Heart of England NHS
NHS Foundation Trust

Council of Governors Meeting
4.00 – 6.00pm on 23 October 2017
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** 24 July 2017	Jacqui Smith	*(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 Q2**	David Rosser	*(Enclosure)*
8.	**Paterson Update**	David Rosser	*(Oral)*
9.	**Care Quality Report Q2** inc Infection Control Update	Julie Tunney	*(Enclosure)*
10.	**Finance Report Q2**	Julian Miller	*(Enclosure)*
11.	**Quality Report update Q2**	David Rosser	*(Enclosure)*
12.	**Annual Report from Chair of Audit Committee**	Karen Kneller	*(Enclosure)*
13.	**Re-appointment of External Auditors**	David Burbridge	*(Enclosure)*
14.	**Compliance and Assurance Report Q2**	David Burbridge	*(Enclosure)*
15.	**Information Governance Annual Report**	David Burbridge	*(Enclosure)*
16.	**Report from CoG Sub-Groups**		
	16.1 Membership & Community Engagement Group	Albert Fletcher	
	16.1.2 19 May 2017 (Approved Minutes)		*(Enclosure)*
	16.1.3 4 October 2017		*(Oral)*
	16.2 Hospital Environment Group	Sue Hutchings	
	16.2.2 25 May 2017 (Approved Minutes)		*(Enclosure)*
	16.2.3 27 July 2017 Approved Minutes		*(Enclosure)*
	16.2.4 28 September 2017		*(Oral)*
	16.3 Patient Experience Group	Tony Cannon	
	16.3.2 19 May 2017 (Approved Minutes)		*(Enclosure)*
	16.3.3 14 July 2017 (Approved Minutes)		*(Enclosure)*
	16.3.4 15 September 2017		*(Oral)*
17.	**Any Other Business Previously Advised to the Chair**		
18.	**Date of Next Meeting:** (Focus Meeting) Monday 23 November 2017, 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 24 July 2017 at 4.00 pm.

PRESENT:	Rt Hon. J Smith (Chair)	
	Mr S Baldwin	Mr G Moynihan
	Mr T Cannon	Mr B Orriss
	Mr K Fielding	Mr M Robinson
	Mr A Fletcher	Mrs J Thomas
	Mr D Hoey	Mr D Treadwell
	Mrs S Hutchings	Dr M Trotter
	Mr P Johnson	Mr T Webster
	Mr M Mahmood	Mr L Williams
	Mrs V Morgan	
IN ATTENDANCE:	Mr D Burbridge	Mr J Miller
	Mr A Edwards	Dame J Moore
	Mrs Hendley	Mrs H Wyton
	Mrs A Hudson (Minutes)	Mrs T Watkins
	Miss M Lalani	

17.058 APOLOGIES & WELCOME

The Chair welcomed everyone to the meeting.

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

Apologies for Directors had been received from Mrs Alexander, Prof Glasby, Ms Kneller and Dr Kinski.

The Chair welcomed the new stakeholder governors Majid Mahmood (Birmingham City Council) and Mike Robinson (Solihull Council).

17.059 DECLARATIONS OF INTEREST

The register was noted. Updates to the registers were noted from Mr Mahmood and from the Chair and CEO.

Resolved.

- To note changes and
- Update the relevant registers.

17.060 MINUTES OF PREVIOUS MEETING

17 May 2017

The minutes of the meeting held on 17 May 2017 were considered and approved as a true record.

26 June 2017

The minutes of the meeting held on 26 June 2017 were considered.

17.055 The Chair of the Hospital Environment Committee (HEC) advised that the KPIs referred to in the minutes had related to the HEC, not the Patient Experience Group.

Subject to the above change, the minutes of the meeting held on the 26 June were approved.

17.061 MATTERS ARISING

17 May 2017

17.041 The Chair reported that the CEO of UHB Charities Ltd had been invited to and would be attending the Chair/Governor breakfast meeting on 4 August.

The Chair, in response to a question, reported that the skill mix for the Charity Board was still being considered and no appointments to the Board had been made.

17.045 The Chair reported that Governors including the Lead Governor could attend public board meetings should they so wish. Due to the timings of the Public Board and CoG meetings, being held on the same day, any questions governors had could be raised either at the end of the board meeting or at the CoG meeting.

17.062 CHAIRS UPDATE

The Chair reported that it had been stated that Ian Paterson could have his prison term increased. Paterson had been sentenced to 15 years in May. The case was being reviewed under the Unduly Lenient Sentence scheme to examine if a longer sentence was appropriate following a concern raised by a complainant.

As part of the virtual MTD review of the mastectomy cohort of Paterson patients, all patients had now been reviewed by the independent review panel. The final group had been due to be seen in clinic during July, unfortunately due to sickness in the clinical team, the remaining 17 patients would be seen by October.

The independent report was not yet complete and would be presented once it had been received.

The content of the letter to be sent to wide local excision patients was being finalised along with the response process and it was expected that letters would be sent towards the end of August. All patients would be offered a range of options as part of the review process.

Case for Change. The Trust had submitted the full business case to NHSI. The Chair and CEO were holding a series of stakeholder briefings including attending the Birmingham and Solihull Scrutiny Committee to give an update on progress.

The first grading for STPs had been published – Birmingham had received advanced.

The Chair and CEO had attended the Trust's first awards ceremony for 50 of the Trust's long serving volunteers to recognise the huge contribution they made.

The Chair, in response to two questions raised, reported that engagement had

included South Staffordshire stakeholders and the proposed merger date was dependent upon phase 1 of the CMA process and the NHSI review of the business case following which both organisations boards would need to decide whether to go ahead with the proposal. Once that decision had been made it would be presented to both CoG meetings for approval. It was anticipated that this would be November at the earliest.

Resolved: to accept the report

17.063 PERFORMANCE REPORT

The Council of Governors considered the Performance Report, presented by the interim Deputy CEO Improvement, summarising the Trust's performance against targets and indicators in the Single Oversight Framework, contractual targets and internal targets Of the five operational performance indicators, the Trust had delivered against 4. The A&E 4 hour standard had not been met and remained a risk. Performance had improved slightly in June at 83.54% compared to 83.3% in May with 22,675 attendances in June 2017 (an average of 756 patients per day).

In terms of the other performance targets, the Trust had met the 18 week referral to treatment target. The only specialty failing to meet the target in month was Trauma and Orthopaedics, at 85.88%. Work was underway to address the problem.

The Trust had met the CCG ambulance handover target of 95% of patients waiting less than 30 minutes (97.19%) and 60 minutes (99.91%) in month. The Trust had implemented a new agreed joint validation process for ambulance delays which had been in operation since late May. This was supported by a dedicated HALO presence on all three sites, combined with a daily validation process between the Trust and WMAS.

The Trust had failed to meet the DTOC target in month, achieving 2.70% against a target of 1.4%.

Of 14 maternity screening indicators (reported quarterly in arrears), the Trust had failed to meet 4. Divisions were working with providers within the network to monitor and report monthly on progress.

A letter from NHSI and NHSE Midlands and East had been sent to Trusts and CCGs in May 2017 regarding public reporting and quality review of cancer long waits. It set out two national objectives to increase the number of providers delivering the 85% cancer 62 day standard to over 70% and for all Trusts to achieve the standard from September 2017. In addition, immediate action had been put in place that required Trusts and CCGs to routinely report the number of <62 day and <104 day breaches, plus outcomes and learning from RCAs, to Public Board meetings. As at 30 June, the Trust had 3½ patients who had breached the <104 day cancer pathway, the half breach was where the Trust shared patient care with another provider.

The Trust had achieved the Stroke target in May, achieving 86.9% against an 80% target.

The Trust had failed to achieve the target for the proportion of patients who present at A&E and were discharged with a TIA and were scanned and treated within 24 hours, with 45% against 63%. The service had reported that 90% of patients were seen within 30 hours.

Mandatory training, appraisal and recruitment were all above target. Sickness and absence was slightly up in month. The new online exit monitoring tool, trialled in

conjunction with Picker Institute, was set to launch in July.

The Chair opened the floor to questions.

The Deputy CEO – Improvement confirmed that other trusts did include minor injury figures, as did HEFT.

In response to a question about GHH A&E, it was advised that it was the inability to recruit sufficient work force to cover clinical slots, which included low numbers of consultants and middle grade doctors that contributed to the slow patient progress through A&E resulting in the target not being achieved. The ED at BHH had a higher skilled group of clinical staff due to the number of hyper acute patients it received and treated.

DTOCs continued to impact on targets, there had been a reduction in the number of community beds regionally that patients could be discharged to. The Trust continued to work with social services to try to improve the situation. The closure of elderly care provision by local councils had also contributed to the rise in DTOCs.

In response to a question on the areas with high voluntary turnover, it was reported that corporate areas were predominately affected rather than front line services.

Resolved: to accept the report

17.064 CLINICAL QUALITY MONITORING REPORT

The Council of Governors considered the Clinical Quality Monitoring (CQM) report presented by the interim Medical Director. The report provided assurance on clinical quality and detailed action being taken following the CQM Group meetings held in June and July 2017. There were currently six investigations in progress into doctors' performance.

There had been two CCS (Clinical Classification System) diagnosis groups with higher than expected results in March 2017**:** Cardiac arrest and ventricular fibrillation (107)' and 'Other gastrointestinal disorders (155)'. The case lists had been reviewed and no clinical issues had been identified.

The Trust SHMI (Summary Hospital – Level Mortality Indicator) and HSMR (Hospital Standardised Mortality Ratio (HSMR) performance were within acceptable limits. The information presented now included comparison with UHB. It was noted that, as the majority of the case load at UHB was elective, it would always show as an outlier.

The Trust's CRAB (Copeland Risk Adjusted Barometer) 30 day surgical mortality O/E (outcome versus expected) ratio had been reviewed and was within the normal range.

The recent Board of Directors' unannounced visit to ward 3 (Renal) at Birmingham Heartlands Hospital on 20 June 2017 had been largely positive from a staff perspective and the visit team noted the positive culture on the ward.

The Chair opened the floor to questions.

The interim Medical Director reported that the General Medical Council was responsible for ensuring that any doctors who had been terminated did not work elsewhere.

Resolved: to accept the report

17.065 CARE QUALITY REPORT

The Council of Governors considered the Care Quality Report presented by the Chief Nurse. There had been no post 48 hour MRSA bacteraemia reported in June 2017. Two cases of pre-48 hour MRSA bacteraemia had been reported and, following a joint review with the CCG, both had been attributed to third party. There had been no lapses in practice identified from either the Trust or the community. There had been five cases of post 48 hour C.Diff reported in June 2017. This was within the Trust's monthly trajectory of five. The total number of cases this year was 10 against a year to date trajectory of 15 cases and an annual trajectory of 64 cases

There had been an outbreak of Vancomycin-Resistant Enterococci (VRE) declared on ward 19 at Birmingham Heartlands Hospital in June 2017 with three patients identified as having VRE bacteraemia of the same strain. Screening of inpatients on the ward had revealed a high proportion of inpatients as being colonised with VRE, there was an on-going action plan being implemented.

There had been 2 avoidable grade 2 pressure ulcers and no reported hospital acquired pressure ulcers (grade 3) in June 2017.

The Trust dementia screening target was 90%, performance for June 2017 was 88.03%. Significant work within divisions was underway.

The Trust target that 90% of all Parkinson's medication was administered within 30 minutes had improved to 82% in June 2017.

Nurse staffing. There were no areas of concern for June 2017. Hot spot areas were Intensive Care Unit BHH, Neonatal Unit and Ward 4 HDU, assurance had been given by Head Nurses that staffing had been maintained at levels suitable for acuity of patients with no shortfalls.

The Trust was the lead partner in the Birmingham and Solihull Partnership that formed one of the national pilot sites for the Nursing Associate programme. Forty-one Nurse Associate Trainees had commenced the training programme in April 2017, with no leavers to date.

Compliance against the 30 day working standard for complaints in May 2017 was 57.3%.

The Friends and Family Test positive responders for May was 95%. The ED had shown a decrease of 3% at 84% compared to the previous month.

There was now a programme of Governor drop in sessions underway and the Chair invited the Chair of the CoG Patient & Staff Experience Committee (PEC) to update the meeting on the format and schedule for the 'Governor Drop In Sessions' that had now been agreed.

The PEC had developed an approach which it was hoped would be well received by staff & patients. The drop-in sessions were a means of completing surveys and not inspections. The administration for the visits was completed by the Patient Experience Team. Survey reports would be presented to the CoG PEC and be included in the full CoG papers. They would also be presented to the Care Quality Group.

It had been agreed that the survey drop-in sessions would be undertaken by public governors and they had been encouraged to volunteers in order to distribute the workload fairly, as well as to promote better understanding of issues faced by

patients and staff in our hospitals. With 18 Public Governors and 24 slots everyone would be able to undertake at least one survey. Although many of the slots on the schedule had been filled, there were still some dates that remained vacant.

The Chair opened the floor to questions.

In response to a question, the Chief Nurse advised that the dementia screening tool was used as a flag by consultants to highlight the possible need for specialist care.

There was a discussion on staff rostering and it was noted that divisions were responsible for ensuring sufficient staff cover. Planning to cover holiday periods such as bank holidays were the responsibility of the ward manager with Matron approval.

Resolved: to accept the report.

17.065.1 Infection Prevention & Control Annual Report for 2016/17.

Dr Abid Hussain, Consultant Microbiologist and Associate Medical Director for Infection Prevention & Control presented the Annual Report for 2016/17 and reported that, for 2016/17, there had been 7 MRSA Bacteraemia attributed to the organisation, there had been an over-performance of C.diff infection against trajectory and a clustering of multiple outbreaks in Q4 2016/17 due to organisation pressures, in terms of patient flow and footfall. There had been some failure of IPC procedure, work to improve the fabric of the wards was required and there was a lack of effective isolation facilities.

Corrective action undertaken in 2016/17 comprised a review of C.diff diagnosis and treatment, reinforcement of Trust cleaning strategies, deployment of new modalities, re-investment in patient bathing products and refurbishment of key clinical areas.

Priorities for 2017/18 included joint working with UHB IPCT, alignment of policies and practice, a review of internal governance structures and IPC delivery across all sites and trajectories.

The Chair opened the floor to questions

In response to a question on the use of antibiotics, the Associate Medical Director for IPC advised that all antibiotics should be used sparingly and appropriately.

The meeting discussed the general state of the estate and the CEO reminded the meeting that when the interim leadership team had taken over, some areas of the estate had been in very poor condition and much work had been undertaken to make remedial repairs where required. The Trust was spending its allocated budget but, due to the years where no spending and refurbishment had taken place, this was taking time.

The Chair reported that Sam Foster, Chief Nurse, would be leaving the Trust at the end of August and, on behalf of the Board and the CoG, formally recorded a vote of thanks for her contribution and dedication during her time at the Trust and wished her well for the future.

Resolved: to accept the report.

17.066 FINANCE REPORT

The Council of Governors considered the paper presented by the interim Finance Director that provided an update on the Trust's financial position for the period ended

30 June 2017. The Trust had delivered an overall deficit of (£4.7m) for month 3 of the 2017/18 financial year, an adverse variance of (£2.3m) against the planned deficit of (£2.4m) pre STF. This moved the year to date deficit to (£13.5m) an adverse variance of (£6.3m) against the planned deficit pre STF of (£7.2m). As a result of under-delivering against the financial plan, the year to date allocation of £3.2m of STF had not been assumed.

The main components of the variance were healthcare income which was (£0.2m) in month / (£1.5m) YTD below seasonal plan. Activity related income was (£1.1m) in month / (£1.9m) YTD. Maternity spells / pathways accounted for 84% of the total variance, following a detailed review it had been identified that maternity spells income had been under recorded by £936k during Q1 due to births being incorrectly categorised between 'standard' and 'with complications'.

There had been some CIP slippage circa (£0.8m) YTD, further work was required to ensure that projects were being delivered upon.

The cash balance at the end of June was £21.7m against the plan of £10.3m at this point, a favourable movement of £11.4m. The Trust had commenced the process for setting up a borrowing facility with NHSI.

The Chair opened the floor to questions.

The meeting discussed the slippage in CIP and the plans in place to achieve targets and it was noted that efficiency targets did include savings from voluntary staff losses and vacancies in corporate areas had not been replaced. The biggest challenge was to reduce spend on agency staff. No wide scale job losses had been planned. The slow start to the year was due to the phasing of the savings and programmes would continue to be pursued.

Resolved: to accept the report.

17.067 QUALITY ACCOUNT UPDATE Q1 2017/18

The Council of Governors considered the report presented by the interim Medical Director that provided an update against each of the 4 priorities and progress was noted. 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.

17.068 COMPLIANCE AND ASSURANCE REPORT

The Council of Governors considered the report presented by the interim Director of Corporate Affairs. The report set out the actions being taken on the internal and external assurance processes. The draft CQC report had been received in June and a draft factual accuracy check undertaken and returned to CQC. The final report was due to be published by the CQC on 28 July. An overall rating had not been included in the new published report as it had been a focussed inspection, therefore the 2014 rating of 'requiring improvement' remained. However, the CQC had acknowledged that significant positive change had been made in a number of areas and the Trust was rated 'good' for 'well-led'. It was expected that the CQC would publish the report on 29 July 2017 and a communication for staff was planned for the day of publication. The CQC had not requested that the Trust hold a Quality Summit at the present time.

Quarterly Divisional Quality Governance reports now included newly published

NICE guidance or updates and Directorate status. There had been a comprehensive review of NICE guidance. There had been 63 National Audits identified as applicable for 2017/18, the Trust was participating in 60.

There was a total of 74 local audits logged on the clinical audit database. It was considered that the number should be higher and divisions were being encouraged to log all audits. Work had been completed to close clinical audits dated pre-2014 logged on the database. There was now more rigour in the system to monitor clinical audits at the Trust.

Resolved: The report was received.

17.069 HEALTH & SAFETY ANNUAL REPORT

The Council of Governors considered the report presented by the interim Director of Corporate Affairs. The report set out the process to ensure that compliance against key requirements the Trust's Health and Safety Policy remained robust. The focus for the health and safety team over the reporting period had been to give continued support to operational colleagues by providing training, advice, inspection and audit; preparation for external visits (as and when required) including HSE inspection, ensuring compliance with the Trust Health And Safety Policy and giving increased support to investigating managers and handlers in order to improve learning from incidents.

The number of reported verbal and aggressive incidents against staff by patients and carers was 356 and 283 respectively. The number included incidents by patients who lacked capacity. The Trust had issued 24 yellow cards and 6 red cards to patients and/or carers. Further work into how the Trust could manage incidents better was being investigated.

The Chair opened the floor to questions.

There was a discussion on how the Trust supported staff subject to social media threats and reassurance was given that staff had access to information and guidelines setting out how to limit the risk and get support.

Resolved: The report was received.

17.070 ANY OTHER BUSINESS

There was none.

17.071 DATE OF NEXT MEETING

The next meeting Council of Governors (focus) meeting was scheduled for Monday 25 September 2017, in the Education Centre, Birmingham Heartlands Hospital.

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Chair

HEART OF ENGLAND NHS FOUNDATION TRUST

COUNCIL OF GOVERNORS

WEDNESDAY 25TH OCTOBER 2017

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

WEDNESDAY 25TH OCTOBER 2017

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%	Sep-17	92.01%
A&E 4 hour access	95%	Sep-17	80.02%
Cancer 62 day - GP urgent referral	85%	Aug-17	87.92%
Cancer 62 day - national screening	90%	Aug-17	100.00%
6 weeks diagnostic test	99%	Sep-17	99.16%

Indicator	Threshold	Current Data Period	Performance
Other National Targets			
Cancer 2 week	93%	Aug-17	95.96%
Cancer breast - 2 week	93%	Aug-17	93.95%
Cancer 31 days- first treatment	96%	Aug-17	98.13%
Cancer 31 days- subsequent treatment -surgery	94%	Aug-17	97.62%
Cancer 31 days - subsequent treatment - drugs	98%	Aug-17	100.00%
Ambulance Handover ≥ 30 minutes	95.5%	Sep-17	98.6% (96)
Ambulance Handover ≥ 60 minutes	99.5%	Sep-17	99.8% (16)
12 hour Trolley waits A&E	0	Sep-17	0
52 week waits	0	Sep-17	0
Cancelled Ops rearranged 28 days	0	Sep-17	0
Urgent operation cancelled x 2	0	Sep-17	0
Sleeping Accommodation Breach	0	Sep-17	0
MRSA	0	Sep-17	0
C.difficile - (post 48 hours)	5	Sep-17	7
VTE risk assessment	95%	Sep-17	97.88%
Duty of Candour (2 months in arrears)	0	Jul-17	0
NHS Number acute	99%	Sep-17	99.66%
NHS Number A&E	95%	Sep-17	98.47%

3.1 Single Oversight Framework

3.1.1 A&E 4 Hour Waits

Performance for the A&E 4 hour wait target has declined in September to 80.02% compared with 82.82% in August 2017.

The following actions/initiatives have been implemented to support ED performance:-

- Clinical Review Group - A clinical team from the Queen Elizabeth Hospital with support from the Chief Operating Officer & Chief Nurse at HEFT have been identified to review working practices and identify supportive measures/recommendations to improve performance.
- Frailty Admission Unit – Remodelling assessment at the front door for elderly frail people.
- Long stay to short stay – Following a bed modelling review, two general medical wards have been converted to medical short stay, one at GHH and one at BHH.
- Recruitment strategy – including the implementation of cross site rotation of ENPs, application the Deanery for increased training numbers, fast track of ACP trainees, 11 medics due to commence August – October, introduction of a Nurse Navigator, block booking of

locums for 3-6 month periods as well as scoping utilisation international fellows to fill vacancy gap.

3.1.2 18 Week Referral to Treatment (Incomplete Pathways)

The incomplete pathway performance shows that the Trust has achieved at aggregate level in September with a performance of 92.01%.

There were three specialties that failed to meet the target in month as shown in the table below:

Table 2: 18 week RTT performance – specialties failing to meet the target in month

Specialty	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17
Dermatology	93.72%	95.14%	94.92%	93.97%	92.60%	91.54%
T&O	83.17%	84.16%	85.88%	85.60%	84.26%	83.65%
ENT	93.68%	93.84%	92.94%	92.15%	90.51%	90.23%

Within the category "other" a number of specialties has failed to meet the target.

Table 3: 18 week RTT performance – category "other"

Specialty	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17
Pain Relief	90.32%	92.46%	90.62%	92.35%	92.20%	89.37%
Community Paeds	95.14%	96.61%	96.94%	91.36%	84.40%	91.20%
Colorectal Surgery	83.33%	95.59%	91.21%	93.98%	85.90%	91.86%
Upper GI Surgery	64.55%	65.95%	61.90%	61.00%	63.19%	60.68%

Dermatology – Significant increased demand for suspected cancer referrals over the summer period put pressure on routine service capacity, backlogs developing in outpatients and for MOHS surgery. Additional clinic and theatre capacity has been identified from October to address these and recover the position.

Trauma and Orthopaedics - Demand for trauma surgery remains high, which has impacted on elective activity and bed capacity pressures have also resulted in a number of elective theatre lists (both inpatient and day case) being cancelled. There also remains a high vacancy rate at junior doctor level.

A number of actions are in place to address junior doctor vacancies, including use of international doctors and a renewed recruitment drive. Four ACPs have recently been appointed and this should result in less elective activity being cancelled due to rota vacancies. Redesign of trauma clinics is in progress to

allocate appropriate number of new appointment slots in line with demand and discussions continue with other provider organisations around the transfer of elective activity during the winter period.

ENT – Demand on inpatient beds has resulted in cancelled elective procedures which, coupled with rising referral demand, has led to deterioration in RTT performance. Additional theatres have now been identified providing fortnightly and weekend WLI sessions from October to address backlogs. In addition, three consultants were recently appointed and theatre session cover is being prioritised.

Pain Management – Reduction in consultant capacity and notable increases in demand have led to backlogs developing in both outpatients and injection clinics. All clinics are being reviewed within the team to identify additional capacity for October and November. Additional injection lists have also been identified. This will be supported by WLI and locum usage.

Community Paediatrics – The service continued to experience reduced consultant capacity which impacted on RTT performance. A newly appointed consultant started in October and this is expected to improve the position.

Colorectal – The specialty narrowly failed the standard this month due to pressure on inpatient beds resulting in theatre cancellations. The service is working to identify additional theatre capacity and undertakes a regular review of upcoming lists to reduce the impact of late cancelations and to maximise the utilisation of any unused lists.

Upper GI – Whilst the position has improved, there remains ongoing pressure on both inpatient beds and theatre capacity making it a challenge to address surgical backlogs. Focussed work on level scheduling benign patients for Upper GI is on-going. The Directorate are undertaking inter provider transfers for routine patients, particularly in light of bed pressures. A locum surgeon has also been recruited to start in November.

3.1.3 Cancer

The Trust met all national cancer targets in August 2017.

3.1.4. Cancer Long Waits

In August, the Trust was accountable for four breaches (six patients) for patients that had waited over 104 days.

Three of these patients were late tertiary referrals from other providers referred in beyond their breach date (0.5 breach for

each). Three patients had complex pathways, involving multiple diagnostic tests before a diagnosis could be reached.

Following root cause analysis, it was determined that no avoidable harm was caused to these patients as a result of their extended pathways.

As at 30th September, the Trust had four patients waiting over 104 days on a cancer pathway. All patients have a treatment date scheduled in October. Three of these patients are tertiary referrals received late in the pathway (Worcester, Walsall and UHCW).

3.1.5 % patients waiting 6 weeks for 15 key diagnostic tests

The Trust met the 6 weeks diagnostic target (99%) in September (99.16%).

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 September.

The total number of MRSA bacteraemia attributed to the Trust year to date is one.

3.2.2 Clostridium difficile

Seven cases of post 48 hour C.diff have been reported in September. This is against a monthly trajectory of five. The total number of cases this year is 31 against a YTD trajectory of 30 cases and an annual trajectory of 64 cases.

Two of the seven cases have been reviewed by the Infection Prevention Control (IPC) team with Microbiology and IPC colleagues from the clinical commissioning group.

One case has been deemed to be avoidable (Good Hope Ward 8) due to inappropriate antibiotic prescribing, and the second case is unavoidable (Heartlands Ward 12). Of the remaining five cases, three will be reviewed once ribotyping results are available and two are awaiting antibiotic reviews to be completed.

3.2.3 Ambulance Handover

The Trust met the CCG target of 95% of patients waiting less than 30 minutes (98.6%) and 60 minutes (99.8%) in September.

There were 96 patients who waited over 30 minutes and 16 patients who waited over 60 minutes for ambulance handover.

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 achieved the target for September, achieving 1.38% against a target of 1.4%, the site and patient numbers waiting are shown in the tables below. This is the first time that the target has been achieved since November 2016.

Table 4: DTOC HEFT and external NHS joint health delays

	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17
BHH	2.48%	2.73%	2.80%	1.48%	1.93%	1.11%
GHH	0.80%	1.02%	1.95%	1.05%	2.36%	1.75%
SH	4.72%	3.20%	4.03%	3.95%	4.39%	1.60%
TRUST	**2.27%**	**2.24%**	**2.70%**	**1.67%**	**2.40%**	**1.38%**

Monthly variance between August and September is in part attributable to reporting block periods (5 weeks for August and only 4 for September). In addition, Solihull SS had a particular focus on DTOC for September 17 which has also marginally improved the position on the Solihull site.

The table below show performance for all delayed transfers of care and actual numbers i.e. those that are health and social delays (internal target 2.5% monitored at the HEFT Length of Stay Group)

Table 5: All DTOC delays

	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17
BHH	4.05%	4.14%	6.01%	3.45%	4.18%	2.97%
GHH	3.20%	3.06%	5.20%	2.50%	4.92%	3.30%
SH	8.18%	8.19%	8.43%	7.15%	6.39%	2.52%
TRUST	**4.39%**	**4.39%**	**6.11%**	**3.90%**	**5.06%**	**3.13%**

4.2 Pressure Ulcer Reduction

There has been no avoidable hospital acquired grade 4 pressure ulcers reported year to date, against a target of zero tolerance.

The Trust has reported no avoidable hospital acquired grade 3 pressure ulcers during August (September position yet to be reported). There have been four avoidable hospital acquired grade three pressure ulcers reported year to date against an annual target 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 Q1 (2017/18). Of the 14 indicators, the Trust has failed to meet 5.

These are:

- Laboratory request forms 10+0 to 20+0 weeks gestation – new validation process instigated in September with daily monitoring in place showing an improved unvalidated October position.
- Newborn Bloodspot – Avoidable Repeat Tests – additional training and new validation process instigated in September showing an improved unvalidated October position.
- Newborn hearing assessment referrals – performed under regional contract with Sandwell and West Birmingham with poor performance attributable to the DNA rate (circa 8 pts). HEFT have requested SWBH implement a call reminder service to prevent further DNAs.
- Newborn Hip Abnormality – performance missed by 1 baby from a total number of referrals of 3. Failure was due to communication issues. A new process is in place to prevent this recurring.

5. Local Indicators – Community Contract

The Trust has a number of community contracts, many of the indicators against these contracts are reported quarterly.

In Q2 2017/18 the Community Paediatric Waiting Times KPI failed to achieve the 92% target at 91.2%, and the Designated Doctor KPI is failing to achieve the 85% year-end target at 68.75% for Q2. All other indicators in this contract have been met.

Community Paediatrics has carried out three WLI sessions with a further two planned to resolve the backlog, with a new Consultant due to commence in post in October covering SARC services.

The Designated Doctor KPI has been affected by long term sickness and recruitment issues covering the SARC SLA which has now been appointed to. Job plans for Community Paediatricians have been reviewed and approved with time allocated for Designated Doctors. This now takes the establishment position up to 3.5 WTE to cover this role.

6. Internal Indicators – Performance

6.1 Dementia Screening

The Trusts performance against the dementia screening 'FIND' element of this metric has decreased in month to 83.39% in September and is failing to meet the 90% target as shown in the table below.

Divisions have been tasked with holding individuals to account for completion of the screening tool with an expectation to demonstrate how they have improved compliance. Additional specific actions have been taken by divisions; campaign carried out to reiterate the importance of dementia screening involving all Clinical Directors and Clinical Leads and nursing staff reminding doctors to complete dementia risk assessment fields.

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

6.2 Information Governance Training

Performance against the Information Governance Mandatory Training target of 95% has continued to improve slightly in month, with performance at 86.97% in September. All clinical divisions and corporate areas still not achieving 95% compliance. Improved compliance was discussed at all divisional review meetings in September with methods for improving training shared across teams.

7. Local Indicators - Workforce

7.1 Mandatory Training

Mandatory Training performance remains above target (85%) and has improved this month to 91.07%, from 90.41% in August.

7.2 Appraisal

Appraisal completion rates have reduced slightly in September to 88.06%, but remains above the 85% target. An internal target of 90% has been agreed and plans are being discussed with Divisions to improve performance. Some corporate teams have shown reductions in particular ICT and rectification plans have been put in place.

7.3 Recruitment

Time to Hire (recruitment) performance is now 6.95 weeks against a target of 6 weeks. The performance of all Divisions against the sub 3 week target has been consistently strong, and management time to hire in September was 3.05 weeks. There have been some delays in clearance processes (i.e. DBS), which are being monitored by HR.

7.4 Voluntary Turnover

Trust turnover rates decreased for the third consecutive month to 10.57%, from 10.59% in August.

The staged reductions are encouraging given recent trends. With the addition of the new online exit monitoring tool the Trust have unexpectedly just missed the October KPI (40%) target by returning 39.60% performance. The Trust will now be focussing on returning 75% performance by March 18 as agreed by the Board of Directors, given the profile and importance attached to this KPI.

7.5 Sickness Absence

Sickness absence rates have increased in September to 4.61% in month and to 4.29% moving annual average against a target of 4.00%. This is compared to 4.18% (in month) and 4.32% (moving annual average) at the same point last year. Increases have been reported across both short and long term absence. Plans to accelerate the flu programme and health and well-being provision in response are now in place, supported by continued management of absence by operational teams.

8. CQUIN Update Q1 2017-18

With the exception of the CQUINs reference 2a & 2b, Timely identification and treatment for Sepsis in emergency departments and inpatient settings, the Trust fully achieved all CQUIN milestones for quarter one of 2017-18 for the Acute and Specialised Services CQUINs.

For Sepsis the Trust out turned at 72% and 59% respectively, against a 90% target. This is an improvement on the quarter 4 position of 56% and 56.8%.

9. Recommendations

The Council of Governors is requested to:

9.1 **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 23RD OCTOBER 2017

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

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) 27th September 2017 and the HEFT Clinical Quality Monitoring Group (CQMG) 3rd October 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: • Investigations into Doctors' performance currently underway • Mortality indicators: CUSUM, SHMI 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	16/10/2017

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 approve the actions identified.

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

There are currently six Doctors subject to MHPS investigation. The investigations relate to four Consultant Grade Doctors, one Specialty Doctor and one Clinical Fellow.

3. Mortality CUSUM

In June 2017 no CCS (Clinical Classification System) groups breached the mortality threshold. One CCS group had a higher than expected mortality. The group was 'Cardiac dysrhythmias' (106). A Deputy Medical Director has reviewed the caselist for this group and identified no further concerns. Please see Figure 1 below.

