TRUST BOARD MEETING IN PUBLIC

Thursday 5 October 2017
At 09:00

VENUE:
Lecture Theatre
Queen Alexandra Hospital
COSHAM
Trust Board Meeting in Public

Held on Thursday 7 September 2017 at 09:00am

Lecture Theatre
Queen Alexandra Hospital

MINUTES

Present:
Mark Nellthorp  Interim Chairman
David Parfitt  Non-Executive Director
Christine Slaymaker  Non-Executive Director
Melloney Poole  Non-Executive Director
Mike Attenborough-Cox  Non-Executive Director
Mark Cubbon  Chief Executive
Tim Powell  Director of Workforce
Chris Adcock  Director of Finance
John Knighton  Medical Director
Rob Haigh  Director of Emergency Care
Sheila Roberts  Interim Chief Operating Officer
Theresa Murphy  Interim Director of Nursing

In Attendance:
Peter Mellor  Director of Corporate Affairs
Teresa Cunningham  PA to Trust Board (minutes)
Abi Williams  Organisational Development Manager
Susie Calvert  Senior Physiotherapist, Critical Care
Julie Smith  Senior Sister, NICU

Item  Minute
No

135/17  Apologies:
None

Declaration of Interests:
There were no declarations of interest.

136/17  Staff Story

Abi Williams, Susie Calvert and Julie Smith were in attendance to give their presentation on ‘Developing a coaching style of leadership’. Please see the presentation below.

The Interim Chairman thanked Abi, Susie and Julie for their presentation and congratulated them on the work undertaken. The Board referenced how well it linked with ‘Well-Led’ and CQC themes, and felt it should be developed further. The Director of Workforce would like to see leadership training made into a core skill.

The Director of Finance asked whether the training was suitable for non-clinical staff as well
as clinical. Abi Williams replied that the training is open to the whole Trust and that staff are encouraged to use the techniques within their own teams.

137/17 Minutes of the Last Meeting – 6 July 2017

The minutes were agreed as a true and accurate record.

138/17 Matters Arising/Summary of Agreed Actions

All actions were completed or on the agenda.

Melloney Poole asked for a further two actions to be added to the action grid from the last meeting, they were:-

114/17 - The Medical Director to circulate the Mental Health Issues action plan to the Board
118/17 - The Interim Director of Nursing and Melloney Poole to meet to discuss the Legal Services Report

Actions: Medical Director, Interim Director of Nursing and Melloney Poole

139/17 Notification of Any Other Business

None.

140/17 Interim Chairman’s Opening Remarks

The Interim Chairman began his report by acknowledging the changes in Board membership; the details of which will be provided within the Chief Executive’s Report.

The Interim Chairman confirmed that the CQC report had now been published and that Board members have had an opportunity to review it. He remarked that he would have preferred the Trust not to have been in the position that necessitated the report but welcomed the raising of the issues within it and the opportunity to correct them.

The Interim Chairman was keen that staff did not feel punished by the report and was confident that their ability and commitment would bring about the necessary changes. He had great pride in all Trust staff.

141/17 Chief Executive’s Report

The Chief Executive began his report by introducing and welcoming Theresa Murphy as the Interim Director of Nursing. He also informed that two Board members had now left the Trust - Ed Donald and Simon Jupp.

The process for recruiting to four Director posts is underway and it is hoped that these appointments can be concluded by the end of October. These posts are Director of Nursing, Chief Operating Officer, Director of Communications and Director of Strategy, Governance & Performance. A new Chairman is also being sought.

The Chief Executive drew attention to key areas of his report:
- Impossible for Government to meet mental health commitments without addressing staff shortfall
- More clinical placements welcome but workforce challenges remain
- Performance figures show urgent action is needed to prepare for Winter
- New charging regulations for overseas visitors
- Mandated support for NHS Trusts under the single oversight framework

Local News:
- Chief Executive 100 day plan. The Chief Executive had held a number of staff engagement events with excellent attendance and feedback. The Quality
Improvement Plan was published on Friday 1st September. Following the publication there will be a Quality Summit supported by NHS Improvement, NHS England and Care Quality Commission later this month. Further actions from system partners following this meeting, along with staff feedback will further enhance the plan:

- Publication of CQC reports
- Visit from the Chief Inspector of Hospitals – Care Quality Commission
- NHS Improvement Agency Programme Stakeholder Group
- Team Brief

Melloney Poole asked the Chief Executive what were the three things that kept him awake at night. The Chief Executive replied:

- As an organisation we are running hot and have a very full hospital. A large number of escalation beds are open which causes more pressure. We need to ensure that patients have appropriate places to go and get appropriate care. The Trust is so busy, it makes the day to day very pressured
- Staff morale is very low. It is a difficult time for all and the Chief Executive and his team wants to support and encourage staff in addressing all of the concerns
- Getting the right sustainable leadership team in place

Melloney Poole asked for a date by when the Board Assurance Framework will be available. The Director of Corporate Affairs replied that work has been taking place over the last month to revise the framework and that it will be shared with the Board at its Workshop at the end of September and in time for inclusion in the October Trust Board agenda.

Mike Attenborough-Cox questioned what the outcome had been from Professor Baker’s recent visit. The Chief Executive replied that he had been grateful for his visit and the opportunity to meet him in person. The visit had been successful and constructive. The Chief Executive will be meeting with the CQC following the expiry of the Section 29a response time, to ensure that all actions have been responded to accordingly.

142/17 Integrated Performance Report

The Medical Director remarked that there was a more concise IPR being presented this month, and that feedback on the report would be welcome.

Quality

The Interim Director of Nursing drew attention to the following areas, with supporting comment from the Medical Director:

- Mental Health:
  - The Mental Health action plan had been circulated previously. Good progress had been made following the CQC visit. An independent review had been carried out to look at vulnerability across all patients throughout the Trust. There was close working with all system partners, with regular meetings. The Medical Director will be attending the Southampton Mental Health Board at the beginning of October in preparation for the first Portsmouth Hospitals NHS Trust Mental Health Board which he will be chairing.
  - Melloney Poole has agreed to be the Non-Executive Director lead for Mental Health
  - An external advisor is undertaking ligature risk assessments across the organisation to improve the safety and management of in-patients with specialist mental health needs. Initial findings had identified multiple ligature points within bed spaces and bathrooms; the majority of which cannot be mitigated. There is a greater need to focus on individual risk assessments
and intervention plans. A specialist advisor is supporting the Trust in the use of appropriate tools and education

- The Terms of Reference for the Mental Health and Mental Capacity Board had been drafted. The first meeting is scheduled to take place in October.
- The Mental Health Liaison Team service specification has now been finalised.

- Pressure Ulcers – three confirmed instances of avoidable grade 3 pressure ulcer damage and zero confirmed 4 pressure ulcer damage in July.
- VTE – a deterioration in compliance had been noted; the 95% target had not been achieved for July. The position has been formally escalated to the Medical Director.
- Dementia – there had been a continued decrease in compliance with dementia screening in July.
- Sepsis:
  - Timely identification of sepsis in emergency departments and acute inpatient settings. A total of 461 patients required screening, 451 of whom had received screening: 97.83% compliance against a target of 90%. Quarter 1 requirement for full payment achieved.
  - Treatment of sepsis in emergency departments and acute inpatient settings. 441 patients required antibiotics, 312 of whom received antibiotics within 1 hour of diagnosis of sepsis: 70.74% compliance against a target of 90%. 10% payment achieved for quarter 1. A plan is currently underway to improve compliance.
  - Antibiotic review - Assessment of clinical antibiotic review between 24-72 hours of patients with sepsis who are still in-patients at 72 hours.
  - Quarter 1: 100% compliance achieved.

- Infection Control:
  - MRSA - The two reported MRSA bacteraemia last month have been referred to NHS England for arbitration and third party attribution has been requested.
  - C.Difficile - 3 patients with C.Difficile were attributed to the Trust in July against a monthly objective of 3.

- HSMR:
  - For the 12 months of April 2016 – March 2017 the rate was 111.8. This is a decrease on the rate previously reported for the same period due to an updated end of year data set featuring a deeper volume of local and national coding. The Trust continues to have a higher than expected HSMR.
  - Work continues to establish whether HSMR includes the correct number of ‘expected’ deaths within its algorithm by investigating the coding of comorbidities, palliative care and how these are processed by Dr Foster.
  - A meeting has been organised with Imperial College London, after issues were identified locally regarding the identification of high scoring comorbidities.
  - The Medical Director is confident that learning and actions from all deaths are being picked up. 351 deaths have been reviewed since May. 70% of deaths were reviewed for avoidability and the majority were unavoidable. The two identified as avoidable compares favourably to what is normal.

The Interim Chairman remarked that whilst the number of deaths appears to be large a significant number of patients who are expected to die are coming into hospital. His concern was for those patients who were approaching death but did not want to die in hospital. The Medical Director confirmed that this matter was something that was being looked into. There is a regular mortality review meeting with commissioners. Commissioners are committed to help improve this situation.

The Interim Chairman felt strongly that whilst the Trust was not a mental health facility, and nor should it be, it needed to provide a safe environment for those patients who were in the hospital and awaiting mental health service support. He queried if we have the right balance. The Medical Director confirmed that our direction of travel was correct and the Trust should strive to recognise that there will always be a significant proportion of patients with mental health issues as well as other vulnerabilities; this proportion was also likely to increase. Melloney Poole echoed his statement and added that the Trust needs to ensure
that its strategy is firmly embedded with regional providers as well as robust protocols in place to ensure that other services provide the same level of service so that the Trust does not become a last resort. The Interim Chief Operating Officer added that there needed to be appropriate training and support for staff.

David Parfitt questioned if Commissioners were aware and committed. The Medical Director confirmed that commissioners were actively involved.

**Operations**

The Interim Chief Operating Officer drew attention to the following areas of her report:

- **A&E** – There had been no breaches of the 12 hr A&E trolley wait standard
- **MFFD** - Continued high levels of medically fit for discharge patients and a deterioration in the delayed transfers of care from 8% last month to 10.4%
- **RTT** - RTT clinical capacity shortfalls affecting delivery of planned performance improvement for orthopaedics (theatre staff), cardiology (outpatient capacity due to registrar shortfall) Gastroenterology (locum gaps and pathway corrections). Clinical harm reviews have taken place in these areas. Gastro reviewed over 500 patients, 25% were closed down and 50% had dates pushed back within national guidance. The next step is to carry out a snap shot review of a number of patients who have been waiting, 6 months, 9 months and 12 months. This approach is appropriate in proportion to the need.
- **Outpatient Waits** - Outpatients waiting longer than clinically appropriate; whilst progress is being made and the longest waiters have been reviewed and managed, the number of patients waiting means progress towards achieving waits within 18 weeks of clinical due date is slow
- **Cancer** – the Cancer 62 day performance was at risk in July as a result of diagnostic delays and diagnostic reporting delays due to specialist radiologist shortfall and capacity to undertake specific procedures requiring radiologist support (fusion biopsy) and capacity for complex robotic surgery. Additional lists had been agreed and were in place for biopsy’s and weekend robotic lists however there is a high risk that the standard will not be delivered in July and August. There had been 4 breaches of the zero tolerance 104 day maximum wait cancer standard

Melloney Poole noted that all major performance indicators were more adverse than they had been at the last Board meeting and that this was extremely disappointing. She added that delayed discharges were planned to be down to 110 by mid-September and stood currently at 235. She considered this to be a very serious position to be in as Winter approached. She asked for robust assurance that the Trust would significantly improve this position by next month. The Interim Chief Operating Officer agreed that the position was disappointing and remarked that the shortfall of staff was being stretched even further. Medically fit for discharge numbers were currently 6 weeks behind trajectory; although there had been some improvement this week. The Director of Emergency Care added that occupied bed days had reduced by 15% over the last week. The assurance comes with the significant staff increase in external services. The Director of Emergency Care believed that the backlog could be reduced as expected.

The Chief Executive recognised that some performance indicators were not going in the right direction but assured that the Trust was looking at sustained access improvements. Some pressures are being seen with a certain cohort of patients/areas which has a knock on effect and these are being worked on. He also assured that lots of improvements were being made within the urgent care pathway and that the internal urgent improvement programme will be relaunched next week. The Chief Executive was meeting with senior leaders to talk through how the plan will work and that there would be additional support to help with improvements. He was confident that there was a lot the Trust could do for itself in order to make improvements and this was being concentrated on. He would update on progress in his report to the Board each month.

Mike Attenborough-Cox asked if a report could be provided at the next meeting regarding
those patients who were fit for discharge in excess of 10 weeks. He remarked that the number of those medically fit for discharge should be down towards 100 by mid-September and that the Trust would not achieve this target. The Director of Emergency Care agreed that the Trust would not reach this target within the agreed time but that the figure would continue to reduce as more domiciliary workers were recruited by Hampshire County and Portsmouth City Councils. Mike Attenborough-Cox expressed his frustration at the failure of the different initiatives that had been designed to resolve this problem.

The Interim Chairman was concerned that patients have an increased risk of harm if they stay here any longer than is necessary. The detrimental effect of doing so, especially on older patients, should not be underestimated. He reflected on the fact that by mid-September, the Trust will be closer to where it started rather than where it needs to be with regards to the number of patients who were medically fit and ready for discharge. The Chief Executive was confident that our health system partners were fully committed to helping bring about the necessary improvements. Whilst it was true that some plans had not progressed at the pace expected, our partners are engaged and working with the Trust to discharge some patients earlier in their pathway in order that other patients pathways can improve.

Christine Slaymaker made reference to the capacity shortfall of Radiologists and pointed out that there had been a suggestion at the Acute Alliance meeting of combining/flexing resources. The Medical Director confirmed that Radiology capacity was being reviewed across Portsmouth and Southampton; the combining of resources could possibly help in the short term but would not be a long term solution.

**Finance**

The Director of Finance drew attention to the following areas of the report:

- The Trust's financial plan for 2017-18 has a surplus target of £9.7m. As a part of this the first two quarters of the financial year have a deficit plan, quarters 3 and 4 a surplus plan. The plan requires a steady financial improvement to be made effectively from July 2017 onwards.
- The annual plan for clinical income reflects the agreement reached with Commissioners on the Aligned Incentives Contract for 2017-18. The annual plan includes an income provision relating to the Sustainability and Transformation Funds (STF) of £13.4m and a financial improvement requirement in the course of the year of £34.6m.
- The Trust's Income and Expenditure position by the end of July was an actual deficit of £8.4m. The financial position in July, as part of this position, was a deficit of £2.3m. The position prior to the assessment of eligibility of STF in July was adverse to plan in month by £1.4m, therefore removing the Trust's option to access allocated Sustainability funds in month. The year to date position still reflects the STF funding achieved in quarter 1, a sum of £1.7m from a potential maximum allocation of £2.0m. A sum of £0.3m was not achieved in the quarter attributed to the A&E performance element.
- The Trust continues to see pay pressures through the high use of temporary staff to maintain urgent care services and additional capacity that has remained open due to the volume of patients that have been in hospital as medically fit for discharge. Non-pay costs include unplanned use of the private sector to support RTT delivery and out of hospital purchase of beds. Pay pressures year to date have been mitigated by a favourable non pay reserve position.
- Significant improvements in financial performance are required from now onwards in order to deliver the plan for the year and an enhanced focus and capacity to support this are necessary and in progress. Delivery of the overall surplus plan is now high risk and the Trust will submit a revised plan to the Board and NHSi at the end of September/beginning of October.

The Director of Finance reported that the Trust was still facing significant financial challenges; some of which were directly connected to plans to improve performance metrics.
and he will need to revise the financial plan accordingly. A revised financial plan will be brought to the next Board meeting.

**Action: Director of Finance**

Christine Slaymaker queried the increase in substantive, bank and agency pay when the plan was to significantly reduce agency pay. The Director of Finance replied that the increase in substantive staff was always part of the plan. It is however, £2.6m over plan. Temporary staffing had not decreased and the issue comes from some pay CIPs not being realised, which is adverse to the plan. The Director of Finance raised concern that there needs to be much more grip - key controls had been put in place for workforce and have formal dashboards to monitor. However, we need to make sure we have alignment between establishment WTE and budget, and that we do not recruit to WTE posts that are not funded. The Director of Finance will look at the alignment of workforce establishment and budget to ensure this does not happen and this will be discussed in the next Finance and Performance meeting.

**Action: Director of Finance**

The Director of Workforce commented that there was an over reliance on temporary staffing in Medicine and that there needs to be urgent Human Resources support in certain areas. The Director of Finance asked if the Trust looks at redeployment to those areas in need. The Director of Workforce confirmed that this was something that was looked into when appropriate.

David Parfitt commented that there appeared to be a lack of grip below Executive level of departments properly controlling their budgets and expressed concern at the likely consequential serious budget deficit. The Director of Finance and Chief Executive are working through a bilateral review with all CSCs. Whilst there are some areas that are struggling it is not through a lack of either attention or commitment.

The Interim Director of Nursing confirmed that she had carried out a forensic look at nursing staff and agencies used, and was holding fortnightly reviews of spend and how to tackle the issues identified.

The Chief Executive responded to Christine Slaymaker's query and commented that there was a need to have any variances to the financial plan properly articulated. With regards to David Parfitt’s query around ‘grip’, he assured the Board that there was a Recovery Board meeting every fortnight to ensure there is ‘grip’, which also reviews a weekly grip dashboard. Actions have been taken and will continue until the right level of grip is in place.

**Workforce**

The Director of Workforce drew attention to the following areas of the report:
- The total workforce capacity increased by 31 FTE to 6977 FTE in July 2017 and is 88 FTE over the new funded establishment
- The temporary workforce capacity increased to 509 FTE in July 2017 and comprises 7.3% of the total workforce capacity.
- The number of shifts that have breached the capped rates or that are off-framework have decreased by 754 shifts to 2072 shifts in July 2017
- The evidence collected for July 2017 indicates that overall staffing levels have decreased from 103.8% to 103.2% compared to planned levels
- The evidence collected for July 2017 indicates that overall CHPPD is 4.9 hours for RNs. This is similarly reported in the previous month and 2.9 for HCSWs
- There will be a detailed refresh of the nursing staff plan and retention plan
- Appraisal compliance has decreased and currently records at 77.8% in July, below the 85% target
- Essential skills compliance increased to 88.2%, and continues to record above the 85% target
- Fire Safety (face to face training) increased to 66.8%
- Information Governance Training has decreased to 86.9%. This is below the
Information Governance Training target (95%)

- Sickness Absence Rate (12 month rolling average) increased to 3.9% in June and remains above the target. In-month sickness absence decreased to 3.5% in June and is above the target.
- 1 whistleblowing referral and no professional registration or safeguarding referrals was reported in July 2017.

Christine Slaymaker reported that whilst visiting the Education team she had learnt that Southampton’s recruitment onto their nursing degrees had been cut dramatically for this September’s intake, which will have a knock-on effect for this Trust. The Education team is working hard in building relationships with Portsmouth University, who have opened a nursing degree course. There will be less nurses coming from Southampton next year and whilst we do receive nurses from other areas, it would be prudent to keep an eye on this.

The Chief Executive replied that the Trust continuously works on strengthening its relationships with universities and nursing providers, in particular Portsmouth University as this is the first year there has been an intake from Portsmouth.

143/17 Care Quality Commission Update

The Interim Director of Nursing drew attention to the following highlights. Further detail is contained within the report provided.

- The CQC had carried out an unannounced inspection of the Queen Alexandra Hospital on 16, 17 and 28 February 2017; inspecting the medical care services and the emergency department.
- The CQC returned on 10 and 11 May 2017 and inspected the key domain of ‘well led’. As part of this inspection they visited the emergency department, four medical care wards and the Acute Medical Unit (AMU) to review ward to board governance arrangements.
- The CQC rated emergency care as requires improvement overall, and the medical care was rated as inadequate overall.
- To note updates on regulatory actions, including actions, exceptions and risks and assurances.
- The Board is asked to agree the level of detail they wish to receive regarding the action plans to support the delivery of all the Regulatory requirements.

Christine Slaymaker raised concern about how evidence will be triangulated to show it is embedded and assurance given that changes have been made and are sustained. The Interim Director of Nursing replied that assurance will come from 1) changes in practice; 2) staff feedback; 3) deep dives and 4) routine reporting through the regulation reporting committee.

Melloney Poole commented that she was impressed that 75+ members of staff have already come forward to assist with the quality improvement plan. The Chief Executive added that over 500 members of staff had engaged in the CQC sessions.

David Parfitt enquired as to the lessons learnt and how they were being applied to areas that had not yet been assessed so that this situation does not occur in those areas. The Interim Director of Nursing replied that the routine use of escalation beds needed to stop and that the Trust needed to reset and adhere to the plans put in place.

Christine Slaymaker reminded that agendas are always shifting and that we need to keep an eye on the external world, especially around mental health, and try to pre-empt agenda shifts to help us stay ahead. The Chief Executive replied that the vision and strategy would be important. He remarked that it is implicit within the Quality and Improvement Plan that it is not just about focusing on compliance. The improvement plan has 5 domains that everyone needed to be aware of and adhere to. Everyone needs to know what good is, without being told by the CQC. The Medical Director added that there was a clear message that everyone wanted to focus on - aspiring to excellence rather than just to comply.
The Interim Director of Nursing presented the report and drew attention to:

**SIRI summary – July 2017**

A total of 60 SIRIs had been reported in May comprising:

- A total of 10 SIRIs were reported in July all were clinical SIRIs:
  - 3 x Avoidable level 3 hospital acquired pressure damage
  - 2 x Unexpected death of patient, potential failure to recognize deterioration
  - 1 x Fall resulting in fractured neck of femur
  - 1 x Fall with head injury, potentially contributing to patient’s death 2 weeks post discharge
  - 1 x Fall potentially contributing to patient’s death
  - 1 x Missed diagnosis of lung cancer
  - 1 x Delay diagnosis potentially resulting in loss of vision
  - 1 x C. Difficile on Part 1 of death certificate

- This compares to 10 clinical SIRIs reported in June
- Of the 10 clinical SIRIs reported in July; all patients or relatives, where applicable or appropriate, were informed of the incident within the deadline and were aware of the on-going investigation
- 149 SIRIs remain open on STEIS (Compared with 371 in May), 107 of these are Breaches of DTA
- 142 SIRIs are in the process of investigation within the Trust (105 DTA breaches)
- 4 clinical SIRIs have had their investigation completed and the reports have been submitted to the Commissioner for their review and sign off; all of these are awaiting closure by the CCG
- Of the DTA breach investigations submitted from January 2017 to date; 225 have been closed by the CCG

David Parfitt commented that whilst a large amount of data was available to see how this Trust was performing there seemed to be little that enabled us to compare with our peers and wondered if any was available. The Medical Director replied that there was benchmarking which indicated that we are close to where we need to be. The Trust needs to focus on near misses and low risk reporting and to ensure that feedback was given to those who had submitted the reports.

Melloney Poole questioned whether the legal services report, SIRI and complaints should be joined up. The Interim Director of Nursing agreed with this comment.

**Statutory Responsibilities for Emergency Planning**

The Interim Chief Operating Officer presented the report and highlighted the following key points:

- All NHS-funded organisations are required to meet the requirements of the Civil Contingencies Act (2004), the Health and Social Care Act (2012), the NHS Standard Contracts, and the NHS England Core Standards for Emergency Preparedness, Resilience and Response (EPRR)
- The report identifies work undertaken to ensure that the Trust is compliant with the statutory requirements placed upon it. It outlines the current position of emergency preparedness and the key activities that have taken place during the last year
- The report to be submitted by the Chief Operating Officer, as the Accountable Officer to the CCG, to support the NHS England Core Standards assurance process
- The Trust is to comply with the agreed work programme monitored via the Trust monthly EPRR Meeting reporting into the Trust Quality and Governance Committee. The Trust is currently compliant with 38 requirement and working on the remaining 8
- All amber areas have been addressed under Governance and deadlines are achievable
- The gap in Emergency Planning support has been addressed. There will be support from the Emergency Planning Officer at Solent NHS Trust until the post at Portsmouth Hospitals NHS Trust is filled in October
Mike Attenborough-Cox has agreed to be the Non-Executive Director lead

The Interim Chief Operating Officer agreed to add the definitions of Major, Critical and Business Continuity to the report for the benefit of the Board.
**Action: Interim Chief Operating Officer**

Melloney Poole enquired whether there were business continuity plans in place following recent cyber-attacks. The Interim Chief Operating Officer assured that the Trust follows national guidance. Cyber initiatives change all the time, however, we are as prepared as we can be for the unknown and the Interim Chief Operating Officer was confident the Trust was able to respond to a major incident.

### 146/17 Urgent Care Transformation Programme

The Director of Emergency Care drew attention to the following main areas:
- ED performance during July had been 79%, a 3% decrease compared to June and against a trajectory of 86%
- There were zero 12 hour DTA breaches in July but 12 during August to date
- As of 21st August, the MFFD backlog was more than 6 weeks behind planned trajectory (average of 243 against a trajectory of 121)
- Please note details of the Red2Green, SAFER, end PJ paralysis, last1000days Campaign
- There had been considerable investment from partners into our programme of work. Hampshire had increased its staffing to support medically fit for discharge
- The Emergency Department medical model had commenced Monday 4th September
- There is enhanced focus on frailty at the beginning of the patients journey

The Interim Chairman asked whether the medical model had started well. The Director of Emergency Care replied that it was very early days yet but the impact was being closely monitored through weekly meetings and feedback from the teams. Further evidence will be shared when it is available. The Interim Chairman questioned what PDSA stood for with regards to Red to Green. The Director for Emergency Care confirmed that this is a tool for continuous improvement planning.

The Medical Director praised the level of personal commitment given by Dr Mark Roland with regards to effectuating the medical model.

### 147/17 Annual Complaints Report

The Interim Director of Nursing presented this item and highlighted the following key points:
- National Standards - The Trust had reported full compliance with the Local Authority Social Services and National Health Service Complaints (England) Regulations 2009 for complaints acknowledged within 3 working days
- Contract Requirements - The Trust had complied with the requirement to provide CCGs with annual numbers of complaints and PALS enquiries by category and outcomes
- Complaints and PALS - Overall complaints had increased by 7% from 648 in 2015/16 to 692 in 2016/17
- PALS contacts had significantly increased from 2171 to 6755
- Parliamentary Health Service Ombudsman - The number of cases referred to the PHSO has slightly reduced this year from 14 to 13 (with 8 so far being not upheld and 2 partially upheld)
- Plaudits - The Trust received 4,397 messages of thanks from patients, relatives and visitors. The Interim Director of Nursing praised PALS for the good quality work they do
- Challenges and Opportunities for 2016/17 - Continue to increase the number of Trust staff attending training on complaints handling and customer care
- Increase the number of formal complaints sent within 30 working days
Melloney Poole reiterated her point that it would be prudent to join up legal services and PALS.

David Parfitt echoed the point that the number of complaints was very small in comparison to the number of patients being seen by the Trust. He was concerned that not all complaints were being made formally. The Interim Director of Nursing responded to say that this is an area that will be focused on more.

148/17 Annual Audit Safeguarding Report

The Interim Director of Nursing presented this item and drew attention to the following key points:

- Seeking Board’s agreement of the 2017/18 work plan
- Appointments have been made for a Head of Adult Safeguarding and a Head of Child Safeguarding
- The number of adult safeguarding referrals had fallen for the second consecutive year, probably due to changing safeguarding thresholds
- Concerns had been raised regarding the application of MCA and DoLS legislation into everyday practice. No evidence of patient harm or that treatment and care decisions would have been different had been found when reviewing cases, however there had been omissions of documentation to evidence robust capacity assessment and best interest decision making processes
- Changes to use of the MCA to accommodate patients in a ‘pre-DoLS’ situation had given rise to a significant increase in DoLS application numbers and associated workload
- Underutilisation of training places had resulted in lower than projected training compliance for Enhanced Level MCA and DoLS
- Prevent - First referral made by the Trust
- Next steps:
  - The business case for a team administrator awaits approval
  - Training review scheduled within 2017/18 work plan to ensure compliance with anticipated Intercollegiate training levels
  - Work is required to improve staff understanding of safeguarding thresholds
  - Develop Trust specific e-WRAP package

Christine Slaymaker felt that the report was hard to follow as it contains both process and performance and she was not sure that it addressed all of the CQC issues. She needed assurance the Trust was fully sighted on the issues. The Interim Director of Nursing replied that she would look to add examples and that she would also include risks in future reports.

Christine Slaymaker also commented that the Trust needed to identify any failings itself through checks and processes rather than wait for them to be identified by the CQC. Melloney Poole added that an early strategic look at top priorities would be key.

The Director of Emergency Care referred to the need to focus on dementia patients and to upskilling the organisation in dementia care. The Interim Director of Nursing confirmed that part of the plan is to have a lead dementia nurse for the Trust.

149/17 Mortality – Learning from Deaths Policy

The Medical Director presented this item and highlighted the following key points:

- The National Quality Board ‘National Guidance on Learning from Deaths (March 2017)’ requires all Trusts to publish a policy, by September 2017, on how it responds to, and learns from, deaths of patients who die under its management and care
- The first draft of the Trust policy is provided to the Trust Board for information and awareness
- The policy will be ratified by the Governance and Quality Committee and published to the 30 September deadline
- The Trust Medical Director takes responsibility for the learning from deaths agenda
There is a Non-Executive Director providing oversight
A specific Mortality Review Group has been established to provide the appropriate oversight of mortality within the Trust and ensure that appropriate learning from deaths is cascaded as appropriate
NHS Improvement guidance for Trust Boards included

The Medical Director announced that the next element is to develop capabilities for the retrospective care note review methodology, which is the preferred methodology in the national guidance. Training has been a little slow but there are now several people signed up to these sessions which start next week. The next step would be to build the capabilities to undertake reviews of all inpatient deaths by the Mortality Review Panel – this would realistically take 6 months. Priority is being given to medical areas in the meantime.

The Director of Emergency Care noted that the approach and leadership in this area taken by Portsmouth Hospitals NHS Trust exceeded the national standard. The Interim Chairman added that, the Trust is not only doing the right thing, but is doing it in the right way and regardless of requirements placed upon us, it is appropriate that all deaths be reviewed and that is what we were working towards.

150/17 Audit Committee Report

Mike Attenborough-Cox informed the Board that the Audit Committee was due to take place on the 21st September and therefore had no update to present.

151/17 Charitable Funds Update

The Director of Corporate Affairs highlighted the following key points:
- Total Funds - Portsmouth Hospitals NHS Trust General Charitable Fund has a fund balance of £1,483,000 as at 31st July, 2017
  - Charitable Income - During the month, the charity received donations, legacy and fundraising income of £60,000
  - Charitable Expenditure - During the month, expenditure of £89,000 was processed
- The Rocky Appeal - The Rocky appeal needs to raise £425,000 to complete its appeal in June 2018
  - Investments - The only investment held is with CCLA of £123,000
- Forthcoming Events:
  - Golf Day, Ageas Bowls, Southampton – 7th September
  - Great South Run - 22nd October
  - Make you Will Month – Throughout October (three solicitors taking part in four locations)

The Director of Corporate Affairs thanked both Sainsbury’s of Waterlooville and Farlington for their much valued support.

Melloney Poole raised concern that the Charitable Funds report states that it updates the Board in its capacity as Trustee, however, Melloney does not feel that the Board is currently fulfilling this element. The Director of Corporate Affairs replied that the Charitable Funds meeting was chaired by a Non-Executive Director and therefore has oversight, but he will of course review the Charitable Funds terms of reference and investigate the legal implications and Trust compliance of the Trustees meeting with the Committee.

Action: Director of Corporate Affairs

152/17 Non-Executive Directors’ Report

Melloney Poole expressed her appreciation of being part of the walkaround that had taken place on the day that the CQC report was published and thanked the Interim Chief Operating Officer for facilitating it. The Interim Chief Operating Officer in turn thanked the Non-Executive Directors and Executive Directors for taking the time to take part.
Mike Attenborough-Cox informed the Board that he and David Parfitt had a very useful meeting with the Non-Executive Directors from South Central Ambulance Service.

The Interim Chairman announced that there was still a Clinical Non-Executive Director vacancy. The recruitment process had been delayed but will be appointed to soon.

153/17 Acute Alliance Steering Group Minutes
Noted.

154/17 Summary of Governors Business

The Director of Corporate Affairs reported that the Governors recognised the workload of the Non-Executive Directors and were happy to support where they can.

The Governors raised concern around performance, in particular, internal metrics for SAFER and discharges and questioned why performance had not improved. The Director of Emergency Care shared the Governors concerns and assured them that there was commitment from all of the senior management team to make improvements.

The Director of Corporate Affairs conveyed that a number of Governors had met with the new Chief Executive and were optimistic at his appointment.

155/17 Company Secretary Papers for Noting

Papers noted.

Christine Slaymaker assured the Board that the risk register was regularly updated and reviewed at the Risk Assurance Committee meeting. After the last meeting, she felt that it was more of an operational meeting and therefore should be chaired by a senior manager. She asked that consideration be given to where the risk register should feed into as the meeting is not currently a Risk Assurance Committee meeting. The Chief Executive confirmed that a review of the current governance structure was underway and a new structure will be proposed in October along with the new Board Assurance Framework. A revised Risk strategy will be presented at the November Board. There will be a new Director of Strategy & Governance in post during the next few months and it will be their responsibility to lead on this.

156/17 Annual Work plan
Noted.

157/17 Record of Attendance
Noted.

158/17 Opportunity for the Public to ask questions relating to today’s Board meeting

Mary Sheppard, Lead Governor, made reference to the increase in complaints and asked which area of the Trust they were mainly coming from and what the plan to rectify the problem was. The Interim Director of Nursing replied that she would look into the question outside of the meeting and will respond directly to the points made. The Interim Chairman pointed out that the Trust needed to raise awareness as to how complaints can be made and that we shouldn’t be wary of them but treat them as an opportunity to identify problem areas and address them.

Roland Howes raised concern around the new format of the IPR and felt that it didn’t now provide enough information. The Interim Chief Operating Officer replied that the report had
been condensed as there was a lot of duplication in reporting. The Director of Workforce
added that all of the information that was required was within the report however, the Board
is still in the process of reviewing how this is best presented.

159/17  Any Other Business

None

The meeting closed at 12:15pm.

160/17  Date of Next Meeting:
Thursday 5 October 2017
Venue: Lecture Theatre, Queen Alexandra Hospital
<table>
<thead>
<tr>
<th>Minute</th>
<th>Agenda Topic</th>
<th>Summary of Action required</th>
<th>Responsibility for Action is with</th>
<th>Due Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>138/17</td>
<td>Matters Arising/Summary of Agreed Actions</td>
<td>The Medical Director to circulate the Mental Health Issues action plan to the Board</td>
<td>Medical Director</td>
<td>October</td>
</tr>
<tr>
<td>138/17</td>
<td></td>
<td></td>
<td>Interim Director of Nursing and Melloney Poole</td>
<td>October</td>
</tr>
<tr>
<td>142/17</td>
<td>Integrated Performance Report: Finance</td>
<td>The Director of Finance will bring the revised financial plan to the next Board meeting</td>
<td>Director of Finance</td>
<td>October</td>
</tr>
<tr>
<td>142/17</td>
<td>Integrated Performance Report: Finance</td>
<td>The Director of Finance will look at the alignment of workforce establishment and budget to order to ensure the Trust is not recruiting to unfunded posts. This will be discussed in the next Finance and Performance meeting</td>
<td>Director of Finance</td>
<td>October</td>
</tr>
<tr>
<td>145/17</td>
<td>Statutory Responsibilities for Emergency Planning</td>
<td>The Interim Chief Operating Officer to add the definitions of Major, Critical and Business Continuity to the report for the benefit of the Board</td>
<td>Interim Chief Operating Officer</td>
<td>October</td>
</tr>
<tr>
<td>151/17</td>
<td>Charitable Funds Update</td>
<td>The Director of Corporate Affairs has been asked to review the Charitable Funds terms of reference and investigate the legal implications and Trust compliance of the Trustees meeting with the Committee</td>
<td>Director of Corporate Affairs</td>
<td>October</td>
</tr>
</tbody>
</table>
**TRUST BOARD PUBLIC – OCTOBER 2017**

**Agenda Item Number: 167/17**

**Enclosure Number: (1)**

**Subject:** Report from the Chief Executive

**Prepared by:**

**Sponsored & Presented by:** Mark Cubbon, Chief Executive

**Purpose of paper**

To update the Board on national and local items of interest

**Key points for Trust Board members**

Briefly summarise in bullet point format the main points and key issues that the Trust Board members should focus on including conclusions and proposals

Note the contents of the report

**Options and decisions required**

Clearly identify options that are to be considered and any decisions required

None required, for information

**Next steps / future actions:**

Clearly identify what will follow the Trust Board’s discussion

None

**Consideration of legal issues (including Equality Impact Assessment)?**

None

**Consideration of Public and Patient Involvement and Communications Implications?**

None

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**Links to Portsmouth Hospitals NHS Trust Board Organisational Priorities, Assurance Framework/ Risk Register**

<table>
<thead>
<tr>
<th>Organisational Priorities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Board Assurance Framework/ Risk Register Reference</td>
</tr>
<tr>
<td>Risk Description</td>
</tr>
<tr>
<td>CQC Reference</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Committees/Meetings at which paper has been discussed/ approved:</th>
<th>Date</th>
</tr>
</thead>
<tbody>
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<td></td>
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</tr>
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</table>
1. The Need to Stop Unsustainable Agency Spending

NHS Improvement (NHSI) have urged Trusts to double their efforts in lowering spend on agency staff. Nationally Trusts had brought around £700m worth of savings last year by adhering to guidance set out by NHSI. National spending on agency staff remains at an unsustainable level both from a quality and economic viewpoint and much is still to be done to reduce spend to a more normal level.

The pressures which drive the increased use of temporary staffing, and in particular agency staffing at our Trust, is understood. We aim to maximise the support on offer to us through NHSI and we will shortly be providing the Trust Board with our plans to deliver a step change improvement in our agency expenditure as part of our overarching Quality Improvement Plan.

2. 100 Day Plan

This is my tenth week as Chief Executive and I continue to be impressed by the level of commitment and passion of our staff, to drive improvements in care for our patients.

The execution of my 100 day plan is going well and I have had the opportunity to meet with over 2700 members of staff, a great number of our Partners and Stakeholders, and importantly, many of our patients. This has been important to enable me to shape the priorities for the leadership of the organisation and to prepare me and the Trust for the challenges ahead. I have been sharing the progress against the plan in a series of blogs which are available on our website.

The feedback from the engagement sessions I have been running remains positive and it is clear to see the motivation and energy from staff who want to make Portsmouth Hospitals a better place for staff and for patients.

3. Leadership Changes

We continue to strengthen the Executive leadership team with the recent substantive appointment of the Director of Communications and Engagement. Emma McKinney will be joining the Executive team in December and I look forward to welcoming her to the Trust.

Interviews and stakeholder events for the substantive Chief Operating Officer, Chief Nurse and Director of Governance, Strategy and Performance posts will take place during the first three weeks of October. These are positive developments and will bring the much needed stability within the Executive team and to the leadership across the organisation.

Sheila Roberts who joined as Interim Chief Operating Officer in February 2017 has recently left the Trust. I extend my thanks for her contribution to the Trust over the past months and we all wish her well for the future. Mr Paul Bytheway joined as Interim Chief Operating Officer on the 25th September and will remain in post until a substantive appointment is made to the role.
Dr Rob Haigh, Director of Emergency Care, who joined us in July 2016 will sadly be leaving the Trust to join Brighton and Sussex University Hospitals NHS Trust, as their Medical Director. Rob has played a key role at this Trust, but this is a wonderful opportunity for Rob and we wish him every success for the future. The responsibilities of the Director of Emergency Care will be incorporated into the portfolio of the Chief Operating Officer once Rob leaves.

4. Operational Challenges

We continue to experience a number of challenges operationally and are taking steps to address all areas of underperformance. While we are starting to see some encouraging signs of improvement in a number of areas, there is still much to do. This will be referenced in more detail during the Chief Operating Officer update.

5. FAB Change Day

On 25th September the Trust held its FAB Day (Academy of Fabulous NHS Stuff). The idea behind the event is to create a mass movement of NHS staff demonstrating the difference they can make by one simple act, proving that large-scale improvement is possible which can make services better, quicker, safer, more reliable and cost efficient. I had the privilege of speaking at the event and hearing more about the wonderful innovations and improvements already underway across the Trust.

The day was a perfect preparation for the national FAB change week which will be held the 13th – 17th November 2017 where we will showcase many more examples of the improvements staff have pledged to make. As a result of the success of our event on the 25th September, we were delighted to hear that a member of the national FAB Change team will be joining us to visit the Trust during FAB change week.

6. Staff Congratulations

I was pleased to hear the Trauma and Orthopaedic Team will be celebrating a number of their achievements at the Houses of Parliament on 26th October 2017 which is in recognition of the great work the team undertake.

7. Open Day

I would like to offer a reminder that the Trust Open Day will take place on Saturday 14th October 2017. The agenda for the day is filled with opportunities for us to showcase some of the great services we provide and importantly to engage fully with our local community, our patients and their carers. I would encourage everyone to support the event.

Mark Cubbon
Chief Executive Officer
Team Brief – September 2017

A chance to...

discuss talk think

inspire listen debate

Passion & Pride
It has been a challenging month with an immense amount of pressure operationally – thank you to everyone for their hard work, commitment and support.

We are working with a company called 20/20 who are helping us progress improvements across our Urgent Care Pathway.

Recruitment to Executive Director positions is happening this month and next.

Thank you to everyone who has attended one of my engagement sessions and given me their feedback. I am so impressed with the energy and resilience of our workforce and the compassion shown to patients.

We have an opportunity to showcase what we do well and encourage a culture of shared learning at our ‘Fab Change’ day this month, but I want us to talk about how proud we are everyday and how we can learn from each other to continually improve the patient experience.

‘Big Conversations’ will be held in November and December using the Listening into Action methodology. A chance to remove any barriers that get in the way of you doing your job effectively. Email Listening.intoaction@porthosp.nhs.uk to book your place.

We are working with more than 75 of you to develop our Quality Improvement Plan resulting from our CQC inspections. The 5 priority areas include:

- Valuing the Basics
- Supporting Vulnerability in patients
- Leading Well through Governance
- Moving Beyond Safe
- Organisation that Learns

How you can help

- Please get involved in Fab Change Day on 25th September in the Lecture Theatre
- Be proud and share your learning with colleagues and good news stories with me
- Book your place at a Big Conversation and look out for more information about how to get involved in our Quality Improvement Plan

Mark Cubbon
Chief Executive
Improvement Plan Approach – Phase 2

Valuing the Basics
Executive Lead: Chief Operating Officer

- Patient at the centre.
- Holistic care.
- Courageous discussions
- Involving patients, families and carers

Organisation that Learns
Executive Lead: Medical Director

- Zero tolerance of bullying.
- Behaviours and compassion.
- Right staff, right skills.
- Staff engagement.

Supporting Vulnerability in patients
Executive Lead: Director of Human Resources

- Safeguarding.
- Mental Health.
- Dementia.
- Mental Capacity Act and Deprivation of Liberty.

Moving Beyond Safe
Executive Lead: Director of Finance

- Urgent Care.
- No ‘avoidable’ deaths.
- Stop Harm to patients.
- Right patient, right bed.

Leading Well through Good Governance
Executive Lead: Director of Nursing

- Leadership at all levels.
- Role clarity, responsibility and accountability.
- Standardising and consistency in processes.
- Being open and transparent.
## Chief Operating Officer’s Report

### Unscheduled Care Key Indicators

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Target</th>
<th>Aug-17</th>
<th>Change from last mth</th>
</tr>
</thead>
<tbody>
<tr>
<td>4 hr arrival to admission/transfer/discharge</td>
<td>95%</td>
<td>74.0%</td>
<td></td>
</tr>
<tr>
<td>12 hr Trolley waits</td>
<td>0</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>Ambulance delays &gt; 30 mins</td>
<td>0</td>
<td>356</td>
<td></td>
</tr>
</tbody>
</table>

### National Trust Development Agency Key Indicators

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Target</th>
<th>Aug-17</th>
<th>Change from last mth</th>
</tr>
</thead>
<tbody>
<tr>
<td>% Incomplete Pathways &lt; 18 wks</td>
<td>92%</td>
<td>91.1%</td>
<td></td>
</tr>
<tr>
<td>Diagnostic waits: 6 weeks</td>
<td>99%</td>
<td>98.0%</td>
<td></td>
</tr>
<tr>
<td>All 2-week wait referrals</td>
<td>93%</td>
<td>97.9%</td>
<td></td>
</tr>
<tr>
<td>Breast symptomatic 2-week wait referrals</td>
<td>93%</td>
<td>93.2%</td>
<td></td>
</tr>
<tr>
<td>31-day diagnosis to treatment</td>
<td>96%</td>
<td>96.1%</td>
<td></td>
</tr>
<tr>
<td>62-day referral to treatment (provisional)</td>
<td>85%</td>
<td>77.0%</td>
<td></td>
</tr>
<tr>
<td>Cancer maximum wait to treatment 104 days</td>
<td>0</td>
<td>13.0</td>
<td></td>
</tr>
</tbody>
</table>
Red2Green, SAFER, Last 1,000 Days, #endPJParalysis

Patients should know the following:
1. What is going to happened to them today?
2. What is going to happened to them tomorrow?
3. When they should be going home?
4. How well they need to be to go home?

Increase in functionality enabling recording of Red2Green status for each patient and the reason for the delay - Red2Green - Go Live 10th October

Rob Haigh
Director of Emergency Care
How you can help

- Familiarise yourself with your CSC/Departments financial objectives and plans to achieve them.
- Tell us when you think we have missed opportunities – either to reduce cost, generate income, or mitigate risks.
- Let us have all your ideas that could make a difference.

The August figures are in the final stages of preparation. They will show a slightly worse figure than was forecast increasing the pressure on the Trusts overall finances including the management of cash and capital.

From July our plans required us to start reducing our costs including those impacted by system transformation plans (e.g. MFFD/LOS/Business Case). These plans required material change and development in process, and there has been significant slippage across areas and as a result, the Trusts has reported adverse performances to its financial plan from last month and increasing in August.

We continue to spend in those high cost areas, including agency staff, much of which is above the price caps and we have continued to outsource activity where we are unable to do in house.

We are working with our teams to prioritise our resources most effectively. Improving our overall financial position is the best way to mitigate these risks and achieve our targets and priorities.

As a result, the Trust is now required to submit a revised financial and operational plan by the end of September. CSC’s have been involved in this process and it will continue over the next few weeks.

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**Finance Director’s Report**

**2017/18 – July 2017 YTD**

<table>
<thead>
<tr>
<th>£000’s</th>
<th>Annual Plan</th>
<th>M4 YTD Budget</th>
<th>M4 YTD Actual</th>
<th>M4 YTD Var</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical Income</td>
<td>(488,411)</td>
<td>(162,554)</td>
<td>(159,807)</td>
<td>(2,747)</td>
</tr>
<tr>
<td>Other Patient Care Income</td>
<td>(5,737)</td>
<td>(1,914)</td>
<td>(1,758)</td>
<td>(155)</td>
</tr>
<tr>
<td>Other Income</td>
<td>(62,060)</td>
<td>(19,083)</td>
<td>(17,758)</td>
<td>(1,325)</td>
</tr>
<tr>
<td><strong>Total Income</strong></td>
<td>(556,209)</td>
<td>(183,550)</td>
<td>(179,322)</td>
<td>(4,228)</td>
</tr>
</tbody>
</table>

| Substantive Pay     | 293,483     | 97,342         | 92,107        | 5,235      |
| Temporary Pay       | 6,041       | 2,704          | 12,190        | (9,486)    |
| **Total Pay**       | 299,524     | 100,046        | 104,297       | (4,251)    |
| Non Pay             | 209,184     | 76,756         | 70,725        | 6,031      |

**EBITDA**            | (47,500)    | (6,749)        | (4,301)       | (2,448)    |

| Depreciation        | 16,906      | 5,715          | 5,725         | (10)       |
| Interest Receivable | (38)        | (13)           | (11)          | (2)        |
| Interest Payable    | 18,786      | 6,278          | 6,281         | (4)        |
| PDC                 | 2,186       | 729            | 729           | (0)        |
| (Profit)/loss on Disposal | 0     | 0              | (8)           | 8          |
| **Total Financing costs** | 37,840 | 12,709         | 12,716        | (7)        |
| **Surplus/Deficit** | (9,660)     | 5,960          | 8,415         | (2,455)    |

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Chris Adcock
Finance Director
**Listening into Action (LiA)**

**Fab Change Day**

Monday 25th September 2017,
Lecture Theatre, Education Centre, QAH,
10am – 3pm

Opening speech by Mark Cubbon, Chief Executive

Invitation open to all staff - come and ‘drop in’ throughout the day to hear and see fantastic innovators, innovations and improvements:

*Research and Innovation*  *Trust Innovators*
*Quality Improvement*  *Patient Improvement*
*Ideas Port*  *Staff Led Change*  *Safety Learning Events*
*PHT/University of Portsmouth Partnership Programme*
*Health and Wellbeing*  *Clinical Audit*
*Freedom to Speak Up*

Take part in the Ideas Poster Competition
Design a poster which outlines your idea for improving patient or staff experience. Email your A4 poster to O.D@porthosp.nhs.uk or bring it along to FAB Change Day on the 25th September. One winner will receive an iPad Air tablet and 2 highly commended will receive an Amazon Fire Tablet. Click here for poster guidance.

*Prizes very generously provided by the Joint Consultative and negotiating Committee*

**Pride of Portsmouth**

Best People Awards 2017
Celebrating excellence through you

Judging panels are now scoring nominations against the Best People criteria. Finalists will receive an invitation from Mark Cubbon, CEO and Mark Nellthorp, Interim Chairman to attend the prestigious Awards Ceremony at the Portsmouth Guildhall taking place in November.

**National Staff Survey 2017**

Your chance to have your say

We need to hear your views about your job and your working environment

Completing this survey is of extreme importance as it helps us shape the future together by improving the working lives of staff, and so provide better care for patients.

We have listened to what you had to say in the 2016 survey and as well as Clinical Service Centre management teams developing improvement plans which seek to address areas of dissatisfaction, we have made positive changes in our Trust.

Please be assured that all completed questionnaires are confidential, no one at Portsmouth Hospitals will see what any individual has written. The reference number on your questionnaire is only used by the external survey company for their purposes.

Surveys will be collected by your management teams and delivered to you from the 20th September.

Over 200 nominations have been received for individuals and teams throughout the Trust for the Pride of Portsmouth, Best People Awards 2017.

GETTING US READY FOR FAB CHANGE WEEK, 13TH TO 17TH NOVEMBER 2017

Contact samantha.coley@porthosp.nhs.uk or tracy.martin@porthosp.nhs.uk with any query.
Director of Workforce and OD Report

Learning and Development

- Our Congratulations to Je Apostol, Jincy Jose and Michael Romano for passing the rigorous practical exam OSCE (Objective Structured Clinical Examination) required by the NMC to become registered nurses in the UK. Congratulations also go to Francesco Giunchi of DCCQ who has passed his IELTS test this month and can now apply to register with the Nursing and Midwifery Council.

- We are looking forward to welcoming 15 new nurses from Italy and Portugal in September who will join the International Transition Programme.

- 12 seconded staff have commenced the 2017 OU Nursing Degree Programme. Another member of staff will be joining stage 2 of the programme in October.

- In September we will commence our new apprenticeship programme for Healthcare Science Level 2 for learners from the Decontamination Department and new Pathology apprentices.

Top 5 courses for Did Not Attends in June 2017:
The Course DNA rate for July was 15%; a 4% deterioration on the previous month.
The rate has not been this high since December 2016. Our top 5 DNA Courses for July were:

1. 140 DNAs Basic Clinical Fire Training (29%)
2. 37 DNAs Blood Awareness Update (35%)
3. 37 DNAs Adult Basic Life Support (24%)
4. 33 DNAs Moving and Handling of Patients (25%)
5. 29 DNAs Advanced Fire Training (23%)

How you can help

- Welcome and support our new intake of overseas nurses.
- Remember to cancel courses if staff are unable to attend, to allow others the opportunity and also reduce the DNA rate.

Tim Powell
Director of Workforce and OD
PAS HARDWARE UPGRADE - 6th to 9th October 2017

• The old PAS hardware must be replaced following multiple failures
• The new hardware will provide a faster and more reliable PAS service and back-up
• PAS will only be available in Read-Only format whilst the system is being migrated
• This is planned for 6pm on Friday 6th October to 9am on Monday 9th October 2017
• Applications that take feeds from PAS will continue to run, but will receive no PAS data during this period (e.g. Bedview, Epro, ICE)
• During the ‘down-time’ period all patient activity data normally recorded on PAS will need to be recorded on paper and entered into PAS immediately after it becomes available
• Services must implement business continuity plans during this time
• Communications will be issued to departments affected

How you can help
• Review business continuity plans and plan to record PAS data manually and enter it retrospectively
• Log any non-urgent IT enquires through http://mycall/ and we will aim to respond to your query within 24-hours
Employee of the Month

The Employee of the Month was Susie Calvert, Physiotherapy Team Leader.

Susie was nominated by Mr Nick Carter, Consultant Upper Gastrointestinal and Bariatric Surgeon who particularly wanted to nominate Susie in looking after one particular patient who was on the Intensive Treatment Unit for some 4 months.

During this time Susie provided outstanding quality of care and formed a very close relationship with both the patient and his wife which was vital in keeping him motivated. Susie acted as her patients advocate and had some difficult conversations with the wider multi-disciplinary team to give the patient more time and allow her to work with him more. Even at the very end she facilitated his return home one last time before he passed away.

Mr Carter said that Susie went much further than the extra mile and deserves so much in recognition of the work she puts in all the time and in particular to this one patient.
Research priorities for Barrett’s Oesophagus:

New investigator led studies recruiting strongly in Diabetes:
• Injectables – multi-site trial with 1,000 patients looking at impact of injectable therapies on quality of life
• DRIVE (testing a new skin sensor for sugar levels).

Collaborations with the University of Portsmouth’s Department of Sports and Exercise Science:
Beet the Cold (Rheumatology) and Dehydr8 & Deactiv8 (Renal) both now open.

Scientist Training Programme trainees at PHT are now eligible for the Clinical Research Network Portfolio – good practice we can promote nationally.

New Professor: Greta Westwood, awarded by University of Southampton “for her important part in enhancing our international reputation for research, teaching and enterprise activities”.

How you can help
• Find out what R&I at PHT are up to
Communications

How you can help
- We want to profile your patient stories and staff successes! Contact: communications@porthosp.nhs.uk
NEW Patient Experience Fund

The Sewing Room Staff at QAH (Carillion) raised £500 to help the brand new Patient Experience Fund. The fund aims to help patients, families and carers have a better experience here at QAH by providing the small things; like a support and advice 'café' for carers. Sarah Balchin (Head of Patient Experiences) said: “As the head of patient experiences, I work very closely with Carillion-they’re an integral part of ensuring we deliver a high quality patient experience.”

Spinnaker Abseil

A mix of 12 patients and staff braved the 328ft descent to raise £5,575 to benefit 9 hospital funds here at QA.

Upcoming Events:
Chocolate & Rum Tasting - 28 September
Make your Will Month – Throughout October
Great Wall Of China Trek - 22-30 September 2018
Great South Run - 22 October
Cascade of this team brief to all staff should also include key messages to be shared at a Clinical Service Centre, Specialty and/or department level

What is the process and timing?

1. Each month the Executive Team deliver key corporate messages at a face to face briefing to Clinical Service Centre and Directorate representatives and staff members

   On the 3rd Friday of each month

2. Clinical Service Centre and Directorate representatives add relevant local key and priority messages. They meet face to face with senior team leaders to brief them on both the Trust wide and their local information

   By the 4th Friday of each month

3. Senior Team Leaders meet face to face with their teams to brief them and this continues to cascade down so that all receive Team Brief from their own line manager

   By the 2nd Friday of the following month

4. After each team Brief session if there are any ideas, actions or feedback that you need to take further action they should be captured centrally with your CSC management team

   As they happen

For example
1. On the 20th January 2017
2. By the 27th January 2017
3. By the 10th February 2017

Link to Team Brief and dates on the Intranet
Feedback

- Team Brief is a two-way communication tool for managers and staff to engage

- Ensure you feedback to your manager

- To improve this team brief feedback your thoughts via the Communications Team

- It is always refreshing to hear honest and constructive comments from staff
Subject: Integrated Performance Report (s) – August 2017

Prepared by
Jane Lowe Head of Performance & Scheduled Care
Tracey Stenning Head of Governance
Leah Wilson Workforce Planning and Intelligence Manager
Steve Smith Head of Financial Management

Sponsored & Presented by:
Sheila Roberts Interim Chief Operating Officer

Purpose of paper
The Board are asked to note the two IPR reports for August 2017. An easy, quick to read executive Summary and a more detailed report.

The reports identify risks and improvement in relation to:
- National & Constitutional Standards
- Regulatory requirements
- Contract Requirements and
- Trust priorities

Key points for Trust Board members
Please refer to the Integrated Performance Reports:
- Performance Outcomes
- KPI and dashboards and
- Executive Summary

Options and decisions required
The Board is asked to note the performance at the end of August 2017

Next steps / future actions:
On-going measurement of all standards

Consideration of legal issues (including Equality Impact Assessment)?
N/A

Consideration of Public and Patient Involvement and Communications Implications?
N/A

Links to Portsmouth Hospitals NHS Trust Board Strategic Aims, Assurance Framework/Corporate Risk Register

<table>
<thead>
<tr>
<th>Strategic Aim</th>
<th>Strategic Aims 1,3,4 and 5</th>
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<td>CQC Reference</td>
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Committees/Meetings at which paper has been approved: N/A
# Contents

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<td>6 Workforce Performance</td>
<td>51</td>
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<tr>
<td>7 Key</td>
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### Integrated Performance Outcomes – August 2017

- The quality position demonstrates deterioration in a number of metrics in August, namely a Never Event, an avoidable MRSA Bacteraemia, further mixed sex accommodation and Duty of Candour breaches. However, Friends and Family Test results remain consistently above the National Average.
- A&E performance was 73.95% (against the improvement trajectory of 88%)
- Average number of MFFD patients occupying acute beds was 246/day
- 12 hour standard – there were 5 breaches of the standard (0 last month)
- RTT standard 91.13% (against the improvement trajectory of 92%)
- There were no breaches of the 52 wk standard
- 7 of the 8 key national cancer standards were achieved
- 6 wk Diagnostic standard performance was 98% and not achieved (standard 99%)
- The Trust is reporting a £8.4m year to date deficit for the 4 months to the end of July 2017. This is £2.45m adverse to the Financial Plan submitted to NHS Improvement.
- It had a cash balance at the end of July 2017 of £4.0m
- The Trust has spent £1.0m of a £8.4m non-PFI capital programme in the year to date.
- Temporary usage recorded at 482 fte a month and comprises 7% of the total workforce capacity.
- The total workforce capacity exceeds the funded establishment by 43 fte.
- Appraisal compliance continues to be below 85% target currently recording at 77.7%
- Sickness absence rate has decreased in – month to 3.4%
## Quality of Care Overview – August 2017

### QUALITY SCORECARD

<table>
<thead>
<tr>
<th>Group</th>
<th>Performance Indicator</th>
<th>Target</th>
<th>Apr-17</th>
<th>May-17</th>
<th>Jun-17</th>
<th>Jul-17</th>
<th>Aug-17</th>
<th>Variation</th>
<th>Q1</th>
<th>Q2</th>
<th>YTD</th>
<th>Monthly trend line</th>
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</thead>
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<td><strong>Pressure ulcers</strong></td>
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### Falls

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<th>Jul-17</th>
<th>Aug-17</th>
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<th>Q1</th>
<th>Q2</th>
<th>YTD</th>
<th>Monthly trend line</th>
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<td>Total falls incidents reported</td>
<td>Monitor</td>
<td>Monitor</td>
<td>179</td>
<td>211</td>
<td>208</td>
<td>204</td>
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<td>-</td>
<td>598</td>
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<td>Falls resulting in severe harm (confirmed including SIRs)</td>
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<td>1</td>
<td>2</td>
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<tr>
<td>Monthly numbers subject to change as incidents are confirmed</td>
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<td>0</td>
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<td>0</td>
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<tr>
<td>Falls resulting in moderate harm (continued)</td>
<td>Monitor</td>
<td>1</td>
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### Medication

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<th>Q2</th>
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<td>Monitor</td>
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<td>1</td>
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### NHS Safety Thermometer

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<th>May-17</th>
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<th>Aug-17</th>
<th>Variation</th>
<th>Q1</th>
<th>Q2</th>
<th>YTD</th>
<th>Monthly trend line</th>
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<tbody>
<tr>
<td>Total harm free care</td>
<td>Monitor</td>
<td>Monitor</td>
<td>96.70%</td>
<td>97.30%</td>
<td>96.90%</td>
<td>96.50%</td>
<td>95.90%</td>
<td>96.97%</td>
<td>96.15%</td>
<td>96.45%</td>
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<td>Trust harm free care</td>
<td>Monitor</td>
<td>Monitor</td>
<td>98.70%</td>
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### Healthcare Acquired Infection

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<th>May-17</th>
<th>Jun-17</th>
<th>Jul-17</th>
<th>Aug-17</th>
<th>Variation</th>
<th>Q1</th>
<th>Q2</th>
<th>YTD</th>
<th>Monthly trend line</th>
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<tr>
<td>MRSA - Avoidable</td>
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<tr>
<td>MRSA - Unavoidable</td>
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<tr>
<td>C Difficie</td>
<td>40 cases</td>
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<td>0</td>
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### Monitoring of incidents

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<th>May-17</th>
<th>Jun-17</th>
<th>Jul-17</th>
<th>Aug-17</th>
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<th>Q2</th>
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<td>Never Events</td>
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<td>Serious Incidents Requiring Investigations (SIRs)</td>
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<td>55</td>
<td>59</td>
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<td>SIRs per 1,000 occupied bed days</td>
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<td>Duty of Candour breaches</td>
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<td>CAS alerts over deadline</td>
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### Other safety metrics

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<th>Q1</th>
<th>Q2</th>
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<th>Monthly trend line</th>
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<tbody>
<tr>
<td>Venous Thrombo-embolus (VTE) screening</td>
<td>95% per month</td>
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<td>95.4%</td>
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**Key:**
- Performance improving
- Performance worsening
- Performance the same
- No concerns
- Some concerns: action required to remain on track
- Significant risk to achieving target
### Quality of Care Overview – August 2017

#### QUALITY SCORECARD

<table>
<thead>
<tr>
<th>Performance Indicator</th>
<th>Target</th>
<th>Apr-17</th>
<th>May-17</th>
<th>Jun-17</th>
<th>Jul-17</th>
<th>Aug-17</th>
<th>Variation</th>
<th>Q1</th>
<th>Q2</th>
<th>YTD</th>
<th>Monthly trend line</th>
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<td><strong>EFFECTIVE</strong></td>
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<td>Trust-wide mortality</td>
<td>Within expected range</td>
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<td>Summary Hospital-level Mortality Indicator (SHMI)</td>
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<td><strong>CARRYING</strong></td>
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<tr>
<td>Dementia</td>
<td>≥ 90% each quarter</td>
<td>76.1%</td>
<td>79.3%</td>
<td>75.9%</td>
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<td>Dementia - Care plan on discharge</td>
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<td><strong>Mixed sex accommodation breaches</strong></td>
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<td>Complaints acknowledged &lt; 3 working days</td>
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<td>0.57</td>
<td>0.53</td>
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<td>Complaints per 1,000 contacts (all types) (reported in month in answer)</td>
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<td>PALS transferred to complaints</td>
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<td>3903</td>
<td>2708</td>
<td>2382</td>
<td>2538</td>
<td>2597</td>
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<td><strong>Patient moves</strong></td>
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<td>&lt;3 after 2100</td>
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<td>Outliers</td>
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<td><strong>WELL-LED</strong></td>
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<tr>
<td>In-patient and day case response rate</td>
<td>Not fall below 15%</td>
<td>34.3%</td>
<td>34.5%</td>
<td>25.7%</td>
<td>32.4%</td>
<td>30.3%</td>
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<tr>
<td>Emergency Department response rate</td>
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<td>14.6%</td>
<td>9.1%</td>
<td>11.3%</td>
<td>11.7%</td>
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<td>11.5%</td>
<td>24.2%</td>
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<tr>
<td>In-patient percentage recommend - positive</td>
<td>Similar or above national average</td>
<td>97.1%</td>
<td>96.5%</td>
<td>96.3%</td>
<td>96.7%</td>
<td>96.9%</td>
<td>96.6%</td>
<td>96.8%</td>
<td>193.4%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>In-patient percentage recommend - negative</td>
<td>Similar or above national average</td>
<td>0.6%</td>
<td>0.4%</td>
<td>0.7%</td>
<td>0.6%</td>
<td>0.6%</td>
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<td>0.6%</td>
<td>1.2%</td>
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<tr>
<td>Emergency Department percentage recommend - positive</td>
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<td>95.0%</td>
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<td>2.2%</td>
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<td>Maternity percentage recommend - positive</td>
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<td>99.3%</td>
<td>97.1%</td>
<td>98.6%</td>
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<td>98.7%</td>
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<tr>
<td>Maternity percentage recommend - negative</td>
<td>Maximise responses</td>
<td>0.3%</td>
<td>0.7%</td>
<td>0.7%</td>
<td>1.4%</td>
<td>0.5%</td>
<td>0.6%</td>
<td>1.0%</td>
<td>1.5%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Maternity response rate</td>
<td>Monitor</td>
<td>39.8%</td>
<td>14.6%</td>
<td>12.9%</td>
<td>15.4%</td>
<td>12.9%</td>
<td>15.3%</td>
<td>14.2%</td>
<td>29.4%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Maternity response rate question 2</td>
<td>Not fall below 15%</td>
<td>20.3%</td>
<td>19.0%</td>
<td>23.4%</td>
<td>21.5%</td>
<td>22.1%</td>
<td>20.9%</td>
<td>21.8%</td>
<td>42.7%</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
# Quality of Care Key Exceptions – August performance

## Exceptions in performance to note

<table>
<thead>
<tr>
<th>Indicator</th>
<th>June</th>
<th>July</th>
<th>Aug.</th>
<th>Comment</th>
</tr>
</thead>
</table>
| Mental Health              | Not applicable |        |        | - The Trust continues to meet the Care Quality Commission (CQC) requirements to submit weekly compliance information in relation to the Section 31 Enforcement Notice Conditions.  
- An external advisor continues the ligature risk assessments across the organisation. An in-depth review of AMU is scheduled for 27th September.  
- There has been increased and sustained performance with Mental Health Risk Assessments for patients attending ED. The number of mental health attendances shows no significant trends. Similarly, there are no trends apparent in the proportion of all ED attendances which were for mental health presentations. |
| Falls incidents            | 3      | 2      | 2      | - 2 confirmed severe harm falls incidents in August; both incidents have been reported as SIRIs and are currently under investigation  
  - 1 fall within Emergency Medicine (AMU) resulting in severe harm.  
  - 1 fall within MSK has been reported as causing moderate harm; however, was found to be severe harm at initial panel, and as such as been reported as a SIRI.  
- The current year-to-date position is 12 confirmed falls incidents, 10 resulting in severe harm and 2 resulting in moderate harm. |
| MRSA (avoidable)           | 1      | 0      | 0      | - The 2 cases referred to NHS England for arbitration in June are complete. 1 case was assigned to Third Parties; 1 case has been assigned to the Trust as avoidable. The case involved a maternity patient who became unwell whilst in labour. Following arbitration by NHS England, the Trust has been asked to provide assurance that appropriate screening programmes are in place for pregnant women who have increased risk factors (such as occupation).  
- The Trust’s year-to-date position is 2 unavoidable and 1 avoidable cases, against an objective of 0 (zero) avoidable cases. |
| VTE screening              | 95.2%  | 94.68% | 95.21% | - VTE risk assessment figure for August has increased to 95.21% (subject to validation); compared to the July figure of 94.68%. Therefore achieving the monthly target of 95%. |
| Never Events               | 0      | 0      | 1      | - 1 Never Event reported in August within CHAT/MSK; whereby an incision was made on an incorrect toe during corrective surgery (wrong site surgery), resulting in low harm. The investigation has commenced with immediate mitigation implemented. |
| Elective HSMR              | 112.02 (Apr. '16 – Mar. '17) | 111.08 (Apr. '16 – Mar. '17) | 111.03 (June '16 – May '17) | - Trust HSMR for the 12 months to May 2017 is 111.3; representing a slight decrease on the rate previously reported. This sits within a confidence interval of 106.4 – 116.34 and is significantly higher than expected.  
- The Clinical Effectiveness and Mortality Steering Group has been split, with a separate Mortality Review Group having been established. The factors contributing to the increases continue to be investigated through this group.  
A coding change to PAS will ensure the correct admission source is recorded against all patients admitted from ED, circa 26,000 pa. These patients will now be graded against a higher (corrected) mortality threshold. Although this coding change will not be seen until the report published in November 2017, following a meeting with Imperial, work has commenced to model the change in 2017/18 with Dr Foster from manually correct information.  
- A review of the delivery and recording of specialist palliative care across the Trust is to be conducted. |
# Quality of Care Key Exceptions – August performance

<table>
<thead>
<tr>
<th>Indicator</th>
<th>June</th>
<th>July</th>
<th>Aug.</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Caring</strong></td>
<td></td>
<td></td>
<td></td>
<td><strong>Dementia screening</strong></td>
</tr>
</tbody>
</table>
|                                               | 75.9% | 69.8% | 75%  | • Increase in compliance with dementia screening noted in August.  
  • The concerns regarding consistently low performance have been formally escalated to the Medical Director.  
  • Initial discussions with IT are underway to determine if screening could be included on the BedView System to aid compliance. This will take some time to build into the system. |
| **Mixed sex accommodation breaches (non-clinically justified)** | 23 breaches (3 occasions) | 16 breaches (2 occasions) | 23 breaches (3 occasions) | • 3 occasions of non-clinically justified mixed sex accommodation breaches affecting a total of 23 patients in August.  
  - All 3 occasions were on the Respiratory High Care Unit (RHCU). Two breaches affected 8 patients, the remaining breach affected 7 patients; all were resolved within 24 hours.  
  • The Trust year-to-date position is 8 occasions of non-clinically justified mixed sex accommodation breaches affecting 62 patients. Therefore, a total of 62 breaches. |
| **Complaints**                                 | 44    | 45    | 57   | • A total of 57 complaints were received in August, an increase from 45 received in July.  
  • An increase has been noted in complaints received in relation to Emergency relating to clinical treatment and admission/discharge. |
| **Responsive**                                 | 140 (4.7) | 154 (5.0) | 131 (4.4) | • Although there has been a reduction in the number of patients moved, the non-achievement of the Medically Fit for Discharge (MFFD) backlog reduction across the whole health and social care system continues to necessitate the process of outlying to create acute bed capacity. As of 28th August the position is 136 patients behind trajectory. Weekly Executive to Executive meetings with system partners are taking place to review contingency plans.  
  • As MFFD patient numbers have not reduced, the plan to reduce escalation capacity has not been delivered to the planned level. This has caused difficulties in terms of finding staff and the cost of opening the capacity. |
| **Outliers**                                    | 2,382 | 2,538 | 2,594 |                                                                                                                                                                                                          |
| **Friends and Family Test ED response rate**    | 9.1%  | 11.3% | 11.7% | • ED response rate increased slightly from 11.3% to 11.7% in August, but to note 200 more responses were received.  
  • Response rate has increased incrementally for the last 3 months from 9.1% – 11.7%; however, the rate remains below the national average of 12.8% (July data) and the contractual requirement of 15%.  
  • Increased scrutiny of return numbers and escalation is being extended.  
  • As part of the FFT contract provider review, additional opportunities for providing feedback (including text messaging and the provision of fixed kiosks) are being considered. |
Mental Health Act Compliance

• The Trust continues to meet the Care Quality Commission (CQC) requirements to submit weekly compliance information in relation to the Section 31 Enforcement Notice Conditions.

• An external advisor continues the ligature risk assessments across the organisation. An in-depth review of AMU is scheduled for 27th September.

• A review is underway relating to the accuracy of mental health incident reporting.

• Discussions continue between mental health service providers, the Trust and Commissioners regarding longer term aspirations for mental health provision.

• As can be seen below, there has been increased and sustained performance with Mental Health Risk Assessments for patients attending ED. The number of mental health attendances shows no significant trends. Similarly, there are no trends apparent in the proportion of all ED attendances which were for mental health presentations.
Pressure Ulcers (reporting only)

August position

Avoidable hospital acquired grade 3 and 4 pressure ulcers
- There have been 2 confirmed cases of avoidable grade 3 pressure ulcer damage; 1 within Medicine and 1 within Surgery and Cancer (this is currently under investigation for potential downgrade as it is thought this was unavoidable) and zero confirmed grade 4 pressure ulcer damage in August. This compares with 3 confirmed grade 3 and 4 pressure damage in July.
- The Trust year-to-date position is 7 avoidable grade 3 and 0 (zero) grade 4 pressure ulcers.

Unavoidable hospital acquired pressure ulcers
- The Trust confirmed 2 unavoidable grade 3 pressure damage in August; comparable to July

Grade 1 and 2 pressure ulcers
- The Trust confirmed a total of 2 grade 1 and 2 grade 2 pressure ulcers in August compared to 8 grade 1 and 2 grade 2 in July.

