Notice is hereby given that a meeting of the Council of Governors
of Heart of England NHS Foundation Trust will be held at
the Harry Hollier Lecture Theatre, Partnership Learning Centre, Good Hope Hospital
on 5 May 2015 from 4.00 to 5.30pm

A G E N D A

		Timing (mins)
1.	Month 12 performance (Oral – J Brotherton/ D Cattell/ A Catto/ S Foster)	30
2.	Reports from CoG Cttee chairs:	
	a. Finance & Strategic Planning (30/03/15) (Enclosure & Oral – A Fletcher)	5
	b. Hospital Environment (05/03/15) (Enclosure & Oral – E Coulthard)	5
	c. Membership & Community Engagement (13/03/15) (Enclosure & Oral – A Fletcher)	5
	d. Patient & Staff Experience (meeting13/03/15) (Enclosure & Oral - M Kelly)	5
	e. Quality & Risk (26/01/15 & 23/03/15) (Enclosure & Oral – L Steventon)	5
3.	Report on the work of the Board Audit Cttee, plus Q&A (Oral – A Lord)	20
4.	2015/16 Annual Plan (Enclosure – D Cattell)	10
5.	Any other business previously advised to the Chair	
6.	Next Meeting – 2 June 2015 at the Village Hotel, The Green Business Park, Dog Kennel Lane, Shirley, Solihull B90 4GW	

Refreshments will be available from 3.30pm

Kevin Smith
Company Secretary
30 April 2015

COUNCIL OF GOVERNORS
FINANCE & PERFORMANCE & STRATEGIC PLANNING COMMITTEE
DRAFT

Minutes of the Finance & Strategic Planning Committee

of the Council of Governors of Heart of England NHS Foundation Trust held BHH Education Centre, on Monday, 30th March 2015

Present:	Mr P Johnson (Acting Chairman for Meeting)	
	Mrs K Bell	
	Mrs O Craig	
	Mr R Hughes	
In attendance:	Mr D Cattell	Director Finance and Performance
	Mrs A Jones	Chief Financial Controller
	Ms J Hodgkiss	Head of Planning and Development
	Ms H Evans	Operations Manager ABC OPD
	Miss L Hamp	Personal Assistant (minutes)

1. APOLOGIES

Mr A Fletcher, Mr M Trotter, Mr B Orriss, Mr M Hutchby, Ms A Khan, Mrs M Vaughan

2. MINUTES OF MEETING HELD ON 14th JANUARY 2015

Mr Johnson agreed to chair the meeting in the absence of Mr Fletcher. Mrs Bell believed that she would be chairing the meeting. It was agreed that Mr Johnson would chair today's meeting and Mrs Bell would chair the subsequent one. It was decided that the Council need to elect a new Chair Person by election.

The minutes of 14th January 2015 were accepted as an accurate record.

3. MATTERS ARISING / ACTION LOG

The following items were discussed under matters arising.

Fraud Policy

- Mr Hughes enquired as to whether the policy covers fraud by a Director of Finance and what procedures were in place. Mrs Jones replied that it does and, if such a matter happened, then procedures would be dealt with via Deloitte and passed on to more senior members for further investigation. Mr Cattell offered to review the current policy and, if deemed necessary, to make adjustments to the policy. **AJ**

Chair Person

- Mr Johnson stated that Mr Fletcher no longer wished to be chairman for the CoG meetings and it was agreed that, at the following meeting, a new Chair Person should be elected.

HR Staffing

Mrs Jones advised that this would be addressed by Hazel Gunter at the next meeting scheduled for 21st May 2015 at Heartlands.

4. OPD CENTRALISATION (IT UPDATE)

Ms Evans summarised the information contained in the report provided and advised that the reduction in waiting lists had progressed slower than originally anticipated. She explained that it was necessary to progress one area at a time to deal with any resistance and ensure properly implemented. It was stated that senior staff members no longer have a choice to oppose centralised booking as the programme of works has been approved.

Ms Evans stated that endoscopy will be a large department to centralise, however there is positive feedback coming through.

Mr Hughes asked what stage we are at. Ms Evans advised that it would likely take an additional 12 months to complete the project. Departments still to be completed included Heartlands diabetes, paediatrics, T & O nursing and ante-natal out-patients. Overall the feedback is that it is better and safer for the patients. The next three areas are being planned include endoscopy, where the ultra-agenda IT system has been amended to reflect new booking rules. Some departments, such as MOs, (skin cancers), would be slower than others. The project team ensure the process is embedded before leaving each area.

Mrs Bell asked if there were problems in endoscopy with patients not being included on lists. Ms Evans acknowledged there had been issues but a new procedure is in place where Ms Price does an e-mail check for all those patients that had gone onto lists.

Ms Evans then went on to clarify the stages that were going to be put into place in future to measure the efficiency of clinics. This would start with a simple clinic start and end time before moving to measuring time per appointment.

5. GHH TREATMENT CENTRE (IT APPOINTMENT LETTERS)

Ms Evans stated that it had not been possible to mute the requested change to letters due to the flexible use of treatment centre areas. Instead, additional volunteer support has been provided who are greeting patients at the door to direct them to the right clinic areas, thereby reducing queuing times.

Mr Johnson asked if car parks were near to treatment centres. Ms Evans stated that there had been a change in parking arrangements at GHH where the staff parking and visitor parking had switched. Mr Johnson then went on to ask if patients just went to where they saw rather than read their letters. Ms Evans responded that on occasions they do turn up on the wrong site.
Mr Johnson asked if it was possible to text patients about appointment reminders like GP surgeries do. Ms Evans went on to say that work was on going with IT to arrange this type of service, however as they had changed IT company there is a re-work on service. An automated service with the facility to change appointments was an option that is currently being worked on.

Ms Hodgkiss stated that work with estates in respect of the signs was in progress. Ms Evans stated that GHH needs better signage especially inside the treatment centre. Mr Hughes commented that external signage would be an issue for the Environment committee.

Mr Johnson asked whether we monitor DNAs. Ms Evans confirmed that they do. Mr Johnson then asked if scheduled clinics take DNAs into account and did it matter if clinics ran late. Ms Evans stated that it does however, there would be knock-on effect if clinic times ran over due to additional commitments that consultants had elsewhere post clinic times, for instance, scheduled surgery. She advised that the Trust refunds additional parking costs if clinics over-ran. Ms Evans also stated that DNAs have fallen from 14.5% to 10% thereby meeting Trust targets, although there was still work to be done.

Mr Johnson then enquired whether reminder letters were sent out to all patients, to which, Ms Evans responded that they did, but it didn't necessarily mean that all patients open / read the letters. Ms Evans then advised that the option of utilising an off-site organisation for printing and postage delivering leave an audit trail of what had been posted out. Ms Evans also went on to say that the Trust is considering using the NHS logo on envelopes to help facilitate patients to recognise an appointment letter rather than junk mail using only the NHS logo eliminates any impact on data protection regulations. The booking service also run an evening booking-calls process to remind patients of their appointments.

Mr Hughes enquired whether the Trust wide policy in respect of DNAs makes reference to patients with dementia when appointments are booked. Ms Evans responded that patients with dementia are not yet given special consideration. However, given that this was such a valid comment the policy needs amending to take into consideration a patient's state and whether Care-Of Information is available. **HE**

Ms Hodgkiss stated that this would need to be included in the Trust-Wide Dementia policy lead by Nial Fergusson. Ms Hodgkiss noted that the dementia strategy / policy will be one part of the Trust's overall strategy. A skeleton strategy is to be presented to Trust Board on 14th April 2015 which will then be presented to the Governors in June 2015.

HE

It was agreed that Ms Evans would talk to Nial Fergusson and then approximately 6 months from now would update this meeting.

6. CORPORATE STRATEGY UPDATES

Corporate Strategy

Ms Hodgkiss outlined that changes that were taking place following on from the meeting 12th January.

Chief Executive and Professor Matthew Cooke were developing a suite of strategies for Board approval. The final version of this document is due to Trust Board in September 2015. Mr Cattell explained that the overall strategy was a clinical strategy with quality aims which would give the overall direction of the Trust and set-out some key quality indicators. This would be supported by a series of enabling strategies including IT, investment and workforce. This would then translate into what it meant for each site. The strategy is not a start from nothing as much of the ground work has been done and feedback from external stakeholders had already been collected and there were ideas coming out of the staff engagement sessions. Mrs Bell asked what ideas had come up in engagement events.

She noted that, whilst comments had been received from those people who are interested, views from nursing staff at patient facing level had not yet been widely heard. Ms Hodgkiss stated that Andrew Foster had commented that he had seen less attendance from staff of lower grades and more would be done to engage within these groups.

The strategy would give a direction of travel and would be refreshed every year to get ideas, thus generating a "Living the Strategy" programme. This will be embedded through appraisals.

Mr Hughes asked about surgical reconfiguration. Ms Hodgkiss responded that the next step is for the CCG to go out to consultation but there is some ambiguity on what is on each site.

Mr Johnson asked whether in terms of morale / culture there is room for improvement. Ms Hodgkiss responded by saying that morale is low requiring an engagement change. Ms Hodgkiss advised improvements could be made by listening / making changes so staff are re-assured they are being listened to. Mrs Bell commented that there was not enough bank staff as agency workers are being utilised more. Agency and locum staff use funding which could be utilised elsewhere.

