The Princess Alexandra Hospital NHS
NHS Trust

Trust Board Meeting

Agenda (Part A in Public)

Date: Thursday 22nd December 2011 at 1:30 pm.

Venue: The Boardroom, Princess Alexandra Hospital, Harlow.

Members of the public are welcome to attend so as to observe the meeting. Questions about any aspects of the running of Trust are welcome and should be addressed to the Chair at the end of the meeting

Item	Subject	Report From	Time & Page
1	**Welcome and Procedural information**	Chair - verbal	**1:30 – 1:35**
2	**Apologies for Absence**	Chair - verbal	
3	**Declaration of Interests** To receive any new or amended declarations of interest from Board Members.	Chair – verbal	
4	**Minutes of the Meeting Held on 27th October 2011** To receive an updated version of the minutes following the comments made at the November Board meeting	Chair - attached	**1:35 – 1:40** Page 3
4.1	**Minutes of the Meeting Held on 24th November 2011** To confirm and sign the minutes of the meeting held on 24th November 2011.	Chair - attached	**1:40 – 1:45** Page 17
5	**Matters Arising from the Minutes**	Chair - verbal	
6	**Action Points (Log)** To review progress against previous actions and to discuss the structure of the document.	Chair – attached	**1:45 – 1:50** Page 29
Quality, Governance and Risk			
7	**Patient Experience Assurance Committee (PEAC)** To receive the Patient Experience Assurance Committee summary report from 16th December	Paper to follow	**1:50 – 2:00**

	2011		
Finance and Performance			
8	**Business Performance Assurance Committee (BPAC)** To receive a report and recommendations from the committee of 20th December and to receive a verbal update on discussions on the Trust Dashboard.	Paper to Follow	**2:00 – 2:15**
9	**Trust Dashboard** This item will be discussed at the BPAC and included in the verbal update from the BPAC Chair.	- attached	Page 41
10	**Sign off SHA Self Certification Return** To note new format and to approve	Chief Executive. Attached	**2:15 – 2:20** Page 63
11	**Executive Team Feedback.** To receive feedback from the Executive Team via the Chief Executive..	Verbal update	**2:20 – 2:25**
12	**Finance Report** To receive an update from the Director of Finance and Information	Director of Finance and Information - attached	**2:25 – 2:30** Page 75
Information			
13	**Record of Attendance**	Trust Board Secretary – attached	Page 87
14	**Minutes from Research & Development Committee**	For noting – attached	Page 91
15	**Input from the Public at Chairs Discretion**	Chair	**2:30 – 2:45** Pages
16	**Date of Next Meeting** Thursday 26th January 2011 at 1:30 pm		
Closure of Part A			
To resolve the representations of the media and other members of the public be excluded from the rest of the meeting, having regard to the confidential nature of the business to be transacted publicity on which would be prejudicial to the public interest: Section 1 (2) Public Bodies (Admissions to Meetings Act) 1960.			

Item 4

SUMMARY REPORT	The Princess Alexandra Hospital NHS Trust
Trust Board Meeting (Part A)	22nd December 2011
Subject:	Minutes of the meeting held on 27th October 2011
Prepared by;	Mr. Derek Greening, Trust Secretary
Approved by:	Ms. Melanie Walker, Chief Executive Officer
Presented by:	Mr. David Barron, Chair

Purpose

At the last meeting concerns were raised about several areas of these minutes; the Board is asked to receive an updated version.

Decision	
Approval	●
Noting	●
Information	
Other	

Corporate Objectives

Safety / outcomes	Financial	Workforce	Estates-Environmental	Regulatory / Statutory	Relationships / Partnerships
●	●	●	●	●	●

Executive Summary

The minutes have not been re-rewritten in light of the comment that they were too verbatim, but this has been taken into account in producing the next set, but all those amendments identified by the Board that required to be changed have been; these are:

- Section 12 (heading)
- Section 12.10
- Action 12.12.2
- Section 9.8 third paragraph
- Section 10 (heading)
- Section 11.5
- Section 11.6 third paragraph
- Section 11.8
- Section 11.9
- Section 13.1
- Section 13.4
- Section 13.8 third paragraph
- Section 13.12
- Action 13.16.3 Additional action.

Key Recommendations

To note and approve

Assurance Framework

This complies with requirements for an Assurance Framework within the Statement of Internal Control.

Next Steps

N/A

Corporate Impact Assessment	
CQC Regulations	10
Financial Implications	●
Legal implications	●
Equality & Diversity	●

The Princess Alexandra Hospital NHS
NHS Trust

Trust Board Meeting (Part A) (Revised Version)
Minutes of the Public Trust Board Meeting

Held on: Thursday 27th October 2011 at 1:30 pm. at
The Princess Alexandra Hospital, Harlow.

Present:

Mr. Gerald Coteman	Chair	(GC)
Mr. Charles McNair (Director of Finance & Information)	Acting CEO	(CM)
Mr. Mark Devonshire	Non-Executive Director	(MDV)
Dr. Claire Feehily	Non-Executive Director	(CF)
Mrs Paula Kerr	Non-Executive Director	(PK)
Mr. Richard Stead	Non-Executive Director	(RS)
Mr. Darren Leech	Chief Operating Officer	(DL)

In Attendance:

Mr. Derek Greening	Trust Secretary	(DG)
Mrs Penny Griffiths	Minute Secretary	(PG)
Mr. Batsirai Katsande	Assistant Director Lead for Performance	(BK)
Ms. Raine Hunt	Communications Lead	(RH)
Dr. Sylvia Thompson	Associate Member	(ST)
Mr. Marc Davis	Director of Integrated Patient Care	(MD)

Members of the Public, Staff in Attendance:

Mr. Charles Jackson	CJ
Ms. Lynne Marriott	LM

(Please note that all numbering is to be prefixed with the Board reference TB/27/10/11)

1 WELCOME AND PROCEDURAL INFORMATION:

1.1 In response to the comments made by the Strategic Health Authority observers at a previous Trust Board meeting, DG requested that mobile 'phones were turned off or at least turned to silent mode during the meeting and that these should not be accessed during the meeting but urgent calls should be taken outside with the Chair's permission.

1.2 In response to a query prior to the meeting DG replied that despite the large number of members who were absent from today's meeting, the Board was quorate as per the Trust's Standing Orders.

1.3 The Chair formally noted that CM was acting as the CEO for the meeting in MW's absence.

2 APOLOGIES FOR ABSENCE:

These were received from:

Ms. Melanie Walker	Chief Executive Officer	(MW)
Ms. Janet Dalrymple	Non-Executive Director	(JD)
Dr. Sandra Dimmock	Medical Director	(SD)
Mrs Yvonne Blücher	Executive Director Nursing & Quality	(YB)
Mr. Mark Gammage	Interim Director of Workforce	(MG)

3 DECLARATION OF INTERESTS

No declarations or alterations were noted.

4 APPROVAL OF THE MINUTES OF 29TH SEPTEMBER 2011.

With the following amendments (please note that minor typographical errors are not included here) the minutes were approved by the Board (errors or additions are underlined).

4.1 *Section 7.7 stated "JD raised the issue of the 2-5% complication rate. Her understanding was that the Trust's rate may be higher than this? If there is a 1 in 20 of a significant risk to the patient, staff should have ensured that the equipment was present.*

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This should have read:-

Section 7.7 - JD raised the issue of the 2-5% complication rate. Her understanding was that the Trust's rate may be higher than this? If there is a 1 in 20 <u>chance</u> of a significant risk to the patient, staff should have ensured that the equipment was present

4.2 There was a section missing from the minutes relating to the patient experience assurance committee section 8. This will now be paragraph 8.10 and reads as –

It was noted that there was a significant risk that the Trust may now not be able to achieve level 2 of the NHSLA accreditation process and whilst there was a risk of not achieving level 1 this was considered to be low.

4.3 *Section 11.13 stated that – "DG asked the Board if they were recommending that the CEO and Chair signed the declaration at level, the Board approved the declaration at level ."*

This should have read -

"*DG asked the Board if they were recommending that the CEO and Chair signed the declaration at level 1, the Board approved the declaration at level 1"*

4.4 *Section 15.4 stated that – "PK stated that the BAF was much better but with regards to the risk associated with relationship working, this was about our capacity and our ability to engage with partners and the public as we try for Foundation Trust status. MW agreed and responded that this was being looked at in light of our strategy development*."

This was discussed with PK stating that this did not accurately reflect the risk that was identified and this was not accurately reflected within the BAF either. Following discussion the following correction was noted. However, this is subject to external discussion between PK and DG as to the exact wording.

The wording should be - PK stated that the BAF was much better but with regards to the risk associated with relationship working, the Non-Executive Members believe that there is a risk to Trust objectives, in particular achievement of Foundation Trust status, due to poor management of our partnership working, especially in clearly identifying who our partners are, PCT, SHA, Public etc. and the lack of assurance on how robust our working relationships with each of them is. MW agreed and responded that this was being looked at in light of our strategic planning processes.

5 MATTERS ARISING FROM THE MINUTES

These were undertaken within item 5.

6 ACTION POINTS (LOG)

6.1 The updated log is attached as agenda item 5.

6.2 DG introduced the new log and asked if this now met with the requirements of the Board, which was confirmed in the positive by members

6.3 The actions were then reviewed and the updates from these are shown on the new log.

7 PATIENT EXPERIENCE REPORT

7.1 A presentation was due. However DG reported that unfortunately this was not received until quite late and was not considered to be up to the standard required by the Board for presentation to the Public. Members asked what the issues with the report were and DG replied that it had only been received that morning

and the AD for Nursing felt that there was not time to put it into the template required for the Board or to ensure that it accurately reflected the actual situation with this complaint. DL stated that he would be discussing this with the relevant AD and that YB would be made aware on her return of the reasons for not taking this to the Board.

7.2 GC reported that he had met a midwife who had won a National award for signing with deaf patients. She was very vibrant and enthusiastic and had developed her skills in her own time and this will be included in the next Chairs blog. He had thanked her on behalf of the Board; MDV asked if we maximising this in the local press. In response RH stated that this was being raised with the media, in particular the local press and radio, and this should be appearing soon. This was also identified as the sort of good example that we should communicate across the Trust in order to replicate elsewhere.

12 TRUST DASHBOARD
(Please note that this item was taken out of sequence of the agenda and this reflects this)

12.1 CM introduced the dashboard and explained that by taking it at this stage in the meeting it would enable the review of the East of England Self Certification and the feedback from the Business Performance Assurance Committee (BPAC) to be put into context.

12.2 There had been detailed discussion in the BPAC on the relevance of the dashboard and to see if any further improvements where required. It was noted that it is now starting to give more insight into areas, particularly efficiency and transformation.

12.3 CM suggested that the Board go through the report taking into account the notes on key areas and ask questions on each page.

12.4 With regards to clinical quality (section 2 page 48-50) it was noted that there had been a significant improvement in the current month that was encouraging, especially when compared to the previous three months.

12.5 The activity was discussed (page 53-54) and it was noted that if we are performing over plan these should be shown as green. One big challenge for transformation is to deliver more efficient management of emergency admissions. This has been a big challenge for years and impacts on bed capacity etc.

12.6 With regards to Access and Targets (pages 55-56) the NEDs noted how satisfying it was to now see so few showing red ratings compared to a few months ago.

12.7 The table for Efficiency (page 59) was discussed with questions being asked to why these were not RAG rated. CM reported that these are mostly internally imposed targets and that by next month we will have our own plan and will be able to RAG rate this based on actual performance for most if not all of these items; for instance emergency LOS last year was 6 days and we now have a

target to reduce this by December by 15% and it should be noted what a challenge this will be.

12.8 It was noted that the figures for sickness absence rates on the Workforce table (Page 61-62) had altered for August and Sept from 3.70% and 3.30% respectively to 3.72% and 3.67%; so the decrease was not as good as we thought.

12.9 Discussion on this ensued with it being noted that there are short and long term sickness rates that can be very useful in determining if we have a problem with sickness that the overall figure cannot. It was also agreed that we should have the figures for appraisals, personal review and development plan (PRDP) and Statutory/Mandatory Training.

12.10 CM then asked the NEDs regarding the forecast reporting if they have a clear view of the risks going forward. CF noted there is a gap particularly if the action plan has not been seen. It was agreed that GC and CM would discuss this outside the meeting and feedback. MDV stated that every exception should have an action plan and the plan should be published on the intranet so that NEDs can see these as and when required.

12.11 DL reported that he and CM were working on the issue of patient follow up appointments.

12.12 PK queried whether sufficient assurance is received through quarterly reports that systems are working; GC replied that this is being looked at in PEAC but that he agreed that quarterly reports were not enough for the dynamic organisation that the Trust is becoming.

12.12.1 **ACTION:** DG and SM to discuss with HR the reasons for the data being changed after validation.

12.12.2 **ACTION;** CM/DG/SM to discuss the need for additional HR indicators but PRDP and appraisals also Statutory and Mandatory training to be included

9 PATIENT EXPERIENCE ASSURANCE COMMITTEE

This was to be taken in part B at the request of JD.

9 BUSINESS PERFORMANCE ASSURANCE COMMITTEE

9.1 It was agreed that DG would in future ensure that this item appeared on the agenda for the Board after the Dashboard.

9.2 RS introduced the exception report from the committee and noted that the committee had spent considerable time discussing the finances.

9.3 Revenue had been discussed as this was not coming into the Trust as expected and some revenue was not coming in at all. This was giving a predicted shortfall of £300k that needs to be addressed.

9.4 Cost were higher than we would want and if we didn't take further actions to address we would be left with significant gaps, but the Execs have provided a plan which will bring the cost plan back on track by end of year.

9.5 The CIP programme was to be discussed later but there were some areas of concern. For instance with regards to places we rent. As we are downsizing then perhaps we should be reducing the areas that we rent; there was an action plan in place, however, to look at buildings owned by PCT.

9.6 Net summary is we believe the overall finances are not as strong as we saw last month and we are forecasting a deficit without additional support. However, we appear to be out performing other Trusts in the East of England in terms of the CIP programme. He also noted that he felt that the execs had taken the right decision to apply for a loan to be available in case we need it and will be available from December.

9.7 CF asked about working capital as at the last Board meeting confidence was expressed that we didn't need the loan? CM responded that since the last meeting we had faced a deadline for applications and the decision had been taken to apply for a provision although this does not mean that we will have to use it. He reported that we had also taken a decision to slow down the capital programme but that some may be deferred into next year.

9.8 MDV asked about winter planning and emergency planning. What is the executive's view of the Trust preparedness for winter? CM advised that there is a risk going forward that if we face increased demand due to the winter this may impact on us in terms of reduction of beds, and in terms of emergency activity. We have a plan in place built around the PCT requirements and we are still on track but it is quite tense at the moment.

DL stated that there had been a slight increase in attendance to A&E and admissions, however, we do get spikes but this appears to be sustained over the past 2 weeks.

CM reported that bed planning is underway and we are 6% above the emergency activity plan. DL reported that there is a logistical move this weekend and we are on track to do this and have put in further contingency measures for the weekend so if the situation changes the patient experience will not be affected.

9.8.1 **ACTION:** DG to amend future agendas so that the Dashboard appears before the BPAC report.

10 SIGN OFF EAST OF ENGLAND SELF CERTIFICATION RETURN

10.1 DG spoke to the updated paper identifying the additional information that had been added as it had not been available when the papers had been produced.

10.2 DG noted that most areas had been discussed within the Dashboard discussion.

10.3 The Board agreed to the Chair and CM as acting CEO to sign these off and for the return to be submitted to the SHA.

11 BOARD ASSURANCE FRAMEWORK

11.1 DG introduced the latest version of the BAF; there are three new areas for the recording of risks from the Assurance Committees sections 7.7 through to 7.10.

11.2 The BAF is now being updated by the Risk, Safety & Compliance Manager with the Executive Directors and discussions are underway with the Business Units on the risks on their registers to identify any risks that need to come to the Board.

11.3 GC asked how the concerns on the front page of the Dashboard related to or were captured by the BAF; DG and CM reported that this is the next step and these would be included within the BAF paper to the next Board.

11.4 DG stated that the BAF and corporate risk register were now one and the same thing but that operational risks only should come to the Board if the risk is so high that the Executives believe that it has to come to the Board.

11.5 GC asked the Board members if they were assured or would they like a session on the BAF. The members requested an opportunity for a learning and Development session on the BAF at a future date.

11.6 RS stated that he was surprised that clinical risks do not seem to be included as surely the Board should be aware as of major import. DG reported that the "Taking on Trust" report from the audit commission on the lessons learned from Mid Staffs stated that only risks that affected the Trusts objectives or risks that had the ability to threaten the Board should come via the BAF. It was felt that some Trusts BAF's were so large that members could not see the essential risks that they needed to be aware of as they had too much to digest.

Our aim is to get information both clinical and non-clinical that has been identified as potential high risks to the Board members as soon as we are aware of it. This will then be taken to the next relevant assurance committee and via this to the Board, at the discretion of the committee, through its exception reports.

In addition an alert system will be developed via NHS.NET email accounts to ensure that NED's are informed of significant issues as quickly as possible.

11.7 CF noted that the BPAC had identified that the financial risks are greater than previously thought and this was not on the BAF so how timely is it. DG responded that the BAF was prepared for the Board and to do this meetings had to be held or a large number of emails sent to gather the data and so it always lags behind the real time situation. This would continue until we had real time data systems such as Datix Web to gather data in real time and the Board could see this as an when they wanted.

11.8 BK stated that this discussion demonstrates the need for the BAF to be dynamic; and the Board and Executive Team have already started to implement this by taking the BAF to clinicians in other forums, such as EMT for instance.

11.9 GC stated that he had asked members of PEAC to identify key issues that they were concerned about. This process had proved to be both contemporary and helpful and was now included as a standing agenda item. He also noted that the Board to Board will produce challenges for assurance and that we need to get on top of this.

11.9.1 **ACTION**: DG to ensure that the BAF picks up the risks identified within the dashboard

11.9.2 **ACTION**: DG needs to make the BAF dynamic by ensuring that it is taken to other forums such as the Extended Management Team for discussion by clinicians.

12 TRUST DASHBOARD

This Item was taken earlier in the meeting.

13 EXECUTIVE TEAM FEEDBACK

13.1 CM gave feedback on the Pathology SHA tendering exercise on direct access to Pathology services which is the contractual arrangements for tests when patients visit GP.

We have formed a partnership with Bedfordshire, West Herts and Luton and Dunstable.

Work is on-going to create a clinical and financial appraisal for the best format of response to the tender which is due next week and he went through the options.

13.2 GC asked what position he was advising the Board to take on this. CM replied that all options would require that each hospital would retain hot and cold lab, and this is a core function within each hospital and he suggested we stayed within the bidding process.

13.3 There was discussion on the process and CM stated that this had improved and we were well placed as we have some peripheral benefits such as our proximity to M11.

13.4 ST asked about if we would now be able to give a presentation on our services as she believed that this had not been the case to date. DL responded that at a previous “Black Hat” meeting our consultants had delivered a comprehensive presentation on our services.

13.5 BK gave an update on the key areas of discussion within the ET with regards to winter planning. This had been to EMT and approved and is on track. The ‘flu vaccine campaign has now commenced. Regarding bed movement - we are

continuing to engage staff through narratives and we are engaging with external stakeholders.

With regards to the strategic side, MD is leading on the clinical strategy, which is on course. In addition, work on the performance framework has also been to ET and will become effective on the 1st January and will be brought to the Board before then. There had also been significant work on a clinically led organisation.

13.6 DL reported that he had been working with HR on a clinically led organisation re consultation process feedback and a paper for sign off by MW was being prepared for her return, particularly around changes arising from the consultation.

13.7 DL also gave an update on the CDC and stated that colleagues are aware that we are working in a partnership with South Essex Partnership Trust who are providers for local health community services having won the tender on the 1st April this year. Prior to submission to the PCT, their Board have decided to withdraw from this partnership which has left us in the situation where we have decided to withdraw from the process but will work collaboratively with the successful bidder when this is decided.

13.8 MD gave feedback on the clinical strategy stating this was a seven stage process and once we have the new clinical leadership in place he will ensure that the clinical leadership from Medical Director down are engaged to assure the process.

It is fairly well advanced for when the new leaders are appointed for discussion with them and in discussions with MW prior to her holiday they had agreed that the deadline for this process was the end of January.

There are to be joint workshops between the Board and the newly appointed clinical leadership team. The Board members will be informed of the event date and venue where we will seek to identify the strategic priorities, which will inform the IBP and LTFM. It was agreed that MD would meet outside of the meeting with NEDs to discuss this and requested that DG ensure that the joint meetings are in diaries.

13.9 With regards to the Performance Management Framework GC reported that he is meeting with BK to discuss how this is put together.

13.10 CF asked how we are to be informed about the winter plan. DL stated that he would bring it to the Board meeting.

13.11 MDV asked about the clinical strategy and was there anything that MD could provide to the NEDs on this; MD replied that he would provide information to the NEDs and would bring it to the Board once the clinical leadership had been appointed.

13.12 ST commented that there had been no mention of the IBP and was concerned that that there was to be no further action until the after the workshop. She continued that as a Board we are supposed to be looking at the next 2 years and we had been told that this would be looked at in October, but we still have no IBP

and we are nearly at the end of the year, so how do we know where we are going and the timing of this was causing her concern.

13.13 CM responded by stating that we know the challenges that await us and the clinical strategy will not change that and it doesn't prevent us planning. SS will start to set out ingredients of next year's plan.

13.14 Discussion continued and MD stated that what is missing is a clear picture of what the big strategic programmes are. This will be used to drive the discussion within the organisation and writing the IBP after all the this work is relatively straight forward. GC stated that the timeframe is likely to be 12-18 months, so while behind we will catch up to meet the FT timeframe. However how we manage our business is the more pressing issue.

ST stated that this now made her feel more comfortable with that timeframe but need to ensure that the IBP is developed and can answer their questions.

MD stated that he would welcome the opportunity to talk offline with NEDs regarding this.

