The Princess Alexandra Hospital NHS Trust

Public Meeting of the Board of Directors

AGENDA

Date and Time: Thursday 1 August 2019 at 09.30 - 13.00

Venue: **The Herts and Essex Hospital**, Haymeads Lane, Bishop's Stortford, Hertfordshire, CM23 5JH in the Medical Secretaries Room, Ground Floor.

Time	Item	Subject	Action	Lead	Page
01 OPENING ADMINISTRATION					
09.30	**1.1**	Apologies	-		
	1.2	Declarations of Interest	-	Chairman	
	1.3	Minutes from meeting held on 06.06.19	Approve	Chairman	4
	1.4	Matters Arising and Action Log	Review	All	13
02 PATIENT STORY					
09.35	**2.1**	Paula's Story			14
03 RISK					
10.00	**3.1**	Significant Risk Register	Review	Chief Medical Officer	18
10.10	**3.2**	Board Assurance Framework 2019-20	Approve	Head of Corporate Affairs	23
04 CHIEF EXECUTIVE'S REPORT					
10.20	**4.1**	CEO's Report	Discuss	Chief Executive	41
05 PATIENTS					
10.40	**5.1**	Learning from deaths presentation (CCCSS)	Discuss	Chief Medical Officer	Pres'n
11.00	**5.2**	Nursing, Midwifery and Care Staff Levels including Nurse Recruitment	Discuss	Director of Nursing and Midwifery	45
11.10	**5.3**	Pathology Services	Discuss	Chief Executive	55
11.20	**5.4**	Maternity Incentive Scheme	Approve	Director of Nursing and Midwifery	57
11.30	**5.5**	Maternity Serious Incident Cluster	Discuss	Director of Nursing and Midwifery	69
BREAK (10 minutes)					
06 PEOPLE					
11.50	**6.1**	Annual Report: Medical Revalidation	Approve	Chief Medical Officer	84
07 PERFORMANCE					

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11.55	**7.1**	Integrated Performance Report	Discuss	Executives	104
08 PLACES					
12.15	**8.1**	Capital Programme	Approve	Chief Executive/Director of Strategy	140
09 GOVERNANCE					
12.25	**9.1**	Reports from Committees: • WFC.22.07.19 • PAF.25.07.19 • QSC.26.07.19 including Annual Research and Development report • CFC.25.07.19	Note	Chairs of Committees	147 148 149 150 160
12.35	**9.2**	Report from Senior Management Team meetings: July 2019	Note	Chief Executive	161
10 QUESTIONS FROM THE PUBLIC					
12.45	**10.1**	Opportunity for Members of the Public to ask questions about the Board discussions or have a question answered.	Discuss	Chairman	
11 CLOSING ADMINISTRATION					
	11.1	Summary of Actions and Decisions	-	Chairman/All	
	11.2	New Issues/Risks	Discuss	All	
	11.3	Reflection on Meeting	Discuss	All	
13.00	**11.4**	Any Other Business	Review	All	

Public Board Meeting dates 2019/20

23 May 2019 (ETB)	3 October 2019
6 June 2019	5 December 2019
1 August 2019	6 February 2020

Board Purpose
The purpose of the Trust Board is to govern the organisation effectively and in doing so to build public

and stakeholder confidence that their health and healthcare is in safe hands and ensure that the Trust is providing safe, high quality, patient-centred care. It determines strategy and monitors performance of the Trust, ensuring it meets its statutory obligations and provides the best possible service to patients, within the resources available.
Board Quoracy
One third of voting members, to include at least one Executive and one Non-Executive (excluding the Chair). Each member shall have one vote and in the event of votes being equal, the Chairman shall have the casting vote.
Ground rules for meetings
1. The purpose of the meeting should be defined on the day (set the contract). 2. Papers should be taken as read. 3. The purpose of a paper must be clearly explained and the decision/s to be made must be identified. 4. Members/attendees are encouraged to ask questions rather than make statements and are reminded that when attending meetings, it is important to be courteous and respect freedom to speak, disagree or remain silent. Behaviour in meetings should be in line with the Trust's Behaviour Charter. 5. Challenge should be constructive and a way of testing the robustness of information. 6. Members/attendees are encouraged to support the Chair of the meeting to ensure the meeting runs to time. 7. The use of mobile phones during meetings should be avoided; phones must be set to silent. 8. If the duration of a meeting is likely to exceed 2 hours a break should be taken at a convenient point.

Board Membership and Attendance – 2019/20			
Non-Executive Director Members of the Board (voting)		**Executive Members of the Board (voting)**	
Title	**Name**	**Title**	**Name**
Trust Chairman	Steve Clarke	Chief Executive	Lance McCarthy
Chair of Audit Committee (AC)	George Wood	Chief Finance Officer	Trevor Smith
Chair of Quality & Safety Committee (QSC)	Dr. John Hogan	Chief Operating Officer	Stephanie Lawton
Chair of Performance and Finance Committee (PAF)	Andrew Holden (Vice Chairman)	Chief Medical Officer	Dr. Andy Morris
Chair of the Workforce Committee (WFC)	Pam Court	Director of Nursing & Midwifery	Sharon McNally
Chair of Charitable Funds Committee (CFC)	Dr. Helen Glenister	**Executive Members of the Board (non-voting)**	
Associate Non-Executive Director (non voting)	Helen Howe	Director of Strategy	Michael Meredith
Associate Non-Executive Director (non voting)	John Keddie	Director of People	Gech Emeadi
		Director of Quality Improvement	Jim McLeish
Corporate Secretariat			
Head of Corporate Affairs	Heather Schultz	Board & Committee Secretary	Lynne Marriott

The Princess Alexandra Hospital NHS
NHS Trust

Minutes of the Trust Board Meeting in Public
Thursday 6 June 2019 from 09:30 – 12:30, PAH Board Room

Present:	
Steve Clarke	**Trust Chairman (TC)**
Pam Court	Non-Executive Director (NED-PC)
Lance McCarthy	Chief Executive Officer (CEO)
Ogechi Emeadi (non-voting)	Director of People (DoP)
Helen Glenister	Non-Executive Director (NED-HG)
John Hogan	Non-Executive Director (NED-JH)
Andrew Holden	Non-Executive Director (NED-AH)
Helen Howe (non-voting)	Associate Non-Executive Director (ANED-HH)
Stephanie Lawton	Chief Operating Officer (COO)
Jim McLeish (non-voting)	Director of Quality Improvement (DoQI)
Sharon McNally	Director of Nursing & Midwifery (DoN&M)
Michael Meredith (non-voting)	Director of Strategy (DoS)
Andy Morris	Chief Medical Officer (CMO)
Trevor Smith	Chief Financial Officer (CFO)
Staff Story:	
Laura Arnone	Deputy Team Leader - Urology, Colorectal, and General Surgery
Martin Smith	Associate Director – Training, Education & Development
Maxine Priest	Theatres
Pam Humphrey	Associate Director of Nursing – Surgery & Critical Care
Elaine Purton	Team Leader
Learning from Deaths:	
Jane Snook	AMD-Medicine
In attendance:	
Laura Warren	Associate Director - Communications
Apologies:	
None received.	
Secretariat:	
Heather Schultz	Head of Corporate Affairs (HoCA)
Lynne Marriott	Board & Committee Secretary (B&CS)

