# Meeting of the Board of Directors

**AGENDA**

**Date and Time:** Thursday 24 November 2016 from 09.00 to 12.00

**Venue:** Boardroom, The Princess Alexandra Hospital, Harlow.

<table>
<thead>
<tr>
<th>Time</th>
<th>Item</th>
<th>Subject</th>
<th>Action</th>
<th>Lead</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>01 OPENING ADMINISTRATION</strong></td>
<td>09.00</td>
<td>1.1</td>
<td>Apologies</td>
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<td></td>
<td>1.2</td>
<td>Declarations of Interest</td>
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<td>Acting Chairman</td>
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<td></td>
<td>1.3</td>
<td>Minutes from Meeting on 27.10.16</td>
<td>Approve</td>
<td>Acting Chairman</td>
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<td></td>
<td>1.4</td>
<td>Matters Arising and Action Log</td>
<td>Review</td>
<td>All</td>
<td>18</td>
</tr>
</tbody>
</table>

| **02 REPORTS FROM THE CHAIR AND CHIEF EXECUTIVE** | 09.05 | 2.1 | Chair’s Opening Remarks | Discuss | Acting Chairman | Verbal |
| | 09.15 | 2.2 | CEO’s Report | Update | Chief Executive | 19 |

| **03 FINANCE AND PERFORMANCE** | 09.30 | 3.1 | Report from Performance and Finance Committee: PAF.21.11.16 | Inform | Chair of PAF | Verbal |
| | 09.40 | 3.2 | Month 7 Finance Report | Discuss | Chief Financial Officer | 23 |
| | 09.55 | 3.3 | CIP Report | Discuss | Director of Business Delivery | 29 |
| | 10.05 | 3.4 | COO Report | Discuss | Chief Operating Officer | 36 |
| | 10.15 | 3.5 | Integrated Performance Report M7 | Inform | Chief Operating Officer | 44 |

| **04 RISK AND GOVERNANCE** | 10.25 | 4.1 | External Visits | Inform | Head of Corporate Affairs | 63 |
| | 10.35 | 4.2 | IG Update Position | Assure | Chief Financial Officer | 67 |

<p>| <strong>05 QUALITY, PATIENT SAFETY AND EXPERIENCE</strong> | 10.45 | 5.1 | Annual reports: Emergency Planning, End of Life Annual Report | Inform | Chief Operating Officer, Chief Nurse | 71, 76 |
| | 11.00 | 5.2 | Report from Quality and Safety Committee: QSC.28.10.16, QSC.16.11.16 | Inform | Chair of QSC | 86 |
| | 11.15 | 5.3 | Nursing, Midwifery and Care Staff Levels | Inform | Chief Nurse | 88 |</p>
<table>
<thead>
<tr>
<th>Time</th>
<th>Item</th>
<th>Description</th>
<th>Action</th>
<th>Person</th>
</tr>
</thead>
<tbody>
<tr>
<td>11.30</td>
<td>5.4</td>
<td>Chief Nurse and Chief Medical Officer Report including actions following CQC</td>
<td>Inform</td>
<td>Chief Nurse/Chief Medical Officer</td>
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**06 QUESTIONS FROM THE PUBLIC**

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<tr>
<td>11.40</td>
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<td>Opportunity for Members of the Public to ask questions about the Board</td>
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<td></td>
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<td>discussions or have a pre-submitted question answered.</td>
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**07 CLOSING ADMINISTRATION**

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<tr>
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<td>Summary of Actions and Decisions</td>
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<td>7.2</td>
<td>New Issues/Risks</td>
<td>Discuss</td>
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<td>All</td>
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<td>7.3</td>
<td>Reflection on Meeting</td>
<td>Discuss</td>
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<td>All</td>
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<tr>
<td>12.00</td>
<td>7.4</td>
<td>Any Other Business</td>
<td>Review</td>
<td>All</td>
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Date of Next Meeting – Monday 19 December 2016
BOARD 2016/17

Meetings, Purpose, Membership and Quoracy

TRUST BOARD MEETING DATES IN 2016-17
(Last Thursday of the month in the PAH Trust Board Room)

<table>
<thead>
<tr>
<th>Date</th>
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<td>28.04.16</td>
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<td>30.06.16</td>
<td>28.07.16</td>
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<td>29.09.16</td>
<td>27.10.16</td>
<td>24.11.16</td>
<td>26.01.17</td>
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<td>23.02.17</td>
<td>30.03.17</td>
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<td>28.09.16</td>
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Annual General Meeting

Board Purpose

The purpose of the Trust Board is to govern the organisation effectively and in doing so to build public and stakeholder confidence that their health and healthcare is in safe hands and ensure that the Trust is providing safe, high quality, patient-centred care. It determines strategy and monitors performance of the Trust, ensuring it meets its statutory obligations and provides the best possible service to patients, within the resources available.

Board Membership and Attendance – 2016/17

<table>
<thead>
<tr>
<th>Title</th>
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<tbody>
<tr>
<td>Trust Chairman</td>
<td>Vacant</td>
<td>Chief Executive Officer</td>
<td>Phil Morley</td>
</tr>
<tr>
<td>Chair of Audit Committee</td>
<td>Stephen Bright</td>
<td>Chief Financial Officer</td>
<td>Trevor Smith</td>
</tr>
<tr>
<td>Chair of Quality &amp; Safety (QSC) Committee</td>
<td>Mike Roberts</td>
<td>Chief Operating Officer</td>
<td>Stephanie Lawton</td>
</tr>
<tr>
<td>Acting Chair/Chair of Performance and Finance (PAF) Committee</td>
<td>Andrew Holden</td>
<td>Chief Medical Officer</td>
<td>Andy Morris</td>
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<tr>
<td>Chair of the Charitable Funds (CFC) Committee</td>
<td>Pam Court</td>
<td>Chief Nurse</td>
<td>Nancy Fontaine</td>
</tr>
<tr>
<td>Non-Executive Director</td>
<td>James Anderson</td>
<td>Director of Pathways &amp; Partnerships (non-voting)</td>
<td>Marc Davis</td>
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<td>Director of HR(non-voting)</td>
<td>Liz Booth</td>
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<td>Improvement Director</td>
<td>Suzie Loader</td>
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Corporate Secretariat

Head of Corporate Affairs | Heather Schultz | Board & Committee Secretary | Lynne Marriott

Board Quoracy

One third of voting members, to include at least one Executive and one Non-Executive (excluding the Chair). Each member shall have one vote and in the event of votes being equal, the Chairman shall have the casting vote.
Minutes of the Trust Board Meeting in Public
Thursday 27 October 2016 from 09:30 – 13:00
Boardroom, Princess Alexandra Hospital, Harlow

Present (Voting Members of the Board):
Andrew Holden  Acting Trust Chairman and Non-Executive Director (ATC-AH)
James Anderson  Non-Executive Director (NED-JA)
Pam Court  Non-Executive Director (NED-PC)
Nancy Fontaine  Chief Nurse (CN)
Stephanie Lawton  Chief Operating Officer (COO)
Andy Morris  Chief Medical Officer (CMO)
Phil Morley  CEO
Mike Roberts  Non-Executive Director (NED-MR)
Trevor Smith  Chief Financial Officer (CFO)

Present (Non-Voting Members of the Board):
Liz Booth  Director of Human Resources (DoHR)

In attendance:
Suzie Loader  Improvement Director

Observing:
Matthew Blow  Deloitte
John Murray  Deloitte

Apologies
Marc Davis  Director of Pathways & Partnerships (DoPP)
Jim McLeish  Director of Business Delivery

Secretariat:
Heather Schultz  Head of Corporate Affairs (HoCA)
Lynne Marriott  Board & Committee Secretary

01 OPENING ADMINISTRATION

1.1 The Acting Trust Chairman (ATC) welcomed members to the meeting, his first as Acting Trust Chairman. He asked the Improvement Director (ID) and colleagues from Deloitte to introduce themselves.

1.2 The ID introduced herself confirming she was the Improvement Director allocated to the Trust by NHSI and that she would be supporting the Trust over the coming year on its improvement journey, particularly in relation to concerns highlighted by the CQC on their recent inspection. The Chief Executive (CEO) stated he was grateful for all the support the Trust was receiving. The work of the ID would also focus on the Trust’s access to a support fund of £250k and how that could be best used to bring the Trust out of special measures.

1.3 Colleagues from Deloitte introduced themselves and confirmed they were in attendance that morning as observers as part of a leadership and governance review instigated by NHSI.

1.1 Apologies

1.4 As above.

1.2 Declarations of Interest

1.5 No declarations were made.

1.3 Minutes of Meeting on 29.09.16.

1.6 The minutes of the meeting held on 29.09.16 were agreed as a true and accurate record of that meeting with the following amendment:

Minute 4.1 – “… the Trust had already reached its threshold for C-diff of ten cases per
# Matters Arising and Action Log

## 1.8
There were no matters arising.

## 1.9
**Action ref:** TB1.28.07.16/39 – Timeline for Changes to the Strategic Risk Register (SRR)

The CMO reported that the SRR had moved on significantly since the previous meeting following conversations with the ID and other Executive colleagues. It was now proposed to set up a Risk Group which he could chair/co-chair with the Chief Financial Officer (CFO). This Group would oversee the Board Assurance Framework (BAF), SRR, Health Group (HG) Risk Registers and the CEO’s Issues & Risk table. It would feed up to the Quality & Safety Committee (QSC) and down to the HGs. The CEO highlighted that the Terms of Reference of QSC would need to be amended to reflect that the Risk Group’s lines of reporting and also that a paper would come to a future Board meeting on how the Risk Group would work and its lines of accountability. In response to a question from Non-Executive Director James Anderson (NED-JA) it was confirmed that the Risk Management Strategy would need to be amended to reflect the establishment of the Risk Group.

## 1.10
In relation to minute 4.2 the ATC asked if there was any update on proposed recruitment via Medacs. In response the Director of HR (DoHR) confirmed that the project (which was due to end on 31.03.17) had already recruited seven nurses and five doctors from overseas – so a good start.

## Reports from the Chair and Chief Executive

### 2.1 Chairman’s Overview

The ATC stated that he did not propose that the Board reviewed what had already been discussed at QSC or Performance & Finance Committee (PAF). For his time as ATC he would focus on four key areas:

1. Responding to the CQC Report
2. Sustainability & Transformation Plan (STP)
3. Accountable Care Partnership (ACP)
4. Delivery

### 2.2 CEO’s Report

The CEO reported on four late items of news not included in his report:

1. There had been an STP meeting the previous week and the submission had been made. The Operational Plan would need to be submitted by 23.11.16 in relation to the running of the STP for years 1 and 2.
2. There had been notification that week that £3m of capital would be returned to the Trust. It would be challenging to spend the entire amount in the current financial year on the projects for which it had been allocated however, it could now be used for items which had been put on hold or to address some potential revenue risks.
3. The CEO had been advised the previous day that the Health Minister Philip Dunne wished to visit the Trust on 17.11.16 with local MP Robert Halfon.
4. The previous day the Trust had received a request for support from the Medical School at Anglia Ruskin University (ARU) which posed some issues for the Trust. The Trust currently had exclusivity for medical students from Queen Mary’s and this could put those monies at risk and it could also mean two different curricula. However, it would be a good opportunity to broaden the hospital’s take of medical students. Members discussed the issue and it was agreed that the CEO would write to ARU asking them to make a presentation to the Board.

**ACTION**

TB1.27.10.16/43 Write to Anglia Ruskin University requesting they make a presentation to the Board around their request re: Medical Students.

**Lead:** Chief Executive Officer

2.3 The CEO reported that media interest since the release of the CQC Report had been minimal.

2.4 NED Pam Court (NED-PC) asked whether any themes had emerged following the Back to Balance sessions with staff. In response the CEO stated that there had been over 500
| 2.5 | In light of the fact that the CEO’s meeting with the Secretary of State had been cancelled, NED James Anderson (NED-JA) asked whether it could be assumed that it would be unlikely any significant capital monies would be made available to the Trust in the next six to twelve months. In response the CEO stated he had received no indication there would be an interim allocation of monies over the next six months. In relation to future capital and the STP, the STP had said it could support £150m of Capital allocation to the Trust over the next one to five years but would need to explore other options to realise the £400m that would be required for a new hospital. |
| 2.6 | The CFO highlighted that it was positive that there had been a quick response around the return of the £3m from the capital to revenue transfer in 2015/16. In response to a question from the CFO it was confirmed that no new date had been set for the meeting with the Secretary of State, but it was hoped it would be sometime around the end of November. |

**03 CARE QUALITY COMMISSION**

**3.1 CQC Report/CN and CMO Joint Report including actions following CQC Report**

| 3.1 | This item was opened by the Chief Nurse (CN) and included both the summary and full reports from the CQC. She provided an overview of the Quality Summit and the on-going actions. She also detailed the very early governance and oversight discussions that had taken place with the ID in relation to the Quality Improvement Plan including the reporting lines to the Quality and safety Committee. Discussions had also focused on the role and preparation of the Oversight meetings (monthly, multi-stakeholder, metric deep dives). She was also keen to establish fortnightly assurance calls with the CQC. The CEO’s presentation to the Quality Summit would be made again to the Board at item 3.2. |
| 3.2 | The staff response to the CQC Report, apart from initial shock, had been very upbeat. Staff agreed that the actions required to move the organisation out of special measures were completely within their gift. The CN felt that services were keen to evidence externally the high levels of care that their teams were delivering. In relation to social media there had been incredible support from the public for many of the organisation’s services. She also reported that offers of support for both herself and the CMO (outside NHSI) had been overwhelming. Work around business intelligence was underway with the Director of Information & IT and although this was the organisation’s biggest challenge, it could be its biggest win. |
| 3.3 | The CMO was pleased to report a huge amount of support for the Executive team from the Consultant body since the release of the CQC Report including personal messages of support for himself. |
| 3.4 | NED-PC asked what the outcome of the Quality Summit had been and whether there was an action plan. In response the CN reported there was a quality improvement plan but it would be crucial not to lose sight of the 2015 plan also and this had already been imported into the new quality improvement programme. Key metrics were currently being agreed for each service and face-to-face service reviews had already commenced. In relation to some services (Critical Care) there were some relatively easy issues to fix. All accountability would feed into both the Executive Management Board (EMB) and QSC and ultimately to the Board. NED-PC stated it would be important for the Board to have oversight of the programme. NED Stephen Bright (NED-SB) agreed and stated that the Trust’s work on outcomes was good but it had been criticised on its evidencing of process and the closing off of issues. Evidencing would be critical going forward to show that required checks/balances were in place. |
| 3.5 | In relation to mortality the CMO reminded members that he had been asked on a couple of occasions to explain the Trust’s weekend mortality figures which had been, until the last couple of months, better than those for weekdays. Accordingly he had undertaken a deep dive in conjunction with Dr. Foster which evidenced that mortality sat within the very elderly |
85+ group and that the Trust (for that group) had a much higher than national average co-morbidity rate. None of that was surprising and the spike had happened during the period February to April. There was more work to do now with ED data from that time and was not related to any particular diagnosis group.

**3.6** In response to a question from NED-JA it was confirmed that the period February to April had actually seen a reduction in complaints, SIs and PALS cases. The CEO stated that the Board needed to see that correlation for assurance and that the deeper dive into ED data should evidence weekday mortality rates, weekend mortality rates and mortality rates for those admitted at the weekend but who died during the week. It was agreed that that would come to November’s Board (although the CMO would not be in attendance – CN to present). The COO stated that the deep dive could also capture where patients were coming from at the weekend and where they were subsequently discharged to.

**ACTION**

**TB1.27.10.16/44** In relation to mortality conduct a deep dive into ED data (attendances, admissions and evidence of overcrowding using ED performance as a surrogate marker) to evidence weekday and weekend mortality rates and also mortality rates for those admitted at the weekend but who died during the week. Deep dive to also capture where patients were admitted from/discharged to.

**Lead:** Chief Medical Officer

**3.7** In response to a concern raised by NED-PC that the CQC Report had highlighted that staff had become complacent about reporting incidents the CN assured the Board that the organisation acknowledged the statement in the CQC report but the Trust had metrics in place which evidenced the opposite.

### 3.2 CEO Presentation – Quality Summit

**3.8** The CEO introduced the presentation which had been presented to the Quality Summit.

**3.9** He began by saying the ‘special measures’ was a very difficult situation for the organisation to be in. He reiterated that the CQC had identified a disconnect between the Board and frontline staff which they had since confirmed related to staff feeling that they couldn’t raise issues because they were not being heard at a senior level and if they were, nothing was being done. There was now an Oversight Committee in place, chaired by NHSI, which would monitor progress against the Trust’s QIP and along with the ID, establish a legacy of quality improvement.

**3.10** He went on to say that the organisation was in distress, financially, operationally, in terms of medical and nurse vacancies and it terms of its estate. Those issues all presented a real challenge for staff and patients alike. The Board was currently under a high level of scrutiny both as a group and as individuals. He displayed a slide which evidenced (RAG rated) the CQC ratings under the five domains for the services inspected which the organisation was now required to display at every point of public access. He acknowledged that this did not make comfortable reading for staff or patients. A small positive was that consideration was being given to Maternity Services displaying a Gold Star to reflect their “outstanding” rating.

**3.11** The CEO reiterated that in the domain of “caring” the Trust had been rated as “good” and that had been reiterated to staff. He also emphasised that the organisation was in the top quartile for the five measures which mattered to patients – mortality rates, infection control, rates of SIs and complaints and being considered a good place of care. He felt there was a disconnect with the Trust’s outcomes and what had been identified in the report. However the CQC had stated the issues identified were not related to outcomes but to processes and being able to demonstrate/evidence processes. The report contained 16 “must do” actions and 22 “should do” actions.

**3.12** The Board’s reflections on the report were:

- It celebrated with its workforce and service users the achievements of its maternity services rating of “outstanding”
- It was pleased to see the recognition of the passion and commitment of its staff reflected in the ‘GOOD’ rating for CARING
- It was pleased to see the recognition of improvements in Outpatient Services
- It recognised the scale and pace of the change required and was committed to improvement
At the Back to Balance sessions it had been reiterated by the Executive Team how important they felt it was that staff should feel listened to and that they had a voice. A staff Council was about to go live and Big Conversations and Specialty meetings would continue.

All areas of outstanding practice had been shared with staff but the following were detailed as the Must Do actions:

**Safe**
- Safe and efficient staffing levels
- Monitoring of drug fridge temperatures
- Resuscitation trolleys and difficult airway trolleys fit and ready for use
- Assessment and triage of patients arriving by ambulance to ED
- Safeguarding: reporting and investigations
- Valuable and beneficial staff appraisals
- Mandatory training rates
- Staff Life Support training in Children and Young People’s Services

**Effective**
- Staff knowledge and provision of care to meet the requirements of the MCA 2005
- Quality of record keeping on critical care

**Responsive**
- Training for staff pertaining to the care of women undergoing all elective gynaecology procedures
- Reduce the impact or likelihood of mixed sex accommodation breaches on HDU
- Sharing the learning from complaints throughout the Trust
- Target, monitor and manage the rapid discharge of patients at the end of their life

**Well-Led**
- Strengthen governance arrangements, including the risk register and board assurance framework to accurately reflect the risks within the organisation
- Ensure that fit and proper persons processes are ratified, assessed and embedded across the Trust board and throughout employment processes

22 “Should Do” actions:

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</tr>
<tr>
<td>Effective</td>
<td>9</td>
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<tr>
<td>Caring</td>
<td>0</td>
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<tr>
<td>Responsive</td>
<td>6</td>
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<tr>
<td>Well-Led</td>
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The CEO outlined the progress made against all actions to date which had been reported back to the CQC.

There were risks for the organisation associated with the CQC ratings which the CEO noted as:
- Potential loss of staff, impacting upon existing vacancy rate and staff shortages
- Reputational damage impacting on future recruitment
- Primary care, commissioners and patient loss of confidence in the services

He assured the Board that actions were underway to mitigate all the above.

The CEO finished by reporting there was a stringent governance process now in place to monitor all QIP actions and there were on-going discussions amongst the Executive Team about mandated areas for the HGs to review e.g. a daily/weekly/monthly dashboard. The on-going five key themes for the improvement journey would be care, process improvement, effective clinical outcomes, estate/environment and safe/consistent staffing. He also detailed the eight areas where the Trust would require help from partners in the coming year.

NED JA asked what was different in the Trust’s approach this time around – the following were noted:
- How the Trust presented its data – it must become smarter
- Executive Director assigned to each HG as a critical friend
- Focus on driving quality outcomes


- Being more forceful with stakeholders and Commissioners about support to be provided e.g. End of Life and Critical Care capacity
- Communication with staff focusing on all three areas of quality finance and performance so that teams were engaged and aware of all the issues

3.20 The CFO highlighted the circa £4m withheld by Commissioners in relation to PBR deductions including re-admissions. He understood there was a piece of work being undertaken and overseen by the Local Delivery Board (LDB) around where that was being reinvested and whether or not it was having the required impact. He asked how far that work had progressed and the potential for those monies to be redeployed for both quality and performance improvements. In response the COO reported that there had been an external review of all the investments made by Commissioners over the previous two years. That work was almost complete and it was expected to be reported back to the LDB at the end of November.

3.21 As a final point and in relation to the CQC Report and what was going to be done differently the CEO stated that the Board had to take ownership now to take the Trust out of special measures, something he felt it had not done the previous year.

3.22 The ATC asked where the newly proposed rule around ambulance handover (maximum 30 minute handover time) would be picked up. The COO stated that she would address it under item 5.4. He also asked whether NED involvement in Schwartz Rounds would be helpful and it was agreed the CMO would provide the NEDs with future dates. It was also agreed some NED involvement would be welcomed during the Health Minister’s visit on 17.11.16. and during the newly established CQC-type internal inspections.

3.3 NHSI Improvement Director: Initial Feedback

3.23 The ID stated that one key area the Trust needed to address was risk management. The establishment of a Risk Group had been highlighted earlier and some additional funding of £250k would now be made available to the Trust. Another area was use of data to not only demonstrate trends but also to identify issues early to allow proactive action. It was also about supporting staff with skills on how to understand, use and present data. She had undertaken visits throughout the Trust to meet staff and feedback was that “Big Conversations” had been very effective and were making a difference. She cautioned there must be feedback to staff from those to help reduce the feeling of a disconnect which the CQC had highlighted. She also believed the establishment of the Risk Group would also facilitate that as risks of 15 or above would be discussed by that group and fed not only up but also down the organisation. She stated she had been made to feel very welcome by the organisation and thanked staff for that.

3.4 Media

3.24 In relation to the Trust’s internal communication strategy in relation to the CQC report, the DoHR reiterated the success of the Back to Balance sessions with staff. She emphasised that the sessions were mandatory for Band 6 and above. It was hoped that the sessions would develop into “On to Excellence” and for the Trust to be the first to move from “special measures” to “outstanding”.

3.25 In relation to external media it would be important for the organisation to remain “open”. It was hoped that local press/media partners would focus on the Trust’s dedicated workforce and how improvement challenges were being met.

3.26 The third audience which would be important for the organisation would be the professional audience (GPs and system partners). The messaging for that cohort would be more technical and provided on a regular basis by her colleagues. In response to a question from the ATC it was confirmed that feedback from GPs whilst limited, had been positive.

04 QUALITY, PATIENT SAFETY AND EXPERIENCE

4.1 Nursing, Midwifery and Care Staff Levels

4.1 This item was presented by the CN who was happy to report that there were some signs of improvement in relation to recruitment. In Month 6 there had been six more starters than leavers for registered nurses/midwives. There was also an improvement in the day fill rate
and a reduction in the number of exception codes. There had also been lower levels of avoidable incidents that could be directly or indirectly related to staffing. Although the data reported was from September with total vacancies across all of nursing, midwifery and care staff of 173.44, October data was now evidencing circa 163 with more incoming staff due. During the summer of 2015 that figure had been around 260. In relation to the ED (and the agreement with Medacs which had been outlined at the previous meeting) where there had been 15 vacancies, some high calibre nurses with ED experience had been lined up to start shortly. Furthermore she was also happy to report that the 17 vacancies in Theatres had now reduced to one and there were no neonatal vacancies. The one risk area which remained was for paediatric nurses.

4.2 In relation to the nurses recruited from India they were now in the process of undertaking the OSCE (Objective Structured Clinical Examination) which, once passed, would enable them to be registered with the Nursing and Midwifery council (NMC). Currently seven had passed and three had failed the OSCE assessment on the second attempt and could not retake for a period of six months. The Trust had no option but to withdraw the certificate of sponsorship for the three individuals and they would be leaving. The remaining eleven nurses were booked to take the OSCE exam for the first time in October and November. International recruitment efforts would continue with a trip to the Philippines in November. She asked colleagues to celebrate with her the good news in relation to nurse staffing.

4.3 NED-JA highlighted that there were good numbers of nursing staff in the pipeline from the Philippines and India but it seemed that the local and national campaigns were delivering and he asked if the balance was right. In response it was confirmed that it was imperative both arms of recruitment ran in parallel.

4.4 The Board then discussed the area of new models of care and that those would require new staff roles in order to be successful. It was suggested that an application be made to Health Education England for some financial resources to undertake training to address that.

4.5 The ATC raised a concern about the movement of nursing staff to cover areas which were short staffed. In response the CN stated that this was a daily requirement but she was mindful of moving staff outside their skillset and breaking up teams. She was in discussion with the DoHR as to how best to test what staff felt about this. The ID suggested one way to measure how staff felt would be to ask them during the newly established Quality Walkabouts. The CEO stated that a buddying arrangement had been agreed for wards and if staff were moved outside this arrangement this could be reported. NED-MR agreed and emphasised that the Board should see the detail and know how staff felt about the moves.

4.6 The CEO noted that the Board would benefit from having oversight of other areas of staffing including medical staffing. NED-MR suggested it might be helpful if the Trust looked into having training development roles as a pilot.

05 FINANCE AND PERFORMANCE
5.1 Report from Performance & Finance Committee (PAF)

This item was introduced by NED-PC who reported that she would be taking over the chair of PAF whilst its current chair (NED-AH) undertook the role of Acting Trust Chair. Key headlines were:

i. Workforce – agency spend had decreased but there was still more work to be done. There were particular concerns around the medical workforce and that consideration should be given to incentivising those staff into joining the organisation. Whilst the Committee supported that proposal it would need to be robustly tracked.
   • Sickness absence – below target
   • Staff turnover – above target
   • Vacancy rates – deterioration in month
   • Appraisal rates – deterioration in month
   In relation to the above the Committee had made a request to Executives to ensure consistency of data and RAG rating in all reports.

ii. The Committee had discussed international recruitment, 100 day challenge, TUPE from ORLA, DBS checks and Junior Doctor Policies - updates were provided on all.
iii. Website – new site to go live very soon.
iv. Finance - year to date deficit £13.5m (£13.1m M5), £0.2m favourable to plan. A number of non-recurrent measures (£1.3m) had supported the position in month and resulted in an 'in month' deficit of £0.4m, £2.1m favourable to plan. The Trust had recently met with Commissioners to discuss a number of disputes. Resolution and work plan agreements had been reached on key issues with the exception of the recovery of short stay income. It was agreed that both parties would request mediation involving respective regulators on this matter. The Trust’s M6 position included £1.8m of income relating to the short stay.
v. The Committee had scrutinised run-rates and challenges particularly in December/February and also year-end projections.
vi. CIPs YTD £6.5m, ahead of plan by £1.5m; the reported position included elements of the non-recurrent benefits (£0.3m) enacted in M6 and the benefit of the re-classification of insourcing costs (£0.4m) which had improved achievement against temporary pay.
vii. Year to date (YTD) capital expenditure was at M6 is £0.9m, an underspend of £2.3m. The proposed re-alignment of capital, as agreed at the previous meetings of PAF and Trust Board, was being managed through weekly capital meetings. The Trust had also now received confirmation of the return of the £3m capital to revenue funding and was considering options for its deployment that year as part of that process.
viii. PAF had supported the Transforming our Care programme and Capital spend which would be discussed in Part II and received an update the STP.
ix. Performance – there had been a review of all areas of performance.
x. The Committee had received a detailed and well-presented report from Cancer, Cardiology and Clinical Services around their CIPs and progress being made.
xi. Carter – focus on Pharmacy and collaboration with East & North Herts NHS Trust (ENHT) and the push towards more ward-based pharmacists.

11 of 99

5.2 The CFO added that the Committee had also undertaken a review of its own effectiveness which had acknowledged a consistently large agenda and a suggestion that the Annual Work Plan be reviewed. NED-PC stated that a suggestion from her would be for the Executive Team to review the reporting template to the Committee, specifically the summary sheet and what was being asked of the Committee when reports were submitted.