Actions and progress to date
- The Tissue Viability Nurse Team (TVN) hosted ‘Independence Day’, a drop in day for staff to enable them to receive education in relation to supporting patients to be independent in hospital. Over 200 staff attended.
- The TVN team are continuing to train members of staff on PURPOSE T, a new pressure ulcer risk assessment tool, which will commence roll out in the Trust during September.

Present on admission
- A total of 101 ‘present on admission’ pressure ulcers were reported in August compared to 110 in July.
- Following review by the TVN team of all present on admission pressure damage, 45 of the 101 reported incidents were deemed to be pressure damage.

Per 1,000 occupied bed days (OBD)
- The Trust has reported 0.1 confirmed grade 3 or 4 avoidable pressure ulcers per 1,000 bed days in August, comparable to July.
Falls (Quality Contract)

**August position**

Target: Monthly monitoring of incidents resulting in moderate, severe or catastrophic harm.

- There have been a total of 2 confirmed severe harm falls incidents in August; both incidents have been reported as SIRIs and are currently under investigation.
  - 1 fall within Emergency Medicine (AMU) resulting in severe harm.
  - 1 fall within MSK has been reported as causing moderate harm; however, was found to be severe harm at initial panel, and as such has been reported as a SIRI.
- The current year-to-date position is 12 confirmed falls incidents, 10 resulting in severe harm and 2 resulting in moderate harm.
- There are currently 6 moderate harm incidents (2x Emergency Medicine (AMU), 2x Medicine, 1x MOPRS, 1x Surgery and Cancer and 1x MSK Outpatients); all of which are currently under investigation.

**Actions and progress to date**

- Comprehensive falls training continues with additional training provided within Medicine and MOPRS.
- Preparation for a falls awareness week in October continues.
- Falls awareness has been promoted through the continence independent day.
- The Trust has been invited to an initial development of an NHS Improvement sponsored Falls practitioner network.
- Preparation for falls Simulation training is progressing.

**Falls per 1,000 occupied bed days**

Target: Quarterly rate of falls incidents resulting in moderate, severe or catastrophic harm per 1,000 occupied bed days of ≤ 0.2 on average each quarter.

- The Trust has reported 0.1 confirmed falls incidents per 1,000 bed days since April 2017.
Medication (Contract & Quality Account)

August position

Target: Monthly monitoring of incidents resulting in moderate, severe or catastrophic harm.

- There has been 1 moderate harm incident confirmed in August within MSK (incident reported in June).
- The current year-to-date position is 3 confirmed moderate harm medication incidents (1x community incident).
- There are currently 9 moderate harm incidents under investigation; 3x Medicine, 4x Emergency Medicine and 1x Surgery and Cancer 1x Women’s and Children.

Actions and progress to date

- Medicines reconciliation completed by pharmacy staff within 24hrs was reported to be 83.7% in July reaching the 80% target.
- Further audit work is being carried out to ensure that fridge monitoring is being carried out correctly.
- Ward CD stock lists have been reviewed and updated and the wards ordering process is being reviewed and service improvements planned to prevent delays and increase safety.

Medication incidents per 1,000 occupied bed days

Target: Quarterly rate of medication incidents resulting in moderate, severe or catastrophic harm per 1,000 occupied bed days of ≥ 0.01 on average each quarter.

- The Trust has reported 0.0 confirmed medication incidents per 1,000 bed days in June, this has remained a constant position since June 2016.

<table>
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<tr>
<th>CSC</th>
<th>Near miss</th>
<th>None</th>
<th>Low</th>
<th>Moderate</th>
<th>Severe</th>
<th>Death</th>
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<td>CHAT</td>
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<td>0</td>
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<td>Head &amp; Neck</td>
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<td>Women &amp; Children</td>
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<td>21</td>
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<tr>
<td>Total</td>
<td>44</td>
<td>154</td>
<td>33</td>
<td>2</td>
<td>0</td>
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Patient Safety Thermometer (Contract)

August position
Target: Submit data to the National Patient Safety Thermometer

- The Trust achieved 100% data collection for August.
- To date the Trust has maintained high submission rates, with 100% being achieved each month.

Actions and progress to date
- Sustain 100% audit submission on all patients and validation of all harm events.

Percentage of harm free care (contract)
Target: Report percentage of harm free care.

- In August, the Trust recorded in-patient harm free care of 98.0%, a slight decrease on the 99.1% recorded in July.
- The total harm free care, which includes pre-hospital admission harm events, was 95.8% in August a decrease on the 96.5% in July. There is no national figure available at the time of this report.
- An increase in catheter and UTI’s has been noted in August. The reason for this is unclear; however, of the 15 recorded in August 10 were old and 4 patients had a UTI unrelated to their catheter.

Actions and progress to date
- Continued monthly reporting to the Director and Deputy Director of Nursing and Head of Nursing for each CSC with feedback to ward teams.
- Specialist nurses working on education.
- Clinical Dashboard available as a hard copy and via the intranet.
- Service improvement work streams for all harm events.

<table>
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<tr>
<th>Month</th>
<th>Total Harm Free Care</th>
<th>Trust Harm Free Care</th>
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<tbody>
<tr>
<td>August 2017</td>
<td>95.8% (1,064)</td>
<td>98.0%</td>
</tr>
<tr>
<td>July 2017</td>
<td>96.5% (1,064)</td>
<td>99.1%</td>
</tr>
<tr>
<td>June 2017</td>
<td>96.9% (1,084)</td>
<td>98.6%</td>
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Types of harm

<table>
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<th>Types of harm</th>
<th>June 2017</th>
<th>July 2017</th>
<th>August 2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pressure ulcers (new and old)</td>
<td>24</td>
<td>29</td>
<td>19</td>
</tr>
<tr>
<td>Falls</td>
<td>3</td>
<td>4</td>
<td>6</td>
</tr>
<tr>
<td>Catheter and UTI</td>
<td>6</td>
<td>3</td>
<td>15</td>
</tr>
<tr>
<td>VTE (new)</td>
<td>4</td>
<td>2</td>
<td>6</td>
</tr>
<tr>
<td>Total patients</td>
<td>1,084</td>
<td>1,064</td>
<td>1,064</td>
</tr>
</tbody>
</table>

The Trust total harm-free care rate is directly affected by these harm categories. An increase in numbers of these categories will result in a decrease in the rate of harm-free care.
Healthcare Acquired Infection (National)

August position

MRSA (Incidence more than 48 hours after admission)

Target: 0 (zero) avoidable

- The Trust reported 3 patients with MRSA bacteraemia in August. The Post Infection Review (PIR) process is complete for all cases, with 2 cases being assigned to South East Hants CCG, and 1 case assigned to the Trust as unavoidable. The Trust assigned case occurred in Medicine (ward C6).
- The 2 cases referred to NHS England for arbitration in June are also complete. 1 case was assigned to Third Parties; 1 case has been assigned to the Trust as avoidable. The Trust case involved a maternity patient who became unwell whilst in labour. Following arbitration by NHS England, the Trust has been asked to provide assurance that appropriate screening programmes are in place for pregnant women who have increased risk factors (such as occupation).
- The Trust’s year-to-date position is 2 unavoidable and 1 avoidable cases, against an objective of 0 (zero) avoidable cases.

C.Difficile (Incidence more than 72 hours from admission)

Target: 40 cases

- The Trust reported 2 patients with C.Difficile attributed to the Trust in August (1x Orthopaedics and 1x ITU) against a monthly objective of 4.
- The Trust’s year-to-date position is 16 cases against a target of 17 cases (annual objective 40 cases).

MSSA bacteraemia (Incidence more than 48 hours after admission)

MSSA bacteraemia are not subject to DH trajectories, but are closely monitored by the Trust due to the high incidence of morbidity and mortality associated with these infections.

- There were 3 patients reported with MSSA bacteraemia attributed to the Trust in August.
Venous Thrombo-embolism Screening (National)

August position

VTE Screening

Target: 95% per month

- The VTE risk assessment figure for August has increased to 95.21% (subject to validation); compared to the July figure of 94.68%. Therefore achieving the monthly target of 95%.
- The National average for VTE assessment (NHS England, Q4 2016-17) is 95.53%.

VTE Appropriate prophylaxis

Target: Monitoring and reporting

- The VTE appropriate prophylaxis figure for August is 99.26% (subject to validation); compared to the July figure of 98.90%.

VTE Serious Incidents Requiring Investigation (SIRIs) and Incidents

Target: Monitoring and reporting

- There have been 0 reported VTE SIRIs in August and no moderate harm events.
- 48 VTE events were reported in August compared to 78 in July.
  - Of these 26 were hospital associated events (HAT), compared to 22 in July and 56 were community associated events (CAT) compared with 56 in July.

VTE Root Cause Analysis (RCA)

Target: Monitoring and reporting

- All VTE HAT events undergo RCA investigation (100%).

Actions and progress to date

- VTE risk assessments continue to be variable in August. Several CSC’s continue to have variable performance, in particular Emergency Medicine, Surgery and Cancer, Medicine and MOPRS.
- Nationally there has been a decrease in the number of organisations achieving the minimum 95% risk assessment. The Medical Director has emailed all Chief of Service and Clinical Director’s about performance.
Serious Incidents Requiring Investigation (SIRIs) (Contract and National)

August position

SIRIs (including HCAIs and as reported on STEIS)

Target: Monitoring and reporting

- 16 SIRIs were reported in August; 5 breaches of DTA and 11 clinical SIRIs, compared to 10 clinical SIRIs in July.
- A total of 3 incidents resulted in the death of the patient.
- This equates to 0.5 SIRIs per 1,000 occupied bed days, compared to 0.3 in July.

SIRIs over 60 day deadline

Target: Monitoring and reporting

- There were 7 open SIRIs at the end of August which exceeded the target date of 60 working days for submission to the Commissioners. 3 had been discussed and an extension approved, 1 cannot be investigated until completion of a police investigation. 3 have not had an extension approved; all within Medicine CSC.

Never Events

Target: 0 (zero)

- There has been 1 Never Event reported in August within CHAT/MSK; whereby an incision was made on an incorrect toe during corrective surgery (wrong site surgery), resulting in low harm. The investigation has commenced with immediate mitigation implemented.
- The Trust year-to-date position is 1 Never Event.

Duty of Candour

The Trust is required to inform the patient and/or other relevant person within 10 operational days that the safety incident (moderate and severe harm) has occurred or is suspected to have occurred.

- All patients or their relatives, where applicable, were informed of the incident within the deadline and are aware of the on-going investigation; with the exception of:
  - 1 breach in MSK where the relatives had not been contacted to offer a copy of the final report; and
  - 1 breach in Medicine where the relatives have not been formally written to confirming an investigation is underway.
Patient safety incidents (excluding SIRIs) (Contract)

August position
Target: Increase in overall reporting of low and no harm incidents and reduce severity of harm

- At the time of reporting 1,659 Safety Learning Events (SLE - incidents) had been reported in August; the top three reported incident categories are:
  - Clinical Event: 280 events (16.9%).
  - Pathology/Blood: 255 events (15.4%).
  - Tissue Damage: 254 events (15.4%).

- This is comparable to Clinical Event, Tissue Damage and Pathology/Blood in July.

- The reported tissue damage incidents include present on admission from the community.

- There were no reported moderate harm or severe harm incidents relating to admission, discharge or transfer.

Actions and progress to date
- Monthly reports detailing the current position of investigations for all moderate, severe harm or death SLEs remain on-going.

<table>
<thead>
<tr>
<th>Month</th>
<th>Reported incidents at time of report</th>
<th>Confirmed incidents at time of report</th>
</tr>
</thead>
<tbody>
<tr>
<td>August 2017</td>
<td>1,659</td>
<td>417</td>
</tr>
<tr>
<td>July 2017</td>
<td>1,619</td>
<td>690</td>
</tr>
<tr>
<td>June 2017</td>
<td>1,641</td>
<td>933</td>
</tr>
</tbody>
</table>
Patient safety incidents (Contract)

- The ‘Total PHT reported Patient Safety Learning Events August 2015 – August 2017’ graph represents the total number of all patient safety incidents reported by Trust staff (including community incidents).

- There is a continued positive trend showing a sustained increase in the number of reported incidents.

- The second graph shows total confirmed incidents by severity for the period April 2017 – August 2017. Severity is coded by the reviewing manager at close of investigation.

- It should be noted that all incidents including SIRIs are graded on the severity of actual harm suffered by the patient.

Definitions of harm:

**Severe**: Any patient safety incident that appears to have resulted in permanent harm (directly related to the incident and not related to the natural course of the patient’s illness or underlying condition and defined as permanent lessening of bodily functions, sensory, motor, physiologic or intellectual, including removal of the wrong limb or organ, or brain damage) to one or more persons receiving NHS-funded care.

**Moderate**: Any patient safety incident that resulted in a moderate increase in treatment (defined as a return to surgery, an unplanned re-admission, a prolonged episode of care, extra time in hospital or as an outpatient, cancelling of treatment, or transfer to another area such as intensive care as a result of the incident) and which caused significant but not permanent harm, to one or more persons receiving NHS-funded care.

**Low**: Any patient safety incident that required extra observation or minor treatment (defined as first aid, additional therapy, or additional medication) and caused minimal harm, to one or more persons receiving NHS-funded care.
Coroner’s recommendations and CAS alerts (Contract)

August position

Coroners recommendations – Regulation 28 reports (preventing future deaths)
Target: Monitoring and reporting
- The Trust has received no Regulation 28 reports in August.

Central Alert System (CAS) Alerts over deadline
Target: Monitoring and reporting
- 18 alerts were issued in August:
  - 1 alert has been completed and closed on the CAS website.
  - 5 alerts are currently being assessed for relevance and have deadline dates as follows:
    - 2x end of September 2017.
    - 2x October 2017.
    - 1x December 2017.
  - 1 alert in relation to Anti-Barricade Devices remains open on the Central Alert website as actions are ongoing within the Trust. This alert has a deadline of February 2018.
  - 1 alert was received in relation to shortage of the Hepatitis B vaccine. This alert was for notification purposes only and has been forwarded to the Trust Medication Safety Officer. This alert has been closed on the Central Alert website.
  - 10 alerts were assessed for relevance to the Trust and subsequently closed as no actions were required.

- 2 Patient Safety Alerts remain outstanding for the Trust these had breach dates of:
  - 1 x June 2017 (‘Restricted use of open systems for injectable medication’. Deadline 07 June 2017).
  - 1 x July 2017 (‘Reducing the risk of oxygen tubing being connected to air flowmeters’. Deadline 04 July 2017).

The actions relating to these alerts are ongoing, the interim Patient Safety Lead for the Trust is working with the specialty leads to complete and close these alerts.

Actions and progress to date
- Implementation of the agreed actions resulting from the internal audit carried out in November 2016.
# National CQUIN Requirements 2017/2019

## August position

Summary of scheme status: **Green £6,552m, Amber - £72k** (£ full year value).

<table>
<thead>
<tr>
<th>CQUIN</th>
<th>Details</th>
<th>August 2017 (M5) Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>1a Staff Health &amp; Wellbeing (£828k - £72k risk)</td>
<td>• 5% point improvement in NHS annual staff survey questions on MSK and stress.</td>
<td><strong>Green</strong> - Internal action plan under way and on track - managed by Occupational Health. Some additional actions planned to raise staff awareness of facilities available to them prior to publication of the staff survey.</td>
</tr>
<tr>
<td>1b Healthy food (£828k - £72k risk)</td>
<td>• Reduction in display and sale of unhealthy foods for NHS staff, visitors and patients.</td>
<td><strong>Green</strong> – Trust controlled areas – action plan under way, Non Trust controlled areas remain a risk, but there is good engagement of site partners to assist. Managed by Dietetics Department</td>
</tr>
<tr>
<td>1c Staff Flu vaccinations (£828k - £72k risk)</td>
<td>• Improving the uptake of flu vaccinations for front line clinical staff.</td>
<td><strong>Green</strong> - Internal action plan under way and on track - managed by Occupational Health</td>
</tr>
<tr>
<td>2a/b Identification &amp; treatment of sepsis (£414k - £36k risk)</td>
<td>• Timely identification &amp; treatment of patients with sepsis in emergency departments and acute inpatient settings.</td>
<td><strong>Amber</strong> - Internal action plan under way and on track - managed by Nursing / Quality. Indicator 2b failed in Q1. Sepsis Group currently devising remedial action plan to regain performance. Q2 remains a risk.</td>
</tr>
<tr>
<td>2c/d Antibiotic consumption (£414k - £36k risk)</td>
<td>• Clinical antibiotic review of patients with sepsis. • Reduction in antibiotic consumption per 1,000 admissions.</td>
<td><strong>Amber</strong> - Dependent on agreement of Local Antibiotic Stewardship plan with CCG – discussion with CCG Quality Lead Clinician led by Medical Director. Managed by Infection Control Department.</td>
</tr>
<tr>
<td>4 Mental Health (£828k - £72k risk)</td>
<td>• Reduce regular attenders with mental health needs who present to A&amp;E.</td>
<td><strong>Green</strong> - Internal action plan under way and on track - managed by Emergency Department</td>
</tr>
<tr>
<td>6 Advice and guidance (£828k - £72k risk)</td>
<td>• To set up and operate A&amp;G services for non-urgent GP referrals.</td>
<td><strong>Green</strong> - Local Advice and Guidance plan agreed by CCG – managed by Alex Lister/ (Martin Fuller TBC).</td>
</tr>
<tr>
<td>7 e-Referrals (£828k - £72k risk)</td>
<td>• Expand e-Referrals to include all incoming referrals / specialties.</td>
<td><strong>Green</strong> - Local Advice and Guidance plan agreed by CCG – managed by Alex Lister/ (Martin Fuller TBC).</td>
</tr>
<tr>
<td>8 Supporting proactive and safe discharge (£828k - £72k risk)</td>
<td>• Increase proportion of emergencies discharged to usual place of residence within 7 days.</td>
<td><strong>Green</strong> - Local system collaboration and action plan agreed by CCG – discussion led and managed by Maria Purse (TBC)</td>
</tr>
</tbody>
</table>
Local and specialised CQUINs: used as an incentive to ensure providers of specialised services offer continuous improvement in line with best practice, benchmarked utilisation, appropriate care and quality indicators.

August position

Summary of scheme status: **Green £1,646k, Amber - £140k (£ full year value).**

<table>
<thead>
<tr>
<th>CQUIN</th>
<th>Details</th>
<th>August 2017 (M5) Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Specialised 1 (£327k): CA2 Standardised dose banding for Chemotherapy.</td>
<td>• Adoption of standardised doses for Chemotherapy to reduce production costs and safety incidents.</td>
<td><strong>Green</strong> - Plan agreed with NHSE • Actions under way to achieve, monitored and tracked internally.</td>
</tr>
<tr>
<td>Specialised 2 (£327k): CA3 Palliative care shared decision making.</td>
<td>• Ensure effective and documented peer discussion and patient involvement for patients with low response to treatment.</td>
<td><strong>Green</strong> - Plan agreed with NHSE • Trust-agreed actions under way to achieve, monitored and tracked internally.</td>
</tr>
<tr>
<td>Specialised 3 (£421k): GE1 CUR software evaluation project.</td>
<td>• Controlled 6-month evaluation of CUR bed utilisation system alongside Trust Bed View system.</td>
<td><strong>Green</strong> - Plan agreed with NHSE to complete 6 months data and review against other Trust system. • Q2 Staff risk mitigated. Other actions under way to achieve, monitored and tracked internally.</td>
</tr>
<tr>
<td>Specialised 4 (£327k): GE3 Medicines Optimisation.</td>
<td>• Adoption of best value medicines in Specialised patients, and additional reporting.</td>
<td><strong>Green</strong> - Some NHSE changes to plan under review • Actions under way to achieve, monitored and tracked internally.</td>
</tr>
<tr>
<td>Specialised 5 (£90k): Dental managed clinical networks.</td>
<td>• Attendance at Network meetings by clinical leads.</td>
<td><strong>Green</strong> - Plan agreed with NHSE • Actions under way, monitored internally using joint steering group plan.</td>
</tr>
<tr>
<td>Specialised 6 (£90k): Orthodontic outcome reporting.</td>
<td>• Recording of PAR scores pre/post treatment &amp; performance reporting / review of improvement.</td>
<td><strong>Green</strong> - Plan agreed with NHSE • Actions under way, monitored internally using agreed joint steering group plan.</td>
</tr>
<tr>
<td>Specialised 7 (£70k): Breast screening programme.</td>
<td>• Develop service improvement action plan with commissioners, and implement under agreed monitoring.</td>
<td><strong>Amber</strong> - Trust-agreed actions under way, internally monitored using proposed plan.</td>
</tr>
<tr>
<td>Specialised 8 (£70k): Bowel screening programme.</td>
<td>• Develop service improvement action plan with commissioners, and implement under agreed monitoring.</td>
<td><strong>Amber</strong> - Trust-agreed actions under way, internally monitored using proposed plan.</td>
</tr>
<tr>
<td>Specialised 9 (£64k): Armed Forces Covenant.</td>
<td>• Embedding the Armed Forces Covenant to improve access to elective services for Armed Forces Personnel.</td>
<td><strong>Green</strong> - Plan agreed with NHSE • Actions under way, monitored internally using agreed joint steering group plan.</td>
</tr>
</tbody>
</table>
Acute Kidney Injury (Contract & Quality Account)

August position

Acute Kidney Injury (AKI)

Target:
- 90% (on average each quarter) compliance with reporting the 4 mandated data sets on discharge summaries.
- Reduction in hospital acquired stage 3 AKI (reviewed 6 monthly) based on 2016/2017 data.

• The Trust achieved 93% compliance with the mandated items on the discharge summary in August, compared to 91% in July.

• The Trust is aiming to reduce the number of hospital acquired Stage 3 AKIs (AKI Alerts triggered ≥48 hours after admission); this will be reviewed in October by comparing AKI episodes recorded during the 2016/17 financial year.

Hospital Acquired AKI by Specialty August 2017

- To make it easier to assess the severity of the acute kidney injuries, they are categorised into 3 stages of alerts depending how much the persons creatinine has increased from their baseline level.
  - Stage 1 Alert: An increase in a persons creatinine that is 1.5 to 1.9 times higher than their baseline. This is often called a "mild AKI".
  - Stage 2 Alert: Same applies as for stage 1 but the increase for a stage 2 alert must be 2.0 to 2.9 times higher than the persons baseline. Stage 2 AKI are more detrimental to a persons health than a stage 1.
  - Stage 3 Alert: The increase for a stage 3 alert must be 3 times or more higher than the persons baseline. Stage 3 alerts are the most severe AKIs.
Mortality indicators: HSMR and SHMI (Contract and Quality Account)

August position

Hospital Standardised Mortality Ratio (HSMR)

Target: To be within expected range.

- The updated Trust HSMR for the 12 months to May 2017 is 111.3; representing a slight decrease on the rate previously reported to March 2017 of 111.8. This sits within a confidence interval of 106.4 – 116.34 and is significantly higher than expected.
- Both the weekday and weekend HSMR for emergency admissions have shown a decrease from the previously reported figure. The weekend / weekday split is based on the patient’s admission date.

Summary Hospital-level Mortality Indicator (SHMI)

Target: To be within expected range.

- There has been no update to the Trust SHMI and remains, for the period January to December 2016 at110.02; a slight decrease from the previous reported quarter’s figure of 110.96. Whilst this figure is above the National Average of 100, it is within the official control limits.

Actions

- The Clinical Effectiveness and Mortality Steering Group has been split, with a separate Mortality Review Group having been established. The factors contributing to the increases continue to be investigated through this group.
- Feedback from recent coding audits has shown there to be no inconsistencies or causes for concern.
- Work continues to establish whether HSMR includes the correct number of ‘expected’ deaths within its algorithm by investigating the coding of admission source, comorbidities, palliative care and how these are processed by Dr Foster.
- A coding change to PAS will ensure the correct admission source is recorded against all patients admitted from ED, circa 26,000 pa. These patients will now be graded against a higher (corrected) mortality threshold.
- Although this coding change will not be seen until the report published in November 2017, following a meeting with Imperial, work has commenced to model the change in 2017/18 with Dr Foster from manually correct information.
- A review of the delivery and recording of specialist palliative care across the Trust is to be conducted.

Definitions:

HSMR: The Hospital Standardised Mortality Ratio (HSMR) is an indicator of healthcare quality that measures whether the mortality rate at a hospital is higher or lower than expected. The national average is 100 and a score of below this indicates less deaths than this average. HSMR covers 56 groups of diagnosis and only relates to patients that have died whilst in hospital.

SHMI: The Summary Hospital-level Mortality Indicator (SHMI) is a high level mortality indicator that is published by the Department of Health on a quarterly basis. It follows a similar principal than HSMR, however SHMI covers all diagnosis groups and relates to all patients that have died (whether the patient died whilst in hospital or not). It does not take account of deprivation.

SHMI adjusted for palliative care: The variables used in the method to calculate the expected number of deaths differ between the SHMI and the HSMR, for example, the HSMR includes an adjustment for palliative care whereas the SHMI does not. An adjustment/allowance is made to the indicator ‘SHMI adjusted for palliative care’ to allow for the number of expected deaths where palliative care is coded.
Dementia (Contract)

August position

Step 1: Find, Assess, Investigate and refer*
Target: 90% on average over each quarter for the three steps.

- There has been a 5% increase in compliance with dementia screening in August to 75%, compared to 69.8% in July.
- A total of 439 patients have been assessed, from a maximum of 585 eligible patients; similar in the number of patients requiring assessment for the last 6 months.
- The concerns about the consistently low performance have been formally escalated to the Medical Director.
- Performance data is sent monthly to the Chiefs of Service to instigate actions to recover the position and the daily distribution lists for all outstanding assessments is cascaded wider across the clinical leadership teams.
- Compliance is discussed with each CSC at the monthly Executive Performance Reviews.
- There are initial discussions with IT to determine if screening could be included on the BedView System to aid compliance. This will take some time to build into the system.

Step 2: Diagnostic assessment*
Target: 90% on average over each quarter for the three steps.

- 100% of all eligible patients (89 in total) received a diagnostic assessment.

Step 3: Referred for further diagnostic advice*
Target: 90% on average over each quarter for the three steps.

- The Electronic Discharge Summary (EDS) includes a mandatory field to inform the GP of any patients who have had a positive diagnosis of dementia in order that the GP can complete further investigations if required. However, as EDS usage is currently variable across the CSCs, a spread sheet is kept of all patients who have a positive diagnosis of dementia to ensure a letter is generated and sent to the GP.

Dementia compliance

<table>
<thead>
<tr>
<th>Step 1</th>
<th>June 2017</th>
<th>July 2017</th>
<th>August 2017</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>75.9%</td>
<td>69.8%</td>
<td>75%</td>
</tr>
<tr>
<td>Step 2</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Step 3</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
</tbody>
</table>

* Definition of steps:
Step 1 – Case finding:
- The number of patients >75 admitted as an emergency who are reported as having a known diagnosis of dementia or clinical diagnosis of delirium, or who have been asked the dementia case finding question, excluding those for whom the case finding question cannot be completed for clinical reasons (e.g. coma).
Step 2 - Assessment:
- Number of above patients reported as having had a diagnostic assessment including investigations.
Step 3 – Onward referral – under development:
- Numbers of above patients who have a plan of care on discharge that is shared with general practice.
Mixed Sex Accommodation (National)

August position

Non-clinically justified single sex accommodation breaches

Target: 0 (zero)

- There have been 3 occasions of non-clinically justified mixed sex accommodation breaches affecting a total of 23 patients in August.
  - All 3 occasions were on the Respiratory High Care Unit (RHCU). Two breaches affected 8 patients, the remaining breach affected 7 patients; all were resolved within 24 hours.

- The Trust year-to-date position is 8 occasions of non-clinically justified single sex accommodation breaches affecting 62 patients. Therefore, a total of 62 breaches.

Clinically justified single sex accommodation breaches

Target: Monitoring and reporting

- There have been 0 (zero) clinically justified breaches in August.

- The Trust year-to-date total is 1 clinically justified single sex accommodation breaches.

Facilities single sex accommodation breaches

Target: Monitoring and reporting

- There have been 0 (zero) single sex accommodation breaches relating to facilities in August.

- The Trust year-to-date total is 0 (zero) single sex accommodation breaches relating to facilities.

Actions

- Ongoing meetings with RHCU and Cardiac Day Unit regarding use of screens and maintaining privacy and dignity for patients.

- Discharge lounge no longer used as escalation capacity.
Complaints (Contract and National)

August position
Target: Monitoring and reporting

- A total of 57 complaints were received in August, an increase from 45 received in July.
- The increase noted in the Emergency Medicine CSC relates to clinical treatment and admission/discharge.
- Reporting per 1,000 contacts is one month arrears; data for July equates to 0.52 compared to 0.53 in June.
- To date 9 complaints received in July have been responded to (9 within 30 working days) and 10 still remain on target.

Responsive - Complaints

**July 2017 UPDATE - Complaints**

<table>
<thead>
<tr>
<th>Category</th>
<th>2014/15</th>
<th>2015/16</th>
<th>2016/17</th>
<th>2017/18</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHAT</td>
<td>44</td>
<td>59</td>
<td>64</td>
<td>56</td>
</tr>
<tr>
<td>CSS</td>
<td>52</td>
<td>68</td>
<td>64</td>
<td>56</td>
</tr>
<tr>
<td>CORP</td>
<td>55</td>
<td>58</td>
<td>62</td>
<td>58</td>
</tr>
<tr>
<td>EMERGY</td>
<td>65</td>
<td>65</td>
<td>64</td>
<td>67</td>
</tr>
<tr>
<td>H&amp;N</td>
<td>59</td>
<td>56</td>
<td>56</td>
<td>60</td>
</tr>
<tr>
<td>MED</td>
<td>55</td>
<td>58</td>
<td>62</td>
<td>56</td>
</tr>
<tr>
<td>MOPRS</td>
<td>55</td>
<td>58</td>
<td>62</td>
<td>56</td>
</tr>
<tr>
<td>MSK</td>
<td>55</td>
<td>58</td>
<td>62</td>
<td>56</td>
</tr>
<tr>
<td>RENTRA</td>
<td>55</td>
<td>58</td>
<td>62</td>
<td>56</td>
</tr>
<tr>
<td>S&amp;C</td>
<td>55</td>
<td>58</td>
<td>62</td>
<td>56</td>
</tr>
<tr>
<td>W&amp;C</td>
<td>55</td>
<td>58</td>
<td>62</td>
<td>56</td>
</tr>
<tr>
<td>TOTAL</td>
<td>45</td>
<td>57</td>
<td>59</td>
<td>59</td>
</tr>
</tbody>
</table>

Complaints by Severity (Aug 2017)

<table>
<thead>
<tr>
<th>Category</th>
<th>2014/15</th>
<th>2015/16</th>
<th>2016/17</th>
<th>2017/18</th>
</tr>
</thead>
<tbody>
<tr>
<td>Major</td>
<td>6</td>
<td>10%</td>
<td>41</td>
<td>72%</td>
</tr>
<tr>
<td>Moderate</td>
<td>10</td>
<td>18%</td>
<td>32</td>
<td>58%</td>
</tr>
<tr>
<td>Negligible/Minor</td>
<td>26</td>
<td>58%</td>
<td>10</td>
<td>18%</td>
</tr>
</tbody>
</table>
Complaints (Contract and National)

August position
Complaint acknowledgment rate (national requirement)
Target: Monitoring and reporting
- 100% of complaints were acknowledged within the 3 working day target.

Parliamentary Health Service Ombudsman (PHSO) (National requirement)
Target: Monitoring and reporting
- The Trust received 2 new notifications from the PHSO.

Plaudits
Target: Monitoring and reporting
- The Trust received 514 messages of appreciation during August.

### Complaints Subjects - August 2017

<table>
<thead>
<tr>
<th>Subjects</th>
<th>Upheld</th>
<th>Part upheld</th>
<th>Not upheld</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACT</td>
<td>29</td>
<td>51%</td>
<td></td>
</tr>
<tr>
<td>ADT</td>
<td>8</td>
<td>14%</td>
<td></td>
</tr>
<tr>
<td>CPWO</td>
<td>3</td>
<td>5%</td>
<td></td>
</tr>
<tr>
<td>AOS</td>
<td>6</td>
<td>10%</td>
<td></td>
</tr>
<tr>
<td>PREMIS</td>
<td>1</td>
<td>2%</td>
<td></td>
</tr>
<tr>
<td>CONSENT</td>
<td>1</td>
<td>2%</td>
<td></td>
</tr>
<tr>
<td>AIDS</td>
<td>2</td>
<td>2%</td>
<td></td>
</tr>
<tr>
<td>TESTS</td>
<td>1</td>
<td>2%</td>
<td></td>
</tr>
<tr>
<td>EOLC</td>
<td>2</td>
<td>3%</td>
<td></td>
</tr>
<tr>
<td>APDELO</td>
<td>3</td>
<td>5%</td>
<td></td>
</tr>
<tr>
<td>SHORT</td>
<td>1</td>
<td>2%</td>
<td></td>
</tr>
<tr>
<td>PROP</td>
<td>1</td>
<td>2%</td>
<td></td>
</tr>
</tbody>
</table>

### Complaints by Subject (Aug 2017)

- **ACT**: Aspects of clinical treatment (29, 51%)
- **ADT**: Admission, discharge & transfer (8, 14%)
- **CPWO**: Communication (3, 5%)
- **AOS**: Attitude of staff (6, 10%)
- **PREMIS**: Premises/Environment (1, 2%)
- **CONSENT**: Consent to treatment (1, 2%)
- **AIDS**: Aids and appliances (2, 2%)
- **TESTS**: Test results (1, 2%)
- **EOLC**: End of Life Care (2, 3%)
- **APDELO**: O/P Delays and cancellations (3, 5%)
- **SHORT**: Shortages of staff (1, 2%)
- **PROP**: Property and expenses (1, 2%)

### Responsive - Complaints

<table>
<thead>
<tr>
<th>Year</th>
<th>Total rec’d</th>
<th>Under review</th>
<th>Upheld</th>
<th>Part upheld</th>
<th>Not upheld</th>
</tr>
</thead>
<tbody>
<tr>
<td>2014-15</td>
<td>16</td>
<td>0</td>
<td>3</td>
<td>9</td>
<td>4</td>
</tr>
<tr>
<td>2015-16</td>
<td>14</td>
<td>0</td>
<td>0</td>
<td>2</td>
<td>12</td>
</tr>
<tr>
<td>2016-17</td>
<td>13</td>
<td>3</td>
<td>0</td>
<td>2</td>
<td>8</td>
</tr>
<tr>
<td>2017-18</td>
<td>9</td>
<td>8</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
</tbody>
</table>
Complaints, PALS (Contract)

August position

PALS contacts
Target: Monitoring and reporting
• 405 contacts were handled by PALS in August, an increase from 388 in July.

Types of contacts (concerns)
• 137 contacts involved concerns about care and treatment. 84% of all contacts were resolved within 5 working days.

Types of contacts (other)
• 268 of contacts related to providing signposting or advice to visitors and support to the Overseas Patient Service and Health Information.

PALS conversion to complaints
Target: Monitoring and reporting
• 2 cases were converted to a formal complaint.

Trust-wide themes
• Common themes through complaints and PALS include poor communication, co-ordination of treatment and delays and cancellations for outpatient appointments (Ophthalmology, Fracture Clinic, Respiratory).

<table>
<thead>
<tr>
<th>August - Trust wide themes</th>
<th>Complaints</th>
<th>PALS</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aspects of Clinical Treatment</td>
<td>29</td>
<td>37</td>
<td>66</td>
</tr>
<tr>
<td>Outpatient Delays &amp; Cancellations</td>
<td>3</td>
<td>35</td>
<td>38</td>
</tr>
<tr>
<td>Communication</td>
<td>3</td>
<td>18</td>
<td>21</td>
</tr>
<tr>
<td>Attitude of staff</td>
<td>6</td>
<td>14</td>
<td>20</td>
</tr>
<tr>
<td>Admission, discharge &amp; transfer</td>
<td>8</td>
<td>4</td>
<td>12</td>
</tr>
</tbody>
</table>
Responsive – Patient Moves

Patient Moves and Outliers

August position
Target: <3 non-clinical moves after 2100

- Although there has been a reduction in the number of patients moved, the non-achievement of the Medically Fit for Discharge (MFFD) backlog reduction across the whole health and social care system continues to necessitate the process of outlying to create acute bed capacity. As of 28th August the position is 136 patients behind trajectory. Weekly Executive to Executive meetings with system partners are taking place to review contingency plans.

- As MFFD patient numbers have not reduced, the plan to reduce escalation capacity has not been delivered to the planned level. This has caused difficulties in terms of finding staff and the cost of opening the capacity.

- From August the Trust has re-assigned the buddy ward cover for Medicine and MOPRS and has allocated some Surgical capacity to Medicine (Ward D7, 18 beds). This has reduced the number of moves; however Bedview has not been changed meaning the outlier position for Medicine is currently overstated by 18. By having dedicated medical beds on D7 patients are covered by a medical base ward team which avoids patient moves and gives medicine more capacity.

<table>
<thead>
<tr>
<th>Patient moves</th>
<th>Medical patient outliers</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Month</strong></td>
<td><strong>2100 - 0000</strong></td>
</tr>
<tr>
<td></td>
<td>No.</td>
</tr>
<tr>
<td>Aug. ‘17</td>
<td>158</td>
</tr>
<tr>
<td>July ‘17</td>
<td>174</td>
</tr>
<tr>
<td>June ‘17</td>
<td>235</td>
</tr>
<tr>
<td>May ‘17</td>
<td>201</td>
</tr>
<tr>
<td>April ‘17</td>
<td>230</td>
</tr>
</tbody>
</table>
Friends and Family Test (FFT) (National)

This month there were 1,214,528 responses to the Friends and Family Test. The following numbers show the proportion of responses that would recommend or not recommend these services to a friend or family member.*

- **Inpatient and day cases**: 96% recommend, 2% not recommend.
- **A&E, walk-in centres and minor injury units**: 86% recommend, 8% not recommend.
- **Outpatients**: 94% recommend, 3% not recommend.
- **Ambulance (including patient transport)**: 89% recommend, 5% not recommend.
- **Maternity (Birth)**: 96% recommend, 1% not recommend.

**Emergency Department**: 95.3% recommend, 1.7% not recommend.

**Outpatient Departments**: 94% recommend, 1.3% not recommend.

**Maternity Services**: 99.5% recommend, 0.5% not recommend.
Friends and Family Test (FFT): Increasing response rate in In-patient areas and ED (National)

**August position**

Target: Inpatient response rate target to be similar or above national average but not fall below 15%. ED response rate target to be 15% or statistically significant response rate

- The In-patient response rate has decreased slightly to 30.3% in August, but remains significantly above the national average of 25.6% (July data).
- The Emergency Departments response rate increased slightly from 11.3% to 11.7% in August, but to note 200 more responses were received.
- The Emergency Department response rate has increased incrementally for the last 3 months from 9.1% – 11.7%; however, the rate remains below the national average of 12.8% (July data) and the contractual requirement of 15%.
- Increased scrutiny of return numbers and escalation is being extended.
- As part of the FFT contract provider review, additional opportunities for providing feedback (including text messaging and the provision of fixed kiosks) are being considered.

**Outpatient Department (OPD)**

- There was an decrease in the number of responses seen in August, with the positive response rate remaining consistent at 94%.

**Actions and progress to date**

- Overall review and refresh via clinical leaders for all services.
- Delivery of focused support to day case areas.
Friends and Family Test Improving positive responses in ED, In-patient areas and maternity

**August position**

**Improving positive responses**

**Emergency Department:**
- The reported satisfaction rate has increased to 95.3%. The Trust continues to exceed the national benchmark of 86% in July.
- The number of patients who would not recommend the Emergency Department has decreased to 1.7% in August. This remains significantly better than the national average of 8% in July.

**In-patient areas:**
- The reported satisfaction rate remained comparable with July at 96.9%. This is above the national average of 96% in July.
- The number of patients who would not recommend In-patient areas has also remained constant at 0.6%. This is below the national average of 2% in July.

**Maternity:**
- The number of patients who would recommend Maternity has increased to 99.5%. This remains consistently high against the national benchmark of 96%.
- The percentage not recommend will continue to be monitored.

---

### Emergency Department - Improving positive responses

<table>
<thead>
<tr>
<th>Month</th>
<th>% recommend (positive)</th>
<th>% not recommend (negative)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Trust</td>
<td>National average</td>
</tr>
<tr>
<td>August ’17</td>
<td>95.3%</td>
<td>-</td>
</tr>
<tr>
<td>July ’17</td>
<td>94.7%</td>
<td>86%</td>
</tr>
<tr>
<td>June ’17</td>
<td>94.6%</td>
<td>87%</td>
</tr>
</tbody>
</table>

### In-patient - Improving positive responses

<table>
<thead>
<tr>
<th>Month</th>
<th>% recommend (positive)</th>
<th>% not recommend (negative)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Trust</td>
<td>National average</td>
</tr>
<tr>
<td>August ’17</td>
<td>96.9%</td>
<td>-</td>
</tr>
<tr>
<td>July ’17</td>
<td>96.7%</td>
<td>96%</td>
</tr>
<tr>
<td>June ’17</td>
<td>96.3%</td>
<td>96%</td>
</tr>
</tbody>
</table>

### Maternity - Improving positive responses

<table>
<thead>
<tr>
<th>Month</th>
<th>% recommend (positive)</th>
<th>% not recommend (negative)</th>
</tr>
</thead>
<tbody>
<tr>
<td>August ’17</td>
<td>99.5%</td>
<td>0.5%</td>
</tr>
<tr>
<td>July ’17</td>
<td>98.6%</td>
<td>1.4%</td>
</tr>
<tr>
<td>June ’17</td>
<td>97.1%</td>
<td>0.7%</td>
</tr>
</tbody>
</table>
Friends and Family Test – Maternity (National)

August position
Target: Response rate for question 2 to be similar or above the national average but not fall below 15%.

• Women are asked to complete a Friends and Family form at four points of contact and respond to four specific questions.
• The national benchmark and; therefore, contract requirement is based on question 2. The response rate has slightly increased to 22.1% from 21.5% in July. The rate is above the National Average of 15% and remains consistently high in comparison to national average.

Actions and progress to date:
• Maternity Services will relaunch the completion of the forms to increase the overall response rate which has reduced to 12.9% in August. This will be actioned through safety huddles and ward leads.

Response themes: The majority of responses are positive.

Positive comments:
Very caring attentive staff. I have had an amazing experience with the care I have received. Staff have acted with kindness in everything they do. All of the team were excellent. Nothing could be improved, the care was flawless. We received excellent care from starting in induction room, right through to being discharged from the labour ward. Every member of staff were friendly supportive and professional at all times.

Negative comments:
• There was a difference in opinion amongst the staff when it came to breast feeding advice and support - This has been feedback to the Infant Feeding Specialist who will update ward staff and support with any training needs.
# Performance Against NHSi Accountability Framework August 2017

## Responsive – Operational Overview

<table>
<thead>
<tr>
<th>National Trust Development Agency Key Indicators</th>
<th>Target</th>
<th>Trend</th>
<th>16/17</th>
<th>Change from last nth</th>
</tr>
</thead>
<tbody>
<tr>
<td>% Incomplete Pathways &lt; 18 wks</td>
<td>92%</td>
<td></td>
<td>89.6% 98.9% 88.9% 88.9% 88.2% 89.1% 90.5% 91.3%</td>
<td>↑ 90.4% 91.4% 91.5% 91.5% 91.1%</td>
</tr>
<tr>
<td>Incomplete Patients waiting &gt; 52 wks</td>
<td>0</td>
<td></td>
<td>0 0 1 1 2 2 0</td>
<td></td>
</tr>
<tr>
<td>Incomplete Patients waiting &gt; 40 wks</td>
<td>0</td>
<td></td>
<td>31 24 29 45 72 65 56 52</td>
<td></td>
</tr>
<tr>
<td>Diagnostic waits: 6 weeks</td>
<td>99%</td>
<td></td>
<td>98.8% 99.0% 99.1% 99.1% 98.9% 98.4% 99.0% 99.1%</td>
<td>↑ 99.0% 99.2% 99.1% 93.1% 98.0%</td>
</tr>
<tr>
<td>Endoscopy waits: 6 weeks</td>
<td>99%</td>
<td></td>
<td>97.7% 97.7% 97.8% 97.3% 98.4% 90.5% 97.0% 97.1%</td>
<td>↑ 97.2% 90.2% 97.5% 98.0% 97.1%</td>
</tr>
<tr>
<td>4 hr arrival to admission/transfer/discharge</td>
<td>95%</td>
<td></td>
<td>81.8% 80.3% 75.9% 75.3% 73.0% 73.7% 75.3% 78.1%</td>
<td>↓ 79.1% 75.0% 81.6% 78.6% 74.0%</td>
</tr>
<tr>
<td>12 hr Trolley waits</td>
<td>0</td>
<td></td>
<td>0 0 0 1 0 0 0 0 44 88 95</td>
<td>↓ 58 38 9 0 5</td>
</tr>
<tr>
<td>All 2-week wait referrals</td>
<td>93%</td>
<td></td>
<td>96.8% 96.9% 97.0% 97.5% 97.4% 96.8% 97.6% 96.7%</td>
<td>↑ 96.8% 96.9% 97.4% 97.0% 97.9%</td>
</tr>
<tr>
<td>Breast symptomatic: 2-week wait referrals</td>
<td>93%</td>
<td></td>
<td>95.2% 97.5% 97.9% 97.2% 94.3% 97.3% 95.0% 94.7%</td>
<td>↑ 95.9% 97.4% 94.8% 97.2% 93.2%</td>
</tr>
<tr>
<td>31-day diagnosis to treatment</td>
<td>96%</td>
<td></td>
<td>98.3% 98.6% 98.2% 96.5% 98.1% 98.6% 98.8% 99.7%</td>
<td>↓ 98.6% 99.0% 99.4% 98.2% 96.1%</td>
</tr>
<tr>
<td>31-day subsequent cancers to treatment</td>
<td>94%</td>
<td></td>
<td>91.0% 93.4% 92.6% 88.3% 96.0% 95.6% 89.1% 98.6%</td>
<td>↓ 93.0% 98.2% 100% 96.9% 100%</td>
</tr>
<tr>
<td>31-day subsequent anti-cancer drugs</td>
<td>98%</td>
<td></td>
<td>100% 100% 100% 100% 100% 100% 100% 100%</td>
<td></td>
</tr>
<tr>
<td>31-day subsequent radiotherapy</td>
<td>94%</td>
<td></td>
<td>97.1% 97.6% 97.6% 97.6% 98.7% 98.8% 98.0% 99.4%</td>
<td>↑ 100% 98.8% 97.5% 99.0% 35.6%</td>
</tr>
<tr>
<td>62-day referral to treatment</td>
<td>85%</td>
<td></td>
<td>84.0% 85.1% 85.0% 83.5% 82.3% 86.4% 84.8% 86.1%</td>
<td>↓ 86.5% 88.1% 82.0% 79.7% 77.0%</td>
</tr>
<tr>
<td>62-day screening to treatment</td>
<td>90%</td>
<td></td>
<td>75.7% 93.6% 100% 84.2% 100% 88.1% 70.8% 100%</td>
<td>↓ 94.1% 84.8% 90.5% 71% 93.9%</td>
</tr>
<tr>
<td>Cancer maximum wait to treatment 104 days</td>
<td>0</td>
<td></td>
<td>8 6 4 7 7 2 4 6</td>
<td></td>
</tr>
<tr>
<td>Canceled urgent operations</td>
<td>0</td>
<td></td>
<td>0 0 0 0 0 0 0 0</td>
<td></td>
</tr>
<tr>
<td>Urgent Operations cancelled for 2nd time</td>
<td>0</td>
<td></td>
<td>0 0 0 0 0 0 0 0</td>
<td></td>
</tr>
<tr>
<td>Canceled operations: 28-day time</td>
<td>0</td>
<td></td>
<td>1 0 0 0 0 1 0 4</td>
<td>↓ 0 0 0 0 0 0 0 0</td>
</tr>
<tr>
<td>Total bed days blocked</td>
<td>N/A</td>
<td></td>
<td>1888 1530 2680 1828 1673 1614 1661 2002</td>
<td>↓ 1868 2358 2294 2089</td>
</tr>
<tr>
<td>Delayed Transfers of Care</td>
<td>3.5%</td>
<td></td>
<td>6.2% 5.8% 9.0% 6.9% 4.9% 5.1% 6.3% 6.5%</td>
<td>↓ 6.9% 8.7% 8.0% 10.4% 9.0%</td>
</tr>
<tr>
<td>30 days emergency readmissions</td>
<td>N/A</td>
<td></td>
<td>6.6% 6.9% 6.5% 6.6% 7.2% 6.9% 6.5% 6.7%</td>
<td>↓ 7.3% 6.4% 6.7% 0.0%</td>
</tr>
</tbody>
</table>
# RTT & Cancer Forecast August and September

## Cancer, Incomplete and Diagnostic Standards Forecast for August & September updated 11/09/17

<table>
<thead>
<tr>
<th>Cancer Standards</th>
<th>Target</th>
<th>Improvement Trajectory</th>
<th>August current</th>
<th>August Forecast</th>
<th>Improvement Trajectory</th>
<th>September current</th>
<th>September Forecast</th>
</tr>
</thead>
<tbody>
<tr>
<td>2 week wait</td>
<td>93%</td>
<td>n/a</td>
<td>97.9%</td>
<td>Currently achieving standard</td>
<td>n/a</td>
<td>94.8%</td>
<td>Currently achieving standard</td>
</tr>
<tr>
<td>2 week wait Breast Symptomatic</td>
<td>93%</td>
<td>n/a</td>
<td>93.2%</td>
<td>Currently achieving standard</td>
<td>n/a</td>
<td>100.0%</td>
<td>Currently achieving standard</td>
</tr>
<tr>
<td>31 day FDT</td>
<td>96%</td>
<td>n/a</td>
<td>96.1%</td>
<td>Currently achieving standard</td>
<td>n/a</td>
<td>90.5%</td>
<td>95 treatments 9 breaches, (average treatments 280 tolerance 11 breaches) potential to recover when all treatments recorded and validated</td>
</tr>
<tr>
<td>31 day Subsequent Chemotherapy</td>
<td>98%</td>
<td>n/a</td>
<td>100%</td>
<td>Currently achieving standard</td>
<td>n/a</td>
<td>100%</td>
<td>Currently achieving standard</td>
</tr>
<tr>
<td>31 day subsequent surgery</td>
<td>94%</td>
<td>n/a</td>
<td>100%</td>
<td>Currently achieving standard</td>
<td>n/a</td>
<td>90.6%</td>
<td>32 treatments 3 breaches, (average treatments 60 tolerance 4 breaches) potential to recover when all treatments recorded and validated</td>
</tr>
<tr>
<td>62 day FDT</td>
<td>85%</td>
<td>85.1%</td>
<td>77.0%</td>
<td>128 treatments 23.5 breaches, (average treatments 125 tolerance 19 breaches) potential to improve when all treatments recorded and validated . high risk given volume of breaches already forecast</td>
<td>85.1%</td>
<td>61.0%</td>
<td>41 treatments 16 breaches, (average treatments 125 tolerance 19 breaches) potential to improve when all treatments recorded and validated . all tumour sites have been asked to target treatment of breaches</td>
</tr>
<tr>
<td>62 day screening</td>
<td>90%</td>
<td>n/a</td>
<td>93.9%</td>
<td>Currently achieving standard</td>
<td>n/a</td>
<td>75.0%</td>
<td>8 treatments 2 breaches, (average treatments 60 tolerance 4 breaches) potential to recover when all treatments recorded and validated</td>
</tr>
<tr>
<td>31 day subsequent radiotherapy</td>
<td>94%</td>
<td>n/a</td>
<td>95.8%</td>
<td>Currently achieving standard</td>
<td>n/a</td>
<td>94.7%</td>
<td>Currently achieving standard</td>
</tr>
<tr>
<td>104 day maximum wait</td>
<td>0</td>
<td>n/a</td>
<td>13</td>
<td>validation on-going (9.5 attributable to trust)</td>
<td>n/a</td>
<td>validation on-going</td>
<td>validation on-going</td>
</tr>
<tr>
<td>62 day consultant upgrade</td>
<td>86%*</td>
<td>n/a</td>
<td>no applicable patients</td>
<td>no applicable patients</td>
<td>n/a</td>
<td>no applicable patients</td>
<td>no applicable patients</td>
</tr>
</tbody>
</table>

## Cancer Submission Deadlines

<table>
<thead>
<tr>
<th>RTT &amp; Diagnostic Standards</th>
<th>Target</th>
<th>Improvement Trajectory</th>
<th>August current</th>
<th>August Forecast</th>
<th>Improvement Trajectory</th>
<th>September current</th>
<th>September Forecast</th>
</tr>
</thead>
<tbody>
<tr>
<td>RTT Incomplete Standard</td>
<td>92%</td>
<td>92.1%</td>
<td>91.09%</td>
<td>validation on-going</td>
<td>92.1%</td>
<td>90.8%</td>
<td>treatment and validation on-going</td>
</tr>
<tr>
<td>RTT 62 wk. maximum wait</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>No breaches of the standard forecast</td>
<td>0</td>
<td>0</td>
<td>No breaches of the standard forecast</td>
</tr>
<tr>
<td>Diagnostic 6 wk. Standard</td>
<td>99%</td>
<td>99.1%</td>
<td>98.0%</td>
<td>main contributors non-obstetric ultrasound 45, CT 40 and MRI 12 breaches</td>
<td>99.1%</td>
<td>95.4%</td>
<td>includes 140 echo breaches and capacity has been approved to undertake in month</td>
</tr>
</tbody>
</table>

Responsive – Operational Overview

August final submission date 5th October

September final submission date 5th November
<table>
<thead>
<tr>
<th>Unscheduled Care Key Indicators</th>
<th>Target</th>
<th>Trend</th>
<th>16/17</th>
<th>17/18</th>
<th>Change from last mth</th>
</tr>
</thead>
<tbody>
<tr>
<td>4 hr arrival to admission/transfer/discharge</td>
<td>96%</td>
<td>0%</td>
<td>A 18%</td>
<td>A 16%</td>
<td>↓</td>
</tr>
<tr>
<td>12 hr Trolley waits</td>
<td>0</td>
<td>0%</td>
<td>A 6%</td>
<td>B 8%</td>
<td>↓</td>
</tr>
<tr>
<td>Patients triaged within 15 mins</td>
<td>66%</td>
<td>0%</td>
<td>A 6%</td>
<td>B 6%</td>
<td>↑</td>
</tr>
<tr>
<td>Patients seen by doctor within 60 mins</td>
<td>46%</td>
<td>0%</td>
<td>A 6%</td>
<td>B 6%</td>
<td>↑</td>
</tr>
<tr>
<td>Ambulance delays &gt; 30 mins</td>
<td>0</td>
<td>0%</td>
<td>A 4%</td>
<td>B 4%</td>
<td>↑</td>
</tr>
<tr>
<td>Ambulance delays &gt; 60 mins</td>
<td>0</td>
<td>0%</td>
<td>A 2%</td>
<td>B 2%</td>
<td>↑</td>
</tr>
<tr>
<td>Arrival to DTA &lt; 2.5 hrs</td>
<td>45%</td>
<td>0%</td>
<td>A 6%</td>
<td>B 6%</td>
<td>↓</td>
</tr>
<tr>
<td>Total bed days blocked</td>
<td>N/A</td>
<td>0%</td>
<td>A 6%</td>
<td>B 6%</td>
<td>↑</td>
</tr>
<tr>
<td>Delayed Transfers of Care</td>
<td>3.5%</td>
<td>0%</td>
<td>A 6%</td>
<td>B 6%</td>
<td>↓</td>
</tr>
<tr>
<td>Medically Fit for Discharge (average / mth)</td>
<td>219</td>
<td>214</td>
<td>A 219</td>
<td>B 215</td>
<td>↑</td>
</tr>
<tr>
<td>30 days emergency readmissions</td>
<td>N/A</td>
<td>0%</td>
<td>A 7%</td>
<td>B 7%</td>
<td>↑</td>
</tr>
<tr>
<td>% of Medical take seen in AEC</td>
<td>33%</td>
<td>0%</td>
<td>A 7%</td>
<td>B 7%</td>
<td>↑</td>
</tr>
<tr>
<td>AMU Bed Occupancy</td>
<td>97%</td>
<td>0%</td>
<td>A 97%</td>
<td>B 97%</td>
<td>↓</td>
</tr>
<tr>
<td>Number of patients on AMU over 24 hours LOS</td>
<td>38.6%</td>
<td>0%</td>
<td>A 38%</td>
<td>B 38%</td>
<td>↑</td>
</tr>
<tr>
<td>FIT Reduction in conversion rate - &gt; 75yrs</td>
<td>67%</td>
<td>0%</td>
<td>A 67%</td>
<td>B 67%</td>
<td>↑</td>
</tr>
<tr>
<td>% of Patients with EDD</td>
<td>96%</td>
<td>0%</td>
<td>A 96%</td>
<td>B 96%</td>
<td>↓</td>
</tr>
<tr>
<td>% of discharges pre 12.00</td>
<td>33%</td>
<td>0%</td>
<td>A 33%</td>
<td>B 33%</td>
<td>↓</td>
</tr>
<tr>
<td>Achievement of weekday discharge target</td>
<td>100%</td>
<td>0%</td>
<td>A 100%</td>
<td>B 100%</td>
<td>↓</td>
</tr>
<tr>
<td>Achievement of weekend discharge target</td>
<td>100%</td>
<td>0%</td>
<td>A 100%</td>
<td>B 100%</td>
<td>↓</td>
</tr>
</tbody>
</table>
August performance against the 4-hour A&E and 12 hr Trolley Wait standards.
- 4 hr standard performance was 73.95% (78.61% last month)
- There were 5 breaches of the 12 hr Trolley Wait Standard.
- Graph 2 shows daily A&E performance for August

Contributing factors
- QA type 1 attendances 302 per day and consistent with August last year. The conversion rate to admission increased to 31% (30.2% last month)
- The Trust treated 4,477 emergency patients (an average of 144 per day compared to 147 per day last August).
- Bed occupancy was 96% (maximum of 99.2%)
- Delayed transfers of care were 9%
- There were an average of 246 patients medically fit for discharge compared to 219 last August.

Actions and progress to date
- Focus on medically fit for discharge patients at system wide weekly executive led meetings to drive down numbers.
Exception Report: Referral to Treatment (RTT)

August Performance against Incomplete RTT standard

- Performance 91.13% (standard & improvement trajectory 92%)
- Total number of patients waiting increased to 30,676
- Numbers waiting more than 18 weeks reduced by 248 to 2,720
- 3 more patients waiting more than 35 wks.
- No breaches of the 52 wk. maximum wait standard.

Contributing factors

- General surgery, Urology and orthopaedics performance improved and better than trajectory.
- Gastroenterology and cardiology positions worsened.
- Gastroenterology due to both correction of pathways and focus on clinical validation of planned patients with an underlying capacity shortfall.
- Cardiology position deteriorated due to clinical shortfall affecting outpatient clinics, options to address this are being progressed.

Actions, progress to date and risks

- Gastroenterology recovery plan is being reviewed and strengthened. Limited operation of endoscopy at Gosport has provided some additional capacity.
- ‘Critical Friend’ support from NHS improvement has been arranged and work programme has commenced.
- Improvements to diagnostic reporting waits in radiology delivered through outsourcing and additional clinical sessions.
- Cardiology refurbishment of catheter labs leading to increased demand for cardiac CT which is greater than capacity. Continued use of cardiac day unit overnight limits effective use of functioning laboratory.
- Financial cost of outsourcing and waiting list initiatives, all are being reviewed with a view to reducing and managing patients within the Trust.
Patients waiting longer than clinically determined date to be seen for an outpatient follow-up

Continued reduction in the number of patients waiting more than 4 months past clinically appropriate date to be seen (6,731 a reduction of 847 since May)

11 patient waiting more than 2 yrs to be seen – clinical validation being undertaken and patient will be appointed if clinically required.

Contributing factors

- Capacity constraints and the need to balance this between new, urgent and cancer patients as well as patients who have had treatment or who require further monitoring.
- Changing clinical management of frequency of review of patients not consistently applied to existing patients, e.g. extending to 1yr, 2yr 5yr review
- Patient compliance (cancellation and DNA)
- Administrative shortfall has meant that validation routines have not been rigorously applied.

Actions, progress to date and minimising risk of harm

- Clinical harm review process has been developed supported by NHSI and has commenced.
- NHSI undertaking a review of gastroenterology pathways and processes against best practice guidance.

Gastroenterology

- 581 patients have been clinically validated (in addition to administrative validation)
- 145 patients (25%) have been discharged
- 306 (53%) review frequency extended as per best practice guidance
- 33 patients have been booked to urgent appointments

August snapshot: Planned Outpatients waiting longer than clinically appropriate date to be seen (key specialties & total trust)

<table>
<thead>
<tr>
<th>Speciality</th>
<th>&gt; 2 yrs</th>
<th>&gt; 1 yr</th>
<th>&gt; 7 months</th>
<th>&gt; 4 months</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gastroenterology</td>
<td>10</td>
<td>808</td>
<td>773</td>
<td>872</td>
</tr>
<tr>
<td>Cardiology</td>
<td>0</td>
<td>0</td>
<td>66</td>
<td>166</td>
</tr>
<tr>
<td>Urology</td>
<td>0</td>
<td>0</td>
<td>35</td>
<td>231</td>
</tr>
<tr>
<td>Ophthalmology</td>
<td>0</td>
<td>2</td>
<td>395</td>
<td>864</td>
</tr>
<tr>
<td>Total Trust</td>
<td>11</td>
<td>966</td>
<td>1868</td>
<td>3886</td>
</tr>
</tbody>
</table>
**Exception Report: Diagnostic 6 wk. referral to test standard**

**August performance against the 6 wk. diagnostic standard**

Trust performance was 98% against the 99% diagnostic standard and improvement trajectory of 99.1%. There were 121 breaches of the standard.

**Contributing factors**

- Only 4 of the breaches were due to the delayed reporting of audiology referrals as all other remaining patients have now been seen.
- Capacity shortfall for Non-obstetric ultrasound (45 breaches) CT (40 breaches) and MRI (12 breaches) compounded by cancellation of outpatient diagnostics focus on inpatient emergency diagnostics to support flow through the hospital as this was at the end of the month the patients could not all be rebooked before month end.

**Actions and progress to date**

- Continued detailed management of patients to reduce risk of month end breaches, supplemented by additional clinical capacity and outsourcing of diagnostics and reporting where appropriate.
- Audiology remaining patients have now been seen.
- Clinical support Services are developing a recovery plan and improvement trajectory to move back to sustainable delivery of the standard before end of September

**Risks**

- Continued reliance on locum capacity to fill clinical gaps and therefore unstable and unsecure workforce.
- Financial impact of use of locums and national clinical shortfall leading to inability to recruit substantively.
- Histological clinical shortfall and inability to recruit substantively, with medium term planned sickness leading to reporting delays.
- Demand greater than capacity for non-obstetric ultrasound and cardiac CT means performance continues to be a risk.
- Cancellation of outpatient diagnostics to progress discharge of emergency inpatients.
Exception Report: Cancelled Operations 28 day Guarantee

August Performance Cancelled Operations 28 day Guarantee

- There were 4 urgent operations cancelled in August all patients have now been treated, and none of these patients were cancelled for a second time.
- 2 were due to list over-runs in general surgery and orthopaedics, 1 cardiology due to bed availability, and 1 gynaecology due to availability of clinical information. All patients have now been treated.
- There were no breaches of the 28 day zero tolerance standard.
- 60 patients in total were cancelled on the day for non-clinical reasons in August. Of these 48% were due to bed availability and 20% due to clinical staff availability.

Contributing factors

- Careful management of the elective programme reduced the number of patients cancelled on the day.
- The Trust declare an internal incident at the end of August which increased the number of cancellations due to bed availability.

Actions, progress to date and risks

- Patients previously cancelled and subject to the 28 day standard are monitored at the weekly assurance meeting.
- All patients with new dates close to breach date have contingency plans in place to reduce risk of a second cancellation.
### Exception report: Cancer Standards (provisional position)

<table>
<thead>
<tr>
<th>August '17</th>
<th>2 week wait</th>
<th>31 day FDT</th>
<th>31 day Subsequent Chemotherapy</th>
<th>31 day subsequent surgery</th>
<th>62 day FDT</th>
<th>62 day screening</th>
<th>2 week wait Breast Symptomatic</th>
<th>31 day subsequent radiotherapy</th>
<th>62 day consultant upgrade</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Target</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Breast</td>
<td>93%</td>
<td>96%</td>
<td>98%</td>
<td>94%</td>
<td>85%</td>
<td>90%</td>
<td>93%</td>
<td>94%</td>
<td>88%</td>
</tr>
<tr>
<td>Breast symptomatic</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>93.2%</td>
<td></td>
</tr>
<tr>
<td>Dermatology</td>
<td>97.7%</td>
<td>98%</td>
<td>100%</td>
<td>100%</td>
<td>92.3%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gynaecology</td>
<td>97.1%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>83.3%</td>
<td>100%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Haematology</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td></td>
<td>72.7%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Head &amp; Neck</td>
<td>96.5%</td>
<td>100%</td>
<td>100%</td>
<td></td>
<td>80.0%</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Lower GI</td>
<td>97.4%</td>
<td>100%</td>
<td>100%</td>
<td></td>
<td>59.3%</td>
<td>60.0%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>100%</td>
<td>100.0%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Respiratory</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td></td>
<td>88.8%</td>
<td></td>
<td></td>
<td></td>
<td>100%</td>
</tr>
<tr>
<td>Sarcomas</td>
<td>86.4%</td>
<td>100%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Upper GI</td>
<td>98.0%</td>
<td>100%</td>
<td>100%</td>
<td></td>
<td>77.3%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Urology</td>
<td>99.5%</td>
<td>83.3%</td>
<td>100%</td>
<td></td>
<td>59.3%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total Trust</strong></td>
<td>97.9%</td>
<td>96.1%</td>
<td>100%</td>
<td>100%</td>
<td>77.0%</td>
<td>93.9%</td>
<td>93.2%</td>
<td>95.8%</td>
<td></td>
</tr>
</tbody>
</table>

**August provisional performance against national cancer standards and contributing factors** (national reporting deadline 3rd October 2017 performance subject to change including additional shared breaches until submission deadline)

- The Trust is currently forecasting achievement 7 of the 8 key national standards, provisionally 62 day first definitive treatment has not been achieved, however validation is not completed and performance is expected to improve once all treatments are recorded and breaches validated but this is unlikely to improve sufficiently to achieve the standard.
- There are provisionally 13 patients who were treated in excess of 104 days (9.5 attributable to the Trust)
Exception report: Cancer Standards continued

**August Performance 62 day first definitive treatment against recovery trajectory (standard 85% trajectory 85%)**

August provisional performance 77% and not achieved. Validation is ongoing and breach sharing guidance has not yet been applied.

**Actions and progress to date**

- The cancer recovery trajectory has been reviewed including detailed stock-take of current actions, performance, backlog and additional capacity.
- All teams reviewing patients who have breached or will breach standard in September to progress pathways to treatment as soon as possible to reduce the number of patients past breach date working across CSC to progress pathways.
- Weekly review of patients 14 days to breach on an individual basis to ensure treatment plan in place and delays mitigated, with root cause analysis of 104 day breaches.
- Additional diagnostic and theatre capacity for urology patients planned for September and October.
- Streamlining of the diagnostic pathway for lower GI patients is progressing

**On-going Risks**

- Diagnostic delays in lower GI and urology have impacted on the 62 day standard, this is improving in lower GI but remains a concern in urology and patients are being treated in excess of 62 days and this is expected to continue into August as the backlog of breached patients is treated.
- Locum shortfall for lower GI both surgical and radiologist this is impacting on capacity and therefore performance against standard, work ongoing to address.
- Histopathology shortfall means that if multiple or late diagnostics are required the turnaround time for results is not fast enough to recover the lost time in pathway.
Exception report: Cancer Standards continued 104 day maximum wait for treatment provisional

Contributing factors and actions taken
- Provisionally 13 patients treated in excess of 104 days. (9.5 of these would be attributable to the trust)
- 1 breast patient - 1 treated at 144 days, patient also diagnosed with lung cancer and treatment of this was completed first with recovery time before further treatment.
- 1 haematology patient - patient treated at 137 days, patient referred to trust at day 97 and treated within 21 days of the decision to treat being made (shared breach)
- 1 lower GI patient - treated at 126 days, treatment planned within target, patient cancelled on day as unfit, angiography required to ensure patient fit for surgery.
- 1 respiratory patient - treated at 120 days, patient was transferred at day 71 and treated within 17 days of decision to treat (shared breach)
- 2 upper GI patients – 1 patient treated at 123 days, patient transferred at day 87 and treated within 14 days of decision to treat (not attributable) 1 patient treated at 117 days, complex pathway with multiple providers, patient also delayed treatment, treated within 21 days of decision to treat. (not attributable)
- 7 urology patients – 1 patient treated at 152 days capacity for MRI and fusion biopsy led to delay, 1 patient treated at 139 days, patient unfit for diagnostics. 1 treated at 134 days, patient not suitable for original diagnostics, and delay in review of patient. 1 treated at 140 days specialist equipment required for treatment. 1 treated at 152 days complex and cardiology opinion required. 1 treated at 138 days, transferred from IOW, treatment delayed due to patient having emergency surgery on IOW. (shared breach) 1 patient treated at 145 days patient unfit for diagnostics and capacity delays.
Exception Report: Stroke Contract Service Standards

July Provisional Performance against key Sentinel Stroke National Audit Programme (SSNAP) using DIY analysis toolkit: Reported in arrears

- The Trust has provisionally achieved 7 of the 13 key measures for July (see table) based on 100 cases (clock starts)
- Scan within 1hr: not achieved, 27% (standard 48%)
- Scan within 12hrs: not achieved but position held at 91% (standard 95%)
- Direct Admission to Stroke Unit: not achieved, 38% (standard 90%)
- % patients who spend 90% of their stay on a Stroke Unit: achieved 81.6% (standard 80%)
- Patients thrombolysed within 1hr: improved to 75% (standard 55%)
- Swallow screen ≤ 4hrs: not achieved 68.4% (target 85%)
- Speech and language assessment within 72hrs: not achieved 51.5% (standard 90%)

Contributing factors

- On-going unscheduled care pressures continue to have a direct impact on the ability to ring-fence beds for acute Stroke patients and directly transfer patients from the Emergency Department to Stroke Unit within the 4hr target.
- Gaps within Stroke Specialist Nurse team impacting on ability to undertake early assessments and diagnosis of patients.
- Significant shortfall of Speech and Language Therapist (SLT) resource across the pathway impacting on performance and patient outcomes.

Actions and progress to date

- On-going analysis to investigate reasons for scanning delays and ways to improve direct admission performance.
- Investigating funding options for additional Locum support for SLT assessments.
- Specialty Doctor post agreed by WCP and recruitment progressing.
- B6 secondment to Stroke Specialist Nurse team progressing with interviews being held early Sept.

### Sentinel Stroke National Audit Programme

<table>
<thead>
<tr>
<th>DIY Toolkit Analysis</th>
<th>Target</th>
<th>Apr</th>
<th>May</th>
<th>Jun</th>
<th>Jul</th>
</tr>
</thead>
<tbody>
<tr>
<td>Scan within 1 hr</td>
<td>46%</td>
<td>40.2%</td>
<td>41.5%</td>
<td>43.8%</td>
<td>27.0%</td>
</tr>
<tr>
<td>Scan within 12hrs</td>
<td>96%</td>
<td>81.5%</td>
<td>79.0%</td>
<td>81.3%</td>
<td>91.0%</td>
</tr>
<tr>
<td>Direct Admission to stroke unit &lt;= 4hrs</td>
<td>90%</td>
<td>94.4%</td>
<td>98.5%</td>
<td>44.9%</td>
<td>38.0%</td>
</tr>
<tr>
<td>% patients who spend 90% of their stay on a stroke unit</td>
<td>80%</td>
<td>81.7%</td>
<td>73.9%</td>
<td>80.6%</td>
<td>81.8%</td>
</tr>
<tr>
<td>Patients thrombolysed &lt;= 1hr</td>
<td>55%</td>
<td>73.3%</td>
<td>63.3%</td>
<td>66.7%</td>
<td>75.0%</td>
</tr>
<tr>
<td>Swallow screen &lt;= 4hrs (if applicable)</td>
<td>85%</td>
<td>75.9%</td>
<td>74.4%</td>
<td>71.1%</td>
<td>69.4%</td>
</tr>
<tr>
<td>OT assessment &lt;= 72 hrs (if applicable)</td>
<td>90%</td>
<td>94.5%</td>
<td>90.9%</td>
<td>92.5%</td>
<td>86.2%</td>
</tr>
<tr>
<td>Physio assessment &lt;= 72 hrs (if applicable)</td>
<td>90%</td>
<td>78.7%</td>
<td>84.4%</td>
<td>100%</td>
<td>87.8%</td>
</tr>
<tr>
<td>Speech &amp; language assessment &lt;= 72 hrs</td>
<td>90%</td>
<td>87.8%</td>
<td>75.5%</td>
<td>92.9%</td>
<td>51.5%</td>
</tr>
<tr>
<td>% patients presenting with stroke who have AF that are anti-coagulated on discharge</td>
<td>60%</td>
<td>92%</td>
<td>100%</td>
<td>100%</td>
<td>90.9%</td>
</tr>
<tr>
<td>% patients with rehab goals established by stroke specialist MDT &lt;= 5 days of admission</td>
<td>80%</td>
<td>37.5%</td>
<td>35.5%</td>
<td>61.3%</td>
<td>83.0%</td>
</tr>
<tr>
<td>% patients &amp; carers with joint care plans on discharge</td>
<td>85%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>% patients supported by stroke skilled ESD team</td>
<td>40%</td>
<td>48.1%</td>
<td>48.3%</td>
<td>50.0%</td>
<td>54.9%</td>
</tr>
</tbody>
</table>
The Trust is reporting an adverse variance against plan year to date of £7.1m against all forms of income. The key components of this underperformance are SLA (clinical contractual) income (£4.9m) and Sustainability and Transformation Funding (£2.1m). The SLA income variance is partially offset by planning reserves established to mitigate risk associated with growth assumptions contained within the income plan. The income position does assume Commissioner funding for the Frailty Intervention Team (£0.4m) and access to Transformation Funding (£2.1m). The SLA income variance is reflected in a continued reliance on premium rate agency staff costs in both unscheduled and scheduled care to maintain capacity and safety. In addition to this the Trust used an exceptional level of medical and nursing agency staff in August, which conflicted with the plan profiling assumptions which were based on material reductions in premium rate costs by this point in the financial year. The non-pay expenditure position is favourable to plan by £6.7m, this includes a favourable reserve provision for cost pressures of £8.7m which contributes to offsetting the adverse income position, and for drug budgets of £0.7m. Outsourcing commitments to non-NHS providers exceeded planned assumptions by £1.6m.