13.15 GC asked about the communication processes to staff re transformation and how effective are they and do we know how staff are receiving these? CF asked what was the version of these events held by staff?

MD reported that RH and he were discussing how the message was getting through. They are going to test it by sending out a questionnaire to get feedback but one concern is that too many messages are going out according to feedback. The CEO briefing next week will be about how to get a message across to middle management to ensure they engage with their staff.

13.16 GC asked that the executive keep the Board updated on how the communication process to staff is going.

13.16.1 **ACTION**: DL to bring winter plan to the next Board meeting in November for information and noting.

13.16.2 **ACTION**: Executives to bring back an update on the processes in place to keep staff informed about the Transformation plan

13.16.3 **ACTION:** DG to discuss with MD the date for the joint workshop and to inform all members of the Board.

14 FINANCE REPORT

14.1 Following on after previous discussions on Dashboard and the BPAC update, CM reported that he would keep the Finance Report brief as most of the report had already been discussed.

14.2 At month 6 the Trust showed just over £1m from under performing and we have put in place specific measures to deal with this; DL is looking at medical spend, locum and agency, YB nursing and CM at non-recurring expenditure.

14.3 The income is full of components which have the ability to vary and we are expecting to do better in the 2nd half of year as significant developments are introduced, one of which relates to the national tariff and outpatient procedures.

14.4 With regards to CIP - we have identified a small number of areas where we are predicting a shortfall and we have already mentioned some of the actions we have put in place such as looking at the areas that we rent and cash loan.

15 CHAIRS REPORT

15.1 The report was noted

16 RECORD OF ATTENDANCE

16.1 The Board noted the attendance log.

17 INPUT FROM THE PUBLIC AT CHAIRS DISCRETION

17.1 Following an invitation for questions from members of the public; CJ asked how much was the figure spent on PFI as it shows signed off in the accounts.

CM responded that he was sorry that he not already responded to CJ on this and stated that the Trust did not have any PFIs and following a subsequent question from CJ responded and this was a standard phrase with the accounts as described by the DOH but that he would check to see if we can remove it in future years so as to not be ambiguous

17.2 CJ asked if the Trust is made aware of new housing projects in the town.

DL responded that we were notified by Essex and Herts of any planning applications that are received in our patch. There had been two in the last four months and we are asked to provide input and comment. We offer opinion and flag it with our commissioners and the council liaise with them too.

17.3 CJ stated that he is under three different hospitals for the same treatment and asked how the funding was arranged i.e. who was the main provider. CM responded that it depends on the service i.e. for renal care we act as landlords for the facility for Broomfield hospital. So would be recorded in Broomfield and pay us a facility charge. Other services there are networks and we pay other hospitals. For instance urology at Chase Farm where we pay them.

18 DATE OF NEXT MEETING

1.30 pm
Thursday, 24th November 2011
Board Room
Trust Headquarters, PAHT

19 ANY OTHER BUSINESS

19.1 DG reported that we had completed the end of October upload of evidence to support our Information Governance self-assessment. Last year we achieved 78% and so far we have a score of 51%. This time however we must be able to prove we are at level 2 for all standards. We have plans to be compliant by the end of the year and the key areas of concern are:

- Staff training - DG now doing twice weekly training.
- Corporate record management - we are in discussion with other leads in SHA for advice.
- Auditing and monitoring - seeking advice from IG forum
- Information asset register - seeking advice from IG forum
- IT systems being picked up by Mr. Anthony Lundrigan, Head of IT.

19.2 The Tripartite formal agreement had been previously circulated and hard copies were available. This was noted by the Board.

19.3 CM reported on an unannounced CQC visit on Monday. This was undertaken on Saunders Ward and focused on Nutrition, Privacy and Cleaning. The team from the CQC carried out interviews with the nursing staff, patients and visitors and reported back very positively.

GC asked that we formally record the Boards thanks to all for handling this so professionally and it is a real test of the system when hospital is full and ready.

It was agreed that once the report is received this should be circulated to NEDs.

CLOSURE OF PART A

To resolve the representatives of the media and other members of the public be excluded from the rest of the meeting, having regard to the confidential nature of the business to be transacted prejudicial to the public interest: Section 1 (2) Public Bodies (Admissions to Meetings Act) 1960.

Item 4.1

SUMMARY REPORT	The Princess Alexandra Hospital NHS NHS Trust
Trust Board Meeting (Part A)	22nd December 2011
Subject:	Minutes of the meeting held on 24th November 2011
Prepared by;	Mr. Derek Greening, Trust Secretary
Approved by:	Ms. Melanie Walker, Chief Executive Officer
Presented by:	Mr. David Barron, Chair

Purpose

To confirm and sign the minutes of the meeting held on 24th November 2011

Decision	
Approval	●
Noting	●
Information	
Other	

Corporate Objectives

Safety / outcomes	Financial	Workforce	Estates-Environmental	Regulatory / Statutory	Relationships / Partnerships
●	●	●	●	●	●

Executive Summary

N/A

Key Recommendations

To note and approve

Assurance Framework

This complies with requirements for an Assurance Framework within the Statement of Internal Control.

Next Steps

N/A

Corporate Impact Assessment	
CQC Regulations	10
Financial Implications	●
Legal implications	●
Equality & Diversity	●

The Princess Alexandra Hospital NHS
NHS Trust

Trust Board Meeting (Part A)
Minutes of the Public Trust Board Meeting

Held on: Thursday 24th November 2011 at 1:30 pm. at
The Princess Alexandra Hospital, Harlow.

Present:

Mr. Gerald Coteman	Chair	(GC)
Ms. Melanie Walker	CEO	(MW)
Ms. Janet Dalrymple	Non-Executive Director	(JD)
Mr. Mark Devonshire	Non-Executive Director	(MDV)
Dr. Claire Feehily	Non-Executive Director	(CF)
Mrs Paula Kerr	Non-Executive Director	(PK)
Mr. Richard Stead	Non-Executive Director	(RS)
Mrs. Yvonne Blucher	Executive Director of Nursing & Quality	(YB)
Dr. Sandra Dimmock	Medical Director	(SD)
Mr. Darren Leech	Chief Operating Officer	(DL)
Mr. Charles McNair	Director of Finance & Information	(CM)

In Attendance:

Mr. Marc Davis	Director of Integrated Patient Care	(MD)
Mrs Penny Griffiths	Minute Secretary	(PG)
Dr. Sylvia Thompson	Associate Member	(ST)

Members of Staff in attendance:

Mrs. Wendy Matthews	Associate Director, Women's and Children's Health	(WM)
Mrs. Liz Fox	Designated Nurse Safeguarding Children and Families, NHS West Essex	(LF)
Mr. Philip Harris	Risk, Safety & Compliance Manager	(PH)
Dr. Jolanta McKenzie	Consultant Histopathologist	(JMcK)
Mrs. Andrea Philip	Maternity Manager	(AP)
Miss Janaki Putran	Consultant Obs & Gynae	(JP)

Members of the Public in attendance:

Mr. Charles Jackson	(CJ)
Mr. Martin	(Mr.M)

(Please note that all numbering is to be prefixed with the Board reference TB/24/11/11)

1 WELCOME AND PROCEDURAL INFORMATION:

1.1 The Chair welcomed the members of the staff and public to the meeting. The procedure in the event of a fire alarm was advised.

2 APOLOGIES FOR ABSENCE:

These were received from:

Mr. Derek Greening	Trust Secretary	(DG)
Mr. Mark Gammage	Interim Director of Workforce	(MG)

3 DECLARATION OF INTERESTS

No declarations or alterations were noted.

4 MINUTES OF THE MEETING HELD ON THE 27th OCTOBER 2011

There was significant discussion on the minutes as to their accuracy and their verbatim feel and that they were not of the appropriate standard. The Chair and Chief Executive apologised for this position.

4.1 Actions:

4.1.1 Chief Executive and Trust Board Secretary to discuss the issues raised and to bring back amendments to the Board in the most appropriate manner.

5 MATTERS ARISING FROM THE MINUTES

These were undertaken within item 6.

6 ACTION POINTS (LOG)

The actions presented within the log were discussed and updated in order. It was agreed that the actions needed to be documented in a more concise and precise manner.

6.1 The Board Noted:

Progress against the actions and those that had been completed.

6.2 Action:

6.2.1 Chair and Trust Board Secretary to review the Structure and Content..

7A PATIENT EXPERIENCE REPORT

7.1 AP gave a presentation which included a background summary of the Early Pregnancy Unit (EPU) and common themes within complaints received regarding the EPU. The presentation outlined action plans and lessons learned.

7.2 The key areas noted were:

7.2.1 In response to a question from GC, on gathering patient experience comments, AP reported that the unit had followed GMC guidelines to undertake a survey, and feedback from patients was generally positive as evidenced by thanks received.

7.2.2 The Board noted the low number of complaints that had been received over a three year period.

7.3 The Board agreed;

To thank the members of EPU for their achievements..

7B SAFEGUARDING

7.5 LF presented an overview of the Safeguarding Children's Clinical Network (SCCN) within Essex, and outlined its purposes and objectives.

7.6 GC asked what was the expectation of PAHT; LF replied that it was a two way process as far as SCCN are concerned with them offering support to provider organisations in their duties and for them the importance of knowing that there are people working within PAHT who support the work that the SCCN and the GP Consortia are undertaking through their frontline work, therefore, the importance of working together. LF commented about the very positive working relationship with PAHT and the high standard of safeguarding work from the Trust.

7.7 In relation to a question, from CF, on the Care Quality Commissioning (CQC) and the framework; LF replied that the Office for Standards in Education, Children's Services and Skills (OFSTED) had returned in July following their previous visit and were pleased with the action plan that had been put in place. It is expected that the CQC will return before the end of the year to review their action plan.

7.8 In response to query from MD with regards to length of time to recruit too the Designated Doctor role LF replied that there were various issues including the part-time nature of the position and reluctance nationally of paediatricians to

undertake the role. LF reported that she is more hopeful of resolution now the SCCN has been set up.

7.9 JD asked if there was a plan for vulnerable adults to be part of SCCN; LF advised that this may be considered in the long-term as SCCN recognises adult vulnerabilities as adults are often parents but the financial arrangements for the non-statutory roles would need to be considered.

7.10 The Board;

Noted the presentation and thanked LF for presenting it.

7.11 Actions:

None were noted

8 PATIENT EXPERIENCE ASSURANCE COMMITTEE (PEAC)

8.1 MDV spoke to the summary report from the PEAC held on 17th November and advised that the format of this newly formed Committee was an improvement and provided assurance that the Executive had monitoring and controls in place to ensure appropriate responses and actions would be applied to situations as they arose.

CF requested that an update on the 4 serious incidents be delivered at the next Trust board meeting.

8.2 The Board:

Noted the report from the Chair of the Patient Experience Assurance Committee.

8.3 Actions:

8.3.1 Director of Nursing & Quality to update Board on 4 Serious Incidents at the December meeting.

9 TRUST DASHBOARD

9.1 CM talked to the Dashboard and gave an overview of the main areas with the document.

9.2 Reference was made to page 39 which indicated that the A&E department had achieved the new standards despite surges in activity, which had also been noted in other parts of the East of England area. There was detailed discussion on whether the Trust would be able to meet the new A&E Standard of 95%

9.3 Meetings with the Business Unit team were being held to put together a recovery plan for achieving targets.

9.4 CF requested details on how we are assessed at the end of year on targets. MW replied that the National 95% target had applied from 1st April and reporting on the new clinical standards from July. However, following a meeting with the SHA this morning they have advised that the clinical standards are not going to be used but that the 4 hour wait will be the target that we will be judged on and this will also be a core target for the Foundation Trust application.

9.5 RS expressed concern that it may appear from an outside perspective that the red metrics are not being addressed, although they have been discussed and actioned at other Committees.

9.6 MW suggested a further sheet to be included within the Dashboard to cross-reference the red metrics with which forums they had already been discussed with.

9.7 The Board:

Noted the contents of the Dashboard

9.7 Actions:

9.7.1 Director of Finance & Information: the first page of the Dashboard to be RAG (red, amber, green) rated by Next Board

9.7.2 Director of Finance & Information: Page 43 "Internal Referral activity" should be shown as a red metric and not green.

10 BUSINESS PERFORMANCE ASSURANCE COMMITTEE

10.1 RS gave a summary of the report and recommendations from the Committee meeting on the 22nd November.

10.2 RS noted that the Committee were assured regarding the Capacity Improvement Programme (CIP).

GC advised that Monitor will require evidence of good CIP performance and congratulated all involved for the huge improvement.

10.3 The Board:

Noted the report from the Chair of the Business Performance Assurance Committee.

10.4 Actions:

None were Noted

11 SIGN OFF EAST OF ENGLAND SELF CERTIFICATION RETURN

11.1 MW reviewed the report with the Board and apologised for the one outstanding area regarding Midwife ratio and advised that would be reviewed and checked before sign off.

11.2 The Board:

were content with the new format and approved the document to be signed off and returned, subject to the change discussed.

11.3 Actions:

11.3.1 Chief Executive to arrange for the Midwife ratio to be altered and to then arrange for it to be returned to the SHA.

12 EXECUTIVE TEAM FEEDBACK

MW advised the Board on the following;

12.1 A Performance Management Review (PMR) monthly meeting had taken place that morning with the SHA. Discussions had taken place relating to

- emergency care as a whole
- the rising number of and difference in plan to admissions and how that links with finances and CIP

CF expressed concerns around the CIP programme for years two and three; MW assured the Board that this had been discussed and a draft plan is being developed and will be brought to the Trust Board meeting in January.

12.2 In response to a query from members at the last Board meeting the Chief Executive gave an update on communications with staff identifying the following actions that had been undertaken:

- Weekly global emails (Melanie's message)
- Regular updates - front page of intranet
- Specific page on the intranet
- Weekly update in staff bulletin
- Good news stories on project improvements (LOS, Ambulatory Care, Departmental moves)
- Regular monthly staff meetings specifically centred around plans for change (managers only meetings, consultant only meetings and open briefings)
- Press release around project improvements (Ambulatory Care)
- Building for Excellence Newsletter (last issued in Sept)
- Screensavers
- Building for excellence notice board displays

- Regularly updated toolkit for managers to help them communicate Building for Excellence issues to their teams
- Intranet has a full library of material, including consultation documents and FAQs
- Visual displays around the hospital, featuring performance updates and good news coverage, amongst other things
- There have been two issues of the Building for Excellence newsletter (with a third scheduled for January) – but they are mainly for external stakeholders

In order to establish if these actions are ensuring that the information is reaching the intended groups of staff; a survey using "SurveyMonkey" has been carried out.

12.3 Consultation documents have been produced for each department which allows staff to comment on the proposals.

One example was that the Medical Secretary Consultation process had resulted in information being received from consultants and secretary's and changes to the draft proposal being made. Interviews for medical secretaries begun yesterday and staff have been informed that some restructures have been delayed but all will be completed by Christmas.

12.4 With regards to appointments;

- Dr. Jolanta McKenzie has been appointed as Medical Director and will take over the role from Dr. Sandra Dimmock on 3rd January.
- Associate Medical Directors (AMD) and Clinical Directors (CD) have also been appointed. These are as follows::

  - AMD Clinical standards: Dr. Jeff Phillips
  - AMD Medical Revalidation and workforce Dr. Radha Rajendram
  - CD Surgery and critical care – Dr. Marcelle Michail
  - CD Medicine – Dr. Yvonne Barlow
  - CD Urgent care – Dr. Peter Bishop
  - CD Women and children – Dr. Sabri Zeidan
  - CD cancer and diagnostics – Dr. Sridhar Redla

- Assessment of senior nurses and heads of operation are taking place and decisions being discussed and reviewed with CDs.
- Assessments for the next level of staff are about to commence and that will complete all staff at Band 8a and above to appoint to new management structure and to support the creation of individual and organisational development plans.
- Clinical Service Group Leaders (CSGL) interviews will take place over the next few weeks and should be completed by Christmas.

12.5 DL has been successful in achieving the Chief Operating Office (COO) role at Milton Keynes Hospital and he and YB are working together to ensure a smooth handover. Mr. John Scott has been appointed as Interim COO an advert for the substantive role will appear in the online HSJ publication.

12.6 The Board:

Noted the report from the Chief Executive and confirmed her thanks to DL for all his hard work and wished him the very best for his future.

12.7 Actions:

12.7.1 Trust Board Secretary to add the Draft CIP plan to the agenda for the January Board.

13 FINANCE REPORT

13.1 CM talked to the Finance Report

13.2 CF drew attention to the emergency pathway and what effect that might have between now and the end of the financial year. CM advised that the impact of increased activity together with bed closures is being closely monitored and worked through.

13.3 CF referred to page 5 of the report which outlined the loan of £3 million and expressed concerns around the cost of the loan, given the cash held figure at the end of October was £5 million. CM replied that the Capital programme had now been staggered and there may now be the resources to cover the expense. However if we do not recover our position as forecast, it was considered prudent to have the funds available. The cost of the loan is relatively small.

13.4 The Board:

Noted the report from the Director of Finance & Information and approved the application to the Department of Health for a £3m loan.

14 BOARD ASSURANCE FRAMEWORK

14.1 GC welcomed PH to the meeting and invited him to present a broad outline of the Board Assurance Framework (BAF)

14.2 PH advised that the report had been prepared with DG and was a work still in progress and that there have been significant changes since the last meeting both to its format to and to the process for updating it.

14.3 It was noted that the BAF had been moved to this part of the agenda to allow for a full review and discussion of the document to take place.

14.4 CF asked if assurance could be given that we have a process that alerts the Board to contemporaneous issues. GC suggested that an integrated risk management review should be undertaken to pull all the risk management tools together and that this should be reviewed by the Audit and Risk Assurance Committee at its next meeting.

MW stated that this could be carried out together with a review of governance for the FT process. PH advised that he would discuss with the ET at the next monthly meeting what would be required to take this forward.

14.5 It was also agreed that a detailed risk assessment is to be carried out as part of the budget setting for 2012/13 and brought to the BPAC for review at the end of February.

14.6 The Board:

Noted the contents of the BAF.

14.7 Actions:

14.7.1 Executive Team A risk management review together with a review of governance for the FT process to be arranged.

14.7.2 Director of Finance & Information to undertake a full risk assessment for 2012/13 budget to be taken to the BPAC meeting on the 21st February.

15 WINTER PLANNING PLAN (SURGE PLANNING)

15.1 GC noted that this item should have been included within the Quality, Governance and Risk section of the agenda.

15.2 The Board:

Noted the plan and endorsed it.

15.3 Actions:

None were Noted

16 CHAIRS REPORT

16.1 The report was noted.

17 RECORD OF ATTENDANCE

17.1 The Board noted the attendance log.

18 INPUTS FROM THE PUBLIC AT CHAIRS DISCRETION

18.1 CJ referred to a recent article in the local newspaper which referred to the closure of 60 hospital beds. CJ expressed his concern that this proposal would compromise an effective service. CJ also drew attention to the patient re-admission rate.

To offer reassurance MW provided a brief overview of the reduction in beds. A number of the 60 beds referred to in the newspaper article were from last year. Some wards are also being reorganised so that patient groups are not scattered around the hospital, which will improve ward round times and provide a better service for patients.

MW thanked CJ for his concern and referred to their forthcoming meeting when she would be very pleased to go through the detail with him.

18.2 Referring to the re-admission rate, MW assured CJ that the hospital is vigilant and ensures very careful planning when discharging patients. MW acknowledged that there are limited facilities in the Community in this part of Essex and discussions with the local PCTs are ongoing around this problem. MW cited as an example the current challenge of having the equivalent of a whole ward of patients (circa 28) who should have gone home but we are unable to discharge them for reasons out of our control.

19 DATE OF NEXT MEETING

1.30 pm
Thursday, 22nd December 2011
Board Room
Trust Headquarters, PAHT

20 ANY OTHER BUSINESS

CLOSURE OF PART A

To resolve the representatives of the media and other members of the public be excluded from the rest of the meeting, having regard to the confidential nature of the business to be transacted prejudicial to the public interest: Section 1 (2) Public Bodies (Admissions to Meetings Act) 1960.

Item 6

SUMMARY REPORT	The Princess Alexandra Hospital NHS Trust
Trust Board Meeting (Part A)	22nd December 2011
Subject:	Action Points (Log)
Prepared by;	Mr. Derek Greening, Trust Secretary
Approved by:	Ms. Melanie Walker, CEO
Presented by:	Mr. David Barron, Chair

Purpose		
To review progress against previous actions	Decision	
	Approval	●
	Noting	●
	Information	
	Other	

Corporate Objectives					
Safety / outcomes	Financial	Workforce	Estates-Environmental	Regulatory / Statutory	Relationships / Partnerships
●	●	●	●	●	●

Executive Summary

N/A

Key Recommendations

To review current progress made against actions from previous Board meetings.