Ms Hodgkiss explained that reputation issues externally had worsened this situation. As part of financial planning a capacity demand exercise had been done to work out what heads and beds the Trust needs. However this might require funding but both Mr Cattell and Mr Locke are aiming to put long-term fixes in place.

Mr Cattell advised that resources in the right place equates to pro-active not re-active action. The Board are considering options for other actions including a more flexible workforce such as paging, a small premium for being on stand-by at short notice.

The ACP strategy, which is with Gary Swann, and a programme for health care assistants is being reviewed by Sam Foster. Mrs Bell stated that training systems for nurses needs to be reviewed.

Mr Cattell summarised that the issues he had heard on the strategy were:

- Governors want to be involved,
- It was important to capture the views of all interested parties,
- Workforce is a large part of the strategy, and
- The estate (what is where).

Mrs Bell asked how we were getting views from the ground level. Lisa Thompson had advised her that forms for staff were being completed on a regular basis but Mrs Bell commented that this leaves staff feeling they are being hounded. Therefore an even balance needs to be achieved to obtain correct / useable feedback for the Strategy Policy.

It was agreed that Hazel Gunter needs to look at some hot-spots. **HG**

7. FINANCE & PERFORMANCE MONTH 11 UPDATE

Mrs Jones highlighted the following key points:

<u>Month 11 Figures</u>

- At Month 11 the Trust had a COSR rating 4 (highest rating) delivering a YTD deficit of £8.4m, £9.4m adverse to Monitor Plan and £2.8m adverse to YTD forecast submitted to Monitor in December. Monitor accepted the revised forecast of £5.6m deficit position.

- Mrs Jones stated that the winter plan included the use of the private sector as part of the revised forecast because is required to improve performance on 18 weeks. Mr Johnson asked if this was in line with other trusts. Mr Cattell advised it was higher than other Trusts and that we would continue with the private sector for an additional 2 / 3 months to assist with the backlog of patients. He then advised re-fix patients coming in would equal capacity allowance. It will take between 6 / 12 months to obtain a capacity / patient ratio.

- Efficiency delivered £14.9m of SIEP (service improvement efficiency plans, formally CIP) YTD, 68% of target and month 11 delivered 71% of in month target. Forecast to deliver £16.5m which is 75% of £24m target. Mrs Jones stated that this is not where we want to be.

- Mr Hughes asked whether the finance budgets are achievable. Mr Cattell stated that it is important for us to start from the right place heads and beds and service provider to put costs into the budget.

- Cash balance £102m, £19m above plan with the majority includes capital not spent and some delays in creditor payments in quarter due to Oracle system upgrade. Debtors were £5m lower than plan which is a positive for the Trust.

- Mr Hughes asked if BCC owed us any money. Mrs Jones advised that they did not owe us money due to non-fining.

- Capital total approved expenditure budget for the year of £41m including £12.m carry forwards. Forecast reduced to £28m in submission made to Monitor in December. Month 11 showed YTD spend of £17.7m, £5.3m lower that YTD forecast. Current forecast £22m which is a further reduction due to site strategy schemes.

- Mrs Jones went on to explain that £15m debt was not an unreasonable level for a Trust this size. However, we are continuing to work on this. It was also confirmed that CCGs have not paid some invoices due to performance issues and maternity is owed c£3m.

Performance

- A&E 4 hour 95% target was missed in November and YTD position is 90.9% and 18 weeks target also not hit.
- Mrs Bell asked if it would be more efficient to move minor injuries out to separate from major.
- Mr Cattell advised that there is a need for increase in capacity and possibly a new-build for A&E at a later date. Investing in quality of service returns money back. This would make the Strategy Plan achievable. Mr Cattell also went on to say that revised trajectories with innovative / radical measures would improve the situation.
- Mr Johnson asked if it would ever improve. Mr Cattell re-iterated that radical / innovative measures were the way forward.
- Cancer targets remain difficult but are on trajectory for the March delivery given the surgical demand for specifics.

Annual Plan

Mrs Jones outlined the revised Monitor time-table where draft numbers are to be submitted in mid-April and final numbers in mid-May. Mr Hughes asked whether it would be £10m deficit or more and could it be improved. Mr Cattell replied that £10m deficit was a realistic forecast at this stage of the recovery programme and it probably could not be improved.

8. ANY OTHER BUSINESS

Mrs Bell asked whether it would be possible for the CoG meetings to spread across the hospital sites and not just in one location. Mrs Jones advised that she would look into GHH **AJ**

and SOL and ascertain what availability there was and forward the required information by e-mail to all attendees.

Mrs Bell and Mr Johnson are going to make arrangements to appoint a Chair Person.

9. DATES OF 2015 MEETING

Dates and venues for future meetings require clarification as the proposed dates were not suitable for all attendees. The following have been proposed and will be confirmed shortly after this meeting.

Thursday, 21st May '15 @ 10.00a.m. – 12.00p.m. BHH Board Room (papers to be issued on 19th May).
Wednesday, 2nd September '15 @ 10.00a.m. – 12.00p.m. – Location - TBC
Wednesday, 21st October '15 @ 10.00a.m. – 12.00p.m. Location - TBC

Committee Chairman

COUNCIL OF GOVERNORS
HOSPITAL ENVIRONMENT COMMITTEE

Minutes of a meeting of the Hospital Environment Committee of the Council of Governors, held at 2.00 p.m. on Thursday, 5 March 2015, in Meeting Room 1, Estates Offices, Heartlands Hospital

PRESENT: Elaine Coulthard (Chair)
Sue Hutchings
David Treadwell
Arshad Begum
John Sellars

IN ATTENDANCE: Steve Waller, General Manager Pathology
Gary Jones, Trust Catering Manager Solihull Hospital
Karen Glenn, Programme Administrator (minutes)

NOT PRESENT: Carol Doyle

15.10 Overview of the Phlebotomy Service at HEFT

Steve Waller, General Manager Pathology, presented an overview and future plans for the Phlebotomy Service provided by HEFT. The following points were noted/ discussed:

- Phlebotomy at Solihull Hospital currently provides a service to hospital wards, A&E and the community.
- The services received on average around 400 – 500 patients per day, 60% of which are GP referrals. Currently the service has over 200 collection points from across the region and aims to have the majority of samples tested within 6 to 8 hours. Bloods generally are not stored over night as this can result in variable readings.
- The X City CCG have given the service 6 months' notice on the contract after which the phlebotomy service will be distributed to GPs to carry out their own tests.
- Steve Waller and his team have been talking to a number of GPs in the area to develop and modernise the service. The current thinking is to either develop 1 large central hub or form a number of smaller Phlebotomy hubs in the community. The smaller hubs would allow easier access to the community, especially the elderly who may otherwise find it difficult to travel to a central hub.
- The next step is to look into possible sites for the hubs and to communicate ideas with GPs and Health Centres.

Elaine Coulthard thanked Steve Waller for his presentation. David Treadwell and Elaine Coulthard have offered to speak to GPs within their areas and distribute any information available. Steve Waller will forward the promotional materials and the list of GP surgeries/health centres to EC and DT.

15.11 APOLOGIES

Apologies were received from Ron Handsaker, Emma Hale and David O'Leary.

It was noted that Barry Clewer had resigned as governor. David Treadwell is concerned that there is a possibility of committee meetings no longer being quorate. Elaine Coulthard acknowledges the

issue, however feels that the committee meetings should continue as long as there are no decisions formally made.

15.12 MINUTES OF THE MEETING HELD ON 8 January 2015

The minutes of the meeting held on 8 January were approved as an accurate record.

15.13 ACTION SHEET FROM MEETING HELD ON 8 January 2015

15.13.1 Treatment Centre at GHH

- John Sellars confirmed that works have been completed and the roadway widened.

15.13.2 Terms of Reference

John Sellars has submitted the TOR to Kevin Smith to review. The approved Terms of Reference have not yet been received therefore this item will remain on the agenda for confirmation at the next meeting on 7 May 2015.

15.13.3 RSU Entrance, GHH

- Elaine Coulthard reported that since the gel dispensers had been relocated to the left hand side of the entrance it has proven difficult to access the dispenser as items such as wheelchairs are often in the way.
- John Sellars will contact Dave Smith put the dispenser back to its original place.

15.13.4 Ward 3 Heating

- John Sellars has been on ward 3 at varying times in the evening to assess the temperature on the ward. During these visits he noted that nurses were in short sleeves and when asked there were no complaints about being cold.
- John Sellars provided temperature charts for various periods the results were distributed to the committee. One chart shows a drop in temperature, when investigated it happened that a cleaner had left a window open. It was also discovered that a heating pump had not been working properly and this has now been replaced.
- Elaine Coulthard brought up concerns of the lack of decant space and ward refurbishment at BHH at the Council meeting.
- John Sellars is aware of their concerns regarding the lack of space at BHH and that this leaves us with no swing space for expansion.
- Sue Hutchings is concerned that BHH will get to a stage where the wards will be uninhabitable. John Sellers is aware of these concerns and the Trust will continue to review the viability of a refurbishment programme.
- Arshad Begum asked if the Maternity project was still going ahead. John Sellars confirmed it is and will bring a presentation to the next committee meeting on 7 May 2015.

15.13.5 GHH A&E Entrance

- Elaine Coulthard reported that although the new revolving doors at GHH are operational, it has been noted that the sensor which detects obstructions is too sensitive and detects and stops the doors from working at the smallest piece of debris.
- John Sellars will ask Dave Smith to investigate the issue.