### Operating Expenditure

<table>
<thead>
<tr>
<th></th>
<th>Plan</th>
<th>Actual / Forecast</th>
<th>Variance</th>
</tr>
</thead>
<tbody>
<tr>
<td>In Month EK</td>
<td>43,821</td>
<td>45,095</td>
<td>(1,274)</td>
</tr>
<tr>
<td>Year to Date EK</td>
<td>220,623</td>
<td>220,117</td>
<td>506</td>
</tr>
</tbody>
</table>

Pay expenditure was £6.2m adverse to plan year to date. The pay link is a continued reliance on premium rate staff costs in both unscheduled and scheduled care to maintain capacity and safety. In addition to this the Trust used an exceptional level of medical and nursing agency staff in August, which conflicted with the plan profiling assumptions which were based on material reductions in premium rate costs by this point in the financial year. The non-pay expenditure position is favourable to plan by £6.7m, this includes a favourable reserve provision for cost pressures of £8.7m which contributes to offsetting the adverse income position, and for drug budgets of £0.7m. Outsourcing commitments to non-NHS providers exceeded planned assumptions by £1.6m.

### Cost Improvement Plans

<table>
<thead>
<tr>
<th></th>
<th>Plan</th>
<th>Actual / Forecast</th>
<th>Variance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Year to Date EK</td>
<td>8,360</td>
<td>7,499</td>
<td>(861)</td>
</tr>
<tr>
<td>Year End Forecast EK</td>
<td>34,566</td>
<td>34,566</td>
<td>0</td>
</tr>
</tbody>
</table>

The CIP challenge for 17/18 is significant and the Trust is approaching this through a genuine system wide approach to improvement with partners across the health system, though this remains a significant risk to the delivery of the programme in full at this time. The detailed programme of work to produce a revised financial plan and detailed forecast for the remainder of 17/18 includes an full review of savings plans and delivery and risk management arrangements. At this stage this has identified a best case shortfall of £10m against the CIP target for the year. The Trust response to this risk assessment will be set out in full within the revised plan to be presented to the Trust Board in October.

### Pay Bill

<table>
<thead>
<tr>
<th></th>
<th>Year to Date EK</th>
<th>Initial Plan</th>
<th>Actual</th>
<th>Variance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Substantive</td>
<td>112,728</td>
<td>114,816</td>
<td>(2,088)</td>
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<tr>
<td>Bank</td>
<td>6,975</td>
<td>8,100</td>
<td>(1,125)</td>
<td></td>
</tr>
<tr>
<td>Agency</td>
<td>5,238</td>
<td>8,210</td>
<td>(2,972)</td>
<td></td>
</tr>
</tbody>
</table>

The 2017-18 plan submitted to the Regulator included detailed workforce expenditure commitments for both substantive and temporary workforce costs. The plan reflected a moderate increase in the size of the substantive workforce in the case of the year. This was offset by a more substantial reduction in the size of the temporary workforce, in particular high cost agencies and premium rate internal locum costs. On-going unmet care pressures and the costs of maintaining high levels of extra capacity, with safe staffing levels including through material premium rate costs means that the pay bill is continuing to exceed planned levels and is placing a material pressure on the Trust’s financial position.
The key factors contributing to the deficit are covered in the relevant individual slides of the report. The Trust is planning to strengthen capacity and capability for delivery. It is undertaking a review of the baseline position and will decide upon significant actions ahead of reporting back to the Regulator in October. An exercise to revise the financial plan and present a detailed forecast to the Board is the first phase of a longer term plan to build a robust strategy for improvement and recovery which is due to commence in October for completion by the end of the financial year.

### Finance Report Month 5 2017/18

<table>
<thead>
<tr>
<th>In Month</th>
<th>Year to date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Plan £k</td>
</tr>
<tr>
<td>Surplus deficit - pre application of STF</td>
<td>668</td>
</tr>
<tr>
<td>STF allocation</td>
<td>(896)</td>
</tr>
<tr>
<td>Net (Surplus)/Deficit</td>
<td>(228)</td>
</tr>
</tbody>
</table>

### In Month

<table>
<thead>
<tr>
<th></th>
<th>Plan £k</th>
<th>Actual £k</th>
<th>Variance £k</th>
</tr>
</thead>
<tbody>
<tr>
<td>Income</td>
<td>(47,249)</td>
<td>(44,373)</td>
<td>(2,876)</td>
</tr>
<tr>
<td>Pay</td>
<td>24,895</td>
<td>26,830</td>
<td>(1,935)</td>
</tr>
<tr>
<td>Non-Pay</td>
<td>18,926</td>
<td>18,266</td>
<td>661</td>
</tr>
<tr>
<td>EBITDA *</td>
<td>(3,427)</td>
<td>723</td>
<td>(4,150)</td>
</tr>
<tr>
<td>EBITDA %</td>
<td>7.3</td>
<td>-1.6</td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Plan £k</th>
<th>Actual £k</th>
<th>Variance £k</th>
</tr>
</thead>
<tbody>
<tr>
<td>Profit / Loss on Disposal of Fixed Assets</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Interest Payable</td>
<td>1,593</td>
<td>1,597</td>
<td>(4)</td>
</tr>
<tr>
<td>Interest Receivable</td>
<td>(3)</td>
<td>(3)</td>
<td>(0)</td>
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<tr>
<td>Depreciation</td>
<td>1,512</td>
<td>1,524</td>
<td>(12)</td>
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<tr>
<td>Adjustment for donated asset income</td>
<td>(25)</td>
<td>(40)</td>
<td>15</td>
</tr>
<tr>
<td>Impairments</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Public Dividend Capital</td>
<td>182</td>
<td>182</td>
<td>(0)</td>
</tr>
<tr>
<td>Net (Surplus) / Deficit</td>
<td>(169)</td>
<td>3,933</td>
<td>(4,152)</td>
</tr>
<tr>
<td>Technical adjustment - donated assets</td>
<td>(59)</td>
<td>(46)</td>
<td>(13)</td>
</tr>
<tr>
<td>Technical adjustment - IFRIC 12</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Performance against Control Total</td>
<td>(228)</td>
<td>3,937</td>
<td>(4,165)</td>
</tr>
<tr>
<td>Surplus %</td>
<td>0.5</td>
<td>-8.9</td>
<td></td>
</tr>
</tbody>
</table>

* EBITDA Earnings before Interest Taxation Depreciation and Amortisation
Progress Report: Income

Finance Report Month 5 2017/18

The clinical income variance year to date is behind plan by £4.9m. There are several key factors contributing to this. The AIC contract has an overperformance against plan of £2.0m (comprising drugs exclusions of £0.4m, over performance on non-elective activity of £0.9m in Q1 and an overperformance on elective activity of £0.6m in Q1). Of these factors only the drugs exclusions remain in the forecast outturn as a potential claim upon the the AIC contract Risk Pool at this time. The NHSE Specialised services PbR contract of has an over performance of £1.7m. An adverse variance of £6.8m exists that covers the 3 CCG NHSI plan which was set with STP growth and demand, before 3 CCG QIPP taken into account (This accounts for £2.1m of the adverse variance). This adverse variance is materially offset by a non pay expenditure reserve provided to undertake growth in activity.

On the basis that the Trust has not functioned within the monthly financial expectations for August it has not assumed any eligibility to the total Sustainability and Transformation funding allocation in month of £0.895m. Missing the 70% element attributable to purely the financial target means that the Trust was not able to access the 15% of the total linked to the front door streaming services of patients in A&E and further the 15% linked to achieving a 90% average A&E performance for 4 hour waits. Securing STF income is dependent on achieving each quarterly financial control total as set out in the financial plan, as part of the overall annual control total specified by NHS Improvement. The Trust is engaging with NHSI in relation to the development of plans and improvement trajectories to achieve sustainability and STF income assumptions going forward will be determined through this process.

<table>
<thead>
<tr>
<th>In Month</th>
<th>Plan £k</th>
<th>Actual £k</th>
<th>Variance £k</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Income</td>
<td>(47,249)</td>
<td>(44,373)</td>
<td>(2,876)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Year To Date</th>
<th>Plan £k</th>
<th>Forecast £k</th>
<th>Variance £k</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Income</td>
<td>(230,799)</td>
<td>(223,695)</td>
<td>(7,104)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Income</th>
<th>Plan £k</th>
<th>Actual £k</th>
<th>Variance £k</th>
</tr>
</thead>
<tbody>
<tr>
<td>SLA income</td>
<td>(41,653)</td>
<td>(39,520)</td>
<td>(2,133)</td>
</tr>
<tr>
<td>Private Patients</td>
<td>(328)</td>
<td>(378)</td>
<td>50</td>
</tr>
<tr>
<td>RTA / Overseas</td>
<td>(61)</td>
<td>(175)</td>
<td>114</td>
</tr>
<tr>
<td>Other income for patient care</td>
<td>(90)</td>
<td>(90)</td>
<td>0</td>
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<tr>
<td>Income For Patient Care</td>
<td>(42,131)</td>
<td>(40,163)</td>
<td>(1,968)</td>
</tr>
<tr>
<td>Education, Training and Research</td>
<td>(1,641)</td>
<td>(1,575)</td>
<td>(66)</td>
</tr>
<tr>
<td>Income Generation</td>
<td>(1,058)</td>
<td>(1,096)</td>
<td>38</td>
</tr>
<tr>
<td>Non patient care services to other bodies</td>
<td>(63)</td>
<td>(14)</td>
<td>(49)</td>
</tr>
<tr>
<td>Rental income from operating leases</td>
<td>(151)</td>
<td>(149)</td>
<td>(2)</td>
</tr>
<tr>
<td>Other Income</td>
<td>(1,308)</td>
<td>(1,375)</td>
<td>67</td>
</tr>
<tr>
<td>STF</td>
<td>(896)</td>
<td>0</td>
<td>(896)</td>
</tr>
<tr>
<td>Other Operating Income</td>
<td>(5,118)</td>
<td>(4,210)</td>
<td>(908)</td>
</tr>
<tr>
<td>Total Income</td>
<td>(47,249)</td>
<td>(44,373)</td>
<td>(2,876)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Year To Date</th>
<th>Plan £k</th>
<th>Forecast £k</th>
<th>Variance £k</th>
</tr>
</thead>
<tbody>
<tr>
<td>Income</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SLA income - CCG</td>
<td>(204,207)</td>
<td>(199,327)</td>
<td>(4,880)</td>
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<tr>
<td>Private Patients</td>
<td>(1,638)</td>
<td>(1,497)</td>
<td>(141)</td>
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<tr>
<td>RTA / Overseas</td>
<td>(303)</td>
<td>(445)</td>
<td>142</td>
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<tr>
<td>Other income for patient care</td>
<td>(450)</td>
<td>(459)</td>
<td>9</td>
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<tr>
<td>Income For Patient Care</td>
<td>(206,598)</td>
<td>(201,728)</td>
<td>(4,871)</td>
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<tr>
<td>Education, Training and Research</td>
<td>(7,910)</td>
<td>(7,915)</td>
<td>5</td>
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<tr>
<td>Income Generation</td>
<td>(4,974)</td>
<td>(4,728)</td>
<td>(246)</td>
</tr>
<tr>
<td>bodies</td>
<td>(358)</td>
<td>(337)</td>
<td>(20)</td>
</tr>
<tr>
<td>Rental income from operating leases</td>
<td>(752)</td>
<td>(745)</td>
<td>7</td>
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<tr>
<td>Other Income</td>
<td>(6,402)</td>
<td>(6,529)</td>
<td>127</td>
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<tr>
<td>STF</td>
<td>(3,806)</td>
<td>(1,714)</td>
<td>(2,092)</td>
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<tr>
<td>Other Operating Income</td>
<td>(24,201)</td>
<td>(21,968)</td>
<td>(2,233)</td>
</tr>
<tr>
<td>Total Income</td>
<td>(230,799)</td>
<td>(223,695)</td>
<td>(7,104)</td>
</tr>
</tbody>
</table>
### Finance Report Month 5 2017/18: Operating Expenditure

The pay overspend year to date is £6.2m adverse to plan. There is a continued reliance on premium rate medical staff costs in unscheduled and scheduled care to maintain capacity and quality. This is evident in a continued use of escalation capacity in medical and nursing staff. This covers additional bed capacity provided in numbers of established wards (£1.4m adverse variance), ward E4 (£0.2m adverse variance) and in external capacity in further assessment beds unfunded (£0.4m adverse variance). In addition to this the Trust used an exceptional level of premium rate agency nursing staff (£0.4m adverse variance) in August and year to date (£1.3m) Planning assumptions, as indicated by the pay savings target (£4.6m adverse variance) were that a reliance on premium rate pay commitments was expected to reduce. Further improvements to the control environment relating to pay expenditure have been introduced across the Trust and will continue to be developed in line with the output of a detailed programme of work. Non-pay is favourable to plan by £6.7m, this includes a favourable reserve provision for cost pressures of £8.7m and for drug budgets of £0.7m. Outsourcing commitments to non-NHS providers exceeded planning assumptions by £1.6m, mainly effecting Orthopaedics (£1m adverse variance) and Gastro (£0.6m adverse variance). Both services have identified a sustained reliance on additional capacity to maintain RTT performance. A report from the Deputy Chief Operating Officer on RTT backlog and delivery proposals is due at the Executive Team on Wednesday 20th September.

### In Month

<table>
<thead>
<tr>
<th></th>
<th>Plan</th>
<th>Actual</th>
<th>Variance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pay</td>
<td>£k</td>
<td>£k</td>
<td>£k</td>
</tr>
<tr>
<td></td>
<td>24,895</td>
<td>26,830</td>
<td>(1,935)</td>
</tr>
<tr>
<td>Non Pay</td>
<td>18,926</td>
<td>18,266</td>
<td>661</td>
</tr>
<tr>
<td>Operational Costs</td>
<td>43,821</td>
<td>45,095</td>
<td>(1,274)</td>
</tr>
<tr>
<td>Pay</td>
<td>£k</td>
<td>£k</td>
<td>£k</td>
</tr>
<tr>
<td></td>
<td>24,895</td>
<td>26,830</td>
<td>(1,935)</td>
</tr>
<tr>
<td>Non Pay</td>
<td>18,926</td>
<td>18,266</td>
<td>661</td>
</tr>
<tr>
<td>Operational Costs</td>
<td>43,821</td>
<td>45,095</td>
<td>(1,274)</td>
</tr>
</tbody>
</table>

### Year To Date

<table>
<thead>
<tr>
<th></th>
<th>Plan</th>
<th>Actual</th>
<th>Variance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pay</td>
<td>£k</td>
<td>£k</td>
<td>£k</td>
</tr>
<tr>
<td></td>
<td>124,941</td>
<td>131,127</td>
<td>(6,186)</td>
</tr>
<tr>
<td>Non Pay</td>
<td>95,682</td>
<td>88,991</td>
<td>6,691</td>
</tr>
<tr>
<td>Operational Costs</td>
<td>220,623</td>
<td>220,117</td>
<td>506</td>
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### In Month

<table>
<thead>
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<th>Plan</th>
<th>Actual</th>
<th>Variance</th>
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</thead>
<tbody>
<tr>
<td>Pay</td>
<td>£k</td>
<td>£k</td>
<td>£k</td>
</tr>
<tr>
<td>Medical and Dental</td>
<td>8,008</td>
<td>8,611</td>
<td>(602)</td>
</tr>
<tr>
<td>Nursing &amp; Midwifery</td>
<td>10,107</td>
<td>10,747</td>
<td>(640)</td>
</tr>
<tr>
<td>Scientific</td>
<td>4,116</td>
<td>4,168</td>
<td>(52)</td>
</tr>
<tr>
<td>Administrative &amp; Ancillary</td>
<td>3,345</td>
<td>3,257</td>
<td>88</td>
</tr>
<tr>
<td>Pay reserves</td>
<td>341</td>
<td>205</td>
<td>135</td>
</tr>
<tr>
<td>Pay savings target</td>
<td>(1,117)</td>
<td>(253)</td>
<td>(864)</td>
</tr>
<tr>
<td>Apprentice levy</td>
<td>95</td>
<td>94</td>
<td>0</td>
</tr>
<tr>
<td>Total Pay</td>
<td>24,895</td>
<td>26,830</td>
<td>(1,935)</td>
</tr>
</tbody>
</table>

### Year To Date

<table>
<thead>
<tr>
<th></th>
<th>Plan</th>
<th>Actual</th>
<th>Variance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pay</td>
<td>£k</td>
<td>£k</td>
<td>£k</td>
</tr>
<tr>
<td>Medical and Dental</td>
<td>40,276</td>
<td>41,607</td>
<td>(1,332)</td>
</tr>
<tr>
<td>Nursing &amp; Midwifery</td>
<td>51,168</td>
<td>52,682</td>
<td>(1,514)</td>
</tr>
<tr>
<td>Scientific</td>
<td>20,475</td>
<td>20,620</td>
<td>(145)</td>
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<tr>
<td>Administrative &amp; Ancillary</td>
<td>16,668</td>
<td>15,993</td>
<td>675</td>
</tr>
<tr>
<td>Pay reserves</td>
<td>692</td>
<td>692</td>
<td>0</td>
</tr>
<tr>
<td>Pay savings target</td>
<td>(4,810)</td>
<td>(253)</td>
<td>(4,557)</td>
</tr>
<tr>
<td>Apprentice levy</td>
<td>473</td>
<td>478</td>
<td>(4)</td>
</tr>
<tr>
<td>Total Pay</td>
<td>124,941</td>
<td>131,127</td>
<td>(6,186)</td>
</tr>
</tbody>
</table>

### Non-Pay

<table>
<thead>
<tr>
<th></th>
<th>Plan</th>
<th>Actual</th>
<th>Variance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Drugs &amp; Medical Gases</td>
<td>5,534</td>
<td>5,527</td>
<td>7</td>
</tr>
<tr>
<td>Supplies and Services - Clinical</td>
<td>4,529</td>
<td>4,615</td>
<td>(87)</td>
</tr>
<tr>
<td>Supplies and Services - General</td>
<td>170</td>
<td>160</td>
<td>10</td>
</tr>
<tr>
<td>Establishment Expenses</td>
<td>396</td>
<td>357</td>
<td>39</td>
</tr>
<tr>
<td>Consultancy Services</td>
<td>69</td>
<td>90</td>
<td>(21)</td>
</tr>
<tr>
<td>Transport Expenses</td>
<td>38</td>
<td>45</td>
<td>(7)</td>
</tr>
<tr>
<td>Premises</td>
<td>1,158</td>
<td>1,125</td>
<td>33</td>
</tr>
<tr>
<td>PFI Operating Costs</td>
<td>2,420</td>
<td>2,512</td>
<td>(93)</td>
</tr>
<tr>
<td>CNST Premium</td>
<td>1,848</td>
<td>1,848</td>
<td>0</td>
</tr>
<tr>
<td>Auditors remuneration</td>
<td>12</td>
<td>13</td>
<td>(2)</td>
</tr>
<tr>
<td>Education and Training</td>
<td>172</td>
<td>113</td>
<td>58</td>
</tr>
<tr>
<td>Services from Other NHS Bodies</td>
<td>254</td>
<td>310</td>
<td>(16)</td>
</tr>
<tr>
<td>Purchase of Healthcare from Non NHS provider</td>
<td>745</td>
<td>1,256</td>
<td>(511)</td>
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<tr>
<td>Non pay reserves</td>
<td>1,697</td>
<td>221</td>
<td>1,476</td>
</tr>
<tr>
<td>Non Pay savings target</td>
<td>(276)</td>
<td>-</td>
<td>(276)</td>
</tr>
<tr>
<td>Other Non Pay</td>
<td>121</td>
<td>73</td>
<td>48</td>
</tr>
<tr>
<td>Total Non-Pay</td>
<td>18,926</td>
<td>26,830</td>
<td>(1,935)</td>
</tr>
<tr>
<td>Total Expenditure</td>
<td>43,821</td>
<td>45,095</td>
<td>(1,274)</td>
</tr>
</tbody>
</table>
Finance Report Month 5 2017/18  

The cash balance at 31st August includes £3.1m of the £4.1m capital cash carried forward from 2016/17. The target cash balance was therefore £4.1m compared to the plan balance of £3.1m.

The Trust has submitted a request for interim financial support of £3.5m per the mandate request to the Board in September and is in dialogue with NHSI regarding this.

### Year To Date

<table>
<thead>
<tr>
<th></th>
<th>Plan</th>
<th>Actual</th>
<th>Variance</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Cash Balance</strong></td>
<td>£3,099</td>
<td>£3,258</td>
<td>£159</td>
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</table>

### Year End Forecast

<table>
<thead>
<tr>
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<th>Plan</th>
<th>Forecast</th>
<th>Variance</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Cash Balance</strong></td>
<td>£1,000</td>
<td>£1,000</td>
<td>£0</td>
</tr>
</tbody>
</table>

### Operating Surplus

<table>
<thead>
<tr>
<th></th>
<th>£2,734</th>
<th>(3,927)</th>
<th>(6,661)</th>
</tr>
</thead>
</table>

### Depreciation

<table>
<thead>
<tr>
<th></th>
<th>£7,290</th>
<th>£7,590</th>
<th>(300)</th>
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</table>

### Other Non Cash I&E Items

<table>
<thead>
<tr>
<th></th>
<th>£230</th>
<th>(84)</th>
<th>(146)</th>
</tr>
</thead>
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### Movement in Working Capital

<table>
<thead>
<tr>
<th></th>
<th>£3,014</th>
<th>9,671</th>
<th>(6,657)</th>
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### Provisions

<p>| | | | |</p>
<table>
<thead>
<tr>
<th></th>
<th>-</th>
<th>-</th>
<th>-</th>
</tr>
</thead>
</table>

### Cashflow from Operations

<table>
<thead>
<tr>
<th></th>
<th>£12,808</th>
<th>13,250</th>
<th>(13,764)</th>
</tr>
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### Capital Expenditure

<table>
<thead>
<tr>
<th></th>
<th>(4,243)</th>
<th>(4,740)</th>
<th>497</th>
</tr>
</thead>
</table>

### Cash receipt from asset sales

<table>
<thead>
<tr>
<th></th>
<th>£8,565</th>
<th>8,528</th>
<th>(37)</th>
</tr>
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</table>

### PDC Received

<p>| | | | |</p>
<table>
<thead>
<tr>
<th></th>
<th>-</th>
<th>-</th>
<th>-</th>
</tr>
</thead>
</table>

### PDC Repaid

<p>| | | | |</p>
<table>
<thead>
<tr>
<th></th>
<th>-</th>
<th>-</th>
<th>-</th>
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</thead>
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### Dividends Paid

<table>
<thead>
<tr>
<th></th>
<th>-</th>
<th>(1,994)</th>
<th>(2,186)</th>
</tr>
</thead>
</table>

### Interest on Loans, PFI and leases

<table>
<thead>
<tr>
<th></th>
<th>(7,847)</th>
<th>(7,879)</th>
<th>32</th>
</tr>
</thead>
</table>

### Capital element of PFI payment

<table>
<thead>
<tr>
<th></th>
<th>(2,864)</th>
<th>(2,696)</th>
<th>(168)</th>
</tr>
</thead>
</table>

### Drawn down on debt

<p>| | | | |</p>
<table>
<thead>
<tr>
<th></th>
<th>-</th>
<th>-</th>
<th>-</th>
</tr>
</thead>
</table>

### Repayment of debt

<p>| | | | |</p>
<table>
<thead>
<tr>
<th></th>
<th>-</th>
<th>-</th>
<th>-</th>
</tr>
</thead>
</table>

### Cashflow from financing

<table>
<thead>
<tr>
<th></th>
<th>(10,566)</th>
<th>(10,477)</th>
<th>89</th>
</tr>
</thead>
</table>

### Net Cash Inflow / (Outflow)

<table>
<thead>
<tr>
<th></th>
<th>(2,001)</th>
<th>(1,949)</th>
<th>(52)</th>
</tr>
</thead>
</table>

### Opening Cash Balance

<table>
<thead>
<tr>
<th></th>
<th>£5,100</th>
<th>£5,207</th>
<th>(107)</th>
</tr>
</thead>
</table>

### Closing Cash Balance

<table>
<thead>
<tr>
<th></th>
<th>£3,099</th>
<th>£3,258</th>
<th>£159</th>
</tr>
</thead>
</table>

The cash forecast at present materially reflects the 2017-18 NHSI planning submission and assumes no repayment of any interim financing in 2017/18. This will be comprehensively updated to reflect the output of the revised forecast to be presented subsequently to the Board and NHS Improvement. The Trust continues to work with NHS Improvement in relation to the management of the liquidity and cash position of the Trust.
The Trust has spent £3.8m of capital YTD. NHSI approved carry forward of unspent CRL into 2017/18 and this is reflected in the Capital Resource Limit. The Trust has made representation to NHS Improvement in relation to our concerns about the revised methodology for the calculation of the Trust’s Capital Resource Limit and have asked for a response in order to provide an update to the Trust Board. The September Board approved the capital programme and the forecast reflects this planned programme.

<table>
<thead>
<tr>
<th>Year To Date</th>
<th>Plan £k</th>
<th>Actual £k</th>
<th>Variance £k</th>
</tr>
</thead>
<tbody>
<tr>
<td>Capital Balance</td>
<td>1,752</td>
<td>3,779</td>
<td>2,027</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Year End Forecast</th>
<th>Plan £k</th>
<th>Forecast £k</th>
<th>Variance £k</th>
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<tbody>
<tr>
<td>Capital Balance</td>
<td>14,164</td>
<td>15,019</td>
<td>855</td>
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</table>

### Risks

The 17/18 Capital Programme remains severely challenged at £4.2m 17/18 capital and £4.1m carried forward from 2016/17. The Trust continues to liaise with NHSI colleagues over the methodology for calculating capital cash sources. A meeting of the Capital Priorities Group is planned for 17/07/17. The Capital Priorities Group reviewed capital requirements and recommended a programme to the Board which was approved at the September Board meeting. DH has confirmed PDC of £0.9m for the A&E Streaming project.
Workforce Executive Summary – key exceptions to note

Performance Theme

- The total workforce capacity decreased by 66 FTE to 6911 FTE in August 17 and is 44 FTE over the new funded establishment.

- The temporary workforce capacity decreased by 27 to 482 FTE in August 17 and comprises 7.0% of the total workforce capacity. This has small decrease in comparison to July 17.

- The number of shifts that have breached the capped rates or are off-framework have increased by 941 shifts to 3013 shifts in August 17.

- The evidence collected for August 17 indicates that overall staffing levels have decreased from 103.2% to 102.6% compared to planned levels.

- The evidence collected for August indicates that overall CHPPD is 4.9 hours for RNs. This is similarly reported in the previous month and 2.9 hours for HCSWs for PHT.

- Appraisal compliance has decreased and currently records at 77.7% in August 17, below the 85% target.

- Essential skills compliance increased to 88.7%, and continues to record above the 85% target.

- Fire Safety (face to face training) increased to 68.8%.

- Information Governance Training has decreased to 88.6%. This is below the Information Governance Training target (95%).

- Sickness Absence Rate (12 month rolling average) maintained at 3.9% in July and remains above the target. In-month sickness absence decreased to 3.4% in July and is above the target.

- No whistleblowing referral and safeguarding referrals were reported in August 17. However, 1 professional registration referral took place in August 17.
Portsmouth Hospitals NHS Trust

28/09/2017

QAH Hospital

Workforce Heat Map – Wards

<5%

≥16%

<3%

<3%

<3%

0

0

<16%

≥3%

≥3%

≥3%

≥1

≥1

14
1.7%
10.5%
1.3%
2.6%
2.4%
2.3%
1.9%
3.3%
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4
23

Sharps

≥85%

RIDDORS

≥85%

Sickness Absence Rolling 12 months
(%)

DNA Rates (%)

<25%

Sickness Absence LT - In Month (%)

Essential Skills
Compliance (%)

<10%

Workforce Wellbeing

Sickness Absence ST - In Month (%)

Appraisal
Compliance (%)

<10%

Sickness Absence
Cost - In Month (£s)

Breaches vs. Total
Temp Shifts (%)

<3%

Workforce Development

Turnover - Rolling
12 months (%)

Leavers (FTE)

Vacancies vs.
Funded
Establishment (%)

Vacancies (FTE)

Total Substantive
Workforce & MoD
(FTE)

Funded
Establishment
(FTE)

Workforce Capacity

Equality & Diversity BME (%)

Aug-17

Turnover - In month
(%)

Month:

10%<12%10%<12%25%<50%80%<85%80%<85%5%<10%
≥3%
Trust

MOPRS

Safe – Workforce

MSK

Surgery

Head & Neck

Medicine

Emergency

Renal

Women's &
Children's
Theatres
Unfunded

Trust
E4
F1
F2
F3
F4
G1
G2
G3
G4
D1
D4
D5
D6
D7
E2
E3
G5
SHCU
SAU
CHOC
D8
C5
C6
C7
D2
D3
E6/7
E8
ED
MAU
G6
G7
G9
RDU
A5/6
MATY
NICU
Paeds
DCCQ (ICU)
CDU

5
6868
0.0
22.4
43.8
43.8
55.8
34.0
43.8
43.8
30.9
42.6
35.3
44.6
53.7
45.6
39.5
41.5
22.2
20.5
40.7
59.2
36.3
44.8
41.8
33.5
37.0
42.2
58.7
41.8
120.1
122.8
25.5
46.0
28.7
15.1
38.1
154.4
109.4
92.0
137.8
23.7

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43.4
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33.0
38.7
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37.3
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28.0
35.8
48.5
36.4
154.7
102.8
26.2
41.7
24.4
13.2
30.1
149.0
101.5
84.4
129.7
18.2

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48.9%
29.8%
83.8%
31.4%
94.3%
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73.0%
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87.1%
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≥10%
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5.2%
8.5%
8.7%

13
£771,346
£2,535
£4,734
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£5,995
£7,337
£2,110
£4,941
£10,299
£7,455
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£5,240
£11,215
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£3,268
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£1,150
£116
£4,753
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£5,100
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£5,643
£3,810
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£3,404
£27,086
£10,268
£12,864
£9,421
£421

2

1

3

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1

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<table>
<thead>
<tr>
<th>Area</th>
<th>Workforce Capacity</th>
<th>Workforce Development</th>
<th>Workforce Wellbeing</th>
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<tbody>
<tr>
<td><strong>Month</strong> Aug-17</td>
<td></td>
<td></td>
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<tr>
<td><strong>Workforce Heat Map – Non-Wards</strong></td>
<td></td>
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<tr>
<td><strong>Vacancy %</strong></td>
<td></td>
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</tr>
<tr>
<td>MOPRS Jr Medical Staff</td>
<td>≥16%</td>
<td>≥5%</td>
<td>≥3%</td>
</tr>
<tr>
<td>MOPRS Sr Medical Staff</td>
<td>&lt;12%</td>
<td>&lt;12%</td>
<td>&lt;3%</td>
</tr>
<tr>
<td>MOPRS Jr Medical Staff</td>
<td>≥12%</td>
<td>≥25%</td>
<td>≥3%</td>
</tr>
<tr>
<td>MOPRS Sr Medical Staff</td>
<td>&lt;80%</td>
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<tr>
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<td>≥50%</td>
<td>≥16%</td>
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</tr>
<tr>
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<td>&lt;16%</td>
<td>&lt;16%</td>
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<tr>
<td><strong>Temp Shifts %</strong></td>
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<td>Anaesthesiology</td>
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<tr>
<td>Critical Care Medical Staff</td>
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<tr>
<td>Day Surgery Theatres</td>
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<td>≥5%</td>
<td>≥3%</td>
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<tr>
<td>Imaging Dept</td>
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<td>&lt;12%</td>
<td>&lt;3%</td>
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<tr>
<td>Pharmacy Dept</td>
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<td>≥3%</td>
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<tr>
<td>Emergency Services CSC Office</td>
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<td>Hearing Clinic</td>
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<tr>
<td>Oral Surgery</td>
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<td>Cardiac Investigation Unit</td>
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<tr>
<td>Cardiology Dept Medical Staff</td>
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<td>Endoscopy</td>
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<td>Gastroenterology</td>
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<td>Respiratory Medicine Staff</td>
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<td>MSK Office</td>
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<td>Orthopaedic's Medical Staff</td>
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<tr>
<td>Renal Dept Office</td>
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<tr>
<td>Renal Sr Nursing Staff</td>
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<tr>
<td>Haematology &amp; Oncology Staff</td>
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<tr>
<td>Oncology Dept Medical Staff</td>
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<tr>
<td>Radiotherapy</td>
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<tr>
<td>Surgical Admin</td>
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<tr>
<td>Surgical Jt Doctors</td>
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<tr>
<td>Community Midwives</td>
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<tr>
<td>Gynaecology Dept Medical Staff</td>
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<tr>
<td>Child Health Dept Medical Staff</td>
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<tr>
<td>Antenatal &amp; Nuchal Screening</td>
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<tr>
<td>Child Health Outpatients</td>
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</table>
### Exception Report: Workforce Capacity

#### Where we want to be: targets and benchmarks
*Target: Establishment of 6,596 FTE, with target of substantive staff in post at 100% of establishment*

#### Key Terms and Definitions
- Funded establishment excludes CIP and includes investments around anticipated activity growth and patient demand in 17/18.
- Total workforce capacity is the sum of the substantive establishment plus the temporary workforce.
- Temporary workforce capacity is the sum of the bank and agency workforce.

#### Trends and Patterns
- The funded establishment has decreased by 21 FTE to 6868 FTE for August 17. This has increased by 73 FTE since April 17.
- The total workforce capacity decreased by 66 FTE to 6911 FTE in August 17 and is 44 FTE over the new funded establishment.
- Substantive workforce capacity has decreased to 6429 FTE in August 17.
- The temporary workforce capacity decreased by 27 to 482 FTE in August 17 and comprises 7.0% of the total workforce capacity. This has small decrease in comparison to July 17.

#### Root Cause analysis and insights
- A significant temporary staffing resource is still required to fill existing vacancies across all areas. Workstreams are in place to switch off high cost temporary staffing and to recruit to these positions substantively.
- Temporary staffing is also being used due to increased patient demand and increased patient acuity, sickness and specialising.
- Weekly monitoring and reporting of temp usage and the price caps for temporary workers continues and fortnightly meetings are held with each CSC to drive further reductions in temporary usage and overall pay bill where possible.

#### Actions and progress to date
- Recruitment will take place, targeting and providing a focus on the ‘hard to recruit’ areas to close the vacancy gap and drive reductions in the temporary workforce.
Safe – Workforce capacity

**Bank & Agency Capped Rate Breaches**

### Trends and Patterns
- The number of shifts that have breached the capped rates or are off-framework have increased by 941 shifts to 3013 shifts in August 17.

### Root Cause analysis and insights
- A significant temporary staffing resource is still required to fill existing vacancies across all areas. Workstreams are in place to switch off high cost temporary staffing and to recruit to these positions substantively.
- Temporary staffing is also being used due to increased patient demand and increased patient acuity, sickness and specialising.
- Agencies are not supply staff at capped rates.
- Weekly monitoring and reporting of temp usage and the price caps for temporary workers continues and fortnightly meetings are held with each CSC to drive further reductions in temporary usage and overall pay bill where possible.

### Actions and progress to date
- Complying with “Taking further action to reduce agency spending”. (NHS Improvement, 7th October 2016)

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<tr>
<th>Staff Groups</th>
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<th>Oct-16</th>
<th>Nov-16</th>
<th>Dec-16</th>
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**Safe Staffing Reports / NQB**

**Where we want to be: targets and benchmarks**
- **Target**: Planned staffing levels are 100%, planned skill mix 70.4% RN:29.6% HCSW ratio

**Trends and Patterns**
The evidence collected for August 17 indicates that overall staffing levels have decreased from 103.2% to 102.6% compared to planned levels.

The planned skill mix has decreased in August 17 for Registered Nurses (RNs), and the actual skill mix for the Trust was 62.5% RNs with 37.5% Health Care Support Workers (HCSWs) which has decreased since July 17.

**Root Cause analysis and insights**
Increase in turnover and vacancy in some CSCs. Supported by the temporary workforce. New starters due in Autumn, monitoring impact on safety and quality.

**Actions and progress to date**
Recruitment continues locally, nationally and internationally. Very successful open day for HCSWs recruited 100 staff between Trust and NHSP. Retention and Recruitment Day for Registered Nurses is in planning.

### Actual Staff Numbers and Skill Mix

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<th>Registered Nurses %</th>
<th>HCSW %</th>
<th>Planned RN:HCSW</th>
<th>Actual RN:HCSW</th>
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<td>93.4%</td>
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<td>113.5%</td>
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<tr>
<td>Feb-17</td>
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<td>115.7%</td>
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<td>Mar-17</td>
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<td>94.4%</td>
<td>127.9%</td>
<td>70.2% : 29.8%</td>
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<td>Jun-17</td>
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<td>127.7%</td>
<td>69.9% : 30.1%</td>
<td>62.5% : 37.5%</td>
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### Planned vs Actual Staff Numbers

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<td><strong>Average Fill Rate</strong></td>
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<td><strong>%</strong></td>
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### Planned vs Actual Staff Hours (Day)

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### Planned vs Actual Staff Hours (Night)

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<td>Queen Alexandra Hospital</td>
<td>69092</td>
<td>27313</td>
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These figures include ED, Day Units, and Flexible/Unfunded Capacity.
Care Hours Per Patient Day Programme

Where we want to be: targets and benchmarks

Introduction
To provide a single consistent way of recording and reporting deployment of staff working on patient wards/units, NHS Improvement have developed, tested and adopted Care Hours per Patient Day (CHPPD). CHPPD is calculated by adding the hours of Registered Nurses (RNs) and Health Care Support Workers (HCSWs) per ward and dividing by the Midnight bed occupancy figures for the ward. CHPPD reports split out RNs and HCSWs to ensure skill mix and care needs are met. The metric aims to illustrate how many hours each patient receives from either a RN or HCSW within any 24 period over the course of a month.

Trends and Patterns
• The evidence collected for August indicates that overall CHPPD is 4.9 hours for RNs. This is similarly reported in the previous month and 2.9 for HCSWs for PHT. HCSWs have continued to be above plan over the last 12 months and during that same period RNs have continued to be below the planned number of hours.
Appraisal and Essential Skills Compliance

Where we want to be: targets and benchmarks

**Target:** The compliance target for Appraisals is 85%

**Trends and Patterns**
- Appraisal compliance has decreased and currently records at 77.7% in August 17, below the 85% target.

**Root Cause analysis and insights**
- In August 17, the 85% appraisal target has been met by CHAT, Head & Neck, Research and Development and Surgery & Cancer CSC.
- Appraisal compliance has increased in month for majority of the CSCs, with the exception of Corporate Functions, Emergency CSC, Medicine, MSK and Renal CSCs.

**Actions and progress to date**
- A targeted approach to address appraisal compliance has been adopted, which will involve informal warnings issued to managers of non-compliant staff.

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Where we want to be: targets and benchmarks

**Target:** the compliance target for Essential skills is 85% (Target for Information Governance is 95%)

**Trends and Patterns**
- Essential skills compliance increased to 88.7%, and continues to record above the 85% target.

**Root Cause analysis and insights**
- Overall Safeguarding Children compliance (All Levels) is currently at 89.1% and is above the 85% target. Level 2 has decreased to 90.6%, and Level 3 continues to be below target and compliance currently records at 81.3%.
- Fire Safety (face to face training) increased to 68.8%.
- Information Governance Training has decreased to 88.6%

**Actions and progress to date**
- The L&D team are highlighting staff who are out of date with 3 or more essential skills. Chiefs of Service are being provided with regular information on Medical and Dental compliance to help meet the requirements of the CQC Action Plan.
Learning & Development - DNA (Did Not Attend) Rates

**Targets** ≤5%  6 – 10%  >10%

**Trends / Patterns:** In August, Course DNA rate improved by 1% on the previous month however remains worse than any other previous month since February.

**Root cause analysis / insights:** The top 5 courses for number of DNAs (see left) are all mandatory training courses that are also below their Essential Skills Compliance target of 85%. The DNA rate for MOPRS CSC and Surgery & Cancer CSC has been 18% or above over the previous 3 months. Renal CSC had the highest DNA rate this month, with a quarter of all places booked not attended. In instances where reasons for DNAs were provided, the most common were short staffed departments and sickness. There were 9 course cancellations in August; 4 were due to insufficient bookings, 3 were at the trainer’s request, 1 was due to the trainer being unavailable, and 1 was down to the training room being unavailable/inappropriate.

**Actions / Progress to date:** L&D continue to raise awareness of this issue via an electronic notice board in the Education Centre and on the Education Dashboard which is accessible to all staff via the Trust intranet. The DNA rate of nursing and midwifery staff is presented monthly at the Professional Nursing & Midwifery Forum. L&D have a text reminder service where everyone booked on a course is sent two text messages; one two weeks prior to the course and another the day before the course.

**Targets** ≤5%  6 – 10%  >10%

**Trends / Patterns**
Corporate Induction attendance improved by 3% in August compared to the previous month with just one person not attending.

**Root cause analysis / insights**
This is the highest attendance rate since July 2016 in which we had a 100% attendance rate. The 1 DNA this month was from Corporate Functions CSC.

**Actions / Progress to date**
Managers are contacted and asked to rebook staff onto a future Induction.

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**Top 5 DNA Courses in August**
1. 135 DNAs Basic Clinical Fire Training (23%)
2. 43 DNAs Blood Awareness Update (19%)
3. 41 DNAs Adult Basic Life Support (19%)
4. 37 DNAs Conflict Resolution (23%)
5. 27 DNAs Mental Capacity Act & Deprivation of Liberty Safeguards (25%)

**Number of Course Cancellations:** 9 out of 184 (4.9%)
New Apprenticeships & Care Certificates Achieved

Where we want to be: targets and benchmarks
Target: Health Education England set a target of 2.39% of our workforce (160) that have started an apprenticeship by the end of 2017/18.

Trends / Patterns: 8 new apprenticeships started in August 2017; 3 based in Corporate Functions CSC, 2 in Surgery & Cancer CSC, 1 in Clinical Support CSC, 1 in Head & Neck CSC, and 1 in CHAT CSC. This gives us a total of 37 so far. Numbers are yet to increase as expected. The Trust is still getting used to the newly introduced Apprenticeship Levy.

Root cause analysis / insights
Apprenticeship Categories:
- 25 Business & Administration (7 in August)
- 10 Functional Skills (1 in August)
- 2 Healthcare Support

Actions / Progress to date: Learning and Development continue to meet with CSC management teams to promote Apprenticeships in the workplace

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Where we want to be: targets and benchmarks
Target: All clinical new starters at bands 1 – 4 are to complete the Care Certificate within 12 weeks of their start date at the Trust. The Trust has set the 6 month period as the final completion date to correspond with the probationary period.

Trends / Patterns: In August there were 15 staff due to complete within 6 months of their start date. 10 of the 15 did so, giving us a rate of 67%. This builds on the previous month’s progress though much improvement is still required.

Root cause analysis / insights:
- MOPRS CSC: 9 of 12 competed on time (75%)
- CHAT CSC: 1 of 1 completed on time (50%) (the 1 that did not was just 12 days overdue)
- Head & Neck CSC: 0 of 1 completed on time (0%)

Actions / Progress to date: Compliance will continue to be addressed through the Nursing & Midwifery Professional Forum. The e-mail reminder system that the Learning & Development department implemented in August is having an impact. It is expected that this will continue to help drive up the compliance over the coming months.

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New Apprenticeships

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</tbody>
</table>

Care Certificate achieved within 6 Months

<table>
<thead>
<tr>
<th>Month</th>
<th>Number of Care Certificates achieved within 6 months</th>
<th>Percentage of Care Certificates achieved within 6 months</th>
</tr>
</thead>
<tbody>
<tr>
<td>J</td>
<td></td>
<td></td>
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<tr>
<td>A</td>
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<td>J</td>
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<tr>
<td>A</td>
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</tr>
</tbody>
</table>

Care Certificates currently in progress: 174
On target to achieve: 154 (89%)
Target already breached: 20 (11%)
Workforce Capacity – Turnover

Where we want to be: targets and benchmarks  Target: < 10%

Trends and Patterns
- Turnover Rate (12 month rolling average) has decreased to 12% in August 17 and remains above the target.

Root Cause analysis and insights
- Majority of the CSCs, with the exception of Head & Neck and Renal CSC are above the rolling 12 month turnover target.
- All staff groups are above the rolling 12 month annual rolling turnover figure, with the exception of our Medical and Dental workforce.

Actions and progress to date
- Focus on inductions for staff.
- Focus on role clarity and objectives for all staff.
- Review of National Staff Survey results and action planning.
- Focus on staff development.
- Focus on managing staff attendance.

<table>
<thead>
<tr>
<th>Turnover rate</th>
<th>In month</th>
<th>Rolling 12 months</th>
</tr>
</thead>
<tbody>
<tr>
<td>TARGET</td>
<td>10%</td>
<td>10%</td>
</tr>
<tr>
<td>CHAT</td>
<td>1.1%</td>
<td>11.0%</td>
</tr>
<tr>
<td>Clinical Support</td>
<td>1.4%</td>
<td>14.5%</td>
</tr>
<tr>
<td>Emergency</td>
<td>0.3%</td>
<td>11.3%</td>
</tr>
<tr>
<td>Head &amp; Neck</td>
<td>0.9%</td>
<td>7.4%</td>
</tr>
<tr>
<td>Medicine</td>
<td>1.2%</td>
<td>15.5%</td>
</tr>
<tr>
<td>MOPRS</td>
<td>1.1%</td>
<td>13.8%</td>
</tr>
<tr>
<td>Musculo-skeletal</td>
<td>0.0%</td>
<td>10.4%</td>
</tr>
<tr>
<td>Renal</td>
<td>0.0%</td>
<td>7.7%</td>
</tr>
<tr>
<td>R&amp;D</td>
<td>0.0%</td>
<td>10.1%</td>
</tr>
<tr>
<td>Surgery &amp; Cancer</td>
<td>1.0%</td>
<td>12.1%</td>
</tr>
<tr>
<td>Women’s &amp; Children’s</td>
<td>0.9%</td>
<td>10.1%</td>
</tr>
<tr>
<td>Corporate Functions</td>
<td>0.5%</td>
<td>11.3%</td>
</tr>
<tr>
<td>Total Trust</td>
<td>0.9%</td>
<td>12.0%</td>
</tr>
</tbody>
</table>

In Month Turnover

Rolling 12 Month Turnover
Workforce Capacity – Absence & Health and Wellbeing

Where we want to be: targets and benchmarks Target: < 3%

Trends and Patterns
- Sickness Absence Rate (12 month rolling average) maintained at 3.9% in July 17 and remains above the target. In-month sickness absence decreased to 3.4% in July 17 and is above the target.

Root Cause analysis and insights
- CHAT, MOPRS, MSK, Research & Development and Women’s & Children’s CSC have the highest rate of in month sickness absence.
- Majority of the CSCs, with the exception of Head & Neck, Medicine, Surgery & Cancer CSC and Corporate Functions, are above the in-month 3% target in July 17.

Actions and progress to date
- HR Manager identified to specifically work with CSCs to reduce sickness absence.
- Due to in-month sickness slowly increasing over previous months, letters have been sent out to managers to distribute to staff who have met the sickness absence triggers as per the sickness absence policy to drive sickness absence down and turn off temporary workforce where possible and necessary.

Occupational Health and Safety Report
- There was 2 RIDDOR incident reported in August 17. These were both seen in Clinical Support CSC; Outpatients and Histopathology
- There were 23 sharps injuries reported in August 17. These were reported within CHAT, Emergency Care, Medicine, MOPRS, MSK, Renal, Research and Development, Surgery and Cancer and Women’s & Children’s CSC.

<table>
<thead>
<tr>
<th>Sickness Absence rate</th>
<th>In Month</th>
<th>Rolling 12 Months</th>
</tr>
</thead>
<tbody>
<tr>
<td>TARGET</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CHAT</td>
<td>4.6%</td>
<td>4.5%</td>
</tr>
<tr>
<td>Clinical Support</td>
<td>2.9%</td>
<td>3.3%</td>
</tr>
<tr>
<td>Emergency</td>
<td>2.9%</td>
<td>4.2%</td>
</tr>
<tr>
<td>Head &amp; Neck</td>
<td>2.9%</td>
<td>2.9%</td>
</tr>
<tr>
<td>Medicine</td>
<td>2.3%</td>
<td>3.2%</td>
</tr>
<tr>
<td>MOPRS</td>
<td>4.5%</td>
<td>6.0%</td>
</tr>
<tr>
<td>Musculo-skeletal</td>
<td>4.8%</td>
<td>4.1%</td>
</tr>
<tr>
<td>Renal</td>
<td>4.2%</td>
<td>5.4%</td>
</tr>
<tr>
<td>R&amp;D</td>
<td>7.0%</td>
<td>3.9%</td>
</tr>
<tr>
<td>Surgery &amp; Cancer</td>
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<tr>
<td>Women’s &amp; Children’s</td>
<td>5.3%</td>
<td>5.0%</td>
</tr>
<tr>
<td>Corporate Functions</td>
<td>1.6%</td>
<td>2.3%</td>
</tr>
<tr>
<td>Total Trust</td>
<td>3.4%</td>
<td>3.9%</td>
</tr>
</tbody>
</table>
Workforce Capacity – Absence & Health and Wellbeing

Health & Wellbeing

Flu Campaign
- Vaccines due to arrive 22nd September 2017.
- All FY1s are being trained to be workplace vaccinators to meet their IM injection competence
- The trust are focussing on 75% of front line workers being vaccinated.
- The trust are expecting high levels of flu this year based on the number of cases in Australia during their winter season. More than double the rate of cases in comparison with the same period last year.
- CSCs have been asked to identify more workplace vaccinators for this season to meet the target set.
- Vaccine takes 21 days to take effect so encouragement of staff to be vaccinated early is key.
Staff Friends and Family Test Pulse Quarter 1 2017/18 (June 2017)

Staff recommending this organisation as a place to receive care and treatment.
Quarter 1 results 2017/18 for Wessex are now available and place Portsmouth 99th of the 232 Trusts surveyed which is a decrease of 31 places. At 84% PHT scores 1% lower than the previous 1/4, 3% higher than England average of 81% and 2% lower than the Wessex average

Staff recommending this organisation as a place to work.
PHT places 135th out of 232 trusts. A negative movement of 40 places. At 62% this is 5% less than the PHT score for the previous quarter, 2% below than the England average of 64% and 8% lower than than the Wessex average.

Quarter 1 was open to all staff by paper or online survey and unregulated, meaning that it was not restricted to one response per person. The survey was open for a 4 week snapshot period in June, during a pressured period and had an 10% response rate.

Data has been shared with CSC’s for in depth analysis and priority will continue to be given to addressing the key areas of concern.

Key actions
- ‘Ask Mark’ engagement sessions; Pride of Portsmouth employee recognition; Freedom to Speak Up cohort of Advocates; Passport to Manage – management development programme to reduce variation of practice; Resilience training and Occupational Health/Counselling support for staff across the pathway; A coaching style of leadership development programme for managers and leaders.
Workforce Governance

Whistleblowing / Safeguarding / Professional Registration
• 1 Professional Registration referrals were received and reported in August 17.
• No whistleblowing referrals were reported in August 17.
• No safeguarding referral was received or reported in August 17.

Revalidation of Medical Staff
• 2 doctors have been revalidated as at 31st August 17. Due to how the revalidation dates have been set by the GMC the numbers due to revalidate are expected to fall this year and next year. The numbers will begin to increase approximately in April 2018 which will be the start of the second cycle.
• 1 doctors has been deferred as at 31st August 17.
• All medical staff are engaged in the validation process.
# Performance Arrows - At a glance performance direction

<table>
<thead>
<tr>
<th>Arrow Type</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Green up</td>
<td>Standard achieved and performance improved from last month</td>
</tr>
<tr>
<td>Green down</td>
<td>Standard achieved but performance deteriorated from last month</td>
</tr>
<tr>
<td>Red up</td>
<td>Standard not achieved but performance improved from last month</td>
</tr>
<tr>
<td>Red down</td>
<td>Standard not achieved and performance deteriorated from last month</td>
</tr>
<tr>
<td>Orange up</td>
<td>Standard not achieved, performance just below standard and improved from last month</td>
</tr>
<tr>
<td>Orange down</td>
<td>Standard not achieved, performance just below standard and deteriorated from last month</td>
</tr>
<tr>
<td>Blue up</td>
<td>Standard for monitoring and reporting only</td>
</tr>
<tr>
<td>Subject:</td>
<td>Care Quality Commission Update</td>
</tr>
<tr>
<td>---------</td>
<td>-------------------------------</td>
</tr>
</tbody>
</table>
| Prepared by: | Tracey Stenning, Head of Governance and Quality  
Joan Wilson, Head of Assurance |
| Sponsored & Presented by: | Theresa Murphy, Interim Director of Nursing  
John Knighton, Medical Director |
| Purpose of paper | To provide an update on progress against the CQC Regulatory requirements. |
| Key points for Trust Board members | Compliance and Regulation Steering Group  
- Establishment of a Compliance and Regulation Steering Group, reporting to the Governance and Quality Committee, to provide assurance that there is continuous and measurable improvement in compliance with the requirements of the CQC. |
| | Quality Improvement Plan – Phase 1  
- Quality Improvement Plan – Phase 1 published 1st September 2017 to deliver the requirements of the Section 29a Warning Notice. Plan underway for Phase 2.  
- Of the 22 actions in Phase 1 of the Quality Improvement Plan 6 have exceeded their deadline; 5 of which are currently rated as amber; the rag rating for these will be amended accordingly. |
| | Section 31* (AMU) issued 3rd March 2017 following inspection 28th February 2017  
- The Trust ensures staffing is at the required level and continues to report compliance to the CQC fortnightly, detailing all incidences where staffing has not been achieved and the actions taken to mitigate risks. |
| | Section 31* (Mental Health) issued 12th May 2017 following inspection 10th and 11th May 2017  
- The Trust continues to meet the CQC requirements to submit weekly compliance information.  
| | Section 29a re-issued 4th July 2017 following inspections 16th, 17th and 28th February and 10th and 11th May 2017  
- ‘Quality Improvement Plan Approach – Phase 1’ published 1st September 2017 to deliver requirements. |
| | Section 31 (Diagnostic and Screening Procedures) issued 28 July 2017  
- Weekly data submission to the CQC commenced 6th September. No further correspondence received from the CQC to date.  
- CQC Specialist Inspector contacted; dialogue opened for direct questions if required. |
### Options and decisions required

*Clearly identify options that are to be considered and any decisions required*

- Trust Board to agree the level of detail they wish to receive regarding the action plans to support the delivery of all the Regulatory requirements.

### Next steps / future actions:

*Clearly identify what will follow the Trust Board's discussion*

- Monthly reporting to Board, CCG and Regulators.

### Consideration of legal issues (including Equality Impact Assessment)?

- Compliance with the Health and Social Care Act.

### Consideration of Public and Patient Involvement and Communications Implications?

- Reputational impact.

### Links to Portsmouth Hospitals NHS Trust Board Organisational Priorities, Assurance Framework/ Risk Register

<table>
<thead>
<tr>
<th>Organisational Priorities</th>
<th>2: Continually improve the patient experience</th>
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<tbody>
<tr>
<td>Board Assurance Framework/ Risk Register Reference</td>
<td>BAF PE4</td>
</tr>
<tr>
<td>Risk Description</td>
<td>Maintenance of compliance with CQC regulations</td>
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<tr>
<td>CQC Reference</td>
<td>All</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Committees/Meetings at which paper has been discussed/ approved:</th>
<th>Date</th>
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</thead>
<tbody>
<tr>
<td>None</td>
<td>n/a</td>
</tr>
</tbody>
</table>
Care Quality Commission update

October 2017
CQC Regulatory Actions and Compliance update

• Compliance and Regulation Steering Group
  - Establishment of a Compliance and Regulation Steering Group, reporting to the Governance and Quality Committee, to provide assurance that there is continuous and measurable improvement in compliance with the requirements of the CQC.
  - The Group will monitor the implementation of the Quality Improvement Plan and receive assurances from the operational leads and CSC Management Teams that actions have been completed and robust evidence is available to support compliance and sustainability. If actions have not been completed, the CSC Management Teams will be expected to provide rationale as to why and revised timescales and actions to ensure compliance.

• Quality Improvement Plan – Phase 1
  - Quality Improvement Plan – Phase 1 (appendix 1) published 1st September 2017 to deliver the requirements of the Section 29a Warning Notice. Plan underway for Phase 2.
  - Of the 22 actions in Phase 1 of the Quality Improvement Plan 6 have exceeded their deadline; 5 of which are currently rated as amber; the rag rating for these will be amended accordingly.

• Regulation 17 issued following inspection 29th and 30th September 2017
  - The requirements of Regulation 17 have been included in the Quality Improvement Plan Approach.

• Section 31 (AMU) issued 3rd March 2017 following inspection 28th February 2017
  - The Trust ensures staffing is at the required level and continues to report compliance to the CQC fortnightly, detailing all incidences where staffing has not been achieved and the actions taken to mitigate risks.
  - Relocation of the TIA clinic has enabled provision of facilities to enable a ‘PitStop’ approach to the care of patients in the GP pathway.
  - The CCG have undertaken four unannounced visits to AMU demonstrating staffing was adequate to meet patients needs and staff were providing compassionate care. Minor issues identified and fed back to staff.

• Section 31 (Mental Health) issued 12th May 2017 following inspection 10th and 11th May 2017
  - The Trust continues to meet the CQC requirements to submit weekly compliance information.

• Section 29a re-issued 4th July 2017 following inspections 16th, 17th and 28th February and 10th and 11th May 2017
  - The Trust is required to make significant improvements by 31st October 2017.
  - ‘Quality Improvement Plan Approach – Phase 1’ published 1st September 2017 to deliver requirements.

• Section 31 (Diagnostic and Screening Procedures) issued 28 July 2017
  - Weekly data submission to the CQC commenced 6th September. No further correspondence received from the CQC to date.
  - CQC Specialist Inspector contacted; dialogue opened for direct questions if required.
Section 31 (AMU - issued 3 March 2017)

1. Ensure that beds only remain open in respect of which the required level of staffing can be provided. The Registered Provider must ensure that beds are opened for patient use, and closed to patient use if care and treatment at the appropriate level can no longer be provided for patients on the Acute Medical Unit.

2. Must ensure that the GP triage referral area has in place, and operates effectively a clearly defined standard operating procedure for crowding and escalation for patient safety concerns. This includes having clearly defined trigger points for escalation of crowding and safety concerns in the GP triage referral area.

3. Must ensure that there are a sufficient number (based on demand) of suitably qualified, competent, skilled and experienced clinical staff placed in the corridor/waiting area, of the Acute Medical Unit entrance and GP triage referral area. The Registered Provider must ensure that staffing is flexed appropriately to meet the acuity and dependency of patients waiting to be seen, treated or admitted to the hospital, so as to ensure their safety.

4. Must, as soon as is reasonably practicable, and in any event by 12pm on 6 March 2017, describe the system the Registered Provider is operating in the Acute Medical Unit at Queen Alexandra Hospital, which incorporates the GP triage referral area and escalation area, so as to comply with the above conditions. The trust must send the Care Quality Commission an update every two weeks in this respect from the week commencing 13 March 2017 at 3pm.

Actions:

- The Trust ensures staffing is at the required level and reports compliance to the CQC fortnightly. This report details all incidences where staffing has not been achieved and the actions taken to mitigate risks.
- 3x per day checks on staffing and oversight by the Director of Nursing.
- Relocation of the TIA clinic has enabled provision of facilities to enable a ‘PitStop’ approach to the care of patients on the GP pathway.
- Daily staffing status report from Nurse in Charge (received by Executives); a clear escalation process is in place when staffing issues arise.

Exceptions and Risks:

- Arrival of GP referred patients in “clusters” linked to GP visiting times.
- Maintaining effective flow of patients requiring simultaneous admission from GP and ED referral pathway at times of pressure.

Assurance:

- Executive led AMU support meetings.
- Fortnightly assurance meetings against the CQC requirements.
- GP Standard Operating Procedure in place and being followed.
- The CCG have undertaken four unannounced visits to AMU demonstrating staffing was adequate to meet patients needs and staff were providing compassionate care. Minor issues identified and fed back to staff.
- Monthly Governance Newsletter circulated to all staff highlighting actions taken when staff have raised concerns/incidents.
Section 31 (Mental Health – issued 12 May 2017)

1. Ensure sufficient numbers of suitably qualified and competent staff in the emergency decision unit in the emergency department to provide safe, good quality care to patients with mental health problems along with all other patient. Staffing levels and skill mix must take into account the acuity of all patients in the department at any given time.

2. Ensure that all patients presenting to the emergency department with mental health problems receive a full assessment of all risks assessment and corresponding risk management plan/care plan.

3. Identify, monitor and observe detained and / or high risk patients with mental health concerns or vulnerable safeguarding issues across the hospital and have oversight of the location of these identified and plan of care of patients at all times.

4. Ensure there are clearly identified leads for mental health provision within the emergency department and acute medical unit at all management levels. Ensure that there is executive level leadership that has accountability for mental health care, safeguarding and Deprivation of Liberty Safeguards within the hospital.

5. Ensure that Deprivation of Liberty Safeguards are applied as per the requirements of Mental Capacity Act, 2005, prior to depriving a person of their liberty.

6. Immediately take action to ensure patients are safe. As a minimum, deploying sufficient, suitably qualified and competent staff and completing robust risk assessments, plans and delivering the identified care and treatment for patients presenting with mental health issues. The trust must send the CQC an update weekly in this respect from the week commencing 22nd May 2017

Actions:
- The Trust continues to meet the CQC requirements to submit weekly compliance information in relation to the Section 31 Enforcement Notice Conditions.
- Trust-wide information day on vulnerable adults took place on 8th September 2017 attended by 168 members of staff across all professions.
- MCA and DoLS intensive training programme (vulnerable adults) commenced on 11th September 2017.
- Mental Health Service Specification agreed by all parties.
- A Mental Health and Mental Capacity Board is being established to commence the end of October. This will be a sub-Committee of Trust Board and chaired by a Non-Executive Director.
- Strengthening resource within the Adult Safeguarding Team.

Exceptions and Risks:
- Need to complete the Trust-wide ligature risk assessment and implement any actions; including education and awareness for staff.
- Reliance on agency staff to provide mental health workforce.
- The Trust is awaiting the outcome of the whole system external Safeguarding review, commissioned by Portsmouth Safeguarding Adult Board.

Assurance:
- System-wide escalation process Standard Operating Procedure in place.
- Fortnightly system call continues.
- Weekly Mental Health project meetings continue; working to the Mental Health Quality Improvement Plan.
- Engagement with third sector stakeholder group.
- Increased and sustained performance with Mental Health Risk Assessments for patients attending ED.
- Continued compliance with safe staffing requirements, balancing staffing against patient acuity.
## Section 29a Warning Notice (re-issued 4 July 2017)

### Areas for Improvement

<table>
<thead>
<tr>
<th>Area</th>
<th>Examples of concerns raised by CQC</th>
</tr>
</thead>
<tbody>
<tr>
<td>Person centred care</td>
<td>Patients and their representatives were not always involved in planning and making decisions about care and treatment</td>
</tr>
<tr>
<td>Privacy, Dignity and Respect</td>
<td>The hospital must declare mixed sex accommodation breaches as they occur in line with Department of Health guidance</td>
</tr>
<tr>
<td>Consent</td>
<td>Covert medication was observed without patient consent or appropriate documentation.</td>
</tr>
<tr>
<td>Safe Care and Treatment - Infection Control</td>
<td>Staff did not always wear personal protective equipment when administering injections, carrying bedpans and making beds</td>
</tr>
<tr>
<td>Safe Care and Treatment - Medicines Management</td>
<td>Staff in medical services must follow the trust's medicine management policy to ensure that medicines are prescribed, stored and administered appropriately</td>
</tr>
<tr>
<td>Safe Care and Treatment - Governance</td>
<td>Staff did not meet the trust's target for appraisal</td>
</tr>
<tr>
<td>Safe Care and Treatment – Patient Care</td>
<td>Patients did not routinely have robust, individualised care plans to enable staff to plan and deliver their care and treatment appropriately</td>
</tr>
<tr>
<td>Safeguard service users from abuse and improper treatment</td>
<td>Review the processes for the safeguarding of vulnerable adults and children to ensure that safeguarding processes work effectively across all services</td>
</tr>
<tr>
<td>Good Governance</td>
<td>Ensure that the culture within the organisation of staff not being willing to raise concerns openly and concerns around bullying are given sufficient priority by the board.</td>
</tr>
<tr>
<td>Staffing</td>
<td>Staffing levels did not always consider the acuity and/or dependency of patients for example detailed under the Mental Health Act.</td>
</tr>
</tbody>
</table>

### Monitoring:

- Weekly Compliance and Regulation Meetings commenced 19th September 2017. Clinical Service Centres will be invited to provide an update on progress against their action plans.
- Continued reporting to the CQC in line with Enforcement Notices with all reports submitted on time to meet with requirements.

### Embedding of Actions/assurance:

- Ward based assessments – ward reviews/peer reviews/ward accreditation.
- Internal assessments to include stakeholders.
- Documentation audits.
- External unannounced/announced visits.

### Communication and Engagement:

- Quality Improvement Plan (QIP) Phase 1 (appendix 1) launched 1st September 2017.
- Chief Executive Officer requests for volunteers to support QIP Approach Phase 2 development.
- Internal Communications commenced 18th September 2017 with programme of photo shots to include front line staff and Executive Team uploaded onto media such as Facebook, Twitter etc.
- Head of Assurance to meet with Patient, Family and Carer Collaborative 19th September 2017 to discuss the QIP Approach and request volunteers to support Phase 2 development.
Section 31 (Diagnostic and Screening procedures – issued 28th July 2017)

1. The Registered Provider must take evidenced based appropriate steps to resolve the backlog of radiology reporting using appropriately trained members of staff. This must include a clinical review, audit and prioritisation of the current backlog of unreported images, (including those taken before January 2017); assess impact of harm to patients, and apply Duty of Candour to any patient adversely affected.

2. The Registered Provider must ensure that they have robust processes to ensure any images taken are reported and risk assessed in line with Trust policy.

3. The Registered Provider must submit their evidenced based decision-making on how the backlog will be addressed to the Commission by the 21 August 2017.

4. From 6 September 2017, and on the Wednesday of each week after, the Registered Provider must report to the Care Quality Commission, NHS Improvement and the NHS England Local Area Team:
   - The total number of images remaining in the backlog (including unreported images pre-January 2017) shown by year of image taken.
   - The current trajectory date of when the backlog (including unreported images pre-January 2017) will be cleared.
   - The proportion of patients waiting less than the trusts KPI for x-rays, CT and MRI.
   - The average waiting time (in days and hours) for a reported plain film (excluding GP requests).
   - The average waiting time (in days and hours) for chest and abdominal films (excluding GP requests).
   - Number of plain film requests (excluding GP requests).
   - Longest waiting time for a reported radiology plain film request.

Actions:
- Weekly data submission to the CQC commenced 6th September. No further correspondence received from the CQC to date.
- CQC Specialist Inspector contacted; dialogue opened for direct questions if required.
- Business case for retrospective reporting approved:
  - 2 companies employed to provide reporting capacity to address the backlog. Trust Radiographic lead in place to liaise with both companies and manage day to day operational support of the radiographers reporting.
  - IT training required; planned start 29th September 2017.
  - Both companies working up trajectory for completion of backlog.
  - Both companies to provide monthly audit data of individual reporters.
- Procurement are drafting a tender for the prospective reporting of the on-going ED plain film demand (approx. 520 per week). In parallel, to prevent backlog continuing, a Single Tender Waiver will be proposed for a 3 month interim period for prospective reporting split between both companies.
- Initial draft of ‘significant finding’ process developed; currently out for comment. Further work required regarding how audit results will be documented.
- Reporting work list being developed from which the reporting radiographer team will identify the cases.
- PACS work list being developed from which the radiologists can review the positive cases.

Risks:
- Resource within the team to undertake the required work and improvements.
- Financial risks involved.

Assurance:
- As noted above.
Quality Improvement Plan – Phase 1 Update

- There are a total of 22 actions within Phase 1 of the Quality Improvement Plan (appendix 1). The status of these actions can be found below.

<table>
<thead>
<tr>
<th>Rag rating</th>
<th>No.</th>
<th>Comment</th>
</tr>
</thead>
</table>
| **RED**    | 1   | • Lack of reporting of chest x-rays (deadline 31st October 2017).  
- CQC Enforcement Notice with weekly reporting.  
- Business case for retrospective reporting approved. |

| AMBER      | 14  | • 4 actions have had their deadlines re-set:  
- Training of staff with MCA and DoLS Application. Deadline reset to 1st October 2017 to incorporate additional training.  
- Audit of appraisals and mandatory training. Reminders targeted at staff and line manager have been distributed. Deadline reset in order for an audit to be completed by 30th September 2017.  
- Safety Learning Events (incident reporting) will be correctly graded when reported. Additional staff training provided. Deadline reset in order for an audit to be completed by 30th September 2017.  
- Staffing numbers to reflect acuity of patients. Deadline reset to 1st October 2017 to incorporate system-wide workforce plan. |

| **GREEN**  | 7   | • 5 actions have exceeded their deadlines and as such will be rag rated as red. Discussion on progress will take place at the weekly Compliance and Regulation Steering Group with the leads and Clinical Service Centre’s.  
- Mixed sex accommodation breaches (deadline 31st July 2017). Non-clinically justified mixed sex accommodation breaches have been reported in line with DH guidance.  
- Embedding of staff responsibilities regarding meeting patient privacy, dignity and respect (deadline 31st August 2017). Recent CCG feedback highlighted further work to be undertaken.  
- Review and assess adherence to storage arrangements (deadline 31st May 2017). Recent CCG feedback highlighted further work to be undertaken.  
- Delivery of mandated safeguarding training programme for all clinical staff to meet with increased expectation of an intercollegiate approach (deadline due 31st August 2017). Revised training programme commenced 11th September 2017.  
- AMU action plan is embedded (deadline due 30th April 2017). Weekly Intensive Support meetings are ongoing. Further work required on recording admission observations onto VitalPAC. |

| **GREEN**  | 7   | • 5 actions are not yet due for completion.  
- These actions will be audited to ensure they remain compliant. |
# Quality Improvement Plan – Phase 1 and 2 Timeline

## PHASE 1

<table>
<thead>
<tr>
<th>Date</th>
<th>Task Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>31st August 2017</td>
<td>Finalise the reviewed and revised plan to address CQC enforcement actions with the Trust Board. This includes a more robust sign off process for queries and updates being issued outside the organisation and an enhanced assurance process.</td>
</tr>
<tr>
<td>1st September 2017</td>
<td>Publish the revised Quality Improvement Plan on the Trust Website.</td>
</tr>
</tbody>
</table>

## Phase 2

<table>
<thead>
<tr>
<th>Date</th>
<th>Task Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>4th September 2017</td>
<td>Commence engagement events with frontline staff and partners to develop the QIP detail.</td>
</tr>
<tr>
<td>22nd September 2017</td>
<td>Quality Summit where the plan will be updated to include actions from system partners to support improvements.</td>
</tr>
<tr>
<td>2nd October 2017</td>
<td>Agree Governance arrangements for the Quality Improvement Plan with the Executive Management Team to include the transformation resource to support the implementation of the plan.</td>
</tr>
<tr>
<td>9th October 2017</td>
<td>Finalise Terms of Reference for Project Board, agree chair, membership, dates for meetings for the next 12 months and invite membership to the first meeting.</td>
</tr>
<tr>
<td>16th October 2017</td>
<td>Finalise design of the plan and prepare for launch</td>
</tr>
<tr>
<td>30th October 2017</td>
<td>Launch the plan internally with staff.</td>
</tr>
<tr>
<td>31st October 2017</td>
<td>Publish the Quality Improvement Plan on the Trust Website and NHS Choices.</td>
</tr>
</tbody>
</table>
Appendix 1: Quality Improvement Plan – Phase 1

Quality Improvement Plan Approach – Phase 1
Appendix 1: Quality Improvement Plan – Phase 1

Foreword

Portsmouth Hospitals NHS Trust is developing a Quality Improvement Plan which will address a number of concerns into the quality of care received by our patients. Many were identified by the Care Quality Commission (CQC) who rated the Trust as “Inadequate” for Medical Care and across the safety domain in Emergency Care. The Board is committed to understanding the root causes of the failings in care provision and intends for the Quality Improvement Plan (QIP), to systematically address those underlying causes. This will ensure this leads to sustainable, high quality care for each and every patient and makes Portsmouth the employer of choice for our local population.