Assurance Framework

This is a requirement under Best Practice from the National Learning Centre's paper on *"Healthy Boards"*

Next Steps

N/A

Corporate Impact Assessment	
CQC Regulations	10
Financial Implications	●
Legal implications	●
Equality & Diversity	●

The Princess Alexandra Hospital NHS
NHS Trust

Action List from the meeting of the Trust Board
November 24th 2011
Part A

Overdue: agreed completion date passed, or predicted completion is outside of agreed date, or if no date agreed.
Due: completion date will fall before next meeting
On Target: Completion date will be met and work is on-going but not due before next meeting

Meeting Date	Minutes Item Reference	Agenda Item & Relevant Brief Description	Action Point	Owner	Due Date (if Applicable	Status	Comments/Updates
Nov 11	8.3.1	PEAC update	• DON & Q to update the Board on the RCA reports following the December PEAC.	YB	22/12/11	Due 22/12/11	On agenda for PEAC on 16/12/2011
Nov 11	9.7.1	Dashboard review	• The first page of the Dashboard to be RAG rated by the next meeting.	CMN	22/12/11	Due 22/12/11	
Nov 11	9.7.2	Dashboard review	• Page 43 “Internal Referral activity” should be shown as red metric and not green.	CMN	22/12/11	Due 22/12/11	
Nov 11	11.3.1	SHA return	• CEO to ensure that the Midwife ration comment is altered and to then arrange for this to be sent to the SHA.	MW	30/11/11	Completed	
Nov 11	12.7.1	CIP draft plan	• To add the draft CIP plan to the agenda for the January Board	DG	13/12/12	On Target	
Nov 11	14.7.1	Board Assurance Framework	• A risk management review together with a review of governance in relation to the FT process.	Executive Team		?	ET to identify a date for this to go into agenda setting.
Nov 11	14.7.2	BAF	• To undertake a full risk	CMN	21/02/12	On Target	

			assessment for 2012/13 budget to be taken to the next BPAC on the 21st February 2012.				
Oct11	11.4	Relationship between the BAF and the Dashboard was discussed.	• BAF to make sure that it picks up the risks identified within the dashboard	DG	November	Completed	Needs a few more months of compliance.
Oct 11	12.9	Trust Dashboard with regards to the alteration in the sickness rates we need to identify why this has occurred	• To be discussed with human Resources.	DG/SM	November	Overdue	The Board had requested that this was split between short and long term sickness on the dashboard and this had not yet been completed
Oct 11	12.11	Additional HR indicators, PRDP, appraisals, Statutory & Mandatory training to be included.	• Discussions to be started on the best way to gather and display this information with feedback in November and first information in December.	DG/SM/CMN	November/ December	Overdue	Target now changed to January Board.
Sept 11	5.3	Action Log discussions	• Develop a new action log format for the next Board and that this is rolled out to all committees of the Board, with a proviso on the timeline for circulation.	DG	Oct 11	Completed	Re 6.2.1 from November chair and TSB to review the structure and content. Now changed to CEO and TBS.
Aug 11	13	Sign off SHA Self Certification Return	• Dashboard to be included earlier within the Trust Board Agenda ahead of SHA return • Explanation required around why some metrics are continuing 'Reds' • YB to meet with JD to discuss Quality data • Discussion to continue within Part B of this meeting as to	CM/YB	Oct 11	Completed	The E0E self certification will be moved to the Finance and Performance section after the Dashboard.

			reasons for lack of data and to agree an action plan				
July 11	10.4.1	Following on from the paper which set up the new committee structure the chair asked that reporting processes from the committees and also the Dashboard should be formally reviewed in 3 months time.	• The new Board Dashboard and performance/risk reporting via the merged committees to be reviewed in three months (October 2011)	GC	Oct 11	Overdue	Update on the progress against the new structure and its reporting processes on the December agenda..

BPAC Actions on Behalf of the Board

Meeting Date	`Agenda Item Reference	Agenda Item & Relevant Brief Description	Action Point	Owner	Due Date (if Applicable	Status	Comments/Updates
Nov - 11	2.2	Minutes of the previous meeting held on 25th October 2011	It was agreed that a comment be included within the dashboard to explain why a green RAG rating might not be good for the Trust.	CM	20/12/11	On Target	
Nov - 11	2.4	Minutes of the previous meeting held on 25th October 2011	YB to request that Social Services raise any concerns with the Trust direct so that these concerns can be acted upon.	YB		On Target	
Nov - 11	3.3	Action Points (Log)	The Committee agreed that the next Board Development session would be held before the December Business & Performance Assurance Committee to discuss targets.	DG	20/12/11	Complete	
Nov - 11	3.5	Action Points (Log)	MG to be invited to the December Business & Performance Assurance Committee to report back on the PRDP target.	CM	24/01/12	On Target	This is now scheduled for the January BPAC.
Nov - 11	3.8	Action Points (Log)	CM/Chief Operating Officer to report back on progress at the January	CM/COO	24/01/12	On Target	

			Business & Performance & Assurance Committee in setting standardised ratios by specialty to inform performance management processes and to aid negotiations with PCTs on 2012/13 commissioning plans.				
Nov - 11	4.1	Trust Dashboard: Month 7	CM to check that the stroke RAG rating target is correct within Clinical Quality as this is still red.	CM		On Target	
Nov - 11	4.4	Trust Dashboard: Month 7	Audit to be carried out in relation to readmissions to determine the levels of readmission within the direct control of PAH and those associated to health system failure. CM/Chief Operating Officer to report back to the January Business & Performance Assurance Committee.	CM/COO	24/01/12	On Target	
Nov - 11	4.5	Trust Dashboard: Month 7	CM to provide the January Business & Performance Assurance Committee with an update on negotiations with the PCT to give the Committee assurance of income forecasts.	CM	24/01/12	On Target	
Nov - 11	4.8	Trust Dashboard: Month 7	Trust Dashboard to be amended as the main theatres monthly position for October is 84% and therefore should be a red RAG rating.	CM	20/12/11	On Target	
Nov - 11	4.10	Trust Dashboard: Month 7	BK to report back to the Business & Performance Assurance Committee on the definition of long term sickness. Definition to be included in the appendix to the Dashboard on new targets.	BK	20/12/11	On Target	
Nov - 11	5.6	Financial Report: Month 7	CM to report back to the December Business & Performance Assurance Committee of negotiations with the PCTs to closure to provide assurance of income forecasts.	CM	20/12/11	On Target	

Nov - 11	8.5	East of England Self Certification	It was agreed that the definitions of Never Events and SIs be added to the appendix of definitions to the Trust Dashboard.	CM	20/12/11	On Target	
Nov - 11	9.2	Board Assurance Framework	CM and RS to update the financial risk definition in light of the current position for the December BPAC.	CM/RS	20/12/11	On Target	
Nov - 11	10.3	Terms of Reference	It was agreed to add to the Terms of Reference that the Director of Workforce will be invited to attend the Business & Performance Assurance Committee on a quarterly basis.	DG	24/01/12	On Target	
Nov - 11	10.4	Terms of Reference	Amendments to job roles were noted in relation to the new management structure and it was therefore agreed to submit the Terms of Reference to the January Business & Performance Assurance Committee once the restructuring of the Trust is complete.	DG	24/01/12	On Target	
Oct - 11	3.6 & 3.7	Action Points (Log)	GC agreed to discuss dates for future Board Development Sessions with DG and to clarify when the next session will be held. Members requested that a Board Development Session be set up within the next month to discuss the new targets.		20/12/11	Complete	It was agreed that the next Board Development session will be held before the December Business & Performance Assurance Committee to discuss targets.
Sept - 11	3.20		CM to liaise with Mark Gammage to request that the PRDP target be looked at to be increased. CM has spoken to MG and further work is being carried out	CM		On Target	Noted that the Trust needs to look into why it is failing to meet the level previously achieved. A new target to be built into the performance framework for the new structure and this piece of work is being carried out at the moment.

Completed Actions

Meeting Date	`Agenda Item Reference	Agenda Item & Relevant Brief Description	Action Point	Owner	Due Date (if Applicable	Status	Comments/Updates
Oct 11	9.2	Business Performance Assurance Committee, it was agreed that it would be more useful if this item was taken after the Dashboard on future agendas	• DG to alter the next agenda to place this update after the Dashboard.	DG	November	Completed	The agenda for November has been altered accordingly
Oct 11	11.10	Need to make the BAF dynamic by ensuring that it is taken to other forums such as the Extended Management Team for discussion by clinicians.	• To take the BAF to the Extended Management Team to discuss clinical risks.	DG	November	Completed	Taken to several EMT and risks associated with maintaining CQC standards raised with the meeting.
Oct 11	13.10	Executive Team Feedback, the winter plan and its presentation to the Board was discussed	• Winter Plan to be brought to next meeting.	DL	November	Completed	On agenda
Oct 11	13.17	Discussion on the communication process for explaining the transformation process to staff.	• Executives to bring back an update on the processes in place to keep staff informed about the Transformation plan.	Executive Team	November	Completed	Verbal update to Board
Sept 11	12.10.1	Trust Dashboard – following discussions around this it was agreed that it would be	• Discuss safeguarding issues	YB/JD	Oct 11	Completed	

		better if JD & YB discussed safeguarding outside the meeting.					
Sept 11	11.8.1	Sign off self certification return – some NEDs asked if a summary could be produced that they would keep identifying the key standards, the target if any and what impact failing to meet it or if we exceed it would have on the Trust.	• A summary of standards to be produced	DG	Oct 11	Completed	
Sept 11	7.9.1	Patient Experience Report – To be clear on how we ensure that actions from SI's, complaints etc are identified, logged and exceptions reported on.	• Discuss how action lists from complaints etc. are monitored	JD/DG		In progress	YB has had a meeting with the Chair to discuss reporting processes and YB has discussed this with the MD and commenced actions relating to this discussion.
Aug 11	18	Following on from Input from a member of the public with regards to financial question arising from each meeting and specific questions on the WIC & UCC	• CJ to meet with CMcN (as per action from the previous TB meeting of 30.6.2011 number 21.6) and subsequently to then meet with either YB or DL for clarification around the changes relating to the Walk-in Centre and Urgent Care Centre	CMcN/YB/DL	Oct 11	Due	
Aug 11	18.15.6	A member of the public requested a portable loop to be installed for the hard of hearing.	• Update on progress regarding portable Loop Listener equipment to be available at meetings.	GC/RH		In Progress	We have identified the portable hearing loop and are planning how to set it up ahead of the next meeting. for this action

Completed BPAC Actions

Meeting Date	Agenda Item Reference	Agenda Item & Relevant Brief Description	Action Point	Owner	Due Date (if Applicable	Status	Comments/Updates
Oct - 11	2.17	Minutes of the previous meeting	CM to provide a paragraph to incorporate 6.8 and 6.11	CM	Nov 11	Complete	(see 2.15 of the minutes).
Oct - 11	2.20	Minutes of the previous meeting	It was agreed that RS and CM would meet on a regular basis to approve the minutes of each Business & Performance Assurance Committee prior to distribution.	CM	Nov 11	Complete	New procedure has been agreed with a summary of the minutes captured and will be circulated 5 days after the meeting.
Oct - 11	3.2	Action Points (Log)	CM agreed to circulate a note to members in relation to 3.5	CM	Nov 11	Complete	(* see note under 3.3 of the minutes).
Oct - 11	4.4	Trust Dashboard: Month 6	It was agreed that the emergency length of stay target should be an amber rating as it is work in progress.	CM	Nov 11	Complete	
Oct - 11	4.11	Trust Dashboard: Month 6	CM to insert a paragraph to explain why a green target may not be good for the Trust in relation to the Trust's finances.	CM	Nov 11	Complete	
Oct - 11	4.13	Trust Dashboard: Month 6	DL to take a view of the Trust's position and to evidence that mitigating actions are in place. DL to also advise when the Trust will return to a green rating.	DL	Nov 11	Complete	Presentation made at the November BPAC by DL.
Oct - 11	4.14	Trust Dashboard: Month 6	A suggestion was made to the Executive Team to translate activity figures into ratios (pounds) and patient numbers to explain the financial situation to clinicians.	CM		Complete	Presentation made at the November BPAC by DL.
Oct - 11	4.26	Trust Dashboard: Month 6	It was agreed to separate long term and short term sickness absence on the dashboard - CM.	CM	Nov 11	Complete	

Oct - 11	4.27	Trust Dashboard: Month 6	The Business & Performance Assurance Committee will review sickness/absence rates in the next quarter.	RS	Jan 12	Complete	
Oct - 11	7.7	Significant Risks Arising from the Recovery Plan	RS to agree a form of words for report to go in Part A.	RS	27/10/11	Complete	
Oct - 11	8.3	East of England Self Certification	It was agreed that given the number of pressure ulcers may change, a commentary be inserted explaining that these numbers have increased because these numbers have now been reported but need to be validated.		Nov 11	Complete	
Oct - 11	8.5	East of England Self Certification	Commentary to be updated with regards to the moderate CQC concerns stating that verbal confirmation was received by the CQC at a recent inspection at the Trust on Monday 24 October 2011.			Complete	Commentary has now been completed but it was reported that the Trust now has one minor concern.
Sept - 11	3.7	With regards to the A&E targets the members require additional training to fully understand the implications.	RS to liaise with DL to highlight the need that a training session to be set up for Board Members to understand the new targets. It was suggested that this may be organised after the August Business & Performance Committee.	RS	23/08/11	Complete	RS/DL still to arrange a Board development session to look at all of the access targets and what the Trust is required to achieve. GC agreed to discuss/agree dates for future Board Development Sessions. Members requested that one be set up within the next month to discuss the new targets.
Sept - 11	3.18	Discussion with regard to the moderate CQC concern over staffing outcome 13 and when can we remove this.	RS requested that an update on where we are in relation to Outcome 13 and the Trust resolves this.	MW		Complete	Still awaiting written confirmation from the CQC. YB received verbal communication that the

							Trust will receive this in the next 2 weeks. Confirmation has now been received.

Item 8

SUMMARY REPORT	The Princess Alexandra Hospital NHS Trust
Trust Board Meeting (Part A)	22nd December 2011
Subject:	Trust Dashboard
Prepared by;	Mr. Charles McNair, Executive Director of Finance
Approved by:	Ms. Melanie Walker, CEO
Presented by:	Mr. Charles McNair, Executive Director of Finance

Purpose

The purpose of this report is to provide detailed performance analysis on the current situation and to bring to attention to the Board any issues or risks.

Decision	
Approval	
Noting	●
Information	●
Other	

Corporate Objectives

Safety / outcomes	Financial	Workforce	Estates-Environmental	Regulatory / Statutory	Relationships / Partnerships
●	●	●	●	●	●

Executive Summary

The Trust Board Dashboard highlights any particular risks and issues in relation to organisational performance.

Key Recommendations

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

Assurance Framework

There is a legal requirement for all NHS organisations to receive regular reports in order to give the Board assurance that financial plans are being delivered and that statutory requirements will be met.

Next Steps

N/A

Corporate Impact Assessment	
CQC Regulations	2.02, 2.03
Financial Implications	●
Legal implications	●
Equality & Diversity	●

Trust Dashboard YTD at Month 08 2011/12

(ending 30th November 2011)

The Princess Alexandra Hospital NHS
NHS Trust

CONTEMPORARY CONCERNS

This months identified issues for Board focus, drawn from red rated items (year to date) on title dashboard (compliance framework and national standards)

Group	Area Of Concern
Clinical Quality	Adverse Events C Diff Never Events
Access & Targets	Diagnostic Waits < 6 weeks Emergency Readmissions
Finance	Actual I&E surplus/deficit (£000s) I&E variance from plan (£000s)
Patient Experience	Single Sex Accommodation

Total Number of Red RAGs by Month

APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR
-	-	-	11	10	8	8	8				

Total Number of Amber RAGs by Month

APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR
-	-	-	-	-	1	2	2				

Total Number of Green RAGs by Month

APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR
-	-	-	-	-	5	4	4				

Trust Dashboard YTD at Month 08 2011/12

(ending 30th November 2011)

The Princess Alexandra Hospital NHS
NHS Trust

Clinical Quality	YTD RAG
CQUIN	
Adverse Events	
CQC concerns	
Never Events	
HSMR *(Dr Foster)*	
MRSA	
C Diff	
Essence of Care	
Stroke	
Central Alert System (CAS) Alerts	
100% compliance WHO checklist	
Red rated areas on Maternity DB	

Activity	YTD RAG
A&E Attendances	
1st OP Attends	
Follow-Up OP Attendances	
OP Procedures	
Day Case Admissions	
In-patient Admissions	
Emergency Admission	
Maternity Deliveries	
Maternity C-Section rate	

Access & Targets	YTD RAG
18 week RTT	
A&E quality standards	
Cancer Wait indicators	
Emergency Readmissions	
Diagnostic Waits < 6 weeks	

Finance	YTD RAG
Risk rating	
I&E variance from plan	
Actual I&E surplus/deficit	
Performance v income plan	
Cost Improvement Plan	
Market Share	

Patient Experience	YTD RAG
Net Promoter Score	
Patient Engagement	
Complaints	
Hospital Cancellations	
Cleanliness	
Single Sex Accommodation	
PROMs score	

Trust Board Strategic Risks	YTD RAG
Financial Risk Rating	
Achievement of CQC standards	
Organisation, capability & leadership	
Meeting national standards and SLA	
Delivery of strategic plans	
Partnership working	

Efficiency (QIPP)	YTD RAG
Bed utilisation	
DNA Rate	
OP Follow ups not paid	
Internal referral activity	
Theatre utilisation	

Workforce	YTD RAG
Sickness Absence Rate	
Turnover Rate	
Vacancy Rate	
Agency/bank spend as % turnover	

Items in bold - Compliance Framework

Items in grey - Local standards

Detail

Trust Dashboard for Month 08 2011/12

(ending 30th November 2011)

The Princess Alexandra Hospital NHS Trust

Clinical Quality 1	Year to date					Monthly Position											
	Actual	Plan	10/11	Variance	RAG	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	FOT
CQUIN (Schemes with red rated elements)	3	0		3	A	6	6	6	4	4	3	3	**				A
VTE risk assessment	91.5%	90%		1.5%	G	90.3%	90.6%	90.8%	90.4%	92.5%	93.6%	92.2%	**				G
Grade 3/4 pressure ulcers - SIs only	37	0		37	R	8	12	6	7	3	0	1	**				R
Adverse Events																	
SIs	22	n/a	26	4	R	2	5	2	2	3	2	5	1				R
All currently open SIs	31	n/a	n/a		R	112	121	74	71	72	32	31	28				R
Falls - SIs only	2	n/a	0	-2	R	0	1	1	0	0	0	0	**				R
Medication errors SIs	3	n/a	0	-3	R	0	0	0	1	0	2	0	0				R
CQC concerns																	
CQC registration without conditions	Yes	Yes		n/a	G	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes				G
CQC Other Concerns	0	0		0	A	2	2	2	2	2	2	0	0				A
Central Alert System (CAS) Alerts	0	0		0	G	0	0	0	0	0	0	0	0				G
Never Events	3	0		-3	R	0	0	2	0	0	0	1	0				R

** Data not yet available in this month

Explanatory notes:

CQUIN. The dashboard shows performance against the total number with no red rated areas of performance. This section also identifies two particular, high profile, schemes (VTE and pressure ulcers) for particular attention

SIs. SIs are shown as both the number of incidents in the month (and over the period YTD) as well as the number of incidents open at the point the report is generated each month. Falls and medication errors are those classified as SIs only

Trust Dashboard for Month 08 2011/12

(ending 30th November 2011)

The Princess Alexandra Hospital NHS
NHS Trust

Commentary - Clinical Quality 1

Serious Incidents (SIs)

4 Serious Incidents occurred in November, of these:
• 2 were grade 3 or 4 pressure ulcers that developed or deteriorated while at PAH (1 validated = avoidable, 1 awaiting validation).
• 1 was a fall resulting in severe injury (fractured hip).
• 1 "other general" serious incidents occurred when the wrong patient underwent a chest X ray. This will be subject to a CEO Scrutiny Panel on 16th December.

28 Serious Incidents were open at the end of November .

CQC Compliance

The 2 Moderate and 1 Minor Concerns relating to Outcomes 13,14 and 7 previously recorded against the Trust were removed in October 2011.

The Review of Maternity Services resulted in 1 Minor Concern being added. This relates to Outcome 13 and staffing levels within Maternity, particularly the Midwife to birth ratio. A response was submitted to the CQC advising how the Trust intends to maintain compliance with this Essential Standard. The deadline for the response was met.

A further review of PAH compliance with Dignity & Nutrition following the original in June 2011 has resulted in the 2 minor concerns also being removed in October 2011.

Trust Dashboard for Month 08 2011/12

(ending 30th November 2011)

The Princess Alexandra Hospital NHS Trust

Clinical Quality 2	Year to date					Monthly Position											
	Actual	Plan	10/11	Variance	RAG	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	FOT
HSMR *(Dr Foster)*	101.7	n/a		n/a	A	97.5	108	89.6	91.6	104.8	116.5	**	**				A
HSMR (QIE)						106.0	106.0	106.0	**	**	**	**	**				
SHMI			99.3			**	**	**	**	**	**	**	**				
MRSA																	
MRSA infection > 48hrs	0	2		0	G	0	0	0	0	0	0	0	0				G
Elective MRSA screening	99.0%	100%		-1.0%	A	98.8%	98.9%	98.7%	99.7%	98.7%	99.0%	99.0%	99.4%				A
Emergency MRSA screening	91.5%	100%		-8.5%	R	87.9%	88.6%	86.9%	91.2%	95.8%	95.3%	94.8%	91.9%				A
C Diff infection > 72hrs	18	8		-10	R	4	3	2	2	0	0	5	2				R
Essence of Care Standards (quarterly audit)																	
Standards rated green/amber	80	84		-4	A	n/a	n/a	80	n/a	n/a	n/a	n/a	n/a				A
Stroke																	
% with 90% of stay on a Stroke Unit	69%	80%		-11%	R	83%	73%	70%	71%	83%	71%	78%	**				A
% admitted direct to SU within 4 Hrs	17%	95%		-78%	R	19%	15%	4%	29%	13%	29%	29%	**				R
% eligible scanned within 1 Hr	87%	60%		27%	G	100%	75%	77%	67%	100%	83%	100%	**				G
100% compliance with WHO surgical checklist	n/a	n/a	n/a	n/a	G	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes				G
Red rated areas on Maternity dashboard	n/a	n/a	n/a	n/a		3	3	3	3	3	2	1	2				A

** Data not yet available in this month

Explanatory notes:

Emergency MRSA. Swabbing includes patients transferred to Ambulatory Ward
Maternity dashboard. Based on the RCOG dashboard
HSMR. Because of the data source used by Dr. Foster for HSMR which is subject to refresh after the latest reporting month and the impact of deaths attributed to the Trust subsequently, the complete monthly series of HSMR scores may change to some degree in comparison with previous months reports. Year to data figure refers to the rolling 12 month total.
HSMR - QIE. Data prepared by Quality Intelligence East which describes the rolling 12 month figure based on the previous four quarters data. The most recent figure available is quarter 1, quarter 2 will be available January 2012.
SHMI - Summary Hospital Mortality Indicator. Will become the tool for use by all Trusts in reviewing mortality rates. It is calculated differently from HSMR and the only data available currently is for 2010-11, reported here.