01 OPENING ADMINISTRATION	
1.1	The Trust Chairman (TC) welcomed all to the meeting.
1.1 Apologies	
1.2	As noted above.
1.2 Declarations of Interest	
1.3	No declarations were made.
1.3 Minutes of Meeting on 04.04.19	
1.4	The minutes of the meeting held on 04.04.19 were agreed as a true and accurate record of that meeting with no amendments.
1.4 Matters Arising and Action Log	
1.5	It was agreed that actions TB1.04.04.19/01, TB1.04.04.19/02 and TB1.04.04.19/04 would be closed. Action TB1.04.04.19 was not yet due.
02 STAFF STORY *(19 minutes)*	
2.1 "Growing our own Staff"	
2.1	This item was introduced by the Director of People (DoP) and she welcomed the Deputy Team Leader – Urology, Colorectal & General Surgery (DTL-UCGS) and her team to the meeting. She handed over to the DTL-UCGS who detailed her story as below.
2.2	The DTL-UCGS was currently working as a qualified Operating Department Practitioner (ODP) but had worked in the NHS for ten and enjoyed a very varied career. Her NHS career

	had started at the age of 17 as a Business Apprentice in the Training Department, she had become a training assistant and working alongside the Critical Care Outreach Team (CCOT) she had realised her desire for a clinical career.
2.3	In 2013 she started her ODP training with a placement at PAH, completed her training in 2015 and was immediately offered a permanent position in Theatres as an ODP. Over the next two years she flourished and was awarded "Most Caring Employee for Surgery HCG" in 2017 and went on to be runner up for "Most Responsible Staff Member at PAH".
2.4	In 2017 she secured a role working for the UK's Organ Retrieval Team as a Senior ODP at a busy cardio thoracic hospital but returned to PAH in 2018 and became the Lead Trainer for manual handling and STEM Ambassador for the Trust.
2.5	At the start of 2019 she took a secondment as a Band 6 Practitioner. As a final point she emphasised that none of the above would have happened without the support and understanding of various teams at the Trust.
2.6	The Chief Medical Officer (CMO) thanked the DTL-UCGS for her presentation and emphasised how the role of the ODP was a critical, integral and well respected part of the Theatre team. Being able to cover three areas as part of her role was a unique and fantastic opportunity.
2.7	In response to a question from NED John Hogan (NED-JH) it was confirmed there were various training and development opportunities offered by the Trust. In addition a staff member was now a Governor at the local STEM academy and students visited the hospital for taster sessions.
2.8	In response to a question from NED Pam Court (NED-PC) the DTL-UCGS confirmed that her experience at PAH had been strengthened by the support and friendship of her colleagues.
2.9	Associate NED Helen Howe (ANED-HH) highlighted that the story being told was one she would welcome seeing replicated across the Trust in terms of culture and suggested creating a video of the story for the Trust's website.
2.10	The TC thanked the DTL-UCGS for relaying her story to the Board.
03 REPORT FROM CHIEF EXECUTIVE	
3.1 CEO's Report *(14 minutes)*	
3.1	The CEO presented his report. Key headlines were: **Performance indicators:** There had been one case of C-difficile in April. In addition performance against the ED remained significantly below where it should be and numbers of attendances continued to increase materially (>9% increase in April 2019 compared with April 2018). Figures for Summary Hospital-level Mortality Indicator (SHMI) would be added in future iterations. **CQC Inspection:** the Ratings Approval Meeting (RAM) would take place that day and it was anticipated the draft inspection report would be with the organisation by the following Monday. A factual accuracy exercise would then be undertaken with a publication date to then be agreed. **NHSE/NHSI Regional East of England Team:** the closer alignment of NHS England and NHS Improvement had taken a significant step with the commencement of the new joint Regional team from 01.04.19. The appointment to the senior leadership roles in the region had now been completed. **Development of Integrated Care System (ICS) and Integrated Care Providers (ICPs):** The last two months had seen much discussion and thought across the STP about how to transition to an ICS over the next two/three years. Within that a framework was emerging for how the ICPs may evolve. **Domestic Services:** the potential for industrial action that day had been averted and the organisation would now work with the service to develop a detailed transformation plan.
3.2	In response to a concern raised by NED-AH as to whether the Trust's current financial position should be included as an indicator, members agreed that the CEO should review the indicators that were included in his report.
ACTION **TB1.06.06.19/05**	**Review the indicators included in the CEO report.** **Lead: CEO**

04 RISK	
4.1 Significant Risk Register (SRR) *(4 minutes)*	
4.1	The Chief Medical Officer (CMO) presented the paper which was taken as read. He highlighted that the second bullet on the cover sheet should read: "20 risks score 20 (increased from **18** in April 2019)". The plan going forward would be to await the CQC's draft report and to then dedicate the next meeting of the Trust's Risk Management Group (RMG) to reviewing the presentation of the SRR and the BAF.
4.2	The TC posed a question in relation to timeframes for actions relating to 'additional Cystoscopy sessions' and 'previously administered medication not showing on JAC' (page 20 of the papers). In response the CMO confirmed that the Cystoscopy list had now been cleared and JAC software was being upgraded; in the meantime robust mitigations were in place.
4.3	In response to two questions from ANED-HH in relation to also establishing a biliary stent register and the vacuum packing of endoscopes to avoid repeat processing, the CMO and Chief Operating Officer (COO) undertook to establish the current position and report back.
ACTION **TB1.06.06.19/06**	**Confirm whether a biliary stent register has been established.** **Lead: Chief Medical Officer** **Confirm whether there has been any discussion around the vacuum packing of endoscopes.** **Lead: Chief Operating Officer**
4.4	In relation to reputational risks, NED Helen Glenister (NED-HG) queried how those would be scored. In response the CMO confirmed the use of a matrix for scoring purposes which contained seven domains including scoring for any reputational element.
4.5	The Board noted the report.
4.2 Board Assurance Framework (BAF) *(4 minutes)*	
4.6	This item was presented by the Head of Corporate Affairs (HoCA) - she reported that the risk scorings had not changed that month and feedback in the CQC's report would dictate next steps.
4.7	The CEO updated colleagues that some initial feedback received from the CQC had been that the Trust's risks were too "wordy" and further work would be undertaken to review the BAF in light of this feedback. The BAF evidenced the risks to delivery of the organisation's strategic objectives and currently the milestones/KPIs reflecting progress were not included and consideration was being given to including those in the refreshed version of the BAF.
4.8	NED-HG cautioned that in the meantime the organisation should retain its current processes and continue to review the BAF until such time as any changes were agreed.
4.9	The TC agreed with the above comment and on behalf of members confirmed the Board noted the current position and risk scores presented.
05 PATIENTS	
5.1 Quality Account 2018/19 *(6 minutes)*	
5.1	The draft Quality Account was presented by the Director of Nursing & Midwifery (DoN&M) and the paper was taken as read. The document would need to be finalised and published on the Trust's website and in order to facilitate that, the Board agreed at that point, to delegate authority to the NEDs and Lead Executives of the Quality & Safety Committee (QSC) to approve the final version of the document outside the Board.
5.2	In response to a question from NED-PC it was confirmed the document had been circulated externally for feedback and this feedback would be included in the report.
5.3	In response to points raised by NED-AH and NED-HG, the DoN&M agreed the current document was very lengthy and this would be reviewed prior to production of the following year's account including addressing of formatting issues within the document.
5.4	ANED-HH reminded colleagues that the CQC had raised concerns in relation to the organisation's Clinical Audit Programme and asked whether a robust process was now in place. In response the CMO confirmed the process was indeed robust with sign-off by Clinical Leads required and logging and tracking via Audit Assure. Members noted that