15.13.6 CHC Inspections

- Catherine Williams has confirmed the updated reports outlining the actions taken following the CHC inspections are circulated to all CHC members.
- Sue Hutchins thinks it would be useful for the committee to receive a copy of the next CHC inspection report and actions.

- John Sellars confirmed that the next inspections will be the PLACE inspection. The process for reporting back has changed and the CHC now report directly after the meeting. Catherine Williams has agreed to forward the report as a priority; John Sellars will present the report to the committee at the next meeting on 7 May 2015.

15.13.7 Privacy Dome in A&E

- Dave Smith, Estates Manager at GHH, has confirmed that the order has been raised and is waiting for the contractor to complete the works.

15.13.8 Restaurant/ Coffee Shop: Food Change

- John Sellars confirmed that the chilled unit for the Costa Coffee shop has been installed and now offers a healthy option.
- Elaine Coulthard feels that the WRVS signage needs updating.

15.13.9 GHH Multi Story Car Park

John Sellars presented an update on the position for the GHH Multi Story Car Park project, main points are:

- The Board is currently reviewing the Capital Plan and a decision is awaited as to which schemes will be taken forward.
- If the decision is made to go ahead with the Multi-Story Car Park and Richard Salt Entrance refurbishment this will solve the issue with the toilets in the RSU.
- BHH Estates Team is in talks with Birmingham City Council re the purchase of the BEN PCT land, which could be used to create car parking space at BHH.

15.13.10 Faith Centre

Arshad Begum has raised the issue of the ablution space within the ladies toilet facilities at BHH Faith Centre. John Sellers acknowledge that he had received Arshad's email which he has forwarded to Jamie Emery and Sarender Chana, for them to contact Arshad and take this forward.

15.14 Ward 3 Heating

This agenda item has been discusses at 15.4.6 above.

15.15 Good Hope Restaurant Refurbishment

Gary Jones has been invited to this meeting to give an update on the GHH Restaurant Refurbishment Scheme, the main points of discuss were as follows:

- Elaine Coulthard commented on the location of the restaurant as it is quite a distance for nursing staff to walk to.
- Gary Jones reported that other location options had been looked at but there is nowhere else suitable to site the restaurant.
- The restaurant has been upgraded and refurbished and renamed "The Orchard Restaurant". Chillers have been installed which offer a range of sandwiches and salads. The restaurant also has the facility to offer a range of hot foods.
- The restaurant is open from 8.00am – 11am for breakfast and 2.00pm – 3pm for lunch. The restaurant remains open between these times serving hot and cold refreshments
- First indications so far are that the restaurant is doing very well.

15.16 Terms of Reference

As discussed at 15.4.4 the ToR have not yet been finalised and will be carried forward for discussion at the next meeting on 7 May 2015.

15.17 Any Other Business

David Treadwell commented on the state of the car parking barriers outside Devon House which are in a poor condition. John Sellars has agreed to look into this.

Elaine Coulthard proposed that the Committee needed a Vice Chairman to lead the Committee meeting when the Chair is unable to attend. David Treadwell proposed Sue Hutchings for Vice Chairman, seconded by Elaine Coulthard, Chair. The meeting agreed and proposed Sue as Vice Chair who was happy to accept the position with immediate effect.

Sue Hutchings expressed her concern at the low numbers of Committee members. The following points have been made:

- David Treadwell is a little concerned that there are instances where the committee meeting is not quorate. Elaine Coulthard does not see this as a problem providing decisions are not made unless the meeting is quorate.
- Arshad Begum is unfortunately unable to attend meetings that are not held at BHH.
- A proposal has been put forward to try and recruit a new committee member.

Sue Hutchings pointed out that the only location that the committee has not visited is the Chest Clinic. John Sellars is happy for the meeting on the 7 May to be held at the Chest Clinic on Great Charles Street, Birmingham.

John Sellars presented background information on the position regarding the Chest Clinic, the main points of discussion were:

- The two buildings adjacent to the Chest Clinic have been sold to a private company. There is a possibility that Birmingham City Council will want to sell the Chest Clinic building also. The Trust is in discussions with our solicitors to ensure that HEFT rights are protected should BCC decide to sell.
- Currently HEFT pay a peppercorn rent to BCC and it is felt that if the building is sold the new owners / landlord could make life difficult for HEFT.

15.18 DATE OF NEXT MEETING

2.00 p.m. on Thursday, 7 May 2015, at Birmingham Chest Clinic, 151 Great Charles Street, Queensway, Birmingham, B3 3HX

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Chairman

PATIENT EXPERIENCE
COMMITTEE OF THE COUNCIL OF GOVERNORS
MEETING
Friday 13th March 2015 at 14:00
Education Centre, Heartlands Hospital

Attendees		**Apologies**
Arshad Begum	Governor	Sheila Blomer
Kath Bell	Governor	Elaine Coulthard
Sue Hutchings	Governor	Jamie Emery
Mike Kelly – Chair	Governor	Sam Foster
David O'Leary	Governor	Lisa Thomson
David Treadwell (part)	Governor	

In Attendance

Richard Brown	Deputy Director, Patient Experience
Peter Colledge	CHC
Frances Linn	CHC
Elaine Tandy	Governance Manager
Tom Webster	CHC
Sandra White	Membership Manager

Bev Bellerby - minutes

Welcome and Apologies

All were welcomed to the meeting. Apologies were received from those shown above.

Minutes of Previous Meeting and Actions Arising

The minutes were accepted as a true record.

Actions arising – item 1 – actioned

Action 2 – actioned

Action 3 – RB gave an update on the feedback from Estates Committee regarding ward refurbishments, etc. The group were concerned that Estates were not completing outstanding works but RB confirmed that heat curtains had been installed as had revolving doors at GHH. There were no areas to move patients to, to allow work to be done in the Tower Block at BHH but capital money was being sought to allow some remedial work to be undertaken.

FL advised that the Ophthalmology area at Solihull was in a terrible condition. OPD had rusty radiators. Wheelchairs could not get up the corridor. Ophthalmology was on Chairman's agenda, so hopefully, some work would be undertaken to improve things there.

Action 4 – check with JE – unsure if JE had met Julie Tunney, Deputy Chief Nurse re patient quality. Invite her to the next meeting – **Action 1**

Action 5 – Actioned

Action 6 – DNA rates had reduced, with increased patient numbers, which was a good result. MK fed the information to the recent CoG meeting.

Quality Accounts

ET gave the meeting an update on where Quality Accounts were. She was doing a draft document which was slightly behind schedule. The paper would be going to EMB on 17th March, to decide on priorities for next year; the Trust only needed between 3 and 6 but had had 7 for several years. ET would ask EMB to look at community services. Sam Foster had become the executive support to Quality Accounts which might give QA a higher profile.

One of the requirements was to externally audit 18 week pathway, which had not been met for some time; EMB were aware. Governors would be asked to pick one so ET asked the group to pick which one they thought was the most important to concentrate on.

ET gave the meeting an overview of what had been done around some of the items on her list; fundamentals of care was not based on figures; it could be audited but would be more difficult and there were no definite outcomes as it was more about emotion and feeling. The other options were falls, pressure ulcers, fractured NOF, stroke, dementia and discharge.

Dementia was well looked after at Solihull but was not so good at BHH. After some discussion, the Governors decided to concentrate on dementia.

Update on Patient Experience and FFT – all sites

RB advised that the feedback was on January's data.

The data showed 90% positive responses from 37% (1864 patients) response rate on recommending or highly recommending the Trust.

The sites were different – BHH 44% response rate – Solihull 45% response rate (up from 21%) – GHH dropped to 20% for Jan from 34%. RB was awaiting the detailed February data to get a better picture, but the figures were likely to have dropped from 37% to around 31% as a Trust. If GHH were low again, some work would be done to find out what had happened, especially compared to the other sites.

BHH's responses were 90% positive and GHH and Solihull were 92% positive

TW asked if the change in senior management had made a difference to feedback. RB had not noticed any change to patient care feedback, which was important but the results had actually become more positive over the last few months.

A&E responses were consistently at 18-19% but really needed to be 20%.

Solihull had a better response rate – 22% for January. AMU was a grey area as the 4-hour A&E clock stopped ticking once patients moved into AMU. It prevented people being sent home too soon or admitted inappropriately and 77% people said they had a positive

experience overall. Solihull was 86% positive (the same as the national average and above the regional average); BHH scored 70%.

Patient Experience was not as bad as it was often thought to be. The FFT results showed that it was good, in the majority of responses.

Update on Complaints

RB advised that he had started to look at complaints in different ways as just knowing the number did not really give much information.

There were 68 new complaints in January, showing fairly steady numbers each month and including formal and informal. Only 0.24% of people that came through the door complained.

RB also looked at all complaints that had been reopened and 35 fitted that category since October 2014. The complaint had to be the same as the original complaint to count as a reopened one. New issues would see a new complaint being recorded. TW was keen to compare the reopened figures with the complaints as a total. RB advised that he could do some work on that.

The Trust had dealt with 21 Ombudsman referrals in a year but only 4 were upheld or partially upheld.

Complaint themes over the 3 quarters of the year had been:

- Delays and cancellations
- Attitude and behaviour
- Appropriate treatment
- Poor information or a lack of information
- Medication issues

Quality Impact Assessments were in place to address changes to systems within the hospital, to ensure that patients were not negatively impacted. Any extra complaints could then be picked up and fed back.