Trust Dashboard for Month 08 2011/12

(ending 30th November 2011)

The Princess Alexandra Hospital NHS
NHS Trust

Commentary - Clinical Quality 2

HSMR

HSMR data was updated in early December, to include September data: 12 month rolling average 101.7 (deteriorated from 100.6 to end of August). Monthly HSMR for September was 116.5 (increased = deteriorated since August where 104.8)

One new Dr Foster Alert in August / September relating to Genitourinary symptoms and ill-defined conditions. 3 deaths under formal review.
HSMR was discussed at the last MRG and a number of higher level risk ratings appearing in the latest Dr Foster data were placed under “detailed review” by the appropriate Business Unit with an expectation for them to formally report back at the January MRG meeting.

MRSA

There has been one, pre 48 hour, case of MRSA bacteraemia in November. The RCA deemed the case as unavoidable though some lessons learnt will be taken forward. The trust continues to have an excellent performance re this.

C Diff

3 cases of Clostridium difficile, 2 of which were post 72 hours, during November, making a total of 18 post 72 hour cases since April 2011 (on trajectory for 2011-12 of 14). A scrutiny Panel will meet in January and monthly thereafter, to confirm whether the cases are infections or colonisation as only infections need to be reported. Hydrogen peroxide vapour deep cleaning of Henry Moore F bay was undertaken.

- 99.4% of Elective admissions were swabbed in November (NB: this figure is awaiting validation & therefore subject to change). This is up from 98.0% in October.
- 91.87% of Emergency admissions were swabbed in November NB: this figure is awaiting validation & therefore subject to change). This is down from 93.5% October.
- These are being monitored and managed within the Business Units.

Trust Dashboard for Month 08 2011/12

(ending 30th November 2011)

The Princess Alexandra Hospital NHS Trust

Patient Experience	Year to date					Monthly Position											
	Actual	Plan	10/11	Variance	RAG	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	FOT
Net Promoter Score	96.0%	95.0%		1.0%	G	95.3%	95.1%	96.3%	96.3%	95.7%	96.6%	96.1%	95.2%				
Patient Engagement	92.9%		n/a			93.8%	93.2%	93.9%	93.2%	91.9%	92.8%	91.9%	93.9%				
Complaints	436	n/a	385	-51	R	44	45	67	60	54	49	57	60				
Hospital Cancellations																	
Total cancelled by Hosp non clinical	8.7%	n/a	9.14%	0.4%	A	8.8%	11.3%	9%	9.2%	7.0%	8.2%	8.0%	8.4%				
Number cancelled two or more times	224	n/a	274	50	A	23	44	29	34	20	23	21	30				
Cancelled at last minute	0.85%	0.80%	1.00%	-0.05%	A	0.49%	1.10%	0.74%	1.17%	0.55%	0.52%	0.55%	1.49%				
Last minute not admitted < 28 days	5.71%	5.00%	3.77%	-0.71%	R	9.1%	3.6%	9.1%	3.0%	14.3%	0.0%	6.7%	**				
Cleanliness																	
Very high risk areas	95.53%	>95%		0.53%	G	94.8%	92.7%	95.44%	96.06%	95.47%	94.90%	96.97%	98.00%				
High risk areas	94.85%	>90%		4.85%	G	93.3%	90.2%	94.15%	94.52%	95.01%	95.61%	97.88%	97.94%				
Single Sex Accommodation	75	0		75	R	27	13	14	6	0	9	6	0				A
PROMs Score (participation rate)	72%	70.20%		1.8%		**	**	**	**	**	72%	**	**				

** Data not yet available in this month

Explanatory notes:

Patient experience. The Net Promoter score is based on answers patients gave to the question “Were you confident in the quality of care you received and would you recommend this hospital to family or friends?” The Patient engagement score is based on answers patients gave to the question “Were you given enough information to enable you to make choices about your care?”

Hospital cancellations. Defined as follows:

- Total cancelled by hospital – non clinical. This is the total number of admissions cancelled by the hospital for non-clinical reasons
- Number cancelled two or more times. This is defined as the total number of admissions cancelled by the hospital for non-clinical reasons for a second or subsequent time
- Cancelled at the last minute. These are admissions cancelled by the hospital for non-clinical reasons on the day of admission
- Last minute not admitted <28 days. Defined as the percentage of admissions cancelled at the last minute (as above), not readmitted within 28 days.

PROMS - This indicator shows the proportion of elective patients admitted for the four surg procedures included who have participated in the survey

Trust Dashboard for Month 08 2011/12

(ending 30th November 2011)

The Princess Alexandra Hospital NHS
NHS Trust

Commentary - Patient Experience

Patient Complaints

The number of complaints for November was 60 (compared to 57 in October).

As reported in previously, the number of complaints compared to this time last year is significantly higher: 50 more complaints in eight months in 2011-12 when compared to the same period in 2010-11.

Analysis of the themes raised in April to November 2011 compared to the same time period in 2010 shows that there has been a significant increase in complaints regarding communication a slight drop in 'clinical' complaints and continued concern regarding discharge, diagnosis and delays.

The most common areas for complaints in April to November 2010 are again the highest to date (both with significantly more complaints than last year)

Hospital Cancellations

31 patients were cancelled in November due to there being no bed. Inevitably, many of these cancellations occurred at the last minute, even though we try, where possible, to forecast bed pressures in advance. This, however, is not always possible. Going forward we will be proactively mapping patients' projected length of stay against the likely number of beds available and identifying shortfalls in advance.

Single Sex Accommodation

Mixed Sex Accommodation breaches were posted on Unify as 0 for November. Aggregate RCA undertaken 17th May 2011 & action plan has been implemented, including weekly escalation to executive & validation by heads of service. Screens to improve privacy & dignity within CCU have been delivered in early December, which should prevent future incidents within that environment. Commissioners visited the Trust during December to review the arrangements for minimising mixed sex accommodation breaches. Whilst we have yet to receive the final report, initial feedback was particularly positive, recognising the implemention of EMSA (Eliminated Mixed Sex Accommodation) action plans.

Trust Dashboard for Month 08 2011/12

(ending 30th November 2011)

The Princess Alexandra Hospital NHS
NHS Trust

Activity	Year to date					Monthly Position											
	Actual	Plan	10/11	Variance	RAG	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
A&E Attendances	55,338	53,453		1885	G	6,954	7,285	7,009	6,705	6,636	6,907	7,012	6,830				
1st OP Attends	45,672	50,468		-4796	R	4,802	5,483	6,598	5,852	5,622	5,599	5,671	6,045				
Follow-Up OP Attend	89,236	87,892		1344	A	8,200	11,658	12,849	11,339	11,453	11,093	10,384	12,260				
OP Procedures	18,111	4,868		13243	G	1,252	1,362	1,621	1,885	1,692	2,648	3,483	4,168				
Day Case Admissions	17,239	16,527		712	G	1,842	2,065	2,455	2,305	2,067	2,136	2,235	2,134				
In-patient Admissions	3,671	3,297		374	G	378	386	504	450	481	539	510	423				
Emergency Admission	15,145	14,000		1145	G	1,825	1,855	1,928	1,820	1,835	1,918	2,000	1,964				
Ambulatory Care (Virtual Ward) ***								171	175	174	241	265	274				
Maternity																	
Deliveries	2,869	2,639		230	G	317	354	354	346	366	349	407	376				
Caesarean Section rate	23.0%	25.8%		-2.80%	G	25.9%	27.7%	27.1%	28.9%	24.9%	22.9%	21.6%	21.8%				

** Data not yet available in this month

Note Activity traffic lights substantial over performance Green minimal variation (< +/- 2.5%) Amber substantial under performance Red

*** Please note that quantity of ambulatory activity is included within Emergency Admissions.

Trust Dashboard for Month 08 2011/12

(ending 30th November 2011)

The Princess Alexandra Hospital NHS
NHS Trust

Commentary - Activity

Trust Dashboard for Month 08 2011/12

(ending 30th November 2011)

The Princess Alexandra Hospital NHS
NHS Trust

Access & Targets 1	Year to date					Monthly Position											
	Actual	Plan	10/11	Variance	RAG	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	FOT
18 week RTT																	
Admitted 95th centile (weeks)	21.6	23		-1.45	G	27.7	31.6	27.3	26.8	28.4	25.5	22.5	21.55				G
Admitted Median (weeks)	8.2	11.1		-2.91	G	8.5	10.7	10.5	9.4	9.4	9.6	8.5	8.19				
Non Admitted 95th centile (weeks)	17.3	18.3		-1.01	G	16.8	16.5	16.5	17.0	17.1	16.9	17.0	17.3				G
Non Admitted Median (weeks)	4.2	6.6		-2.4	G	3.7	4.4	4.9	4.2	4.6	4.6	4.1	4.2				
Incomplete 95th centile (weeks)	16.7	28		-11.3	G	20.8	20.1	18.6	17.9	18.2	17.9	17.6	16.7				G
Incomplete Median (weeks)	5.2	7.2		-2.03	G	5.6	5.3	5.3	5.7	5.9	5.9	5.5	5.17				
Admitted Backlog >18 wks	115	104		11	A	634	617	472	398	342	173	141	115				
Non-admit Backlog >18 wk	171	n/a		n/a		75	80	82	96	185	315	284	171				
A&E quality standards																	
Unplanned re-attend within 7days	5.0%	<5%		0.01%	A	-	-	-	5.0%	4.8%	5.0%	4.5%	5.5%				G
Total time in A&E 95th centile	4h 50m	<4hrs		+0h 50m	R	-	-	-	3h59m	4h 00m	4h 00m	5h 12m	6h 28m				G
Left with out being seen	1.4%	<5%		-3.60%	G	-	-	-	1.9%	0.6%	1.5%	1.2%	1.4%				G
Time to initial assessment 95th centile	3min	<15min		-12m	G	-	-	-	4min	3min	2min	2min	2min				G
Time to treatment Median	26min	<60min		-24m	G	-	-	-	38min	20min	22min	20min	27min				G
% less than 4 hr wait	94.2%	95.0%		-0.8%	R	91.3%	95.0%	95.5%	96.4%	95.3%	95.5%	93.7%	89.8%				G

** Data not yet available in this month

Trust Dashboard for Month 08 2011/12

(ending 30th November 2011)

The Princess Alexandra Hospital NHS
NHS Trust

Commentary - Access & Targets 1

A&E Quality Standards

4 hour wait - a monthly performance of 89.8% was disappointing and makes recovery of the yearly position very challenging. There are various reasons for the drop in performance which include:

1. The number and acuity of patients attending the department - the rise in ambulance attendances continues. The Trust is in dialogue with the PCT about this.

2. Work is ongoing to ensure senior review of patients in the A&E Department so that appropriate decisions are made in a timely way and that issues are escalated appropriately.

3. Further detail analysis is underway in order to fully understand the reasons for reduced bed availability and increased emergency lengths of stay. A detailed report will be presented to Part B of the Trust Board.

Trust Dashboard for Month 08 2011/12

(ending 30th November 2011)

The Princess Alexandra Hospital NHS
NHS Trust

Access & Targets 2	Year to date					Monthly Position											
	Actual	Plan	10/11	Variance	RAG	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	FOT
Cancer Wait indicators																	
14 day GP Urgent	94.8%	93.0%		1.8%	G	93.1%	93.1%	94.6%	93.4%	93.4%	94.2%	93.4%	**				G
14 day Breast Screening	94.6%	93.0%		1.6%	G	93.0%	93.5%	94.4%	93.8%	96.0%	94.5%	95.5%	**				G
31 day 1st treatment	98.5%	96.0%		2.5%	G	98.0%	96.4%	100.0%	100.0%	97.9%	100.0%	100.0%	**				G
31 day Subsequent Drug	100%	98.0%		2.0%	G	100%	100%	100%	100%	100.0%	100.0%	100.0%	**				G
31 day Subsequent Surgery	100%	94.0%		6.0%	G	100%	100%	100%	100%	100.0%	100.0%	100.0%	**				G
62 day GP Urgent	88.3%	85.0%		3.3%	G	85.5%	84.6%	94.4%	85.1%	86.8%	95.7%	95.7%	**				G
62 day Breast Screening	95.1%	90.0%		5.1%	G	90.9%	100%	93.3%	90.9%	92.9%	100.0%	91.7%	**				G
62 day Consultant Upgrade	96.0%	90.0%		6.0%	G	100%	88.9%	93.3%	100.0%	100.0%	100.0%	100.0%	**				G
Emergency Readmissions																	
< 30 days (initial non-elective adm)	11.2%	8.45%		2.71%	R	11.5%	11.2%	10.3%	12.1%	11.1%	11.0%	11.5%	**				R
Ambulatory Care patients as % of re-adm	13.7%							13.3%	11.7%	14.6%	13.6%	15.5%	**				
< 30 days (initial elective adm)	2.90%	0%		2.90%	R	2.70%	2.77%	2.61%	2.90%	3.23%	2.61%	3.50%	**				R
Ambulatory Care patients as % of re-adm	20.25%							19.4%	15.2%	19.7%	24.1%	22.97%	**				
Diagnostic Waits < 6 weeks																	
Magnetic Resonance Imaging	97.8%	100%		-2.21%	R	85.6%	99.5%	100%	100%	100%	100%	100%	100%				A
Computed Tomography	99.6%	100%		-0.37%	R	98.7%	99.3%	99.0%	100%	100%	100%	100%	100%				A
Non-obstetric ultrasound	94.8%	100%		-5.16%	R	71.7%	98.6%	100%	100%	100%	100%	100%	100%				A
Colonoscopy	75.2%	100%		-24.80%	R	58.0%	64.1%	74.2%	73.3%	79.4%	94.4%	100%	100%				A

** Data not yet available in this month

Trust Dashboard for Month 08 2011/12

(ending 30th November 2011)

The Princess Alexandra Hospital NHS
NHS Trust

Commentary - Access & Targets 2

Trust Dashboard for Month 08 2011/12

(ending 30th November 2011)

The Princess Alexandra Hospital NHS
NHS Trust

Efficiency (QIPP)	Year to date					Monthly Position											
	Actual	Plan	10/11	Variance	RAG	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Bed utilisation																	
Emergency LoS	5.6	5.6	6.2	0.0	G	5.7	6.0	5.4	5.5	5.5	5.3	5.2	5.9				
Elective LoS	3.2	3.1	3.4	0.1	R	3.2	4.0	3.2	3.2	3.3	3.1	3.0	2.7				
Maternity Bed occupancy	67.4%	n/a	67.9%	n/a		65%	61%	66%	66%	66%	76%	68%	72%				
Paediatric Bed occupancy (inc NICU)	71.5%	n/a	75.0%	n/a		64%	67%	74%	76%	57%	76%	74%	85%				
Adult acute Bed occupancy (excl CC)	92.1%	n/a	90.7%	n/a		90%	94%	93%	90%	90%	92%	93%	95%				
Outpatient DNA Rate	10.8%	n/a		n/a		10.2%	11.4%	11.3%	11.2%	11.6%	10.4%	10.0%	9.5%				
OP Follow-up above limit & not paid	8461	0		n/a	R	891	1106	2546	1603	1880	-1781	820	1396				
Internal referral activity	4727	6309		-1582	G	541	682	690	628	653	559	479	495				
Theatre utilisation																	
Main theatres	86%	85%		1%	G	86%	84%	88%	85%	88%	85%	84%	79%				
ADSU theatres	85%	90%		-5%	R	80%	76%	86%	82%	83%	84%	90%	88%				

** Data not yet available in this month

Explanatory notes:

Emergency and Elective LOS. This is calculated as adult acute LOS and excludes Maternity, Well Baby and Paediatric activity but includes EAU, against a target of reduction phased over month 1-9

Bed occupancy. Split into adult acute, maternity and paediatric activity

Trust Dashboard for Month 08 2011/12

(ending 30th November 2011)

The Princess Alexandra Hospital NHS
NHS Trust

Commentary - Efficiency (QIPP)

Emergency LOS

Work is ongoing to identify the main reasons for the increase this month after a gradual improvement over the previous months. Immediate actions include additional senior support at the weekends to facilitate discharges and there is a further push in relation to criteria led discharge. LOS data has been produced by procedure, consultant and ward and this will be used to identify problem areas more accurately so that recovery plans can be produced. Following discussions at PEAC a detailed report is going to Part B of the Trust Board.

Theatre Utilisation

Utilisation dropped in Main Theatres due to the 31 cancellations which occurred as a reuslt of no beds being available. If bed capacity continues to be an issue then the planned level of elective activity will have to be reviewed to ensure optimum use of resources. If the planned level is reduced this will inevitably have a negative impact on 18 week performance. This is currently being assessed.

Trust Dashboard for Month 08 2011/12

(ending 30th November 2011)

The Princess Alexandra Hospital NHS
NHS Trust

Workforce	Year to date					Monthly Position											
	Actual	Plan	10/11	Variance	RAG	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Sickness Absence Rate	4.23%	3%		1.23%	R	4.07%	3.24%	3.95%	3.80%	3.70%	3.30%	4.06%	4.23%				
Long Term Sickness												1.69%	1.62%				
Short Term Sickness												2.37%	2.61%				
Turnover Rate	11.7%	12%		-0.3%	G	11.5%	11.3%	11.4%	11.1%	11.2%	11.1%	11.4%	11.7%				
Vacancy Rate	6.2%	n/a		n/a		6.1%	5.9%	5.4%	4.3%	5.7%	6.9%	6.7%	6.2%				
Agency and bank spend as a % of turnover	6.0%	n/a		n/a		5.8%	5.1%	5.5%	6.2%	6.4%	6.5%	5.8%	6.5%				
PRDP completion		80.0%										80.0%	77.0%				

** Data not yet available in this month

Trust Dashboard for Month 08 2011/12

(ending 30th November 2011)

The Princess Alexandra Hospital NHS
NHS Trust

Commentary - Workforce

Sickness Absence Rate

It is proving difficult to meet the Trust's target on sickness absence. The year to date percentage is still below 4% but above the target of 3%. The rate for October has increased slightly overall, attributable to increases in Child Health and Estates and Facilities.

Turnover Rate

The labour turnover rate increased slightly in October, which may be due to staff leaving through voluntary or compulsory redundancy.

Vacancy Rate

The vacancy rate remains under the Trust target.

PRDP Completion

PRDP's are still being completed to the Trust's plan.

Trust Dashboard for Month 08 2011/12

(ending 30th November 2011)

The Princess Alexandra Hospital NHS
NHS Trust

Finance	Year to date					Monthly Position											
	Actual	Plan	10/11	Variance	RAG	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Risk rating	3	3		0	G	3	2	2	2	2	2	3	3				
I&E variance from plan (£000s)	-405	853		1,258	R	-938	352	-80	88	-420	-38	-30	-192				
Actual I&E surplus/deficit (£000s)	-405	N/A		-405	R	-1,496	364	-115	-33	-268	11	768	364				
Performance v income plan (£000s)	118,667	118,535		132	G	12,924	15,072	15,058	14,833	14,676	15,163	15,783	15,158				
Cost Improvement Plan (£000s)	-5,652	-6,647		995	R	-508	-462	-587	-540	-631	-644	-1,215	-1,065				
Market Share																	
Outpatient Referrals	62.7%				A	64.2%	64.4%	62.7%	61.9%	62.0%	60.3%	**	**				
Elective Admissions	68.3%				A	67.3%	66.2%	70.0%	71.6%	67.7%	67.0%	**	**				
Maternity Deliveries	87.5%				A	93.7%	84.9%	82.9%	87.4%	84.9%	88.2%	**	**				

** Data not yet available in this month

Trust Dashboard for Month 08 2011/12

(ending 30th November 2011)

The Princess Alexandra Hospital NHS
NHS Trust

Commentary - Finance

The detailed narrative with regard to financial performance is included in the Finance Director's report to the Board.

Item 10

SUMMARY REPORT	The Princess Alexandra Hospital NHS NHS Trust
Trust Board Meeting (Part A)	22nd December 2011
Subject:	NHS East of England PMR Self Certification – November 2011
Prepared by;	Derek Greening, Trust Secretary
Approved by:	Executive Team
Presented by:	Derek Greening, Trust Secretary

Purpose

To present the Provider Management Regime Self Certification for November 2011.

Decision	
Approval	•
Noting	
Information	
Other	

Corporate Objectives

Safety / outcomes	Financial	Workforce	Estates-Environmental	Regulatory / Statutory	Relationships / Partnerships
•	•	•	•		

Executive Summary

The Trust is required to submit the PMR Self Certification each month to the NHS East of England. This document consists of a series of governance, financial, contractual and Board indicators and statements which are weighted. The Trust's 'score' will trigger various levels of responses form the Provider Development Team at the SHA.

Key Recommendations

The Board is asked to approve the self assessment in preparation for its return to the SHA.

Assurance Framework

Links to the Safety/Outcomes, Financial, Workforce and Estates/Environmental objectives within the Assessment Framework.

Next Steps

The approved self assessment will be returned to the SHA – 23rd December 2011

Corporate Impact Assessment	
CQC Regulations	Primary link to Regulation 16 – Assessing and monitoring the quality of service provision
Financial Implications	N/A
Legal implications	N/A
Equality & Diversity	N/A

NHS
East of England

SELF-CERTIFICATION RETURNS
Organisation Name:
Princess Alexandra Hospital
Monitoring Period:
Nov 2011

NHS EoE
Provider Management Regime
2011/12

NHS 65
East of England

NHS Trust Governance Declarations : 2011/12 In-Year Reporting

Name of Organisation:	Princess Alexandra Hospital	Period:	November 2011

Organisational risk rating

Each organisation is required to calculate their risk score and RAG rate their current performance as per the 2011/12 Provider Management Regime, in addition to providing comment with regard to any contractual issues and compliance with CQC essential standards:

Key Area for rating / comment by Provider	Score / RAG rating*
Governance Risk Rating (RAG as per NHS EoE PMR guidance)	2
Financial Risk Rating (Assign number as per NHS EoE PMR guidance)	3.0/Green
Contractual Position (RAG as per NHS EoE PMR guidance)	Green

*** Please type in R, A or G**

Governance Declarations

NHS East of England organisations, subject to the Provider Management Regime, must ensure that plans in place are sufficient to ensure compliance in relation to all national targets and including ongoing compliance with the Code of Practice for the Prevention and Control of Healthcare Associated Infections, CQC Essential standards and declare any contractual issues.