5.3 In relation to recruitment incentives the DoHR alerted the Board that this was being pushed in a number of areas. The ATC stated he felt that was an issue for the Executive Team and that NHSI should be alerted to the payment of recruitment incentives by some Trusts in light of the fact that the NHS was trying to reduce its pay bill. The DoHR stated that she agreed with the ATC’s request.

5.4 NED-JA stated he welcomed the improvements in coding which had been highlighted and asked if there were tracked metrics being seen for that. In response NED-PC reported that there were. The CFO added that the start of an improvement had been seen but there was still some way to go to address the backlog but there was now clarity on where the issues lay with plans in place to address those. However it was still evident from Back to Balance sessions that areas were still being flagged where full activity was not being entered onto the system.

5.2 Month 6 Finance Report

5.5 This item was introduced by the CFO who reported that it was evident from his paper that the non-recurrent measures enacted had achieved the plans set for Q2 and discussed at the last Board meeting. It had enabled the organisation to receive STF funds worth £1.7m in
the quarter. However the underlying position needed to improve to evidence the impact of
tighter controls from the 30, 60 and 90 day action plans and the proposals from the Back to
Balance sessions. In summary the underlying position still remained at circa £2.8m of
deficit per month with the forecast outturn requiring that to be in the region of £2.5m. The
organisation needed therefore to effect the £300k run-rate improvement either through
tightened controls e.g. reductions in delegated authority levels, catalogue restrictions and
restrictions on use of agency staff. All the above measures were within the organisation’s
gift. In addition the Trust would need to drive down its insourcing/outsourcing in terms of
delivery of activity and service levels.

5.6 NED-JA asked whether the £2.1m favourable in month of which £1.3m was specifically non-
current measures equated to £0.8m favourable. In response the CFO stated that it was not
due to the impact of the STF monies coming back for not only M6 but also the preceding
two months.

5.7 The CFO highlighted that there would need to be a Board discussion on the proposed
control totals for the next two years which would be linked to the STP discussions to take
place in the private session later that day.

5.3 CIP Report

5.8 This item was presented by the COO who reported that CIPs were on track to deliver. YTD,
the Trust had forecast delivery of £5.0m; actual delivery had resulted in £6.46m, £1.46m
ahead of plan. The improvement in M6 was predominantly due to the non-recurrent
financial measures (documented within the Finance Report). Whilst there had been
consistent progress there were key areas to focus on to ensure delivery. Each of the project
initiation documents (PIDs) and associated risk logs were being assessed regularly by the
EDST to ensure that mitigation was sufficient and, where necessary, risks were being
escalated to PAF. The current forecast was to over-deliver against the £12m target by
£1.8m.

5.9 There were no red schemes at present and 30 pipeline schemes were being worked
through. HG confidence levels continued to increase.

5.10 NED-JA stated that there had been great progress and he welcomed the focus on cost
reduction – he asked if there were any opportunities to claw-back in other areas, specifically
in relation to Carter. In response the COO stated that in relation to Carter there had been a
presentation at that week’s PAF on the opportunities in Pharmacy. That work was being led
by the Director of Business Development and there had been positive discussions on that
with ENHT in addition to car-parking and security, laundry and some back office functions.
A Carter Board had been established across both organisations with Executive leadership
and oversight. In terms of the split between cost reduction and the remaining three CIP
quadrants that work was still on-going. The Trust would start to see a shift in efficiency and
productivity specifically in relation to the work being undertaken with Theatres.

5.11 Also in relation to Carter the CN highlighted that in relation to wound care products work
was underway with East of England Ambulance Trust to ensure both organisations were
using the same products. Similar work was also underway with SEPT which would have a
positive impact on the number of community acquired pressure ulcers.

5.12 In relation to over-delivery in the month the CFO reported that that had been impacted by
the non-recurrent measures enacted in the month and some re-coding between pay and
non-pay costs – the actual underlying position was marginally above the planned position.
This had been recorded as delivery of a CIP, albeit in an unplanned way.

5.13 As further assurance the CFO reported that the CIP tracker currently in place (following
work with PwC) made it better to control what went onto the tracker to ensure that it was
cost reduction or income recovery and not cost avoidance. He further added that circa 60%
of the CIPs for the year to date (£4m) were pay CIPs and the pay position overall was
underspent by £1m after the delivery of those CIPs. So whilst there were financial
pressures in the system predominantly around non-pay, the actual non-pay CIPs were
relatively small at circa 20% and were being offset by overspends in other areas e.g.
outsourcing/insourcing costs.
### 5.14 The paper was presented by the COO and taken as read. She drew the Board’s attention to the following areas:

i. At the time of writing the report the Trust was planning to achieve the RTT national standard and it had, finishing at 92.2% which was slightly above the standard for the second consecutive month. She was now working with the HGs on their admitted and non-admitted trajectories and recovery of those standards. These were not reported nationally but were being closely monitored internally and reported to EMB on a monthly basis. Trajectories would be signed off by the end of the month and she expected they would be delivered by the end of February 2017. This linked to the reduction on the reliance of insourcing.

ii. In terms of diagnostics, again the organisation continued to deliver the standard. There were a couple of areas where there was still further work being undertaken but there were no overall issues.

iii. Cancer standard had been delivered for August and the Trust was still on trajectory. The 62 and 31 day standards had been delivered only falling short in the 31 day subsequent surgery which had been down to one patient. There had been particular challenges with the management of that patient which she did not expect to be repeated in future. In addition to looking at overall cancer performance she and the CEO had been meeting with individual tumour site leads to address the challenges being faced in delivering those standards. A piece of work had also been commissioned with Internal Audit to review the systems and processes for managing that standard.

iv. In terms of the ED, performance against the 4 hour standard had deteriorated slightly in September from 73.60% in August to 73.06%. There were a higher number of paediatric majors failures in September with a slight increase in the number of minors patient failures. Action had been initiated within Paediatrics to address this with additional senior consultant presence to support during peak periods of activity. The ENP team had relocated their service from the main ED department into the previous discharge lounge which had improved flow and performance throughout October. However, performance continued to remain below the national standard and behind STF trajectories. This level of performance placed the Trust in the lowest 10% both regionally and nationally of all acute Trusts. Actions to address performance were being taken and monitored both internally through weekly HG performance meetings and monthly through the LDB. Despite the poor performance, long waits in ED and overcrowding, to date no patient harm had been identified. During periods of overcrowding, senior consultant patient reviews had been undertaken to maintain safety with an escalation to executive level if there were any concerns. Ambulance batching continued to be a challenge.

### 5.15 The Trust had been successful in getting the system to agree resilience funding.

### 5.16 The Short-Stay Observation Ward had been opened on 03.10.16 – this had previously been the majors ambulatory area in the ED. Works were now fully completed and the ward was being fully utilised with 10-20 patients flowing through on a daily basis. There had been shadow reporting for the month of October to ensure all the systems and processes and training had been completed before figures were reported externally. The Trust had hit 91% the previous Saturday and had seen some days during the previous two weeks where the high 80s had been reached. The opening of the Observation Ward took the year to date position to just short of 79% compared to 73% previously. The following week the COO and the CN would be meeting with Herts Community Trust in relation to the Minor Injuries Unit with a view to taking over and running the service which would provide a 1% increase overall in performance.

### 5.17 Teams were in the process of rolling out the “Safer” programme of work and support had now been gained from ECIP (Emergency Care Intensive Care Programme) to roll out the red and green days.

### 5.18 The COO went on to report that in relation to the ambulance position a letter had been
received that week from the Ambulance Service confirming that they had now been given permission to implement their 30 minute rule for handovers. After 30 minutes they would complete the handover paperwork and then leave the patients in the hospital. There had been a long discussion around that the previous day with system partners and it had been agreed that the CEO would write to the Ambulance Service as the Chair of the LDB to request further face-to-face discussion. The Trust could not accept those terms and had concerns about the approach.

5.19 NED-MR reminded members that the Board had agreed the ED target would be extremely challenging and it recognised there were steps that could be taken to improve the situation but the issue was a system issue. He asked therefore if there was an opportunity now, given that the Trust was in special measures, to challenge back to the system and to link that to the ACP agenda and what best practice looked like across the system. In response the COO stated that what the organisation had not been able to access was a robust evidence based capacity tool for capacity planning both in acute and across the system and it was now exploring that in conjunction with NHSI and ECIP. The LDB would be used as the vehicle to facilitate a solution to the problem.

5.20 The CEO reported that the LDB had agreed to the following:

   i. The refurbishment of Gibberd Ward (which the Trust could not staff) so the LDB would come back with a plan as to how partners could best use that – e.g. for moving patients from hyper-complex areas or for re-ablement which would reduce length of stay (LOS) for the Trust and free up bed space.

   ii. An event would be held with GPs to review the use of Sydenham House (SH) – Commissioners had stated that funding for use of the facility was not in their budget for the current year nor was it within their commissioning intentions for the following year. However they had agreed to come back with a model that used money already in the system to use SH as step up beds from general practice. A plan would be drawn up by the end of January 2017.

   iii. An integrated discharge team was now in place and every partner had ceded control of their beds to that team.

5.21 In summary NED-MR stated that it was clear there were a number of initiatives proposed but what was not being seen was a comprehensive plan across the whole patient pathway for both preventing admissions and dealing with those who had already been admitted. In response the CEO reported that the LDB had agreed five mandated improvement workstreams. There had been partial assurance on the Emergency Care Recovery Plan but there was no overall daily dashboard for the system. The winter plan had gained full assurance. The CEO added that the Transforming our Care plans would create an additional 57 beds which would help keep the Trust on trajectory for performance.

5.22 The CEO asked whether, in relation to RTT, PAF scrutinised the rate for Removal Other Than Treatment (ROTT) and was the organisation assured it was appropriately removing patients. A ROT rate higher than 5% was an issue. The COO agreed to include that within the RTT report to PAF.

**ACTION**

<table>
<thead>
<tr>
<th>TB1.27.10.16/45</th>
<th>ROTT Rate to be included in RTT section of COO Report to PAF and Board.</th>
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</thead>
<tbody>
<tr>
<td><strong>Lead:</strong> Chief Operating Officer</td>
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</tbody>
</table>

5.23 NED-PC enquired if members should revisit previous discussions around having Board to Board meetings and which partners should be included in the meetings. Members agreed to discuss this further offline.

**ACTION**

<table>
<thead>
<tr>
<th>TB1.27.10.16/46</th>
<th>Discuss Board to Board meetings and partners to be included.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>CEO/Acting Chair</strong></td>
<td></td>
</tr>
</tbody>
</table>

5.5 Integrated Performance Report M6

5.24 This item was introduced by the COO who drew the Board’s attention to clinic cancellations. Under the “responsive” domain numbers had reduced in September from 79 to 28. Although this was still high she assured the Board that the issue was addressed in detail at EMB with the AMDs and a continuous downward trend was now emerging.
5.25 In relation to “quality” the CN noted two serious incidents reported for September. 94% of incidents reported via Datix were low or no harm. Of cardiac arrests reported only one was deemed avoidable. In relation to infection control the Trust continued to record one of the lowest rates of MRSA and MSSA infection nationally. The organisation had reported 11 cases of C-difficile that year, three of which had been successfully appealed leaving eight cases considered to be Trust apportioned. There were currently only 35 open complaints in the organisation all within timeframe and only 18 new ones recorded in the month of September. If the trend continued the Trust would finish the year on a lower number than it had the previous year. Despite vacancies across staff groups the Friends & Family Test was scoring 95% and in Maternity, 95%. ED compliments were now far outweighing complaints and lunchtime learning had been established to learn from complaints. “PALS to the People” was now taking place on the wards on a weekly basis. The C-section rate was 25.7% which was 0.7% above the national average with 1:1 labour at 100% despite the 18 registered midwife vacancies. Peri-natal mortality was at 1.56% against a national average of 4.5% - a position now held by the Trust for the past three years.

| 5.26 | It was agreed that this item would be discussed in the private session that afternoon. |

### 6.0 RISK AND GOVERNANCE

#### 6.1 Board Assurance Framework

| 6.1 | This item was presented by the HoCA who reported that nine of the risks had been reviewed at PAF and changes had been supported. PAF had also supported the removal of risk 4.1. Due to the timing of meetings that month QSC had not yet reviewed their two risks. The CN highlighted that there had been discussion at QSC about increasing the rating of the two risks on the back of the reputation damage ensuing from the CQC Report. |

| 6.2 | A discussion then ensued amongst members with the CEO stating that he was finding it difficult to reconcile some of the risk ratings in light of the CQC Report. The following were therefore agreed: |

Risk 3.2 (QSC) – rating to be increased back to 16.  
Risk 3.4 (PAF) – 12 too low  
Risk 4.1 (PAF) – rating to be increased to 16.  
Risk 5.2 – risk narrative to be reworded and rating to be increased to 20 |

It was suggested that PAF should re-consider their risks and perhaps move this item to the top of the agenda for their next meeting and the risks allocated to QSC would be discussed at their meeting the following day. |

#### 6.2 External Visits

| 6.3 | The HoCA stated that this item was for noting with the full report being available to members in the Resources area of Diligent. |

#### 6.3 Report from Audit Committee

| 6.4 | There were no questions on either the Committee’s Report to Board or the Auditor Panel Report. The revised Terms of Reference for the Audit Committee were approved. |

#### 6.4 Report from Charitable Funds Committee

| 6.5 | This item was presented by NED-PC, Chair of CFC and key highlights were: |

i. The M5 report for Charitable Funds Account was noted and showed that the net income received during the period 01.04.16 to 31.08.16 was £23,261. There had been a slight improvement of £5k in the General Fund since the previous meeting.  
ii. The Committee approved the use of the FRS102 SORP for preparation of the charity accounts for 2015/16.  
iii. A levy (£1300) had been introduced to fund the new Fundraising Regulator (replacing the Fundraising Standards Board). The Committee discussed whether the...
levy was mandatory and agreed that further discussions would take place offline. The Board agreed that this should be discussed further at the next meeting of the Corporate Trustee.

iv. Appointment of the Fundraising Co-ordinator had been extended until March. The ‘office’ location for the Fundraising Coordinator was discussed and the benefits of having an office in the main hospital building were noted although it was acknowledged that there were currently limited office spaces available.

v. The CFC received a detailed presentation on the Breast Unit Fundraising from Mr Patel. An update on the Breast Research nurses and the Charity team was noted and the DoHR would meet with the research nurses and Charity team to discuss their employment status.

vi. The CFC considered the use of Charitable Funds to fund two appointments: Oncoplastic Research Fellow (fixed term for 1 year) and Oncology Research Fellow (between PAH and UCLH), for a 1 year fixed term. The appointments were supported subject to agreement from the Medical Director and fund approval.

vii. A request to spend Charitable Funds on breast screening equipment was noted and the CFC was informed that this would be funded from the Radiology fund. A further request for Resuscitation kit was considered but declined due to the significant cost of the equipment, lack of clarity on which fund it was to come from and for further discussions on whether this could be included in the Capital Programme.

6.6 The use of charity funds for the volunteers’ lunch was discussed and it was agreed that a request would be considered offline by the CFO.

07 QUESTIONS FROM THE PUBLIC

There were no members of the public present.

08 CLOSING ADMINISTRATION

8.1 Summary of Actions and Decisions

As listed in the shaded boxes above.

8.2 New Issues/Risks

There were no comments from members.

8.3 Reflection on Meeting

There were no comments from members.

8.4 Any Other Business

The CFO requested the following reductions (on behalf of PAF) to delegated authority levels:
Requisitions over £9,999k to now require the Lead Executive’s authorisation
All requisitions over £49,999k to now require the authorisation of two Executives (the Lead Executive plus the CFO)

The Board agreed the above changes.

Signed as a correct record of the meeting:

Date: 24.11.16

Signature: 

Name: Andrew Holden
| Title:       | Acting Trust Chairman |


<table>
<thead>
<tr>
<th>Action Ref</th>
<th>Theme</th>
<th>Action</th>
<th>Lead(s)</th>
<th>Due By</th>
<th>Commentary</th>
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<tbody>
<tr>
<td>TBI.30.06.16/25</td>
<td>Risk Management Training</td>
<td>Board to receive an update on the roll out of training.</td>
<td>CMO</td>
<td>TBI.24.11.16 TBI.30.03.17</td>
<td>Risk Management training, covering risk awareness and the fundamentals of risk assessment, is currently delivered as part of Trust induction. Further work is underway to develop an online programme targeting both staff and the board. This will be based on our Risk Management Strategy which will be updated in light of the recent CQC report. A provider company has already been identified to help with the design of the training. Work will commence with the company in the New Year and an update on progress will be presented to the Trust board in March 2017.</td>
<td>Open</td>
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<tr>
<td>TBI.28.07.16/37</td>
<td>IPR</td>
<td>Add a progress update narrative and RAG-rate the &quot;Requires Support&quot; section of the IPR.</td>
<td>COO</td>
<td>TBI.29.09.16 TBI.24.11.16</td>
<td>Actioned.</td>
<td>Closed</td>
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<tr>
<td>TBI.29.09.16/40</td>
<td>Internal Quality &amp; Safety Metrics</td>
<td>QSC to consider whether internal Quality and Safety standards/metrics are required.</td>
<td>QSC</td>
<td>QSC.16.11.16</td>
<td>Transferred to QSC action log and discussed at QSC.16.11.16. Progress to be monitored by QSC.</td>
<td>Closed</td>
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<tr>
<td>TBI.29.09.16/41</td>
<td>Deployment &amp; Development Action Plan</td>
<td>Provide quarterly reporting to the Board on the progress against actions alongside trends, activity and performance.</td>
<td>DoHR</td>
<td>TBI.26.01.16</td>
<td>Item not yet due.</td>
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<tr>
<td>TBI.27.10.16/43A</td>
<td>Future Medical Students</td>
<td>Write to Anglia Ruskin University requesting they make a presentation to the Board around their request re: Medical Students.</td>
<td>CEO</td>
<td>TBI.24.11.16</td>
<td>Verbal update to be provided at TB1.24.11.16.</td>
<td>Open</td>
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<tr>
<td>TBI.27.10.16/44</td>
<td>Mortality Deep Dive</td>
<td>In relation to mortality conduct a deep dive into ED data (attendances, admissions and evidence of overcrowding using ED performance as a surrogate marker) to evidence weekday and weekend mortality rates and also mortality rates for those admitted at the weekend but who died during the week. Deep dive to also capture where patients were admitted from/discharged to.</td>
<td>CMO</td>
<td>TBI.24.11.16</td>
<td>Addressed at item 5.4 @ TBI.24.11.16.</td>
<td>Proposed for closure</td>
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<tr>
<td>TBI.27.10.16/45</td>
<td>Referral Other Than Treatment</td>
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<td>COO</td>
<td>TBI.24.11.16</td>
<td>Addressed at item 3.4 @ TBI.24.11.16.</td>
<td>Proposed for closure</td>
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<tr>
<td>TBI.27.10.16/46</td>
<td>Board to Board Meetings</td>
<td>Discuss Board to Board meetings and partners to be included.</td>
<td>CEO/Acting Chair</td>
<td>TBI.24.11.16</td>
<td>CEO attending NED meeting on 24.11.16.</td>
<td>Proposed for closure</td>
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### Executive Summary

This report provides an overview on a number of key current matters within the Trust.

### Recommendation

The Board is asked to receive this paper as an update on 24 November 2016.

### Trust Strategic Objectives

- Quality and patient safety: delivering great patient outcomes and personalised care
- Operational performance: delivering all regulatory and national operating standards
- Managing our resources: delivering value through improved efficiency and increased productivity
- Engaging with and developing our people: delivering great opportunities through learning, research and innovation
- Planning our future with partners: delivering on our commitments and ensuring an organisation fit for the future

### NHS Constitution

All seven NHS Principles

### Implications

- **Risk**: There are no risks associated with this report other than those outlined.
- **Legal/Regulatory**: There are no legal or regulatory considerations associated with this report other than those outlined in the report.
- **Resources**: There are no resource implications associated with this report.

### Table

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<tr>
<td>Report Title</td>
<td>Chief Executive’s Report</td>
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<tr>
<td>Lead Director/Manager</td>
<td>Phil Morley – Chief Executive</td>
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<td>Report Author</td>
<td>Phil Morley – Chief Executive</td>
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<td>Executive Summary</td>
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<tr>
<td>Recommendation</td>
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<td>Strategic Corporate Objectives 2016/17:</td>
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<td>• Quality and patient safety: delivering great patient outcomes and personalised care</td>
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<tr>
<td>Appendix</td>
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</table>
Chief Executive’s Report - Public
Trust Board – 24 November 2016

1.0 Decisions to be Made Today – if applicable

2.0 Policy Requirements – if applicable

3.0 Internal Updates – Verbal

4.0 External Updates – Verbal

4.1 CQC Inspection Report response from Malcolm Morley, Harlow Council

Philip Dunne, Minister of State for the Department of Health, Robert Halfon, MP for Harlow and Kathy Maclean will visit to the Trust on 7 December

5.0 National Updates / In the News

Health budgets will see cuts

5.1 Jeremy Hunt has admitted his claim of an extra £10bn for the NHS involves cuts in other health budgets. The Health Secretary was forced to make the concession in the Commons after five senior MPs accused him of misleading the public. Led by Dr Sarah Wollaston, the Conservative chairman of the Commons health select committee, they said the figure has been created by excluding money for recruiting and training NHS staff, and cuts to spending on improving public health. Mr Hunt said that while the NHS was being given an extra £10bn over six years, “the Government has never claimed there was an extra £10bn increase in the Department of Health’s budget. I have always accepted that painful and difficult economies in central budgets will be needed in order to fund that plan.” Meanwhile Jonathan Ashworth, the shadow health secretary, has asked the UK Statistics Authority to investigate Theresa May’s statement that the government is giving the NHS an extra £10bn.

Four million unnecessary admissions

5.2 A Local Government association (LGA) commissioned study, to find out if better integrated care services could save money, says that of 15.9m hospital admissions in 2015, almost four million were unnecessary, at a cost of £1bn, and estimated that up to 45% of decisions about the care of patients could be improved. The chairman of the LGA’s Community Wellbeing Board, Izzi Seccombe, said the study highlighted the need for “robust reviews” by different professionals at critical decision-making junctures, and added: “Councils, care providers, charities and the NHS are united around the need for central government to fully fund adult social care.” The LGA research was based on analysis of attendance and admission data going back two years and derived through GP, district nurse and discharge coordinator interviews.

Health committee writes to chancellor to express concern over NHS finances

5.3 NHS Providers chief executive Chris Hopson was interviewed by BBC News and ITV News regarding the letter sent from the health select committee to the chancellor expressing concern about the finances of the NHS. Speaking to the BBC, Chris noted that we gave evidence to the mini-inquiry that preceded the letter, and we were saying much the same thing: there is now a very clear gap between the quality of service our politicians and patients are expecting from the NHS and the funding increases that are being made available. Chris said: “The extra demand and cost for running the NHS goes up 4% a year, every year, and we’re now in a 10-year period where the funding increases for the NHS are less than 1%. It doesn’t take very many years of a gap of 3% before the NHS starts to understandably creak.” Asked whether there were two groups looking at the figures and interpreting them in different ways, he said: “There is an element that both sides are right, but the nervousness here is
that we are in a dialogue of the deaf. Yes the government is right to say that if you take a year either side of the spending review and just look at the money going to NHS England which then dispenses to CCGs, then yes, it is £10bn.”

5.4 However, he added it was “crucial” to look at the total amount. As the letter to the chancellor says, there are significant reductions in funding, for example in health education and public health, which means that some of our members are going to get less money for their junior doctor trainees, while community trusts are losing public health funding. Chris said: “The argument the NHS is making is exactly the same as the argument the health committee is making: please consider the whole Department of Health budget, don’t just focus on a small bit of it, and, at the same time, talk about the spending review period. If you do all of that, the figure that comes out is the £4.5bn the health committee is saying.” Chris highlighted that if we look at 2017/18 and 2018/19, we’re actually talking about a real terms decrease in terms of per head of population. He said: “We’ve actually spent most of the increase that was given in the spending review and we’re now looking at much lower levels of increase for the next 2-3 years.”

Labour requests inquiry into prime minister’s £10bn for NHS claim

5.5 Jonathan Ashworth, the shadow health secretary, has written to the UK Statistics Authority (UKSA) to ask them to investigate Theresa May’s statement that the government is giving the NHS an extra £10bn, following criticism from five members of the Commons health select committee who have described the statement as “incorrect”. Ashworth wrote: “I would be grateful if you would conduct and urgent inquiry into the government’s NHS spending plans and the accuracy of recent statements made by the prime minister and ministers, in particular claims that the NHS budgets will increase in real terms by £10bn between 2014-15 and 2020-21.” Jeremy Hunt maintained that the figure was correct when questioned in the House of Commons, and said the five select committee members were wrong to contest his and May’s claims.

Poor A&E performance becoming the norm

5.6 A crisis in adult social care combined with a lack of funding has led to poor performance in A&E “becoming the norm” across many NHS trusts, according to a new report by the Commons Health Committee. The MPs found that A&E departments are now routinely missing the national target to deal with 95% of patients within four hours. MPs expressed concern over a continued fall in standards, adding that while in the past NHS trusts would experience their most intense problems in the winter, now “pressures are high year round”. The report also noted that if the number of doctors had kept pace with the increasing number of patient admissions, there would now be 8,074 doctors working in A&E departments rather than 5,300. MPs also heard that a number of trusts were resorting to hiring carers in order to ease bed-blocking.

CQC finds patients waited two months for hair washing

5.7 Hospital patients had to wear incontinence pads overnight and wait two months to have their hair washed because hospital staff were too busy, an inquiry by NHS inspectors has concluded. A&E patients were also being treated in corridors and in chairs because the Queen Elizabeth Hospital in Woolwich, south London, was under such pressure. The Care Quality Commission said that the hospital "requires improvement". Lewisham and Greenwich NHS Trust said: "The report does note that we have made progress since the last CQC inspection in February 2013... We recognise there is more to do."
Three trusts face over £2bn shortfall

5.8 Newly published Sustainability and Transformation Plans (STPs) show three health areas alone face a combined shortfall of more than £2.4bn by the end of the decade. Birmingham and Solihull faces a £712m shortfall by 2020, South West London £828m and North Central London £876m. Mark Rogers, CEO of Birmingham Council, said: “Both health and council services are facing huge challenges. There are real concerns about the health and wellbeing of our communities.” The North Central London STP says it is not “able to deliver universally for everyone to the standards we would like,” as “there are challenges with meeting acute standards, as well as issues workforce sustainability.”

Shortage of 3,000 A&E doctors revealed amid warnings NHS faces ‘toughest winter yet’

5.9 Accident & Emergency departments need almost 3,000 more doctors to cope with unprecedented pressures which could trigger a major crisis this winter, MPs have warned. A report by the Commons Health Committee says hospitals are “running too hot” with record occupancy levels leaving too few empty beds to cope with surges in demand. Experts said the NHS was “going in to its toughest winter yet, with the odds stacked against it.” MPs said hospitals had too few staff to respond to pressures which are being fuelled by cuts in social care services.

5.10 A&E departments need at least 8,000 doctors – 50 per cent more than the 5,300 currently employed - to keep pace with the rise in emergency admissions in the last five years, the report says. More than 1,000 more consultants would be needed to match demand, the report says, citing evidence from the Royal College of Emergency Medicine (RCEM). The head of the Health Committee last night raised fears that a “cold snap” could be enough to push services into chaos.

NHS structures complex and confused

5.11 The way the NHS in England is organised is hindering its ability to meet its challenges, according to a review led by former Health Secretary Alan Milburn, who suggested the current system was “confused and complex”. The review, for consultants PwC, called for a gradual evolution of the structures, saying those who worked in the health service supported reform. The report was critical of the changes introduced in 2012 by then Health Secretary Andrew Lansley, which have resulted in the creation of “myriad” national organisations, including NHS England, NHS Improvement, Health Education England and Public Health England, and said it meant hospitals and other services faced the “daunting challenge of managing competing requirements”.

6.0 Hot off the Press – Verbal

7.0 Issues Log – Referenced in Private Board papers.

Author: Phil Morley – Chief Executive
The purpose of this report is to outline the financial performance at M7 including key risks to delivery of year end forecast.

The key issues for the attention of the Board of Directors are:

1. The ‘in month’ deficit was £2.4m, £0.1m worse than plan. The year to date deficit is £15.9m (£13.5m M6), £0.1m better than plan. The Trust continues to forecast a year end outturn of £29.7m, in line with its control total.

2. Key headlines in the month:
   (i) Pay expenditure on plan in the month.
   (ii) Non pay was £0.5m overspent including £0.4m of costs incurred on insourced activity provided by a third party.
   (iii) Total income over-performed by £0.4m in the month although this was mainly driven by non-recurrent items.