The Board will be required to focus its agenda on monitoring the delivery of the plan, creating the conditions that allow staff to do their job well, remove blocks to success and manage any risks to delivery. It will seek the support of partner organisations including the Clinical Commissioning Group (CCG), Local Authority (LA), Healthwatch. NHS Improvement to provide an element of external scrutiny thereby ensuring the Board’s assurance processes are robust. A critical facet of the plan will be the engagement of frontline staff, not only in its development, but in the improvement journey. This will ensure that the impact of any improvement made is risk assessed and understood. It will also work to support the feedback from the CEO’s 100 day plan and specifically the element of listening to staff and acting on feedback.

The Board is committed to ensuring that the improvements required are undertaken consistently and at pace. Working with all staff in the Trust and with the support of partner organisations and agencies, the Board is confident that the plan will deliver improved outcomes for further CQC inspections. Furthermore, by developing and embedding a culture of continuous improvement and supporting frontline staff to improve services through innovation the Board has set the ambition to be at “Good” by 2023.

The development of the Quality Improvement plan will be in 2 Phases, this will ensure that the enforcement actions are addressed whilst a more detailed and frontline engaged plan is developed, which will lead to sustained change. Quality Improvement themes for Phase 2 have been identified as:

- Valuing the Basics
- Supporting Vulnerability in patients
- Organisation that Learns
- Moving Beyond Safe
- Leading Well through Good Governance
Appendix 1: Quality Improvement Plan – Phase 1

The table below provides the timeline for both Phase 1 and 2.

<table>
<thead>
<tr>
<th>Phase 1</th>
</tr>
</thead>
<tbody>
<tr>
<td>31st August 2017</td>
</tr>
<tr>
<td>1st September 2017</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Phase 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>4th September 2017</td>
</tr>
<tr>
<td>22nd September 2017</td>
</tr>
<tr>
<td>2nd October 2017</td>
</tr>
<tr>
<td>9th October 2017</td>
</tr>
<tr>
<td>16th October 2017</td>
</tr>
<tr>
<td>30th October 2017</td>
</tr>
<tr>
<td>31st October 2017</td>
</tr>
</tbody>
</table>

Arrangements for external progress reporting

Current arrangements are the responsible Executive signs off any queries and report submissions to external bodies.

Due to vacancies at Board level, the current arrangements will be enhanced by any information externally submitted will be signed off by the Executive Management Team which meets on a weekly basis. This arrangement will remain in place until 31 October 2017.
Appendix 1: Quality Improvement Plan – Phase 1

The existing arrangement actions have been RAG rated and an additional category has been added to provide evidence of assurance.

**Key:**

<table>
<thead>
<tr>
<th>Status Rating</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Red</td>
<td>The action has not started, is delayed beyond its target date or will not be achieved by its target date.</td>
</tr>
<tr>
<td>Yellow</td>
<td>The action is underway and expected to be completed by the deadline date.</td>
</tr>
<tr>
<td>Green</td>
<td>The action is complete and evidence has been submitted by the action owner.</td>
</tr>
<tr>
<td>Blue</td>
<td>The action is complete and evidence has been validated. Validation includes a review of evidence by the relevant Clinical Service Centre Management Team and formal approval by the Governance and Quality Committee.</td>
</tr>
</tbody>
</table>

**Monitoring progress of the Action Plan**

Monitoring of all actions will be undertaken on a weekly basis by the Executive Director of Nursing, who will update Executives on a weekly basis and Trust Board on a monthly basis, as part of a formal reporting process.
Appendix 1: Quality Improvement Plan – Phase 1

Quality Improvement Actions – Person centred care

<table>
<thead>
<tr>
<th>How the regulation was not being met</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>CQC findings</strong></td>
</tr>
<tr>
<td>Patients and their representatives were not always involved in planning and making decisions about their care and treatment.</td>
</tr>
<tr>
<td>The needs of patients living with dementia were not fully considered.</td>
</tr>
<tr>
<td>Care plans for patients living with dementia did not broadly consider communication options.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>How the regulations will be met</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Care records demonstrate that patients, carers and families are involved in planning and making decisions.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Areas for Improvement</th>
<th>Improvement action</th>
<th>Outcome</th>
<th>Responsible person</th>
<th>Deadline Date</th>
<th>Assurance /Evidence</th>
<th>Current status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Completion of patient care records by registered nursing staff</td>
<td>Embedding of staff responsibilities regarding documentation</td>
<td>Nursing documentation</td>
<td>Deputy Director of Nursing</td>
<td>31/08/2017</td>
<td>Nursing documentation audits Quality Care reviews</td>
<td>Green</td>
</tr>
<tr>
<td>Ensure a consistent approach to meeting needs of patients with dementia across GSC</td>
<td>Review and re-launch dementia care documentation</td>
<td>Improved care for patients with dementia Improved staff knowledge and skills</td>
<td>Head of Nursing Medicine for Older People, Rehab and Stroke</td>
<td>31/08/2017</td>
<td>Nursing documentation audits Quality Care reviews Sit and see programme Peer reviews</td>
<td>Green</td>
</tr>
</tbody>
</table>
### Appendix 1: Quality Improvement Plan – Phase 1

**Quality Improvement Actions – Privacy, Dignity and respect**

<table>
<thead>
<tr>
<th>How the regulation was not being met</th>
<th>How the regulations will be met</th>
</tr>
</thead>
</table>
| CQC findings Patients should not be transferred from ambulance trolleys in the corridor outside pit stop. Staff should move | Zero mixed sex accommodation breaches occur in line with DH guidance  
Staff to consistently maintain patient privacy and dignity                                                                   |
| the patient to a more discreet area before attempting transfer, unless urgent transfer is required due to the patient’s    |                                                                                                                                                                                                                             |
| clinical condition                                                                                                                                                                      |
| The hospital must declare mixed sex accommodation breaches as they occur in line with Department of Health guidance        |                                                                                                                                                                                                                             |
| Conversations between the navigator nurses should be held in a private area to preserve the patient’s dignity and respect   |                                                                                                                                                                                                                             |

<table>
<thead>
<tr>
<th>Areas for Improvement</th>
<th>Improvement action</th>
<th>Outcome</th>
<th>Responsible person</th>
<th>Deadline Date</th>
<th>Assurance /Evidence</th>
<th>Current status</th>
</tr>
</thead>
</table>
| Ensure that staff adhere to DH guidance to avoid any mixed sex accommodation (MSA) breaches               | Review areas highlighted e.g. Cardiac Day Unit, Renal and escalation areas                                                      | Risk assessment will be carried out and where potential appropriate, screens should be used in line with DH guidance | Head of Nursing for Critical HSDU, Anaesthetics and Theatres                     | 31/07/17      | Safety Learning Events (SLE) raised for non clinically justified breaches  
Clinically Justified breaches included in report to Board Screens observed in use Daily reporting of compliance with MSA requirement | Amber          |
| Ensure that staff maintain patient privacy and dignity along the emergency pathway                         | Embedding of staff responsibilities regarding meeting patient privacy, dignity and respect                                     | Patients are moved to a discreet area in a timely manner. Patient privacy and dignity is maintained | Head of Nursing for each Clinical Service Centre (CSC)                         | 31/08/17      | Feedback from: Quality Care reviews  
Sit and see programme Peer reviews CCG visits                                         | Amber          |
Appendix 1: Quality Improvement Plan – Phase 1

Quality Improvement Actions – Consent

<table>
<thead>
<tr>
<th>How the regulation was not being met</th>
</tr>
</thead>
<tbody>
<tr>
<td>CQG findings: Planning and delivery of care was not always carried out in accordance with the Mental Capacity Act (MCA) 2005 and associated Deprivation of Liberty Safeguards.</td>
</tr>
<tr>
<td>Staff were not aware of their responsibilities under the Mental Capacity Act 2005.</td>
</tr>
<tr>
<td>Covert medication observed without patient consent or appropriate documentation. (Acute Medical Unit Plan)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>How the regulations will be met</th>
</tr>
</thead>
<tbody>
<tr>
<td>Appropriate and timely Deprivation of Liberty (DOLs) Applications</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Areas for Improvement</th>
<th>Improvement action</th>
<th>Outcome</th>
<th>Responsible person</th>
<th>Deadline Date</th>
<th>Assurance /Evidence</th>
<th>Current status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ensure staff understand their responsibilities in line with MCA and DOLs standards</td>
<td>Training of staff with MCA and DOLs application</td>
<td>Early identification, notification and application of MCA and DOLs required</td>
<td>Associate Director of Quality and Governance</td>
<td>31/05/17</td>
<td>Increase in appropriate DOLs applications, Weekly targeted clinical reviews, CCG unannounced visits</td>
<td>Amber</td>
</tr>
</tbody>
</table>
Appendix 1: Quality Improvement Plan – Phase 1

Quality Improvement Actions – Safe care and treatment – Infection Control

<table>
<thead>
<tr>
<th>How the regulation was not being met</th>
</tr>
</thead>
<tbody>
<tr>
<td>CGC findings</td>
</tr>
<tr>
<td>Staff did not always wear personal protective equipment when administering injections, carrying bedpans and making beds.</td>
</tr>
<tr>
<td>Equipment was not clean.</td>
</tr>
</tbody>
</table>

How the regulations will be met
- No evidence of cross infection

<table>
<thead>
<tr>
<th>Areas for Improvement</th>
<th>Improvement action</th>
<th>Outcome</th>
<th>Responsible person</th>
<th>Deadline Date</th>
<th>Assurance /Evidence</th>
<th>Current status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staff to adhere to the trust PPE policy</td>
<td>Training to raise staff awareness of their responsibility in adherence with trust policy</td>
<td>Staff consistently wear the correct protective equipment</td>
<td>Lead Nurse Infection Prevention &amp; Control</td>
<td>31/5/17</td>
<td>Feedback from: Quality Care reviews, Sit and see programme, Peer reviews, CCG visits</td>
<td>Green</td>
</tr>
<tr>
<td>Equipment to be cleaned in line with trust policy</td>
<td>Wards are compliant with National Patient Safety Agency (NPSA) requirements</td>
<td>Heads of Nursing for each CSC</td>
<td></td>
<td>31/5/17</td>
<td>Feedback from: Quality Care reviews, Sit and see programme, Peer reviews, CCG visits</td>
<td>Green</td>
</tr>
</tbody>
</table>
Appendix 1: Quality Improvement Plan – Phase 1

### Quality Improvement Actions – Safe care and treatment – Medicines Management

<table>
<thead>
<tr>
<th>How the regulation was not being met</th>
<th></th>
</tr>
</thead>
</table>
| CQC findings | Medicines reconciliation was not always carried out in a timely manner.  
Observation of medication and IV fluids left unattended (Staff in AMU left a bay completely unattended for 11 minutes) (AMU Plan).  
Sharps boxes were overfull, and some did not have lids.  
Medicine fridge temperatures on AMU were not recorded daily and where recorded were consistently outside the recommended temperature range.  
Staff in the medical services must follow the trust’s medicine management policy ensure that medicines are prescribed, stored and administered appropriately. |

<table>
<thead>
<tr>
<th>How the regulations will be met</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>• Standards and policies are consistently met</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Areas for Improvement</th>
<th>Improvement action</th>
<th>Outcome</th>
<th>Responsible person</th>
<th>Deadline</th>
<th>Assurance /Evidence</th>
<th>Current status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ensure that staff adhere to trust medicine management policy</td>
<td>Staff adherence to the policy to be audited</td>
<td>Peer review and audit will demonstrate staff adherence to policy</td>
<td>Director of Pharmacy</td>
<td>31/05/17</td>
<td>Audit SLE reported relating to non adherence to policy</td>
<td>Green</td>
</tr>
<tr>
<td>Medicines are stored correctly</td>
<td>Review and assess adherence to current storage arrangements</td>
<td>Audit will demonstrate adherence to policy</td>
<td>Director of Pharmacy</td>
<td>31/8/17</td>
<td>Audit Peer review Care reviews</td>
<td>Amber</td>
</tr>
</tbody>
</table>
### Appendix 1: Quality Improvement Plan – Phase 1

#### Quality Improvement Actions – Safe care and treatment – Governance

<table>
<thead>
<tr>
<th>CQC findings</th>
<th>How the regulation was not being met</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency equipment was not consistently checked and serviced in accordance with trust policy.</td>
<td>Incidents and near misses were not always reported. Staff did not always receive feedback from incidents they reported.</td>
</tr>
<tr>
<td>Staff did not meet the Trusts target for completion of appraisals.</td>
<td>Undertake harm reviews on adults to identify where lessons can be learned or mortality ratios reduced. Improve compliance with Regulation 28 coroner reports for preventing future deaths.</td>
</tr>
<tr>
<td>Undertake harm reviews on adults to identify where lessons can be learned or mortality ratios reduced. Improve compliance with Regulation 28 coroner reports for preventing future deaths.</td>
<td>Staff working with patients must have sufficient knowledge and skills to care for patients presenting with mental health condition</td>
</tr>
<tr>
<td>Staff mandatory training and appraisals did not meet hospitals own targets</td>
<td>Ensure that staff are assessed and signed off as competent to deliver patient care</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>How the regulations will be met</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Mandatory training and appraisals will achieve the target percentage</td>
</tr>
<tr>
<td>• A programme to ensure that staff undertake core skills training</td>
</tr>
<tr>
<td>• Learning from Deaths framework is embedded</td>
</tr>
<tr>
<td>• Incidents are correctly reported</td>
</tr>
</tbody>
</table>

#### Areas for Improvement

<table>
<thead>
<tr>
<th>Areas for Improvement</th>
<th>Improvement action</th>
<th>Outcome</th>
<th>Responsible person</th>
<th>Deadline Date</th>
<th>Assurance/Evidence</th>
<th>Current status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Training and</td>
<td>Audit of appraisals and mandatory training numbers</td>
<td>All staff have had their appraisals</td>
<td>Head of Organisational Development</td>
<td>31/3/17 Audit to be completed by 30/9/17</td>
<td>Audit CSC performance reports</td>
<td>Amber</td>
</tr>
<tr>
<td>development</td>
<td></td>
<td>All clinical staff have undertaken their mandatory training</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Improved SLE</td>
<td>SLE reported will be correctly graded</td>
<td>Staff will be competent in grading SLE correctly and will receive timely updates on outcomes</td>
<td>Associate Director Governance &amp; Quality</td>
<td>31/5/17 Audit to be completed by 30/9/17</td>
<td>Sample audit from Datix</td>
<td>Amber</td>
</tr>
<tr>
<td>reporting</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Learning from</td>
<td>Designing and implementing a system to undertake learning from deaths</td>
<td>Embedded learning from harm reviews</td>
<td>Medical Director</td>
<td>31/10/17 Audit of deaths from harm</td>
<td></td>
<td>Amber</td>
</tr>
<tr>
<td>deaths</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Appendix 1: Quality Improvement Plan – Phase 1

Quality Improvement Actions – Safe care and treatment – Patient Care

<table>
<thead>
<tr>
<th>How the regulation was not being met</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>CQC findings</td>
<td>There was no medical staff allocated to the pink area or the winter pressures ward. Patients did not routinely have robust, individualised care plans to enable staff to plan and deliver their care and treatment appropriately and mitigate any identified risks. Patients in the emergency department who had been referred to the medical team were not routinely reviewed in a timely way (Medical Model). Staff working within the emergency pathway did not recognise that patients with mental health needs present with increased risk and did not take practicable steps to mitigate risks (Mental Health plan).</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>How the regulation will be met</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients on the emergency pathway will be referred and seen by the medical team in a timely manner</td>
<td></td>
</tr>
</tbody>
</table>

### Areas for Improvement

<table>
<thead>
<tr>
<th>Areas for Improvement</th>
<th>Improvement Action</th>
<th>Outcome</th>
<th>Responsible person</th>
<th>Deadline Date</th>
<th>Assurance /Evidence</th>
<th>Current status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recruitment of staff</td>
<td>Proactive recruitment strategy</td>
<td>Compliant rota</td>
<td>Director of Unscheduled Care</td>
<td>31/3/17</td>
<td>Timeliness of medical review</td>
<td>Green</td>
</tr>
<tr>
<td>Not all patients have a plan of care</td>
<td>Review use of existing flags within the Bedview system to identify vulnerable patients and how this information can be used in a more intelligent manner.</td>
<td>Patients will have an individualised plan of care</td>
<td>Chief of Service Emergency Department (ED)</td>
<td>30/6/17</td>
<td>Audit of Bedview Documentation audit</td>
<td>Green</td>
</tr>
</tbody>
</table>
Appendix 1: Quality Improvement Plan – Phase 1

**Quality Improvement Actions – Safeguarding service users from abuse and improper treatment**

<table>
<thead>
<tr>
<th>How the regulation was not being met</th>
<th>How the regulation will be met</th>
</tr>
</thead>
<tbody>
<tr>
<td>CQC findings</td>
<td></td>
</tr>
<tr>
<td>Inadequate documentation of the need for further physical or chemical restraint of a patient to prevent injury to staff (Mental Health Action Plan).</td>
<td>Plans of care in place for patients with mental health issues</td>
</tr>
<tr>
<td>Patients' liberty was deprived by the use of bed rails, with no DoLS in place and no bed rails assessment undertaken (Mental Health Action Plan).</td>
<td>Zero breach in Deprivation of Liberty Safeguards (DoLS)</td>
</tr>
<tr>
<td>Review the processes for the safeguarding of vulnerable adults and children to ensure that safeguarding processes work effectively across all services.</td>
<td></td>
</tr>
<tr>
<td>Safeguards must be put in place when children or young people are admitted into adult environments such as the EDU to ensure they are sufficiently safeguarded from avoidable harm</td>
<td></td>
</tr>
</tbody>
</table>

**Areas for Improvement**

<table>
<thead>
<tr>
<th>Improvement action</th>
<th>Outcome</th>
<th>Responsible person</th>
<th>Deadline Date</th>
<th>Assurance /Evidence</th>
<th>Current status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ensure patients are protected against risk of unsafe care and treatment</td>
<td>Delivery of a mandated intensive safeguarding training programme for all clinical staff to meet with the increased expectations of an inter-collegiate approach</td>
<td>Correct application of safeguarding standards</td>
<td>Associate Director Governance &amp; Quality</td>
<td>31/8/17</td>
<td>Evidence of quarterly review of Vulnerable patient Action Plan at Quality &amp; Governance Committee</td>
</tr>
<tr>
<td>Staff understand and adhere to standards of safeguarding</td>
<td>Correct reporting of DoLS</td>
<td>Correct application of DoLS applied</td>
<td>Associate Director Governance &amp; Quality</td>
<td>30/9/17</td>
<td>Evidence of quarterly review of Vulnerable patient Action Plan at Quality &amp; Governance Committee</td>
</tr>
</tbody>
</table>
Appendix 1: Quality Improvement Plan – Phase 1

Quality Improvement Actions – Good Governance

<table>
<thead>
<tr>
<th>How the regulation was not being met</th>
<th>How the regulation will be met</th>
</tr>
</thead>
<tbody>
<tr>
<td>Governance processes were not effective at identifying risks and improving safety and quality of</td>
<td>Embedding governance framework at all levels within the organisation</td>
</tr>
<tr>
<td>services.</td>
<td></td>
</tr>
<tr>
<td>Improve the flow and capacity throughout the hospital. This will prevent patients being cared for</td>
<td>Successful completion of staff training and development</td>
</tr>
<tr>
<td>in the ED longer than necessary</td>
<td></td>
</tr>
<tr>
<td>Management of records did not always protect confidentiality of patient information.</td>
<td>Successful completion of the AMU plan</td>
</tr>
<tr>
<td>Recurring themes relating to previous Acute Medical Unit inspection (AMU Plan).</td>
<td></td>
</tr>
<tr>
<td>Review of Board Assurance Framework (BAF), board minutes and processes for reporting at board</td>
<td>Immediate review of risks associated with reporting of chest x-rays in</td>
</tr>
<tr>
<td>to ensure risks are identified and managed by the trust, and that minutes are appropriately</td>
<td>radiology.</td>
</tr>
<tr>
<td>recorded.</td>
<td></td>
</tr>
<tr>
<td>Develop a vision and strategy for the trust</td>
<td></td>
</tr>
<tr>
<td>Ensure that the culture within the organisation of staff not being willing to raise concerns</td>
<td></td>
</tr>
<tr>
<td>openly and concerns around bullying are given sufficient priority by the board</td>
<td></td>
</tr>
<tr>
<td>Immediate review of risks associated with reporting of chest x-rays in radiology.</td>
<td></td>
</tr>
</tbody>
</table>

Areas for Improvement

<table>
<thead>
<tr>
<th>Areas for Improvement</th>
<th>Improvement action</th>
<th>Outcome</th>
<th>Responsible person</th>
<th>Deadline Date</th>
<th>Assurance /Evidence</th>
<th>Current status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adherence to information governance requirements</td>
<td>Achieving training requirements and application in practice</td>
<td>Reduction in information governance breaches</td>
<td>Senior Information Risk Owner SIRO</td>
<td>31/10/17</td>
<td>SLE raised</td>
<td>Amber</td>
</tr>
<tr>
<td>AMU meets required governance standards</td>
<td>Weekly review of Action Plan</td>
<td>AMU Action plan is embedded</td>
<td>Director of Unscheduled Care</td>
<td>30/4/17</td>
<td>Weekly reviews by CQC CCG unannounced visits</td>
<td>Amber</td>
</tr>
<tr>
<td>Board governance responsibilities are understood and</td>
<td>Rewrite BAF and provide training session for the Board</td>
<td>Risks are clearly identified and monitored</td>
<td>Corporate Secretary</td>
<td>12/10/17</td>
<td>BAF will be reviewed by Board on a quarterly basis</td>
<td>Amber</td>
</tr>
</tbody>
</table>
Appendix 1: Quality Improvement Plan – Phase 1

<table>
<thead>
<tr>
<th>Areas for Improvement</th>
<th>Improvement action</th>
<th>Outcome</th>
<th>Responsible person</th>
<th>Deadline Date</th>
<th>Assurance /Evidence</th>
<th>Current status</th>
</tr>
</thead>
</table>
| Staff voice being heard and acted upon | Staff encouraged to raise concerns internally  
CEO 100 day plan  
Meet Mark engagement sessions | Feedback from staff sessions will lead to 6 themes of work which will be embedded in an OD Plan  
Improved learning across the trust from staff raising and sharing concerns | AD Organisational Development | 31/10/17 | Staff survey results (National and FFT)  
Issues raised internally via SLE | Amber                       |
| Lack of reporting of chest x-rays | Develop a plan to address management of the backlog and identify any harm to patients | Standardised process for managing x-ray reporting                                                                                           | Imaging Services Manager       | 31/10/17 | Retrospective harm reviews  
SLE raised                                                                 | Red                         |
## Appendix 1: Quality Improvement Plan – Phase 1

### Quality Improvement Actions – Staffing

<table>
<thead>
<tr>
<th>How the regulation was not being met</th>
</tr>
</thead>
<tbody>
<tr>
<td>CQC Findings</td>
</tr>
<tr>
<td>Induction processes for agency staff was variable and not robust.</td>
</tr>
<tr>
<td>Staff shortages in Acute Medical Unit (AMU plan)</td>
</tr>
<tr>
<td>Staffing levels did not always consider the acuity and dependency of patients for example patients detained under the Mental Health Act (AMU plan).</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>How the regulation will be met</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Appropriate number of skilled staff on duty to meet patient acuity</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Areas for Improvement</th>
<th>Improvement action</th>
<th>Outcome</th>
<th>Responsible person</th>
<th>Deadline Date</th>
<th>Assurance /Evidence</th>
<th>Current status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ensure there are an appropriate number of staff on duty who have received appropriate training to enable them to fulfill their duties</td>
<td>Staffing numbers to reflect acuity of patients. Escalation of staff shortages.</td>
<td>Skill mix matches patient acuity.</td>
<td>Head of Organisational Development and Head of Employee Resourcing</td>
<td>31/8/17 Deadline reset to incorporate system wide workforce plan 1/10/17</td>
<td>Compliance with rota rules Workforce metrics (i.e. turnover, sickness)</td>
<td>Amber</td>
</tr>
<tr>
<td>Subject:</td>
<td>Quality Performance Report to the Trust Board (August 2017 position)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>---------</td>
<td>---------------------------------------------------------------</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prepared by:</td>
<td>Annie Green, Head of Risk Management. Fiona McNeight, Associate Director of Quality and Governance</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sponsored by:</td>
<td>Teresa Murphy, Interim Director of Nursing</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Presented by:</td>
<td>Teresa Murphy, Interim Director of Nursing</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Purpose of paper</td>
<td>This report updates the Trust Board on significant incidents. Discussion requested by Trust Board Regular Reporting For Information / Awareness</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| Key points for Trust Board members | Trust Board are asked to consider alongside the Integrated Performance Report. **SIRI summary – August 2017**  
- A total of 16 SIRIs were reported in August; 5 breaches of DTA and 11 clinical SIRIs, 1 of which was a Never Event:  
  - 2 x Alleged physical abuse of patient.  
  - 2 x Avoidable level 3 hospital acquired pressure damage.  
  - 1 x Unexpected death of patient, potential failure to recognize deterioration.  
  - 1 x Fall resulting in fractured neck of femur.  
  - 1 x Fall resulting in open fracture to wrist.  
  - 1 x Death of premature baby born with fractured spine.  
  - 1 x Missed diagnosis of sigmoid tumour.  
  - 1 x Alleged sexual abuse of patient.  
  - 1 x Wrong site surgery; incision made on incorrect toe – Never Event.  
  
This compares to 10 clinical SIRIs reported in July.  
- Of the 11 clinical SIRIs reported in August; all patients or relatives, where applicable or appropriate, were informed of the incident within the deadline and are aware of the on-going investigation with the exception of 1 instance within Medicine CSC.  
- 152 SIRIs remain open on STEIS (Compared with 149 in July), 97 of these are Breaches of DTA.  
  - 47 SIRIs are in the process of investigation within
the Trust (14 DTA breaches).
- 10 clinical SIRIs have had their investigation completed and the reports have been submitted to the Commissioner for their review and sign off, all of these are awaiting closure by the CCG.
- 2 events on completion of investigation and receipt of post mortem were agreed with the CCG to be downgraded from SIRI status. One was a fall which occurred in July 2017 within Medicine CSC and one relating to a cardiac arrest following removal of central line which occurred in May within CHAT CSC.

**September 2017**
As of 14/09/2017 4 Clinical SIRIs have been confirmed.

<table>
<thead>
<tr>
<th>Options and decisions required</th>
<th>Trust Board are asked to note the report and feedback any areas of concern or where further information is required.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Next steps / future actions:</strong></td>
<td>This quality report forms part of the Integrated Performance Report and will continue to be submitted for information on a monthly basis.</td>
</tr>
<tr>
<td>Clearly identify what will follow the Trust Board’s discussion</td>
<td>Consideration of legal issues (including Equality Impact Assessment)?</td>
</tr>
<tr>
<td></td>
<td>Considered – no impact.</td>
</tr>
<tr>
<td>Consideration of Public and Patient Involvement and Communications Implications?</td>
<td>None – private report.</td>
</tr>
</tbody>
</table>

### Links to Portsmouth Hospitals NHS Trust Board Strategic Aims, Assurance Framework / Corporate Risk Register

<table>
<thead>
<tr>
<th>Organisational Priorities</th>
<th>Organisational priority 1: Deliver safe, high quality patient centered care. Organisational priority 2: Continually improve the patient experience.</th>
</tr>
</thead>
<tbody>
<tr>
<td>BAF/Corporate Risk Register Reference (if applicable)</td>
<td></td>
</tr>
<tr>
<td>Risk Description</td>
<td></td>
</tr>
<tr>
<td>CQC Reference</td>
<td>All domains</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Committees/Meetings at which paper has been approved:</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td></td>
</tr>
</tbody>
</table>
This report aims to provide the Trust Board with assurance that serious incidents requiring investigation (SIRI’s) including Never Events are identified, reported, investigated fully and lessons learnt across Portsmouth Hospitals NHS Trust. The Trust approach to SIRI’s is to be open and transparent and to use incidents as an opportunity for the Trust to learn and improve care for patients.

Current SIRI Position 2016/17-2017/18

<table>
<thead>
<tr>
<th>SIRI</th>
<th>Aug</th>
<th>Sep</th>
<th>Oct</th>
<th>Nov</th>
<th>Dec</th>
<th>Jan</th>
<th>Feb</th>
<th>Mar</th>
<th>Apr</th>
<th>May</th>
<th>Jun</th>
<th>Jul</th>
<th>Aug</th>
</tr>
</thead>
<tbody>
<tr>
<td>New</td>
<td>3</td>
<td>12*</td>
<td>11**</td>
<td>9</td>
<td>15***</td>
<td>40</td>
<td>94</td>
<td>115</td>
<td>55</td>
<td>59#</td>
<td>19</td>
<td>9&quot;</td>
<td>16</td>
</tr>
<tr>
<td>Under investigation</td>
<td>Nil</td>
<td>Nil</td>
<td>Nil</td>
<td>1</td>
<td>Nil</td>
<td>Nil</td>
<td>2</td>
<td>Nil</td>
<td>Nil</td>
<td>7#</td>
<td>2</td>
<td>9</td>
<td>16</td>
</tr>
<tr>
<td>Submitted to CCG</td>
<td>3</td>
<td>12</td>
<td>11</td>
<td>8</td>
<td>15</td>
<td>40</td>
<td>94</td>
<td>115</td>
<td>55</td>
<td>52</td>
<td>17</td>
<td>Nil</td>
<td>Nil</td>
</tr>
<tr>
<td>Closed by CCG</td>
<td>3</td>
<td>12</td>
<td>11</td>
<td>8</td>
<td>15</td>
<td>38</td>
<td>92</td>
<td>113</td>
<td>Nil</td>
<td>Nil</td>
<td>Nil</td>
<td>Nil</td>
<td>Nil</td>
</tr>
</tbody>
</table>

* reported as 13 in September, October, November and December reports however one event was downgraded from SIRI status following completion of the investigation.

** reported as 12 in October and November reports however one event was downgraded from SIRI status following completion of the investigation.

*** reported as 16 in December, January and February reports however one event was downgraded from SIRI status following completion of the investigation.

# reported as 60 in June report however one event was downgraded from SIRI status following receipt of the post mortem report.

" reported as 10 in July report however one event was downgraded from SIRI status following receipt of the post mortem report.

Current Never Event Position 2016/17-2017/18

<table>
<thead>
<tr>
<th>Never Event</th>
<th>Aug</th>
<th>Sep</th>
<th>Oct</th>
<th>Nov</th>
<th>Dec</th>
<th>Jan</th>
<th>Feb</th>
<th>Mar</th>
<th>Apr</th>
<th>May</th>
<th>Jun</th>
<th>Jul</th>
<th>Aug</th>
</tr>
</thead>
<tbody>
<tr>
<td>New</td>
<td>Nil</td>
<td>Nil</td>
<td>Nil</td>
<td>Nil</td>
<td>2</td>
<td>Nil</td>
<td>Nil</td>
<td>1</td>
<td>Nil</td>
<td>Nil</td>
<td>Nil</td>
<td>Nil</td>
<td>1</td>
</tr>
<tr>
<td>Under investigation</td>
<td>Nil</td>
<td>Nil</td>
<td>Nil</td>
<td>Nil</td>
<td>Nil</td>
<td>Nil</td>
<td>Nil</td>
<td>Nil</td>
<td>Nil</td>
<td>Nil</td>
<td>Nil</td>
<td>Nil</td>
<td>1</td>
</tr>
<tr>
<td>Submitted in month to CCG</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>2</td>
<td>NA</td>
<td>NA</td>
<td>Nil</td>
<td>1</td>
<td>Nil</td>
<td>Nil</td>
<td>Nil</td>
<td>Nil</td>
</tr>
<tr>
<td>Closed by CCG</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>2</td>
<td>NA</td>
<td>NA</td>
<td>Nil</td>
<td>Nil</td>
<td>Nil</td>
<td>Nil</td>
<td>Nil</td>
<td>Nil</td>
</tr>
</tbody>
</table>

New incidents in August

During August 16 Serious Incidents Requiring Investigation (SIRI’s) have been reported; 5 breaches of DTA target and 11 clinical incidents. The table below provides information on those clinical events reported this month, initial grading and the due date for submission of the investigation report to Fareham and Gosport Clinical Commissioning Group (CCG).

<table>
<thead>
<tr>
<th>Incident date</th>
<th>Datix/STEIS number and date reported CSC/Ward</th>
<th>Incident Summary</th>
<th>Immediate actions taken</th>
<th>Initial Grading</th>
<th>Date due for Submission to CCG</th>
<th>Patient outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>02/03/2017</td>
<td>Unexpected death of</td>
<td>Investigation</td>
<td>Death</td>
<td>26.10.2017</td>
<td>Patient died</td>
<td></td>
</tr>
<tr>
<td>Incident date Datix/STEIS number and date reported CSC/Ward</td>
<td>Incident Summary</td>
<td>Immediate actions taken</td>
<td>Initial Grading</td>
<td>Date due for Submission to CCG</td>
<td>Patient outcome</td>
<td></td>
</tr>
<tr>
<td>----------------------------------------------------------</td>
<td>-----------------</td>
<td>------------------------</td>
<td>----------------</td>
<td>-------------------------------</td>
<td>----------------</td>
<td></td>
</tr>
<tr>
<td>27733 2017/19581 0408/2017 Medicine/C7</td>
<td>21yr old patient with myocarditis.</td>
<td>commenced</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>15/06/2017 25985 2017/19720 07/08/2017 Emergency Medicine/AMU</td>
<td>Alleged potential psychological and physical abuse of patient by 3 members of staff.</td>
<td>Investigation commenced</td>
<td>Severe Harm</td>
<td>27.10.2017</td>
<td>Patient discharged home</td>
<td></td>
</tr>
<tr>
<td>08/08/2017 28983 2017/19871 Surgery &amp; Cancer/D7</td>
<td>Hospital acquired level 3 pressure damage</td>
<td>Investigation commenced</td>
<td>Severe harm</td>
<td>30.10.2017</td>
<td>Patient discharged</td>
<td></td>
</tr>
<tr>
<td>09/08/2017 29362 2017/20266 14/08/2017 Emergency Medicine/AMU</td>
<td>Inpatient fall resulting in fractured neck of femur requiring surgical intervention.</td>
<td>Investigation commenced</td>
<td>Severe harm</td>
<td>03.11.2017</td>
<td>Patient discharged home with follow up care.</td>
<td></td>
</tr>
<tr>
<td>31/07/2017 28804 2017/20525 16/08/2017 Emergency Medicine/ED</td>
<td>Missed opportunity to diagnose/follow up treatment for a sigmoid tumour.</td>
<td>Investigation commenced</td>
<td>Death</td>
<td>07.11.2017</td>
<td>Patient died</td>
<td></td>
</tr>
<tr>
<td>26/06/2017 26642 2017/20796 18/08/2017 Medicine/D2</td>
<td>Patient allegation of potential physical abuse of another patient overnight by HCSW.</td>
<td>Staff suspended. Investigation commenced</td>
<td>Moderate harm</td>
<td>09.11.2017</td>
<td>Patient discharged</td>
<td></td>
</tr>
<tr>
<td>18/08/2017 29871</td>
<td>Inpatient fall resulting in an open fracture to</td>
<td>All preventative measures in place</td>
<td>Severe Harm</td>
<td>14.11.2017</td>
<td>Patient being cared for on</td>
<td></td>
</tr>
</tbody>
</table>
Incidents under investigation in August
152 SIRI’s remain under investigation (97 DTA breaches). There are currently seven SIRIs which have exceeded the target date of 60 working days (27 July, 31 July 03 August, 08 August, 14 August x 2 and 17 August) for submission to the Commissioners. Three have extensions approved by the Commissioners, 1 cannot be investigated until police investigation is complete; the three without agreed extensions, due 31 July, 03 August and 08 August, sit within Medicine CSC.

Reports submitted to Commissioner in August.
The Trust completed, closed and submitted 12 clinical SIRI investigation reports to the CCG during August. The following actions were identified as a result of the completed clinical investigations:

<table>
<thead>
<tr>
<th>Incident date Datix/STEIS number and date reported CSC/Ward</th>
<th>Incident Summary</th>
<th>Immediate actions taken</th>
<th>Initial Grading</th>
<th>Date due for Submission to CCG</th>
<th>Patient outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>2017/21169 23/08/2017 MSK/D6</td>
<td>the right wrist requiring surgical intervention</td>
<td>Investigation Commenced</td>
<td></td>
<td></td>
<td>D6</td>
</tr>
<tr>
<td>21/08/2017 30075 2017/21694 31/08/2017 Medicine/E8</td>
<td>Hospital acquired level 3 pressure damage.</td>
<td>Investigation commenced</td>
<td>Severe Harm</td>
<td>22.11.2017</td>
<td>Patient discharged</td>
</tr>
</tbody>
</table>

### Incidents under investigation in August

- 152 SIRI’s remain under investigation (97 DTA breaches).
- There are currently seven SIRIs which have exceeded the target date of 60 working days (27 July, 31 July 03 August, 08 August, 14 August x 2 and 17 August) for submission to the Commissioners. Three have extensions approved by the Commissioners, 1 cannot be investigated until police investigation is complete; the three without agreed extensions, due 31 July, 03 August and 08 August, sit within Medicine CSC.

### Reports submitted to Commissioner in August

The Trust completed, closed and submitted 12 clinical SIRI investigation reports to the CCG during August. The following actions were identified as a result of the completed clinical investigations:

<table>
<thead>
<tr>
<th>2017/10699 22373</th>
<th>Actions</th>
<th>In month update</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient discharged home with known foreign object insitu. Patient died at home 12 days later – Post Mortem concluded object was a 17cm pencil causing ruptured diaphragm and right lung as cause of death</td>
<td>1. Radiologists to receive notification of this. 2. Incident to be shared at Radiology Governance meeting 3. Radiologists to receive notification of this. 4. Incident to be shared at Radiology Governance meeting 5. Learning to be shared via communications and at CSC 6. Learning to be shared via communications and at CSC governance meetings 7. Learning to be shared across the organisation</td>
<td>1. End September 2017 2. End September 2017 3. End September 2017 4. End September 2017 5. End September 2017 6. End September 2017 7. End October 2017</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>2017/12821 23879</th>
<th>Actions</th>
<th>In month update</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alleged assault of patient by member of staff</td>
<td>1. Feedback the outcome of the investigation to the staff involved on the night of the event (*to include the agency). 2. Feedback the outcome of the investigation to the SALT involved in</td>
<td>1. Completed 2. Completed 3. Completed 4. Completed</td>
</tr>
</tbody>
</table>
the event.
3. Wider trust learning on Police involvement where a crime is suspected at the earliest opportunity. Ward staff to refer to the PHT safeguarding policy and procedures, found on the PHT Intranet
4. Raise awareness amongst all staff on best practice when undertaking neurological signs, specifically on the use of the trapezius squeeze when applying central painful stimuli.

<table>
<thead>
<tr>
<th>2017/10086 22119</th>
<th>Actions</th>
<th>In month update</th>
</tr>
</thead>
<tbody>
<tr>
<td>2017/3462 16921</td>
<td>Actions</td>
<td>In month update</td>
</tr>
<tr>
<td>-----------------</td>
<td>---------</td>
<td>-----------------</td>
</tr>
<tr>
<td><strong>Inpatient fall resulting in subdural haematoma - patient died 6 weeks post fall</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| **1.** Initial Training sessions/trolley dashes completed by Falls Nurse Specialist and MOPRS Practice Educators. The sessions included:  
Primary topic on bed rail assessments and appropriate bed height.  
Falls assessment and planning with RNs  
Importance of undertaking lying and standing blood pressures to exclude postural hypotension.  
Discussion about falls documentation and evidencing actions and strategies to minimise the risk of falls.  
The importance of neurological observations  
Falls Champion to continue to lead with undertaking ward based training of staff.  
Falls Champion to undertake monthly falls documentation audit of 10 patients to review compliance on completion of risk assessment and actions taken. Audit to be feedback to the team and immediate action taken if poor compliance evident. | **1.** End September 2017  
**2.** End September 2017  
**3.** End October 2017 and ongoing  
**4.** End October 2017  
**5.** End November 2017  
**6.** Completed  
**7.** Completed  
**8.** Completed  
**9.** End September 2017  
**10.** Completed  
**11.** Completed | |
| **2.** Current compliance list printed and placed in folder- staff identified who require further training  
Staff to be written to regarding expectations of fall training, including expected timescale and to be held to account to deliver.  
Face to Face Level 2 training session to be attended by all G1 staff. Compliance to be monitored by the ward sisters. | | |
| **3.** Fall risk is assessed for all patients, and they are placed in the most appropriate bed space, as ward geography and patient dependency allows. ECO shifts are requested in a timely manner, and are highlighted both on the ward off duty and within the CSC Nursing bleep holders information folder.  
All staff aware to raise any concerns regarding staffing and patient safety to the MOPRS Matron/CSC Bleep holder. Also discussed at the MOPRS Operational Meeting held three times daily. (letter to all | | |
Head of Nursing/Matron to review current staffing level against Safer Nurse Care tool audit and take into consideration high number of cubicles on ward (11)

4. Falls Collaborative (a 90 day improvement plan for falls prevention which is national and led by the NHS Improvement with the aim to reduce falls that cause harm) has been commenced on G1 ward in July 2017. This includes:
- Working in collaboration to understand what the key priorities are for the G1 staff to support safe care
- Working to improve documentation so that the risk assessment and plan of care is easier to use.
- Improving communication about falls risk factors, especially when patients move wards.
- Introducing real-time post-falls review (SWARMS).

A meeting was held on 19.7.17 with the Falls lead nurse and senior nursing team on G1 to begin process mapping to identify areas they wish to improve, this will be done using Plan, do, study, act cycles (PDSA).

To share outcomes from the Falls Collaborative across the CSC – during the process and when completed.

5. Meeting held on 22.6.17 with the Senior Clinical Educator Simulation, MOPRS Practice Educator, MOPRS Governance Coordinator and Falls Lead Nurse to discuss arranging falls simulation training with a scenario to include:
- A falls risk patient who has delirium with a live actor – scenario to be in two parts to include the admission phase and completion of documentation/handover, followed by fall in bathroom, falls management and post-falls care.
- Total training time of 1.25 hours will include pre and post debrief + scenario.

Dates arranged for the simulation training. CSC to support ward in releasing staff to attend. Audit to be completed for attendance.
6. To review administration of Dols process and ensure that following policy across CSC
   To ensure legal and consistent process is applied.
7. To review night break practices across CSC to ensure that patient care is safe overnight – and reinforce expectations
8. Critical review of incident and falls management by Head of Assurance to review practice and identify any areas for improvement or further learning
9. Written and verbal update to all staff regarding the safeguarding process to be given.

   Ward incidents and patient feedback to be reviewed to ensure that correct process is being followed.

   To use the lessons learnt from this incident to support improvements in safeguarding process.

   CSC Management Team to undergo refresher training.
10. All staff to receive formal written update regarding completing timely statements for all clinical incidents that require further investigation
11. Review professional conduct of Registered Nurses involved in incidents against NMC decision tree to consider if further action required.

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<tr>
<th>2017/7822 19828</th>
<th>Actions</th>
<th>In month update</th>
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</table>
| Delayed diagnosis of lung carcinoma potentially contributing to patient's poor prognosis | 1. Radiographers should be encouraged to ‘Red Dot’ an OPD CXR if they are worried that it looks abnormal. The radiology department should introduce a formal process by which radiographers may escalate their concerns to a Radiologist for a report. This should be supported by ongoing education.  
2. The Rheumatology department need to assess whether failure of letters to reach GPs is a departmental issue. If this is a local departmental issue, then Rheumatology should review their practice of distributing GP letters in line with other departments.  
3. Consultant Rheumatologists should review all investigations requested at the time of | 1. Completed  
2. Completed  
3. End September 2017 |
<table>
<thead>
<tr>
<th><strong>2017/13296 24200</strong></th>
<th><strong>Actions</strong></th>
<th><strong>In month update</strong></th>
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</table>
| Unwitnessed inpatient fall resulting in fractured right neck of femur requiring surgical intervention. | 1. SAFE transfer document has been implemented on all MOPRS wards which includes a handover of the reason for admission, treatment plan, assessments, falls risk and expected discharge and next step in the patient’s journey.  
2. Initial Training sessions/trolley dashes completed by Falls Nurse Specialist and MOPRS Practice Educators. The sessions included:  
   • Primary topic on bed rail assessments and appropriate bed height.  
   • Falls assessment and planning with RNs  
   • Importance of undertaking lying and standing blood pressures to exclude postural hypotension.  
   • Discussion about falls documentation and evidencing actions and strategies to minimise the risk of falls.  
   • The importance of neurological observations  
    Falls Champion to continue to lead with undertaking ward based training of staff.  
    Falls Champion to undertake monthly falls documentation audit of 10 patients to review compliance on completion of risk assessment and actions taken. Audit to be feedback to the team and immediate action taken if poor compliance evident.  
3. Current compliance list printed and placed in folder- staff identified who require further training.  
   Staff to be written to regarding expectations of fall training, including expected timescale and to be held to account to deliver.  
   Face to Face Level 2 training session to be attended by all G1 staff. Compliance to be monitored by the ward sisters.  
4. Falls Collaborative (a 90 day improvement plan for falls prevention which is national and led by the NHS Improvement with the aim to reduce falls that cause harm) has been commenced on G1 ward in July 2017. This include  
   • Working in collaboration to understand | 1. Completed and on-going  
2. Completed  
3. Completed  
4. End October 2017  
5. End November 2017 |
what the key priorities are for the G1 staff to support safe care
• Working to improve documentation so that the risk assessment and plan of care is easier to use.
• Improving communication about falls risk factors, especially when patients move wards.
• Introducing real time post falls review (SWARMS).

A meeting was held on 19.7.17 with the Falls lead nurse and senior nursing team on G1 to begin process mapping to identify areas they wish to improve, this will be done using Plan, do, study, act cycles (PDSA).

To share outcomes from the Falls Collaborative across the CSC – during the process and when completed.

5. Meeting held on 22.6.17 with the Senior Clincial Educator Simulation, MOPRS Practice Educator, MOPRS Governance Coordinator and Falls Lead Nurse to discuss arranging falls simulation training with a scenario to include:
   - A falls risk patient who has delirium with a live actor – scenario to be in two parts to include the admission phase and completion of documentation/handover, followed by fall in bathroom, falls management and post falls care.
   - Total training time of 1.25 hours will include pre and post debrief + scenario.
   Dates arranged for the simulation training. CSC to support ward in releasing staff to attend.
   Audit to be completed for attendance.

<table>
<thead>
<tr>
<th>2016/30745 13236</th>
<th>Actions</th>
<th>In month update</th>
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<tbody>
<tr>
<td>Patient suffered MI whilst on waiting list for angiogram, causing irreversible damage. Waiting list has increased. Patient requires urgent bypass and outcome may now be affected.</td>
<td>1. To reduce CDU admissions. CDU admissions to remain under 7 with urgent angiography appointments being scheduled within 2 weeks and routine appointments to be scheduled within 6 weeks, in line with current best practice. 2. Establish a standard for waiting list times for angiography/angioplasty.</td>
<td>1. Completed 2. Completed</td>
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<tr>
<th>2017/16614</th>
<th>Actions</th>
<th>In month update</th>
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</table>
17 day old baby admitted from maternity center in collapsed state to CAU; required transfer to PICU where he subsequently died. Event reported to the police and is part of a current ongoing investigation. Referred for serious case review as alleged non accidental injury.

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<tr>
<th>Actions</th>
<th>In month update</th>
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<tbody>
<tr>
<td>1. New pathways have been created and will be published with new maternity notes -Training for staff will be created and advertised -Individual midwife to review how they undertake mental health assessments; to undertake a personal reflection 2. Review of competencies by practice education team: -To review the conflict of opinion guidance to provide a pathway for MSW’s -To identify training needs of the MSW’s with regards to managing difficult conversation training targeted at MSWs 3. To be incorporated in the current rolling mandatory training of all staff within PHT Update safeguarding children and young people practice guidance/operational policy to include this guidance. 4. New PHT guideline and/or pathway to be developed for the identification and management of potential NAI. 5. Task and finish group across both organisations to be created to ensure that both pathways are the same. 6. Multi-professional meeting arranged to review the case and look at wider learning across multiple agencies -Changes in practice to be highlighted and circulated to all agencies 7. Audit action plan to be completed. 8. Actions of key individual staff members to be further reviewed using the NMC Decision Tree</td>
<td>1. End October 2017 2. End October 2017 3. Completed and on-going 4. End December 2017 5. End October 2017 6. End October 2017 7. End March 2018 8. End September 2017</td>
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<tr>
<th>2017/15445 25714</th>
<th>Actions</th>
<th>In month update</th>
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<tbody>
<tr>
<td>Inpatient fall resulting in fractured left hip requiring surgical intervention.</td>
<td>1. To share report with staff involved with patient- regarding good practice. 2. To feedback to staff regarding proactive pain management for any patients who may have suffer injuries as a result of a fall or clinical incident. To monitor effectiveness of pain management in the event of any clinical incident. 3. Ensuring best practice in management of pain post fall</td>
<td>1. Completed 2. Completed and on-going 3. Completed</td>
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<tr>
<th>2017/15472 25682</th>
<th>Actions</th>
<th>In month update</th>
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</table>
Inpatient fall resulting in right peri-prosthetic fractured femur requiring surgical intervention.

1. Share outcome of investigation with ward team through face to face conversation, all ward email, noticeboard and in 'latest news' information file.
2. Identify 4 RNs and 4 CSWs to take on the challenge of improving compliance in postural blood pressure taking. Ensure senior nurses on ward are supportive and encouraging.
3. Wednesday and Saturday to be ‘audit’ day.
4. Share positive feedback through face to face, email, noticeboard and info file.
5. Raise issue of single sex ward with Matrons and Head of Nursing.
6. Introduce a TAG team approach to ensure MDT ownership of patients who are at risk of falls and ensuring consistent observation when nursing staff need to undertake clinical care of other patents.
7. Refresh Safeguarding training to ensure safeguarding alerts are sent appropriately.

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<tr>
<th>2017/10865 15115</th>
<th>Actions</th>
<th>In month update</th>
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<tbody>
<tr>
<td>Possible anaphylactic reaction resulting in the patient sadly dying.</td>
<td>1. Education around the rare occurrence of anaphylaxis after multiple drug doses have been administered. 2. Organisational learning. 3. Sharing information about missing documentation.</td>
<td>1. End September 2017 2. End September 2017 3. Completed</td>
</tr>
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<tr>
<th>2017/15859 26266</th>
<th>Actions</th>
<th>In month update</th>
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<tr>
<td>8.</td>
<td>Use this incident an example to support the case for an electronic prescribing system for the Trust.</td>
<td></td>
</tr>
<tr>
<td>9.</td>
<td>Include abbreviation is not acceptable in junior doctor induction diabetes session.</td>
<td></td>
</tr>
<tr>
<td>10.</td>
<td>Document on Datix and ongoing monthly spot check review of any abbreviations of U for Units used and direct feedback to prescribers/nursing staff wherever possible.</td>
<td></td>
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<tr>
<td>11.</td>
<td>Liaison with Learning and Development to review essential skills handbook and training to see if improvements need to be made and explore possibility of having mandatory medicines safety questions with essential skills.</td>
<td></td>
</tr>
</tbody>
</table>
**Subject:** Examples of Complaints

| Prepared by: | Marion Brown, Theresa Murphy, Director of Nursing |
| Sponsored & Presented by: | |

**Purpose of paper**
The Board are asked to consider the complaints.

**Key points for Trust Board members**
Briefly summarise in bullet point format the main points and key issues that the Trust Board members should focus on including conclusions and proposals.

<table>
<thead>
<tr>
<th>Complaint 1</th>
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<tbody>
<tr>
<td>Unhappy with father's discharge process and that he was discharged with a catheter in place, which family were unaware of and no provisions provided for catheter. Also lack of communication with District Nurses.</td>
</tr>
<tr>
<td><strong>Improvements as a result of complaint:</strong></td>
</tr>
<tr>
<td>- This complaint highlighted a serious weakness in the use of the Discharge Lounge as an overnight facility. Confirmation given that the Discharge Lounge is no longer being used for patients staying overnight.</td>
</tr>
<tr>
<td><strong>Domain:</strong> Safe and Responsive</td>
</tr>
<tr>
<td><strong>Actions already undertaken.</strong></td>
</tr>
</tbody>
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<table>
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<tr>
<th>Complaint 2</th>
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<tbody>
<tr>
<td>Unhappy with long wait in Day Surgery Unit for procedure to take place and cold environment.</td>
</tr>
<tr>
<td><strong>Improvements as a result of complaint:</strong></td>
</tr>
<tr>
<td>- Letter that is sent to patients with confirmation of their procedure date does now advise that when attending Day Surgery they could potentially be waiting all day, as Theatre lists can change.</td>
</tr>
<tr>
<td><strong>Domain:</strong> Well Led and Responsive</td>
</tr>
<tr>
<td><strong>Actions already undertaken.</strong></td>
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</tbody>
</table>

**Options and decisions required**
Clearly identify options that are to be considered and any decisions required.

**Next steps / future actions:**
Clearly identify what will follow the Trust Board's discussion.

**Consideration of legal issues (including Equality Impact Assessment)?**
<table>
<thead>
<tr>
<th>Consideration of Public and Patient Involvement and Communications Implications?</th>
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<thead>
<tr>
<th>Links to Portsmouth Hospitals NHS Trust Board Organisational Priorities, Assurance Framework/ Risk Register</th>
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<tbody>
<tr>
<td>Organisational Priorities</td>
</tr>
<tr>
<td>Board Assurance Framework/ Risk Register Reference</td>
</tr>
<tr>
<td>Risk Description</td>
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<tr>
<td>CQC Reference</td>
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<tr>
<th>Committees/Meetings at which paper has been discussed/ approved:</th>
<th>Date</th>
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141
Mr Tim Powell  
The Chief Executive  
Portsmouth Hospitals NHS Trust  
Portsmouth  
PO6 3LY  

Monday 19 June 2017 10am  

Dear Mr Powell  

I would like to draw attention to a very poor experience that my father has had at Queen Alexandra Hospital. He was admitted on Saturday May 13th 2017 and subsequent to that admittance he picked up both urine and chest infections.
I received a phone call on the morning of Tuesday June 13th 2017 from ward where my father had been under care, stating that they had arranged transport and were going to drop him home at midday! He lives alone and is nearly 94 years old! I responded by informing them my father did not have a key and I would collect him between 4 to 4.30. By leaving work early from Hythe Southampton I duly arrived at 4.25.

A nurse met me at North Entrance within 10 minutes of my call saying I had arrived. She had my father in a wheelchair and assisted me to my car, whereupon she handed me 2 bags, one containing his clothes and the other his tablets. She said there were instructions relating to his new tablets enclosed and left us to it.

On returning to my father’s home, I made my father comfortable, then did some shopping and made him a meal. Shortly afterwards my father wanted to use the toilet, so I assisted him to the bathroom and then returned after a few minutes to find my father rather distressed, saying he could not pee. To my utter astonishment, at that point, I realised my father still had his catheter and leg bag fitted! The reason he was distressed was that it was full to bursting, so he could not pass any more urine due to the obvious back pressure he was getting from the bag. Consider for a moment that it had been the intention of the hospital to deliver my father to his home alone!! How could he possibly have managed?

At no point had I been told that my father still had a catheter, or for that matter been shown how it worked or what to do in the event it needed emptying.

It was now 9pm in the evening. I rang Ward and asked why a 93 1/2 year old man had been discharged with a catheter and leg bag which he (being hampered by his age, lack of memory and perception of what was going on) and I had no knowledge of. She told me it was joint decision by various members of the staff and social services whom I was supposed to have liaised with. I told her no one from social Services had spoken to me about my father’s discharge and neither had any nursing staff or doctors. I expressed my view this was an appalling situation and that my father should never have been discharged in this manner, without any forewarning of the situation he was now in. She kept apologising but said there was nothing she could do! I told her I would have to call an ambulance and she said that was up to me!

So here I was not knowing how to deal with my poor father’s distressing situation completely in the dark about the catheter or how to empty the leg bag, without any help, guidance, notes or details in the bags which I took from the nurse at the discharge point!
Left with no option I called 999 and explained the situation. I was told a paramedic would call me back. About 15 minutes later a paramedic rang me. I explained the situation. He said he would call ward and call me back. He rang back only 5 minutes later to tell me there was nothing he could do as the nurse on ward said my father HAD to have the catheter! He did explain to me how to empty the catheter bag which I duly did at 10pm and again at 4am when my father was again in obvious distress. I do not live with my father but stayed that night as my father obviously could not manage the catheter on his own. I am astounded that no one involved in his care at the hospital thought of that and simply discharged him regardless!

At 8.15am the following morning I was at my father’s GP surgery to get some help. The receptionist rang the District Nurse’s office, which was shut until 8.45am. I waited until then and then explained the situation to the District Nurse. She was appalled that my father had been discharged in this manner and said she would visit at 10.30am. She asked me about the equipment (night bags, additional leg bags, straps etc) that the discharge nurse must have given me. I explained I had no such items and had not been given any indication that my father had a catheter at all! She found this absolutely astounding!

When she arrived, she told me that she had phoned ward and asked why they had not informed the District Nurse’s Office of my father’s discharge with a catheter, which apparently is MANDATORY for any patient being discharged with a catheter, so that the District Nurse can arrange visits to care for the patient!!

ward were very unhelpful at which point the District Nurse phoned the Matron, whom she said was astonished at the situation and would be looking into it!!

The District Nurse then asked to see my father’s Discharge Notes…he had NONE!

Thankfully the District Nurse had brought all the necessary equipment and showed me how to use it all, which I and latterly Bluebird Care (once I could get the care package in place!!) have been doing ever since.

In summary I would be obliged if you could explain to me how:

1. A 93 1/3 year old man can be discharged without consultation to me, his son, about any care package that he might or would need being put in place.

2. That he could be discharged with a catheter in place that I had no knowledge of or were given instructions regarding the care needed.

3. There were no materials given (i.e. nights bags, leg bags or any other form of catheter package)

4. There was no information supplied to the District Nurse about the catheter care that my father would need after his discharge, which apparently is mandatory.

5. There was no information regarding my father’s discharge sent to his GP surgery.

6. And there were no Discharge notes given, which surely is the icing on a very poor cake!
I look forward to your reply and explanation of all of the above points at your earliest convenience.

Yours sincerely

Footnote: (Monday 19 June 2017 at 2.30pm)

I have just been informed that Bluebird Care have phoned the paramedics due to my father being poorly (he has not been right since being discharged) and my father has just been taken back to Q A Hospital.

I DO hope he has a better outcome this time!
11 August 2017

Our Ref: MC16B/181

Dear [Name]

Re: [Specific Information]

I am writing in response to your letter dated 19 June 2017 which describes your father’s poor experience and difficulties with his discharge from Queen Alexandra Hospital recently. I am sorry to hear that things did not go as well as we would have expected and apologise for the distress that was caused as a result.

The Trust aims to provide the highest standard of care for all of our patients therefore I am grateful for having had the opportunity to look into the issues you have raised. In line with the Trust’s formal complaints policy, staff from the Complaints Team have co-ordinated an investigation on my behalf and information has been received from the following members of staff to allow me to respond to your complaint:

- [Name], Discharge Lounge
- [Name], Lead for Discharge Services
- [Name], Ward Sister

I was also sorry to hear that your father had been discharged without appropriate consultation with you or an appropriate package of care being put in place. Having carried out a review of your father’s medical records, she confirms that there is a note that his next of kin was made aware on admission (13 May 2017) that the plan was for him to return home with a restart of the package of care.

It was also documented that your father was privately funded and that the care agency was Blue Bird Care. It was also discussed, according to the medical records, that the next of kin (son) did the shopping and that your father was usually mobile independently with either a stick or frame.

On 12 June 2017, the day before discharge, it was noted that you had pre-warned the Care Agency that your father would need a package of care to restart the next day (13 June 2017). It also stated that you were happy to bridge any gaps if the care was unable to restart for any reason and you were very pleased that your father was going home.

Normally, on the day of a patient’s discharge, Ward staff will give a detailed handover to the next of kin and ensure that they relay all information to help facilitate a safe and comfortable discharge. In this case the full details of his discharge and catheter care would have been discussed with both you and your father if he had still been on [Specific Equipment] at the time of discharge.
Having reviewed his records, I have been informed that your father was transferred to the Discharge Lounge the day before his discharge and the handover of his care and discharge arrangements were carried out by a member of the Patient Flow Team and not Ward staff. At this point it seems that there was a poor handover and the Discharge Lounge Team were not informed that your father needed catheter advice and equipment, as well as referral to the District Nursing Team to provide input for a patient with a new catheter prior to his discharge from the hospital.

[Redacted] acknowledges that a call was received from you on 13 June 2017 at 21:40hrs and the Nurse on duty provided advice on how to empty the catheter bag using the valve at the bottom of the bag and suggested that the Sister could call you in the morning, but unfortunately the call was ended before any telephone numbers could be sought.

[Redacted] has looked into the issues raised regarding the Discharge Lounge and confirms that on 14 June 2017, he received a telephone call from Ward Sister advising that your father had not been given any advice or supplies. On reviewing the details of the handover that took place at 17:02hrs, on 12 June 2017, it appears that there was no information passed to his Team that there was any requirement to supply catheter bags or refer to the District Nursing Team.

Your complaint has clearly highlighted serious weaknesses in the use of Discharge Unit as an overnight facility and I am pleased to say that the Discharge Lounge is no longer being used for patients staying overnight. We fully appreciate the importance of ensuring that patients have a smooth transfer from the hospital back to their home environment and I am very sorry that in your father’s case this did not happen.

I hope that this response will help to provide you with reassurance and confidence that the Trust has listened to your concerns and addressed them appropriately. I can confirm that the Senior Management Teams involved are fully aware of the details of your complaint and will continue to work with their Teams to ensure that every effort is made to manage patient discharges more effectively in future.

Should you have any concerns about the investigation of your complaint, then please contact the Complaints Team who will assist and advise you further on 02392 286000 ext 3470/3471 or via email at PHT.Complaints@porthosp.nhs.uk.

The Trust aims to resolve this matter with you, but if you are unhappy with the way your complaint has been handled then you also have the right to refer this to the Parliamentary and Health Service Ombudsman (www.Ombudsman.org.uk).

Yours sincerely,

[Signature]

Mark Cubbon
Chief Executive
Complaints Coordinator

From: [Redacted]
Sent: 08 May 2017 18:00
To: [Redacted]
Subject: PHT Complaints

Good afternoon,

I would like to complain to the Qa hospital trust regarding my treatment today, details as follows:

I would like to give my account for details following my admission to hospital this morning, for an operation. And the poor care from the hospital trust, I called the hospital last week 19-5-17 to confirm times, I was advised to be Nil by mouth, from 0:00 and only have clear fluids up to 06:30 am on the 8-5-17, as I was booked in for the operation am (was told be forth in) I attended day surgery unit at 06:30 and booked in with receptionist at 06:45, my obs were carried out at 07:45 and was seen by the surgeon at 08:00, then the anaesthetist which came round advised me would be late morning around 11:30, On seeing surgeon I was advised that I could have a small amount of either water or black coffee due to the lateness of operation, I waited in reception when I was given painkillers at 10:00-10:30, the reception area was cold and most people were complaining about coldness at no point was I offered drinks to keep me hydrated, I had to ask for a blanket to try and warm myself up, throughout the morning I asked for updates as to when operation would be, as I started feeling light headed and dehydrated, at no point was I offered anything to drink, I was told that operation had to be put back and would be carried out around 13:00-13:30 around 12:30, when waiting in the reception a other patient arrived which I started speaking to and she was an afternoon operation, 13:30 pasted and still no information was forward to me, bearing in mind that I was meant to be 4th and my last meal was on the 7-5-17 at 18:00 apart eating a light snack as didn’t want to jeopardise the operation as AM appointment, now being nil by month for over 12hrs, I again asked for and update were I was told would be next down, some 8.5hrs after admittance, still feeling, weak, cold, hungry and dehydrated, around 14:45 I again asked as my Energy levels felt even Lower at 15:15 I had no option to discharge myself to have something to eat and be collected. could you please look into the complaint. I look forward to reply in this matter.

Yours faithfully,
6 June 2017

Our Ref: TP/SM/mh/

Dear [Name]

I am writing in response to your email sent to us on 8 May 2017. I was very sorry to learn of your concerns you have raised regarding the delays experienced on the day of your surgery, but am grateful for the opportunity to look into this for you.

In line with the Trust's formal complaints policy, staff from the Complaints Team have co-ordinated an investigation on my behalf and information has been received from the following members of staff to allow me to respond to the issues you have raised:

- Business Manager, Women & Children's Clinical Service Centre
- Day Surgery Unit

I would also like to assure you that the Senior Management Team of the relevant Clinical Service Centres have been made aware of the details of your concerns to ensure that any learning or actions required will be taken forward.

I am aware that in your email you have raised specific concerns, and for clarity, I will respond to these in the order they appear.

You advise that whilst waiting in the Day Surgery Unit, you were cold and not offered a drink: [Name] was sorry to hear that you were cold whilst waiting for your procedure, although she is aware that you were provided with a blanket. A request was made to Carillion plc (Queen Alexandra's Hospital's Facilities Management Team) who have checked the air conditioning temperature and have confirmed that there was no fault in the system on this day. The system is centrally controlled and a constant temperature was maintained in both the main waiting room and the area where you sat when you were changed. However, we recognise it is problematic ensuring a temperature which is suitable for everyone and we will continue to monitor this.

With regard to you being offered a drink, [Name] explains that staff are sometimes unaware of the directions provided to a patient from Surgeons and Anaesthetists, especially if they do not share this information with staff on the Day Surgery Unit. Having spoken to the staff on duty that day, [Name] advises that no one can remember being informed that you could have a drink, neither is it documented. Drinks are not offered on a regular basis due to the quick changing nature of surgery and that a patient may have to be starved (of fluids for two hours) to prevent complications during and after surgery.
would like to assure you that she has discussed this with her Nursing staff at the morning huddles.

You were due to have your procedure late morning, but this was changed to the afternoon. It is noted that you were advised by the Surgeon that you would be going to Theatre late in the morning, but unfortunately, you had not gone down by 3.00pm.explains that unfortunately, there are times when operations can develop complications and overrun and confirms that this is what caused your delay. She would like to apologise that you were not kept informed or updated with regard to the delay and all staff have been reminded of the importance of keeping patients updated.

As you had been in Day Surgery Unit since 6.30am and had still not gone to Theatre by 3.15pm, you discharged yourself: It is acknowledged that you were in the Department for an extended period of time and you therefore made the decision to discharge yourself. To ensure that this does not happen again, the Gynaecological Waiting List Department have been given a letter to send out with procedure dates for patients attending Day Surgery to potentially expect to wait all day.

It is documented that your husband contacted the Day Surgery Unit to ask if you could return and have your procedure on this day, which he was told you could do, provided you had not had anything to eat or drink. He confirmed that he would be ten minutes.explains that following this telephone call, the Theatre was paused to wait your return, and when you had not arrived after thirty five minutes, the list continued.

explains that as advised by you left the Theatre Suite prior to your operation and as such declined your surgery and removed yourself from the waiting list. It was also disappointing that you did not return for surgery later that day as agreed with your husband. This led to the cancellation of another patient, as staff were holding the Theatre time for you. has confirmed that on this occasion the Gynaecology Department will offer you another surgery date, which will be sent to you shortly.

I would like to add my own apology again to those above for the delay you experienced and would like to take this opportunity to wish you well with your procedure and recovery... I hope this response will help to provide you with reassurance and confidence that the Trust has listened to your concerns and addressed them appropriately.

At this stage, if you have any concerns about the investigation of your complaint, then please contact the Complaints Team on 02392 286000 ext 3470/3471 or via email at PHT.Complaints@northhosp.nhs.uk who will assist and advise you further.

The Trust will make every effort to resolve this matter with you; however you also have the right to refer your complaint to the Parliamentary and Health Service Ombudsman if you are unhappy with the way your complaint has been handled. E-mail: pheo.enquiries@ombudsman.org.uk or telephone 0345 015 4033.

Yours sincerely

Tim Powell
Chief Executive
Subject: Complaints and PALS Report – Quarter 1 2017/18

Prepared by: Marion Brown, Head of Complaints and PALS
Sponsored & Presented by: Theresa Murphy, Interim Director of Nursing

Purpose of paper
In line with DoH Regulations, this report is to provide assurance to the Board of compliance with current legislation of NHS complaints handling.

Key points for Trust Board members
Briefly summarise in bullet point format the main points and key issues that the Trust Board members should focus on including conclusions and proposals

- 142 formal complaints received (17% reduction from Quarter 4 2016/17 and 28% reduction from Quarter 1 of previous year.
- 100% acknowledged within national standard of 3 working days
- 1,506 contacts received by PALS, 91% resolved within 5 working days
- 1,725 compliments/plaudits received

Options and decisions required
Clearly identify options that are to be considered and any decisions required

The Trust Board are asked to note the contents of this report and provide any feedback if required.

Next steps / future actions:
Clearly identify what will follow the Trust Board's discussion

Consideration of legal issues (including Equality Impact Assessment)?
Report is required in line with NHS Complaints Regulations (2009)

Consideration of Public and Patient Involvement and Communications Implications?
We rely on public and patient feedback to provide us with this rich source of feedback.

Links to Portsmouth Hospitals NHS Trust Board Organisational Priorities, Assurance Framework/ Risk Register

<table>
<thead>
<tr>
<th>Organisational Priorities</th>
<th>Deliver safe, high quality, patient centred care. Improve patient experience as a result of feedback received through complaints and PALS contacts.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Board Assurance Framework/ Risk Register Reference</td>
<td>1.4</td>
</tr>
<tr>
<td>Risk Description</td>
<td>Failure to meet requirements of NHS Complaints Regulations 2009, CCG contract requirements, CQC requirements and achieve internal and external standards around patient experience as measured through Francis Report and Clwyd Review 2013</td>
</tr>
<tr>
<td>CQC Reference</td>
<td>Regulation 16: Receiving and Acting on Complaints</td>
</tr>
<tr>
<td>Committees/Meetings at which paper has been discussed/ approved:</td>
<td>Date</td>
</tr>
<tr>
<td>-------------------------------------------------------------</td>
<td>------</td>
</tr>
<tr>
<td>Patient Experience Committee</td>
<td></td>
</tr>
</tbody>
</table>
COMPLAINTS AND PALS REPORT
QUARTER 1 2017-18 (1 April 2017 to 30 June 2107)

1. INTRODUCTION
The aim of this report is to provide the Trust’s Board with an overview of the complaints and concerns received during Quarter 1 2017/18.

2. KEY POINTS
- 142 formal complaints received (17% reduction from Quarter 4 (171) and a 28% reduction from Quarter 1 of the previous year – 197).
- 100% acknowledged within national standard of 3 working days.
- 1,506 contacts were received by PALS, 91% resolved within 5 working days.
- Trends through complaints and PALS remain: Aspects of clinical treatment, Outpatient appointment delays and cancellations (Gastroenterology and Cardiology) and delays in scanning and reporting at Radiology.
- 1,725 compliments/plaudits have been received.

3. PERFORMANCE INDICATORS
The Trust achieved 100% compliance with its statutory requirement to acknowledge all complaints within 3 working days.

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Q4 2016/17</th>
<th>Q1 2017/18</th>
</tr>
</thead>
<tbody>
<tr>
<td>No. of complaints acknowledged within 3 working days</td>
<td>171 (100%)</td>
<td>141 (100%)</td>
</tr>
<tr>
<td>No. of responses sent within deadline (30 working days)</td>
<td>71 (42%)</td>
<td>66 (47%)</td>
</tr>
<tr>
<td>No. of complaints sent after required deadline</td>
<td>94 (55%)</td>
<td>39 (28%)</td>
</tr>
<tr>
<td>No. of complaints ongoing</td>
<td>6 (3%)</td>
<td>36 (25%)</td>
</tr>
<tr>
<td>No. of complaints involving weekend incident</td>
<td>18 (11%)</td>
<td>5 (3%)</td>
</tr>
</tbody>
</table>

The continued pressure on the hospital is impacting on staff’s ability to provide a timely investigation and response to a large number of complaints. 75 complaints received in Quarter 1 are still under investigation, but we can review the performance in Quarter 4 which shows that the number of complaints which were sent within the target (30 working days) was 71 (42%).
4. SUBJECTS
In keeping with national data, the majority of complaints received involved aspects of Clinical Treatment (59), a reduction is seen in complaints about Admission, Discharge and Transfer (25 - previous quarter 32).

