)**	**(11.9)**	**(11.8)**
TOTAL ASSETS EMPLOYED		**203.5**	**160.6**	**207.0**	**207.3**
Financed by:					
	Public Dividend Capital	196.7	196.7	196.7	196.7
	Income and Expenditure Reserve	(45.9)	(88.0)	(43.3)	(42.7)
	Donated Asset Reserve	(0.2)	(0.2)	(0.2)	(0.2)
	Revaluation Reserve	52.9	52.1	53.8	53.5
	Merger Reserve	0.0	0.0	0.0	0.0
TOTAL TAXPAYERS EQUITY		**203.5**	**160.6**	**207.0**	**207.3**

5. Capital Expenditure (Non-Current Assets)

The initial capital programme for 2017/18 totalled £18.1m, this included £16.0m of internally funded schemes and £2.1m of costs associated with the enabling works for ACAD for which a DH loan has been approved. This programme was subsequently uplifted to £20.1m as a result of anticipated slippage of £1.0m on 2016/17 schemes and £1.0m slippage on the costs of ACAD. This is the value at which the final plan was submitted to NHSI.

Table 16 below details the planned trajectory of the £20.1m together with the actual spend from April to December. Expenditure to date is £9.3m against a plan at this point of £14.9m, slippage of £5.6m against the plan. The most notable items of slippage relate to medical equipment replacement £5.9m and enabling works costs associated with ACAD of (£0.8m) offset by ahead of plan expenditure within ICT of (£1.1m). Further detail on capital expenditure can be found in Appendix 1.

Table 16: Capital Programme Trajectory vs Actuals



6. Current Assets

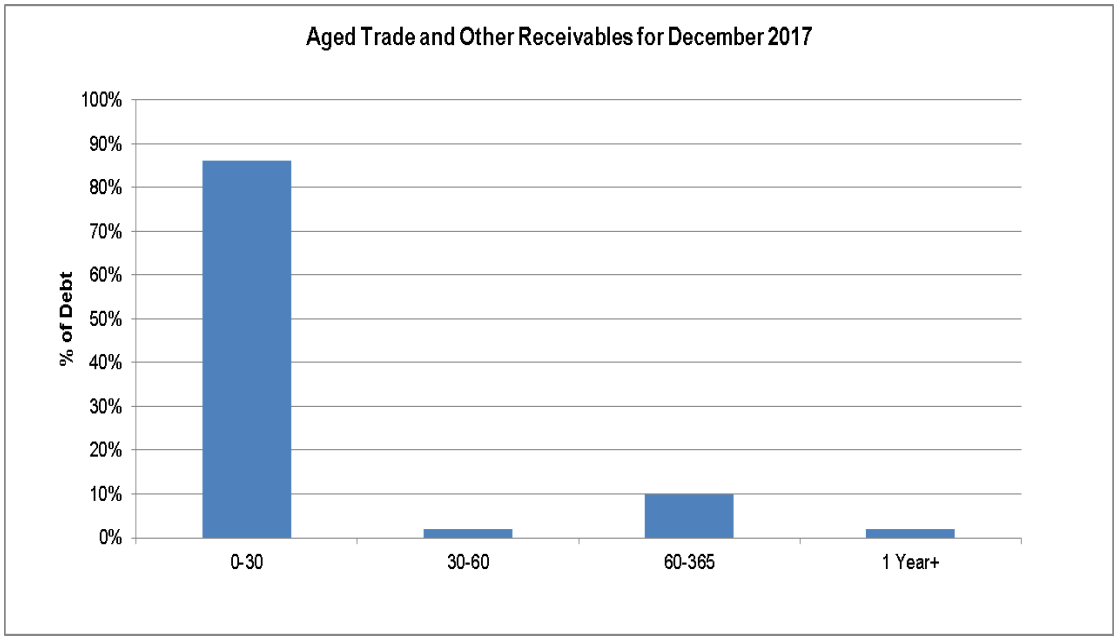
The Trust's total current assets (excluding cash and inventories) amount to £35.6m at 31 December 2017. This represents a (£15.0m) adverse variance against the plan at this point of the year. The balance is broken down as detailed in table 17 below.

Table 17: Analysis of Current Assets (excluding Inventories and Cash)

	YTD Actual December 2017 £m	YTD Plan December 2017 £m
Trade Receivables	27.9	48.1
Bad Debt Provision	(9.6)	(10.8)
Other Receivables	0.8	2.3
Trade and Other Receivables	**19.1**	**39.6**
Accrued Income	2.8	3.5
Other Financial Assets	**2.8**	**3.5**
Prepayments	13.7	7.5
Other Current Assets	**13.7**	**7.5**
TOTAL	**35.6**	**50.6**

Analysis of the age profile of Trade Receivables (unpaid invoices issued by the Trust) is summarised in table 18 below.

Table 18: Aged Debt Analysis



Overdue debt now stands at £9.2m of which £2.1m relates to CCG/NHS England healthcare income contracts within the top 10 balances. This represents an overall increase of (£1.7m) on the position at the end of November 2017. The top balances (outside of CCG/NHS England Healthcare Income contracts) are:

- Burton Hospitals Foundation Trust (£1.2m > 30 days, £1.5m total) – this is an increase of (£0.1m) on the greater than 30 days and (£0.1m) on the total debt from the position at the end of November 2017. Debt associated with maternity pathways from 15/16 onwards accounts for (£1.2m) with the remainder relating to ad hoc recharges for medical staffing, radiology and pathology which are currently being validated.

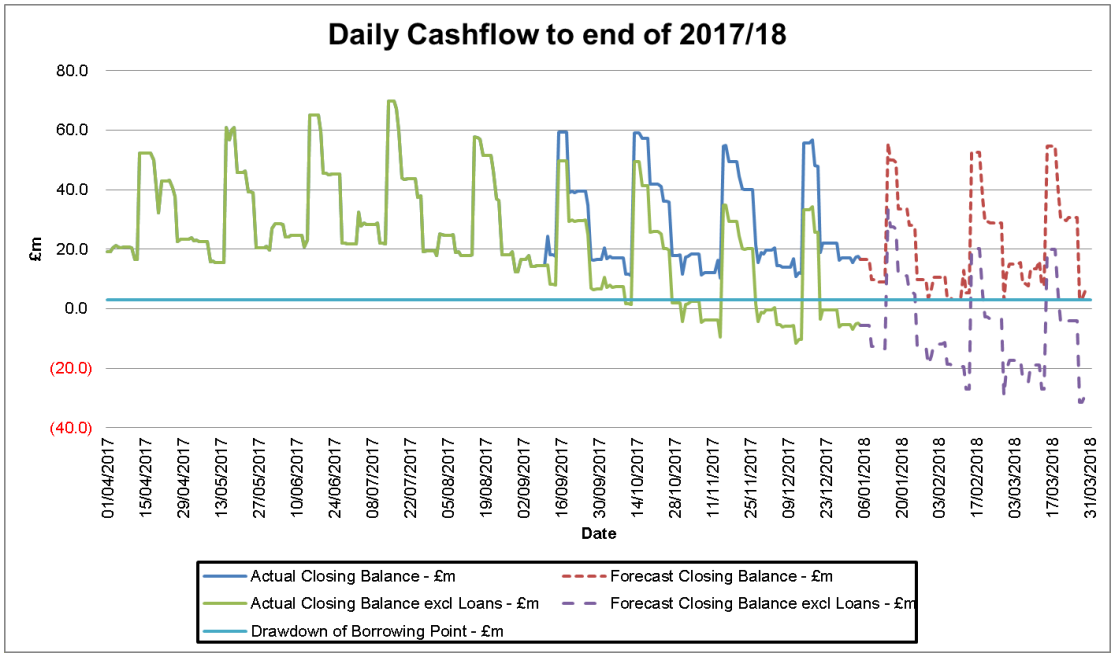
- Sandwell and West Birmingham Trust (SWBH) (£0.8m > 30 days, £1.2m total) – this is an increase of (£0.1m) on the total debt compared to November whilst the overdue debt has remained consistent. Maternity pathways account for £0.9m of the total debt with the remainder predominantly relating to prior year surgical SLA provision.

7. Cash Flow

The cash balance at the end of December 2017 was £16.9m, a decrease of £1.4m during December and a positive variance of £13.9m against the planned balance of £3.0m. However during December, the Trust made a further draw of £2.4m against its working capital facility taking the year to date facility to £22.4m.

Table 19 below details the anticipated cash balances to the end of the 2017/18 financial year, both including and excluding the anticipated working capital draws. This demonstrates that the Trust is likely to need further borrowing each month in order to remain above the minimum cash balance of £3.0m at all times.

Table 19: Daily Cashflow Forecasting as at 31 December 2017



8. NHS Improvement Finance and Use of Resources Metric

8.1 Finance and Use of Resource Metrics

The Finance and Use of Resource (UoR) metric has replaced the previous Financial Sustainability Risk rating (FSRR). Each metric is scored between 1 (best) and 4 (worst) and then an average is calculated to derive the overall UoR score for the provider. Where providers have an overall score of 3 or 4 for finance and use of resources, this will identify a potential support need under this theme, as will providers scoring a 4 against any of the individual metrics. Providers in financial special measures will default to an overall score of 4 on this theme. The individual metrics scored against are detailed in table 20 below.

Table 20: Scoring Mechanism for Finance and Use of Resources Metric

				Use of Resource Metrics			
Area	**Metric**	**Weight**	**Definition**	**1**	**2**	**3**	**4**
Financial Sustainability	Capital Service Capacity	20%	Degree to which the provider's generated income cover its financial obligations	>2.5x	1.75-2.5	1.25-1.75	<1.25
	Liquidity (days)	20%	Days of operating costs held in cash or cash-equivalent forms, including wholly committed lines of credit available for drawdown	>0	(7)-0	(14)-(7)	<(14)
Financial Efficiency	I&E Margin	20%	I&E surplus or deficit / total revenue	>1%	1%-0%	0%-(1%)	<(1%)
Financial Controls	Distance from Finance Plan	20%	Year-to-date actual I&E surplus/deficit in comparison to year-to-date plan I&E surplus/deficit	≥0%	(1%)-0%	(2%)-(1%)	≤(2%)
	Agency Spend	20%	Distance from provider's cap	≤0%	0%-25%	25%-50%	≥50%

8.2 Trust Performance

The Trust has been put into segment 3 as was anticipated. This means mandated support must be complied with to address specific issues and help move the Trust into segment 2.

With regards the Finance and Use of Resource Metric, the December year to date metric scoring is detailed in table 21 below.

Table 21: Trust Scoring Year to Date

			Use of Resource Metrics	
Area	**Metric**	**Weight**	**Actual**	**Score**
Financial Sustainability	Capital Service Capacity	20%	(6.74)	4
	Liquidity (days)	20%	(48.24)	4
Financial Efficiency	I&E Margin	20%	(8.37%)	4
Financial Controls	Distance from Finance Plan	20%	(6.92%)	4
	Agency Spend	20%	0.45%	2

The rating has deteriorate in month due to the agency ceiling now being a 2 after reporting agency costs of £20,142k against a ceiling of £20,052k. This means an overall unrounded rating of 3.6 which will get rounded up to a 4.

9. Conclusion

The Trust has reported an actual deficit of (£4.9m) for December 2017 (month 9) compared to a pre STF planned deficit of (£2.4m), an adverse variance of (£2.5m). This moves the year to date deficit to (£43.0m) against a planned deficit pre STF of (£21.7m), an adverse variance of (£21.3m). As a result of under-delivering against the financial plan, the year to date allocation of £13.4m of STF has not been assumed.

A revised year end forecast was been submitted to NHS Improvement as part of the month 6 return indicating a likely full year deficit of (£48.4m) against a pre-STF planned deficit of (£28.8m), an adverse variance of (£19.6m). Following receipt of winter funding, NHSI will expect this deficit to improve to (£46.2m). However, given the underperformance in Healthcare Income since the forecast, it is unlikely that the revised forecast will be received.

The cash balance at the end of December is £16.9m against the plan of £3.0m at this point, a favourable movement of £13.9m. However, this includes a £22.4m working capital loan.

10. Recommendations

The Council of Governors is requested to:

- Receive the contents of this report.

Julian Miller
Interim Director of Finance
16 January 2018

Appendix 1 Quarter 3 Capital Update December 2017

1. Purpose

This paper provides an update at Month 9 YTD (December 2017) Capital Expenditure, remaining contingency balance and revised capital forecast.

2. Capital Programme 2017/18 M9 Year to Date Update:

Table 1 outlines expenditure incurred and approved Oracle orders year to date. This also includes the A&E streaming which been funded by NHS England. There has been a PDC Drawdown of £160k for this scheme based on the full costs that have been incurred.

Table 1 - 2017/18 Capital Programme – Expenditure incurred M9 YTD

Division	Total 2017/18 Start point Capital Budget £'000	Orders Raised £'000	Expenditure Incurred M9 YTD £'000	YTD NHSI Plan £'000	Variance to YTD NHSI Plan £'000
1 CSS (incl Radiology)	2,774	1,444	531	1,148	617
2 Women's & Children's	875	723	715	495	(220)
3 Emergency Care	2,109	1,396	835	972	137
4 Medicine	826	182	237	324	87
5 Surgery	801	466	309	387	78
Corporate	67	0	0	0	0
Operational	**7,452**	**4,211**	**2,629**	**3,326**	**699**
ICT	3,590	1,872	2,852	1,762	(1,090)
FAC	3,504	2,127	1,732	1,503	(229)
Contingency	508	0	0	3,976	3,976
GHH Maternity Upgrade	0	0	0	1,700	1,700
Other Total	**7,602**	**3,999**	**4,584**	**8,941**	**4,357**
Total capital before ACAD	**15,054**	**8,210**	**7,213**	**12,267**	**5,056**
ACAD - loan funded	3,165	1,721	788	2,600	1,812
ACAD Self-Check-In Kiosk	48	16	18		(18)
Demolition of Bordesley House	700	116	120		(120)
ACAD Completion of Health Club	130	336	308		(308)
Oncology Bungalow	197	36	95		(95)
PMO Costs	751	95	450		(450)
Site Master Planning	55	28	23		(23)

Division	Total 2017/18 Start point Capital Budget £'000	Orders Raised £'000	Expenditure Incurred M9 YTD £'000	YTD NHSI Plan £'000	Variance to YTD NHSI Plan £'000
Total ACAD	**5,046**	**2,349**	**1,802**	**2,600**	**798**
Total including ACAD	**20,100**	**10,559**	**9,015**	**14,867**	**5,853**
External Funding	496	199	159	160	1
Charitable funds	1,117	117	94	0	(94)
Total including External Funding	**21,713**	**10,874**	**9,268**	**15,027**	**5,760**

The key issues by division are summarised below;

- Division 1 Clinical Support Services (Including Radiology)

  Division 1 has an allocated budget of £2.7m for 2017/18, which includes a £0.6m carry over. The majority of machines, trollies and power tools have been delivered and these projects are complete. However, within Pharmacy, the outstanding projects include an Air Conditioning unit for GHH & SOL, an IT upgrade and a replacement system for mediator FHSA reporting. The first two are still work in progress. The replacement system is likely to have a Q4 spend and needs ICT support on the project. There is also a decision being awaited on a potential collaboration with UHB. Radiology have three projects likely to commence in 2018/2019 which include the MRI Scanner Turnkey Works and the ED Room conversion to X-Ray Room 1.

- Division 2 Women's and Children's

  Division 2 has a total approved 2017/18 budget of £0.9m. Ultrasound machines/scopes and Dragar caleo incubators represent £0.4m. Orders have now been raised for the majority of projects. The main orders outstanding are the Baby tagging system and C Section business case totalling £0.1m for which papers are being written.

- Division 3 Emergency Care

  The 2017/18 allocated budget for Division 3 is £2.1m of which £0.5m is for Respiratory Negative Pressure Rooms funded by NHS England. This is going through the tendering process and is forecasting completion of works in 2018/19. UV Systems for Cath Labs, Monitors, Echo Machines and Echocardiography Ultrasound represent the largest projects totalling £1m. Orders have been raised for the majority of projects. Significant projects outstanding include the CCW / UV System for Cath Labs, Plasmablade, Belmont Infuser and Management system for secure cupboard all totalling £0.3m.

- Division 4 Medical Specialties

  Division 4 has been allocated budget in 2017/18 of £0.8m. Some of the high value projects include the Mole Mapper and Purchase of power equipment within podiatric

surgery which total £0.1m and these projects are complete**.** The biggest project is the Development of Chemotherapy Capacity and Improvement in Environment at £0.5m. This has yet to be completed although the capital has been forecasted be spent in Quarter 4.

- Division 5 Surgery

  Division 5 has been allocated budget in 2017/18 of £0.8m. The high value projects include VAS 5G Ultrasound, Ophthalmology GHH Theatre Microscope, Vascular US machine AAA and Fundus Camera representing £0.3m of total budget. The main projects outstanding are the Olympus Laser Machines, Microscope, Scanner and Field Machines which are forecasted to be ordered this financial year. There is also the Vanguard move enabling works at BHH representing £0.1m, which are forecasted to be complete in the financial year.

- Corporate Directorates (Including ICT)

  This division has a 2017/18 allocated budget is £3.6m. The larger value projects include Heartlands LAN Fibre Links, Telco Platform, WIFI Modernisation, Modernisation of DB Service including BI/HI provision and Technical linking of HEFT-UHB (links only - 5yr) totalling £1.7m. The majority of orders have been completed and there will be ongoing works that will be forecasted to complete in 2018/19.

- Facilities

  The division have been allocated budget in 2017/18 of £3.7m. The high value projects include Fothergill heating system, LV panels, Catering Equipment, AEC Relocation representing £1.2m. The majority of orders have been raised with enabling works forecasted to be completed in 2017/18. The main one outstanding is OPD/A&E Plant room for which the costs have increased and works will commence in 2017/18 and complete in 2018/19. There are also a few schemes that are funded by charitable funds such as RSU entrance and Education Refurbishment that will fall into the new financial year 2018/19.

- Contingency

  There is £0.5m contingency remaining this financial year.

- ACAD

  £3.2m was originally agreed and allocated against the main ACAD at the beginning of the financial year 2017/18. Further monies of £1.8m have been authorised for Demolition of Oncology Bungalow and Bordesley House, Refurbishment of Health Club, Pilot Self Check in Kiosk and PMO costs. This totals £5.0m for ACAD this financial year with works ongoing for the next 4 years. The majority of schemes are behind schedule with the 2017/18 and will now complete in the next financial year.