3. The income position includes sustainability funding of £4.3m YTD compared to available funds of £4.6m, the shortfall relating to non-achievement of the A&E trajectory. The cumulative position on Patient Treatment Income is £3.2m over-performance, including £1.8m (M1-M6) of short stay income subject to dispute and mediation now scheduled for November.

4. Excluding the non-recurrent income benefits the normalised actual in month deficit would have been £2.9m. It should be noted that this remains above the re-forecast October deficit (£2.6m) required to meet the control target.

5. The Trust YTD CIP target is £6.1m and it has achieved £7.6m. The majority of the over delivery relates to the non-recurrent solutions deployed in M6.

6. Total agency spend in the month was £1.4m, £8.9m YTD against an annual target of £13.66m. Although agency expenditure has significantly reduced compared to last year the run-rate will need to average £1m per month until the year end to achieve the year-end target.

7. The most significant risks to delivery of the control total for the year are:
   (i) CCG and Trust income recovery including Short Stay income and resolution of Maternity pathway payments.
   (ii) Full delivery of CIPs, including delivery of the agency reduction of £6.9m in order to achieve the annual target of £13.6m.
(iv) The need to reduce the level of expenditure on insourcing/outsourcing arrangements.
(v) Achievement of Sustainability funding.

8. Year to date capital expenditure M7 is £1.5m, underspent by £2.8m. The Trust continues to have weekly capital meetings involving Executives to finalise priorities for funds in light of urgent capacity requirements. The Trust has also received notification that the £3m capital from 2015/16 will now be returned and therefore the annual capital allocation has been re-established at £11.7m. Given the stage of the financial year and requirements to develop business cases, obtain approvals and ensure procurement processes are followed, it is unlikely the Trust will now be able to spend its capital allocation in full this year. The Capital Group is therefore reassessing the forecast outturn and the Trust is liaising with NHSI to discuss potential options to manage capital between financial years.

9. The Trust has received a revision to control targets for 2017/18 and 2018/19. The Trust is currently assessing the impact of the control target on the CIP and planning requirements for 2017/18. The Trust must make all efforts to achieve the control target and is liaising closely with NHSI to discuss the control target and opening plan submission (24 November 2016).

10. The Trust is required to sign two year contracts with Commissioners by 23 December 2016 and to lodge final plans at that time. Provider and Commissioner Intentions have been exchanged and initial contract offers and counter offers exchanged, at this stage there remains a significant financial gap between respective positions.

<table>
<thead>
<tr>
<th>Recommendation</th>
<th>The Board is asked to:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Note the key financial matters, discuss the financial position and consider the financial forecast and associated risks.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Trust Strategic Goal</th>
<th>Excellent Value</th>
</tr>
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<tbody>
<tr>
<td>NHS Constitution</td>
<td>This paper pertains mainly to NHS Principle 6: The NHS is committed to providing best value for taxpayers’ money and the most effective, fair and sustainable use of finite resources.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Implications</th>
</tr>
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<tbody>
<tr>
<td>Risk</td>
</tr>
<tr>
<td>Achieving Financial Plan BAF 001</td>
</tr>
<tr>
<td>Availability of Capital Investment BAF 002</td>
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<tr>
<td>Achieving Statutory Obligations BAF 007</td>
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<tr>
<td>Maintaining a positive cash balance BAF 009</td>
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<td>Legal/Regulatory</td>
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<td>Statutory break even duty and achievement of Capital Resource Limit</td>
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<table>
<thead>
<tr>
<th>Resources</th>
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<tbody>
<tr>
<td>Previously Considered by</td>
</tr>
<tr>
<td>Performance and Finance Committee</td>
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<table>
<thead>
<tr>
<th>Appendices</th>
</tr>
</thead>
<tbody>
<tr>
<td>Appendix 1: Summary Income and Expenditure Account</td>
</tr>
<tr>
<td>Appendix 2: Statement of Financial Position (formerly Balance Sheet)</td>
</tr>
<tr>
<td>Appendix 3: Cashflow</td>
</tr>
<tr>
<td>Appendix 4: Capital Expenditure</td>
</tr>
</tbody>
</table>
# APPENDIX 1: Summary Income and Expenditure Account

<table>
<thead>
<tr>
<th></th>
<th>Month Budget £m</th>
<th>Month Actual £m</th>
<th>Month Variance £m</th>
<th>YTD Plan £m</th>
<th>YTD Actual £m</th>
<th>YTD Variance £m</th>
<th>Annual Budget £m</th>
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</thead>
<tbody>
<tr>
<td><strong>INCOME</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>OTHER INCOME</td>
<td>0.9</td>
<td>1.3</td>
<td>0.4</td>
<td>6.2</td>
<td>7.5</td>
<td>1.4</td>
<td>10.6</td>
</tr>
<tr>
<td>PATIENT TREATMENT INCOME</td>
<td>15.4</td>
<td>15.5</td>
<td>0.1</td>
<td>107.0</td>
<td>110.6</td>
<td>3.6</td>
<td>182.8</td>
</tr>
<tr>
<td>STF INCOME 2016/17</td>
<td>0.7</td>
<td>0.6</td>
<td>(0.1)</td>
<td>4.6</td>
<td>4.3</td>
<td>(0.3)</td>
<td>7.9</td>
</tr>
<tr>
<td><strong>INCOME Total</strong></td>
<td>17.0</td>
<td>17.4</td>
<td>0.4</td>
<td>117.8</td>
<td>122.4</td>
<td>4.6</td>
<td>201.3</td>
</tr>
<tr>
<td><strong>PAY</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PAY Total</td>
<td>(12.7)</td>
<td>(12.7)</td>
<td>0.1</td>
<td>(87.4)</td>
<td>(86.3)</td>
<td>1.0</td>
<td>(151.3)</td>
</tr>
<tr>
<td><strong>NON PAY</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>NON PAY Total</td>
<td>(6.6)</td>
<td>(7.1)</td>
<td>(0.5)</td>
<td>(46.5)</td>
<td>(52.0)</td>
<td>(5.5)</td>
<td>(79.6)</td>
</tr>
<tr>
<td><strong>NET POSITION</strong></td>
<td>(2.3)</td>
<td>(2.4)</td>
<td>(0.1)</td>
<td>(16.0)</td>
<td>(15.9)</td>
<td>0.1</td>
<td>(29.7)</td>
</tr>
</tbody>
</table>
### APPENDIX 2: Statement of Financial Position

<table>
<thead>
<tr>
<th></th>
<th>31 March 2016 £'000</th>
<th>31 Oct 2016 £'000</th>
<th>Forecast 2016/17 £'000</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>NON-CURRENT ASSETS</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Property, Plant and Equipment</td>
<td>127,916</td>
<td>125,121</td>
<td>132,688</td>
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<tr>
<td>Intangible Assets</td>
<td>13,649</td>
<td>12,819</td>
<td>11,877</td>
</tr>
<tr>
<td><strong>TOTAL NON-CURRENT ASSETS</strong></td>
<td><strong>141,565</strong></td>
<td><strong>137,940</strong></td>
<td><strong>144,565</strong></td>
</tr>
<tr>
<td><strong>CURRENT ASSETS</strong></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Inventories</td>
<td>4,407</td>
<td>4,407</td>
<td>4,407</td>
</tr>
<tr>
<td>Trade and Other Receivables</td>
<td>16,681</td>
<td>17,065</td>
<td>12,333</td>
</tr>
<tr>
<td>Cash and Cash Equivalents</td>
<td>1,524</td>
<td>6,661</td>
<td>2,449</td>
</tr>
<tr>
<td><strong>TOTAL CURRENT ASSETS</strong></td>
<td><strong>22,612</strong></td>
<td><strong>28,133</strong></td>
<td><strong>19,189</strong></td>
</tr>
<tr>
<td><strong>TOTAL ASSETS</strong></td>
<td><strong>164,177</strong></td>
<td><strong>166,073</strong></td>
<td><strong>163,754</strong></td>
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<tr>
<td><strong>CURRENT LIABILITIES</strong></td>
<td></td>
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<td></td>
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<tr>
<td>Trade and Other Payables</td>
<td>(28,527)</td>
<td>(30,384)</td>
<td>(27,597)</td>
</tr>
<tr>
<td>Provisions</td>
<td>(2,336)</td>
<td>(299)</td>
<td>(77)</td>
</tr>
<tr>
<td>Borrowings</td>
<td>(338)</td>
<td>(268)</td>
<td>(180)</td>
</tr>
<tr>
<td>DH Working Capital Loan</td>
<td>(300)</td>
<td>0</td>
<td>0</td>
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<tr>
<td><strong>TOTAL CURRENT LIABILITIES</strong></td>
<td><strong>(31,401)</strong></td>
<td><strong>(30,961)</strong></td>
<td><strong>(27,854)</strong></td>
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<tr>
<td><strong>NET CURRENT ASSETS/LIABILITIES</strong></td>
<td><strong>(8,789)</strong></td>
<td><strong>(2,183)</strong></td>
<td><strong>(8,665)</strong></td>
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<tr>
<td><strong>TOTAL ASSETS LESS CURRENT LIABILITIES</strong></td>
<td><strong>132,776</strong></td>
<td><strong>135,126</strong></td>
<td><strong>135,900</strong></td>
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<tr>
<td><strong>NON-CURRENT LIABILITIES</strong></td>
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<tr>
<td>Trade and Other Payables</td>
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<td></td>
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<tr>
<td>Provisions</td>
<td>(1,037)</td>
<td>(1,122)</td>
<td>(1,046)</td>
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<td>Borrowings</td>
<td>(286)</td>
<td>(60)</td>
<td>(96)</td>
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<tr>
<td>DH Working Capital Loan</td>
<td>(39,054)</td>
<td>(54,454)</td>
<td>(69,019)</td>
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<td><strong>TOTAL NON-CURRENT LIABILITIES</strong></td>
<td><strong>(40,377)</strong></td>
<td><strong>(55,636)</strong></td>
<td><strong>(70,161)</strong></td>
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<td><strong>ASSETS LESS LIABILITIES(TOTAL ASSETS EMPLOYED)</strong></td>
<td><strong>92,399</strong></td>
<td><strong>79,486</strong></td>
<td><strong>65,739</strong></td>
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<tr>
<td><strong>TAXABLE EQUITY</strong></td>
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<tr>
<td>Public Dividend Capital</td>
<td>122,912</td>
<td>125,912</td>
<td>125,912</td>
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<tr>
<td>Retained Earnings Reserves</td>
<td>(78,623)</td>
<td>(94,504)</td>
<td>(108,283)</td>
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<tr>
<td>Revaluation Reserve</td>
<td>48,110</td>
<td>48,078</td>
<td>48,110</td>
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<tr>
<td><strong>TOTAL</strong></td>
<td><strong>92,399</strong></td>
<td><strong>79,486</strong></td>
<td><strong>65,739</strong></td>
</tr>
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</table>
## APPENDIX 3: Cash Flow

<table>
<thead>
<tr>
<th>Cash Flows from Operating Activities</th>
<th>31 March 2016 £’000</th>
<th>31 Oct 2016 £’000</th>
<th>Forecast 2016/17 £’000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Net Operating Cost Before Interest</td>
<td>(34,151)</td>
<td>(13,873)</td>
<td>(26,027)</td>
</tr>
<tr>
<td>Depreciation and Amortisation</td>
<td>6,831</td>
<td>5,012</td>
<td>8,711</td>
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<tr>
<td>Impairments and Reversals</td>
<td>171</td>
<td>120</td>
<td>120</td>
</tr>
<tr>
<td>Interest Paid</td>
<td>(326)</td>
<td>(642)</td>
<td>(847)</td>
</tr>
<tr>
<td>Dividend (Paid)/Refunded</td>
<td>(3,556)</td>
<td>(1,393)</td>
<td>(2,545)</td>
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<tr>
<td>(Increase)/Decrease in Inventories</td>
<td>115</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>(Increase)/Decrease in Trade and Other Receivables</td>
<td>(3,689)</td>
<td>(1,384)</td>
<td>(650)</td>
</tr>
<tr>
<td>Increase/(Decrease) in Trade and Other Payables</td>
<td>8,984</td>
<td>3,803</td>
<td>3,148</td>
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<tr>
<td>Provisions Utilised</td>
<td>(1,855)</td>
<td>(110)</td>
<td>(140)</td>
</tr>
<tr>
<td>Provisions</td>
<td>931</td>
<td>(842)</td>
<td></td>
</tr>
<tr>
<td><strong>Net Cash Inflow/(Outflow) from Operating Activities</strong></td>
<td>(26,557)</td>
<td>(9,409)</td>
<td>(18,230)</td>
</tr>
</tbody>
</table>

### Cash Flows from Investing Activities

| Interest Received                  | 21                  | 18                 | 24                       |
| Payments for Property, Plant and Equipment | (8,126) | (3,205) | (12,952) |
| Payments for Intangible Assets      | (1,516)             | (198)              | (268)                    |
| **Net Cash Inflow/(Outflow) from Investing Activities** | (9,621) | (3,395) | (13,196) |

| **Net Cash Inflow/(Outflow) Before Financing** | (36,178) | (12,704) | (31,426) |

### Cash Flows from Financing Activities

| RWC Support                        | 15,700             | 8,640             | 8,640                   |
| Public Dividend Capital Received   | 1,020              | 3,000             | 3,000                   |
| Public Dividend Revenue Received   | 0                  |                   |                         |
| Loans Received from DH             | 39,054             | 6,760             | 29,966                  |
| **Loans Repaid to DH**             | 15,700             | (8,640)           |                         |
| Loans Repaid to DH                 | (600)              | (300)             | (300)                   |
| Other Loans Repaid                 | (255)              | (116)             | (211)                   |
| Capital Element of Payments        | (224)              | (53)              | (103)                   |
| Public Dividend Capital Repaid in Year | (3,000) | | |
| **Net Cash Inflow/(Outflow) from Financing Activities** | 35,994 | 17,931 | 32,351 |

| **Net Increase/(Decrease) in Cash and Cash Equivalents** | (184) | 5,137 | 925 |

| Opening Cash and Cash Equivalents  | 1,708              | 1,524             | 1,524                   |
| Cash and Cash Equivalents         | 1,524              | 6,661             | 2,448                   |
### APPENDIX 4: Capital Expenditure Summary

<table>
<thead>
<tr>
<th></th>
<th>Month Actual £’000</th>
<th>YTD Budget £’000</th>
<th>YTD Actual £’000</th>
<th>YTD Variance £’000</th>
<th>Annual Plan £’000</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>ESTATES</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Maternity Ventilation and Theatre Recovery Upgrade</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>850</td>
</tr>
<tr>
<td>Aseptic Unit</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>900</td>
</tr>
<tr>
<td>Fracture Clinic</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>2,000</td>
</tr>
<tr>
<td>Other Buildings Works</td>
<td>151</td>
<td>586</td>
<td>351</td>
<td>(235)</td>
<td>1,285</td>
</tr>
<tr>
<td><strong>TOTAL ESTATES</strong></td>
<td>151</td>
<td>586</td>
<td>352</td>
<td>(234)</td>
<td>5,035</td>
</tr>
<tr>
<td><strong>MEDICAL EQUIPMENT</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Equipment Replacement</td>
<td>65</td>
<td>919</td>
<td>341</td>
<td>(578)</td>
<td>2,270</td>
</tr>
<tr>
<td>Endoscopy Equipment</td>
<td>0</td>
<td>690</td>
<td>0</td>
<td>(690)</td>
<td>690</td>
</tr>
<tr>
<td><strong>TOTAL MEDICAL EQUIPMENT</strong></td>
<td>65</td>
<td>1,609</td>
<td>341</td>
<td>(1,268)</td>
<td>2,960</td>
</tr>
<tr>
<td><strong>IT</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>EPR</td>
<td>85</td>
<td>163</td>
<td>201</td>
<td>48</td>
<td>289</td>
</tr>
<tr>
<td>Medicine Management</td>
<td>139</td>
<td>374</td>
<td>211</td>
<td>(163)</td>
<td>801</td>
</tr>
<tr>
<td>LIMS Pathology</td>
<td>14</td>
<td>246</td>
<td>122</td>
<td>(126)</td>
<td>248</td>
</tr>
<tr>
<td>Nurse Tech. Fund E/OBS</td>
<td>5</td>
<td>155</td>
<td>108</td>
<td>(47)</td>
<td>283</td>
</tr>
<tr>
<td>ICR/SHSW</td>
<td>15</td>
<td>329</td>
<td>76</td>
<td>(253)</td>
<td>339</td>
</tr>
<tr>
<td>PACS</td>
<td>0</td>
<td>195</td>
<td>0</td>
<td>(195)</td>
<td>400</td>
</tr>
<tr>
<td>Trust Wireless and Guest</td>
<td>27</td>
<td>155</td>
<td>27</td>
<td>(128)</td>
<td>350</td>
</tr>
<tr>
<td>NHS Mail</td>
<td>0</td>
<td>123</td>
<td>1</td>
<td>(122)</td>
<td>200</td>
</tr>
<tr>
<td>Other</td>
<td>7</td>
<td>364</td>
<td>57</td>
<td>(327)</td>
<td>856</td>
</tr>
<tr>
<td><strong>TOTAL IT</strong></td>
<td>292</td>
<td>2,116</td>
<td>803</td>
<td>(1,313)</td>
<td>3,716</td>
</tr>
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<td><strong>GRAND TOTAL</strong></td>
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<td>4,311</td>
<td>1,496</td>
<td>(2,815)</td>
<td>11,711</td>
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<tr>
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<td>Trust Board</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
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<td>---------------------</td>
<td>-----------------------------------------------------------------------------</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Date</td>
<td>24 November 2016</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Report Title</strong></td>
<td>CIP Plan Report – 2016/17 Month 7</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td><strong>Lead Director/ Manager</strong></td>
<td>Stephanie Lawton – Chief Operating Officer</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Report Authors</strong></td>
<td>Chetna Patel, Associate Director of Business Delivery</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Freedom of Information (FOI) Status</td>
<td>Unrestricted □ Restricted ■</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Action Required</td>
<td>Approval □ Decision □ Discussion ■ Information ■ Assurance ■ Other □ (specify)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Executive Summary</strong></td>
<td>The 2016/17 Cost Improvement Programme (CIP) for PAH has a target of £12m split including cost improvement (£5.1m) and temporary staffing reduction (£6.9m). PID documentation has been updated consistently and pipeline ideas have been progressed to mitigate against any under-delivery. Progress against this continues to be monitored through the Executive budget setting meetings and Executive led Delivery Challenge Meetings (DCMs). YTD, the Trust was forecast to deliver £6.1m; actual delivery has resulted in £7.5m, £1.4m ahead of plan. Whilst there has been consistent progress, there are key areas to focus on to ensure delivery. These are detailed within the paper. Each of the project initiation documents (PIDs) and associated risk logs are being assessed regularly by the EDST to ensure that mitigation is sufficient and, where necessary, risks are escalated to the PAF Committee. The Trust is on track to over-deliver against the £12.0m target by £2.1m. <strong>CIP Conclusion and Next Steps:</strong> The key priorities are to: • Maintain momentum to ensure delivery of the 2016/17 target. • Assess and score the risks of non-delivery of the programme, identifying mitigating actions where appropriate. • Identify and implement mitigating actions to address the shortfall of risks of under-delivery. • Maintain the level of scrutiny and support to HCGs and corporate teams. • Embedding the Carter recommendations where appropriate. • Ensure that the CIP tracker and monitoring dashboard remain fully functional. • Reinforce actions and communication on agency staff reductions • Support the scoping and development of plans for the coming year.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Recommendation</strong></td>
<td>The Board is asked to discuss the report and determine the level of assurance provided and whether this meets its needs.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>--------------------</td>
<td>---------------------------------------------------------------------------------------------------------------</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| **Trust Strategic Goal** | Excellent Operational Performance  
Increasing Clinical Productivity and Growing Elective Market Share  
Manage Emergency Demand and Redesign Emergency Care Pathway. |
| **NHS Constitution** | This paper pertains mainly to NHS Principle 6:  
*The NHS is committed to providing best value for taxpayers’ money and the most effective, fair and sustainable use of finite resources.* |
| **Implications** |  |
| **Risk** | Achieving Financial Plan BAF 001  
Achieving Statutory Obligations BAF 007  
Maintaining a positive cash balance BAF 009 |
| **Legal/Regulatory** | Statutory break even duty |
| **Resources** |  |
| **Previously Considered by** | PAF  
Date: 21.11.16 |
| **Appendices** | Appendix 1: M7 CIP dashboard |
1. Executive Summary

1.1 The total savings plan for the year is £12m for cost improvement and temporary staffing reduction. This is comprised of £5.1m cost improvement and £6.9m in agency/temporary staff reduction.

1.2 Year to date (YTD), the Trust has delivered savings of £7.5m against a target of £6.1m.

2. Month 7 and YTD Cost Improvement Programme Delivery

2.1 Month 7, the Trust delivered £0.85m, against a plan of £1.0m, which resulted in an under-achievement of £0.25m.

2.2 Of the £7.5m savings made YTD £3.8m (51%) is against temporary spend reductions and £3.7m (49%) has been saved on other CIP schemes.

2.3 Chart 1: YTD savings – Plan against Actual

<table>
<thead>
<tr>
<th>Quadrant</th>
<th>Plan</th>
<th>Actual</th>
<th>Variance</th>
<th>Stage delivered</th>
<th>RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>CCCS</td>
<td>1,047</td>
<td>1,177</td>
<td>924</td>
<td>656</td>
<td>2,637</td>
</tr>
<tr>
<td>Corp. Central</td>
<td>1,054</td>
<td>1,183</td>
<td>558</td>
<td>317</td>
<td>2,763</td>
</tr>
<tr>
<td>Estates and Facilities</td>
<td>451</td>
<td>608</td>
<td>157</td>
<td>106</td>
<td>564</td>
</tr>
<tr>
<td>FAWS</td>
<td>451</td>
<td>608</td>
<td>157</td>
<td>106</td>
<td>564</td>
</tr>
<tr>
<td>Medical</td>
<td>451</td>
<td>608</td>
<td>157</td>
<td>106</td>
<td>564</td>
</tr>
<tr>
<td>Surgery</td>
<td>451</td>
<td>608</td>
<td>157</td>
<td>106</td>
<td>564</td>
</tr>
</tbody>
</table>

2.4 Quadrant delivery against CIPs comprised of:
- Income: £0.05m against an in-month plan of £0.08m
- Clinical Effectiveness: £0.1m against an in-month plan of £0.4m
- Efficiency & Productivity: £0.1m against an in-month plan of £0.2m
- Cost Reduction: £0.4m against an in-month plan of £0.06m

2.5 Table 1: Month 7 and YTD Cost Improvement Programme Quadrant Delivery

<table>
<thead>
<tr>
<th>Quadrant</th>
<th>Plan</th>
<th>Actual</th>
<th>Variance</th>
<th>Stage delivered</th>
<th>RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical Effectiveness</td>
<td>439,198</td>
<td>95,928</td>
<td>(343,270)</td>
<td>2,455,423</td>
<td>100%</td>
</tr>
<tr>
<td>Cost Reduction</td>
<td>329,549</td>
<td>647,783</td>
<td>318,234</td>
<td>1,841,567</td>
<td>100%</td>
</tr>
<tr>
<td>Income</td>
<td>83,323</td>
<td>50,928</td>
<td>(32,405)</td>
<td>416,667</td>
<td>100%</td>
</tr>
<tr>
<td>Productivity &amp; Efficiencies</td>
<td>246,215</td>
<td>6,606</td>
<td>(239,609)</td>
<td>1,244,901</td>
<td>100%</td>
</tr>
<tr>
<td>TOTAL</td>
<td>1,098,496</td>
<td>805,245</td>
<td>(293,251)</td>
<td>6,138,558</td>
<td>100%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Quadrant</th>
<th>Plan</th>
<th>Actual</th>
<th>Variance</th>
<th>Stage delivered</th>
<th>RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical</td>
<td>2,201,341</td>
<td>2,201,341</td>
<td></td>
<td>2,201,341</td>
<td>100%</td>
</tr>
<tr>
<td>Productivity &amp; Efficiencies</td>
<td>318,234</td>
<td>318,234</td>
<td></td>
<td>318,234</td>
<td>100%</td>
</tr>
<tr>
<td>TOTAL</td>
<td>4,139,585</td>
<td>4,139,585</td>
<td></td>
<td>4,139,585</td>
<td>100%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Quadrant</th>
<th>Plan</th>
<th>Actual</th>
<th>Variance</th>
<th>Stage delivered</th>
<th>RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical Effectiveness</td>
<td>2,455,423</td>
<td>2,455,423</td>
<td></td>
<td>2,455,423</td>
<td>100%</td>
</tr>
<tr>
<td>Cost Reduction</td>
<td>1,841,567</td>
<td>1,841,567</td>
<td></td>
<td>1,841,567</td>
<td>100%</td>
</tr>
<tr>
<td>Income</td>
<td>416,667</td>
<td>416,667</td>
<td></td>
<td>416,667</td>
<td>100%</td>
</tr>
<tr>
<td>Productivity &amp; Efficiencies</td>
<td>1,244,901</td>
<td>1,244,901</td>
<td></td>
<td>1,244,901</td>
<td>100%</td>
</tr>
<tr>
<td>TOTAL</td>
<td>6,138,558</td>
<td>6,138,558</td>
<td></td>
<td>6,138,558</td>
<td>100%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Quadrant</th>
<th>Plan</th>
<th>Actual</th>
<th>Variance</th>
<th>Stage delivered</th>
<th>RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical</td>
<td>(254,082)</td>
<td>(254,082)</td>
<td></td>
<td>(254,082)</td>
<td>100%</td>
</tr>
<tr>
<td>Productivity &amp; Efficiencies</td>
<td>(1,198,457)</td>
<td>(1,198,457)</td>
<td></td>
<td>(1,198,457)</td>
<td>100%</td>
</tr>
<tr>
<td>TOTAL</td>
<td>1,190,165</td>
<td>1,190,165</td>
<td></td>
<td>1,190,165</td>
<td>100%</td>
</tr>
</tbody>
</table>
2.6 The YTD recurrent and non-recurrent split is £6.6m (87%) and £0.9m (13%) respectively. The Trust continues to achieve good recurrent savings; however, specific focus needs to be paid to this as the year progresses, as the achievement of recurrent CIPs in the last quarter of 2015/16 reduced.

2.7 **Table 2: Summary of Cost Improvement Delivery – Recurrent & Non Recurrent**

<table>
<thead>
<tr>
<th>Scheme</th>
<th>Recurrent</th>
<th>Non-recurrent</th>
<th>Total</th>
<th>%age recurrent</th>
<th>RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>CCCS</td>
<td>180,036</td>
<td>26,097</td>
<td>206,133</td>
<td>87%</td>
<td></td>
</tr>
<tr>
<td>Corp. Central</td>
<td>(80,990)</td>
<td>36,833</td>
<td>(44,157)</td>
<td>183%</td>
<td></td>
</tr>
<tr>
<td>Estates and Facilities</td>
<td>114,866</td>
<td>6,208</td>
<td>121,074</td>
<td>95%</td>
<td></td>
</tr>
<tr>
<td>NHWS</td>
<td>70,215</td>
<td>70,215</td>
<td>140,430</td>
<td>100%</td>
<td></td>
</tr>
<tr>
<td>Medical</td>
<td>221,664</td>
<td>221,664</td>
<td>443,328</td>
<td>100%</td>
<td></td>
</tr>
<tr>
<td>Surgery</td>
<td>275,887</td>
<td>275,887</td>
<td>551,774</td>
<td>100%</td>
<td></td>
</tr>
<tr>
<td>TOTAL</td>
<td>781,677</td>
<td>69,138</td>
<td>850,816</td>
<td>92%</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Scheme</th>
<th>Recurrent</th>
<th>Non-recurrent</th>
<th>Total</th>
<th>%age recurrent</th>
<th>RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>CCCS</td>
<td>945,871</td>
<td>108,007</td>
<td>1,053,879</td>
<td>90%</td>
<td></td>
</tr>
<tr>
<td>Corp. Central</td>
<td>508,097</td>
<td>674,687</td>
<td>1,182,784</td>
<td>43%</td>
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</tr>
<tr>
<td>Estates and Facilities</td>
<td>439,341</td>
<td>119,120</td>
<td>558,461</td>
<td>79%</td>
<td></td>
</tr>
<tr>
<td>NHWS</td>
<td>316,713</td>
<td>316,713</td>
<td>633,426</td>
<td>100%</td>
<td></td>
</tr>
<tr>
<td>Medical</td>
<td>2,762,275</td>
<td>305</td>
<td>2,763,579</td>
<td>100%</td>
<td></td>
</tr>
<tr>
<td>Surgery</td>
<td>1,616,255</td>
<td>66,355</td>
<td>1,682,610</td>
<td>96%</td>
<td></td>
</tr>
<tr>
<td>TOTAL</td>
<td>6,589,051</td>
<td>968,474</td>
<td>7,557,525</td>
<td>87%</td>
<td></td>
</tr>
</tbody>
</table>

2.8 The EDST has been working closely with HCGs and Corporate Teams to develop schemes to deliver this year’s savings programme. The focus continues to be on identifying as many recurrent schemes as possible that will deliver clinical effectiveness, and efficiencies and productivity.