5. TOP 5 SUBJECTS - COMPARISON TO PREVIOUS QUARTER
Given the overall reduction in the number of complaints received, as expected, compared to Quarter 4 there has been a reduction in the top 5 most common themes from complaints.

<table>
<thead>
<tr>
<th></th>
<th>Q4</th>
<th>Q1</th>
<th>Variance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aspects of Clinical Treatment</td>
<td>70</td>
<td>59</td>
<td>↓11</td>
</tr>
<tr>
<td>Admission, Discharge and Transfer</td>
<td>32</td>
<td>25</td>
<td>↓7</td>
</tr>
<tr>
<td>Communication</td>
<td>17</td>
<td>12</td>
<td>↓5</td>
</tr>
<tr>
<td>Attitude/Behaviour</td>
<td>16</td>
<td>11</td>
<td>↓5</td>
</tr>
<tr>
<td>OP Appt delay/cancel</td>
<td>12</td>
<td>6</td>
<td>↓6</td>
</tr>
</tbody>
</table>

6. BREAKDOWN BY QUARTER
There is a rise in complaints involving Corporate Services which is due to the Integrated Discharge Bureau now coming under their remit. Compared to Quarter 1 of last year, there has been a considerable rise in the number of complaints involving MOPRS; the rise is expected given the pressure on this area of the hospital and most common theme appears to be aspects of patient discharge. A considerable reduction in complaints is seen at Head & Neck.

<table>
<thead>
<tr>
<th>CLINICAL SERVICE CENTRE</th>
<th>Q1 16/17</th>
<th>Q2 16/17</th>
<th>Q3 16/17</th>
<th>Q4 16/17</th>
<th>Q1 17/18</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical Support Services</td>
<td>7</td>
<td>7</td>
<td>8</td>
<td>7</td>
<td>9</td>
</tr>
<tr>
<td>Corporate Services</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>Medicine for Older People, Stroke, Rehab</td>
<td>4</td>
<td>6</td>
<td>12</td>
<td>13</td>
<td>13</td>
</tr>
<tr>
<td>Emergency Department</td>
<td>33</td>
<td>29</td>
<td>23</td>
<td>36</td>
<td>28</td>
</tr>
<tr>
<td>Head &amp; Neck</td>
<td>18</td>
<td>16</td>
<td>16</td>
<td>12</td>
<td>1</td>
</tr>
<tr>
<td>Medicine</td>
<td>45</td>
<td>30</td>
<td>32</td>
<td>32</td>
<td>27</td>
</tr>
<tr>
<td>Renal &amp; Transplant</td>
<td>7</td>
<td>2</td>
<td>4</td>
<td>4</td>
<td>3</td>
</tr>
<tr>
<td>Theatres, Anaesthetics, Critical Care</td>
<td>2</td>
<td>3</td>
<td>1</td>
<td>6</td>
<td>4</td>
</tr>
</tbody>
</table>
7. SEVERITY OF RISK ASSOCIATED
During Quarter 1, the majority of complaints were graded as moderate risk (66%). Only 14% were considered high risk and were shared with the Trust's Risk and Legal Teams to ensure that these are handled through the most appropriate process.

All high risk complaints are reviewed monthly at the Quality Triangulation Meeting which is chaired by the Director of Nursing and attended by Head of Risk and Head of Legal Services.

<table>
<thead>
<tr>
<th>GRADE OF SEVERITY</th>
<th>No.</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Green (Low risk)</td>
<td>28</td>
<td>20%</td>
</tr>
<tr>
<td>Yellow (Moderate risk)</td>
<td>94</td>
<td>66%</td>
</tr>
<tr>
<td>Amber (High risk)</td>
<td>20</td>
<td>14%</td>
</tr>
<tr>
<td>Red (Extreme risk)</td>
<td>0</td>
<td>0%</td>
</tr>
</tbody>
</table>

8. COMPLAINT OUTCOMES
Currently 67 complaints received in Quarter 1 have been responded to and we can report the following outcomes:
- 12 (18%) upheld
- 26 (39%) partially upheld
- 21 (31%) not upheld
- 8 (12%) were withdrawn by the complainant.

9. LEARNING FROM COMPLAINTS
The following table shows some of the examples of improvement which have been implemented as a result of complaints which were upheld.

<table>
<thead>
<tr>
<th>Received</th>
<th>CSC/Department</th>
<th>Listening and Learning</th>
</tr>
</thead>
<tbody>
<tr>
<td>April 2017</td>
<td>Clinical Support - Dietetics and Nutrition</td>
<td>A mother raised concern about the advice given by a Dietician - following which her child then suffered an anaphylactic episode. A check list is now being produced for consultations with allergy patients to ensure that all elements of the allergic reaction are considered. A review is also underway of the Allergy Clinic arrangements to improve multi-disciplinary team working.</td>
</tr>
</tbody>
</table>
Daughter believed that if an assessment had been performed, then a heart attack would have been diagnosed. The Renal Colic Pathway between the Emergency Department and Urology has been updated as a result of this complaint, with a clear referral process now in place.

A family were unhappy with a delay in providing pain relief to their relative who was end of life care. A new programme of education is in place around End of Life Care and the Observation Ward has been re-designed to allow for a single room for end of life patients. The Head of Nursing is due to deliver a departmental policy and pathway to incorporate the changes and ensure that they are sustainably implemented going forward.

10. TRUST WIDE THEMES FROM COMPLAINTS AND CONCERNS

The following table shows a breakdown of the primary reason for the complaint or PALS concerns raised. Compared to Quarter 4 there has been a reduction in the complaints involving Outpatient appointment delays and cancellations (Gastro and Cardiology), but a rise in Aspects of Clinical Treatment.

<table>
<thead>
<tr>
<th>Trust wide themes</th>
<th>Complaints</th>
<th>PALS</th>
<th>Q1 Total</th>
<th>Q4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outpatient appt delay/cancellation</td>
<td>6</td>
<td>116</td>
<td>122</td>
<td>146</td>
</tr>
<tr>
<td>Communication</td>
<td>11</td>
<td>92</td>
<td>103</td>
<td>141</td>
</tr>
<tr>
<td>Aspects of Clinical Treatment</td>
<td>59</td>
<td>72</td>
<td>131</td>
<td>95</td>
</tr>
<tr>
<td>Admission,Discharge &amp; Transfer</td>
<td>25</td>
<td>32</td>
<td>57</td>
<td>80</td>
</tr>
<tr>
<td>Inpatient appt delay/cancellation</td>
<td>6</td>
<td>54</td>
<td>60</td>
<td>48</td>
</tr>
</tbody>
</table>

11. KO41(a) QUARTERLY SUBMISSION

a) Point of Delivery: The table below provides a summary of the total numbers of complaints by point of service delivery which is a requirement of the quarterly submission to the Department of Health. Of note is the reduction in complaints involving Outpatients.

<table>
<thead>
<tr>
<th>Point of delivery</th>
<th>Q1 16/17</th>
<th>Q2 16/17</th>
<th>Q3 16/17</th>
<th>Q4 16/17</th>
<th>Q1 17/18</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatients</td>
<td>81</td>
<td>64</td>
<td>73</td>
<td>76</td>
<td>72</td>
</tr>
<tr>
<td>Outpatients</td>
<td>75</td>
<td>64</td>
<td>65</td>
<td>51</td>
<td>34</td>
</tr>
<tr>
<td>Emergency Dept</td>
<td>33</td>
<td>27</td>
<td>23</td>
<td>34</td>
<td>30</td>
</tr>
<tr>
<td>Maternity</td>
<td>8</td>
<td>5</td>
<td>5</td>
<td>10</td>
<td>6</td>
</tr>
<tr>
<td>Other</td>
<td>0</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>197</strong></td>
<td><strong>162</strong></td>
<td><strong>166</strong></td>
<td><strong>171</strong></td>
<td><strong>142</strong></td>
</tr>
</tbody>
</table>

b) Age Range: The Trust is required to ensure that the services provided are accessible to patients of all ages and that there is no evidence of age discrimination. The data for this quarter is in keeping with previous data.

<table>
<thead>
<tr>
<th>Age range</th>
<th>Q1 16/17</th>
<th>Q2 16/17</th>
<th>Q3 16/17</th>
<th>Q4 16/17</th>
<th>Q1 17/18</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 to 5 years</td>
<td>6</td>
<td>6</td>
<td>8</td>
<td>11</td>
<td>3</td>
</tr>
<tr>
<td>6 to 17 years</td>
<td>5</td>
<td>5</td>
<td>6</td>
<td>9</td>
<td>3</td>
</tr>
<tr>
<td>18 to 25 years</td>
<td>5</td>
<td>7</td>
<td>8</td>
<td>11</td>
<td>6</td>
</tr>
<tr>
<td>26 to 55 years</td>
<td>64</td>
<td>51</td>
<td>38</td>
<td>39</td>
<td>32</td>
</tr>
<tr>
<td>Age Group</td>
<td>Total rec’d</td>
<td>Under review</td>
<td>Upheld</td>
<td>Part upheld</td>
<td>Not upheld</td>
</tr>
<tr>
<td>-------------------</td>
<td>-------------</td>
<td>--------------</td>
<td>--------</td>
<td>-------------</td>
<td>------------</td>
</tr>
<tr>
<td>56 to 64 years</td>
<td>24</td>
<td>18</td>
<td>20</td>
<td>11</td>
<td>19</td>
</tr>
<tr>
<td>65 to 74 years</td>
<td>37</td>
<td>28</td>
<td>26</td>
<td>18</td>
<td>21</td>
</tr>
<tr>
<td>75 years and over</td>
<td>55</td>
<td>38</td>
<td>52</td>
<td>53</td>
<td>38</td>
</tr>
<tr>
<td>Unknown</td>
<td>1</td>
<td>9</td>
<td>4</td>
<td>19</td>
<td>20</td>
</tr>
</tbody>
</table>

12. PARLIAMENTARY & HEALTH SERVICE OMBUDSMAN (PHSO)

The second stage of the NHS Complaints process is referral to the PHSO for independent review. During Quarter 1 the Trust received notification of 4 complaints which had been referred to the PHSO.

<table>
<thead>
<tr>
<th>Year</th>
<th>Total rec’d</th>
<th>Under review</th>
<th>Upheld</th>
<th>Part upheld</th>
<th>Not upheld</th>
</tr>
</thead>
<tbody>
<tr>
<td>2014-15</td>
<td>16</td>
<td>0</td>
<td>3</td>
<td>9</td>
<td>4</td>
</tr>
<tr>
<td>2015-16</td>
<td>14</td>
<td>0</td>
<td>0</td>
<td>2</td>
<td>12</td>
</tr>
<tr>
<td>2016-17</td>
<td>13</td>
<td>3</td>
<td>0</td>
<td>2</td>
<td>8</td>
</tr>
<tr>
<td>2017-18</td>
<td>4</td>
<td>4</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

13. COMPLAINTS HANDLING EVALUATION

The Trust supports the recommendations of the report by the Local Government Ombudsman, Healthwatch and the Parliamentary and Health Service Ombudsman “My expectations for raising concerns and complaints” which describes a vision of what good would look like from a service user’s perspective. The framework involves 5 simple “I” statements and these are used to structure the questions asked in our evaluation.

Despite attempting to get feedback from 140 complainants via three different methods during Quarter 1, the Complaints Team received feedback from only 42 complainants (26 by post, 2 by online survey, and 14 by telephone contact).

<table>
<thead>
<tr>
<th>Questions</th>
<th>Q4 16-17</th>
<th>Q1 17-18</th>
</tr>
</thead>
<tbody>
<tr>
<td>Did you feel confident to speak up?</td>
<td>86%</td>
<td>95%</td>
</tr>
<tr>
<td>Did you feel that making a complaint was simple?</td>
<td>81%</td>
<td>88%</td>
</tr>
<tr>
<td>Did you feel that you were listened to and understood?</td>
<td>73%</td>
<td>76%</td>
</tr>
<tr>
<td>Did you feel that your complaint would make a difference?</td>
<td>50%</td>
<td>64%</td>
</tr>
<tr>
<td>Would you feel confident to make a complaint in the future?</td>
<td>86%</td>
<td>93%</td>
</tr>
</tbody>
</table>

Examples of the comments received:

- "I wish I was told to do this 6 months ago"
- "I was very impressed with how my complaint was dealt but still feel very angry that it shouldn't have got to this stage as it was clear to everyone that my mother should definitely not been discharged to her home"
- "Listen to the person making the complaint and ascertain what motivates them to complain. Our complaint was not about money or compensation, it was about looking at what was missed so that appropriate treatment could be ascertained"
- "I thought 6 months was quite excessive to investigate a complaint" "I feel it was not until I pointed out the seriousness of the complaint did something happen. However saying this, the outcome met our needs and my mum was more than happy with the level of apology received. Can you please pass our thanks onto the CEO for their support"
- "If they had been explained or listened to we wouldn't be writing to complain, or complete this review with these comments"

The results of the evaluation this quarter are reassuring with an increase in positive responses to all of the questions. However the area where we continue to see the lowest figures are in Question 4 (Did you feel that your complaint would make a difference?) although this has increased since the previous quarter.
14. PATIENT EXPERIENCE COMMITTEE
The purpose of the Patient Experience Committee is to review the Trust’s complaints processes in a systematic and detailed way through the analysis of actual complaints, to ascertain the learning that can be applied to continuously improve the overall quality of the services the Trust provides, with the ultimate aim of improving patient experience.

The committee is chaired by two Non-Executive Directors and Governors attend when possible. Meetings are held on a quarterly basis and at each meeting 3 Clinical Service Centres are asked to send a representative to demonstrate the learning and improvements that have been achieved through responding to complaints.

Verbal feedback is given on a quarterly basis to the Trust Board.

There was no Committee meeting in Quarter 1 due to the resignation of the Non-Executive Directors involved, however the Trust intends to reappoint and continue the valuable work provided by this Committee.

15. PATIENT ADVICE AND LIAISON SERVICE (PALS)
The PALS team handled 1,566 contacts during Quarter 1. The principle of PALS is to effect speedy resolution of concerns and this principle is reflected in the table below with 1,211 (77%) of contacts resolved within 5 working days.

<table>
<thead>
<tr>
<th>Patient Advice &amp; Liaison Service (PALS) contacts</th>
<th>Quarter 1</th>
<th>Quarter 2</th>
<th>Quarter 3</th>
<th>Quarter 4</th>
<th>Quarter 1 2017/18</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total contacts received</td>
<td>1,443</td>
<td>1,813</td>
<td>1,669</td>
<td>1,830</td>
<td>1,506</td>
</tr>
<tr>
<td>Resolved within 5 working days</td>
<td>1,211 (84%)</td>
<td>1,720 (95%)</td>
<td>1,526 (91%)</td>
<td>1,678 (92%)</td>
<td>1,372 (91%)</td>
</tr>
<tr>
<td>Unresolved - Passed to Complaints</td>
<td>n/a</td>
<td>5 (0.2%)</td>
<td>5 (0.3%)</td>
<td>8 (0.4%)</td>
<td>6 (0.3%)</td>
</tr>
</tbody>
</table>

16. PALS MONTHLY COMPARISON
The number of contacts received by PALS peaked in May and has now become more stable. Many of the contacts received by PALS involve other departments within the Trust and they continue to support the work of Health Information, Overseas Patient Service, Voluntary Services and Bereavement.
17. MONTHLY COMPARISON OF ALL CONTACTS RECEIVED
The following graph reflects the consistency in the number of formal complaints being received each month compared to the high number of people using the PALS route to have their concerns resolved quickly and effectively.

![Graph showing monthly comparison of complaints and PALS contacts](image)

18. SOCIAL MEDIA
The Complaints Team continue to monitor feedback received through social media sites, including Care Opinion and NHS Choices. During Quarter 1 a total of 113 comments were posted online about the Trust's services and 81% of these were positive (91 positive and 22 negative).

All positive comments are acknowledged and forwarded to the CSC (Clinical Service Centre) involved to share with their teams as it is just as important for staff to learn from positive feedback. The Complaints Team also share these positive comments via Twitter and with the Communications Team for posting onto the Trust's own Facebook page.

<table>
<thead>
<tr>
<th>Total Stories by CSC</th>
<th>Positive</th>
<th>Negative</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical Support Services</td>
<td>3</td>
<td></td>
<td>3</td>
</tr>
<tr>
<td>Critical Care, HSDU, Anaesthesia, Theatres</td>
<td>6</td>
<td>6</td>
<td>12</td>
</tr>
<tr>
<td>Emergency Department</td>
<td>22</td>
<td>1</td>
<td>23</td>
</tr>
<tr>
<td>Head &amp; Neck</td>
<td>9</td>
<td>3</td>
<td>12</td>
</tr>
<tr>
<td>Medicine</td>
<td>6</td>
<td>5</td>
<td>11</td>
</tr>
<tr>
<td>Musculoskeletal</td>
<td>9</td>
<td>6</td>
<td>15</td>
</tr>
<tr>
<td>Renal &amp; Transplant</td>
<td>2</td>
<td></td>
<td>2</td>
</tr>
<tr>
<td>Surgery &amp; Cancer</td>
<td>18</td>
<td>1</td>
<td>19</td>
</tr>
<tr>
<td>Women &amp; Children</td>
<td>8</td>
<td>5</td>
<td>13</td>
</tr>
<tr>
<td>General (June)</td>
<td>8</td>
<td>1</td>
<td>9</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>91</strong></td>
<td><strong>22</strong></td>
<td><strong>113</strong></td>
</tr>
</tbody>
</table>

All negative comments are acknowledged and shared with the CSC involved to look into. As people do not share their full details on social media sites, this makes investigation almost impossible. The Complaints Team therefore post a response asking them to contact PALS by private message to give more details and allow an investigation to be carried out into the concerns they have raised.
19. TRAINING FOR STAFF IN COMPLAINTS HANDLING

The Care Quality Commission’s Regulation 16: Receiving and Acting on Complaints requires that all staff must know how to respond when they receive a complaint and the Complaints Team are actively involved in setting up training for all staff throughout the Trust.

During 2015/16 the Complaints Team provided training to 846 members of staff throughout the Trust and then increased this the following year (2016/17) to 1,177.

Over the last 3 months the Complaints Training Officer has provided training to 361 members of staff. The chart below shows that we have a good turnout of administration staff at Clinical Support Services, but numbers are low at the CSCs and in particular we see very few doctors taking part in the training sessions.

20. PLAUDITS

During Quarter 1 1,725 plaudits were received about Portsmouth Hospitals NHS Trust. Some examples are listed below and, although these have been anonymised for this report, these are presented without alteration to grammar or spelling:

Emergency Department: “I find it hard to believe how quickly i was treated and how professionally the procedure and after care was administered. Arriving by ambulance in pain and distressed having just suffered a heart attack i was quickly put at ease by the way the staff worked like a well oiled machine - I knew I was in good hands. I feel I owe you my life. Thank you all”.

Paediatrics: “Fantastic treatment from all staff for my granddaughter and reassurance for her mother couldn’t of asked for more very busy but were brilliant since treatment like a different girl today thank you very much”.

Urology: “My father dies of the consequences of neglecting his prostate dysfunction. I was consequently referred because my PSA level was a little abnormal though ‘it might be normal for you’ came as a relief. Incredibly impressed by the quality of the consultation which as much psychological problem (given my family history) as well (and mainly) a physical problem. Wholly satisfied with my engagement with the consultant and the outcomes to date. Can’t praise at all highly enough: good questions, attentive, listening and focused engagement”.

Day Surgery Unit: “Can’t say I loved the experience of having surgery, but what a magnificent team of Drs and nurses you have in theatre admissions and DSU, can’t fault
the service. Your all amazing hardworking people, keep up the good service and continue smiling”.

Renal Ward G7: “I want to say a huge thank you to all the staff on G7 for the care they showed me during a two week stay. Nothing was too much trouble and the care was second to none again thank you so much”.

Fracture Clinic: “The fracture clinic reception nurses and doctors has been excellent. Had a crush injury on my left hand and would like to give the department 6 stars”.

Gastroenterology Unit: “Recently I have had 4 visits to QA and each time I was very happy with the professional and caring service I received from all the staff concerned”.

Haematology: “Having been treated at QA for around a year now, I can honestly say that the service has been excellent. The doctors, nurses, HCA’s and administrators have all offered a good level of care, explaining things clearly and giving the time needed. I am sure all the other staff are equally committed. The hospital is clean and normally well organised, although it can be a little frustrating to get through to the right person my telephone. Be aware that the site gets busy at peak times. I recommend arriving with plenty of time to spare”.

21. UPDATE AND CURRENT INITIATIVES

PALS Volunteers: Since the introduction of ward visits in January 2017, PALS Volunteers have provided assistance to 487 patients in the Discharge Lounge and across various inpatient areas. Due to its continuing success we hope to continue this initiative and have asked Heads of Nursing to let PALS know if there is anywhere in the hospital they would like the volunteers to visit.

Staff Training: The Complaints Team aims to increase the number of staff at the CSCs having training in how to handle complaints.

22. CONCLUSION

It is positive to note that despite ongoing pressure at the hospital, the Trust is not seeing an increase in the number of people making formal complaints and only 18% of those complaints were upheld and needed action to be taken.

From our evaluation, it is clear that the process of investigating and responding to complaints is taking too long, but also people felt if they had the information or support from staff involved when the incident happened then they would not have had to make a formal complaint. It is hoped that by increasing the number of training sessions offered to staff in dealing with complaints this will help to address both of these problems.

23. RECOMMENDATION

The Board is asked to note the contents of this report.

Marion Brown
Head of Complaints & PALS
July 2017
Subject: Revalidation – Annual Report

Prepared by / Sponsored by / Presented by: John Knighton, Medical Director

Purpose of paper: For approval

Key points for Trust Board members:
- Briefly summarise in bullet point format the main points and key issues that the Trust Board members should focus on including conclusions and proposals.
- Portsmouth Hospitals NHS Trust (PHT) has a Revalidation process that is compliant with national guidelines with governance and quality assurance. Board awareness of implications of revalidation.

Options and decisions required: For approval

Next steps / future actions:
- Clearly identify what will follow the Trust Board’s discussion.

Consideration of legal issues (including Equality Impact Assessment)?
- None

Consideration of Public and Patient Involvement and Communications Implications?
- None

Links to Portsmouth Hospitals NHS Trust Board Strategic Aims, Assurance Framework/Corporate Risk Register

<table>
<thead>
<tr>
<th>Strategic Aim</th>
<th>Strategic Aim 1</th>
</tr>
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<tbody>
<tr>
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<td>Not applicable</td>
</tr>
<tr>
<td>Risk Description</td>
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</tr>
<tr>
<td>CQC Reference</td>
<td>Not applicable</td>
</tr>
</tbody>
</table>

Committees/Meetings at which paper has been approved: None
Medical Revalidation – Trust Board Update and Annual Report

1. **Introduction**

Launched by GMC in December 2012.

Culmination of work between NHS employers, GMC, CQC, BMA and patient groups.

A previous paper presented to Board in September 2016. Revalidation numbers are provided to Board within the monthly Integrated Performance Report.

2. **Process**

PHT is a Designated Body for Revalidation and John Knighton is the Responsible Officer (RO). Revalidation for an individual doctor runs over a 5 year cycle. The process is reliant on a robust appraisal process and presentation of a portfolio of evidence of personal development. Within each 5 year cycle there must be evidence of annual appraisal along with a 360 degree patient review and a 360 degree colleague review. PHT has adopted the review template recommended by the GMC. Appraisal includes a review of all complaints and involvement in any significant clinical incidents. The whole Revalidation process was reviewed by the National revalidation team.

3. **Update**

On 5 June 2014 the Chief Executives of the General Medical Council (GMC), Care Quality Commission (CQC), Monitor and Trust Development Authority (TDA) wrote to Trust Chairs asking them to confirm that they were supporting the Revalidation process. They recommended that Board members should:

- Monitor the frequency and quality of medical appraisals
- Check there are effective systems for monitoring the conduct and performance of doctors
- Confirm that feedback from patients is sought periodically

NHS Revalidation Support Team established an Organisational Readiness Self-Assessment toolkit that allows Trusts to benchmark themselves.

NHS revalidation team have reviewed PHT as a Designated Body.

4. **Position in Portsmouth Hospitals Trust**

PHT is a designated body and the Responsible Officer (RO) was revalidated in January 2014.

- There are currently 532 doctors which have PHT as their designated body (DB).
- To date 399 doctors have successfully revalidated. There are 17 doctors left to revalidate until the end of the initial cycle which ends March 2018. The Medical Director is also due to revalidate again on 5th January 2019.
- 100 deferrals have been submitted mainly due to incomplete paperwork or the doctor being new to the UK or the hospital (59 people have been deferred once and 17 more than once).
- Deferral is regarded by the GMC as a neutral act with no implications to the doctor.
- No doctor has been referred as ‘non-engagement’ and thus at risk of loss of licence to practice by GMC.
The number of doctors due to revalidate has slowly started to decline as we approach the end of the first 5 year cycle; however this will start to increase again from 1st April 2018.

In April / May 2017 PHT provided information in response to the NHS England Annual Organisational Audit. Details of the audit accompany this paper.

5. Senior doctor Appraisal

PHT has used an electronic system for monitoring consultant activity with regard to appraisal, job planning, annual and study leave and thus we have had an advantage over some organisations with regard to the process and organisation of revalidation. This is called CRMS and provides consultants with easy access to aspects of their administrative work confidentially but transparently and gives the Trust access to job plans, appraisal etc on a ‘need to know’ basis.

The PHT revalidation / appraisal team consists of:
- RO - John Knighton
- Trust Appraisal Lead – Mike Homer-Ward
- Appraisal leads within CSC’s
- HR support – Caroline Man and Natasha Hobson

All PHT senior doctors use CRMS. Appraisal dates are monitored and recorded on CRMS. All appraisers are trained according to NHS Revalidation guidelines – these guidelines change and as a result of the recent recommendations about the flavour of appraisal we have amended our instructions to appraisers regarding the quality and depth of discussion that needs to take place and introduced the concept of a ‘Trust values’ based review.

PHT has a total of 139 doctors who are recognised as appraisers 120 of which are actively appraising. The Trust has arranged another session of New Medical Appraiser Training; this was held on 23rd November 2016, 20 doctors attended. 95 appraisers have received their annual update training in 2017, we have arranged a further update session, 10 doctors are currently booked on this. Anyone who does not complete this update training will cease to be an appraiser. When revalidation commenced PHT had appraisal dates that were not split evenly over the year but centred around March (prior to pay progression sign-off). The appraisal team thus assigned appraisers and appraisal dates to consultants to facilitate the appraisal review and quality assurance and separated these over the 12 months of the year. This process was completed during 2014.

At appraisal each doctor is required to bring details of complaints, significant clinical events and potential litigation to be discussed. To facilitate this, the Trust has developed a spreadsheet for all senior doctors and this information is added to on a continuous basis. However it has now been recognised that the use of the Datix system would provide more comprehensive information.

As the designated body (DB), appraisal at PHT involves the entire medical practice of each individual and thus includes activities such as Private Practice, support for clubs (Rugby clubs etc) and anything that encompasses medical practice. To ensure all work, not just NHS practice is reviewed and discussed at appraisal the Scope or Practice section has been enhanced.

6. Quality assurance

Appraisal summaries and PDP’s are available to the RO and Appraisal Lead for the Trust through CRMS and review of each appraisal takes place as part of Quality
Assurance. There is a feedback audit to the appraisers from both the appraisees and also from the Trust Lead for appraisal to maintain and raise standards.

PHT has undergone an Independent Verification Visit on the Revalidation process from NHS England Revalidation Team and the findings from this were largely positive.

7. **Further developments in appraisal for PHT**
   - Improvements in Consultant performance information
   - Formal link to Trust values
   - Link between appraisal and job planning – this has now been agreed but deferred due to a review of the CRMS system.

8. **Summary**

PHT has an appraisal system that:
   - Is regulated through CRMS which is familiar to senior hospital doctors
   - Complies with national guidance with update training provided annually
   - Takes account of patient complaints and significant clinical events
   - Is a ‘whole practice’ appraisal.
   - Has a Quality Assurance process and provides feedback to the appraisers.
   - Is rated as “meeting all core standards, quality assured with some quality improvement” by NHS England Revalidation Team.
<table>
<thead>
<tr>
<th>Subject:</th>
<th>Guardian of Safe Working Hours Quarterly Report</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prepared by:</td>
<td>Dr P Young</td>
</tr>
<tr>
<td>Sponsored &amp; Presented by:</td>
<td>John Knighton – Medical Director</td>
</tr>
<tr>
<td>Purpose of paper</td>
<td>Information</td>
</tr>
</tbody>
</table>
| Key points for Trust Board members | - Exception report data Q2  
- Trainee vacancy rates  
- Data collection and analysis problems |
| Options and decisions required | - Improved administrative help for Guardian |
| Next steps / future actions: | - Regular quarterly report |
| Consideration of legal issues (including Equality Impact Assessment)? | N/A |
| Consideration of Public and Patient Involvement and Communications Implications? | None |

Links to Portsmouth Hospitals NHS Trust Board Organisational Priorities, Assurance Framework/ Risk Register

<table>
<thead>
<tr>
<th>Organisational Priorities</th>
<th>Nationally mandated report by 2016 Junior Doctor Contract</th>
</tr>
</thead>
<tbody>
<tr>
<td>Board Assurance Framework/ Risk Register Reference</td>
<td></td>
</tr>
<tr>
<td>Risk Description</td>
<td></td>
</tr>
<tr>
<td>CQC Reference</td>
<td></td>
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Committees/Meetings at which paper has been discussed/ approved: None (will be copied to LNC)
Q2 Board

1. Exception reports

Summary

Total 72

<table>
<thead>
<tr>
<th>By Area</th>
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<tbody>
<tr>
<td>T&amp;O</td>
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</tr>
<tr>
<td>ENT</td>
<td>SHO</td>
</tr>
<tr>
<td>Medicine</td>
<td>SpR</td>
</tr>
<tr>
<td>MOPRS</td>
<td></td>
</tr>
<tr>
<td>Urology</td>
<td></td>
</tr>
<tr>
<td>Obstetrics</td>
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</tbody>
</table>

(51 complete, 21 still open)

All relate to hours and rest

Narrative

The pattern of exception reports is reasonably similar to Q1 and reflects known rota gaps within Trauma & Orthopaedics and to a lesser extent Medicine. The majority of reports are from Foundation Year doctors which perhaps reflects the fact that they have been on the 2016 contract longer and are more familiar with the exception reporting process. There still appear to be some problems with Educational Supervisors receiving DRS log in details and also some trainees. The process is time consuming and not intuitive and the HR team will feed this back to DRS and plan to talk to other DRS users to see if there are alternate approaches. There remains an issue with some exception reports not being dealt with in a timely fashion. The matter has been brought up at the Educational Supervisors forum and by Director of Medical Education directly. If the problem persists a more formal process will be set up to remind individuals of the necessary response times.

2. Work Schedule Reviews

None requested by Guardian

Narrative

Some Departments have struggled with writing rotas that are compliant with the 2016 Contract and have required significant input from the HR team which in some cases has led to work schedules being issued late. In future there should be fewer such problems with rotas rewritten only if service needs change. The medical HR team have already held a meeting with rota co-ordinators in an effort to share best practice across departments.
3. Locum Data

Data incomplete, available data difficult to interpret

Narrative

The only locum data available is a report from NHS Professionals which details all locum shifts in a given time period. This report includes both trainee and consultant locum and additional shifts and is not broken down by grade of doctor or nature of shift e.g. planned additional activity or locum for absent/sick colleague or rota gap. No data is available from any other agency for which trainees may work. NHS Employers guidance for Guardians suggests data should be sought from individual doctors about such work. I do not think the compliance rate for such a request would be high, is unlikely to be accurate and would be of little value.

This data is relevant for two principal reasons:

(i) Schedule 3 para 43 ‘where a doctor intends to undertake hours of paid work as a locum, additional to the hours set out in the work schedule, the doctor must initially offer such additional hours of work exclusively to the service of the NHS via an NHS staff bank.’

(ii) Schedule 3 para 39 ‘...where a doctor has opted out of the WTR average weekly working hours, overall hours are restricted to a maximum average of 56 hours per week, across all or any organisations with whom the doctor is contracted to work or otherwise chooses to work.’

With the available data I am unable to determine if either of these elements are being complied with. I have made it clear at Junior Doctors Forum and on other occasions when speaking to trainees that they have a professional obligation to ensure they are fit and safe to work and this includes not working excessive hours.

In future I will try to get the available NHSP data refined so as to at least ensure no trainees are exceeding 56 hours per week by working an excessive number of shifts for the Trust.

4. Vacancy Report

<table>
<thead>
<tr>
<th></th>
<th>Deanery</th>
<th>Trust</th>
<th>Overall</th>
</tr>
</thead>
<tbody>
<tr>
<td>April</td>
<td>9%</td>
<td>33%</td>
<td>14%</td>
</tr>
<tr>
<td>May</td>
<td>9%</td>
<td>34%</td>
<td>15%</td>
</tr>
<tr>
<td>June</td>
<td>9%</td>
<td>32%</td>
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</tr>
<tr>
<td>Trust</td>
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<td></td>
<td>116</td>
</tr>
<tr>
<td>Funded</td>
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</tr>
<tr>
<td>Approved</td>
<td></td>
<td></td>
<td>85</td>
</tr>
</tbody>
</table>

Narrative

The overall vacancy rate has been consistent over some time and equates typically to around 70 posts not filled, spread fairly evenly between the different type of post. Presumably Deanery posts go unfilled because there are insufficient suitable applicants. I have no information on why Trust posts go unfilled. At the next regional Guardian meeting I will ask how other Trusts compare.
5. Fines

None levied

Narrative

The lack of fines should not be taken as an indication that no rota breaches warranting a fine have occurred. Currently it is not possible to easily add additional hours recorded via exception reports to an individual doctors work schedule. The DRS software cannot do this nor can any of the commercially available software. Presently the only option is for the Guardian to total the number of exception reported hours for each individual doctor, request their work schedule from HR and manually calculate their average hours over their rota cycle. This is not a practical prospect with over 400 trainees in the Trust. Although I have done this for a select few trainees and can demonstrate there have been reasons why fines could be issued, I have elected not to until such times as the resources are available to do this for all trainees and all reasons.

Briefly fines can be issued for;

(i) exceeding an average of 48 hours worked per week
(ii) exceeding 72 hours in any 7 consecutive days
(iii) less than 11 hours continuous rest between shifts
(iv) insufficient breaks

6. Hours monitoring/Diary Card Exercises

None

Narrative

No such exercises were completed in the reporting period and none will now be undertaken. Exception reports are now the only mechanism by which trainee hours are monitored.

Guardian Comments

The process of trainee transition to the 2016 contract has been a difficult process with much learning to be done by all parties. That the process has gone relatively smoothly in Portsmouth has been due to the very hard work of the medical HR team. Now that most rotas are established the process of issuing work schedules and rotations should, in future, become easier.

There are currently a number of problems that prevent me providing the Board with the assurance required under the 2016 Junior Doctors Contract.

(i) Limitations of software to allow proper analysis of exception reported hours and issue appropriate fines. I am not aware that this will be available from DRS in a reasonable time frame so it is necessary to put in place an alternate solution. I believe this will need to be done by logging all exception reported hours (when verified by Educational Supervisors) and calculating average working hours for each trainee that completes an exception report. This would need to be repeated for each rota cycle. It is not practical for the Guardian to do this so there is a need for additional administrative resource.
(ii) There is insufficient data available to determine if any trainees are working in excess of the 56 hours per week mandated by the 2016 contract and WTR. Refining the available NHSP data should, in future, at least allow a determination that no trainee is doing that by working additional shifts in the Trust.

(iii) There remains a problem with timely response to exception reports by educational supervisors. This has improved compared to Q1 but still does not meet the deadlines set out in the contract. DME and Guardian have explained the process at ES forum. In future it may be necessary to issue more direct reminders to individuals – another argument for some additional administrative resource.

(iv) Not all trainees are familiar with the details of exception reporting and reports are rare in some specialties. Thus far few reports have been received from more senior trainees, this may simply reflect the fact that few have been on the new contract in Q1/2. In future all trainees will receive some explanatory documentation about exception reporting from HR and the process will be covered during induction training. The new ‘chief registrar’ will be invited to the Junior Doctor Forum and will hopefully be another avenue to encourage trainees to use the system.
<table>
<thead>
<tr>
<th>Subject:</th>
<th>Board Assurance Framework</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sponsored &amp; Presented by:</td>
<td>Peter Mellor, Director of Corporate Affairs</td>
</tr>
<tr>
<td>Purpose of paper</td>
<td>Adoption of revised Board Assurance Framework</td>
</tr>
</tbody>
</table>

**Key points for Trust Board members**

*Briefly summarise in bullet point format the main points and key issues that the Trust Board members should focus on including conclusions and proposals*

- The Well-Led Review Framework issued by the Trust Development Authority (TDA), now part of NHS Improvement, requires all trust boards to have in place “…clear and effective processes for managing risks, issues and performance…” (Key Line of Enquiry (KLOE) 5)

- The Trust has had a Board Assurance Framework (BAF) in place to support the management of strategic risks in the Trust for several years. However, in its report of 24.08.17, the Care Quality Commission (CQC) required the Trust to “review the Board Assurance Framework, board minutes and processes for reporting to the Board to ensure risks are identified and managed by the Trust” (CQC report 28.08.17, page 5)

- The format and content of the Trust’s BAF have consequently been reviewed and revised, with the intention of:
  - ensuring strategic priorities and the risks to their delivery are clearly expressed
  - articulating the known causes of those risks, to support their improved management
  - describing the methods by which the risks are currently managed or controlled
  - recording relevant assurance available to the Trust to indicate whether current management is effective
  - describing plans for further management / control of the risk and for obtaining additional assurance and the effectiveness of risk management
  - allocating responsibility for the delivery of those plans and measuring the progress and effectiveness

- Changes to Board operation to ensure that the BAF becomes an integral part of the Board’s practice and an effective tool in the management of strategic risk / delivery of strategic priorities are also proposed:
  1. that in future the BAF should be updated and reported to the Board on a quarterly basis, as part of a suite of documents also to include
     - a quarterly report on delivery of the Trust’s strategic priorities
     - a quarterly report on high level operational risks
  2. that all Board and board sub-committee agendas include prompts to consider whether any agenda item and/or associated discussion should be added to or reflected in the BAF
  3. that the Board should formally refer the approved BAF to the Audit Committee each quarter, so that it can be taken into account in the development of the Trust Audit Plan
iv) that the Board should formally refer the approved BAF to the Finance and Performance Committee each quarter, so that it can be taken into account in the development of the Trust's capital programme

- The associated proposed changes to the Trust's Risk Management Strategy are set out elsewhere on the Board’s agenda

**Options and decisions required**

*Clearly identify options that are to be considered and any decisions required*

The Board is asked to

1. adopt the Board Assurance Framework set out at appendix 1, with or without amendment, as required
2. approve, in principle, the amendments to the Trust Risk Management Strategy set out at i - iv above (these amendments are included in the associated paper proposing a revised Risk management Strategy)

**Next steps / future actions:**

*Clearly identify what will follow the Trust Board’s discussion*

The Board Assurance Framework will become part of the annual work plan of the Trust Board of Directors, in support of the Board’s delivery of the Trust’s strategic priorities.

**Consideration of legal issues (including Equality Impact Assessment)?**

There are no aspects of the proposed Board Assurance Framework that either support or detrimentally affect any group or individual holder of any of the protected characteristics any more than any other.

Adoption of an effective Board Assurance Framework will support the Trust in the fulfilment of a number of its legal, regulatory and contractual obligations.

**Consideration of Public and Patient Involvement and Communications Implications?**

Adoption and publication of an effective Board Assurance Framework will support transparency in the Trust’s business and its relationship with internal and external stakeholders.

There are no formal consultation obligations in connection with the adoption of a Board Assurance Framework.

### Links to Portsmouth Hospitals NHS Trust Board Organisational Priorities, Assurance Framework/ Risk Register

<table>
<thead>
<tr>
<th>Organisational Priorities</th>
<th>All</th>
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<tbody>
<tr>
<td>Board Assurance Framework/ Risk Register Reference</td>
<td>A revised Board Assurance Framework is proposed by the report</td>
</tr>
<tr>
<td>Risk Description</td>
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**Committees/Meetings at which paper has been discussed/ approved:**

<table>
<thead>
<tr>
<th>Board Workshop</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>28.09.17</td>
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</table>
The Board Assurance Framework (BAF) is a process and document via which the Trust Board can record and oversee the management of risks to the achievement of the Trust's corporate strategic objectives and priorities. The Trust's priorities for 2017/18 are set out at page 2. Risks to delivery of those objectives are summarised at page 3, and the Board Assurance Framework begins at page 4.

The BAF is an essential tool in the delivery of corporate objectives, and is reviewed formally at the Trust Board’s meetings on a quarterly basis. It is used more frequently by the Trust’s Executive Directors and senior leaders in the operational management of the Trust. The actions set out in the BAF and allocated to Executive Directors are included in individuals’ objectives. Updates to the action plans described in the BAF are sought every quarter prior to the BAF’s presentation to the Trust Board.

Operational risks managed via the Trust risk register may also have an impact on delivery of corporate objectives. Where there are relevant risks scoring 15 or more on the Trust risk register, these are indicated on the BAF below.

The risks set out in the BAF are rated according to the matrix set out below, which is in common usage across the NHS and adapted from AS/NZS 4360:1999, a globally recognised standard for risk measurement and management. Impact score x likelihood score = risk rating.

<table>
<thead>
<tr>
<th>Impact score</th>
<th>Negligible</th>
<th>Minor</th>
<th>Serious</th>
<th>Major</th>
<th>Catastrophic</th>
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</thead>
<tbody>
<tr>
<td>Likelihood score</td>
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<td>Unlikely</td>
<td>Moderate</td>
<td>Likely</td>
<td>Certain</td>
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<td>3</td>
<td>4</td>
<td>5</td>
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<tr>
<td>Unlikely</td>
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Further information about the risk rating matrix and examples of circumstances in which different ratings will apply can be found in the Trust’s Risk Management Strategy. The objective of effective risk management is to bring risk ratings down to a level which the Trust can tolerate (the target rating).

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Colour code</th>
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</thead>
<tbody>
<tr>
<td>CEO Chief Executive Officer</td>
<td>Complete Action completed</td>
</tr>
<tr>
<td>DoN Director of Nursing</td>
<td>On track Action on track for completion by due date</td>
</tr>
<tr>
<td>DoF Director of Finance</td>
<td>At risk Minor threat to completion by due date / minimal delay</td>
</tr>
<tr>
<td>DHR Director of Human Resources</td>
<td>Overdue Action not completed by due date</td>
</tr>
</tbody>
</table>
### Corporate Priority

<table>
<thead>
<tr>
<th><strong>1: Deliver safe, high quality, patient centred care (PS)</strong></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1a</td>
<td>Reducing level of HSMR</td>
</tr>
<tr>
<td>1b</td>
<td>Increasing Safety Thermometer of harm free care</td>
</tr>
<tr>
<td>1b i</td>
<td>Improved timeliness of identification and treatment for sepsis in ED and admission areas</td>
</tr>
<tr>
<td>1b ii</td>
<td>Minimising the number of hospital acquired grade 3 and 4 pressure ulcers</td>
</tr>
<tr>
<td>1b iii</td>
<td>Reducing level of medication incidents</td>
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</table>

<table>
<thead>
<tr>
<th><strong>2: Continuously improve the patient experience (PE)</strong></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>2a</td>
<td>Ensure patient experience is not compromised by limited capacity (inc ambulance holds and patient moves)</td>
</tr>
<tr>
<td>2b</td>
<td>Achieve quality &amp; safety metrics as outlined in Urgent Care Improvement Plan</td>
</tr>
<tr>
<td>2c</td>
<td>Achieve positive patient experience through full engagement with families, carers and patients</td>
</tr>
<tr>
<td>2d</td>
<td>Maintenance of compliance with CQC regulations</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>3: Ensure delivery of national constitutional standards (CS)</strong></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>3a</td>
<td>Achieve 4 hour A&amp;E performance target</td>
</tr>
<tr>
<td>3b</td>
<td>Meet the referral to treatment waiting time</td>
</tr>
<tr>
<td>3c</td>
<td>Cancer pathway targets are met</td>
</tr>
<tr>
<td>3d</td>
<td>Achieve the diagnostic procedure wait target</td>
</tr>
<tr>
<td>3e</td>
<td>Reduction in delayed transfers of care</td>
</tr>
<tr>
<td>3f</td>
<td>Meet the SAFER target for the percentage of patients discharged by midday seven days a week</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>4: Create a healthy organisational culture where staff report they are well led and have high levels of satisfaction working in the trust (OC)</strong></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>4a</td>
<td>National staff survey results place the Trust in the top 20% for staff engagement</td>
</tr>
<tr>
<td>4b</td>
<td>National staff survey results show an improvement in the number of staff reporting bullying and harassment</td>
</tr>
<tr>
<td>4c</td>
<td>Achievement of race equality standard</td>
</tr>
<tr>
<td>4d</td>
<td>Demonstrate an improvement in the CQC for the well-led domain for leadership and culture</td>
</tr>
<tr>
<td>4e</td>
<td>Develop strategies to ensure hard to recruit to roles are filled</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>5: Achieve financial health and sustainability (FH)</strong></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>5a</td>
<td>Delivery of income and expenditure control total</td>
</tr>
<tr>
<td>5b</td>
<td>Delivery of cost improvement programme</td>
</tr>
<tr>
<td>5c</td>
<td>Management of cash within agreed limits</td>
</tr>
<tr>
<td>5d</td>
<td>Management of capital resources within limits in line with business plan objectives</td>
</tr>
<tr>
<td>No</td>
<td>Ref</td>
</tr>
<tr>
<td>----</td>
<td>-----</td>
</tr>
<tr>
<td>1</td>
<td>BAF1</td>
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<tr>
<td>2</td>
<td>BAF2</td>
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<td>18</td>
<td>BAF18</td>
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<tr>
<td>19</td>
<td>BAF19</td>
</tr>
<tr>
<td>20</td>
<td>BAF20</td>
</tr>
</tbody>
</table>
Patient flow through the Trust and throughout the wider health and social care system in the area is poor, leading to risk of:

- Delayed transfers of care and associated deterioration in patient wellbeing
- Increased patient harm (including from delayed emergency (SCAS) response arising from prolonged ambulance handover times)
- Impaired patient experience / patient engagement
- Reduced ability to deliver quality and safety metrics
- Reduced performance against constitutional access standards
- Reduced staff engagement / experience (and consequent high staff turnover and sickness absence) as a result of sustained increased workload
- Failure to deliver income and expenditure control total
- Reduced ability to deliver cost improvement programmes

<table>
<thead>
<tr>
<th>Objectives affected</th>
<th>Lead</th>
<th>Date id’d</th>
<th>Source</th>
<th>Initial rating</th>
<th>Target rating</th>
<th>Current rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient flow</td>
<td>COO</td>
<td>09.08.17</td>
<td>Risk assm’t</td>
<td>20 4x5</td>
<td>12 4x3</td>
<td>20 4x5</td>
</tr>
</tbody>
</table>

**Rationale for target rating**

Impact is not amenable to reduction; focus for the 17/18 BAF is on reducing the frequency / likelihood that the impact on patients and staff will continue.

**Trust risk register links**

11, 15, 16, 18, 19, 24, 34, 99, 233, 302, 784, 794

**Causes of the risk**

- Discharge planning and execution are not consistent across the Trust
- Maintaining escalation capacity attenuates clinical efficiency
- Lack of standardisation in clinical teams, systems and processes across the Trust
- Frailty has become a feature of all clinical services but is not recognised as such in any strategy or service plan
- Working arrangements with Portsmouth City Council and Hampshire County Council (eg, re: funding decisions, placements) not effective in ensuring consistently prompt patient discharge
- Clinical Commissioning Group processes for funding decisions and placements etc slow
- Domiciliary care resources in the area do not meet demand
- Residential care capacity in the area does meet demand
- Local authority funding for complex residential care does not always match market forces

**Current methods of management**

- Trust has 50 extra beds open and 100 patients outlying, an increase on this point in 2016
- Deployment of, and reliance on, premium cost workforce to manage patient volumes
- Reactive responses to individual patients' needs
- Usual range of clinical governance monitoring and response
### Current assurance

- Decrease in Emergency Department complaints:
  - Q1 2016/17 – 33
  - Q4 2016/17 – 36
  - Q1 2017/18 – 28
- Reduction in complaints and PALS contacts re: admission, discharge and transfer
  - Q4 2016/17 – 80
  - Q1 2017/18 – 57
- Q1 Inpatient FFT satisfaction (96.6%) above nat avg (96%)
- Q1 ED FFT satisfaction score (94.5%) above nat avg (87%)
- Non-clinical patient moves at night decreased Q2 = 317 (Q1 = 1036)
- SIRIs per 1000 bed days Q2 = 0.4 (Q1 = 1.4)
- Other incidents Q2 = 3278 (Q1 = 4887)
- 01.02.17 CQC report summary, pages 3 (2 items)
- Mixed sex accommodation breaches: Q2 = 39 (Q1 = 23)
- Outliers increased: Q2 = 5135 (Q1 = 7953)
- Harm free care Q2 = 98.55% (Q1 = 98.67%)
- One Never Event in Q2
- 24.08.17 CQC report summary, pages 2 (1 item), 3 (1 item)
- 01.02.17 CQC report summary, pages 3 (3 items), 4 (2 items)
- 3 associated “must do” requirements CQC report 24.08.17
- 1 associated “must do” requirement, 4 associated “should do” requirements CQC report 01.02.17
- Delayed Transfers of Care at 9% in August (target 3.5%)
- Total bed days blocked in August 2689 (July 2294)
- Four hour access standard at 78.6% in August (target 95%)
<table>
<thead>
<tr>
<th></th>
<th>average length of stay in MOPRS from 22 days to 14 days</th>
<th>with CSC Senior Management Teams, KPIs agreed. Only marginal reduction in LoS achieved so far.</th>
</tr>
</thead>
<tbody>
<tr>
<td>7</td>
<td>Review and revise complex discharge model with support of wider system</td>
<td>DUC 28.02.18 23.08.17: Weekly Whole System Discharge Delivery Board has created a Steering Group to promote the review</td>
</tr>
</tbody>
</table>
### BAF2: Information management and technology (IM&T)

<table>
<thead>
<tr>
<th>Objectives affected</th>
<th>Lead</th>
<th>Date id’d</th>
<th>Source</th>
<th>Initial rating</th>
<th>Target rating</th>
<th>Current rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Trust’s IT systems and information reporting do not provide adequate support for delivery of Trust strategic objectives, leading to reduced ability to:</td>
<td>DHR</td>
<td>09.08.17</td>
<td>Risk assn’t</td>
<td>20 4 x 5</td>
<td>4 4 x 1</td>
<td>20 4 x 5</td>
</tr>
<tr>
<td>• Produce and deliver timely and accurate diagnoses and treatment</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Monitor and react to patients’ condition and safety</td>
<td></td>
<td></td>
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<td></td>
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<tr>
<td>• Support improved patient management processes</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>• Manage and monitor the timely allocation of resources</td>
<td></td>
<td></td>
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<tr>
<td>1,3 1,2 2,3,4,5 1,2,3,4,5</td>
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</tbody>
</table>

#### Rationale for target rating
Expectation that new Trust Strategy and 5-year plan will identify funding to take forward IM&T Strategy from 2018/19

#### Trust risk register links
- Datix 360/IT10
- Datix 362/IT13

### Causes of the risk
- Historic lack of investment in IT and information; lack of current capital available for investment (see also BAF8)
- Lack of clarity re: Trust strategy (see also BAF4)
- Historic Trust focus on tactical developments to meet immediate needs rather than strategic

### Current methods of management
- Responsive allocation of available capital to most urgent / safety-critical updates and repairs
- Focus of IM&T staff resources on maintaining service and addressing critical risks
- Utilising existing IT Department resource to progress eHospital Programme through SOC, OBC & OBS stages.
- Submitted bids for national digital funding for eHospital Programme via STP

### Current assurance

<table>
<thead>
<tr>
<th>Positive assurance</th>
<th>Negative assurance</th>
</tr>
</thead>
<tbody>
<tr>
<td>• 8,521 IT incidents resolved Apr-Aug, 97.8% within SLA target times. Customer satisfaction rating = 5.68 out of 6</td>
<td>• 2 PAS failures: 27 Aug (14 hours) &amp; 3 Sept (9 hours), one with data corruption. System recovered both times &amp; data restored. No patient harm caused</td>
</tr>
<tr>
<td>• IT Capital Programme 2017/18 approved Sept to address most critical priorities within £1.5M allocation</td>
<td>• To prevent further PAS failures, weekly back-ups suspended</td>
</tr>
<tr>
<td>• Cyber security alerts received = 20; Impacted on trust = 0</td>
<td>• IT Capital Programme unable to address c.£2M identified critical priorities or c.£2.1M additional bids</td>
</tr>
<tr>
<td>• Viruses detected &amp; stopped = 8</td>
<td></td>
</tr>
</tbody>
</table>

### Planned actions to reduce the risk / improve assurance

<table>
<thead>
<tr>
<th>Action</th>
<th>Lead</th>
<th>Due</th>
<th>Update</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Procure specialist IT Financing consultancy services to advise Trust on potential financing models for IT investments</td>
<td>DHR</td>
<td>30.09.17</td>
<td>20.09.17: Head of IT leading post-quotation negotiations with external consultancy. Contract should be in place end Sept. 17.</td>
</tr>
<tr>
<td>2</td>
<td>Complete review of potential financing models for IT investments &amp; present recommendations</td>
<td>DHR</td>
<td>30.11.17</td>
<td>20.09.17: Dependent upon 1.</td>
</tr>
<tr>
<td></td>
<td>Description</td>
<td>DoF</td>
<td>Date</td>
<td>Note</td>
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<td>-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>-------</td>
<td>------</td>
<td>-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>3</td>
<td>Identify funding sources for implementation of revised IM&amp;T Strategy</td>
<td>DoF</td>
<td>31.03.18</td>
<td><strong>20.09.17:</strong> Partly dependent upon 2&amp;4. To be developed as part of Trust 5-year plan underpinning Strategy.</td>
</tr>
<tr>
<td>4</td>
<td>Develop and adopt a revised IM&amp;T Strategy to underpin Trust Strategy with 5-year investment plan reflecting agreed funding models</td>
<td>DHR</td>
<td>30.04.18</td>
<td><strong>20.09.17:</strong> Partly dependent upon 5. CSC consultations planned for Oct-Dec.</td>
</tr>
</tbody>
</table>
Portsmouth Hospitals NHS Trust 2017/8 Board Assurance Framework

### BAF3: Lack of attention to basic, compassionate care

<table>
<thead>
<tr>
<th>Objectives affected</th>
<th>Lead</th>
<th>Date id'd</th>
<th>Source</th>
<th>Initial rating</th>
<th>Target rating</th>
<th>Current rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reduced patient safety</td>
<td>DoN</td>
<td>23.08.7</td>
<td>CQC report</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Impaired patient experience</td>
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<td></td>
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</tr>
<tr>
<td>Non-compliance with contractual, constitutional, regulatory and legal obligations</td>
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</tbody>
</table>

**Objectives:**
- Reduced patient safety
- Impaired patient experience
- Non-compliance with contractual, constitutional, regulatory and legal obligations

**Rationale for target rating**

**Trust risk register links**
- 13, 22

**Causes of the risk**
- Clinical governance systems are ineffective, leading to failure to identify and act on poor care (see also BAF14)
- The Trust’s systems for learning from incidents and complaints are poor (see also BAF14)
- Other

**Current methods of management**

**Current assurance**

- Positive assurance
  - Q1 Inpatient FFT satisfaction (96.6%) above nat avg (96%)
  - Q1 ED FFT satisfaction score (94.5%) above nat avg (87%)
  - Q1 OPD FFT satisfaction score (94%) increase on Q4
  - Reduction in formal complaints to Trust for Q1
    - 17% reduction on Q4 2016/17
    - 28% reduction on Q1 2016/17
  - Dementia screening Q2 100%
  - SIRIs per 1000 bed days Q2 = 0.4 (Q1 = 1.4)
    - Other incidents Q2 = 3278 (Q1 = 4887)
  - Q2 VTE screening 95.2% (target = 95%)
  - No avoidable MRSA in Q2
  - Q2 c.diff = 5 (Q1 = 11)
  - CQC report 24.08.17, page 2
  - 24.08.17 CQC report summary, page 2 (1 item)

**Negative assurance**

- Mixed sex accommodation breaches: Q2 = 39 (Q1 = 23)
- Harm free care Q2 = 98.55% (Q1 = 98.67%)
- Q2 avoidable grade 3 pressure ulcers = 5 (Q1 = 2)
- 01.02.17 CQC report summary, page 4 (1 item)
- 8 associated “must do” requirements CQC report 01.02.17

**Planned actions to reduce the risk / improve assurance**

<table>
<thead>
<tr>
<th>Action</th>
<th>Lead</th>
<th>Due</th>
<th>Update</th>
<th>Status</th>
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181
<table>
<thead>
<tr>
<th>Column 1</th>
<th>Column 2</th>
<th>Column 3</th>
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<tbody>
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</tbody>
</table>
### BAF4: Organisational Strategy

<table>
<thead>
<tr>
<th>Purview</th>
<th>Objectives affected</th>
<th>Lead</th>
<th>Date id’d</th>
<th>Source</th>
<th>Initial rating</th>
<th>Target rating</th>
<th>Current rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Trust’s organisational strategy is poorly defined. As a result, focus is diverted from core functions, leading to</td>
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<tr>
<td>• Potential for increased patient harm</td>
<td>1b, ii, ii</td>
<td>CEO</td>
<td>24.08.17</td>
<td>Ext ass’ment</td>
<td>16 x 4</td>
<td>8 x 2</td>
<td>16 x 4</td>
</tr>
<tr>
<td>• Poor / frustrating experience for patients</td>
<td>2a-c, 2d, 3</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>• Poor performance against contractual / constitutional / regulatory demands</td>
<td>4a, b, d, e</td>
<td></td>
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<td></td>
<td></td>
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<tr>
<td>• Poor / frustrating experience for staff − leading to high turnover</td>
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<tr>
<td>• Difficulty in achieving financial balance / health − leading to financial unsustainability</td>
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</table>

**Rationale for target rating**

The impact of poor organisational strategy is not significantly amendable to change, but the introduction of a clear organisational strategy, supported by relevant infra-structure strategies, will reduce the likelihood that patients and staff will suffer as a consequence of unclear or poorly defined strategy.

**Trust risk register links**

13, 18, 19, 794

### Causes of the risk

- There is an imbalance in some parts of the Trust between core DGH functions and sub-specialties
- Lack of clinical strategy, impairing organisational control over best use of resources
- The Trust is required to operate within a number of local delivery systems (eg, Solent Acute Alliance, Portsmouth /South East Hampshire Accountable Care system)

### Current methods of management

- Usual clinical governance systems used to identify and address problems in patient safety, patient experience, clinical effectiveness etc
- Existing performance and financial management systems

### Current assurance

**Positive assurance**

- Q1 Inpatient FFT satisfaction (96.6%) above nat avg (96%)
- Q1 ED FFT satisfaction score (94.5%) above nat avg (87%)
- Q1 OPD FFT satisfaction score (94%) increase on Q4
- 24.08.17 CQC report summary, page 3 (2 items)
- 97.9% of patients on 2 Week Wait pathway for breast cancer seen on time in August (target 93%)
- No patients waiting more than 52 weeks in August
- All 31 day cancer wait targets met during August

**Negative assurance**

- Harm free care Q2 = 98.55% (Q1 = 98.67%)
- 24.08.17 CQC report summary, page 3 (1 item)
- 1 associated “must do” requirement CQC report 24.08.17
- 18 RTT for August 91.1% (target 92%)
- Diagnostic wait for August 98% (target 99%)
- Four hour wait standard in ED 74% in August (target 95%)
- Delayed Transfers of Care in August 9% (target 3.5%)
- Four urgent operations cancelled during August
- 62 day cancer waits (RTT and screening to treatment) both failed during August
- 11 patients waiting more than 104 days for cancer
treatment in August
• Pulse survey: staff recommendation of PHT as place to work 62% in Q1, 65% in Q4

<table>
<thead>
<tr>
<th>Planned actions to reduce the risk / improve assurance</th>
<th>Lead</th>
<th>Due</th>
<th>Update</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Develop and implement financial governance systems to ensure close alignment of investment decisions with clinical and corporate strategy</td>
<td>DoF</td>
<td>31.12.17</td>
<td>21.09.17: Review of financial governance in hand following NHSI observations</td>
<td>On track</td>
</tr>
<tr>
<td>2. Develop and implement clear, appropriately networked clinical and corporate strategies to guide further organisational development, supported by</td>
<td>CEO</td>
<td>31.03.18</td>
<td>21.09.17: Action will transfer to new Director of Strategy, Governance &amp; Performance on appointment</td>
<td>On track</td>
</tr>
<tr>
<td>• Long term financial model, including capital and revenue resourcing plan</td>
<td></td>
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<tr>
<td>• Estates strategy</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>• IM&amp;T strategy</td>
<td></td>
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<tr>
<td>• Workforce and Organisational development strategy</td>
<td></td>
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</tr>
<tr>
<td>3. Review existing services and plan for adjustment, according to clinical and corporate strategies</td>
<td>COO</td>
<td>30.06.18</td>
<td>21.09.17: Dependent on delivery of organisational strategy</td>
<td>On track</td>
</tr>
</tbody>
</table>
### BAF5: Organisational culture

<table>
<thead>
<tr>
<th>Objectives affected</th>
<th>Lead</th>
<th>Date id’ed</th>
<th>Source</th>
<th>Initial rating</th>
<th>Target rating</th>
<th>Current rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>1a, 1b</td>
<td>DHR</td>
<td>09.08.17</td>
<td>Risk assm’t</td>
<td>16 4 x 4</td>
<td>4 2 x 2</td>
<td>16 4 x 4</td>
</tr>
</tbody>
</table>

#### Rationale for target rating
The Trust must aspire to reduce both the impact and likelihood of poor care and poor patient experience arising from poor management and leadership.

#### Trust risk register links
302, 303, 304

### Causes of the risk
- Changes in senior leadership team
- Current lack of impact of Passport to Manage (new, not embedded, no released time)
- Succession planning is not effective
- Lack of organisational accountability framework
- Workforce strategy no longer reflective of organisation’s needs
- Relative lack of improvement methodologies
- Scheme of delegation no longer fit for purpose
- Medical engagement with management / leadership is inconsistent

### Current methods of management
- Passport to Manage – not yet embedded, no released time
- CSCs take individual approach to performance management
- Existing patient safety / patient experience / financial management systems and models
- “Respect Me” hotline providing advice on how to handle bullying and harassment

### Current assurance
#### Positive assurance Q2
- Reduction in formal complaints to Trust for Q1
  - 17% reduction on Q4 2016/17
  - 28% reduction on Q1 2016/17
- Q1 Inpatient FFT satisfaction (96.6%) above nat avg (96%)
- Q1 ED FFT satisfaction score (94.5%) above nat avg (87%)

#### Negative assurance Q2
- Harm free care Q2 = 98.55% (Q1 = 98.67%)
- 1 Never Event in Q2
- 24.08.17 CQC report summary, pages 2 (3 items), 3 (4 items)
- 01.02.17 CQC report summary, page 3 (1 item)
Portsmouth Hospitals NHS Trust 2017/8 Board Assurance Framework

- Q1 OPD FFT satisfaction score (94%) increase on Q4
- SIRIs per 1000 bed days Q2 = 0.4 (Q1 = 1.4)
  - Other incidents Q2 = 3278 (Q1 = 4887)
- 24.08.17 CQC report summary, page 4 (1 item)
- Q1 Pulse survey results “I feel able and supported to raise concerns about unsafe practice”: 76% (Q4 76%)
- 0.9% turnover in August, 1.3% in July
- 54 contacts to new Respect Me hotline
- Essential Skills training at 88.7% in August (above target of 85% since June)
- 2 associated “must do” requirements CQC report 24.08.17
- Q1 Pulse survey: staff recommendation of PHT as place to work: 62% (Q4 65%)
- Q1 Pulse survey: bullying, harassment, abuse dealt with swiftly and appropriately: 56% (Q4 53%)
- Q1 Pulse survey: " I am able to make improvements happen": 64% (Q4 N/A)
- Rolling 12 month staff turnover 12% in August
- Sickness absence above target in August: 3.4%
- Establishment posts 93.6% filled, including MoD personnel

<table>
<thead>
<tr>
<th>Planned actions to reduce the risk / improve assurance</th>
<th>Lead</th>
<th>Due</th>
<th>Update</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Workforce strategy to be refreshed</td>
<td>DHR</td>
<td>15.11.17</td>
<td>11.08.17: Refresh work allocated to Head of Employee Resourcing. Revised strategy to be presented to November Board.</td>
<td>On track</td>
</tr>
<tr>
<td>2. Implement NHSI Culture and Leadership (C&amp;L) Programme</td>
<td>CEO</td>
<td>30.11.17</td>
<td>12.09.17: Listening into Action programme has commenced as a forerunner to implementation of NHSI C&amp;L Programme</td>
<td>On track</td>
</tr>
<tr>
<td>3. Develop and implement Accountability Framework</td>
<td>CEO</td>
<td>tbc</td>
<td>21.09.17: likely to be part of the outputs from the Culture and Leadership programme. Date of implementation will be clearer once that programme is underway</td>
<td>On track</td>
</tr>
<tr>
<td>5. Develop and introduce suite of cultural improvement indicators</td>
<td>DHR</td>
<td>31.12.17</td>
<td>21.09.17: Meeting 19.09.17 identified range of indicators (eg staff survey scores, patient survey scores, patient feedback, complaints and compliments, staff complaints, bullying and harassment and whistle blowing) to use as basis for further consultation. Indicators to be linked to</td>
<td>On track</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>wider People Strategy.</td>
<td></td>
</tr>
<tr>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>Board appointments stabilised</td>
<td>CEO</td>
<td>31.01.18</td>
<td>12.09.17: A number of key roles (executive and non-exec) out to advert and appointment processes in train</td>
</tr>
<tr>
<td>7</td>
<td>Review organisational structure</td>
<td>CEO</td>
<td>30.04.18</td>
<td>12.09.17: Modification of existing structure to ensure appropriate visibility of key risks, accountabilities and provide support to CSCs in hand</td>
</tr>
<tr>
<td>8</td>
<td>External review of bullying and harassment issues identified by CQC and associated engagement programme (linked to Organisational Development Strategy)</td>
<td>CEO</td>
<td>30.04.18</td>
<td>04.09.17: Review to start end of September. Procurement in hand.</td>
</tr>
<tr>
<td>9</td>
<td>Board / Director development programme to be developed and implemented</td>
<td>CEO</td>
<td>30.06.18</td>
<td>12.09.17: design and specification to be completed once Board appointments closer to completion</td>
</tr>
</tbody>
</table>

See also BAF13
**BAF6: Skills and knowledge**

<table>
<thead>
<tr>
<th>Objectives affected</th>
<th>Lead</th>
<th>Date id’d</th>
<th>Source</th>
<th>Initial rating</th>
<th>Target rating</th>
<th>Current rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>Affected</td>
<td>DHR</td>
<td>09.08.17</td>
<td>Risk assm’t</td>
<td>16 4 x 4</td>
<td>8 4 x 2</td>
<td>16 4 x 4</td>
</tr>
</tbody>
</table>

**Rationale for target rating**

The Trust is unable to reduce the impact of low levels of required skills and knowledge, but can aim to reduce the likelihood that the risk will arise by ensuring the provision and uptake of effective induction, training and development.

**Trust risk register links**

21, 23, 234, 462

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**Causes of the risk**
- Failure to release staff to complete / attend training
- Training capacity offered does not match trainees’ / departments’ needs (including venue, timing, format etc)
- Inconsistent approach between Clinical Service Centres

**Current methods of management**
- Military clinical colleagues supporting areas to release staff for backlog of training
- Professional Nursing and Midwifery Forum now reviewing training performance on a monthly basis and holding Heads of Nursing to account for delivery of improvement

**Current assurance**

<table>
<thead>
<tr>
<th>Positive assurance Q2</th>
<th>Negative assurance Q2</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Q1 Inpatient FFT satisfaction (96.6%) above nat avg (96%)</td>
<td>• 24.08.17 CQC report summary, page 3 (1 item)</td>
</tr>
<tr>
<td>• Q1 ED FFT satisfaction score (94.5%) above nat avg (87%)</td>
<td>• 01.02.17 CQC report summary, page 4 (1 item)</td>
</tr>
<tr>
<td>• Q1 OPD FFT satisfaction score (94%) increase on Q4</td>
<td>• 1 associated “must do” requirement CQC report 24.08.17</td>
</tr>
<tr>
<td>• Reduction in formal complaints to Trust for Q1</td>
<td>• 1 associated “must do” requirement CQC report 01.02.17</td>
</tr>
<tr>
<td>• 17% reduction on Q4 2016/17</td>
<td>• Appraisal compliance at 77.7% (below target of 85% since April and deteriorating)</td>
</tr>
<tr>
<td>• 28% reduction on Q1 2016/17</td>
<td>• Q1 Pulse survey: staff recommendation of PHT as place to work: 62% (Q4 65%)</td>
</tr>
<tr>
<td>• SIRIs per 1000 bed days Q2 = 0.4 (Q1 = 1.4)</td>
<td></td>
</tr>
<tr>
<td>o Other incidents Q2 = 3278 (Q1 = 4887)</td>
<td></td>
</tr>
<tr>
<td>• Essential Skills training at 88.7% in August (above target of 85% since June)</td>
<td></td>
</tr>
</tbody>
</table>

**Planned actions to reduce the risk / improve assurance**

<table>
<thead>
<tr>
<th>Action</th>
<th>Lead</th>
<th>Due</th>
<th>Update</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Develop phased training plan to ensure nursing and AHP staff undertake all required</td>
<td>DoN</td>
<td>30.09.17</td>
<td><strong>09.08.17:</strong> HoNs have plan under development. Production and implementation to be monitored via</td>
<td>On track</td>
</tr>
<tr>
<td>training in a timely manner</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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Portsmouth Hospitals NHS Trust 2017/8 Board Assurance Framework
<table>
<thead>
<tr>
<th></th>
<th>Action</th>
<th>Responsible</th>
<th>Date</th>
<th>Details</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>Workforce strategy to be refreshed</td>
<td>DHR</td>
<td>15.11.17</td>
<td>11.08.17: Refresh work allocated to Head of Employee Resourcing. Revised strategy to be presented to November Board.</td>
<td>On track</td>
</tr>
<tr>
<td>3</td>
<td>Introduction of “Training Passport” for whole STP</td>
<td>DHR</td>
<td>tbc</td>
<td>11.08.17: UK core skills framework in use across Acute Alliance. STP wide training passport in development with support of external advisers to the STP. Date for implementation not yet known.</td>
<td>On track</td>
</tr>
<tr>
<td>4</td>
<td>Training Needs Analysis review</td>
<td>DHR</td>
<td>31.12.17</td>
<td>11.08.17: Completed annually, next due for review by end of December.</td>
<td>On track</td>
</tr>
<tr>
<td>6</td>
<td>Review of face to face training capacity offer</td>
<td>DHR</td>
<td>31.12.17</td>
<td>11.08.17: Review to include consideration of venues, timing, format of face to face training sessions to improve accessibility</td>
<td>On track</td>
</tr>
<tr>
<td>7</td>
<td>Consider possibility of identifying and reporting on learning / training needs as root causes in incidents, complaints etc</td>
<td>DHR</td>
<td>28.02.18</td>
<td>12.09.17: Action will be passed to incoming Director of Strategy, Governance and Performance on appointment</td>
<td>On track</td>
</tr>
<tr>
<td>5</td>
<td>Further review of Training Needs Analysis to reflect changing organisational needs in light of new Clinical / Organisational Strategy</td>
<td>DHR</td>
<td>31.05.18</td>
<td>21.09.17: Organisational strategy due for completion by 31.03.18</td>
<td>On track</td>
</tr>
</tbody>
</table>

See also BAF 2 actions
Some key external partnerships / collaborations fail to provide support for, and/or obstruct delivery of, the Trust’s objectives and priorities, leading to inability to

- Deliver safe, high quality patient centred care
- Continually improve patient experience
- Ensure delivery of national constitutional standards
- Achieve financial health and sustainability

**Objectives affected**

<table>
<thead>
<tr>
<th>ID</th>
<th>Date id’ed</th>
<th>Source</th>
<th>Initial rating</th>
<th>Target rating</th>
<th>Current rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>CEO</td>
<td>Risk ass’ment</td>
<td>16 x 4</td>
<td>12 x 3</td>
<td>16 x 4</td>
</tr>
</tbody>
</table>

**Rationale for target rating**

Improvements in the robustness and clarity of the Trust’s own organisational and clinical strategies will help to reduce the impact of external partnerships on delivery of Trust strategic objectives. Improving the Trust’s own contribution to the external partnerships in question should make them less likely to hamper delivery of Trust objectives.