3. 2017/18 Forecast

The 2017/18 forecast has reduced from £19.7m to £17.1m, a decrease of £2.6m based on current capital projects. This is shown by division in table 2. The main reasons for the decrease are:

- £1.6m decrease in ACAD costs due to the programme slipping

- £1.3m decrease in Operational spend due to some projects now unlikely to complete this year (£0.4m of Negative Pressure room spend to move into next year as given a March start date, Radiology schemes slippage £0.4m, Facilities scheme slippage £0.1m, £0.5m ICT schemes where there is no spend on the scheme so far this year
- Decrease in charity funded schemes of £0.5m due to the Good Hope Education centre improvements scheme, which has moved into 2018/19
- Offset by increase of £0.3m in externally funded bids due to new A&E capital monies from PDC.

Table 2 – 2017/18 Capital Forecast 2017/18

New Division	Sum of Approved Budget £'000	Sum of Forecast 2017/18 Total £'000	Differences £'000
1 CSS (inc Radiology)	2,774	1,957	817
2 W&C	875	857	17
3 EC	2,109	1,682	427
4 MS	826	800	256
5 Sur	801	784	17
ACAD	5,046	3,456	1,590
CD	3,658	3,327	316
CF	1,116	157	960
Contingency	508	568	-60
ExtF	496	168	327
FAC	3,504	3,356	148
Grand Total	**21,712**	**17,114**	**4,585**

The forecast was reviewed at CPG on 10 January 2018 and it was agreed to bring forward £1.5m of priority capital schemes planned for 2018/19. Including this the revised full year forecast for 2017/18 is £18.6m, i.e. £1.5m below the original NHSI plan value.

HEART OF ENGLAND NHS FOUNDATION TRUST

COUNCIL OF GOVERNORS

MONDAY 22ND JANUARY 2018

Title:	Quality Account Update for Quarter 3 2017/18 (October - December 2017)
Responsible Director :	Dr David Rosser, Interim Executive Medical Director
Contact	Samantha Baker, Quality Development Support Manager; Mariola Smallman, Head of Quality Management;

Purpose	To provide an update on the Quality Account for Quarter 3 2017/18 (October – December 2017). To receive and note the contents of this report.
Confidentiality Level & Reason	N/A
Annual Plan Ref	N/A
Key Issues Summary:	The Council of Governors will consider: • Trust Quality Improvement Priorities 2017/18; • Mortality (SHMI, HSMR and Crude Mortality); • Patient safety indicators; • Clinical effectiveness indicators
Recommendations	The Council of Governors is asked to note the content of the Quarter 3 2017/18 Quality Account.

Approved by:	Dr David Rosser	Thursday 11th January 2018

1. INTRODUCTION AND EXECUTIVE SUMMARY

The aim of this paper is to present the Trust's Quality Account Update for Quarter 3 2017/18.
The Council of Governors is asked to approve the contents of this report and Appendix A.

2. BACKGROUND

Quarter 3 2017/18 Quality Account Update

2.1 The Quality Account Update report for Quarter 3 2017/18 (October to December 2017) is shown in Appendix A. The latest available data is included in the report. There has been a delay in receiving data for certain indicators from the national team; these indicators will be updated as soon as the data becomes available.

2.2 Performance for Quality Improvement Priorities:

- Overall Trust performance has dropped across the three hospital sites in Quarter 3 and is currently 77%. However Solihull are consistently maintained >82% for this Quarter.
- Screening for sepsis – performance is similar to the previous quarter for both inpatients and emergency patients (December data not available at time of reporting).
- Percentage of acute inpatients receiving antibiotics within one hour of being diagnosed with sepsis is similar to the previous quarter. Performance for Emergency patients (October data only) has improved.
- No performance data is available for the implementation of the Surgical Site Infection bundle.
- There has been no MRSA bacteraemia apportioned to HEFT this quarter. The number of CDI cases remains below trajectory.

3. RECOMMENDATION(S)

The Council of Governors is asked to note the content of the Quarter 3 2017/18 Quality Account.

Appendix A

Quality Account Update for Quarter 3, 2017/18 (October – December 2017)

Contents

Quality Account Update for Quarter 3, 2017/18 (October – December 2017)

Introduction

The Trust published its Quality Account Report in June 2017 as part of the Annual Report and Accounts. The report contained an overview of the quality initiatives undertaken in 2016/17, performance data for selected metrics and set out four priorities for improvement during 2017/18:

Priority 1: Reduce avoidable harm to patients from omission and delay in receiving Parkinson's disease medication
Priority 2: Improve early recognition of sepsis and reduce hospital acquired sepsis
Priority 3: Reducing surgical site infection after major surgery
Priority 4: Improve infection rates for *Clostridium difficile* and MRSA

This report provides an update on the progress made for the period October to December 2017 towards meeting these priorities and updated performance data for the selected metrics. This update report should be read alongside the Trust's Quality Account Report for 2016/17.

Quality Improvement Priorities

Priority 1: Reduce avoidable harm to patients from omission and delay in receiving Parkinson's disease medication

Background

Since June 2015 the Trust has focused on reducing the number of omitted and delayed doses of Parkinson's disease (PD) medication.

PD medications are time critical. If medications are delayed or omitted, patients rapidly deteriorate in terms of their ability to move, speak and swallow. When this happens, patients are at risk of falls, pressure ulcers, aspiration pneumonia and neuroleptic malignant syndrome. This can be fatal. There is also evidence showing that PD patients in whom medication has been delayed or missed have an increased length of stay (Martinez-Ramirez et al, Movement disorders 2015). The importance of timely PD medication in hospital is recognised nationally in the Parkinson's UK "Get it on time" campaign.

Baseline data (2015) at HEFT showed 14,000 delayed doses and 3,500 missed doses of PD medication annually across the three Trust sites. The data also identified that only 53% of inpatients were receiving their PD medication within 30 minutes of the prescribed time.

This data, combined with several clinical incidents, formed the impetus for the development of a Quality Improvement (QI) team to address this issue. The Trust aim is for 90% of PD medication to be administered within 30 minutes.

Performance

Overall Trust performance has dropped across the three hospital sites in Quarter 3 and is currently 77%. However Solihull are consistently maintained >82% for this Quarter (see Table 2 below).

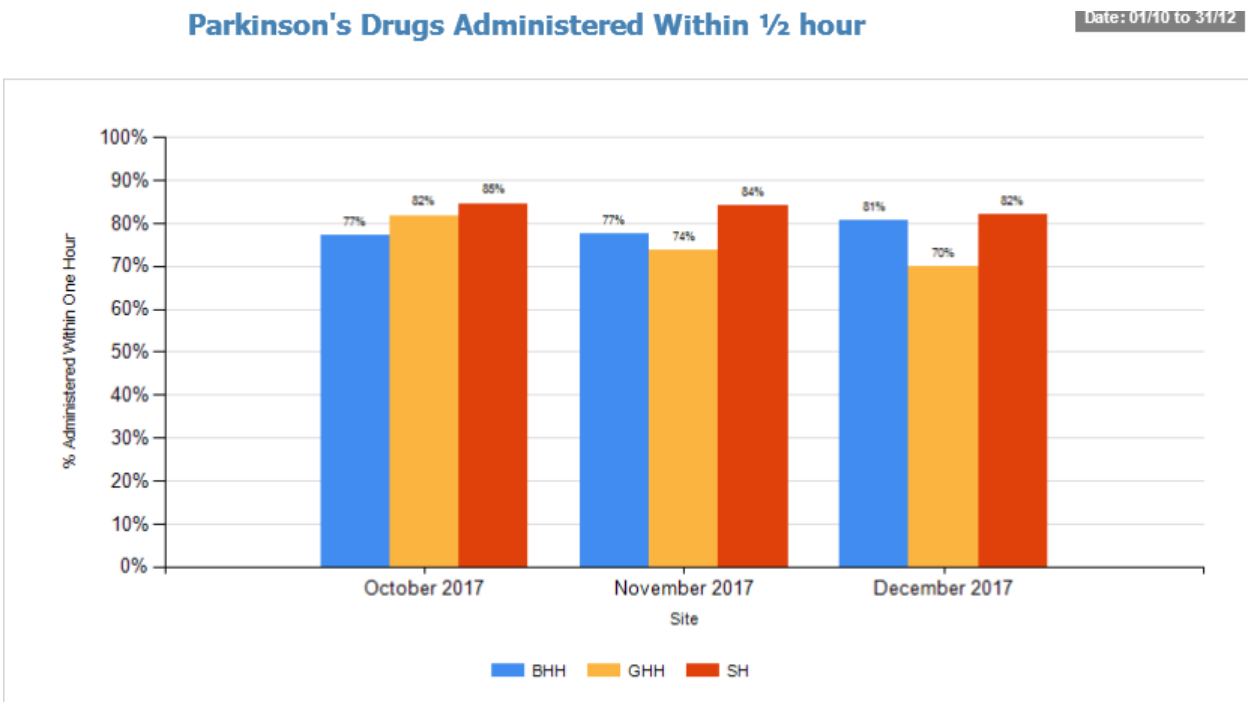
Table 1 – Performance by Quarter

	2015/2016				2016/2017				2017/2018		
	Q1	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**
Overall Trust % (Target 90% PD medication administered within 30 minutes)	51%	58%	54%	59%	71%	75%	75%	76%	81%	82%	77%
Total doses prescribed	9106	10320	9891	9251	9689	9012	11683	12692	12784	12613	10979
Total doses administered within 30 minutes	4306	5967	5441	5500	6849	6734	8740	9653	10344	10346	8496
Total doses administered late	3499	3467	3507	3024	2268	1897	2368	2364	1969	1780	1796
Total doses non-administered (omitted)	926	886	943	727	572	381	575	675	471	487	687

Table 2 – breakdown by site and month

	BHH	GHH	SH
October 2017	77%	82%	85%
November 2017	77%	74%	84%
December 2017	81%	70%	82%

Graph – Quarter 3 2017/18, Parkinson's Disease medication performance by hospital site



Initiatives to be implemented in 2017/18

- A review of Trust-wide reasons for omissions and delays in the administration of Parkinson's disease medication continues. Areas with increased omissions and delays were visited by the PD QI team. The findings of these were in relation to increased clinical pressures, staffing shortages and agency nurses who are unable to use the Trust Electronic Prescribing (EP) system. These issues and concerns were escalated to Divisional Head Nurses via the monthly exception reports.

- An audit of omissions and delays in Parkinson medication has been undertaken in ED BHH (non EP area). Following this a PD sticker has been developed. The aim of the sticker is to prompt staff to think and act on Parkinson's medication at the time of triage. There has been a delay in trialling the PD stickers due to winter pressures.

- Monitoring of omissions and delays will continue for Quarter 4 and where required, areas will be visited to identify reasons and support the drive further improvements. There will be a particular focus on Good Hope Hospital this quarter. Additional communications will be cascaded to remind staff of the importance of timely administration of Parkinson's administration

How progress will be monitored, measured and reported

- Progress will continue to be measured at ward, speciality, divisional and Trust levels via the live electronic medication dashboard which links directly to the Trust Electronic Prescribing (EP) system.

- Ward and divisional performance continues to be monitored via the Nursing and Midwifery Care Quality Dashboard and exception reports. This is reported monthly to the Chief Executive's Group (CEG) by the Deputy Chief Nurse.

- The PD Quality Improvement team continue to meet regularly to monitor progress and report to the Safer Medicines Practice Group (SMPG) and Sign up to Safety workstream lead.

- Progress is publicly reported in the quarterly quality report updates.

Update following external audit

Following a review by the Trust external auditors of the antibiotics improvement priority in 2016/2017 quality account, it was recommended that Trust's local indicators which are reported to the Trust board and sub-committees should have clear definitions. Definition for STAT dose antibiotics and Parkinson's medication have been developed; these include the names of the drugs and where there are any exclusions, e.g. if the drug has been charted as not required or as a PRN dose (when required).

Priority 2: Improve early recognition of sepsis and reduce hospital acquired sepsis

Background

Sepsis is defined as “life threatening organ dysfunction caused by a dysregulated response to infection”. It is a syndrome, described by a set of clinical criteria and not truly a diagnosis in and of itself. This makes recognising it complicated. Previous definitions were based on the systemic inflammatory response (SIRS) criteria. In 2016 these were replaced as they were felt to be insufficiently sensitive. The NICE guidance published that year defined sepsis using broader clinical criteria. An audit at Birmingham Heartlands Hospital (BHH) indicated that these new standards have the potential to increase the proportion of medical admissions classed as septic by 50% (i.e., to one third of the medical take).

The Trust has had well publicised clinical pathways for sepsis management in place for several years. These have been updated and now take account of the NICE guidance changes. We have taken this opportunity to launch a number of other changes which are detailed below. This is with the aim of improving:

- Reliable recognition and screening of sepsis;
- Timely and reliable escalation and sepsis treatment;
- Reviewing and de-escalating antibiotics where possible.

Performance

Indicator 2a Timely identification of sepsis
(December's audit result were not available at the time of writing)

	(i) Emergency departments		
	Patient NEEDED sepsis screening according to the local protocol and RECEIVED sepsis screening	Patient NEEDED sepsis screening according to the local protocol	%
Apr-17	12	26	46.2%
May-17	13	34	38.2%
Jun-17	28	41	68.3%
Quarter 1	53	101	52.5%
Jul-17	9	24	37.5%
Aug-17	29	51	56.9%
Sep-17	8	21	38.1%
Quarter 2	46	96	47.9%
Oct-17	15	31	48.4%
Nov-17	-	-	-
Dec-17			
Quarter 3	15	31	48.4%

	(ii) Acute inpatient departments		
	Patient NEEDED sepsis screening according to the local protocol and RECEIVED sepsis screening	Patient NEEDED sepsis screening according to the local protocol	%
Apr-17	44	55	80.0%
May-17	36	38	94.7%
Jun-17	30	31	96.8%
Quarter 1	110	124	88.7%
Jul-17	46	52	88.5%
Aug-17	34	38	89.5%
Sep-17	23	27	85.2%
Quarter 2	103	117	88.0%
Oct-17	31	32	96.9%
Nov-17	25	31	80.6%
Dec-17			
Quarter 3	56	63	88.9%

Indicator 2b: Percentage of patients diagnosed with sepsis who received antibiotics within 1 hour
(December's audit result were not available at the time of writing)

	(i) Emergency departments		
	Patient was diagnosed with sepsis and received IV antibiotics within 1 hour of diagnosis	Patients diagnosed with sepsis	%
Apr-17	2	10	20.0%
May-17	2	11	18.2%
Jun-17	14	26	53.8%
Quarter 1	18	47	38.3%
Jul-17	2	6	33.3%
Aug-17	6	28	21.4%
Sep-17	2	6	33.3%
Quarter 2	10	40	25.0%
Oct-17	8	15	53.3%
Nov-17	-	-	-
Dec-17			
Quarter 3	8	15	53.3%

	(ii) Acute inpatient departments		
	Patient was diagnosed with sepsis and received IV antibiotics within 1 hour of diagnosis	Patients diagnosed with sepsis	%
Apr-17	18	25	72.0%
May-17	16	20	80.0%
Jun-17	11	14	78.6%
Quarter 1	45	59	76.3%
Jul-17	21	28	75.0%
Aug-17	15	17	88.2%
Sep-17	9	10	90.0%
Quarter 2	45	55	81.8%
Oct-17	11	16	68.8%
Nov-17	8	9	88.9%
Dec-17			
Quarter 3	19	25	76.0%

Initiatives implemented 2017/18

Admitting areas and inpatient wards

- CQUIN re-audit identified some issues with data quality and true performance for screening. 1 hr antibiotics is around 70% - a number of changes are being made to the audit to improve reliability
- HEFT sepsis team are aiming to work with UHB to create electronic tools suitable for both organisations (e.g. using PICS)
- More robust reporting systems to the Patient Safety Group are now in place
- New audit database will launch in Quarter 1 and will facilitate identifying precise point where delays occur.

How will progress be monitored, measured and reported

The national sepsis CQUIN promotes timely identification and treatment for sepsis in both admitting areas (e.g., ED, AMU) and inpatient areas. This is monitored by the Trust's Performance team. The CQUIN has 3 key elements for audit and ultimately we need to achieve 90% in each area.

- The percentage of patients who meet the criteria for sepsis screening and are screened for sepsis using the Trust recognised screening tool.
- The percentage of patients defined as septic who receive their IV antibiotics within 1 hour.
- The percentage of patients having a documented antibiotic review within 24-72hrs by a senior decision maker.

In previous years CQUIN audit data and sepsis improvement work was conducted by a dedicated sepsis nurse and associated team. Following organisational changes this responsibility has transferred to the individual divisions. It is worth noting that meetings have taken place between the sepsis groups at HEFT and our University Hospitals Birmingham partners. There are differences in how the organisations have defined sepsis screening and how the cohorts for audit are identified. It is unlikely that this will change in the short term and will limit the extent to which audit data can be compared.

Priority 3: Reducing surgical site infection after major surgery

Background

Surgical Site Infections (SSI) comprise up to 20% of all of healthcare-associated infections. At least 5% of patients undergoing a surgical procedure develop a SSI and they represent the second most common hospital acquired infection (after UTI). SSI's range in severity from a spontaneously limited wound discharge within a few days of an operation to a life-threatening postoperative complication. Most surgical site infections are caused by contamination of an incision with microorganisms from the patient's own body during surgery and NICE states that the majority of SSI's are preventable.[1] SSI can severely affect the patient's experience after surgery and quality of life; they are costly and are associated with considerable morbidity, extended hospital stays and increased rates of readmission.

A care bundle is a small set of evidence-based practices that can be delivered together to improve patient outcomes. Based on NICE and WHO guidelines[2], a SSI Bundle was established and introduced to Theatre 1 and 3 at BHH for a trial period in 2016. 170 patients undergoing major abdominal surgery were evaluated and a dedicated, independent nurse evaluated the patients for SSI. The overall SSI rate at 30 days was 29% and 28% in the standard group and the bundle group respectively. However, surgical readmissions within 30 days were 6% in the bundle group compared to 20% in the standard care group. This suggests that the trialled bundle needs to be used 7 times to prevent one readmission. A revised bundle has been developed and will be introduced with additional efforts made to ensure compliance.