Supporting detail is required where compliance cannot be confirmed.

Please complete sign **one** of the two declarations below. If you sign declaration 2, provide supporting detail using the form below. Signature may be either hand written or electronic, you are required to print your name.

Governance declaration 1

The Board is satisfied that plans in place **are sufficient** to ensure continuing compliance with all existing targets (after the application of thresholds), and with all known targets going forward. The board is satisfied that plans in place are sufficient to ensure ongoing compliance with the Code of Practice for the Prevention and Control of Healthcare Associated Infections (including the Hygiene Code) and CQC Essential standards. The board also confirms that there are no material contractual disputes.

Signed by:		Print Name:	Melanie Walker
on behalf of the Trust Board	Acting in capacity as:	Chief Executive	
Signed by:		Print Name:	Gerald Coteman
on behalf of the Trust Board	Acting in capacity as:	Chair	

Governance declaration 2

For one or some of the following declarations Governance, Finance, Service Provision, Quality and Safety, CQC essential standards or the Code of Practice for the Prevention and Control of Healthcare Associated Infections the Board cannot make Declaration 1 and has provided relevant details below.

The board is suggesting that at the current time there is **insufficient assurance available** to ensure continuing compliance with all existing targets (after the application of thresholds) and/or that it may have material contractual disputes.

Signed by :		Print Name :	
on behalf of the Trust Board	Acting in capacity as:		
Signed by :		Print Name :	
on behalf of the Trust Board	Acting in capacity as:		

If Declaration 2 has been signed:

Please identify which targets have led to the Board being unable to sign declaration 1. For each area such as Governance, Finance, Contractual, CQC Essential Standards, where the board is declaring insufficient assurance please state the reason for being unable to sign the declaration, and explain briefly what steps are being taken to resolve the issue. Please provide an appropriate level of detail.

Target/Standard:	
The Issue :	
Action :	

Target/Standard:	
The Issue :	
Action :	

ACUTE
GOVERNANCE RISK RATINGS 2011/12

Princess Alexandra Hospital

Insert YES (target met in month), NO (not met in month) or N/A (as appropriate)
See separate rule for A&E

Ref	Area	Indicator	Sub Sections	Threshold	Weighting	April 2011	May 2011	Jun 2011	July 2011	Aug 2011	Sept 2011	Oct 2011	Nov 2011	Dec 2011	Jan 2012	Feb 2012	Mar 2012	Comments where target not achieved in month?
1	Safety	Clostridium Difficile	Are you below the ceiling for your monthly trajectory	Contract with PCT	1.0	no	No	No	No	Yes	Yes	No	No					2 new cases in November. YTD is 18 versus full year ceiling of 14.
2	Safety	MRSA	Are you below the ceiling for your monthly trajectory	Contract with PCT	1.0	yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes					
3	Quality	[1] All cancers: 31-day wait for second or subsequent treatment, comprising either:	Surgery	94%	1.0	yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes					
			Anti cancer drug treatments	98%														
			Radiotherapy	94%														
4	Quality	[1] All cancers: 62-day wait for first treatment, comprising either:	From urgent GP RTT	85%	1.0	yes	no	yes	Yes	Yes	Yes	Yes	Yes					
			From consultant screening service referral	90%														
5a	Patient Experience	[1] RTT waiting times – admitted	95th percentile	23 wks	1.0	no	No	No	No	No	No	Yes	Yes					
5b	Patient Experience	[1] RTT waiting times – non-admitted	95th percentile	18.3 wks	1.0	yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes					
6	Quality	[1] All Cancers: 31-day wait from diagnosis to first treatment		96%	0.5	yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes					
7	Quality	[1] Cancer: 2 week wait from referral to date first seen, comprising either:	all cancers	93%	0.5	yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes					
			for symptomatic breast patients (cancer not initially suspected)	93%														
8a	Quality	A&E (Q1): Total time in A&E	Total time in A&E (95th percentile)	≤ 4 hrs	1.0	no	yes	Yes	Yes	Yes	Yes	no	no					
8b	Quality	A&E (from Q2): NB Please record actual number failing	Total time in A&E (95th percentile)	≤4 hrs	1.0 (failing 3 or more) OR 0.5 (failing 2 or less)													
			Time to initial assessment (95th percentile)	≤15 mins														Figure for Nov 2011 - 2 min
			Time to treatment decision (median)	≤60 mins														Figure for Nov 2011 - 27 min
			Unplanned re-attendance rate	≤5%														Figure for Nov 2011 - 6.6%
			Left without being seen	≤5%														Figure for Nov 2011 - 1.4%
9	Quality	Stroke indicator:		TBC	0.5	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a					Still to be defined. SHA will advise.
17	Patient experience	Certification against compliance with requirements regarding access to healthcare for people with a learning disability		N/A	0.5	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes					
		CQC Registration																
A	Safety	CQC Registration	Are there any compliance conditions on registration outstanding.	0	1.0	no	no	no	no	no	no	no	no					
B	Safety	CQC Registration	Are there any restrictive compliance conditions on registration outstanding.	0	2.0	no	no	no	no	no	no	no	no					
C	Safety	Moderate CQC concerns regarding the safety of healthcare provision		0	1.0	yes	yes	yes	yes	yes	Yes	no	no					Moderate concerns formally removed by the CQC in October.
D	Safety	Major CQC concerns regarding the safety of healthcare provision		0	2.0	no	no	no	no	no	no	no	no					
E	Safety	Failure to rectify a compliance or restrictive condition(s) by the date set by the CQC with the condition(s)		0	3.0	no	no	no	no	no	no	no	no					
NB	**Safety**	**Any CQC Enforcement Actions**		**0**	4.0	no	no	no	no	no	no	no	no					
				TOTAL		4.0	4.0	3.0	3.0	2.0	2.0	2.0	2.0					

RAG RATING :

GREEN	= Score Less than 1
GREEN AMBER	= Score between 1 and 1.5
AMBER / RED	= Score between 2 and 3.5
RED	= Score Over 4

[1] **Cancer data for current month is predicted performance as actual data is not available until early next month.**

FINANCIAL RISK RATING 2011/12

Princess Alexandra Hospital

Insert the Score (1-5) Achieved for each Criteria Per Month

Criteria	Indicator	Weight	Risk Ratings 5	4	3	2	1	Annual Plan 2011/12	Apr 2011	May 2011	June 2011	Jul 2011	Aug 2011	Sept 2011	Oct 2011	Nov 2011	Dec 2011	Jan 2012	Feb 2012	Mar 2012	Comments on Performance in Month
Underlying performance	**EBITDA margin %**	25%	11	9	5	1	<1	3	1	2	2	2	2	2	3	3					
Achievement of plan	**EBITDA achieved %**	10%	100	85	70	50	<50	5	1	1	1	2	3	3	3	3					
Financial efficiency	**Return on assets %**	20%	6	5	3	-2	<-2	3	3	3	3	3	3	3	3	3					
	I&E surplus margin %	20%	3	2	1	-2	<-2	2	1	1	1	1	1	2	2	2					
Liquidity	**Liquid ratio days**	25%	60	25	15	10	<10	4	3	3	4	4	4	4	4	4					
Average	**Weighted Average**	**100%**						**3.3**	**1.9**	**2.2**	**2.4**	**2.5**	**2.6**	**2.8**	**3.1**	**3.1**	**0.0**	**0.0**	**0.0**	**0.0**	
Overriding rules	**Overriding rules**							3	1	2	2	2	2	2	3	3					
Overall rating	**Final Overall rating**							**3.0**	**1.0**	**2.0**	**2.0**	**2.0**	**2.0**	**2.0**	**3.0**	**3.0**					

Overriding Rules :

Max Rating	Rule
3	Plan not submitted on time
3	Plan not submitted complete and correct
2	PDC divident not paid in full
2	One Financial Crieterion at "1"
3	One Financial Crieterion at "2"
1	Two Financial Criteria at "1"
2	Two Financial Criteria at "2"

FINANCIAL RISK TRIGGERS 2011/12

Princess Alexandra Hospital

Insert "Yes" / "No" Assessment for the Month

	Criteria	Apr 2011	May 2011	June 2011	Jul 2011	Aug 2011	Sept 2011	Oct 2011	Nov 2011	Dec 2011	Jan 2012	Feb 2012	Mar 2012	Comments on Performance in Month
1	Unplanned decrease in EBITDA margin in two consecutive quarters	No	No	No	No	No	No	No	No					
2	Quarterly self-certification by trust that the financial risk rating (FRR) may be less than 3 in the next 12 months	No	No	No	No	No	No	No	No					
3	FRR 2 for any one quarter	No	No	Yes	Yes	Yes	Yes	Yes	Yes					
4	Working capital facility (WCF) agreement includes default clause	No	No	No	No	No	No	No	No					
5	Debtors > 90 days past due account for more than 5% of total debtor balances	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes					
6	Creditors > 90 days past due account for more than 5% of total creditor balances	Yes	Yes	No	No	No	No	No	No					
7	Two or more changes in Finance Director in a twelve month period	No	Yes	Yes	Yes	Yes	Yes	Yes	No					
8	Interim Finance Director in place over more than one quarter end	Yes	No	No	No	No	No	No	No					
9	Quarter end cash balance <10 days of operating expenses	Yes	Yes	No	No	No	No	No	No					
10	Capital expenditure < 75% of plan for the year to date	No	No	Yes	Yes	Yes	Yes	Yes	Yes					
	TOTAL	**4**	**4**	**4**	**4**	**4**	**4**	**4**	**3**	**0**	**0**	**0**	**0**	

NB **Scoring: An answer of "YES" = 1.0**

RAG RATING :

GREEN	**= Score between 0 and 1**
AMBER	**= Score between 2 and 4**
RED	**= Score over 5**

CONTRACTUAL RISK RATINGS 2011/12

Princess Alexandra Hospital

Insert R, A or G into appropriate row for the Month

Criteria	RAG	Apr 2011	May 2011	Jun 2011	Jul 2011	Aug 2011	Sept 2011	Oct 2011	Nov 2011	Dec 2011	Jan 2011	Feb 2011	Mar 2011	Comments on Performance in Month
Contracts agreed and signed Both provider and commissioner fulfilling terms of contract	G					G	G	G	G					
Provider and Commissioner are in dispute over terms of the contract Performance notices have been issued by either provider or commissioner for breach of contract	A	A	A	A	A									
Provider and Commissioner are in dispute over the terms of the contract, with NHS EoE being asked to intervene / arbitrate. A number of performance notices have been issued by either provider or commissioner for breach of contract	R													

QUALITY

Princess Alexandra Hospital

Insert Performance in Month

	Criteria	Unit	Apr 2011	May 2011	June 2011	Jul 2011	Aug 2011	Sept 2011	Oct 2011	Nov 2011	Dec 2011	Jan 2012	Feb 2012	Mar 2012	Comments on Performance in Month
1	Hospital Mortality Standardised Ratio (HSMR)	Ratio	106.0	106.0	106.0										The HSMR data for the Trust as reported to the Board via its Dashboard (from Dr Foster) is as follows: * April 2011 - 97.5 * May 2011 - 108 * June 2011 - 89.6 * July 2011 - 91.6 * August 2011 - 104.8 * September 2011 - 116.5 With regards to the September figure this was discussed at the last MRG and a number of higher level risk ratings appearing in the latest Dr Foster data were placed under "detailed review" by the appropriate Business Unit with an expectation for them to formally report back at the January MRG meeting.
2	Venous Thromboembolism (VTE) Screening	%	90.3	90.6	90.8	90.4	92.5	93.6	92.2						Awaiting validated figures
3a	Elective MRSA Screening	%	98.8	98.9	98.7	99.7	98.7	99.0	99.0	99.4					
3b	Non Elective MRSA Screening	%	87.9	88.6	86.9	91.2	95.7	95.3	94.8	91.97					
4	Single Sex Accommodation Breaches	Number	27	13	14	6	0	9	6	0					
5	Open Serious Incidents Requiring Investigation (SIRI)	Number	112	121	74	71	72	32	31	28					
6	"Never Events" in month	Number	0	0	2	0	0	0	1	0					
7	CQC Conditions or Warning Notices	Number	0	0	0	0	0	0	0	0					One minor concern relating to birth to mid-wife ratio raised in October. Currently being discussed with the NHS West Essex.
8	Central Alert System (CAS) Alerts	Number	0	0	0	0	0	0	0	0					
9	RED rated areas on your maternity dashboard?	Number	3	3	3	3	3	2	1	2					
10	Falls resulting in severe injury or death	Number	0	1	0	1	0	0	0	1					
11	Grade 3 or 4 pressure ulcers	Number	8	12	6	7	3	0	1	2					
12	100% compliance with WHO surgical checklist	Y/N	Y	Y	Y	Y	Y	Y	Y	Y					
13	Formal complaints received	Number	50	49	57	62	54	49	57	60					
14	Agency and bank spend as a % of turnover	%	5.79	5.1	5.45	6.18	6.37	6.92	5.83	6.45					
15	Sickness absence rate	%	3.24	3.45	3.95	3.87	3.72	3.67	4.06	4.23					

Board Statements

Princess Alexandra Hospital

Nov-11

For each statement, the Board is asked to confirm the following:

	For CLINICAL QUALITY, that:	Response
1	The Board is satisfied that, to the best of its knowledge and using its own processes and having had regard to the SHA's Provider Management Regime (supported by Care Quality Commission information, its own information on serious incidents, patterns of complaints, and including any further metrics it chooses to adopt), its NHS trust has, and will keep in place, effective arrangements for the purpose of monitoring and continually improving the quality of healthcare provided to its patients.	✓

If the Trust Board is unable to make the above statement, the Board must:

2	Be satisfied that, to the best of its knowledge and using its own processes (supported by CQC information and including any further metrics it chooses to adopt), its Trust has, and will keep in place, effective arrangements for the purpose of monitoring and continually improving the quality of healthcare provided to its patients.	
3	Be satisfied that, to the best of its knowledge and using its own processes, plans in place are sufficient to ensure ongoing compliance with the CQC's registration requirements	
4	Certify it is satisfied that processes and procedures are in place to ensure that all medical practitioners providing care on behalf of the NHS foundation trust have met the relevant registration and revalidation requirements.	
5	Be satisfied that the Trust is embedding patient experience into the servie design, improvement and delivery cycle.	

	For SERVICE PERFORMANCE, that:	Response
6	The board is satisfied that plans in place are sufficient to ensure ongoing compliance with all existing targets (after the application of thresholds), and compliance with all targets due to come into effect during 2011/12.	✓

	For RISK MANAGEMENT PROCESSES, that:	Response
7	Issues and concerns raised by external audit and external assessment groups (including reports for NHS Litigation Authority assessments) have been addressed and resolved. Where any issues or concerns are outstanding, the board is confident that there are appropriate action plans in place to address the issues in a timely manner	✓
8	All recommendations to the board from the audit committee are implemented in a timely and robust manner and to the satisfaction of the body concerned	✓
9	The necessary planning, performance management and risk management processes are in place to deliver the annual plan	✓
10	A Statement of Internal Control ("SIC") is in place, and the trust is compliant with the risk management and assurance framework requirements that support the SIC pursuant to the most up to date guidance from HM Treasury (see http://www.hm-treasury.gov.uk)	✓
11	The trust has achieved a minimum of Level 2 performance against the key requirements of the Department of Health's Information Governance Toolkit	✓

	For COMPLIANCE WITH THE NHS CONSTITUTION, that:	Response
12	The Board is assured that the trust will, at all times, have regard to the NHS constitution	✓

	For BOARD, ROLES, STRUCTURES AND CAPACITY, that:	*Response*
13	The Board maintains its register of interests, and can specifically confirm that there are no material conflicts of interest in the Board	✓
14	The Board is satisfied that all directors are appropriately qualified to discharge their functions effectively, including setting strategy, monitoring and managing performance, and ensuring management capacity and capability	✓
15	The selection process and training programmes in place ensure that the non-executive directors have appropriate experience and skills	✓
16	The management team have the capability and experience necessary to deliver the annual plan	✓
17	The management structure in place is adequate to deliver the annual plan objectives for the next three years.	✓

	Signed on behalf of the Trust:	*Print name*	*Date*
CEO		**Melanie Walker**	
Chair		**Gerald Coteman**	

NHS EoE Provider Management Regime

NHS 72 East of England

Ref	Area	Details
Thresh-olds	The SHA will not utilise a general rounding principle when considering compliance with these targets and standards, e.g. a performance of 94.5% will be considered as failing to achieve a 95% target. However, exceptional cases may be considered on an individual basis, taking into account issues such as low activity or thresholds that have little or no tolerance against the target, e.g. those set between 99-100%.	
1	C.Diff	Performance against contract with main commissioner
2	MRSA	MRSA objective: those trusts which are not in the best performing quartile for MRSA should deliver performance that is at least in line with the MRSA objective target figures calculated for them by DH. The SHA expects those NHS trusts without a centrally calculated MRSA objective to agree an MRSA target for 2011/12 that at least maintains existing performance. Where a trust has an annual MRSA objective of six cases or fewer and has reported six cases or fewer in the year to date, the MRSA objective will not apply for the purposes of the SHA's Provider Management Regime If a trust with an annual objective of six cases or fewer declares a risk of exceeding the de minimis level and its annual MRSA objective in-year, but has not yet done so, it will be required to [provide, and then] report monthly against, an MRSA action plan until the risk has been satisfactorily addressed.
3	Cancer: 31 day wait	31-day wait: measured from cancer treatment period start date to treatment start date. Failure against any threshold represents a failure against the overall target. The target will not apply to trusts having five cases or less in a quarter.
4	Cancer: 62 day wait	62-day wait: measured from day of receipt of referral to treatment start date. This includes referrals from screening service and other consultants, including consultant upgrades. Failure against either threshold represents a failure against the overall target. The target will not apply to trusts having five cases or less in a quarter. For patients referred from one provider to another, breaches of this target are automatically shared and treated on a 50:50 basis. These breaches may be reallocated in full back to the referring organisation(s) provided there is written agreement to do so between the relevant providers (signed by both Chief Executives) in place at the time the trust makes its monthly declaration to the SHA.
5a&b	RTT	While performance is measured on an aggregate basis, NHS trusts are required to meet the threshold on a monthly basis – consequently failure in any month represents failure for the quarter and should be reported via the exception reporting process.
6	Cancer	Measured from decision to treat to first definitive treatment. The target will not apply to trusts having five cases or fewer in a quarter.
7	Cancer	Measured from day of receipt of referral – existing standard (includes referrals from general dental practitioners and any primary care professional). Failure against either threshold represents a failure against the overall target. The target will not apply to trusts having five cases or Specific guidance and documentation concerning cancer waiting targets can be found at: http://nww.connectingforhealth.nhs.uk/nhais/cancerwaiting/documentation
8a	A&E (Q1)	In Quarter one - 95th percentile waits for 4 hours or less to be used
8b	A&E (Q2)	From Quarter two: • 95th percentile waits for 4 hours or less to be used • Time to initial assessment: for ambulance arrivals. Initial assessment to include a pain score and early warning score. • Time to treatment decision: time from arrival to see a decision-making clinician (defining management plan and may potentially discharge the • Unplanned reattendance rate: within 7 days of original attendance. Includes patients referred back by another health professional. The SHA will not score this for paediatric specialist NHS trusts. • Left without being seen The SHA will keep these measures under review during 2011/12 and may change its implementation in line with national policy.
9	Stroke	The SHA will consider its introduction during 2011/12 following publication of DH's technical guidance.
10	Mental Health: CPA	7-day follow up: **Numerator**: The number of people under adult mental illness specialties on Care Programme Approach who were followed up (either by face-to-face contact or by phone discussion) within seven days of discharge from psychiatric inpatient care. **Denominator:** the total number of people under adult mental illness specialties on Care Programme Approach who were discharged from psychiatric inpatient Contact can include face-to-face or telephone contact. Guidance on what should and should not be counted when calculating the achievement of this target can be found on Unify2. For 12 month review (from Mental Health Minimum Data Set): **Numerator:** The number of adults in the denominator who have had at least one formal review in the last 12 months. Date last seen by care coordinator will be used as a proxy for formal Care Programme Approach review during 2011/12. **Denominator:** The total number of adults who have received secondary mental health services and who were on the Care Programme Approach at any point during the reporting period. For full details of the changes to the Care Programme Approach process, please see the implementation guidance, Refocusing the Care Programme Approach on the Department of Health's website. All patients discharged to their place of residence, care home, residential accommodation, or to non-psychiatric care must be followed up within seven days of discharge. Where a patient has been transferred to prison, contact should be made via the prison in-reach team. Exemptions from both the numerator and the denominator of the indicator include: • patients who die within seven days of discharge; • where legal precedence has forced the removal of a patient from the country; or • patients discharged to another NHS psychiatric inpatient ward.
11	Mental Health: DTOC	**Numerator:** The number of non-acute patients (aged 18 and over) whose transfer of care was delayed averaged over the quarter. **Denominator:** Number of non-acute patients (aged 18 and over) admitted to the trust, summed across the quarter. Delayed transfers of care attributable to social care are excluded.
12 a) b) c) d)	Mental Health: I/P and CRHT	This indicator applies only to admissions to the NHS trust's mental health psychiatric inpatient care. The following cases can be excluded: • admissions to psychiatric intensive care units; • internal transfers of service users between wards in a trust and transfers from other trusts; • patients recalled on Community Treatment Orders; or • patients on leave under Section 17 of the Mental Health Act 1983. An admission has been gate-kept by a crisis resolution team if they have assessed the service user before admission and if they were involved in the decision-making process, which resulted in admission. For full details of the features of gate-keeping, please see Guidance Statement on Fidelity and Best Practice for Crisis Services on the Department of Health's website. As set out in Guidance Statement on Fidelity and Best Practice for Crisis Services the crisis resolution home treatment team should: provide a mobile 24 hour, seven day a week response to requests for assessments; be actively involved in all requests for admission: for the avoidance of doubt, 'actively involved' requires face to face contact unless it can be demonstrated that face-to-face contact was not appropriate or possible. For each case where face-to-face contact is deemed inappropriate, a declaration that the face-to-face contact was not the most appropriate action from a clinical perspective will be required; be notified of all pending Mental Health Act assessments; be assessing all these cases before admission happens; and