TW mentioned psychological elements that affected patients' opinion of the hospital, such as broken lifts, a lack of drinks facilities, etc. The Trust should declare the number of people seen at each hospital. DOL mentioned a leaflet that was sent out and the figures were too small and needed to be bigger. RB agreed size 12 or 14 was optimum.

SH raised an issue around relatives/carers needing drinks in A&E and added UHB had a drinks facility which worked well. On waiting room counters they had drinks of water available. Elaine Coulthard volunteered at GHH, which involved her handing out drinks to visitors, but it would be good to be the same across the sites. RB offered to speak to Hilary Clemson, A&E Matron. **Action 2**

SH advised that at UHB they had a board where you could insert counters to say what you liked about the Trust. RB advised that it has been stopped as it is not a recommended way to collect data, as it could not be audited, accurately.

TW commented that the new way of feeding back on complaints was much more interesting to the meeting and thanked RB for his hard work on collating the data.

AOB

FL mentioned a nice story in the press in Solihull about how the hospital was going to develop.

RB asked if there was still a GP liaison service in the Trust. SW advised it was disbanded around 2 years ago. DT asked how the Trust was promoted with GPs and CCGs. RB advised that GP lectures still existed.

SW was a member of her local PPG; she had been invited to give a presentation to the PPG network of around 20 members, which would promote the Trust.

KB was also on her GP's PPG but it was not in the Birmingham area. She advised patients that they could come to HEFT and other Birmingham hospitals but her GP was not keen to advertise it as she thought it could have a detrimental effect on their local hospital.

FL attended 'Solihull Together' meeting which included Solihull Hospital and Solihull Council and also the local GPs with an aim of making things work well in the region.

SH asked staff to give their Pride of Nursing nominations to the Birmingham Mail.

KB did a night time visit with Sam Foster and Ann Keogh on 29th December and visited several wards and A&E. She advised that it was useful but did not answer the questions if patients were disturbed at night by noise, dementia patients, etc.

They were also supposed to do another one to go to look at the environment of the tower block which was supposed to be rearranged. She asked if it was going to be reorganised. RB suggested mentioning it to Sam and pick up the ward area to prevent separate visits being undertaken.

Date of Next Meeting

Friday 15th May, 12:00 noon, Boardroom, Heartlands

Action Log

Action No.	Date	Action	Person responsible	Completion Date
1	09.01.15	Meet Julie Tunney, Deputy Chief Nurse re patient quality. Invite her to the next meeting	Jamie Emery	Before next meeting on 15.05.15
2	13.03.15	Speak to A&E Matron re providing drinks to relatives/carers when in A&E	Richard Brown	Before next meeting on 15.05.15

APPROVED AT MARCH MEETING

Minutes of a meeting of the

COUNCIL OF GOVERNORS

QUALITY AND RISK

Heart of England NHS Foundation Trust

Education Centre-Solihull Hospital - Monday 26th January 2015 10.00am

Present	Title	Initials
Liz Steventon	Chair & Public Governor	LS
Kath Bell	Public Governor	KB
Barry Orriss	Public Governor	BO
Anne McGeever	Public Governor	AM
Andrew Lydon	Public Governor	AL
David Treadwell	Public Governor	DT
Jammi Rao	Non-Executive Director	JR
In Attendance:		
Louise Rudd	Head of Clinical Governance	LR
Ann Keogh	Director of Medical Safety	AK
Sam Foster	Chief Nurse	SF
Clive Ryder	Interim Medical Director	CR
Juliette Stem	Governance	JS
Maria Conneely	Minutes	MC

1.Apologies for absence

Heidi Lane & Mark Pearson

2.Minutes of the previous meeting

The minutes were accepted as a true and accurate record.

3.Actions from previous meetings

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

SF was asked if she could give an update on effective employment of nursing/other staff (Action 4). She responded by explaining that not all clinics have a trained nurse assigned to them and that it depended upon the nature of the clinic and whether some patients attending the clinic might need nursing intervention. SF commented that her nursing colleagues believe that they have a firm control over nurse cover required for each clinic, and how clinics are organised, and each clinic is planned around patient need.

SF explained that her nursing colleagues are quite keen to progress some other technological advances such as the automated check-in that they have at the Birmingham Queen Elizabeth Hospital. This should be possible with the support of the new interim ICT director.

There was a discussion about Pathology and whether routine Full Blood Counts (FBC) are used to identify B12 deficiency (Action 13). In summary CR confirmed that the results from FBC's were not routinely reviewed to check for this deficiency unless requested to do so.

DT commented on the time span between the Governors Quality & Risk (Q & R) committee meetings and how the momentum can be lost in time spent reviewing the actions list. The Chair explained that this is why the committee introduced the Action Plan Tracker, as historically some items could fall off the action list but now the Tracker, included with the minutes, should allow us to keep actions open from previous meetings.

DT asked about actions which the committee considered were more time critical and the Chair explained that updates for such actions could be emailed between meetings or brought up at the general COG meetings.

AL informed the committee that he had attended a dementia seminar last weekend and had taken the opportunity to have a discussion with Niall Ferguson, which had answered some of the questions that he had raised at previous meetings. To keep the group informed of such discussions the Chair suggested that

AL could provide a written summary at the next meeting.

ACTION: AL to provide a summary paper / update (re discussions around dementia) for next meeting

SF asked about the action around development of a Dementia checklist and asked what was the aim of the action. AL re-iterated his concerns that when patients with dementia come into hospital, it can be common for other clinical conditions to get overlooked.

SF expressed concern that the action may already be covered under the Dementia Strategy and suggested that it may be useful to invite Niall Ferguson and Philip Hall to present the Dementia Strategy and four key work-streams at the COG meeting, following which this committee could request assurance on the key areas of delivery of the strategy and in turn report back to COG. SF stated that Governors who were not able to attend the governor presentation would be welcome to attend workshops that were being delivered as part of the Strategy.

The Chair asked whether there was an opportunity for a governor to sit on the Dementia Strategy Board (DSB) and asked AL if he would be willing to attend on behalf of this group and the COG.
AL agreed to this and SF explained that the Board was very new and the underpinning framework to support it was still being established. SF confirmed that it would sit within the Quality & Improvement work stream alongside other key quality improvements.

AL expressed his view that he had major reservations about the priorities in the quality account.

ACTION: MC to find out the dates of DSB meetings
ACTION: LS to ask the Trust Chairman to invite presentation of Dementia Strategy at future COG meetings and inform Kevin Smith (KS), Company Secretary, of proposed Governor representation

4.Matters arising from minutes

BO asked about the loss of historical information now that records are computerised citing an example from his recent experience.

CR explained that it is unlikely that the records are lost, more that they are difficult to find or expensive to access, particularly if the records have not yet been scanned and the physical records are stored off site. AK offered to look into this particular case for BO if he wished (with provision of his written consent).

ACTION: BO to provide written consent to AK if investigation of the example he cited was required.

There was a discussion on rewarding nurses and SF explained that all the sites were taking part in:

- Cupcake Friday for newly qualified nurses
- Staff wellbeing days.
- Corporate “Thank-you” cards from Chief executive to staff who have been personally named by patients.

There were also efforts around multi-professional debrief & resilience building. SF commented that whilst things are starting to emerge in addition to the main staff recognition awards, we cannot ignore the significant amount of pressure there is at the moment. At every shift change there is the stressful situation of clinical staff continually having to review how safe the sites are and move staff around to maintain safe cover. SF also mentioned an example of this when on a particular shift two wards at GHH had no qualified nurse cover and required staff to be moved.

5.Questions to Clive Ryder: Interim Medical Director

CR1 What doctors and consultants are being investigated

In summary CR confirmed:

- 10 are under investigation, 2 are excluded, and 4 have significant restrictions.
- We don’t have to wait until staff have done wrong to investigate them. There is often a pattern of behaviour that suggests a doctor may be struggling.
- Sometimes rather than it being a problem individual it can be a systemic Trust issue.
- We are under pressure to get the balance right for the patient, employee and Trust

CR2 How can we ensure that the Trust truly is putting the patient first when we are dealing with doctors / consultants under investigations

In summary CR explained:

- We have to do what is safe for the patient. However there is a need to carefully balance the impact of any actions taken:
- If we have to take a Doctor out of practice or severely restrict their practice we may have stopped them doing harm to a certain group of patients but they will then not be available to see another group of patients. This means that someone else will have to pick up this additional workload which in turn will have an impact. For example, if there is one procedure that a Doctor does not do well, then as long as you are sure that he does the other aspects of his job appropriately you are supposed to try and keep him in work
- If we make a decision to take someone out of practice this can be seen as pre-judging an investigation. The investigation process, despite attempts to shorten it, can take 12 months if there are serious, significant concerns.
- Doctors /consultants represent a higher investment for the country and the government direction is encapsulated in 'maintaining our professional standards'. This has made it more difficult for Trusts to exclude staff. It is considered to be guidance but is being used as law.