Performance

No performance data is available for Q1, Q2 or Q3, 2017/18 for this quality priority. An audit has commenced.

[1] https://www.nice.org.uk/guidance/cg74/chapter/introduction
[2] http://www.who.int/gpsc/ssi-prevention-guidelines/en/

Priority 4: Improve infection rates for *Clostridium difficile* and MRSA

Performance

MRSA Bacteraemia

The national objective for all Trusts in England in 2017/18 is to have zero avoidable MRSA bacteraemia. During Quarter 3, 2017/18, there were zero avoidable MRSA bacteraemia apportioned to HEFT.

All MRSA bacteraemias are subject to a post infection review (PIR) by the Trust in conjunction with the Clinical Commissioning Group (CCG). MRSA bacteraemias are then apportioned to HEFT, the CCG or a third party organisation, based on where the main lapses in care occurred.

The table below shows the Trust-apportioned cases reported to Public Health England for the past three financial years:

Time Period	2015/16	2016/17	2017/18 Q1	2017/18 Q2	2017/18 Q3
HEFT Apportioned	4	7	0	1	0
Agreed trajectory	0	0	0		

Clostridium difficile Infection (CDI)

The Trust's annual agreed trajectory is a total of 64 cases during 2017/18. Each case is also reviewed to see whether there were any lapses in care – a lapse in care means that correct processes were not fully adhered to, therefore the Trust did not do everything it could to try to prevent a CDI. During Quarter 3 2017/18, HEFT reported 16 cases in total, of which one[3] had a lapse in care. The Trust uses a post infection review (PIR) tool with the local CCG to identify whether there were any lapses in care which the Trust can learn from.

The table below shows the total Trust-apportioned cases reported to Public Health England for the past three financial years:

Time Period	2015/16	2016/17	2017/18 Q1	2017/18 Q2	2017/18 Q2
Lapses in care	14	18	4	4	1*
Trust-apportioned cases	61	76	10	21	16
Agreed trajectory	64	64	64		

[3] * At the time of reporting, not all of the cases for December 2017 had been reviewed for potential lapses in care

Initiatives being implemented in 2017/18

A robust action plan has been developed to tackle Trust-apportioned MRSA bacteraemias and CDI:

- Strict attention to hand hygiene and the correct and appropriate use of PPE (Personal Protective Equipment). Ensuring all staff are compliant in performing hand hygiene and adhere to PPE policy.
- Ensuring all relevant staff understand the correct procedure for screening patients for MRSA before admission, on admission and the screening of long stay patients.
- Ensuring the optimal management of all patients with MRSA colonisation and infection, including decolonisation treatment, prophylaxis during procedures, and treatment of established infections.
- Ensure appropriate antimicrobial use including use of Octenisan hair and body wash.
- Optimise patient outcomes and reduce the risk of adverse events and antimicrobial resistance through prudent antimicrobial prescribing and stewardship.
- Careful attention to the care and documentation of any devices, ensuring all procedures are being followed as per Trust policy.
- Ensure all relevant staff are performing infection prevention and control audits and acting on the results.
- Providing and maintaining a clean environment throughout the Trust including the implementation of the deep cleaning programme.
- Ensure all staff are aware of their responsibility for preventing and controlling infection through mandatory training attendance.
- Ensure post infection review investigations are completed and lessons learnt are fed back throughout the Trust.
- Continuation of the reviews by the infection prevention and control team of any area reporting two or more cases of CDI.

How progress will be monitored, measured and reported

- The number of cases of MRSA bacteraemia and CDI will be submitted monthly to Public Health England and measured against the 2017/18 trajectories.
- Performance will be monitored via the clinical dashboard. Performance data will be discussed at divisional quality and safety meetings, the nursing and midwifery quality meetings and the Trust Infection Prevention Committee (TIPC) meetings.
- Any death where an MRSA bacteraemia or CDI is recorded on part one of the death certificate and any outbreaks of CDI and MRSA will continue to be reported as serious incidents (SIs) to Birmingham CrossCity Clinical Commissioning Group (CCG).
- Post infection review (PIR) and root cause analysis will continue to be undertaken for all MRSA bacteraemia and CDI cases.
- Progress against the Trust infection prevention and control annual programme of work will be monitored by the infection prevention and control strategic management group and reported to the Board of Directors via the infection prevention and control quarterly and annual reports. Progress will also be shared with Commissioners.

Mortality

The Trust continues to monitor mortality as close to real-time as possible with senior managers receiving daily emails detailing mortality information and on a longer term comparative basis via the Trust's Clinical Quality Monitoring Group. Any anomalies or unexpected deaths are promptly investigated with thorough clinical engagement.

The Trust has not included comparative information due to concerns about the validity of single measures used to compare trusts.

Summary Hospital-level Mortality Indicator (SHMI)

The NHS Digital first published data for the Summary Hospital-level Mortality Indicator (SHMI) in October 2011. This is the national hospital mortality indicator which replaced previous measures such as the Hospital Standardised Mortality Ratio (HSMR). The SHMI is a ratio of observed deaths in a trust over a period time divided by the expected number based on the characteristics of the patients treated by the trust. A key difference between the SHMI and previous measures is that it includes deaths which occur within 30 days of discharge, including those which occur outside hospital.

The SHMI should be interpreted with caution as no single measure can be used to identify whether hospitals are providing good or poor quality care[4]. An average hospital will have a SHMI around 100; a SHMI greater than 100 implies more deaths occurred than predicted by the model but may still be within the control limits. A SHMI above the control limits should be used as a trigger for further investigation.

The Trust's latest SHMI is 87 for the period April – August 2017 which is within tolerance. The latest SHMI value for the Trust, which is available on the HSCIC website, is 90 for the period April – June 2017. This is within tolerance.

The Trust has concerns about the validity of the Hospital Standardised Mortality Ratio (HSMR) which was superseded by the SHMI but it is included here for completeness. HEFT's HSMR value is 99 for the period April – September 2017 as calculated by Health Informatics. The validity and appropriateness of the HSMR methodology used to calculate the expected range has however been the subject of much national debate and is largely discredited[5][6]. The Trust is continuing to robustly monitor mortality in a variety of ways as detailed above.

[4] Freemantle N, Richardson M, Wood J, Ray D, Khosla S, Sun P, Pagano, D. Can we update the Summary Hospital Mortality Index (SHMI) to make a useful measure of the quality of hospital care? An observational study. BMJ Open. 31 January 2013.

[5] Hogan H, Healey F, Neale G, Thomson R, Vincent C, Black, N. Preventable deaths due to problems in care in English acute hospitals: a retrospective case record review. BMJ Quality & Safety. Online First. 7 July 2012.

[3] Lilford R, Mohammed M, Spiegelhalter D, Thomson R. Use and misuse of process and outcome data in managing performance of acute and medical care: Avoiding institutional stigma. The Lancet. 3 April 2004.

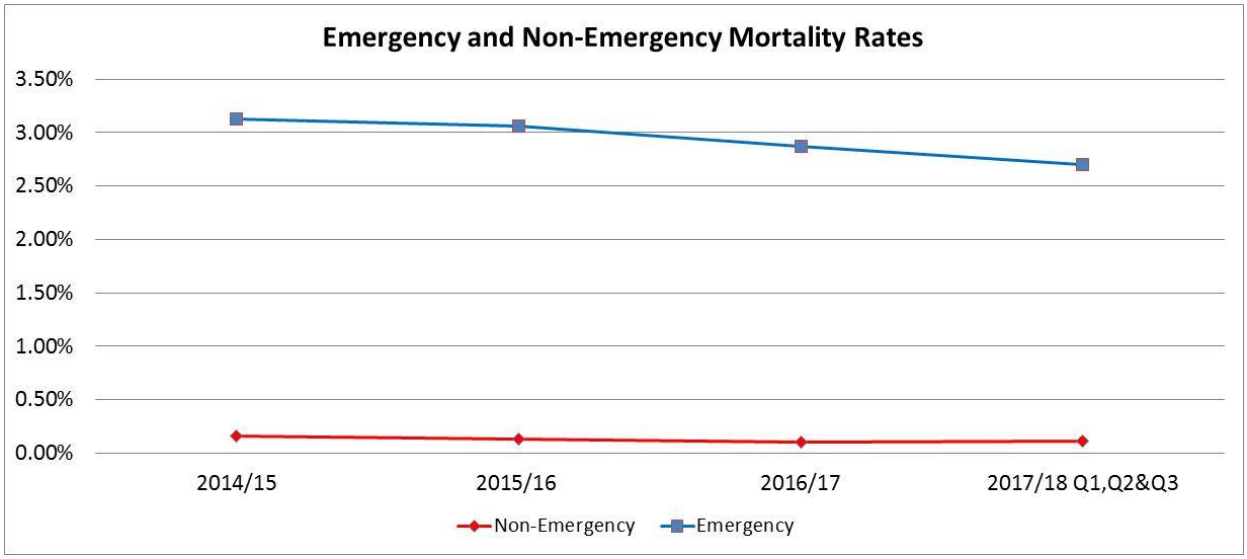
Crude Mortality

Quarter 3 data was not available at the time of reporting. The report will be updated when it becomes available.

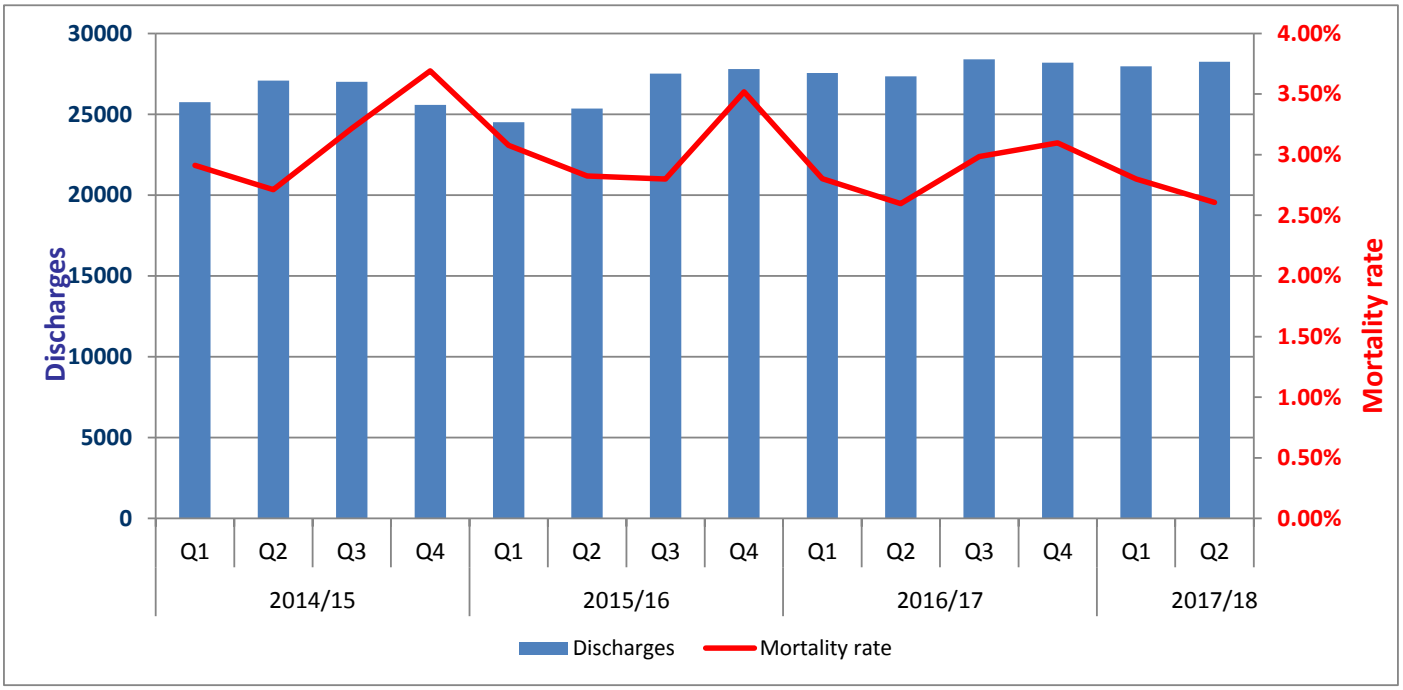
The first graph shows the Trust's crude mortality rates for emergency and non-emergency (planned) patients. The second graph below shows the Trust's overall crude mortality rate against activity (patient discharges) by quarter for the past two calendar years. The crude mortality rate is calculated by dividing the total number of deaths by the total number of patients discharged from hospital in any given time period. The crude mortality rate does not take into account complexity, case mix (types of patients) or seasonal variation.

The Trust's overall crude mortality rate for Quarter 2 2017/18 is 2.61%, this is a slight increase on Quarter 2 2016/17 (2.60%) and Quarter 2 2015/16 (2.82%).

Emergency and Non-emergency Mortality Graph



Emergency Crude Mortality Graph



Selected Metrics

Patient safety indicators
Quarter 3 data is not yet available for all indicators.

Indicator	Data source	2015/16	2016/17	2017/18 Q1-Q3	Peer Group Average (where available)
1a. Patients with MRSA infection /100,000 bed days (includes all bed days from all specialties) *Lower rate indicates better performance*	Trust MRSA data reported to PHE, HES data (bed days)	0.9	1.9	0.7 (Q1-Q2)	**0.58** April 2016 – March 2017 Acute trusts in West Midlands
1b. Patients with MRSA infection /100,000 bed days (aged >15, excluding Obstetrics, Gynaecology and elective Orthopaedics) *Lower rate indicates better performance*	Trust MRSA data reported to PHE, HES data (bed days)	0.4	0.4	0.7 (Q1-Q2)	**0.64** April 2016 – March 2017 Acute trusts in West Midlands
2a. Patients with *C. difficile* infection /100,000 bed days (includes all bed days from all specialties) *Lower rate indicates better performance*	Trust CDI data reported to PHE, HES data (bed days)	13.5	16.0	15.2 (Q1-Q2)	**13.77** April 2016 – March 2017 Acute trusts in West Midlands
2b. Patients with *C. difficile* infection /100,000 bed days (aged >15, excluding Obstetrics, Gynaecology and elective Orthopaedics) *Lower rate indicates better performance*	Trust CDI data reported to PHE, HES data (bed days)	5.9	6.8	17.1 (Q1-Q2)	**15.27** April 2016 – March 2017 Acute trusts in West Midlands

Indicator	Data source	2015/16	2016/17	2017/18 Q1-Q3	Peer Group Average (where available)
3a. Patient safety incidents (reporting rate per 1000 bed days) *Higher rate indicates better reporting*	Provisional Datix and Trust admissions data (not validated)	34[7]	34[8]	47.73 (Q1 only - awaiting bed days data)	**59.1** October 2016 – March 2017 Acute (non-specialist) hospitals NRLS website (Organisational Patient Safety Incidents Workbook)
3b. Never Events *Lower number indicates better performance*	Datix	6	2	7	*Not available*
4a. Percentage of patient safety incidents which are no harm incidents *Higher % indicates better performance*	Provisional Datix	73%[9]	75%[10]	98%	**89.4%** October 2016 – March 2017 Acute (non-specialist) hospitals NRLS website (Organisational Patient Safety Incidents Workbook)

[7] NRLS data
[8] NRLS data April – September 2016
[9] NRLS data
[10] NRLS data April – September 2016

Indicator	Data source	2015/16	2016/17	2017/18 Q1-Q3	Peer Group Average (where available)
4b. Percentage of patient safety incidents reported to the National Reporting and Learning System (NRLS) resulting in severe harm or death *Lower % indicates better performance*	Provisional Datix	0.65%[11]	0.6[12]	0.9%	**0.38%** October 2016 – March 2017 Acute (non-specialist) hospitals NRLS website (Organisational Patient Safety Incidents Workbook)
4c. Number of patient safety incidents reported to the National Reporting and Learning System (NRLS) **Higher number indicates better reporting culture**	Provisional Datix	15,449[13]	7,899[14]	14,537	**10,963** (6 months) October 2016 – March 2017 Acute (non-specialist) hospitals NRLS website (Organisational Patient Safety Incidents Workbook)

[11] NRLS data
[12] NRLS data April – September 2016
[13] NRLS Data
[14] NRLS data April – September 2016

Clinical effectiveness indicators
Quarter 3 data is not yet available for all indicators.

Indicator	Data Source	2015/16	2016/17	2017/18 Q1-Q2	Peer Group Average (where available)
5a. Emergency readmissions within 28 days (%) (Medical and surgical specialties - elective and emergency admissions aged >15) % *Lower % indicates better performance*	HED data	7.63%	7.90%	7.99% April – August 2017	England: **7.46%** Q1-Q2 2017/18
5b. Emergency readmissions within 28 days (%) (all specialties) *Lower % indicates better performance*	HED data	7.99%	8.23%	8.23% April – August 2017	England: **7.57%** Q1-Q2 2017/18
5c. Emergency readmissions within 28 days of discharge (%) *Lower % indicates better performance*	PMS 2	15.15%	15.09%	15.17%	*Not available* This is the information used in the Trust's LOS Board reporting. Latest Position YTD (April – October 2017): **15.16%**
6. Falls (incidents reported as % of patient episodes) *Lower % indicates better performance*	Datix and Trust admission data	*Not available*	0.98%	0.98%	*Not available*
7. Stroke in-hospital mortality *Lower % indicates better performance*	SSNAP data	11.64%	11.04%	11.89%	*Not available*

Notes on patient safety & clinical effectiveness indicators

The data shown is subject to standard national definitions where appropriate.

1a, 1b, 2a, 2b: Receipt of HES data from the national team always happens two to three months later; these indicators will be updated in the next quarterly report.

3a: The NHS England definition of a bed day ("KH03"). For further information, please see this link:
http://www.england.nhs.uk/statistics/statistical-work-areas/bed-availability-and-occupancy/

4c: The number of incidents shown only includes those classed as patient safety incidents and reported to the National Reporting and Learning System.

5a, 5b, 5c: Readmissions data is available 28 days after the end of the quarter and will be updated in the next quarterly report.

5c: This indicator only includes patients readmitted as emergencies to the Trust within 28 days of discharge and excludes cancer patients. The data source is the PMS 2 system. The data for previous years has been updated to include readmissions from 0 to 27 days and exclude readmissions on day 28 in line with the national methodology. Any changes in previously reported data are due to long-stay patients being discharged after the previous years' data was analysed.

6: Previous years' data updated since previous report.