	progress was reported to QSC.
5.2 Mortality Improvement Plan and Learning from Deaths *(45 minutes)*	
5.5	The CMO introduced the Associate Medical Director for Medicine (AMD-M) who would take members through the "Learning from Deaths" element of the item. He handed over to the AMD-M. She provided details of the case as follows:
5.6	A very elderly, frail patient with life threatening co-morbidity presented to ED after a fall at home and fractured neck of femur (#NoF). After discussion with intensive care, anaesthetic and orthopaedic colleagues and then with the family, the patient underwent surgery but with a predicted high risk of death. Ceilings of care were agreed and shared with the family. The patient's care was further compromised by difficulty obtaining suitably matched blood. Following surgery, the patient deteriorated and subsequently died.
5.7	The AMD-M highlighted areas of care that had gone well as well as what could have been done differently. The newly established work-streams (park of the Mortality Improvement Programme) would support improvements and the emphasis on "Right patient right ward" would assist in fast-tracking to the wards.
5.8	NED-JH raised a concern around professional standards and in particular the apparent poor documentation during the patient journey. In response the AMD-M confirmed work was now underway to address that.
5.9	In response to a question from NED-PC it was confirmed a policy was in place for #NoF patients' haemoglobin to be above 90 before leaving recovery. It was also confirmed that in relation to decisions around DNACPR, this was talked about more now particularly at 'red-to-green' meetings and with robust challenge from nursing staff.
5.10	In response to a question from ANED-HH the CMO confirmed that a Lead Medical Examiner and six Medical Examiners (including one external) would be appointed that afternoon which would enable a review of all inpatient deaths by the end of the financial year.
5.11	The TC thanked the AMD-M for presenting the case.
5.12	In terms of an update on mortality in general the CMO reminded members that it would take time for a change to be seen in HSMR/SHMI. However, he was pleased to report a downward shift in the 12 monthly HSMR by just under 1% in the last three months and in-month HSMR for the last three months had been "as expected". The tracker (previously requested by the Board) was now nearly 80% populated and the Mortality Improvement Board that week had not raised concerns or risk around any of the projects.
5.13	In response to a question from ANED-HH the CMO confirmed that in terms of what excellence looked like for #NoF the Trust worked to best practice tariff. The trajectory was a changing target as the work moved forward but the tracker did evidence progress despite not yet reaching the end result in terms of #NoF. In response to a question from NED-JH the CMO confirmed that the tracker absolutely correlated and triangulated with other sources of data he was seeing e.g. best practice tariff/Dr. Foster.
5.14	The DoQI reminded members that the Mortality Improvement Programme was a significant programme of work with 18 projects over five work-streams to address patient pathways. There was significant progress that was not yet captured in the tracker and metrics were now being recorded that had not been recorded before, hence the continual shift in data.
5.15	ANED-HH highlighted that the Quality Account had indicated that the organisation's palliative care coding was below national average. In response the CMO confirmed that was correct and work modelled by Dr. Foster indicated that better coding did reduce HSMR. Plans were in place to extend the organisation's palliative care service and the Recording & Reporting work-stream would also address the palliative care coding rate.
5.16	After a short discussion it was agreed that the MIB would continue to report monthly to QSC with any concerns escalated to the Board by QSC. At the same time the Mortality Tracker would be inserted into the Integrated Performance Report (IPR). In October there would be a report to the Board which would be a look back on the previous six to eight months of work by the MIB.
ACTION **TB1.06.06.19/07**	**Mortality Tracker to form part of the IPR as of July 2019.** **Lead: Chief Medical Officer**

ACTION **TB1.06.06.19/08**	**Progress on work undertaken by MIB to be reported to TB1.03.10.19.** **Lead: Chief Medical Officer**
5.3 Nursing, Midwifery and Care Staff Levels including Nurse Recruitment *(14 minutes)*	
5.17	This paper was presented by the DoN&M. Key headlines were: • Whilst the Registered Nurse/Midwife (RN/M) fill rate had dropped in month, the overall fill rate (RN/M and HCA) for the wards remained static. • There had been a reduction in NHSP demand. • The overall nursing vacancy position remained broadly unchanged in M1 as did the Band 5 vacancy rate. The Band 5 pipeline recruitment plan had been slow to start but had picked up. The target offer rate continued to have strong focus with a projected stepped increase in the number of new starters from August 2019.
5.18	NED-AH raised a concern that the vacancy rate had increased from the previous report. In response the DoN&M confirmed the target was less than 10% but would change depending on the pipeline. It was not a target but a forecast of what the recruitment programme would deliver. Currently the organisation was behind trajectory due to start dates delaying the progress. A business case for international recruitment would go to Executive Management Team (EMT) the following day with suggestions for speeding up the process. NMC processes were also taking from four to nine weeks on average.
5.19	In response to continuing concerns from NED-AH that vacancies had increased by circa 50 that month it was agreed that an additional line would be added to the report to show "variation from target". The TC agreed that it appeared some of the assumptions made may have been optimistic. In response the CEO agreed that the assumptions would be listed in conjunction with the target. The trajectory would remain and then members would be able to monitor and track progress and any changes would be updated at Board. NED-AH and the DoN&M would discuss further outside the meeting.
ACTION **TB1.06.06.19/09**	**Revise Hard Truths Report to show:** **1. Target (10%)** **2. Variation from target** **3. Assumptions made** **Lead: Director of Nursing & Midwifery**
5.20	In response to a question from ANED-HH it was confirmed that midwifery vacancies were not a challenge and were reported in the first section of the report.
5.21	The CEO added that in terms of good news, staff redeployment hours were reducing and Care Hours Per Patient Day (CHPPD), whilst still below target, were increasing.
06 PEOPLE	
6.1 Freedom to Speak Up Self-Assessment *(4 minutes)*	
6.1	The DoP presented the Trust's Freedom to Speak Up Self-Assessment which reflected where the Trust had met/partially met or not met the expectations along with the supporting evidence and actions. It focussed on leadership and governance where there had been significant progress from partially met to fully met. An area for improvement was around patient safety and links to the Patient Safety & Quality Group. .
6.2	NED-PC welcomed the movement in scorings and stated that WFC had requested a plan on how to achieve the next steps in relation to addressing the themes of concerns raised to the FTSUG's. In response to a question from NED-JH it was confirmed that current themes (as reported by the FTSUGs) were bullying and harassment – Unconscious Bias training would now be undertaken by key staff. Themes would now be built into the HCG Performance Reviews and the FTSUGs would be invited to those.
6.3	An error on page eight of the report was noted – the Chair of QSC was John Hogan (not Helen Glenister).
6.4	The Board approved the Self-Assessment.
07 PERFORMANCE	
7.1 ED Performance – Next Steps *(26 minutes)*	
7.1	This paper was presented by the Chief Operating Officer (COO) and had also been

	presented at PAF. She was able to confirm that May performance had been 74%, an improvement on April. Work with ECIST was gaining momentum and as of the following week teams would start to pull patients through from the Assessment Unit ('golden patient of the day'). In alignment with that, work was underway with NHSI to review rotas and medical plans in ED in particular.
7.2	The COO continued. Long stay patients had now reduced from 58 in April to 35 as of that day. There were no longer any patients in the hospital over 100 days and now only five just over 50 days with plans in place for each. The Trust had been identified as one of the first six trusts to be on weekly reporting for patients over 21 days.
7.3	The COO updated that the team had now recruited to all ED tracker positions so trackers in place seven days per week in ED. Two interim Clinical Leads were in place and the new AMD would start on 09.09.19.
7.4	In terms of June performance that was currently at 84% week to date and there had been two days that week where Paediatric ED had recorded 100%. Workforce remained challenging but to recruit an additional 9.5 middle grade doctors to achieve establishment over the next six months.
7.5	A good news story was the Frailty Service. The team were now looking to roll the service out over seven days. There would be a new integrated front door model from the end of the summer and the GP out-of-hours contract awarded at the end of April was now starting to embed.
7.6	Winter planning had started already and work was underway to look at capacity in the system with a real drive to have extra capacity in place that year by November. By December the organisation would also need to meet all the requirements to become an Urgent Care Treatment Centre and an Expert Oversight Group (EOG) was currently working through those standards.
7.7	NED-JH asked some further questions around medical staffing. In response the COO confirmed that of the 9.5 doctor vacancies to be recruited to, they were currently filled by locums/long line locums. The appointment of the new AMD would bring the number of consultants to seven (against an establishment of 12). It was hoped the work with the Midlands & East Lead for Emergency Care would reduce current vacancies.
7.8	The TC thanked the COO for her update and wished her well with upcoming recruitment.
Members took a ten minute break.	
7.2 Integrated Performance Report *(17 minutes)*	
7.11	The COO introduced the item and handed over to appropriate Executive colleagues for relevant sections. Key points to note under the 5P headings were:
7.12	**Patients:** The DoN&M highlighted the report now included data around Maternity and Mental Health. There had been an increase in the number of pressure ulcers but that was in line with new NHSI standards and she had no concerns.
7.13	**Performance:** The COO reported that the standards for Diagnostics and RTT had both been met. The Cancer standard had not been met but this was now on track. .
7.14	**People:** The DoP reported that compliance with statutory/mandatory training had been above target for the past six months. The key focus now would be reducing the nursing vacancy rate and 'time to hire'.
7.15	**Places:** The DoQI highlighted the continuing improvement in Catering Services and reduction in waste management. Training and appraisal compliance rates for Estates & Facilities were above trajectory for both.
7.16	**Pounds:** The CFO reported that initial indications for Month 2 were continued high levels of temporary and agency staff and whilst activity had picked up in-month it had tailed off leading to underperformance in–month. CIP and QIPP targets both remained unidentified and with shortfalls in delivery. Actions in place to address the above were in place with discussions underway with Commissioners to agree financial principles for the coming year, re-issue of 'grip and control' check-lists to the organisation, discretionary spend restrictions, weekly meetings with the Medicine HCG around temporary staffing and additional CIP sessions with budget holders. The situation needed to be addressed as a matter of urgency and increased monitoring from Regulators had already begun.