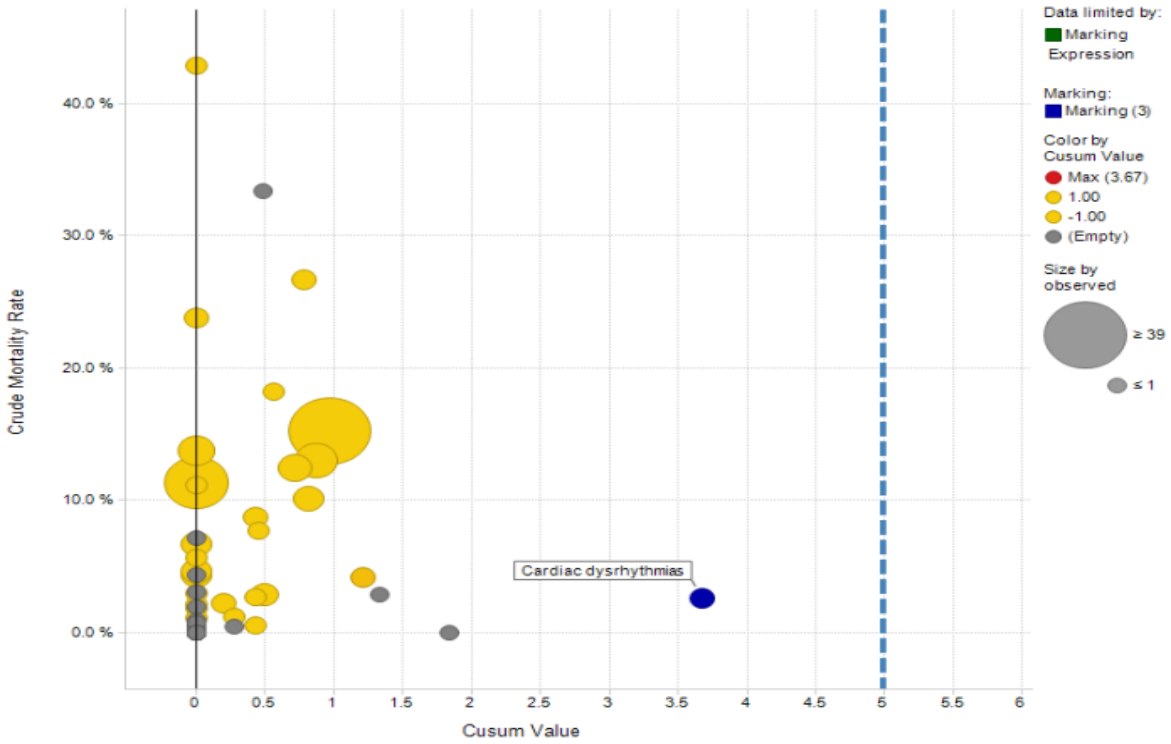


Figure 1: HEFT CUSUM in June 2017 for HSMR CCS Groups

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

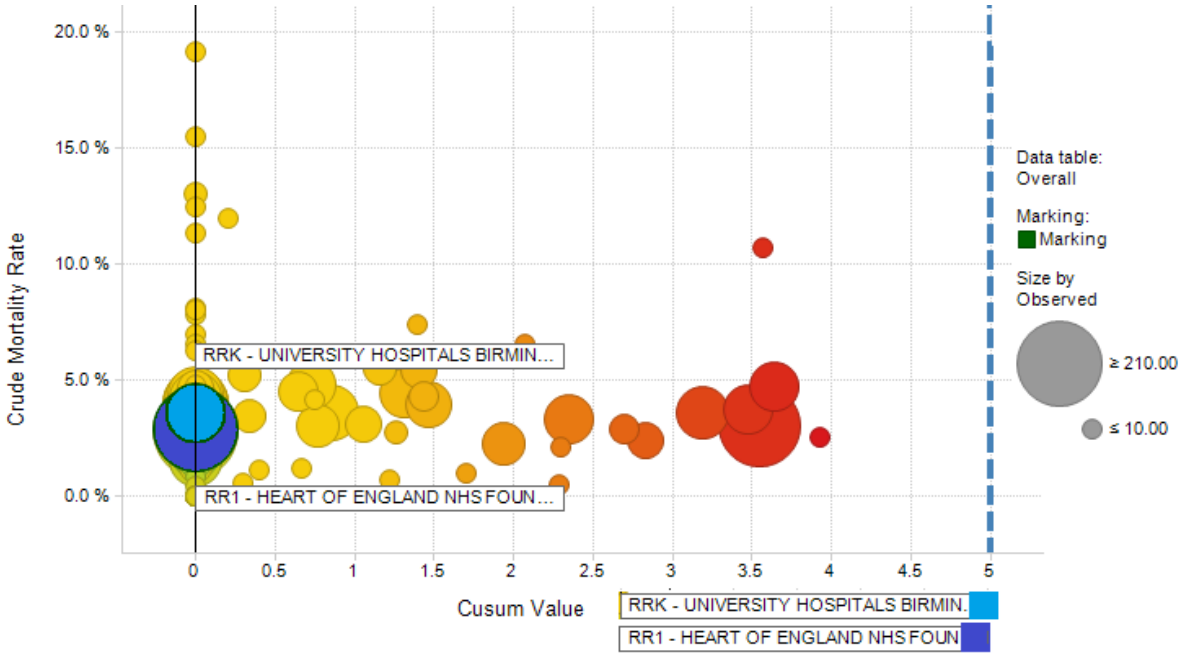


Figure 2: HEFT CUSUM in June 2017 at Trust level. UHB CUSUM included for benchmarking purposes.

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

The Trust's SHMI performance for April 2017 to May 2017 was 86. The Trust has had 703 deaths compared with 819 expected. The Trust is within the acceptable limits as shown in Figure 3 below.

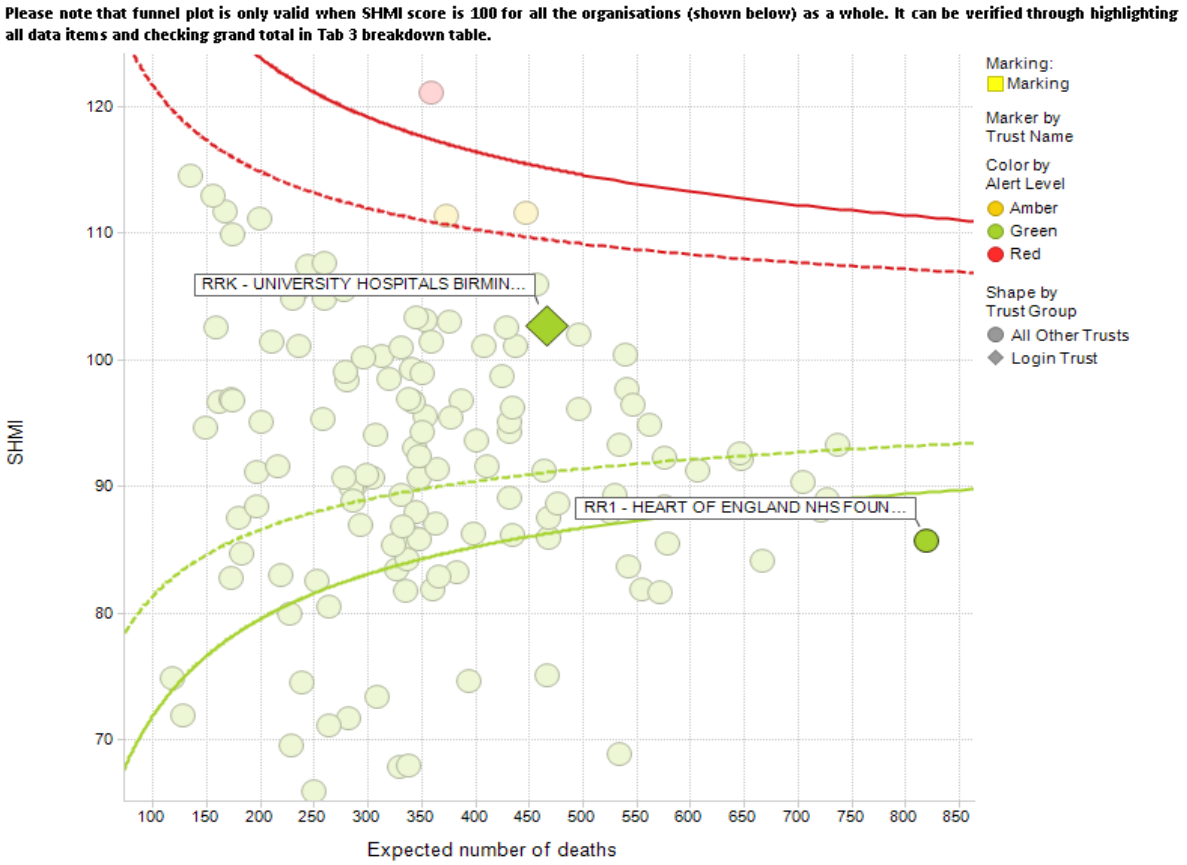


Figure 3: HEFT SHMI April 2017 to May 2017. UHB SHMI included for benchmarking purposes.

5. Mortality – HSMR (Hospital Standardised Mortality Radio)

The Trust's HSMR for the period April 2017 to June 2017 was 98.97 which is within acceptable limits. The Trust had 656 deaths compared with 662 expected (see Figure 4 below).

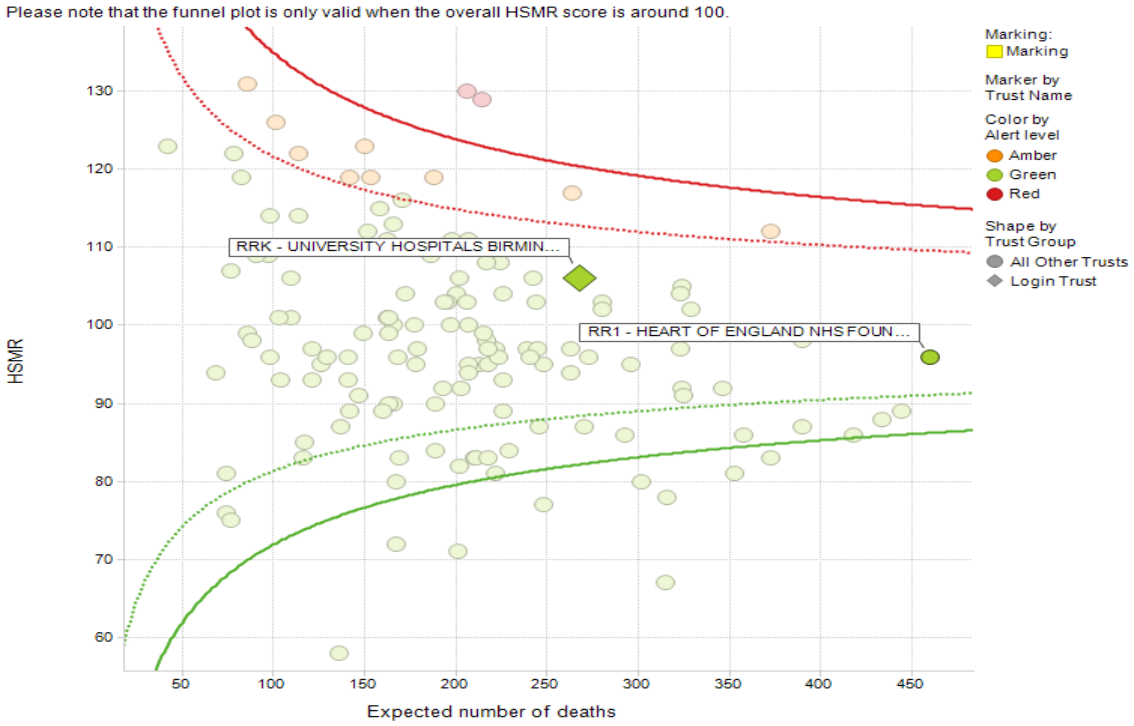


Figure 4: HEFT HSMR April 2017 to June 2017. UHB HSMR included for benchmarking purposes.

6. Board of Directors' Unannounced Governance Visits

The visit scheduled for September 2017 was cancelled.
The visit in October 2017 was to Ward 16 (Paediatrics) at Birmingham Heartlands Hospital. This visit will be reported in a future report.

7. Recommendations

Council of Governors is asked to:
Receive the information set out in this report and accept the actions identified.

David Rosser
Interim Executive Medical Director
16th October 2017

HEART OF ENGLAND NHS FOUNDATION TRUST
COUNCIL OF GOVERNORS
MONDAY 23RD OCTOBER 2017

Title:	**Care Quality Board Report**	
Responsible Director:	Kevin Bolger, Interim Deputy Chief Executive Improvement	
Contact:	Julie Tunney, 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 August and September 2017.	
Annual Plan Ref:		
Links to Trust Clinical Strategy		Yes
Links to Capacity/Demand and Annual Plan		Yes
Links to Quality/Safety		Yes
Other - Please Specify		
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** - Seven cases of post 48 hour Clostridium difficile have been reported in September 2017. This is above the Trust monthly trajectory of five. The total number of cases this year is 31 against a year to date trajectory of 30 cases and an annual trajectory of 64 cases. Four cases of CPE were identified in September 2017. Two were identified from screening samples and two further cases were identified from clinical samples. There were no incidents or outbreaks of infection reported. **Tissue Viability** - The number of avoidable grade 2 pressure ulcers reported in August 2017 was seven. There were no avoidable grade 3 hospital acquired pressure ulcers reported in August 2017. **Dementia Screening** - Performance for September 2017 is at 83.39% and has not met the 90% Trust Target.	

	Parkinson's Medication - Compliance in September 2017 has improved to 82.03% but has not met the 90% Trust target. **Admissions, Discharges and transfers (ADT)** - Compliance against this standard has fallen slightly in month to 87.87% for September 2017, compared to 88.45% in August 2017. Performance remains non-compliant against the Trust target of 95%. **Nurse Staffing** - There are no areas of concern for September 2017. Hot spot areas are ITU at Heartlands, ITU at Good Hope, Neonatal Unit (NNU) and Hyper Acute Stroke Unit (HASU). Assurance is given by Head Nurses that staffing is maintained at safe levels for acuity of patients in line with national guidelines. **Complaints** - The response rate for August 2017 is currently at 48.1%. This performance figure is not validated and is expected improve on validation. However, the 85% target will not be achieved. **Friends and Family Test (FFT)** - During September 2017, the percentage of positive responders has remained static in month at 94% for inpatients. For the Emergency Departments, the positive responder score was 79% and has decreased from last month (82% in August). Response rates have decreased for September to 33% compared to 37% in August for inpatients. Response rate has dipped for EDs at 12%.
Recommendations:	The Governors are asked to consider the information set out in this report.
Signed: Kevin Bolger	**Date:** 16th October 2017

HEART OF ENGLAND NHS FOUNDATION TRUST
COUNCIL OF GOVERNORS
MONDAY 23RD OCTOBER 2017

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 September 2017.

The total number of MRSA bacteraemia attributed to the Trust year to date is one.

3.2 Clostridium Difficile

Seven cases of post 48 hour Clostridium difficile have been reported. This is over the Trust monthly trajectory of five. The total number of cases this year is 31 against a year to date trajectory of 30 cases and an annual trajectory of 64 cases.

Two of the seven cases have been reviewed by the Infection Prevention Control (IPC) Team with microbiology and IPC colleagues from the Clinical Commissioning Group.

One case has been deemed to be avoidable (Good Hope ward 8) due to inappropriate antibiotic prescribing, and the second case is unavoidable (Heartlands ward 12). Of the remaining five cases, three will be reviewed once ribotyping results are available and two are awaiting antibiotic reviews to be completed.

3.3 MRSA Screening

Compliance with MRSA screening achieved the target of 90% for the month of September 2017 with emergency screening achieving 91% compliance and elective screening achieving 90% compliance.

3.4 Carbapenemase Producing Enterobacteriaceae (CPE)

Four cases of CPE were identified in September 2017. Two were screening samples: one from a patient presenting at Heartlands antenatal clinic who had undergone healthcare abroad, and one from the Castle Vale Renal Dialysis Unit patient who was screened at the request of his holiday dialysis unit. Two further cases were identified from clinical samples: one from a urine specimen (Heartlands ward 21) and the second from a sample of peritoneal fluid (Heartlands ward 12).

3.5 Outbreaks and Incidents

There were no outbreaks of infection reported in September 2017.

4. Tissue Viability

4.1 Avoidable Grade 2 Pressure Ulcers

The number of avoidable grade 2 pressure ulcers reported in August 2017 was seven.

The Trust has reported a total of 44 avoidable grade 2 pressure ulcers year to date against a trajectory of no more than 102 for the year.

4.2 Avoidable Grade 3 Pressure Ulcers

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

A total of 4 avoidable grade 3 pressure ulcers have been reported year to date against an annual trajectory of 36. This means that the Trust is currently on target to achieve the required 10% reduction in Grade 3 pressure ulcers.

4.3 Care Quality Metrics - Tissue Viability Assessment

Tissue viability metrics were compliant at 97% in August 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 September 2017 has reduced and is non-compliant at 83.39%.

Performance by division is as follows:-

	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17
Division 1	66.67%	100.00%	90.91%	100.00%	100.00%	100.00%	100.00%
Division 2	N/A	50.00%	N/A	100.00%	50.00%	100.00%	N/A
Division 3	88.90%	89.97%	87.45%	89.37%	88.25%	83.93%	83.37%
Division 4	93.67%	88.79%	92.92%	94.12%	93.22%	90.53%	87.50%
Division 5	79.64%	86.73%	82.38%	82.98%	85.09%	85.71%	81.62%
TRUST	**87.93%**	**89.31%**	**87.11%**	**88.76%**	**88.11%**	**84.72%**	**83.39%**

Due to the overall non-compliance against this KPI, divisions have been tasked with holding individuals to account for completion of the screening tool with an expectation to demonstrate how they have improved compliance. In addition to this, division 3 and division 5 have commenced the following specific actions:

During September 2017, a campaign was carried out in **Division 3** to reiterate the importance of dementia screening involving all Clinical Directors and clinical leads. Junior Doctor's performance in dementia screening is also being reviewed as part of their appraisal portfolio assessments.

In **Division 5** nursing staff are reminding Doctors to complete the dementia risk assessment fields. Persistent non-compliance by individuals will result in those individuals being reported to the Head of the School of Medicine (HEWM), and will also require a meeting with the Divisional Director and Head of Operations which may result in formal performance management.

Divisional performance is monitored through Trust wide Divisional Reviews where there will be an expectation to see 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 and compliance against this in September 2017 has improved to 82.03% (80.10% in August 2017).

The overall percentage figure has, to date, included a cohort of patients that require Parkinson's medication for clinical reasons other than Parkinson's disease. To ensure that the compliance figure is accurate, work has been undertaken to cleanse the data and remove any prescribed as required (PRN) doses. This has been fed back to divisions and the expectation is that they will focus on local actions to improve performance. Where individual performance is identified as a contributory factor, performance improvement notices have been issued and will be monitored by the Head Nurse(s).

7. Admissions, Discharges and Transfers (ADT)

Compliance against this standard has fallen slightly in month to 87.87% for September 2017, compared to 88.45% in August 2017. Performance remains non-compliant against the Trust target of 95%.

Performance by Division as of September 2017 is as follows:-

	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17
Division 1	79.79%	80.14%	82.33%	80.11%	79.50%	78.93%
Division 2	92.37%	92.80%	92.78%	91.30%	92.05%	91.66%
Division 3	89.74%	89.75%	89.74%	88.99%	89.00%	86.91%
Division 4	82.46%	82.91%	83.53%	82.76%	82.16%	86.19%
Division 5	85.56%	89.17%	89.98%	90.61%	90.47%	89.88%
TRUST	**87.37%**	**88.58%**	**83.65%**	**88.32%**	**88.45%**	**87.87%**

Although compliance against the ADT standard is non-compliant, performance has improved overall when compared to the same period last year as shown in the table below:-

	2016	**2017**
August	84.83%	88.45%
September	83.82%	87.87%

Actions to continue to improve performance include:

- Divisional rectification plans across all divisions commenced in September 2017. Trajectories have been set within divisions for all wards with an increased uptake in training.

- Cascade training is planned for throughout October and November 2017. All Supervisory Ward Sisters will undertake training and become cascade trainers. Performance for this indicator will form part of the Supervisory Ward Sisters one-to-one meetings and is also being monitored at the monthly divisional confirm and challenge meetings.

8. Nurse Staffing

8.1 Compliance with UNIFY

There are no areas of concern for September 2017.

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

Divisional Area	Qualified compliance	HCA compliance
Division 1 wards	97%	112%
Division 1 critical care	86%	93%
Division 2 Paediatrics	92%	127%
Division 2 O&G	91%	93%
Division 3	94%	110%
Division 4	99%	117%
Division 5	95%	108%
Trust Overall	**95%**	**110%**

Hot spot areas are ITU at Heartlands, ITU at Good Hope, Neonatal Unit (NNU) and Hyper Acute Stroke Unit (HASU). Assurance is given by Head Nurses that staffing is maintained at safe levels for acuity of patients in line with national guidelines.

Ward 9 Heartlands continues to have a number of qualified vacancies and reduced bank fill over September 2017. The ratio of Health Care Assistants (HCAs) was increased to mitigate risk.

8.2 Vacancy Position

There were 419 WTE qualified nursing / midwifery vacancies in August 2017, an increase of 68 in month. The increase in vacancies this month is largely because the funded establishments have now been realigned to include the 25% headroom.

There are 128 planned nursing / midwifery starters across November 2017 to January 2018. There is a Trust-wide recruitment event planned for December 2017.

9. Friends and Family Test (FFT)

During September 2017, the percentage of positive responders has remained static in month to 94% for inpatients. For the Emergency Departments, the positive responder score was 79% and has decreased from last month (82% in August).

Response rates have decreased for September to 33% compared to 37% in August for inpatients. Response rate has dipped for EDs at 12%.

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

10. Complaints

Performance against the Trust response rate within 30 days is not improving at the required pace and in line with the trajectory. The response rate for August 2017 is currently at 48.1%. This performance figure is not validated and is expected improve on validation. However the 85% target will not be achieved.

The un-validated August 2017 Divisional performance is currently as follows:

	Complaints Response Rate
Division 1	60.0%
Division 2	26.7%
Division 3	45.2%
Division 4	38.9%
Division 5	61.3%

The total number of complaints received during August was 106 and the total number closed was 86.

The total number of complaints received during September 2017 was 82 and the total number closed was 98.

The live complaints caseload is currently at a total of 205.

A whole systems review of complaints was undertaken in September 2017. This review focused on the complaints processes at Heart of England NHS Foundation Trust, aligning process against the current methodology used at University Hospitals Birmingham.

Key issues that have been identified within the process at HEFT are as follows:

- Consent - New complaints will be registered and investigation commenced as is normal practice, however the 30 working day period will not start until consent from the patient or appropriate person is received.

- Meetings - Heart of England NHS Foundation Trust current process is to attempt to meet with complainants within 30 working days of receipt of complaint. At times, however, there are circumstances in which a meeting cannot be arranged during this time. The new process will count such complaints as achieving the 30 day response time if a meeting is offered by the Trust within the 30 working days.

The above actions will take place with immediate effect with the expectation that performance will improve from September 2017 with closed cases. In practice, however, Divisions will be responsible for ensuring momentum with responding to such complaints in line with Trust policy.

The changes to the policy and practice are anticipated to show an immediate improvement in performance against the 30 working day response time.

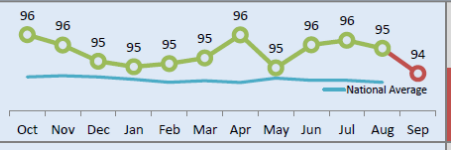
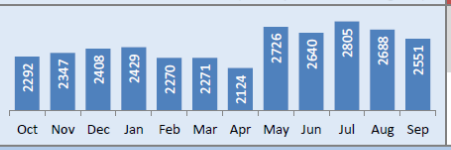
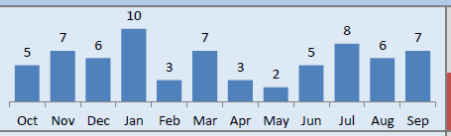
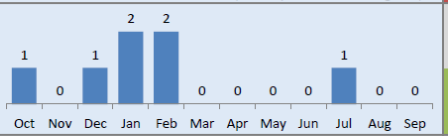
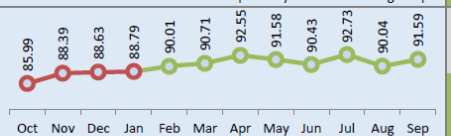
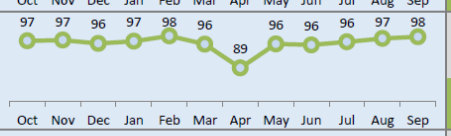
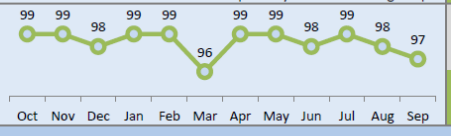
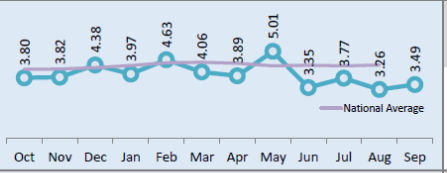
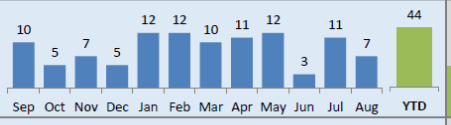
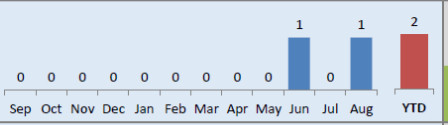
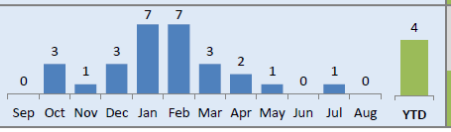
Appendix
Care Quality Dashboard - September 2017

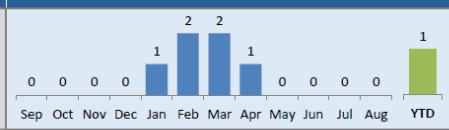
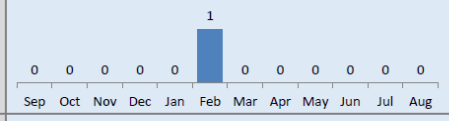
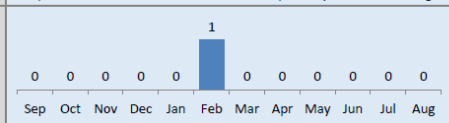
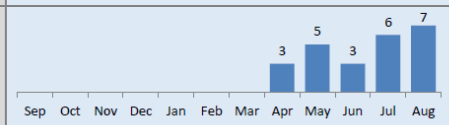
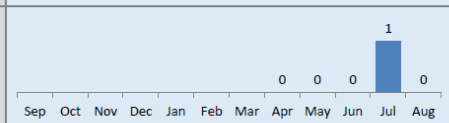
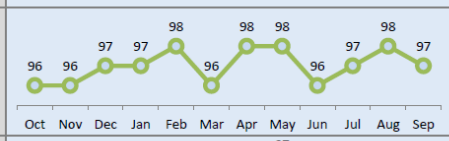
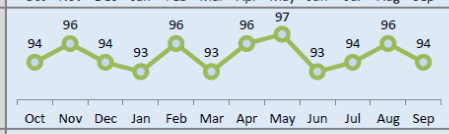
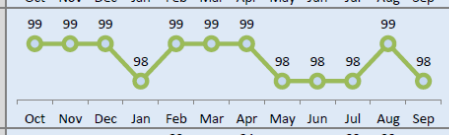
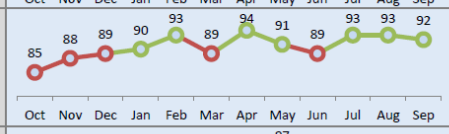
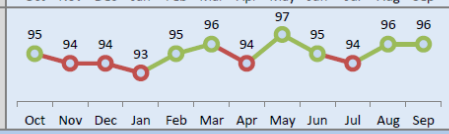
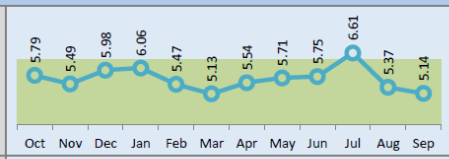
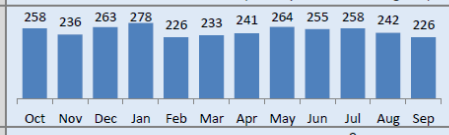
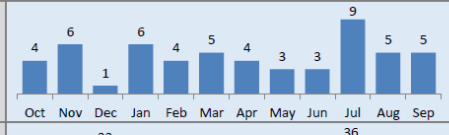
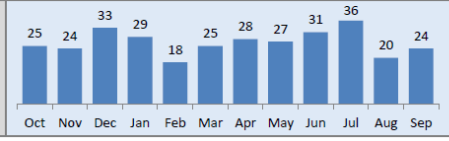
Nursing & Midwifery
Ward to Board Assurance Report

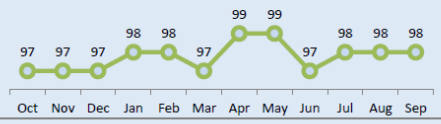
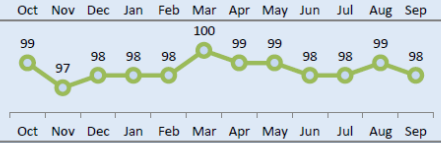
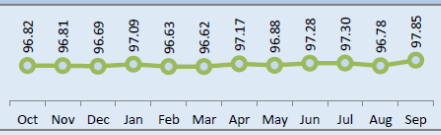
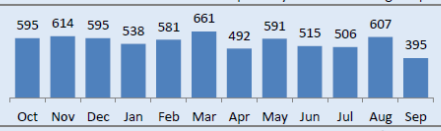
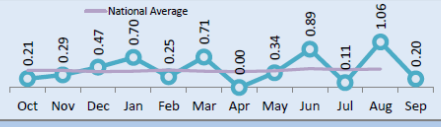
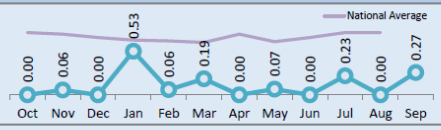
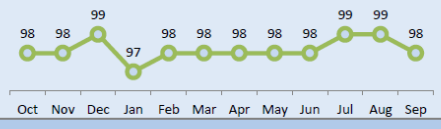
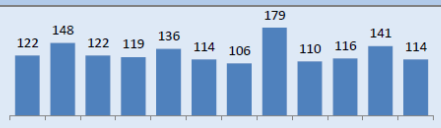
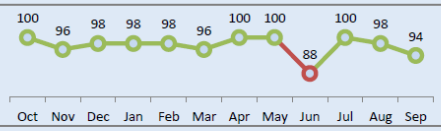
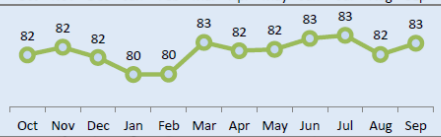
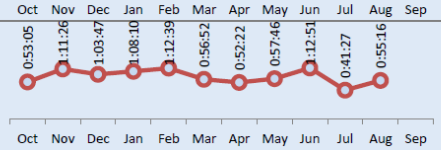
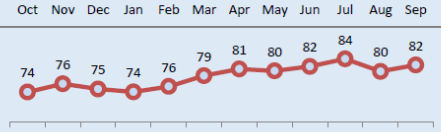
Building healthier lives

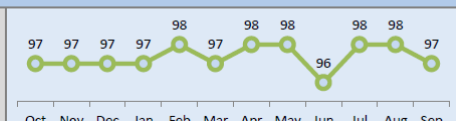
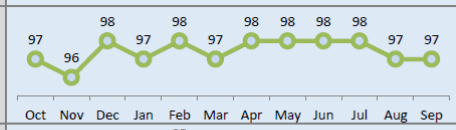
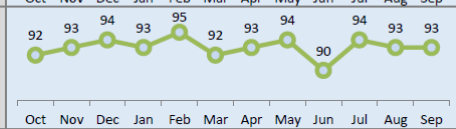
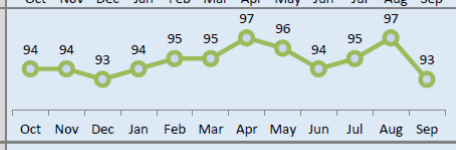
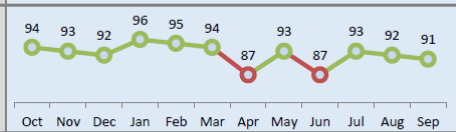
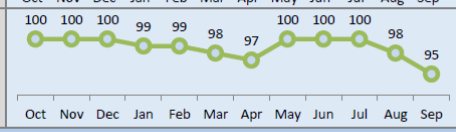
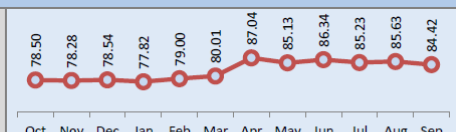
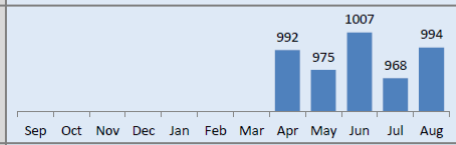
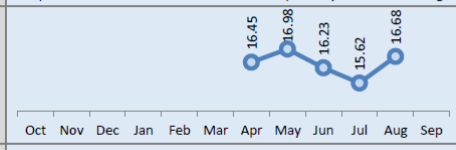
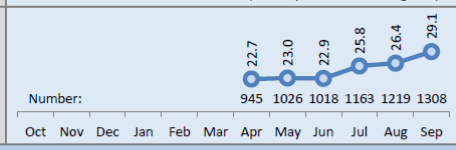
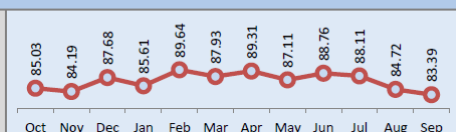
Heart of England NHS
NHS Foundation Trust

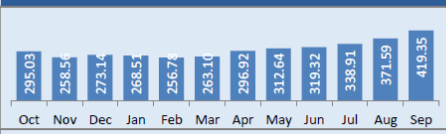
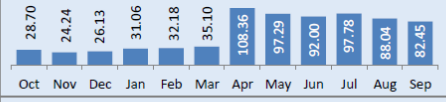
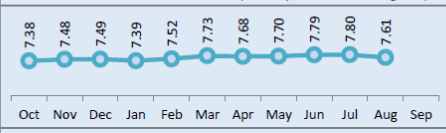
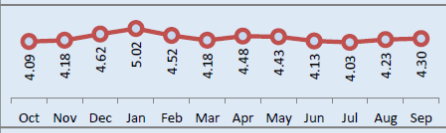
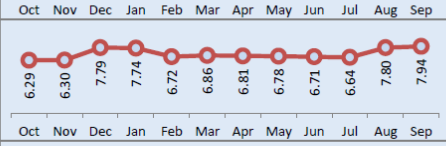
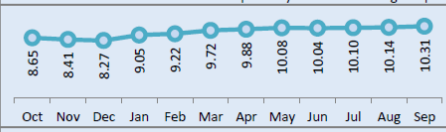
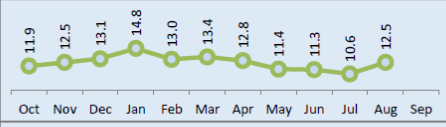
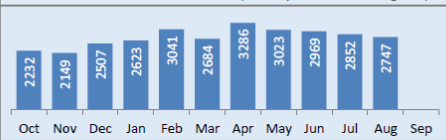
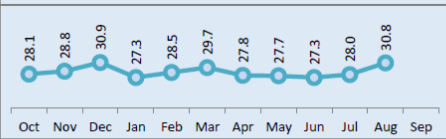
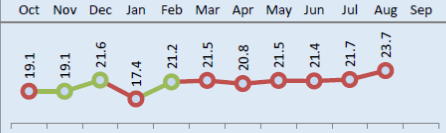
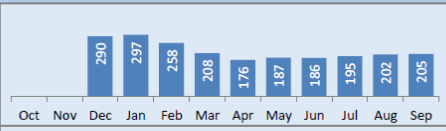
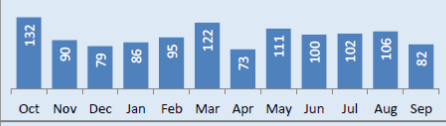
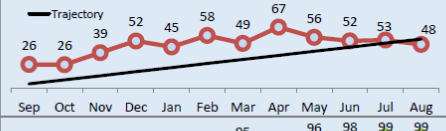
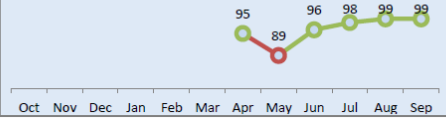
TRUST LEVEL OVERVIEW