Quality Account, 2017/18 Quarter 3 Update - Additional information

Quality Priority 3 – Surgical Site Infection (SSI)

The SSI bundle pilot for a specific patient cohort is now live. The 2 month pilot commenced in December 2017.

Work has begun on aligning theatre skin products for all theatres across Heartlands, Good Hope, Solihull and Queen Elizabeth hospitals, and should encompass the skin preps included in the SSI bundle.

Infection Control audits commenced 8th January; the report is expected in February or March.

The Obstetric Theatre lead has confirmed that they are moving to use chlorprep (instead of chlorhexidine) in line with the rest of theatres. Gynae theatres are consistent with the rest of theatres already.

Findings from the pilot and Infection Control audit will inform next steps. These may include a business case by Theatres regarding skin prep and associated cost pressures, and a business case by General Surgery to fund the SSI bundles.

HEART OF ENGLAND NHS FOUNDATION TRUST
COUNCIL OF GOVERNORS
22 JANUARY 2018

Title:	**QUARTER 3 COMPLIANCE AND ASSURANCE REPORT**
Responsible Director:	David Burbridge, Interim Director of Corporate Affairs
Contact:	Louisa Sorrell, Interim Head of Clinical Safety and Governance

Purpose:	To provide the Council of Governors with information regarding internal and external compliance as of 31 December 2017.	
Confidentiality Level & Reason:	None	
Annual Plan Ref:	Affects all strategic aims	
Key Issues Summary:	• CQC outstanding actions • The Trust either meets all NICE recommendations, or is working towards meeting all the recommendations, in 69% of cases • There were 2 external visits in Q3	
Recommendations:	The Council of Governors is asked to receive the report.	
Approved by:	David Burbridge	Date: January 2018

HEART OF ENGLAND NHS FOUNDATION TRUST

COUNCIL OF GOVERNORS

22 JANUARY 2018

COMPLIANCE AND ASSURANCE REPORT

PRESENTED BY THE INTERIM DIRECTOR OF CORPORATE AFFAIRS

1 Purpose

1.1 The purpose of this paper is to provide the Audit Committee with information regarding internal and external compliance as of 31 December 2017.

2 Trust Compliance with Regulatory Requirements - Care Quality Commission (CQC)

2.1 A Care Quality Commission (CQC) inspection was carried out within Heart of England NHS Foundation Trust (HEFT) in quarter 3 2016/2017. The inspection commenced with an unannounced visit on 6 September 2016 and a further visit 18 to 21 October 2016.

2.2 HEFT received the draft report from the CQC for factual accuracy in June 2017 and the final report was published on 2 August 2017.

2.3 CQC did not rate the trust overall for this inspection as they did not inspect the exact same services and domains as in December 2014. However they did give the "Well-led "section a rating as they felt they had sufficient information to do so at an overall level.

2.4 The overall rating for the Trust on the CQC website remains: requires improvement which is the same as the 2014 inspection despite the improvements noted during the 2016 inspection:

2.4.1 Safe: requires improvement

2.4.2 Effective: good

2.4.3 Caring: requires improvement

2.4.4 Responsive: requires improvement

2.4.5 Well-led: good

2.5 The CQC ratings for the services inspected are set out in appendix 1.

2.6 Summary of the recommendations

2.5.1 The recommendations in the report were a combination of area specific and Trust wide recommendations, and were split into "must do" (18) and "should do" (44) recommendations.

2.5.2 Further information regarding the CQC's comments under regulation 15 (Premises and Equipment 1b), specifically relating to security and access to the critical care unit, was requested to assist the Trust in its response to this point. As a result of the request for further information, the CQC removed this requirement notice; therefore there are now a total of 17 "must do" and 44 "should do" recommendations.

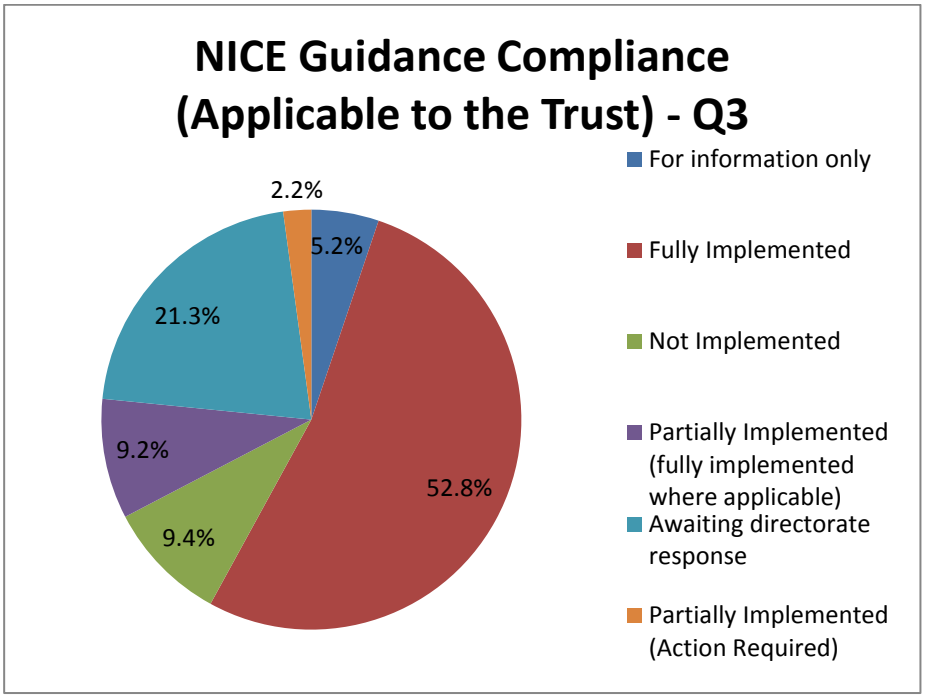
2.5.3 The majority of the "should and must do" recommendations have been completed or form part of "business as usual". A report outlining outstanding/on-going actions will be presented to the Directorate Quality and Safety Meetings with exception reporting to the Divisional Quality and Safety Meetings until all action are deemed complete.

2.5.4 9 out of the 17 "must do" actions are now complete. An update on the progress of these actions is outlined in appendix 2.

3 Trust compliance with NICE guidance

3.1. The graph below shows the current compliance levels for NICE guidance. The Trust either meets all recommendations, or is working towards meeting all recommendations, in 69% of cases.

Figure 1: Trust compliance with NICE Guidance



3.2 There has been a steady rise over the last year in the number of guidelines awaiting response from directorates. The Clinical Audit and Governance Facilitation Teams are actively working with Directorates and Divisions to increase response rates and compliance with NICE guidelines.

4 Trust Compliance with External Visits/Peer Reviews

4.1 There were 2 external visits during Q3. The table below also includes 1 visit from Q2 that was not included in the Q2 report, and 8 visits where updates on outstanding actions have been received. The current status of the visits are as follows:

4.1.1 Positive assurance: (no concerns or risks were identified or all actions have been completed and evidenced) – **1** visit

4.1.2 Neutral assurance (concerns/risks were found and an action plan has been received by the Safety and Governance Directorate to address all shortfalls) – **8** visits

4.1.3 Negative assurance (major concerns/risks were identified during the visit or identified actions are overdue) – **2** visits

Date of visit	Inspecting Organisation	Division and area inspected	Outcome of Visit	Assurance Level	Assurance / outstanding actions
18 – 19 Oct 2016	External Maternity Review	Division 2 Maternity Services	One of the members of the review team had previously assisted in the 2014 HEFT CQC inspection and the report identified that there has been significant progress since the CQC inspection in 2014. There was evidence of improved inter-departmental working especially notable on the GHH site. There are 19 actions in total.	Neutral Assurance	An action plan has been developed and approved at the CQMG meeting in July 2017. 14 of the 19 actions have now been completed. The remaining 5 actions are ongoing and currently due to be completed by the deadlines.
24 Jan 2017	Public Health England (PHE) Screening Quality Assurance Visit	Division 1 Pathology Division 2 Gynaecology	The QA team identified 6 high priority findings: 1. Lack of administrative support for the hospital based programme co-ordinator (HBPC) 2. Backlog of data collection for national invasive cervical cancer audit due to lack of administrative support for the HBPC 3. Difficulties producing and reviewing cervical screening performance data & circulating to staff 4. Cervical histological specimen turnaround times are not meeting national standards 5. Waiting times for colposcopy appointments are not meeting national standards 6. Attendance of colposcopists at colposcopy MDT meetings does not meet the national standard	Negative Assurance	The action plan is progressing with a number of actions now complete. Public Health England (PHE) Screening Quality Assurance (SQAS) have requested that further evidence be submitted by the end of December 2017. The evidence required has not yet been submitted as the Hospital-Based Programme Co-ordination (HBPC) is currently on sick leave. Evidence for the laboratory related findings has been supplied by the HBPC's deputy. A meeting of the senior laboratory team is planned for 09/01/2018 to review outstanding SQAS requests for evidence.
7 Feb 2017	Unannounced visit from Birmingham Cross City CCG	Division 5 Ward 4, BHH Thoracic Surgery Division 4 Ward 3, BHH	This visit was conducted in response to 3 MRSA outbreaks and 2 MRSA bacteraemia cases during the period of October 2016 to January 2017. The	Positive Assurance	7 actions were developed and the Safety and Governance Directorate have received an action plan from division 4 and all actions are now complete.

Date of visit	Inspecting Organisation	Division and area inspected	Outcome of Visit	Assurance Level	Assurance / outstanding actions
		Renal	outbreaks affected wards 3, 4 and 30. Wards 3 and 4 were visited during this inspection.		
21 April 2017	Environment Agency: Radioactive substances Activity	Division 1 Radiology	Routine compliance assessment visit. The report was received by HEFT on the 14 June 2017 and 2 minor recommendations were made.	Neutral Assurance	The following action is still ongoing: *Apply for a variation so that the permit includes the appropriate limits for accumulation of solid waste, particularly for Tc-99m*. The Division has requested an extension until 1 February 2018 to allow for the Trust merger to take place to avoid the need to apply for a further variation when the Trust changes its name.
13 June 2017	Specialist Urology Cancer Services Review NHS England Quality Surveillance Team	Division 5 Urology	2 serious concerns were identified. A serious concern is an issue that, whilst not presenting an immediate risk to patient or staff safety, is likely to seriously compromise the quality of patient care, and therefore requires urgent action to resolve. The serious concerns identified are: 1. The reviewers are not assured that all appropriate patients are being offered access to minimally invasive surgery 2. There has been little progress in developing the recovery package. Lack of psychological support in the patients' pathway may affect the quality of the patient experience.	Neutral Assurance	A meeting was scheduled at UHB to discuss access to robot surgery. An EVAS has been submitted for a band 6 nurse to provide support in oncology clinics and a band 5 nurse to provide holistic needs assessment. An update on these actions will be provided in the Q4 2017/18 report.
19 & 20 July 2017	Human Tissue Authority (HTA)	Division 1	The Trust met the majority of the HTA standards, 3 major and seven minor shortfalls were found against the following standards: • Governance and	Neutral Assurance	All evidence to complete the action plan was submitted to the HTA. Additional evidence relating to the retention of tissue following Post Mortem has since been requested.

Date of visit	Inspecting Organisation	Division and area inspected	Outcome of Visit	Assurance Level	Assurance / outstanding actions
			quality • Traceability • Premises/facilities and • Equipment standards There remains 2 outstanding major shortfalls: 1. Wet tissue samples that are stored following PM examination at another licensed establishment are in pots that are not labelled with details on the type or amount of tissue they contain and therefore are not traceable. 2. Tissue taken at Post Mortem examinations conducted at the establishment is processed into blocks and any residual wet tissue is disposed of. In the case of the tissue taken during PM examinations at the other licensed establishment, any residual wet tissue is stored. The purpose of the retention and storage of these samples is unclear, although in some cases it may be at the request of the family pending a medico-legal case.		Confirmation that this evidence has been sent and accepted will be confirmed in the Q4 2017/18 report.
12 July 2017	National Peer Review: Trauma Audit	Division 5	1 immediate risk and 4 serious concerns were identified during the review. The immediate risk related to significant challenges in accessing spinal injury care pathways at UHB. The serious concerns are outlined below: 1. Appropriately trained	Neutral Assurance	Immediate Risk: Meeting held 19/10/2017 with Kevin Bolger & Neurosurgeons. Discussions re: shared login capability, timeliness of responses from neurosurgeons, use of reverse NORSE. Outreach from UHB a long term goal. Serious concerns:

Date of visit	Inspecting Organisation	Division and area inspected	Outcome of Visit	Assurance Level	Assurance / outstanding actions
			Emergency Trauma Nurse /AHP available 24/7. 2. The review team were not reassured that Level 1 or Level 2 training was being delivered. 3. Administration of Tranexamic Acid (TXA) according to CRASH-2 protocol. 4. Provision of Trauma and Rehabilitation Coordinator Service 7 days/week		The actions to address serious concerns are ongoing. A business case is being developed in relation to the provision of a Trauma and Rehabilitation Coordinator Service 7 days/week with a submission date of March 2018. Update to be included in Q4 2017/18 report.
7 August 2017	Cardiothoracic Surgery Review: Getting it Right First Time (GIRFT)	Division 5	The following notable practice was identified: 1. Busy, safe, cost effective unit 2. Exemplary low length of stay 3.Exemplary discharge practices, including excellent patient follow up, e.g. chest drain clinic 4 actions have been identified from this review relating to: 1. Cancellation rates 2. Lung cancer resection rates 3. Management of Empyema 4. Coding	Negative Assurance	An update on actions has not been received by the Safety and Governance Department for Q3. Update to be included in Q4 2017/18 report.
25 Sept 2017	Obstetrics and Gynaecology: Getting it Right First Time (GIRFT)	Division 2	The following notable practice was identified: 1. Median days between incident and report is 19 days 2. Low instrumental delivery rate 3. Low episiotomy rate 4. Low 3rd and 4th degree tear rate 5. Low neonatal complication (hypoxic-ischaemic encephalopathy) rate.	Neutral Assurance	9 areas were identified that needed to be addressed and an action plan has been developed. Update to be included in Q4 2017/18 report.
9 – 13 October 2017	Joint Local Area SEND Inspection (Solihull)	Divisions 2 and 4	The inspection identified 20 areas of strength and 22 areas for further improvement.	Neutral Assurance	An action plan based on the recommendations for further improvement is in the process of being developed.

Date of visit	Inspecting Organisation	Division and area inspected	Outcome of Visit	Assurance Level	Assurance / outstanding actions
					Update to be included in Q4 2017/18 report.
17 – 20 October 2017	United Kingdom Accreditation Service	Division 1 Laboratory Medicine – BHH/GHH/ Sol	19 findings were raised during the surveillance visit. The recommendation was that accreditation is maintained. This recommendation is subject to the satisfactory close out of all the mandatory improvement actions raised by this assessment.	Neutral Assurance	All evidence was submitted to UKAS prior to 17/11/17. 15 findings have been cleared. Further evidence has been requested and submitted for 1 finding. Still waiting to hear regarding 3 findings. Update to be included in Q4 2017/18 report.

5 Outcome of audits

5.1. National Audits

5.1.1. The Trust is currently either participating in, or has participated in, 44/58 National Audits/registries and 10/11 Clinical Outcome Review Programmes (CORP) listed on the HQIP Quality Accounts which are actively collecting data during 2017/18, and that are applicable to acute and community trusts. There are 14 audits and 1 CORP currently not participated in by the Trust:

- Adult cardiac surgery – cardiac surgery not performed in the trust
- BAUS Urology Audits - Female Stress Urinary Incontinence Audit – Not performed
- BAUS Urology Audits -Urethroplasty Audit – Not performed
- Falls and Fragility Fractures Audit Programme – Fracture Liaison service database - the trust does not have this service in place
- National Audit of Pulmonary Hypertension – no service
- National Clinical Audit of Specialist Rehabilitation for Patients with Complex Needs following Major Injury (NCASRI) – trust is not a major trauma centre
- National Congenital Heart Disease – no service in place
- National Core Diabetes Audit – Currently not possible to fully participate due to extensive resource requirement to do so
- Neurosurgical National Audit Programme – Trust does not perform Neurosurgery
- Paediatric Intensive Care Audit Network (PICANet) – The Trust does not have Paediatric Intensive Care
- Prescribing Observatory for Mental Health (POMH-UK) – all four workstreams
- Medical and Surgical CORP - Cancer in Children, Teens and Young Adults – no service in place

5.2. Local Audits:

5.2.1. The table below provides an overview of the number of local audits registered on

the Trust's Clinical Audit Database within the last 12months.

Quarter	Month	Total Audits Registered	Total Audits Started	Total Audits Completed
3 – 2017/18	December	41	15	0
	November	65	38	1
	October	33	24	1
2 - 2017/18	September	26	18	0
	August	15	11	1
	July	42	24	3
1 – 2017/18	June	43	13	1
	May	31	21	2
	April	31	22	3
4 – 2016/17	March	35	26	4
	February	55	33	2
	January	38	28	2

6. Novel Techniques and Interventional Procedures (NTIPs)

6.1. Proposals Approved

6.1.1. Since 2004 the NTIP Group has received 63 proposals and approved 57 proposals. Of the six proposals that did not receive approval, three were not approved by the Group and three were disbanded by the proposer. Of the 57 proposals approved, seven of these procedures are no longer performed in the trust.

6.1.2. For 2017/2018 five new proposals have been approved by the NTIP Group (table 1). There are currently no proposals being reviewed by the NTIP Group.

Table 1: 2017/2018 NTIP approved proposals

NTIP no	Title	Date Approved	Proposer	Directorate
59	UroLift Laser	Apr-17	Vivek Wadhwa	Urology
60	Hilotherm Bandage	May-17	Mark Dunbar	Trauma & Orthopaedics
61	Insertion of arm portacaths	October-17	Matthew Fowler	Oncology and Haematology
62	Introduction of Trans-anal TME (TaTME) procedure to treat patients with rectal cancer	October-17	David McArthur	Surgery
63	Intravesical Hyperthermic Mitomycin	October-17	Laura Johnson	Urology

6.2. Audit position

6.2.1. In accordance with the Clinical Audit Policy and Procedure and the Policy for the Introduction and Development of New Techniques and Interventional Procedures, all implemented NICE and Non-NICE Interventional Procedures should be audited. Audits should be completed following completion of 25 cases or six months after the approval of the procedure, for procedures that are more rarely performed the audit period may be extended to 12 months, if required.