Ref	Area	Details
e)		be central to the decision making process in conjunction with the rest of the multidisciplinary team
13	Mental Health	Monthly performance against commissioner contract. Threshold represents a minimum level of performance against contract performance, rounded down.
14	Mental Health: MDS	Patient identity data completeness metrics (from Mental Health Minimum Data Set) to consist of: • NHS number; • Date of birth; • Postcode (normal residence); • Current gender; • Registered General Medical; • Practice organisation code; and • Commissioner organisation code. Numerator: count of valid entries for each data item above. NB For details of how data items are classified as VALID please visit the data quality constructions available on the Information Centre's website: www.ic.nhs.uk/services/mhmds/dq Denominator: total number of entries.
15	Mental Health: CPA	**Outcomes for patients on Care Programme Approach:** • Employment status: **Numerator:** The number of adults in the denominator in paid employment (i.e. those recorded as 'employed') at the time of their most recent assessment, formal review or other multi-disciplinary care planning meeting, in a financial year. Include only those whose assessments or reviews were carried out during the reference period. The reference period is the last 12 months working back from the end of the reported quarter. **Denominator:** The total number of adults (aged 18-69) who have received secondary mental health services and who were on the Care Programme Approach at any point during the reported quarter. • In settled accommodation: **Numerator:** The number of adults in the denominator who were in settled accommodation at the time of their most recent assessment, formal review or other multi-disciplinary care planning meeting. Include only those whose assessments or reviews were carried out during the reference period. The reference period is the last 12 months working back from the end of the reported quarter. **Denominator:** The total number of adults (aged 18-69) who have received secondary mental health services and who were on the Care Programme Approach at any point during the reported quarter. • Having an HoNOS assessment in the past 12 months: **Numerator:** The number of adults in the denominator who have had at least one HoNOS assessment in the past 12 months. NOTE: When implemented MHMDS v4 will allow services to report all HoNOS variants, including those for young people and people in secure services. Until this time trusts should report standard HoNOS inclusive of all ages and ward types. **Denominator:** The total number of adults who have received secondary mental health services and who were on the Care Programme Approach during the reference period.
16a	Ambulance Cat A	Life threatening
17	Learning Disabilities: Access to healthcare	Meeting the six criteria for meeting the needs of people with a learning disability, based on recommendations set out in Healthcare for All (2008): a) Does the NHS trust have a mechanism in place to identify and flag patients with learning disabilities and protocols that ensure that pathways of care are reasonably adjusted to meet the health needs of these patients? b) Does the NHS trust provide readily available and comprehensible information to patients with learning disabilities about the following criteria?: • treatment options; • complaints procedures; and • appointments. c) Does the NHS trust have protocols in place to provide suitable support for family carers who support patients with learning disabilities? d) Does the NHS trust have protocols in place to routinely include training on providing healthcare to patients with learning disabilities for all staff? e) Does the NHS trust have protocols in place to encourage representation of people with learning disabilities and their family carers? f) Does the NHS trust have protocols in place to regularly audit its practices for patients with learning disabilities and to demonstrate the findings in routine public reports? Note: Boards are required to certify that their trusts meet requirements a to f above at the annual plan and in each quarter. Failure to do so will result in the application of the service performance score for this indicator.
18	DTCs	Performance against contract with main commissioner
19	GUM Access	Access to GUM within 48hours against a target of 95% compliance.
20	Chlamydia Screening	Performance against contract with main commissioner
21	Smoking Quitters	Performance against contract with main commissioner
22	6 Wk Wait Diagnostics	Access to diagnostics against a target of 100% compliance
23	New birth visits	Performance against contract with main commissioner
24	HPV	Human Papillomavirus (HPV) uptake Performance against contract with main commissioner
25	Comm'ty Equip Store	Responses within 7 days
26 a	Urgent DN	Response by a DN within 24 hours of receiving an urgent request / referral
26 b	Non-Urgent DN	Response by a DN within 48 hours of receiving a non-urgent request / referral

Item 12

SUMMARY REPORT	The Princess Alexandra Hospital NHS Trust
Trust Board Meeting (Part A)	22nd December 2011
Subject:	Finance Report
Prepared by;	Mr. Charles McNair, Executive Director of Finance
Approved by:	Ms. Melanie Walker, CEO
Presented by:	Mr. Charles McNair, Executive Director of Finance or deputy in absence

Purpose

The purpose of this report is to provide detailed financial analysis on the current situation and to bring to attention to the Board any issues or risks.

Decision	
Approval	
Noting	●
Information	●
Other	

Corporate Objectives

Safety / outcomes	Financial	Workforce	Estates-Environmental	Regulatory / Statutory	Relationships / Partnerships
	●	●	●	●	●

Executive Summary

The financial report as attached.

Key Recommendations

The Board is asked to note the contents of this report and to:

- Review the financial recovery measures, which will be discussed in detail at the Business & Performance Assurance Committee, and verbally updated to the Board.

Assurance Framework

There is a legal requirement for all NHS organisations to receive regular reports in order to give the Board assurance that financial plans are being delivered and that statutory requirements will be met.

Next Steps

N/A

Corporate Impact Assessment	
CQC Regulations	2.02, 2.03
Financial Implications	●
Legal implications	●
Equality & Diversity	

THE PRINCESS ALEXANDRA HOSPITAL NHS TRUST
TRUST BOARD – 22nd DECEMBER 2011

EXECUTIVE SUMMARY

Issue: **Month 8, 30th November 2011 – FINANCE REPORT**

Status: **For Information**

Introduction

This paper provides the Trust Board with details of the Trust's financial performance as at Month 8 (to 30th November 2011), and comprises the following sections:

- **Year to Date Performance – Month 8**
- **Forecast Year End Position 2011/12**
- **Financial Risks & Mitigations**
- **Capital Programme 2011/12**
- **Cash Position**
- **Balance Sheet**
- **Better Payment Policy Performance**
- **Action**

1. Year to Date Performance

The Trust is reporting a cumulative to Month 8 deficit of £1,258,000 before technical adjustments against the revised plan. The revised plan phases income and expenditure throughout the year to take into account the profiles of clinical activity and the implementation of the Cost Improvement Programme (CIP).

Overall, this represents a further deterioration against budget in the month of £192,000. The income position to Month 8 remains ahead of plan at £132,000. However, expenditure continues to overspend against plan. The position deteriorated by £633,000 in the month. Details of activities to remedy the position are included within this section below.

It should be noted that the absolute income and expenditure deficit is £405,000. The difference between the reported position against plan and the absolute position is due to the profiling of budgets, including the phasing of the Cost Improvement Programme, which accelerates towards the latter half of the financial year, particularly from Month 8.

A Trust's Reported NHS financial performance position is derived from its retained surplus/(deficit), but adjusted for impairments. An impairment charge is not considered part of the organisation's operating position. Impairments of £421,000 have been incurred during the year; these are technical adjustments and are not included for the purposes of SHA monitoring; they also have a financial benefit to the Trust, generating a reduction in Depreciation charges incurred for the year. The impairment was generated by the release of certain items of prior year's capitalised expenditure which is deemed to be more appropriately revenue expense. This item has been reported to the SHA through the monthly standard reporting mechanism.

Month 8: Income & Expenditure Summary

The reported position reflects the application of the £13.0m cost improvements and transitional funding support. The transitional support is treated as an income receivable in the analysis. The overall position is summarised in the table below, with the supporting detail attached in appendix 1.

Description	Current Month			Year to Date			Annual
	Actual £'000	Budget £'000	Variance £'000	Actual £'000	Budget £'000	Variance £'000	Budget £'000
NHS Clinical Income	14,273	14,126	147	111,059	110,553	506	165,401
Other Income	884	991	(107)	7,608	7,982	(374)	11,817
Total Income	**15,157**	**15,117**	**40**	**118,667**	**118,535**	**132**	**177,218**
Pay	9,950	9,558	(392)	78,797	77,728	(1,069)	115,604
Non Pay	4,369	4,128	(241)	33,642	32,814	(828)	51,518
Centrally held CIPS	0	0	0	0	0	0	(529)
Total Expenditure	**14,319**	**13,686**	**(633)**	**112,439**	**110,542**	**(1,897)**	**166,593**
EBITDA	**838**	**1,431**	**(593)**	**6,228**	**7,993**	**(1,765)**	**10,625**
Less Net Interest	27	33	6	213	266	53	399
Less Depreciation	342	536	194	4,171	4,425	254	6,554
Less PDC Dividend	106	306	200	2,248	2,448	200	3,672
Net Surplus/(Deficit) - excluding impairments	**363**	**556**	**(193)**	**(404)**	**854**	**(1,258)**	**0**

Expenditure Performance

Overall Pay is over spent by £1,069,000 against plan. The monthly bank and agency bill was £977,000 in Month 8 compared with £920,000 last month. This represents 9.82% of the total Pay spend.

In month, the position on Pay is £392,000 overspent with £275,000 of unachieved CIPs targets reflected into the position. Medical staffing is £251,000 overspent in month, the main area of concern continues to be in both A&E £31,000 and EAU £61,000. Anaesthetics incurred an overspend in Month 8 of £32,000; this is believed to be a non-recurrent increase. Orthopaedic Medical staffing overspent by £21,000 in Month 8; in previous months, costs have been funded to clear the 18-weeks backlog.

Non-pay over spent by £242,000 in month and is cumulatively £828,000 overspent. Reductions in non-pay budget as a result of the planned impact of CIP schemes, and £49,000 of transformation costs account for much of this variance. Expenditure on Non-PbR Drugs was higher in the month, although these costs are matched by increased income receivable.

The 12 month rolling I and E graph is attached at Appendix 2. In November, as discussed, costs have increased slightly compared to the previous month; additional transitional costs account for this increase.

Overall the expenditure position shows a net overspend of £1,897,000 excluding interest. The position includes the full phasing of the £13.0 million CIPS targets, with £6,647,000 applied for months 1-8.

To ensure that the overspend can be controlled and the year to date impact reversed, the following actions are being taken.

- Continued reviews of overspending areas to implement a recovery plan.

- A review of medical staffing locum usage is being conducted to identify avoidable expenditure.
- Resources and non-recurrent spend is being targeted for cost avoidance/reduction.
- Continuation of controls on nurse temporary and agency spend.

The Executive Team are meeting to discuss these additional actions necessary to deliver the financial balance at the year end.

Income Performance

NHS Clinical Income in-month position is £147,000 above plan, and £506,000 above plan year-to-date.

Figure 2 below shows income performance by patient type:

Description	Current Month			Year to Date			Annual
	Actual £'000	Budget £'000	Variance £'000	Actual £'000	Budget £'000	Variance £'000	Budget £'000
Accident & Emergency	757	733	24	6,124	6,015	109	8,936
Critical Care	612	560	52	4,414	4,478	(64)	6,716
Direct Access	480	459	21	3,726	3,671	55	5,505
Elective Income	1,375	1,518	(143)	12,511	13,216	(705)	18,492
Day Cases	1,682	1,630	52	12,405	12,450	(45)	18,529
Non Elective Income	5,490	4,602	888	40,100	37,410	2,690	56,113
Outpatient Firsts	1,056	1,148	(92)	8,190	9,040	(850)	13,321
Outpatient Follow-ups	1,027	1,085	(58)	7,918	8,525	(607)	12,571
Outpatient Procedures	612	181	431	3,484	1,389	2,095	2,127
Block - excluding CQUIN	1,244	1,245	(1)	9,954	9,959	(5)	14,946
CQUIN	183	183	0	1,463	1,464	(1)	2,196
Transitional Funding	433	433	0	3,466	3,466	0	5,200
Additional SHA support	420	420	0	420	420	0	2,100
Other (NeoNatal Pilot, Drugs over perform, LeakagePID)	320	137	183	1,004	706	298	1,131
SLA Validations (see Table 3)	(1,418)	(208)	(1,210)	(4,120)	(1,656)	(2,464)	(2,482)
Total NHS Clinical Income	**14,273**	**14,126**	**147**	**111,059**	**110,553**	**506**	**165,401**
Non Patient SLA	82	108	(26)	1,001	1,135	(134)	1,701
Education, Training	410	410	0	3,263	3,266	(3)	4,801
Other Income (see Table 4)	392	473	(81)	3,344	3,581	(237)	5,315
Total Other Income	**884**	**991**	**(107)**	**7,608**	**7,982**	**(374)**	**11,817**
Total Income	**15,157**	**15,117**	**40**	**118,667**	**118,535**	**132**	**177,218**

Other (Non Clinical) Income under-performed by £107,000 in-month, and is under-performing £374,000 year-to-date.

Table 4 below shows Other income split by income type:

Description	Current Month			Year to Date			Annual
	Actual £'000	Budget £'000	Variance £'000	Actual £'000	Budget £'000	Variance £'000	Budget £'000
County Council	0	8	(8)	8	60	(52)	90
Income Other - Patients	10	22	(12)	140	179	(39)	269
Non NHS - Other	3	3	0	27	23	4	34
Prescriptions	2	2	0	16	14	2	21
Non NHS - Private Patients	50	53	(3)	392	427	(35)	640
Net Dining Room Receipts	52	59	(7)	486	469	17	704
House Rental	4	6	(2)	33	44	(11)	66
Mortuary Fees	10	12	(2)	73	94	(21)	141
Vending Machine Income	6	7	(1)	45	59	(14)	89
Injury cost recovery scheme	31	68	(37)	501	543	(42)	815
Other	224	233	(9)	1,623	1,669	(46)	2,446
Total Other Income	**392**	**473**	**(81)**	**3,344**	**3,581**	**(237)**	**5,315**

2. Forecast Year End Position 2011/12

The reported position of £1,258,000 under performance represents a small deterioration of the position reported to the Board last month.

On the expenditure side, there is concern regarding the deteriorating position. The measures being taken will be further intensified to return costs to within financial balance.

A review of the year end position will be considered at the Business and Performance Assurance Committee prior to the Board meeting.

The Trust has presented income settlement proposals cumulative to month 6, to our two main Commissioners. We have reached an agreement with NHS Hertfordshire and are awaiting confirmation from NHS West Essex.

3. Financial Risks and Mitigations

At the August Board meeting the following key risks were identified:

- Transitional support receipt
- Cost Improvement Run Rate
- Ambulatory Care Target
- Potential Financial Gap

Regarding transitional support a revised application for £5.2m was submitted to NHS Hertfordshire and NHS West Essex. Both Primary Care Trusts have confirmed their contributions, and we have invoiced both organisations for their respective contributions.

A review of the Cost Improvement run rate will be presented to the November Business and Performance Assurance Committee and reported to the Board.

The Trust has intensified the income reconciliation processes with its two main Commissioners; NHS West Essex and NHS Hertfordshire. The actions taken are described earlier in this report.

We continue to explore opportunities to reduce costs to mitigate the risk of a financial gap emerging. We have prepared full year income projections which indicate a degree of over performance. If correct, this will offset some of the overspend being incurred.

Discussions with our main Commissioners will be required in January to agree the level of over performance, so that these may be reflected in our year end forecast position.

4. Capital Programme 2011/12

Cumulative capital expenditure as at 30 November was £1,213k against a plan of £3,498k. Forecast capital expenditure at the year end is £6,467k. The expenditure profile has been deliberately weighted towards the end of the financial year, to assist with the cash position. A schedule of the capital programme is at Appendix 5.

The Radiology Scheme is now underway.

The NICU project has commenced with construction well underway.

An additional piece of radiological equipment to be used to support Breast Surgery treatment has been approved by the Investment Scrutiny Group (ISG).

Business Cases are reviewed by the ISG to ensure consistency to the Trust's Business Plan and achieved value for money.

5. Cash Position

The cash held at 30 November was £3.092m. This included an advance payment of £2.75m received from West Essex PCT on 30 November relating to contract income for December.

The Working Capital Loan is reflected in the planned cash position below. The loan has now been approved by the Department of Health and £3 million will be transferred into the Trust's bank account on 15 December.

The Trust is anticipating payment of NHS Hertfordshire's transitional support in December.

Planned Monthly Cash Position

Month	£'000
December	7,038
January	7,866
February	7,586
March	4,285

6. Statement of Financial Position

The Statement of Financial Position as at 30 November 2011 is attached at Appendix 4. The forecast year end statement of financial position assumes delivery on the financial plan.

7. Better Payment Practice Code

The Better Payment Practice Code sets a target for payment of all invoices received from both NHS and non-NHS trade creditors, in value and volume, to be paid within 30 days of receipt of goods or a valid invoice (whichever is later) unless other payment terms have been agreed.

At least 95% of invoices paid within 30 days or within agreed contract terms is required for compliance.

The Trust's cumulative performance against the target to 30 November was:

Better Payment Practice Code	Number	£'000s
Total trade invoices paid in the year	21,878	28,338
Total trade invoices paid within target	20,035	23,038
Percentage of trade invoices, paid within target	91.58%	81.30%
Total NHS invoices paid in the year	1,262	9,045
Total NHS invoices within target	1,076	6,970
Percentage of NHS invoices paid within target	85.26%	77.06%

Action

The Board is asked to note the contents of this report and to:

- Review the financial recovery measures, which will be discussed in detail at the Business & Performance Assurance Committee, and verbally updated to the Board.