3. **Scheme Governance**

3.1 There are a total of 99 schemes, 31 of which are pipeline. The 68 developed schemes are governance RAG’d as per the table below.

3.2 **Table 3: Scheme RAG rating**

<table>
<thead>
<tr>
<th>Schemes (RAG)</th>
<th>Number of Schemes</th>
<th>%age</th>
</tr>
</thead>
<tbody>
<tr>
<td>RED Schemes</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>AMBER Schemes</td>
<td>21</td>
<td>23%</td>
</tr>
<tr>
<td>GREEN Schemes</td>
<td>47</td>
<td>77%</td>
</tr>
<tr>
<td>TOTAL</td>
<td>68</td>
<td>100%</td>
</tr>
<tr>
<td>Pipeline Schemes</td>
<td>31</td>
<td>-</td>
</tr>
</tbody>
</table>

3.3 All schemes have been moved from the Red RAG and are in delivery. The focus for EDST going forward is to further progress all Amber schemes.

3.4 HCGs and Corporate teams continue to use the new monitoring dashboard to track progress against their schemes.

4. **Scheme Assurance**

4.1 The EDST uses the dashboard to report on high value schemes to ensure that there is enough traction on the delivery and appropriate scrutiny is maintained. The month 7 dashboard can be found in Appendix 1.
5. Pipeline

5.1 To off-set any underachievement of plans within each area, all HCG’s and Corporate areas continue to review and develop their pipeline schemes where viable.

5.2 Of the 31 pipeline schemes, 13 schemes have a value associated with them, totalling £0.86m.

6. Forecast Outturn

6.1 To date, the Trust has forecast a delivery of £14.1m against a CIP target for 2016/17 of £12.0m.

6.2 Chart 2: 2016/17 Actual and forecast performance against CIP plan and CIP target

6.3 The Trust needs to deliver £4.4m (37%) in the remainder of the year to achieve the CIP target of £12.0m.

7. Escalation Points

7.1 The key risks are recorded within each PID and discussed regularly, i.e. fortnightly assurance meetings.

7.2 To ensure all risks against delivery of the programme are captured and mitigated against, the EDST maintains a Programme Risk Register.

7.3 Items for Escalation:

- Ability to capture savings against schemes within the Efficiency and Productivity, and Clinical Effectiveness quadrants.
  - Identification of schemes within Clinical Effectiveness and Efficiency and Productivity quadrants has proved challenging. To address this, the Trust is reviewing the CIP framework for next year.
- Continue to reinforce actions and communication on agency staff reductions.

8. CIP Conclusion and Next Steps

8.1 The Trust has proactively been using the CIP dashboard to monitor and report on the progress of schemes.
8.2 A further workshop took place on 15 November where clinical leads, service managers and ward managers were invited to contribute their thoughts and ideas to the development of the CIP programme next year. The session also focussed on maintaining momentum for the delivery of savings for the remainder of the year, paying specific attention to the delivery of the 30, 60, 90, 100 day plans.

8.3 Following the workshop, all HCGs and Corporate teams are invited to begin exploring and developing the CIP plans for the forthcoming year.

8.4 The key priorities for the coming month are to:
- Maintain momentum to ensure delivery of the 2016/17 target.
- Assess and score the risks of non-delivery of the programme, identifying mitigating actions where appropriate.
- Identify and implement mitigating actions to address the shortfall of risks of under-delivery.
- Maintain the level of scrutiny and support to HCGs and corporate teams.
- Embedding the Carter recommendations where appropriate.
- Ensure that the CIP tracker and monitoring dashboard remain fully functional.
- Reinforce actions and communication on agency staff reductions
- Support the scoping and development of plans for the coming year.

9. **CIP Recommendation**

9.1 The Board is asked to note and discuss the month 7 financial results for the cost improvement programme, the actions being taken to deliver the 2016/17 CIP and to discuss the key risks.

*Author:* Chetna Patel  
*Date:* 15 November 2016
<table>
<thead>
<tr>
<th>Project</th>
<th>Sponsor</th>
<th>Trust Board</th>
<th>Project Status</th>
<th>Action</th>
<th>Score</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Repatriated Basildon Cardiology Clinics</td>
<td>Julie Matthews</td>
<td>1</td>
<td>Complete</td>
<td>Action 1: There are others biosimilar initiatives planned for next year and the teams are working on this.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
**Meeting Title** | Trust Board  
---|---  
**Date** | 24 November 2016  
**Report Title** | Constitutional Operational Standards: RTT, Cancer, Diagnostics, Emergency Care (ED) Standards.  
**Lead Director/Manager** | Stephanie Lawton, Chief Operating Officer  
**Report Author** | Richard Hammond, Deputy COO Urgent Care  
| Anne Carey, Deputy COO Planned Care  
**Freedom of Information (FOI) Status** | Unrestricted □  
| Restricted ■ (select using ■)  
**Action Required** | Approve □  
| Decide □  
| Discuss □  
| Inform ■  
| Assure □  
| Ratify □  
| Update □  
| Review □  
| Other □ (specify)  
**Executive Summary** | The paper outlines the core operational performance for the Princess Alexandra Hospital for the month of October [September for Cancer]. Performance is measured against the national standards and agreed recovery trajectories. The paper details the areas of delivery and the actions taken to address the areas of on-going risk. Specific actions to support improvement in the recovery of the 4 hour standard are detailed in the paper. Local and Regional escalation meetings are in place on a monthly basis to review and monitored implementation and delivery of action plans associated with the 5 key mandated priorities for all acute Trusts in Winter 2016/17. Delivery of RTT, Diagnostics and cancer are continuing in line with agreed STF trajectories.  
| National Standard | October 2016 | Month Trajectory  
|---|---|---  
| ED | 95% | 80.2% | 91%  
| Cancer | 85% | 87.5% (September) | 85%  
| Diagnostics | 99% | 99.5% | 99%  
| RTT | 92% | 93.1%* | 92%  
**Recommendation** | The Trust Board are asked to note the contents of the report and the actions being undertaken to improve and sustain operational performance.  
**Trust Strategic Goal** | Objectives 1, 2, 4, 5 and 6  
| Excellent safety and clinical outcomes: benchmarked against the best.  
| Excellent experience for patients and carers: delivering personalised care.  
| Excellent value.  
| Excellent morale and staff engagement.  
| Excellence in compliance and meeting standards.  
**NHS Constitution** | Principles 1, 4, 5 and 7  
| The NHS provides a comprehensive service available to all.  
| The NHS aspires to put patients at the heart of everything it does.  
| The NHS works across organisational boundaries and in partnership with other organisations in the interest of patients, local communities and the wider population.  
| The NHS is accountable to the public, communities and patients that it
Implications

<table>
<thead>
<tr>
<th>Risk</th>
<th>There are a number of risks to delivery of operational performance for the remainder of this financial year. Mitigating actions are in place with daily and weekly operational meetings to monitor and review performance, take any required remedial actions to achieve the required performance outcomes.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Legal/Regulatory</td>
<td>National NHS Contract</td>
</tr>
<tr>
<td>Previously Considered by</td>
<td>Date</td>
</tr>
</tbody>
</table>
Operational Delivery of Constitutional Operational Standards October 2016

1.0 Purpose

This report presents a summary of the operational performance for core standards in each of the key operational areas. The paper details the Trust performance in October (September for Cancer) together with performance against STF trajectories.

2.0 Background

The Trust continues to experience challenges with the delivery of the four hour ED standard. A system wide action plan is in place, as well as a plan to sustain a reduction in the numbers of delayed discharges. Diagnostic continues to demonstrate consistent delivery and the performance against the RTT and cancer 62 day standards have been maintained for October and September performance respectively.

3.0 Operational Performance and Recovery Trajectories 16/17

3.1 Emergency Care

<table>
<thead>
<tr>
<th>Data Set</th>
<th>National standard</th>
<th>October 2016</th>
<th>Month Trajectory</th>
</tr>
</thead>
<tbody>
<tr>
<td>Planned Attendances 2016/17</td>
<td>95%</td>
<td>80.2%</td>
<td>91%</td>
</tr>
<tr>
<td>Actual Attendances</td>
<td>8020</td>
<td>8931</td>
<td>8461</td>
</tr>
<tr>
<td>Breaches to achieved planned Trajectory</td>
<td>1736</td>
<td>1512</td>
<td>1389</td>
</tr>
<tr>
<td>Actual Breaches</td>
<td>1986</td>
<td>2350</td>
<td>2487</td>
</tr>
<tr>
<td>Original STF Trajectory 2016/17</td>
<td>77.20%</td>
<td>81.90%</td>
<td>83.00%</td>
</tr>
<tr>
<td>Actual Performance</td>
<td>75.2%</td>
<td>73.7%</td>
<td>70.6%</td>
</tr>
<tr>
<td>Target performance</td>
<td>95.00%</td>
<td>95.00%</td>
<td>95.00%</td>
</tr>
<tr>
<td>breaches to achieve new trajectory</td>
<td>2369</td>
<td>2176</td>
<td>1675</td>
</tr>
</tbody>
</table>

- October ED month performance increased to 80.2% against a trajectory of 91%. This is an increase in performance from September which was 73.06%.
Delivery of the actions to improve the Trust’s ability to achieve the 4 hour standard are being monitored through the Local Delivery Board, Regional escalation meetings and through the implementation of key work streams.

- **Actions and Improvements**
  
  - LOS over 7 days has reduced from 243 patients in August to 171 patients in October. Number of patients over 50 days has reduced from 18 to 7 patients with the longest LOS now 79 days compared to 321 in August, with plans in place for the longest stay patient to be transferred by end of November.
  - Average NEL LOS in April was 6.3 days – now reduced to 5.6 days in October.
  - DTA’s 6.30am each day in April was 18 patients, in October this has reduced to average of 5 patients.
  - The percentage DTOC patients has decreased from 8.3% to 6.89%
  - The system wide Local Delivery Plan based on the national 5 mandated priorities has been submitted with further work being undertaken on the ambulance work streams at present.
  - The Trust joined the ECIP2 programme in October with the first internal audit of all hospital and community stranded patients taking place. Review of ED/Patient flow 15/16 November 2016.
  - Roll out and full implementation of SAFER under way with roll out all wards will be completed by end of November.
  - Red and Green Days - roll out to start 1st December.
  - 10 bedded Observation Ward opened on the 3rd October. This short stay area has been used to improve flow, reduce the number of patients staying in ED over 4 hours and to reduce the number of overnight DTAs. Impact on performance has been positive and is expected to continue.
  - Additional assessment space has been created by relocating the ENP service into a location adjacent to ED. Throughput has improved and performance achieving over 99%.
  - The refurbishment of an old ward area has commenced which will create an additional 18 beds for winter capacity. Work is expected to be completed by the 10th December. A series of ward moves are also planned from the 16th December to realign the main trust bed base. Further procurement is underway to commence building work on an additional 28 bedded area, however the clinical and operational model are still under discussion with system partners and commissioners. This area should be completed by the end of February 2017.

### 3.2 Referral to Treatment (RTT)

<table>
<thead>
<tr>
<th>National Standard</th>
<th>October 2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>Incomplete</td>
<td>92%</td>
</tr>
<tr>
<td>Admitted</td>
<td>90%*</td>
</tr>
<tr>
<td>Non Admitted</td>
<td>95%*</td>
</tr>
</tbody>
</table>

*non reportable

Performance against the 92% incomplete RTT standard has continued to be achieved for the third month, with a slight over performance in month.
A comparison of the performance between the October 2015 and the October 2016 position is set out above. Since Oct 2015, performance against the RTT standard has improved by 13.8% from 79.2% to 93%. A total of 6477 pathways have been removed from the PTL through a combination of treatment and validation. Of these 3419 pathways were >18 weeks and 3060 pathways were < 18 weeks. A review of those patients who are removed from the patient tracking list prior to any treatments or appointments taking place is currently under review.

Thirty three out of thirty-six specialties are achieving, with many over-performing, against the 92% RTT standard. The three remaining services who are not achieving the standard have plans in place to provide the additional capacity required to deliver the standard by the end of December 2016. However both Oral Surgery (including Max Fax and Skin) and Trauma & Orthopaedics are high risk due to shortage of specialist teams able to undertake some of the complex procedures.

In addition, performance against the Admitted and Non-Admitted Standards has also improved, with all clinical service agreeing trajectories for delivery by the end of March 2017. The reliance on insourcing has started to reduce across general Surgery, Colorectal and Vascular as volumes have reduced significantly and PAH clinical teams are now able to accommodate and deliver in-house solutions.

Monitoring of all standards is undertaken at the weekly PTL meetings and reviewed at the Access Board. Individual specialty meetings have been held with Executive Directors, Clinical, Nursing and Operational leads.

### 3.3 Cancer 62 day

<table>
<thead>
<tr>
<th></th>
<th>National Standard</th>
<th>September 2016</th>
<th>Month Trajectory</th>
<th>National average</th>
</tr>
</thead>
<tbody>
<tr>
<td>62 Day</td>
<td>85%</td>
<td>87.5%/88.9%*</td>
<td>85%</td>
<td>82.6%</td>
</tr>
<tr>
<td>31 Day</td>
<td>94%</td>
<td>85.7%</td>
<td>94%</td>
<td>95.8%</td>
</tr>
</tbody>
</table>

*revised based on new NHS guidance.
The Trust delivered against the 62 day standard and trajectory in September. However the Trust failed the 31 day, due to one (Skin) patient out of the seven patients treated who failed this standard.

An internal audit of the processes within Cancer Services is currently underway and is due to report shortly. It is anticipated that this will highlight areas where processes can be strengthened to realise the improvements required to ensure consistent performance against the standards.

3.4 Diagnostic

<table>
<thead>
<tr>
<th>National Standard</th>
<th>October 2016</th>
<th>Month Trajectory</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diagnostics</td>
<td>99%</td>
<td>99.5%</td>
</tr>
</tbody>
</table>

The Trust continues to deliver against the standard and the agreed trajectories and realise further improvement on an already achieving standard.

4. Conclusion

It is evident from the significant amount of data analysis that ED attendances are increasing year on year, length of stay (LOS) for patients in ED is rising, ie those patients who spend more than 12 hours in ED and the Trust’s short stay activity is decreasing. The reduction in short stay admissions accounts for approximately 500 admissions per month. The conversion rate for our patients has steadily declined over the last 18 months and now stands at 17% which is the 7th lowest in the country. It is recommended that during winter conversion rates should be around 28% decreasing to 25% in summer months. Work is underway to reduce the number of long stay or stranded patients (>7days days) in the Trust via a number of projects and initiatives, such as SAFER Patient Flow Bundle, red and green days, introduction of internal professional standards, integrated discharge planning team, etc. All of these initiatives will improve quality, flow and operational performance.
Regional escalation meetings will continue to be held with Chief Executive, Accountable Officers and System leaders until the standards have improved and can be sustained.

Performance across Cancer is fragile but there are delivery plans in place to support this with confidence that the additional operational support and oversight will support delivery throughout the remainder of the year. RTT and Diagnostics will continue to achieve national standards.

5. Recommendations

The Trust Board are asked to note the areas of continued delivery and to support the work underway to drive improvements in quality, safety and operational performance in the 4 hour standard recovery.

Stephanie Lawton
Chief Operating Officer
Integrated Performance Report

October 2016

Building for excellence
Complaints continue to remain under robust control; allowing our total number of open complaints to fall to an all-time low of 35, therefore reaching target. In addition to the Trust's success of open complaints; we are currently reporting zero breaches, therefore all complaints being investigated and resolved/closed within 25 working days. This has allowed the Patient Experience Team to support our wards with proactive PALS/Compliments resolution and work is taking place to support HCGs with their shared learning.

In addition to the PALS desk, the team are also delivering PALS to the People (PTTP), enabling our elderly and those with reduced mobility to access our services from their bedside. Every Thursday PTTP visit all inpatient ward areas, spending time capturing feedback which we wouldn't have achieved without taking the service mobile.

In November 2016, PALS and Essex Libraries collaborate as The Patient Experience Team visit our patients in Harlow Town Centre. Harlow Library has agreed for PALS to base themselves in the library once a week, capturing patient feedback in a natural and clinical-free environment.

Outpatient and theatre activity being closely monitored to ensure performance is efficient. Systems and processes in place to ensure no activity is cancelled without Executive discussion and approval. Theatre efficiency and productivity programme has commenced with early signs of improvement. Additional work to review the cancellation processes for all outpatient activity is in place. This has shown a significant reduction in cancellations from August to date.

Three Serious Incidents were reported in October 2016 and comprehensive RCA investigations have commenced. Incident reporting remains consistent and greater than 94% of all incidents reported remain in the near miss, no harm or minor harm category. To date, there have been 11 cases of Trust-attributed Clostridium difficile against the national ceiling on 10 cases. Three of the 11 cases have been successfully appealed at the North Essex Scrutiny Panel, on the basis that no lapse of care had occurred. In contractual terms with the CCG, the Trust has therefore had eight cases of Trust-attributable cases (although nationally we continue to report 11 cases). The RCA has taken place for the October case, and this will be taken to the North Essex Scrutiny Panel of appeal in December as we believe there were no lapses in care.

Achievement of the 4-hour constitutional standard remains challenging. The first meetings of the Local Delivery Board have taken place with commitment from system partners to work jointly on development and implementation of the winter capacity plan. Internally discussions have been held throughout September in relation to additional bed capacity and use of facilities onsite. Plans have been presented to committees with agreement to proceed in October. Delivery of the constitutional standards for RTT and cancer in this reporting period have been achieved. Diagnosis continues to achieve the standard.

There is a strong focus on the new Development and Deployment Strategy, this strategy will support the key metrics reported. The new appraisal system has been developed to support the vision to develop and retain our talented staff.

Sickness for the Trust has remained consistent for the last two months. Turnover has reduced by 0.5% which takes it to its lowest point in the rolling year. Agency spend has increased this month, however corrective short term and longer term actions have now been identified and put into place to reduce this.

Building for excellence
# Surgery & Critical Care Health Group Summary

## Key Priorities 2016-2017

- Achieve Constitutional standards in RTT, Cancer, ED and Diagnostics and sustain this position
- Continue to meet or exceed CIP Target
- Deliver the identified improvements in theatre efficiency and productivity.
- Improve recruitment & retention of staff

## Working Well

- Theatre review completed and FOT in place. Weekly targeted meetings to ensure traction and movement. Theatre lists being back filled. Additional sessions and SPA sessions being utilised for three session and weekly working.
- SHG is over performing against agency staffing forecast.
- CIP's currently over delivering against target FOT to over deliver
- COG/CIG meetings are now scheduled with a renewed focus on business objectives, RTT Finance, Pals, Theatre Utilisation, Cancer
- Eye Unit - Plans in place for Nursing staff appraisals, Mandatory training, leadership and staff development. Eye Unit environment has been 'Leaned' which has improved the patient experience.
- No advice and guidance outstanding for the HG.
- Morale within the team continues to improve.
- Reduction in Locum and Agency Spend - The SHG had continued to see a reduction in Locum and Agency spend due to tighter processes on booking locum doctors, better management of rotas, and better forward planning.

## Concerns

- Plans being developed for compliance with all RTT metrics (Admitted, Non Admitted and Incomplete)
- HDU/ITU capacity causes concerns with delivering Cancer and Elective order book.
- Staffing on wards remains a concern and there is a rolling programme of recruitment.
- First appointments for 2WW requires improvement as capacity does match demand. On going work to re-align shortfalls.
- Delays with Fracture clinic re-location back to PAH
- Concerns over Cancer - pathology shortages, review of escalation process in place.

## Requires Support

- Medical Staffing vacancies across specialties has resulted in a dependence on locums to support services
- Pre-assessment - support required for estates work for the physical re-location from Galen House.
- The physical colocation of the SHG team is an important enabler of team cohesion and function. Temporary workarounds will be found but a longer term more satisfactory solution is needed.
- Re launch and review of the Healthgroup Board Meetings. Focus on the 30,60,90,100 day delivery of the plans.

## Action Required

<table>
<thead>
<tr>
<th>Action Required</th>
<th>Who by</th>
<th>Domain List</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ability to fast track Medical staffing vacancies.</td>
<td>SHG</td>
<td>Workforce and Operational</td>
</tr>
<tr>
<td>Estates expedite planned works</td>
<td>Estates</td>
<td>Workforce and Operational</td>
</tr>
<tr>
<td>Medium Impact</td>
<td>Surgical</td>
<td>Workforce and Operational</td>
</tr>
<tr>
<td>Medical staffing vacancies</td>
<td>SHG</td>
<td>Workforce and Operational</td>
</tr>
<tr>
<td>Medical staffing vacancies</td>
<td>SHG</td>
<td>Workforce and Operational</td>
</tr>
<tr>
<td>Space utilisation review</td>
<td>Management</td>
<td>Workforce and Operational</td>
</tr>
<tr>
<td>Medium Impact</td>
<td>Associate Medical Director</td>
<td>Workforce and Operational Development</td>
</tr>
<tr>
<td>Efficient use of CIG &amp; COG</td>
<td>Workforce and Operational Development</td>
<td></td>
</tr>
</tbody>
</table>

## Building for excellence

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The Princess Alexandra Hospital

46 of 99

Trust Board (Part 1)-24/11/16
Medicine Health Group summary

Key Priorities 2016-2017

- Improve patient safety, outcomes and experience
- Recruitment and retention of medical and nursing staff across key specialties and wards
- Improve staff wellbeing, engagement and involvement
- Achieve greater grip on aspects of finance and performance
- Achieve greater integration, which for us means patient centred, well coordinated and sustainable care
- Improving patient flow, reducing patient delays, reducing ED crowding, removing exit block from ED and improvement against the four hour standard via Transforming
- Develop strategy based upon staff feedback from quality framework analysis (enablers) and performance captured in our balanced scorecard (results)
- Repatriation of medical outletters to Saunders Ward, which will include a surgical liaison area for shared care patients
- Delivery of an in-house Patient @ Home service
- Jag Accreditation for the PAH Endoscopy Service
- Delivery CIP savings and a sustainable reduction in temporary staff expenditure
- Non Invasive Ventilation (NIV) Service to Locke Ward

Working Well

- Managing Outletters - Through the Transforming our Care Specialty Workstream the MHG is leading the change in process of managing outliers throughout the Trust since the retirement of Dr Alice Dains. New SOP written and Outletter reports going out daily.
- RTT and cancer waiting times - The MHG has seen a steady increase in performance in RTT and cancer waiting times since the start of year. August & September have proved challenging months for Gastro, but better use of Insourcing for October has seen all Medicine specialties achieve targets.
- Sharing the Learning - The latest Sharing the Learning event was Trustwide and well attended
- ED Dashboard and Performance Meetings - The ED Dashboard is now on Qlikview and is used in the daily performance meetings to analyze issues from the previous day. We need to see this start to make a difference. The ED Operational Team has been increased with Peter and Melissa joining the team. Peter is working with Curtis to start 2 hourly ward rounds.
- SAFER Matron seconded in to post - This appointment will help the MHG continue the good work started on the SAFER programme. Red and Green days will also be rolled out as part of this programme.
- Dementia Quality Mark awarded to Lister Ward. 3 more wards (Henry Moore, Locke and Ray) soon to complete the process.
- Frailty Matron - This appointment and the redesign of the pathway has given fresh impetus to the service which has started to take patients again since the start of October. This has been well received by local GPs and the CCG at a recent conference

Concerns

- ED Performance against target. Due to ED crowding, shortage of substantive doctors and nurses, and lack of patient flow, performance against the 4 hour target is very poor. The ED Observation Ward has been created in the Majors Ambulatory area. This is a temporary location pending internal ward and bed moves.
- Staff Retention and Morale - Sickness down to 3.36, though still above target.
- JAG Accreditation - the first submission has been made to JAG and a lot of progress has been made with environmental changes to the Endoscopy Unit. However due to all the changes in ED and EAU, we are concerned whether Estates will have the resources to help with further required changes. Space realisation agreed with Surgery - need to make sure changes happen. Mock visit arranged for 10.11.16.
- Gastroenterology - Staffing remains an issue and the ability to recruit substantive and locum clinicians remains challenging. The service is vulnerable due to its dependency on the use of costly agency Endoscopists.
- Saunders Ward has transferred to the Medicine Health Group. Recruitment is ongoing into all vacant clinical posts. Staff are being supported during the transition to ensure effective communication is maintained during this period of change. The picture has improved throughout morale and performance improving.
- Reduction in Locum and Agency Spend - The MHG had continued to see a reduction in Locum and Agency spend due to tighter processes on booking locum doctors, better management of rotas, and better forward planning of Endoscopy lists.

Requires Support

<table>
<thead>
<tr>
<th>Action Required</th>
<th>Who by</th>
<th>Domain List</th>
</tr>
</thead>
<tbody>
<tr>
<td>ED Performance - Initial CQC Recovery Plan. The MHG has been developed which sets out a detailed recovery plan in response to the concerns raised.</td>
<td>Site Team, Surgery, MHG</td>
<td>Quality</td>
</tr>
<tr>
<td>Refurbishment of Winter Ward side rooms to facilitate the relocation of haematology patients, creating additional side room capacity.</td>
<td>MGH</td>
<td>Quality</td>
</tr>
<tr>
<td>Medical staffing - ongoing number of consultant vacancies in Gastroenterology which is being mirrored nationally is impacting on the ability to deliver and sustain RTT performance.</td>
<td>Recruitment</td>
<td>Workforce and Operational Development</td>
</tr>
<tr>
<td>General Recruitment - ED Consultants/Nurses</td>
<td>Recruitment</td>
<td>Quality</td>
</tr>
</tbody>
</table>

Building for excellence

The Princess Alexandra NHS Trust

Trust Board (Part 1)-24/11/16
Cancer, Cardiology & Clinical Support Services

Key Priorities 2016-2017

- Achieving performance with Cancer Wait Times, Diagnostic standards and RTT, focus on delivery of CIPs and ensuring all quality standards are met.
- Developing Pharmacy Services to support the needs of patients, Trust and local health economy. This will be through full pharmacy services review including infrastructure, environment and workforce. The team are working to the recommendations that 80% of pharmacist resource is used for direct medicine optimisation activities, medicine governance and safety remits. This will form phase 2 of the pharmacy workforce plan to be fully embedded by 2020.
- Working collaboratively with all HCGs to improve patient pathways. This will be through the Transforming Care Programme.

Working Well

- Radiology: Achievements against the new IPSs are progressing well with the median time for a critical CT scan halving in the last 3 weeks.
- Cardiology: Intense focus on the RTT position and validation has enabled the service to achieve the 92% target. Financially the department is now making a profit for the first time in 2 years.
- Outpatients: The department has continued to deliver an effective service during a large increase in demand generated by Insourcing clinics via the 18 week Support team.
- Pharmacy: An enhanced pharmacy service on Kingsmoor which has seen 53% of TTA's completed at ward level within 30 minutes Antimicrobial pharmacist, Medication Safety Officer and Paediatric pharmacist all in post.
- Pathology: Successfully achieving the Internal Professional Standards for turnaround times for Pathology tests via ED and EAU.
- Cancer: The performance against the 62 day standard and 2w for September was met by the Trust.
- Therapies: Therapy support to the new Frailty Assessment Unit is working well and aiding faster discharges.

Concerns

- Radiology: Continual growth in activity is leading to an ever increasing number of scans being outsourced for reporting due to the consultant radiologist capacity.
- Cardiology: Paediatric 24 hour tape service has been ceased following safety concerns. Suitable alternatives for paediatric department needs to be resolved ASAP.
- Outpatients: Increase in demand for short notice set up and support of additional clinics is causing a financial and resource stress on the OP department.
- Pharmacy: It is feared that the business case for the new EAU build will not encompass the pharmacy support required which may hinder support for other inpatient wards as staff are prioritised to this area once built.
- Pathology: Delay in LIMS upgrade (although necessary) is hindering progression of the information and data that the Pathology department can produce.
- Cancer: Non Delivery of the 31 day first treatment standard for September. Internal audit now underway to assess service.