6.2.2. Audits have been completed for 30 of the 50 approved NTIP proposals which are still used in the Trust.

6.2.3. For the remaining 20 audits, these are either ongoing, overdue, have not yet commenced or the Clinical Audit team are awaiting confirmation of current status/completion from the proposer.

6.2.4. The Clinical Audit team are now requesting audit updates on a quarterly basis and proposers have been requested to register audits where these are missing on the clinical audit database.

7. Recommendation

The Council of Governors is asked to accept this report.

David Burbridge
Interim Director of Corporate Affairs
January 2018

Appendix 1- CQC ratings by site/service

Birmingham Heartlands Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Inadequate	Requires improvement	Requires improvement	Requires improvement	Requires improvement	Requires improvement
Medical care	Requires improvement	Good	Good	Requires improvement	Good	Requires improvement
Surgery	Requires improvement	Good	Good	Requires improvement	Requires improvement	Requires improvement
Critical care	Good	Good	Good	Requires improvement	Good	Good
Outpatients and diagnostic imaging	Good	Not rated	Good	Good	Good	Good

Good Hope Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Requires improvement	Good	Good	Requires improvement	Good	Requires improvement
Medical care	Good	Good	Good	Requires improvement	Good	Good
Surgery	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement
Outpatients and diagnostic imaging	Good	Not rated	Good	Good	Good	Good

Solihull Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Good	Good	Good	Good	Good	Good
Medical care	Good	Good	Good	Good	Good	Good
Surgery	Good	Good	Good	Good	Requires improvement	Good
Outpatients and diagnostic imaging	Good	Good	Good	Good	Requires improvement	Good

Castle Vale Renal Dialysis Unit

	Safe	Effective	Caring	Responsive	Well-led	Overall
Medical care	Good	Good	Good	Good	Good	Good

Runcorn Road Renal Dialysis Unit

	Safe	Effective	Caring	Responsive	Well-led	Overall
Medical care	Good	Good	Good	Good	☆ Outstanding	Good

Adult Community Services

	Safe	Effective	Caring	Responsive	Well-led	Overall
Community health services for adults	Good	Good	Good	Good	Good	Good
Outpatient and diagnostic imaging services – satellite sites	Good	Not rated	Good	Good	Good	Good

Appendix 2 – HEFT action plan for 'must do' CQC recommendations

Division 1: Clinical Support Services MUST RECOMMENDATIONS

REQUIREMENT NOTICES	SITE	SPECIALITY	EXECUTIVE LEAD	OPERATIONAL LEAD	CQC RECOMMENDATION	HEFT RESPONSE/COMMENTS	DEADLINE
Regulation 12 (2) (h) **R09**	BHH	CRITICAL CARE	Kevin Bolger	John Sellars, Director of Asset Management	The three side rooms in intensive care at Birmingham Heartlands Hospital did not have negative pressure to contain any bacteria within the room to reduce the risk of cross infection to other patients.	No active plans in place to replace and will be considered as part of the overall site strategy	No further action

Division 3: Emergency Care: **MUST RECOMMENDATIONS**

REQUIREMENT NOTICES	SITE	SPECIALITY	EXECUTIVE LEAD	OPERATIONAL LEAD	CQC RECOMMENDATION	HEFT RESPONSE/COMMENTS	DEADLINE
M12 Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment Premises and Equipment 1(b), 1©	BHH	ED	Kevin Bolger	John Sellars, Director of Asset Management	The Trust must ensure that the premises are suitable for the service provided, including the layout, and be big enough to accommodate the potential number of people using the service at any one time.	Site strategy shared with NHS Improvement (+E) as part of the case for changes.	Complete
M3 Regulation 12(2) (d)	BHH	ED	Jonathan Brotherton, Director of Operations	Sarah Moulton, Group Manager and Deputy Head of Operations	The Trust must ensure it is doing all that is reasonably practicable to mitigate any risks in relation to patients waiting in the corridors,	• All signage has been reviewed to ensure it is clear where ambulances should report to • Reinforced the role of the point of	

REQUIREMENT NOTICES	SITE	SPECIALITY	EXECUTIVE LEAD	OPERATIONAL LEAD	CQC RECOMMENDATION	HEFT RESPONSE/COMMENTS	DEADLINE
					delays in triage and ambulance handover times.	contact/assessment nurse for handover • Monthly meetings with the Ambulance Service Senior Operations Manager and Hospital Ambulance Liaison Officers (HALO's) to discuss performance, issues and service improvements • Designated computers for handover • Site based HALOs • Daily HALO reports • Escalation and deployment of corridor nurse - ED flow co-ordinator escalates any delays over 20 mins to ED Consultant and nurse in charge • All over 30 min delays validated jointly between the Trust and Ambulance service to learn from any delays (SOP agreed) • Additional trolleys purchased to ensure timely handovers • Monthly data reported has shown a significant improvement in our handover delays - Trust month end sign off from performance.	On-going
M4 Regulation 12 (2) (h)	BHH	ED	Margaret Garbett, Interim Chief Nurse	Gill Abbot, Senior Nurse Infection Control	The Trust must ensure infection control procedures including hand washing, the use of protective clothing and cleaning procedures meet the requirements to prevent the spread of infections.	• Wards complete a monthly hand hygiene audit and environmental audit. Any score below 90% triggers a request by the infection prevention and control team for an action plan to be developed and implemented and for the audits to be carried out weekly.	

REQUIREMENT NOTICES	SITE	SPECIALITY	EXECUTIVE LEAD	OPERATIONAL LEAD	CQC RECOMMENDATION	HEFT RESPONSE/COMMENTS	DEADLINE
						• The infection prevention and control audit results for hand hygiene and environment are reported on the Ward to Board Dashboard and discussed at the monthly Care Quality Meeting which is chaired by the Chief Nurse and attended by Divisional Head Nurses. • The facilities team carry out a monthly cleaning audit with the results reported to the supervisory ward sister and the matron for the ward and also to the infection prevention and control team. Any issues or concerns are highlighted directly to the infection prevention and control team. The environmental cleaning scores are discussed at the Food and Environment Group which meets quarterly. • There is an annual programme of monthly hand hygiene education and compliance activities carried out throughout the Trust. • There are policies and procedures for hand hygiene and standard precautions and a cleaning matrix. • The infection prevention and control nurses carry out annual peer hand hygiene and environment audits. • Hand hygiene, personal protective equipment and cleaning are included in mandatory training	Complete

REQUIREMENT NOTICES	SITE	SPECIALITY	EXECUTIVE LEAD	OPERATIONAL LEAD	CQC RECOMMENDATION	HEFT RESPONSE/COMMENTS	DEADLINE
						which is completed every two years for all staff in clinical areas or with patient contact. • No specific concerns have been identified by the infection control team in the regular audits within ED therefore no specific actions have been instigated.	
M5 None	BHH	ED	Margaret Garbett, Interim Chief Nurse	Dawn Chaplin, Head Nurse Patient Experience	There must be effective systems to make sure that all complaints are investigated without delay.	**Current/planned actions to address the requirement** • Revised complaints policy and leaflets provided to all ward areas. • Working together with divisions to resolve complaints within 30 working days as part of the policy and best practice guidelines for complaints management. • Better alignment between complaints staff and divisions with responsible person allocated to a specialty and division. **New system in place:** Day 1 a complaint is launched to the Triumvirate and appropriate Ward/Matron or Consultant is informed of the complaint or concern raised. o Complaint entered onto Datix and acknowledged within 3 working days. o Complainants are asked how they wish their complaint to be resolved i.e. with a meeting or formal response o All statements requested by day 10	Complete

REQUIREMENT NOTICES	SITE	SPECIALITY	EXECUTIVE LEAD	OPERATIONAL LEAD	CQC RECOMMENDATION	HEFT RESPONSE/COMMENTS	DEADLINE
						o Escalated to division if no response by day 15 o Draft prepared and out to Division by day 20 o On completion of draft a thorough QA process is instigated to provide clinical and Divisional accuracy re services and QA of complaints to make sure all questions are answered before the final sign off by the Chief Nurse. **Evidence demonstrating the Trust is taking appropriate steps to address the requirement.** • KPI reported through performance, reduction in complaints over 12 month period, escalation to triumvirate and head of complaints when complaint responses are delayed. • Weekly escalation document sent to heads of division and chief nurse indicating progression of every complaint by division. Monthly assurance information submitted to Board by Chief Nurse. • Quarterly complaint and patient experience report submitted to the CCG. • Progress in relation to complaints management is discussed at the Trust board via the Quality Paper which is presented by the Chief Nurse. Complaints management is also included in the Aggregated Report that is presented monthly at	

REQUIREMENT NOTICES	SITE	SPECIALITY	EXECUTIVE LEAD	OPERATIONAL LEAD	CQC RECOMMENDATION	HEFT RESPONSE/COMMENTS	DEADLINE
						the Care Quality Management Group meeting. A Trust wide peer review was undertaken in collaboration with UHB in October 2017 and commended by Trust Board.	
M12 Regulation 12 (2) (g)	GHH	ED	Dave Rosser/Alan Jones	Tania Carruthers, Clinical Director Pharmacy	The ED at Good Hope Hospital must ensure they follow policies and procedures about managing medications; including storage, checking medications are in date, and safe disposal of medications.	**Actions taken** • Controlled Drugs (CD) Newsletter Nov16 (for information regarding returns of CDs and opiate patch administration) • Controlled Drugs Newsletter May17 (for information regarding returns of CDs and opiate patch administration) • Medicines Safety Matters Newsletter No.17 (for information regarding fridge and room temps) • Safe Medication Practice Group Minutes 3/11/16 (reference to verbal feedback from CQC & specific issues to follow up). • Safe Medication Practice Group six monthly report April 2017 (reference to room temperatures in report presented to Clinical Quality Monitoring Group). • Safe Medication Practice Group 6-monthly report Apr16 (Reference to Safe & Secure Handling audit report 2015) • Safe Medication Practice Group minutes May 2016 (reference to safe & secure handling of medicines audit 2015 and on-going	March 2018 - can be closed when evidence is obtained following the quarterly audits commencing January 2018

REQUIREMENT NOTICES	SITE	SPECIALITY	EXECUTIVE LEAD	OPERATIONAL LEAD	CQC RECOMMENDATION	HEFT RESPONSE/COMMENTS	DEADLINE
						actions followed up) • Medicines Management Group six monthly report (April 2016) (Reference to Safe & Secure Handling of Medicines Audit 2015) • Pharmacy Quality & Safety meeting minutes November 2016 (p2) and January 2017 (on p2) (reference to on-going completion of ward storage audits and proposed use of 'respond by' documentation for ward feedback). • Delays in completion of audits mean that 2016 report is due for reporting to the relevant committees/groups in Sept 2017. • Dispensing standards - p11 - amended to reflect pharmacy adding expiry dates to dispensed liquid medication (attachment) Controlled Drugs • All CD liquids with shortened expiry upon opening must be supplied with a specific expiry date. e.g. the date 28 or 90 days after the dispensing date will be the expiry date (dependent on product information) • Information sent to ward managers and matrons regarding room temperature thermometers Safe Medication Practice Group June 16 (reference to actions to implement room temperature • Topping up audit is completed weekly	

REQUIREMENT NOTICES	SITE	SPECIALITY	EXECUTIVE LEAD	OPERATIONAL LEAD	CQC RECOMMENDATION	HEFT RESPONSE/COMMENTS	DEADLINE
						• Quarterly medicines management audit has been undertaken, this will be increased to monthly from Sep17 **Update 27/11/2017** • The 2016 audit has been presented at the Medicines Management Group 13/09/2017 • The last action above has been amended following discussion at the Pharmacy Q&S Group. A new audit proforma for the ward storage audit has been developed; this will include an escalation plan. The revised audit will be undertaken quarterly and will commence in January 2018. The results will be formally presented at the Pharmacy Q&S meetings and SMPG.	
M4 Regulation 12 (2) (h)	GHH	ED	Margaret Garbett, Interim Chief Nurse	Gill Abbot, Senior Nurse Infection Control	ED must ensure that cleanliness standards are maintained throughout the department in order to ensure compliance with infection prevention and control requirements. (The Emergency department at Good Hope Hospital had blood on the floor from a previous patient which was not cleaned before the cubicle was used for the next patient).	• Emergency departments are cleaned by domestic staff in line with the national specification for cleaning and a quarterly audit of cleanliness is carried out by the facilities team. • The department completes a monthly environmental audit and a peer audit is carried out by the infection prevention and control team annually and then as required. • The infection prevention and control team advise that cubicles, couches and equipment in clinical	Complete

REQUIREMENT NOTICES	SITE	SPECIALITY	EXECUTIVE LEAD	OPERATIONAL LEAD	CQC RECOMMENDATION	HEFT RESPONSE/COMMENTS	DEADLINE
						areas are decontaminated between patient use using disinfectant wipes or hypochlorite solution. • The department have introduced a laminated checklist in each cubicle which is completed and signed as evidence that the cubicle has been cleaned and checked between patients. • The staff in the department use the green indicator tape to identify that equipment has been cleaned between patients.	

Division 4: Medicine: MUST RECOMMENDATIONS

REQUIREMENT NOTICES	SITE	SPECIALITY	EXECUTIVE LEAD	OPERATIONAL LEAD	CQC RECOMMENDATION	HEFT RESPONSE/COMMENTS	DEADLINE
M01 Regulation 18: Staffing	SOL	MEDICINE	Margaret Garbett, Interim Chief Nurse	Andrea Field, Associate Head Nurse	The Trust must ensure staffing is in line with Safer Staffing Guidelines	Executive Board Note: The recommendation within the CQC report relates to nursing workforce only at Solihull A quarterly staffing report is provided to commissioners to provide assurance of safe staffing levels, this includes: 1. Monthly staffing compliance to agreed establishments by Division/ Speciality 2. Mitigation where any area falls below the agreed level of compliance 3. Evidence of compliance with NHS Standard Contract 5.2.4 relating to workforce acuity and dependency reviews. • There are circa 247 qualified vacancies across the Trust (nursing and midwifery) with a planned 196 Band 5 RN/RM new starters between August and October 2017.	Complete (actions ongoing)

REQUIREMENT NOTICES	SITE	SPECIALITY	EXECUTIVE LEAD	OPERATIONAL LEAD	CQC RECOMMENDATION	HEFT RESPONSE/COMMENTS	DEADLINE
						• The Trust holds monthly Saturday recruitment events throughout the year for Band 5 registered nurses • Discussions around safe staffing are held at the Care Quality Meetings chaired by the Chief Nurse (recent meeting dates 21st March 2017, 20th April 2017, 24th May 2017, 21st July 2017, 17th August 2017). • Key workforce issues including monthly safe staffing compliance are reported in the 'Ward to Board' quality reports that are presented to the Trust Board by the Chief Nurse on a monthly basis.	
M08 Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment Premises and Equipment 1(b), 1©	CASTLE VALE RENAL UNIT	RENAL	Jonathan Brotherton, Director of Operations	John Sellars, Director of Asset Management	The Trust must review and improve security and access arrangements at the unit.	A full security audit has been arranged involving the Trust's LSMS to identify any shortfalls in local procedures and physical access restriction required. Once the audit has been completed a bid for funding will be made to rectify all high risks. This audit will also be extended to our other renal unit located in Balsall Heath (Runcorn Road) Survey carried out and completed. Identified approximately £10k cost	Feb-18
M09 Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment Premises and Equipment 1(b), 1©	CASTLE VALE RENAL UNIT	RENAL	John Sellars, Director of Asset Management	Sharon Rogers, Group Manager, Division 4	The Trust must review its clinical waste storage at the unit.	• The issue with regards to working bin locks has been taken up several times with the current contractor and there is a programme of visits arranged by the facilities team to inspect the site to assess the storage area and look at workable solutions to secure it. • There is a plan to review the unit to assess the feasibility of creating an outside	Complete

REQUIREMENT NOTICES	SITE	SPECIALITY	EXECUTIVE LEAD	OPERATIONAL LEAD	CQC RECOMMENDATION	HEFT RESPONSE/COMMENTS	DEADLINE
						secure unit for clinical waste, this will be discussed at the waste management group meeting In discussion with Landlord for approval to create a new secure unit. This is additional to the CQC requirements.	
M10 Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment Premises and Equipment 1(b), 1©	CASTLE VALE RENAL UNIT	RENAL	John Sellars, Director of Asset Management	Sharon Rogers, Group Manager, Division 4	The Trust must ensure only clinical waste skips with working locks are accepted and used at the unit.	• The issue with regards to working bin locks has been taken up several times with the current contractor and there is a programme of visits arranged by the facilities team to inspect the site to assess the storage area and look at workable solutions to secure it. • The issue of faulty locks on clinical waste bins has been bought to the attention of the Trust's clinical waste contractor. • The department manager will develop a checklist for completion each week when the waste bins are delivered, this will include: Broken locks, damaged lids, dirty bins, faulty wheels. • Any waste bins found to be unsatisfactory will not be accepted	Complete
M11 Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment Premises and Equipment 1(b), 1©	CASTLE VALE RENAL UNIT	RENAL	John Sellars, Director of Asset Management	Sharon Rogers, Group Manager, Division 4	The Trust must review its waste audit process to ensure audits are carried out properly and are effective.	• The Trust has a Waste Management Policy • Waste audits are undertaken quarterly by the Estates Department • Any areas of non-compliance are reported to the ward manager/department manager • A monthly facilities meeting is held and audit results are reviewed at this meeting • A quarterly multi-professional waste management group meeting takes place	

REQUIREMENT NOTICES	SITE	SPECIALITY	EXECUTIVE LEAD	OPERATIONAL LEAD	CQC RECOMMENDATION	HEFT RESPONSE/COMMENTS	DEADLINE
						New processes implemented in response recommendations • In addition to the above processes in place within Estates, the department manager undertakes a monthly waste audit, the Matron will check the audit process and findings bi-monthly to ensure that it is robust • The department manager will develop a checklist for completion each week when the waste bins are delivered, this will include: Broken locks, damaged lids, dirty bins, faulty wheels. • Any waste bins found to be unsatisfactory will not be accepted	Feb-18
M12 Regulation 12 (2) (g)	GHH	SURGERY	Dave Rosser/Alan Jones	Tania Carruthers, Clinical Director Pharmacy	The Trust must consistently maintain medicines within their correct storage conditions to ensure medicines are suitable for use.	Actions taken: • Controlled Drugs (CD) Newsletter Nov16 (for information re. returns of CDs and opiate patch administration) • Controlled Drugs Newsletter May17 (for information regarding returns of CDs and opiate patch administration) • Medicines Safety Matters Newsletter No.17 (for information regarding fridge and room temps) • Safe Medication Practice Group Minutes 3/11/16 (reference to verbal feedback from CQC & specific issues to follow up). • Safe Medication Practice Group six monthly report April 2017 (reference to room temperatures in report presented to Clinical Quality Monitoring Group). • Safe Medication Practice Group 6-monthly report Apr16 (Reference to Safe & Secure Handling audit report 2015)	March 2018 Can be closed when evidence is obtained regarding the quarterly audits commencing January 2018