7.17	In response to a question from NED-JH the CFO confirmed in the previous two to three years agency costs had steadily reduced and targets had been met or exceeded. Currently the run rate for temporary staff was £1.2m per month against an achievement the previous year of £9.6m. The CMO confirmed that requests for temporary staff had plateaued over recent weeks but, at the same time, agency costs had risen. In addition it was confirmed some consultants were changing their working patterns due to pension changes, which was being reviewed particularly in relation to additional sessions.
7.18	In response to a question from NED-PC the CFO confirmed the new pay reforms had been complex with a shortfall in the previous year covered by a payment to the Trust at the end of the financial year. There would then be two years uplift in tariff to cover the gap but it was unclear currently if that would suffice. The DoP cautioned there were two issues in terms of pensions. The first was the changes to NHS pensions and employer contributions, the second was around the tax allowance which was a national issue.
7.19	In summary the CFO stated he felt the financial position was retrievable. .
7.20	In response to a question from NED-PC in relation to confidence around delivery of CQUINS the CFO confirmed there were two challenges being addressed; ongoing conversation with Commissioners in relation to the start dates for trajectories and teams progressing elements of the schemes within their remits.
7.21	The TC thanked Executive colleagues for their updates.
08 GOVERNANCE *(10 minutes)*	
8.1 Information Governance Update: Data Security Protection Toolkit (DSPT) Publication 31.03.19	
8.1	This update was presented by the CFO. The paper provided the Board with the publication scores for the Data Security Protection Toolkit (DSPT) 31.03.19. The Trust was required to publish a 'baseline' assessment by 31.10.18 and full annual self- assessment using the new toolkit by 31.03.19, both of which had taken place on time.
8.2	The Trust submitted a critical standards 'not' met publication as of 31.03.19 but provided its Improvement Plan to NHS Digital (NHSD); Outstanding areas of DSPT compliance were being addressed via the Improvement Plan. Key matters to be completed included 95% compliance rate for Data Security Awareness training, data flow mapping and contract clauses associated with GDPR in line with previous Board agreed timescales. The Trust remained on track to deliver by the end of July and non-compliance with training was being escalated.
8.3	The CMO flagged there were no sanctions in place for non-compliance with statutory/mandatory training for medical staff. Letters had gone out to those who were non-compliant The DoQI cautioned it should be clear first why certain staff were not compliant before penalties were applied but agreed all staff should be treated the same.
8.4	Members agreed that whilst sanctions for medical staff had been discussed previously, no further action shad been agreed. The new terms of Agenda for Change stipulated that for non-clinical staff there would be no pay progression unless training/appraisal had been completed whereas for medical/dental staff that rule did not apply. After a short discussion it was agreed the COO would discuss this with AMDs to ensure training was completed by medical staff in their HCG.
ACTION TB1.06.06.19/10	**COO to discuss with AMDs actions to ensure statutory/mandatory training is completed by medical staff in their HCG. Lead: Chief Operating Officer**
8.5	The CFO summarised by saying that compliance with the DSPT would continue to be monitored by the IG Steering Group and PAF. In response to a question from the TC he confirmed he would check whether or not there would be any penalties for non-compliance.
ACTION TB1.06.06.19/11	**Confirm what, if any, penalties there are for non-compliance with DSPT. Lead: Chief Financial Officer**
8.6	The TC thanked the CFO for his update and looked forward to confirmation that compliance with the Toolkit had been achieved.
8.2 NHS Provider Licence Condition FT4: Self-Assessment *(1 minute)*	
8.7	This item was presented by the CEO. He reminded members that NHS trusts were

	required to self-certify against the NHS Provider Licence and self-certify ('confirmed' or 'not confirmed') against Condition FT4 by 30.06.19.
8.8	The template provided reflected the requirements for condition FT4 and the proposed declaration of 'confirmed' in relation to each of the six statements for Condition FT4. A brief commentary against each of the statements was also included.
8.9	Members approved the declaration of 'confirmed'.
8.3 Reports from Committees *(8 minutes)*	
8.10	Key points presented by Committee Chairs were:
8.11	Workforce Committee – WFC.20.05.19 (Chair - NED Pam Court) • CPD funding - PAHT would receive £78,550.90 (£118,121.65 minus STP top slice of 33.5%).
8.12	Audit Committee – AC.23.05.19 (Interim Chair – NED Andrew Holden) • Approval of the 2018/19 Annual Accounts and Financial Statements and recommendation that the Board adopt them and that the associated statements were signed on behalf of the Trust. • The Annual Report and Annual Governance Statement were reviewed and recommended to the Extraordinary Board for approval
8.13	Performance and Finance Committee – PAF.23.05.19 (Chair – NED Andrew Holden) • M1 results (as discussed earlier) were reported as £763k behind plan which could result in a £1,057k loss of PSF/FRF funds. The focus going forward would be around reducing temporary staffing spend and delivering on activity. •
8.14	Quality & Safety Committee – QSC.24.06.19 (Chair – NED John Hogan) • The Trust had had two confirmed (unrelated) measles incidences in April/May. Tracing and following up of patients who had been in contact with the cases had taken place. • The issue surrounding monitoring and tracking of patients following stent insertion had been declared as a Serious Incident. Assurance was provided around identification of missed patients, the undertaking of harm reviews and that outpatient appointments had been booked where required.
8.15	Strategy Committee – SC.24.05.19 (Chair – Trust Chairman Steve Clarke) • PAHT 2030 - staff engagement events would be held during June with key messages from those informing discussions which would take place at the leadership event on 23.07.19. Our New Hospital - the outcome of a meeting with NHSE/I was received and this would be discussed later in the private Board session. • The Board approved the Committee's Terms of Reference.
8.4 Report from Senior Management Team Meetings (7 & 21.05.19)	
8.16	A list of recent items discussed was provided for information and noted by the Board.
09 QUESTIONS FROM THE PUBLIC	
9.1	There were no questions from the public.
10 CLOSING ADMINISTRATION	
10.1 Summary of Actions and Decisions	
10.1	These are presented in the shaded boxes above.
10.2 New Issues/Risks	
10.2	No new risks or issues were identified.
10.3 Reflections on Meeting	
10.3	Members agreed the Board Room was now too small for meetings and with two new NEDs about to join, an offsite venue should be considered going forward.
10.4 Any Other Business (AOB)	
10.4	There were no items of AOB.

The Princess Alexandra Hospital NHS
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Signed as a correct record of the meeting:	
Date:	01.08.19
Signature:	
Name:	Steve Clarke
Title:	Trust Chairman

Trust Board Meeting in Public
Action Log - 01.08.19

Action Ref	Theme	Action	Lead(s)	Due By	Commentary	Status
TB1.06.06.19/05	CEO Update	Review the indicators included in the CEO report.	CEO	TB1.01.08.19	To be addressed at item 4.1 at TB1.01.08.19.	Proposed for closure
TB1.06.06.19/06	Biliary Stent Register/Packing of Endoscopes	• Confirm whether a biliary stent register has been established. • Confirm whether there has been any discussion around the vacuum packing of endoscopes.	CMO COO	TB1.01.08.19 TB1.01.08.19	Actioned. Options being explored as part of the service review.	Proposed for closure
TB1.06.06.19/07	Mortality Tracker	Mortality Tracker to form part of the IPR as of July 2019.	CMO	TB1.01.08.19	Actioned.	Closed.
TB1.06.06.19/08	Progress from MIB	Progress on work undertaken by MIB to be reported to TB1.03.10.19.	CMO	TB1.03.10.19	Not yet due.	Proposed for closure
TB1.06.06.19/09	Hard Truths Report	Revise Hard Truths Report to show: • Target (10%) • Variation from target • Assumptions made	DoN&M	TB1.01.08.19	To be addressed at item 5.2 at TB1.01.08.19.	Proposed for closure