Requires Support

<table>
<thead>
<tr>
<th>Action Required</th>
<th>Who by</th>
<th>Domain List</th>
</tr>
</thead>
<tbody>
<tr>
<td>High Impact</td>
<td>Portering Management</td>
<td>Workforce and Operational Development</td>
</tr>
<tr>
<td>High Impact</td>
<td>EMB</td>
<td>Project and Business Constraints</td>
</tr>
<tr>
<td>High Impact</td>
<td>Exec Board</td>
<td>Project and Business Constraints</td>
</tr>
<tr>
<td>Medium Impact</td>
<td>Human Resources</td>
<td>Workforce and Operational Development</td>
</tr>
</tbody>
</table>

- Radiology: Continued lack of Portering supply to Radiology (below agreed levels) is hindering ability to achieve IPSs for TOC program.
- Action Required: High Impact Portering allocation and resources for Radiology to be resolved/
- Who by: Portering Management
- Domain List: Workforce and Operational Development
- Pharmacy: Confirmation needed to ensure the development of the business case for EAU encompasses adequate pharmacy resources.
- Action Required: High Impact Confirmation that pharmacy resources have been discussed and are appropriately reflected in the business case.
- Who by: EMB
- Domain List: Project and Business Constraints
- Pathology: Clarification required regarding anticoagulation service tender. Additional support required to ensure the department is ready to work with other interested parties in a new joint working arrangement.
- Action Required: High Impact Clarification on the Trust’s preference on the way forward for the anticoagulation service is required.
- Who by: Exec Board
- Domain List: Project and Business Constraints
- Cancer: Engagement and co operation with Internal Audit to ensure the review reflects process gaps accurately and identifies the steps required to improve delivery of cancer standards.
- Action Required: Medium Impact Findings from external review of Cancer to be shared with CCCS management team.
- Who by: Human Resources
- Domain List: Workforce and Operational Development

Building for excellence

The Princess Alexandra Hospital

Trust Board (Part 1)-24/11/16
Family and Women Health Group Summary

Key Priorities 2016-2017

- Nursing/Midwifery and Medical Staffing Recruitment
- Safeguarding & Mandatory Training for all staff groups
- Achieving an improved CQC outcome

Working Well

- Caesarean section rate lowered to 25.0% in October 2016
- Consistency of having consultant LW cover and presence, also supported by having consistency of staffing through giving locums fixed rota for 1 month at a time
- Triumverate working cohesively. Nursing, midwifery and medical leadership has improved
- RITT 18 weeks standards now achieving above 92% - gynaec 97.2 and paed 99.8 and achieving all gynaec cancer targets
- Achieving ST2 KPI for haemoglobinopathy screening since implementing the bookings of all the East & North Herts women directly that choose to deliver at PAH
- 24 hour Paediatric nurse cover, for Emergency Department, delivered
- Recruitment of substantive O&G Consultant to start in November and Paediatric Consultant who started in September
- Newly developed services - Outpatient hysteroscopy service now up and running
- Clinical outcomes: Stillbirth rate is well below national average (1.9 per 1000 vs national average 4.2)
- Dolphin Ward drug cupboards changed in line with CQC Comments
- Safeguarding team now fully established
- Round table discussion with ED and O&G following a SI with learning and action plan to develop a flow chart for obstetric women coming into ED and improved communications between shifts
- Gynaec inpatient pathways developed and communicated to support appropriate care and treatment in a dedicated female surgical ward.

Concerns

- Medical, midwifery and nursing staff shortages and the difficulty with recruiting to these posts
- Shared emergency gynaec pathways and competencies for staff developed waiting to be signed off at PSQ and shared across all wards and departments in the Trust
- Data Quality - this has improved but the health group had to take out a midwife full time to manage all the data quality concerns
- Caesarean section rate 25% for October but need to keep consistently at this level - NICE guidance supports maternal request for caesarean sections so all women requesting a c/s without a medical indication have to see another consultant first as well as the birth reflection midwife. Continued audit is needed over the next few months to identify themes and trends
- Dolphin Ward inpatient beds are blocked with children that are really suitable for ambulatory care
- Labour ward theatre does not meet National operating standards and there is only 1 theatre when there is a requirement for 2 labour ward theatres

Requires Support

Labour Ward Theatre Refurbishment -

- Action Required: Recommend that the Trust board accepts the ATI business case put forward for the Labour ward theatre refurbishment to meet National theatre operating standard - this is now on hold to support ED / EAU
- Who by: Labour Ward Matron
- Domain List: Quality

Ventilation in room 9 only blowing out cold air and cannot be regulated - too cold for mothers and babies

- Action Required: High Impact
- The ventilation system was going to be renewed at the same time as the New theatre H54refurbishment but is now on hold to support ED / EAU
- Who by: Labour Ward Matron
- Domain List: Quality

Location for the development of a Paeds Assessment & Ambulatory Unit - subject to full business case and commissioner approval for the activity.

- Action Required: High Impact
- Identify suitable location for the Paeds Ambulatory / Assessment area to be confirmed. Business case to be developed and presented for approval.
- Who by: Head of Childrens Services/Finance/commissioners
- Domain List: Quality

Continued difficulty in recruitment of specialist staff throughout the healthgroup.

- Action Required: High Impact
- Recruitment systems and processes to be streamlined to ensure efficient and productive to meet health group requirements.
- Who by: AD Nursing and Midwifery, Head of Midwifery
- Domain List: Workforce and Operational Development

Space to increase our ANC bookings

- Action Required: Medium Impact
- To review use of HER and SMH
- Who by: Community and Birthing Unit Matron
- Domain List: Research and Innovation

Safe Effective Caring Responsive Well Led
## SAFE - Quality Key Measures

<table>
<thead>
<tr>
<th>Metric</th>
<th>Standard</th>
<th>Previous Month</th>
<th>Latest Month</th>
<th>Trend</th>
</tr>
</thead>
<tbody>
<tr>
<td>MRSA</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Elective MRSA Swabbing</td>
<td>0%</td>
<td>96.43%</td>
<td>95.05%</td>
<td></td>
</tr>
<tr>
<td>Non Elective MRSA Swabbing</td>
<td>0%</td>
<td>98.45%</td>
<td>94.11%</td>
<td></td>
</tr>
<tr>
<td>C-Diff (National surveillance database)</td>
<td>0.83</td>
<td>2</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Safety Thermometer</td>
<td>95%</td>
<td>91.76%</td>
<td>93.55%</td>
<td></td>
</tr>
<tr>
<td>Cardiac arrest (avoidable)</td>
<td>4.5</td>
<td>1</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>VTE risk assessment</td>
<td>95%</td>
<td>98.86%</td>
<td>97.98%</td>
<td></td>
</tr>
<tr>
<td>VTE Prophylaxis</td>
<td>95%</td>
<td>98.04%</td>
<td>98.90%</td>
<td></td>
</tr>
<tr>
<td>Serious Incidents</td>
<td>0</td>
<td>2</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Never Events</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Hospital Acquired Grade 4 pressure ulcers</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Hospital Acquired Grade 3 pressure ulcers</td>
<td>4</td>
<td>2</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Hospital Acquired Grade 2 pressure ulcers</td>
<td>8</td>
<td>8</td>
<td>6</td>
<td></td>
</tr>
<tr>
<td>Mixed Sex Accommodation breach</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Safer Staffing Average fill rate - registered nurses / midwives (%) Day</td>
<td>95%</td>
<td>76.71%</td>
<td>79.70%</td>
<td></td>
</tr>
<tr>
<td>Safer Staffing Average fill rate - registered nurses / midwives (%) Night</td>
<td>95%</td>
<td>82.31%</td>
<td>83.90%</td>
<td></td>
</tr>
<tr>
<td>Mortality - HSMR</td>
<td>0</td>
<td>93.3</td>
<td>0</td>
<td></td>
</tr>
</tbody>
</table>
This case will be taken to the North Essex HCAI Scrutiny Panel in December for appeal. The Trust are appealing this case based on the RCA demonstrating compliance with policies, and the case therefore being unavoidable.

Key Themes - There was compliance with Trust Infection Prevention and Control and Antimicrobial policies for this case.

Actions
• On-going actions relating to pressure ulcers and falls are being led by the specialist teams as part of the initiatives within their roles
• Information from Safety Thermometer data is shared with the Infection Control Team and Continence Advisor to enable any actions to be taken where necessary
• VTE data relating to all aspects of the management of VTE is shared with the Lead for VTE (Matron in CCCS HG) and any concerns are fed back to the wards at the time of survey to address and action

Three Serious Incidents identified in October
1 incident involving potential harm caused to a patient as a direct result of delays in follow up.
1 incident involving delay in diagnosis, with potential harm as a consequence.
1 incident involving potential surgical procedure error - unknown level of harm.

Key Themes -
• Pressure ulcers (Hospital Acquired) – 3 (2 grade 2 & 1 grade 3)
• Falls with harm - 0
• Catheter & UTI - 5
• VTE - 3 new hospital acquired

Actions
• Recruitment campaigns to address vacancies.
• Developing rotation posts and secondment opportunities to improve retention.
• Review CHPD data as available to identify possible improvements for staff deployment and productivity.
• Thrice daily patient dependency and acuity assessments.
## EFFECTIVE

<table>
<thead>
<tr>
<th>Metric</th>
<th>Standard</th>
<th>Previous Month</th>
<th>Latest Month</th>
<th>Trend</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non elective readmissions</td>
<td>8.50%</td>
<td>8.27%</td>
<td>9.27%</td>
<td></td>
</tr>
<tr>
<td>Elective readmissions</td>
<td>2.50%</td>
<td>1.96%</td>
<td>2.19%</td>
<td></td>
</tr>
<tr>
<td>Delayed Transfers of Care all</td>
<td>4%</td>
<td>7.34%</td>
<td>5.80%</td>
<td></td>
</tr>
<tr>
<td>Delayed Transfers of Care Hospital</td>
<td>1%</td>
<td>2.86%</td>
<td>2.28%</td>
<td></td>
</tr>
<tr>
<td>Delayed Transfers of Care Other</td>
<td>4%</td>
<td>4.48%</td>
<td>4.48%</td>
<td></td>
</tr>
<tr>
<td>Length of Stay - elective</td>
<td>4.15</td>
<td>3.30</td>
<td>3.30</td>
<td></td>
</tr>
<tr>
<td>Length of Stay - Non elective</td>
<td>5.14</td>
<td>6.30</td>
<td>5.60</td>
<td></td>
</tr>
<tr>
<td>Daycase Rate</td>
<td>81%</td>
<td>87.70%</td>
<td>87.20%</td>
<td></td>
</tr>
<tr>
<td>Theatre utilisation</td>
<td>90%</td>
<td>95.56%</td>
<td>93.39%</td>
<td></td>
</tr>
<tr>
<td>Total planned and Unscheduled Caesarean Sections</td>
<td>25%</td>
<td>25.70%</td>
<td>25.00%</td>
<td></td>
</tr>
<tr>
<td>Midwife to Birth ratio</td>
<td>&lt;1:30</td>
<td>1:32</td>
<td>1:32</td>
<td></td>
</tr>
<tr>
<td>1:1 care in labour</td>
<td>100%</td>
<td>100%</td>
<td>100.00%</td>
<td></td>
</tr>
<tr>
<td>Still Births</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>WHO surgical checklist</td>
<td>100%</td>
<td>98.78%</td>
<td>100.0%</td>
<td></td>
</tr>
<tr>
<td>Clinical Trials - Approval</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td></td>
</tr>
</tbody>
</table>
### Effective - Key Messages

<table>
<thead>
<tr>
<th>Key Themes</th>
<th>Risks</th>
<th>Actions</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Key Themes</strong></td>
<td><strong>Risks</strong></td>
<td><strong>Actions</strong></td>
</tr>
<tr>
<td>1. Assessment &amp; awaiting OT equipment</td>
<td></td>
<td>• Launch of integrated Hospital Discharge Services</td>
</tr>
<tr>
<td>2. Management of patient and family choice</td>
<td></td>
<td>• Review of CHC process</td>
</tr>
<tr>
<td>3. Delays in CHC paperwork completion</td>
<td></td>
<td>• Ensuring referrals received for section 2 and section 5</td>
</tr>
<tr>
<td>4. Delays in mental health assessments</td>
<td></td>
<td>• Weekly scrutiny of top delays</td>
</tr>
<tr>
<td>5. Access to rehabilitation</td>
<td></td>
<td>• Daily LOS 7 plus day review.</td>
</tr>
<tr>
<td>6. Capacity within residential and nursing home.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Inability to flex criteria for community capacity leading to unfilled beds.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. Lack of capacity for complex care packages</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Key Themes - Non elective readmissions

- 1% increase from August, to 9.25% which is 0.75% above standard. Impact likely due to the lack of short stay capacity within the Trust, the low conversation rate form attendance to admission, and the increase number of patient with multiple comorbidies.

### Key Themes - Delayed transfers of Care

- The midwife to birth ratio remains static at 1:32. The benefit of recent recruitments have been offset by the retirement of seven midwives.

### Key Themes - Length of stay

- High number of delayed patients within hospital due to community capacity and family issues.
- Poor streaming of patient due to capacity issues.
- High bed occupancy current range 98 – 100%

### Key Themes - Midwife to birth ratio

<table>
<thead>
<tr>
<th>Month</th>
<th>Delayed transfers of Care</th>
<th>Non Elective Readmissions</th>
<th>Length of stay</th>
<th>Midwife to birth ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oct-15</td>
<td><a href="http://example.com/delayed-transfers">Graph</a></td>
<td><a href="http://example.com/non-elective-readmissions">Graph</a></td>
<td><a href="http://example.com/length-of-stay">Graph</a></td>
<td><a href="http://example.com/midwife-to-birth-ratio">Graph</a></td>
</tr>
</tbody>
</table>

---

Trust Board (Part 1)-24/11/16
<table>
<thead>
<tr>
<th>Metric</th>
<th>Standard</th>
<th>Previous Month</th>
<th>Latest Month</th>
<th>Trend</th>
</tr>
</thead>
<tbody>
<tr>
<td>Complaints - New</td>
<td>25</td>
<td>18</td>
<td>20</td>
<td></td>
</tr>
<tr>
<td>Parliamentary &amp; Health Service Ombudsman</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Compliments</td>
<td>50</td>
<td>157</td>
<td>76</td>
<td></td>
</tr>
<tr>
<td>Friends &amp; Family Test - % of patients likely to recommend the Trust (Inpatients)</td>
<td>90%</td>
<td>95.04%</td>
<td>96.28%</td>
<td></td>
</tr>
<tr>
<td>Friends &amp; Family Test - % of patients likely to recommend the Trust (Outpatients)</td>
<td>90%</td>
<td>86.97%</td>
<td>90.79%</td>
<td></td>
</tr>
<tr>
<td>Friends &amp; Family Test - % of patients likely to recommend the Trust (A &amp; E)</td>
<td>90%</td>
<td>88.33%</td>
<td>99.05%</td>
<td></td>
</tr>
<tr>
<td>Friends &amp; Family Test - % of patients likely to recommend the Trust (Maternity)</td>
<td>90%</td>
<td>94.97%</td>
<td>99.53%</td>
<td></td>
</tr>
<tr>
<td>Metric</td>
<td>Standard</td>
<td>Previous Month</td>
<td>Latest Month</td>
<td>Trend</td>
</tr>
<tr>
<td>-----------------------------------------------------------------------</td>
<td>----------</td>
<td>----------------</td>
<td>--------------</td>
<td>-------</td>
</tr>
<tr>
<td>Proportion of Patient treated within 4 hours in ED</td>
<td>95%</td>
<td>73.06%</td>
<td>75.22%</td>
<td></td>
</tr>
<tr>
<td>Proportion of Majors Patient treated within 4 hours in ED Adults</td>
<td>95%</td>
<td>58.94%</td>
<td>59.69%</td>
<td></td>
</tr>
<tr>
<td>Proportion of Majors Patient treated within 4 hours in ED Paeds</td>
<td>95%</td>
<td>84.16%</td>
<td>86.13%</td>
<td></td>
</tr>
<tr>
<td>Proportion of Minors Patients treated within 4 hours in ED Adults</td>
<td>95%</td>
<td>98.94%</td>
<td>99.44%</td>
<td></td>
</tr>
<tr>
<td>Proportion of Minors Patients treated within 4 hours in ED Paeds</td>
<td>95%</td>
<td>99.15%</td>
<td>99.26%</td>
<td></td>
</tr>
<tr>
<td>12 Hour Trolley waits in ED</td>
<td>0%</td>
<td>0</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Ambulance Handovers less than 15 minutes</td>
<td>95%</td>
<td>25.11%</td>
<td>24.14%</td>
<td></td>
</tr>
<tr>
<td>Ambulance Handovers &gt;15&lt;30 minutes</td>
<td>95%</td>
<td>50.50%</td>
<td>52.64%</td>
<td></td>
</tr>
<tr>
<td>Ambulance Handovers &gt;30 &lt; 60 minutes</td>
<td>95%</td>
<td>18.82%</td>
<td>15.99%</td>
<td></td>
</tr>
<tr>
<td>Ambulance Handovers greater than 60 minutes</td>
<td>95%</td>
<td>9.35%</td>
<td>8.70%</td>
<td></td>
</tr>
<tr>
<td>Cancelled Operations for Non Clinical reasons</td>
<td>0</td>
<td>46</td>
<td>34</td>
<td></td>
</tr>
<tr>
<td>Cancelled operations - breach of 28 day standard</td>
<td>0</td>
<td>4</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Urgent operations cancelled</td>
<td>0</td>
<td>8</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Urgent operations cancelled for a second or more time</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>RTT Incomplete Standard</td>
<td>92%</td>
<td>92.0%</td>
<td>93.1%</td>
<td></td>
</tr>
<tr>
<td>RTT over 52 week waiters</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Diagnostic times - Patients seen within 6 weeks</td>
<td>99%</td>
<td>99.31%</td>
<td>99.50%</td>
<td></td>
</tr>
<tr>
<td>Short Notice Outpatient Hospital Clinic Cancellations (&lt;6 Weeks)</td>
<td>0</td>
<td>28</td>
<td>30</td>
<td></td>
</tr>
<tr>
<td>Outpatient DNA Rate</td>
<td>7%</td>
<td>8.70%</td>
<td>7.80%</td>
<td></td>
</tr>
<tr>
<td>Cancer two week waits</td>
<td>93%</td>
<td>96.90%</td>
<td>95.90%</td>
<td></td>
</tr>
<tr>
<td>Cancer two week waits - Breast symptomatic</td>
<td>93%</td>
<td>93.60%</td>
<td>97.30%</td>
<td></td>
</tr>
<tr>
<td>Cancer 31 Day First</td>
<td>96%</td>
<td>97.30%</td>
<td>94.30%</td>
<td></td>
</tr>
<tr>
<td>Cancer 31 Day Subsequent Drug</td>
<td>98%</td>
<td>100.00%</td>
<td>100.00%</td>
<td></td>
</tr>
<tr>
<td>Cancer 31 Day Subsequent Surgery</td>
<td>94%</td>
<td>85.70%</td>
<td>100.00%</td>
<td></td>
</tr>
<tr>
<td>Cancer 62 Day</td>
<td>85%</td>
<td>87.50%</td>
<td>86.30%</td>
<td></td>
</tr>
<tr>
<td>Cancer 62 Day Screening</td>
<td>90%</td>
<td>100.00%</td>
<td>100.00%</td>
<td></td>
</tr>
<tr>
<td>Cancer 62 Day Cons Upgrage</td>
<td>90%</td>
<td>100.00%</td>
<td>90.70%</td>
<td></td>
</tr>
</tbody>
</table>
## RESPONSIVE ~ PERFORMANCE - Key messages

### A & E Patients seen under 4 hours

![Graph](image)

### Ambulance Handovers

![Graph](image)

### Cancelled Operations

![Graph](image)

### Short Notice Outpatient Hospital Cancellations (<6 Weeks)

![Graph](image)

### Outpatient DNA Rate

![Graph](image)

### Cancer 31 Day First

![Graph](image)

---

**Key Themes:**
- High numbers of medically fit patients within the hospital, causing delay to patient flow out of ED.
- Clinical space within ED which often leads to overcrowding.
- Staffing issues as a result of medical and nursing sickness.
- Ambulance batching, high conveyance particularly between 4 and 8pm.

**Actions:**
- System wide bed capacity planning, transforming our Care, streamlining of patients through the hospital.
- Increasing numbers with new Patients at Home.
- Formation of a Local Delivery Board to replace the System Resilience Groups (SRG).

The five national mandated priorities have been included in a system wide delivery plan. Additional West Essex CCG agreed additional investment of £20k. Being used for the ED Operational Team and additional SpR cover in ED.

Early Paediatric review and escalation of all potential patient failures.

---

**Key Themes:**
- 100% of 157 patients seen within 4 hours.

**Actions:**
- To support RTT recovery an additional 122 164 patients.

---

**Key Themes:**
- Total 34
  - 1. Emergency / Trauma
  - 10. rebooking reason
  - 12. Bed issues
  - 2. lack of theatre time
  - 9. Other

**Actions:**
- Further review of cancellation reasons to provide more granular detail to enable greater learning and opportunities for improvement.

---

**Key Themes:**
- There were 30 clinics cancelled within 6 weeks’ notice for October. A slight increase from the previous month. This impacted 322 patients.
- There were 24 reductions in clinics affecting 164 patients.
- To support RTT recovery an additional 122 short notice clinics ran during September giving extra capacity for 1191 patients.

**Actions:**
- The information on short notice cancellation is produced monthly and shared with HCS’s AMD’s. In order to reduce the number of avoidable short notice cancellations, a process has been put in place that cancels and reductions of clinics at short notice cannot be submitted to the Outpatient Appointments Department without first being authorised by the AMD or ADO. This is being rigorously policed.

---

**Key Themes:**
- Continued trend of improvement to DNA Rate from similar reporting period last year. Rates for follow up DNA’s continue to be higher than new appointments, which identifies need for correct clinical decision making in relation to patient pathways and appropriate discharging.

**Actions:**
- New DNA Process was launched 11.07.16 in line with Trust Access Policy. Fax switch off from 01.07.16 and collaborative working with the CCG to move to full EBS service (formerly Choose and Book) plus phone me key drivers for cancellations and allow remedial actions to be taken.

---

**Key Themes:**
- 5 patients breached out of 87 treated (4 skin and 1 Lung).
  - Reasons for breaches –
    - 2 Skin patients were removed as clinicians believe lesions not to be cancer.
    - 1 Skin patient, insufficient capacity to offer choice.
    - 1 Skin patient DNA’d minor op, unable to pass as outpatient treatment only
    - 1 Complex lung patient who required further line biopsy.

**Actions:**
- Dermatology have now recruited additional staff which has enabled them to increase capacity, particularly for minor ops, which would have potentially prevented two of the skin patients from breaching.

---

**Key Themes:**
- Patient at home taken over from Orla
- Observation Ward opened
- New ED Operational team

**Actions:**
- The five national mandates of priorities have been included in a system wide delivery plan. Additional West Essex CCG agreed additional investment of £20k. Being used for the ED Operational Team and additional SpR cover in ED.

---

**Key Themes:**
- ENP moved to the discharge lounge
- Observation Ward opened
- Patient at Home taken over from Orla

**Actions:**
- Earlier Paediatric review and escalation of all potential patient failures.

---

**Key Themes:**
- Reduced bed capacity within the health economy, particularly between 4 and 8pm.
- Ambulance batching, high conveyance.

**Actions:**
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**Key Themes:**
- Clinical space within ED which often leads to overcrowding.
- Staffing issues as a result of medical and nursing sickness.
- Ambulance batching, high conveyance particularly between 4 and 8pm.
- Reduction of beds within the health economy, cira 66:
  - Patient at home taken over from Orla
  - Observation Ward opened
  - ENP moved to the discharge lounge
  - New ED Operational team

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<th>Metric</th>
<th>Standard</th>
<th>Previous Month</th>
<th>Latest Month</th>
<th>Trend</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sickness Absence</td>
<td>4%</td>
<td>3.66%</td>
<td>3.51%</td>
<td></td>
</tr>
<tr>
<td>Staff Turnover Voluntary</td>
<td>11%</td>
<td>14.50%</td>
<td>14.82%</td>
<td></td>
</tr>
<tr>
<td>Agency &amp; Bank Staffing Spend</td>
<td>15%</td>
<td>11.00%</td>
<td>17.00%</td>
<td></td>
</tr>
<tr>
<td>Appraisals</td>
<td>92%</td>
<td>58.00%</td>
<td>59.00%</td>
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</tr>
<tr>
<td>Values Training</td>
<td>92%</td>
<td>80.00%</td>
<td>80.00%</td>
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</tr>
</tbody>
</table>
Key Themes:
Our Voluntary Turnover is 14.8%. Lower than this time last year and still above target rate of 12%. Recruitment & Retention difficulties in certain key areas, including Nursing & Midwifery.

High turnover rate (57%) among employees with less than 24 months' service indicates a problem with our on-boarding of new recruits. Career development and are reasons for the current turnover rate.

Actions
The trust is going out to tender for a bank provider. The expectation is that the chosen provider should be in place for 1st April 2017. The drive in the specification is based on bank recruitment and migration of agency staff to bank. The temporary staffing policy is in draft format will be implemented as per our audit report. This should lead to a reduction in agency spend. We are actively working with the healthgroups to identify vacancies that are driving agency spend, and fast tracking recruitment into these posts.

Finance have chosen an agency to fill vacant specialist posts and are actively working with them to reduce their agency costs.

A&E and EAU recruitment trials is ongoing till 31/03/17. This will place permanent doctors and nurses within both areas, reducing their reliance on agency spend. If successful, the scheme will be rolled out trust wide.

Key Themes:
Agency spend has increased since September 2016, due in part to September 2016 receiving a £207K adjustment made from Bank to payroll. With tighter financial measures in place in booking and authorisation of agency shifts – spend will continue to decrease.  A ban on off framework agency staff currently in place and has been enforced by NHS Improvement with CEO authorisation required on all off framework usage) with the cap on how much agency workers can be paid.

Direct Engagement is being utilised which in October has achieved a saving in the region of £45K VAT recoverable costs. Agency governance is in place in terms of nursing shifts going through the Deputy Chief Nurse to be authorised, non medical staff seeking executive approval and locum shifts being authorised by department AMD or CMD when shifts are above capped rates.

Actions
Workflows are being assessed in terms of NHSI reporting and a temporary staffing policy will be implemented as per our audit report. This should lead to a reduction in agency spend with a policy in place and workflows will make the data more transparent to work with. Creative recruitment options are being used, incl. advertising in European medical journals for Consultants in Medicine and the RCN journal

A&E and EAU recruitment trials is ongoing. This will place perm doctors and nurses within both areas, reducing their reliance on agency spend. If successful, the scheme will be rolled out trust wide.

Key Themes:
The 2016 CD&C report details that “Staff must be provided with appraisals that are valuable and benefit personal development”. The new Development and Deployment (D&D) Strategy [approved by EMB in September 2016] sets out the PAHT commitment to 1. The recruitment of the talented staff at all levels that we need for our future as an Integrated Care Organisation/Accountable Care Organisation, 2. The development and retention of our talented staff: 3. How we effectively deploy our talented staff; 4. How we succession plan, and build our employer branding on steady improvement and sustainability. A new appraisal scheme launched in October 2016 providing clearer, simpler paperwork and a range of new support resources. Over 70 managers have so far received training for the new scheme. (Future) By December 2016, a new reporting process will be introduced providing health care groups/directorates with activity against planned trajectories (in addition to the RAG reports). Appraisal training will continue to be delivered at high-volume [average 60 places per month] until March 2017, after which 30 places per month will be available. From April 2017, a performance-evidenced pay progression scheme will be piloted whereby all staff band 8A and above will require an up to date appraisal in order to receive their pay increment on time. This scheme will then be further rolled out pending evaluation.

Actions
Staff appraisal compliance continues to be monitored and monthly RAG reports are provided to all senior managers, health care group and directorate management teams. [New/recent] The Trust’s appraisal compliance trajectory has been renewed for November 2016 onwards, with a focus on steady improvement and sustainability. A new appraisal scheme was launched in October 2016 providing simpler, clearer paperwork and a range of new support resources. Over 70 managers have so far received training for the new scheme. (Future) By December 2016, a new reporting process will be introduced providing health care groups/directorates with activity against planned trajectories (in addition to the RAG reports). Appraisal training will continue to be delivered at high-volume [average 60 places per month] until March 2017, after which 30 places per month will be available. From April 2017, a performance-evidenced pay progression scheme will be piloted whereby all staff band 8A and above will require an up to date appraisal in order to receive their pay increment on time. This scheme will then be further rolled out pending evaluation.

Key Themes:
• A session on the PAHT Values, Standards and Behaviours is delivered on all Induction courses for all new starters (this includes all Corporate, Special Apprentice and Student Inductions)
• Ad hoc VSB sessions are provided when required
• A ‘refresh’ of the VSB and the training sessions (including the video’s used) is planned for 2017

Actions
• Vales training mandatory as part of the Trust Induction
• Compliance reports sent out to HCG’s and Corporate areas on a monthly basis
• A monthly trajectory target for Values training and our other key Care (Statutory/Mandatory) training topics to deliver a realistic, achievable and sustainable level of compliance has been agreed. This is planned to deliver 90% compliance on all key Core training requirements by September 2017.