- SF commented that it is easier in nursing because if it is around a medicine error, for example, you can reasonably work through whether you should stop someone from administering medicines, but if there is a lack of confidence in other areas of their practice, then we tend to exclude across the board. In general if the concern is around a technical skill it is easier to make a reasonable judgement.
- There is a lot of evidence to suggest that someone who has been suspended/excluded for a period of 6 weeks or more has a decreased likelihood of ever returning to their job. Therefore it is better if we can make a reasonable adjustment and keep them in the workplace

CR3 How soon is information being shared with the governors and who make the decision as to when it is considered appropriate

CR informed the Committee that:

- Doctors who are excluded have to be reported to Board at a regular interval and there is a Non-Executive Director (NED) attached to their investigation to make sure that it happens.
- It would be inappropriate to give identifiable information to the public about people that we were investigating, and might have the effect of avoiding investigations and discourage people from coming forward with their concerns

The Governors explained that they do need to be assured of progress with cases and be provided with a way to keep track of new cases and any trends. Action **JR to keep committee informed**

The committee asked how the need for investigations come**s** to light. CR responded by informing the committee that the following factors have been used

- Patient complaints
- Datix incident reports
- Personal communication from staff members
- Serious Untoward Incident Investigations
- Directorate
- Site/Division
- Appraisal/revalidation process

CR went on to say there are two main groups who appear to struggle: - Doctors within their first few years of taking up a consultant's post. They are often the most supported and therefore tend to get picked up and managed appropriately and the second group are well-established doctors who may have got "left behind" with current ways of working. The job that you learned on day 1 is not the job you are doing 10 years down the line

LS asked if these difficulties could have been picked up in the appraisal system and are the Trust up-to-date with consultant appraisals. CR assured the Committee that he felt that we were "ahead of the curve" with the consultant appraisal process.

CR4 In the light of the Kennedy review what is considered a timely manner to inform patients that their doctor/consultant is under investigation. How soon would we recall patients?

CR commented that it was difficult to get this right and often several meetings were needed to judge how and when patients should be recalled. CR explained that such decision-making was easier when there was a measurable clinical test to support the recall approach.

CR explained the decision to recall was a complex balance of the need to deliver safe patient care with the desire not to worry patients unnecessarily. This can be a difficult balance. Sometimes it is possible to target small groups of patients which makes the decision easier. There are some difficulties with recall:

- Unable to provide clear advice to patients about their safety risk
- Staff available to carry out clinical review.

CR5 What is the situation with regards to the JAG accreditation

CR explained that the endoscopy unit build is back on which will help support JAG accreditation. He explained that we are currently missing out on some screening work, which has a potential financial impact. The new building will provide an improved environment in which to host the endoscopy service.

CR6 Are you confident that your doctors know how to treat patients with dementia?

CR explained that core medical training taught that if a patient comes in with a label you should never assume that the label is what is causing the current symptoms, however sometime clinicians can forget to look for common things. He commented that, in his opinion, there were becoming almost too many screenings that need to be completed in ED, so that doctors may not fully focus on the patient's needs.

AK explained that junior doctors have acronyms to help with assessing patients such as PINCH ME (Pain, Infection, Nutrition, Constipation, Hydration/Hypoxia, Medication, Environment) to help remind them of tasks they need to run through.

There was also a discussion about the role of the GP in the management and follow-up of such conditions and it was noted that all GP practices have access to iCare, although some choose not to use it.

CR7 What changes have been implemented since the Kennedy Review and what checks are being made to ensure that the Trust does not find itself in that situation again?

CR commented that he feels that our hospitals are now a much safer place to be than they were before the Kennedy Review. He reiterated his view that you can never be complacent or fully confident and commented on the responsibilities outlined in the "Duty of Candour" and "Raising Concerns" Policies as well as other local & national initiatives.

KB discussed an example of a young doctor not knowing how to raise a concern about a consultant. The key points of the discussion were:

- There were now forums to enable discussions of this nature, for example the "Risky Business Forum" run by AK.
- It is easier to raise institutional/system issues but much harder if it is about a person's behaviour/bullying.

CR8 Are you confident that we do not have any 'rogue' consultants working in the Trust now?

CR's overall answer was "No". He went on to explain that The Trust has had a huge input into Consultant appraisals/re-validation that was the Department Of Health (DOH) response to Shipman. However, re-validation does not solve the problem of rogue doctors. If doctors are very bright and very bad they can cover things up.

CR explained that the thing he found most disappointing was when peers ignore what is going on in their own departments.

CR9 What is your recruitment strategy to ensure safe patient care and do you see a need for role changes as our patient profile changes?

CR commented that going forward there is a potential problem developing to allow the delivery of good quality medical care in the NHS in the future. The current view seems to be that we need the same number of doctors or fewer doctors. It is a concern that we start from a low baseline in terms of number of consultants and the reality is a lot of the roles previously delivered by Junior doctors will have to be delivered by someone else, whether that is senior doctors or non-medics

The question of who trains the Doctors remains. There have been attempts to turn medical training into books and simulation, however, there is a huge problem and we need strategies and resources to sort it out.

CR explained that we have to design our workforce to help lessen the impact of these changes and noted that SF had already explained about Advanced Clinical Practitioners, (ACP) which he agreed was an extremely sensible strategy that the TRUST should support and introduce quickly.

There was a general discussion about politics and the changes it meant to the NHS as well as the "Better Care Fund" and the challenges posed by the increasing number of doctors who are specialists rather than generalists.

CR10 As we had a SUI resulting in a Neo-natal death through delays in transferring a patient from Good Hope to Heartlands via the Neo-Natal transport `team what actions have been proposed to ensure that when surgical reconfiguration takes place that procedures are in place for the safe and speedy transfer of patients between the sites?

CR explained the Surgical Reconfiguration gives us an opportunity to look at patient pathways and make sure they are correct rather than designed around bricks & mortar. At the consultation events a lot of questions have been have asked around internal hospital transport (patients and/or relatives).

DT commented that the issues around transport had been covered in the planning document that had been published.

CR commented on the current thinking about the best place for treatment, saying that the NHS could learn from the army, where they have to consider whether treatment is most appropriate "At scene", "At 1st place of safety" or "At final destination".

The Chair commented that there were rumors circulating that, according to the Ambulance Service patients are not brought to Solihull A&E. SF explained that they will bring planned admissions from GP's and also occasional patients requiring resuscitation where clinical need (e.g. cardiac arrest) dictates but not acute cases or sick children.

CR11 Under Multi Disciplinary Teams (MDT) a point was raised that following the Safety Visits that BO had taken part in some time ago it was apparent that not all surgical teams were functioning effectively. Some teams were not holding team meetings, or briefing sessions at the start of surgery; but more importantly some nurses felt that they were being put under pressure by consultants to skip or fast track some of the pre-op checks. Please respond to this

CR and SF acknowledged that the MDT working was not perfect, for example, there are tensions between the 3 groups in theatre: anesthetists, surgeons and nurses who are all under pressure.

CR noted that whilst some consultants may not yet "believe" in the WHO's (World Health Organisation) "Safer Steps to Surgery" they should nevertheless, do as required. The WHO checklist is audited and fed back to clinical teams. Deloitte were commissioned to do a review of Theatres and when completed the report will go to the Audit committee. It was noted that it should also go to the Quality & Risk committee.

ACTION: AK to schedule an Internal Audit Theatre Review for the Q&R Committee

SF commented that she was able to discuss cases where individuals have been spoken to and dealt with and that escalation processes in theatre are in place regarding WHO checklists, although it is unfortunate that they are needed.
AK commented that these are also being reported as incidents, which is good as it suggests that things are moving and people are able to talk about it.

CR12 Following SF comments on the loss of the Sexual Health Service tender and the need to understand the impact that this will have. What are the risks, current and potential, in relation to the sustainability of associated services at HEFT? Could you please update on this?

CR explained that the Trust is aware of the impact on the HIV services and potential knock-on impact on the Infectious Disease Unit (which the Trust are very proud of) and should seek to protect it as a Trust.
HIV services are more difficult to deliver. We are still in discussion with Birmingham Council – we need to have a conversation with University Hospitals Birmingham (UHB) to decide who is going to provide the service.

CR13 The chair invited any other questions:

AL asked for an update on the Trust and what was the position with Monitor and the CQC.
CR commented that from Monitor's point of view, there was a 30-day plan, which is all about establishing what was wrong. This is followed by a 90-day plan, which is about turning the diagnostics into change. CR explained that the idea was the patient becomes central, so that all other services wrap around this concept and the conversations move from "what can you do for the money?" to "what is required?" He explained that corporate structures and departments would also need to support this idea.

CR outlined that the 90-day plan makes HEFT write down what changes are to be implemented. We are only in week 9 of the plan; therefore there are still only variable amounts of detail under each of the main headings.

AL asked about the intention for Quality & Safety to displace the dominance of finance & performance in the management of HEFT, as outlined by Andrew Catto to the Governors breakfast meeting in December.
CR responded- There has been significant change in the organisation in the last two months and it is clear that quality & safety of patients and Trust staff is the main priority.

SF commented that since September 100 extra beds for winter have been made available, we pay a premium rate to our staff to man those beds. There is an exit plan to open a substantive ward at Good Hope however this goes against the overall plan, which was about bed reduction. SF explained that previously plans were driven by financial drivers however now the move is to make sure that they are balanced by quality.

DT asked when could we stop using the term 'interim' as he thought it was giving a bad message.

CR outlined that the challenge of "interim" CEO will be to make things less 'interim'. These roles are a recognition that the permanent appointments will need to be made in a timely manner.

6. Board Quality & Risk Minutes

The Chair asked if there were any questions arising from the minutes of the Quality and Risk Committee. The following queries were raised

Page 4 – last paragraph: Divisional Compliance Report on Mandatory training.

The Committee was informed that the data quality that had informed this report had been questioned and was being looked at. JR would be asked to comment at the next meeting.

ACTION: Question for JR: What is the current position re: mandatory training and how are we managing it

DT asked if the COG Patient Experience Committee was now also covering clinical effectiveness, SUI's and other issues looked at by this Committee.