REQUIREMENT NOTICES	SITE	SPECIALITY	EXECUTIVE LEAD	OPERATIONAL LEAD	CQC RECOMMENDATION	HEFT RESPONSE/COMMENTS	DEADLINE
						• Safe Medication Practice Group minutes May 2016 (reference to safe & secure handling of medicines audit 2015 and on-going actions followed up) • Medicines Management Group six monthly report (April 2016) (Reference to Safe & Secure Handling of Medicines Audit 2015) • Pharmacy Quality & Safety meeting minutes November 2016 (p2) and January 2017 (on p2) (reference to on-going completion of ward storage audits and proposed use of 'respond by' documentation for ward feedback). • Delays in completion of audits mean that 2016 report is due for reporting to the relevant committees/groups in Sept 2017. • Dispensing standards - p11 - amended to reflect pharmacy adding expiry dates to dispensed liquid medication (attachment) Controlled Drugs • All CD liquids with shortened expiry upon opening ust be supplied with a specific expiry date. e.g. the date 28 or 90 days after the dispensing date will be the expiry date (dependent on product information) • Information sent to ward managers and matrons regarding room temperature thermometers Safe Medication Practice Group June 16 (reference to actions to implement room temperature •Weekly top up audits undertaken • Quarterly medicines management audits undertaken, this will be increased to monthly from September 2017 **Update 27/11/2017**	

REQUIREMENT NOTICES	SITE	SPECIALITY	EXECUTIVE LEAD	OPERATIONAL LEAD	CQC RECOMMENDATION	HEFT RESPONSE/COMMENTS	DEADLINE
						• The 2016 audit has been presented at the Medicines Management Group 13/09/2017 • The last action above has been amended following discussion at the Pharmacy Q&S Group. A new audit proforma for the ward storage audit has been developed; this will include an escalation plan. The revised audit will be undertaken quarterly and will commence in January 2018. The results will be formally presented at the Pharmacy Q&S meetings and SMPG	
M15 Regulation 12 (2) (h)	GHH	SURGERY	Margaret Garbett, Interim Chief Nurse	Divisional Head Nurses and Divisional Directors	The Trust must ensure that theatre staff wear appropriate clothing outside of theatres to reduce the risk of spread of infection.	• A revised uniform policy was launched throughout the Trust in July 2017, supported by a communications campaign and a programme of check and challenge by the senior nurses • The uniform policy was discussed at the following meetings: o Monthly Care Quality meeting o Quarterly Trust Infection Prevention Committee o Surgery Quality & Safety Meeting When the revised Uniform Policy was launched in July 2017 there was a two week period of monitoring by divisions and corporate nurses. Once this had closed the process is to now follow the key responsibilities in the policy i.e. Managers to manage locally and address any transgressions	Complete, monitoring of compliance on-going

Division 5: Surgery: MUST RECOMMENDATIONS

REQUIREMENT NOTICES	SITE	SPECIALITY	EXECUTIVE LEAD	OPERATIONAL LEAD	CQC RECOMMENDATION	HEFT RESPONSE/COMMENTS	DEADLINE
M12 Regulation 12 (2) (g)	BHH	SURGERY	Dave Rosser/Alan Jones	Tania Carruthers, Clinical Director Pharmacy	The Trust must consistently ensure medicines are stored appropriately and are suitable for use.	**Actions taken:** • Controlled Drugs (CD) Newsletter Nov16 (for information re. returns of CDs and opiate patch administration) • Controlled Drugs Newsletter May17 (for information regarding returns of CDs and opiate patch administration) • Medicines Safety Matters Newsletter No.17 (for information regarding fridge and room temps) • Safe Medication Practice Group Minutes 3/11/16 (reference to verbal feedback from CQC & specific issues to follow up). • Safe Medication Practice Group six monthly report April 2017 (reference to room temperatures in report presented to Clinical Quality Monitoring Group). • Safe Medication Practice Group 6-monthly report Apr16 (Reference to Safe & Secure Handling audit report 2015) • Safe Medication Practice Group minutes May 2016 (reference to safe & secure handling of medicines audit 2015 and on-going actions followed up) • Medicines Management Group six monthly report (April 2016) (Reference to Safe & Secure Handling of Medicines Audit 2015) • Pharmacy Quality & Safety meeting minutes November 2016 (p2) and January 2017 (on p2) (reference to on-going completion of ward storage audits and proposed use of 'respond by' documentation for ward feedback). • Delays in completion of audits mean that 2016 report is due for reporting to the relevant committees/groups in Sept 2017. • Dispensing standards amended to reflect pharmacy adding expiry dates to dispensed liquid medication Controlled Drugs • All CD liquids with shortened expiry upon opening must be supplied with a specific expiry date. e.g. the date 28 or	March 2018 Can be closed when evidence is obtained regarding the quarterly audits commencing January 2018

REQUIREMENT NOTICES	SITE	SPECIALITY	EXECUTIVE LEAD	OPERATIONAL LEAD	CQC RECOMMENDATION	HEFT RESPONSE/COMMENTS	DEADLINE
						90 days after the dispensing date will be the expiry date (dependent on product information) • Information sent to ward managers and matrons regarding room temperature thermometers Safe Medication Practice Group June 16 (reference to actions to implement room temperature • Weekly top up audits undertaken • Quarterly medicines management audits undertaken, this will be increased to monthly from September 2017 **Update 27/11/2017** The 2016 audit has been presented at the Medicines Management Group 13/09/2017 The last action above has been amended following discussion at the Pharmacy Q&S Group. A new audit proforma for the ward storage audit has been developed; this will include an escalation plan. The revised audit will be undertaken quarterly and will commence in January 2018. The results will be formally presented at the Pharmacy Q&S meetings and SMPG	
M07 Regulation 12 (2) (g)	BHH	SURGERY	Dave Rosser/Alan Jones	Tania Carruthers, Clinical Director Pharmacy	The Trust must ensure staff are trained and competent to administer medicines under PGDs.	• NICE Guidance Patient Group Directions (GPG2) - a gap analysis was completed in November 2016. This was updated in August 2017 & shared with Medicines Management Group August 2017 • The PGD policy was reformatted into a procedure in Q4 2016/17 whilst on-going work was undertaken to complete a significant review of the procedure . The revision took account of the feedback from CQC in October 2016, the outcome of a PGD audit and the NICE Guidance. • The draft new procedure was discussed at Safe Medication Practice Group on 6th July 2017. • The new procedure was approved by the Trust Medicines Management Group on 9th August 2017 Next steps: 1. MSO will deliver training and awareness to lead pharmacists across all sites within next 2 weeks. A	Dec-17 – update not received as of 31st December 2017

REQUIREMENT NOTICES	SITE	SPECIALITY	EXECUTIVE LEAD	OPERATIONAL LEAD	CQC RECOMMENDATION	HEFT RESPONSE/COMMENTS	DEADLINE
						presentation has been developed to facilitate this and is on the medicines management website. 2. Pharmacists will be supporting with the training and awareness in their areas once communications have been issued. MSO will help deliver training to areas not covered by them. 3. Two weeks prior to launch w/c 2nd October 17, all wards and departmental managers will be advised of their responsibilities with implementation of the PGD procedure. 4. w/c 2nd Oct launch the PGD procedure will be launched Trust wide via Comms and will direct registered staff to the medicines management website for the presentation. 5. Registered staff will be expected to sign a staff signature list on the ward to say they have read the procedure supported by the presentation. This will be retained on each ward/dept. 6. As each member of staff has read each relevant PGD for their area, they must sign a separate authorised staff list which is kept on each ward/dept 7. Mini audit will be completed at 3 months by pharmacy governance to check paperwork completed correctly 8. A biannual audit will be included on the pharmacy Forward Audit Plan for 18-24 months' time. A PGD Moodle is being developed which will streamline the process going forward e.g. will accommodate centralised for PGDs and PGDs in operation on each ward/dept. This will support PGD awareness training for new starters. This should be completed by the end of December 17.	

REQUIREMENT NOTICES	SITE	SPECIALITY	EXECUTIVE LEAD	OPERATIONAL LEAD	CQC RECOMMENDATION	HEFT RESPONSE/COMMENTS	DEADLINE
M16 Regulation 12 (2) (h)	SOL	SURGERY	Margaret Garbett, Interim Chief Nurse	Martin Richardson	The hospital did not collect data to determine rates of surgical site infection at Solihull Hospital.	• The Trust has contributed to the mandatory requirement for audit of surgical site infection in one type of orthopaedic operation for one quarter a year. This was carried out in 15/16 at Heartlands Hospital for fractured neck of femur. This is not performed at Solihull. Heartlands Hospital is also contributing voluntarily to large bowel surgery SSI which is not carried out at Solihull. • The surgical division 5 will review and develop a programme of collection of surgical site infection data, including post discharge, to ensure we maintain the mandatory T&O reporting and continue to contribute and increase our participation in the voluntary surveillance. • Further work will be undertaken to develop an on-going monitoring process for surgical site infection as captured within the Copeland Risk Adjusted Barometer tool. • The infection prevention and control team are currently collecting data relating to rates of surgical site infection in Solihull community services within podiatric surgery.	Dec-17 – update not received as of 31st December 2017

Heart of England NHS
NHS Foundation Trust

Minutes of a meeting of the, Membership & Community Engagement Group of the Council of Governors of Heart of England NHS Foundation Trust held in the Boardroom, Birmingham Heartlands Hospital on 4 October 2017 at 2.00pm

PRESENT: A Fletcher, Chair
T Cannon, Governor
S Hutchings, Governor.
J Thomas, Governor
D Treadwell, Governor

IN ATTENDANCE: F Alexander, Interim Director of Communications
Mr Burbridge, interim Director of Corporate Affairs
A Hudson (Minutes), Senior Executive Assistant
S White, Membership & Community Engagement Manager

17.07 INTRODUCTION AND APOLOGIES

The Chair welcomed everyone to the meeting. Apologies had been received from Mr Hoey and Mr Webster.

The interim Director of Corporate Affairs advised that he needed to leave the meeting for a short while at 2.30pm for a telephone call.

17.08 MINUTES OF PREVIOUS MEETING

The minutes of the meetings held on 19 May 2017 were approved as an accurate true record.

17.09 MATTERS ARISING

The interim Director of Communications in response to a question from the Chair advised that no decision on whether there would be governor representation on the new Charity Board had been made at the present time.

It was noted that the Governor photo boards on each of the sites would be in situ by the end of the following week.

In response to a question, the interim Director of Communications reported that the Trust website was in the process of being up dated.

Constituency boundaries would be discussed under AOB.

17.010 MEMBERSHIP RECRUITMENT EVENTS

The Group received an update on membership including the events which had been held over the summer to increase membership from the Membership & Community Engagement Manager. Membership now stood at 15629 public, 10,557 staff giving a total membership of 26,186. The recruitment events held between June and September had increased the membership by 259. Recruitments events had also been held at each of the site AGMs and at Fresher events at local universities.

There was a debate on the appropriateness of some of the recruitment events. It had been shown that it had been difficult to recruit members in the clinical outpatient setting.

In response to a question, as to whether the Trust approached complainants to become members, the interim Director of Communications advised that she was not sure of the process at HEFT, but at UHB this was the case, they also contacted those who wrote in complimenting the care they received.

In response to a question, the split between public and patient membership was broadly similar at UHB to the membership at HEFT.

There was a discussion on how the staff membership could be used more effectively to increase membership numbers.

It was suggested that contact should be made with Healthwatch to see if the Trust could attend their meetings.

The Governor membership engagement sessions would be recommencing the following week, there were a few dates yet to be assigned and volunteers from all governors were still being sought.

AH agreed to upload the dates to the Governor Portal.

A formal vote of thanks was recorded to governors who had supported the events.

17.011 PREPARING FOR POTENTIAL POST-MERGER MEMBERSHIP STRATEGY

The interim Director of Corporate Affairs and the interim Directors of Communications presented an overview of potential post-merger membership strategy and the preparatory work and the role of the MCE Group in that process prior to the merger taking place.

The Group were reminded of the work that the HEFT / UHB joint working group had undertaken that had considered what the options were around the single membership. That work had included brainstorming sessions with governors from both organisations to consider what work would be required to be undertaken as one trust. This had included the make-up of the Council of Governors to reflect the constituencies covered by the new organisation. The role of this group would be to continue to help the development of the membership strategy as part of the Patient, Carer and Community Council (PCCC) that included members from the CoG Hospital Environment and Patient Experience Groups.

Local site engagement would include each site having a PCCC along with sub-groups. Elected Governors being members of the relevant site-based PCCC e.g. Solihull & Meriden Governors members of Solihull PCCC. The members of the PCCC sub-groups undertaking PLACE surveys and reporting to the PCCC. Governors visits being undertaken and reported back to PCCC. Arrangements for PCCCs to engage with local (site) management and one governor from each of the Council/Panel to attend Chief Nurse's Care Quality Group (CN CQG).

There was a lengthy discussion on the details around the membership of the PCCC and how reporting would be undertaken and the following was noted:

The PCCC would report into the CN CQG and then into CoG via a report from the Chief Nurse.

Feedback from the site PCCC's would be presented by an elected governor, which may not necessarily be the chair of that PCCC if the Chair was not an elected Governor. It was the role of the PCCC to elect their Chair. The Governor representative would be the vessel by which feedback from the PCCC was received.

It was the expectation that local management representation, that included estates, would attend PCCC meetings.

PLACE assessments would be standardised across each of the sites following national criteria.

It was being explored how the membership Health Seminars could be undertaken across the different sites. Suggestions included rotating the seminars, video links and recording the sessions.

The interim Director of Corporate Affairs reported that some preparation work was required to be undertaken pre-merger including the need to have a full complement of Non-Executive Directors in post on Day 1.

To do this, a meeting of the UHB CoG Nominations, Appointments and Remuneration Committee would be required to meet to agree the process for NED appointment and to hold interviews. Members of the HEFT committee would be invited to participate in the process. Details of dates would be circulated to the members of that committee.

17.012 ANY OTHER BUSINESS

17.012.1 Boundaries and Constituencies. The interim Director of Corporate Affairs presented the final map and proposed names of the nine new constituencies that had taken into account the new Birmingham ward boundaries. The meeting held a lengthy debate following which agreed that the principle of combining a geographic descriptor with a local prefix was preferred eg:

1. Lichfield, Northwest & Northeast
2. Tamworth
3. Sutton Coldfield North
4. Sutton Coldfield South
5. Birmingham North
6. Birmingham West
7. Birmingham Central
8. Birmingham Heartlands
9. Birmingham East

17.012.2 Membership Events – would continue to be held. The names for each of the hospitals would not change just the overarching organisation name changed to University Hospitals Birmingham NHS FT.

17.012.3 Governor representation on new UHB Charities Ltd Board. The interim Director of Communications advised the panel had now completed the skills audit required. It was for the Board of the Trust to consider individuals they would like to nominate who had the appropriate requirements for appointment. There were three vacancies to be filled.

17.013 DATE OF NEXT MEETING

10.30am, 12 January 2018, Boardroom, Devon House, Heartlands Hospital

.....

Chair

Action Log

Action No.	Date	Action	Owner	Status	Complete Date
17.04.08 17.09	19.5.17 4.10.17	Update photo board for Governors across all sites Governor photo boards on each of the sites to be in situ by 20.10.17	NB		
17.010	4.10.17	Healthwatch to be contacted to see if the Trust could attend their meetings.	SW		
17.010	4.10.17	Dates of the membership engagements sessions to be uploaded to the Governor Portal.	AH		

Heart of England NHS
NHS Foundation Trust

Minutes of a Meeting of the Council of Governors Hospital Environment Committee of Heart of England NHS Foundation Trust held at 2.00 p.m. on Thursday, 28 September 2017, in Room 2, the Education Centre, Solihull Hospital, Lode Lane, Solihull B91 2JL

PRESENT:	Sue Hutchings (Chair) Stan Baldwin Keith Fielding Derek Hoey Gerry Moynihan David Treadwell David Wallis Andy Edwards Chris Davies
IN ATTENDANCE:	Jean Thomas Ann Harwood (minutes)

17.35 APOLOGIES

There were no apologies.

Jean Thomas advised that the Hospital Environment Committee (HEC) is recognised as being very effective and felt that it is a "shining example of what a committee should be". As there are very strong links with the Patient Experience Group she queried whether the two committees should work together but form separate committees for each site. Andy Edwards felt that they should be separate standalone committees as the HEC's remit relates to the HEFT Estate rather than patient experience and advised that there will be a review of all committee structures across HEFT. Members were happy for Jean Thomas to continue to attend HEC meetings when she is available.

17.36 MINUTES OF MEETING HELD ON 27 JULY 2017

The minutes of the meeting held on 27 July 2017 were approved as an accurate record with the following point noted:

- *Item 17.29.3: Guttering at GHH and SH*: the fourth bullet point states that "Derek Hoey reported that there was some low level guttering outside the main entrance at SH that requires clearing", however Derek Hoey advised that he had been referring to the low level guttering around the entrance to the Orchard Restaurant at GHH. Ann Harwood to amend the minutes to reflect this.

17.37 DECLARATION OF INTEREST / REGISTER OF INTEREST
(in respect of any agenda items to be discussed)

- As agreed at the last meeting Ann Harwood has forwarded the amendments agreed at that meeting to Angie Hudson. However Angie Hudson has clarified that this item refers to any conflict of interest that may be relevant for Hospital Environment Committee members in respect of each meeting's agenda items. Members are required to declare any such conflict of interest.
- The full Register of Interest will be discussed and updated at the CoG meetings.
- Gerry Moynihan advised that he is a member of the local neighbourhood forum and as such will be involved in the consultation group for the ACAD planning application. Sue Hutchings agreed to check with David Burbridge as to whether this constitutes a conflict of interest. David Treadwell advised that he is also a member of a local neighbourhood forum but there are no conflicts of interest. It was also noted that David Wallis is Director of Knowle, Dorridge & Bentley Heath Neighbourhood Plan Ltd.