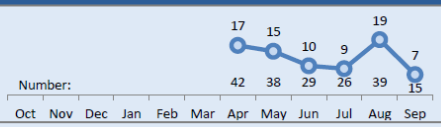
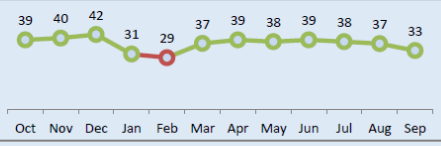
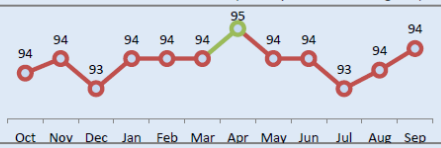
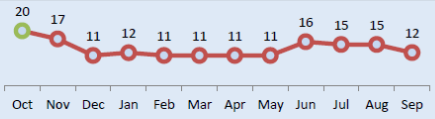
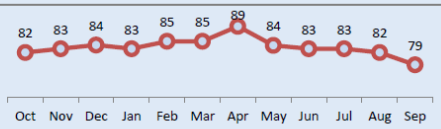
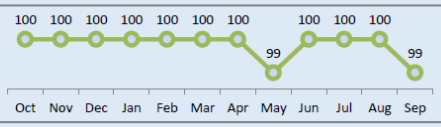
Ref	Indicator Name	Target	Performance		Wards / Areas Not Achieving Target
	Harm Free Care				
1	Harm Free Care *% of patients receiving harm free care recorded via NHS Safety Thermometer*	≥95%		In Month Position Sep-17 94%	17 SH (67%), 21 GHH (73%), 30 BHH (78%), 22 HDU / ITU GHH (80%), HDU BHH (83%), 27 BHH (86%), AMU SS GHH (86%), 21 BHH (88%), 7 GHH (89%), ITU BHH (90%), 20A SH (90%), 28 BHH (91%), 23 HASU BHH (93%), 24 BHH (93%), 10 GHH (93%), 14 GHH (93%), 17 GHH (93%)
2	Incidents Reported *Number of incidents reported*			In Month Position Sep-17 2551	Top categories in month: Tissue viability (724), Security (302), Admission transfer and discharge (266), Patient fall (246), Medication (141), Ongoing care monitoring and review (122), Maternity (122), Safeguarding (114), Lab investigations (71), Treatment or procedure (70)
	Infection Control				
3	Clostridium Difficile *Number of avoidable cases*	≤5		In Month Position Sep-17 7	8 GHH (2), 3 BHH (1), 12 BHH (1), 19 BHH (1), AMU SS GHH (1), 19 SH (1)
4	MRSA *Number of cases*	*0*		In Month Position Sep-17 0	
5	MRSA Screening (Emergency) *% of patients screened*	≥90%		In Month Position Sep-17 91.59%	23 ASU BHH (0%), 12 GHH (46%), 7 GHH (50%), 20A SH (50%), 2 BHH (53%), 22 AMU 2 BHH (56%), 18 BHH (60%), 24 GHH (73%), 9 GHH (75%), 19 BHH (77%), 17 GHH (80%), 30 BHH (83%), 11 GHH (86%), 8 BHH (86%), 14 GHH (87%), 6 CCU BHH (88%), 16 GHH (88%)
6	Hand Hygiene Compliance *% compliance with hand hygiene*	≥85%		In Month Position Sep-17 98%	Endoscopy SH (60%), AMU GHH (71%)
7	Care Quality Metrics: Environment Score *% compliance with environment indicators*	≥90%		In Month Position Sep-17 97%	5 BHH (75%), AMU SH (75%), 17 SH (80%), AMU SS SH (80%), 23 HASU BHH (86%), 21 GHH (86%)
	Tissue Viability				
8	Pressure Ulcer Prevalence *% of patients with a pressure ulcer (old and new) reported via NHS Safety Thermometer*			In Month Position Sep-17 3.49%	Number of pressure ulcers: 30 BHH (5), 21 BHH (3), AMU SS GHH (3), 27 BHH (2), 28 BHH (2), 7 GHH (2), 10 GHH (2), 21 GHH (2), 22 HDU / ITU GHH (2), 20A SH (2), 3 BHH (1), 5 BHH (1), 6 BHH (1), 9 BHH (1), 10 BHH (1), 11 SAU BHH (1), 23 HASU BHH (1), 24 BHH (1), HDU BHH (1), ITU BHH (1), 8 GHH (1), 14 GHH (1), 17 GHH (1), 24 GHH (1), 17 SH (1), 19 SH (1), 20B SH (1), AMU SS SH (1)
9a	Avoidable Grade 2 Pressure Ulcers *Number of avoidable cases*	*<102 at year end*		In Month Position Aug-17 5	
9b	Avoidable Grade 2 Pressure Ulcers (Community) *Number of avoidable cases*	*<4 at year end*		In Month Position Aug-17 0	
10a	Avoidable Grade 3 Pressure Ulcers *Number of avoidable cases*	*<36 at year end*		In Month Position Aug-17 1	

Ref	Indicator Name	Target	Performance	In Month Position	Wards / Areas Not Achieving Target
10b	Avoidable Grade 3 Pressure Ulcers (Community) *Number of avoidable cases*	*<7 at year end*		In Month Position Aug-17 0	
11a	Avoidable Grade 4 Pressure Ulcers *Number of avoidable cases*	*0*		In Month Position Aug-17 0	
11b	Avoidable Grade 4 Pressure Ulcers (Community) *Number of avoidable cases*	*0*		In Month Position Aug-17 0	
12a	Avoidable Suspected Deep Tissue Injury (SDTI) Pressure Ulcers *Number of avoidable cases*			In Month Position Aug-17 7	
12b	Avoidable Suspected Deep Tissue Injury (SDTI) Pressure Ulcers (Community) *Number of avoidable cases*			In Month Position Aug-17 0	
13	Care Quality Metrics: Tissue Viability *% compliance with tissue viability indicators*	*≥95%*		In Month Position Sep-17 97%	1 BHH (79%), PAU BHH (83%), SCBU GHH (84%), 10 GHH (85%), 12 GHH (87%), AMU SS SH (89%), 12 BHH (91%), NNU BHH (91%), 2 BHH (92%), 23 ASU BHH (92%), 22 HDU / ITU GHH (92%), 24 BHH (93%), 9 GHH (93%), 23 HASU BHH (94%)
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 Sep-17 94%	1 BHH (33%), 12 BHH (50%), 6 BHH (70%), 21 GHH (71%), 23 HASU BHH (75%), 24 BHH (80%), NNU BHH (80%), PAU BHH (80%), AMU GHH (83%), 10 GHH (88%), 19 BHH (89%), 12 GHH (89%)
15	Care Quality Metrics: SSKIN Bundle - Repositioning frequency completed *The repositioning frequency has been completed*	*≥90%*		In Month Position Sep-17 98%	10 GHH (50%), ITU BHH (75%), AMU GHH (75%), AMU SH (75%)
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 Sep-17 92%	23 ASU BHH (43%), AMU SS SH (50%), 8 BHH (67%), 21 ECAU BHH (70%), SCBU GHH (70%), 5 BHH (75%), 23 HASU BHH (75%), 12 GHH (78%), 9 BHH (80%), 24 BHH (80%), 2 GHH (80%), 10 GHH (86%), 8 SH (86%)
17	Matrons Assurance: Overall Tissue Viability Score *% compliance with matrons assurance metrics for tissue viability*	*≥95%*		In Month Position Sep-17 96%	5 BHH (79%), 12 GHH (79%), 16 GHH (85%), 1 BHH (90%), 9 BHH (90%), 14 GHH (90%), 19 BHH (91%), 4 BHH (92%), 21 BHH (94%), HDU BHH (94%), 15 SH (94%)
	Inpatient Falls				
18	Falls Rate *Falls rate per 1,000 occupied bed days*	*≤6.36*		In Month Position Sep-17 5.14	15 BHH (19.23), 12 BHH (14.59), 18 BHH (13.95), 21 GHH (13.83), 22 AMU 2 BHH (13.44), 1 BHH (12.85), 14 SH (10.05), 24 GHH (9.60), 20 AMU 1 BHH (8.71), 15 GHH (8.70), 7 BHH (8.45), 8 GHH (8.13), 7 GHH (8.05), 20A SH (7.84), 21 BHH (7.59), 30 BHH (7.23), 11 GHH (7.14), 9 GHH (7.01), 2 BHH (7.00), 10 GHH (6.98), AMU SS GHH (6.70), 10 BHH (6.85), 15 SH (6.56)
19	Falls Incidence *Number of inpatient falls*			In Month Position Sep-17 226	
20	Injurious Falls *Number of falls resulting in a fracture or head injury*			In Month Position Sep-17 5	8 BHH (1), 22 AMU 2 BHH (1), 11 GHH (1), 15 GHH (1), 20B SH (1)
21	Recurrent Fallers *Number of patients falling twice or more during the same admission*			In Month Position Sep-17 24	1 BHH (2), 22 AMU 2 BHH (2), 8 GHH (2), 12 GHH (2), 15 SH (2), AMU SS SH (2), 2 BHH (1), 3 BHH (1), 7 BHH (1), 18 BHH (1), 27 BHH (1), 28 BHH (1), 2 GHH (1), 11 GHH (1), 15 GHH (1), 21 GHH (1), 23 CCU GHH (1), AMU SS GHH (1)

Ref	Indicator Name	Target	Performance		Wards / Areas Not Achieving Target
22	Care Quality Metrics: Falls Assessment *% compliance with overall falls assessment indicator*	≥90%		In Month Position Sep-17 98%	AMU SS SH (69%), 23 HASU BHH (83%), ITU BHH (83%), 22 HDU / ITU BHH (86%)
23	Care Quality Metrics: Manual Handling *% compliance with overall manual handling indicator*	≥90%		In Month Position Sep-17 98%	9 GHH (83%), 10 GHH (83%)
	VTE				
24	VTE Screening *% of patients screened for VTE*	≥95%		In Month Position Sep-17 97.88%	14 SH (78%), ITU BHH (80%), 2 GHH (84%), 14 GHH (85%), 15 GHH (87%), 10 BHH (92%), 8 GHH (92%), 16 GHH (92%), 5 BHH (93%)
25	VTE Screening *Number of patients NOT screened*			In Month Position Sep-17 388	Top areas for number NOT screened: DSU GHH (57), 14 SH (46), DPU SH (39), 2 GHH (37), AMU GHH (15), 5 BHH (12), 14 GHH (10), 5 GHH (9), DSU BHH (9), 10 BHH (9), 15 GHH (7), 1 BHH (7), 17 GHH (6), 16 GHH (5)
26	Prevalence of New VTE *% of patients with a new (hospital acquired) VTE reported via NHS Safety Thermometer*			In Month Position Sep-17 0.20%	Number of new VTE: 27 BHH (1), 17 GHH (1), 21 GHH (1)
	UTI				
27	CAUTI *% of catheterised patients with a UTI reported via NHS Safety Thermometer*			In Month Position Sep-17 0.27%	Number of CAUTI: 24 BHH (2), 30 BHH (1), 14 GHH (1)
28	Care Quality Metrics: Continence Assessment *% compliance with overall continence assessment indicator*	≥90%		In Month Position Sep-17 98%	HDU BHH (86%), 11 GHH (87%), 14 SH (89%)
	Medication				
29	Medication Incidents *Number of medication incidents reported via Datix*			In Month Position Sep-17 114	Number of medication incidents resulting in moderate, severe, or catastrophic harm: **One incident resulted in Moderate Harm on Ward 9 BHH**
30	Care Quality Metrics: Medication - Secure Medicines / Cupboard *% compliance with indicator*	90%		In Month Position Sep-17 94%	5 BHH (0%), 17 SH (0%), 22 HDU / ITU GHH (75%)
31	Antibiotic STAT Doses *% of antibiotic STAT doses administered within 1 hour*	≥80%		In Month Position Sep-17 83%	6 BHH (40%), 17 GHH (53%), 7 GHH (55%), 22 AMU 2 BHH (64%), 10 BHH (67%), 24 GHH (67%), 8 SH (67%), 9 BHH (69%), 2 BHH (70%), 10 GHH (72%), 17 GHH (73%), 2 GHH (76%), 14 GHH (76%), 23 CCU GHH (78%), 24 BHH (79%)
32	Antibiotic STAT Doses *Average time taken for doses administered* ***AFTER*** *1 hour*	≤1 hour		In Month Position Sep-17	Top maximum delay to administer AFTER 1 hr:
33	Parkinsons Medication *% of Parkinsons medication administered within 30 minutes*	≥90%		In Month Position Sep-17 82%	
34	Guardrails © Medication Safety Software (for IV systems) *% compliance with use of Guardrails © medication safety software*			In Month Position Sep-17	

Ref	Indicator Name	Target	Performance		Wards / Areas Not Achieving Target
	Care Quality Metrics				
35	**Care Quality Metrics: Overall Clinical Score** *% compliance with overall care quality metrics*	≥95%		**In Month Position** Sep-17 97%	ED GHH (76%), Paeds ED GHH (83%), 10 GHH (88%), 23 HASU BHH (90%), NNU BHH (91%), 9 GHH (91%), AMU SS SH (92%), 21 BHH (93%), Delivery Suite BHH (93%), ED BHH (93%), 12 GHH (93%), Paeds ED GHH (93%), SCBU GHH (94%)
36	Care Quality Metrics: Observations *% compliance with observations indicator*	≥90%		**In Month Position** Sep-17 97%	10 GHH (82%), 9 GHH (89%)
37	Care Quality Metrics: Fluid Balance *% compliance with fluid balance indicator*	≥90%		**In Month Position** Sep-17 93%	5 BHH (71%), 21 GHH (72%), 23 ASU BHH (76%), 12 GHH (77%), 23 HASU BHH (78%), 9 GHH (81%), 17 SH (81%), 30 BHH (82%), 26 BHH (83%), 10 GHH (83%), 14 GHH (83%), 14 SH (83%), 17 GHH (89%)
38	Care Quality Metrics: Nutritional Assessment *% compliance with nutritional assessment indicator*	≥90%		**In Month Position** Sep-17 93%	23 HASU BHH (65%), 9 BHH (68%), 21 BHH (75%), 20 AMU 1 BHH (81%), NNU BHH (82%), 29 BHH (83%), 5 BHH (84%), 10 GHH (84%), PAU BHH (85%), 8 BHH (86%), 24 GHH (86%), ITU BHH (87%), 12 GHH (87%), 21 GHH (88%), AMU SS SH (88%), 22 AMU 2 BHH (89%), 26 BHH (89%)
39	Care Quality Metrics: Blood Glucose Monitoring *% compliance with blood glucose monitoring indicator*	≥90%		**In Month Position** Sep-17 91%	8 BHH (50%), 21 BHH (56%), 15 SH (67%), 9 GHH (71%), 10 GHH (71%), 16 GHH (71%), 15 SH (75%), AMU SH (75%), 14 SH (78%), 23 ASU BHH (79%), 24 BHH (79%), 12 BHH (81%), 7 BHH (82%), 6 BHH (84%), 20 AMU 1 BHH (88%), AMU GHH (89%)
40	**Care Quality Metrics: Community Services Overall Score** *% compliance with overall care quality metrics*	≥95%		**In Month Position** Sep-17 95%	
	Patient Flow				
41	ADTs *% of discharges completed within 2 hours*	≥95%		**In Month Position** Sep-17 84.42%	
42	Readmissions: 28 days *Number of patients readmitted within 28 days of discharge* Data One Month in Arrears			**In Month Position** Aug-17 994	
43	Discharges before 12pm *% of patients discharged before 12 o'clock midday*			**In Month Position** Sep-17	
44	Discharge Lounge Utilisation *% of patients utilising the discharge lounge*			**In Month Position** Sep-17 29.1%	Wards with lowest NUMBER of discharges to the discharge lounge in month: 26 BHH (0), 19 BHH (2), 23 ASU BHH (6), 21 BFAU BHH (10), 23 HASU BHH (10)
	Dementia				
45	Dementia Screening *% of eligible patients screened for dementia*	≥90%		**In Month Position** Sep-17 83.39%	
	Nurse Staffing				
46	UNIFY Compliance *Overall compliance in month*	≥90%	Qualified Compliance: 95%	HCA Compliance: 110%	Hot Spot Areas: ITU BHH, ITU GHH, NNU, HASU

Ref	Indicator Name	Target	Performance		Wards / Areas Not Achieving Target
47a	Registered Vacancy Position *Number of WTE Vacancies for registered nursing staff*			In Month Position Sep-17 419.35	
47b	Unregistered Vacancy Position *Number of WTE Vacancies for unregistered nursing staff*			In Month Position Sep-17 82.45	
48	Care Hours per Patient Day *Number of care hours per patient day*			In Month Position Sep-17	
49a	Sickness: Registered Staff *% of nursing & midwifery sickness in month*	≤4%		In Month Position Sep-17	
49b	Sickness: Unregistered Staff *% of nursing & midwifery sickness in month*	≤4%		In Month Position Sep-17	
50	Turnover *% of staff turnover*			In Month Position Sep-17	
51	e-Rostering KPI: Unfilled Duties *% of planned duty hours that were left unfilled*	<30%		In Month Position Sep-17	
52	e-Rostering KPI: Additional Duties *Number of duties rostered in addition to planned staffing levels*	*0*		In Month Position Sep-17	
53	e-Rostering KPI: Unavailability *% of leave and unavailability*			In Month Position Sep-17	
54	e-Rostering KPI: Temporary Staffing *% of duties filled by bank and agency staff*	<20%		In Month Position Sep-17	
	Patient Experience				
55	Live / Open / Active Complaints *Number of active complaints*			In Month Position Sep-17 205	
56	New Complaints Received *Number of new complaints received in month*			In Month Position Sep-17 82	
57	Complaints Response Rate *% of complaints responded to within 30 days or less* Data One Month in Arrears	≥80%		In Month Position Aug-17 48%	NB: Data is taken from a live system and is accurate at the time of reporting. Complaints are closed on a daily basis meaning that monthly data will continue to change after reporting. Final monthly
58	Complaints KPI: Complaints Sent to Divisions *% of complaints sent to Divisions / Operational Teams within one working day*	≥90%		In Month Position Sep-17 99%	

Ref	Indicator Name	Target	Performance		Wards / Areas Not Achieving Target
59	Complaints KPI: Complaints Older than 50 Days *% of complaints older than 50 days without a response*			In Month Position Sep-17 7%	
60	Friends & Family Test: Inpatients *% response rate*	≥30%		In Month Position Sep-17 33%	4 GHH (0%), PAU BHH (3%), 15 BHH (5%), 24 BHH (5%), 26 BHH (7%), AMU GHH (9%), 2 BHH (10%), 16 BHH (10%), 7 BHH (12%), 24 GHH (12%), 20B SH (13%), 14 BHH (16%), NNU BHH (17%), 17 SH (17%), 5 GHH (19%), 23 CCU GHH (19%), 1 BHH (20%), AMU SS GHH (21%), 14 GHH (22%), 20 AMU 1 BHH (24%), Cedar BHH (25%), 17 GHH (26%), 8 BHH (27%), 6 BHH (29%), 7 GHH (29%), SCBU GHH (29%), AMU SS SH (29%)
61	Friends & Family Test: Inpatients *P ositive responder score*	≥95%		In Month Position Sep-17 94%	PAU BHH (71%), 16 BHH (73%), 8 BHH (76%), 18 BHH (80%), NNU BHH (80%), SCBU GHH (80%), 2 BHH (85%), 14 GHH (85%), 1 BHH (86%), 4 BHH (86%), 2 GHH (89%), Maple BHH (90%), 20B SH (90%), 8 GHH (91%), AMU GHH (91%), 11 SAU BHH (92%), 29 BHH (92%), 11 GHH (92%), 15 GHH (92%), 17 GHH (92%), AMU SH (92%), 3 BHH (93%), 20 AMU 1 BHH (93%), 28 BHH (93%), 5 BHH (94%), 9 GHH (94%), 21 GHH (94%)
62	Friends & Family Test: Emergency Departments *% response rate*	≥20%		In Month Position Sep-17 15%	
63	Friends & Family Test: Emergency Departments *P ositive responder score*	≥95%		In Month Position Sep-17 79%	
64	Care Quality Metrics: Patient Safety & Dignity *% compliance with patient safety and dignity indicator*	≥90%		In Month Position Sep-17 99%	9 GHH (88%)
65	Compliments *TBC*			In Month Position Sep-17	
66	Wards / Departments with improvement plans				
67	Areas of good practice				

HEART OF ENGLAND NHS FOUNDATION TRUST

COUNCIL OF GOVERNORS

MONDAY 23 OCTOBER 2017

Title:	Finance Report to 30 September 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 30 September 2017 (Month 6 2017/18).
Confidentiality Level & Reason	Confidential
Annual Plan Ref	
Key Issues Summary:	• The Trust 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 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 (£5.8m) against a planned deficit pre STF of (£2.4m), an adverse variance of (£3.4m). • The year to date position at month 6 is a deficit of (£28.6m) against a planned deficit pre STF of (£14.5m), an adverse variance of (£14.1m). • 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 has been submitted to NHS Improvement 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 is predicated on NHS clinical income returning to plan. • The cash balance is £16.4m at 30 September 2017, including (£9.8m) of interim revenue support (working capital loan).
Recommendations	The Council of Governors is requested to: • Receive the contents of this report.

Approved by:	Julian Miller	17 October 2017

HEART OF ENGLAND NHS FOUNDATION TRUST

COUNCIL OF GOVERNORS

MONDAY 23 OCTOBER 2017

FINANCE REPORT FOR THE PERIOD ENDING 30 SEPTEMBER 2017

PRESENTED BY THE INTERIM DIRECTOR OF FINANCE

1. Introduction

This report covers the first six months of the 2017/18 financial year, for April to September 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 (£5.8m) for September 2017 (month 6) compared to a pre STF planned deficit of (£2.4m), an adverse variance of (£3.4m). This moves the year to date deficit to (£28.6m) against a planned deficit pre STF of (£14.5m), an adverse variance of (£14.1m).

The key variances against the plan year to date include:

- Under-performance against clinical income targets (£4.4m);
- Under-delivery against CIP targets (£2.6m) – of which (£0.7m) is a gap in the programme, (£1.3m) relates to phasing and (£0.6m) relates to slippage against planned delivery; and
- Under-delivery against FRP/stretch savings target (£4.7m) – of which (£3.1m) is a gap in the programme, (£0.6m) relates to phasing and (£1.0m) relates to slippage.
- Non-identification of recurrent savings to replace 2016/17 non-recurrent benefits of (£3.8m).

As a result of the adverse financial performance, the allocation of STF year to date (£3.3m in quarter 1, £4.2m quarter 2) totalling £7.4m, has not been recognised and this forms part of the (£28.6m) year to date deficit.

A revised year end forecast has been submitted to NHSI 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). Further details are set out in section 2.7.

The cash balance at the end of September is £16.4m against the plan of £3.0m at this point, a favourable movement of £13.4m. However, this includes a £9.8m working capital loan.

2. Income & Expenditure

2.1 Summary Position

The Trust's income and expenditure position as at the end of September is a (£28.6m) deficit against the planned deficit pre STF of (£14.5m).

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

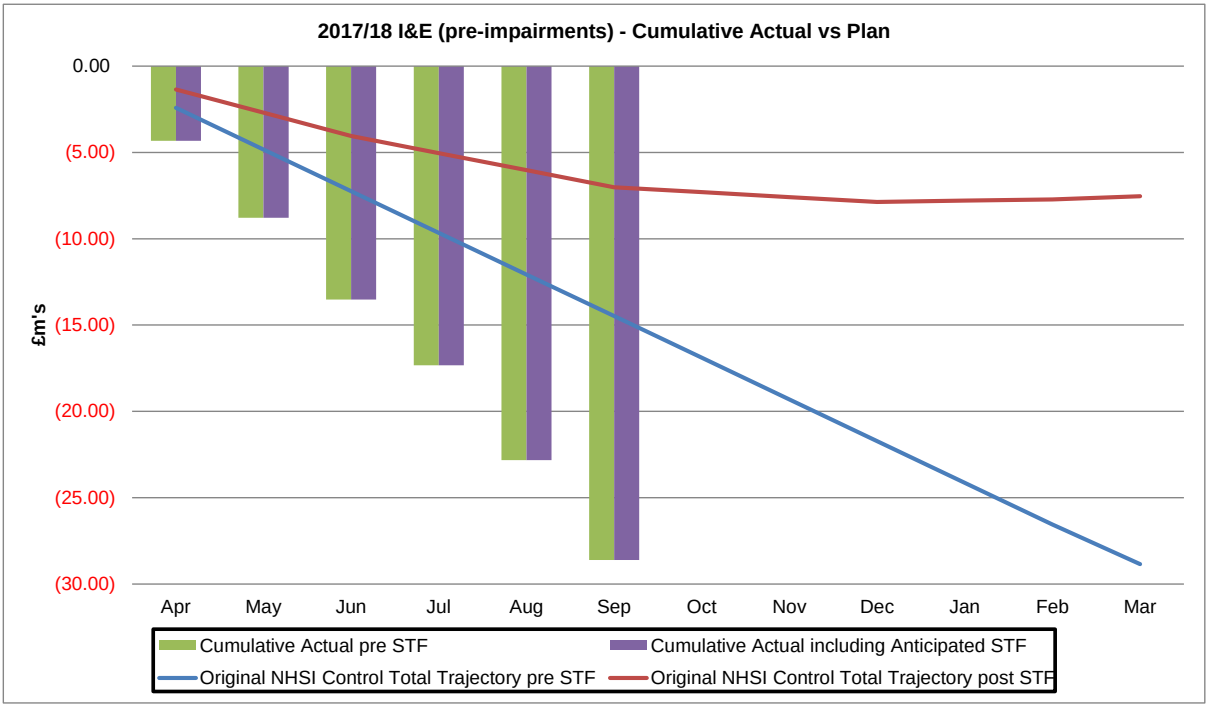


Table 2 below summarises the Trust's income and expenditure position at the end of September with analysis of expenditure from section 2.2 and operating revenue from section 2.6 below.

Table 2: Income and Expenditure Plan vs Actual

	In Month Plan £m	In Month Actual £m	In Month Variance £m	YTD Plan September £m	YTD Actual September £m	Variance £m
Control Total Items						
Operating Revenue (excluding STF)	58.5	56.4	(2.1)	350.8	343.0	(7.8)
Operating Expenses	(58.9)	(61.2)	(2.2)	(353.7)	(361.3)	(7.6)
EBITDA	**(0.5)**	**(4.8)**	**(4.3)**	**(2.9)**	**(18.2)**	**(15.3)**
Depreciation	(1.3)	(1.0)	0.3	(8.0)	(7.7)	0.3
Interest Receivable	0.0	0.0	0.0	0.0	0.0	0.0
Interest Payable	(0.0)	(0.0)	0.0	(0.1)	(0.1)	0.0
PDC Dividend	(0.5)	0.1	0.6	(3.2)	(2.6)	0.6
Other Finance Costs	(0.1)	(0.0)	0.0	(0.3)	(0.0)	0.3
Control Total Surplus/(Deficit) (pre STF)	**(2.4)**	**(5.7)**	**(3.3)**	**(14.5)**	**(28.5)**	**(14.0)**
STF Income	1.4	0.0	(1.4)	7.5	0.0	(7.5)
Control Total Surplus/(Deficit) (post STF)	**(1.0)**	**(5.7)**	**(4.7)**	**(7.0)**	**(28.5)**	**(21.5)**
Gain/(Loss) on Asset Disposal	0.0	(0.1)	(0.1)	0.0	(0.1)	(0.1)
Donations and Grants Received	0.0	0.0	0.0	0.0	0.0	0.0
Depreciation on Donated Assets	0.0	0.0	0.0	0.0	0.0	0.0
Total Surplus/(Deficit) Before Impairments	**(1.0)**	**(5.8)**	**(4.8)**	**(7.0)**	**(28.6)**	**(21.6)**
Impairment (Losses) / Reversals	0.0	0.0	0.0	0.0	0.0	0.0
Surplus / (Deficit) After Impairments	**(1.0)**	**(5.8)**	**(4.8)**	**(7.0)**	**(28.6)**	**(21.6)**

2.2 Operating Expenditure Analysis

The adverse operating expenditure variance of (£2.2m) in month and (£7.6m) 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	10.7	11.4	(0.7)	63.1	66.7	(3.6)
Nursing	14.6	15.3	(0.7)	88.3	92.5	(4.2)
Other	12.2	11.5	0.6	73.3	69.8	3.5
Total Pay	**37.5**	**38.2**	**(0.8)**	**224.7**	**229.1**	**(4.3)**
NON PAY						
Drugs	6.2	6.2	0.0	37.3	37.5	(0.3)
Clinical Supplies & Services	6.0	6.3	(0.3)	36.0	36.4	(0.4)
Other	9.3	10.4	(1.1)	55.7	58.3	(2.6)
Total Non Pay	**21.5**	**23.0**	**(1.5)**	**129.0**	**132.2**	**(3.2)**
GRAND TOTAL	**58.9**	**61.2**	**(2.2)**	**353.7**	**361.3**	**(7.6)**

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 quarters 1 and 2 averages in 2017/18.

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	Mth 6
MEDICAL & DENTAL	10.5	10.5	11.0	11.0	10.9	11.3	11.4
NURSING & MIDWIFERY	15.3	14.9	15.1	15.5	15.5	15.4	15.3
OTHER SUPPORT STAFF	4.8	5.0	4.8	4.8	4.8	4.8	4.8
PAMS	2.2	2.2	2.2	2.2	2.2	2.3	2.3
PROFESSIONAL & TECHNICAL (PTB)	2.3	2.2	2.3	2.3	2.4	2.3	2.3
SCIENTIFIC & PROFESSIONAL	0.6	0.7	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
Pay Total	**37.4**	**37.3**	**37.7**	**37.9**	**38.0**	**38.3**	**38.2**

Overall the monthly average pay costs have increased by a further (£0.3m) in quarter 2 compared to quarter 1, predominantly within medical staffing. The main areas of increase compared to quarter 2 of 2016/17 (after inflation adjustment) relate to Medical staffing (increase of £0.8m) and Nurse staffing (increase of £0.5m).

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 £11.4m in September, which is (£0.1m) higher than the expenditure in August and is (£0.5m) higher than the rolling twelve month average (adjusted for pay inflation) overall.

The September expenditure on consultant medical staff was £6.4m which is broadly in line with August. September expenditure on non-consultant staff was £5.0m which is a further (£0.1m) higher than in August.