**Trust risk register links**

233

**Causes of the risk**

- Insularity on the part of the Trust, and lack of strong relationships with partners on which to build
- Recent instability of leadership within the Trust over during 2017, leading to inability to influence strategic partnerships with other organisations
- Wide-spread stress in the local / regional health and social care system, leading to lack of capacity to develop partnerships and new ways of working etc
- Some partnerships are newly formed and not yet able to deliver objectives

**Current methods of management**

- Attending partnership etc meetings where possible

**Current assurance**

- Positive assurance

**Planned actions to reduce the risk / improve assurance**

<table>
<thead>
<tr>
<th>Action</th>
<th>Lead</th>
<th>Due</th>
<th>Update</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>CEO</td>
<td>31.10.17</td>
<td><strong>21.09.17:</strong> initial choice of partnership representatives may need to be further revised in due course in light of coming appointments</td>
<td>On track</td>
</tr>
<tr>
<td>2</td>
<td>CEO</td>
<td>31.12.17</td>
<td><strong>21.09.17:</strong> Proposal to be raised with system</td>
<td>On track</td>
</tr>
<tr>
<td>partnership working at all strategic partnership boards to ensure added value</td>
<td>partners</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Portsmouth Hospitals NHS Trust 2017/8 Board Assurance Framework

### BAF8: Capital deficit

<table>
<thead>
<tr>
<th>Objectives affected</th>
<th>Lead</th>
<th>Date id'd</th>
<th>Source</th>
<th>Initial rating</th>
<th>Target rating</th>
<th>Current rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>1, 2a, 2b 2a, 2c, 2d, 4a, 4d, 4e 2c, 2d, 5b, 5c, 5d</td>
<td>DoF</td>
<td>2015</td>
<td>Risk ass'ment</td>
<td>16 4x4</td>
<td>8 4x2</td>
<td>16 4x4</td>
</tr>
</tbody>
</table>

**Rationale for target rating**

Impact of inadequate capital funding is unlikely to be reduced. The Trust’s efforts to attract additional resource, explore alternative solutions and sources of funding, and resolve, with NHSI, technical issues associated with CRL are intended to reduce the likelihood of those impacts being felt.

**Trust risk register links**

35, 360, 362, 783, 784, 785, 786, 788

### Causes of the risk

- Loan of £20m taken out in 2009 to replace significant proportion of clinical equipment. Equipment purchased is now reaching the end of its life; plans for replacement are not fully developed
- Historic lack of investment in information and communication technology (ICT) systems required to support delivery of clinical care and associated administration (see also BAF2)
- Decision to exclude Emergency Floor at Queen Alexandra Hospital from PFI and subsequent lack of strategic commitment to modernisation
- Restriction of spending of capital since 2013 as a result Trust’s I&E performance and associated constrained cash position
- NHSI re-specification of how PFI accounting applies to calculation of CRL, leading to significant reduction in CRL from 2017

### Current methods of management

- Responsive repairs to equipment to extend life of assets where possible
- Lease of certain items of equipment (eg endoscopes)
- Continuous prioritisation of spending and active management of CRL through capital programme work-streams

### Current assurance

**Positive assurance**

- Decrease in Emergency Department complaints:
  - Q1 2016/17 - 33
  - Q4 2016/17 - 36
  - Q1 2017/18 - 28
- Q1 ED FFT satisfaction score (94.5%) above nat avg (87%)
- 8,521 IT incidents resolved Apr-Aug, 97.8% within SLA target times. Customer satisfaction rating = 5.68 out of 6
- IT Capital Programme 2017/18 approved Sept to address

**Negative assurance**

- Significant numbers of incidents associated with damaged / missing equipment reported:
  - Q1 17/18 = 94
  - Q4 16/17 = 117
  - Q1 16/17 = 76
- 390 patient safety incidents in ED reported during August – highest number amongst all CSCs
- 2 PAS failures: 27 Aug (14 hours) & 3 Sept (9 hours), one
most critical priorities within £1.5M allocation
- Cyber security alerts received = 20; Impacted on trust = 0
- Viruses detected & stopped = 8

with data corruption. System recovered both times & data restored. No patient harm caused
- To prevent further PAS failures, weekly back-ups suspended

IT Capital Programme unable to address c.£2M identified critical priorities or c.£2.1M additional bids

### Planned actions to reduce the risk / improve assurance

<table>
<thead>
<tr>
<th>Action</th>
<th>Lead</th>
<th>Due</th>
<th>Update</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>Capital Strategy to be revised to optimise the management of resources within these constraints</td>
<td>DoF</td>
<td>07.09.17</td>
<td>07.09.17: Revised strategy approved by the Board</td>
</tr>
<tr>
<td>4</td>
<td>Make application to national programme for replacement of Linear Accelerator</td>
<td>DoF</td>
<td>15.10.17</td>
<td>07.09.17: Response awaited from NHSE</td>
</tr>
<tr>
<td>1</td>
<td>Seek change to mechanism for determining Trust’s internal capital resource limit</td>
<td>DoF</td>
<td>31.10.17</td>
<td>06.09.17: Negotiations with NHSI opened. Response to Trust letter promised as part of NHSI Deep Dive Review</td>
</tr>
<tr>
<td>3</td>
<td>Seek alternative capital sources through STP</td>
<td>DoF</td>
<td>31.10.17</td>
<td>07.09.17: Submissions made; Trust awaiting response from STP</td>
</tr>
<tr>
<td>6</td>
<td>Review alternative sources of financing capital programme through leases, managed equipment service contracts and other partnership arrangements and present options paper to the Board</td>
<td>DoF</td>
<td>15.12.17</td>
<td>07.09.17: Some leasing already commenced, further opportunities under investigation</td>
</tr>
<tr>
<td>5</td>
<td>Develop and implement long term financial model, including capital and revenue resourcing plan, to support revised clinical and organisational strategy</td>
<td>DoF</td>
<td>31.03.18</td>
<td>07.09.17: Revised clinical/organisational strategy awaited</td>
</tr>
<tr>
<td>7</td>
<td>Develop and present ED re-configuration business case to Trust Board and key regulators</td>
<td>DoF</td>
<td>31.03.18</td>
<td>07.09.17: under development</td>
</tr>
</tbody>
</table>
Radiological capacity in the Trust cannot meet demand for radiology services, leading to delays in diagnosis and treatment, and consequent increased risk of

- Patient harm
- Poor patient experience
- Failure to meet national constitutional standards and regulatory requirements and consequent regulatory / legal action
- Financial penalties
- Missed opportunities to maximise income in a timely way

Rationale for target rating

The impact of inadequate radiological capacity cannot be reduced, but the likelihood of patients and the Trust experiencing the anticipated problems can be reduced by the development of additional, reliable capacity

Trust risk register links

13, 19, 31, 321, 784

Causes of the risk

- Rise in demand for diagnostic imaging as a result of increased activity and changed clinical practice
- Capacity has not increased significantly
- Throughput to CT equipment is significantly beyond its expected / specified capacity
- CT equipment reaching the end of its expected life and there are frequent breakdowns
- National shortage of appropriately qualified staff; difficulties in recruiting locally

Current methods of management

- Day to day responsive repairs
- Reactive responses to individual patients’ needs
- Usual range of clinical governance monitoring and response
- Deployment of, and reliance on, additional working hours to manage times when patient volumes exceed capacity
- Outsourcing, including a proportion of plain film reporting

Current assurance

Positive assurance

- Clinical Harm review has started; backlog of 2000 images now reported

Negative assurance

- Complaints re: scanning and reporting in radiology
- Significant proportion of complaints and PALS contacts received in Q1
- 1 associated "must do" requirement CQC report 24.08.17
- Diagnostic wait times in August 98% (target 99%), but improved on July (93.1%)

Planned actions to reduce the risk / improve assurance

<table>
<thead>
<tr>
<th>Action</th>
<th>Lead</th>
<th>Due</th>
<th>Update</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>COO</td>
<td>02.11.17</td>
<td>01.09.17: Agenda item booked for November meeting</td>
<td>On track</td>
</tr>
<tr>
<td>#</td>
<td>Task Description</td>
<td>Assigned To</td>
<td>Current Status</td>
<td>Action Date</td>
</tr>
<tr>
<td>----</td>
<td>----------------------------------------------------------------------------------</td>
<td>-------------</td>
<td>----------------</td>
<td>-------------</td>
</tr>
<tr>
<td>2</td>
<td>Clinical harm review of over 40,000 chest x-rays unread over last 2 years to assess impact of previous decision not to report ED x-rays</td>
<td>MD</td>
<td></td>
<td>31.11.17</td>
</tr>
<tr>
<td>3</td>
<td>Clinical Harm review of backlog of unreported MR and CT scans to be completed</td>
<td>MD</td>
<td></td>
<td>31.11.17</td>
</tr>
<tr>
<td>4</td>
<td>Trust strategy for imaging and radiology to be developed and presented to Board for approval (to include full details of capital requirements and options for finance)</td>
<td>COO</td>
<td></td>
<td>31.11.17</td>
</tr>
<tr>
<td>5</td>
<td>Review need for additional temporary CT scanner for winter period and source funding and secure resource if required</td>
<td>COO</td>
<td></td>
<td>15.12.17</td>
</tr>
<tr>
<td>6</td>
<td>Independent review of governance and decision making around radiological capacity and service provision to be commissioned and reported to Board (plus external regulators) to inform further development of service and revision of governance arrangements</td>
<td>CEO</td>
<td></td>
<td>???</td>
</tr>
</tbody>
</table>
## BAF10: Mental Health skills and resources

<table>
<thead>
<tr>
<th>Objectives affected</th>
<th>Lead</th>
<th>Date id’d</th>
<th>Source</th>
<th>Initial rating</th>
<th>Target rating</th>
<th>Current rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>The quality and availability of mental health care in the Trust do not match patients’ needs, leading to increased risk of</td>
<td>MD</td>
<td>16.08.17</td>
<td>CQC report</td>
<td>16 x 4</td>
<td>12 x 3</td>
<td>16 x 4</td>
</tr>
<tr>
<td>• Safety incidents (patients, staff)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Poor patient experience</td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Failure to deliver services in line with access standards (particularly in ED)</td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Failure to meet legal and regulatory requirements (including in connection with consent)</td>
<td></td>
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</tr>
</tbody>
</table>

### Rationale for target rating
The impact of unmet mental health needs is unlikely to be reduced, but the likelihood of patients or staff suffering as a result will be reduced by the measures planned.

### Trust risk register links
21, 234

### Causes of the risk
- Inconsistency of specific knowledge and training in managing people with mental health vulnerabilities amongst general staff cohort
- Lack of sufficient numbers of specialist mental health trained staff in the Trust
- Partnership arrangements between the Trust and local mental health care providers do not meet patients’ needs
- Rising demand for mental health care service in the acute setting

### Current methods of management
- Use of agency specialist mental health staff
- Embedded Mental health liaison team co-commissioned by PHT and Southern Health
- Fortnightly system-wide teleconference to coordinate services across all relevant providers
- Mental Health Action plan under weekly review

### Current assurance
#### Positive assurance
- Mental health risk assessment completed in ED in approx. 85% – 90% of cases audited
- Incidents associated with unmet mental health need reducing: Q1 17/18: 19 reported Q4 16/17: 35 reported

#### Negative assurance
- Trust still required to submit weekly data to CQC
- 24.08.17 CQC report summary, page 2 (3 items)
- 3 associated “must do” requirements CQC report 24.08.17
- 3 associated “must do” requirement, 1 associated “should do” requirement CQC report 01.02.17

### Planned actions to reduce the risk / improve assurance

<table>
<thead>
<tr>
<th>Action</th>
<th>Lead</th>
<th>Due</th>
<th>Update</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Mental health and vulnerability board (including NED membership) to be established</td>
<td>MD</td>
<td>24.10.17</td>
<td>12.09.17: Membership largely agreed. Terms of reference under development</td>
</tr>
<tr>
<td>2</td>
<td>Complete ligature risk assessments in priority areas and develop action plan to address</td>
<td>MD</td>
<td>31.12.17</td>
<td>12.09.17: Risk assessments underway and complete in some areas. Action plans to address findings in development as each assessment completed.</td>
</tr>
<tr>
<td></td>
<td>Increase level of service commissioned from the Liaison team</td>
<td>MD</td>
<td>30.04.18</td>
<td>12.09.17: Negotiations underway, funding agreed. Formalisation of agreement and associated recruitment etc awaited</td>
</tr>
</tbody>
</table>
**BAF11 – Emergency preparedness and resilience**

<table>
<thead>
<tr>
<th>Objectives affected</th>
<th>Lead</th>
<th>Date id'd</th>
<th>Source</th>
<th>Initial rating</th>
<th>Target rating</th>
<th>Current rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>COO</td>
<td>??</td>
<td>Risk Assm't</td>
<td>15</td>
<td>6</td>
<td>15</td>
</tr>
<tr>
<td>2</td>
<td></td>
<td></td>
<td></td>
<td>5x3</td>
<td>3x2</td>
<td>5x3</td>
</tr>
</tbody>
</table>

**Rationale for target rating**

Effective, embedded emergency preparedness, response and resilience plans will reduce the impact of an emergency incident, and the likelihood that the worst of the potential impacts arise.

**Trust risk register links**

Nothing specifically related.

**Causes of the risk**

- Governance around Emergency preparedness processes inadequate
- Resource available to address EP issues and associated governance inadequate
- Increased profile and requirements for national assurance

**Current methods of management**

- Emergency preparedness portfolio allocated to COO plus part time (1 day per week) external adviser from neighbouring Trust

**Current assurance**

<table>
<thead>
<tr>
<th>Positive assurance</th>
<th>Negative assurance</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>External resource procured and Gap analysis completed 07.09.17 – 46 standards- 38 green, 8 amber</td>
<td></td>
</tr>
<tr>
<td></td>
<td>o Reported to Board 7 September</td>
</tr>
</tbody>
</table>

**Planned actions to reduce the risk / improve assurance**

<table>
<thead>
<tr>
<th>Action</th>
<th>Lead</th>
<th>Due</th>
<th>Update</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>COO</td>
<td>30.09.17</td>
<td>12.09.17: EPRR Working Group next meeting 19.09.17; Quality &amp; Governance Committee meeting in October</td>
<td>On track</td>
</tr>
<tr>
<td>2</td>
<td>COO</td>
<td>31.10.17</td>
<td>12.09.17: Experienced individual appointed, due to start end of October.</td>
<td>On track</td>
</tr>
<tr>
<td>3</td>
<td>COO</td>
<td>31.03.18</td>
<td>12.09.17: Actions plans in development by part time external resource. Completion, refinement and implementation of action plans included in work plan for new employee.</td>
<td>On track</td>
</tr>
</tbody>
</table>
### BAF12: Safeguarding

<table>
<thead>
<tr>
<th>Objectives affected</th>
<th>Lead</th>
<th>Date id’d</th>
<th>Source</th>
<th>Initial rating</th>
<th>Target rating</th>
<th>Current rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>There inconsistent levels of the awareness and specialist knowledge needed to deliver adequate safeguarding for patients and others to whom the Trust has a duty, leading to risk of:</td>
<td>DoN</td>
<td>24.08.17</td>
<td>External review</td>
<td>12</td>
<td>8</td>
<td>12</td>
</tr>
<tr>
<td>- Increased patient harm</td>
<td></td>
<td></td>
<td></td>
<td>4x3</td>
<td>4x2</td>
<td>4x3</td>
</tr>
<tr>
<td>- Impaired patient experience</td>
<td></td>
<td></td>
<td></td>
<td>2d</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Regulatory non-compliance / intervention (including unlawful detention / restraint)</td>
<td></td>
<td></td>
<td></td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Staff injury arising from violence</td>
<td></td>
<td></td>
<td></td>
<td>2</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### Rationale for target rating
The impact of poor safeguarding cannot be reduced, but increased awareness of signs, symptoms and escalation systems will reduce the likelihood of patients or others suffering harm.

#### Trust risk register links
21, 48, 462

### Causes of the risk
- Previous low profile of safeguarding generally within the Trust, but particularly adult safeguarding, Mental Capacity Act issues (including restraint) and Deprivation of Liberty Safeguards
- Safeguarding governance arrangements inadequate
- Specialist knowledge not at appropriate levels
- Low levels of understanding, despite reasonable compliance with training programme

### Current methods of management
- Named Safeguarding doctors and nurses in post
- New, trained Named Midwife for Safeguarding in post
- Training programme in place
- External support from CCG in place 2.5 days per week
- Head of Adult Safeguarding in post as of 04 September 2017

### Current assurance

#### Positive assurance Q2
- Combined Safeguarding Level 1 & 2 = 95.9% (target = 85%)
  - Safeguarding Children Level 1 = 98.3%
  - Safeguarding Children Level 2 = 92.1%
  - Safeguarding Adults Level 1 = 98%
- Prevent training uptake - 607 of current staff have attended HealthWRAP (Classroom training)
- 6,221 staff (88%) have done some form of basic Prevent and basic MCA & DoLS training via Induction or completing the Essential Skills booklet in the last 12 months.

#### Negative assurance Q2
- Combined Safeguarding at Level 3 & 4 = 81.3% (target = 85%)
  - Safeguarding Children Level 3 = 81.2%
  - Safeguarding Children Level 4 = 100%
- DoLS and MCA training uptake
  - 2514 of current staff have attended MCA & DoLS classroom training.
  - MCA & DoLS enhanced training uptake 74% (target = 85%)
- 24.08.17 CQC report summary, page 3 (4 items)
### Planned actions to reduce the risk / improve assurance

<table>
<thead>
<tr>
<th>Action</th>
<th>Description</th>
<th>Lead</th>
<th>Due</th>
<th>Update</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Separate committees for safeguarding of adults and children to be established to ensure appropriate levels of focus</td>
<td>DoN</td>
<td>31.10.17</td>
<td><strong>12.09.17:</strong> Revised terms of reference under development. First meetings of new Committees to be booked.</td>
<td>On track</td>
</tr>
<tr>
<td>2</td>
<td>Review process for ensuring audits conducted under Section 11 Children Act 2004 are fed back to the Trust Board and LSCB</td>
<td>DoN</td>
<td>31.10.17</td>
<td><strong>12.09.17:</strong> 2015/16 audit has been submitted. Process for 16/17 to be reviewed</td>
<td>On track</td>
</tr>
<tr>
<td>3</td>
<td>Training programme and content (including Board level training) to be reviewed</td>
<td>DoN</td>
<td>31.12.17</td>
<td><strong>12.09.17:</strong> New Head of Safeguarding to conduct review</td>
<td>On track</td>
</tr>
<tr>
<td>4</td>
<td>Band 8c Head of Safeguarding to be appointed</td>
<td>DoN</td>
<td>31.12.17</td>
<td><strong>09.08.17:</strong> Post out to advert, interview 26.09.17</td>
<td>On track</td>
</tr>
<tr>
<td>5</td>
<td>External peer review (to be conducted by acute sector specialist) of adult and children's safeguarding services (including governance arrangements).</td>
<td>DoN</td>
<td>31.12.17</td>
<td><strong>12.09.17:</strong> Suitable individuals to be identified</td>
<td>On track</td>
</tr>
<tr>
<td>6</td>
<td>Awareness-raising programme to be developed and introduced</td>
<td>DoN</td>
<td>31.01.18</td>
<td><strong>12.09.17:</strong> New Head of Safeguarding to coordinate</td>
<td>On track</td>
</tr>
<tr>
<td>7</td>
<td>Trust to support / cooperate with Pan-Portsmouth Safeguarding review led by Local Safeguarding Children Board (LSCB)</td>
<td>DoN</td>
<td>tbc</td>
<td><strong>12.09.17:</strong> LSCB has not yet indicated date</td>
<td>On track</td>
</tr>
</tbody>
</table>
### Portsmouth Hospitals NHS Trust 2017/8 Board Assurance Framework

#### BAF13: Organisational improvement

<table>
<thead>
<tr>
<th>Objectives affected</th>
<th>Lead</th>
<th>Date id'd</th>
<th>Source</th>
<th>Initial rating</th>
<th>Target rating</th>
<th>Current rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>1a - b 2a - d 3a - f 4a, c, d 5a - b</td>
<td>MD</td>
<td>24.08.17</td>
<td>Staff feedback</td>
<td>12</td>
<td>6</td>
<td>12</td>
</tr>
</tbody>
</table>

#### Rationale for target rating

Impact of inconsistent improvement methodology is unlikely to be reduced, but consistent use and monitoring of a well-developed and well-implemented methodology across the Trust will significantly improve the success of change programmes.

#### Trust risk register links

13, 15, 304, 784, 785, 788

### Causes of the risk

- Trust has no comprehensive improvement methodology – individual service centres adopt their own preferred approaches
- Trust governance arrangements do not support oversight of local Quality Improvement initiatives (see also BAF14)
- Trust does not rationalise unsuccessful initiatives or disinvest in unsuccessful / unnecessary initiatives (see also BAF5)
- The quality of investigations into incident and complaints is inconsistent

### Current methods of management

- Existing clinical, corporate and financial governance
- Pulse staff survey
- Continuous Improvement Steering Group established and meeting regularly

### Current assurance

#### Positive assurance

- Reduction in formal complaints to Trust for Q1
  - 17% reduction on Q4 2016/17
  - 28% reduction on Q1 2016/17

#### Negative assurance

- 24.08.17 CQC report summary, page 2 (1 item)
- 01.02.17 CQC report summary, page 3 (1 item)

### Planned actions to reduce the risk / improve assurance

<table>
<thead>
<tr>
<th>Action</th>
<th>Lead</th>
<th>Due</th>
<th>Update</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>MD</td>
<td>30.09.17</td>
<td>12.09.17: Event held and list prepared – to be used in consultation process</td>
<td>Complete</td>
</tr>
<tr>
<td>2</td>
<td>DHR</td>
<td>30.11.17</td>
<td>12.09.17: Awaiting Exec level sign off</td>
<td>On track</td>
</tr>
</tbody>
</table>
### Portsmouth Hospitals NHS Trust 2017/8 Board Assurance Framework

<table>
<thead>
<tr>
<th></th>
<th>Outline strategy for continuous improvement (modelled on Institute of Healthcare Improvement methodology (Improvement Academy)) to be presented to Board</th>
<th>DHR</th>
<th>31.12.17</th>
<th>12.09.17: Consultation meetings begin in October</th>
<th>On track</th>
</tr>
</thead>
<tbody>
<tr>
<td>4</td>
<td>Develop assurance indicators based on • Defined improvements in the priorities • Staff satisfaction and engagement • Number of registered quality improvement projects • Implementation plan compliance</td>
<td>MD</td>
<td>31.12.17</td>
<td>25.09.17: Indicators will be available once methodology is designed and implemented, and projects begin to run under the new framework</td>
<td>On track</td>
</tr>
</tbody>
</table>
Governance systems across the Trust are ineffective in the delivery and monitoring of high standards of care, treatment and performance, leading to risk of:

- Failure to identify and address poor quality / unsafe care
- Failure to ensure comprehensive learning, across the Trust, from incidents and complaints
- Waste and duplication of resources, including staff time
- Failure to improve performance against constitutional access standards
- Failure to identify and address poor staff experience (see also BAF5, BAF15)
- Breach of legal, constitutional and contractual obligations (including, specifically, information governance obligations)

<table>
<thead>
<tr>
<th>Causes of the risk</th>
<th>Current methods of management</th>
<th>Current assurance</th>
<th>Planned actions to reduce the risk / improve assurance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Instability within Board</td>
<td>Existing corporate and clinical governance systems are in operation</td>
<td>Positive assurance</td>
<td>Action</td>
</tr>
<tr>
<td>Governance systems, processes and structures have not kept pace with the demands of the expanding Trust and its key regulators</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Rationale for target rating**

The impact of poor governance on quality, use of resources and effective leadership will always be major, but a revision of governance systems and the introduction of improvements will reduce the likelihood of poor governance giving rise to such detrimental effects.

**Trust risk register links**

Nothing specifically related

### Current assurance

**Positive assurance**

- 24.08.17 CQC report summary, page 3 (6 items)
- 01.02.17 CQC report summary, page 3 (1 item), page 4 (1 item)
- 7 associated “must do” requirements CQC report 24.08.17
- 4 associated “must do” requirements, 2 associated “should do” requirements CQC report 01.02.17

### Planned actions to reduce the risk / improve assurance

<table>
<thead>
<tr>
<th>Action</th>
<th>Lead</th>
<th>Due</th>
<th>Update</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Director with explicit responsibility for corporate and clinical governance to be appointed</td>
<td>CEO</td>
<td>31.12.17</td>
<td><strong>12.09.17:</strong> Post out to advert and shortlisted</td>
</tr>
<tr>
<td>2</td>
<td>Further actions tbc once appointee is in post</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Objective</th>
<th>Initial rating</th>
<th>Target rating</th>
<th>Current rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>Governance systems</td>
<td>4 x 3</td>
<td>4x1</td>
<td>4x3</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Source</th>
<th>Initial rating</th>
<th>Target rating</th>
<th>Current rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>External review</td>
<td>12</td>
<td>4</td>
<td>12</td>
</tr>
</tbody>
</table>

- | | | |

---

203
<table>
<thead>
<tr>
<th>BAF15: Recruitment and retention</th>
<th>Objectives affected</th>
<th>Lead</th>
<th>Date id’d</th>
<th>Source</th>
<th>Initial rating</th>
<th>Target rating</th>
<th>Current rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Trust is struggling to recruit and retain staff in a number of key areas (including, particularly, band 5 nursing, MOPRS, General Medicine), leading to a risk of:</td>
<td></td>
<td>DHR</td>
<td>01.08.17</td>
<td>Risk assm’t</td>
<td>12</td>
<td>6</td>
<td>12</td>
</tr>
<tr>
<td>• Increased patient harm</td>
<td>1a, 1b</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Impaired patient experience</td>
<td>2a, 2b, 2c</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Failure to comply with regulatory requirements</td>
<td>2d</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Staff disengagement (see BAF5)</td>
<td>4a, 4d</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Rationale for target rating

Improved workforce management should ensure that the right staff, with the right skills, knowledge and support are available and able to meet patients’ needs promptly and effectively.

### Trust risk register links

15, 22, 31, 321, 406, 794

### Causes of the risk

- National shortages of key trained staff (eg, nurses, doctors)
- Geographical location
- Inconsistent approach to staff engagement between Clinical Service Centres
- Continued pressure in a number of clinical areas means that extra capacity beds remain open long term, diverting skilled substantive staff from ward areas to escalation areas

### Current methods of management

- Use of overtime and bank staff to plug gaps in shifts
- Use of agency staff where absolutely necessary to maintain safe staffing
- Re-locate staff across the Trust to maintain safe levels
- Wide range of recruitment methodologies (overseas events, social media, open days, links to Universities, recruitment consultancies, head hunting)
- Exit interview programme

### Current assurance

#### Positive assurance Q2

- Q1 Inpatient FFT satisfaction (96.6%) above nat avg (96%)
- Q1 ED FFT satisfaction score (94.5%) above nat avg (87%)
- Q1 OPD FFT satisfaction score (94%) increase on Q4
- SIRIs per 1000 bed days Q2 = 0.4 (Q1 = 1.4)
  - Other incidents Q2 = 3278 (Q1 = 4887)

#### Negative assurance Q2

- 1 Never Event in Q2
- 1 associated “should do” requirement CQC report 01.02.17
- Pulse survey: staff recommendation of PHT as place to work 62% in Q1, 65% in Q4
- Only 54 exit interviews completed for 529 leavers 01.04.17 - 31.08.17
- Time from vacancy notification to HR to recruitment Q1
Portsmouth Hospitals NHS Trust 2017/8 Board Assurance Framework

99 days, Q2 84 days
- Rejected job offers: Q1 = 23, Q2 = 27
- Q1 Pulse survey: staff recommendation of PHT as place to work: 62% (Q4 65%)
- Q1 Pulse survey: bullying, harassment, abuse dealt with swiftly and appropriately: 56% (Q4 53%)
- Q1 Pulse survey: "I am able to make improvements happen": 64% (Q4 N/A)
- Rolling 12 month staff turnover 12% in August
- Sickness absence above target in August: 3.4%
- Establishment posts 93.6% filled, including MoD personnel
- Temporary workforce expenditure in August £3,622,018. Above £3,000,000 consistently since May

Planned actions to reduce the risk / improve assurance

<table>
<thead>
<tr>
<th>Action</th>
<th>Lead</th>
<th>Due</th>
<th>Update</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Two further overseas recruitment events (Philippines and Italy)</td>
<td>DHR</td>
<td>30.09.17</td>
<td>11.08.17: Events booked</td>
</tr>
<tr>
<td>2</td>
<td>Healthcare Support Worker campaign to reduce agency use</td>
<td>DHR</td>
<td>01.10.17</td>
<td>11.08.17: Campaign started 11.08.17. Implementation monitored through DU Workbook</td>
</tr>
<tr>
<td>3</td>
<td>Workforce strategy to be refreshed</td>
<td>DHR</td>
<td>02.11.17</td>
<td>11.08.17: Refresh work allocated to Head of Employee Resourcing. Revised strategy to be presented to November Board.</td>
</tr>
<tr>
<td>4</td>
<td>Enhance partnership with NHS Professionals to enhance the provision of temporary staff including a system wide collaborative bank.</td>
<td>DHR</td>
<td>30.11.17</td>
<td>11.09.17: Meeting with NHSP took place 04.09.17 with further system wide meeting on collaborative bank taking place 14.09.17</td>
</tr>
<tr>
<td>5</td>
<td>Implement plans for revised and new roles to support difficult to recruit posts.</td>
<td>DHR</td>
<td>30.11.17</td>
<td>21.09.17: Education Director has written to all CSC Chiefs of Service to identify the scope for Physician Associates role project underway with Portsmouth University. Workshop for Medicine specialties to identify further roles for development being arranged.</td>
</tr>
<tr>
<td>Objectives affected</td>
<td>Lead</td>
<td>Date id'd</td>
<td>Source</td>
<td>Initial rating</td>
</tr>
<tr>
<td>---------------------</td>
<td>------</td>
<td>-----------</td>
<td>--------</td>
<td>---------------</td>
</tr>
<tr>
<td>Non-employed staff</td>
<td>DHR</td>
<td>11.09.17</td>
<td>Risk Assmnt</td>
<td>12</td>
</tr>
</tbody>
</table>

**Rationale for target rating**
Feedback from staff in training and military staff indicates that in some areas there are low levels of engagement and an imbalance between service needs and individual training needs.

**Trust risk register links**
Nothing specifically related

**Causes of the risk**
- Inconsistent leadership of non-employed staff groups
- Inconsistent induction arrangements
- Inconsistent understanding of the needs / expectations of non-employed staff groups
- Inconsistent understanding of the expectations of / engagement with Deanery and Military stakeholders

**Current methods of management**
- Junior doctor engagement opportunities with CEO and Medical Director on a bi-monthly basis
- Quarterly meeting re: Military Defence Contract
- GMC survey action plan

**Current assurance**

<table>
<thead>
<tr>
<th>Positive assurance</th>
<th>Negative assurance</th>
</tr>
</thead>
<tbody>
<tr>
<td>None currently available</td>
<td>Pulse survey: employed staff recommendation of PHT as place to work 62% in Q1, 65% in Q4</td>
</tr>
</tbody>
</table>

**Planned actions to reduce the risk / improve assurance**

<table>
<thead>
<tr>
<th>Action</th>
<th>Lead</th>
<th>Due</th>
<th>Update</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>CEO</td>
<td>31.10.17</td>
<td><strong>21.09.17:</strong> Discussion with CEO awaited.</td>
<td>On track</td>
</tr>
<tr>
<td>2</td>
<td>DHR</td>
<td>30.11.17</td>
<td><strong>11.09.17:</strong> Director Medical Education to undertake lead role and develop initial plans for discussion at SMT 11.10.17</td>
<td>On track</td>
</tr>
<tr>
<td>3</td>
<td>DHR</td>
<td>30.11.17</td>
<td><strong>11.09.17:</strong> Guardian report to be presented to</td>
<td>On track</td>
</tr>
<tr>
<td></td>
<td>systems to support contractual compliance introduced.</td>
<td></td>
<td>October 2017 Trust Board Meeting</td>
<td></td>
</tr>
<tr>
<td>---</td>
<td>----------------------------------------------------</td>
<td>---</td>
<td>-------------------------------</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Standard local induction arrangements introduced and monitored through local competency arrangements.</td>
<td>DHR 30.11.17</td>
<td>11.09.17: Meeting with Director Education 13.09.17</td>
<td>On track</td>
</tr>
<tr>
<td>5</td>
<td>Examine ways to assess experience of military staff working in the Trust</td>
<td>DHR 30.11.17</td>
<td>21.09.17: Learning &amp; Development team considering options for carrying out assessments in ways which best support the Trust in the effective deployment of military staff. Existing methods already in use by military units to be included in consideration.</td>
<td>On track</td>
</tr>
<tr>
<td>6</td>
<td>Deanery reports, local surveys, informal feedback and GMC survey results to be reviewed in detail for suitable assurance data</td>
<td>DHR 30.11.17</td>
<td>21.09.17: Meeting with Director of Education to conduct review planned for end of October</td>
<td>On track</td>
</tr>
</tbody>
</table>
### BAF17: Disconnect between the Trust Board and other staff

<table>
<thead>
<tr>
<th>Objectives affected</th>
<th>Lead</th>
<th>Date id’d</th>
<th>Source</th>
<th>Initial rating</th>
<th>Target rating</th>
<th>Current rating</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>CEO</td>
<td>24.08.17</td>
<td>CQC report</td>
<td>12</td>
<td>4</td>
<td>12</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>(3 x 4)</td>
<td>(2 x 2)</td>
<td>(3 x 4)</td>
<td></td>
</tr>
</tbody>
</table>

#### Rationale for target rating

The cumulative effect of addressing this risk and the actions set out at BAF5, BAF6, BAF8, BAF14, BAF15, BAF16 and BAF20 is likely to be a reduction in both the potential impact of an actual or perceived disconnect (because there will be improved monitoring and management systems in place to identify and address such impacts) and in the likelihood that any disconnect will be felt. A reduction in both scores is therefore achievable.

#### Trust risk register links

13, 19, 302, 303, 304, 784, 785, 794

#### Causes of the risk

- Ineffective Clinical Governance systems
- Board and senior leadership instability

#### Current methods of management

- All Board member engagement / visits / events etc recorded by Exec admin team
- Clinical Quality Review visits
- Existing Organisational Development Strategy
- Listening into Action
- Weekly CEO staff engagement sessions

#### Current assurance

**Positive assurance**

- Staff survey results are in top quartile for staff engagement

**Negative assurance**

- 24.08.17 CQC report summary, page 2 (2 items)
- Pulse survey: staff recommendation of PHT as place to work 62% in Q1, 65% in Q4

#### Planned actions to reduce the risk / improve assurance

<table>
<thead>
<tr>
<th>Action</th>
<th>Lead</th>
<th>Due</th>
<th>Update</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>See actions set out at</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>BAF5</td>
<td>BAF14</td>
<td>BAF20</td>
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<tr>
<td>BAF6</td>
<td>BAF15</td>
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<tr>
<td>BAF8</td>
<td>BAF16</td>
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</tr>
</tbody>
</table>

208
### BAF18: Emergency floor

The physical environment (layout, capacity and fabric) of the emergency floor at the Queen Alexandra Hospital is poor, leading to:

- Delays in patient assessment during periods of overcrowding, including delays to ambulance handover
- Impaired coordination / delivery of care at times of overcrowding
- Increased risk of patient harm from cold weather in HALO areas
- Increased risk of harm to patients and staff arising from inadequacy of appropriate environment in which to deliver acute mental health care
- Poor patient and staff experience
- Inefficiency, including disproportionate rate of admission at peak times to reduce emergency floor over-crowding

<table>
<thead>
<tr>
<th>Objectives affected</th>
<th>Lead</th>
<th>Date</th>
<th>Source</th>
<th>Initial rating</th>
<th>Target rating</th>
<th>Current rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>COO</td>
<td>2010</td>
<td>Risk Ass'mt</td>
<td>12</td>
<td>2</td>
<td>12</td>
</tr>
<tr>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td>3x4</td>
<td>1x2</td>
<td>3x4</td>
</tr>
</tbody>
</table>

#### Rationale for target rating

In the long run (3-5 years), redevelopment will remove the problems associated with current layout and condition of the building. As a result, the likelihood that anyone (staff or patient) will suffer because of the layout will be very low. In the short to mid term however, the risk will remain high until the redevelopment is complete.

#### Trust risk register links

16

### Causes of the risk

- Historic lack on investment in the Emergency floor; exclusion of the emergency floor from the PFI project
- Lack of available capital for re-development (see also BAF8)
- Lack of clarity re: Trust strategy (see also BAF8)

### Current methods of management

- Deployment of, and reliance on, premium cost workforce to manage times when patient volumes exceed capacity
- Reactive responses to individual patients' needs
- Usual range of clinical governance monitoring and response

### Current assurance

#### Positive assurance

- Decrease in Emergency Department complaints:
  - Q1 2016/17 - 33
  - Q4 2016/17 - 36
  - Q1 2017/18 - 28
- Q1 ED FFT satisfaction score (94.5%) above nat avg (87%)
- 01.02.17 CQC report summary, page 3 (1 item)
- No 12 hour trolley waits in August (peak of 95 in March)

#### Negative assurance

- 390 patient safety incidents in ED reported during August - highest number amongst all CSCs
  - 9 SIRIs in ED in August (including 5 DTAs)
- 01.02.17 CQC report summary, page 3 (2 items)
- 1 associated "must do" requirement CQC report 24.08.17
- 1 associated "should do" requirement CQC report 01.02.17
- Four hour access standard at 78.6% in August (target 95%)
<table>
<thead>
<tr>
<th>Action</th>
<th>Planned action</th>
<th>Lead</th>
<th>Due</th>
<th>Update</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Develop and present ED re-configuration business case to Trust Board and key regulators</td>
<td>DoF</td>
<td>31.03.18</td>
<td>07.09.17: under development</td>
<td>On track</td>
</tr>
<tr>
<td>2</td>
<td>Creation of Urgent Care Centre commissioned by CCG to divert non-ED patients</td>
<td>COO</td>
<td>31.03.18</td>
<td>25.09.17: Director of Delivery (Fareham and Gosport and South Eastern Hampshire Clinical Commissioning Groups) - will be leading/discussing commissioning of the new service in terms of staffing and immediate operational performance. Start up arrangements to be discussed with Trust COO in coming week.</td>
<td>At risk</td>
</tr>
</tbody>
</table>
## BAF19: Trust leadership

The Trust’s senior leadership has been unstable, and the leadership structure is unsuitable. These factors inhibit the holding to account of leaders in the Trust, leading to impaired ability to deliver improved

- Patient safety
- Patient experience / engagement
- Performance against national constitutional standards
- Staff satisfaction
- Response to bullying and harassment
- Performance in the well-led assessment
- Financial health and sustainability

<table>
<thead>
<tr>
<th>Objectives affected</th>
<th>Lead</th>
<th>Date id’d</th>
<th>Source</th>
<th>Initial rating</th>
<th>Target rating</th>
<th>Current rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>1a - b</td>
<td>CEO</td>
<td>01.10.17</td>
<td>Risk ass’ment</td>
<td>12</td>
<td>4</td>
<td>12</td>
</tr>
<tr>
<td>2a – d</td>
<td></td>
<td></td>
<td></td>
<td>3 x 4</td>
<td>2 x 2</td>
<td>3 x 4</td>
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<td>3a – f</td>
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<td>4a, 4e</td>
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<td>4b</td>
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<td>4d</td>
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<td>5</td>
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</tbody>
</table>

### Rationale for target rating

Improving resilience at all levels of the organisation through improved organisational culture, the implementation of an accountability framework (BAF5) and revising organisational structure will make the Trust as a whole less dependent on the most senior tiers of leadership and management, thereby reducing the impact of instability at board level. Making a number of key executive appointments in the coming months will reduce the likelihood of further instability.

### Trust risk register links

13, 19, 302, 304, 784

### Causes of the risk

- Departure of Chief Executive
- Significant use of interims over last 12 months

### Current methods of management

- Usual clinical governance systems

### Current assurance

#### Positive assurance

- Reduction in formal complaints to Trust for Q1
  - 17% reduction on Q4 2016/17
  - 28% reduction on Q1 2016/17
- Q1 Inpatient FFT satisfaction (96.6%) above nat avg (96%)
- Q1 ED FFT satisfaction score (94.5%) above nat avg (87%)
- Q1 OPD FFT satisfaction score (94%) increase on Q4
- SIRIs per 1000 bed days Q2 = 0.4 (Q1 = 1.4)
  - Other incidents Q2 = 3278 (Q1 = 4887)
- Q1 Pulse survey results “I feel able and supported to raise concerns about unsafe practice”: 76% (Q4 76%)
- 0.9% turnover in August, 1.3% in July
- 54 contacts to new Respect Me hotline

#### Negative assurance

- Harm free care Q2 = 98.55% (Q1 = 98.67%)
- 1 Never Event in Q2
- Q1 Pulse survey: staff recommendation of PHT as place to work: 62% (Q4 65%)
- Q1 Pulse survey: bullying, harassment, abuse dealt with swiftly and appropriately: 56% (Q4 53%)
- Q1 Pulse survey: “I am able to make improvements happen”: 64% (Q4 N/A)
- Rolling 12 month staff turnover 12% in August
- Sickness absence above target in August: 3.4%
<table>
<thead>
<tr>
<th>Action</th>
<th>Lead</th>
<th>Due</th>
<th>Update</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>See all actions at BAF5</td>
<td></td>
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</tbody>
</table>
## BAF20: Support functions

<table>
<thead>
<tr>
<th>Objectives affected</th>
<th>Lead</th>
<th>Date</th>
<th>Source</th>
<th>Initial rating</th>
<th>Target rating</th>
<th>Current rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>There is a lack of capacity and expertise in a number of key support functions, including Finance, HR, Corporate Governance, strategy and the Transformation Team leading to impaired ability to</td>
<td>CEO</td>
<td>Risk ass’ment</td>
<td>12</td>
<td>4</td>
<td>12</td>
<td></td>
</tr>
<tr>
<td>• Deliver improvements to patient safety</td>
<td></td>
<td></td>
<td>3 x 4</td>
<td>2 x 2</td>
<td>3 x 4</td>
<td></td>
</tr>
<tr>
<td>• Deliver improvements to patient experience</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Deliver against national constitutional standards</td>
<td></td>
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</tr>
<tr>
<td>• Recruit and retain the best staff to all areas of the Trust</td>
<td></td>
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<td></td>
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<tr>
<td>• Achieve financial health &amp; sustainability</td>
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</tbody>
</table>

### Rationale for target rating

The introduction of improved systems and processes, including an accountability framework (BAF5), and the introduction of improved IMT systems (BAF2) will help reduce the impact of back-office under capacity. Addressing capacity and expertise issues identified in the planned review will also reduce the likelihood that such problems will arise.

### Trust risk register links

13, 22, 19, 406, 784, 785, 786, 788

### Causes of the risk

- Prioritisation of investment in clinical services and functions over back office / support services
- Data Quality Group meets regularly

### Current methods of management

- Acknowledgement of the risks presented by lack of both specialist knowledge and skills (eg, planning) and general capacity (eg, for ensuring and assuring data quality)

### Current assurance

- Positive assurance
  - None available currently
- Negative assurance
  - None available currently

### Planned actions to reduce the risk / improve assurance

<table>
<thead>
<tr>
<th>Action</th>
<th>Lead</th>
<th>Due</th>
<th>Update</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Create and appoint to new Director of Strategy, Governance and Performance role</td>
<td>CEO</td>
<td>31.12.17</td>
<td>21.09.17: Advert closed 17.09.17; interviews 09.10.17</td>
</tr>
<tr>
<td>2</td>
<td>Recruit to Trust Secretary post</td>
<td>CEO</td>
<td>31.12.17</td>
<td>21.09.17: model JD and person specs being sought. Action to transfer to new Director role upon appointment</td>
</tr>
<tr>
<td>3</td>
<td>Recruit Head of Strategy to lead and support planning functions</td>
<td>CEO</td>
<td>31.12.17</td>
<td>21.09.17: model JD and person specs being sought. Action to transfer to new Director role upon appointment</td>
</tr>
<tr>
<td>4</td>
<td>Undertake capacity and capability review of back</td>
<td>CEO</td>
<td>31.12.17</td>
<td>21.09.17: New Director to undertake</td>
</tr>
<tr>
<td></td>
<td>office functions</td>
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<td>---</td>
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</tr>
<tr>
<td>5</td>
<td>Look at alignment of back office functions across STP and ACS</td>
<td>CEO</td>
<td>31.03.18</td>
<td><strong>21.09.17</strong>: To be raised at STP meetings. Dependent on collaboration of partners</td>
</tr>
</tbody>
</table>
Subject: Infection Prevention Annual Report

Prepared by: Infection Prevention Team
Sponsored & Presented by: John Knighton – Medical Director & DIPC

Purpose of paper: To note and discuss

Key points for Trust Board members:
Briefly summarise in bullet point format the main points and key issues that the Trust Board members should focus on including conclusions and proposals:

- The Trust had 33 cases of Clostridium difficile infection against an objective of 40 cases, therefore achieving its objective.
- The Trust had 1 unavoidable case of MRSA bloodstream infection attributed to the organisation and performed better than the national average for MRSA bloodstream infections by occupancy/activity.
- The Trust achieved its lowest rate of MSSA bloodstream infection since 2012. This is better than the national average.
- 11,974 clinical reviews were carried out by the IP Team.
- The Team had a 34% increase in referrals for vascular access intervention and assessment. 780 PICC/midlines, and 132 cannulas were placed by the Team.
- The Team carried out 527 peer-review NPSA audits in 2016/17, compared with 392 the previous year.
- 69.0% of frontline staff received the influenza vaccine compared with 63.2% across England.

Options and decisions required:
Clearly identify options that are to be considered and any decisions required: None of note

Next steps / future actions:
Clearly identify what will follow the Trust Board’s discussion: None of note

Consideration of legal issues (including Equality Impact Assessment)? None of note

Consideration of Public and Patient Involvement and Communications Implications? For dissemination to general public and relevant stakeholders

Links to Portsmouth Hospitals NHS Trust Board Strategic Aims, Assurance Framework/Corporate Risk Register

<table>
<thead>
<tr>
<th>Strategic Aim</th>
<th>Safe</th>
</tr>
</thead>
<tbody>
<tr>
<td>BAF/Corporate Risk Register Reference (if applicable)</td>
<td>3-1617 (current rating – 12)</td>
</tr>
<tr>
<td>Risk Description</td>
<td>Trust fail to achieve objectives for reducing healthcare associated infections</td>
</tr>
<tr>
<td>Committees/Meetings at which paper has been approved:</td>
<td>Date</td>
</tr>
<tr>
<td>-----------------------------------------------------</td>
<td>------</td>
</tr>
<tr>
<td>Infection Prevention Management Committee</td>
<td>For next IPMC</td>
</tr>
</tbody>
</table>
Foreword

Globally, sepsis is a more common cause of death than myocardial infarction or any particular cancer. In the UK, a study conducted by a PHT consultant showed that 5.1% of deaths were associated with sepsis as an underlying cause. We also know that a large proportion of patients admitted to an ITU department have sepsis as their cause for deterioration and that if the diagnosis had been identified earlier the outcome may have been different. For these reasons infection control remains a fundamentally important component of healthcare in PHT and in the NHS generally. PHT therefore needs to celebrate the infection control results for the hospital in 2016/17, which have probably been the best ever that we have reported. We have demonstrated excellent results in terms of control of the nationally reportable MRSA bloodstream and *C. difficile* infections but also showed real improvements in MSSA bloodstream infection rates.

There is no doubt that there will be a greater emphasis in the future on clinical review and thus reporting of gram negative infections such as *E. coli* bacteraemias but PHT is well placed to accept this challenge and we have already begun auditing these cases.

In summary, we have had a very good year in infection control with regard to control of bacterial infection rates, viral infections such as norovirus and also managed the risks associated with unusual and potentially important resistant infections that pose such a threat to hospital and patient care in the future. These achievements have been made through a dedicated and highly competent staff who should take the credit for this real patient benefit. We look forward to replicating these excellent results in the next year.

Simon Holmes

Medical Director & DIPC
Executive Summary

- The Trust continues to be compliant with all ten criteria of the Code of Practice for the prevention and control of healthcare associated infection
- The Infection Prevention Team continue to provide the Trust with a full range of specialist services including; the prevention and management of healthcare associated and multi-drug resistant infections, a specialist vascular access service, clinical education and training, surveillance, cleaning and decontamination expertise and water quality and safety
- 11,974 documented clinical reviews of patients were carried out by the Team in 2016/17
- The Team placed 780 Peripherally Inserted Central Catheters/Midlines, 132 Cannulas and carried out 751 other vascular access related interventions in 2016/17
- The Trust had 33 cases of Clostridium difficile infection against an objective of 40 cases, therefore achieving its objective. The Trust continues to perform better than the national average with a rate of 9.2 cases per 100,000 occupied bed days (national rate 13.2)
- The Trust had 1 unavoidable case of MRSA bloodstream infection, therefore achieving its objective. The Trust remains below the national average with a rate of 0.3 cases per 100,000 occupied bed days (national rate 0.9)
- The Trust achieved its lowest rate of MSSA bloodstream infection since 2012, with a rate of 6.9 cases per 100,000 occupied bed days (national rate 8.8)
- The Team carried out 527 peer-review NPSA audits in 2016/17, compared with 392 the previous year
- 69.0% of frontline staff received the influenza vaccine compared with 63.2% across England
- The microbiology department continue to oversee the Trust’s prudent antimicrobial prescribing strategy
THE TEAM

Simon Holmes
DIPC & Medical Director

Caroline Mitchell
Associate Director Infection Prevention & Patient Safety

Debbie Keyte
Lead Nurse

Kathryn Noble
Manager/Analyst

Edith Yormesor

Sophie Sweeney

Fernando Lopes

Natalie Simmons

Infection Prevention Nurse Specialists
Tina Chase

Terry Joy

Shirley Johnson
Surveillance Practitioner

Gemma Kwiatkowski
Team Administrator

Sarah Cobb

Amy Bowers

Becci Davis

Jasmine Manuell

Senior Infection Prevention Practitioners

Infection Prevention Practitioners
Annual Report 2016-2017 Infection Prevention
THE INFECTION PREVENTION TEAM

1.1 Team Structure

Throughout 2016/17 the management of the Infection Prevention Team (IPT) remained as part of the Clinical Safety and Quality directorate of Corporate Functions. The team remain accountable to the Director of Infection Prevention and Control (DIPC) who is the strategic lead for the team. The DIPC chairs the Infection Prevention Management Committee (IPMC) and reports on infection matters to the chief executive officer and provides monthly updates to the Trust Board as part of the Trust’s quality and safety portfolio. Dr Mitchell remained in her role as Associate Director of Infection Prevention and Patient Safety. The posts of surveillance lead, water safety and quality lead, decontamination lead and sepsis lead are also held by Dr Mitchell.

Dr Wyllie remains in the position of Infection Prevention Doctor, as nominated by the microbiology department. In December 2016, Helen Campbell joined the Trust as Decontamination Manager, replacing Darren Carter.

Throughout 2016/17, the team had only one change to its core structure (figure 1). Jasmine Manuell joined the Team as an Infection Prevention Practitioner in November 2016, replacing Chris Ralph who vacated the position in August.

Figure 1. Team Structure
1.2 Awards and Publications

Portsmouth Hospitals NHS Trust (PHT) was one of the CHKS Top Hospitals for 2017. The award recognises PHT as one of the top performing CHKS client trusts, and is based on the evaluation of over 20 key performance indicators covering safety, clinical effectiveness, health outcomes, efficiency, patient experience and quality of care. One of the indicators is reported *C. difficile* rate for patients aged 2 and over which the IPT continues to work hard on to deliver below the national average (section 4).

In 2016, the IPT designed a poster on the Trust’s work on reducing Norovirus outbreaks. The poster was submitted to the Patient Safety Congress and was successfully shortlisted and displayed at the event.

1.3 Infection Prevention Management Committee

The IPMC is the main forum for discussion concerning changes to policy or practice relating to infection prevention. The membership of the committee is multi-disciplinary and includes representation from all CSC’s, senior management and supporting organisations, as well as external agencies such as Public Health England (PHE) and Clinical Commissioning Groups (CCGs). The committee meets quarterly and is chaired by the DIPC.

The IPMC met on four occasions in 2016/17. The meetings were well attended and provided a useful forum for discussion on healthcare associated infection policy and related policies and procedures within the Trust. Key actions arising from these meetings include:

- Implementation of a Trust-wide CPE screening protocol for all inter-hospital transfers and patients who have recently received treatment in an overseas hospital
- Surgical site infection surveillance extended to include consecutive quarters of hip and knee replacement surgery, in order to gain a baseline infection rate.

The IPMC also monitors the risk relating to HCAI on the Trust risk register. During 2016/17, this remained rated at 12.
REGISTRATION, INSPECTION AND COMPLIANCE

The Trust continues to be compliant with all ten criteria of the Health and Social Care Act (2008) Code of Practice.

The Trust was inspected by the Care Quality Commission (CQC) in September 2016 as a follow up to a previous inspection in March. The inspection was unannounced, focussed on the emergency care pathway, and identified that significant improvements had been made within the emergency department since the inspection in March 2016. The inspection identified some concerns relating to infection control procedures in AMU (Acute Medical Unit) and on the medical wards. As a result of the findings, a comprehensive action plan was initiated. Actions required to resolve non-compliance are:

- Re-enforcement of adherence to infection control standards to improve compliance with heath and safety and HCAI requirements and maintain low levels of infection
- Ensuring wards are compliant with the NPSA requirements
- Ensuring that compliance is met with the hand hygiene requirements

The IPT continue to support the AMU by providing infection prevention education, peer review audits and an enhanced presence in the unit. These measures will continue throughout 2017/18.

The Trust is compliant with National Institute for Health and Care Excellence (NICE) quality standards and clinical guidelines. On behalf of the Trust, the IPT complete gap analyses of new guidance to provide assurance against these standards (QS49, QS61, QS90, QS113). The Trust Risk Assurance Committee (RAC) has monitored and approved a risk relating to HCAI on the Trust risk register. The risk was rated at 12 throughout 2016/17. The mitigating actions and risk assessments are monitored on a monthly basis by the risk assurance committee as well as the IPMC.

The IPT have reviewed and updated 15 policies in 2016/17, and developed a number of new policies. The team also consult and advise on other Trust policies.

As part of criteria 3 of the Code of Practice (accessibility of information), the IPT own a number of patient information leaflets which are reviewed and updated regularly. The IPT manage a Trust intranet page which houses a wide variety of resources including; infection information, audits and reports, and training videos. This can be accessed 24 hours a day by staff. An external internet page is also managed by the Team and provides information to the public and visitors. The IPT also publish a weekly Infection Prevention dashboard, which allows the CSCs and departments to track their performance on a number of performance measures. It also allows staff to view the overall Trust position of certain metrics. This dashboard is discussed in senior medical and nursing forum and contributes to the quality heat map for each CSC. This in turn is discussed at every CSC performance review.
3.1 The Infection Prevention Team

The Team consists of single and dual-role specialist nurses and practitioners in infection prevention and/or vascular access. The core functions of the Team can be split into 4 domains, namely;

1. Specialist Knowledge of Infection and Infection Prevention
2. Specialist Infection Skills
3. Surveillance and Assurance
4. Education and Competency

Key activity roles include;

- The prevention and management of healthcare associated infections (HCAI) and multi-drug resistant (MDR) infections
- Timely isolation and the enforcement of strict transmission precautions for all transmissible infections
- Act as an expert resource for all vascular access i.e., portacaths and Hickman lines etc.
- Provide an out-of-hours, including weekends, specialist advice service on all elements of infection prevention and vascular access
- Lead on the prevention and management of communicable disease outbreak e.g., Norovirus
- Act as an expert resource in communicable diseases for the Occupational Health Department in the assessment, diagnosis and treatment of healthcare professionals within the Trust and critically assess any impact on patients as a result of some illness or poor health
- The provision of an infection prevention service including; advice and consultation, education, and microbiological support to the South Central Ambulance Service (SCAS)
- Specialist decontamination services ranging from the commissioning of all new and refurbished clinical areas, the compliance of the theatre ventilation systems and compliance of all endoscopy and sterile services with the required standards for decontamination
- The water quality and safety schedule of work to ensure that the quality of water in all clinical areas is of the required standard appropriate for the wellbeing of staff, patients and visitors
- The provision of a specialist vascular access service for patients through cannulation or placement of Peripherally Inserted Central Catheters (PICC) lines or Midlines, which includes education and competency assessment of practitioners within the Trust
- Facilitate the data collection and report submission in line with the requirements of the national Sepsis CQUIN
- The surveillance and audit of healthcare associated infections including ward surveillance for hand hygiene, environmental cleaning, device care, the cleanliness of medical equipment and surgical site infections
- Contribute to the flu vaccine programme managed by the Occupational Health Department
- The education of all substantive and temporary staff on hand hygiene, infection prevention and relevant aspects of decontamination, clinical skills including cannulation, blood cultures, phlebotomy, IV administration and central line handling
- Act as a host for nurses in the Armed Forces, providing training to become specialists in infection prevention
- The education of clinical skills to academic students on placement at PHT (Wessex Deanery, University Students)
3.2 Team Activity

A total of 11,974 documented clinical reviews of patients (not including the activity within the Vascular Access service) were recorded by the IPT in 2016/17. This remains comparable with the number of reviews recorded in 2015/16 (figure 2).

The breakdown of reviews by type remains similar to recent years (figure 3), although the following are of interest:

- The increase in the number of reviews for new cases of MRSA identified in 2015/16 continued in 2016/17. This is not unexpected given that admissions to the Trust continue to increase.
- The IPT carried out 31% more C. difficile case reviews than in 2015/16. This is partly in response to changes in laboratory enteric testing and methodology which has resulted in more samples receiving C. difficile testing. This is particularly the case for community samples, however, will result in a review by the team as and when the patient is admitted.
- The number of influenza reviews reduced by 62% compared with 2015/16, and instead mirrored the 2014/15 workload. This is due to the reduction in positive swabs identified in the 2016/17 flu season (section 4.6).

During 2016/17, the number of clinical reviews conducted by each team member (per year) was approximately 2,395 (figure 4). This is only 3 reviews per year, per clinical staff member, less than in 2015/16. Since this is only one domain of the Team’s work, and activity in the other areas, such as; vascular access, audit and surveillance has continued to increase, 2016/17 has been our most productive year to date.


3.3 The Vascular Access Service

The Team continues to offer an expert and comprehensive Vascular Access service to the Trust. This includes:

- The placement of single, double and triple lumen PICC lines and Midlines
- The insertion of complex cannulas
- Specialist advice on line selection, placement, care and trouble-shooting
- Complex phlebotomy
- Training, education and competency assessment


95% of line placements were placed successfully, mostly with ultrasound guidance. This is consistent with previous year’s activity.

In January 2017, the Team were gifted a new ultrasound machine by the League of Friends.

The team received 2,147 referrals for intervention and assessment.

Of the referrals received in 2016/17, 1,709 (79.6%) were accepted, following a thorough vetting process, for intervention/advice by the Team. This is comparable to 2015/16 (78.4%).

Table 1. Vascular Access Referrals

<table>
<thead>
<tr>
<th>Type</th>
<th>2015/16 Total</th>
<th>2016/17 Q1</th>
<th>2016/17 Q2</th>
<th>2016/17 Q3</th>
<th>2016/17 Q4</th>
<th>2016/17 Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Advice</td>
<td>89</td>
<td>28</td>
<td>42</td>
<td>36</td>
<td>51</td>
<td>157</td>
</tr>
<tr>
<td>Blocked line</td>
<td>103</td>
<td>51</td>
<td>47</td>
<td>38</td>
<td>45</td>
<td>181</td>
</tr>
<tr>
<td>Cannula placement</td>
<td>155</td>
<td>59</td>
<td>65</td>
<td>60</td>
<td>86</td>
<td>270</td>
</tr>
<tr>
<td>Chest X-ray check</td>
<td>41</td>
<td>13</td>
<td>32</td>
<td>34</td>
<td>24</td>
<td>103</td>
</tr>
<tr>
<td>Infected line</td>
<td>10</td>
<td>5</td>
<td>5</td>
<td>5</td>
<td>2</td>
<td>17</td>
</tr>
<tr>
<td>Displaced line</td>
<td>40</td>
<td>12</td>
<td>9</td>
<td>13</td>
<td>6</td>
<td>40</td>
</tr>
<tr>
<td>Guidewire exchange</td>
<td>14</td>
<td>6</td>
<td>6</td>
<td>10</td>
<td>4</td>
<td>26</td>
</tr>
<tr>
<td>Thrombosed vessel</td>
<td>5</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Leaking line</td>
<td>12</td>
<td>3</td>
<td>13</td>
<td>4</td>
<td>5</td>
<td>25</td>
</tr>
<tr>
<td>Line review</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Phlebotomy</td>
<td>12</td>
<td>6</td>
<td>17</td>
<td>4</td>
<td>5</td>
<td>32</td>
</tr>
<tr>
<td>PICC placement</td>
<td>968</td>
<td>284</td>
<td>302</td>
<td>266</td>
<td>227</td>
<td>1079</td>
</tr>
<tr>
<td>Port access</td>
<td>112</td>
<td>29</td>
<td>24</td>
<td>27</td>
<td>31</td>
<td>111</td>
</tr>
<tr>
<td>Other</td>
<td>37</td>
<td>27</td>
<td>42</td>
<td>12</td>
<td>21</td>
<td>102</td>
</tr>
<tr>
<td><strong>Total Referrals</strong></td>
<td><strong>1599</strong></td>
<td><strong>524</strong></td>
<td><strong>606</strong></td>
<td><strong>509</strong></td>
<td><strong>508</strong></td>
<td><strong>2147</strong></td>
</tr>
</tbody>
</table>
3.4 Michaela’s Story

“I am not supposed to be alive. I know I am so fortunate. Life is too short. I cannot praise the NHS and Debbie’s team enough. If it wasn’t for them, I wouldn’t be talking to you right now.”

“I am a very, very lucky person and I have been told many times that I should do the lottery,” Michaela, aged 47, says.

In 2015 Michaela, a mum of three, took a rare trip to London with her husband of 21 years, Tom. She had had pain in her leg for most of the day, but ignored it. However, on the car ride back home her condition deteriorated. “I started feeling really sick. I had so much pain in my stomach that Tom actually had to pull over. Then I got physically sick.” Michaela’s discomfort became so intense that she could not get back into the car. Her husband called for an ambulance and Michaela was rushed to QA Hospital.

“It turned out that I had a blood clot in my bowel,” Michaela says. Michaela was rushed to theatre. “My family said they talked to me, but I do not remember anything. I knew my husband was walking with me as I was being wheeled towards theatre. I woke up three days later in critical care.”

Michaela had to have seven metres taken out of her bowel. “My family was told I might not make it. I only have two metres left of my bowel now.”

Michaela was in QA hospital for seven weeks and had a Hickman line put in so she could get nutrition. However, she has struggled with infections.

“The first infection I had, I was totally unaware that I was even ill. All I knew was that I felt very depressed. Apparently I had a temperature but I didn’t even know I had one.” Fortunately, Michaela had a scheduled appointment with her dietician who suspected that Michaela’s Hickman line had become infected. “By then it felt like something was crawling underneath my skin.”

Michaela immediately went to Infection Control at QA Hospital and was seen by Debbie Keyte the Lead Nurse for Infection Prevention. “Thank god for Debbie,” Michaela says. “She caught it early before the infection could develop into sepsis.” Although thrilled to be cured of this infection, it would not be the last time she would struggle. “I have had three PICC lines and four Hickman lines that have had infections. Unfortunately, I am prone to them.”

Michaela admits that her infections have been quite
frightening experiences. “One time my husband and I went to Cardiff with my daughters and I started to feel sick and dizzy and my ear was particularly painful. The next day my leg started hurting and my husband took me straight to the A&E where they took bloods. It turned out that I had yet another infection in my Hickman line and my hip had an infection as well.”

Michaela credits the QA Infection Prevention team with literally saving her life. “Debbie actually has given me the out-of-hours mobile number and Terry Joy, one of the senior infection prevention practitioners, has been brilliant. He has done my PICC line and is always calm and reassuring and always talks me through it because he knows how much I hate having it done.”

Michaela has had surgery on her bowel and is now able to eat small amounts of food. However, she still needs her Hickman line for nutrients. “I will need it for the rest of my life but that is okay,” she says.

One of Michaela’s joys, outside of her family (which includes three grandchildren), is teaching. As soon as she felt well enough she went back to her teaching assistant job in a local primary school.

### 3.5 VitalPAC IPC Manager

Since 2010, the IPT have used VitalPAC IPC Manager to provide real-time reporting and surveillance of relevant organisms. IPC Manager is a bespoke software system designed by the IPT at Portsmouth Hospitals NHS Trust in conjunction with The Learning Clinic (TLC). It works by taking live feeds from both the microbiology reporting system and patient administration system, as well as routine nursing observations recorded on VitalPAC. This allows timely identification of emerging outbreaks and infections, whilst also alerting the IPT to any patients being admitted to the Trust with a previously identified infection requiring intervention.

#### VitalPAC IPC Manager Upgrade

During 2016, the IPT and microbiology worked with our IT service and TLC to upgrade VitalPAC (including IPC Manager) to the Standard Build provided by TLC. The move to standard build allowed for additional organisms to be built into the software, namely:

- Campylobacter
- CPE
- E.coli bacteraemia
- Influenza (types other than H1N1)
- RSV
- Salmonella
- Shigella

As part of the upgrade, a number of changes were made to the VitalPAC. One of which was the addition of the midline care bundle, allowing for electronic documentation of midlines, as had been the case for cannulas, central venous devices, and urinary catheters, for some time.

The standard build rolled out Trust-wide in December 2016, and the IPT continues to work with our IT services and TLC to ensure the system functions to the ever changing needs of the service.
3.6 Sepsis CQUIN

Sepsis is a potentially life-threatening condition and is recognised as a significant cause of mortality and morbidity. In England, almost 37,000 deaths are attributed to sepsis each year. Of these, 11,000 are estimated to be preventable. As part of the patient safety agenda to reduce mortality related to sepsis and improve patient outcomes, a national sepsis CQUIN (Commissioning for Quality and Innovation) was introduced in 2015. The CQUIN focussed on improving compliance with timely sepsis screening and prompt antibiotic administration for patients presenting with signs of sepsis. In 2016, the CQUIN was extended to also include inpatients who deteriorate due to sepsis. The indicator is measured by an audit of patient notes, which the IPT have been responsible for since the CQUIN’s introduction.

In 2016/17, the IPT reviewed over 1,700 sets of patient notes.

To address low compliance with timely treatment (table 3), an action plan has been developed. The Trust is also working with the regional sepsis group to adopt their pathway and gain agreement on definitions for the 2017/18 CQUIN to ensure standardised benchmarking.

<table>
<thead>
<tr>
<th>Table 2. Sepsis screening</th>
<th>Emergency Departments and Direct Admit areas</th>
<th>Acute inpatient settings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Compliance achieved</td>
<td>Target</td>
<td>Compliance achieved</td>
</tr>
<tr>
<td>Quarter 1</td>
<td>94.66%</td>
<td>90%</td>
</tr>
<tr>
<td>Quarter 2</td>
<td>94.74%</td>
<td>90%</td>
</tr>
<tr>
<td>Quarter 3</td>
<td>98.35%</td>
<td>90%</td>
</tr>
<tr>
<td>Quarter 4</td>
<td>96.89%</td>
<td>90%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Table 3. IV antibiotic administration and empiric review</th>
<th>Emergency Departments and Direct Admit areas</th>
<th>Acute inpatient settings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Compliance achieved</td>
<td>Target</td>
<td>Compliance achieved</td>
</tr>
<tr>
<td>Quarter 1</td>
<td>49.74%</td>
<td>30%</td>
</tr>
<tr>
<td>Quarter 2</td>
<td>49.78%</td>
<td>35%</td>
</tr>
<tr>
<td>Quarter 3</td>
<td>42.69%</td>
<td>45%</td>
</tr>
<tr>
<td>Quarter 4</td>
<td>49.78%</td>
<td>65%</td>
</tr>
</tbody>
</table>
3.7 Public and Staff Engagement

The IPT participated in a number of events attended by the public including:

- Hand Hygiene Awareness, May 2016
- National Nurses Day, May 2016
- Love Your Bones, June 2016
- Trust Open Day, October 2016

For these events, the Team occupied a stand in the main atrium to promote infection prevention and public health messages. These events are an important opportunity to provide information on; hand hygiene influenza awareness, environmental cleanliness, viral gastroenteritis, and vascular access. The Team also provided practical hand hygiene sessions for the public and gave away free tottle bottles of alcohol gel.

In September 2016, the Team joined other members of the Trust, to spread awareness of Sepsis. This involved visiting the wards to speak with staff, patients and relatives about the signs of sepsis and the six fundamental therapies designed to reduce the mortality of patients with sepsis.

3.8 Feedback from our Colleagues

The orthopaedic wards would like to thank the IPT for their support, guidance and time that has enabled the wards to improve Infection Prevention standards.

This was achieved by the IPT sharing information and knowledge in an approachable, non-judgemental manner and not losing confidence that the teams would succeed. Thank you for empowering the orthopaedic wards to take ownership of the daily challenges and be proud of the area they work in, providing a safe area to care for high risk patients.

Sue Bradshaw, Matron for MSK CSC

The Acute Medical Unit have been positively (and gratefully) supported by the IPT, almost daily, since the formal CQC Report launch in June 2016, in which specific key issues were highlighted related to Infection prevention.

The IPT have continued to regularly provided education, reminders and a general increased awareness of the huge importance of the fundamental standard precautions that underpin routine safe practice and ultimately improve the protection to both staff and patients from infection.

This concentrated collaboration will ensure that EVERY member of staff will always apply standard precautions at all times and to all patients - the ultimate aim is to ensure that best practice becomes second nature and the risks of infection are minimised.

Bev Vaughan, Matron for AMU
Performance against national and local objectives

4.1 Clostridium difficile

C. difficile infection has been subject to enhanced surveillance since 2007, and is reported via the Public Health England (PHE) data capture system. Since 2007, national rates of C. difficile infection have declined dramatically, although rates of Trust-attributed C. difficile infection remained approximately stable between 2013/14 and 2015/16. In 2016/17, there was a slight reduction in rate (per 100,000 bed days) of Trust-attributed C. difficile cases nationally, from 14.9 in 2015/16 to 13.2 in 2016/17.

During 2016/17, there were 120 toxin positive samples reported by the laboratory, compared to 114 in 2015/16. The attribution of cases in 2016/17 followed a similar pattern to that of 2015/16 (figure 6).

The Trust objective for 2016/17 remained at ≤ 40 cases. PHT achieved this with 33 Trust-attributed cases. This was a small increase on the 2015/16 performance of 29 Trust-attributed cases. However, PHT remains below the national average with a rate of 9.2 cases per 100,000 bed days compared to 13.2 cases nationally (figure 7).

The Trust continued to implement a C. difficile action plan which was monitored through IPMC. Key elements of the plan included:

- Carried out root cause analysis of all Trust-attributed cases of C. difficile to elicit the root cause and learning
Performance against national and local objectives

- Prompt/timely management of patients with suspected or confirmed *C. difficile*
- Continued increased surveillance of clinical and domestic cleaning
- Increased surveillance of hand hygiene compliance and peer-review audit programme
- Increased our fleet of Bioquell BQ-50 Hydrogen Peroxide vapour machines to 4
- Hosted *C. difficile* case review meetings with the CCGs and neighbouring Trusts as part of a whole system approach to managing *C. difficile*.

Root cause analysis of the 33 cases identified the following key themes:

- The cases occur in all areas of the Trust. A reduction in cases identified from MOPRS CSC was noted from 2015/16 however, it remains that cases are most prevalent in MOPRS and Medicine CSC (figure 8) where the patients often have a long length of stay, multiple co-morbidities, and require multiple courses of antibiotic therapy.
- 5 cases involved patients outlied to another specialty.
- 3 cases were delayed samples. This includes cases where the patient came in with, or started having diarrhoea within the first 3 days of admission, but no sample was sent until later in the admission (there is a ≥ 72 hour cut-off for attribution to acute trust).

All Trust-attributed cases of *C. difficile* are sent to the PHE reference laboratory for ribotyping. In January 2017, 2 cases on the same ward were identified as being the same strain. This suggests that there was patient-to-patient onward transmission. As a result, a comprehensive action plan was initiated including;

- Weekly NPSA and hand hygiene audits
- Thorough decontamination of the ward and all equipment
- All staff re-visited the infection prevention policies

Following this, no other cases arose on this ward.

In recent years, PHE have acknowledged the fact that some cases can occur even if best practice is followed and the patient receives flawless care from acute trusts. In addition to this, the increasing proportions of cases arising from non-inpatients has driven PHE to recognise that the current trust apportioning algorithm does not take into account the complex healthcare pathways that *C. difficile* patients may have. Therefore, as of April 2017 a new trust-apportioning mechanism will be introduced using data on prior health care exposures. *C. difficile* will remain a key priority for the Trust in 2017/18.
4.2 MRSA bloodstream infections

MRSA bloodstream infections have been subject to enhanced surveillance since 2005 and all positive cases are reported via the PHE data capture system. Nationally, the incidence of MRSA bloodstream infection declined year-on-year between 2007/08 and 2014/15, before rising slightly in 2015/16 and then remained at the same level for 2016/17.