The Princess Alexandra Hospital
NHS Trust Board (Part 1) - 24/11/16
## Efficiency & Finance

### Month 6 Activity details (further details expanded in the Month 6 Financial Performance report)

### M7 Income & Expenditure

<table>
<thead>
<tr>
<th>Description</th>
<th>Month Budget</th>
<th>Month Actual</th>
<th>Month Variance</th>
<th>YTD Budget</th>
<th>YTD Actual</th>
<th>YTD Variance</th>
<th>Annual Budget</th>
<th>£m</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>INCOME</strong></td>
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<td></td>
<td></td>
<td></td>
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<tr>
<td>OTHER INCOME</td>
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<td>1.3</td>
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<td>7.5</td>
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<tr>
<td>PATIENT TREATMENT INCOME</td>
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<td>13.8</td>
<td>(1.7)</td>
<td>107.0</td>
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<td>ST INCOME 2016/17</td>
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<td>1.6</td>
<td>4.6</td>
<td>4.3</td>
<td>0.3</td>
<td>7.8</td>
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<tr>
<td><strong>INCOME Total</strong></td>
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<td>17.4</td>
<td>0.4</td>
<td>117.8</td>
<td>122.4</td>
<td>4.6</td>
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<tr>
<td>Total</td>
<td>(12.7)</td>
<td>(12.7)</td>
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<td>(87.4)</td>
<td>(86.3)</td>
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<td><strong>NON PAY</strong></td>
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<td></td>
</tr>
<tr>
<td>Total</td>
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<td>(7.1)</td>
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### M6 Capital

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<tr>
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<th>Month £'000</th>
<th>YTD £'000</th>
<th>YTD Var £'000</th>
<th>Annual £'000</th>
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<td><strong>ESTATES</strong></td>
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<td>MATERNITY VENTILATION AND THEATRE RECOVERY UPGRADE</td>
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<td>ASEPSC UNIT</td>
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<td>FRAGILE UNIT</td>
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<td>OTHER BUILDINGS WORKS</td>
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<td></td>
<td></td>
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<td>595</td>
<td>276</td>
<td>(379)</td>
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<tr>
<td>MEDICAL EQUIPMENT</td>
<td>39</td>
<td>595</td>
<td>276</td>
<td>(379)</td>
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<td><strong>TOTAL MEDICAL EQUIPMENT</strong></td>
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<tr>
<td>ERM</td>
<td>31</td>
<td>135</td>
<td>116</td>
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<td>STS</td>
<td>39</td>
<td>516</td>
<td>75</td>
<td>(241)</td>
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<tr>
<td>LMS PATHOLOGY</td>
<td>12</td>
<td>117</td>
<td>107</td>
<td>(10)</td>
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<td>SUTURE TENT FUND ESS</td>
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<td>133</td>
<td>104</td>
<td>(29)</td>
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<td>EMBASSY</td>
<td>5</td>
<td>130</td>
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<td>OTHER</td>
<td>21</td>
<td>289</td>
<td>90</td>
<td>(199)</td>
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<td><strong>TOTAL FI</strong></td>
<td>101</td>
<td>1,536</td>
<td>511</td>
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<td><strong>GRAND TOTAL</strong></td>
<td>112</td>
<td>3,241</td>
<td>544</td>
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### M6 CIPS

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<tr>
<th>Healthcare Group</th>
<th>Month Target</th>
<th>Month Actual</th>
<th>Month Var</th>
<th>YTD Target</th>
<th>YTD Actual</th>
<th>YTD Var</th>
<th>Annual Plan</th>
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<td>0.9</td>
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<td>FAWS</td>
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<td>0.1</td>
<td>(0.0)</td>
<td>0.6</td>
<td>0.2</td>
<td>(0.3)</td>
<td>1.1</td>
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<td>Medical</td>
<td>0.4</td>
<td>1.1</td>
<td>0.6</td>
<td>2.2</td>
<td>2.5</td>
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<td>Surgery</td>
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<td>0.7</td>
<td>2.1</td>
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<td>Central Budgets &amp; Reserves</td>
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<td>0.5</td>
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<td>(0.2)</td>
<td>1.0</td>
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</tr>
<tr>
<td>Estates and Facilities</td>
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<td>0.1</td>
<td>(0.0)</td>
<td>0.8</td>
<td>0.4</td>
<td>(0.4)</td>
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<tr>
<td><strong>Grand Total</strong></td>
<td>1.1</td>
<td>2.6</td>
<td>1.5</td>
<td>5.0</td>
<td>6.5</td>
<td>1.5</td>
<td>12.0</td>
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</table>

### M7 Statement of Financial Position

<table>
<thead>
<tr>
<th>Description</th>
<th>31 March 2016</th>
<th>31 Oct 2016</th>
<th>Forecast 2016/17</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>NON-CURRENT ASSETS</strong></td>
<td>£'000</td>
<td>£'000</td>
<td>£'000</td>
</tr>
<tr>
<td>PROPERTY, PLANT AND EQUIPMENT</td>
<td>127,916</td>
<td>125,121</td>
<td>132,688</td>
</tr>
<tr>
<td>INTANGIBLE ASSETS</td>
<td>13,649</td>
<td>12,819</td>
<td>11,871</td>
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<tr>
<td><strong>TOTAL NON-CURRENT ASSETS</strong></td>
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<td>137,940</td>
<td>144,565</td>
</tr>
<tr>
<td><strong>CURRENT ASSETS</strong></td>
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</tr>
<tr>
<td>INVENTORIES</td>
<td>4,407</td>
<td>4,407</td>
<td>4,407</td>
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<tr>
<td>TRADE AND OTHER RECEIVING ASSETS</td>
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<td>17,065</td>
<td>12,333</td>
</tr>
<tr>
<td>CASH AND CASH EQUIVALENTS</td>
<td>1,524</td>
<td>6,661</td>
<td>2,449</td>
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<td><strong>TOTAL CURRENT ASSETS</strong></td>
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<td>28,133</td>
<td>19,189</td>
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<tr>
<td><strong>TOTAL ASSETS</strong></td>
<td>164,177</td>
<td>166,072</td>
<td>163,754</td>
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<tr>
<td><strong>CURRENT LIABILITIES</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>TRADE AND OTHER PAYABLES</td>
<td>(28,527)</td>
<td>(30,384)</td>
<td>(27,597)</td>
</tr>
<tr>
<td>PROVISIONS</td>
<td>(2,336)</td>
<td>(2,995)</td>
<td>(777)</td>
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<td>BORROWINGS</td>
<td>23</td>
<td>4,268</td>
<td>610</td>
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<tr>
<td>DH WORKING CAPITAL LOAN</td>
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<td><strong>TOTAL CURRENT LIABILITIES</strong></td>
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<td>(30,951)</td>
<td>(27,854)</td>
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<tr>
<td><strong>NET CURRENT ASSETS/ (LIABILITIES)</strong></td>
<td>(8,799)</td>
<td>(8,665)</td>
<td>(8,665)</td>
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<tr>
<td><strong>TOTAL ASSETS LESS CURRENT LIABILITIES</strong></td>
<td>132,776</td>
<td>135,122</td>
<td>135,900</td>
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<tr>
<td><strong>NON-CURRENT LIABILITIES</strong></td>
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<tr>
<td><strong>TOTAL NET EXPENDITURE</strong></td>
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</tr>
<tr>
<td>CCG schemes</td>
<td>Weight</td>
<td>FY 2016/17 income potential</td>
<td>Q1 Target</td>
</tr>
<tr>
<td>-----------------------------------</td>
<td>--------</td>
<td>----------------------------</td>
<td>-----------</td>
</tr>
<tr>
<td>1. NHS Staff Health and Wellbeing</td>
<td>30.00%</td>
<td>£1,158,996</td>
<td>£71,032.75</td>
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<tr>
<td>2. Sepsis</td>
<td>10.00%</td>
<td>£386,332</td>
<td>£96,583</td>
</tr>
<tr>
<td>3. Antimicrobial Resistance</td>
<td>10.00%</td>
<td>£386,332</td>
<td>£19,316.60</td>
</tr>
<tr>
<td>4. Care Homes MDT</td>
<td>12.50%</td>
<td>£482,915</td>
<td>£120,728.75</td>
</tr>
<tr>
<td>5. Integrated Workforce Development</td>
<td>12.50%</td>
<td>£482,915</td>
<td>£48,291.50</td>
</tr>
<tr>
<td>6. Stroke</td>
<td>8.00%</td>
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<td>£86,931.45</td>
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<tr>
<td>7. Cancer</td>
<td>9.00%</td>
<td>£347,699</td>
<td>£34,769.88</td>
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<tr>
<td>TOTAL CCGs</td>
<td>100%</td>
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<td>£490,062</td>
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<table>
<thead>
<tr>
<th>Specialist commissioning CQUIN schemes</th>
<th>Pro-term Babies</th>
<th>Hypothermia Prevention</th>
<th>Two year follow up assessment for very preterm babies</th>
<th>Nationally Standardised Dose Banding Adult</th>
<th>Total Specialist NHS E CQUIN at 2% for 2016/17</th>
<th>NHS E Non Specialist CQUIN Oral Health</th>
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</thead>
<tbody>
<tr>
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<td>Achieved</td>
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<td>£7,440</td>
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<td>Achieved</td>
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<tr>
<td>Q2 Target</td>
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<td>£9,300</td>
<td>£7,440</td>
<td>£21,389</td>
<td>£16,625</td>
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<td>Q2 Prediction</td>
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<td>Q3 Achieved</td>
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<td>£16,625</td>
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<tr>
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<td>£9,300</td>
<td>£11,160</td>
<td>£25,109</td>
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<td>Q3 Prediction</td>
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<tr>
<td>Q4 Target</td>
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<td>Q4 Prediction</td>
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CQUIN - Key Messages

Introduction - As in other years, PAH has agreed a number of CQUINs with Commissioners - West Essex CCG, East and North Herts CCG and NHS England (NHS E). The value of the CQUINs is approximately 2.5% of the value of contracts held by PAH. There has been a minor change to CQUIN funding in ‘16/17. Namely NHS E CQUINs have been set at 2% of the value of contracts held by PAH with NHS E as opposed to the usual 2.5%. There are twelve CQUIN schemes in total – three national CQUIN schemes, five local CQUINs and four CQUINs from NHS England (three specialised and one non-specialised CQUIN). Total value to PAH of CQUIN schemes is just over £4million.

Internal Monitoring and Delivery of CQUINs - Each CQUINs has a named lead (or leads) and a senior management lead for the process, Sharon Cullen (SC), Deputy Chief Nurse. There is a CQUIN operational group led by SC and she’s supported by the Contract Manager, Gerard Darcy (GD). This group meets monthly to review progress against milestones and to identify risks to delivery before submission of quarterly updates. In addition, the Contracts Manager (GD) meets local CCG leads on a monthly basis to discuss progress and any issues that may arise regards delivery.

Submission of Quarterly Progress Reports and Evidence of delivery of CQUIN - As in previous years, PAH is required to report against progress on a quarterly basis and evidence that progress, such as data, audits, reports and patients’ stories. This CQUIN progress report and evidence of delivery is required by the Commissioners just after the middle of each month after the quarter that is being reported on.
## Supporting Information

### Incomplete Performance as at 31st October 2016

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Within 13W</th>
<th>Within 14W-18W</th>
<th>Breached 19W-52W</th>
<th>Total</th>
<th>Perf (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accident &amp; Emergency</td>
<td>1</td>
<td>1</td>
<td></td>
<td>1</td>
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</tr>
<tr>
<td>Anaesthetics</td>
<td>21</td>
<td>5</td>
<td>26</td>
<td>26</td>
<td>100.0%</td>
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<tr>
<td>Anticoagulant Service</td>
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<td>5</td>
<td>93</td>
<td>93</td>
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<tr>
<td>Breast Surgery</td>
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<td>31</td>
<td>265</td>
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</tr>
<tr>
<td>Cardiology</td>
<td>887</td>
<td>177</td>
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<tr>
<td>Chemical Pathology</td>
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</tr>
<tr>
<td>Clinical Oncology</td>
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<td>8</td>
<td>54</td>
<td>54</td>
<td>100.0%</td>
</tr>
<tr>
<td>Colorectal Surgery</td>
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<td>7</td>
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<td>12</td>
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<tr>
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<td>118</td>
<td>34</td>
<td>947</td>
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<tr>
<td>Diabetic Medicine</td>
<td>22</td>
<td>1</td>
<td>23</td>
<td>23</td>
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</tr>
<tr>
<td>Dietetics</td>
<td>105</td>
<td>15</td>
<td>120</td>
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<td>100.0%</td>
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<tr>
<td>Endocrinology</td>
<td>137</td>
<td>11</td>
<td>2</td>
<td>150</td>
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</tr>
<tr>
<td>ENT</td>
<td>920</td>
<td>129</td>
<td>61</td>
<td>1110</td>
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</tr>
<tr>
<td>Gastroenterology</td>
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<td>68</td>
<td>32</td>
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<tr>
<td>General Medicine</td>
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<td>9</td>
<td>1</td>
<td>66</td>
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<tr>
<td>General Surgery</td>
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<tr>
<td>Gynaecology</td>
<td>681</td>
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<td>21</td>
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<tr>
<td>Haematology</td>
<td>238</td>
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<td>9</td>
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<tr>
<td>Interventional Radiology</td>
<td>16</td>
<td>2</td>
<td>18</td>
<td>18</td>
<td>100.0%</td>
</tr>
<tr>
<td>Medical Oncology</td>
<td>52</td>
<td>12</td>
<td>64</td>
<td>64</td>
<td>100.0%</td>
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<tr>
<td>Medicine for the Elderly</td>
<td>4</td>
<td>4</td>
<td>4</td>
<td>4</td>
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<tr>
<td>Nephrology</td>
<td>12</td>
<td>3</td>
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<td>15</td>
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<tr>
<td>Neurology</td>
<td>391</td>
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<tr>
<td>Obstetrics</td>
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<td>2</td>
<td>3</td>
<td>3</td>
<td>100.0%</td>
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<tr>
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<td>1428</td>
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<tr>
<td>Optometry</td>
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<td>15</td>
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</tr>
<tr>
<td>Oral &amp; Maxillo Facial Surgery</td>
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<td>1</td>
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</tr>
<tr>
<td>Oral Surgery</td>
<td>546</td>
<td>163</td>
<td>178</td>
<td>887</td>
<td>79.9%</td>
</tr>
<tr>
<td>Paediatric Diabetic Medicine</td>
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<td>1</td>
<td>2</td>
<td>2</td>
<td>100.0%</td>
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<tr>
<td>Paediatrics</td>
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<td>782</td>
<td>99.7%</td>
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<tr>
<td>Physiotherapy</td>
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<td>4</td>
<td>100.0%</td>
</tr>
<tr>
<td>Radiology</td>
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<td>84</td>
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<tr>
<td>Respiratory Medicine</td>
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<td>6</td>
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<tr>
<td>Rheumatology</td>
<td>244</td>
<td>14</td>
<td>3</td>
<td>261</td>
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<tr>
<td>Stroke Medicine</td>
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<td>1</td>
<td></td>
<td>1</td>
<td>100.0%</td>
</tr>
<tr>
<td>Trauma &amp; Orthopaedics</td>
<td>1539</td>
<td>405</td>
<td>305</td>
<td>2249</td>
<td>86.4%</td>
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<tr>
<td>Urology</td>
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<td>210</td>
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<tr>
<td>Vascular Surgery</td>
<td>1</td>
<td>1</td>
<td></td>
<td>1</td>
<td>100.0%</td>
</tr>
<tr>
<td>Other</td>
<td>2</td>
<td>2</td>
<td></td>
<td>2</td>
<td>100.0%</td>
</tr>
<tr>
<td>Neonatology</td>
<td>7</td>
<td>7</td>
<td></td>
<td>7</td>
<td>100.0%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>11874</strong></td>
<td><strong>2065</strong></td>
<td><strong>1032</strong></td>
<td><strong>14971</strong></td>
<td><strong>93.1%</strong></td>
</tr>
<tr>
<td>Meeting Title</td>
<td>Trust Board</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>-------------------</td>
<td>--------------------------------------</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Date</td>
<td>24 November 2016</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Report Title</td>
<td>External Visits/Reviews</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lead Director/Manager</td>
<td>Phil Morley - Chief Executive Officer</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Report Author</td>
<td>Heather Schultz – Head of Corporate Affairs</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Freedom of Information (FOI) Status</td>
<td>Unrestricted ■ Restricted □</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Action Required</td>
<td>Approval □ Decision □ Discussion □ Information ■ Assurance □ Other □ (specify)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Executive Summary</td>
<td>The attached report provides a brief summary of the reports/outcomes of external visits/reviews received since the last Board meeting. The full reports are available to Board members in the resource section of Board Books.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Recommendation</td>
<td>The Board is asked to note the attached report.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Trust Strategic Objective</td>
<td>All Strategic Objectives.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>NHS Constitution</td>
<td>All seven NHS Principles</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Implications</td>
<td>As outlined within the individual reports.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Legal/Regulatory</td>
<td>UK Corporate Governance Code and Monitor’s Code of Governance</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Resources</td>
<td>None identified.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Previously Considered by</td>
<td>N/A</td>
<td>Date</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Appendix</td>
<td>Report attached.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
## External Agency Visits and Inspections

### External Agency Visits in month (Reports awaited)

<table>
<thead>
<tr>
<th>External Agency</th>
<th>Date of Visit</th>
<th>Purpose/Area visited</th>
<th>Key headlines/Verbal Feedback</th>
<th>Executive Lead and Committee</th>
<th>Executive Actions/recommendations</th>
<th>Revisit date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Human Tissue Authority</td>
<td>Nov 2016</td>
<td>Mortuary</td>
<td>The HTA visited after the CQC report came to their attention. They had a planned visit for December over 2 days but brought forward day 1 into November to review the mortuary facilities. They spent a day reviewing the estates and facilities within the mortuary and the data on fridge compliance. The concerns within the CQC report had already been addressed and the team were satisfied with their review and findings. There were no immediate concerns and the HTA will write to the Trust ahead of the second visit in December.</td>
<td>CMO &amp;QSC</td>
<td>No immediate concerns or actions.</td>
<td>Dec 2016</td>
</tr>
</tbody>
</table>

### External Agency Visits in month (Reports received)

<table>
<thead>
<tr>
<th>External Agency</th>
<th>Date of Visit</th>
<th>Title of Report</th>
<th>Key headlines</th>
<th>Executive Lead and Committee</th>
<th>Actions/recommendations</th>
<th>Revisit date</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Euro Environmental LTD</td>
<td>Aug 2016</td>
<td>Risk Assessment &amp; Water Hygiene Survey Report</td>
<td>This report outlined four high priority areas requiring urgent remedial action to improve water safety and reduce the risk of Legionella forming in the water system.</td>
<td>DOBD H&amp;S Committee &amp;QSC</td>
<td>Detailed recommendations outlined in the report. A detailed delivery plan is being established and external contractors appointed to undertake these works which will see the remedial actions being delivered by the end of December 2016.</td>
<td>Nov 2017</td>
</tr>
<tr>
<td>2. East of England Critical Care</td>
<td>Aug 2016</td>
<td>Peer Review Revisit Report Critical Care</td>
<td>The team were able to see improvements from the original peer review with some standards changing</td>
<td>CMO &amp;QSC</td>
<td>Actions are detailed in the report and a RAG status is given to each standard. The unit will need to</td>
<td>TBC</td>
</tr>
</tbody>
</table>
## External Agency Visits and Inspections

| Operational Delivery Network | Services The Princess Alexandra Hospital | Operational Delivery Network Services The Princess Alexandra Hospital to GREEN status. It was evident that the biggest challenge to the unit continues to be effective patient flows. Data highlighted lengthy delays in the timely discharge of patients to ward level with high numbers of discharges occurring out of hours. In addition to the difficulties with patient flows is the high number of delayed admissions. The review team were aware that this is a hospital wide system problem and recognised that the bed base for the population it serves is too low. | develop its plan and actions to address these outstanding areas. The Network will require a copy of the action plan and will be monitoring progress against this. A written update on progress against the outstanding areas will be required within six months. |
| 3. East of England Trauma Network NHS England | June 2016 Peer Review Visit Report | Some areas of good practice were noted: - TARN data improvement - Appointment of a permanent Trauma Coordinator - Executive team support has improved - Very good engaged Transfusion Practitioner as part of MBL team - praised externally. | CMO &QSC No immediate risks identified but 5 serious concerns were raised: - The Trauma Unit Emergency Department does not have any nurse trained to the necessary level for paediatrics between the hours of 0100 and 0800. - The latest TARN dashboard shows a rolling year value of zero indicating that no tranexamic acid was potentially given to patients in their resuscitation. - The TU should have a trauma group that meets at least quarterly. - There should be a rehabilitation coordinator who is responsible for coordination and communication regarding the patient’s current and future rehabilitation including oversight of the rehabilitation prescription. - A number of elements of the review
### External Agency Visits and Inspections

<table>
<thead>
<tr>
<th>Date</th>
<th>Agency</th>
<th>Inspection Details</th>
<th>Recommendations</th>
<th>Timeframe</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nov 2016</td>
<td>NHS Improvement</td>
<td>IPC visit to review actions taken to address breach against plan; C. difficile.</td>
<td>Consider introducing a way of documenting isolation. Undertake master classes with Matrons and ward managers in how to undertake rapid infection prevention walk round. Strengthen staff awareness of their roles and responsibilities towards infection prevention. Review infection prevention audits in order that assurance around cleanliness is improved. Actions will be implemented and monitored through QSC.</td>
<td>Within 3 months</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Two wards visited: Saunders and Harvey Ward. Themes identified from the walk around: Poor compliance with personal protective equipment, multi-use products in use, poor equipment decontamination, poor hand hygiene, contaminated toilet brushes and raised toilet seats, dirty pull cords. In addition, concerns related to decontamination of equipment when it is taken off the ward and the condition of the cleaners trolleys.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Suggested to the panel that the Trauma system at the Trust was disjointed, lacking engagement and direction, and unsupported.
### Meeting Title
Trust Board.

### Date
24.11.16

### Report Title
Information Governance (IG) Position Statement

### Lead Director/Manager
Trevor Smith, Chief Financial Officer (CFO) & Senior Information Risk Owner (SIRO)
Lynne Fenwick, Director of Information & Information Technology (DoIIT)

### Report Author
Tracy Goodacre, Information Governance Manager (IGM)

### Freedom of Information (FOI) Status
- Unrestricted
- Restricted

### Action Required
- Approval
- Decision
- Discussion
- Information
- Assurance
- Other (specify)

### Executive Summary
This summary paper sets out the current position in relation to the IGT 31.10.16 V14 performance update, and areas of concern to note.

### Recommendation
It is recommended that the Trust Board note:
- IGT V14 performance update submission scores, achievements evidenced, and actions required for improvement.

### Trust Strategic Objective
Excellent operational performance: meeting regulatory and national operating standards.

### NHS Constitution
3) The NHS aspires to the highest standards of excellence and professionalism.
5) The NHS works across organisational boundaries and in partnership with other organisations in the interests of the patient, local communities and the wider population.
7) The NHS is accountable to the public, communities and patients that it serves.

### Implications

#### Risk
Information Governance Toolkit (IGT) - aspiring Foundation Trusts must be at level 2 IGT compliance as a minimum standard.

**NHS Standard Contract 2016/2017 General Conditions CG21.2** – states a Provider must complete and publish an annual Information Governance assessment using the NHS Information Governance Toolkit, and must achieve a minimum level 2 performance against all requirements in the relevant Toolkit to be classed as a trusted organisation.

**Information Commissioner's Office (ICO)** - the ICO has regulatory powers for dealing with non-compliance of the Data Protection Act 1998 which include any of the following: - To serve information notices, issue undertakings, serve enforcement notices, conduct consensual audits, serve assessment notices to undertake compulsory audits, issue monetary penalties of up to £500,000.00, and/or prosecute those who commit offences under the Data Protection Act. The ICO can also report any data protection issues of concern to Parliament.

#### Legal/Regulatory
IGT V14 - the Department of Health and the Health and Social Care Information Centre (HSCIC) jointly produced an Information Governance Toolkit (IGT) to assist organisations to achieve the aims of good Information Governance practice.

### Resources

| IGT level 2 compliance – IGT level 2 compliance – All Trust staff are required to undertake annual statutory mandatory IG training in order for the Trust to be able to evidence its compliance. |

It is recommended that an Accessible Information Standards task and finish group continue to work closely with the project lead to ensure this standard is implemented effectively.

### Previously Considered by

| See previous IG Position Statements for dates/details of papers presented to Trust Board prior to 2016 :- |
| Date |
| IG Position Statement – Trust Board. | 28.01.16 |
| SIRO sign off meeting – IGT V13 suggested publication scores (verbal approval with IGM). | 30.03.16 |
| IG Quarterly Update / Exception Report – EMB. | 12.04.16 |
| IG Position Statement – Trust Board. | 28.04.16 |
| SIRO sign off meeting – IGT V14 suggested baseline assessment scores (verbal approval with IGM). | 28.07.16 |
| IG Exception Report – EMB. | 16.08.16 |
| IG Quarterly Update / Exception Report – EMB. | 20.09.16 |
| SIRO sign off meeting – IGT V14 suggested performance update scores (verbal approval with IGM) | 26.10.16 |
| IG Quarterly Update / Exception Report – EMB. | 15.11.16 |

### Appendices
Information Governance Position Statement on: -
Information Governance Toolkit (IGT) 31.10.16 Version 14 (V14) Performance Update

1.0 PURPOSE

1.1 The purpose of this IG position statement is to bring to the attention of the Trust Board the scores for the IGT 31.10.16 V14 performance update, and any areas of concern to note.

2.0 BACKGROUND

2.1 As a key part of the Information Governance agenda, the Health and Social Care Information Centre (HSCIC) jointly produced an Information Governance Toolkit (IGT). The Toolkit has been made available to assist organisations to achieve the aims of Information Governance, and encompasses:

- Information Governance Management
- The Confidentiality NHS Code of Practice
- Data Protection Act 1998
- Information Security
- Information Quality
- Records Management
- Freedom of Information Act 2000

2.2 The IGT covers the six following sets of initiatives:

- Information Governance Management
- Confidentiality and Data Protection Assurance = Confidentiality NHS Code of Practice & Data protection Act 1998
- Information Security assurance = Information Security Management NHS Code of Practice
- Clinical Information Assurance - Health Records Management & Records Management NHS Code of Practice
- Secondary Uses Assurance = Information Quality & Payment By Results
- Corporate Information Assurance = Freedom of Information Act 2000, Corporate Records Management & Records Management NHS Code of Practice

2.3 The Toolkit also contains specific organisational views. It is the tool by which organisations can assess their compliance with current legislation, standards and national guidance.

2.4 Failure to achieve level 2 compliance within the IGT is a limiting factor for any aspiring Foundation Trust (FT) as FT’s must be at level 2 IGT compliance as a minimum standard. In addition, failure to achieve minimum level 2 compliance could result in potential consequences for patients, staff, and the organisation if through this it failed to protect confidential and personal identifiable information, such as:

- Distress, harm, and loss of patient / staff trust;
- Potential critical media coverage and subsequent reputational issues;
- Regulatory action from the Information Commissioners Office (ICO).

2.5 The NHS Standard Contract 2016/2017 General Conditions CG21.2 – states that a Provider must complete and publish an annual Information Governance assessment using the NHS Information Governance Toolkit, and must achieve a minimum level 2 performance against all requirements in the relevant Toolkit to be classed as a trusted organisation.
3.0 PROPOSAL

3.1 The Trust’s suggested percentage score for the 31.10.16 V14 performance update submission has increased from 78% to 81%, with zero requirements now showing as below level 2. The Trust will therefore be showing a green ‘satisfactory rating’ for this latest submission.

3.2 Following the IGT baseline assessment submission of the 31.07.16, the two requirements showing red as of that time have now been evidenced at level 2 or above, with the two further requirements having shown to be at risk of failing to maintain level 2 in time for the 31.10.16 performance update having also been evidenced sufficiently.

3.3 However, evidence in relation the latter two requirements link predominantly to the current Accessible Information Standards (AIS) and IG training compliance action plans. Progress of which will need to be monitored and clearly shown to be effective if these levels are to remain in place for the final V14 publication of the 31.03.2017. Requirement details are as follows: -

- **14-112**: Information Governance awareness and mandatory training procedures are in place and all staff are appropriately trained.
- **14-203**: Patients, service users and the public understand how personal information is used and shared for both direct and non-direct care, and are fully informed of their rights in relation to such use.