Table 5.1: Senior Medical Expenditure per Month

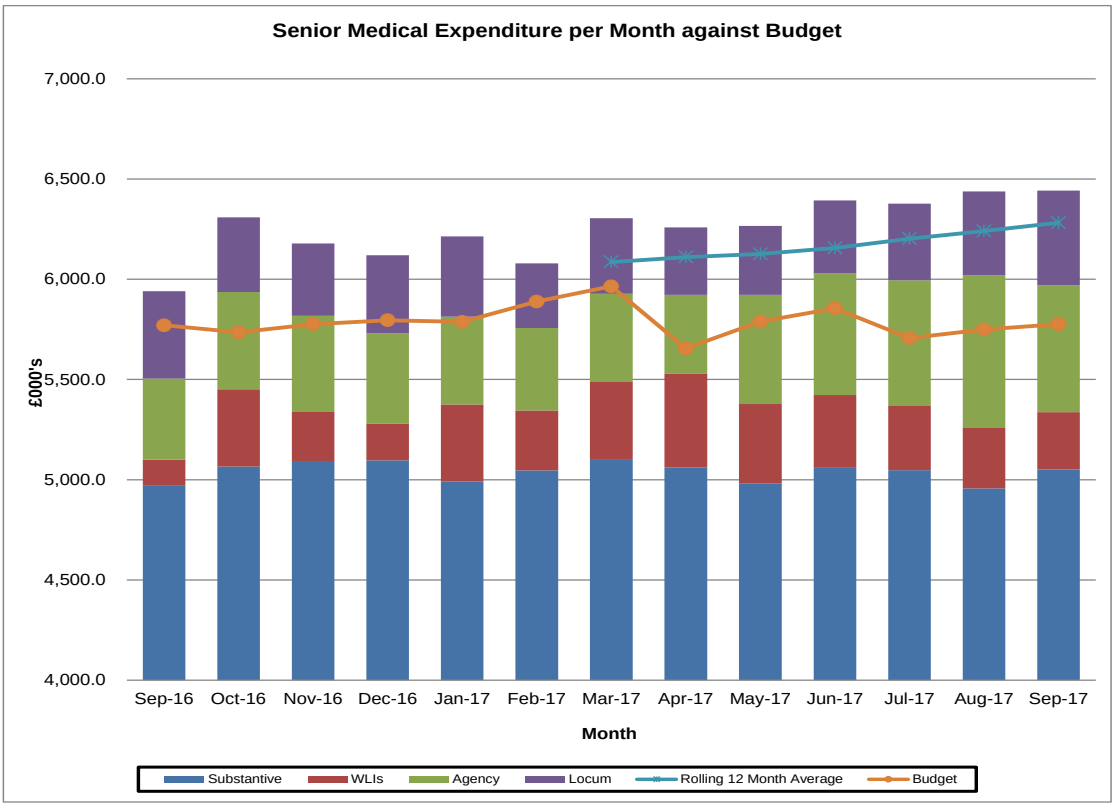
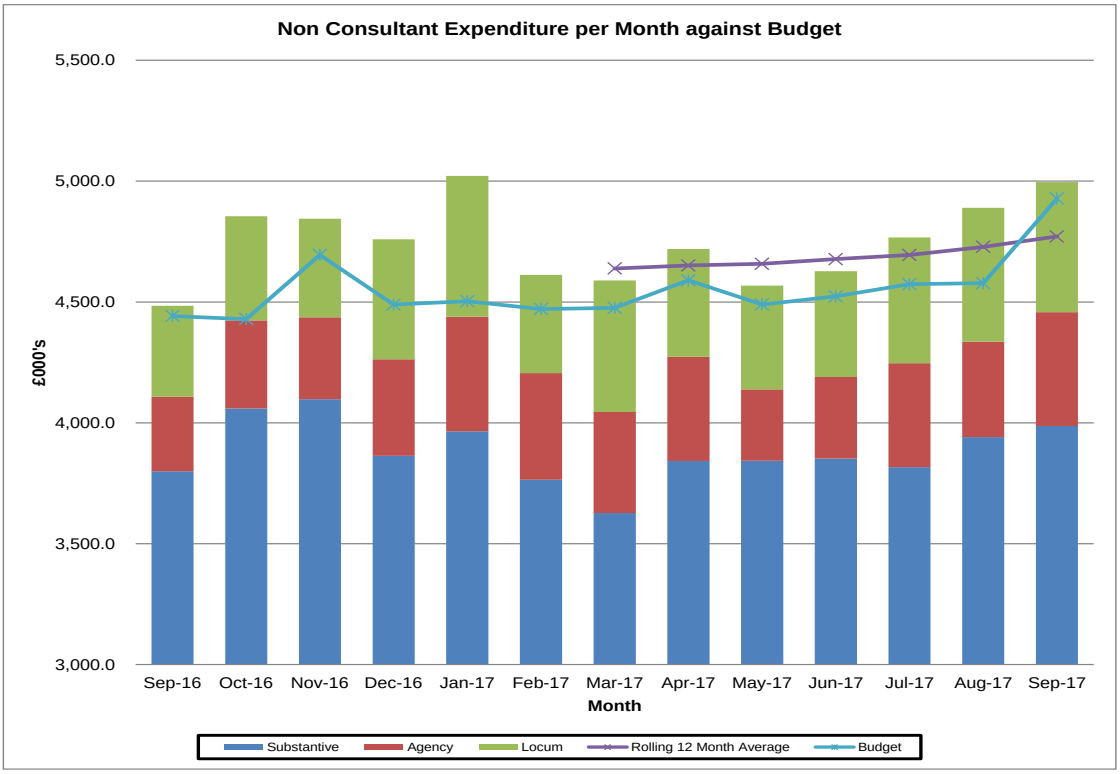


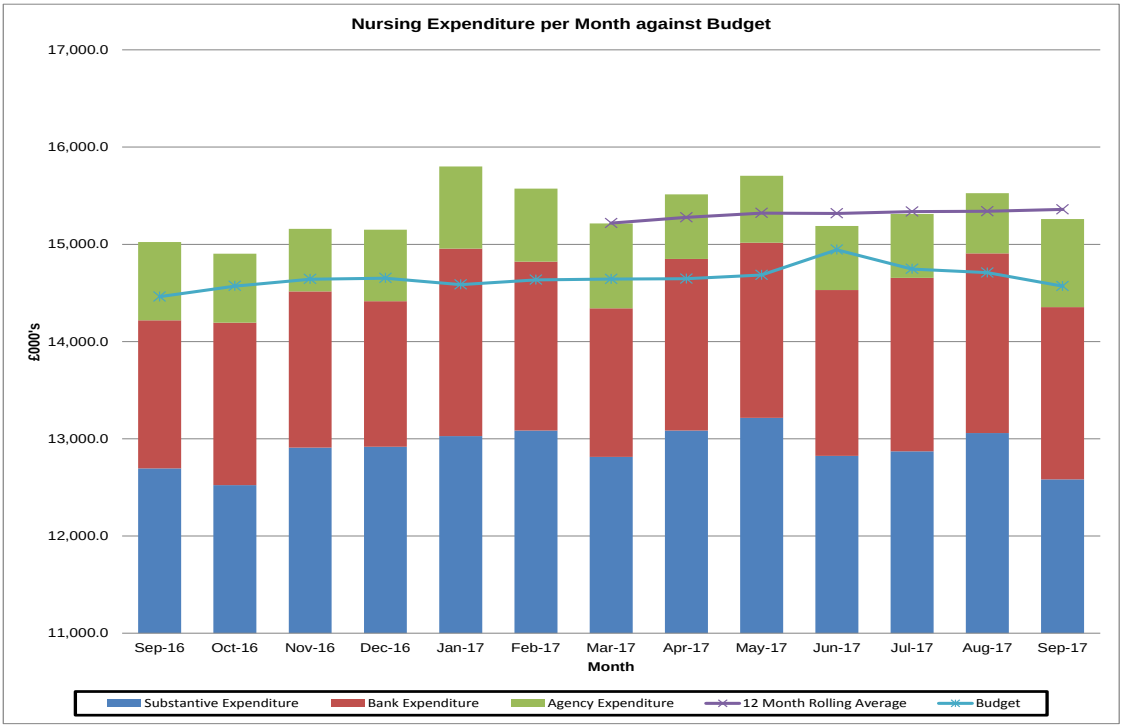
Table 5.2: Non-Consultant Medical Expenditure per Month



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 September was £15.3m which is £0.2m lower than the expenditure in August and is £0.1m lower 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 and 2 averages 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	Mth 6
Clinical Supplies	5.8	5.7	5.9	6.2	6.0	6.1	6.3
Drugs	5.8	6.1	6.0	6.3	6.2	6.3	6.2
Less: Pass Through Items	(5.9)	(6.5)	(6.5)	(6.6)	(6.2)	(6.5)	(6.7)
Clinical Supplies and Drugs Subtotal	***5.6***	***5.4***	***5.5***	***5.8***	***6.0***	***6.0***	***5.9***
Non-Clinical Supplies	1.6	1.6	1.6	1.7	1.6	1.6	1.6
Premises	2.5	2.5	2.6	2.8	2.6	2.8	2.8
Purchase of Healthcare Services NHS	0.7	0.7	0.6	0.5	0.6	0.7	0.7
Purchase of Healthcare Services Non NHS	0.6	0.6	0.4	0.4	0.6	0.6	0.6
Other	5.2	3.7	3.1	3.4	4.2	4.3	4.8
Grand Total	**16.2**	**14.5**	**13.8**	**14.7**	**15.5**	**15.8**	**16.3**

2.4.1 Drugs and Clinical Supplies and Services

The expenditure on drugs and clinical supplies increased to £12.6m in September, an increase of (£0.6m), but was largely offset by an increase in cost per case drugs and devices of £0.5m for which additional healthcare income will be received. The quarterly averages in table 7 above show that the costs of clinical supplies and drugs which are within tariff, have remained broadly consistent through quarters 1 and 2, but remain (£0.6m) higher than the quarter 2 average in 2016/17.

2.4.2 Other Non-Pay

The increase in the other non-pay expenditure reflects the costs associated with a permanent injury charge claim recognised in the month.

2.5 Divisional Performance

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	(461.3)	(459.6)	(1.7)	(2,697.4)	(2,658.9)	(38.4)
	NON PAY EXPENDITURE	2,588.7	3,242.2	(653.5)	14,719.6	17,046.6	(2,327.0)
	PAY EXPENDITURE	7,974.1	8,024.2	(50.1)	47,359.8	48,201.9	(842.1)
D1 Total		**10,101.5**	**10,806.9**	**(705.4)**	**59,382.0**	**62,589.5**	**(3,207.5)**
D2	INCOME	(431.0)	(371.4)	(59.6)	(2,611.8)	(2,461.3)	(150.5)
	NON PAY EXPENDITURE	1,038.8	1,214.5	(175.7)	6,246.4	7,200.8	(954.5)
	PAY EXPENDITURE	4,641.3	4,654.0	(12.7)	28,871.3	28,821.1	50.2
D2 Total		**5,249.1**	**5,497.1**	**(247.9)**	**32,505.9**	**33,560.7**	**(1,054.8)**
D3	INCOME	(344.2)	(313.1)	(31.1)	(1,920.3)	(1,822.0)	(98.3)
	NON PAY EXPENDITURE	2,530.5	2,794.9	(264.4)	15,039.1	16,558.7	(1,519.6)
	PAY EXPENDITURE	7,579.0	8,134.3	(555.3)	44,866.0	47,925.3	(3,059.4)
D3 Total		**9,765.3**	**10,616.1**	**(850.8)**	**57,984.9**	**62,662.1**	**(4,677.2)**
D4	INCOME	(194.0)	(187.4)	(6.6)	(1,146.6)	(1,287.1)	140.5
	NON PAY EXPENDITURE	4,237.3	4,410.2	(172.9)	25,294.5	27,595.3	(2,300.9)
	PAY EXPENDITURE	6,459.2	6,706.4	(247.3)	38,587.4	40,064.5	(1,477.1)
D4 Total		**10,502.5**	**10,929.3**	**(426.8)**	**62,735.3**	**66,372.8**	**(3,637.5)**
D5	INCOME	(139.1)	(147.3)	8.3	(834.7)	(899.1)	64.4
	NON PAY EXPENDITURE	3,747.7	3,527.8	219.9	21,877.1	21,279.4	597.7
	PAY EXPENDITURE	5,446.0	6,009.6	(563.7)	32,573.2	35,611.3	(3,038.1)
D5 Total		**9,054.6**	**9,390.2**	**(335.5)**	**53,615.7**	**55,991.6**	**(2,376.0)**
Grand Total		**44,673.1**	**47,239.5**	**(2,566.4)**	**266,223.7**	**281,176.7**	**(14,953.0)**

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

- Division 1 (CSS) - Radiology (£253k) non pay predominantly on clinical supplies and outsourcing of reporting, (£180k) pay primarily on Radiographer bank and agency premium rate cover. Theatres pay of (£23k) on nursing and professional and technical staffing.

- Division 2 (W&C) - Obstetrics (£104k) non pay and Paediatrics (£53k) non pay primarily due to unmet CIP targets. Income under-performance of (£60k) predominantly due to reduced Maternity PbR income from other organisations.

- Division 3 (Emergency) - Nursing overspends of (£449k) across the division with (£235k) in Accident and Emergency, (£108k) in Acute Medicine and (£37k) in Respiratory. Medics overspend of (£149k) across the division with Accident and Emergency presenting the biggest pressure at (£182k). 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) - Unmet CIP targets in non-pay across the division with Elderly Care and Therapies presenting the biggest pressures in this area. Drug overspends of (£222k) driven by Clinical Haematology and Oncology (£175k). Nursing overspends of (£78k) driven by Elderly Care (£78k). Medic overspends of (£101k) with the biggest pressure in Elderly Care (£68k).

- Division 5 (Surgery) - Medical overspends of (£517k) with the biggest pressures in Trauma and Orthopaedics (£235k) and Gastroenterology (£166k).

2.6 Income Analysis

2.6.1 Total Operating Income

Total operating income (excluding STF) is (£2.1m) below plan in September taking the year to date under-performance to (£7.8m) as shown in table 9 below.

Table 9 – Income against Plan

	In Mth Plan September £m	In Mth Actual September £m	Variance £m	YTD Plan September £m	YTD Actual September £m	Variance £m
Clinical - NHS	(52.7)	(51.6)	(1.2)	(316.3)	(313.5)	(2.8)
Clinical - Non NHS	(0.9)	(0.7)	(0.2)	(4.6)	(4.4)	(0.1)
Other	(4.8)	(4.1)	(0.7)	(29.9)	(25.1)	(4.8)
TOTAL	**(58.5)**	**(56.4)**	**(2.1)**	**(350.8)**	**(343.0)**	**(7.8)**

NHS Clinical Income is a further (£1.2m) below plan in September moving the year to date under-performance to (£2.8m). Within this, excluded drugs and devices were £0.6m above plan in September with over-performance of £1.9m for the year to date.

The remaining variance of (£1.8m) under-performance in September against the seasonal healthcare income target related to activity moves the year to date under-performance to (£4.7m).

The main areas of variance during September and year to date are detailed in table 10 below:

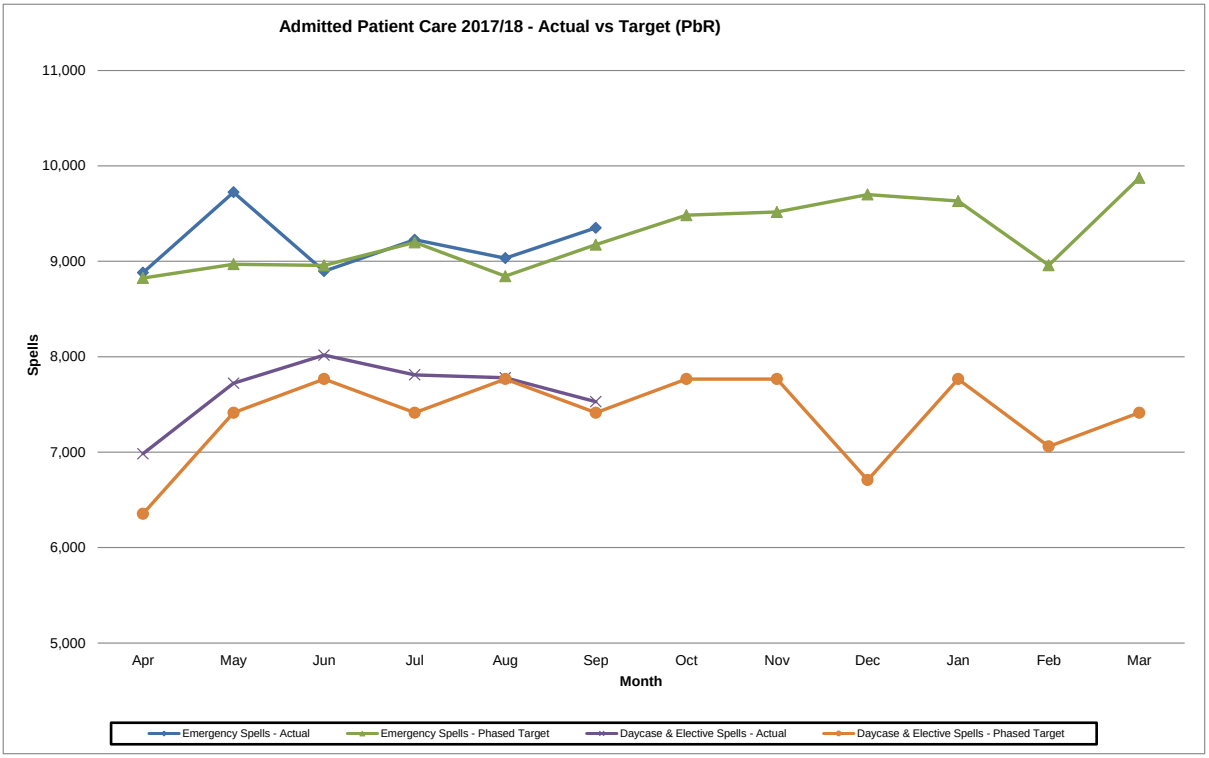
Table 10 – Healthcare Income Variances by Point of Delivery

	In Month Variance	YTD Variance
Maternity Spells/Pathways	(0.5)	(1.3)
Emergency Activity	(0.1)	0.2
Accident and Emergency	0.1	0.5
Elective/Daycase Spells	(0.6)	(1.3)
Outpatients	(0.3)	(1.6)
Other	(0.4)	(1.2)
Grand Total	**(1.8)**	**(4.7)**

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 September.

Table 11.1: Trust Inpatient Activity



The September in-month activity position reflects a 1.9% over-performance in emergency pathways (175 spells) against the seasonally phased plan, resulting in year to date over-performance against the seasonal plan of 2.1% (1,142 spells). Emergency ambulatory work continues to over-perform by 240 spells in the month whilst emergency inpatient admissions have this month under-performed by (58) spells.

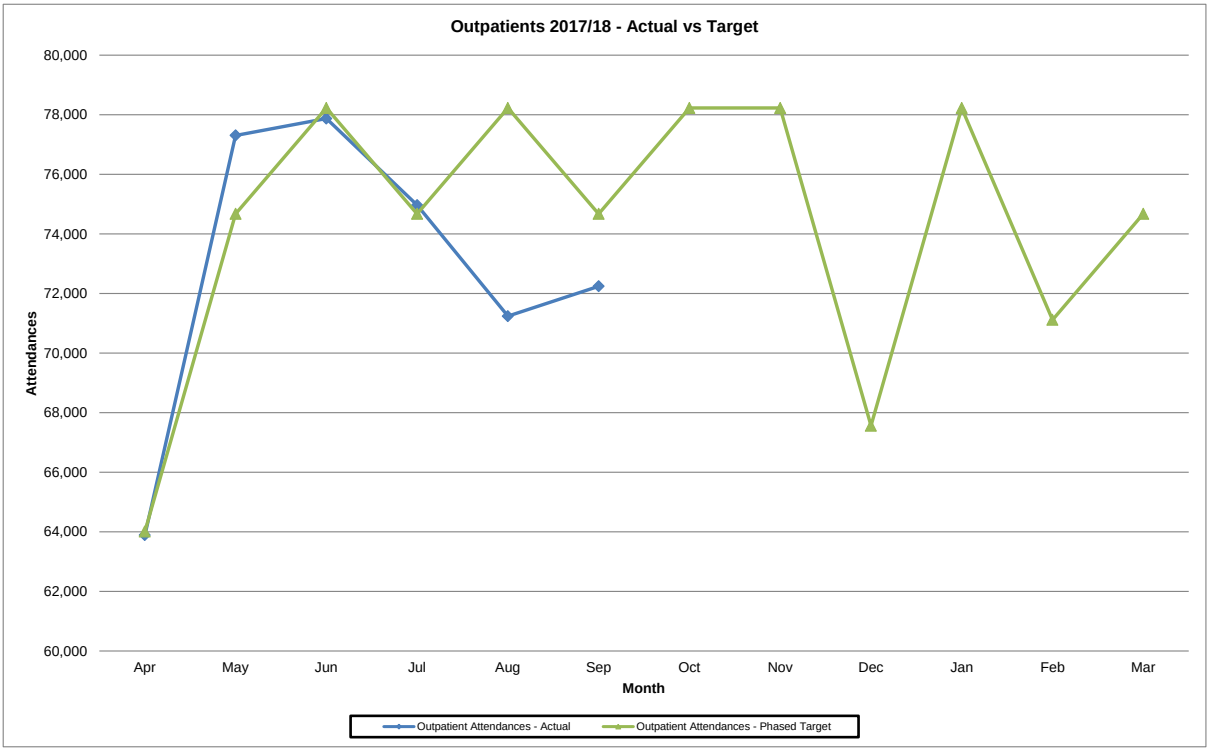
A&E activity has shown a (0.6%) under-performance in September (131 attendances) increasing the year to date under-performance to (0.4%), (482 attendances).

The elective and daycase activity was 1.6% above plan in September (116 cases) taking the year to date over-performance to 3.9% (1,713 cases).

2.6.3 NHS Clinical Income/Activity – Outpatients

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

Table 11.2: Trust Outpatient Activity



Outpatient activity in month has under-performed by (3.3%) in September (2,430 attendances) taking the year to date position to under-performance of (1.6%) (6,969 attendances). The main areas of over-performance in the month are within Cardiology (571 attendances, 11.5%) and Ophthalmology (471 attendances, 6.8%). Largest areas of under-performance in the month relate to Therapies (1,518 attendances, 18.3%), Diabetes (668 attendances, 15.9%) and ENT (392 attendances, 10.6%).

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	607	(75)	(1,032)	**(499)**
2 - W&C	(230)	(398)	(1,991)	**(2,620)**
3 - Emergency	386	635	(656)	**365**
4 - Medicine	(1,994)	(1,474)	(569)	**(4,038)**
5 - Surgery	(308)	(362)	(624)	**(1,294)**
Central Risks	0	0	3,311	**3,311**
Total	**(1,540)**	**(1,673)**	**(1,562)**	**(4,775)**

2.6.5 Other Miscellaneous Operating Revenue

The adverse variance of (£0.7m) against the planned other operating revenue in September is broadly in line with previous months and is predominantly driven by slippage on income cost improvement schemes of (£0.5m) built into the plan.

2.7 Year End Forecast

The Trust has 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 (excluding 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 has been reasonably positive with regard to the controls in place and there was an acknowledgement of the scale of the challenge facing the Trust, however it is not yet clear whether the revised forecast will be accepted.

It should be noted that the further adverse movement in month 6 within Healthcare Income, is contrary to the assumption that this will recover back in line with plan and therefore this presents a significant downside risk attached to the forecast.

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 September 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	238.9	108.1	784.8	845.1	60.3	1,569.6	1,476.7
FACILITIES	146.4	137.1	(9.3)	878.4	648.4	(230.0)	1,756.7	1,260.6
TRUSTWIDE EDUCATION SERVICES	33.6	106.4	72.8	201.8	106.4	(95.3)	403.5	911.5
RESEARCH & INNOVATION	8.1	0.0	(8.1)	48.5	0.0	(48.5)	96.9	0.0
CSS	209.7	130.0	(79.7)	1,258.4	730.0	(528.4)	2,516.7	2,111.4
WOMENS & CHILDRENS	106.3	38.0	(68.3)	637.7	232.0	(405.7)	1,275.3	511.0
EMERGENCY CARE	185.3	162.3	(23.0)	1,111.7	573.0	(538.7)	2,223.3	2,166.1
MEDICINE	202.9	503.2	300.3	1,217.4	956.2	(261.2)	2,434.8	2,139.2
SURGERY	171.5	87.0	(84.5)	1,029.0	451.0	(578.0)	2,058.0	2,358.3
TOTAL	**1,194.6**	**1,403.0**	**208.4**	**7,167.4**	**4,542.1**	**(2,625.3)**	**14,334.8**	**12,934.8**

The variance against the year to date target of (£2.6m) reflects a combination of slippage on schemes initially identified to deliver year to date (£0.6m), planned phasing adjustments (£1.3m) and target with schemes unidentified (£0.7m).

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 £4.7m, the delivery against which is detailed in table 14 below.

Table 14: Year 2 Cross Cutting Schemes

Month 6							
Workstream / Project	**Scheme Start**	**In Mth Target**	**In Mth Actual**	**YTD Target**	**YTD Actual**	**Full Year Target**	**Full Year Forecast**
Length of Stay	Jun-17	104	0	417	0	1,042	0
Theatre Productivity	Apr-17	44	44	258	258	524	524
Diagnostics	Apr-17	8	8	50	8	100	58
Procurement: National & Local Standardisation	Apr-17	2	2	29	29	41	41
Procurement: UHB Alignment	Aug-17	68	50	136	80	544	600
Procurement: Direct Source Pricing	Aug-17	17		33	0	133	0
Procurement: GHX Renewal	Oct-17	0		0	0	114	0
Procurement: Review 111 Other Contracts	Oct-17	0		0	0	114	0
Procurement: Mobile Phones	Apr-17	2	2	11	11	22	22
Medical: International Fellows	Apr-17	0		0	0	0	0
Medical: Business Case Pipeline	Jun-17	23	0	136	0	272	0
Medical: E-rostering & Compliance with Policies	Jul-17	0		0	0	0	0
Nursing: Matron Review	Apr-17	9	9	55	55	111	111
Nursing: E-rostering & Compliance with Policies	Jun-17	83	0	255	0	755	125
Nursing: ACP	Sep-17	57	19	82	44	426	194
Corporate: Updated Communications	Apr-17	2	2	12	13	25	25
A&C: Balance to full year effect of restructures	Apr-17	65	65	350	350	698	698
Grand Total		**485**	**202**	**1,824**	**847**	**4,921**	**2,398**
Balance to find from original FRP following validation				*658*	*0*	*1,315*	
Balance to find from stretch targets				*2,450*	*0*	*4,900*	
Total FRP/Stretch Target				**4,932**	**847**	**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 (£1.0m) slippage on the planned delivery to date and (£0.6m) of under-delivery in the position which relates to the planned phasing of the schemes. A further (£3.1m) 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). Work continues to try to identify further programmes to close this gap.

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 (£3.9m) 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 30 September 2017.

Table 15: Statement of Financial Position

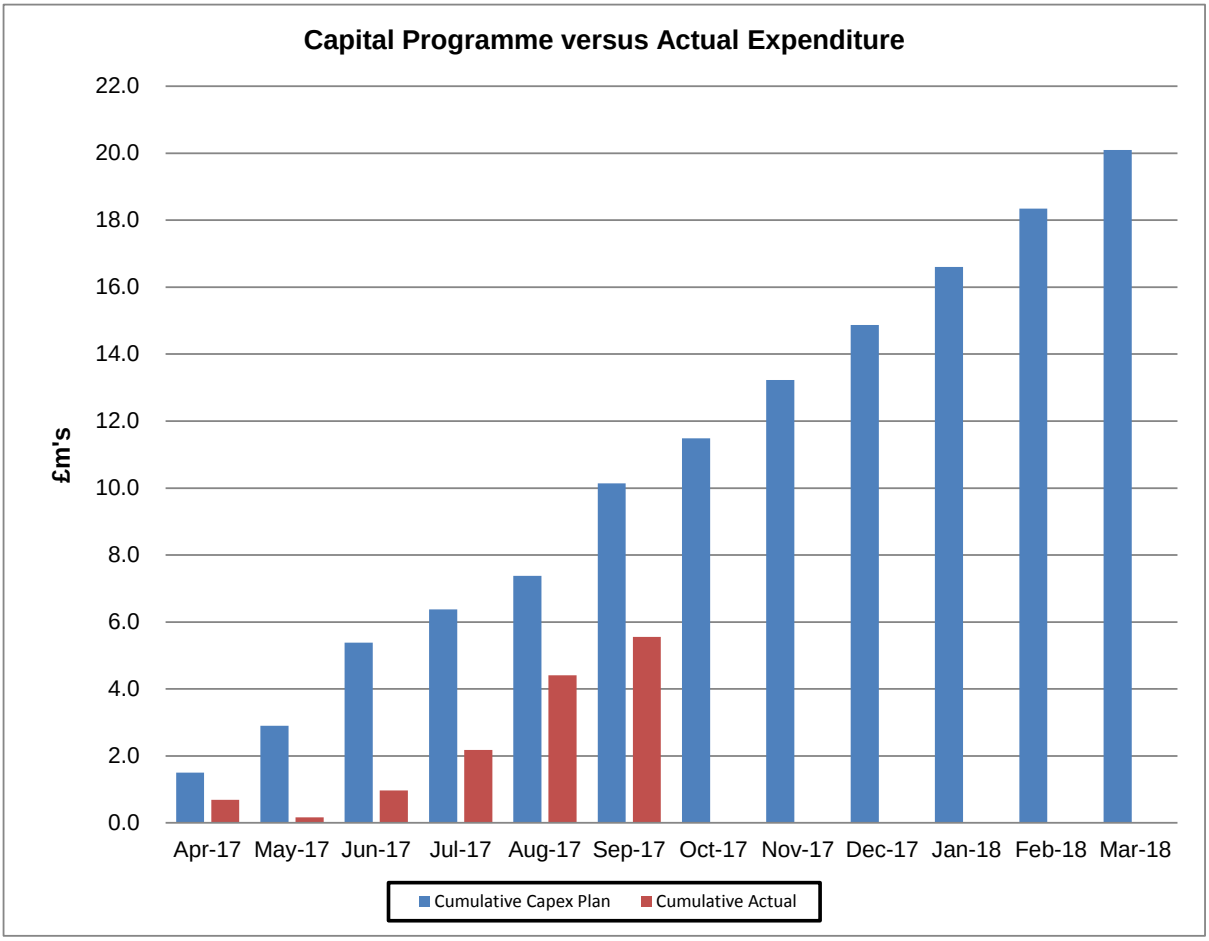
		Actual Mar-17 £m	Actual Sep-17 £m	Plan Sep-17 £m	Annual Plan Mar-18 £m
Non Current Assets:					
	Property, Plant and Equipment	248.1	246.0	257.4	259.8
	Intangible Assets	2.0	1.9	9.4	9.1
	Trade and Other Receivables	1.0	1.3	1.6	1.6
	Other Assets	3.8	3.7	3.7	3.6
	Total Non Current Assets	**254.8**	**253.0**	**272.1**	**274.0**
Current Assets:					
	Inventories	10.7	11.0	11.0	10.0
	Trade and Other Receivables	32.2	93.1	46.1	43.8
	Cash	19.2	16.4	3.0	3.0
	Total Current Assets	**62.2**	**120.4**	**60.1**	**56.8**
Current Liabilities:					
	Trade and Other Payables	(102.4)	(116.9)	(101.6)	(98.8)
	Borrowings	(0.5)	(0.5)	(0.5)	(0.5)
	Working Capital Loan	0.0	(9.8)	(1.0)	(3.5)
	Provisions	(3.2)	(3.7)	(2.9)	(2.4)
	Tax Payable	0.0	0.0	0.0	0.0
	Other Liabilities	(6.3)	(58.0)	(6.5)	(6.5)
	Total Current Liabilities	**(112.4)**	**(188.8)**	**(112.4)**	**(111.6)**
Non Current Liabilities:					
	Borrowings	(3.3)	(3.1)	(3.1)	(6.0)
	Provisions	(6.2)	(6.2)	(5.8)	(5.8)
	Other Liabilities	0.0	(0.4)	(3.0)	0.0
	Total Non Current Liabilities	**(9.5)**	**(9.6)**	**(11.9)**	**(11.8)**
TOTAL ASSETS EMPLOYED		**195.1**	**174.9**	**207.8**	**207.3**
Financed by:					
	Public Dividend Capital	196.7	196.7	196.7	196.7
	Income and Expenditure Reserve	(45.9)	(74.0)	(42.8)	(42.7)
	Donated Asset Reserve	(0.2)	(0.2)	(0.2)	(0.2)
	Revaluation Reserve	52.9	52.4	54.1	53.5
	Merger Reserve	0.0	0.0	0.0	0.0
TOTAL TAXPAYERS EQUITY		**203.5**	**174.9**	**207.8**	**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 September. Expenditure to date is £5.6m against a plan at this point of £10.1m, slippage of (£4.5m) against the plan. The most notable items of slippage relate to medical equipment replacement (£4.9m) and enabling works costs associated with ACAD of (£1.1m) offset by ahead of plan expenditure within ICT of £1.4m.

Table 16: Capital Programme Trajectory vs Actuals



6. Current Assets

The Trust's total current assets (excluding cash and inventories) amount to £93.1m at 30 September 2017 an increase of (£4.0m) during September and (£46.9m) higher than plan. The balance is broken down as detailed in table 17 below.

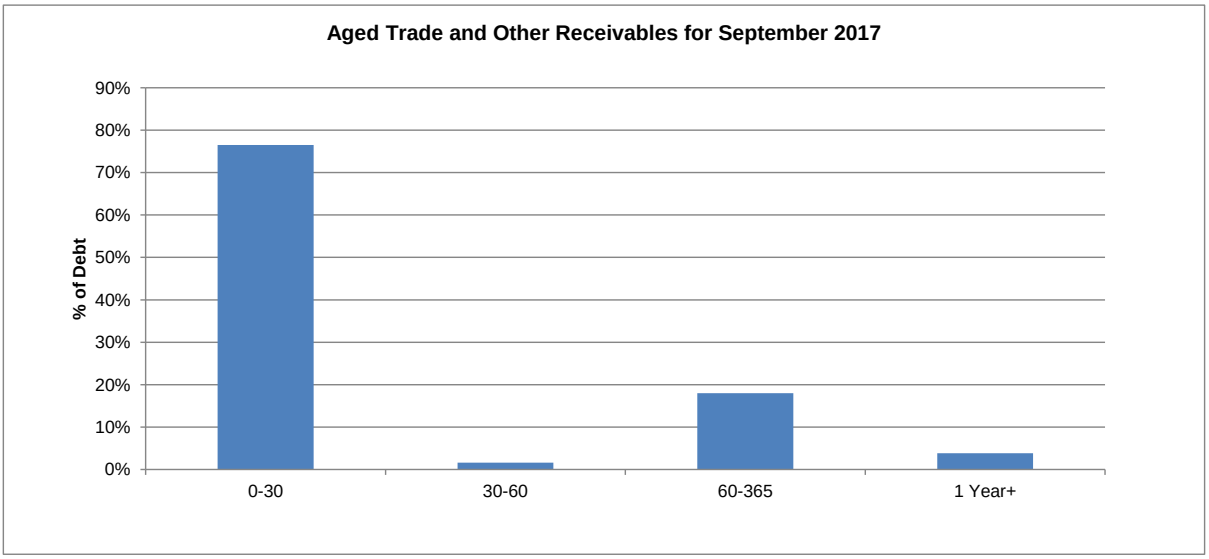
Table 17: Analysis of Current Assets (excluding Inventories and Cash)

	YTD Actual September 2017 £m	YTD Plan September 2017 £m
Trade Receivables	85.3	42.1
Bad Debt Provision	(11.9)	(9.3)
Other Receivables	2.2	2.3
Trade and Other Receivables	**75.7**	**35.1**
Accrued Income	3.0	3.5
Other Financial Assets	**3.0**	**3.5**
Prepayments	14.4	7.5
Other Current Assets	**14.4**	**7.5**
TOTAL	**93.1**	**46.1**

The main movement against the plan is as a result of billing commissioners earlier for the mandate payment, in order to ensure the cash is received into the Trust in a timely manner. This results in increased trade receivables at the end of each month offset by increased deferred income (within Other Liabilities).

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 £17.1m of which £9.5m relates to CCG/NHS England healthcare income contracts within the top 10 balances. This represents an overall increase of (£0.1m) on the position at the end of August 2017. The top balances (outside of CCG/NHS England Healthcare Income contracts) are:

- Burton Hospitals Foundation Trust (£0.9m > 30 days, £1.1m total) – this is a reduction of £0.2m on both the greater than 30 days and the total debt from the position at the end of August 2017. Debt associated with maternity pathways for 15/16 and 16/17 accounts for (£0.4m), with a further (£0.5m) relating to current year maternity pathway queries. The remainder relates to ad hoc recharges which are currently being validated. The queries around the 2016/17 contract remain under discussion.