8. Appendices

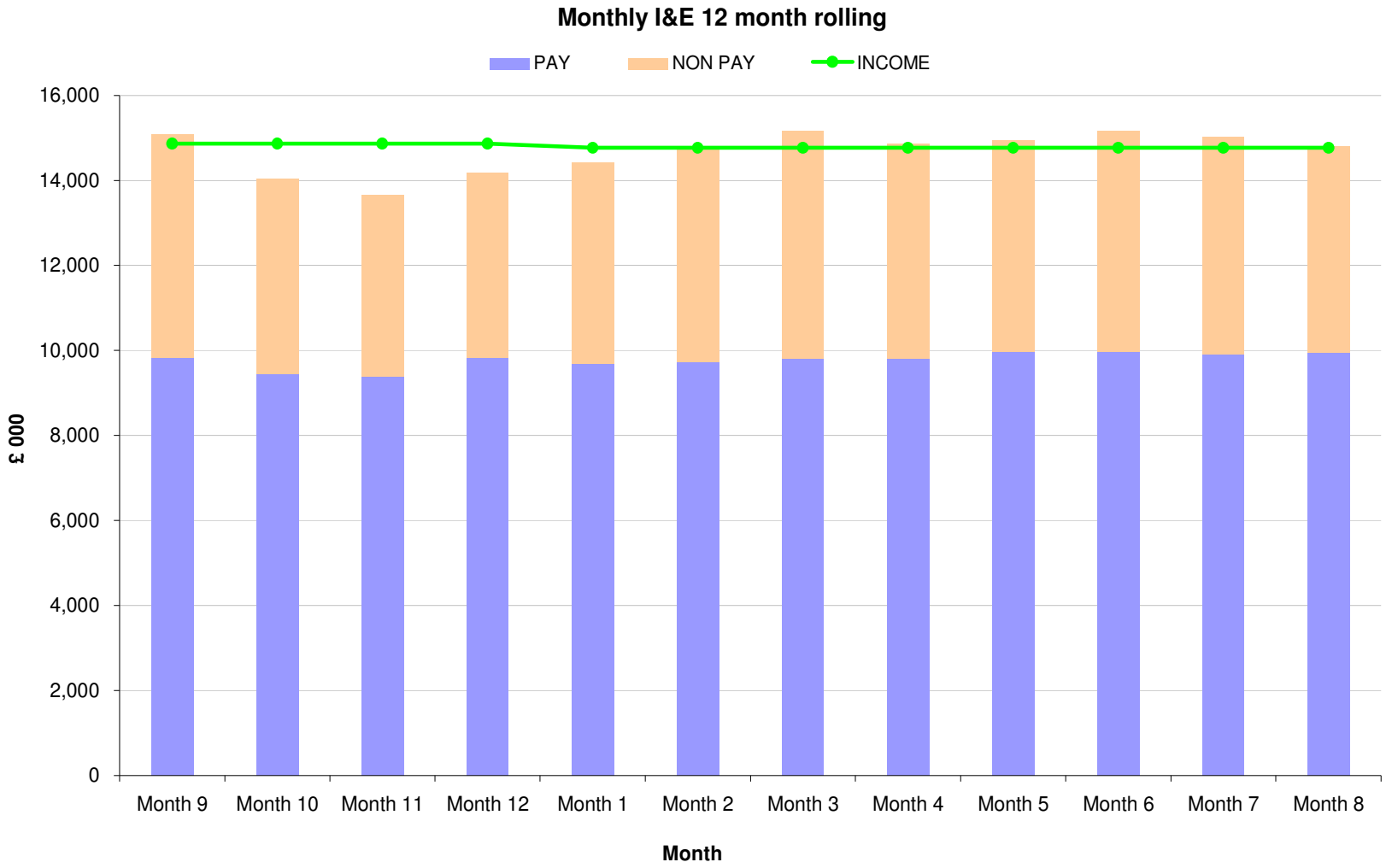
8.1. Appendix 1

THE PRINCESS ALEXANDRA HOSPITAL NHS TRUST
MONTH 8 2011-12

Appendix 1

Exp	Exp 4	WTE Bud.	WTE Cont.	WTE Worked.	WTE Paid.	Annual Budget.	Current Month Budget.	Current Month Actual.	Current Month Variance.	YTD Budget.	YTD Actual.	YTD Variance.
	DEPARTMENT OF HEALTH					0	0	-2	2	0	-3	3
	DONATION RESERVE					0	0	0	0	0	-43	43
	EDUCATION, TRAINING & RESEARCH					-4,801	-410	-411	1	-3,265	-3,263	-2
	INCOME FROM SERVICE AGREEMENTS					-165,001	-13,813	-13,935	122	-111,268	-111,638	371
	NON NHS OTHER					-415	-35	-15	-20	-276	-186	-90
	NON NHS PRIVATE PATIENTS					-638	-53	-50	-3	-426	-385	-41
	OTHER INCOME					-5,547	-738	-715	-23	-2,756	-2,663	-93
	RTA INCOME					-815	-68	-31	-37	-543	-484	-59
INCOME Total						-177,218	-15,117	-15,158	41	-118,535	-118,667	132
	ADMIN & CLERICAL	492.98	465.17	479.36	473.68	12,594	1,067	1,011	56	8,506	8,205	301
	ANCILLARY	251.81	245.17	255.27	302.80	5,668	474	475	-1	3,854	3,935	-81
	MAINTENANCE & WORKS STAFF	28.46	26.26	27.34	28.01	859	68	68	0	586	583	3
	MEDICAL	396.19	368.25	394.41	362.59	35,468	2,877	3,127	-251	23,443	24,666	-1,223
	NURSING	1,143.59	1,070.68	1,135.63	1,163.54	42,216	3,456	3,503	-47	28,194	27,812	382
	OTHER EMPLOYEES	0.00	0.00	0.00	0.00	190	190	140	50	190	140	50
	QiPP EFFICIENCIES - PAY	1.50	0.00	0.00	0.00	-2,018	-275	0	-275	-791	0	-791
	SCIENTIFIC, THERAPEUTIC & TECH	372.02	340.69	345.13	343.60	14,353	1,190	1,132	58	9,513	9,125	388
	SNR MANAGERS	99.92	94.68	102.77	103.09	6,275	511	493	18	4,233	4,331	-98
PAY Total		2,786.47	2,610.90	2,739.91	2,777.31	115,604	9,558	9,950	-392	77,728	78,797	-1,069
	BLOOD PRODUCTS					1,203	95	86	9	822	842	-20
	DRUGS DRESSINGS & GASES					11,753	930	1,205	-275	8,256	8,568	-312
	ESTABLISHMENT EXPENSES					2,670	219	212	7	1,784	1,719	64
	GENERAL SUPPLIES & SERVICES					2,906	228	231	-4	1,944	1,889	56
	INTERNAL RECHARGES					0	-0	0	-0	0	0	0
	LAB EQUIP & CONSUMABLES					1,925	160	177	-17	1,283	1,382	-99
	MED & SURG EQUIPMENT					10,443	822	900	-79	7,083	7,047	35
	MISCELLANEOUS					6,388	500	360	140	3,613	3,470	142
	NON NHS PURCHASE OF HEALTHCARE					1,480	75	187	-112	1,057	1,393	-336
	PATIENT APPLIANCES					619	51	56	-5	412	440	-28
	PREMISES & FIXED PLANT					4,010	327	433	-106	2,707	3,011	-304
	RESERVES					1,662	241	-1	242	-103	-103	-0
	SERVICES FROM OTHER NHS BODIES					4,027	306	370	-64	2,800	2,861	-62
	UTILITIES					1,438	135	122	13	847	867	-21
	X RAY EQUIP & CONSUMABLES					466	39	31	8	311	254	57
NON PAY Total						50,989	4,128	4,369	-242	32,814	33,642	-828
EXPENDITURE Total						166,593	13,686	14,319	-633	110,542	112,439	-1,897
Net Total		2,786.47	2,610.90	2,739.91	2,777.31	10,625	1,431	839	-592	7,992	6,228	-1,765
	DEPRECIATION					6,554	536	342	194	4,425	4,171	254
	DIVIDEND PAYMENT					3,672	306	106	200	2,448	2,248	200
	INTEREST					399	33	27	7	266	213	53
Total as per FIMS Month 8		2,786.47	2,610.90	2,739.91	2,777.31	0	555	364	-192	853	-405	-1,258
	IMPAIRMENTS					0	0	421	421	0	421	-421
Grand Total Month 8						0	555	-57	-613	853	-826	-1,680

8.2. Appendix 2



8.3. Appendix 3

Plan

Sub Category	Sum of MTH 1	Sum of Mth 2	Sum of MTH 3	Sum of MTH 4	Sum of MTH 5	Sum of MTH 6	Sum of MTH 7	Sum of MTH 8	Sum of MTH 9	Sum of MTH 10	Sum of MTH 11	Sum of MTH 12	Sum of Total
Back office	- 39,963	- 59,798	- 49,881	- 64,837	- 64,835	- 64,835	- 323,100	- 350,709	- 350,702	- 350,706	- 350,707	- 350,600	- 2,420,673
Bank / Agency	- 166,209	- 40,645	- 47,914	- 47,912	- 47,911	- 47,913	- 72,911	- 72,911	- 72,913	- 72,911	- 72,911	- 72,918	- 835,979
Clinical Administration							- 52,085	- 52,085	- 52,085	- 52,085	- 52,085	- 52,075	- 312,500
De-layering	- 44,402	- 4,589	- 4,588	- 4,589	- 4,589	- 4,588	- 4,589	- 4,589	- 4,588	- 4,589	- 4,589	- 4,588	- 94,877
Diagnostics/Path/Pharmacy	- 10,283	- 10,283	- 10,285	- 10,284	- 10,284	- 10,285	- 52,368	- 52,368	- 56,119	- 56,118	- 56,117	- 56,114	- 390,908
Estates	- 31,559	- 31,559	- 31,558	- 31,559	- 31,559	- 31,558	- 83,059	- 83,059	- 83,058	- 86,926	- 86,926	- 86,924	- 699,304
Extra Contribution													-
FM	- 3,999	- 3,999	- 4,001	- 3,999	- 3,999	- 37,334	- 37,332	- 37,332	- 37,334	- 37,332	- 37,332	- 37,340	- 281,333
Income leakage		- 50,000	- 25,000	- 25,000	- 25,000	- 25,000	- 75,000	- 75,000	- 75,000	- 75,000	- 75,000	- 75,000	- 600,000
LOS & Bed Management	- 130,084	- 130,084	- 130,084	- 130,084	- 130,084	- 130,084	- 264,483	- 264,485	- 264,487	- 390,541	- 390,543	- 390,538	- 2,745,581
New Investment Review		- 50,000	- 143,415	- 73,649	- 79,004	- 60,716	- 46,239	- 46,239	- 45,394	- 43,079	- 43,079	- 69,186	- 700,000
Non Recurrent Expenditure Review					- 62,501	- 62,501	- 62,501	- 62,501	- 62,501	- 62,501	- 62,501	- 62,493	- 500,000
Outpatients	- 65,734	- 65,734	- 65,734	- 119,901	- 119,901	- 119,901	- 206,341	- 206,342	- 206,341	- 206,342	- 206,341	- 206,312	- 1,794,924
PA Deduction / Clinical Pay	- 9,558	- 9,558	- 9,557	- 26,172	- 26,172	- 26,173	- 60,142	- 60,142	- 60,141	- 60,142	- 60,142	- 60,133	- 468,032
Procurement	- 5,120	- 5,120	- 60,954	- 60,953	- 60,953	- 60,954	- 60,953	- 60,953	- 60,954	- 60,953	- 60,953	- 60,959	- 619,779
Sickness			- 20,001	- 20,001	- 20,001	- 20,001	- 20,001	- 20,001	- 20,001	- 20,001	- 20,001	- 19,991	- 200,000
Theatres	- 24,851	- 24,852	- 24,852	- 24,852	- 24,852	- 24,852	- 24,852	- 24,852	- 24,852	- 24,852	- 24,852	- 24,861	- 298,232
Grand Total	**- 531,762**	**- 486,221**	**- 627,824**	**- 643,792**	**- 711,645**	**- 726,695**	**- 1,445,956**	**- 1,473,568**	**- 1,476,470**	**- 1,604,078**	**- 1,604,079**	**- 1,630,032**	**- 12,962,122**

Actual

Sub Category	Sum of MTH 1	Sum of Mth 2	Sum of MTH 3	Sum of MTH 4	Sum of MTH 5	Sum of MTH 6	Sum of MTH 7	Sum of MTH 8	Sum of MTH 9	Sum of MTH 10	Sum of MTH 11	Sum of MTH 12	Sum of Total
Back office	- 39,963	- 59,798	- 49,881	- 64,837	- 64,835	- 64,835	- 255,850	- 255,854					- 855,853
Bank / Agency	- 157,466	- 31,899	- 22,140	- 22,139	- 45,058	- 26,723	- 51,722	- 51,722					- 408,867
Clinical Administration	-	-	-	-	-	-	-	-					-
De-layering	- 44,402	- 4,589	- 4,588	- 4,589	- 4,589	- 4,588	- 4,589	- 4,589					- 76,523
Diagnostics/Path/Pharmacy	- 10,283	- 10,283	- 10,285	- 10,284	- 10,284	- 59,616	- 48,382	- 48,382					- 207,800
Estates	- 31,559	- 31,559	- 31,558	- 31,559	- 31,559	- 31,558	- 49,726	- 49,726					- 288,804
Extra Contribution	-	-	-	-	-	-	-	-					-
FM	- 3,999	- 3,999	- 4,001	- 3,999	- 3,999	- 4,001	- 3,999	- 3,999					- 31,996
Income leakage	-	- 50,000	- 25,000	- 25,000	- 25,000	- 25,000	- 75,000	- 75,000					- 300,000
LOS & Bed Management	- 130,084	- 130,084	- 130,084	- 130,084	- 130,084	- 130,084	- 414,483	- 264,485					- 1,459,472
New Investment Review	-	- 50,000	- 143,415	- 73,649	- 79,004	- 60,716	- 46,239	- 46,239					- 499,262
Non Recurrent Expenditure Review	-	-	-	-	- 62,501	- 62,501	- 62,501	- 62,501					- 250,004
Outpatients	- 65,734	- 65,734	- 65,734	- 65,734	- 65,734	- 65,734	- 90,734	- 90,734					- 575,872
PA Deduction / Clinical Pay	- 9,558	- 9,558	- 9,557	- 17,865	- 17,865	- 17,866	- 17,865	- 17,865					- 117,999
Procurement	- 1,787	- 1,787	- 57,620	- 57,620	- 57,620	- 57,620	- 60,953	- 60,953					- 355,960
Sickness	-	-	- 20,001	- 20,001	- 20,001	- 20,001	- 20,001	- 20,001					- 120,006
Theatres	- 12,903	- 12,904	- 12,904	- 12,904	- 12,904	- 12,904	- 12,904	- 12,904					- 103,231
Grand Total	**- 507,738**	**- 462,194**	**- 586,768**	**- 540,264**	**- 631,037**	**- 643,747**	**- 1,214,948**	**- 1,064,954**	**-**	**-**	**-**	**-**	**- 5,651,649**

Underachievement of CIPs	**- 24,024**	**- 24,027**	**- 41,056**	**- 103,529**	**- 80,609**	**- 82,948**	**- 231,008**	**- 408,614**					**- 995,814**

8.4 Appendix 4

STATEMENT OF FINANCIAL POSITION AS AT 30 NOVEMBER 2011

	Opening 1 April 2011 £000	Year to Date 31 November 2011 £000	Forecast 31 March 2012 £000
Non-current assets			
Property, plant and equipment	117,119	113,918	117,314
Intangible assets	13	11	10
Trade and other receivables	5	5	5
Total non-current assets	117,137	113,934	117,329
Current assets			
Inventories	3,852	3,852	3,852
Trade and other receivables	6,588	12,684	6,588
Cash and cash equivalents	4,344	3,092	4,285
Total current assets	14,784	19,628	14,725
Total assets	131,921	133,562	132,054
Current liabilities			
Trade and other payables	(12,980)	(17,870)	(14,507)
DH working capital loan	(2,730)	(1,365)	(600)
Borrowings	(1,272)	(538)	(217)
Provisions	(79)	(83)	(83)
Total current liabilities	(17,061)	(19,856)	(15,407)
Net current assets/(liabilities)	(2,277)	(228)	(682)
Total assets less current liabilities	114,860	113,706	116,647
Non-current liabilities			
Borrowings	(1,445)	(1,169)	(797)
DH working capital loan	0	0	(2,100)
Provisions	(491)	(435)	(401)
Total non-current liabilities	(1,936)	(1,604)	(3,298)
Total assets employed	112,924	112,102	113,349
Financed by taxpayers' equity:			
Public dividend capital	74,133	74,133	74,133
Retained earnings	2,436	1,614	2,861
Revaluation reserve	36,355	36,355	36,355
Total taxpayers' equity	112,924	112,102	113,349

8.5 Appendix 5

THE PRINCESS ALEXANDRA HOSPITAL NHS TRUST
CAPITAL PROGRAMME 2011/2012
ACTUAL SPEND AND FORECAST OUT-TURN AS AT 30TH NOVEMBER 2011

	Project Lead	Planned Spend 2011/2012	Expenditure to date	Forecast Out-turn at 31/03/12
		£000	£000	£000
BACKLOG				
STEAM MAINS	C Austin	24.1	18.2	24.1
HAROLD WARD PLANT ROOM	C Austin	5.9	5.9	5.9
ROAD REPAIRS	C Austin	14.9	14.9	14.9
FLOORING REPAIRS	C Austin	14.2	14.2	14.2
NURSE CALL	C Austin	5.0	4.0	5.0
NEONATAL AIRCONDITIONING	C Austin	0.4	0.4	0.4
LIFT REFURBISHMENT/REPLACEMENT	M Mizen	200.0	21.2	200.0
Sub total		**264.5**	**78.8**	**264.5**
SALIX ENERGY EFFICIENCY LOAN SCHEME				
DOMESTIC HEATING PLATE HEAT EXCHANGERS (SALIX)	C Austin	2.8	2.8	2.8
LED LIGHTING (SALIX)	M Mizen	195.0	168.3	195.0
Sub total		**197.8**	**171.1**	**197.8**
HEALTH & SAFETY - GENERAL				
FIRE ACT	C Austin	17.6	2.3	17.6
SITE SIGNAGE	C Austin	6.0	1.9	6.0
Sub total		**23.6**	**4.2**	**23.6**
DEVELOPMENT AGREED				
EMERGENCY WARD REFURBISHMENT	C Austin	55.0	26.3	55.0
JAG DEVELOPMENTS FOR DSU & THEATRES	C Austin	200.0	15.6	200.0
RADIOLOGY DEPARTMENT DEVELOPMENT	C Austin	741.6	22.8	485.1
MODULAR MIDWIFERY EXPANSION	C Austin	-	-	-
NEONATAL UPGRADE	C Austin	1,017.5	140.6	1,017.5
UPGRADE OF STROKE UNIT	C Austin	0.4	0.4	0.4
GYNAECOLOGY AMBULATORY AREA	C Austin	12.2	12.4	12.4
HDU AREA ON DOLPHIN WARD	C Austin	50.0	2.1	50.0
CAR PARKING AND EXPANSION	C Austin	200.0	6.0	200.0
EAU	C Austin	60.0	12.4	60.0
CANCER SERVICES CENTRALISATION	C Austin	50.0	30.5	50.0
WARD RECONFIGURATION	M Mizen	40.0	1.9	40.0
Sub total		**2,426.7**	**271.0**	**2,170.4**
IT				
PACS	C McNair	-	6.4	6.4
PC REPLACEMENT	C McNair	50.0	31.4	50.0
PATHOLOGY & RADIOLOGY ORDER COMMS MILESTONE PAYMENTS	C McNair	82.0	-	82.0
ESSA DISAGGREGATION	C McNair	400.0	84.5	400.0
PAS REPLACEMENT PROJECT	C McNair	125.0	120.6	125.0
SAN	C McNair	52.4	3.5	52.4
SINGLE SIGN-ON	C McNair	-	28.3	28.3
PACS SAN	R Duncombe	67.0	-	67.0
CHEMOCARE - ELECTRONIC PRESCRIBING OF CHEMOTHERAPY	R Duncombe	130.0	2.2	130.0
ELECTRONIC INCIDENT REPORTING	P Harris	26.0	-	26.0
INFOFLEX ANTENATAL	W Matthews	-	7.6	7.6
Sub total		**932.4**	**284.5**	**974.7**
OTHER				
CAPITALISATION OF REVENUE ITEMS	-	-	-	-
UNALLOCATED FUNDS	ISG	-	-	-
CONTINGENCY FUND	ISG	-	-	-
Sub total		**-**	**-**	**-**
EQUIPMENT				
MEDICAL EQUIPMENT				
Power Tools for Orthopaedics	Mags Farley	30.0	59.9	59.9
Small Moving & Handling Aids	Phil Harris	40.0	-	40.0
Mortuary Chiller & Trolleys	Rob Duncombe	24.7	-	24.7
CACS to be allocated	Rob Duncombe	25.3	-	25.3
Prosound Alpha 6 Scanner	Wendy Matthews	40.0	39.6	39.6
Radiology Department Development Equipment	Rob Duncombe	1,740.0		1,128.6
4* Servo I Adult Ventilators	Mags Farley	132.6	132.6	132.6
6TV Multiplane Cardiac Probe	J Featherstone	16.2	-	16.2
Arthroscopy Camera System	Ian Hanmore	57.0	-	80.5
Ultrasound Scanners	Rob Duncombe	164.0	-	158.1
Mattresses	-	10.0	-	10.0
IORT Equipment	-	293.2	-	293.2
Other - Purchased Leases		-	29.3	47.1
FINANCE LEASES				
Current Year Renewals		438.6	11.1	223.9
Aixplorer Multi-wave Ultrasound	Rob Duncombe	64.2	64.2	64.2
Pathfinder ECG analyser	Jim McLeish	24.4	24.4	24.4
SAN	Charles McNair	365.4	-	365.4
Echo Machine Vivid E9	J Featherstone	-	-	60.0
DONATED EQUIPMENT		42.6	42.6	42.6
Sub total		**3,508.2**	**403.7**	**2,836.3**
TOTAL CHARGE AGAINST CRL		**7,353.2**	**1,213.3**	**6,467.3**

FUNDING		
DEPRECIATION	7,115.6	7,115.6
SALIX ENERGY EFFICIENCY LOAN SCHEME 2011/12	195.0	195.0
DONATED ASSET INCOME	42.6	42.6
TOTAL FUNDING	**7,353.2**	**7,353.2**

PROGRAMME DEFICIT/(SURPLUS)	**(0.0)**	**(885.9)**

Item 13

SUMMARY REPORT	The Princess Alexandra Hospital NHS Trust
Trust Board Meeting (Part A)	22nd December 2011
Subject:	Record of Attendance
Prepared by;	Mr. Derek Greening, Trust Secretary
Approved by:	
Presented by:	Mr. David Barron, Chair

Purpose

To provide the Chair with a record of attendees at meetings to enable poor attendance to be identified and corrected.

Decision	
Approval	
Noting	●
Information	
Other	

Corporate Objectives

Safety / outcomes	Financial	Workforce	Estates-Environmental	Regulatory / Statutory	Relationships / Partnerships
		●			

Executive Summary

N/A

Key Recommendations

Board members to review their attendance

Assurance Framework

To enable the Chair to ensure that there is adequate representation by members at the Board meetings to ensure all business can be undertaken in accordance with standing orders.