The Post Infection Review (PIR) process was implemented in 2013 to aid a zero-tolerance policy for MRSA bloodstream infections. The PIR process involves a multi-disciplinary review of the case to determine the root cause of the bloodstream infection, and also highlight and address any associated learning. Following this process, each case is attributed to either the Trust, CCG or a third party. Since the introduction of the PIR process, rates of Trust and CCG-attributed MRSA bloodstream infection have fallen, whilst rates of third party attributed cases have increased, reflecting the complexity of a large proportion of cases.

During 2016/17, PHT reported and investigated 7 cases of MRSA bloodstream infection. Of the 7 cases investigated, 1 was attributed to PHT. This case occurred in October 2016 and was deemed ‘unavoidable’ by expert panel. This compares with 1 ‘avoidable’ case of Trust-attributed MRSA bloodstream infection in 2015/16, although this case resulted from a contaminated blood culture and was felt not to be a true bloodstream infection.

PHT remains below the national average with a rate of 0.3 cases per 100,000 bed days compared to 0.9 cases nationally (figure 10).

In 2016/17, PHT had 0 avoidable and 1 unavoidable case attributed to it, therefore achieving its target of zero avoidable cases.

Of the remaining 6 cases investigated by PHT, 3 were attributed to the CCG and 3 cases to third parties.

The Trust has continued to implement and monitor a comprehensive Staphylococcus action plan, which was initiated in 2013/14. The key elements of this plan include:

- Timely admission screening for MRSA and robust repeat screening every seven days
- Improving and sustaining high levels of hand hygiene
- ‘Right device, right situation’ message for indwelling devices
- Timely and accurate record keeping of indwelling device insertion and management checks and care
- Prompt and timely removal of devices within the framework set by national stipulated guidance
- Full compliance with asepsis or aseptic non touch technique (ANTT) where indicated
have increased steadily, from 7.8 in 2012/13 to 8.8 in 2016/17.

In 2015/16, after implementation of a number of interventions, the Trust saw a marked decrease in Trust-attributed cases of MSSA bloodstream infection. This improvement was sustained in 2016/17, and the Trust achieved it’s lowest rate of MSSA infections since 2012.

In 2016/17, PHT had 25 cases attributed to it, compared to 26 in 2015/16.

PHT remains below the national average with a rate of 6.9 cases per 100,000 bed days compared to 8.8 cases nationally (figure 12).

Root cause analysis of the 25 Trust-attributed cases identified;

- 8%, 28% and 36% of Trust-attributed MSSA bloodstream infections occur by day two, four, and seven, respectively
- The bloodstream infections occur in all areas of the Trust but are most prevalent in Medicine CSC (figure 14)

4.3 MSSA bloodstream infections

MSSA bloodstream infections have been subject to enhanced surveillance since 2011 and all positive cases are reported via the PHE data capture system. Nationally, the incidence of MSSA bloodstream infection has increased year-on-year since surveillance began in 2011, with a 31% increase reported between 2011/12 and 2016/17. Similarly, Trust-attributed MSSA bloodstream infection rates
Monitoring and promoting the use of the bespoke cannulation pack, which was introduced in the Trust in July 2015.

Daily and weekly reporting of indwelling device check and removal compliance

The largest proportion of infections are related to indwelling devices and care (table 2), although a small reduction from 2015/16 has been noted.

The IPT plan to continue the following interventions throughout 2017/18:

- An increased Trust-wide focus on MSSA bloodstream infection monitored through IPMC
- Continued use of BioPatch to reduce catheter-related bloodstream infections
- Monitoring and promoting the use of Octenisan wash; a lotion with anti-staphylococcus aureus action to reduce the risk of infection to patients
- Program of audit for intravenous devices (section 5.5)

**Table 2. Source of MSSA**

<table>
<thead>
<tr>
<th>Source</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Central Venous Catheter</td>
<td>20.00%</td>
</tr>
<tr>
<td>Peripheral Venous Cannula</td>
<td>12.00%</td>
</tr>
<tr>
<td>Skin/soft tissue</td>
<td>12.00%</td>
</tr>
<tr>
<td>Prosthesis</td>
<td>8.00%</td>
</tr>
<tr>
<td>Wound</td>
<td>8.00%</td>
</tr>
<tr>
<td>Urology</td>
<td>8.00%</td>
</tr>
<tr>
<td>Respiratory</td>
<td>8.00%</td>
</tr>
<tr>
<td>Bone/joint</td>
<td>8.00%</td>
</tr>
<tr>
<td>Other</td>
<td>8.00%</td>
</tr>
<tr>
<td>unknown</td>
<td>8.00%</td>
</tr>
</tbody>
</table>

**4.4 E.coli bloodstream infections**

Since the mid-2000s, E.coli has been the major cause of bloodstream infection, and has been subject to mandatory surveillance since 2011. Nationally, the incidence of E.coli has been rising since 2003 and in recent years the increase has accelerated. Approximately, 75% of cases nationally, are identified within 2 days of admission and therefore have their onset in the community. In 2016/17, 390 E.coli bloodstream infections were reported by the Trust. Of which, 74% were community-onset cases, similar to the national picture (figure 15). Benchmarking against other acute Trusts is not possible, as PHE had not adopted an apportioning algorithm for this type of infection. Nevertheless, the IPT record, monitor and investigate cases of post 48-hour E.coli bloodstream infection in order to identify core themes and learning for staff.

In 2016/17, PHT reported **104 cases** of post 48-hour E.coli bloodstream infection.**27% increase compared to 2015/16**
In 2016/17, the Trust saw a **27% increase** in Trust-attributed cases of E.coli bloodstream infection, compared to 2015/16.

Analysis of Trust-apportioned (post 48-hour) cases show that the **primary focus is urinary tract infection** (table 3), which is in-line with the national picture. PHE acknowledge that the difference in epidemiology between this type of infection and those involving Staphylococcus Aureus, indicates the need for tailored interventions, rather than merely a repeat of previously used measures.

In 2016, the Secretary of State for Health announced a new initiative to reduce Gram-negative bloodstream infections by 2021. As a result of this, PHE have mandated that Klebsiella and Pseudomonas bloodstream infections be included as part of this surveillance. In addition to this, the surveillance has also been extended to gather enhanced data on focus of infection, risk factors and previous healthcare exposure. PHE have also activated the apportioning algorithm (pre/post 48 hours), so that Trusts and CCGs can be benchmarked against each other. These changes came into effect in April 2017. In 2017/18, the IPT will work closely with their community counterparts to assist them in achieving a 10% reduction in E.coli bloodstream infections by the end of 2017/18.

### 4.5 Multi-drug resistant organisms

The Trust continues to monitor multi-drug resistant organism colonisation and infection. However, it is not part of the mandatory surveillance to PHE. As a result of the increased antimicrobial resistance seen worldwide, the Trust widened its screening protocol in recent years. It is therefore, not surprising that the detection of these organisms has increased. The significance of this is yet to be determined as nationally there is no baseline to benchmark against as Trusts use different screening protocols.

**Glycopeptide-Resistant Enterococcus (GRE)**

Enterococci are bacteria that are resistant to glycopeptide antibiotics, such as Vancomycin and Teicoplanin. GRE are sometimes referred to as Vancomycin-Resistant Enterococci (VRE).

Since the development of the Trust’s screening programme, the number of patients found to be colonised with GRE has increased, although in the last 12 months have begun to stabilise (figure 17).
Extended Spectrum Beta-Lactamase (ESBL) and Amp-C Producing Organisms

ESBL and Amp-C are enzymes that have developed resistance to some antibiotics. Some bacteria produce these enzymes, which can make treating infections more difficult as antibiotic treatment choice is limited.

The national prevalence of these bacteria has increased continuously over the last few years. In April 2014, the laboratory testing and reporting regimen changed to include improved tests for Amp-C producing organisms, resulting in a significant rise in detected and reported isolates (figure 18). Incidence of these types of organisms are expected to remain a cause for concern.

**Carbapenemase-Producing Enterobacteriaceae (CPE)**

Enterobacteriaceae are bacteria that usually live harmlessly in the human gastrointestinal tract. Some of these bacteria produce carbapenemase enzymes resulting in resistance to all or almost all antibiotics. The Trust continues to implement the enhanced screening of all inter-hospital transfers and those who have recently received treatment in an overseas hospital for carriage of CPE.

As a result of the enhanced screening programme, 3 inpatients were identified to be carrying CPE in 2016/17. A further 5 patients were identified from community samples, of which 1 patient has since received treatment at PHT. All patients were well and the organism did not result in infection requiring treatment. Precautions were taken to minimise the risk of transmission to other patients and the environment. In cases where a CPE positive patient came into contact with other patients prior to notification of the positive result, an outbreak meeting with PHE was held. Whereby screening of contacts and equipment was necessary, **no onward transmission was found**.

**Acinetobacter**

The IPT was involved in the investigation of 2 cases of highly resistant Acinetobacter during 2016/17. This involved decontamination and screening of the clinical environment and equipment, and screening of patients. Due to the excellent infection prevention practices at PHT, **no onward transmission from either case was identified**.
4.6 Influenza

The IPT continued to play a key role in preparing for, and managing influenza in 2016/17, including:

- Chairing the Influenza Planning Committee
- Working with the Operations Team to plan patient flow
- Managing patient tests and isolation requirements
- Assessing patients with influenza-like illness
- Encouraging influenza vaccination uptake amongst healthcare workers
- Working with emergency planners to ensure the Trust has a robust winter flu plan, including a pandemic flu plan

The IPT provided fit testing of respirator masks to over 200 staff members, including 36 flu champions who were trained to cascade the training throughout the Trust on behalf of the team.

Emergency influenza boxes were again prepared by the IPT and distributed to 11 locations around the Trust. These included stock items such as; respirator face masks, gloves, aprons, throat swabs and management guides and algorithms, for quick and easy access for staff.

Moderate levels of influenza activity were seen in the community in the UK in 2016/17, with influenza A (H3N2) the predominant virus circulating for the majority of the season, peaking in week 1 of 2017. The impact of influenza A (H3N2) was predominantly seen in older adults, and a consistent pattern of outbreaks in care homes was noted. As a result, admissions to hospitals amongst older adults was observed. Levels of excess all-cause mortality were elevated particularly in the elderly, but were lower than the 2014/15 season in which influenza A (H3N2) also dominated.

1078 flu tests were performed between August 2016 and the end of March 2017. Of these, 228 were positive, with activity peaking at week 1, in line with the activity seen nationally (figure 19).

The majority of cases were influenza A (non-H1N1), with only 7 influenza B cases and 0 (zero) influenza A (H1N1) cases (figure 20).
From April 2016, as part of a new health and wellbeing CQUIN indicator, there was an increased focus on flu vaccinations for frontline healthcare workers. A target of 75% vaccinated was set in order for Trusts to receive 100% of the CQUIN payment. There was a strong commitment from the Trust to the flu vaccine campaign with a number of new initiatives being introduced. These included:

- #ImmuniseYourSelfie campaign on social media
- Weekly fruit baskets for the departments with the most improved vaccine uptake
- Prize draw for those who receive the vaccine

Vaccine uptake significantly improved nationally in 2016/17 with 63.2% of frontline staff receiving the vaccine in England, compared to 50.6% in 2015/16. At PHT, performance also increased greatly with 69.0% of frontline staff receiving the vaccine, compared with 57.7% the previous year (figure 21).

4.7 Outbreaks of infectious gastroenteritis

The Trust continues to monitor suspected cases of infectious gastroenteritis, including Norovirus, and reports any outbreaks to PHE via the Hospital Norovirus Outbreak Reporting System (HNORS). In order to capture the winter peak of norovirus activity in one season, for reporting purposes, the norovirus season runs from week 27 in year 1 to week 26 in year 2.

During 2016/17, there were 435 (490 [2015/16]) reported hospital outbreaks in England. Of these, 407 (465 [2015/16]) resulted in ward/bay closure or restrictions to admission and 318 (359 [2015/16]) were reported as laboratory confirmed Norovirus. As reporting of Norovirus is voluntary, this is likely to be a significant under representation of viral gastroenteritis in hospitals.

PHT had zero ward closures due to infectious gastroenteritis in 2016/17. The IPT continues to provide the Trust with a 24-hour, 7 day a week infection prevention service which includes the detection and management of potentially infectious cases of diarrhoea and vomiting. This service ensures continuity of advice and management throughout the week and improves assessment of symptomatic patients outside normal working hours, which has been shown to significantly reduce the number of overnight/weekend ward closures.
SURVEILLANCE

5.1 Cleanliness: National Patient Safety Association (NPSA) Audits

The cleanliness of the clinical environment has remained a key priority in 2016/17 as it is crucial in assisting the Trust with control of infections such as C. difficile, Norovirus and multi-drug resistant organisms. All wards carry out monthly self-audits of compliance whilst the IPT carry our peer review audits for assurance. The IPT continues to compile all the audits carried out across the Trust and monitors the submissions to ensure that the self-audited scores are a true reflection of what is found. Clinical areas are encouraged to audit a good proportion of the ward/area, rather than a couple of rooms, and to audit everything in the room, rather than picking out only a few items, as this can skew the audit result. Any areas felt to be struggling with either the audit submission or the compliance with the audit receive training and support by the IPT.

In line with previous years, the self-audits scored 97.1% compliance on average (figure 22). Emergency Medicine CSC’s compliance continues to be lower than other CSC’s. This is because there are fewer departments within the CSC to submit audits, and as a result, the average compliance is skewed if an audit result is low. The IPT have encouraged the AMU, which is a large department with a vast patient turnaround, to break down their audits into each area (i.e., Red, Orange etc.). This also allows easier monitoring of compliance and resolution of any issues identified.

For additional assurance, the IPT carries out unannounced peer-review audits across all clinical wards and departments. Any audits scoring below 90% receive support and fortnightly re-audits until a sustained improvement is noted. In 2016/17, the IPT carried out 527 peer review audits. This is an increase from 392 in 2015/16. The main focus for the Team was to sustain minimal ‘red’ or ‘unacceptable’ scores (audits scoring below 85%), while increasing the number of ‘acceptable’ or ‘green’ scores (audits scoring above 95%). Results from the peer-review audits have increased year-on-year, and in 2016/17 57.9% audits scored above 95%, compared to 34.2% in 2015/16 (figure 23). Only 29 (5.5%) of the 527 audits carried out scored below 85% which is a marked improvement on last year (18.4%).
A small increase in ‘unacceptable’ audits was noted in quarter 1 compared to quarter 4 of the previous year. However, the increase seen in 2016/17 was much smaller than in previous years, and subsequent quarters identified our lowest proportion of audits scoring below 85% since this audit programme began. In addition, the proportion of audits scoring above 95% increased throughout the year, reaching a peak of 67.2% in quarter 4 (figure 24).

5.2 Hydrogen Peroxide Decontamination Service

The IPT continues to operate an (in-house) hydrogen peroxide decontamination service. This involves using a hydrogen peroxide robot to decontaminate a room with hydrogen peroxide vapour. This process occurs after domestic and clinical cleaning to kill all forms of vegetative bacteria, bacterial spores, fungi, fungal spores and viruses. The advantages of hydrogen peroxide vapour is that it is effective, gets to difficult to reach surfaces and once complete, precipitates into harmless oxygen and water.

The aim is to decontaminate clinical and non-clinical areas after they have been used to care for patients with infections, such as;

- Clostridium difficile
- Glycopeptide-resistant Enterococcus
- Carbapenemase-producing Enterobacteriaceae
- Acinetobacter

It is also used to decontaminate areas after sewage leaks and estate maintenance, such as, sprinkler upgrades. The IPT will often perform this service out-of-hours to minimise impact on service delivery.

In 2016/17, the IPT increased its fleet of Bioquell BQ50 machines to 4, replacing previous machines which had come to the end of their lifecycle. The Bioquell BQ50’s allow a cubicle to be decontaminated in under 2 hours and is a vast improvement in the previous turnaround time of 4 hours. This greatly reduces the downtime after which a bed can be reoccupied.
5.3 Patient-Led Assessment of the Care Environment (PLACE) 2016

The aim of the national PLACE assessment scheme is to provide a snapshot of how organisations are performing against a range of non-clinical activities which impact on the patient experience of care.

PHT scored consistently above the national average for all aspects of the PLACE 2016 assessment, with the exception of organisational food (figure 25). Improvements in Cleanliness, Condition, appearance & maintenance, and Dementia scores were recorded by the PLACE assessors.

5.4 Hand Hygiene

During 2016/17, the IPT continued monitoring hand hygiene compliance in clinical areas with monthly self-assessment hand hygiene audits. The current tool incorporates a number of factors including: the proportion of opportunities for hand hygiene taken, technique, naked below the elbow and use of personal protective equipment.

On average, all areas scored above 90% compliance with PHT achieving 97% compliance overall (figure 26). This is consistent with 2015/16.

In July 2016, Charitable Funds procured 9 additional Pure Hold hygiene handles for installation within a number of public locations around the hospital. These promote the use of hand gel on opening of doors.

For assurance, the IPT continued a programme of peer-audit of hand hygiene and PPE-use compliance. All staff members practising incorrect hand hygiene technique were approached by members of the IPT at the time of the audit.

100 peer-review audits were carried out in 2016/17

Whilst the number of audits carried out has increased, the scores indicate that compliance requires improvement in some clinical areas. Hand hygiene will remain as a key priority for 2017/18.
5.5 TEAL Audits (Intravenous Access Devices)

Throughout 2016/17, the IPT continued its targeted programme of device monitoring through TEAL (Training, Education, Audit & Liaison) audits. These clinical audits provide quantitative data on indwelling devices, including indication, insertion procedure and the on-going standard of care for feedback to ward areas and CSCs as part of quality monitoring.

Key findings include:

- 88% were peripheral venous cannulas, a small reduction from 90% recorded from the audits in the previous 2 years
- Intravenous devices were most commonly inserted for medications, fluids and antibiotics (figure 27). Although it was not possible to determine a reason for insertion for 6% of the devices audited, this is an improvement on 11% in 2015/16 and 28% in 2014/15.
- 43% of patients audited had at least one intravenous device in-situ. Whilst this is a small increase on 39% in 2015/16, it remains an improvement on 58% [2014/15]. Ensuring patients have the right device in the right situation remains a key message of the IPT, as well as to remove devices as soon as they are no longer clinically needed.

The TEAL audits have identified that device care has improved or been sustained compared with the previous year’s audits (table 4).

In 2016/17, the team audited

806 patients and
373 IV access devices

![Figure 27. Indication for intravenous device](image)

<table>
<thead>
<tr>
<th>Table 4. Indwelling device TEAL audit results 2016/17</th>
<th>2014/15</th>
<th>2015/16</th>
<th>2016/17</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of wards audited</td>
<td>18</td>
<td>35</td>
<td>43</td>
</tr>
<tr>
<td>Number of audits completed</td>
<td>18</td>
<td>52</td>
<td>44</td>
</tr>
<tr>
<td>Number of patients audited</td>
<td>215</td>
<td>912</td>
<td>806</td>
</tr>
<tr>
<td>Number of IV devices audited</td>
<td>132</td>
<td>374</td>
<td>373</td>
</tr>
<tr>
<td>IV Device Prevalence (%)</td>
<td>57.67%</td>
<td>38.60%</td>
<td>42.80%</td>
</tr>
<tr>
<td>% IV devices with insertion details documented</td>
<td>85%</td>
<td>88%</td>
<td>89%</td>
</tr>
<tr>
<td>% IV devices with an appropriate reason for insertion documented</td>
<td>72%</td>
<td>89%</td>
<td>94%</td>
</tr>
<tr>
<td>% IV devices with on-going care documented in the 24hrs prior to audit</td>
<td>68%</td>
<td>67%</td>
<td>71%</td>
</tr>
<tr>
<td>% IV devices still clinically indicated at time of audit</td>
<td>68%</td>
<td>81%</td>
<td>82%</td>
</tr>
</tbody>
</table>
45% of devices were recorded on VitalPAC by the person who placed the device. The importance of recording the device on VitalPAC, by the person who placed the device, features heavily as part of our teaching. As a result, this has improved by 7% [2015/16] and 13% [2014/15], although we acknowledge that further improvement is required.

95% of devices were in date (not overdue removal). This has improved from 93% in 2015/16.

71% of devices had on-going care documented in the previous 24 hours; an improvement of 4%, from 67% in 2015/16.

The proportion of devices correctly labelled with the insertion date improved 2%, to 82% in 2016/17.

The proportion of devices with clean and healthy entry sites increased from 97% [2015/16] to 98% [2016/17].

82% of devices were still clinically indicated at the time of audit. This is consistent with 2015/16 and suggests that the improvement in 2015/16 has been sustained.

Overall, a significant improvement in the care and management of intravenous devices has again been identified.

This is largely due to the interventions made by the IPT in recent years, as part of our focus on reducing line related infections (section 4.3).

5.6 TEAL Audits (Urinary Catheters)

Since 2012, the IPT have conducted point-prevalence audits of urinary catheter care as part of the TEAL programme. In 2016, the Secretary of State for Health launched an important programme to reduce healthcare associated Gram-negative bloodstream infections by 50% by 2021. Given that approximately 47% of all E.coli bloodstream infections have a urinary source, the IPT have focussed on urinary catheter audits in 2016/17.

The team audited 845 patients and 148 urinary catheters.

Key findings include:

- 18% of patients audited had a urinary catheter in-situ (table 5). This is a small reduction compared to 2015/16 when 21% of patients had a urinary catheter. This indicates that healthcare professionals in both primary and secondary care are starting to consider the appropriate use of urinary catheters in patients.

Table 5. Urinary Catheter TEAL audit results 2016/17

<table>
<thead>
<tr>
<th></th>
<th>2014/15</th>
<th>2015/16</th>
<th>2016/17</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of wards audited</td>
<td>9</td>
<td>14</td>
<td>40</td>
</tr>
<tr>
<td>Number of patients audited</td>
<td>254</td>
<td>273</td>
<td>845</td>
</tr>
<tr>
<td>Number of Urinary Catheters audited</td>
<td>42</td>
<td>57</td>
<td>148</td>
</tr>
<tr>
<td>Urinary catheter Prevalence (%)</td>
<td>16.54%</td>
<td>20.88%</td>
<td>17.51%</td>
</tr>
<tr>
<td>% Urinary catheters with insertion details documented</td>
<td>69%*</td>
<td>87%*</td>
<td>74%*</td>
</tr>
<tr>
<td>% Urinary catheters with an appropriate reason for insertion</td>
<td>76%</td>
<td>79%</td>
<td>93%</td>
</tr>
<tr>
<td>% Urinary catheters with on-going care documented in the 24hrs prior to</td>
<td>67%</td>
<td>60%</td>
<td>58%</td>
</tr>
<tr>
<td>% patients, with a urinary catheter in-situ, on treatment for a catheter associated urinary tract infection</td>
<td>4.8%</td>
<td>5.3%</td>
<td>2.0%</td>
</tr>
</tbody>
</table>

*of those catheters inserted within Portsmouth Hospitals NHS Trust
Urinary catheters are most commonly inserted for urinary retention and fluid monitoring (figure 28). Whilst the proportion inserted for acute retention has remained similar to 2015/16, the proportion inserted for chronic retention has risen dramatically; from 5% [2015/16] to 24% [2016/17]. It is thought to reflect an increased focus on the better continence of patients.

Appropriateness of catheterisation has improved 14% and 93% of urinary catheters had an appropriate reason for insertion documented.

The rate of catheter associated urinary tract infection (CA-UTI) remains below the national average. This is supported by the monthly Safety Thermometer data submission, which continues to be validated by the IPT.

**The improvement noted in 2015/16 of documentation of catheter insertion has not been sustained in 2016/17.**

**Documentation of on-going care has further reduced to 58% in 2016/17,** compared with 60% and 67% in 2015/16 and 2014/15 respectively. This is of concern and the IPT will focus on this in 2017/18.

### 5.7 Surgical Site Infection Surveillance

The IPT carried out surgical site infection surveillance (SSIS) on behalf of the Trust, and reports the findings to PHE.

**Repair of Neck of Femur (NOF)**

In April-June 2016, the IPT carried out surveillance of NOFs (table 6). The national average benchmark for infections identified in inpatients and on readmission was 1.3%.

PHT therefore, was below the national benchmark for this type of infection (0.9%).

### Total Knee Replacement (TKR)

During July-September 2016, 201 TKR’s were carried out. Of these, 4 patients developed an infection. Therefore, the Trust’s rate of SSI was above the national average. The circumstances of all patients with infections were investigated and no commonalities were found. The patients who experienced infection were complicated by a number of factors including underlying malignancy and trauma which are known to increase infection risk. The following actions were carried out to provide assurance and in response to the increased rate of infection noted;

- Environmental audits
- Review of certification and validation of ventilation in Theatres
- Review of tourniquet cuffs and hip replacement clamps

**Table 6. Operations and Surgical Site Infections**

<table>
<thead>
<tr>
<th></th>
<th>Total no.</th>
<th>No. inpatient/ readmission</th>
<th>% infected</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>PHT</strong></td>
<td>117</td>
<td>1</td>
<td>0.9%</td>
</tr>
<tr>
<td><strong>All hospitals</strong></td>
<td>63,116</td>
<td>851</td>
<td>1.3%</td>
</tr>
</tbody>
</table>
Review of cyro cuffs
Review of hand hygiene compliance
Review of dressing change protocol
Reinforcement of ring-fenced beds on elective orthopaedic ward
Deep clean and hydrogen peroxide decontamination of elective orthopaedic ward

The IPT continued surveillance of TKR’s throughout the remainder of 2016/17, and the Trust’s SSI rate was in-line with the national average in both quarters.

Total Hip Replacement (TKR)
233 THR’s were carried out in July-September 2016, of which 3 patients developed a SSI. Whilst PHT’s rate of SSI was above the national average, it remained within expected limits.

The IPT continued surveillance of this type of surgery for the rest of 2016/17. In quarter 3, the rate of SSI was above the national average. It is important to note that the numbers of patients with SSI are very low and often any more than one patient with an SSI can place the Trust above the national average.

In quarter 4, 0 infections were identified. Therefore, the Trust was below the national average.

The IPT plan to continue surveillance of TKR’s and THR’s for at least part of 2017/18.

Table 7. Operations and Surgical Site Infections

<table>
<thead>
<tr>
<th>Total Knee Replacement</th>
<th>No. inpatient/ readmission</th>
<th>% infected</th>
</tr>
</thead>
<tbody>
<tr>
<td>PHT Jul-Sep 2016</td>
<td>201</td>
<td>4</td>
</tr>
<tr>
<td>All hospitals</td>
<td>119,795</td>
<td>709</td>
</tr>
<tr>
<td>PHT Oct-Dec 2016</td>
<td>178</td>
<td>1</td>
</tr>
<tr>
<td>All hospitals</td>
<td>120,253</td>
<td>702</td>
</tr>
<tr>
<td>PHT Jan-Mar 2017</td>
<td>165</td>
<td>1</td>
</tr>
<tr>
<td>All hospitals</td>
<td>120,603</td>
<td>680</td>
</tr>
</tbody>
</table>

Table 8. Operations and Surgical Site Infections

<table>
<thead>
<tr>
<th>Total Hip Replacement</th>
<th>No. inpatient/ readmission</th>
<th>% infected</th>
</tr>
</thead>
<tbody>
<tr>
<td>PHT Jul-Sep 2016</td>
<td>233</td>
<td>3</td>
</tr>
<tr>
<td>All hospitals</td>
<td>116,574</td>
<td>854</td>
</tr>
<tr>
<td>PHT Oct-Dec 2016</td>
<td>206</td>
<td>2</td>
</tr>
<tr>
<td>All hospitals</td>
<td>116,253</td>
<td>842</td>
</tr>
<tr>
<td>PHT Jan-Mar 2017</td>
<td>156</td>
<td>0</td>
</tr>
<tr>
<td>All hospitals</td>
<td>116,164</td>
<td>831</td>
</tr>
</tbody>
</table>
5.8 ECDC Point Prevalence Survey

In November-December 2016, PHT took part in a Point Prevalence Survey conducted by the European Centre for Disease Prevention and Control (ECDC). The survey aims to estimate the total prevalence of healthcare associated infections (HAI) and antimicrobial use in acute care hospitals in the EU. The IPT and Microbiology carried out the survey, on behalf of the Trust.

Key findings include:

» 46% of patients had a cannula in-situ
» 5.7% of patients had a central venous catheter in-situ
» 23% of patients had a urinary catheter in-situ
» 1.5% of patients were intubated

The most prevalent types of HAI at PHT, as well as nationally, were Pneumonia/Lower Respiratory Tract infection, Urinary Tract infection, and Surgical Site infection. The full report with comparative data from other centres is due in late 2017.

991 patients were audited
101 had a HAI
341 were on antimicrobials
6.1 Education and Training

Staff education is one of the core functions of the IPT. On average, around 5,000 staff members are trained per year across a variety of sessions, including:

- Quality and Safety Training
- Setting Direction Induction Training
- Junior Doctors Induction
- Cannulation Study Day
- IV Study Days
- Medicine development days
- NICU essential updates
- Infection Prevention for Healthcare support workers
- Link advisors 2 day course
- Link advisors meetings
- IV updates—overseas nurses
- Clinical skills for medical students
- Infection Prevention for Carillion staff
- Phlebotomy workshops
- Nutrition steering group workshops
- Respirator mask fit testing
- Military assistants—cannulation and phlebotomy
- Clinical practical sessions for FY1

In addition to these internal teaching sessions, the IPT also provide face-to-face education to a number of external groups. These include:

- IV competency updates for Solent NHS Trust
- Care of IV devices at the Rowan’s Hospice
- The education of clinical skills to academic students on placement at PHT (Wessex Deanery, University Students)

The Team also receive numerous requests per month for bespoke sessions tailored to a ward or departments specific needs. These include topics such as:

- Line care
- Dressings
- Competency assessment
- Portacath access
- Cannula removal
- Identification of different types of line
- Decontamination of the environment and equipment
- Hand Hygiene
- Personal Protective Equipment (PPE) Use
6.2 Link Advisors

Infection Prevention Link Advisors are a fundamental part of infection prevention within the Trust, acting as role models in clinical areas and providing information to colleagues. In 2016/17, the IPT ran two full training courses to prepare new link advisors, and to update those already in the role. These sessions are multi-disciplinary including teams from around the Trust, such as Microbiology and HSDU, as well as external visitors, such as representatives of companies whose products are in-use around the Trust. As well as these training courses, two additional ‘meeting dates’ were held to provide a two hour session for topical education, discussion and feedback.

One of the hot topics at all link advisor sessions is cleaning and decontamination. A practical audit session was included on both training courses to better enable the link advisors to submit accurate and reliable NPSA audits. This allows us to monitor the Trust and ensure resolution of issues in a timely fashion.

Other training topics for link advisors included:
- The role of the link advisor
- Norovirus
- Multi-drug resistant organisms
- Staph aureus inc. MRSA
- Clostridium difficile
- PHT objectives 2016/17
- Octenisan & Suppression
- Isolation & PPE
- Intravenous device care
- Sharps safety
- BioPatch
- FFP3 fit testing
- Reports and audits
- Decontamination with Hydrogen Peroxide
- Sterilisation of equipment
- Hand Hygiene
- Actichlor-Plus

6.3 Our feedback

"Helpful course for newly qualified nurses like myself...gives one a lot of confidence"

"This course was crucial for my learning needs"

"The trainer was very approachable and friendly, whilst still challenged practice"

"...gave me confidence to become a more capable, competent practitioner"

"...clearly competent, knowledgeable, experienced instructor"

"Very practically focused; strong emphasis on clinical regulation and risk prevention"

"The trainer listened to any problems and provided relevant answers and solutions..."

"The person running the course was friendly and enthusiastic and made the learning experience enjoyable..."
DECONTAMINATION AND WATER SAFETY

7.1-7.3; Report compiled by Helen Campbell, Decontamination Manager
7.4; Report compiled by John A’Court, Head of Estates and Facilities

7.1 Decontamination

The Hospital Sterilisation and Disinfection Unit (HSDU) processed 184,942 trays of surgical instruments during 2016/17, up from 175,540 in 2015/16 (figure 29). This is an increase of 8.54% since 2014.

THE HSDU continues to demonstrate compliance with the requirements of ISO 13485:2003 and the Medical Device Regulations to ensure that they are providing decontaminated invasive medical devices that are fit for purpose. The HSDU received six-monthly external audits from The British Standards Institute (BSI) in September 2016 and March 2017. 7 minor non-conformities were raised throughout the 2 visits, with a timely resolution.

The product conformity data (error rate) shows that during 2016/17 the quality key performance indicator for the service was achieved (figure 30). The objective was to keep all errors below 1%.

New and updated standards

Health Technical Memorandums (HTM) have been issued covering various aspects of decontamination. The main changes are for Trusts to test for residual protein with a limit of 5 µm.

HSDU is transitioning from ISO 13485:2003 to ISO 13485:2016 and will be audited against this standard in September 2017.
7.2 Endoscopy

In the last year, the operational integrity of the Trust’s three endoscopy decontamination hubs has been greatly compromised due to continuous problems relating to:

1. The microbiological quality of the final rinse water in the automatic endoscope reprocessing units
2. The failure of the existing Reverse Osmosis (RO) units to provide an uninterrupted supply of sterile water
3. Technical failures of the equipment

This has resulted in delays and cancellations of patients, some of who are on time critical care pathways e.g. cancer waiting lists. The IPT, along with the Development Team, has sought to support both Carillion and PHT colleagues to enable a quicker resolution to these complex and sometimes intractable problems which have plagued the operational capacity of the unit (figure 31). The RO plants and the endoscopy washer/disinfectors are due for replacement because of the age of the machines and also the number of cycles completed. A business case has been submitted and a working group has been set up with regular meetings to ensure a safe, cost effective solution for the Trust.

7.3 Decontamination Committee

The Decontamination Committee met 2 times in 2016/17. The group has addressed a number of important decontamination issues relating to cleaning schedules and products, theatre ventilation, endoscopy water quality and the decontamination of medical devices. The group reports into IPMC for governance purposes.
7.4 Water


The Trust’s PFI Service Provider continues its program of improvement works on the domestic water system. The Contractor maintains the large domestic water systems in line with the HSE L8 Approved Code of Practice (incorporating HSG274 (2014)) achieving consistent flow and temperatures within the system. A system balanced in this way maintains confidence in its ability to deliver quality water.

The following were reported at the WSG;

✍️ The alterations and improvements to water distribution systems have been completed for the retained estate. However, the validation of the improvements is yet to occur despite these works being completed over 2 years ago.

✍️ A joint water sampling programme had been drawn up, which has provided good results. PHT and CSL intend to continue with a sampling programme.

✍️ Water treatment for Endoscopy disinfection equipment has suffered repeated quality issues and a CSL trialled a thermal RO machine for endoscope decontamination in HSDU from July 2016, the trial was successful and CSL have since purchased the machine. It is proposed to roll out the alternative to all Endoscopy units, however, this is subject to funding constraints as well as logistics.

✍️ The Trust has engaged an external adviser to assist in the preparation of a Water Safety Plan as recommended in the DoH Guidance HTM 04-01 (2016).

✍️ Water dispensers programme of continual maintenance, cleaning and sampling has been developed by CSL.

✍️ Prompted by the revision of HTM 04-01, the Trust has embarked on a programme to remove unnecessary thermal mixing valves (TMV) as agreed in problematic areas throughout the Trust.

✍️ Carillion continue to be responsible for the sampling and water quality of ice machines and water dispensers.

✍️ A procedure for the removal of POU filters has been drawn up with input from PHT, CSL, PHT’s Authorised Engineer for Water, and CSL’s Authorised Engineer for Water.

✍️ A business case has been drawn up and submitted for approval for the replacement of Endoscopic Washer Disinfectors. CSL are in process of contractual arrangements with the purchase of further Thermal RO machines, but cannot proceed until the outcome of the PHT business case for replacement washers is confirmed.

✍️ BMS system for monitoring of water temperatures within the system, is discussed each fortnight at the Water meeting, temperatures on the whole are good. Exceptions are investigated and remedial work implemented to correct these anomalies.
8.1 Antimicrobial Prescribing

Antimicrobial prescribing within Portsmouth Hospital NHS Trust is monitored and managed by the Antimicrobial Management Group (AMG) who report to the Trust Formulary and Medicines Group and to IPMC.

The AMG meet quarterly. The purpose of the AMG is:

- Manage safe, effective and economic use of antimicrobials within the Trust
- Ensure that evidence-based local antimicrobial guidelines are in place, are being adhered to and are reviewed regularly
- Ensure regular auditing of the guidelines, antimicrobial stewardship practice and quality assurance methods
- Regularly report the organisation’s retrospective antibiotic consumption data (especially highlighting the uses of broad spectrum antibiotics such as Tazocin, quinolones and carbapenems)
- To ensure compliance with criterion 3 and 9 of The Heath and Social Care Act 2008: Code of Practice on the prevention and control of infections, updated in March 2015
- To support and adhere to the DH antimicrobial guidance “Start Smart, then focus”
- Review compliance with the national CQUINS around antimicrobial stewardship, launched in April 2016 from NHS England

8.2 Key developments in 2016/17

- Appointment of new consultant medical microbiologist from August 2016, Dr Ruan Simpson. Dr Simpson has taken ownership of antimicrobial ward rounds across the surgical directorate and acute medical unit.
- Completion of the development of an antimicrobial e-learning package. Designed for junior doctors and pharmacists, to help develop their understanding of prescribing and reviewing patients on antimicrobials. This package has not been made mandatory hence there has been limited use.
- New Gentamicin drug chart designed and piloted on the MOPRS wards. Unfortunately not being used by ED hence introduction of the new chart was not implemented.
8.3 Antimicrobial Usage and Expenditure

**Table 7. Top spend antibiotics in £**

<table>
<thead>
<tr>
<th>Antibiotic</th>
<th>Expenditure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Benzylpenicillin</td>
<td>162,051</td>
</tr>
<tr>
<td>Co-Amoxiclav</td>
<td>85,873</td>
</tr>
<tr>
<td>Piperacillin &amp; Tazobactam</td>
<td>79,332</td>
</tr>
<tr>
<td>Daptomycin</td>
<td>59,204</td>
</tr>
<tr>
<td>Flucloxacillin</td>
<td>56,302</td>
</tr>
<tr>
<td>Rifaximin</td>
<td>53,243</td>
</tr>
<tr>
<td>Meropenem</td>
<td>44,319</td>
</tr>
<tr>
<td>Chloramphenicol</td>
<td>41,877</td>
</tr>
</tbody>
</table>

**Table 8. Top spend antifungals in £**

<table>
<thead>
<tr>
<th>Antifungal</th>
<th>Expenditure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Posaconazole</td>
<td>312,849</td>
</tr>
<tr>
<td>Ambisome</td>
<td>214,115</td>
</tr>
<tr>
<td>Caspofungin</td>
<td>75,740</td>
</tr>
<tr>
<td>Voriconazole</td>
<td>25,850</td>
</tr>
<tr>
<td>Fluconazole</td>
<td>7,725</td>
</tr>
<tr>
<td>Nystatin</td>
<td>7,412</td>
</tr>
<tr>
<td>Micafungin</td>
<td>5,833</td>
</tr>
</tbody>
</table>

8.4 Compliance with antimicrobial CQUIN targets

Antimicrobial resistance (AMR) has risen alarmingly over the last 40 years and inappropriate and overuse of antimicrobials is a key driver. The CQUIN aims to reduce antibiotic consumption and encourage a prescribing review within 72 hours of commencing an antibiotic. The targets for 2016/17 were:

- 1% reduction in total antibiotic prescribing compared to 2013/14
- 1% reduction in Tazocin prescribing compared to 2013/14
- 1% reduction in carbapenem prescribing compared to 2013/14
- 90% of all antimicrobial prescriptions to have been reviewed within 72 hours by quarter 4

We achieved 11% reduction in Tazocin prescribing and 27% reduction in Carbapenem prescribing compared to 2013/14 (figures 34 & 35).
In addition, 91% of all prescriptions across the Trust were reviewed within 72 hours by quarter 4. We did not achieve a 1% reduction in total antibiotic prescribing; indeed there was a 12% increase compared to 2013/14 and a 3% increase compared to 2015/16 (figure 36).

The huge reduction in carbapenem prescribing was achieved through proactive switching of carbapenem antibiotics to alternative antimicrobial agents such as Temocillin, Ciprofloxacin or Gentamicin by the microbiology team. Some carbapenem prescriptions needed to be replaced by two or three alternative antibiotics hence the reduction in carbapenem prescribing did contribute to the overall increase in total antibiotic prescribing.

Further compliance with the antimicrobial CQUIN will require more antimicrobial pharmacist time and would be greatly facilitated by the introduction of electronic prescribing.

8.5 Antimicrobial Prescribing audits

Point prevalence study 2016
The results of the annual point prevalence study in June 2016 were encouraging in that a further reduction in inappropriate prescribing was seen. Overall the proportion of inappropriate prescriptions was 5.6%, a fall from 8.8% in 2015. The proportion of inappropriate prescriptions for treatment was 4.7% with 20% of prophylaxis prescriptions deemed inappropriate. Hence the prescribing of prophylactic antibiotics remains high. This inappropriate prescribing has been fed back to the clinical teams involved. The results of the audit have been fed back to all prescribers via CD forum, via the Infection Prevention Management Committee and to individual clinical teams.

Antifungal audit 2016/17
Data was collected prospectively from 30 patients across the Trust including paediatrics who were identified as being on anti-fungals by the ward pharmacists between 16th Jan-17th Feb 2017. Antifungal prescriptions were audited against 6 defined standards including documented indication, choice of anti-fungal, dosage, administration and duration. Fluconazole was the most frequently prescribed anti-fungal at 63% with amphotericin the second most commonly prescribed antifungal at 17%. Overall compliance with the documented standards was 92%, an increase in compliance from 64% in an audit carried out in 2016. Hence this audit demonstrated an improvement in prescribing practice of antifungal agents which was partly attributed to the introduction of guidance for the treatment of oral/oesophageal candidiasis.
Audit of the appropriateness of intra-peritoneal Vancomycin and Gentamicin for empirical treatment of peritonitis in patients on peritoneal dialysis

There were 79 individual patient episode specimens received between 1st Jan-31st Dec 2016. Of the 48 positive cultures, one Gram positive isolate, a vancomycin resistant enterococcus was resistant to Vancomycin and all Gram negative isolates were sensitive to Gentamicin and Ciprofloxacin. Hence empirical use of I/P Vancomycin and I/P Gentamicin is still appropriate for the treatment of suspected peritonitis in CAPD patients.

Audit of appropriateness of IV Piperacillin-Tazobactam for the treatment of neutropenic sepsis

The empirical combination of IV Tazocin and IV Gentamicin for neutropenic sepsis covered 94 of the 99 (95%) bacteraemic episodes in 2015 in haematology and oncology patients with suspected neutropenic sepsis. The bacteraemic episodes not covered included a recurrent Pseudomonal bacteraemia in a patient with AML, a recurrent resistant Klebsiella Pneumoniae bacteraemia in a haematology patient who also had Pseudomonas aeruginosa and a Citrobacter in his blood cultures and 2 VRE bacteraemias. These results were fed back to the clinical teams via email and by a presentation delivered by Dr Wyllie on 22nd August 2016.

Audit plan for 2017/18

- Annual trust wide point prevalence study in June 2017
- Monthly empirical 72hr review audit
- Carbapenem and Pip/Taz appropriateness audits
- Audit of surgical antibiotic prophylaxis
- Re-audit of appropriateness of I/P Vancomycin and Gentamicin for treatment of PD peritonitis
- Re-audit of appropriateness of Tazocin for treatment of ventilator-associated pneumonia
- Re-audit of appropriateness of Tazocin for the treatment of neutropenic sepsis in haematology and oncology patients

8.6 Antimicrobial stewardship rounds

Antimicrobial stewardship rounds continue to expand. All clinical areas are now visited at least once a week by a microbiologist. Most of the rounds include the support from a pharmacist.

8.7 Staffing

Microbiology – the current 4.7 WTE consultant microbiology staff provide a 24hr service with a 1 in 5 on-call rota. Virology is lead by Kelly Bicknell, clinical scientist with the support of the microbiologists. Pharmacy – 0.5 WTE 8a pharmacist is struggling to provide the support required to promote good antimicrobial stewardship. A business case has been submitted to provide a full time trust lead antimicrobial pharmacist.

8.8 Guidelines

The microguide app has been reviewed and guidelines on many respiratory infections updated over the past year. Treatment of severe hospital-acquired pneumonia was changed from IV Piperacillin-Tazobactam to IV Chloramphenicol in December 2016 in response to the global shortage of Tazocin and due to the clinical need to preserve the effectiveness of Tazocin for use in neutropenic sepsis. Microguide has been very successful with over 4000 downloads in the last 2 years, with over 12,000 views. This information only includes the app views and downloads and does not include the number of times the guide is accessed on the intranet.

8.9 The challenges facing antimicrobial prescribing

- Ensuring that all antimicrobials are prescribed according to Trust policy in a timely manner in the absence of electronic prescribing with a limited workforce
- Controlling the ever-increasing use of broader spectrum antimicrobial agents particularly Piperacillin-Tazobactam and Meropenem
- Managing antimicrobial use to ensure that the development of bacterial resistance is limited
- Ensuring antimicrobial prescribing supports the trust in achieving the MRSA bacteraemia and C.difficile case target
8.10 AMG Strategy  
Our strategy to comply with all nine components of best practice for antibiotic prescribing is outlined in the table below.

<table>
<thead>
<tr>
<th>Component</th>
<th>Description</th>
<th>Compliance criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Urgent treatment of infection emergencies</td>
<td>Prompt empirical treatment of severe sepsis with appropriate antimicrobial needs to be started within one hour of diagnosis</td>
<td>Empirical prescribing guidance in place and microbiology and pharmacy are involved in the diagnosis and management guidance for sepsis. Compliance with administration of antibiotic within an hour of patient presentation or recognition of sepsis is being monitored as part of the sepsis CQUIN and by A&amp;E</td>
</tr>
<tr>
<td>2. Communication of decision to prescribe antibiotics</td>
<td>Clear documentation of the clinical decision to start antimicrobial therapy in the patient’s case notes</td>
<td>Included in annual point prevalence audit</td>
</tr>
<tr>
<td>3. Appropriate use of microbiology culture</td>
<td>Appropriate specimens need to be sent for microbiological analysis prior to commencement or change in antimicrobial therapy</td>
<td>Included in annual point prevalence audit</td>
</tr>
<tr>
<td>4. De-escalation of antimicrobial therapy</td>
<td>Daily clinical review and review of culture results should be documented By 48 hours, antimicrobial prescribing decisions are to stop, switch IV to oral, change, continue or to convert the patient to OPAT</td>
<td>Continual monitoring of consumption of broad spectrum agents</td>
</tr>
<tr>
<td>5. Guideline choice of agent(s)</td>
<td>Antimicrobials should be selected according to local guidelines and epidemiology</td>
<td>Included in annual point prevalence audit</td>
</tr>
<tr>
<td>6. Antimicrobial review</td>
<td>An expected duration should be documented on the prescription or in the case notes</td>
<td>Included in annual point prevalence audit</td>
</tr>
<tr>
<td>7. IV duration</td>
<td>Treatment with IV antimicrobials should not continue beyond 48-72 hours unless recommended by local guideline or microbiologist</td>
<td>Included in annual point prevalence audit</td>
</tr>
<tr>
<td>8. IV-to-oral switch</td>
<td>Treatment with IV antibiotics should be switched to oral therapy within 24 hours of meeting IV to oral switch criteria outlined in local guideline</td>
<td>Annual IV to oral switch audit</td>
</tr>
<tr>
<td>9. Total duration</td>
<td>Treatment with antibiotics should not continue beyond 7 days (IV and oral) unless recommended by a local guideline or microbiologist. Rationale for continuing use should be clearly documented in the patient’s medical notes.</td>
<td>Included in annual point prevalence audit</td>
</tr>
</tbody>
</table>

References
Subject: Urgent Care Transformation Programme Performance

Prepared by: Maria Purse, Urgent Care Transformation Programme Manager
Sponsored by: Rob Haigh, Emergency Director of Emergency Care

Purpose of paper: Monthly Urgent Care Transformation Programme progress and performance report

Key points for Trust Board members
Briefly summarise in bullet point format the main points and key issues that the Trust Board members should focus on including conclusions and proposals

- ED performance achieved for August was 73.9%, a decrease of 5% when compared to the previous month (July 2017) against a proposed trajectory of 88%
- There were tbc hour DTA breaches in August
- Percentage of patients triaged in 15 mins during August increased by 2% to 83%, up from 81% in July
- The average MFFD patients for August was 243 up from 209 in July, occupied bed days during August has reduced to 3,048 from 3,344 in July
- MFFD backlog remains behind trajectory with an average of 246 against a trajectory of 110
- Portsmouth Hospitals Red2Green/SAFER/#endPJparalysis/Last 1,000 Days Campaign has been launched with a Bedview Go Live date of 10th October

Options and decisions required
Clearly identify options that are to be considered and any decisions required

For information

Next steps / future actions:
Clearly identify what will follow the Trust Board’s discussion

Monitored and actions agreed through the weekly UCTP Committee chaired by the CEO and the Monthly UCTP Board chaired by the Executive Director for Emergency Care

Consideration of legal issues (including Equality Impact Assessment)?
Assessed within original Project Initiation Document

Consideration of Public and Patient Involvement and Communications Implications?
Considered within each work stream

Links to Portsmouth Hospitals NHS Trust Board Organisational Priorities, Assurance Framework/ Risk Register

Organisational Priorities

Board Assurance Framework/ Risk Register Reference
<table>
<thead>
<tr>
<th>Risk Description</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>CQC Reference</td>
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</table>

<table>
<thead>
<tr>
<th>Committees/Meetings at which paper has been discussed/ approved:</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>UCTP Board – Monthly</td>
<td></td>
</tr>
<tr>
<td>UCTP Committee – weekly</td>
<td></td>
</tr>
<tr>
<td>A&amp;E Delivery Board – Monthly &amp; A&amp;E Delivery Board Ops Group - monthly</td>
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</tr>
</tbody>
</table>
Urgent Care Transformation Programme

Presented by: Rob Haigh – Exec Director, Emergency Medicine

Prepared by: Maria Purse - Urgent Care Transformation Programme Manager

Report to Trust Board – 5th October 2017
Headline Summary – August 2017

- ED performance during August was 73.9% (a 5% decrease compared to the previous month) against a trajectory of 88%.
- There were 5 hour DTA breaches in August – full RCAs are being undertaken and will be reported to the joint quality oversight group.
- Triaged <15 mins increased by 2% to 83% (standard > 95%)
- 55% of patients were seen by an appropriate ED clinician within 60 mins during August, an increase of 2% compared to the July positon.
- Discharges before 1200 increased to 21% (19% reported in June and 20% in July), the required standard is 33%. Detailed focus on increasing this number has been in place thought-out September.
- The average number of MFFD patients in August was 243 (up from 209 in July) although occupied bed days fell by 9% to 3,048. This reflects a reduction in the number of patients with the longest LOS’s.
- MFFD backlog remains behind trajectory with an average of 243 against a trajectory of 110
- During August patient moves decreased and the number of outliers reduced. This increased patient safety. 10 additional MOPs beds were provided on A6 and 18 Medical beds on D7 - each with dedicated Consultant and appropriate specialty MDT support. This (new arrangement) has reduced the numbers of teams with outlied patients and has improved the efficiency of care during September.
- The bed de-escalation trajectory was on track during August, other than during a very short period of a heightened escalation status. Recovery (9 beds), Discharge Lounge (5 beds) and the Renal Day Unit (6 beds) remained closed in August.
- The Red2Green/SAFER Trust Wide Campaign goes Live on 10th October increasing access for all clinical staff, and highlighting delay reasons (e.g delays in imaging or accessing specialist review) with new escalation process in place through site ops meetings.
## Performance against Urgent Care Transformation Programme KPIs

### Primary Indicators

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Target</th>
<th>Target Date</th>
<th>Sep-16</th>
<th>Oct-16</th>
<th>Nov-16</th>
<th>Dec-16</th>
<th>Jan-17</th>
<th>Feb-17</th>
<th>Mar-17</th>
<th>Apr-17</th>
<th>May-17</th>
<th>Jun-17</th>
<th>Jul-17</th>
<th>Aug-17</th>
</tr>
</thead>
<tbody>
<tr>
<td>A&amp;E 4 hr wait standard</td>
<td>89%</td>
<td>Mar-17</td>
<td>80%</td>
<td>76%</td>
<td>75%</td>
<td>73%</td>
<td>74%</td>
<td>75%</td>
<td>78%</td>
<td>79%</td>
<td>75%</td>
<td>82%</td>
<td>79%</td>
<td>74%</td>
</tr>
<tr>
<td>Patient triaged in 15 mins - All Patients</td>
<td>95%</td>
<td>Dec-16</td>
<td>71%</td>
<td>73%</td>
<td>75%</td>
<td>76%</td>
<td>76%</td>
<td>84%</td>
<td>83%</td>
<td>86%</td>
<td>83%</td>
<td>81%</td>
<td>83%</td>
<td>83%</td>
</tr>
<tr>
<td>Patient triaged in 15 mins - Ambulance Arrivals Only</td>
<td>95%</td>
<td>Dec-16</td>
<td>89%</td>
<td>83%</td>
<td>85%</td>
<td>85%</td>
<td>95%</td>
<td>96%</td>
<td>95%</td>
<td>91%</td>
<td>93%</td>
<td>91%</td>
<td>90%</td>
<td></td>
</tr>
<tr>
<td>Patient seen by Doctor in 60 mins</td>
<td>95%</td>
<td>Dec-16</td>
<td>53%</td>
<td>52%</td>
<td>57%</td>
<td>56%</td>
<td>60%</td>
<td>60%</td>
<td>59%</td>
<td>62%</td>
<td>53%</td>
<td>54%</td>
<td>53%</td>
<td>53%</td>
</tr>
<tr>
<td>Ambulance Handovers delays &gt;30 mins</td>
<td>0</td>
<td>0</td>
<td>222 delays (10% of total ambulance arrivals in month)</td>
<td>724 delays (20% of total ambulance arrivals in month)</td>
<td>679 delays (19% of total ambulance arrivals in month)</td>
<td>883 delays (24% of total ambulance arrivals in month)</td>
<td>927 delays (27% of total ambulance arrivals in month)</td>
<td>640 delays (22% of total ambulance arrivals in month)</td>
<td>671 delays (21% of total ambulance arrivals in month)</td>
<td>338 delays (10% of total ambulance arrivals in month)</td>
<td>473 delays (14% of total ambulance arrivals in month)</td>
<td>272 delays (8% of total ambulance arrivals in month)</td>
<td>396 delays (12% of total ambulance arrivals in month)</td>
<td>432 delays (12% of total ambulance arrivals in month)</td>
</tr>
</tbody>
</table>

### Secondary Indicators

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Target</th>
<th>Target Date</th>
<th>Sep-16</th>
<th>Oct-16</th>
<th>Nov-16</th>
<th>Dec-16</th>
<th>Jan-17</th>
<th>Feb-17</th>
<th>Mar-17</th>
<th>Apr-17</th>
<th>May-17</th>
<th>Jun-17</th>
<th>Jul-17</th>
<th>Aug-17</th>
</tr>
</thead>
<tbody>
<tr>
<td>SAFER – 95% of Patients with an EDD</td>
<td>100%</td>
<td>Feb-17</td>
<td>88%</td>
<td>89%</td>
<td>89%</td>
<td>89%</td>
<td>91%</td>
<td>93%</td>
<td>92%</td>
<td>92%</td>
<td>92%</td>
<td>91%</td>
<td>88%</td>
<td>88%</td>
</tr>
<tr>
<td>SAFER - 33% Daily discharges by midday</td>
<td>33%</td>
<td>Feb-17</td>
<td>18%</td>
<td>20%</td>
<td>21%</td>
<td>22%</td>
<td>22%</td>
<td>20%</td>
<td>20%</td>
<td>21%</td>
<td>20%</td>
<td>19%</td>
<td>20%</td>
<td>21%</td>
</tr>
<tr>
<td>SAFER – TTIs pre 1500 hrs</td>
<td>N/A</td>
<td>N/A</td>
<td>52%</td>
<td>49%</td>
<td>51%</td>
<td>13%</td>
<td>14%</td>
<td>13%</td>
<td>14%</td>
<td>14%</td>
<td>13%</td>
<td>15%</td>
<td>15%</td>
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</tr>
<tr>
<td>Serious Untoward Incidents</td>
<td>N/A</td>
<td>N/A</td>
<td>13</td>
<td>12</td>
<td>9</td>
<td>16</td>
<td>40</td>
<td>94</td>
<td>116</td>
<td>56</td>
<td>60</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mortality Non Elective HSMR</td>
<td>94.01 - 103.39</td>
<td>N/A</td>
<td>109.83</td>
<td>109.43</td>
<td>108.18</td>
<td>109.77</td>
<td>110.71</td>
<td>109.82</td>
<td>109.92</td>
<td>109.85</td>
<td>111.19</td>
<td>112.02</td>
<td>111.8</td>
<td></td>
</tr>
<tr>
<td>Bed Occupancy</td>
<td>90.00%</td>
<td>N/A</td>
<td>96.42%</td>
<td>94.87%</td>
<td>95.45%</td>
<td>94.56%</td>
<td>96.70%</td>
<td>96.80%</td>
<td>95.06%</td>
<td>94.06%</td>
<td>94.91%</td>
<td>94.87%</td>
<td>95.39%</td>
<td>96.08%</td>
</tr>
<tr>
<td>Bed Occupancy AMU</td>
<td>85.00%</td>
<td>N/A</td>
<td>98.28%</td>
<td>89.49%</td>
<td>103.00%</td>
<td>106.00%</td>
<td>107.00%</td>
<td>107.00%</td>
<td>104.00%</td>
<td>102.30%</td>
<td>102.06%</td>
<td>100.23%</td>
<td>102.89%</td>
<td>102.40%</td>
</tr>
<tr>
<td>A&amp;E Conversion rate</td>
<td>N/A</td>
<td>N/A</td>
<td>33%</td>
<td>33%</td>
<td>35%</td>
<td>33%</td>
<td>33%</td>
<td>31%</td>
<td>31%</td>
<td>31%</td>
<td>31%</td>
<td>30%</td>
<td>31%</td>
<td></td>
</tr>
<tr>
<td>Stranded Patients &gt;7 days (last day of month)</td>
<td>N/A</td>
<td>N/A</td>
<td>570</td>
<td>577</td>
<td>580</td>
<td>583</td>
<td>628</td>
<td>615</td>
<td>602</td>
<td>575</td>
<td>608</td>
<td>592</td>
<td>627</td>
<td>619</td>
</tr>
<tr>
<td>Achievement against discharge targets</td>
<td>100.00%</td>
<td>Apr-16</td>
<td>102.19%</td>
<td>101.73%</td>
<td>104.00%</td>
<td>99.60%</td>
<td>91.53%</td>
<td>93.66%</td>
<td>99.28%</td>
<td>96.80%</td>
<td>83.75%</td>
<td>85.47%</td>
<td>79.30%</td>
<td></td>
</tr>
<tr>
<td>Medically Fit For Discharge (last day of month)</td>
<td>279</td>
<td>249</td>
<td>234</td>
<td>237</td>
<td>251</td>
<td>256</td>
<td>239</td>
<td>246</td>
<td>239</td>
<td>245</td>
<td>259</td>
<td>243</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medically Fit For Discharge Occupied Bed Days</td>
<td>3185</td>
<td>3915</td>
<td>2921</td>
<td>2712</td>
<td>3271</td>
<td>3715</td>
<td>3806</td>
<td>4386</td>
<td>3874</td>
<td>3344</td>
<td>3315</td>
<td>3048</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Delayed Transfer of Care - Reported Patients</td>
<td>51</td>
<td>80</td>
<td>49</td>
<td>54</td>
<td>54</td>
<td>62</td>
<td>68</td>
<td>56</td>
<td>74</td>
<td>85</td>
<td>82</td>
<td>93</td>
<td>na</td>
<td></td>
</tr>
<tr>
<td>Delayed Transfer of Care - Reportable Bed Days</td>
<td>1530</td>
<td>2680</td>
<td>1828</td>
<td>1673</td>
<td>1614</td>
<td>1661</td>
<td>2062</td>
<td>1866</td>
<td>2358</td>
<td>2294</td>
<td>2689</td>
<td>na</td>
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</tr>
</tbody>
</table>

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Total Trust Performance
FIT Team Performance Report – Week ending 20\textsuperscript{th} August 2017

**KPI1** Conversion rate for 75+ years old patients attending ED (i.e. the percentage of patients being admitted into a hospital bed out of the total number attending ED)

<table>
<thead>
<tr>
<th>KPI1 (75+)</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Baseline</td>
<td>73%</td>
</tr>
<tr>
<td>Phase two target</td>
<td>67%</td>
</tr>
<tr>
<td>Week ending 24/09/17</td>
<td>68%</td>
</tr>
</tbody>
</table>

**KPI2**: a Length of Stay (LOS) of less than 72 hours (i.e. the number of 75+ years old patients being discharged who stayed in hospital less than 3 days). Days are defined as midnight boundaries crossed.

<table>
<thead>
<tr>
<th>KPI2 (75+)</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Baseline</td>
<td>110</td>
</tr>
<tr>
<td>Phase Two Target</td>
<td>140</td>
</tr>
<tr>
<td>Week ending 24/09/17</td>
<td>181</td>
</tr>
</tbody>
</table>

**KPI3** Early identification of Frailty (i.e. the percentage of 75+ years old patients screened for frailty markers out of the total number attending ED)

<table>
<thead>
<tr>
<th>KPI3 (75+)</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Baseline</td>
<td>35%</td>
</tr>
<tr>
<td>Phase Two Target</td>
<td>90%</td>
</tr>
<tr>
<td>Week ending 24/09/17</td>
<td>60%</td>
</tr>
</tbody>
</table>
Whole Trust Performance against SAFER (8-week comparison)

### Discharge Dashboard

#### Weekly Discharge Performance Weeks Commencing 31/07/2017 to 18/09/2017

<table>
<thead>
<tr>
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</tr>
</thead>
<tbody>
<tr>
<td>All Patients Have EDD</td>
<td>95 %</td>
<td>87%</td>
<td>88.7%</td>
<td>90.8%</td>
<td>89.4%</td>
<td>88.8%</td>
<td>92.4%</td>
<td>94.8%</td>
<td>92.9%</td>
</tr>
<tr>
<td>Review - all patients with LOS &gt; 7 Days</td>
<td>No Target</td>
<td>484</td>
<td>481</td>
<td>496</td>
<td>490</td>
<td>501</td>
<td>488</td>
<td>466</td>
<td>462</td>
</tr>
<tr>
<td>Discharges - TTO before 3pm on the day prior to discharge</td>
<td>85 %</td>
<td>56%</td>
<td>51%</td>
<td>63%</td>
<td>55%</td>
<td>55%</td>
<td>54%</td>
<td>47%</td>
<td>57%</td>
</tr>
</tbody>
</table>

#### PATIENT FLOW

| Flow of patients from AMU between 8am and 10am | No Target | 13 | 4 | 8 | 10 | 7 | 9 | 10 | 11 |
| Discharges by 0900 (1849) | 231 | 37 | 28 | 35 | 33 | 35 | 30 | 33 | 25 |
| Early Discharge - 33% of patients discharged by Midday | 33 % | 20.5% | 17.7% | 18.2% | 17.6% | 18.7% | 20.4% | 21% | 16.3% |
| Transfers to Discharge Lounge | No Target | 12.6% (93) | 9.9% (77) | 13.4% (92) | 13.6% (103) | 11.1% (76) | 14.7% (112) | 18.9% (150) | 14.7% (118) |
| Achievement of total discharges against target | 100 % | 68.6% (740/1079) | 72.2% (779/1079) | 63.8% (688/1079) | 70.3% (758/1079) | 63.7% (667/1079) | 70.7% (763/1079) | 73.4% (792/1079) | 74.5% (864/1079) |
| Fit To Leave An Acute Bed | No Target | 232 | 243 | 260 | 246 | 248 | 238 | 247 | 246 |

Report run: 26/09/2017 09:56:41
Red2Green is not for performance purposes, it is to ensure all patients have a value added day at the same time as identifying where delays are in their journey. Red2Green is a way of working, ensuring delays aren’t the norm or accepted and today’s work is completed today.

A Red day is when the patients do not receive an intervention to support their pathways of care through to discharge.

A Green day is a day when then the patient does receive an intervention to support their pathway of care through to discharge.

Red2Green in Bedview 1.7. Go Live 10th October
- Increase in functionality will reconfigure the Patient Summary Page supporting the rapid review of each patient at the morning Board Round by pulling necessary information into one page.
- Allow documentation of the patients R2G status.
- Enable staff to allocate a delay reason for any Red days.

Red bed days vs Green bed days
Unnecessary Waiting + Sleep Deprivation = Deconditioning

If you had 1,00 days left to live how many would you choose to spend in hospital?
<table>
<thead>
<tr>
<th>Subject:</th>
<th>Charitable Funds Activity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prepared by:</td>
<td>Sabeena Shetty, Accountancy Technician</td>
</tr>
<tr>
<td>Sponsored &amp; Presented by:</td>
<td>Peter Mellor, Director of Corporate Affairs</td>
</tr>
<tr>
<td>Purpose of paper</td>
<td>To update the Trust Board, in their capacity as Trustee, on recent charity activity.</td>
</tr>
</tbody>
</table>

**Key points for Trust Board members**

Briefly summarise in bullet point format the main points and key issues that the Trust Board members should focus on including conclusions and proposals.

The report provides information on total funds, income, and expenditure for the period up to August 2017.

**Options and decisions required**

Clearly identify options that are to be considered and any decisions required.

To note and receive the report.

**Next steps / future actions:**

Clearly identify what will follow the Trust Board’s discussion.

To be reported monthly.

**Consideration of legal issues (including Equality Impact Assessment)?**

Not applicable.

**Consideration of Public and Patient Involvement and Communications Implications?**

Not applicable.

**Links to Portsmouth Hospitals NHS Trust Board Organisational Priorities, Assurance Framework/ Risk Register**

<table>
<thead>
<tr>
<th>Organisational Priorities</th>
<th>Not applicable</th>
</tr>
</thead>
<tbody>
<tr>
<td>Board Assurance Framework/ Risk Register Reference</td>
<td>Not applicable</td>
</tr>
<tr>
<td>Risk Description</td>
<td>Not applicable</td>
</tr>
<tr>
<td>CQC Reference</td>
<td>Not applicable</td>
</tr>
</tbody>
</table>

**Committees/Meetings at which paper has been discussed/ approved:**

Charitable Funds Committee  
**Date:** 14th Sept 2017
PORTSMOUTH HOSPITALS NHS TRUST GENERAL CHARITABLE FUND
REPORT TO TRUST BOARD – September 2017

Issue for consideration:
To update the Trust Board, in their capacity as Trustee, on recent charity activity.

1. **Total Funds**
   Portsmouth Hospitals NHS Trust General Charitable Fund has a fund balance of £1,436,000 as at 31st August, 2017.

2. **Charitable Income**
   During the month, the charity received donations, legacy and fundraising income of £46,000, including the following items of note:
   - A legacy of £9,000 was left for the General Amenity Charitable fund.
   - A donation of £4,400 was received for the Walter Duncan Paediatric Prosthetic fund

3. **Charitable Expenditure**
   During the month, expenditure of £59,000 was processed, including the following items of note:
   - General Amenity Charitable fund spent £15,000 on medical equipment.

4. **The Rocky Appeal**
   The Rocky appeal needs to raise £387,000 to complete its appeal in June 2018.

5. **Investments**
   The only investment held is with CCLA of £124,000.

6. **Fundraising**
   **A) Press Releases:**
   - July and August were consistent for press releases with 17 articles, this equates to reaching over 70,000 readers from a variety of magazines, newspapers and online media through fundraising events and articles.
     - 15 x The Portsmouth News – 37,257print, 28,485 online
     - 1 x About My Area – 15 – 35,000 online weekly
     - 1 x Hampshire Chamber magazine – 4,500 printed monthly, 13,000 readership
     - 1 x Ems magazine – delivered to 6,500 homes
     - 1x Express FM – 13,500 Social media followers
   - Social media support is currently standing at:
     - Facebook followers: 1,261 (+52)
     - Twitter followers: 1,123 (+39)
     - LinkedIn: 74 (+4)

   **B) Community and Events:**
   - £5,195 raised in Ness’ Legacy for Renal
     Ness’ friend Neil tasked himself with a triathlon- a 600m swim, 27 mile bike ride, and 6 mile run. Neil said: “I said I wanted to do something for charity in Ness’ memory and his family chose the Renal Unit. The department really became like a second home to him and his family, and the staff have been truly amazing.”
C) New Patient Experience Fund:
   - The Sewing Room Staff at QAH (Carillion) raised £500 to help the brand new Patient Experience Fund. The fund aims to help patients, families and carers have a better experience here at QAH by providing the small things; like a support and advice ‘café’ for carers. Sarah Balchin (Head of Patient Experiences) said: “As the head of patient experiences, I work very closely with Carillion—they’re an integral part of ensuring we deliver a high quality patient experience"
   - **Children’s Bubbles Summer Fayre** - 16th July, QAH £4,697
   - **Spinnaker Tower Abseil** - 26th August, £5,575 raised by 12 participants to benefit 9 hospital funds
   - **Golf Day** - 7th September, Ageas Bowl Southampton saw 11 teams take part and raise £2,011
   - **Oncology Appeal ‘Mile of 5ps’** this has been an appeal since May 2017 with patients donating their 5 pence pieces to Oncology, and has to date raised £919. The target is £4,320

D) Corporates and Trusts:
   - **Asda** donated £200 to Rheumatology and £300 to Paediatrics ED
   - **HMS Victorious Association** donated £200 to Respiratory
   - **Business Builders Networking** are supporting both PHC Neurology Department and Brain Tumour Research as their chosen charity of the year till July 2018

E) The following charity led events have been arranged:
   - **Great South Run** - 22nd October, Southsea
   - **Make a Will Month** - throughout October. We have four solicitors on board this year
   - **Lights for Love** - 7th December, St Coleman’s Church, Cosham
   - **Christmas Jumper Day** - 15th December
   - **Choirs in QA** - 2nd to 21st December
   - **Great Wall of China Trek** - 22nd to 30th September 2018
**Subject:** Solent Acute Alliance (SAA) Update

**Prepared by:** Tristan Chapman, Programme Director (SAA)
**Sponsored & Presented by:** Peter Mellor, Director of Corporate Affairs

**Purpose of paper**
For noting

**Key points for Trust Board members**
*Briefly summarise in bullet point format the main points and key issues that the Trust Board members should focus on including conclusions and proposals*

Please note the Solent Acute Alliance Steering Board minutes of 18th September 2017

**Options and decisions required**
*Clearly identify options that are to be considered and any decisions required*

N/A

**Next steps / future actions:**
*Clearly identify what will follow the Trust Board’s discussion*

N/A

**Consideration of legal issues (including Equality Impact Assessment)?**

N/A

**Consideration of Public and Patient Involvement and Communications Implications?**

N/A

**Links to Portsmouth Hospitals NHS Trust Board Organisational Priorities, Assurance Framework/ Risk Register**

| Organisational Priorities | N/A |
| Board Assurance Framework/ Risk Register Reference | N/A |
| Risk Description | N/A |
| CQC Reference | N/A |

**Committees/Meetings at which paper has been discussed/ approved:**

| Solent Acute Alliance Steering Group | 10.07.17 |
SOLENT ACUTE ALLIANCE STEERING BOARD MINUTES | 18TH September 2017 | Isle of Wight, Large Meeting Room

Please note these minutes are not signed off and may be altered.