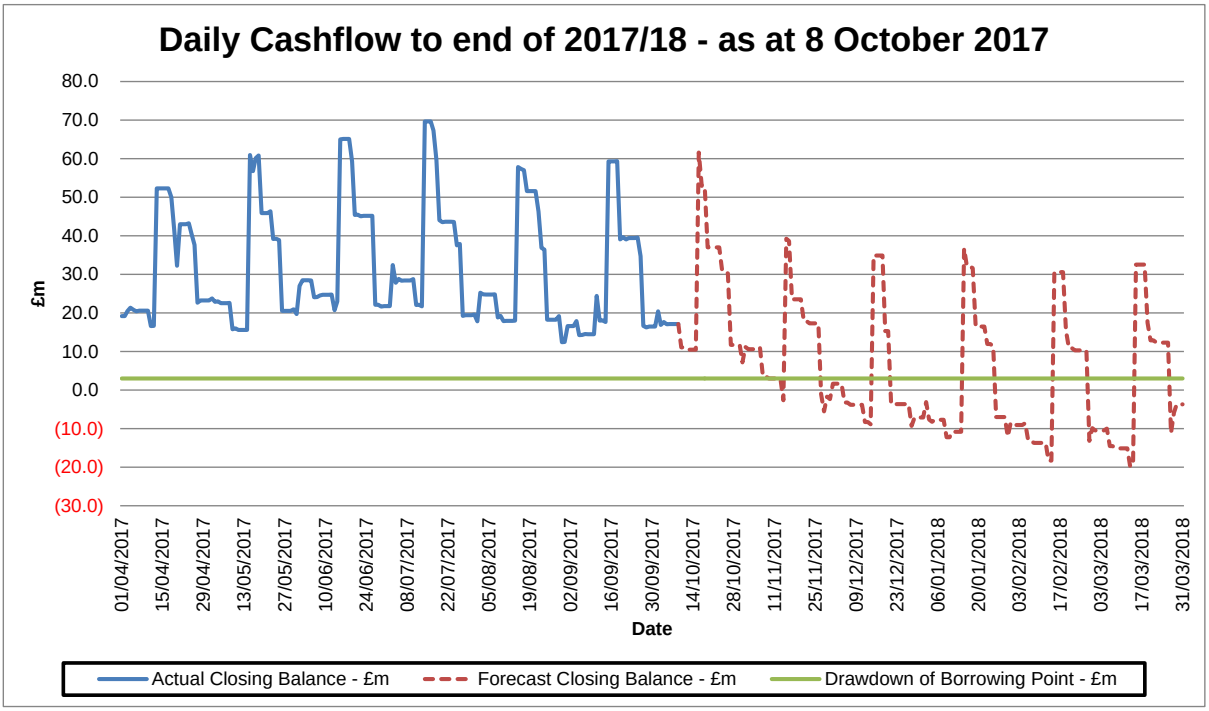
- Sandwell and West Birmingham Trust (SWBH) (£0.6m > 30 days, £0.9m total) – this is an increase of (£0.1m) on both the overdue debt and the total debt compared to August 2017. The majority of the overdue debt relates to prior year surgical SLA provision.

7. Cash Flow

The cash balance at the end of September 2017 was £16.4m, an increase of £4.0m during September and a positive variance of £13.4m against the planned balance of £3.0m. However during September, the Trust made its first drawdown against its working capital facility and therefore the above balance includes £9.8m of loan funding.

Table 19 below details the anticipated cash balances to the end of the 2017/18 financial year, including the working capital draws in September and October but without any future 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 8 October



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 September 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%	(6.42)	4
	Liquidity (days)	20%	(40.21)	4
Financial Efficiency	I&E Margin	20%	(8.30%)	4
Financial Controls	Distance from Finance Plan	20%	(6.34%)	4
	Agency Spend	20%	(4.17%)	1

This rating is anticipated to continue throughout the financial year but is only being maintained through the Trust's delivery against the agency ceiling.

9. Conclusion

The Trust has recorded an overall deficit of (£5.8m) during month 6 of the 2017/18 financial year, an adverse variance of (£3.4m) against the planned deficit of (£2.4m) for the month pre STF. This moves the year to date deficit to (£28.6m) an adverse variance of (£14.1m) against the planned deficit pre STF of (£14.5m). As a result of under-delivering against the financial plan, the year to date allocation of £7.4m of STF has not been assumed.

A revised year end forecast has 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). Given the further unexpected shortfall in Healthcare Income in month 6, this forecast includes significant downside risk.

The Trust's cash balance as at 30 September 2017 was £16.4m, a favourable variance of £13.4m against the planned balance at this point. However, this includes cash of £9.8m received from a working capital loan facility.

10. Recommendations

The Council of Governors is requested to:

- Receive the contents of this report.

Julian Miller
Interim Director of Finance
17 October 2017

HEART OF ENGLAND NHS FOUNDATION TRUST

COUNCIL OF GOVERNORS

Monday 23rd October 2017

Title:	Quality Account Update for Quarter 2, 2017/18 (July – September 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 2, 2017/18 (July – September 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 2, 2017/18 Quality Account.

Approved by:	Dr David Rosser	17/10/17

HEART OF ENGLAND NHS FOUNDATION TRUST
COUNCIL OF GOVERNORS
Monday 23rd October 2017

QUALITY ACCOUNT UPDATE REPORT FOR QUARTER 2, 2017/18

PRESENTED BY EXECUTIVE MEDICAL DIRECTOR

1. **Introduction**

The aim of this paper is to present the Trust's Quality Account Update for Quarter 2, 2017/18.
The Council of Governors is asked to approve the contents of this report and Appendix A.

2. **Quarter 2, 2017/18 Quality Account Update**

2.1 The Quality Account Update report for Quarter 2, 2017/18 (July to September 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:

- Reducing delays and omissions in medication for Parkinson's Disease - Overall performance has continued to improve across the three hospital sites.
- Screening for sepsis – performance is similar to the previous quarter for both inpatients and emergency patients.
- Percentage of acute inpatients receiving antibiotics within one hour of being diagnosed with sepsis continues to improve. Performance for Emergency patients remains variable.
- There is no update for the implementation of the Surgical Site Infection bundle.
- There has been one MRSA bacteraemia apportioned to HEFT this quarter. The number of CDI cases has increased since Quarter 1 is currently below trajectory.

3. **Recommendations**

The Council of Governors is asked to:

- **Note** the content of the Quarter 2, 2017/18 Quality Account report.

Appendix A

Quality Account Update for Quarter 2, 2017/18 (July – September 2017)

Contents

Quality Account Update for Quarter 2, 2017/18 (July – September 2017)

Introduction

The Trust published its eighth 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 (C Diff) and MRSA

This report provides an update on the progress made for the period July to September 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

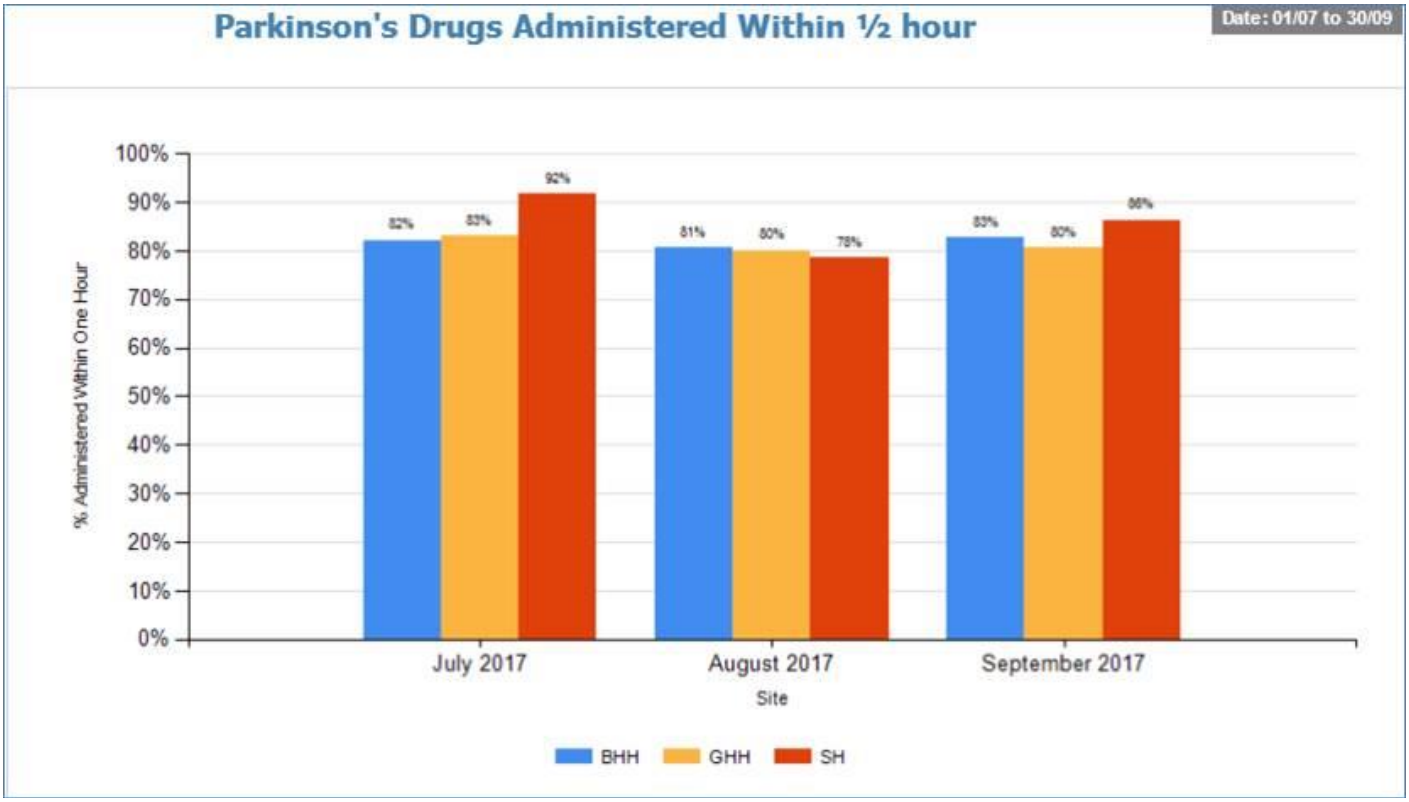
Overall performance has continued to improve across the three hospital sites and is 82% for Quarter 2, 2017/18. This is an improvement on the same period during 2016/17 and 2015/16 – see Table 1 below for detail.

It is expected that performance will continue to improve as the nurse responder bleep system is more widely utilised across all wards. In addition, the stocks of emergency PD medication have increased and have been added to the pharmacy out of hours cupboard to support timely administration.

Table 1 – Performance by Quarter, including previous Quarter 2's for comparison

			2017/18	
	2015/16 Q2	2016/17 Q2	Q1	Q2
Overall Trust % (Target 90% PD medication administered within 30 minutes)	58%	75%	81%	82%
Total doses prescribed	10320	9012	12784	12613
Total doses administered within 30 minutes	5967	6734	10344	10346
Total doses administered late	3467	1897	1969	1780
Total doses non-administered (omitted)	886	381	471	487

Graph – Quarter 2, 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 is currently being undertaken by the PD Quality Improvement team. This will identify and target any specific areas that require further improvement.

- An audit of omissions and delays in Parkinson medication has been undertaken in ED BHH (non-Electronic Prescribing area). Following this a PD sticker has been developed which is currently being trialled. The aim of the sticker is to prompt staff to think and act on Parkinson's medication at the time of triage.

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 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.

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

(September’s audit result were not available at the time of writing)

	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			
Quarter 2	38	75	50.7%

	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			
Quarter 2	80	90	88.9%

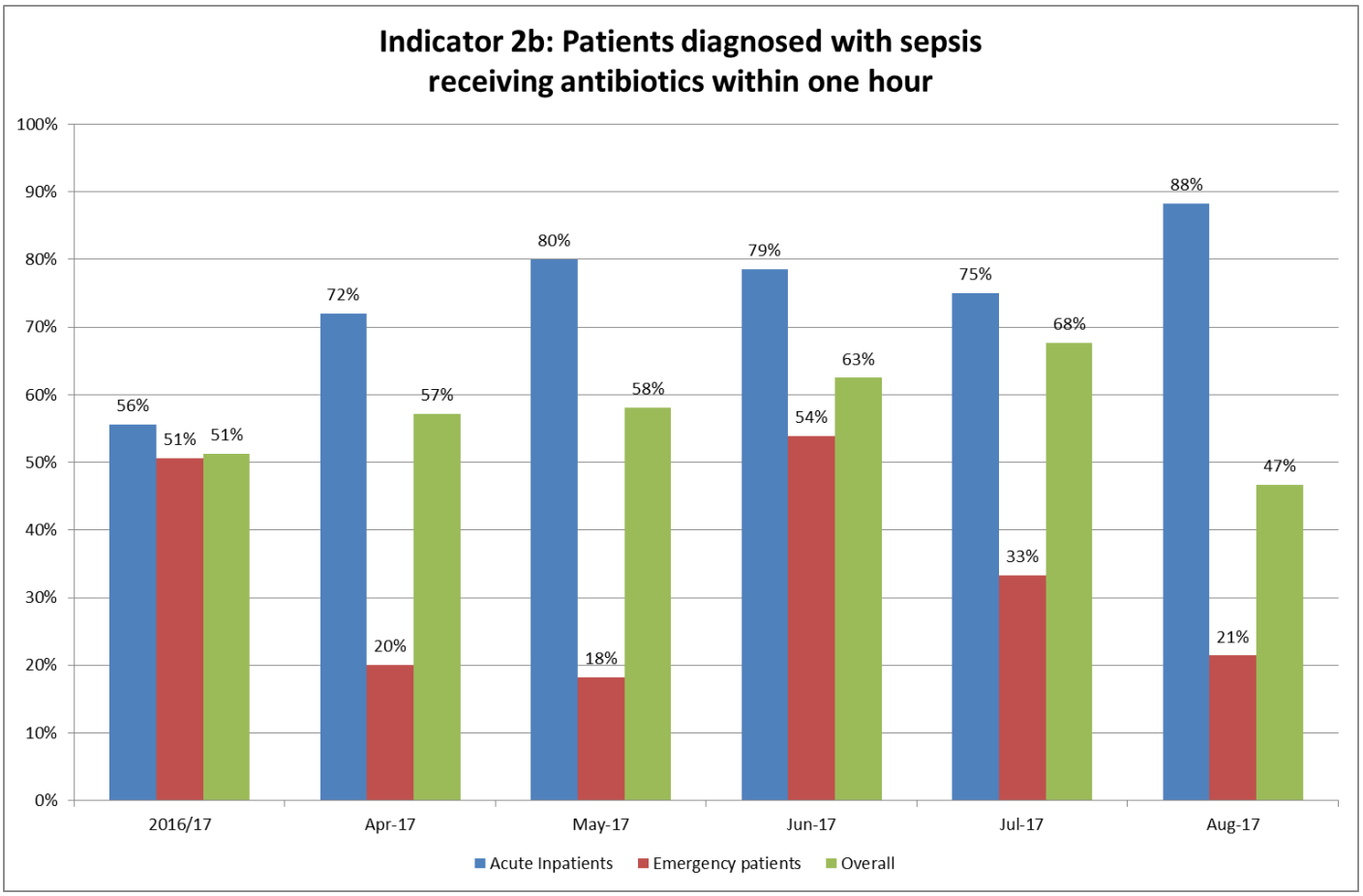
Indicator 2b: Percentage of patients diagnosed with sepsis who received antibiotics within 1 hour

Results by Quarter:

	2016/17	2017/18				
		Q1	Q2	Q3	Q4	YTD
Acute Inpatients	56%	76%	80%			78%
Emergency patients	51%	38%	24%			32%
Overall	51%	59%	56%			58%

Notes :
2016/17 data relates to Quarter 2 data only
2017/18 Quarter 2 data is July & August 2017 only

Results by month:



Note - 2016/17 data relates to Quarter 2 data only.

Initiatives to be implemented 2017/18

- Following the dissemination of the new sepsis pathway the nursing metric audits were updated to include the sepsis screening element of the pathway.
- A sepsis and deteriorating patient 'Lesson of the Month' is planned for October 2017.
- Learning from the 'Lesson of the Month' will be shared with the junior doctors at the Risky Business forums.
- The 2017 edition of the junior doctor's memory bank will include information on sepsis and the new sepsis pathway.

Admitting areas and inpatient wards

- The relaunched adult Modified Early Warning Score (MEWS) chart with new sepsis screening check boxes and new adult sepsis screening tool are both now in use.
- Rolling training is delivered to all new nurses at Trust induction via the new Acute Illness Management (AIM) course and to junior doctor risky business forums.
- The Divisional leads have been made aware of the changes to sepsis management and the requirements of the sepsis CQUIN.
- Rather than limit the Trust to the minimum CQUIN requirement, the sepsis team have identified those factors which we feel will most improve the clinical care of patients with sepsis and will include these in CQUIN data collection. This includes whether blood cultures were taken, the time band of antibiotic administration if beyond 1 hour, and whether patients fell into the sickest group. This will enable us to understand the potential clinical impact of improvement work, beyond CQUIN achievement.

Paediatrics

- Sepsis teaching sessions have been delivered to 108 of the paediatric staff (total 120); this includes qualified nurses (hospital and community based), health care assistants (HCA) and nursery nurses. Plans are underway to train all new starters as they arrive and training dates have been set to capture the remaining staff members. In July 2017 drop in sessions were increased to facilitate wider teaching.
- Doctors are attending ward based scenario sessions and Birmingham Children's Hospital is delivering RAPT training at the Good Hope Hospital (GHH) site for the multidisciplinary team.
- Sepsis scenarios continue to be included on the paediatric recognition and management of the deteriorating child study day which occurs monthly.
- A paediatric sepsis tool has been developed and piloted and is currently with the printing team; the patient safety team will assist with trust wide communication about the launch of the new form. Staff within paediatrics will receive face to face communication about the new form.
- The new version of the Paediatric Early Warning Score (PEWS) is now in place; this includes a prompt box on the right hand side to remind staff to consider sepsis. The introduction of a carer/nurse concern box allows staff to record parental concerns regarding subtle signs of deterioration.
- The patient safety team will support the paediatric directorate with communication and raising awareness with the revised PEWS and new sepsis pathway.
- The training programme to support the launch will include the lessons learned from serious incidents.

Maternity

- SSI prevention to be included as a MATNEOQI project.
- A new maternity sepsis tool and the updated MEOWS chart will be launched by the end of 2017 with support of midwifery trainers.

- Updated Caesarean section leaflet now in use to including correct information about pre-operative hair removal and advice to patients about post-operative wound care.
- Education and training on sepsis and the new pathway provided to new doctors at Trust induction.
- Results of surgical site infection (SSI) audit from Infection Control expected.

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 or Q2, 2017/18, and there are no updates to report for this quality priority.

[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 (C Diff) 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 2, 2017/18, there was one 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
HEFT Apportioned	4	7	0	1
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 2, 2017/18 HEFT reported 21 cases in total, of which 3[3] had lapses 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
Lapses in care	14	18	4	3*
Trust-apportioned cases	61	76	10	21
Agreed trajectory	64	64	64	

[3] * At the time of reporting, the cases for September 2017 had not 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 learned 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 96.72 for the period April 2016 – February 2017 which is within tolerance. The latest SHMI value for the Trust, which is available on the HSCIC website, is 96.58 for the period July 2015 – June 2016. 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 96.31 for the period February 2017 – March 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[56]. 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.

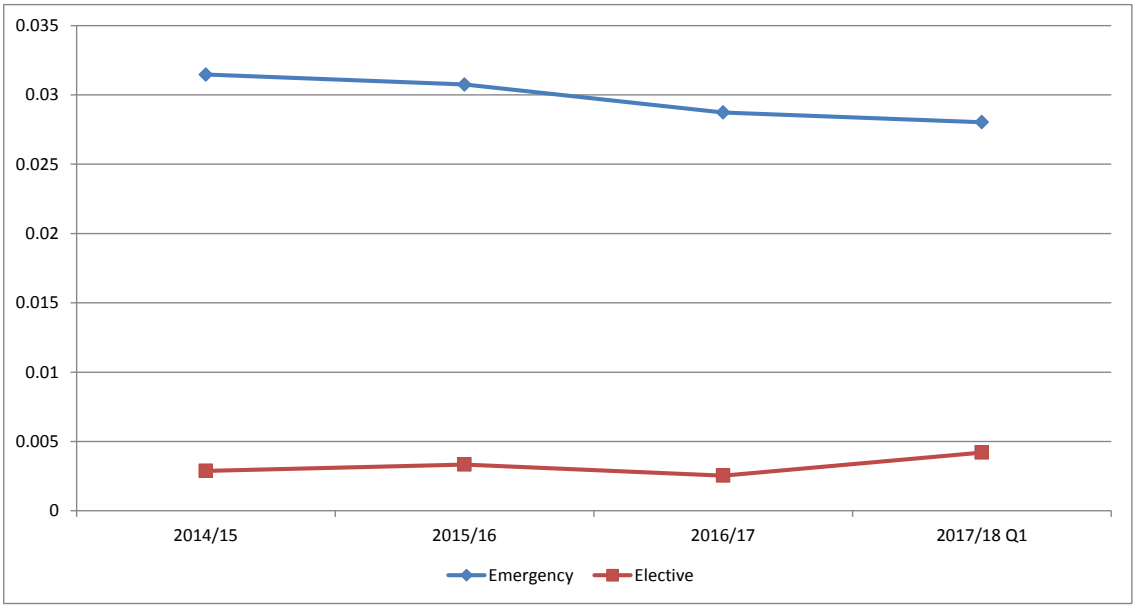
Crude Mortality

Quarter 2 data was not available at the time of reporting. The report will be updated when it becomes available.

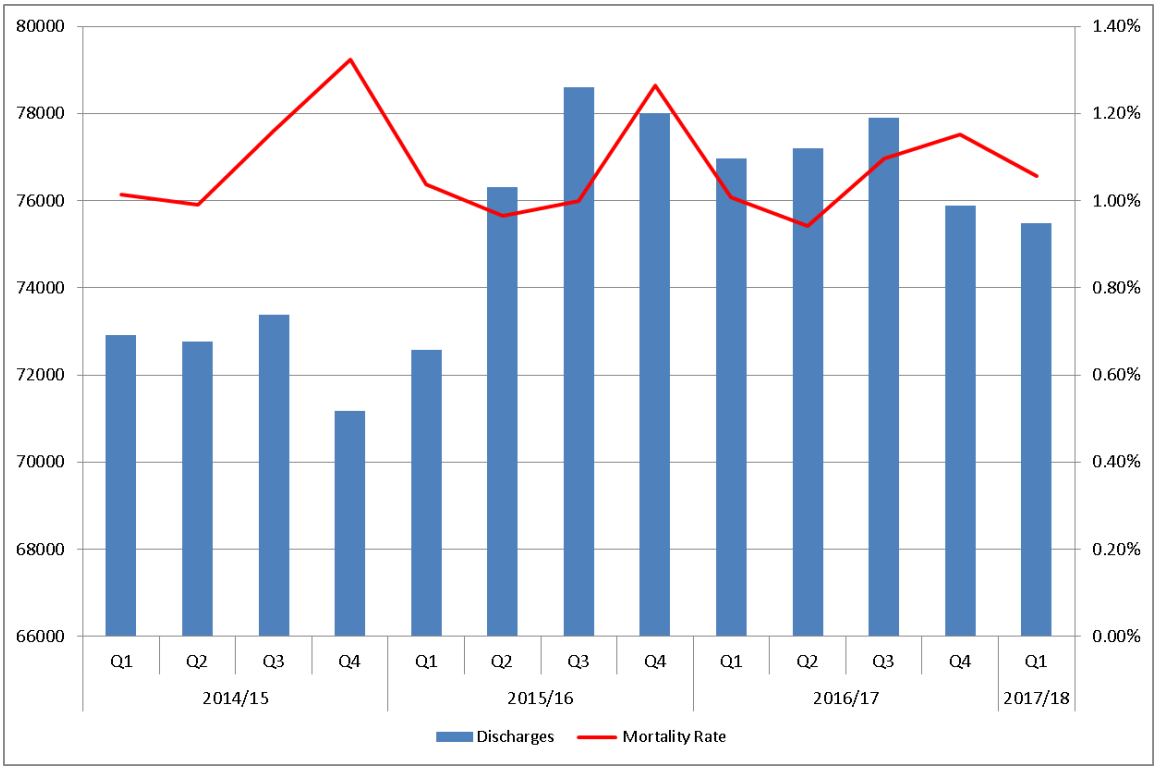
The first graph shows the Trust's crude mortality rates for emergency and non-emergency (planned) patients. The second graph below shows the Trust's overall crude mortality rate against activity (patient discharges) by quarter for the past two calendar years. The crude mortality rate is calculated by 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 1, 2017/18 was 1.06%, this was a slight increase on Quarter 1, 2016/17 (1.01%) and Quarter 1, 2015/16 (1.04%).

Emergency and Non-emergency Mortality Graph



Overall Crude Mortality Graph



Selected Metrics

Patient safety indicators
Quarter 2 data not yet available for all indicators.
Indicators marked with a * are Q1 only.

Indicator	Data source	2015/16	2016/17	2017/18 Q1-Q2	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	0.0*	**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	0.0*	**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	7.7*	**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	8.4*	**15.27** April 2016 – March 2017 Acute trusts in West Midlands

Indicator	Data source	2015/16	2016/17	2017/18 Q1-Q2	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*	**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	4	*Not available*
4a. Percentage of patient safety incidents which are no harm incidents *Higher % indicates better performance*	Provisional Datix	73%[9]	75%[10]	Data being validated	**89.4%** October 2016 – March 2017 Acute (non-specialist) hospitals NRLS website (Organisational Patient Safety Incidents Workbook)
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)

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

Indicator	Data source	2015/16	2016/17	2017/18 Q1-Q2	Peer Group Average (where available)
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]	9,610	**10,963** (6 months) October 2016 – March 2017 Acute (non-specialist) hospitals NRLS website (Organisational Patient Safety Incidents Workbook)

Clinical effectiveness indicators
(Quarter 2 data not yet available)

Indicator	Data Source	2015/16	2016/17	2017/18 Q1	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%	7.92%	England: **7.40%**
5b. Emergency readmissions within 28 days (%) (all specialties) *Lower % indicates better performance*	HED data	7.99%	8.23%	8.19%	England: **7.54%**
5c. Emergency readmissions within 28 days of discharge (%) *Lower % indicates better performance*	PMS 2	15.15%	15.09%	15.09%	*Not available* This is the information used in the Trust's LOS Board reporting. Latest Position YTD (April – August 2017): **14.92%**

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

Indicator	Data Source	2015/16	2016/17	2017/18 Q1	Peer Group Average (where available)
6. Falls (incidents reported as % of patient episodes) *Lower % indicates better performance*	Datix and Trust admission data	0.98%	1.23%	1.23%	*Not available*
7. Stroke in-hospital mortality *Lower % indicates better performance*	SSNAP data	11.64%	11.04%	13.25%	*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, 7: The majority of the data is due to be validated for September and will be available towards the end of the month. This will be updated in the next quarterly report.

Heart of England NHS
NHS Foundation Trust

HEART OF ENGLAND NHS FOUNDATION TRUST

Council of Governors

MONDAY 23 OCTOBER 2017

Title:	**AUDIT COMMITTEE ANNUAL REPORT**
Presented by:	**Karen Kneller, Chair, Audit Committee**
Responsible Director:	David Burbridge, Director of Corporate Affairs
Contact:	Angie Hudson, Senior Executive Assistant to Director of Corporate Affairs, Ext. 43297

Purpose:	For the Chair of Audit Committee to provide the Council of Governors with the Audit Committee Annual report. The report provides a summary of the Audit Committee's work and its opinion of the adequacy and effectiveness of the Trust's risk management, control and governance processes.
Confidentiality Level & Reason:	None
Annual Plan Ref:	N/A
Key Issues Summary:	The attached report summarises the Audit Committee's opinion that the Trust's risk management, control and governance processes are adequate and effective and may be relied upon by the Board of Directors and the Council of Governors. It provides details of the information supporting that opinion, the role and operation of the Committee, the Committee's conclusions and its identified priorities for 2017/18.
Recommendation:	The Council of Governors is asked to **receive** the report and **note** the Audit Committee's identified priorities for 2017/18.

Authorised by: K Kneller	**Date:** October 2017

Heart of England NHS
NHS Foundation Trust

HEART OF ENGLAND NHS FOUNDATION TRUST

COUNCIL OF GOVERNORS

MONDAY 23 October 2017

2016/17 ANNUAL REPORT TO THE COUNCIL OF GOVERNORS

1 Introduction

1.1 The Committee's chief function is to advise the Board on the adequacy and effectiveness of the Trust's systems of internal control, risk management and governance and also its arrangements for securing economy, efficiency and effectiveness.

1.2 In order to discharge this function, the Audit Committee prepares an annual report for the Board and also for the Chief Executive in her role as Accounting Officer. This report was presented to the Board of Directors' meeting at the meeting held on 23 October 2017. This report includes information provided by the Trust's Internal and External Auditors and by other assurance providers.

2 Audit Committee's Opinion

2.1 The Board recognises that no assurance given can ever be absolute. The best assurance which can realistically be provided to the Board is that there are no major weaknesses in the Trust's risk management, control and governance processes and in its other relevant arrangements.

2.2 The Audit Committee's opinion, based on the material summarised in section 3 below, is that considerable progress has been made in addressing the major weaknesses in the Trust's risk management, control and governance processes and in its other relevant arrangements, that existed at the time of, and indeed, led to, the intervention by Monitor in October 2015. Whilst further work is continuing and the changes made need to become embedded, the Audit Committee believes that the Board of Directors may place a reasonable amount of reliance on such processes and arrangements. This extends, in the Committee's opinion, to compliance with regulatory requirements, including Health & Safety at Work Act and associated Regulations, FT Code of Governance, CQC Essential (Fundamental) Standards and the process for preparing the Annual Governance Statement (AGS).

2.3 Specific areas where further work is required include the Information Governance Toolkit and the Risk Management process.

3 Information supporting the Committee's Opinion

Summarised below are the key sources of information and assurance that the Audit Committee has taken into account in arriving at the opinion expressed above.

3.1 External Audit

3.1.1 The audit opinion of the External Auditors, KPMG, for 2016/17 was qualified. 'This opinion was based on the fact that whilst the Trust has not received any new enforcement undertakings in year, there were a range of enforcement undertakings issued in previous years, covering areas of financial sustainability, operational performance and governance which are still in place as at 31 March 2017. With the exception of this, they were satisfied that, in all other significant respects the Trust has in place proper arrangements to secure, economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2017.

3.1.2 As part of the Quality Accounts Audit for 2016/17, KPMG has audited two mandated performance indicators '18 weeks referral to treatment' and 'A&E four-hour wait', as well as a local indicator 'stat dose of prescribed antibiotics administered within an hour' which was chosen by the Council of Governors.

3.1.3 The Trust received a clean limited assurance opinion on the content of the 2016/17 Quality Report 18 week incomplete RTT pathways

3.1.4 The A&E four-hour wait was not subject to a limited assurance opinion based on the design of the process in place to capture data for ambulance arrivals. In line with last year, the Trust starts the clock for ambulance arrivals at the time of registration rather than when handover occurs or 15 minutes after the ambulance arrive at A&E. The clock start is predominantly within 5 minutes of ambulance arrival. The crews book in with the receptionist located in ED with the HALO or in main ED reception, the patient is then handed over to the clinical team. The Board of Directors has agreed that this practice is in the best interests of the patient.

3.1.5 The local indicator 'stat dose of prescribed antibiotics administered within an hour', chosen by the Council of Governors, was not subject to a limited assurance opinion as KPMG had been unable to gain evidence to confirm the accuracy of data sample records where the prescribed and administered times were the same.

3.1.6 KPMG's full audit report was provided to the Audit Committee in May 2017.

3.1.7 The External Auditors made seven recommendations on the financial statements 2016/17 work. The key recommendation relates to limiting access to the Trusts server room to IT staff.

3.1.8 During the year, the Chair of Audit Committee met privately with the External Auditors.

3.1.9 The Audit Committee members also met privately with the External Auditors. This type of meeting, which is in line with best practice in corporate governance, provides an important opportunity for the Committee members and/or the External Auditors to identify and discuss any confidential concerns or issues.

3.2 Internal Audit

3.2.1 Deloitte's Head of Internal Audit Opinion is derived from the reviews of three core internal audits (key financial controls, payroll, CQC, information systems management and board assurance framework (BAF) and risk management). Each of the three reviews received *"moderate"* opinion. Consequently, the Head of Internal Audit Opinion for 2016/17 states that for the Core Internal Audit Programme Opinion ''*substantial assurance can be given. As while there is a basically sound system…..there is some evidence of non-compliance that may put some of the system objectives at risk".*

3.2.2 The Head of Internal Audit Opinion for board assurance framework and risk management received 'moderate' assurance *"on the overall adequacy and effectiveness of the Trust's framework of governance, risk management and control''.*

3.2.3 During the financial year 2016/17 Internal Audit issued nine core internal audit reports and one performance report of which one internal audit report received full assurance and five substantial assurance and three moderate assurance for core internal reports".

3.2.4 Due to operational pressures, the timing of external reviews and reporting timelines, three reviews (patient administration system, CQC and information governance) have not been completed.

3.2.5 One performance review (medical equipment library) and one follow-up up review (quality indicators) were undertaken. As a result of carrying out the reviews no areas of control weakness relating to governance, risk management or internal controls impacted on the overall *'substantial'*.

3.2.6 During the year, the Chair of Audit Committee met privately with the Internal Auditors.

3.2.7 The Audit Committee members also met privately with the Internal Auditors. This type of meeting, which is in line with best practice in corporate governance, provides an important opportunity for the Committee members and/or the Internal Auditors to identify and discuss any confidential concerns or issues.

3.2.8 The current internal audit contract is in its third year and was due to expire as at 31 March 2017. Because of the uncertainty over the duration of a future contract award, due to the proposed organisational change, it was agreed that the contract was extended on a flexible basis in the short term.

3.3 Other Assurance Providers

3.3.1 Local Counter Fraud Specialist (LCFS)

a) The LCFS service is provided by Deloitte. The Audit Committee received and approved the Annual Plan relating to counter fraud work. The number of days allocated in the Annual Plan for counter fraud work for 2016/17 was 100 days.

b) During the course of the year, the Committee received regular progress reports, together with an Annual Report. 67 days were spent on proactive counter fraud work and a further 30 days on undertaking preliminary enquiries into 24 referrals and investigations.

c) The proactive work plan included a review of single tender waivers, cash-handling within the catering department, patient travel expenses, overseas visitors, on-site private patient work carried out in the trust and pre-employment agency checks.