17.38 MATTERS ARISING FROM MEETING HELD ON 27JULY 2017

17.38.1 Availability of Stationery Items in the Main Entrance at BHH

- Sue Hutchings has discussed with Tony Cannon as to whether this item could be picked up during the Patient Experience Ward Drop-in sessions. It was agreed that rather than adding this as another item on the ward drop-in questionnaire it could be included on a prompt list as part of a general item re what patients think about the Trust's retail outlets.
- David Treadwell reminded members that as the BHH Main Entrance is a PFI the Trust has no influence over any decisions relating to this area. He queried what need there is for a Marks & Spencer food outlet in a hospital. Chris Davies confirmed that the decision would have been made by Assura who manage the Main Entrance, however they do consult with HEFT for their view prior to agreeing any leases to ensure there are no conflicts of interest, Health & Safety issues etc.
- David Treadwell queried whether the issue re signage stating that the Main Entrance building is not managed by HEFT has been resolved. Chris Davies agreed to check whether this was discussed at the last meeting with Assura.
- Gerry Moynihan queried whether the UHB acquisition would give an opportunity to renegotiate the PFI contract. Andy Edwards confirmed that the PFI contract will need to be re-assigned to the new Trust.

17.38.2 Guttering at SH

As discussed under item 17.36, this item relates to the low level guttering around the entrance to the Orchard Restaurant at GHH. Chris Davies agreed to follow this up with Dave Smith, Estates Manager at GHH.

17.38.3 Treatment Centre, GHH

The Action Plan has been updated with the actions taken to resolve the issues raised at the last meeting, the majority of which have completion dates of October 2017. Item to be carried forward to the November meeting for a further update.

17.38.4 Water Dispenser, Treatment Centre, GHH

Dave Smith has confirmed that the cup dispenser has been re-attached to the water cooler. However the cups being used are too small for the dispenser and the Senior Sister has been advised to either purchase larger cups or a cup dispenser suitable for the existing cups. Derek Hoey agreed to check that this issue is now resolved and report back at the next meeting in November.

17.38.5 Gel Dispensers

The Estates Managers for each site have been requested to redecorate the areas in the main entrances where gel dispensers have been removed. An update has been provided for each site as follows:

- *GHH*: a site survey is to be undertaken to ensure that all areas relating to the old gel dispensers are made good by the end of October 2017. Item to be carried forward to the November meeting for a further update.
- *BHH*: Estates staff have been instructed to fill the holes and make good the décor. All areas are currently being checked to ensure these works are complete.
- *SH*: where hand gel dispensers have been removed Estates staff have been instructed to fill the holes left behind and to touch up the decorations. All areas will be checked and any remedial action taken. It was noted that areas requiring repairs had been picked up during the PLACE inspection at SH on 8 May 2017.
- Jean Thomas advised that when one of the hand gel dispensers on a ward at GHH had run out she had informed the ward staff who advised that they had run out of stock. Chris Davies confirmed that wards are responsible for ordering their own hand gel and that they operate a top up system so that they don't run out of supplies. Jean Thomas agreed to

raise this at the Patient Experience Committee. In addition when members are on the wards they will check the position with hand gel dispensers themselves.

- It was agreed to keep this item on the agenda until all sites are complete.

17.38.6 Bedford Road Car Park

At the last meeting it was reported that there is a large pothole in the Bedford Road Car Park. Dave Smith has advised that the manhole (service duct) has dropped and needs to be raised. He is obtaining a quotation for this work with completion planned in October 2017. Item to be carried forward to the November meeting for an update.

17.39 PLACE INSPECTION ACTION PLANS: UPDATE

A copy of the latest updated PLACE inspection action plans was circulated and discussed as follows:

- The cleaning issues were discussed and addressed at the time they were picked up.
- The Estates Managers for each site have reviewed and updated their actions. It was noted that the works order has been recorded for some actions and the call number for others. This is down to the terminology used and relates to the same call logging system.
- There are some Estates actions outstanding as there is an issue with being able to gain access to these areas/ wards due to Infection Control precautions which require bays etc. to be closed whilst the works are being carried out.
- Where ward issues have not been completed this will be picked up at the Patient Experience group.
- Ann Harwood to e-mail the action plans round to members for their review/ comments so that any major concerns/ issues can be discussed at the next meeting in November. Ann Harwood to also forward the updated GHH action log to Catherine Williams.
- Derek Hoey queried what the process will be for the areas which state that additional funding is required. Chris Davies advised that a bid for funding will be submitted to the Trust's Capital Prioritisation Group.
- Andy Edwards asked what the current position is with the Deep Cleaning Programme. Chris Davies confirmed that the Deep Cleaning Programme for every ward across the Trust had commenced in May 2017. Deep cleans were carried out at GHH as there was a decant ward available and the deep cleans were carried out following some Estates work. The SH deep cleans were also completed. However only a few deep cleans have been completed at BHH due to there being no decant ward. Members agreed that the wards at BHH are very 'tired' looking and queried whether a programme of refreshing the wards over 3-4 weeks during the summer could be a way forward. Chris Davies agreed to feed this back with a view to looking at what can be done at BHH from April 2018 but this can only be achieved if a decant ward is available.
- Dave Smith, Estates Manager at GHH, has advised that there are some additional pressures in the building department at GHH at present as the department has been struggling to meet demand in relation to carpenters, builders and painters. Dave Smith is reviewing this including the issues with recruitment as there are a number of trade staff vacancies. It was agreed to pick this up for an update at the November meeting.
- Stan Baldwin was concerned that the notice boards on some of the wards are cluttered and have out of date notices on them. Andy Edwards advised that this had also been picked up during the Non-Exec unannounced visits together with the fact that some of the wards have clinical and patient specific information displayed. It was agreed that this is an issue for the Communications Team and Stan Baldwin agreed to pick this up and feedback at the next meeting.
- Sue Hutchings also advised that the signage is out of date in some areas at SH. Chris Davies agreed to pick this up with Jim Fitzgerald, Estates Manager at SH with a request that all signage at SH be reviewed to ensure that it is up to date.

17.40 ACAD UPDATE

An update on progress with the ACAD project was circulated to members for information and was discussed as follows:

- The Outline Business Case (OBC) is currently being developed for presentation to the Trust Board on 23 October. If the Board approves the OBC it will then be submitted to NHSI for consideration prior to development of the Full Business Case (FBC).
- If the project is approved by the NHSI then there will be discussions around how ACAD should be procured i.e. the P21 route or as a PFI/PPP.
- Andy Edwards confirmed that the project will be funded completely from external funding.
- David Treadwell requested that consideration be given to providing some landscaping around the new build once complete, bearing in mind that there will be maintenance costs for trees, bushes etc. It was agreed that any landscaping should not have an effect on car parking provision. Chris Davies advised that the project is still in its early stages with the floor plans having only just been agreed with the Operations Teams and a decision on landscaping is much further down the line. The roadway issues are currently being considered and as part of this there will be a temporary access road to ACAD.
- A public consultation event is being arranged for 6.00 p.m. on Wednesday, 4 October, in the Lecture Theatre at BHH. Leaflets have been delivered to all residents who live within a ½ mile radius of BHH. Mark Piggott and Sue Wintle from the Programme Management Office will be attending the event to give a presentation and answer questions.
- Gerry Moynihan was concerned that funding approval is vague and currently the Trust does not have the money to build ACAD. Andy Edwards advised that Dame Julie Moore has been involved in many discussions with NHSI and there is not likely to be a definitive answer on funding until Final Business Case stage. The local community will be kept informed on progress including the roadway plans and how the construction traffic will be managed.
- Access to ACAD will be via a connecting corridor (new ward block) at the top of the escalators in the Main Entrance.
- Chris Davies gave an overview on the plans for car parking which will mean that the number of visitor spaces will be retained and more staff car parking will be moved off site. A planning application has been submitted to Birmingham City Council to create a surface car park for staff on the land opposite Belchers Lane which is currently being used as a rough surface car park.
- It was agreed that Ann Harwood would e-mail a copy of the ACAD update, floor plans and elevations to members with the minutes.

17.41 ANY OTHER BUSINESS

17.41.1 <u>RSU Entrance at GHH</u>

Chris Davies confirmed that a business case has been approved by the Chief Executive Group for refurbishment of the RSU entrance, which is being funded from a charitable donation. The refurbishment works will extend to the lift area, the toilets will be stripped out and an extended seating area created for the coffee shop, space is being taken from the Drs Mess to create public toilets. The funding also includes works to the façade and external canopy to the entrance. The scheme is currently out to tender and the start date for these works will be confirmed shortly.

17.41.2 <u>Birmingham Chest Clinic Relocation</u>

The future location of the Chest Clinic is currently being reviewed, one of the proposals being considered is for the Chest Clinic to relocate to Attwood Green. The current Chest Clinic location is poor and the upper floors are being converted into luxury flats by the new owner. Chris Davies agreed to ask John Sellars to give an update on the Chest Clinic proposals at the next meeting in November.

17.41.3 Appointments Office

- David Treadwell queried where the appointments staff currently located in Lyndon Place are moving to. Chris Davies confirmed that these staff will be moving to 163 Yardley Green Road.
- It was also noted that some IT staff have moved from Bordesley House to UHB offices and the remaining IT staff will move to the old Health Club once the refurbishment works are complete.

17.41.4 Toilet at SH

Gerry Moynihan advised that in the second toilet along the main corridor from the stairs used by Physiotherapy, that the ledges on fascia formica panels are dusty along the top of the panels. Chris Davies agreed to review and ensure this element is picked up.

17.41.5 ICT Infrastructure

It was agreed that this would be a regular agenda item for updates at future meetings.

17.42 DATE OF NEXT MEETING:

Thursday, 23 November 2017 at 2.00 p.m.,
in Meeting Room 1, Estates Building, Heartlands Hospital

.....
Chair

Heart of England NHS
NHS Foundation Trust

Agreed Minutes of a meeting of the
Patient & Staff Experience Group of the
Council of Governors
of Heart of England NHS Foundation Trust
held on Friday 15th September 2017 at 10.00am
in the Boardroom, Devon House, Birmingham Heartlands Hospital

PRESENT:	**CANNON, Antony (AC)**	**Chair (and Chair of the GHH PCP)**
	CHAPLIN, Dawn (DC)	Head Nurse, Patient Experience
	FIELDING, Keith (KF)	Governor
	HUTCHINGS, Susan (SH)	Governor
	PASSEY, Louise (LP)	Governor
	THOMAS, Jean (JT)	Governor
	WEBSTER, Thomas (TW)	Governor
IN ATTENDANCE:	EMERY, Jamie (JE)	Head of Patient Services & Engagement
	RUDGE, Kevin (KR)	Chair of the SOL PCP
MINUTES:	HIGGINS, Vickie (VFH)	Executive Assistant

17.045 Welcome

AC welcomed everyone to today's meeting, especially due to the short notice of having the meeting held slightly earlier than planned.

17.046 Apologies for Absence

Apologies were received from Stan Baldwin, Anne Horton, Karen Kneller and Julie Tunney.

17.047 Minutes of the Previous Meeting

After one minor amendment around initials, the minutes of the meeting held on Friday 14th July 2017 were agreed as an accurate record and have been forwarded to Angela Hudson.

17.048 Matters Arising

AC advised the GHH PCP met yesterday but did not receive an update from Shahzad Razaq concerning the recovery of prescriptions charges. **Action :** Shahzad Razaq to be invited to attend a future meeting and give an update to the Group.

17.049 Feedback / Verbal Reports from PCP Meetings

BHH : AC advised Anne Horton (Deputy Chair) had had an operation recently but had developed an infection. The Group wishes her a speedy recovery.

SH : KR advised the last meeting was very good, well-attended and saw three presentations:-

- Jacqui Smith and Martin Nadin with regard to the merger.
- Gill Abbott from Infection Control with regard to MRSA prevention.
- Neil Mallett from Division 3 (Emergency Care) with regard to recruitment and retention.

GHH : AC advised there was the same presentation from Martin Nadin and expressed thanks for the excellent work in achieving first stage approval from the CMA for the Case For Change. This was the first merger of NHS Trusts in the country to be approved at this stage, which shows the competence of the work of the team. Gill Abbott also gave an excellent presentation on the use of Octenisan body wash.

There was an update from Division 5 by Matrons Gail Moore and Caroline Deekes on behalf of Lynn Fisher, Head Nurse. There was a detailed discussion on nurse recruitment and the problems the Division is facing in obtaining staff.

17.050 Patient Experience Dashboard

AC advised he was pleased to see this dashboard and the only issue was the font size when printed on A4

The Group reviewed the FFT data, showing high levels of patient participation (39% contributing). This was a good patient sample with around 2,500 responses each month, every month. KPIs were at 30% and the Trust saw 92% to 95% positive recommender rates.

The Group reviewed the Performance Data and the Trust Patient Experience survey. New questions included those around pain, buzzers and dignity and respect.

DC discussed complaints data, an increase in response rates and the high level of data - ie. every week, each area and each Division receives live data. They should be 85% compliant by Mar18 and were currently in the mid-50s. The 50 working day data should be zero but there will always be a few. However, they were at 67 a few months ago.

AC felt complaints figures should be given relative to the possible responder score - ie. a very small number distorts the actual picture. Wards should also be defined. However, DC advised some wards change, such as Flex Wards and Dementia Wards (see attached document - “Divisions List - Matrons & Senior Sisters”).

17.051 PLACE 2017 Action Plans

AC felt this had improved, with the remaining outstanding issues highlighted in blue (Nursing Wards). There were also positive and negatives - ie. noticeboards, marks on walls, etc. - but it was felt minor issues were not relevant to patient care. Some were “awaiting funding” or “awaiting review”. These needed to be followed through and SH advised this would be discussed at the next Hospital Environment meeting on Thursday 28th September.

It was agreed the Group could not judge this year’s data without seeing the data from previous years. SH advised Catherine Williams held previous data and KF suggested they establish the data now and compare this year to next year. A comparison could then be made against the national average.

JT felt the PLACE Inspections had deteriorated year-on-year and asked about the actions and areas to be addressed - ie. respect and dignity. JT will discuss further with AC.

17.052 Update : Governor Drop-In Programme

The Group reviewed the report for the first ‘Drop In’ on Ward 30 BHH The responses to the questions on training were particularly interesting (question 18). KF felt this should be fed into staff development programmes. It was suggested the form should include a description of the type of Ward/Department being surveyed. **Action :** DC.

KF was asked about staff feedback and body language and LP felt staff may have appeared to be comfortable but may not have been. KF also suggested the front page of the survey was altered to the present tense, rather than the past tense. **Action :** DC.

SH advised she met with patients and not staff, asking what their experiences were, did they mind being surveyed, what was good and bad and what did we do well and what could be improved. SH stressed this was just a survey and not an inspection.

AC asked what grades of staff were surveyed, HCAs or Staff Nurses and KF felt it was unfair to say. DC suggested staff nurses - ie. HCAs in the bedded rooms - but we would get a bigger picture when more surveys have been done.

JT asked if there was any resentment and DC felt there was not. Staff were sharing good practice and spoke of personal issues, support and training and AC suggested the survey should focus on what additional training they felt they needed rather than ask them to grade their competence. Some patients were not aware there was a television in the Day Room, so communications could be improved.

KF felt we were not doing enough drop-ins, as it would take five years to get around all the wards AC agreed but said that the workload was a consideration. After the proposed merger, there would be 20 Public Governors only to cover four hospitals and the Birmingham Chest Clinic. With two Governors per team and the need to allow for ad hoc Drop-Ins if required, it would need very careful planning to increase to two scheduled 'Drop-Ins' per month. SH asked if more lay people could be involved taken from the existing PCP panels and AC agreed this was a possibility but the initial response could have been better.

TW agreed with KF and felt we were not doing enough.

AC summarised this was a survey and not an inspection. It needed more support and ideally a higher frequency - ie. two per month involving two Governors and one Lay Member - but was concerned that the programme would not get that level of support.

17.053 Patient Passport

AC felt this was moving along nicely and confirmed the Sub Group (JT, LP, SH and AC) met on Friday 18th August 2017. AC had also circulated the latest draft, which had been produced by HEFT's Medical Illustration department.

AC had met with Lorraine Longstaff (LL), Adult Safeguarding lead, and was very impressed. LL had made a few observations - ie. The legal section should include provision for 'advanced decisions' and a safeguarding section to identify any care and support concerns - DC felt that it would be useful to get some feedback from the Carer's Forum.

It was agreed that patients would be sent a 'Passport Form' with their admission paperwork and that copies would be available on the wards and assessment units.

AC advised of the outstanding issues - ie. who should be the point of contact if a patient needed further information on the 'Patient Passport,' DC suggested this should be the Ward Staff and AC suggested adding; "Any concerns on how to complete the passport should be discussed with the Nursing Staff on admission."

AC advised he had met with Emma Hartill, Deputy Head Nurse from Division 4, who was happy to run some trials on the Elderly Care Wards and the Assessment Unit on Ward 21 at GHH

17.054 Presentation : Macclesfield District General Hospital

LP advised she met with Lyn Bailey on Thursday 6th April 2017, the lead for autism training and work. This was a District General Hospital and not a Foundation Trust.

LP walked around the hospital and discussed policies and training. Patient Passports were used (Attachment 1) and Risk Assessments (Attachment 2). They had also won a national award in 2013 for their pilot on training around dental outpatients and paediatrics. All staff received basic training in autism awareness. Some areas also had an autism champion to help patients and family members. There were leaflets (Attachment 3), calm boxes, an e-Learning package for staff, an "Open To Autism" project and an autism noticeboard. They have regular contact with the Autism Alliance and Autism Charter and had signed up to six workstreams. Lots of work was being done but this was complex and difficult, which required dedication to make it work.

JE asked if there was a team of staff or whether this was just Lyn's role and LP advised Lyn was part of Patient Experience. No-one else was doing this work - they were very dedicated.

JT asked how much time was dedicated to this and what the time commitment was and LP agreed to find out.

SH asked how patients with autism were currently treated and DC advised of reasonable adjustments such as a quiet environment, involving the carers, NOK issues and nurses. However, it still required greater awareness and support but would be a very big piece of work.