4.0 NEXT STEPS

4.1 An IGT improvement plan and evidence report will be updated following the V14 performance update submission, and will be circulated to requirement owners to help assist with future evidence reviews throughout the remaining Version 14 submissions.

4.2 IG training compliance continues to be addressed through management reports, the Executive Management Team, and Trust wide communications as this currently falls below the minimum expected 95%. This is expected to rise ahead of the 31.03.17 final V14 publication following the introduction of the Executive escalation process for staff who remain non-compliant, with letters now being sent to all non-compliant staff requesting completion of this training within 10 working days, or face the real risk of sanctions being imposed.

4.3 The Accessible Information Standards task and finish group will need to continue working closely with, and under the guidance of the project lead to ensure this standard is implemented effectively.

4.4 The Information Governance Steering Group (IGSG) will continue to escalate IG concerns through to EMB. The Director of Information & Information Technology (DoIT), IG Manager, Senior Information Risk Owner (SIRO), and Caldicott Guardian will continue to meet on a regular basis to discuss IG risks and issues.

5.0 RECOMMENDATION

5.1 It is recommended that the Trust Board note the V14 IGT performance update scores, achievements evidenced since the 31.07.16 V14 baseline assessment, and the areas which require further attention/monitoring.

5.2 It should be noted that appropriate actions are continually being assessed and addressed through the Information Governance Steering Group (IGSG) and EMB, in order to improve compliance ahead of subsequent IGT submissions.

Author: Tracy Goodacre, Information Governance Manager
Date: 27.10.2016
### Executive Summary

This paper is to provide assurance to the Trust Board that the Trust is compliant with the requirements of a Category One Responder laid down by the Civil Contingencies Act 2004.

### Recommendation

1. The Board are asked to note and accept.

### Trust Strategic Objective

Excellent safety and clinical outcomes for patients: benchmarked against the best
Excellent operational performance: meeting regulatory and national operating standards

### NHS Constitution

| NHS Principles: | The NHS aspires to the highest standards of excellence and professionalism. The NHS works across organisational boundaries and in partnership with other organisations in the interest of patients, local communities and the wider population. The NHS is accountable to the public, communities and patients that it serves. |

### Implications

There is a risk of contract action, regulatory compliance action or legal action should the Trust not be compliant with its Emergency Planning, Resilience and Response duties.

### Legal/Regulatory

- Civil Contingencies Act 2004
- Health and Social Care Act 2012
- NHS England EPRR Core Standards
- NHS Standard Contract

### Resources

- Previously Considered by: Performance and Finance Committee
- Date: 21/11/16

### Appendices

n/a
1. PURPOSE

i. This paper provides a report on the Trust’s emergency preparedness in order to meet the requirements of the Civil Contingencies Act (CCA) 2004 and the NHS England Emergency Preparedness Framework 2013.

ii. The Trust has a suite of plans to deal with Major Incidents and Business Continuity issues. These conform to the CCA (2004) and current NHS-wide guidance.

2. BACKGROUND

i. The Civil Contingencies Act 2004 outlines a single framework for civil protection in the United Kingdom. Part 1 of the Act establishes a clear set of roles and responsibilities for those involved in emergency preparation and response at the local level. The Act divides local responders into two categories, imposing a different set of duties on each. Category 1 responders are those organisations at the core of the response to most emergencies, and are subject to the full set of civil protection duties. Category 2 responders have a lesser set of duties and are required to co-operate and share relevant information with other Category 1 and 2 responders.

ii. The Trust is a Category 1 responder, and as such the Trust is subject to the following civil protection duties:

- assess the risk of emergencies occurring and use this to inform contingency planning
- put in place emergency plans
- put in place business continuity management arrangements
- put in place arrangements to make information available to the public about civil protection matters and maintain arrangements to warn, inform and advise the public in the event of an emergency
- share information with other local responders to enhance co-ordination
- cooperate with other local responders to enhance co-ordination and efficiency

3. EMERGENCY PLANNING, RESILIENCE AND RESPONSE (EPRR)

i. The NHS England requirements for Emergency Planning, Resilience and Response are laid out with the Core Standards Document. The Trust submission for this was received and accepted by NHS England and the Local Health Resilience Partnership as providing substantial compliance.

ii. The Local Health Resilience Partnership (LHRP) provides a forum for health agencies within a Local Resilience Forum (LRF) area to work together both strategically and tactically on EPRR. The trust is committed to the work of this group and is fully engaged with the partnership, both attending the Operational and Strategic Group meetings, and Task and Finish Groups.

iii. Along with the LHRP the Trust engages directly with the LRF, and is committed to continue this work through attendance at the Work on Tuesday events, which see’s all agencies come together as part of a single day of working to progress the work of the LRF. The Trust Emergency Planning and Resilience Manager regularly attends these events on behalf of the Trust.

iv. The development of the A&E Local Delivery Boards, has seen the Emergency Planning and Resilience Manager joining the Programme Delivery Team for the West
4. MAJOR INCIDENT PLAN

i. This Plan details the Trust’s actions in the event of an incident (either internal or external) which overwhelms the usual capacity of a service to respond. Such an event will require the hospital to employ a different method of working in order to manage the situation.

ii. Since the previous annual report, the Trust has launched its updated Major and Critical Incident Plan, including action card information on all wards and departments, and with staff information leaflets provided to all staff.

5. BUSINESS CONTINUITY MANAGEMENT SYSTEMS

i. Business Continuity Management is a management process that helps to manage the risks to the smooth running of an organisation or delivery of a service, ensuring that the business can continue in the event of a disruption. These risks can be from the external environment (e.g., power failures or severe weather) or from within an organisation (e.g., systems failures or loss of key staff). A business continuity event is any incident requiring the implementation of special arrangements within an NHS organisation in order to maintain or restore services. For NHS organisations, there may be a long ‘tail’ to an emergency event, e.g., loss of facilities, provision of services to patients injured or affected in the event, etc.

ii. The Emergency Planning and Resilience Team are currently working with healthcare groups to fully review the Trust Business Continuity Arrangements.

iii. Following the completion of the Healthcare Groups Business Impact Analysis and Business Continuity Plans, these documents will then form an updated Trust Wide Business Continuity Plan.

6. EMERGENCY PLANNING AND RESILIENCE TEAM DEVELOPMENT

i. The Emergency Planning and Resilience Team have continued to maintain their Professional Development, through their attendance at both health and multi-agency meetings and events.

ii. The Trust has fully adopted the use of ResilienceDirect¹ as a method of sharing planning and response information related to Resilience, including information for on-call managers and executives.

7. LIVE INCIDENTS, EXERCISES AND TRAINING

i. The Winter of 2015/16 once again proved challenging for the Trust, in terms of capacity. The Emergency Planning and Resilience Team, continued to provide support to the Operational Team, through the co-ordination of information flows with external Health and Social Care Partners, the Clinical Commissioning Group, and with members of the Trust Executive and Senior Manager Team.

¹ ResilienceDirect is an online private ‘network’ which enables civil protection practitioners to work together – across geographical and organisational boundaries – during the preparation, response and recovery phases of an event or emergency.
ii. The Trust made good use of its Emergency Planning arrangements during this period, with appropriate escalation, including declaration of Critical Incidents, during the periods which posed most risk in terms of patient safety and quality.

iii. The Trust continues to engage with multi agency exercising across Essex, to enable plans to be validated, including Exercises Cygnus, a National Pandemic Flu Exercise.

iv. The Emergency Planning and Resilience Team has worked with partners across the Essex Health Economy to develop an Essex Wide Training Needs Analysis. This document and the associated training packages will be used by the Emergency Planning team to deliver training across the organisation, and will also enable those staff moving between health organisations within Essex to have their existing training ‘move with them’.

v. The previous year saw a great deal of work undertaken across the Trust due to the British Medical Association Junior Doctor Industrial Action. The Trust was able to develop a joined up and validated approach to the management of the risk posed by this action, and to ensure mitigation was in place.

vi. The Trust remains prepared for incidents at all times, which is reflected in terms of the number of Major Incident Standbys which currently average 1 a month.

8. HORIZON SCANNING AND FUTURE WORK

i. The Emergency Planning and Resilience Manager is currently working with the Operational Teams to support development of plans for the coming winter period, including updating of the Trust Operational Escalation Plan to align with the latest requirements from NHS England, including the introduction of standardised national Operational Pressure Escalation Levels (OPEL’s) to replace the current Green, Amber, Red and Black system.

ii. Whilst the Trust have substantial compliance key lines of work over the coming months will be formed from those areas not yet green on the NHS England Core Standards Document as completed during the 2016/17 Assurance Assessment.

iii. Along with those areas for development identified during the National Assurance Programme, the Emergency Planning and Resilience Team, are also working on actions identified during the recent CQC inspection of the Trust as part of the Quality Improvement Programme.

iv. Key areas of work over the coming year are:
   i. Staff awareness training, to ensure that all staff are not just aware of, but also confident with their roles during a major incident.
   ii. Update training for Trust Commanders to ensure their confidence during an emergency
   iii. Continuing work on Business Continuity Management Systems to ensure that Healthcare Groups have up-to-date and validated Business Continuity Plans in place.

v. These identified pieces of work will be included within an Emergency Planning and Resilience Work Plan for the next financial year.

9. SUMMARY

i. The past year has seen significant developments in the Trust’s resilience arrangements, most notably in compliance with the NHS England Core Standards for
EPRR; however, this work must be continued to ensure that the position is maintained and improved upon.

10. RECOMMENDATION

i. The Board is asked to note and accept this report.

Author: Christopher Allen - Emergency Planning and Resilience Manager

Date: 15th November 2016
### Executive Summary

This report outlines the activity undertaken by the Princess Alexandra Hospital Specialist Palliative Care Team (SPCT) from April 2015 to March 2016. The team is managed by the Cancer, Cardiology and Clinical Support Services Health Care Group (CCCS) within Princess Alexandra Hospital NHS Trust (PAH). The team continues to see an increase in the number of patients being referred, in 2014/15, 478 new patient referrals were received, this rate has increased to 525 new patient referrals in 2015/16. The CQC report published in September 2015 awarded End of Life Care at PAH a rating of “Requires Improvement”.

### Recommendation

The Board is asked to note the report.

### Trust Strategic Goal

- Quality and patient safety: delivering great patient outcomes and personalised care
- Operational performance: delivering all regulatory and national operating standards
- Managing our resources: delivering value through improved efficiency and increased productivity
- Engaging with and developing our people: delivering great opportunities through learning, research and innovation

### NHS Constitution

1) The NHS provides a comprehensive service, available to all.
2) Access to NHS services is based on clinical need, not an individual’s ability to pay.
3) The NHS aspires to the highest standards of excellence and professionalism.
4) The NHS aspires to put patients at the heart of everything it does.
5) The NHS works across organisational boundaries and in partnership with other organisations in the interest of patients, local communities and the wider population.

### Implications

**Risk**

As outlined in the report.

**Legal/Regulatory**

CQC standards.

**Resources**

As outlined in the report.

**Previously Considered by**

QSC.16.11.16

**Date**

**Appendices**

End of Life Annual Report
## Tab 5.1 EP and EoL_complete

<table>
<thead>
<tr>
<th>Trust Board (Part 1)-24/11/16</th>
</tr>
</thead>
</table>
Contents

Introduction .................................................................................................................. 3
Key Achievements ......................................................................................................... 4
Dying Matters ............................................................................................................... 5
Key Challenges ............................................................................................................ 5
Workload of MDT and Clinical Activity of the Team. .................................................. 6
  MDT Meeting. ............................................................................................................. 6
  Clinical Activity of the team 2015/16 ................................................................. 6
  Diagnosis of patients referred, who were discussed at Specialist Palliative Care MDT ................................................................. 6
Growth in Referrals to SPCT ..................................................................................... 7
CQC report published September 2015 ................................................................. 7
Meetings Attended by the Team Members ............................................................ 8
Training and Education ............................................................................................ 9
Princess Alexandra Hospital End of Life Steering Group ............................................ 9
Future plans .............................................................................................................. 9
Introduction

This report outlines the activity undertaken by the Princess Alexandra Hospital Specialist Palliative Care Team (SPCT) from April 2015 to March 2016.

The team is managed by the Cancer, Cardiology and Clinical Support Services Health Care Group (CCCS) within Princess Alexandra Hospital NHS Trust (PAH).

The team is based in the Gibberd Bungalow on the main Harlow site at PAH and comprises of the following team members:

<table>
<thead>
<tr>
<th>Gill Robertson</th>
<th>Lead Clinician for Palliative Care, and Macmillan Palliative Care Clinical Nurse Specialist.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Julie Rodgers</td>
<td>Macmillan Palliative Care Clinical Nurse Specialist</td>
</tr>
<tr>
<td>Trevor Farrington</td>
<td>Macmillan Palliative Care Clinical Nurse Specialist (from 29/02/2016)</td>
</tr>
<tr>
<td>Angela Wasdell</td>
<td>CNS Macmillan Nurse (from October 2016, covering Julie who is taking a secondment teaching at ARU)</td>
</tr>
<tr>
<td>Dr Qamar Abbas</td>
<td>Honorary Palliative Medicine Consultant (Dr Abbas is contracted for 2 sessions per week Wednesday morning and Thursday afternoons).</td>
</tr>
<tr>
<td>Dr John Zeppetella</td>
<td>Honorary Palliative Medicine Consultant (Dr Zeppetella is contracted for two sessions per week (Tuesday and Friday Mornings) (Dr Yvonne Barlow, Acute Medicine Consultant with a Diploma in Palliative Medicine left the Trust in August 2015).</td>
</tr>
</tbody>
</table>

All SPCT Nurse Specialists are educated to Masters Level; Julie has completed a Post Graduate Certificate in Medical Education, and Trevor is an Independent Nurse Prescriber.

The team continues to see an increase in the number of patients being referred, in 2014/15, 478 new patient referrals were received, this rate has increased to 525 new patient referrals in 2015/16.

The CQC report published in September 2015 awarded End of Life Care at PAH a rating of “Requires Improvement”.

Tab 5.1 EP and EoL_complete

Trust Board (Part 1)-24/11/16

79 of 99
Key Achievements

The SPCT have achieved a number of key achievements in 2015/16, these include:

- The appointment of a third CNS post: A successful bid was made to Macmillan to fund the appointment of a third CNS, with a particular remit to collaborate with the Lead Dementia Nurse and Dementia Champions to improve End of Life care for patients dying with dementia.

- Six day working: The team now operate six days per week, from May 2016, this was achieved following the appointment of a third CNS post.

- Additional 0.2 WTE Palliative Medicine Consultant: Our Consultants are well known within the Trust and provide invaluable support to the medical teams. Dr Abbas is also a member of the Ethics committee.

- CQUIN achieved: The 2015/16 Transfer of Care CQUIN was achieved, with the lead clinician having taken over the responsibility for delivery from the Discharge team in Quarter four. Angela Wasdell was seconded to the role of End of Life Discharge Facilitator, to fulfil the CQUIN requirement. This CQUIN also required two Critical Incident Analysis meetings for the hospital per quarter, chaired by Dr Abbas.

- Shared learning: The team attended critical incident analysis (CIA) meetings jointly with St Clare Hospice and SEPT. These meetings took place every two months, with one case per organisation brought to the meeting for discussion. The meetings developed action plans to address the issues raised, which were then reported to West Essex CCG.

- Mandatory end of life care training: Since April 2014 the team have provided end of life face to face training (3 hours) for all new clinical staff during their induction week. This is held on a Friday afternoon twice a month.

- Junior Doctors’ induction: The team continue to participate in the Trusts induction for the new junior doctors, incorporating the end of life mandatory training. This enables the junior doctors to be aware of the team at the start of their placements. As in 2014/15, this has prompted an increase in referrals and a productive working relationship with the junior doctors.

- New training package developed: The team collaborated with UCL partners to develop the Milestones blended learning package. These materials have been used by Angela Wasdell during her rollout of Recognising Dying training (part of End of Life Discharge Facilitator role).

- Close collaborative working with the Acute Oncology Team (AOS). Weekly meetings are being held between the AOS and SPCT (Friday morning to ensure Palliative Medicine Consultant involvement) to support the team and provide an integrated plan of care to the patients shared by both teams. This has continued and resulted in more timely referrals between the teams and joint assessments which enhance patient care and experience. The SPC team are now based with the AOS team.

- SC@LE training: The team were successful in a joint bid with Andrew Foster (Medical Skills Lead) to Health Education East of England Deanery for a grant to develop simulation training in end of life care: Simulating Care at Life’s End.
PAH Specialist Palliative Care – Annual Report – 2015/16

(SC@LE). The training day has been run monthly since March 2015, with delegates from different care settings (acute, community and hospice) attending.

- Poster presentation: A poster was accepted for the National Association of Palliative Care Educators’ conference in December 2015, outlining the model for SC@LE, and the associated positive outcomes.

- Collaborative educational opportunities: The team have developed a joint list of educational opportunities with Tracy Reed (End of Life Education Facilitator in SEPT), which covers PAH, community and hospices.

- Schwartz Rounds: Jill Herbert, Lead Cancer Nurse, was successful in a bid to Macmillan to fund PAH joining the Schwartz Round Programme. Julie Rodgers is the Lead Facilitator for these, and to date five have been held.

- Kings Fund Research: PAH are taking part in the Kings Fund/University of Sheffield national evaluation of Schwartz rounds.

- UCL research: The team, alongside and working collaboratively with the Dementia Lead and Caroline Ashton (Lister Ward Manager) have participated in the development of heuristics for end of life care in dementia, with UCL.

- Patients First: The team were one of ten successful bids nationally to the Foundation of Nursing Studies Patients First programme, supported by the Burdett Trust for Nursing. Our project is about co-design of individualised care planning, and transformative learning.

- Integrated working: PAH have been invited to join the East Herts End of Life Stakeholders meeting since August 2015. The team are represented by Dr Zeppetella. Dr Monica Bose is Clinical Pathway Lead for End of Life in the Accountable Care Organisation work stream.

- The Trust took part in the National Care of the Dying Audit for Hospitals in 2015. The outcome measures are different to the previous national audit, so comparison is limited. PAH is achieving the national average for the majority of outcomes. The results show an improvement in evidence of multi-professional decision making.

Dying Matters

The PAH Patient Panel Conference this year (May 2016) will focus on advance care planning. Claire Henry, Chief Executive of the National Council for Palliative Care has agreed to be the Keynote Speaker.

“Why Dying Matters” conference being held for 2nd and 3rd year students (Nurses, AHPs and Paramedics) is planned for 1st July 2016 at Greenacres Woodland Burial Park in Epping.

Key Challenges

The SPCT face a number of key challenges in 2016/17, these include:

- The release of generalist staff for training organised by the Macmillan Specialist Palliative Care Team.

- PAH do not have level 3/4 psychological support for patients or families.
• The SPCT team do not currently meet the NICE guidance for the provision of seven day services or 24 hours access to specialist advice.

• A shared register with community is not currently possible, due to the CCGs use of information and software systems that PAH are currently unable to access. This has also precluded an alert system being developed, enabling patients on GPs’ GSF register (patients who are likely to die within the next year) to be flagged in the Emergency Department.

• The team do not currently have an electronic database and have limited administration support.

• Dr Abbas has developed a single community prescription form for use when discharging patients to either CCG area, East Herts pharmacy lead has been reluctant to engage with this, thus far.

• The team are keen to use the AMBER framework which can support care decisions when prognosis is uncertain. Unfortunately a bid to National Council for Palliative Care “Building on the Best: Improving end of life care in acute hospitals” to enable this was unsuccessful in January. The Trust Development Authority has recommended that we pursue this.

Workload of MDT and Clinical Activity of the Team.

MDT Meeting.

The MDT meets each Wednesday at 11.30. The MDT meeting consists of Macmillan Palliative Care CNS, Consultant in Palliative Medicine, Discharge Facilitator, OT, fortnightly representative from East Herts Specialist Palliative Care Team and MDT Coordinator.

A proforma for each patient who is discussed is created with the summary of the input from the team and advice to the ward team. This is then entered into the patient’s notes and faxed to the GP.

Each patient has information regarding their Preferred Place of Death recorded on Infoflex, and for those patients who are known to have died the team record whether PPD was achieved (with reasons why not, if applicable).

Clinical Activity of the team 2015/16

The team received 525 new patient referrals in 2015/16, compared to 478 referrals 2014/15, an increase of 9.8%.

• 170 patients were seen by Dr Abbas from April 2015 to March 2016.
• 117 patients were seen by Dr Zeppetella from September 2015 to March 2016.
• 86 patients were seen by Dr Barlow from March 2015 to August 2015.

Diagnosis of patients referred, who were discussed at Specialist Palliative Care MDT

Both cancer and non-cancer patients were discussed at the SPCT MDT, the breakdown of referrals can be seen in the table below. Non cancer referrals included dementia (55), Heart conditions (19), Respiratory disease (26), and neurological disease (15). Of these patients 10% did not achieve their Preferred Place of Death (PDD).
<table>
<thead>
<tr>
<th>Type of Patient</th>
<th>Number of Referrals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cancer</td>
<td>346</td>
</tr>
<tr>
<td>Non cancer</td>
<td>179</td>
</tr>
<tr>
<td>% Non cancer</td>
<td>34%</td>
</tr>
</tbody>
</table>

Growth in Referrals to SPCT

CQC report published September 2015

The CQC, as part of their 2015 report, made a number of recommendations following their inspection:

- **Need for an End of Life Care Plan**: An End of Life Care Plan is required to replace the current Decision Support Tool. In response to this recommendation a comprehensive care plan, together with supporting documents have been designed, and are currently in the ratification process and are due to launch April 2016. The care plan is based on the Leadership Alliance for the Care of Dying People “five priorities for end of life care”, and NICE guidelines for care of dying adults, published December 2015. The team have also considered aspects of the care plan in use at Basildon hospital, which were commended by the CQC.

- **Work towards a 7 day service**: A plan for a 6 day service, following the required Induction period for the CNS who joined the team 29/02/2016 has been developed and implemented.

- **Improve compliance with DNACPR completion requirements**: Compliance within the Trust was audited December 2015, a simulation training workshop has been completed, and compliance is monitored regularly at Clinical Friday. Since November 2015 CCOT provide a summary of the Cardiac Arrest RCAs monthly to the End of Life Steering Group. Themes that arise are being incorporated into future
training sessions. Exemplar DNACPR forms are located on the Trusts shared electronic X drive, allowing all staff to access these documents freely. Guidelines for resolving disagreements around DNACPR decisions are currently in draft format.

- **Recording of PPD in notes:** A PPD sticker is now in use, the sticker is placed in the patients case notes by the SPCT and Discharge teams.

- **End of Life Care should be a topic for Clinical Friday review:** To date there have been two clinical Fridays that have taken place for end of life care, in addition to those focussing on DNACPR. Feedback from staff has been that they are aware of how to access advice, support and guidance when caring for patients at the end of their lives, but that medical decision making can be delayed. Dr Abbas is presenting two “Recognising Dying” workshops, in response to this feedback.

- **Improve incident reporting:** The patient engagement team have assigned a code for complaints relating to end of life care. These, together with the outcomes of CIA meetings are fed back to the End of Life Steering group, on a monthly basis, to inform future training needs.

- **Appointment of full time Palliative Medicine Consultant:** A Job Description has been produced and sent to the Royal College of Physicians for approval. Consultant sessions have been increased to 0.6 WTE from September 2016, however Dr Barlow now left the Trust. The Trust has been unable to recruit an additional 0.2 WTE, as neither of our local hospices have the capacity to support this increase.

- **Appointment of Non-Executive Director:** The appointment of a Non-Executive Director for end of life care remains work in progress

- **Develop vision and strategy for the service:** The aim is to develop a 5 year plan once the Consultant is in post. In mitigation, the service development plan centres on the CQC recommendations and National Audit results.

### Meetings Attended by the Team Members

The SPCT attend a number of key meetings to promote and provide expertise in end of life care, these include:

- Weekly MDT (all)
- Lung MDT (Dr Barlow/Dr Abbas)
- Upper GI MDT (JR)
- Cancer of unknown primary MDT (Dr Abbas)
- Monthly End of Life Project Group (all)
- Mortality (GR)
- Patient experience group (GR or JR)
- CCG End of Life Worksteam (GR)
- Senior Practitioners (GR)
- Trust CNS (JR)
- Cancer CNS (GR & JR)
- DNACPR (GR and Dr Abbas)
- Deteriorating patient (GR)
- Organ Donation (GR)
- Cancer Senior Practitioners meeting (GR)
- Coding and Information (GR)
• AOS malignancy of unknown origin (GR/JR/Dr Abbas)
• CIA meetings twice per quarter (GR/JR/Dr Abbas)
• CQUIN meeting monthly (GR)
• CCSSHG P,S & Q monthly (GR)
• Dementia steering group (JR)

Training and Education

The SPC team continue to be included within the induction programme for EU staff who are joining the Trust and continue to deliver training about the hospice movement and the expectations of the nurses in end of life care within the Trust.

Induction for all new clinical staff includes a three hour face to face session on end of life including communication, symptom control, identifying dying patients and advance care planning.

The CQUIN CIA meetings are attended by PAHT Macmillan Specialist Palliative Care Team, St Clare Hospice and the SEPT Community Team. The meetings are chaired by the St Clare Hospice Medical Director. Resulting action plans are written and shared with the CCG and within the three organisations involved.

Princess Alexandra Hospital End of Life Steering Group

The Steering Group met on the first Wednesday of each month in the seminar room of the Cellular Pathology building.

The group is wide ranging and multidisciplinary, consisting of hospital representatives as well as representatives from the Community Trust, Hospices, CCG and a lay member who also sits on the patients’ panel.

The group reports to the Trusts Patient Quality and Safety Committee quarterly. The focus of the group for 2016-17 will be the Quality Improvement Plan for End of Life Care at PAH.

Future plans

The future plans of the SPCT include:

• A Job Description for a full time Consultant in Palliative Medicine has been developed and is currently with the Royal College of Physicians for approval.
• To develop a network of End of Life Care Champions in clinical areas, comprising of representatives from different clinical and non-clinical groups.
• To develop an action plan based on the NCDAH results.
• To provide further input to Dementia Champions’ training.
• To source funding for the AMBER care pathway.
• To explore the use of COSMIC to flag patients’ end of life care needs and required decisions.
• The production of a business Case for the development of increased Specialist Palliative Care Team and End of Life Team to support end of life care at PAH that can work in collaboration with the local health economy.
• The End of Life Steering Group Terms of Reference to be updated to ensure that the group leads and monitors the End of Life Quality Improvement Plan in response to the 2016 CQC Report.
BOARD OF DIRECTORS

MEETING DATE: 24 November 2016

AGENDA ITEM NO: 5.2

REPORT TO THE BOARD FROM: Quality & Safety Committee

REPORT FROM: Mike Roberts - Chair

DATE OF COMMITTEE MEETING: 16.11.16

SECTION 1 – MATTERS FOR THE BOARD’S ATTENTION

The following are highlighted for the Board to note or to take action:

Items for escalation to the Board from the meeting were noted as:

QSC.28.10.16

The October meeting of QSC was held after the October Board meeting due to unforeseeable issues and a short summary of the meeting has been included:

Some areas of good news: Lister Ward had received the Quality Mark. Huge progress was noted in the Eye Unit (appraisal/training rates/team-working/zero complaints) and Theatres (staffing) and Trust wide complaints were down to 3.

The number of C-diff cases was noted as a concern, as well as resourcing and engagement issues around Clinical Audit/Effectiveness. QSC received a very powerful patient complaint highlighting very poor care – staff were galvanised into action after hearing how the family felt.

Risks noted at QSC.16.11.16:
1. Maternity theatres - FAWS Health Group escalated their concern about the ongoing issue with only one maternity theatre being available for use.

2. QIP – QSC recognised the need for a PMO type approach to be adopted in relation to managing the Trust’s QIP process; an IT solution would also need to be considered. QSC was concerned about the ability of the Trust to deliver the required improvements in ED performance and noted that a whole system solution was required and that partners needed to be engaged in the solution.

3. End of Life Care – resourcing issues remain an area of concern for the team and QSC suggested that this issue is escalated to the Oversight meeting.

4. Infection Control - The Committee received an update on the NHSI peer review which had taken place the previous day. The detailed outcomes of this review will be reported to Board in the External Visits Report but highlights new risks to the organisation.

SECTION 2 – ITEMS FOR THE BOARD’S INFORMATION AND ASSURANCE

The following are highlighted for the Board’s awareness and/or assurance:

FAWS Report – The FAWS team presented their six monthly report highlighting 4 areas for further discussion; complaints, stillbirth rates, safeguarding and gynaecology services. QSC commended the team and noted that the use of only one maternity theatre continued to be an area of concern.

CQC Improvement Plan – QSC received the QIP which was to be published by close of business on
the day of the meeting. The plan is dynamic and will be updated on an ongoing basis.