3.3.2 Financial Reporting

a) Throughout the reporting year, the Committee received regular progress reports on the Single Tender Quotes/Approvals.

b) The Committee reviewed the 2016/17 pre-audited annual accounts and annual report at the 24 May 2017 meeting and recommended to the Board of Directors their signature by the Accounting Officer.

3.3.3 Management

a) The Committee received quarterly updates on clinical governance audit activity, complaints, incidents and claims; a bi-annual health & safety report; annual reports on compliance with the Freedom of Information Act 2000; compliance with the policy on controlled documents; IG Toolkit compliance and research governance.

b) The Trust undertook a revaluation of the land and buildings of the Trust under MEAV (modern equivalent asset valuation) required within the Trust's accounting policies.

c) It approved the revised Local Anti-Fraud, Bribery and Corruption Policy

d) It further received regular updates from management on progress with the implementation of agreed management action resulting from recommendations contained in internal audit reports (e.g. quality indicators follow-up). Where implementation of agreed recommendations was not achieved within the recommended timeframe, the Committee sought explanations from management as to the reasons for such delays and assurance that recommendations would be implemented.

e) The Committee considered the threat of cyber attack and requested an update on the security in place at the Trust.

f) The Committee received the annual report on Compliance with the Monitor's Code of Governance. It was concluded that the Trust would have to make the same declarations under the 'comply and explain' rule as in previous financial years as the Trust decided not to obtain external advisors to market test the remuneration levels of the chair and other NEDs at least once every three years.

g) The Committee further reviewed and recommended the draft Annual Governance Statement (AGS) at the 24 May 2017 meeting and recommended to the Board of Directors their signature by the Accounting Officer.

4 The Role and Operation of the Audit Committee

4.1 Membership of the Committee

4.1.1 The members of the Committee during 2016/17 were as follows:

Ms Karen Kneller – Chair

Mr Andy Edwards

Prof Jon Glasby (up to 31 March 2017)

Mrs Jackie Hendley (from June 2016)

Dr Mike Kinski (from June 2016)

Dr Jammi Rao (resigned 31 May 2016)

4.1.2 The members of the Committee disclosed their interests, which included the following, in the Trust's Register of Interests:

Ms Karen Kneller - CEO , Criminal Case Review Commission; Fee paid judge Social Entitlement Chamber; Fitness to Practice Member for General Dental Council and Vice Chair (unremunerated) of BRAP, an equalities think tank.

Mr Andy Edwards - Couch Perry & Wilkes - in receipt of annuity following business sale until May 2019; Voluntary role as a business mentor for the Prince's Trust

Prof Jon Glasby - Professor / Head of School, University of Birmingham; Senior Fellow, NIHR School for Social Care Research; Fellow of Royal Society of Arts; Board Member – Campaign for Social Services.

Ms Jackie Hendley – Director - SC Advisory Services Ltd; Director - Smith Cooper - IT Services Ltd; Director – Smith Cooper Ltd; Partner/Member – SHH 101 LLP.

Dr Mike Kinski - Prof of Business Change – Middlesex University; NED – Bristol City Council Holding Company; NED – Forest Coachlines Pty Ltd (Australia).

Dr Jammi Rao - Director - Gorway Global Ltd; Board Director - Welcome CIC; Trustee - Faculty of Public Health; Visiting Professorship - Public Health, School of Health, Staffordshire University

4.1.3 The Committee's principal support officer throughout the year was the interim Director of Corporate Affairs. The Chief Financial Controller, Director of Finance, Chief Nurse; Director of Operations; Director of Workforce & OD, together with representatives of both the External and Internal Auditors attended the meetings of the Committee as a matter of course. Other directors and officers of the Trust attended meetings of the Committee as and when required.

4.2 Operation of the Committee

4.2.1 Meetings and attendance

The Committee is required to meet at least four times a year. A total of six ordinary meetings took place during 2016/17 and were attended as follows:

Director	Meetings attended
Ms Karen Kneller – Chair	All
Mr Andy Edwards	All
Prof Jon Glasby (up to 31 March 2017)	3
Mrs Jackie Hendley (from June 2016)	3 of 4
Dr Mike Kinski (from June 2016)	3 of 4
Dr Jammi Rao (resigned 31 May 2016)	2 of 2

The quorum for meetings of the Committee is two members. All ordinary meetings of the Committee during the period were quorate.

4.2.2 Self-assessment

The annual self-assessment for 2016/17 is under way and its findings will be reported to the Board of Directors.

4.2.3 Annual Cycle

The Committee has also maintained its practice of agreeing an annual cycle of business which is designed to facilitate forward planning and to assist the Committee in ensuring that all aspects of its terms of reference are being fulfilled.

4.2.4 Reports

During the reporting period, the Audit Committee submitted formal reports to the Board of Directors' meetings following each Audit Committee meeting.

5 Priorities for 2017/18

The Committee has identified the following priorities for attention during the 2017/18 financial year:

5.1 Monitoring and reviewing the effects of changes in the general economic climate (including BREXIT) on the Trust's financial position and the Trust's ability to recruit and retain a sufficiently skilled workforce;

5.2 Monitoring the proposed acquisition with University Hospitals Birmingham NHS Foundation Trust;

5.3 Monitoring and assessing the Trust's ICT systems to include functionality, security arrangements against cyber risks and exploring the need to procure additional 'cyber insurance';

5.4 Monitoring the effectiveness and robustness of the Trust's quality systems (including Data Quality), with particular regards to the assurance requirements for the Quality Report;

5.5 Continue to monitor the effectiveness and robustness of the Trust's risk management systems and its Assurance Framework;

5.6 Continuing to make best use of the Internal Auditors, as the "eyes and ears" of the Committee, by regularly reviewing the scope of their work so as to ensure that it appropriately reflects both the risks currently faced or anticipated and the Trust's current priorities; and

5.7 Reviewing accounting policies to ensure that they remain appropriate and keeping a watching brief on the ongoing impact of the introduction of International Financial Reporting Standards.

6 Recommendation

The Council of Governors asked to receive this report on the work of the Audit Committee during the 2016/17 financial year.

Karen Kneller
Chair of the Audit Committee
October 2017

HEART OF ENGLAND NHS FOUNDATION TRUST

Council of Governors

MONDAY 23 OCTOBER 2017

Title:	**RE-APPOINTMENT OF EXTERNAL AUDITORS**
Responsible Director:	David Burbridge, Director of Corporate Affairs
Contact:	Angie Hudson, Senior Executive Assistant to Director of Corporate Affairs, Ext. 43297

Purpose:	To seek approval by the Council of Governors to re-appoint KPMG as External Auditors for a further 12 months.
Confidentiality Level & Reason:	None
Annual Plan Ref:	N/A
Key Issues Summary:	The Trust appointed KPMG LLP as external auditors for three financial years from 1 April 2016 to undertake statutory audits and provide opinions on the Trust's Annual Report and Accounts, the Quality Report and the Charitable Funds Annual Report and Accounts. KPMG are entering the second of their three year term as external auditors. The Council of Governors are required to approve the re-appointment of the external auditors on an annual basis. The Audit Committee shall make a recommendation to the Council of Governors as to the re-appointment. **Recommendation** The Council of Governors is asked to consider and, if thought fit, approve the recommendation of the Audit Committee regarding the re-appointment of KPMG LLP as the Trust's External Auditor for FY 2017/18.

Authorised by: D Burbridge	**Date:** October 2017

HEART OF ENGLAND NHS FOUNDATION TRUST

Council of Governors

23rd October 2017

Title:	**QUARTER 2 COMPLIANCE AND ASSURANCE REPORT**
Responsible Director:	David Burbridge, Interim Director of Corporate Affairs
Contact:	Ann Keogh, Head of Clinical Safety and Governance

Purpose:	To present an update to the Council of Governors of the internal and external assurance processes around compliance with NICE and local guidelines, national and local clinical audits, NCEPOD and Novel Techniques.	
Confidentiality Level & Reason:	None	
Annual Plan Ref:	Affects all strategic aims	
Key Issues Summary:	Final CQC report received and response prepared to the requirement notices Summary of external visits undertaken since Q2 2016/17 Increasing numbers of NICE guidance awaiting response from Directorates Update on review of Clinical Guidelines : 45% of clinical guidelines are out of date	
Recommendations:	The Council of Governors is asked to receive the report.	
Approved by:	David Burbridge	Date: October 2017

HEART OF ENGLAND NHS FOUNDATION TRUST

Council of Governors

23rd October 2017

COMPLIANCE AND ASSURANCE REPORT

PRESENTED BY THE INTERIM DIRECTOR OF CORPORATE AFFAIRS

1 **Purpose**

The purpose of this paper is to provide the Council of Governors with information regarding internal and external compliance.

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 6th September 2016 and a further visit 18th to 21st 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 2nd 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 current report describes the ratings each core service achieved and how that compared to the previous inspection.

2.5.1 ED overall rating:

a) BHH: requires improvement (inadequate in 2014)

b) SH: good (requires improvement in 2014).

c) GHH was requires improvement (same as 2014)

2.5.2 Medical Care overall rating:

a) GHH and SH: good (improvement on the previous inspection).

b) BHH remained the same with a rating of requires improvement.

2.5.3 OPD DI:

a) BHH and GHH increasing their ratings to good from requires improvement.

b) SH remained the same with a good rating.

2.5.4 **Surgery** was rated as requires improvement at BHH and GHH, with good at SH. Not rated in 2014

2.5.5 **Critical Care** achieved a good rating at this inspection at BHH.

2.5.6 The Chest Clinic, Runcorn Road Dialysis, Castle Vale Renal Unit and Community adult services were all rated good for all domains, with the exception of Runcorn Road Dialysis well-led domain which achieved an outstanding rating.

2.5.7 The CQC ratings are for the services inspected are set out in **Appendix 1**.

2.6 Requirement Notices

The following "Requirement Notices" were identified within the final CQC report, where it was considered that HEFT did not meet the CQC fundamental standards:

2.6.1 Safe Care and Treatment - Regulation 12 2 (d), (g), (h)

a) Medical and nursing staff at both Birmingham Heartlands Hospital and Good Hope Hospital in outpatients, theatres and the ED did not follow good IPC practices.

b) The Trust did not collect data to determine rates of surgical site infection at Solihull Hospital.

c) 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.

d) The environment in ED at Birmingham Heartlands Hospital did not meet the needs of patients waiting. Having patients waiting in the corridor compromised their safety, resulted in ambulance waits and prolonged handover waits.

e) In the surgical department at Birmingham Heartlands Hospital expired controlled medicines for patients were not disposed of correctly. Staff did not record fridge temperatures accurately and temperatures exceeded recommended limits. Staff supplied and administered medicines under Patient Group Directions (PGD) when they were not trained to do so.

2.6.2 Premises and Equipment – Regulation 15 1(b), 1(c)

All premises and equipment used by the service provider must be secure and suitable for the purpose for which they are being used

a) The premises in ED were not suitable for the service provided, including the layout and size to accommodate the potential number of people using the service at any one time.

b) Security and access to the critical care unit was not sufficiently robust.

c) Security and auditing of clinical waste storage did not meet required standards.

2.6.3 Regulation 18: Staffing

Sufficient numbers of suitably qualified, competent, skilled and experienced persons must be deployed in order to meet the requirements of this part.

a) Solihull Hospital Medical Care - ensure staffing numbers are sufficient to meet the needs of patients. We saw that staffing levels were not sufficient to meet the needs of patients.

2.7 Summary of the recommendations

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

2.7.2 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 sent to the Directorate Quality and Safety Meetings with exception reporting to the Divisional Quality and Safety Meetings.

2.7.3 The Trust has prepared a response to 17 of the 18 breaches of regulations (the "must do" recommendations, set out in **Appendix 2)**

2.7.4 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 has been requested to assist the Trust in its response to this point.

3 Trust Compliance with Regulatory Requirements - NICE guidance

3.1 Overall Position (Data Extracted 06/10/17)

3.1.1 The Clinical Audit team have undertaken a baseline assessment of NICE guidance to date and the current status. They are working with the Divisions and Directorates to update the status where they have not been fully implemented or implemented where applicable.

3.1.2 1,148 unique NICE guidelines applicable to the Trust have been published to date.

Guidance Fully Implemented	414 (36.1%)
Guidance Fully Implemented (Where Applicable)	80 (7.0%)
Guidance Not Applicable	390 (34.0%)
Guidance Not Implemented	72 (6.3%)
Guidance Partially Implemented (Action Required)	17 (1.5%)
Guidance for information only	16 (1.4%)
Guidance awaiting a response from directorates	159 (13.9%)

3.1.3 The figures above include 29 guidance published on the last working day of September 2017. This guidance was distributed to divisions on 4th October within agreed timescales for the distribution of newly published or updated guidance. Divisions are requested to provide a response within 30 working days of publication, at the time of the report the deadline had not been reached.

3.1.4 It should be noted that there has been a steady rise over the last year in the number of guidance items awaiting response from directorates. The Clinical Audit and Governance Facilitation Teams are actively working with Directorates and Divisions to clarify the position and gain updates.

3.2 **Quarter 2 Guidance**

3.2.1 The table below summarises all unique guidance published in Q2. Divisional and directorate level information is provided via Divisional Quarterly Governance Reports.

3.2.2 Please note that at the time of the report theSeptember 2017 guidance had been distributed to divisions; however the 30 day period for response from directorates had not been reached. This guidance is included within the data below within the awaiting response category.

	For information only	**I**	**NA**	**NI**	**PI (FIWA)**	**Awaiting directorate response**	**Grand Total**
TA (Technology appraisal guidance)	3	7				22	32
CG (Clinical guidelines)						9	9
NG (NICE Guidelines)						7	7
QS (Quality Standards)						7	7
IPG (Interventional procedures guidance)			3	1		6	10
MIB (Medtech innovation briefing)	5		3		1	6	15
PH (Public Health guidance)						2	2
DG (Diagnostics guidance)	1					1	2
HST (Highly specialised technologies guidance)						1	1
MTG (Medical technologies guidance)						1	1
ES (Evidence summary)	1						1
Grand Total	**10**	**7**	**6**	**1**	**1**	**62**	**87**

Guidance: Fully Implemented I; Not Applicable NA; Not Implemented NI; Partially Implemented (Action Required) PI (AR); Fully Implemented (Where Applicable) PI(FIWA)

3.3 **Good Practice Guidance on Patient Group Directions**

3.3.1 Patient group directions allow healthcare professionals to supply and administer specified medicines to pre-defined groups of patients, without a prescription. This guideline (MPG2) covers good practice for developing, authorising, using and updating patient group directions.

3.3.2 In March 2017, changes were made to update the format of this guideline in response to the changes, the Pharmacy Directorate have completed a NICE baseline assessment against the updated guidance which shows that the Trust meets all 65 recommendations (100%).

3.4 **NICE Public Board Meeting**

3.4.1 NICE held their public board meeting at Birmingham Heartlands Hospital on 20 September 2017. An area of note from the meeting is

NICE's intention to increase capacity within their technology appraisal (TA) programme.

3.4.2 Prior to 2014/15 NICE produced on average 30 TAs per year. The 2017/18 target is 55 TAs. It is anticipated that this may rise to 75 TAs each year.

3.4.3 Technology appraisals assess the clinical and cost effectiveness of health technologies - such as new pharmaceutical and biopharmaceutical products - but also include procedures, devices and diagnostic agents. This ensures that all NHS patients have equitable access to the most clinically and cost-effective treatments that are available.

3.4.4 Regulations require Clinical Commissioning Groups, NHS England and Local Authorities to comply with recommendations in a technology appraisal within 3 months of its date of publication.

4 Trust Compliance with External Visits/Peer Reviews

4.1 An updated External Agency Policy was approved at the Chief Executives Group on the 24th July 2017, which sets out the process for ensuring the appropriate coordination and evaluation of external recommendations arising from external agency visits, inspections, accreditations and peer review/assessment.

4.2 Since Q2, 2016/17 there were **2** external visits during Q3,16/17, **2** external visits during Q4, 16/17, **4** during Q1, 17/18 and **3** during Q2, 17/18.

4.3 The current status of the external visits **(Appendix 3)** using the definitions within the policy are as follows:

4.3.1 Positive assurance: No concerns or risks were identified or all actions have been completed and evidenced**: 2 visits**

4.3.2 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**

4.3.3 **Negative assurance:** Major concerns/risks were identified during the visit or identified actions are overdue: **1 visit** see below:

Public Health England (PHE) Screening Quality Assurance Visit

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

There were 16 actions within the 3 month time frame and 5 within 6

months. An update was sent to SQAS 04/10/17 detailing progress

3 month actions: 1 action is incomplete as outlined below:

- Update the Hospital Based Programme Co-ordination (HBPC) job description to include indicative time and details of administrative support. The JD has been updated and is currently with HR for sign off

6 month actions: 2 are complete, 3 are overdue and outlined below:

- Data collection for the national invasive cervical cancer audit is up to date
- Cervical histology specimen turnaround times meet national standards
- Audit adherence to the national human papilloma virus (HPV) triage and test of cure protocol

5 Clinical Audits

5.1 Forward Audit Programme

5.1.1 The 2017/18 Forward Audit Programme (FAP) was approved by Audit Committee on 24 July 2017 and included all level 1 (national must do audits) and level 2 (internal must do audits). Directorates were requested to populate the level 3 (department priority) and level 4 (clinician interest) audits. The FAP is owned at divisional level and is aligned to the Trust's strategic and corporate objectives. Both national and local audits are included within the FAP.

5.1.2 In July 2017 there was a 38.5% FAP return rate which had increased to 62.7% by 20 September 2017. The Clinical Audit Team is actively chasing the outstanding FAPs.

5.1.3 The current number of divisional audits and their priority levels, as indicated on the FAPs, are shown below.

Division	**Level 1: External 'Must Do' Audit**	**Level 2: Internal 'Must Do' Audit**	**Level 3: Specialty/Clinical Department Priority**	**Level 4: Clinician Interest**	**Total**
Div 1 (CSS)	12	24	14	24	74
Div 2 (W&C)	15	9	22	11	57
Div 3 (Em Care)	23	6	7	5	41
Div 4 (Med)	38	4	15	18	75
Div 5 (Surg)	29	12	7	9	57
Grand Total	**117**	**55**	**65**	**67**	**304**

5.1.4 To enable effective monitoring of audit status and to evidence assurance of implementation the directorates must ensure that all FAP audits are registered on the Clinical Audit Database. At 20 September 2017, 205 of the 304 FAP audits, so far identified by directorates, had not been registered on the Clinical Audit Database.

5.1.5 A member of the Clinical Audit is meeting with 2-3 Directorate Audits Leads per week to support completion of the FAP and ongoing

updating of the Audit database. This will also be followed up and monitored by the Safety and Governance Teams via divisional and directorate governance meetings and will form part of the Quarterly Quality Governance Reports distributed to Divisions and Directorates.

5.2 National Audits

5.2.1 There are 117 level 1 external "must do" audits that are identified on the Forward Audit Programme. The table below shows the status of these level 1 audits as at 6th October 2017. At present there are 55 national audits that are applicable to the Trust and reportable in the Quality Account (This will change over the year as amendments are made to the National Clinical Audit Directory by HQIP

Division	Approved by Directorate Audit Lead	Completed - Data collection, analysis and audit report complete. Action plan developed.	Signed off - All identified actions implemented. Evidence saved to Clinical Audit Database.	Submitted on Clinical Audit Database by Clinical Lead	To be Added to Trust Audit Database by directorate audit lead	Grand Total
Div 1 (CSS)				1	11	12
Div 2 (W&C)	1			6	8	15
Div 3 (Em Care)	3			5	15	23
Div 4 (Med)					38	38
Div 5 (Surg)	2	2	1		24	29
Grand Total	**6**	**2**	**1**	**12**	**96**	**117**

6 National Confidential Enquiry into Patient Outcome and Death (NCEPOD)

6.1 Studies in progress

6.1.1 Cancer in Children, Teens and Young Adults

This study was not applicable to the Trust.

6.1.2 Acute Heart Failure

Case note submission is on-going during September and October 2017.

6.1.3 Peri-operative Diabetes Management

Peri-operative diabetes patient identifier spreadsheet was submitted to NCEPOD in June 2017.

6.1.4 Young People Mental Health Study

Case notes have been submitted to NCEPOD. One set of case notes is outstanding; this has been followed up with the clinician in September 2017.

6.2 **Published reports**

6.2.1 A key role of NCEPOD is to make recommendations based on the findings of the reports undertaken. Recommendations are based on themes that emerge during analysis of the data collected.

6.2.2 Status of current NCPEOD Reports as at 20 September 2017. The Clinical Audit Team will gain updates on the historical reports and provide an update in Q3.

NCEPOD Report	Specialty Lead	Published	Current Status	Recs. fully met
Acute Non Invasive Ventilation	TBC	July 2017	Leads to be invited to initial working group.	TBC
Mental Health Care in General Hospitals	Trust wide	January 2017	Ongoing action plan.	8/21
Acute Pancreatitis	Surgery	July 2016	Ongoing action plan.	6/18
Sepsis	Infectious Diseases	November 2015	Ongoing action plan	14/21
Gastrointestinal Haemorrhage	Gastroenterology	July 2015	Action plan developed areas of non-compliance risk assessed and included on the Directorate risk register.	19/21
Tracheostomy Care	Anaesthetic	June 2014	Ongoing action plan	13/25
Alcohol Related liver disease	Acute Medicine	June 2013	Ongoing action plan	19/28
Cardiac Arrest procedures	Resuscitation	June 2012	Ongoing action plan.	16/21
Peri-operative care	Surgery	December 2011	Ongoing action plan	8/11
Surgery in Children	Surgery	October 2011	Ongoing action plan	14/17
Elective and Emergency Surgery in the Elderly	Surgery	November 2010	Ongoing action plan	12/24

7 **Novel Techniques and Interventional Procedures (NTIPs)**

7.1 **Proposals Approved**

7.1.1 Since 2004 the NTIP Group has received 63 proposals and approved 57 proposals. Of the six proposals that did not received 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.

7.1.2 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

7.2 **Audit position**

7.2.1 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.

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

7.2.3 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.

7.2.4 The Clinical Audit team has requested updates from NTIP proposers in September 2017 where the audit status is not confirmed complete and although some responses have been received, a number are outstanding and will be followed up in October 2017.

8 Clinical Guideline Compliance

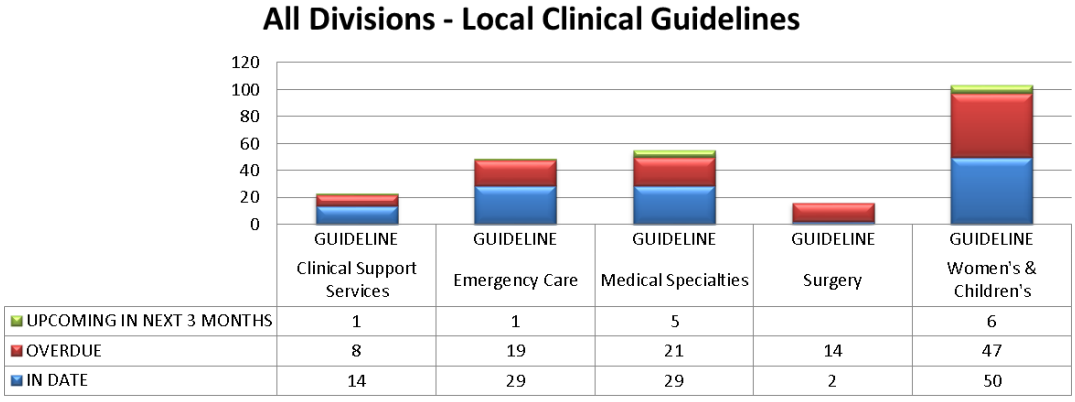
8.1 A review of the current guidelines status has shown that there are currently 274 documents housed centrally on the Trust's Guidelines SharePoint site across all 5 Divisions, however not all of the documents are clinical guidelines. A number of the documents are flow charts, checklists and referral forms, not clinical guidelines. When these documents are removed from the total count the number of clinical guidelines remaining is 246. The documents, that are not clinical guidelines, are owned by Division 2 (18) and Division 4 (10). These are being reviewed with a plan to include them in the relevant existing guidelines as appendices.

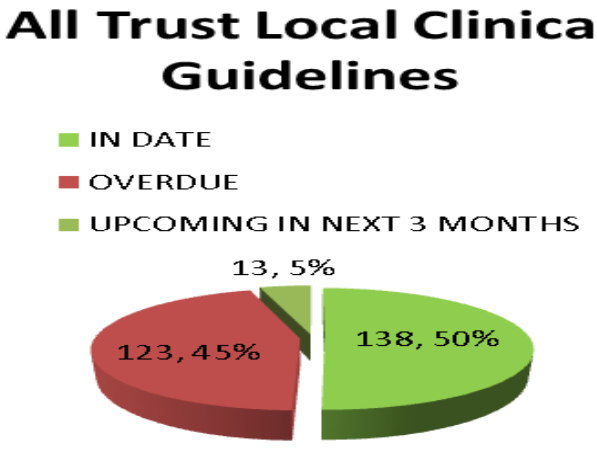
8.2 In addition there were seven links within the guideline site which were being counted as clinical guidelines. These links are to internal HEFT sites where guidelines are housed. These have been removed from the guidelines list and now sit in a 'Useful Links' section on the Clinical Guidelines Site (see table below):

Useful Link	Department	Division
Stroke Guidelines and Pathways	Emergency Department	ED
Nursing Guidelines	N/A	N/A
Pharmacy (Antibiotic Guidelines)	Pharmacy	Clinical Support Services
Enteral Feeding Guidelines	Nutrition	Surgery
Critical Care Guidelines	Critical Care	Clinical Support Services
Dermatology Guidelines	Dermatology	Medical Specialites
Haematology & Oncology SOP	Haematology & Oncology	Medical Specialites

8.3 These Guidelines will need to be formally approved as Clinical Guidelines as per Trust policy and then added to the main Trust site. This will allow version control of the documents, regular review and assurance that the guideline is accessed from one location.

8.4 **Status of all 274 Local Clinical Guidelines currently housed centrally**





8.5 An evaluation of the guideline process and issues raised in previous reports has resulted in the following:

8.6 **Ratification groups**

8.6.1 All new guidelines should be are overseen by the Clinical Guideline Group and uploaded onto the Trust intranet site once ratified. All working/minor updated guidelines are currently not taken to CGG for ratification, this action sits within the divisions and specialities with an expectation that they are peer reviewed (with a local terms of reference – TOR) and disseminated as appropriate.

8.6.2 It has been noted that not all guidelines are being ratified by the Clinical Guideline Group, there a number of groups within directorates that have taken on the role of ratification of clinical guidelines. This has led to a lack of a standardised process and an absence of a cohesive mechanism for ensuring that guidelines meet an adequate trust standard. The Terms of Reference for these subgroups has been reviewed and updated to ensure standardisation.

8.7 **Clinical guidelines tracker**

The local clinical guideline tracker has been developed allowing accurate data to be pulled quickly at divisional and directorate level and will be able to be displayed as a dashboard.

8.8 **Guideline documents**

The guideline team are currently liaising with directorates and divisional leads to remove documents that are not guidelines from the Trust's Guidelines SharePoint site. These are to be integrated into the appropriate guideline, to ensure easy access to referral forms etc the front page of the guideline will contain hyperlinks to all of the documents/appendices within the guideline.

8.9 **Guidelines held by directorates**

8.9.1 It has been identified that clinical guidelines exist within directorates that are not housed on the Trust Guidelines SharePoint site but in local sites and within departmental files. Again, there is no assurance of the ratification processes around these guidelines or evidence of update and review in line with best practice.

8.9.2 The Guidelines Team are currently liaising with the relevant directorate leads to review guidelines that are held this way. They will be providing support to ensure that these guidelines are compliant with the Trust clinical guideline process, are moved onto the formal Trust guideline site and removed from the local site.

8.10 **Clinical Guidelines Group (CGG) meeting**

It has been agreed that the CGG meeting will be held monthly rather than bi-monthly to increase the rate of guideline approval by the CGG and reduce the number of out of date guidelines.

8.11 **Risk Register**

8.11.1 Currently those guidelines which are not linked to the Trust site but are available to staff pose a risk to the organisation as there is no assurance of the ratification processes around these guidelines or evidence of update and review in line with best practice. Where possible the use of external accredited sites is recommended.

8.11.2 2 new risks have been identified in relation to the clinical guideline process, these are:

a) Guidelines held on local sites that do not comply with the Trust guideline process

b) The integration of guidelines across HEFT and UHB following the proposed merger

8.11.3 Both of these risks have been assessed and included on the Safety and Governance Directorate Risk Register.

8.11.4 In addition, there is an existing risk on the risk register relating to the number of out of date guidelines on the Trust clinical guideline site.

8.12 **Joint University Hospitals Birmingham (UHB) and HEFT guideline working group**

8.12.1 A working group has been established to support the process of integration of guidelines across both organisations. The group is in the process of cross referencing the guidelines currently used at UHB and HEFT. In addition the process for management of clinical guidelines across both organisations is being reviewed with a view to establishing a single process moving forward.

8.12.2 As part of this process, any new guidelines or guidelines under review within each organisation will be reviewed by the relevant speciality in both trusts to ensure that they are aligned as much as possible, and where differences exist, these will highlighted within the new/updated guideline.

9 **Recommendation**

The Council of Governors is asked to recieve this report.

David Burbridge

Interim Director of Corporate Affairs

October 2017

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 Response to CQC Requirement Notices

Require-ment notices	Type and number	Site and specialty	Exec lead	Operation-al lead	CQC recommendation	HEFT response/comments	Dead Line	Monitoring group
Regulation 18: Staffing	MUST 01	SOL MED	Julie Tunney, 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. • 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.	On-going	Divisional Staffing Meetings Care Quality Group Executive Board
Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment Premises	MUST 02	BHH ED	Kevin Bolger	John Sellars, Director of Asset Manage-ment	Trust must ensure that the premises is suitable for the service provided, including layout, and be big enough to accommodate the potential number of people using the	Site strategy shared with NHS Improvement (+E) as part of the case for changes	Complete	Executive Board

Require-ment notices	Type and number	Site and specialty	Exec lead	Operation-al lead	CQC recommendation	HEFT response/comments	Dead Line	Monitoring group
&Equipment 1(b), 1(c)					service at any one time.			
Regulation 12(2) (d)	MUST 03	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, delays in triage and ambulance handover times.	• All signage has been reviewed to ensure it is clear where ambulances should report to • Reinforced the role of the point of 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 minutes 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	Division 3 Quality and Safety Group
Regulation 12 (2) (h)	MUST 04	BHH ED	Julie Tunney, 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	• 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. • 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.	On-going	Care Quality Group/TIPC

Require-ment notices	Type and number	Site and specialty	Exec lead	Operation-al lead	CQC recommendation	HEFT response/comments	Dead Line	Monitoring group
					infections.	• 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 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.		
None	MUST 05	BHH ED	Julie Tunney, 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:** o 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.	On-going	Performance against complaints management is monitored at Divisional Performance Review Meetings

Require-ment notices	Type and number	Site and specialty	Exec lead	Operation-al lead	CQC recommendation	HEFT response/comments	Dead Line	Monitoring group
						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 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 the Care Quality Management Group meeting. • A Trust-wide complaints review will commence in Quarter 3.		
Regulation 12 (2) (g)	MUST 06	BHH SURG	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).•	On-going	Safe Medication Practice Group Medicines Management Group

Require-ment notices	Type and number	Site and specialty	Exec lead	Operation-al lead	CQC recommendation	HEFT response/comments	Dead Line	Monitoring group
						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 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, to increase to monthly from September 2017		
Regulation 12 (2) (g)	MUST 07	BHHS URG	Dave Rosser/ Alan Jones	ania Carruthers, Clinical Director Pharmacy	The Trust must ensure staff are trained and competent to administer medicines	• 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	Nov-17	Care Quality Group Safe Medication Practice Group Medicines

Require-ment notices	Type and number	Site and specialty	Exec lead	Operation-al lead	CQC recommendation	HEFT response/comments	Dead Line	Monitoring group
					under PGDs.	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 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 Communications 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/department 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.		Management Group

Require-ment notices	Type and number	Site and specialty	Exec lead	Operation-al lead	CQC recommendation	HEFT response/comments	Dead Line	Monitoring group
						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.		
Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment Premises and Equipment 1(b), 1©	MUST 08	CASTLE VALE RENAL UNIT	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)	Feb-18	Safety Group
Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment Premises and Equipment 1(b), 1©	MUST 09	CASTLE VALE RENAL UNIT	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 secure unit for clinical waste, this will be discussed at the waste management group meeting	Dec-17	Waste Management Group
Regulation 15 HSCA	MUST 10	CASTLE	John Sellars,	Sharon Rogers,	The Trust must ensure only clinical	• The issue with regards to working bin locks has been taken up several times with the current contractor and there is a	Sep-17	Waste Management

Require-ment notices	Type and number	Site and specialty	Exec lead	Operation-al lead	CQC recommendation	HEFT response/comments	Dead Line	Monitoring group
(RA) Regulations 2014 Premises and equipment Premises and Equipment 1(b), 1©		VALE RENAL UNIT	Director of Asset Management	Group Manager, Division 4	waste skips with working locks are accepted and used at the unit.	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		Group
Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment Premises and Equipment 1(b), 1©	MUST 11	CASTLE VALE RENAL UNIT	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 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	Waste Management Group
Regulation 12 (2) (g)	MUST 12	GHH ED	Dave Rosser/	Tania Carruthers, Clinical	The ED at Good Hope Hospital must ensure they follow	Actions taken:• Controlled Drugs (CD) Newsletter Nov16 (for information re. returns of CDs and opiate patch administration)• Controlled Drugs Newsletter May17 (for	On-going	Safe Medication Practice Group

Require-ment notices	Type and number	Site and specialty	Exec lead	Operation-al lead	CQC recommendation	HEFT response/comments	Dead Line	Monitoring group
			Alan Jones	Director Pharmacy	policies and procedures about managing medications; including storage, checking medications are in date, and safe disposal of medications.	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 - 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 • Quarterly medicines management audit has been undertaken, this will be increased to monthly from Sep17		Medicines Management Group
Regulation 12 (2) (h)	MUST 13	GHH ED	Julie Tunney,	Gill Abbot,	The ED must ensure that cleanliness	• Emergency departments are cleaned by domestic staff in line with the national specification for cleaning and a quarterly	On-going	Care Quality Group

Require-ment notices	Type and number	Site and specialty	Exec lead	Operation-al lead	CQC recommendation	HEFT response/comments	Dead Line	Monitoring group
			Interim Chief Nurse	Senior Nurse Infection Control	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).	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 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.		Trust Infection Prevention & Control Group
Regulation 12 (2) (g)	MUST 14	GHHS URG	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) • Safe Medication Practice Group minutes May 2016 (reference to safe & secure handling of medicines audit 2015 and on-going actions followed up)	On-going	Safe Medication Practice Group Medicines Management Group

Require-ment notices	Type and number	Site and specialty	Exec lead	Operation-al lead	CQC recommendation	HEFT response/comments	Dead Line	Monitoring group
						• 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 •Weekly top up audits undertaken • Quarterly medicines management audits undertaken, this will be increased to monthly from September 2017		
Regulation 12 (2) (h)	MUST 15	GHHS URG	Julie Tunney, 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	On-going	Divisional Quality Safety Meetings
Regulation 12 (2) (h)	MUST 16	SOL	Julie Tunney, Interim	Martin Richardson	The hospital did not collect data to determine rates of	• 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	Dec-17	Division 5 Quality and Safety Group

Require-ment notices	Type and number	Site and specialty	Exec lead	Operation-al lead	CQC recommendation	HEFT response/comments	Dead Line	Monitoring group
		SURG	Chief Nurse		surgical site infection at Solihull Hospital.	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.		Trust Infection Prevention & Control Group
Regulation 12 (2) (h)	Regulation	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 . This has been reviewed but the cost is prohibitive and will go into the site strategy. We attempt to mitigate against the risks of infecting HCWs through a detailed process of infection control supervision of the cases and training of staff. We also have to consider other infections that require respiratory precautions like influenza, and of course the neutropaenic septic patients that require positive pressure rooms. There have been no recorded events of nosocomial cross transmission of tuberculosis in the critical care unit. The management of patients with tuberculosis involves close supervision by infection control through the maintenance of closed ventilation circuits as well as adequate respiratory precautions. Whilst these measures have been effective so far, they are not a substitute for isolation rooms that have negative pressure capability. The longer term solutions will involve refurbishment of the current facilities or the	On-going	Executive Board

Require-ment notices	Type and number	Site and specialty	Exec lead	Operation-al lead	CQC recommendation	HEFT response/comments	Dead Line	Monitoring group
						commissioning of new isolation rooms with negative pressure capability."		
Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment Premises and Equipment 1(b), 1(c)	Regulation	BHH critical care			Security and access to the critical care unit was not sufficiently robust.	Comment in CQC report Staff also showed us the ITU waiting room, which was located within another department. Staff told us that as the waiting area was so small that frequently relatives were in the corridor. The other department provided emergency treatment and access may be difficult if staff needed to get the patient on a trolley in an emergency.		The Trust has asked CQC for more information on this breach to assist with our response.