Trust Board

Patient Story: 1 August 2019

The Princess Alexandra Hospital NHS Trust

Patient Stories at Trust Board

Paula's Story

1st August 2019

respectful | caring | responsible | committed

Trust Board

Patient Story: 1 August 2019

NHS
The Princess Alexandra Hospital
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This is Paula's Story

A 60 year old lady admitted to Netteswell Admissions Unit (NAU) on the 20th July 2018 for an operative procedure

Paula was a known mental health patient suffering from schizophrenia

She was asked to attend NAU at 07:00 and was accompanied by her family

Paula was listed for surgery in the afternoon due to the clinical needs of the other patients on the operating list

During her time waiting Paula became very upset and agitated and left the hospital, therefore her surgery was cancelled

She was rebooked for surgery and had her procedure 5th October 2018

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2

Trust Board

Patient Story: 1 August 2019

Immediate Action

- Theatre Matron informed- patient pathway organised for next admission – successful admission and operation performed
- Round table meeting with the family

Learning

- Standardised process required - Development of a Standard Operating Procedure for Mental Health Patients Undergoing Surgical and Anaesthetic Procedures

Trust Board

Patient Story: 1 August 2019

NHS
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Mental Health First Aid (MHFA)

Earlier this year PAH trained 21 members of staff in MHFA. These carefully selected members of staff have been trained to detect and support any individual with mental health issues and learnt to:

- Spot the early signs of a mental health issue
- Feel confident in how to offer and provide initial help to a person experiencing a mental health issue
- Preserve life where a person may be at risk of harm to themselves or others
- Help stop mental ill health from getting worse
- Guide someone towards appropriate treatment and other sources of help
- Understand the stigma that exists around mental health

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The Princess Alexandra Hospital NHS
NHS Trust

TRUST BOARD
1 AUGUST 2019

3.1

Agenda Item:	3.1
Presented by:	Dr Andy Morris – Chief Medical Officer
Prepared by:	Sheila O'Sullivan – Interim Associate Director of Governance & Quality Lisa Flack - Compliance and Clinical Effectiveness Manager
Date prepared:	9 July 2019
Subject / Title:	Significant Risk Register

Purpose:	Approval		Decision		Information	√	Assurance	√

Executive Summary: [please don't expand this cell; additional information should be included in the main body of the report]	This paper presents the Significant Risk Register (SRR) and was produced from Risk Assure system using the risk registers for all our services. . There are a total of 85 risks with a score of 15 or more. • There are no risks with a score of 25 • 20 risks score 20 (the same as in June 2019) A summary of each risk and the actions planned to manage and mitigate them is detailed within this paper. • 21 risks with a score of 16, (reduced from 23 in June 2019) • 44 risks score of 15, (increased from 38 in June 2019) 8 new risks (scoring 15 and above) have been raised since 1 April 2019. One of these is for endoscopy ventilation, scoring 20.
Recommendation:	Trust board is asked to i) Note the content of the Significant Risk Register ii) Take assurance from the actions currently in place or planned

Trust strategic objectives: [please indicate which of the 5Ps is relevant to the subject of the report]	Patients	People	Performance	Places	Pounds
	√	√	√	√	√

Previously considered by:	Risk Management Group reviews risks monthly as per annual work plan.
Risk / links with the BAF:	There is crossover for the risks detailed in this paper and the BAF
Legislation, regulatory, equality, diversity and dignity implications:	Management of risk is a legal and statutory obligation
Appendices:	Nil

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The Princess Alexandra Hospital NHS
NHS Trust

1.0 INTRODUCTION

This paper details the Significant Risk Register (SRR) across the Trust; the registers were pulled from the web based Risk Assure system on 9 July 2019. The Trust Risk Management Group meets monthly and reviews risks across the Trust, including significant risks. There is an annual work plan so each area can be reviewed in detail on a rotation.

2.0 CONTEXT

2.1 The Significant Risk Register (SRR) is a snap shot of risks across all Healthcare groups and Corporate departments at a specific point and includes all items scoring 15 and above.
The risk score is arrived at using a 5 x 5 matrix of consequence X likelihood, with the highest risk scoring 25.

2.2 There are 85 (81) significant risks on our risk register. The breakdown by service is detailed in the table below.

	Risk Score				
	15	16	20	25	Totals
CCCS	7 (5)	5 (5)	2(1)	0 (0)	14 (10)
Estates & Facilities	8(8)	0 (0)	2(2)	0 (0)	10 (10)
Finance	2 (2)	0 (0)	0 (0)	0 (0)	2 (2)
IM&T and IG	0 (0)	1 (2)	0 (0)	0 (0)	1 (2)
Information Data Quality and Business Intelligence	1(1)	0(0)	0(0)	0(0)	1(1)
Non-Clinical Health & Safety	2(1)	0 (0)	0 (0)	0 (0)	2(1)
Nursing	0 (0)	1 (1)	0 (0)	0 (0)	1 (1)
Operational	1 (1)	0 (0)	4 (4)	0 (0)	5 (5)
Research, Development & Innovation	0(0)	0(0)	1(0)	0(0)	1(1)
Resilience	1 (1)	0(0)	0(0)	0(0)	1 (1)
Workforce	0 (0)	1 (1)	0 (0)	0 (0)	1 (1)
Child Health	1(1)	0 (0)	0 (0)	0(0)	1 (1)
Women's Health	2(1)	1(2)	0 (0)	0 (0)	3 (3)
Medicine	4 (4)	7 (8)	7 (7)	0 (0)	18 (19)
Surgery	15 (13)	5 (5)	4 (5)	0 (0)	24 (23)
Totals	44 (38)	21 (23)	20(20)	0 (0)	85 (81)

(The scores from the June 2019 paper are in brackets)

2.3 The Trust does not have any risks scoring 25.

2.4 There are 20 risks with a score of 20; the key areas are detailed below.

2.5 Patients:

- Require a robust process to monitor and track patients that have had urinary stent insertion to ensure timely removal and reduce risks to patient's treatment (URO004/2018 on register since June 2018).
  Action: The team have developed a manual method to capture all stent patients until the electronic solution is in place.

- Dose reductions to be applied faithfully as directed by user and not incorrectly interpreted by the EPMA system (CMS/2019/360 on register since January 2019)
  Action: Dose reduction should be detailed in the memo tab against the chemotherapy drug. Communication of memo tab given to prescribers, to apply dose reductions and use a separate dose reduction box. This issue has been reported to the supplier with request for a bug fix to resolve. Anticipate this being amended in version 7, planned introduction at the end of summer 2019.

- Applying a dose reduction to oral chemotherapy on a different administration days needs to be correctly applied on EPMA (CMS/2019/383 on register since February 2019)
  Action: Mitigating SOP developed and cascaded. Actions for prescribers and pharmacists detailed on the protocol. Nurses required to be vigilant for doses especially when dose reductions are applied. As above request the supplier to provide a remedy for the next version to be launched end of summer 2019. Monitoring Datix safety incidents.

- Reduce the backlog of patients waiting for flexible re-cystoscopy, (includes cancer and surveillance patients) resulting in patients being overdue their procedure (URO010/2018, on register since September 2018)
  Action: Additional cystoscopy sessions through Alliance completing 4 sessions per weekend. The backlog is reducing.

2.6 People

- Three clinical areas have insufficient numbers of Registered Nurses – Harold (JS02), Fleming (03) and Saunders (Saun04) all on the register since July 14),
  Action: Recruitment and retention action plans are in place with daily reviews of staffing numbers and rotation of staff to ensure safety.

- Medical Urology workforce depleted due to staff leaving, sickness and one less junior on the rotation (URO001/2015 on register since June 2015)
  Action: Agency consultants and junior doctors are in place to cover the rota. A rolling recruitment plan developed to fill the consultant vacancies. In progress of implementing the actions from the Royal College of Urologist review. We are working with CCG partners to request external support, in addition to liaising with UCLH and Queens Hospitals to develop joint posts. UCLH consultant to join NHSP and provide ad-hoc sessions

2.7 Performance

- Statutory compliance risk for failure to deliver 4 hour ED standard (001/2017 on register since April 2014).
- Quality and safe care impacted by failure to deliver the 4 hour ED standard, on Medicine teams register (MED57 on register since July 2016).
- Quality and safe care impacted by failure to deliver the 4 hour ED standard, on the Medical teams risk register (ED012 on register since July 2016).
  Action: Daily monitoring and review of previous breaches numbers and patterns in place aimed to limit deterioration in performance. Weekly assurance of surge plan and progress against the KPIs. Improvement plan in place across the emergency

care pathway with trajectory set for compliance. Performance is improving across all patient flow pathways.