LR explained that reciprocal arrangements had been put in place between the two committees when the Terms of Reference were last revised.

The Chair clarified that she would expect this Committee would deal with the safety aspects of an issue and the Patient Experience Committee would focus on the patient experience elements.

ACTION: AK to speak to Lisa Thomson to understand how the Patient Experience Committee **works**

and how the two Committees can work together on issues

7. Kennedy Task Force update

JR briefly outlined the 22-page summary from Ian Kennedy (IK), which was a follow up to his initial report.

The report was critical of the Trust's response to the original report, particularly the manner in which delivery of the actions had been approached. The Trust had established a Task Force to oversee the delivery of the actions however the Trust hadn't made the actions part and parcel of the working practice of the Trust.

JR highlighted the work-stream around changing the culture of the organisation, acknowledging that it would take some time to achieve this and that IK had been critical that our approach had been reactionary.

JR also commented that the Deloitte Governance review & Mortality review had been published since the initial report and delivery of the actions from all of these reviews would need an integrated approach.

The overall suggestion was that we no longer need the 10 Kennedy work-streams, instead focusing on three:

- Breast recall
- Safety & quality of care
- Culture change

That each of these needed an executive-led work-stream, therefore allowing the NED's to challenge and scrutinize rather than deliver these actions. In summary JR confirmed that we do not need the taskforce in its current form.

JR briefly highlighted that achieving and measuring culture change will be the real on-going challenge

8. Feedback following night visit

KB presented a report summarising the night time ward visits that she undertook with SF and AK. In summary:

- The purpose was to visit several wards in response to a concern raised by MP at a previous meeting that patients did not feel safe at night on our hospital wards, with issues such as low staffing, noisy wards, unanswered call bells and wandering confused patients.
- The Emergency Department (ED) and various wards were visited and staff spoken to - who in the most part seemed happy in their work, however some issues were highlighted re: Health Care assistant (HCA) temporary staffing arrangements, suitability of the bereavement room for parents who had experienced a miscarriage (the use of gynaecological charity funds to address this is now being considered).
- There was only one ward with a general air of unhappiness, which appeared untidy with patient notes scattered across the nurse station and there was an open, unlocked, unsupervised medicines trolley although all the staff on the ward were busy with patient care. (The Chief Nurse has taken action to understand the issues on this ward).
- KB also highlighted some areas of good practice, including "pop-up wall paper" and "memory bank" to support patient with dementia.
- In summary most of the wards they had visited appeared calm and under control and they had not observed any patients wandering about wards. KB concluded that whilst the visits were useful they had not answered the question of whether patients felt unsafe at night as due to the late hour, most patients were either settled for the night or asleep, therefore could not be approached for their input.

SF discussed that all sites have a 'worry ward'; this is often when the lead nurse is not there (e.g. sick leave, recruitment) and these areas are kept under surveillance.

SF highlighted a piece of work being undertaken with ICT (Information, Communication and Technology) to link the Jonah Board, the Bed Office, the Clinical Site Bed Management Picture and also loop into the Discharge Hub. The aim of this would be to improve communication around bed management, capacity and flow and reduce some of the non-value-added work that is needed to maintain the current system.

KB, SF and AK agreed to conduct more night visits in the calendar, but overall felt quite positive coming away as nothing appeared to be really concerning on that night, despite it being busy.

ACTION: SF to inform KB of further dates re: ward visits

9. SitRep report

The Chair invited question about SitRep. In summary the discussion was around:

- Is there a problem with delayed diagnosis, as this seems to be a factor in a number of current open SUI's? Discussion followed about specialist areas only being focussed on their own area of results information and not necessarily what else the results might say. Also around the role of working with patients and GP's so that they know when they should expect their results and what to do if they don't get them.
- What is a SUI, what is our threshold in declaring a SUI and has it changed. Discussion followed around interpretation of the national incident framework being variable across organisations and that the Trust has intentionally lowered its threshold on what is a SUI.
- AK informed the committee that in her view there was a need for a regional group to share learning from SUI's and move toward a more common threshold for declaring a SUI.

10. AOB

DT asked if there was a policy regarding patients walking around the corridor with dirty/spoiled garments/dressings.
AK explained about the Infection control policy and also the role that staff take to help patients maintain their privacy and dignity.

The chair suggested that members of the committee consider any questions that they would like to raise with Jammi Rao at the next meeting and forward these to her.

ACTION: Members of the Committee forward any questions that they wish to pose to JR to LS

11. 2015 Dates:

Date	Time	Venue
Tuesday 12th May 2015	10:45am to 13:00hrs	SOLIHULL Education centre - room 6
Wednesday 8th July 2015	10:30am to 13:00hrs	HEARTLANDS Education centre – room 2
Monday 28th Sept 2015	10:30am to 13:00hrs	SOLIHULL Education centre – room 1
Monday 23rd Nov 2015	10:30am to 13:00hrs	HEARTLANDS Education centre – room 1

11. Action log

Date of minutes	Item	ACTIONS FROM PREVIOUS MEETINGS	Target date	Owner
Dec 14	1	Update on current & possible risks and sustainability of associated services at the Chest Clinic	Jan15	**CR**
Dec 14	2	Investigate Risks over maintaining the Chest Clinic – awaiting an update from the Estates team who are completing a risk assessment.	Jan 15	**LR**
~~Dec 14~~		~~Waiting times for Biopsy results at GHH & report back at 26th January meeting~~	~~Jan 15~~	~~**LR/CR**~~
~~Dec14~~		~~Report back on effective employment of nursing/ other staff (page 4) bring update to March meeting – if not possible bring to May meeting~~ ~~Whether nurses were actually nursing or being used as a chaperone to patients~~	~~May 15~~	~~**SF**~~
Dec 14	3	**Questions to JR re: rolling review members of staff under investigation- carry over each meeting**	Mar 15	**LS/JR**
Dec 14	4	**Questions to JR re: Kennedy 6 month follow up report- carry over to March meeting**	Mar 15	**LS/JR**
Dec 14	5	This committee to receive feedback that was given to Trust following the CQC visit as soon as possible- update Jan – delay with report as the person completing the surgical part is unwell	ASAP	**JR/LL**
Dec 14	6	Report back on SUI referring to transfer of neo-natal patient from GHH to BHH- To bring sui at a glance to May meeting	May 15	**AK**
Dec 14	7	Confirm area where we are bottom of matrix for Patient Experience, (Page 3 Q&RC minutes) and report back 26th January meeting- LR to email out asap	Jan 15	**LR**
~~Dec 14~~		~~Update on JAG accreditation – Delayed as HEFT need to re-apply~~ ~~HEFT has asked for deferral until its known where as a Trust we are going~~	~~Rolling action till resolved~~	~~**AK**~~
		ACTIONS FROM THIS MEETING		
Jan 15	8	AL to provide summary paper / update (re discussions around dementia) for next meeting	Mar 15	**AL**
Jan 15	9	MC find out the dates of meetings		**MC**
Jan 15	10	LS ask Trust Chairman to invite presentation of Dementia Strategy at future COG and inform KS of proposed Governor representation		**LS**
Jan 15	11	BO to provide written consent to AK if investigation of the example he cited was required.		**BO**
Jan 15	12	AK to schedule Internal Audit Theatre Review for Q&R Committee		**AK**
Jan 15	13	**Question for JR: What is the current position re: mandatory training and how are we managing it**	MAR 15	
Jan 15	14	AK to speak to Lisa Thomson to understand how the Patient experience group works and how the two Committees can work together on issues		**AK**
Jan 15	15	SF to inform COG of further dates re: ward visits		**SF**
Jan 15	16	Members of the Committee forward any questions that they wish to pose to JR to LS		**All**
Jan15	17	JR to keep committee informed of the status of staff under investigation		**JR**

TEMPLATE BOARD PAPER

Title: Annual Plan Return (APR)						**Attachments:**	Y
From: Director of Finance and Performance		**To**: Trust Board					
The Report is being provided for:							
Decision	Y/N	Discussion	Y/N	Assurance	**Y/**N	Endorsement	Y/N
The Board is being asked to:							
Receive an update on the development of the 2015-16 APR.							
Key points/Summary:							

The Trust is required to submit a final 2015-16 APR to Monitor by the 14th May 2015. A draft version of the IIP was submitted on time to Monitor on the 12th April 2015 having been signed off by the Monitor Standing Committee as delegated by the Trust Board.

This paper provides an update summary on what we have to do, what we have done so far, what we still have to do and how and when we plan to do it.

The attached paper contains a Monitor prescribed narrative section which the Board is able to review. This is not yet populated given critical information is still to be approved (the IIP) or provided (Initial Strategy view).

The golden thread running through the 2015-16 APR has to be Trust Recovery. Trust Recovery will merge seamlessly into implementation of Trust Strategy in due course.

The attached papers are not yet complete, content is summarised and format is provided for information.
Board members are asked to comment on assumptions and provide comments on future content, particularly in relation to the IIP.

The summary paper outlines how we have reached this point and at the end of the document it outlines what still needs to be done and where assurance is provided and where approval is given before submission on the 14th May.

The Board is specifically asked to note the assurance process followed by the Trust Executives so far.

The critical elements of the APR are;

1. **Governance** – sign off process
2. **Finance** – financial planning assumptions and following from activity levels
3. **Narrative** – ranging from Strategy (Pyramid of Priorities) to operational delivery of performance targets
4**. Communications** – a full communications plan must be developed to summarise the key elements of the operating plan to ensure cascade throughout the Trust to enable delivery of key priorities.