LP advised Macclesfield was very small but autism had increased - around 700,000 people in the UK were autism specific (or 1 in 100), with around 2.8 million families affected. There were lots of children with autism but many were classed as having mental health problems.

TW thanked LP for her presentation and advised, as a Governor, he was not aware of any problems at the Trust and this would be difficult to overcome.

AC was also not sure of any problems but could look at what HEFT was doing to avoid any potential problems - there did not appear to be many complaints at the moment.

17.055 Complaints Team's "Snakes and Ladders" Game

Staff are praising an inventive approach to complaints handling training using a twist on the traditional snakes and ladders game. The Trust has recently introduced a new complaints process as it continues its drive to improve the experience for service users.

DC devised the game as part of the complaints process training with the aim being early intervention and resolution by looking at how we get the message out around the complaints process in a slightly more memorable and usable way, so the information really sticks. DC devised a snakes and ladders game to compliment other resources.

The game has 30 squares to represent the 30 days to complete the process. They use real but anonymous complaint scenarios and each team receives a case study, following the board from receiving the complaint to requesting statements, drafting the response and a response letter enabling resolution. However, there are snakes and ladders along the way, which can either delay or expedite the process. For example, escalating to senior members of staff will see you go up a ladder or being defensive or inaccurate will see you go down a snake to the beginning of the process again.

The game covers all areas of complaints and gets the teams to think about what they would do. Feedback has been very positive and there will be more sessions going forward, so everyone in the Trust understands the process.

AC and the Group thanked DC for showing them this innovative and interesting initiative.

17.056 Any Other Business

17.056.1 Complaints Pathway

JT asked about complaints the Governors received, which used to be referred to Sam Foster and AC asked DC to clarify the route.

DC advised any complaints received via Julie Tunney's office, addressed to the Chief Nurse or the Chief Executive go directly to Julie and are then passed to her. It was agreed Governors should contact DC concerning any complaints they receive for the moment. JT agreed this makes sense and was the best process.

17.056.2 Compliments & Criticisms

SH asked where compliments in the press went as there had been quite a few recently, with lots of nice things said about the hospital and certain wards.

DC advised Ward compliments went to the Ward Sister and Head Nurse. However, it was agreed they needed to be captured centrally - maybe via the Communications Team.

AC advised he had received an email from Fiona Alexander confirming this matter was in hand.

DC advised of the IR2 system used on maternity and ITU. This was time-consuming but staff were being encouraged to use it.

TW discussed his collections for the "Friends of Good Hope", where the response had been fantastic - in one 30-minute slot, he had collected £51.

AC advised the "Friends of Good Hope Charity" regularly collects money and had recently been appointed "Charity of the Year" by Sainsbury's Local, which was very gratifying. The last collection raised over £1,000 in three days. DC thanked TW for all his hard work.

AC advised HEFT was now working with the new hospital charity on joint projects via Mike Hammond at UHB.

17.056.3 Fitness & Wellbeing

TW advised he had recently taken up Tai Chi at GHH and his balance had much improved. Attendance had doubled at GHH, which was very good.

AC also advised of a friend with a lung condition that had recently started dance classes and SH advised singing could help with COPD.

17.057 Next Meeting

The next meeting will take place on Friday 17th November 2017 at 12.00pm in Room 4, Education Centre, Birmingham Heartlands Hospital.

Heart of England NHS
NHS Foundation Trust

PATIENT & STAFF EXPERIENCE GROUP OF THE COUNCIL OF GOVERNORS

Schedule of Matters Brought Forward and Action Points

Date Raised	Minute Number	Details	Action	Due	Status	Completed
19May17	17.028	Dawn Chaplin to bring the 'snakes and ladders game' to the next meeting.	DC	15Sep17	Presented.	**15Sep17**
14Jul17	17.039	Dawn Chaplin will try to arrange a meeting with Shropshire Community Health NHS Trust's and obtain more copies of the "Observe & Act Course Handbook".	DC	15Sep17	Ongoing.	
14Jul17	17.043.3	Louise Passey to give a 10-minute presentation from her visit to Macclesfield District General Hospital.	LP	15Sep17	Presented.	**15Sep17**
15Sep17	17.048	Shahzad Razaq to be invited to attend a future meeting to give an update to the Group on the recovery of prescription charges.	VFH	31Dec17		
15Sep 17	17.052	Dawn Chaplin to action amendments to the Governor Drop-In Survey Form.	DC	27Sep17		

PATIENT & STAFF EXPERIENCE GROUP OF THE COUNCIL OF GOVERNORS

G L O S S A R Y

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

ATTACHMENT 1 (Front)

Name Patient Passport

Insert Picture here...

Medical Information

Risks (Please complete reasonable adjustment (RA) care plan

Communication

Support / Environment

ATTACHMENT 1 (Back)

PLEASE MAKE SURE THIS FORM TRAVELS WITH ME THROUGHOUT THE HOSPITAL

INFORM THE PATIENT JOURNEY TEAM OF MY ADMISSION

Name:

Address:

Telephone Number: Date of Birth: / /

Next of Kin:

Preferred/Alternative Contact (please specify) if different to Next Of Kin:

Advocate:

G.P:

Known Allergies:

Last known tetanus :

National Health Number :

Religion:

Ethnicity:

Completed by: Date:

Reviewed by: Date:

cwp Cheshire and Wirral Partnership NHS

david·lewis leading forward to the future

ATTACHMENT 2

Please Insert patient Information sticker

RISK ASSESSMENT/REASONABLE ADJUSTMENTS CARE PLAN

Patient's Name:

Issue	Risk identified	Reasonable adjustment
Communication		
Capacity and best interests		
Mobility		
Medication		
Pain		
Eating/drinking		
Dysphagia swallowing difficulties leading to increased risk of choking or aspiration		
Behaviour		
Personal hygiene		
Discharge, (including pre-discharge meeting)		
Other		

Completed by (Print Name):

Checked by Nurse (Print Name):

Date updated:

Version 2: 21.8.13

ATTACHMENT 3 (Front)

If you would like more information about the Open2Autism project, or if you are having problems contacting one of our Autism Link Staff then please contact one of the Autism Project Leads:

Sam Leonard

Email: sam.leonard1@nhs.ne:
Telephone: 01625 663988

Lyn Bailey

Email: lynbailey@nhs.net
Telephone 01625 663981

Or write to:
Lyn Bailey
2nd Floor
New Alderley House
Macclesfield District General Hospital
Victoria Road
Macclesfield
SK10 3BL

Comments, compliments or complaints

We welcome any suggestions you have about the quality of our care and our services.

Contact us:

Freephone: 0800 161 3997
Phone: 01625 661449
Textphone: 01625 663723

Customer Care, Reception, Macclesfield District General Hospital, Victoria Road, SK10 3BL

For large print, audio, Braille version or translation contact the Communications and Engagement Team on **0800 195 4194**

Admission information The trust accepts no responsibility for the loss of, or damage to, personal property of any kind, in whatever way the loss or damage may occur, unless deposited for safe custody. Please leave valuables at home. If you need to bring personal items that are expensive, for example micro hearing aids, please be aware that you do so at your own risk.

The Information Standard
Certified member
This organisation has been certified as a producer of reliable health and social care information.
www.theinformationstandard.org

POSITIVE ABOUT DISABLED PEOPLE

East Cheshire NHS Trust does not tolerate any form of discrimination, harassment, bullying or abuse and is committed to ensuring that patients, staff and the public are treated fairly, with dignity and respect.

East Cheshire NHS
NHS Trust

Children & Adults with Autistic Spectrum Conditions

Patient Information

Open2Autism Project

East Cheshire NHS Trust
www.eastcheshire.nhs.uk

@eastcheshirenhs

Ref: 11583 Review: 12/2016

ATTACHMENT 3 (Back)

The Open2Autism Project

East Cheshire NHS Trust has been looking at ways to improve access to our services for adults, children and young people with autism.

In February 2013 we launched our "Open2Autism" project which has provided basic autism awareness training to all of our doctors, nurses and health care staff.

Autism Link Staff

As well as basic autism awareness training, we have also provided more in depth training in autism to key members of staff across our hospital and community services.

We call these members of staff our "Autism Links" and they are there to help support you when you access any of our services.

How can Autism Link Staff help?

There are a number of things that we can do to help support you when you access our services, whether that's coming into the hospital, attending an outpatient appointment or seeing one of our staff in your own home.

This may involve things like:

- finding you a quiet area to sit and wait for an appointment or procedure
- discussing procedures and expectations with you prior to your appointment
- re-arranging appointment times if you'd find a later or earlier time more manageable
- arranging for visits to a clinic, ward or department before you come in for your treatment
- adjusting the environment if you are sensitive to things like noise or lights
- helping you to manage any fears and anxieties in a way that supports you.

How to contact an Autism Link

You can find contact details for our Autism Link Staff via the "Open2Autism" web page on the Trust's website: http://www.eastcheshire.nhs.uk/Our-Services/open2autism.htm

Other information you may find useful

There is a wide variety of written information available on the Trust's website which you may find useful when preparing for your hospital visit.

These include things like hospital maps and floor plans, information leaflets about different departments and procedures, and some photographs of common clinical areas like X-Ray, Pre-op Clinic and Outpatients.

Heart of England NHS
NHS Foundation Trust

Agreed Minutes of a meeting of the
Patient & Staff Experience Group of the Council of Governors
of Heart of England NHS Foundation Trust
held on Friday 17th November 2017 at 12.00pm
in Room 4, Education Centre, Birmingham Heartlands Hospital

PRESENT:	**CANNON, Antony (AC)**	**Chair (and Chair of the GHH PCP)**
	FIELDING, Keith (KF)	Governor
	HUTCHINGS, Susan (SH)	Governor
	THOMAS, Jean (JT)	Governor
	WEBSTER, Thomas (TW)	Governor
IN ATTENDANCE:	EMERY, Jamie (JE)	Head of Patient Services & Engagement
	RUDGE, Kevin (KR)	Chair of the SH PCP
MINUTES:	HIGGINS, Vickie (VFH)	Executive Assistant

17.058 Welcome

AC welcomed everyone to today's meeting.

17.059 Apologies for Absence

Apologies were received from Stan Baldwin, Dawn Chaplin, Louise Passey and Julie Tunney.

17.060 Minutes of the Previous Meeting

After one minor amendment in section 17.049 to change the word injection to infection, the minutes of the meeting held on Friday 15th September 2017 were agreed as an accurate record and have been forwarded to Angela Hudson.

17.061 Matters Arising

The action points have been updated and are at the back of these minutes.

17.062 Update : Recovery of Prescription Charges

Unfortunately, Shahzad Razaq was unable to attend today's meeting but has been invited to the next meeting.

17.063 Feedback / Verbal Reports from the PCP Meetings

SH - KR advised of the recent well-attended meeting, which saw two speakers. Firstly, was Lynn Fisher, Head Nurse for Division 5. She advised Nursing Care Metrics were at 95% for the last 12 months for surgery, which looked at preventing harm to patients around pressure ulcers and falls. For the next 12 months, gastroenterology was a high risk. Secondly, was Siân Bradshaw, Policy Assurance Officer. She advised the Equality for Patients Policy had been approved, along with its nine characteristics, and would be working with UHB for updated, single policies.

GHH - AC advised they received the same presentation from Siân Bradshaw, which was excellent. She was doing a great job and is very well-spoken. There was also a nursing update from Emma Hartill, Deputy Divisional Head Nurse for Division 4, around winter planning and opening Ward 3, GHH.

BHH - JT was very impressed with their two speakers. Firstly, Davina Thomas, Head Nurse for Division 3, gave a very positive update. Secondly, the talk on ACAD from Karen Tongue was extremely interesting. This was an opportunity to see the detail and refinements required to meet demands. There were funding issues and disruption and parking was also discussed. Planning approval should be received by the end of the month, to commence next year, following final DoH approved.

17.064 Patient Experience Dashboard

JE discussed the Patient Experience Dashboard, weekend night versus day data, FFT and changing the questions.

JT asked if positive comments - ie. “good job” - were seen and JE advised all comments were shared and available to the Senior Nurses.

JE advised of a downward trend on FFT - 38% to 37% to 33% - but the internal KPI target was 30%, so this was still valid data from a high number of response rates and the data was no less valid. The bottom two wards - ie. Ward 8 at BHH and Paediatrics - were notoriously difficult areas, with PAU the lowest ($^{7}/_{10}$).

AC agreed it was difficult to collect responses and felt areas of concern were Ward 8 at BHH and A&E at SH. JE advised many responses were via text and likely to be more negative.

AC felt complaints were positive and going in the right way and JE agreed as figures were much improved from two years ago. There was a great system and process in place and they were heading in the right direction.

SH discussed DNAs and AC felt this was heading in the wrong direction - 10.69%. The appointments system was also discussed at the previous evening’s PCP at GHH. AC felt the appointments system was not fit for purpose and JT agreed it may be difficult to cancel, especially if you are calling in and are in a queue. It was felt this was not just a HEFT issue and became an issue when the system was centralised. JE advised not all appointments were centralised - ie. Gynaecology - but this was still a main reason for patients contacting PALS. AC felt the whole system needed to be reviewed and asked if QEHB had a similar problem. KR advised their DNA figures were displayed at the QE.

JT asked what happens if a patient is DNA and JE advised we would contact their GP for another appointment. Failure to attend the second time could mean they were discharged from future treatment. Unfortunately, there was no standard letter.

AC suggested reminders by text and JE advised this was done for certain areas but not all. KF felt it required a standardised and robust process and JE advised, a few years ago, they would call patients to ask why they had not attended and there were varying reasons. JT suggested the Volunteers and/or Governors could help with this and JE advised Helen Evans currently looks after the text reminder service. AC felt it would be beneficial to see how it works and the costs involved. **Action :** VFH to invite Helen Evans and/or Alan Baldwin to attend a future meeting to discuss further.

17.065 Update : Governor Drop-In Programme

AC advised this had been very well-received by the staff but were concerned this was just another inspection. JE suggested they were not called inspections and AC suggested survey engagement sessions.

AC advised they had visited Ward 21, GHH. This was a good team who were motivated but concerned around the pressure to discharge short stay dementia patients before they felt they were ready. They were also often moved too many times, which could cause more harm.

JT asked about transgender patients and felt this could be a growing issue. JE advised if staff were unsure, they should speak to their Sister or Matron for support, as and where appropriate. SH felt toilet issues also needed serious thought. AC suggested the "Other" section be used, if this came up.

SH had spoken to a Scottish patient with issues around delayed transfer from BHH to SH and the ambulance service asking who would be funding the transfer. However, this was a very good ward but, at certain points, there were no staff around but this may have been due to staff handover.

AC asked who reviewed these reports and JE advised a summary would go, internally, to Trust Board and then to the CCG, with details around the wards visited, issues raised, positives and negatives, etc.

KF discussed concerns around patient's valuables. He had attended a tradeshow recently, which promoted the use of lockers, as per the leisure industry. These could be used on dementia wards and suggested HEFT approached the UHB Charity for funding.

JE agreed this could be an issue on most wards - ie. hearing aids and teeth were often mislaid at a great deal of cost and inconvenience.

Action : AC to talk to Mike Hammond, QEHB Charity, with regard to a possible trial.

17.066 Update : Patient Passport

AC advised this was still being considered by the relevant people at UHB. HEFT had been positive and Dawn Chaplin had spoken to the Head Nurses, who liked it and could see its benefit.

For a pilot, the design needs to be cleared by Communications and then printed. However, due to the possible merger, from a Trust-wide perspective, this needed full UHB agreement.

AC was still applying lots of pressure but felt a recent lacking of enthusiasm.

17.067 Any Other Business

17.067.1 Incident at BHH

SH advised of an incident in the main car park at BHH last Wednesday at approximately 2.00pm involving a friend of a friend (Volunteer). This person was just leaving when a man opened the back door of her car, got in and said; "Drive!" This was a complete stranger. She said; "No, get out!" and, after a brief altercation, he fled. Her brother reported the incident to security but there was no CCTV footage for that area. This could have been a lot worse.

JE asked if the police had been involved and an IR1 filled in but SH was not sure. SH will ask her to send the details through to JE, who will raise this directly with John Sellars in Estates. Security should have a log of this and JE will follow it up.

17.067.2 NHS Elect Conference

JE advised he and Dawn Chaplin had attended a conference recently around the "Disney Approach to Care". This was very good and extremely interesting. JE also suggested a book by Fred Lee called; "If Disney Ran Your Hospital". Both were around courtesy, safety courtesy, patient experience, etc. from a different perspective - ie. when giving directions, do not point but use the flat of your hand. The keynote speaker was an American magician who used to work for Disney.

17.067.3 Carer's Forum

JT asked if Margaret Meixner had disbanded the Carer's Forum. JE advised she had not and that the next event was next week (Wednesday 22nd November 2017) at SH. There would also be the annual conference next year, which was being held at the Tally Ho.

17.068 Confirmation of the Next Meeting

The next meeting will take place on Friday 12th January 2018 at 12.30pm in the Boardroom, Devon House, Birmingham Heartlands Hospital.

Heart of England NHS
NHS Foundation Trust

PATIENT & STAFF EXPERIENCE GROUP OF THE COUNCIL OF GOVERNORS

Schedule of Matters Brought Forward and Action Points

Date Raised	Minute Number	Details	Action	Due	Status	Completed
14Jul17	17.039	Dawn Chaplin to arrange meeting with Shropshire Community Health NHS Trust and obtain more copies of the "Observe & Act Course Handbook".	DC	15Sep17	Meeting on 06Dec17.	
15Sep17	17.048	Shahzad Razaq to be invited to attend future meeting to give an update on the recovery of prescription charges.	VFH	12Jan18	Invited to attend the next meeting.	
15Sep 17	17.052	Dawn Chaplin to action amendments to the Governor Drop-In Survey Form.	DC	27Sep17	Ongoing.	
17Nov17	17.064	Helen Evans and/or Alan Baldwin to be invited to attend the next meeting to discuss the appointments system.	VFH	12Jan18		
17Nov17	17.065	Antony Cannon to talk to Mike Hammond, QEHB Charity, with regard to a possible trial of lockers in dementia wards.	AC	12Jan18		

Heart of England NHS
NHS Foundation Trust

PATIENT & STAFF EXPERIENCE GROUP OF THE COUNCIL OF GOVERNORS

G L O S S A R Y

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