Appendix 3 : External visits

Date of Visit	Inspecting Organisation	Division and Area Inspected	Outcome of Visit	Assurance Level	Assurance/Outstanding Actions
18 –21 Oct 16	CQC Inspection		See separate report	Neutral Assurance	
18 -19 Oct16	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.	Neutral Assurance	An action plan has been developed and approved at the CQMG meeting in July 2017; there are 19 actions in total. The Governance Facilitation Team are supporting division 2 are working closely with the directorate to monitor progress with the action plan.
24/01/17	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 actions are broken down into 3 month, 6 month and 12 month timeframes. There were 16 actions within the 3 month time frame and 5 within 6 months. An update was sent to SQAS 04/10/17 detailing progress **3 month actions:** 1 action is incomplete as below: • Update the Hospital Based Programme Co-ordination (HBPC) job description to include indicative time and details of administrative support. The JD has been updated and is currently with HR for sign off **6 month actions:** 2 complete, 3 overdue as below: • Data collection for the national invasive cervical cancer audit is up to date • Cervical histology specimen turnaround times meet national standards • Audit adherence to the national human papilloma virus (HPV) triage and test of cure protocol

07/02/17	Unannounced visit from Birmingham Cross City CCG	Division 5 Ward 4, BHH Thoracic Surgery	The visit to conducted in response 3 MRSA outbreaks and 2 MRSA bacteraemia cases during the period of October 2016 to January 2017. The outbreaks affected wards 3, 4 and 30. Wards 3 and 4 were visited during this inspection.	Neutral Assurance	7 actions were developed and 6 of these have been completed. The final action is in relation undertaking a deep clean on ward 4. This was due in June 2017; however it has not been undertaken due to capacity issues. **Note: An overall rating of neutral assurance has been applied as 1 action is outstanding but is beyond the control ward 4**
		Division 4 Ward 3, BHH Renal	See above		The Safety and Governance Directorate have received an action plan from division 4 in and all actions are now complete
21/04/17	Environment Agency: Radioactive substances Activity	Division 1 Radiology	Routine compliance assessment visit The report was received by HEFT on the 14th June 2017 and 2 minor recommendations were made	Neutral Assurance	The Safety and Governance Directorate have received an action plan and progress is currently within the timeframe set
13/06/17	Birmingham Cross City CCG	Division 4 Ward 12, Elderly Care, GHH	Safeguarding Assurance Visit	Positive Assurance	Overall positive feedback, 3 minor recommendations made. An action plan was developed and Safety & Governance have received confirmation that all actions are complete

13/06/17	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 are outlined below: 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	The Safety and Governance Directorate has received an action plan. A meeting is scheduled at UHB 11/10/17 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.
05/2017	Farwell Audit EL(97)52	Division 1 Pharmacy	**General Summary** This was a well organised and much improved unit. While there are a few deficiencies that require attention, some important, overall this unit operates safely and the auditor was confident in the awarded rating: **Low Risk**	Positive Assurance	An action plan has been developed. 1 important deficiency was identified during the audit and the action for this is complete. A further 11 actions have been developed based on comments or minor deficiencies and these are all progressing within the allocated timescales.

19 & 20 07/17	Human Tissue Authority	Division 1	The Trust met the majority of the HTA standards, three major and seven minor shortfalls were found against the following standards: • Governance and quality • Traceability • Premises/facilities and • Equipment standards 1 Major shortfall action is complete and the remaining 2 are due for completion 31/10/17 The 2 outstanding major shortfalls are outlined below: 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 PM 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.	Neutral Assurance	A corrective and preventative action (CAPA) plan has been developed. The actions for 3 of the 7 minor shortfalls are now complete and the remaining 4 are due for completion 31/10/17
12/07/17	National Peer Review: Trauma Audit	Division 5	1 immediate risk and 4 serious concerns were identified during the review. The immediate risk related to theatre significant challenges in accessing spinal injury care pathways at UHB The serious concerns are outlined below: • Appropriately trained Emergency Trauma	Neutral Assurance	Immediate Risk: A meeting with UHB is scheduled for late September/early October 17 Serious concerns: Actions have been developed and are due to be

			Nurse /AHP available 24/7 • The review team were not reassured that Level 1 or Level 2 training was being delivered. • Administration of Tranexamic Acid (TXA) according to CRASH-2 protocol • Provision of trauma and rehabilitation Coordinator Service 7 days/week		completed by end Nov 2017
07.08.17	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	Neutral Assurance	4 actions have been identified from this review relating to: 1. Cancellation rates 2. Lung cancer resection rates 3. Management of Empyema 4. Coding

HEART OF ENGLAND NHS FOUNDATION TRUST

COUNCIL OF GOVERNORS

23rd October 2017

Title:	Information Governance Annual Report and Update
Responsible Director :	David Burbridge Director of Corporate Affairs
Contact	Rachael Blackburn

Purpose	To provide an update on the Trusts current position in relation to Information Governance, changes in the last financial year, current compliance position and key pieces of work for the coming year.
Confidentiality Level & Reason	N/A
Annual Plan Ref	N/A
Key Issues Summary:	• 2016/17 IG Toolkit submission: This was submitted as 'not satisfactory' and requires significant work for 2017/18. • Overview of work undertaken in 2016/17, including a change in leadership for IG. • Detail on the strategic direction and priority work areas required for 2017/18 to improve IG within the Trust. • Current incident themes in the trust.
Recommendations	The Board is asked to review the report noting the current gaps in the organisation and the work needed to rectify them.

Approved by:	Information Governance Group	10th April 2017

HEART OF ENGLAND NHS FOUNDATION TRUST

Council of Governors

23rd October 2017

INFORMATION GOVERNANCE (IG) ANNUAL REPORT

1. Introduction

1.1. Information Governance (IG) provides a framework to ensure all information held by the Trust (including clinical and corporate) is handled in a legal, secure, efficient and effective manner, in order to comply with the law. It also supports the delivery of organisational objectives including the provision of good quality care for our patients. IG covers all information systems and processes used to hold information whether electronic or paper based. This is the first of what will become an annual report on all activities covered under the IG agenda.

1.2. IG will remain at the forefront of NHS priorities in light of the release of the new General Data Protection Regulations. The Trust will be required to have a robust action plan in place (monitored by the Information Governance Group) to ensure it is compliant when the new regulations become law in mid-2018.

1.3. In the last financial year there have been significant changes in the leadership of this agenda within the Trust. A new Executive lead (David Burbridge) took on Board ownership for IG and in June 2016 operational responsibility was given to the Head of Risk and Compliance. At that time there was not a substantive Head of IG in post and this role was filled in October 2016. The change of leadership has resulted in significant improvements to the governance of IG but in doing so has also highlighted areas of concern regarding IG practice across the Trust which had not previously been identified which need to be addressed urgently.

2. Summary

2.1. 2016/17 Information Governance Toolkit Submission

A "Not Satisfactory" rating with a score of 40% has been submitted to the Health and Social Care Information Centre (HSCIC aka NHS Digital) for 16/17. A level 2 is the minimum level for passing a requirement and the Trust achieved a level 2 or above on only 13 of the 45 requirements.

Whilst in itself, this score does not create additional IG risks; it does bring potential risk to the Trust in terms of reputation, ability to work with other NHS Trusts and compliance with various regulatory requirements/expectations.

Some other implications of this submission are it places requirements on the Trust such as creating an action plan for achieving future compliance which the Trust can be monitored against and could impact on other Trusts being willing to share data with us as we are no longer a Trusted organisation.

There are a number of areas of work the Trust will need to focus on in relation to the toolkit; some of these are detailed in section 4 of this paper.

2.2. Freedom of Information Act Compliance (FOI)

The Trust received 736 in 2016/17 compared to 619 requests in 2015/16, showing a significant increase. The Trust responded to 85% of requests within the legal requirement of 20 working days.

2.3. Serious Incidents: ICO Reporting

The Trust reported 3 serious incidents (level 2) to the ICO in 2016/17. These included inappropriate use of system access, which has been identified as a theme over the last year; and loss of detailed handover documentation. In all three incidences the ICO determined not to take any formal action against the Trust due to the ICO audit that was being undertaken in December 2016 and the serious action taken by the Trust in relation to disciplinary and remedial action.

In 2016/17:

- A total of 194 incidents that identified IG as the compliance area, were reported on Datix.
- Of these 3 incidents were reported to the Information Commissioners Office (ICO) as they met the threshold for reporting. These related to inappropriate use of system access and loss of sensitive personal data which ended up in the public domain.
- The top incident themes were:
    - Inappropriate use of system access- this includes staff looking at records of their own, family, friends and colleagues.
    - Lack of appropriate safeguards to maintain security- this includes data left easily accessible in public areas, loss of handovers/ notes and failure to secure work areas.

3. Overview of key areas of work undertaken within 2016/17

3.1. IG covers a number of areas including: Corporate Records Management; Freedom of Information and, Data Protection and Confidentiality.

3.2. The IG team provide support in a number of areas which are business as usual, including, providing expert, and sometimes 'hands on' advice to clinical and corporate teams such as tender support, new Information Sharing arrangements, provision of training, organisational change such as new services/ office moves, new contracts, projects, tailored training, incident management and investigation, as well as day to day customer and client services. This is in addition to the annual work plan that is required to support the IG Toolkit submission and general work plan for business improvement/ planning. Some specific areas are outlined below.

3.3. Strategic IG

Significant work was undertaken soon after the changes to leadership outlined above to bring IG related policies up to date, to fully resource the team, to develop a clear picture of the current status of IG and develop plans for improvement. In addition, an Executive lead IG Group was re-established with a new attendee list to ensure key roles and all divisions are represented and that there was a robust governance process in place for monitoring progress with IG performance. Working to develop a culture of IG is central to this and significant awareness-raising has been undertaken in the area, as it is this which will ensure processes are adhered to and become embedded in the day to day working for all staff.

3.4. IG Training

The IG toolkit sets organisations a target of 95% of staff to undertake annual IG training. In October 2016 the Trust had a compliance level of around 20%; since then the IG Team have worked hard to deliver comprehensive face to face training (complimented by an e-learning package) and has managed to increase the compliance level to 75%[1], which, whilst being a challenge to the team has also been a significant achievement. As part of this work, new training content was also needed in order to meet national standards.

3.5. Corporate Records Management

The Trust is required to have a defined approach for corporate records (everything except individual patient records) of all types in all formats, throughout their life cycle, from planning and creation through to ultimate disposal, to ensure we have a 'corporate memory'. In 2016/17 a new policy and suite of procedures were developed and approved to support staff in this area, and as a basis for further required work in relation to implementation throughout the Trust.

3.6. Information Commissioners Office (ICO) Audit

In December 2016 the ICO undertook a mandatory audit of 2 key areas- Data Protection Governance and Training and Awareness. This was as a result of a number of serious incidents reported to the ICO in 2014/15 where concerns were raised about the Trust approach to IG.

These areas were chosen due to the nature of incidents that had occurred. It is important to note that these 2 areas form a small part of the IG Assurance Framework remit.

The final report graded the Trust as Limited Assurance. The ICO report stated that: *There is a limited level of assurance that processes and procedures are in place and delivering data protection compliance. The audit has identified considerable scope for improvement in existing arrangements to reduce the risk of non-compliance with the DPA*.

As part of the report the ICO highlighted areas of good practice and made a number of recommendations, which are being used to develop an improvement plan for 2017/18. Delivery against this action plan will be reported to the Audit Committee.

3.7. Legacy Decisions

During the year, as practice and process has been reviewed, it has become evident that decisions/ actions taken prior to the current team being in place have, in some cases, been incorrect. This this not only presents a potential risk to the Trust but has also impacted upon the resources within the IG Team as practices have been challenged and unpicked. Examples of this include:

- Previously submitting a 'satisfactory' (level 2) IG Toolkit with a high percentage score which was not accurate;
- Providing a leaflet to all staff attached to pay slips and marking this as compliant formal annual training.

[1] As at 29/03/17

- Approval to send text messages to any patients that present through ED in the Trust, to seek feedback, without seeking consent which is required by the Information Commissioners Office.
- Failure to site exemptions on FOI responses which is a legal requirement when refusing information.

3.8. Freedom of Information

The Freedom of Information (FOI) Act provides a right to request recorded information held by the Trust, and we are required to respond within a statutory timeframe of 20 working days. In the last 9 months the process has been thoroughly reviewed and streamlined, with a robust escalation process to ensure that compliance with the national target is achieved. In addition face to face training has been provided to the FOI Leads to assist them in carrying out their roles

This has resulted in a marked improvement in compliance with that target and significantly reduced the backlog which had built up early in 2016.

3.9. Incident Management

A thorough review and update has been taken in relation to how IG incidents are scored, managed and investigated by the IG Team, to ensure that appropriate investigation and resulting actions are taken to mitigate the risk of re-occurrence. This includes review of all IG related incidents which are scored and followed up as appropriate, regular reporting to the IG Group, clear roles and responsibilities for those involved operationally (such as the requirement to inform the affected data subject) and a formal link being established with HR to ensure disciplinary action is considered and taken where appropriate.

4. 2017/18 Priorities

The IG function has developed a comprehensive work plan, which is constantly being reviewed according to the needs of the organisation and is responsive to changes in legal and national requirements in order to provide the Board with assurance in relation to IG activities.

4.1. Strategic Direction

An important piece of work for 2017/18 will be to consider and define a strategic direction in relation to a number of IG related work priorities and legal and national requirements including: the General Data Protection Regulations (GDPR) due for implementation by May 2018; a number of national and government papers such as The Power of Information2, which sets out a 10 year strategy, IG Toolkit requirements, and this should be used to inform decisions.

It is clear that a significant programme of work is necessary for the coming year in order to change the Trust culture and behaviours in relation to IG principles. The list below highlights just some of the priorities which will form part of the much wider programme of work:

[2] http://www.england.nhs.uk/2012/05/21/the-power-of-information/

4.2. General Data Protection European Directive/ Regulation (GDPR)

The GDPR was released in May 2016 and must be implemented for May 2018. The government has confirmed the UK's decision to leave the EU will not affect the commencement of GDPR, and our compliance with these will be of importance when we are no longer in Europe to show us a trusted country to work with. The GDPR is the most significant change to Data Protection since it was released in 1998 and increases the requirements on organisations in relation to processing personal data beyond those within the Data Protection Act. The importance of the regulations is reflected in the new potential monetary penalty levy which has been set at a maximum of 30 million euro.

The Trust needs to undertake a comprehensive gap analysis to determine the level of work to meet the new regulations; however it is already clear that significant work will be required due us not meeting current Data Protection requirements.

4.3. Information Governance Toolkit

A number of pieces of work will link into the IG Toolkit as the overall compliance monitoring tool. A process has been developed to ensure this work is effectively planned with an aim to submit a satisfactory submission in March 2018.

4.4. Information Governance Training (IGT Req. 112)

Achieve an annual level of 95% compliance which is a national requirement through the NHS Operating Framework 2010/2011 and monitored through the IG Toolkit. The Trust needs to create new nationally compliant content for both new starters and existing staff and to ensure all relevant staff are monitored, e.g. volunteers, junior doctors and student nurses.

4.5. Contracting (IGT Req. 110)

A process developed and embedded to ensure all contracting activities (existing and new) need to be reviewed for possible IG requirements and to ensure appropriate clauses are agreed and are regularly monitored for Data Processors.

4.6. Information Governance Awareness (IGT Req. 200s)

There is a need to develop a communications plan to maintain and develop awareness on an annual basis, particularly around key risk areas, such as safe-haven (secure email) and legitimate access to system. In order to maintain and increase the cultural improvements/ awareness in the Trust over the past year, communications need to be regular and is vital to achieving this.

4.7. Information Sharing

Clear processes and approval arrangements providing assurance, need to be developed and implemented throughout the Trust so that all sharing of personal data is clearly identified, mapped and risk assessed (data flow mapping). This is a significant exercise and the results will create a further subset of work in relation to any compliance failings identified, reviewing arrangements for how data is transferred securely and developing and approving appropriate data sharing agreements will third party organisations we share with.

4.8. Information Asset Ownership (IAO) (IGT 300s)

With cyber security at the forefront of government agenda IAO is an important area to develop. The Trust needs to develop a phased work plan based on priorities for the continuation and improvement of the current IAO framework. This work will further progress made to date, with a focus on looking to define a long term, workable, framework for the Trust. This is a key area for the Trust and one which needs to be effectively embedded with the right people, in the right roles.

To be successful this work requires support from staff across the organisation, especially the Trust SIRO, and recognition of the importance of the IAO role.

4.9. Corporate Records Management

A plan needs to be developed for implementation of a corporate records programme throughout the Trust, including an audit programme, to comply with the policy and procedures already agreed. This plan would impact upon all areas of the Trust and is a fundamental shift in the way staff manage their information.

4.10. ICO Audit Actions

The ICO audit report identified a number of required actions for the Trust which we will be monitored against over the coming year. Failure to achieve these could result in further and greater action by the ICO.

5. Conclusion

5.1.1. The Trust is in a more positive position at year end. There is now a clear and honest picture of the current gaps in the implementation of a robust IG framework, awareness of the associated risks and these are recorded, and the work needed to rectify this identified. The work identified is a significant task for the Trust and will require input from all divisions.

5.1.2. IG will remain at the forefront of NHS priorities in light of the Caldicott 3 review, National Data Guardian Security Standards and release of the General Data Protection European Directive[3] (GDPR) and is integral to the overall future strategic direction of the Trust.

5.1.3. The IG function requests that the Council of Governors recognise and accept the strategic direction and priority areas detailed above, to support a successful IG Toolkit submission, minimise current risks, improve the culture of IG awareness in the Trust and prepare for GDPR implementation.

[3] It has been confirmed the UK will still be required to comply with directive.

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 19 May 2017 at 10.30am

PRESENT:	A Fletcher, Chair T Cannon, Governor D Hoey, Governor J Thomas, Governor D Treadwell, Governor T Webster, Governor
IN ATTENDANCE:	F Alexander, Interim Director of Communications N Boileau, Senior Communications Officer S White, Membership & Community Engagement Manager L Jenkins (Minutes), Executive Assistant

17.01 INTRODUCTION AND APOLOGIES

17.01.01 AF welcomed everyone to the meeting.
Apologies received from: Mr Burbridge, Mr Emery, Rt Hon J Smith & Mrs S Hutchings

17.02 MINUTES OF PREVIOUS MEETING

17.02.01 The minutes of the meetings held on 17 February 2017 were approved as an accurate true record.

17.03 MATTERS ARISING

17.03.01 DT requested an item, boundaries to be discussed. AF stated would be discussed under AOB.

17.04 PROGRESS ON MEMBERSHIP RECRUITMENT & ENGAGEMENT PLAN

17.04.01 FA advised S Hutchings presented at the Council of Governors meeting yesterday the membership plan. A number of governors and colleagues submitted ideas to engage and recruit new members. FA tabled:

1. Plan of what we are doing
2. Details of Governors drop in sessions

17.04.02 SW has drafted a letter to all Governors detailing the drop in sessions which also includes the proposed dates. We need the Committee to agree the contents of the letter, which will then be distributed with the appendix of dates. The Chair of the Trust will write to all Governors again if there is limited response.

17.04.03 FA walked through the letter and feedback was provided. All Governors to advise SW of their chosen 2 dates to support. Discussion followed on how Governors to respond with their chosen dates.

17.04.04 **ACTION:**
SW – Forwarded approved letter and appendix to Governors.

17.04.05 Programme:
FA walked through the programme and recapped the discussion from the meeting in February. The plan takes into consideration how to use social media and face to face engagement. We need to produce a membership recruitment pack to assist in recruitment, which will include redesigning leaflets, using incentive 'freebies' and branded stands will be available along with charity goods.

17.04.06 FA continued we need to review the website so members can sign up on line. We are looking at case studies re: what role is and how fits in with the Trust. Karen Stevens in Communications is looking into the social media side and work is happening in the background. SW has met with South and City College and they want to get involved and FA is looking into this.

We are still working on attending GP surgery to recruit new members as this is a missed opportunity but is proving difficult.

17.04.07 A discussion followed on updating the photo board for Governors.

17.04.08 **ACTION:**
NB – to update Governor photo boards across all sites

17.04.09 FA continued we are looking at completing a monthly article on Governors and including it in the monthly health seminars. We are also looking at including Community Services. A discussion followed on working with other Trusts and advertising each other. FA also clarified if Governors had personal twitter etc accounts, they could re-tweet HEFT tweets, again raising the profile and sending out messages and updates.

17.04.10 **The Committee agreed the Membership Recruitment & Engagement Plan.**

17.05 ANY OTHER BUSINESS

17.05.01 Boundaries and Constituencies
DT stated the importance of boundaries and constituencies presented and provided a high level overview of future boundaries and a copy of the proposals for 2020. The lead Governor has agreed to bring this to the attention of D Burbridge. He questioned can Trust boundaries relate to Government boundaries? FA responded that with the potential merger the boundaries will widen. Boundaries would mirror Parliament ward constituencies, so we should clarify these and mirror. A detailed discussion followed on; constitution, boundaries & constituencies, pre & post merger which would need clarity and Governor elections & length of service. TC advised D Burbridge has completed a piece of work of constituencies and boundaries.

17.05.02 **ACTION:**
FA – compile a 'Questions and Answers' sheet for Governors

17.05.03 Health Seminars
JT advised at the Chair's breakfast meeting, patient experience was discussed including DNA's, appointment letters and lack of consistency, suggested contents for PCPs and to gain and share experience. The Chair is considering setting up a 'think tank' to improve and make consistent. JT will make an announcement at the next Health Seminar and will gain feedback.

17.05.04 Merger timescales
FA advised if all actions and approvals are received then the earliest time for decision would be October. We are unsure if the Committee needs to meet before the next

meeting in September. The Board will approve the application which will require ratifying by the Council of Governors in June/July. A discussion followed as to whether a meeting is required June/July to discuss the constitution. FA will liaise with D Burbridge if needed and schedule a meeting if required. We will need to think about merging membership if the merger is successful.

17.05.05 The Committee noted the sad loss of Francis Linn – who had previously been a Governor. Governors and staff attended the funeral. The Committee discussed the possibility of a memorial.

17.06 DATE OF NEXT MEETING

17.06.01 10.30am, 15 September 2017, Boardroom, Devon House, Heartlands Hospital

.....
Chair

Action Log

Action No.	Date	Action	Owner	Status	Complete Date
17.05.02	19.5.17	Compile a 'Questions and Answers' sheet for Governors for membership drop-ins and other Governor activities	FA	Complete	July 2
17.04.08	19.5.17	Update photo board for Governors across all sites	NB	Ongoing	
17.04.04	19.5.17	Forwarded approved letter and appendix to Governors, re: Governors drop in sessions	SW	Complete	
17.005	17.2.17	1. Membership Manager to contact all Governors in order to discuss their willingness to participate and gather any ideas they may have. 2. The results to be collated and form the work plan to be presented to the March meeting of the CoG. 3. Amy Passey to be invited to a future meeting.	SW FA/ SH/ AH	Completed Completed Completed – Nicola Boileau attended	Jun17 Mar 17 May 17

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, 25 May 2017, in Meeting Room 1, Estates Building, Heartlands Hospital

PRESENT: Sue Hutchings (Chair)
Stan Baldwin
Keith Fielding
Derek Hoey
David Treadwell
David Wallis
Andy Edwards
John Sellars

IN ATTENDANCE: Ann Harwood (minutes)

17.18 APOLOGIES

There were no apologies.

17.19 MINUTES OF MEETING HELD ON 30 MARCH 2017

The minutes of the meeting held on 30 March 2017 were approved as an accurate record.

17.20 MATTERS ARISING FROM MEETING HELD ON 30 MARCH 2017

17.20.1 CPU Walkabout

At the last meeting following the CPU walkabout there were concerns raised relating to the siting of the Hazard signs and cleaning schedules. However neither Gary Jones or Mike Read, who accompanied members on the walkabout, could recall any conversation or comments regarding these issues. Gary Jones has requested that if members could expand on these concerns he would be happy to investigate them. Members were unable to recall what the issues were however if they remember anything this will be raised again at the next meeting.

17.20.2 Food Tasting Session

- Following the complimentary comments made at the last meeting with regard to catering, members endorsed these and stated that they were very impressed with the facilities and the food produced in the CPU. JFS agreed to pass on this positive feedback from the Governors to the Catering Team.
- Sue Hutchings advised that she has contacted Fiona Alexander following the detrimental comments on hospital food made in a recent article by Prue Leith. Fiona Alexander has contacted Prue Leith's publicity people with an offer for her to sample the food served at HEFT. Fiona Alexander is also going to contact the winner of the latest series of Master Chef and invite her to attend a food tasting session.

17.20.3 Main Entrance at BHH

At the last meeting Gerry Moynihan had queried whether some signage could be installed in the Main Entrance at BHH to indicate that the building is not owned by HEFT and therefore HEFT has no control over who the retail outlets are leased to. John Sellars advised that this issue will be added to the agenda for the next quarterly meeting between Assura and HEFT which has been arranged for the 11 July 2017.

17.20.4 Ward Condition Assessments

Jim Fitzgerald, Estates Manager at Solihull Hospital, has confirmed that the comment referring to ward 20a, which was shown against the reporting line for wards 18/19 at SH, was a typing error which has now been corrected and the information referring to ward 20a is now shown on the correct line of the SH ward condition assessments.

17.20.5 Presentation on Signage in Minors and Majors at BHH

- John Sellars confirmed that signage on each site is reviewed when services are moved around. The signage at GHH has been reviewed as part of some works carried out on this site. There are no routine checks of signage carried out but if Estates notice anything wrong with the signage this is reported and addressed. Signage is reviewed prior to the annual PLACE inspections.
- Keith Fielding stated that he had seen 2 cars that day attempting to enter the visitors' car park via the exit. John Sellars advised that quotes have been received for 2 new signs to replace the existing directional signs; these signs will also include information on the 30-minute free parking. John Sellars also advised that as part of the ACAD project the exit and entrance to the visitors' car park will be relocated and signage will be reviewed then.
- David Treadwell queried whether the Trust is happy with the level of security provided at HEFT. John Sellars advised that the Emergency Planning Procedures are being reviewed and staff are made aware of the procedures and have been asked to be more vigilant. West Midlands Police have had a presence in the Main Entrance at BHH.

17.20.6 Bordesley Green Ward Meeting re Parking Issues

As agreed at the last meeting Gerry Moynihan has e-mailed a copy of the Bordesley Green Ward meeting minutes to Sue Hutchings and Ann Harwood. Sue Hutchings has emailed Jacqui Smith regarding the invite for a Trust representative to attend a future ward meeting to discuss the parking issues raised. Jacqui Smith was not aware of this and advised that no invitation has been received. A briefing event is being arranged for local councillors and car parking will be included as part of this briefing.

17.20.7 Stationery Items

David Treadwell queried whether there has been any movement with regard to the availability of simple stationery items in the Main Entrance as since M&S have taken over the retail outlet on the First Floor, there is nowhere where items such as pens, notepaper etc can be purchased. Kevin Bolger has advised that he would look into this. John Sellars agreed to discuss this with Kevin Bolger at his next meeting with him.

17.21 TERMS OF REFERENCE: PROPOSED AMENDED VERSION

David Burbridge has suggested some changes to the Terms of Reference as follows:

- That the word 'committee' be replaced with 'group' so that all Board meetings are known as committees and CoG meetings known as groups, however this is flexible. Members agreed to keep the title Hospital Environment Committee.
- That appointment to the committee/ group should be for 2 years rather than 3 years. As CoG members are elected for a period of 3 years it was agreed that for consistency the Hospital Environment Committee members should also be elected for 3 years.
- The paragraph on Quorum to be replaced with "the quorum for the committee/ group shall be four". A new sentence has been added to state that "the Chair of any meeting shall have a casting vote in the event of an equality of votes". Members were happy with these amendments.
- Meetings to be held on a quarterly rather than bi-monthly basis. Members discussed this proposal and agreed that they would prefer these meetings to remain as bi-monthly for the time being.
- Under 'Duties' to remove the words 'in detail' under 7.2.

- It was agreed that Ann Harwood would amend the ToR as discussed and circulate as the final version.
- Keith Fielding will develop some draft KPIs for discussion at the next meeting in July.

17.22 ESTATES STRATEGY UPDATE

John Sellars gave an update on the Estates Strategy and presented the proposed site layout drawings for the BHH site. The following points were noted/ discussed:

- The Estates Strategy is being driven by the Estates Department following discussions with the clinical teams as there is currently no Clinical Strategy to follow. However this will change with the UHB merger as UHB are producing a Clinical Strategy. The current plans won't reflect this but there are no known conflicts at present.
- Currently the only strategic scheme being actively progressed is the ACAD (Ambulatory Care and Diagnostics) project (phase 1) although discussions have also taken place with the DoH re phases 2 and 3. The DoH has approved initial funding of £3.1m for ACAD to carry out the initial design work and for some enabling works.
- As part of the enabling works Bordesley House will be demolished within the next 6 months. The old Gym building is being converted to office space to accommodate the remaining IT staff currently located in Bordesley House.
- There are also plans to vacate Lyndon Place by the end of December 2017. The lease on Lyndon Place expires at the end of March 2018. The Access, Booking and Choice staff will move to 163 Yardley Green Road. Kevin Bolger and Julian Miller are supportive of these moves. A saving of approx £300k per year will be achieved by vacating Lyndon Place.
- Planning permission is being sought to create a permanent car park for staff on the land purchased from BEN PCT. This car park will accommodate approx 250 spaces.
- In 2011/ 12 the previous ACAD scheme had been at the point of going out to tender when it was withdrawn. The current ACAD project is progressing in detail with the 1:100 layout drawings having been signed off; the next stage is to develop the 1:50 drawings. It is proposed to use P22 as the procurement process. The ACAD building will accommodate outpatients, therapies, day surgery, and day case endoscopy, and will resolve all the immediate issues on the BHH site. The day unit will be open 23 hours per day. The ACAD building will be sited in between the Main Entrance and MIDRU building. This scheme is phase 1 of 3 phases which from an Estates point of view will resolve the major issues at BHH. There will be legacy space created which will be refurbished.
- *Lower Ground Floor*: imaging and diagnostics will be located on this floor and will include CT scanners and x-ray machines. As this floor is built into the bank the floor area is smaller than the remaining floors but will be the most expensive part of the build. Work is underway with the clinical teams and the Architect on the design. Karen Tongue is co-ordinating this aspect and will ensure that the building meets dementia friendly principles and current NHS standards.
- *Ground Floor*: this will be the main outpatient floor, there will be a reduction in the number of outpatient rooms to those currently available but these will be used more intensely. All the rooms have windows to maximise the natural light, to preserve confidentiality these will be high level windows. There will be a number of specialist rooms which are being designed with involvement from the relevant ops teams. The layout includes central seating areas with some sub-wait areas, self check-in pods and electronic screens. Discussions are currently underway with Assura with regard to whether the majority of the self check-in pods could be located in the Main Entrance. It was noted that although the Main Entrance is a PFI it will revert back to the Trust after 25 years from when it was built.
- *First Floor*: this floor will include therapies, audiology, ENT, ophthalmology and the fracture clinic.
- *Second Floor*: the endoscopy and day case units will be located on this floor. It was noted that corridor and door widths will be wide enough to accommodate patients being wheeled in on beds. All floors will be accessible via stairs and lifts.
- *Roof Space*: the roof is mainly flat but will also accommodate the plant room, bed store and the centralised decontamination unit. There will be 4 light wells in the flat roof to bring as much light as possible into the building. It was noted that energy saving schemes such as solar panels are included in the plans. There will be some natural ventilation although

treatment areas will have mechanical ventilation.