Once the Board sign off the plan, regular updates on progress will be presented back to the Board for assurance on delivery and determination of risk.

Recommendation(s):
Note the development of the APR, further work and delegate authority to MSC once further work to complete the documentation is made by Trust Executives.
Assurance Implications:

Strategic Risk Register	**Y**/N	Performance KPIs year to date	**Y**/N
Resource/Assurance Implications (e.g. Financial/HR)	**Y**/N	Information Exempt from Disclosure	Y/**N**
Which other Committees has this paper been to? *(e.g. F & PC, QRC etc)*			
Trust Executives, EMB, Finance and Performance Committee			

Heart Of England NHS Foundation Trust

Annual Plan Return – update paper to 5th May private Trust Board

1. Introduction

The draft of the Annual plan was submitted to Monitor on 12th April following sign off by the Monitor Standing Committee, following delegated authority by the Trust Board.

The final Annual plan will need to be submitted on the 14th May.

Monitor has now provided us with feedback on our draft submission that we can use for the submission on the 14th May. The key financial planning assumptions that were first discussed by the Executive team and in Finance and Performance Committee meetings in February, March and April and that were used for the draft submission will remain the same for the final submission.

The prescriptive narrative to accompany the also prescriptive finance and performance templates for the annual plan submission will recognise that we are in recovery as a Trust and will reference in detail the Integrated Improvement Plan as that key recovery vehicle. The Annual Plan will also reference the production of the Trust Strategy. Recovery must lead into Strategy implementation in due course.

This paper is an update to the Trust Board on progress of development and recognises that not only are there still moving parts (the IIP and the development of the Strategy) but there remains more to plan and therefore to include in the final document over the coming ten days or so.

The Board is asked to delegate authority to the Monitor Standing Committee on the 13th May to provide the final review and approval prior to submission to Monitor on the 14th May.

Steps so far and next steps are outlined at the end of this update paper.

2. Planning Assumptions

Our key financial planning assumptions have not changed from the draft submission and are shown below.

The activity assumption has been updated to reflect our discussions with the Commissioners that a forecast growth baseds on a 2 year average growth is reasonable for planning and also shown in the table below. We feel activity, particularly Emergencies are on the prudent side and a risk based financial gain share is being formulated for activity above this planning level.

Activity levels	Using 2 year average growth rates. A&E 2.7%, Emergency 3.1%, Elective 3.6%, Outpatients 1.1%
Efficiency Target	Min of £24m, rising to a stretch plan of £30m
Service reduction	Costs reduction of lost services will be 70% of income
Investments	Improving services £13m,
Continuity of Service Rating	Minimum 3
Deficit	-£9.9m
Capital Investment	£49.4m
Closing cash	c£49.5m

The schedule below shows that we are planning for a £9.9m deficit in 15/16. This recognises our commitment to investing in improving quality of our services and meeting our performance targets. This is clearly outlined in our Recovery phase under the single banner of the IIP.

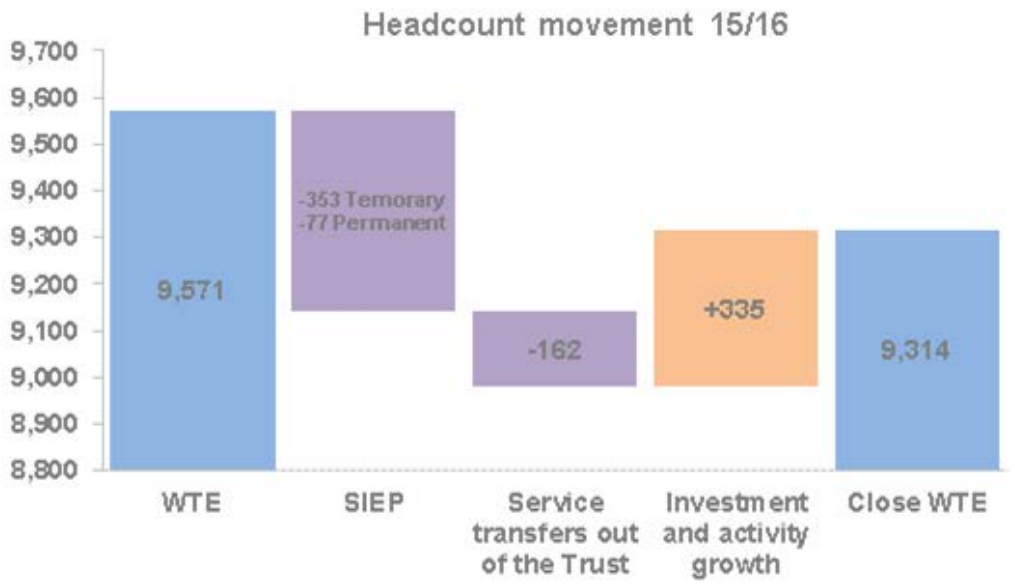
SOCI	15/16 Plan
NHS clinical icome	570.1
Non NHS clinical income	1.6
non clinical income	63.9
Operating Income Total	**635.5**
employee expenses	(407.8)
non pay	(214.4)
Operating Expenses (inc in EBITDA) Total	**(622.2)**
depreciation	(17.1)
Impairment	0.0
Operating Expenses (exc from EBITDA) Total	**(17.1)**
finance income	0.3
Other Non-Operating income	(0.3)
Non Operating Income Total	**0.0**
PDC	(5.9)
other fiannce costs	0.0
interest expense	(0.3)
Non Operaitng Expenses Total	**(6.1)**
Grand Total	**(9.9)**

Investment in Improvement - Quality

The investment in improving quality will have recurrent and non-recurrent elements.

Recurrent	
Investment in Care- £10.0m	
Demand and Capacity – detailed scenario modelling on bed and theatre requirements to support A&E improvement trajectory and sustainable RTT.	
Business Case Review Group – a recommendation of further investment following submission of business cases to deliver improved care.	
PMO and change management	
Further initiatives – a short list of local initiatives to support delivery of compliance.	
Non-recurrent	
Governance Support	£1.4m
External Assurance	£0.5m
Independent Sector – additional capacity requirements to clear backlog on RTT	£5m

The chart below provides a summary of the planned movement in the staff numbers required, expressed in Whole Time Equivalents (WTE). The plan will show a net reduction from 9571 to 9314, and the detailed analysis will show a plan for fewer temporary staff.



Plan Phasing

The quarterly phasing of the annual financial plan reflects a number of assumptions, shown below:

- Income, pay expenses and non-pay expenses per quarter are driven by activity per quarter
- The delivery of the majority efficiency plans is expected towards the end of the year
- The majority of additional costs during winter will be phased in q4, and lesser amounts in q1 and q3.
- The impact of reducing services (sexual health, CAHMs, community) will be from q2.

The table below shows the high level of phasing assumptions of the planned £9.9m deficit.

£m	Q1	Q2	Q3	Q4	Total
Deficit	-6.0	-1.3	-0.4	-2.2	-9.9

3. Planning Narrative

Monitor provides a very prescriptive template for us to complete the narrative to accompany the Annual Plan. We are in the process of bringing together all information to complete the narrative template and the appendix shows the Blank narrative so as the Board are aware of the expected content.

Members are asked to comment on what they might like to see included.

*As a starter for ten, t*he **Context**, **Performance** and **Recovery** sections below provide a summary of the key themes that we will expand on when completing the template.

CONTEXT

In the June 2014 submission, we outlined our strategic themes as Transforming Acute Care, Investing in out of hospital services, providing good or outstanding services, developing a more distinctive identity for our hospitals and create a truly patient centred culture.

To work towards the strategic themes, our focus over the next 2 years was expected to be on delivering a reduction in the acute footprint, reconfiguring surgical services, integrating the health and social care system in Solihull and achieving and outstanding or good CQC rating.

Unfortunately, owing to unplanned and significant increases in A&E attendances, Emergency admissions and Cancer referrals, nationally and locally, during 14/15 our resources have had to be largely focussed on trying to achieve the key access targets and quality performance. We have had to use the private sector much more than planned and place a greater reliance on more temporary nurses and locums. This has been at the expense of making good progress towards our Strategic Themes during 14/15.

PERFORMANCE

The increase in demand has prevented us from implementing our planning approach i.e. reducing our acute footprint and in terms of our CQC rating; we have achieved a good rating for Effectiveness, but require improvement for the other parts of the rating.

In terms of other progress,

- *We have completed the 1st of 2 public consultations for reconfiguring Surgical Services.*
- *We have made further progress towards integrating the health and social care system in Solihull by collaborating to develop an Urgent Care Centre following the downgrade of the A&E service at Solihull Hospital.*
- *We have developed a pilot to explore alternative workforce models using Advanced Care Practitioners.*
- *We have reconfigured Stroke services akin to the London Model*

However, our performance against access and quality targets and the results of the most recent CQC report has dominated HEFT's immediate horizon. Our performance has resulted in being subject to Monitor undertakings and a Governance review which has in turn lead to changes in the executive team and the appointment of an Interim CEO, an Interim Finance Director and an Interim IT Director.

RECOVERY

Our focus is now on recovery. We expect this to take 18 months to 2 years to complete however the latter stages of Recovery will merge seamlessly into Strategy implementation.