- No patient will spend a journey time greater than 12 hours from arrival in ED to discharge from ED (002/2016 raised July 2016) l
- No ED patient to wait for longer than 12 hours to be admitted (003/2016 on register since July 16).
  Action: Development of surge escalation plan. Improvement plan is in place across the patient pathway with trajectory set for compliance. A medical assessment improvement plan is in place. The capacity model to inform inpatient developments over the next 12 months and work to improve non-elective length of stay in progress. The trackers working in the ED escalate patients not meeting department targets to the consultant and nurse in charge.

- Failure to achieve 85% of all patients referred by GP to receive treatment within the cancer 62 day standard (005/2016 on register since July 2016)
  Action: Speciality level recovery plan with trajectories and mitigation are in place. Monitored at weekly tumour site and trust level meetings.

- Endoscopy unit does not comply with Health and ventilation recommendations (Endo 080719 on register since July 2019)
  Action: need to commission an air handling unit for the endoscopy unit. Costings and timetable for work completion need to be confirmed.

- Endoscopy patients have interrupted service as result of decontamination washer failure which will impact JAG accreditation (Endo002 on register since October 2017).
  Action: Agreement with the Rivers hospital to decontaminate our scopes when trust machines are not working. Building work required to install the new washers anticipated to be completed by end of August 2019.

2.8 Places:

- Effective lifts to LOLER regulations (EFM015 on register since June 2018).
  Action: Lifts inspected six monthly in line with regulations. High risk remedial works are acted upon immediately. Service contract with a competent contractor in place, this includes emergency work. Remedial work is part of backlog maintenance programme with prices for work received. Delay in the start of this project, date to be confirmed. The Trust is now to re-tender the scheme and expect appointment of the new contractor by end of August.

- Electrical mains incoming cables are unsupported to the site (EFM032 on register since April 2019)
  Action: Initial work was completed over May bank holiday weekend. The works to the faulty gland plant have been completed and have a safe assured N1 electrical panel. Final black building test on the new generator installation is booked for mid-July to test that it engages under a power failure.

- Infrastructure in main theatres requires work on flooring, walls, door/frames, worktops require an upgrade (The002/2019 on register since Marchs 2019)
  Action: Work completed during March and April in theatres 5, 6 and 7 to repair the floor and other essential infrastructure. Further work is planned.

2.9 Pounds:

- Loss of 8% budget for the Clinical Research team will impact on overheads and set up fees. (R&D17.07.1802 on register since 17 July 2012, upgraded to a 20 in April)

Action: Continue to win contracts for commercial studies to mitigate for the reduction in funding. Trust team are renegotiating with North Thames Clinical Research Network.

3.0 RECOMMENDATION

Trust board are asked to note the content of the SRR and take assurance from the actions currently in place or planned

The Princess Alexandra Hospital NHS
NHS Trust

Trust Board - 1 August 2019

3.2

Agenda Item:	3.2
Presented by:	Heather Schultz - Head of Corporate Affairs
Prepared by:	Heather Schultz - Head of Corporate Affairs
Date prepared:	26 July 2019
Subject / Title:	Board Assurance Framework 2019/20

Purpose:	Approval	x	Decision		Information		Assurance	

Executive Summary:	The BAF risks are presented for review. The risks have been reviewed with Executive leads, discussed at the Executive Management Team meeting and at the relevant Committees in July. A summary of the changes is attached and Appendix A provides an overview of all the risks and the proposed risk ratings. BAF risks 2.2 and 4.1 are proposed for closure and a new risk has been added; Risk 2.3.
Recommendation:	The Board is asked to approve the changes to the risks.

Trust strategic objectives: [please indicate which of the 5Ps is relevant to the subject of the report]	Patients	People	Performance	Places	Pounds
	x	x	x	x	x

Previously considered by:	EMT on 18 July, WFC 22 July, PAF 25 July and QSC 26 July 2019.
Risk / links with the BAF:	As indicated in the attached BAF
Legislation, regulatory, equality, diversity and dignity implications:	Compliance with the Code of Governance.
Appendices:	Appendix A - summary of risks

The Princess Alexandra Hospital NHS
NHS Trust

3.2

Board Assurance Framework 2019/20 - August 2019

1.0 PURPOSE

The BAF 2019/20 is presented to the Board for review. The risks have been aligned to the revised strategic objectives for 2019/20. Each of the risks have been reviewed with the executive leads and updated.

More specific detail has been included in relation to the sources of assurance following comments received from CQC. The Trust's vision, goals and objectives are summarised at the front of the BAF and progress against the objectives will be reported to Board commencing in October 2019.

2.0 ANALYSIS

Following discussion of the risks at each of the Committees in July 2019, the following changes to the BAF are recommended:

Risk 2.2 Internal Communication is proposed for closure. The risk score has reduced to 6 which is the target score for the risk. Workforce Committee received a paper providing an update on Communications and recommended the closure of the risk.

Risk 2.3 Inability to recruit, retain and engage our people has been added to the BAF as a new risk scoring 12. WFC reviewed the risk and recommended that the risk reflect specific detail around medical staffing/vacancies. The risk has been updated to reflect this recommendation.

Risk 4.1 Supporting Functions is proposed for closure following discussions at EMT and PAF. The risk relating to lack of modernisation in corporate departments is reflected in other BAF risks (2.1, 3.1 and 5.1) and PAF recommended closure of the risk.

A summary of the BAF risks is attached as Appendix A.

3.0 RECOMMENDATION

The Board is asked to approve the proposed changes to the risks.

Author: Heather Schultz - Head of Corporate Affairs

5P	Executive Lead	Committee	BAF Risks August 2019	Current risk score	Trend/Comment
	Chief Nurse/Chief Medical Officer	QSC	1.1 Outcomes:Variation in outcomes in clinical quality, safety, patient experience and 'higher than expected' mortality.	16	
	Chief Finance Officer/DoI&IT	PAF	1.2 EPR Concerns around availability of functionality for innovative operational processes together with data quality and compliance with system processes	16	
	DoP/DoN	WFC	2.1 Nurse Recruitment Inability to recruit to critical nursing roles.	16	
	DoP	WFC	2.2 Internal Engagement: Failure to communicate key messages and organisational changes to front line staff.	6	**Proposed for closure.**
	DoP	WFC	2.3 Inability to recruit, retain and engage our people	12	**New risk.**
	DoS	Strategy Committee	3.1 Estates & Infrastructure Concerns about potential failure of the Trust's Estate & Infrastructure and consequences for service delivery.	20	
	DoS	Strategy Committee	3.2 Financial and Clinical Sustainability across health and social care system Capacity and capability to deliver long term financial and clinical sustainability across the health and social care system.	16	
	DoS	Strategy Committee	3.3 Strategic Change and Organisational Structure Capacity & capability of senior Trust leaders to influence both internally and externally the required strategic changes.	12	
	DoS	Strategy Committee	3.4 Sustainability of local services Failure to ensure sustainable local services whilst the new hospital plans are in development.	16	
	DCFO/DQI	PAF	4.1 Supporting Functions (including Finance, IT, and Estates and Facilities) Concerns around the need to modernise the systems, processes, structures, capacity & capability of the business support functions.	12	**Proposed for closure.**

	COO	PAF	4.2 4 hour Emergency Department Constitutional Standard Failure to achieve ED standard	20	⟷
	CFO	PAF	5.1 Finance Concerns around failure to meet financial plan including cash shortfall.	15	⟷

The Princess Alexandra Hospital NHS
NHS Trust

The Princess Alexandra Hospital Board Assurance Framework

2019-20

Our Patients – we will continue to improve the quality of care and experiences that we provide **our patients** and families, integrating care
Our People – we will support and develop our people to deliver high quality care within a culture that improves engagement, recruitment
Our Places – we will maintain the safety of and improve the quality and look of **our places** and work with our partners to develop an OBC
Our Performance – we will meet and achieve **our performance** targets, covering national and local operational, quality and workforce indicators
Our Pounds – we will manage **our pounds** effectively and modernise our corporate services to achieve our agreed financial control total