- The next stage is to get the plans signed off by the Ops Team which will be by mid-June at the latest. The detailed drawings and the Outline Business Case will then be prepared to be submitted to the DoH by the end of July 2017 The DoH have not yet confirmed how the scheme will be funded.
- Completion is planned for approx 2½ years time. This will then allow the demolition of the existing Outpatients and provide the space for phase 2.
- Fiona Alexander and the Comms team are currently working on the Communications Strategy.
- In the meantime some minor refurbishment/ cosmetic works will be carried out in the existing outpatients e.g. new lighting, painting, new carpets and seating. These works will have a 3-year lifespan when ACAD will be completed.
- *Phase* 2: John Sellars showed members a site map which includes the proposals for ACAD and phase 2 which is currently planned as a 4-storey acute tower on the old Outpatient Department site. The current proposal is for the ground floor to be a new A&E and emergency care department; the second floor will house ITU and Radiology; the third floor will include 2 wards and AMU; and the fourth floor will include 3 wards. The final decision has not yet been made and it could be that the Princess of Wales unit could move into this tower block.
- *Phase 3*: the current proposal is for a new ward block to be sited on the current A&E site, this could be 7-8 storeys and will replace the current tower block. John Sellars advised that it is not cost effective to refurbish the existing tower block. The timescale for completion of phases 2 and 3 is 6-8 years.
- Sue Hutchings queried what the situation is with regard to the refurbishment of ward 5 at BHH. John Sellars advised that the plan is to spend £200k to £300k on refurbishing the ward if access to the ward is given.
- David Treadwell queried what the plans are for the Richard Salt Unit at GHH. It was noted that Dave Smith, GHH Estates Manager, is having plans drawn up to refurbish the existing entrance.
- John Sellars is currently liaising with UHB re the old Estate at the QE hospital.

Members thanked John Sellars for an interesting presentation.

17.23 PHONE CHARGES FOR PATIENTS

- Sue Hutchings mentioned a recent newspaper article which talks about “hospital rip off phone charges for visitors” and queried what the charges are for relatives when they phone patients via the Hospedia system provided at HEFT. It was noted that Hospedia are one of the main providers of bedside communication and entertainment systems in hospitals nationally. John Sellars advised that the Hospedia contract sits with the ICT department, all the equipment belongs to Hospedia whose charges are nationally agreed for television, telephone, internet etc. It was noted that TV channels are free during the morning; Sue Hutchings queried what the charges are for the afternoon and evening. John Sellars advised that there are posters displayed around each hospital site which show the different packages available and the charges. Patients are allowed to use their mobile phones on the majority of wards but are not allowed to charge them due to a number of incidents that have occurred. Keith Fielding queried whether it would be possible to look at one of the bedside systems with a representative from Hospedia. John Sellars stated that this would need to be organised by ICT.
- Sue Hutchings reported that the Patient Carer Panels will be carrying out ward inspections similar to the previous CHC inspections and will be using a standard questionnaire which could include a section on the Hospedia system. She agreed to discuss this with Tony Cannon as to whether the Patient Experience Committee could pick this up.

- John Sellars confirmed that following the PLACE inspections on each site the action plans are being completed by the Head of Estates and Head of Facilities for discussion at the Statutory Compliance meeting which he Chairs on a monthly basis. All the actions are to be completed by the end of August.
- Sue Hutchings queried what was happening with regard to the guttering at GHH and SH where in some areas there is a lot of growth coming out of the gutters. John Sellars advised that some areas are difficult to access and require scaffolding e.g. the courtyard areas at SH. He agreed to contact Dave Smith, Estates Manager at GHH, and Jim Fitzgerald, Estates Manager at SH, and request that they review the guttering on their sites.

17.24 ANY OTHER BUSINESS

17.24.1 Estates Building

Keith Fielding queried why visitors are not required to sign in at the Estates Building reception desk as there is no record of visitors in the building in the event of an evacuation. It was noted that all contractors are required to sign in on arrival.

17.24.2 Staff Parking

- David Wallis raised concern re the availability of parking for staff at SH as he was aware of a complaint from a consultant who was fined for parking on red lines and queried whether there are many complaints received from staff. John Sellars advised that generally there are no issues with the main staff car park at SH, this complaint related to the "consultant's car park", there have been a few complaints re parking in this area. In general parking fines tend to be cancelled for first offences and are usually only enforced for repeated offenders.
- There are however issues with staff parking at BHH and GHH. It is envisaged that the new staff car park on Yardley Green Road should resolve the problems at BHH. The issues at GHH will take longer to resolve.
- David Treadwell queried what the plan is for the Bordesley House car park. John Sellars stated that during the ACAD project there will be a temporary road via the perimeter of the site to the contractors' compound. In the long term it is planned that there will be a visitors car park on this site

17.24.3 Portering and Cleaning Contract

John Sellars confirmed that the Portering and Cleaning contract at BHH will be transferring in-house from the 1st October 2017.

17.25 DATE OF NEXT MEETING:

Thursday, 27 July 2017 at 2.00 p.m.,
in the Floyer Room, Partnership Learning Centre, Good Hope Hospital

.....
Chair

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, 27 July 2017, in the Floyer Room, Partnership Learning Centre, Good Hope Hospital, Rectory Road, Sutton Coldfield, B75 7RR

PRESENT: Sue Hutchings (Chair)
Keith Fielding
Derek Hoey
Gerry Moynihan
David Treadwell
John Sellars

IN ATTENDANCE: Jean Thomas
Karen Glenn (minutes)

17.26 APOLOGIES

Apologies were received from Stan Baldwin, David Wallis and Andy Edwards.

Sue Hutchings introduced Jean Thomas, Lead Governor and member of the Membership and Community Engagement Group, to the meeting.

17.27 MINUTES OF MEETING HELD ON 25 May 2017

The minutes of the meeting held on 25 May 2017 were approved as an accurate record.

17.28 DECLARATION OF INTEREST / REGISTER OF INTEREST

The Register of Interest was agreed with the following amendments:

- Lloyds TSB are no longer a single entity, therefore reference to TSB to be deleted
- Derek Hoey reported that reference to South East Staffordshire to be amended to Staffordshire only

These amendments will be forwarded to Angie Hudson to update the Register of Interests.

17.29 MATTERS ARISING FROM MEETING HELD ON 25 May 2017

17.29.1 Main Entrance at BHH

John Sellars advised that the issue of signage indicating that the Main Entrance at BHH is not owned by HEFT will be discussed further with Assura with a view to them reviewing their signage in the Main Entrance. However it was noted that HEFT has very little influence on how this building is administered.

17.29.2 Stationery Items:

Concerns were raised at the May meeting in relation to the lack of stationery items available for purchase from M&S such as greeting cards, pens etc., as these items had been available for purchase from the previous retailer. John Sellars will request Chris Davies to discuss with Assura as to whether M&S are able to expand their range. Sue Hutchings suggested that this may be an issue that could be picked up during the Patient Experience Ward Drop-in Sessions and agreed to speak to Tony Cannon.

17.29.3 Guttering at GHH and SH

- John Sellars confirmed that the clearing of all guttering at BHH has been completed. Low level gutters at SH and GHH have been cleaned however the high level guttering in the courtyard areas at SH and high level guttering at GHH, will require the erection of scaffolding which will be costly. Unfortunately due to the financial pressures the Trust is facing the Estates team are unable to meet the financial cost this year. It is hoped that it may be possible to incorporate the cost of this work within other projects should the opportunity present itself.

- Derek Hoey reported that there is still some low level guttering outside the Orchard Restaurant at GHH that requires clearing.

17.30 TERMS OF REFERENCE: PROPOSED AMENDED VERSION

- Sue Hutchings confirmed that the Terms of Reference have been completed and forwarded to Angie Hudson to present to CoG.
- Derek Hoey queried that due to items covered by the Committee should reference to disabled access be mentioned in the Terms of Reference. Following the discussion it was agreed that any issues regarding disabled access is the remit of the Patient Experience and Social Inclusion Groups. However it was recognised that there may be some overlap.

17.31 PROPOSED KPIs

The proposed KPIs prepared by Keith Fielding had been circulated to the group prior to the meeting. Following a discussion it was agreed that:

- Members attendance can be easily verified and reported against the KPI.
- Sue Hutchings confirmed that reports are submitted to CoG and the AGM, therefore this KPI is measureable.
- *Estates related walkabouts*: the Committee would have to negotiate with Estates when the walkabouts would be able to take place. John Sellars confirmed he is happy to facilitate with any arrangements however, there may be difficulty in arranging access to wards. Members were asked to consider where they would like to visit and put forward suggestions. David Treadwell voiced concerns that due to practical aspects and the amount of visits carried out by other groups, two per year may be too onerous. Following a discussion it was agreed that two visits per year is achievable and will provide evidence to record against the KPI. John Sellars suggested that the visits could be combined with these Committee meetings which are held at each site.
- Following the review Sue Hutchings asked if the Committee felt there was anything further to add to the KPIs. Gerry Moynihan asked that it be noted that the Committee are there for the patients not themselves or the Trust.
- PLACE inspection recommendations with an Estates based element will be picked up at this Committee and any element which has links with the Patient Experience Group will be taken up by that group. The measure of patient satisfaction will come via patient experience; the difficulty is in how the outcomes are measured as this is the only group which has a set of KPIs as far as members are aware.

17.32 PLACE INSPECTION ACTION PLANS

- John Sellars presented the PLACE Inspection Reports. The inspections are undertaken once a year and a report for each site is circulated. Each area is given 6 months to address the issues on the report.
- The issues highlighted in green and yellow are Estates issues. All issues that have a health and safety concern are prioritised and other issues are completed as much as budgets will allow. Progress against the reports is monitored by the Statutory Compliance Group. Any issues requiring capital investment are placed on the Capital Bids list for funding.
- Sue Hutchings suggested that the reports are brought to each of the Committee meetings to review progress; these could also act as a prompt for walkabouts in line with the KPIs.
- Keith Fielding brought to members' attention an item regarding the storage room (080) at the Fracture Clinic, GHH, and feels that clarification on some of the responses is required. John Sellars will make enquiries, seek clarification and report his findings at the next meeting.
- The blue sections of the report refer to clinical areas and will be updated by the clinical teams. These will be picked up by Tony Cannon and will be monitored via the Patient Experience Group.

- Jean Thomas highlighted the issues regarding AMU at SH which appears to be badly damaged and dirty. Jim Fitzgerald, Estates Manager at SH, will be looking at this and prioritising work. When completing the reports John Sellars will ask teams to expand on comments to give clarity on work carried out.
- Sue Hutchings will speak to Catherine Williams at the next Governors meeting to discuss the process once the reports have been updated and sent back to her.

17.33 ANY OTHER BUSINESS

17.33.1 Treatment Centre GHH

On a recent visit to the Treatment Centre, Derek Hoey was made aware of the following:

- A patient was overheard complaining about the lack of dropped curbs from the disabled car park onto the pavement outside the entrance for wheelchair access.
- Concern over inadequate signage placed on the revolving door warning patients/visitors of an uneven slab. This sign has been in place for at least a week and he would have expected the slab to have been repaired by now.
- Signage for clinic areas (A, B & C) are flush with the wall and not easily visible to patients when approaching from the Main Entrance. There are also a number of A4 paper signs with arrows directing patients.
- Strong/direct sunlight affects the ability to read the digital patient calling screen in Phlebotomy.
- The height of the reception desk at each clinic is not wheelchair friendly and wheelchair patients are unable to see the receptionist from behind the computer screen.
- The renaming of check-in areas/ PODs is confusing to patients. Sue Hutchings stated that this is a useful learning curve to demonstrate the use of standardised NHS signage.
- John Sellars will speak to Dave Smith, Estates Manager at GHH, to discuss the issues raised today and will take instruction from the teams on signage for areas.

17.33.2 Water Dispenser, Treatment Centre, GHH

During recent visits it had been noted that there were no cups at the water dispenser for at least 3 days. It was also noted that the cup dispenser was broken and when enquiries were made about the lack of cups the advice had been that these were in the stores awaiting delivery. John Sellars will feed this back to the portering team to ensure cups are locally stored and replenished regularly.

17.33.3 Gel Dispensers

Members expressed concern over the removal of gel dispensers from the Main Entrance. John Sellars explained that Infection Control had removed the dispensers from public areas due to the units being damaged and the contents being stolen for consumption. Derek Hoey has concerns that not providing hand gel in the entrance could lead to cross infection when greeting patients/visitors. Sue Hutchings suggested that the area in which the dispensers had been removed should be re-decorated.

17.33.4 Devon House

- Gerry Moynihan has noticed the poor condition of the wooden window frames at Devon House and enquired if there are any plans to repair them. John Sellars reported that these works are placed on the Capital Bids list on a yearly basis and where possible window frames are repainted. Those that pose a danger are prioritised and repaired, however due to lack of funding it is not possible to repair/replace all of the windows. HEFT is completing a Site Strategy and the future of the building is still to be decided.
- David Treadwell enquired if there has been any progress with barriers at Devon House. John Sellars reported that this is a low priority for Estates; however the barriers are scheduled for replacement.

17.33.5 Bedford Road Car Park

Jean Thomas reported a large pothole in the GHH Car Park which is very deep and may cause damage to vehicles as well as posing a risk to pedestrians. John Sellars will report this to Dave Smith.

17.33.6 ICT Infrastructure

Work is currently taking place across the BHH site to lay new cabling for the ICT infrastructure. It was noted that ACAD will be a paperlite building and consultants will be using digital dictation. The main computer system will be based at UHB and there will be two 'hubs' servicing HEFT sites. Steve Chilton, Director of ICT, is heading up this work. Keith Fielding will bring this up for further discussion at the Chairs breakfast meeting.

17.33.7 UHB / HEFT Merger

Members enquired if there had been any further news regarding the merger with UHB. John Sellars advised it is not likely that there will be any further communication until November at the earliest. Sue Hutchings advised that there may be an opportunity to discuss this at the Governors Seminar on 4th August.

17.33.8 Head Nurse

Sam Foster, Head Nurse, will be taking up a position at the John Radcliffe Hospital, Oxford. Julie Tunney will deputise until the post has been filled. This may take a few months as vacant posts are not advertised until the post becomes vacant.

17.33.9 Chair of Governors Meeting

Sue Hutchings reported that in the CoG Annual Infection Prevention and Control Report the key points of infection included 'fabric of the wards', specifically wooden doors, and asked whether John Sellars had been made aware of the issues. John Sellars confirmed he has been briefed by Kevin Bolger. Where wards are heavily utilised e.g. ward 19 at BHH the Facilities teams are finding it difficult to gain access for deep cleans. Some work has been completed to remove carpets and individual rooms have been decorated where possible. When the clinical areas are available for handover further deep cleans and maintenance will be completed.

17.33.10 ACAD

John Sellars gave an update on progress with ACAD as follows:

- Floor Plans and Operational Policies have been signed off and handed to the Architect to move to the next stage which is developing the 1:50 drawings.
- Planning for the demolition of Bordesley House and Oncology Bungalow and Car Parking has commenced as part of the enabling work.
- The team are developing the NHSI Business Case which is required for funding from the Treasury. John Sellars will provide a bullet point update for the next meeting.
- Keith Fielding asked if it was possible to have the ACAD project plans forwarded to him as he would like to see the programme. John Sellars explained that due to the large volume of documents it is not possible for the project plans to be sent electronically and agreed to bring copies of the drawings and programme to the next meeting.

17.33.11 NHS Surplus Land

David Treadwell has concerns over the Governments encouragement to NHS Trusts to sell surplus land and queried if there is any threat to HEFT. John Sellars reported that this is only a suggestion from the Government to look at land that is surplus to the Estate. John Sellars feels this is a sensible thing to do, to release land not required by Trusts for development, as it will help to raise income.

17.34 DATE OF NEXT MEETING:

Thursday, 28 September 2017 at 2.00 p.m.,
in Room 2, Education Centre, Solihull 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 in Room 6, Education Centre, Birmingham Heartlands Hospital on Friday 19th May 2017 at 12.30pm

PRESENT:	**CANNON, Antony (AC)**	**Chair (and Chair of the GHH PCP)**
	BALDWIN, Stan (SB)	Governor
	CHAPLIN, Dawn (DC)	Head Nurse, Patient Experience
	FIELDING, Keith (KF)	Governor
	FOSTER, Sam (SF)	Chief Nurse & Executive Lead
	KNELLER, Karen (KK)	Associated NED
	THOMAS, Jean (JT)	Governor
	WEBSTER, Thomas (TW)	Governor
IN ATTENDANCE:	RUDGE, Kevin (KR)	Chair of the SOL PCP
MINUTES:	HIGGINS, Vickie (VFH)	Executive Assistant (Minutes)

17.022 Welcome

AC welcomed everyone to today's meeting and, in particular, KR as this was his first meeting as the new Chair of the SOL PCP.

17.023 Apologies for Absence

Apologies were received from Sheila Blomer, Mick Corser, Susan Hutchings, Louise Passey and Jane Teall.

AC advised Frances Linn past away last month, which was very sudden and unexpected. Her funeral was on Friday 12th May 2017 and AC asked to acknowledge her contribution to the Group. It was agreed she would not be replaced due to her being a Non-Voting Lay Member, as opposed to a Governor.

17.024 Minutes of the Previous Meeting - Friday 20th January 2017

The minutes of the meeting held on Friday 20th January 2017 were agreed as an accurate record and have been forwarded onto Angela Hudson.

17.025 Minutes of the Previous Meeting - Friday 17th March 2017

The minutes of the meeting held on Friday 17th March 2017 were agreed as an accurate record and have been forwarded onto Angela Hudson.

17.026 Matters Arising

The outstanding actions have been updated and are at the back of these minutes.

17.027 Patient Experience and Activity Dashboard

SF advised the dashboard was not being presented at today's meeting as the data had not yet been validated by the Performance Team. However, the A&E target was at 82%, which was not ideal but heading in the right direction. The Trust had seen over 900 attendances during the last two Mondays and it was not clear why. SF will validate the dashboard and circulate with a narrative. It does not duplicate the Board Report and is simply a snapshot of where we are in a one-page document.

JT, on behalf of the Council of Governors, congratulated everyone for the running of International Nurses Day on Friday 12th May 2017.

17.028 Update from the Complaints Team

DC advised there were 434 live complaints in the system in Feb16. They were now at 182. With regard to response rates (ie. complaints closed within 30 working days), Feb17 was at 58% - the Trust's target was 85%, so this was heading in the right direction.

FLRs were previously very high but had reduced markedly - again in the right direction. Many were due to people requesting a follow-up meeting. In Mar17, live complaints over 50 working days were 67. They were now down to 40, with more to do - ie. enhanced data quality checks, ensuring the letter was read correctly and answered appropriately. KPIs were being focused on, linking in with specialties - ie. safeguarding, falls and children's services.

AC asked about the reaction of the Divisions concerned and DC felt some were not taken seriously but were now acted upon.

On behalf of the Group, AC expressed his appreciation for the hard work currently being done.

SB asked about the context of the 85% target, which still had a long way to go and DC confirmed many complaints were extremely complex and took a lot of time to complete.

KK felt FLRs were down due to more being right the first time and those that were left were the more complex cases. SF advised complaints were previously at 500 and the Trust still received around 100 per month. However, Nurses and Consultants now took accountability and there was some healthy competition between the Divisions, as well as Blitz Days, and every complaint being signed off by SF.

TW would like to see the figures put into context - ie. the amount of people making a complaint against the number of people attending - to show a comparison and success stories. DC advised IR1s captured the data and letters often say; "the nurses were lovely but…". DC advised complaints were reviewed as soon as they came in to check for any patient safety incidents and SF advised some complaints come via the Chief Executive's office.

AC asked if SF acknowledged the complaints received and SF advised all complaints go through the same complaints process - ie. a Trust acknowledgement from the Complaints Team advising the complaint was now being investigated.

SB asked about when SF took Complaints over and SF advised this was in Oct15, when it went Clinical, which fitted better but was not unique to the Trust. AC agreed this was a very positive move and SF would now be reluctant to give it up. SF felt responses were very poor when she first took them over but was now much improved. AC felt the Trust could be setting a standard and SF advised of sharing events with QEHB and the newly-devised 'snakes and ladders game', which DC would bring to the next meeting. **Action : DC.**

17.029 Feedback / Verbal Reports from PCP Meetings

BHH - AC advised he had spoken to Mick Corser, who had a standing commitment on Friday's so could not attend that often. AC to propose that the BHH PCP Vice Chair attend in his place.

SOL - KR advised they met on Wednesday 3rd May 2017 (his first meeting). There was a very good presentation by Andrea Field and Claire Whittle on the Associate Nurse programme. There was also an update on Division 5 from Louise Everett and Jenny Lanfermeijer spoke about DNA issues at HEFT and their cost implications. AC felt the appointments procedure required a larger scoping as it was a patients' first impression of the Trust and had raised it during the Chair's Breakfast meeting. This might warrant setting up a Task & Finish Group.

GHH - AC advised Andrea Field and Claire Whittle gave an excellent presentation on the Associate Nurse programme and spoke about HCA progression and apprenticeship schemes.

SF advised the Associate Nurse programme was a controversial scheme looking at going into most acute areas but some were difficult to recruit to - ie. Theatres. They were looking to convert regular nurses to Associate Nurses and Divisions were happy to progress cohorts. The issue was around saving money, so they were looking to convert Band 5s and backfill the posts, with Bank Staff also covering. It had to be affordable but it was a huge opportunity and worth the investment. SF was Chair and sat on the National Trailblazer Group for ACPs. The two-year pilot programme would use our own HCAs, with ACPs in Neonates, Emergency Department and Critical Care.

AC felt this was very interesting and had the full support of the Governors.

17.030 PLACE Inspections (GHH)

As the report for SOL was not yet available, it was agreed this should be deferred to the next meeting.

17.031 Update on Visit to Macclesfield District General Hospital

As LP was unable to attend today's meeting, it was agreed this should be deferred to the next meeting.

17.032 Any Other Business

17.032.1 National Patient Survey

SF advised the Picker Institute would shortly be presenting their findings from the NPS. This was a public document and planned improvements would be circulated within the next few weeks to PCPs, the Divisional teams and this Group.

DC advised there had been over 300 responses and there was a Workshop taking place on Tuesday 23rd May 2017 at SOL to discuss their findings.

17.032.2 Inclusion Agenda

AC advised the Sub Group had not yet met but they were gathering information around identifying vulnerable patients on admission and how data was recorded.

There were "Governor's Drop In Sessions" and tabled document 5a. AC took the Group through this, which outlined complaints themes, compliments, FFT feedback data and details on the visit and debrief. This draft form was to be used as a guide.

AC tabled document 5b, which was to be used from Sep17 onwards. SF gave a background to the Trust's unannounced visits, which had a pre-meet, the visit itself and a debrief. This was then reported through Trust Board, the CQMG for the Medical Director and the Care Quality Group.

KR asked if this was for wards or outpatients and DC advised document 5c was for outpatient areas and also confirmed the forms could be used at the Birmingham Chest Clinic.

AC asked who would complete the reports and SF advised someone from the Corporate Team would attend, be the scribe and complete a draft for the attendees, circulating documents for factual accuracy.

KR asked if feedback would be offered to the patients and SF advised they would if actions could be dealt with before leaving the department. If not, they would be reported on and followed up. The action plans would not be huge but could be managed easier, looking at key issues.

KF felt question 5 around patients and staff required a tick box. AC requested any further suggestions be directed to DC.

SF advised if a patient was given a leaflet on the ward, it was logged in their notes. SF also advised there had been a number of sharing events around pressure ulcers and falls, which received good attendance.

KF asked about document control and DC advised the forms were owned by the Patient Experience Team and would be managed by Catherine Williams. It was also suggested the word "DRAFT" be put on the documents.

17.032.3 PLACE Inspections

KF discussed the recent PLACE Inspections on the three sites and was disappointed at the Infection Control standards and how the Governors and volunteers were dressed - ie. jackets, ties and long-sleeved shirts. KF asked if there were guidance notes available and SF advised the Infection Control Team usually spent a few minutes with people beforehand.

AC advised there used to be a pre-inspection briefing but was not well-attended. The team should ensure they took place and were well-attended. SF agreed they needed to get the briefing and preparation right, especially on the ward, with top tips and information on how to escalate issues.

KF also felt the recent meetings were chaotic at the beginning and AC suggested they met with a senior member of staff on the ward to see if there was anything they needed to be aware of. This was an opportunity to resolve issues - ie. a broken heating unit in the Fothergill Block.

17.033 Confirmation of the Next Meeting

The next meeting will take place on Friday 14th July 2017 at 12.30pm in the Boardroom, Devon House, Birmingham Heartlands Hospital.

Heart of England NHS
NHS Foundation Trust

COUNCIL OF GOVERNORS - PATIENT & STAFF EXPERIENCE GROUP

Schedule of Matters Brought Forward and Action Points

Date Raised	Minute Number	Details	Action	Due	Status	Completed
20May16	16.011	NPS results to be circulated.	SF	Nov16		To be removed
20May16	16.011	Night shifts for new nurses to be discussed with Veronica Morgan.	SF	Nov16		To be removed
20May16	16.012	Theresa Price to be invited to discuss DNAs.	SF	Nov16	Theresa Price invited to the Nov16 meeting.	To be removed
23Sep16	16.033	Michael Kelly to speak to Angela Hudson re. dates of COG and PCP meetings.	MK	Nov16		To be removed
23Sep16	16.034	Julie Tunney to send Care Quality Strategy dates to Michael Kelly for COG.	JT	Nov16		To be removed
17Mar17	17.017	Vickie Higgins to circulate the latest Clinical Quality Report with these minutes.	VFH	24Apr17	Complete.	21Apr17
17Mar17	17.020.1	Frances Linn to send Jamie Emery the information re. a recent possible IG breach.	FL	24Apr17		To be removed
19May17	17.028	Dawn Chaplin to bring the 'snakes and ladders game' to the next meeting.	DC	14Jul17		

Patient & Staff Experience Group of the Council of Governors of Heart of England NHS Foundation Trust

G L O S S A R Y

Abbreviation	Definition
BCU	Birmingham City University
BHH	Birmingham Heartlands Hospital
COG	Council of Governors
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
HEFT	Heart of England NHS Foundation Trust
MFFD	Medically Fit For Discharge
NPS	National Patient Survey
PCP	Patient Community Panel
PHSO	Parliamentary & Health Service Ombudsman
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

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 in the Boardroom, Devon House, Birmingham Heartlands Hospital
on Friday 14th July 2017 at 12.30pm

PRESENT:	**CANNON, Antony (AC)**	**Chair (and Chair of the GHH PCP)**
	BALDWIN, Stan (SB)	Governor
	CHAPLIN, Dawn (DC)	Head Nurse, Patient Experience
	FIELDING, Keith (KF)	Governor
	HUTCHINGS, Susan (SH)	Governor
	KNELLER, Karen (KK)	Associated NED
	PASSEY, Louise (LP)	Governor
	THOMAS, Jean (JT)	Governor
IN ATTENDANCE:	BRADSHAW, Siân (SKB)	Policy Assurance Officer
	RUDGE, Kevin (KR)	Chair of the SOL PCP
	TUNNEY, Julie (JTu)	Deputy Chief Nurse
MINUTES:	HIGGINS, Vickie (VFH)	Executive Assistant

17.034 Welcome

KF welcomed everyone to today's meeting as AC was running slightly late.

17.035 Apologies for Absence

Apologies were received from Sam Foster.

17.036 Minutes of the Previous Meeting

The minutes of the meeting held on Friday 19th May 2017 were agreed as an accurate record and have been forwarded onto Angela Hudson.

17.037 Matters Arising

The outstanding actions have been updated and are at the back of these minutes.

17.038 Equality for Patients Policy

SKB advised of new legal duties around the Equality Act 2010, around:-

- age;
- disability;
- gender reassignment;
- marriage or civil partnership (in employment only);
- pregnancy and maternity;
- race;
- religion or belief;
- sex; and
- sexual orientation.

SKB's is a new role looking at the processes and the requirements of our "service users" (rather than patients). SKB was looking at a number of areas, with specific work around learning disabilities. SKB was also working with DC's team with "My Passport".

LP asked if autism was covered and SKB confirmed it was, via DC's team. They were also looking at Dementia Friendly and hospital signage. The Equality for Patients policy will also cover the Accessible Information Standard, which was due to be completed by 2016. This will include partially-sighted patients receiving the appropriate documentation during their entire time at the hospital. SKB will work on the policy, with a draft coming to this Group within a few months.

SB asked about SKB's role, to which she confirmed was Policy Assurance Officer and a new post. SKB would look at out of date policies, take them to the appropriate Group for approval, escalating to Trust Board or Chief Executive's Group where necessary and conduct follow-up monitoring.

SB discussed issues around parking at the Education Centre. DC suggested SB makes contact with Margaret Meixner.

17.039 Governor Drop In Programme

AC advised these would not clash with the Membership Drop in Sessions and would be around engagement with patients and their relatives. A timetable had been drawn up and teams would include a Matron, Dawn Chaplin/Jamie Emery, two Governors and a PCP Panel Member from each site. There would be a briefing session at the beginning, a crib sheet to be followed and visits would cover areas of specific interest.

DC presented a booklet produced by Shropshire Community Health NHS Trust, which she had picked up during a recent conference. This was similar to PLACE Inspections, Back To The Floor and Drop In Sessions and was entitled; "Observe & Act Course Handbook". This is being supported by NHS England and may be suitable for adoption by HEFT. They were willing to come to HEFT and talk about the process, either in Birmingham or Shropshire. AC stated he felt it was well worth exploring as the level of detail was quite impressive. **Action : DC will try to obtain more copies of the handbook and arrange a further meeting.**

AC felt the drop in sessions should be the responsibility of all Governors and will look to them for their availability. JT felt some would require training and AC suggested the first sessions would be conducted by those on this Committee, until everyone was up to speed. DC had looked at themes and suggested visits to Cardiology, Respiratory and Elderly Care, with one per month as there were lots of wards to cover. Areas could also change - looking at both good and bad wards. AC advised reports would come to this Group, then to the Chairman's Council of Governors Committee and then through the Care Quality Group.

DC felt "Inspection" should be changed to "Engagement Visit". The Group agreed. JTu advised they would cover this at their Away Days and KK felt it was a positive experience.

The Group discussed the questionnaires (attached). The only difference between the two was "Ward" area and "Outpatient" area. AC suggested "Any other comments" be included - ie. television or telephone issues.

LP suggested "autism" was included in question 18 and would be interested to see if it was identified. After some discussion it was decided that Question 19 should be reworded so staff could write in details of any area where they felt they need further training. Training needs would be identified from the gradings given to each question, plus the Question 19 response, which might identify new areas not previously considered.

17.040 Feedback / Verbal Reports from PCP Meetings

SH - KR gave an update. There had been lots of comments and feedback but no answers. One patient had an LOS of 120 days but could not be discharged as they had nowhere to go - not home or into a home within the Community. Wendy Crathorne from the Discharge Team spoke and suggested we required a purpose-built place to go to in between. DC agreed this was frustrating and AC felt there were many reasons for not discharging and this needed to be focused on. JT agreed, with issues around the Social Services process and waiting for family or carers. JTu advised there were lots of meetings going on - ie. Red To Green, ADTs, etc. - and this was frustrating but happened every day. There was then a discussion on step down beds and how some Trusts were joint funding them with their local authority.

GHH - AC advised the recovery of prescription charges was discussed, with issues around not paying at the time and then receiving a letter from Finance demanding payment and warning of debt collectors. Shahzad Razaq, from the Senior Pharmacy Team, spoke and advised the whole question of prescription charges and their recovery was being looked at by the Pharmacy Accountant and an update would be given at the next meeting.

BHH - AC advised the last two meetings have now been cancelled and some work needed to be done to build up the Panel. It was suggested maybe the local Governors at BHH could help. AC recommended an invite to new members be put in the BHH Hospital Newspaper and the 'Heart & Soul' Magazine as a start.

AC advised Ann Horton, Deputy Chair, had been invited to join this Group as, unfortunately, Mick Corser could not attend Friday meetings.

17.041 Update - PLACE Inspections

AC advised DC and Catherine Williams had done an excellent job on the reports and they were currently chasing the actions.

SH felt there could be an overlap with Estates issues held by John Sellars, reporting through the Hospital Environment Committee. It was agreed, because of the involvement of PCP Panel members, this Committee would also maintain an overview.

SB asked about the colours and was advised Green was for Estates, Blue was for the Wards and Yellow was for Domestics.

KK asked about Birmingham Chest Clinic and AC advised this was an out-patient facility and not covered by the PLACE remit.

17.042 Complaints' "Snakes & Ladders" Game

This was not covered at today's meeting due to time constraints. **Action : VFH will put this on the agenda for the next meeting (20 minutes).**

17.043 Any Other Business

17.043.1 Inclusion Agenda:-

AC advised this would cover all patients and was automated at UHB. With the merger, this could become fully electronic but huge resources would not be put into this.

AC showed the Group the "Hospital Passport" brochure (attached), which is to be discussed at the first Sub Committee meeting, to be reviewed and for the Group to come to a consensus. Other issues were around those that were colourblind, so the boxes could include hatches. When finalised, the nursing and corporate teams could identify those vulnerable patients.

SH asked if this currently in use and AC advised it was but only at SH. DC felt we required a universal one, with good foundations and being more inclusive. LP advised Macclesfield District General Hospital used a similar "passport" for autism and had won awards.

JTu advised this could be electronic in the future via PICS but this could take two years.

AC suggested the Sub Committee (AC, SB, DC, KF, SH and LP) met in August 2017. The date suggested was Friday 18th August 2017 at 10.30am. KF is unable to make this date but feels there is ample knowledge and experience in place without his attendance. **Update : VFH has booked Room 3 in the Education Centre at BHH from 10.30am to 12.15pm.**

17.043.2 Dashboard:-

The Dashboard was not available for today's meeting but will be circulated to the Group once it was ready.

17.043.3 Visit to Macclesfield District General Hospital re. Autism:-

As there was no time to discuss this at today's meeting, LP will give a 10-minute presentation at the next meeting. **Action - LP.**

17.044 Confirmation of the Next Meeting

The next meeting will take place on Friday 15th September 2017 at 10.00am 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
19May17	17.028	Dawn Chaplin to bring the 'snakes and ladders game' to the next meeting.	DC	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		
14Jul17	17.043.3	Louise Passey to give a 10-minute presentation from her visit to Macclesfield District General Hospital.	LP	15Sep17		

PATIENT & STAFF EXPERIENCE GROUP OF THE COUNCIL OF GOVERNORS

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MFFD	Medically Fit For Discharge
NPS	National Patient Survey
PCP	Patient Community Panel
PHSO	Parliamentary & Health Service Ombudsman
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