<table>
<thead>
<tr>
<th>Item</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Welcome/Introductions</td>
<td>Tristan Chapman</td>
</tr>
<tr>
<td></td>
<td>Fiona Dalton</td>
</tr>
<tr>
<td></td>
<td>Eve Richardson</td>
</tr>
<tr>
<td></td>
<td>David French</td>
</tr>
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<td></td>
<td>Peter Hollins (Chair)</td>
</tr>
<tr>
<td></td>
<td>John Knighton</td>
</tr>
<tr>
<td>2 Minutes &amp; Actions 10.7.17</td>
<td>Reviewed throughout meeting</td>
</tr>
<tr>
<td>3 IOW ASR (SP)</td>
<td>Current Position:</td>
</tr>
<tr>
<td></td>
<td>-2 meetings been held with MD's to review the IOW proposal and written feedback provided</td>
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<tr>
<td></td>
<td>-As of 18/9/2017 McKinsey to provide project support.</td>
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<td></td>
<td>-Timescale to deliver blueprint: taken through local care board and CCG next month.</td>
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<tr>
<td></td>
<td>-Commitment from Wessex strategic clinical network to provide oversight.</td>
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<tr>
<td></td>
<td>-From 5th of October IOW must have finalised blueprint with costed options to go through CCG. By end of October should be able to present preferred options.</td>
</tr>
<tr>
<td></td>
<td>Areas of difficulty:</td>
</tr>
<tr>
<td></td>
<td>-CCG’s aspiration to have prime provider models for some IOW services, which was not part of the original design</td>
</tr>
<tr>
<td></td>
<td>-Mainland organisations would struggle to provide some services 'on island'.</td>
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<tr>
<td></td>
<td>Overview:</td>
</tr>
<tr>
<td></td>
<td>-Core model for surgery agreed</td>
</tr>
<tr>
<td></td>
<td>-Core model for medicines, not quite reached agreement</td>
</tr>
<tr>
<td></td>
<td>-Core model for paediatrics, not agreed</td>
</tr>
<tr>
<td></td>
<td>-Core model for obstetrics agreed</td>
</tr>
<tr>
<td></td>
<td>-ENT is the biggest challenge.</td>
</tr>
<tr>
<td></td>
<td>Priorities:</td>
</tr>
<tr>
<td></td>
<td>-Most important to ensure that the model makes sense clinically and financially.</td>
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<tr>
<td></td>
<td>-IOW struggle for low level elective activity but requires an on call service</td>
</tr>
<tr>
<td></td>
<td>-Need to review option 3 for viability</td>
</tr>
<tr>
<td></td>
<td>Deliver this work between October &amp; January for the four areas (Integrated services UHS/PHT prime provider)</td>
</tr>
<tr>
<td></td>
<td>ACTION: Paper for October 5th to define what is agreed and what further work is required. No more than 4 sides of A4, signed off by the medical director (SP)</td>
</tr>
<tr>
<td></td>
<td>-clinical model agreed</td>
</tr>
<tr>
<td></td>
<td>-clinical model not agreed, clearly describe why</td>
</tr>
<tr>
<td></td>
<td>-clinical model agreed but requires detail</td>
</tr>
<tr>
<td></td>
<td>-The 'ask' has also highlighted issues that all trusts have. Should justify the reasons the ask has been declined, so there is understanding</td>
</tr>
<tr>
<td>4 Pathology (TC)</td>
<td>UHS view – support composition of network and willing to host hub</td>
</tr>
<tr>
<td></td>
<td>IOW view- concerns for cellular and microbiological pathology. Keen for improvement of technology to communicate between laboratories, keen to work with other providers, very uncomfortable about proposal outlined in the letter</td>
</tr>
<tr>
<td></td>
<td>PHT view- tested extensively up to 2013, and this failed. Physical transfer times across the region are not acceptable for some samples and services. Concerns</td>
</tr>
</tbody>
</table>
| 5 | Renal (DF) | **Paper:**
- What additional resource needed to have an integrated service with enhanced inpatient support
- What are the financial options who will take the outpatients
  - Clarity on financial impact of transferring outpatients to PHT
  - Clarity on financial impact of addition PA’s
**ACTIONS:**
- James Adams & Robert Lewis need to agree on PA allocation
- Get agreement on model for outpatients and associated financial agreement
| 6 | RTT (TC) | **Paper:**
- Number of meetings with COO’s, some offers made but none coming to fruition.
**DECISION:** Judgement not good use of alliance time. Recommendation to close, but endorse the principle of cross organisational support.
**ACTION:** Note to look at RTT data in 6 months’ time (Due March 2018)  
| 7 | Back Office (TC) | **Paper:**
- Note that Simon Jupp has moved off this project and Tim Powell will be picking this up.
- IOW has an island back office programme ongoing. Likely that there are items for local authority, and items for alliance.
- Noted there is a capacity shortfall in PHT and on the IOW to fulfil back office work.
**ACTION:** IOW to get an update on this work- may have completed some work within this workstream
**Ask & Offer:** Nothing back from PHT and IOW to date.
**ACTION:** Documents developed to date on ask & offer to be redistributed (TC)
  - Frank Sims to receive docs for IOW
  - John Knighton to receive docs for PHT
  - UHS to share UHS ask and offer presentation
**Update due at November Board**
**RISK:** If we do no demonstrate progress will receive a higher mandate to improve.
| 8 | Pharmacy (CM) | **Procurement & Distribution:**
- Options appraisal due October
- OBC projected for November
**Outsourced Outpatients:**
- Challenge to IOW & PHT for capital and estate to achieve similar benefits to UHS requires separate pharmacy store
- UPL offer of support if capacity issues are present: support identify potential opportunities and financial detail
- Options appraisal drafted in October
**Aseptics:**
- Options appraisal for information (UHS) due October.
- Options appraisal for information (PHT); TBC
<p>| | |</p>
<table>
<thead>
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<tbody>
<tr>
<td>9</td>
<td>Spinal/Orthopaedic (DS)</td>
</tr>
<tr>
<td><strong>ACTION:</strong> Feedback on Akeso requested from Pharmacy (CM)</td>
<td></td>
</tr>
<tr>
<td><strong>Update:</strong></td>
<td></td>
</tr>
<tr>
<td>- Writing clinical pathway and broad agreement but detail unfinished</td>
<td></td>
</tr>
<tr>
<td>- Work underway between both teams</td>
<td></td>
</tr>
<tr>
<td><strong>Issue:</strong></td>
<td></td>
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<tr>
<td>Specialist commissioners request pause until commissioners are in agreement with proposals.</td>
<td></td>
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<tr>
<td><strong>PHT:</strong></td>
<td></td>
</tr>
<tr>
<td>- PHT is considering stopping elective orthopaedics in order to focus on emergency dept. for 6 months. A formal decision has not yet been made.</td>
<td></td>
</tr>
<tr>
<td>- Emergency and clinically urgent electives are going to UHS.</td>
<td></td>
</tr>
<tr>
<td>- Commissioner concerns highlighted over non-urgent patients who maybe deteriorating</td>
<td></td>
</tr>
<tr>
<td>- Need to understand the impact of any potential pause for transfer</td>
<td></td>
</tr>
<tr>
<td>- Commissioners are unsure that patients are getting the right spinal service</td>
<td></td>
</tr>
<tr>
<td><strong>ACTION:</strong> Interim pathway in place, which can be shared. (TC)</td>
<td></td>
</tr>
<tr>
<td>Analyse the demand, cost and contingency plan of an alternative provider for elective orthopaedics in case PHT are unable to support transfers</td>
<td></td>
</tr>
<tr>
<td><strong>Post meeting note:</strong> A commissioner/provider meeting was held on Thursday 21st September to discuss in detail the information above.</td>
<td></td>
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</tbody>
</table>

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<thead>
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<tbody>
<tr>
<td>10</td>
<td>Wave 2 Capital Bids (TC)</td>
</tr>
<tr>
<td>IOW CSR Placeholder: Felt that nationally there will be IOW moneys. Recognition that it is still unknown how the capital will be applied (estates, mainland investment, IT). By December, there should be a plan for IOW, North Hampshire and greater understanding of the impact of the PHT &amp; UHS plan.</td>
<td></td>
</tr>
<tr>
<td>Theatres: Need to understand this bid in the context of work that is completed within the private sector and amount of money spent on intermediate elective services.</td>
<td></td>
</tr>
<tr>
<td>PHT Linacs: The forward plan for Linacs needs to be looked at as a region, and clarify what the plan is for radiotherapy. The cancer alliance will take forward this work.</td>
<td></td>
</tr>
<tr>
<td>PHT E-Hospital: Bid submitted</td>
<td></td>
</tr>
<tr>
<td>Any bid that looks organisational will not progress. System or STP wide bids have higher chance of success.</td>
<td></td>
</tr>
</tbody>
</table>

| 11 | Plastics & Radiology RTE (CM) |
| Plastics: Salisbury to take forward list of actions for the provision of plastics within the region, and provide reports to SAA. |
| Radiology: SAA to support the teams in delivering actions. |
| Action list to be distributed when confirmed by operational leads |

| 12 | Orthopaedics (TC) |
| The region is an outlier in rightcare data and the STP wishes to look at how orthopaedics could be delivered differently. |
| - Data analysis is being completed to understand how patients are flowing across the STP patch. |

| 13 | PMO Capacity |
| PMO at capacity for the Autumn |

| 14 | Vascular (FD) |
| **ACTION:** Ask MD’s to host an hours meeting to reflect on what has gone well, what hasn’t and what remains outstanding. |
| PMO to support this. |

| 15 | Dates of Next meeting |
| 16.10.17 PHT 10am |
## Subject:
Company Secretary Papers to Note

### Prepared by / Sponsored by / Presented by:
Peter Mellor, Director of Corporate Affairs & Business Development

### Purpose of paper
For Information / Awareness

### Key points for Trust Board members
Briefly summarise in bullet point format the main points and key issues that the Trust Board members should focus on including conclusions and proposals

To receive and note the minutes from the following Committees:

- **Audit Committee**
  - 23rd May 2017

- **Planning and Performance TAG Meeting**
  - 6th June 2017

- **Best Hospital, People and Care Meeting**
  - 23rd June 2017

- **Finance and Performance Committee**
  - 27th July 2017
  - 31st August 2017

- **Charitable Funds Committee**
  - 14th September 2017

### Options and decisions required
Clearly identify options that are to be considered and any decisions required

The Board is asked to note the minutes.

### Next steps / future actions:
Clearly identify what will follow the Trust Board’s discussion

The minutes will continue to be submitted to Trust Board on a monthly basis.

### Consideration of legal issues (including Equality Impact Assessment)?
N/A

### Consideration of Public and Patient Involvement and Communications Implications?
N/A

### Links to Portsmouth Hospitals NHS Trust Board Organisational Priorities, Assurance Framework/ Risk Register

<p>| Organisational Priorities | N/A |
| Board Assurance Framework/ Risk Register Reference | N/A |</p>
<table>
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</table>

<table>
<thead>
<tr>
<th>Committees/Meetings at which paper has been discussed/ approved:</th>
<th>Date</th>
</tr>
</thead>
</table>
Audit Committee  
Tuesday 23 May 2017

Present: Mike Attenborough-Cox, Non-Executive Director and Chair of the Committee  
Christine Slaymaker, Non-Executive Director Designate  

In attendance: Chris Adcock, Director of Finance left the Committee at 10am  
Peter Mellor, Director of Corporate Affairs left the Committee at 10am  
Fiona McNeight, Associate Director of Quality and Governance  
Lee Williams, Head of Financial Accounting  
Mike Townsend, Internal Audit  
Giles Parratt, Internal Audit  
Helen Thompson, External Audit  
Tom Wilkins, External Audit  
Karen Travers, Local Counter Fraud Specialist left the Committee at

Minutes:  
Susan Boyle, PA to the Director of Finance

Item  Minute  
13/17 Apologies  

Apologies were received from Lesley Heasman – Internal Audit.

14/17 Any other business not raised in advance of the meeting  
The Chair welcomed and introduced Christine Slaymaker, the Trust’s new Non-Executive Director Designate to the Committee.

15/17 Minutes from the previous meeting  
Both Fiona McNeight and Helen Thompson requested for more detail around the concerns raised regarding the process and reporting of the BAF to be included within the minutes.

Fiona also requested for the following sentence to be amended to read: 10/17 a) Governance and Quality Committee – “She also highlighted a change to the DoLS process following a previous CQC visit.”

16/17 Internal Audit Recommendations  
Peter Mellor tabled the list of recommendations and management responses and for Christine’s benefit, gave an overview on the process. Christine requested for this information to be circulated prior to the Committee as she will not have had time to digest all the information. Chris Adcock highlighted that he has since agreed with tiaa to have a cut-off point in the month in order for them to review and provide an internal audit view on the management responses. The Chair asked tiaa if they were content with the responses to the recommendations rated as red, but Mike echoed that he has not had a chance to read the detail and will not be able to comment. It was agreed for the document to be circulated along with the papers going forward.

Action: Peter Mellor / Committee Secretary

17/17 Internal Audit  
a) Annual report  
Giles Parratt presented the Annual Report to the Committee advising overall, reasonable assurance has been given. He drew attention to the comparison table of last years assurance assessments carried out and the Chair made reference to the new split assurance opinion of limited and reasonable. Giles went on to advise on the amount of audits that had been undertaken along with their outcomes.

The Chair highlighted the recent cyber-attack on the Health Service. Peter Mellor confirmed that IT advised that the Trust’s security is more advanced than other Trusts and that a presentation will be coming to Trust Board in the near future. Giles confirmed that the audit for cyber security is due to take place in quarter one of the audit plan.
b) **Audit Progress Report**
Giles presented the report advising that all audits for 2016/17 have been completed and that appendix B indicates early planning for next year.

c) **Review of Critical Financial Assurance - SBS**
Giles presented the audit report advising that their overall opinion was of reasonable assurance and that the audit was given 2 recommendations. He advised there were no areas of particular concern, only regarding the level of the Trusts aged debt over 90 days overdue.

Chris Adcock highlighted the recovery work which is being undertaken to enhance processes and that this work is reported through to the Finance and Performance Committee. Christine Slaymaker asked what the root cause of the debt is and Lee Williams confirmed this is mostly due to late payments by Private Health companies and the NHS Property Services Ltd.

d) **Review of the BAF and Risk Management**
Giles presented the report advising that their overall opinion was split between reasonable and limited assurance. This was due to the BAF not being presented to the Board as a regular item. Fiona McNeight highlighted the implementation timetable date of September querying whether we should wait until then. Peter Mellor advised that these dates were agreed with Internal Audit and that he had met with the Chief Executive and New Non-Executive Director Melanie Poole to agree a way forward.

Christine Slaymaker sought clarification as to whether the Trust has any strategic objectives and Peter confirmed not as such hence not being able to agree a BAF. He did advise that operational priorities were identified however tia felt they were too operational. He also advised of a review that had taken place a month previous to the CQC visit which endorsed the concerns. Christine Slaymaker highlighted her concerns and requested the Trust to set its strategic objectives and produce a draft BAF in 4 weeks. Peter Mellor agreed, however he advised that the Trusts Strategic Objectives will need to be agreed via the Board and it was agreed for the BAF to be included on the next Trust Board agenda.

**Action: Peter Mellor**

Chris Adcock highlighted that the BAF currently reflects the Trusts priorities but not the objectives, however, as part of the Recovery Plan, he will be using a Recovery rules and Procedure document which will set out best practices to build our governance structure. Chris agreed to share this with Christine.

**Action: Chris Adcock**

Helen Thomson highlighted that section 4.3 within the Annual Governance Statement which is being presented to the Committee will need to be updated as the concerns raised regarding the BAF are not accurately reflected. It was agreed for Peter Mellor to draft some words and for Lee Williams to seek agreement from Tom Wilkins in readiness to be presented to Trust Board for formal approval.

**Action: Peter Mellor**

e) **IG Toolkit**
Giles presented the report advising that their overall opinion was reasonable assurance. With no further comments, the Committee noted the audit.
f) **Assurance Review of Private Patient Income**
Giles presented the report advising that their overall opinion was reasonable assurance as they felt the overall process worked well, their only concern related to Private Patient debt. A discussion then ensued as to whether keeping the Private Patient unit is cost affective. Peter Mellor confirmed that the Unit accumulates £3.3m of external money per year. He then queried the management response regarding the patient picking up the costs if the insurance companies won’t pay and Lee confirmed this will be in instances where the insurance company dispute the procedures carried out by the hospital, not endorsed or out of tariff. It was agreed for tiaa to revise the audit with clear management responses in readiness for the next meeting.

**Action: tiaa**

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g) **Assurance Review of Governance of CAS Alerts**
Giles presented the report advising that their overall opinion was reasonable assurance and just asked the Committee to note the key findings.

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h) **Comparator Review of Agency Nurse Staffing**
Giles presented the comparator report to the Committee for information only. He advised that it is just an analysis which identifies the values of agency nurse staff and maps the Trusts position, so no assurance opinion has been given. Chris Adcock highlighted his concerns stating that agency staff is a big problem for the Trust and we need to ensure plans are in pace for the remainder of the year. He suggested for tiaa to make contact with the new Director of Nursing to discuss how to take this forward. Chris confirmed agency is also being worked through via the Recovery Programme.

**Action: tiaa**

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i,j &k) **CBN re Cybersecurity and Fraud Digest**
The Committee noted the CBN’s and Fraud Digest

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18/17 **Annual Accounts**

**Annual Report**
Lee Williams advised the Committee that the Annual Reports and Accounts were discussed at the informal meeting in April and presented to the Board in May, who then gave authority for the Audit Committee to approve and sign off today. Unfortunately due to the Committee not being quorate, the Accounts could not be approved and it was agreed for Lee to present a paper along with the outcome from the meeting to the Board to be formally ratified. Peter Mellor confirmed that any changes that had been made to the report are highlighted within the coversheet presented today.

**Action: Lee Williams**

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Christine Slaymaker asked the External Auditors if there is anything that they were nervous of. Helen Thompson confirmed that apart from the changes that need to be made to the Annual Governance Statement around the BAF as mentioned earlier, their only concerns are around the financials. Christine then asked how much External Audit relies on Internal Audit when forming their conclusions. Tom Wilkins advised that they ask tiaa to test a number of controls and then complete their own audit around the systems which in this case have all come back fine with no concerns.

Christine asked if External Audit had any ongoing concerns they wishes to raise. Helen Thompson confirmed that the Trust will be issued with a Section 30 letter as it’s failed to meet the break-even duty for the 3rd year running. Christine stated that if the Trust didn’t have to pay any interest towards the PFI then the Trust could break even. Chris Adcock agreed that the hospital is expensive to run and that’s why it is so important to use it productively.

The Chair queried the 3 year break even asking whether the 5 year extension would then come into effect. Helen advised unfortunately the guidance published on the Department of Health website is not current (2012) and that no decision has been made for an
extension. Helen confirmed she would be re-issuing the report to Chris Adcock to review and to return by close of play today for submission. Looking ahead, a Section 30 letter will be reissued every year until the new guidance is issued.

Chris Adcock wished to highlight an amendment to the third paragraph on page 30 as the Trust Board Workshop that was due to review the Recovery Plan in April was cancelled so will need to be re arranged and reflected in the Annual Report.

**Action: Peter Mellor**

The Committee then went onto the Annual Governance Statement highlighting that section 4.3 needs to be updated reflecting the earlier conversation regarding the BAF and Assurance, for the Internal Audit report to be included and to reference the new split assurance level.

**Action: Lee Williams & Fiona McNeight**

### 19/17 External Audit

Tom Wilkins advised the Committee on the status of their opinion advising that the general testing is now completed and shows good progress has been made.

Helen Thompson then presented the Executive Summary advising of the work completed around the accounting estimates which showed no real concern. She then went on to the Value for Money highlighting that the Trust did not deliver its planned control total surplus of £1.2m due to the STF money not being received and subsequently recorded a deficit of £17.8m. She also highlighted that Operational Performance, particularly with the Emergency Department, continues to fall behind national targets, although improvements have been seen. She concluded that their overall opinion was of a qualified conclusion and that a discussion will now need to take place between Chris Adcock and NHSI about the concerns raised. She advised they understand the targets are made by NHSI but are concerned that the Trust is unable to deal with the changes being made. She advised the Trust is now looking at plans to address these changes and that NHSI do appreciate the efforts being made however, if the Trust is not able to improve its position, an adverse opinion will be given in September. Helen highlighted that the work already done to move away from the PbR contract and better working relationships with the Commissioners is a good step for the Trust, but still faces challenges with regards to the CQC and its own Governance, which again needs to be reflected in the BAF.

A discussion then ensued around the Trusts CIPs and the importance to achieve them. Christine Slaymarker suggested that the Audit Committee recommend to the Chairman that the next Trust Board Workshop at the end of June is to be solely allocated to CIPs.

**Action: Peter Mellor**

Helen then summarised advising that overall, they have an unqualified opinion relating to the finances, has nothing to add to the reports and that a Section 30 will be issued.

Lee Williams referred to Appendix C, Management Representation Letter and confirmed that the letter had been prepared, as per the template at Appendix C, and shared with the Committee Chairman and the Director of Finance. The final version will be sent to Tom.

**Action: Lee Williams**

The Chair suggested for the Audit Results Report document to be circulated to the Board. It was agreed for Helen to update and send to Lee to circulate to the Board. A discussion then ensued relating to the Trust Board viewing the documents and it was agreed for Tom Wilkins to attend the Trust Board on the 1st June to ensure approval is given and enable E&Y to sign their opinion on the Annual Report, Annual Governance Statement and Accounts.

**Action: Tom Wilkins and Lee Williams**
20/17 Financial Controls

a) Debt Write-off and Update
Lee Williams presented the Debt write off update to the Committee highlighting that £18,490 has been written off due to overseas visitors and that he has now included some narrative relating to the income as previously requested.

Karen Travers asked whether the fraud team were involved in trying to locate the debt for the over salary payment as she may be able to track them down. Lee confirmed yes they were for the 2007 overpayment.

The Committee noted the paper and agreed to write off the Debts exceeding £1,000.

b) SFI Breach
Lee Williams presented the logs to the Committee. Chris Adcock advised this is not the report that he wishes to present to this Committee however, the work being undertaken to regularise contracts will help with the volume of these, along with the work being carried out with the Recovery Plan.

Lee highlighted that the narrative has now been included around the Establishment, again as previously requested; the Budgets are being monitored at monthly Finance and Budget meetings with each CSC and that going forward, the Nominal Roll will include a follow up outcome column.

Action: Lee Williams

21/17 Local Counter Fraud

Karen Travers presented to the report to the Committee advising that there is nothing new contained within the report that hasn’t already been reported. The Self Review Toolkit has been completed and the Trust came out with a Green rating. She advised of a couple of red areas in the risk assessments in Procurement and invoices but confirmed these are due to her being over cautious and are currently in hand.

Chris Adcock asked if she was content with the level of referrals being made to her, she advised yes and that currently they are looking into one with an Agency who has falsified some references. She advised this is currently being picked up with herself and Natalie Sanderson in HR.

22/17 Board Assurance Framework

Peter Mellor presented the BAF to the Committee advising that this version was presented to the Trust Board in early May. He highlighted an increase in risk relating to compliance with the CQC regulations which went from a 12 to a 16 and confirmed that all other risks are being managed appropriately. Chris Adcock wished to highlight the time issue in updating the financial risks on a monthly basis due to the current work underway.

23/17 Internal Control and Risk Management

a) Governance and Quality Committee
Fiona McNeight advised the minutes are reflective of the challenges and concerns raised at the meeting. She also advised that the Imaging Capacity paper referred to was submitted to the Board.

b) Risk and Assurance Committee
A discussion ensued over who would be the new Chair of the Committee since Liz Conway has left the Trust. It was concluded that as it stands, no indication as to who this would be has been discussed or agreed by the Chair of the Trust.

c) Finance and Performance Committee
The Committee noted the minutes. Fiona McNeight requested that going forward, a coversheet is included for both the Risk and Assurance Committee and Finance and Performance Committee, highlighting any key issues.

Action: Chris Adcock
24/17 Action Log from 23rd March
All items were either complete or not yet due.

25/17 Audit Committee Admin
a) Audit Committee Timetable
The timetable was noted.

b) Items to raise with Trust Board
   • Board Assurance Framework
   • Annual Governance Statement
   • Annual Accounts
   • Section 30 Letter

c) Date of the next meeting
   Thursday 21st September 2017

d) Any other business
   Peter Mellor advised that Paul Travers, the new Local Security Management Specialist has now joined the Trust and will be introduced to the Committee in December.

   The meeting closed at 11.45am

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<tr>
<th>Attendees</th>
<th>Mar</th>
<th>Apr – internal meeting</th>
<th>May – Annual Accounts</th>
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COUNCIL OF GOVERNORS TRUST ADVISORY GROUP
PLANNING AND PERFORMANCE
Tuesday 6 June 2017
10.30 – 12.30
Boardroom, Education Centre, QAH

MINUTES

Present:

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<tr>
<th>Richard Mackay (Chair)</th>
<th>Ken Thompson</th>
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<td>Robin Lander-Brinkley</td>
<td>Roland Howes</td>
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<td>Jocelyn Booth</td>
<td>Frances Bates</td>
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In attendance: Dawn Humphrey (Minutes)
Peter Mellor, Director of Corporate Affairs
Lucy Wiltshire, Head of Organisational Development

ITEM MINUTE

1 Apologies

Apologies were received from Robin Marsh, Adel Resouly, Lez Ward, Mary Sheppard and Ernie Wells.

2 Previous Minutes

The minutes of the previous meeting on 18 April were agreed as a true and accurate record.

3 Action Grid / Matters Arising

Item 3 - Richard Mackay confirmed that the Director of Corporate Affairs was arranging a visit to the Integrated Discharge Service and would canvass the Governors to see who would be interested in attending.

All remaining actions had been completed and therefore removed from the grid.

4 Follow Up Answers on March IPR

It was agreed that the Governors would now be provided with the IPR on the same day that it was sent to the Trust Board, which would allow them more time to absorb the information and return with any questions they might have.

The Governors expressed their disappointment at the lateness of the answers to their questions, which had been sought from Maria Purse, Urgent Care Transformation Programme Manager. The Director of Corporate Affairs explained that she had been on annual leave but would feed back their comments to her. In future, if it was not possible to provide answers within the given time frame/deadline, then the respondent would be asked to let us know in good time.

Question 1
Ken Thompson felt that a root cause analysis should have been undertaken to determine why Dementia screening continued to remain non-compliant against target rate. The Director of Corporate Affairs explained that there was recognition that due to the pressures of work, the junior doctors had been ‘distracted’ and the actions listed, were being taken to re-focus their efforts.
Frances Bates asked how patients were identified for Dementia screening. The Director of Corporate Affairs felt sure that patients would automatically be identified and screened based on age. However, if a younger person presented with ‘odd’ behaviour, then they might also be screened, but he would look into this and provide her with an answer.

**Action: Director of Corporate Affairs**

Frances Bates highlighted that she had not seen any reference to DOLS or safeguarding in the IPR, which she presumed was linked to Dementia screening. The Director of Corporate Affairs went on to say that the CQC Inspectors had, during their latest inspection on 10 & 11 May, focused on the Emergency Department, in terms of the Mental Health Act, deprivation of liberty and of our capacity for vulnerable patients. He described the work which was being done to improve the provision for vulnerable and mental health patients at the hospital, which would include a significant investment in training and extra resource to deal with DOLS applications. Our daily operational report now gave details of the number of mental health patients under section in the hospital, which we would not have previously been aware of and, as a consequence, may not have been looking after them appropriately.

Frances Bates requested that someone attend the Best Hospital TAG meeting in September to deliver a presentation on DOLS. Frances Bates also asked for the name of the member of staff responsible for DOLS at this Trust. The Director of Corporate Affairs would ensure that she was provided this information.

**Action: Dawn Humphrey**

**Question 3**

Robin Lander Brinkley remarked that if a graph was illegible and the clarity could not be improved upon, then perhaps it should not be include in the IPR. The Director of Corporate Affairs agreed and his comment would be fed back to Mandy Mugridge.

**Question 5**

Roland Howes asked about the concerns around the level of RN vacancies. The Director of Corporate Affairs clarified that this referred to Registered Nurses and confirmed that there had been a recent recruitment drive, with a positive outcome resulting in the recruitment of 100 nurses from the Philippines.

**Question 10**

Ken Thompson felt that although there were initiatives to reduce the MFFD back log of patients that the IDS team was not cost effective and asked if cheaper alternatives were available. The Director of Corporate Affairs explained that the IDS service provided a 7 day a week rota, which included staff from community partners in addition to our own staff. The hospital had a requirement to discharge 150 people daily and of those, 70 per cent were the responsibility of the hospital and not the IDS. However, there was work underway to try and improve that, with a commitment from community healthcare partners to addressing 100-150 of the MFFD patients by September.

The Director of Corporate affairs reminded that following the presentation by Paul Thomas, IDS Lead, at the Full Council of Governors meeting on 18 May, that he would be arranging for a small group of Governors to visit to visit the IDS offices in the near future, so that they could gain a better understanding of the complexities of the patients that they were dealing with.

**Question 11**

Details had yet to be provided by Information Services. However, The Director of Corporate Affairs confirmed that the Medical Director had given assurance that this hospital compared well with other Acute Trusts, in terms of 30 days emergency readmissions.

**Question 14**

Ken Thompson referred to the Trust’s continuing work towards achieving a 3 per cent reduction in sickness absence and wondered whether this was a realistic figure. The Director of Corporate Affairs stated that staff sickness was a substantial financial cost to the Trust each year and that we must put in place mechanisms to support and relieve pressure on staff, rather than concentrating on just changing the target.
Well Led Organisation

Lucy Wiltshire, Head of Organisational Development, was in attendance to deliver the attached presentation, which had been circulated to the Governors:

Please also see link to the NHSI website – Culture and Leadership Programme, The Kings Fund document, referred to on page 11 of the presentation:

https://improvement.nhs.uk/resources/culture-and-leadership

Lucy Wiltshire explained that a full CQC Inspection would consider five specific areas: Safe, Effective, Caring, Responsive and Well Led. Recently NHSI and the CQC had revised the five key components of Well Led Framework, which would be increased to eight, and went on to explain each of them.

Roland Howes asked how people were selected to become leaders. Lucy Wiltshire explained that there was a clear, structured internal, as well as external, recruitment process. Internal advertising was used only if a talent pipeline for succession planning had been identified.

Robin Lander Brinkley asked if being 'leadership led' applied to middle management as well as senior management and at executive level. Lucy Wiltshire explained what was meant by this phrase and likened it to being a slice both through and across the organisation.

Lucy Wiltshire concluded by saying that her own vision was for Portsmouth to have its own Improvement Academy and for all 7,500 members of staff to have had the opportunity to receive training and coaching in improvement skills which could be applied in the workplace, within the next 3 years. She would like to see evidence of the change in those staff who had been trained in this area, and most importantly, the impact that this would have on our patients. Her challenge was to think about how the training might be delivered in different ways to best accommodate staff.

The Governors thanked Lucy Wiltshire for a very interesting and positive presentation and she indicated that she would be happy to provide an update in December.

Agenda Items for the next meeting

The Director of Finance would be asked to provide an update on how we were progressing with the Financial Plan for 2017-18, following his presentation to this TAG in April.

The agenda item for the November meeting would be agreed at the next TAG in September.

Items of concern requiring feedback to full Council of Governors

Ken Thompson highlighted that NHS England had £130m for the purchase of new Radiotherapy machines and wondered if this Trust had applied for any of that funding.

Action: Director of Corporate Affairs

Any Other Business

There was none.

Date of Next Meeting

Tuesday 5 September at 10.00 – 12.00, Boardroom, Education Centre, E Level, QAH
COUNCIL OF GOVERNORS’ TRUST ADVISORY GROUP

BEST HOSPITAL, PEOPLE AND CARE

Friday 23 June 2017

13.30 – 15.30

Room 12, Education Centre, E Level, QAH

MINUTES

Present: Sarah Edmonds (Chair) Richard Mackay
Roland Howes Jocelyn Booth
Frances Bates

In attendance: Dawn Humphrey (Minutes)
Peter Mellor, Director of Corporate Affairs
Linda Field, Head of Nursing for MOPRS & AMU
Marian Moffatt, Matron for Stroke & Rehabilitation Services
Maria Purse, Quality Improvement Programme Manager – Unscheduled Care
Andy Courtney, Senior Operations Manager – PTS Hampshire, SCAS
Stacey Warren, Business Manager - PTS Hampshire, SCAS

1 Apologies

Apologies were received from Mary Sheppard, Robin Marsh, Robin Lander Brinkley, Cllr Luke Stubbs and Lez Ward.

2 Minutes of the last meeting

The minutes of the last meeting on 28 April were agreed as a true and accurate record.

3 Action Grid / Matters Arising

Item 8 - Phlebotomy Service
Peter Mellor updated that the General Manager for Clinical Support was in conversation with the Clinical Commissioning Groups (CCG) about the future provision of this service, however a decision had yet to be reached. It had been agreed that whoever the provider, the information contained in the Phlebotomy Service leaflet, should and will, be accurate.

All actions, with the exception of item 4 (SAFER), had been completed and were therefore removed from the grid.

4 Update on progress of recommendations from Stroke/MOPRS Peer Review

Linda Field, Head of Nursing for MOPRS & AMU and Marian Moffatt, Matron for Stroke & Rehabilitation Services, were in attendance to present the attached update; hard copies of which had been handed to the group:

![Stroke Update for Governors June 17.p](image)

Although recognised as having an excellent reputation for Stroke Services, more recently the service had suffered due to staffing issues, but they pointed out that the challenges they faced operationally were also being seen across the board.
Marion Moffatt explained the detail of the MOPRS/Stroke Peer review, undertaken in 2014 and talked through the measures that were being put in place to address the situation, including a recruitment drive and the appointment of a new Band 7 member of staff with both elderly care and stroke experience.

Peter Mellor asked what determined if a patient received Thrombolytic therapy. Marion Moffatt explained that the best outcomes were achieved with an onset time of less than 3 hours, although a clinical decision could be made to administer the drug later than that. Trials were currently being conducted for 4.5 - 6 hours.

5 Agenda for Next Meeting

There was a discussion around the resulting report from the most recent CQC visit. Peter Mellor confirmed that we had yet to receive their draft report, but that there had been serious concern expressed at the way in which we care for patients with mental health issues whilst in AMU. He advised that the Trust was seeking to introduce a new medical model on the basis of improving general patient safety.

It was suggested that the agenda item for the next meeting might be to consider the report from the CQC and the action plan that had been agreed to address any necessary improvements. It was agreed that Sarah Edmonds would take a view outside of this meeting.

Action: Sarah Edmonds

Peter Mellor advised that the interim Chairman, Mark Nellthorp, had offered to meet with the TAG Chairs, prior to the Full Council of Governors meeting on 11 July, should they wish to do so.

Action: Dawn Humphrey

There was a further discussion around the two ‘Governors in Shadow’ meetings organised by Mary Sheppard in April. Peter Mellor agreed that he would discuss how we progress the issues raised in the feedback from these meetings at the next TAG Chairs meeting on 5 July, and then feedback to the Full Council of Governors. Sarah Edmonds would ensure that her own comments were sent to Mary Sheppard, as she was unable to attend the TAG Chairs meeting.

Action: Sarah Edmonds/Director of Corporate Affairs

6 Committee Feedback

Finance Committee

Richard Mackay advised that the Finance Committee scheduled for 27 April had been cancelled due to it not being quorate.

Patient Experience

Sarah Dowling, Senior Dietician had attended this meeting and reported that following the PLACE interviews, they would be focussing on vulnerable patients who were unable to eat, as well as ordering meals for ‘special’ patients.

Quality Care Reviews

Jocelyn Booth highlighted the Quality Care Reviews, which were run by Alison Fitzsimmons, and likened to ‘mini CQC inspections’. A group of staff from across the hospital meet each month and descend on a pre-chosen area to ask questions of staff and patients and gain their feedback. She felt that the Governors might benefit from joining these reviews and would forward the dates to Dawn Humphrey, to invite any Governor that might be interested.

Action: Dawn Humphrey

Engagement Champion Award for 2017

Jocelyn Booth announced that the Trust had been awarded the “Engagement Champion of the Year” (Membership Engagement Services) in May, in recognition of its commitment to actively involving patients, families, carers and members of the local community on the design, delivery and monitoring of our services. The judging panel which included the Head of Patient Experience at NHSI said that the trust showed a bold and creative approach and has advanced beyond the boundaries of what engagement in health had previously achieved.
Jocelyn Booth remarked that the attendance at both the Equality Impact Group and Patient Experience Committee meetings had been low and was becoming an issue. Peter Mellor reminded that if the hospital was on Black Alert, then staff would clearly need to prioritise patient care over attendance at meetings.

Jocelyn Booth stated that she was unaware of the Board Assurance Framework. Peter Mellor explained that the BAF was a collection of those serious risks that threatened the Trust’s strategic objectives; that it was available on the internet and formed part of the Public Trust Board papers and was updated monthly.

**Risk Assurance Committee**

Roland Howes expressed concern that this committee had not met for several months. Peter Mellor explained that this would have been due to diaries/availability, given the recent changes within the Non-Executive Director cadre but clarified the process and assured him that no risk would be left unaddressed.

7 **Patient Transport**

Maria Purse, Quality Improvement Programme Manager, Unscheduled Care was accompanied by Andy Courtney, Senior Operations Manager – PTS Hampshire, South Central Ambulance Service (SCAS) and Stacey Warren, Business Manager - PTS Hampshire, SCAS, to deliver the attached presentation:

![Patient Transport Service - 17 June.pptx](image)

Maria Purse explained that although Patient Transport currently sat with her, it would shortly become the responsibility of Carla Bramall, the PHT Lead for Discharge Services.

Peter Mellor reminded the Governors that Hayley Wagner, who had been responsible for patient transport, previously advised them that much of the fault with patient transport lay with the hospital and not the SCAS drivers.

Jocelyn Booth asked if the 10% of most aborted trips occurred after 3.00pm. Stacey Warren did not have that level of detail available.

Andy Courtney explained that SCAS did hold events in hospitals to raise awareness; anyone with an interest/responsibility in patient transport could attend and discuss issues around access to properties etc. Around 60 people had attended the last event and a further session was being held at QAH in August.

Maria Purse talked through the steps that were being taken to improve patient transport in the hospital, such as working with people who negotiate the patient transport contract, discussions at board rounds around discharge arrangements and weekly meetings to build relationships with the Hospital Liaison Manager. She conceded that there had been a gap in data being shared with matrons, which would assist them in managing patient transport effectively.

Richard Mackay asked about the eligibility for patient transport. Stacey Warren answered that the ward, outpatients department or GP surgery booked the transport and at the point of using the online system or if they were to phone through to the contact centre, questions were asked which would determine the patient’s eligibility. If they were not eligible, then an alternative provider would be offered, such as a voluntary organisation, which formed part of their contractual obligations.

Maria Purse informed the Governors that Carla Bramall, the Lead for discharge Services was putting together a proposal for the staffing of the Discharge Lounge and within that proposal, was a dedicated person to lead and support the booking of patient transport. There would also be a review of the Discharge Planning Team as they had a pivotal role in this.
More Band 3 assistants had been requested, who would be ward based, to assist a senior qualified nurse and also to have conversations with relatives.

Maria Purse explained that she was working with the CCGs to see if some funding could be made available for a dedicated SCAS vehicle with a driver/dedicated crew for particular one patient journeys, in instances such as needing to meet a package of care or if there was a narrow window of time to convey a patient to a hospice. This service would be directed by the Operations Centre and the vehicle held onsite at QAH.

8 Any Other Business

A small group of Governors would visit the IDS offices on 3 July and a further visit would be arranged in August for those Governors who were interested, but unable to attend on 3/7.

Action: Dawn Humphrey

Date of Next meeting

Tuesday 12 September at 11.00 – 13.00, Executive Meeting Room, F Level, QAH.
FINANCE & PERFORMANCE COMMITTEE
MINUTES
Thursday 27 July 2017
9.30am – 12noon
Trust HQ Meeting Room

Present:  David Parfitt - Non Executive Director (Chair)
          Michael Attenborough-Cox – Non Executive Director
          Chris Adcock – Director of Finance
          Rebecca Kopecek – Director of Workforce
          Gary Bryant – Operational Director of Finance
          Richard MacKay – Council of Governor

Minutes:  Susan Boyle – PA to the Director of Finance

In Attendance: Sheila Roberts – Interim Chief Operating Officer for item
               Rob Haigh – Director of Emergency Care

ITEM  MINUTE
49/17 Apologies
Apologies were received from: Christine Slaymaker - Non Executive Director Designate, Peter Mellor – Director of Corporate Affairs, Nicola Ryley – Director of Nursing, Ed Donald – Chief Operating Officer, Michelle Dixon – Deputy Chief Operating Officer and Kevin Nederpel – Deputy Director of Finance.

50/17 Minutes from Previous meeting 29 June 2017
Christine Slaymaker highlighted that in 2nd and 4th paragraph on page two should read ‘pay’ and not ‘PAYE’, subject to this the minutes were agreed as a true and accurate record of the meeting.

51/17 Action Log 29 June 2017
05/17 Satellite Unit – Chris Adcock advised the Committee that the procurement rules and procedures are in place, and that the problem has been effective use and compliance. He confirmed that Alan Hoskins attended the General Managers meeting and that a new contract amnesty letter has been drafted. Due to the ongoing delay of this letter being sent out, the Committee requested for it to be circulated to the CSC’s within the next week.

Action: Chris Adcock

12/17 Month 9 Ops Report (diagnostic equipment reliability) – Kevin Nederpel was asked to feedback to Procurement and the Supplier the concerns raised regarding the reliability of the equipment and enquire whether there are any grounds for compensation for the periods when the equipment has been out of use as a result of the tubes failing. As Kevin was not present, it was agreed for him to pick this up and report back to the next meeting.

Action: Kevin Nederpel

43/17 Finance and Performance – A discussion around the use of a coversheet ensued but Chris Adcock advised that the Director of Finance briefing was intended to provide a summary of the standard finance reports and give an overview of all key issues within the papers, so it was agreed that this would suffice going forward.

44/17 Reference Costs Submission – An email from Ian Howe, head of Financial Planning and Information was circulated to the Committee along with the papers and Gary Bryant asked whether the information provided gave members the assurance requested. Chris Adcock advised that he had recently reviewed and signed off the annual submission and reported that the level of detail and drill down capability was materially improved from previous years due to the use of the PLICS system the Trust invested in. The Committee confirmed that this provided further assurance they had sought.

52/17 Finance and Performance Reports
1) Director of Finance Update
Forecast Review - Chris Adcock advised that the Quarter 1 detailed forecast review will be presented to the Committee next month however based on the current expenditure run rate of the organisation which had delivered an £8m deficit for Quarter 1, extrapolated forward it was clear that without material improvement, the Trust would be in material adverse variance for the remainder of the year. At this stage the CSC forecasts and the quality of improvement plans present a material risk in this regard. He advised that an initial year end forecast paper setting out the baseline forecast and potential scenarios for recovery was being presented to EMT next week. He confirmed that NHSi have been briefed on the scale of the challenge and will be visiting the Trust on the 31st July to commence a deep dive review on the Trusts financial position, governance arrangements and recovery plan. This review will help inform
the detailed actions and support arrangements required to support the recovery of this position.

Mike Attenborough-Cox highlighted his concerns regarding the financial position and the extent to which managers were taking responsibility for this situation. Chris Adcock advised that NHSi will be continuing to work alongside the Executives and new members of the team to agree the best way forward. The Chair noted the position but advised he is confident that Chris and the Executives will set out arrangements to mitigate this.

Aligned Incentive Contract - Chris Adcock advised that a Joint Executive Board meeting has been set up next week to go through in detail what the AIC means to our respective organisations as well as to individuals, risk management, planning and decision making process.

Capital - The issues raised with NHSi in relation to the capital restrictions are still unresolved however NHSi have advised this will also be picked up as part of the Deep Dive review.

PFI Commercials – It was agreed for a written update to be presented to the Committee next month. Chris advised that all parties recognise the output of the work in relation to the commercial disputes but have still to reach a set of agreements on the outstanding issues around the retained estate. He also advised that Brian Saunders from the Department of Health has agreed to arrange an independent review in order to identify a way forward in relation to this item. It was agreed for the update to be brought to the next meeting and then onto the Trust Board.

Action: Chris Adcock

2) Month 3 Finance Board Report

Gary Bryant gave an overview of the financial report highlighting that the conditions associated with the performance element of Q1 STF allocations had been changed to focus on 90% 4 hr performance and GP streaming. He confirmed that unfortunately the Trust will miss the STF funding for A&E Performance although it is expected that the 15% for the GP streaming will be secured.

Mike Attenborough-Cox highlighted his concerns relating to income and overseas patients. A discussion then ensued and it was agreed for Lee Williams, Head of Financial Accounting, and Deborah Stemp, Private and Overseas Patient Finance Manager attend the next Committee and present a flow diagram of people in the system.

Action: Lee Williams

3) Month 3 Contract & Income Management Report

Chris Adcock advised the purpose of the report is to provide the Committee with updates on the performance against the contract including CQIN, and any performance related disputes. He reminded the Committee that even when the AIC is signed the provisions of the national standard contract still apply. He advised that the Executives need to meet to review the detail of the Aligned Incentive Contract agreement and decide a way forward which supports the decision to move away from PbR.

Richard McKay questioned whether there will be any savings in headcount within the team. Chris advised the current Contract Team is a small team who will continue to manage all other contracts and the continued existence of PbR contracts for associate commissioners and NHSE Specialised Services, which impacted on the ability to fully redeploy capacity at this stage.

Action: Gary Bryant / Lee Williams

4) Cash and Working Capital update

Gary Bryant advised the Committee that there has been a continued improvement on aged debts and that he was now leading for PHT on the on-going national problem relating to NHS Property Services. He confirmed that currently the cash is being managed well and creditors are being paid on time however, if the mitigations put in place to recover the control total are insufficient, cash shortfalls will become in Q2 and the Trust will need to seek cash support from the Department of Health. Chris Adcock advised that this will be relayed to NHSi at the Deep Dive session in order to get their support for future cash requirements. Richard McKay questioned how the Trust goes about prioritising payments to 3rd parties. It was agreed for Gary to ask Lee Williams to include a section on this in the report next month.

Action: Gary Bryant / Lee Williams

5) Capital Programme

Gary Bryant advised that unfortunately there is no report to present today as the Capital Priorities Group that was scheduled for the 17th July was cancelled, due to the meeting not being quorate. He confirmed another meeting has gone in the diary for the 31st July so the Committee should expect to see a report at the next meeting.

Action: Gary Bryant
Chris Adcock highlighted that the Trust will be receiving £855k to support the GP Streaming and that active conversations are continuing regarding A&E reconfiguration. He agreed to keep the Committee updated.

**Action: Chris Adcock**

### 53/17 Q1 Forecast and Recovery Plan

Chris Adcock advised that the Financial Recovery plan update presented to the Committee today had been discussed with the Executives at the Recovery Board and will continue to be reported through this Committee for information. He highlighted the 9 point plan run rate comparison but raised his concerns that the focus in some areas had slipped since external support had been phased out. He confirmed that MOPRS LoS savings have slipped and remain high risk as the escalation plan and business case is adrift and that actions to deliver the milestones are not currently in place. He advised he will be discussing this with his Executives colleagues. The Committee raised its concerns with the lack of action plans in place and it was suggested for a Deep Dive review into each project is included on future agendas and for the relevant workstream lead to be invited.

**Action: Chris Adcock**

### 54/17 Other Updates

**MRI Scanner Business Case**

Gary Bryant gave a verbal update to the Committee advising that ultimately due to the totality of the case, it would need to be submitted to the Trust Board for formal approval. It was agreed for the full business case to be written up and be presented to the Committee in August, and then submitted to the Trust Board in September, along with the two contracts.

**Action: Gary Bryant**

### 55/17 Month 3 Operational Performance Report

Sheila highlighted the following keys issues from the report:

There were 9 breaches of the 12hr trolley wait standard for June, however so far there have not been any reported for July. Mike Attenborough-Cox asked what the reason was for these delays and Sheila advised this is ultimately due to patient flow within the hospital.

The Trusts RTT performance is currently reporting at 91.53%, which is very close to the national standard target of 92%. Cancer waits are reporting positively and Sheila advised that she will be presenting a national report to the Trust Board in October. She also advised that she had attended a meeting on Stroke earlier in the week and agreed to circulate the presentation to the Committee for information.

**Action: Sheila Roberts**

Rob Haigh attended the meeting and highlighted the following key issues from the report:

Meetings with system partners are continuing on a weekly basis. The Chair asked if Rob had confidence that the Trust is able to get back on track. Rob advised that the schemes rely on workforce and recruitment however; he confirmed the recruitment is now completed and staff will be going through the training phase. Richard McKay asked if there are clear actions and milestones. Rob confirmed yes and that an escalation plan has also been agreed.

Mike Attenborough-Cox asked if length of stay is improving. Rob confirmed the 2 biggest CSCs experiencing problems with LoS are Medicine and Elderly Care but he confirmed that he is aware of what actions need to be taken in order to make an impact. Sheila shared an example of how a cultural change within the Trust is required and confirmed that this is on her radar and is managing appropriately via the CSC Monthly Performance Reviews. Richard McKay asked if there was anything the Committee could do to help. A discussion then ensued and it was agreed for the time of the next meeting to be reduced and for the NEDs to attend a ward round session with Sheila Roberts and Rob Haigh so they can see first-hand the challenges experienced on the wards.

**Action: Committee Secretary**

Sheila advised she had a ‘1000 Day’ document and agreed to share this with the Committee for information.

**Action: Sheila Roberts / Rob Haigh**
Papers for noting

1) Finance report – HIOW STP Month 3
   The Director of Finance presented the paper to the Committee for information asking whether they would like a routine focus on reporting on STP to ensure awareness of the cost implications that may occur. The Committee agreed for a regular update to be included on the agenda.
   Action: Chris Adcock

Any other Business
   The Committee Secretary highlighted the amended dates for the remainder of the year and agreed to circulate them to the Committee.
   Action: Committee Secretary

Date of Next Meeting – Finance and Performance Committee
   The next meeting will be held on: 31 August 2017.
   Trust HQ Meeting Room
   9am and 12 noon

   The meeting closed at 11.45
FINANCE & PERFORMANCE COMMITTEE
MINUTES
Thursday 31 August 2017
10am – 12noon
Trust HQ Meeting Room

Present:
David Parfitt - Non Executive Director (Chair)
Christine Slaymaker, Non-Executive Director
Michael Attenborough-Cox – Non Executive Director
Mark Cubbon, Chief Executive
Chris Adcock – Director of Finance
Tim Powell – Director of Workforce
Sheila Roberts – Interim Chief Operating Officer
Theresa Murphy – Interim Chief Nurse
Kevin Nederpel – Deputy Director of Finance
Gary Bryant – Operational Director of Finance
Peter Mellor – Director of Corporate Affairs
Richard MacKay – Council of Governor
Gary Bryant – Operational Director of Finance

Minutes:
Susan Boyle – PA to the Director of Finance

In Attendance:

ITEM
59/17 Apologies
Apologies were received from: Peter Mellor – Director of Corporate Affairs, Nicola Ryley – Director of Nursing, Ed Donald – Chief Operating Officer and Michelle Dixon – Deputy Chief Operating Officer.

The Chair requested for a standard item to be added to the agenda regarding Conflicts of Interest. There were no conflicts of interest noted at the Committee.

Action: Committee Secretary

60/17 Minutes from Previous meeting 27 July 2017
The minutes were agreed as a true and accurate record of the meeting.

61/17 Action Log 27 July 2017
12/17 Month 9 Ops Report (diagnostic equipment reliability/ compensation for downtime) – Kevin Nederpel advised he had relayed the Committees questions to Neil Routledge from Procurement who confirmed that the Trust does not receive any compensation due to the downtime of equipment. He did however confirm Neil will raise with the Director of Procurement to see whether this is something that could be considered to be added to contracts going forward. Sheila Roberts suggested for this to be raised at the next Capital Investment Group.

Action: Sheila Roberts

52/17 (2) Month 3 Finance Report (Overseas Patients) – It was agreed to defer inviting the Head of Financial Accounting and Private Patients Manager till October.

Action: Company Secretary

52/17 (5) Capital Programme (GP Streaming & A&E Reconfiguration) - It was agreed for Chris to provide an update to the Committee next month.

Action: Chris Adcock

55/17 Month 3 Operational Report (‘1000 day’ document) – Sheila Roberts advised that the document has now been published and the booklets are on order. She also advised that Brian Dolen has been invited to come into the Trust on the 25th October to relaunch Memory Lane, and it was agreed for the NEDs to be invited.

Action: Sheila Roberts
All other actions were either covered off on the agenda, complete or not yet due.

62/17 Finance and Performance Reports

1) Director of Finance Update

Chris Adcock presented his report to the Committee highlighting that it is separated into four sections. Section 1 sets out the STP financial recovery requirements, section 2 sets out the STP submissions which includes a status update, with sections 3 and 4 covering the delivery of the plan and devolved accountability.

Richard McKay enquired on the status of the Emergency Reconfiguration business case. Chris advised that this is not yet well developed and will be a complex project as it is a reconfiguration of the entire emergency floor and not just the A&E department however, a working group has been established to pick up the process. Chris confirmed that NHSI have been engaged in discussions at this early stage and recognise its importance to the Trust. The Trust however will be required and expected to have considered all routes to financing this and this will need to include the existing PFI.

It was agreed for Chris Adcock, Sheila Roberts and Mark Cubbon to agree a timeline to get the resource in place and bring back to a future meeting.

Action: Chris Adcock, Sheila Roberts and Mark Cubbon

Christine Slaymaker raised her concerns regarding the time it will take to conclude the issues around flow and how the reconfiguration won't sort out the current problems. Mark Cubbon stated that the Emergency Department is not fit for purpose and whilst in this transition we will have to work out how to co-locate diagnostic services and the Trust will continue at pace to improve the care to patients whilst the reconfiguration proposals are developed.

Peter Mellor directed the Committee to page three of the Director of Finance update querying whether the Trust had secured funding for the two linear accelerators. Chris Adcock advised that the Trust had been unsuccessful in the first round bids to the national programme in this regard, and that this had been attributed to not having identified a preferred supplier. As a result the Trust had instigated the procurement process in order that 2nd wave bids could be submitted. He advised the committee that the linear accelerator replacement programme had been submitted as part of the STP capital bidding process on the basis that all external capital requirements for the next four years were required to be incorporated into this process.

Allan Coffey suggested that a scenario where the Trust failed to secure external capital for the linear accelerator replacement programme would need to be incorporated into the Trust's financial strategy.

Christine Slaymaker highlighted that the report suggests the Trust has grip and control however the evidence doesn't show this, and questioned how we are approaching this. Chris advised immediate steps are being taking to enhance the controls already in place and to increase capacity for financial improvement including through the appointment of the Interim Director of Financial Recovery.

The Chair said he appreciated the devolved accountability process going forward but echoed Christine's views on control. Mark Cubbon reassured the Committee that the Recovery Board recognises the controls required, the Executive Team are fully on board and that a control dashboard will be presented to EMT on a weekly basis. He also confirmed that this Committee will continue to receive papers from the Recovery Board.

Action: Committee Secretary

The Committee then discussed the Cash and Working Capital paper and Chris advised that a new Board approved mandate for a working capital facility will be required in order for the Trust to access the cash support required as a result of continuing adverse I&E performance. A lengthy discussion then ensued in respect of the assurance that could be provided that all
options in relation to the management of working capital had been exhausted prior to approving access to cash support. Gary Bryant was tasked with providing further information on this in order that this could be considered at by the Board at the next meeting. Mark Cubbon assured the Committee that the Executives are taking responsibility and that the Recovery Board actions are being put into place, which will then be fed into this Committee. He also gave assurance that the plan for this year, along with an organisation strategy to go forward and get the Trust at a stable financial position for the future years, will be presented to this Committee in due course for approval and then submitted to NHSi.

Christine Slaymaker then questioned if all the 9 work streams were on track. Chris Adcock advised that there were material issues with delivery of the 9 workstreams, in particular MOPRs/LOS and workforce.

63.17 Capital Programme
Gary Bryant introduced the capital programme paper setting out the basis behind the production of the revised capital plan taking into account the restricted Capital Resource Limit set out by NHS Improvement. The intention had been to take the programme to the Trust Board workshop, however it was agreed that to confirm formal Board approval a private board meeting would be required.

Gary advised that the demand for capital which had been identified through the prioritisation process materially exceeded available resources, and that the Capital Priorities Group, Chaired by the Chief Operating Officer has been established to oversee the production and delivery of the plan and the ongoing process of prioritisation. He also advised that the programme is currently contains a contingency due to the decision that two of the items, Pharmacy Robot and Renal Dialysis Machines can be deferred till next year. Gary confirmed that the Capital Priorities Group will continue to provide an update to this Committee. The Chair advised that he was content that the new Capital Priorities Group is now established and that the team have managed to make a contingency. The Committee supported the recommendation for the Capital Programme to be presented to the Board for approval.

Action: Gary Bryant

64/17 Q1 Forecast
Due to time constraints, it was agreed that a substantive conversation will take place at the Trust Board Workshop later that afternoon.

65/17 Recovery Board Terms of Reference
The Committee ratified the Recovery Board Terms of Reference.

66/17 PFI Commercials
Due to time constraints, it was agreed to defer this update to the next meeting in September.

Action: Committee Secretary

67/17 Other Updates
MRI Scanner Business Case
Chris Adcock advised that the paper being presented to the Committee was requesting ratification of the procurement process prior to Trust Board for approval due to the value. The Chair highlighted that the procurement recommendation was not to go with the cheaper option. The Committee members advised this was due to the quality of the imaging and the amount of training required, would outweigh the costs. Mike Attenborough-Cox asked whether a benchmarking exercise to establish reliability of the proposed machines had been carried out. Sheila Roberts confirmed that the reliability of the machines had been assessed as part of the process.

The Chair highlighted that the figures within the table in the executive summary were correct however not in the annex. It was agreed for this to be updated and the Committee were content to make the recommendation to the Board.

Action: Gary Bryant
Chris Adcock advised that the Operating Tables and Stacks paper presented to the Committee was not the final paper and would need to be updated for presentation to the Trust Board.

68/17 Month 4 Performance Report
Due to time constraints it was agreed to defer the discussion on the Month 4 Operations Report as it will be discussed the following week at the Trust Board.

69/17 Papers for noting
The Committee noted the minutes of the meetings.

70/17 Regular Updates
The Committee received the updates in relation to the Devolved Accountability and Strengthening Financial Delivery papers.

71/17 Any other Business
Mike Attenborough-Cox advised he is still concerned that the Trust is still accepting the numbers of patients Medically Fit for Discharge within the hospital that a very clear message needs to be presented to our partners. It was recognised that the problem was not entirely related to external factors and that the Trust needed to ensure that internal systems and processes were operating as they should be as part of discussions with partners. Mark Cubbon highlighted he and his colleagues were very much aware of the likelihood of deterioration to a patient’s health whilst waiting to be discharged and that the Trust had sought support from NHSI and ECIP as well as engaging consultancy support to help ensure that the Trust is able to make rapid progress in relation to these issues and advised he will share this with the Committee in the near future.

**Action: Mark Cubbon**

The Chair highlighted that previously the Committee were advised that the health system were all signed up and that training was underway of new staff to help with the issues highlighted. Mark Cubbon advised that this staffing was to cover Hampshire and that the people who had been employed have filled the missing gaps, they are now looking to add additional staff. He confirmed that he has had discussions with both Authorities and the Director of Social Services of Hampshire.

72/17 Date of Next Meeting – Finance and Performance Committee
The next meeting will be held on: Monday 25 September 2017.
Trust HQ Meeting Room
11.30am to 1.30pm

The Chair requested for the Committee Secretary to look into dates for next year’s meetings.

**Action: Committee Secretary**

The meeting closed at 12.30

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CHARITABLE FUNDS COMMITTEE MEETING

Thursday 14TH Sept 2017
Board Room, Education Centre, E Level

Present: Mark Nellthorp (Chair) Non-Executive Director

Attendees: Peter Mellor (PM) Director of Corporate Affairs
Sarah Balchin (SB) Head of Patient Experience
Kim Sanderson (KS) Radiotherapy Services Manager
Victoria Greenshields (VG) Fundraising Manager
Sam Corkill (SC) Chief Accountant
Lee Williams (LW) Head of Financial Accounting
Amanda Lipsham (AL) Financial Accountant
Gary Bryant (GB) Operational Director of Finance
Caroline Cawkill (CC) Matron – Critical Care

Minutes: Paula Lang (PL) Fundraising Administrator

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<td>Minutes of the last meeting</td>
<td>GB stated that his title was Operational Director of Finance. SB said on para 2 page 2 - the word &quot;could&quot; to be changed to &quot;may&quot;</td>
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</tbody>
</table>
| 3    | Matters Arising | Review of rolling action points  
Expenditure Requests  
QA Carers Team Magnet Application  
SB asked if this could be removed from the action grid until such time that there has been a review of alert magnets. This can be revisited again when the new needs are clear.  
Expenditure requests  
Standing/Raising Aid: MOPRS have purchased this, so can be removed from action grid. |
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<thead>
<tr>
<th>ITEM</th>
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<tbody>
<tr>
<td><strong>Expenditure requests</strong></td>
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<td><strong>Review of Patient advice and liaison service (PALS)</strong></td>
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<td>MN said that this needs to be discussed when the permanent DON is appointed.</td>
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<td>MN</td>
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<td>A discussion is needed to determine if this space would be suitable for Fundraising and if so, to find an alternative for PALS. SB asked about the space where the Wellbeing team are. LW thought they were in Lancaster, but PM said PCC have acquired this space, although it does not seem to be in use much.</td>
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<td>PM</td>
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<td>MN stated that any future expenditure requests that are approved by the CFC, should be reviewed after 3 months and a reminder sent if expenditure not paid in full, and all approvals will lapse at 6 months.</td>
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<td><strong>Terms of Reference</strong></td>
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<td>On agenda</td>
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<td><strong>Investments</strong></td>
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<td><strong>Risk Register</strong></td>
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<td>PM has looked into the possibility of employing a professional grant writer, but thinks it will better suited for the soon to be appointed Director of Comms and Fundraising. VG said that she had provided details of Trusts and Grants for Rocky to look at.</td>
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<td>SB</td>
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<td>SB and PM agreed to have some informal talks to find anyone that may be able to help in the trust.</td>
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<td>PM</td>
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<td><strong>Charity Income &amp; Expenditure Trends</strong></td>
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<td><strong>Distribution of charity costs challenge</strong></td>
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<td>PM met with the Hayley Wagner and stated that there could be no allowances made and pointed out that there had been many years that the fund benefitted from Investment income. HW seemed satisfied with the outcome. To be removed from the action grid.</td>
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<td>4</td>
<td><strong>Expenditure Requests</strong></td>
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<td></td>
<td>No requests.</td>
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| 5    | **Committee Information**  
|      | **Charity Commission guidance: The essential Trustee** |
|      | SC presented this to the committee, in order to refresh the committee on the 6 main duties of charity trustees. |
| 6    | **Fundraising** |
|      | **Fundraising Report**  
|      | VG presented this to the Committee and highlighted the following: |
|      | • Press releases were exceptionally high in June and July.  
|      | • The Bubbles Fund raised £4,697 in their first Summer Fayre. |
|      | VG also told the committee that the donation station at north entrance had been broken into again and that the supplier was going to provide stronger locks. |
|      | SC said that the legacy from Wimbledon (£100k) should be recorded as a Cancer Services rather than General Amenity as this was the general purpose legacy which was used to part repay the funds borrowed from Cancer Services by the Rocky Appeal in 16/17 to help pay the 4th Da Vinci Robot invoice. |
|      | **Fundraising Policy**  
|      | VG presented this to the Committee and said that she would like to make the rules stricter for staff raising monies from outside charities not listed as exceptions. |
|      | After discussion from the committee, the changes to the policy would be made by removing named charities. The committee would confirm which charities could raise funds via a committee process. |
|      | CC said that staff would need to be informed of any changes. Sources for this could be the Link, the Charity newsletter or a pop up network message. |
|      | LW said all new policies were distributed to managers and a summary of changes are listed on the front cover. |
|      | **Fundraising & Admin Budget**  
<p>|      | AL presented this to the Committee. |</p>
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<td>7</td>
<td>GB asked if a forecast could be supplied for Income and Expenditure for the remainder of this financial year.</td>
<td>VG</td>
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<td>AL and VG to work together on this report.</td>
<td>AL</td>
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<td></td>
<td><strong>Rocky Appeal</strong></td>
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<td><strong>Rocky Appeal Financial Activity</strong></td>
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<td>AL presented this to the Committee, highlighting the following points for discussion:</td>
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<td>• Rocky income is averaging 16k per month.</td>
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<td>• The potential <strong>shortfall of £203K</strong> in funds needed to be raised to cover the last Da Vinci Robot invoice as well as Rocky payroll costs. If the Trust becomes partially liable for the Da Vinci invoice payment, the VAT exemption status would be forfeited, and a further amount of £75K becomes payable, <strong>increasing the potential shortfall to £278k</strong>.</td>
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<td>• MN said that other arrangements should be put into place to raise shortfall.</td>
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<td>• PM said that ML was returning to work shortly and a return to work meeting is scheduled to put a tangible plan into action to address this problem.</td>
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<td>• Committee agreed that commencement of grant writing would be invaluable. A plan is needed for this to become achievable.</td>
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<td>• SB said she will talk to L&amp;D to see if they have anyone available to assist with the grant application process.</td>
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<td>• CC mentioned that the University of Portsmouth students are looking for projects and may be interested in providing assistance with the grant writing process.</td>
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<td>• KS asked if the local clinical teams have been approached to provide funds for the Rocky shortfall. SC said that Lorraine Farrow had sought assistance from depts using the robot (prior to year end 16/17) however no departments had volunteered funds other than Cancer Services, who provided a loan of £150K</td>
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<td></td>
<td><strong>Rocky Appeal 16-17 update</strong></td>
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<td>• SC said that all monies owed by Rocky had been repaid to Cancer Services. (£100k from the legacy and £50k from Rocky funds raised)</td>
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<td></td>
<td><strong>Rocky Appeal progress update.</strong></td>
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<td>ML was absent so did not present this.</td>
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<td>8</td>
<td>Financial Activity report</td>
<td>AL</td>
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**Financial Activity**

AL presented this to the Committee. SC said that the potential shortfall for the Rocky Appeal would be highlighted in this report for the next meeting.

**All Fund Balances Report**

This was presented to the Committee.

MN commented that some funds are still not spending their monies.

SC pointed out that funds are needed to cover management and fundraising costs, but at the same time, funds need to be spent in line with Charity objectives.

SC said that the Charities Balance Sheet had increased from £1,283K to £1,380K since the March 2017.

**General Amenity**

SC presented this to the Committee.

General discussions concluded that: the General Amenity must not go overdrawn, and expenditure must be looked at and prioritised when requested.

Amendments to the report where discussed and agreed. (There will be sections showing committed allocations and one showing uncommitted allocations).

Regarding the Mental Health Champions Development Project, which has a balance of £4451.47, SB said that they only spent £500 and that this balance can be released to the ‘uncommitted balance’.

The Committee questioned the unused balance for 16/17 of £1000 for the Learning and Disability Liaison Team. PL said she would find out what this is.

**Post note – The £1000 needs to be removed as this was an estimate of the income to be raised by the LD for the Sensory Voyager. The team have raised £466.90 year to date and this was shown on the committed 2017/18 allocation section of the report. (therefore the £1000 will be removed from the report)**

**Post note – SC has sent out an amended General Amenity statement.**

The Chair asked for an update on the General Amenity to be emailed to Committee members on a monthly basis.
### 16-17 Charity Annual Accounts & Report 1 and 2

SC presented this to the Committee. Highlights included:
- The target of 10% set for increasing income from 15-16 to 16-17 was achieved. The actual percentage achieved was 17%.
- General increase in donations trust and grants, although trading income had slightly decreased.
- Rocky income and expenditure decreased.
- Management and Admin costs steady at £42,000.
- Fundraising costs increased from £144k in 15-16 to £161K in 16-17
- £1.3m income target had been agreed for 17-18.
- Change to wording for the Reserves section was agreed, and would be updated to include:
  A reserve equal to £1 million should be held to provide continuity for achievement of objectives in the event of income fluctuations and
  The charity needs to maintain the uncommitted reserves at this level.

### Reserves and Investment of Funds

The committee discussed what level of funds would be available for investment, bearing in mind income raised to date during 17/18 is being spent at the same pace, and therefore it will be difficult to increase reserves.

SC highlighted that expenditure has exceeded income since 2008/09 and if this continued the issue of whether or not the charity is a ‘going concern’ would need to be addressed.
SC confirmed that as at the end of August 17/18 charity funds had only increased by £97K.

AL suggested monitoring expenditure to ensure this does not exceed income in the financial year 17-18

SC presented a table comparing PHC with two other South Coast large acute hospitals charities detailing their income, expenditure and investments. This showed that whilst these charities were earning much higher investment income than us, they had a much higher value of reserves to invest. PHC cannot hope to earn investment income of this level with total funds that equate to one years spend.

MN said that this was not a fair comparison as the charities used had more fundraising resources. MN asked VG to come up with a more suitable comparison.

SC said that doubling the number of fundraising staff was currently not an option given that the charity can only cover its costs for another 6 years (if income and expenditure levels stay the same). Doubling costs could reduce the remaining life of the charity to only 3 years.

It was accepted by all that investing funds via a broker in order to achieve higher investment income was not a viable option given the current level of funds available.
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<td>9</td>
<td>It was agreed that some COIF near cash investments can be looked at for a better source for investing the reserve. AL to investigate these options.</td>
<td>AL</td>
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<td>LW asked for it to be recorded that spending plans were not being requested this year.</td>
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|      | **Distribution of Charity costs challenge update**  
See item 3 of these minutes for details. Challenge satisfied.                                                                                     |        |
| 9    | **Policies & Procedures**                                                                                                                                                                               |        |
|      | **Terms of Reference**                                                                                                                                                                                  |        |
|      | LW presented this and said that the CFC was not currently set up and administered in the same way as other committees.                                                                                  |        |
|      | After various discussions suggesting changes, the policy was approved by the committee subject to these changes.                                                                                          |        |
|      | PL to add attendance table to minutes. LW offered to provide a template.                                                                                                                               | PL     |
| 9    | **Post Meeting Note – LW emailed PL template**                                                                                                                                                           | LW     |
| 9    | **Charitable Funds Code of Procedures**                                                                                                                                                                | LW     |
|      | LW said this was due to expire in Sept 2017 and asked for this to be changed to Dec 2017 and will bring to November meeting.                                                                               |        |
|      | LW requested that the committee minute the fact that the £15 function allocation was no longer available to staff, and therefore the existing Staff Function Policy needs to be removed from the intranet page, following this meeting. All agreed this should be actioned. | LW     |
| 10   | **Risk Register**                                                                                                                                                                                       | LW     |
|      | LW presented this to the Committee.                                                                                                           |        |
|      | SC said that (item.5) Reserves Policy on the register needs to be updated. As spending plans have not been requested this year and in line with the updated reserves policy, the action 'To achieve agreed reverse levels, spending plans need to be monitored and achieved' should be removed. All agreed. |        |
| 11   | **Date of next meeting**  
9th November 2017  
E level boardroom 11.45am                                                                                                                         |        |
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<th>ITEM</th>
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<tr>
<td>12</td>
<td>Any other business</td>
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<td>VG asked what the official line is for donors wishing to fundraise for Rocky near to or after the appeal ends, particularly for legacy wording.</td>
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<td>MN asked SC to provide a form of words for the Rocky Fundraising literature and legacy wording.</td>
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<td><strong>Post meeting note</strong> – SC provided to Fundraising team.</td>
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<td>Trust Board Date</td>
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| **February**     | ß Staff Story  
ß Chief Executive Report  
ß Integrated Performance Report  
ß Charitable Funds Update  
ß CQC Improvement Notice and Urgent Care  
ß Board Assurance Framework (BAF)  
ß Review Finance & Performance Committee TOR | ß Quality Report (SUI’s)  
ß Papers for noting  
ß Example of Incident  
ß Q3 forecast review  
ß Quarterly Legal Services Report  
ß Summary of Governors Business  
ß Urgent Care Transformation Programme |
| **March**        | ß Urgent Care Patient Story  
ß Chief Executive Report  
ß Integrated Performance Report  
ß Charitable Funds Update  
ß Contract Negotiations  
ß Equality & Diversity Annual Report  
ß Quarterly Complaints Report  
ß CQC Improvement Notice and Urgent Care  
ß Board Assurance Framework (BAF)  
ß Quarterly Research and Innovation Report | ß Quality Report (SUI’s)  
ß Papers for noting  
ß Example of Complaint  
ß Urgent Care Transformation Programme |
| **April**        | ß Staff Story  
ß Chief Executive Report  
ß Integrated Performance Report  
ß Charitable Funds Update  
ß National Staff Survey  
ß Annual Education, Learning & Development Report  
ß Audit Committee Report  
ß Audit Committee Forward Planner  
ß CQC Improvement Notice and Urgent Care  
ß Board Assurance Framework (BAF) | ß Quality Report (SUI’s)  
ß Papers for noting  
ß Example of Incident  
ß Draft Quality Account Priorities  
ß Quarterly Legal Services Report  
ß Summary of Governors Business  
ß Urgent Care Transformation Programme |
| **May**          | ß Patient Story  
ß Chief Executive Report  
ß Integrated Performance Report  
ß Charitable Funds Update  
ß CQC Improvement Notice and Urgent Care  
ß Board Assurance Framework (BAF)  
ß Junior Doctor Contracts and Trust Guardian Report | ß Quality Report (SUI’s)  
ß Papers for noting  
ß Example of Complaint  
ß Draft Quality Accounts  
ß Urgent Care Transformation Programme |
| **June**         | ß Staff Story  
ß Chief Executive Report  
ß Integrated Performance Report  
ß Charitable Funds Update  
ß Annual Paediatric Safeguarding Report  
ß Quarterly Complaint Report  
ß CQC Improvement Notice and Urgent Care  
ß Board Assurance Framework (BAF)  
ß Final Quality Accounts  
ß Quarterly Research and Innovation Report | ß Quality Report (SUI’s)  
ß Papers for noting  
ß Example of Incident  
ß Summary of Governor Business  
ß Urgent Care Transformation Programme |
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<tr>
<th>Month</th>
<th>Reports</th>
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<tr>
<td>July</td>
<td>Urgent Care Patient Story</td>
<td>Quality Report (SUI's)</td>
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<td>Chief Executive Report</td>
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<td>Safer Staffing Report Nursing &amp; Midwifery</td>
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<td>Board Assurance Framework (BAF)</td>
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<td>Final Annual Governance Statement</td>
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<td>September</td>
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<td>Annual Staff Health and Well-being Report</td>
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<td>December</td>
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<td>Quarterly Research and Innovation Report</td>
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# TRUST BOARD ATTENDANCE RECORD

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<th>06-Oct-16</th>
<th>03-Nov-16</th>
<th>01-Dec-16</th>
<th>02-Feb-17</th>
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<td>Mark Cubbon</td>
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