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Risk Key														
Extreme Risk		15-25												
High Risk		8-12	**The Princess Alexandra Hospital Board Assurance Framework 2019-20**											
Medium Risk		4-6												
Low Risk		1-3												
Risk No		**PRINCIPAL RISKS**				**KEY CONTROLS**	**ASSURANCES ON CONTROLS**	**BOARD REPORTS**						
		Principal Risks		**RAG Rating (CXL)**	**Executive Lead and Committee**	**Key Controls**	**Sources of Assurance**	**Positive Assurances on the effectiveness of controls**	**Residual RAG Rating (CXL)**	**Gaps in Control**	**Gaps in Assurance**	**Review Date**	**Changes to the risk rating since the last review**	**Target RAG Rating (CXL)**
		What could prevent the objective from being achieved	What are the potential causes and effects of the risks		Which area within our organisation this risk primarily relate to	What controls or systems are in place to assist in securing the delivery of the objectives	Where we can gain evidence that our controls/systems, on which we are placing reliance, are effective	We have evidence that shows we are reasonably managing our risks and objectives are being delivered		Where are we failing to put controls/systems in place or where collectively are they not sufficiently effective.	Where are we failing to gain evidence that our controls/systems, on which we place reliance, are effective			
								Evidence should link to a report from a Committee or Board.						
	Strategic Objective 1: Our Patients - we will continue to improve the quality of care and experiences that we provide our patients and families, integrating care with our partners and improving our CQC rating													
BAF 1.1		Variation in outcomes in clinical quality, safety, patient experience and 'higher than expected' mortality.	Causes: i) Unwarranted variation in care ii) System wide flow	4 X 5= 20	Director of Nursing/ Chief Medical Officer **Quality and Safety Committee**	i) Robust quality and safety governance structures in place including infection control ii) Performance management of unacceptable behaviour and revised Accountability Framework iii) Robust Appraisal/ medical revalidation process (2 positive peer reviews) - 360° feedback and Fitness to Practice process in nursing iv) RCA methodology workshops v) End of Life and deteriorating patient simulation programme for all staff. and Whole System Steering Group vi) Mandated & focused education & training in communication skills such as breaking bad news training. vii) Sharing the Learning Programme well embedded viii) Monthly Commissioner reviews of quality and Safety xii) Risk Management Training Programme xiv) Escalation prescribing processes xv) Electronic handovers and E-Obs and observation compliance reports xvi) Schwartz Rounds xviii) NHSI/NHSE Oversight xix) Red2 Green Board rounds supported by ECIST xx) Implementation of Medical Examiners with reporting software and Board oversight xxi) Patient Experience Strategy xxii) NED lead appointed for Mortality xxiv) Mortality Strategy including dashboard, tracker, updates on workstreams and learning from deaths. xxv) Introducing '15 steps' walkabouts from January 2019 xxvi) Nursing Establishment review xxvii) Safer Staffing policy xxviii) Real time patient feeback implemented across all wards xxix) Robust management of periods ont increased incidences of Infection Control (MRSA/VRE) xxx) Robust management of variations in neonatal outcomes xxxi) Engagement in external reviews MBRRACE and LeDeR and Healthcare Safety Investigation Branch (maternity) xxxii) Medical examiners (MEs) and Lead ME appointed.	i) National Surveys ii) Cancer Survey iii) CEO Assurance Panels iv) SIG meetings v) QSC, PAF, Risk Management Group and Board meetings vi) Patient Safety and Quality meetings, PRMs and Patient Experience meetings vii) Infection Control Committee viii) Integrated Safeguarding meetings ix) Patient Panel meetings x) PLACE Inspections xi) Medicines Management Committee xii) CCG audits xiii) End of Life and Mortality Groups xiv) AKI & Sepsis Group xv) Urgent Care Improvement Board xvi) Mortality ~~Surveillance~~ Review Group xvii) Mortality Improvement Board	i) Improvement in some areas of the National Inpatient Survey and NACEL Survey ii) CQUIN reports to SMT/PAF/QSC (June 2019) iii) CEO Assurance Panels (as required) iv) Reports to QSC on Patient Experience June 19, monthly Serious Incidents, monthly Safer Staffing, Patient Panel July 19, Safeguarding, monthly Infection Control v) Monthly Mortality Improvement report to QSC and monthly IPR report ~~and CN/CMO reports~~ vi) Dr Foster reports, CQC inspection reports (March 18 and draft June 19) and GIRFT reports vii) Real time Dr Foster reports and engagement viii) GMC Survey results (July 2018) ix) Clinical Audit report 18/19 - tiaa (limited assurance) v) CMO/CFO Coding Meetings and quarterly Coding reports to PAF (June 19) vi) Positive staff survey outcomes (2018) measuring safety culture and engagement vii) Freedom to Speak Up Guardians quarterly reports to WFC (May 19) and Guardian of Safe Working reports to Trust Board (Dec18). viii) Patient stories and learning from deaths presentations to Public Board meetings (bi-monthly) ix) Internal Audit reports tiaa 2019: Safeguarding (substantial assurance) and Complaints (reasonable assurance) x) International Nurse Recruitment business case to SMT/PAF and Board (June/July 19)	4x4=16	~~i) Internal/External Comms in development and improving (launch date to be agreed).~~ Lack of modernisation in some reporting processes including: i) Evolving clinical audit approach- improved tracking of local audits and drive to improve collation and input of data for national audits ii) Disparity in local patient experience surveys versus inpatient survey iii) Staffing, site capacity and constraints iv) Access to Qlikview **ACTIONS:** i) Inpatient Survey action plan in place and Staff Survey action plan in place iii) Ongoing work with Dr Foster in relation to mortality iv) Review of quality/safety and risk leadership structure	i) Clinical evidence of improvements made following compliance with national audits, NICE,NCEPOD. ii) Demonstrating an embedded learning programme from Board to ward.	02/07/2019	**Risk rating not changed; target date for achieving target risk rating amended**	4x3 =12 (Target date ~~July~~ Dec 2019 - to review progress against Mortality Improvement Strategy workstreams ~~and following receipt of inpatient survey results)~~
			Effects: i) Poor reputation ii) Increase in complaints/ claims or litigation iii) Persistent poor results in National Surveys iv) Recurrent themes in complaints involving communication failure v) Loss of confidence by external stakeholders vi) Higher than expected Mortality rates										