Health and Safety - QSC received an update on areas of Health and Safety and commended the progress being made. Staffing within the team remains an issue but recruitment and resourcing is being discussed. A number of areas of statutory compliance were flagged as red whilst safety was green and the Committee requested that the risks be prioritised and rated to assist the Committee.

Winterbourne Review – QSC received an update on the actions taken since the Winterbourne review and noted the progress made.

Infection Control – The Committee received an update on Infection Control and noted that 11 cases of C. difficile have been reported to date. 3 of the 11 cases have been appealed and a further appeal will be lodged in December.

SI Report - QSC received a refreshed format of the monthly SI report with trends over the last year and an update on serious incidents and legal cases for October 2016. 3 incidents meeting the Serious Incident criteria were reported in October and 2 new legal claims were received.

Safer Staffing – QSC received the monthly update on safer nursing and midwifery staffing levels. The Committee noted the percentage fill rates and the changes to the definition and way in which Exception Code 4 reporting is to be made. The report provided the Care Hours Per Patient Day (CHPPD). Limited benchmarking information is available and QSC will continue to monitor this data. Recruitment progress was noted with more starters than leavers reported in month.

Nursing Revalidation – all Q1 and Q2 registrants have been successfully revalidated and going forward information on revalidation will be included in workforce reporting.

BAF Risks – QSC reviewed and supported the amendments to BAF Risks 1.1 and 3.2

Quality and Safety Dashboard – an update on the dashboard was welcomed and it was noted that it would include all the metrics for each of the wards.

Breast Screening QA Report – received an update on the action plan put in place following the 3 yearly assessment of the screening programme and requested that the team return in January with outcome measures including audit outcomes.

End of Life Annual Report – QSC received the annual report and noted the resourcing concerns highlighted above. DNACPR work is underway and an increase in referrals was reported along with an increase in non-malignant referrals. The report is included within the resource area for Board members.

SECTION 3 – PROGRESS AGAINST THE COMMITTEE’S ANNUAL WORK PLAN

The Committee’s progress against its Annual Work Plan is set out below:

The Committee is making good progress against its work plan.
**Meeting Title** | Trust Board  
---|---  
**Date** | 24.11.2016  
**Report Title** | Report on Nursing, Midwifery and care staff levels  
**Lead Director** | Professor Nancy Fontaine, Chief Nurse  
**Report Author** | Sharon Cullen, Deputy Chief Nurse  
**Freedom of Information (FOI) Status** | Unrestricted ■ Restricted □  
**Action Required** | Approval □ Decision □ Discussion ■ Information ■ Assurance ■ Other □ (specify)  

### Executive Summary

This summary report identifies  
1. Safer staffing data for the October 2016 Unify submission which shows a marginal improvement in actual staffing against plan  
2. CHPPD data submitted for October 2016  
3. Month 7 vacancy position for nursing and midwifery workforce provided by the healthcare groups, which shows a reduction in registered nurse vacancies (10.88 WTE).  
4. Currently 15 pre-registration nurses and 7 pre-registration midwives are working towards NMC registration, once successful they will reduce the vacancy rate further.  
5. Starters and leavers trends for nursing and midwifery workforce which shows 7 more starters than leavers in month 7  
6. The trend of quality metrics with a comparison to the position in October 2015

### Recommendations

The Trust Board is asked to receive the summary of information describing the nursing, midwifery and care staff data submission for September 2016.

### Trust Strategic Objective

All

### NHS Constitution

All NHS Principles especially Principle 3: The NHS aspires to the highest standards of excellence and professionalism.

### Implications

### Risk

The provision of a monthly report to the Trust Board meets the national recommendations associated with publishing staffing data regarding nursing, midwifery and care staff.

### Previously Considered by

The Trust Quality and Safety Committee received the detailed Safer Staffing (Hard Truths) report  

<table>
<thead>
<tr>
<th>Date</th>
<th>16 November 2016.</th>
</tr>
</thead>
</table>

### Appendices

Appendix 1: Comparison of CHPPD data for adult in patient wards August, September and October 2016
NURSING, MIDWIFERY AND CARE STAFF LEVELS (October 2016)
Trust Board – 24.11.16

1.0 PURPOSE
1.1 To provide the Trust Board with evidence of compliance with the collection of Care Hours Per Patient Day (CHPPD) and submission to NHS Improvement.
1.2 To assure Trust Board that gaps in planned levels of nursing, midwifery and care staff in October 2016 were reviewed and actions taken to mitigate risk.

2.0 BACKGROUND
2.1 This summary report of the October 2016 Safer Staffing report is provided to the Trust Board in line with the National Quality Board (NQB) recommendations (updated in July 2016).
2.2 The Trust Quality and Safety Committee received the detailed Safer Staffing (Hard Truths) report on 16th November 2016.

3.0 ANALYSIS
3.1 Safer Staffing Data submission
The Trust submitted planned and actual nursing, midwifery and care staff levels for October 2016 to the NHS database (Unify) on 15th November 2016.

3.11 Table 1 shows the average fill rate against agreed planned staffing levels for October 2016 and includes the position reported in August and September 2016 for comparison. Table 1.1 represents the average fill rate for the emergency Department (ED).

<table>
<thead>
<tr>
<th></th>
<th>Days - registered nurses / midwives (%)</th>
<th>Days - Average fill rate - care staff (%)</th>
<th>Nights - registered nurses / midwives (%)</th>
<th>Nights - Average fill rate - care staff (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trust Average</td>
<td>80.1%↑</td>
<td>93.1%↓</td>
<td>84.7%↑</td>
<td>102.9%↑</td>
</tr>
<tr>
<td>September</td>
<td>77.68%</td>
<td>94.21%</td>
<td>83.64%</td>
<td>97.66%</td>
</tr>
<tr>
<td>August</td>
<td>75.3%</td>
<td>86.3%</td>
<td>81.9%</td>
<td>98%</td>
</tr>
</tbody>
</table>

Table 1.1: ED average fill rate for all shifts October 2016

<table>
<thead>
<tr>
<th></th>
<th>Days - registered nurses / midwives (%)</th>
<th>Days - Average fill rate - care staff (%)</th>
<th>Nights - registered nurses / midwives (%)</th>
<th>Nights - Average fill rate - care staff (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>A&amp;E Nursing</td>
<td>80.0%↔</td>
<td>113.4%↑</td>
<td>89.9%↓</td>
<td>94.9%↑</td>
</tr>
<tr>
<td>ENP Service</td>
<td>121.3%↑</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The Emergency Department is included in the Safer Staffing report but is recorded separately as it is not part of the UNIFY Hard Truths reporting.

3.2 Exception Codes:
A review of the exception code reporting has been undertaken; HCG’s have identified that there is a need to ensure that real-time adjustments are being made to address concerns from wards where actual staffing levels are unlikely to meet the care needs of patients. The definition and way in which Exception Code 4 reporting is used will be changing from December 2016. The proposed changes are being implemented in order to address the gaps identified by the ward team without delay thereby optimising the likelihood of meeting patient care needs. This will be done in conjunction with the use of the Safe care dependency and acuity tool and existing escalation measures.

3.3 Care Contact Hours Per Patient Day (CHPPD)
In line with NQB recommendations, the Trust calculates CHPPD on a monthly basis by taking the actual hours worked (split into registered nurses/midwives and healthcare support workers)
3.31 What we know so far:
- When compared to other Trusts are actual CHPPD are low (Model hospital March 2016).
- CHPPD focuses upon the number of patients on a given ward at midnight and the number of actual nursing and care staff hours worked. It does not take into account the dependency or acuity of the patients.
- The monthly data collection allows us to compare the CHPPD in each ward (Appendix 1).
- Table 2 shows the Trust average (excluding clinical services where higher staffing levels are routinely required due to the acuity of the client group).
- We are waiting guidance from the newly appointed nurse advisor with NHS Improvement as well as further information from the Model hospital portal on how we might utilise CHPPD to drive change in line with Carter recommendations.

### Table 2 Care Hours Per Patient Day August – October 2016

<table>
<thead>
<tr>
<th></th>
<th>Registered midwives / nurses</th>
<th>Care Staff</th>
<th>Overall</th>
</tr>
</thead>
<tbody>
<tr>
<td>October 2016</td>
<td>2.8</td>
<td>2.3</td>
<td>5.2</td>
</tr>
<tr>
<td>September 2016</td>
<td>2.6</td>
<td>2.3</td>
<td>4.9</td>
</tr>
<tr>
<td>August 2016</td>
<td>2.8</td>
<td>2.3</td>
<td>5.0</td>
</tr>
</tbody>
</table>

*Trust average for adult in patient wards in Safer Staffing report. This excludes those areas where high staffing levels are required due to the acuity of the patients (Critical Care, EAU, Dolphin, Neo Natal Unit and Maternity)*

3.32 Table 2.1 shows what the CHPPD could be if the Trust were to consistently achieve planned staffing levels against a fully occupied ward. The purpose of showing this is to put the actual data into context against what our funded establishment would provide should we successfully address our nursing and care staff vacancies.

### Table 2.1 Target CHPPD based upon funded establishment

<table>
<thead>
<tr>
<th>CHPPD</th>
<th>Registered nurse</th>
<th>Care Staff</th>
<th>Overall</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.3</td>
<td>2.1</td>
<td>5.4</td>
<td></td>
</tr>
</tbody>
</table>

3.4 Patient safety incidents:
Graph 1 provides an overview of the Trust’s Quality Metrics which are in line with those recommended by the NQB. The data is for the past quarter with a comparison to data from October 2015.

**Graph 1: Patient Safety Incidents**
3.41 There has been an overall increase in the number of medication error/omissions reported. This is an intended improvement; aiming to bring Trust reporting in line with national reporting. Currently our reporting of medication incidents equates to 6.53% against 11.4% nationally for a Trust of comparable size.

3.5 Recruitment and Turnover
3.51 The month 7 vacancy position in the Health Care Groups (HCG’s) continues show small improvements in relation to the number of vacancies. Overall the registered nurse vacancy has reduced by 10.88 WTE. There are currently a 15 pre-registration nurses and 7 pre-registration midwives working towards NMC registration, once successful they will reduce the vacancy rate further.

**Graph 2: Vacancies at end of Month 6 by Healthcare Group**

<table>
<thead>
<tr>
<th>Healthcare Group</th>
<th>Total Vacancies</th>
</tr>
</thead>
<tbody>
<tr>
<td>MHCG</td>
<td>107.62</td>
</tr>
<tr>
<td>Surgery &amp; C.Care</td>
<td>22.39</td>
</tr>
<tr>
<td>FAWS</td>
<td>41.7</td>
</tr>
<tr>
<td>CCCS</td>
<td>17.16</td>
</tr>
<tr>
<td>RN</td>
<td>13.47</td>
</tr>
<tr>
<td>RM</td>
<td>18.4</td>
</tr>
<tr>
<td>HCSW</td>
<td>7.41</td>
</tr>
<tr>
<td>Total</td>
<td>6.5</td>
</tr>
<tr>
<td>Total</td>
<td>1</td>
</tr>
</tbody>
</table>

NB. CCSS only has 1 in patient ward.

3.52 Nursing and midwifery starters and leavers (October 2016) are displayed in Table 4 & Graph 2.

**Table 4: Registered nurse and midwife starters and leavers - 2016/17**

<table>
<thead>
<tr>
<th>Month</th>
<th>Registered Starters</th>
<th>Pre-Reg nurse starters</th>
<th>Total Starters</th>
<th>Leavers</th>
<th>+/-</th>
</tr>
</thead>
<tbody>
<tr>
<td>April 2016</td>
<td>16</td>
<td>14</td>
<td>30</td>
<td>22</td>
<td>+8</td>
</tr>
<tr>
<td>May 2016</td>
<td>10</td>
<td>5</td>
<td>15</td>
<td>10</td>
<td>+5</td>
</tr>
<tr>
<td>June 2016</td>
<td>12</td>
<td>1</td>
<td>13</td>
<td>18</td>
<td>-5</td>
</tr>
<tr>
<td>July 2016</td>
<td>10</td>
<td>5</td>
<td>15</td>
<td>11</td>
<td>+4</td>
</tr>
<tr>
<td>August 2016</td>
<td>11 +17*</td>
<td>1</td>
<td>12 +17*</td>
<td>15</td>
<td>-3</td>
</tr>
<tr>
<td>September 2016</td>
<td>8</td>
<td>7</td>
<td>15</td>
<td>9</td>
<td>+6</td>
</tr>
<tr>
<td>October 2016</td>
<td>15</td>
<td>5</td>
<td>20</td>
<td>14</td>
<td>+6</td>
</tr>
</tbody>
</table>

**Graph 2: The trend for starters and leavers in registered and pre-registered nurse and midwife posts**

Excludes the 17 staff joiners from TUPE
At the time of reporting, the second campaign to the Philippines was underway; verbal update will be available at the Board meeting on 24th November 2016.

RECOMMENDATION

4.1 The Trust Board is asked to receive the summary of information describing the nursing, midwifery and care staff data submission for October 2016.

Author: Sharon Cullen Deputy Chief Nurse

Date: 17th November 2016
## Appendix 1: Comparison of CHPPD data for adult inpatient wards August, September and October 2016

<table>
<thead>
<tr>
<th>Ward Names</th>
<th>Aug-16</th>
<th>Sep-16</th>
<th>Oct-16</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Registered midwives/nurses</td>
<td>Care Staff</td>
<td>Overall</td>
</tr>
<tr>
<td>Flemming Ward</td>
<td>3.2</td>
<td>2.2</td>
<td>5.4</td>
</tr>
<tr>
<td>Harold Ward</td>
<td>2.6</td>
<td>2.6</td>
<td>5.2</td>
</tr>
<tr>
<td>Harvey Ward</td>
<td>3.6</td>
<td>3.1</td>
<td>6.7</td>
</tr>
<tr>
<td>Henry Moore Unit</td>
<td>2.2</td>
<td>2.7</td>
<td>4.9</td>
</tr>
<tr>
<td>Kingsmoor Ward</td>
<td>2.5</td>
<td>1.5</td>
<td>4.0</td>
</tr>
<tr>
<td>Lister Ward</td>
<td>2.2</td>
<td>3.0</td>
<td>5.2</td>
</tr>
<tr>
<td>Locke Ward</td>
<td>2.6</td>
<td>2.1</td>
<td>4.7</td>
</tr>
<tr>
<td>Penn Ward</td>
<td>3.0</td>
<td>1.8</td>
<td>4.8</td>
</tr>
<tr>
<td>Ray Admissions Unit</td>
<td>2.3</td>
<td>2.1</td>
<td>4.4</td>
</tr>
<tr>
<td>Saunders Ward</td>
<td>2.6</td>
<td>1.5</td>
<td>4.1</td>
</tr>
<tr>
<td>Stroke Unit</td>
<td>3.5</td>
<td>2.6</td>
<td>6.1</td>
</tr>
<tr>
<td>Tye Green Ward</td>
<td>2.4</td>
<td>2.4</td>
<td>4.8</td>
</tr>
<tr>
<td>Winter Ward</td>
<td>2.7</td>
<td>2.5</td>
<td>5.2</td>
</tr>
<tr>
<td><strong>Trust average (excluding FAWs, Critical Care and EAU)</strong></td>
<td><strong>2.8</strong></td>
<td><strong>2.3</strong></td>
<td><strong>5.0</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Ward Names</th>
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<th>Sep-16</th>
<th>Sep-16</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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<td>1.5</td>
<td>4.0</td>
</tr>
<tr>
<td>Penn Ward</td>
<td>3.0</td>
<td>1.8</td>
<td>4.8</td>
</tr>
<tr>
<td>Saunders Ward</td>
<td>2.9</td>
<td>2.1</td>
<td>4.9</td>
</tr>
<tr>
<td>Surgery average (excluding Critical Care)</td>
<td><strong>2.8</strong></td>
<td><strong>1.8</strong></td>
<td><strong>4.6</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Ward Names</th>
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<tr>
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<td>Care Staff</td>
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<td>2.6</td>
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<td>Harvey Ward</td>
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<td>Henry Moore Unit</td>
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</tr>
<tr>
<td>Lister Ward</td>
<td>2.2</td>
<td>3.0</td>
<td>5.2</td>
</tr>
<tr>
<td>Locke Ward</td>
<td>2.6</td>
<td>2.1</td>
<td>4.7</td>
</tr>
<tr>
<td>Ray Admissions Unit</td>
<td>2.3</td>
<td>2.1</td>
<td>4.4</td>
</tr>
<tr>
<td>Saunders Ward</td>
<td>2.6</td>
<td>1.5</td>
<td>4.1</td>
</tr>
<tr>
<td>Stroke Unit</td>
<td>3.5</td>
<td>2.6</td>
<td>6.1</td>
</tr>
<tr>
<td>Winter Ward</td>
<td>2.7</td>
<td>2.5</td>
<td>5.2</td>
</tr>
<tr>
<td><strong>Medicine average (excluding EAU)</strong></td>
<td><strong>2.7</strong></td>
<td><strong>2.4</strong></td>
<td><strong>5.2</strong></td>
</tr>
<tr>
<td>Meeting Title</td>
<td>Trust Board (Public)</td>
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<tr>
<td>--------------------</td>
<td>----------------------</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Date</td>
<td>24/11/16</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Report Title</td>
<td>Progress on Quality Governance Responsibilities Briefing by Chief Nurse</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| Lead Director/Manager | Professor Nancy Fontaine Chief Nurse  
Dr Andy Morris Chief Medical Officer |
| Report Author      | Professor Nancy Fontaine Chief Nurse  
Dr Andy Morris Chief Medical Officer |
| Freedom of Information (FOI) Status | Unrestricted ■ Restricted □ |
| Action Required    | Approval □ Decision □ Discussion ■ Information ■ Assurance □  
Other (specify)     |
| Executive Summary  | The purpose of this paper is to provide the Trust Board with a summary of the CQC improvement actions and progress on quality improvements in light of the latest CQC report. The paper includes the latest update on Trust mortality. |
| Recommendation     | I. The progress on the Quality Improvement plan, including KPIS demonstrating trends in improvement, will be presented to the Quality and Safety Committee every month |
| Trust Strategic Objective | All Trust objectives |
| NHS Constitution   | All NHS Principles with particular emphasis on principle 3:  
The NHS aspires to the highest standards of excellence and professionalism. |
| Risk               | Linked to all CQC Fundamental Standards |
| Resources          | Framework of Quality Assurance for Responsible Officers and Revalidation (FQA)  
CQUIN framework agreement with Commissioners |
| Appendices         | Appendix 1, CQC Quality Improvement Plan, 16 November 2016 |
Compliance with Quality and Safety Governance Responsibilities  
Trust Board: 24.11.16 

1.0 PURPOSE  
1.1 The purpose of this paper is to provide the Trust Board with a summary of progress against the CQC improvement recommendations.  

2.0 BACKGROUND  
2.1 The Trust was rated as ‘Requires Improvement’ following the CQC Inspection in July 2015, with ‘good’ for caring across the organisation, ‘outstanding’ in maternity for caring and well led and ‘inadequate’ for effective end of life care. The Outpatients service was rated ‘inadequate’ under the safe domain. The 2016 inspection rated the organisations as ‘inadequate’ overall and placed the Trust in special measures for up to 12 months.  

3.0 GOVERNANCE & THE QUALITY IMPROVEMENT PROCESS  
3.1 The Executive Team have commenced the face to face meetings with all services on a rolling programme, where all members of the team present their specific improvement plan with key performance indicators and improvement outcomes to the Executive and the relevant health group leaders. Each service presents on a three weekly cycle. This approach allows the services to raise any areas or issues that they feel unable to progress and Executive support is required. Further, the meetings allow a deeper understanding of the progress on outcomes. There has been positive feedback from the health groups about this approach, particularly since more junior members of staff across the professions have been involved and have presented their own data. The CEO will chair the December meetings with the 3 services rated inadequate [EoL, ED & Critical Care].  

3.2 The monthly health group assurance and challenge meetings present all of the service improvements with outcome data as appropriate. This is a broader challenge approach encompassing all the services / team improvements under the auspices of each health group.  

3.3 The monthly Patient Quality & Safety group, chaired by the CMO will present by exception through a standardised template progress on the actions, as this meeting is attended by colleagues from the CCG. Furthermore, the Quality Improvement plan (QIP) is presented and discussed in detail every month, with the health groups at the Quality and Safety Committee and is also a standing agenda item at the monthly Commissioner Quality Contract Review meeting. Finally, the monthly multi-stakeholder ‘CQC Oversight meeting’, chaired by NHS Improvement also review progress and the Trust presents information through deep dives into specific services/teams.  

3.4 On 16 November 2016, the Trust sent the first QIP to the CQC and NHSI colleagues and uploaded this onto the newly constructed external facing micro-website, 28 days after the Quality Summit as agreed. This demonstrated to our local population and stakeholders our progress to-date and will be refreshed monthly. This requirement only applies to the ‘must’s’ and ‘should’s’ stated in the report. The Board will see that the plan is structured thematically rather than verbatim from the report, to allow for greater understanding and readability. (Appendix 1). The Trust has externally reported 29 areas: 1 GREEN (actions and outcomes on track); 3 AMBER-GREEN; 24 AMBER (progress commenced) and 1 RED (scoping as the actual issue is not clear).  

3.5 Listening to the health groups and corporate governance team, the greatest handicap and risk to the improvements is being able to demonstrate our outcome data through run charts and having the PMO and Informatics resources to coordinate such large amounts of data. This issue was discussed at QSC and the Improvement Director is working on a business case to submit to the regulator to ask for further support.
3.6 As part of learning from other organisations, the Trust has contacted an experienced PwC colleague who worked alongside Sherwood Acute Trust to offer a review of the improvement approach. Further, learning from Wye Valley Trust and their QIP approach has been organised for the forthcoming month. The Chief Executives from Basildon and BHRT have also agreed to come and share their own ‘special measures’ experiences with the Executive Team and Board.

3.7 The new look quality assurance inspections have commenced fortnightly, which include external partners, e.g. Commissioners. The ED was completed in October and Critical Care and paediatrics are being undertaken on November 23rd. All feedback is integrated within the services area QIP’s.

4.0 QUALITY IMPROVEMENT AREAS

4.1 The Safeguarding processes and training are demonstrating improved rates and are meeting their trajectories.

4.2 The Registered Nurse (RN) staffing levels are demonstrating improvement with more starters than leavers and an enhanced RN fill rate for ED (80%).

4.3 The Human Tissue Authority (HTA) have undertaken a preliminary inspection of the mortuary environment as the regulators of mortuary services and have agreed PAH have met the required standards. The full inspection is organised for December as final ratification.

4.4 All gynaecology pathways with required competencies and staff information have been compiled into a Trust booklet. The December capacity transformation will also allocate a specific gynaecology inpatient area on Melvin ward.

4.5 For end of life, there is now electronic recording of those patients with a DNACPR. The Trust strategy has been finalised and included in this Board agenda.

4.6 The new appraisal documentation has been received positively; the engagement and call to action from the health groups, regarding appraisal rates and statutory mandatory training, has been robust and rigorous and beginning to demonstrate improved compliance.

5.0 MORTALITY UPDATE

5.1 HSMR

The HSMR for August 2015 to July 2016 was 97.2 and statistically ‘as expected’. This is higher than last month and is the fifth consecutive rise. This is now flagging as a high relative risk and has been for the last 3 reports. Of note, however, is the dramatic fall in reported spells for July (about 50% of normal) and this seems to be a factor related to delayed coding returns. If this is correct, the returns will be corrected retrospectively and the HSMR would be expected to fall.

This has been as expected or lower than expected for 21 months. PAH ranks 8th/17 for relative risk, whereas in July it was 3rd.

The crude death rate within the HSMR basket is 4.1% versus the EoE peer group rate of 3.6%.

There are no diagnostic outliers.

There is no significant difference for weekday (as expected) and weekend (as expected) HSMR for emergency admissions. This has changed from last month’s reporting in which the mortality was higher for weekend admissions (but still as expected).

The palliative care coding rate is 2.67% versus the national rate of 3.45%. This is a rise from last month and the best performance to date.
5.2 SMR
All diagnosis SMR for August 2015 to July 2016 was 96.9 and statistically as expected. This is higher than last month and is the fifth consecutive rise. This has been as expected or lower than expected for 21 months. PAH ranks 8th/17 for relative risk. This is a fall from 5th three months ago.

There are 2 outlying diagnostic groups with higher than expected SMR:
Intestinal infection (16 v 7.4 expected deaths and previously reported)
Asthma (3 v 0.44 expected deaths and previously reported)

These will be validated and then audited if correct.

5.3 CUSUM alerts
There is one alert and that is bleeding from internal nose. This is a coding error (patient had cirrhosis) and will be corrected.

5.4 Patient Safety Indicators
Two of these are related to mortality:
Deaths after surgery: within expected range
Deaths in low risk diagnosis groups: lower than expected

5.5 SHMI
The SHMI for April 15 to March 16 was 100.3 and higher than the last three quarters but is as expected. Nationally this is middle of the pack.

5.6 Summary
The statistical markers for mortality have risen slightly in the last 6 reported months but remain lower than expected or as expected. HSMR and SMR have been as expected or better than expected for 21 months. The very recent (statistically insignificant) increases relate to presumed under reporting of spells but is under review.

Palliative care coding remains below that expected but has seen a sustained rise for the last 3 months and the highest ever reported.

The rise in mortality might be of concern but this is not statistically significant. In addition the data returns from the Trust to Dr Foster have shown a decrease in patient spells in the order of 50%. This is due to a data transfer problem from the SUS database into Dr Foster. This is now being reviewed and should be possible to correct. The mortality increase over the period February to April was also reviewed in more detail. The Trust data was reviewed along with the West Essex CCG data and with their clinical support. There were increased ED attendances in February and March but in the same magnitude for November. The ED 4 hour performance was poorer in the second half of January but this improved thereafter. There was an increased length of stay over 7 days for the period December 2015 to June 2016 with a peak through January but this was not as high as a spike through the summer and autumn of 2015. There is no obvious pattern to attendances, performance, LOS and mortality. It is therefore impossible to say that overcrowding did or did not contribute to mortality.

6.0 RECOMMENDATIONS AND NEXT STEPS
6.1 The Board will have a monthly briefing specifically on the CQC improvement plan with KPI progress from the CMO and CN.

Authors: Chief Nurse & Chief Medical Officer
Date: 17.11.16
<table>
<thead>
<tr>
<th>Ref No</th>
<th>Domain</th>
<th>Identified areas for improvement</th>
<th>Desired Outcomes</th>
<th>Actions</th>
<th>Review Date</th>
<th>Direction of Progress (as at 31 Dec 2016)</th>
<th>RAG Rating</th>
<th>Date Completed</th>
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<tr>
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<td>Sustain staffing levels for the resuscitation area in the Emergency Department.</td>
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**The Princess Alexandra Hospital NHS Trust**
<table>
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<tr>
<th>Code</th>
<th>Description</th>
<th>Key</th>
<th>Actions/Outcomes</th>
<th>Status</th>
<th>Date</th>
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<td>CQCS2</td>
<td>Future sustainability of Maternity Services</td>
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<td>CQCS4</td>
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<td>CQCS15</td>
<td>Identify trends and learn from complaints and incidents relating to EOL care</td>
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<td>CQCM3</td>
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<td>CQCM4</td>
<td>Improved Governance and Risk Management arrangements</td>
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<td>CQCM11</td>
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<td>CQPN</td>
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**Key**
- B: Desired outcome achieved
- G: Actions and outcomes on track
- AG: Actions in place. Progress requires external engagement
- A: Actions commenced
- RA: Actions identified not yet initiated
- R: Scoping commenced. Awaiting progress

**Legend**
- ++: Amber
- +: Green
- ↔: Amber-Green
- ↑: Amber-Red

**Notes**
- CQCM14: Scoping the learning from complaints
- CQCS10: Responsive
- CQCS1: Responsive
- CQCS2: Responsive
- CQCS4: Responsive
- CQCS15: Responsive
- CQCM3: Well led
- CQCM4: Well led
- CQCM11: Well led
- CQCM16: Well led

**Actions/Outcomes**
- CQCM14: Systematic learning reaching all levels of staff
- CQCS10: Answering patient call bells in ED.
- CQCS1: Centralising appointment booking
- CQCS2: Future sustainability of Maternity Services
- CQCS4: Centralising appointment booking
- CQCS15: Systematic learning reaching all levels of staff
- CQCM3: Improved Staff Appraisals
- CQCM4: Improved Governance and Risk Management arrangements
- CQCM11: Improve Mandatory Training Records
- CQCM16: Ratify and embed Fit and Proper Persons Process (FPP)

**Status**
- Date: 31 Jan 2017
- Date: 31 Dec 2016
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- Date: 31 January 2017
- Date: 31 December 2016
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- Date: 31 Jan 2017
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**Status Details**
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