Next Steps

N/A

Corporate Impact Assessment	
CQC Regulations	
Financial Implications	
Legal implications	●
Equality & Diversity	

Record of Attendance from September 2011 –

Board Member	Part A 29/9/11	Part B 29/9/11	Part A 27/10/11	Part B 27/10/11	Part A 24/11/11	Part B 24/11/11	Part A 22/12/11	Part B 22/12/11	Part A 26/1/12	Part B 26/1/12
Mr Gerald Coteman	✓	✓	✓	✓	✓	✓				
Mrs Janet Dalrymple	✓	✓	A	A	✓	✓				
Mr. Mark Devonshire	✓	✓	✓	✓	✓	✓				
Dr. Claire Feehily	✓	✓	✓	✓	✓	✓				
Mrs Paula Kerr	✓	✓	✓	✓	✓	✓				
Mr Richard Stead	✓	✓	✓	✓	✓	✓				
Dr Sylvia Thompson (Associate Member)	✓	✓	✓	✓	✓	✓				
Mrs Melanie Walker	✓	✓	A	A	✓	✓				
Mrs Yvonne Blücher	✓	✓	A	A	✓	✓				
Dr Sandra Dimmock	✓	✓	A	A	✓	✓				
Mr Darren Leech	✓	✓	✓	✓	✓	✓				
Mr Charles McNair	✓	✓	✓	✓	✓	✓				
Mr Marc Davis Director of Integrated Patient Care	✓	✓	✓	✓	✓	✓				
Mr. Robert Duncombe Associate Director, Cancer & Diagnostics	✓ (for part)									
Mr. Derek Greening Trust Secretary	✓	✓	✓	✓						
Mrs. Penny Griffiths Minute Secretary	✓	✓	✓	✓	✓	✓				
Ms. Sara Howlett EoE	✓	✓								
Ms. Raine Hunt Head of Communications	✓		✓							
Mr. Batsirai Katsande Assistant Director Lead for Performance	✓	✓	✓	✓						

Record of Attendance from September 2011 –

In Attendance	Part A 29/9/11	Part B 29/9/11	Part A 27/10/11	Part B 27/10/11	Part A 24/11/11	Part B 24/11/11	Part A 22/12/11	Part B 22/12/11	Part A 26/1/12	Part B 26/1/12
Mr Steve Swayne Director of QIPP	✓	✓	A	A		✓				
Mrs. Wendy Matthews Associate Director, Women's and Childrens Health					✓ (for part)					
Mrs. Liz Fox, Designated Nurse Safeguarding Children & Families, NHS West Essex					✓ (for part)					
Mr. Phillip Harris, Risk, Safety & Compliance Manager					✓					
Dr. Jolanta McKenzie, Consultant Histopathologist					✓					
Mrs. Andrea Philip, Maternity Manager					✓ (for part)					
Miss Janaki Putran, Consultant, Obstetrics & Gynaecology					✓ (for part)					
Mr. Alan Warren EoE	✓									
Members of the Public/Stakeholders										

Record of Attendance from September 2011 –

Mrs. Cathy Gooding LINk	✓									
Mr. Charles Jackson			✓		✓					
Ms. Lynne Marriott			✓							

Item 14

SUMMARY REPORT	The Princess Alexandra Hospital NHS Trust
Trust Board Meeting (Part A)	22nd December 2011
Subject:	Minutes from the research & Development Committee from September-November 2011
Prepared by;	Ms. Chris Cook, Research & Innovation (Interim Clinical Effectiveness) Manager
Approved by:	Dr. Sylvia Thompson, Non-Executive Director
Presented by:	Mr. David Barron, Chair

Purpose

For noting

Decision	
Approval	
Noting	●
Information	●
Other	

Corporate Objectives

Safety / outcomes	Financial	Workforce	Estates-Environmental	Regulatory / Statutory	Relationships / Partnerships
●		●		●	

Executive Summary

N/A

Key Recommendations

To note

Assurance Framework

There is a requirement for the minutes of key committees to be brought to the Board on a regular basis

Next Steps

N/A

Corporate Impact Assessment	
CQC Regulations	10
Financial Implications	
Legal implications	
Equality & Diversity	

The Princess Alexandra Hospital NHS
NHS Trust

Research & Development Committee Minutes

Meeting name & venue	Research & Development Committee – Training Room 2, Parndon Hall, PAH
Meeting date & time	Friday 16th September, 2011 – 08.00 hrs. to 09.00 hrs.
Attendees	Chris Cook – Research & Innovation (Interim Clinical Effectiveness) Manager Evelyn Holmes – Haemato-Oncology Pharmacist John Hassler – Management Accountant Adrian Cullen – Head of Cancer Services Carol Keel – Site Research Nurse Co-ordinator – CLRN Hannah Prince – Library Manager Dr. R. Sethuraman – Consultant Anaesthetist Shelley Brown – Specialist Biomedical Scientist – Cellular Pathology Richard Brown – Senior Biomedical Scientist – Cellular Pathology Dr. Dev Dutta – Consultant Anaesthetist – Vice Chair – Medical Lead – Acting Chair Dr. Salam Al-Sam – Consultant Histopathologist
Apologies for absence	Dr. Sylvia Thompson – Chair – R&D Committee Tessa Light – Research Co-ordinator – Cancer Services Terry Clarke – Lay Member – R&D Committee Andrew Foster – Clinical Skills Facilitator Jill Troup – Head of Cardiac & Stroke Services Rob Duncombe – Chief Pharmacist & A.D. Cancer & Core Business Unit Dr. Deya Elsandabesee – Consultant for Women's Health
Not Present	Dr. Vasi Sundarasen – Consultant Histopathologist
In Attendance	Dr. Paul Roberts – CLRN Manager – Essex & Herts Cluster 3

	Action Taken/Outstanding (from previous meeting)	**By Whom**	**By When**
	Action Complete **Action Outstanding**		

		100910/09 – Honorariums & Process to be developed for ST/TC & CAC BU 191110/06 – Operational Capability Statement - Timeline to be confirmed with the Cluster 3 Manager of the CLRN – ongoing – RSS Framework group to meet in April, 2011 190911/07 – MHRA Inspection – CC/CK to develop Action Plan 171210/03 - £88k contingency funding to provide pathology support the cancer trials becoming increasingly pathology heavy, also Pharmacy Technician post to support the Research Trial Pharmacist 171210/10 Further enquiries regarding the proposed changes to the national research strategy to be made. 110211/08 ST/CC to compare this to the existing Trust approval letter and to consider the funding statement within it. 200511/03 – space required for research teams, including clinical resources. 200511/15 – Although ratified at the last meeting, the Terms of Reference were forwarded to the Compliance Manager to ensure standardisation with Trust documentation. There are some issues with reporting systems and CC advised to forward to the Interim Trust Secretary for advice.	**CC** **PR** **CC/CK** **ST/CC/JH** **TC** **ST/CC** **CC**	**Ongoing** **Ongoing** **October, 2011** **Urgent** **Ongoing** **Ongoing** **Urgent**
Agenda Ref.	**Topics**	**Minutes**	**By Whom**	**By When**
160911/02	**Minutes of Meeting**	There was no meeting in August, the July meet was not quorate, therefore there are no minutes available. The June minutes are not yet available – to be ready for ratification at the October, 2011 meeting. The May minutes were agreed as a true and accurate record.		
160911/03	**Matters Arising**	See action log above. 191110/06 – Operational Capability Statement - Timeline to be confirmed with the Cluster 3 Manager of the CLRN – ongoing – RSS Framework group to meet in April, 2011 – PR to ask CLRN Governance Manager when this task should be complete.	**PR**	
160911/04	**Project Reviews**	**None.**		
160911/05	**Allocation of Projects Received**	**None.**		
160911/06	**Update of**	**See Attached.**		

	Ongoing Projects	It was agreed that where the are presently very few non-portfolio studies to review, and that the project review section of the R&D Committee agenda could be used to problem solve low recruiting studies, as well as making decisions on observational study involvement. Studies to be investigated are:- IST-3 Metasin/Cup Lungboost	**CC**	
160911/07	**NIHR Research Support Services Framework**	**PAHT Recruitment –** Email from PR outlining standardised definition of recruitment data from the NIHR, to be adhered to from 1st April, 2011 for all new studies. Unfortunately the Trust have already been victim to this legislation as EUSOS was carried out w/b 4.4.11 and all available research nurse support put into this project – then advised, retrospectively, that this recruitment does not count towards PAHT's totals. The new legislation implies that where patient consent is not sought, no recruitment figures will aligned to the Trust – See updates of projects above. TC asked what happens if a patient were to be recruited to a trial but then drops out of the study – PR advised that for all studies signed consent form + participation counts as recruitment. HP also queried the status of recruitment for observational studies – PR to obtain clarification and feedback at the October meeting with a definition of "participation". All recruitment data so far must be submitted by 30th September, 2011 or it will not count towards next year's funding. The PAHT are currently on target for projected recruitment, Homash2 and Calories will take it above. Weighting of Randomised Control Trials is now counts as 15 patients v 1 patient per observational trial; concerns were raised regarding the reputation of the Trust via the published league tables and how meaningful are these league tables if there is not absolute clarity on the recruitment definition now to be used. **MHRA Inspection –** CC/CK to develop an action plan as per last meeting (June). See Action Log above.	**PR** **CC/CK**	
160911/08	**R&D Finance Report**	Budget Statements Circulated. Details are to be discussed at the Mid-review on 28th September, 2011. PR mentioned other streams of funding available including SFS of around £30k, 3 x £10k for targeting device companies, including the adoption of "Pebble". CC/ST had previously expressed an interest in Pebble, therefore PR to present at the October meeting. Another PA session is being requested for Dr. K. Ahmed for all the work and support he has give so far in Rheumatology, but also the Trust research	**PR**	

		agenda. The CLRN Board met recently and approved guidance on commercial income, PR has reservations that the CLRN are to reserve 20% of all portfolio commercial income, where this is not practiced by other CLRN's – to be discussed further.	**ALL**	
190911/09	**Any Other Business**	SAS was particularly interested in the funding streams for the adoption of device research due to a meeting he had recently, set up by NHS Innovations East, which SAS would like to develop into a research trial at PAH in conjunction with the company concerned. CC clarified that the funding is only available for portfolio trials, and this proposal would not be eligible. SAS was advised to contact the RDSU for support with developing the research, CC to contact NHS Innovations East to find out if there is genuine interest at this time. SAS to present at the October meeting. GCP Refresher courses are now available from the CLRN – PR/CK able to deliver; CK is delivering the full session on ICU over two afternoons. Workshop for attracting Commercial Research will be held on 19th October, 2011 at SMH. CC recently attended a SBK course in Paddington on Attracting Commercial Partners; much of the success of other Trusts is the thorough feasibility, as well as R&D Management being involved in the study details from the earliest stages. Medical device research is also the way forward as most clinical trials involving medicinal products are now adopted onto the NIHR portfolio. Contact details of some of the presenters were obtained along with their presentations – CC to develop an Action Plan.	**DD/CC** **CC** **SAS** **CC**	
160911/10	**Date of Next Meeting**	Friday 14th October, 2011 in Training Room 2, First, Parndon Hall, PAHT.		

13th October, 2011

The Princess Alexandra Hospital NHS
NHS Trust

Research & Development Committee Minutes

Meeting name & venue	Research & Development Committee – Training Room 2, Parndon Hall, PAH
Meeting date & time	Friday 14th October, 2011 – 08.00 hrs. to 09.00 hrs.
Attendees	Dr. Sylvia Thompson – Chair – R&D Committee Carol Keel – Site Research Nurse Co-ordinator – CLRN Evelyn Holmes – Haemato-Oncology Pharmacist John Hassler – Management Accountant Terry Clarke – Lay Member – R&D Committee Tessa Light – Research Co-ordinator – Cancer Services Andrew Foster – Clinical Skills Facilitator Dr. Dev Dutta – Consultant Anaesthetist – Vice Chair – Medical Lead Hannah Prince – Library Manager Dr. Salam Al-Sam – Consultant Histopathologist WendyThomas, Head of Clinical Governance
Apologies for absence	Chris Cook – Research & Innovation (Interim Clinical Effectiveness) Manager
Not Present	Dr. Vasi Sundarasen – Consultant Histopathologist Rob Duncombe – Chief Pharmacist & A.D. Cancer & Core Business Unit Shelley Brown – Specialist Biomedical Scientist – Cellular Pathology Richard Brown – Senior Biomedical Scientist – Cellular Pathology Dr. Deya Elsandabesee – Consultant for Women's Health Jill Troup – Head of Cardiac & Stroke Services Adrian Cullen – Head of Cancer Services Dr. R. Sethuraman – Consultant Anaesthetist Dr. P. Roberts – Cluster 3 CLRN Manager

	Action Taken/Outstanding (from previous meeting)	**By Whom**	**By When**
	Action Complete **Action Outstanding** 100910/09 – Honorariums & Process to be developed for ST/TC & CAC BU	 **CC**	 **Ongoing**

		191110/06 – Operational Capability Statement - Timeline to be confirmed with the Cluster 3 Manager of the CLRN – ongoing – RSS Framework group to meet in April, 2011 Ongoing – MHRA Inspection 171210/03 - £88k contingency funding to provide pathology support the cancer trials becoming increasingly pathology heavy, also Pharmacy Technician post to support the Research Trial Pharmacist 171210/10 Further enquiries regarding the proposed changes to the national research strategy to be made. 110211/08 ST/CC to compare this to the existing Trust approval letter and to consider the funding statement within it. 200511/03 – space required for research teams, including clinical resources *200511/15* ***– Although ratified at the last meeting, the Terms of Reference were forwarded to the Compliance Manager to ensure standardisation with Trust documentation. There are some issues with reporting systems and CC advised to forward to the Interim Trust Secretary for advice.***	**PR** **ALL** **ST/CC/JH** **TC** **ST/CC** **CC**	**Ongoing** **Urgent** **Urgent** **Ongoing** **Ongoing** **Ongoing** **Ongoing**
Agenda Ref.	**Topics**	**Minutes**	**By Whom**	**By When**
240611/02	**Minutes of Meeting**	June, 2011 minutes agreed as true and accurate September, 2011 minutes to be ratified at November 2011 meeting		
240611/03	**Matters Arising**	See action log above.		

141011/04	**Proposed Research – Pathology**	**SA presented very early stage research proposal. Visiting Oxford site before next R&D meeting & will feed back to R&D in November to see if the project is viable & if viable will need help with producing a business case considering – support costs, running costs, disposable cost, technician costs**	**SA**	
141011/05	**Registering & Releasing Data**	**RD not present, ST to meet with RD and Trust Secretary before the next R&D Committee meeting. Information Governance needs to be involved**	**RD/ST**	
141011/06	**Project Reviews**	**589** **A Pilot Study comparing the effectiveness of peripheral nerve block in forefoot surgery for post operative pain relief when administered at the beginning of surgery rather than at the end,** Researcher: Dr Jean Osei-Kufuor – Core Surgical Trainee Year 2 – PAHT	**DD/TC/JH/RD**	

		Project Not Approved **The R&D Committee liked the concept of the research proposal but had some issues on study design:** • **Concerns that the exclusion criteria were not sufficiently tight to exclude confounding factors (e.g., diabetic patients with neuropathy).** • **Further detail is required on who will be performing the pain assessments, can this be single-blinded and more detail on when the assessments are to be done.** • **Concerns over the timings of assessments relative to the intervention and subsequent surgery (variable duration of surgery will make time to assessments variable).** **The committee acknowledged that this was described as a pilot study, and on this basis were prepared to accept the sample size but considered that improvements to the study design and assessments would render the results more relevant as an hypothesis generator for further research. The Committee would like you to review the protocol and re-submit this project for approval. The committee would welcome your attendance at the R&D meeting to go through the proposal.** **489-220208 - Amendment** National Diet and Nutrition Survey 2008-2012, Researcher: Dr. Birgit Teucher - Survey Co-ordinator - MRC Human Nutrition Research – Cambridge **Approved**	**HP/JH/AC**	

141011//07	**Allocation of Projects Received**	**None.**	**AF/ST**	

141011//08	**Update of Ongoing Projects**	**Nil**	**CC**	
141011//09	**NIHR**	**MHRA Inspection –** CC/CK have developed an action plan & a dossier of	**CC/CK**	

	Research Support Services Framework	documents in preparation for a MHRA inspection. These need to be reviewed by a sub-committee of the R&D Committee & an extraordinary meeting will need to be arranged. ST & TC are happy to attend extraordinary meeting; Once time is set – invite all committee members to 'pop in' **Standardised Definition of Recruitment Data – Clarification –** PR not present, deferred to next month	**PR**	
141011//10	**R&D Finance Report**	Budget Control report for ending 30 September 2011 & R&D Project income & expenditure discussed	**JH**	
141011//11	**Any Other Business**	**Medical Records:** CK – Updated R&D Committee re Research Flag in Medical Records – in front of Correspondence section in patient notes – SOP to be written; To get Research flagged on CAS Cards; **Using TV's to Promote Research** – CC & CK have applied via PAH Communications Team – NIHR Survey Monkey to use the accredited programme on the TVs in areas such as OPD **Comments Book** – CK – The research nurse team have a pt comments book which has proved popular, however the team is now looking at devising a card system & will get back to R&D with more details **Fire Trial:** DD informed R&D that he received a letter to say that the data collected from PAH was excellent data & that they were entitled to £2500.00. DD wants to donate this to IT Charitable fund	**DD/CC**	
141011//12	**Date of Next Meeting**	Friday 11th November, 2011 in Training Room 4, ,Parndon Hall, PAHT.		

28th October, 2011

The Princess Alexandra Hospital NHS
NHS Trust

Research & Development Committee Minutes

Meeting name & venue	Research & Development Committee – Training Room 4, Parndon Hall, PAH
Meeting date & time	Friday 11th November, 2011 – 08.00 hrs. to 09.00 hrs.
Attendees	Dr. Sylvia Thompson – Chair – R&D Committee Chris Cook – Research & Innovation (Interim Clinical Effectiveness) Manager Rob Duncombe – Chief Pharmacist & A.D. Cancer & Core Business Unit Evelyn Holmes – Haemato-Oncology Pharmacist John Hassler – Management Accountant Terry Clarke – Lay Member – R&D Committee Andrew Foster – Clinical Skills Facilitator Dr. Dev Dutta – Consultant Anaesthetist – Vice Chair – Medical Lead Hannah Prince – Library Manager Dr. R. Sethuraman – Consultant Anaesthetist Shelley Brown – Specialist Biomedical Scientist – Cellular Pathology Richard Brown – Senior Biomedical Scientist – Cellular Pathology Dr. Salam Al-Sam – Consultant Histopathologist
Apologies for absence	Carol Keel – Site Research Nurse Co-ordinator – CLRN Tessa Light – Research Co-ordinator – Cancer Services Shelley Brown – Specialist Biomedical Scientist – Cellular Pathology Richard Brown – Senior Biomedical Scientist – Cellular Pathology Dr. Deya Elsandabesee – Consultant for Women's Health
Not Present	Dr. Salam Al-Sam – Consultant Histopathologist Dr. Vasi Sundarasen – Consultant Histopathologist Jill Troup – Head of Cardiac & Stroke Services Adrian Cullen – Head of Cancer Services Dr. R. Sethuraman – Consultant Anaesthetist Dr. P. Roberts – Cluster 3 CLRN Manager
Present	Dr. Khalid Ahmed – Consultant Rheumatologist

		Action Taken/Outstanding (from previous meeting)	By Whom	By When
		Action Complete **191110/06** – Operational Capability Statement - Timeline to be confirmed with the Cluster 3 Manager of the CLRN – ongoing – RSS Framework group to meet in April, 2011. To be agreed at December meeting and signed off by Trust Board by January, 2012 **200511/03** – space required for research teams, including clinical resources **Action Outstanding** **100910/09** – Honorariums & Process to be developed for ST/TC & CAC BU Ongoing – MHRA Inspection **171210/03** - £88k contingency funding to provide pathology support the cancer trials becoming increasingly pathology heavy, also Pharmacy Technician post to support the Research Trial Pharmacist - Decision to be made by 3.12.11 **171210/10** Further enquiries regarding the proposed changes to the national research strategy to be made. **110211/08** ST/CC to compare this to the existing Trust approval letter and to consider the funding statement within it. **200511/15** – Although ratified at the last meeting, the Terms of Reference were forwarded to the Compliance Manager to ensure standardisation with Trust documentation. There are some issues with reporting systems and CC advised to forward to the Interim Trust Secretary for advice. **111111/09** – Standardised Definition of Recruitment Data **141011/05** – Registering and Releasing Data. ST/RD met with Trust Interim Secretary on 10.11.11 which resulted in seven questions to take back to the company requesting participation of PAHT in the data sharing scheme. ST to compose an email response back to PH Associates.	**CC** **ST/CC/JH** **TC** **ST/CC** **CC** **PR** **ST**	**Ongoing** **Urgent** **Ongoing** **Ongoing** **Ongoing** **Dec 2011** **Dec 2011**
Agenda Ref.	**Topics**	**Minutes**	**By Whom**	**By When**
111111/02	**Minutes of Meeting**	The September, 2011 minutes were agreed as true and accurate record.		
111111/03	**Matters Arising**	See action log above. **141011/11** – Funding for FIRE Trial – DD was advised that this is to be kept within the R&D budget restrictions and used accordingly.	**ST**	**Dec 2011**

111111/04	**DP Golimumab Funding**	Dr. K. Ahmed (KA) was present for this agenda item. ST introduced KA, explaining the issue around the drug trial, now NICE approved and that now that more trials are active across the Trust, in various specialties, end of trial drug usage needs to be dealt with to add clarification to future research activity. The main Issue raised was, could the R&D committee/function influence anything within the remit of the CTA prior to the trial commencing? RD explained that the with this particular trial drug the patient lives in Hertfordshire and the PCT Medical Advisor is rigid around the rules of approved trial drugs. EH raised concerns that the drug company did not make it clear that the drug, once NICE approved, could only be used with Mithatrexate; had the Trust been informed this situation may not have arisen. ST suggested the way forward would to consider the provision of the trial drug beyond the trial as part of the feasibility process, formalising end of trial status of treatment with NICE so that the Patient and the PI are aware and to negotiate with drug companies on this basis. If this is not feasible, to consider inclusion of the subject within the CTA, but not sure if this would be accepted. EH to check if the Pharmaceutical company for this trial were aware of the limitations. A decision will then be made how to take this forward.		
111111/05	**Project Reviews**	**Substantial Amendments** **<u>576- 240611 – TC/RB/JH</u>** An evaluative investigation into the experiences that mentors who have had mentoring pre-registration student nurses, who have had learning difficulties in their clinical placements (e.g. dyslexia): Debbie Cubbitt – Practice Education Facilitator – PAHT TC/RB could not see what the amendment was and requested that the amendments are outlined and a summary provided. It was agreed to feedback to the PI and to then process and approve electronically.		

111111/06	**Allocation of Projects Received**	**None.**		

111111/07	**Update of Ongoing Projects**	See report attached. RS informed the Committee that spotlight is now closed to recruitment and that the quality of the Trust data is good. Real 3 is now closed to recruitment due to safety reasons, there has been an increase in the number of deaths due to the trial drug, the PI is reviewing the PAHT cases. The Trust has been asked to destroy the drug.		
111111/08	**NIHR Research Support Services Framework**	**Capability Statement**: To be emailed to committee with a view to accepting/changing details for sign off by the Trust Board. **Standardised Definition of Recruitment Data** – clarification by PR – not present – deferred to December, 2011 meeting.		
111111/09	**R&D Finance Report**	JH stated that the £88k Contingency funding needed to be used by 31.3.11 or would have to be handed back to the CLRN. Ideas were requested from the Committee. Cancer Services are to move William's Day Unit at the weekend; RD advised there was some space that could be utilised for the Research Nurse Team/Research clinical space. RD/CC to assess the space of Williams Day.		
111111/10	**Any Other Business**	None		
111111/11	**Date of Next Meeting**	Friday 9th December, 2011 in Training Room 4, Parndon Hall, PAHT.		

8th December, 2011