We have developed an Integrated Improvement Plan (IIP) which is made up of six work-streams; Governance, Mortality, A&E, RTT, IT, Culture. The delivery of each work-stream is led by an Executive SRO; there is a Project Management Office to track delivery and an overall programme director to ensure delivery.

The IIP Recovery Plan will be reviewed by the Trust Board on 5th May and discussed with Monitor and all system Stakeholders on the 20th May.

In addition to the IIP Recovery Plan, our recovery involves an extensive staff engagement plan under the pyramid of priorities. We have distilled our strategic themes for our 5 year plan into; SAFE & CARING, EFFECTIVE and ENGAGING and will involve our staff, patients, commissioners and our communities to review these strategic themes and revisit the Trust Values by Q3.

The Trust recognises that a strategy is needed for the organisation to create a vision for the future. This will be developed by the summer of 2015 ready for later implementation to drive the trust forward from the later stages of recovery. The Board will lead this process.

Early thinking is outlined below;

***Safe and Caring**: Our Patients' well-being will not be put at risk from receiving care in our hospitals.*

***Effective:** Our care will have positive impact on our patients.*

***Engaging:** Our Patients, our Staff, our Commissioners and our communities have a key role determining the way we provide care.*

4. Next Steps - Approval Process

It is critical the Board is updated on the next steps.

This provides assurance that all staff that need to be involved in production have been and that all content that needs to be included has been. It also ensures that the Board will be able to track implementation progress of the APR itself through three major themes;

1. The IIP (as outlined elsewhere on this agenda)
2. The Trust Strategy

3. The Integrated Performance Report

In terms of assurance and future approval;

- The Executive team has reviewed the planning assumptions regularly at their weekly meetings during February, March and April
- Finance and Performance Committee has reviewed the finance and planning assumptions in February, March and April
- The draft activity assumptions were submitted to Monitor in February The Monitor Standing Committee approved the draft submission in April and the draft submission including draft financial plans were submitted to Monitor in April
- The Executive Team will review and sign of the final financial plans and the narrative prior to presentation to the MSC on the 13th May.

If the Trust Board is content that delegated authority for approval is passed to the Monitor Standing Committee (MSC), then the MSC on 13th will provide further review and final sign-off prior to submission on 14th May.

Appendix – Template for the planning narrative

HEFT Monitor Plan : Narrative

a separate summary of the full operational plan narrative that is suitable for external communication, which we will then publish on our website. This should exclude any commercially sensitive information, but otherwise be consistent with the full version.

Style: Bullet point form is perfectly acceptable (but not mandatory). We would also encourage the use of tables and charts, in order to support commentary and show the impact of key assumptions.

Length: As a guide the operational plan should not exceed 20 pages

Executive Summary

ONLY REQUIRED IF PLAN IS LARGER THAN REQUESTED (20 pages) AND SHOULD DETAIL EACH SUBSECTION BREIFLY (sorry, that was taken direct quote from them!)

- ✓ **Establishing strategic Context (recommit / refresh or recreate)**
- ✓ **Progress against delivery of the strategy**
- ✓ **Plan for Short Term Resilience (Quality Priorities, Operational Requirements and Financial Forecast)**

Establishing Strategic Context

MAXIMUM OF 3 PAGES

☐**Significant variations in performance on strategic goals or in the progress of strategic initiatives: this involves effective performance tracking and open recognition of both good and poor performance.**

☐ Changes in the overall performance of the foundation trust, such as a deterioration in financial or quality performance (in particular we would expect some brief commentary of performance against plan in 2014/15 and drivers of any major variance), or significant missed access targets.

☐ Significant changes in the external environment, such as an unexpected merger of other healthcare providers, deteriorating financial stability at the commissioning organisation, the collapse of a local provider or part of the primary care system, or the emergence of previously unavailable strategic options.

☐ Local commissioning assumptions and affordability restraints, so the foundation trust only puts in place initiatives that the LHE has the resources to support.

☐ Significant changes in government or regulatory policy: such as post-election shifts in policy on access targets, tariff levels and structure; organisational restructuring; or changes in regulatory standards.

Depending on the outcome of this analysis, this section of the operational plan should briefly explain how the board has, or intends to:

1) **Recommit** to the strategy: If the strategy's underpinning assumptions are still accurate, and implementation is on track, the foundation trust is likely to recommit to the strategy. This means briefly revisiting its delivery and ongoing development.

2) **Refresh** the strategy: If the foundation trust is happy with its strategy but the external environment has changed, it may want to refresh its strategy. This would involve checking whether it needs to change any assumptions or outputs.

3) **Recreate** the strategy: If the foundation trust does not have a strategy to meet its goals – perhaps because the LHE has changed or the trust has identified new performance issues – it is likely to need to recreate its strategy.

Progress against Delivery of the Strategy

MAXIMUM 5 PAGES

The operational plan needs to set out how the foundation trust will achieve sufficient progress on its strategic agenda, ie how the strategy will be delivered over the plan period. We would expect this section to include:

☐ A summary of how the foundation trust and its LHE partners intend to respond to the 'Five Year Forward View', particularly in the context of the joint planning guidance set out in 'The Forward View into action: partnership and planning for 2015/16'.

☐ Translation of the strategic initiatives into goals, targets and KPIs by year, so that they are reflected in the operating plan from year one onwards.

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☐ Clear actions to address any poor performance identified, as part of **effective performance management undertaken in the strategic context.**

☐ A summary of productivity, efficiency and CIP programmes[18], **including key themes and the extent to which these are tactical or transformational schemes. This should include plans to improve efficiency and productivity through the more effective use of information and technology (may also be addressed in the capital programme).**

☐ A description of the capital programme, with particular reference to how it **supports the strategic agenda.**

☐ How resources have been reallocated over the period to reflect strategic **priorities. This will mean agreeing responsibility for delivery and providing individuals with the support.**

Plan for Short Term Resilience

Quality Priorities – MAX 2 PAGES

- the local and national commissioning priorities

☐ the foundation trust's quality goals, as defined by its strategy and quality account

☐ an outline of existing quality concerns (from Care Quality Commission or other parties) and plans to address them

☐the key quality risks inherent in the plan and how these will be managed.

Operational Requirements MAX 3 PAGES

Foundation trusts should outline their assessment of **operational requirements** over the next year, based on robust activity and capacity modelling, and building on lessons from this year's winter and system resilience planning. This section should cover:

☐ an assessment of the inputs needed (such as physical capacity, workforce, workforce development, IT and beds), based on the foundation trust's understanding of its expected activity levels

☐ an analysis of the key risks, and how the foundation trust will be able to adjust its inputs to match different levels of demand.

Financial Forecasts MAX 7 PAGES

This should all connect to the **financial forecasts** in the foundation trust's final operational plan. These will comprise one year of financial projections, and should be

well-modelled and based on reasonable assumptions.[19] The forecasts should also be supported by a clear financial commentary narrative.

The financial template has been refreshed for 2015/16 to reflect these four key drivers, and it now has a number of summary tables and bridges which you may wish to include in the narrative document to support the commentary.

Collectively these should articulate the impact of:
1) **financial pressure,** being the local reflection of the planning assumptions set out in the joint planning guidance preceding this document

2) **activity,** relating to underlying demand movements and the impact of commissioning intentions

3) **other** key movements, such as investment in quality or non-recurrent income or expenditure

4) **strategic initiatives,** such as, but not limited to, CIPs, service developments and transactions.

The financial template has been refreshed for 2015/16 to reflect these four key drivers, and it now has a number of summary tables and bridges which you may wish to include in the narrative document to support the commentary.
The first three items of the list above collectively represent the baseline or 'do nothing' scenario. The strategic initiatives (in item four) are the tactical and transformational responses by the foundation trust designed to close this gap.
The narrative financial commentary should address:
☐ assumptions underpinning these drivers.

☐ impact of these drivers on the overall financial forecasts, and in particular on forecast risk ratings and liquidity

☐ consideration of any sensitivity analysis[20]

☐ material variances between the financial projections for 2015/16 in last year's five year plan, and forecasts for the same one-year period in this year's operational plan (this should either be explained in silo or cross-referred to the strategic context). Please note that material variances between the financial projections for 2014/15 in last year's plan and the actual 2014/15 outturn should have been covered in the strategic context.
Because of the required submission dates (27 February 2015 and 10 April 2015), each foundation trust's draft and final operational plans will be developed before a final 2014/15 year-end financial position is known. Therefore foundation trusts should use a projected year end outturn for 2014/15 based on the most up-to date and relevant information available.
We expect the 2014/15 outturn to be an accurate and carefully-considered indication of the foundation trust's year-end position. The outturn will be compared to the actual

results reported in the quarter four submission. Unreasonable variances, which may constitute an indication of poor governance, may be subject to further investigation. The template to be completed by foundation trusts for the 2015/16 quarterly submissions will also be amended, so that it reflects the key changes we have made to the annual planning template.

Board Declarations for Sustainability and Resilience

We are asking foundation trust boards to make a number of declarations alongside their operational plans. The narrative should clearly support the declarations and trusts may wish to explicitly reference this:

☐**Sustainability.** We expect boards to be able to refresh the declaration of sustainability made in the 2014/15 strategic plans based on the 2015/16 strategic context and expected progress against the strategic agenda over the next two years.

☐**Resilience.** Based on the analysis undertaken we would expect boards to be able make a judgement on quality, operational and financial resilience over the next two years, as asserted in the 'Continuity of Services condition 7: Availability of Resources' and 'Interim/planned term support requirements' declarations.