Risk Key															
Extreme Risk		15-25													
High Risk		8-12	**The Princess Alexandra Hospital Board Assurance Framework 2019-20**												
Medium Risk		4-6													
Low Risk		1-3													
Risk No		**PRINCIPAL RISKS**				**KEY CONTROLS**	**ASSURANCES ON CONTROLS**	**BOARD REPORTS**							
		Principal Risks		**RAG Rating (CXL)**	**Executive Lead and Committee**	**Key Controls**	**Sources of Assurance**	**Positive Assurances on the effectiveness of controls**	**Residual RAG Rating (CXL)**	**Gaps in Control**	**Gaps in Assurance**	**Review Date**	**Changes to the risk rating since the last review**	**Target RAG Rating (CXL)**
		What could prevent the objective from being achieved	What are the potential causes and effects of the risks		Which area within our organisation this risk primarily relate to	What controls or systems are in place to assist in securing the delivery of the objectives	Where we can gain evidence that our controls/systems, on which we are placing reliance, are effective	We have evidence that shows we are reasonably managing our risks and objectives are being delivered		Where are we failing to put controls/systems in place or where collectively are they not sufficiently effective.	Where are we failing to gain evidence that our controls/systems, on which we place reliance, are effective			
								Evidence should link to a report from a Committee or Board.						
	Strategic Objective 1: Our Patients - we will continue to improve the quality of care and experiences that we provide our patients and families, integrating care with our partners and improving our CQC rating **Strategic Objective 5: Our Pounds - we will manage our pounds effectively and modernise our corporate services to achieve our agreed financial control total for 2019/20 and our local system control total**													
BAF 1.2		**EPR** Concerns around availability of functionality for innovative operational processes together with data quality and compliance with system processes.	Causes: i) Poor engagement with the system, usability, time/skills ii) Timely system fixes/enhancements	**5 X 4= 20**	Chief Financial Officer/Chief Operating Officer/Chief Medical Officer **Performance and Finance Committee**	i) Weekly DQ meetings held at ADO level ii) Programme management arrangements established with Data Quality Recovery Programme to 'Health Group Challenge' meetings, EMB and Trust Board. Governance via Performance and Finance Committee to Trust Board. iii) Increased training application support, mobile training support, RTT validators & staff awareness sessions. iii) Performance Mgt Framework in place. iv) Training programme. v) Super users in place to deliver focused support. vi) Transformation function extended to ensure high level issues affecting delivery of benefits and reporting are captured and managed through to process review, fix and system enhancement to improve usability vii) Access Policy viii) Functionality enhanced through deployment of alternate solutions (e-Obs, Portal, Meds management) ix) Development of capacity planning tools/information x) PWC review and actions identified xi) DQ meetings re-structured xii) ICT Newsletter issued xiii) New training process for locums xv) New daily Cambio meetings/roadmap xvi) Daily ICT/COSMIC meetings ongoing xvii) Real time data now available xviii) OBS requirements reviewed to assess gaps xix) Contract review completed xx) CDS 011 now live xxi) Maternity MDS configuration will be complete by 17/6/19. CI 2.2 teasting planned. All to be dleivered by 30/6/19 to enable flow of new national Maternity Dataset to NHSD database. Xxii) Monthly Contract Performance monitoring meeting with supplier established	i) Access Board ii) ICT Programme Board (chaired by CFO) iii) Board and PAF meetings iv) Weekly meetings with Cambio vi Weekly DQ meetings vi) Monthly performance reviews vii) Monthly EPR Board to Board meetings	i) Weekly Data Quality reports to Access Board and EDB ii) External Audit reports to Audit Committee on Quality Account Indicators (July 19 - adverse conclusion) iii) Monthly DQ reports to PAF (July 19) and quarterly ICT updates (July 19) iv) ~~PWC report and action plan~~ vi) ~~Trust Board workshop April 2017~~ ~~vii) Cambio roadmap and governance structure reports to PAF~~	**4 X 4= 16**	i) Continue to develop 'usability' of EPR application to aid users ii) Resource availability iii) Capacity within operational teams iv) Elements of system remain onerous (completion of discharge summaries) v) External system support vi) Compliance with refresher training vii) Cambio delivery schedule slippage	Reporting mechanism on compliance of new staff/interims/junior doctors with the system and uptake of refresher training - monitoring process being developed. Quality of delivery of PFM - testing processes and actions identified by tiaa internal audit. Internal Audit reporting on testing, limited assurance.	Jul-19	Risk rating unchanged	**4x3=12** **Sept 2019 (subject to monthly review of progress)**
			Effects: i)Patient safety if data lost, incorrect, missing from the system. ii) National reporting targets may not be met/ missed. iii) Financial loss to organisation through non-recording of activity, coding of activity and penalties for not demonstrating performance iv) Inability to plan and deliver patient care appropriately							**ACTIONS:** i) Ongoing training and support ii) Restructure of IT team (resourcing) iii) Re-establishing relationship/engagement with Cambio iv) Refresher training underway v) Revised roadmap to incorporate new statutory/legal requirements e.g GDPR				

Risk Key		
Extreme Risk		15-25
High Risk		8-12
Medium Risk		4-6
Low Risk		1-3

The Princess Alexandra Hospital Board
Assurance Framework 2019-20

Risk No		PRINCIPAL RISKS				KEY CONTROLS	ASSURANCES ON CONTROLS	BOARD REPORTS						
		Principal Risks		RAG Rating (CXL)	Executive Lead and Committee	Key Controls	Sources of Assurance	Assurances on the effectiveness of controls	Residual RAG Rating (CXL)	Gaps in Control and Actions	Gaps in Assurance	Review Date	Changes to the risk rating since the last review	Target RAG Rating (CXL)
		What could prevent the objective from being achieved	What are the potential causes and effects of the risks		Which area within our organisation this risk primarily relate to	What controls or systems are in place to assist in securing the delivery of the objectives	Where we can gain evidence that our controls/systems, on which we are placing reliance, are effective	We have evidence that shows we are reasonably managing our risks and objectives are being delivered		Where are we failing to put controls/systems in place or where collectively are they not sufficiently effective.	Where are we failing to gain evidence that our controls/systems, on which we place reliance, are effective			
								Evidence should link to a report from a Committee or Board.						
	Strategic Objective 2: Our People – we will support and develop our people to deliver high quality care within a culture that improves engagement, recruitment and retention and results in further improvements in our staff survey results. **Strategic Objective 4: Our Performance - we will meet and achieve our performance targets, covering national and local operational, quality and workforce indicators**													
BAF 2.1		**Nurse Recruitment** Inability to recruit ~~to critical nursing roles~~ sufficient numbers of registered nurses.	**Causes:** National shortages of appropriately qualified staff Competition from neighbouring hospitals ~~National drive to increase nursing number leaving market shortfall (demand outstrips supply)~~ Locality of PAHT **Effects:** i) Pressure on existing staff to cope with demand leading to overworked staff and increased sickness ii) Low staff morale and impact on engagement iii) Shortcuts and failure to follow processes and procedures due to workload and fatigue leading to higher chances of patient safety errors occurring iv) Lower staff retention rates v) Reduced attendance at training courses vi) Impact on patient experience	5 X 4 =20	Director of People and Director of Nursing **Workforce Committee**	i) Participation in local and regional job fairs ii) Targeted overseas recruitment activity and proactive recruitment campaigns iii) Apprenticeships and work experience opportunities iv) Use of new roles ~~to bridge gaps~~ in line with national direction v) Use of recruitment and retention premia as necessary vi) Use of TRAC recruitment tool vii) Use of a system to recruit pre-qualification students ~~viii) Use of enhanced adverts, social media and recruitment days~~ viii) Working in collaboration with STP and LWAB	i) PAF, QSC, WFC, EMT, SMT, Workforce and Board meetings ii) PRMs and Health Group Boards iii) Recruitment and Retention Group iv) People Board	i) Safer Staffing Reports (monthly to QSC and Board) ii) Workforce report (progress on recruitment, retention, bank and agency) to WFC 22.05.19 iii) Incident reporting and monthly SI reports to QSC iv) Internal Audit report 18/19 on Recruitment (substantial assurance) v) International Nurse recruitment business case to SMT, PAF (June 2019) and Board (July 2019) vi) Monthly IPR report	4 x 4 = 16	i) Dedicated ~~nurse recruiter~~ resources for nursing recruitment ii) Limited ability to influence some of the pre-employment timeframes due to external requirements e.g. NMC registration ~~ii) Detailed pipeline and trajectory~~ ~~iii) Career escalator~~ Actions: Registered nurse vacancy rate to be included in IPR Ongoing monitoring of pre-employment phase of recruitment process to minimise delays	None noted.	02/07/2019	**Risk rating not changed but target date for achieving target risk rating amended to January 2020 in line with current recruitment trajectory.**	**4 x 3 = 12** **~~Nov 2019~~** **January 2020**

Risk Key														
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Risk No		**PRINCIPAL RISKS**				**KEY CONTROLS**	**ASSURANCES ON CONTROLS**	**BOARD REPORTS**						
		Principal Risks		**RAG Rating (CXL)**	**Executive Lead and Committee**	**Key Controls**	**Sources of Assurance**	**Positive Assurances on the effectiveness of controls**	**Residual RAG Rating (CXL)**	**Gaps in Control and Actions**	**Gaps in Assurance**	**Review Date**	**Changes to the risk rating since the last review**	**Target RAG Rating (CXL)**
		What could prevent the objective from being achieved	What are the potential causes and effects of the risks		Which area within our organisation this risk primarily relate to	What controls or systems are in place to assist in securing the delivery of the objectives	Where we can gain evidence that our controls/systems, on which we are placing reliance, are effective	We have evidence that shows we are reasonably managing our risks and objectives are being delivered		Where are we failing to put controls/systems in place or where collectively are they not sufficiently effective.	Where are we failing to gain evidence that our controls/systems, on which we place reliance, are effective			
								Evidence should link to a report from a Committee or Board.						
	Strategic Objective 2: Our People – we will support and develop our people to deliver high quality care within a culture that improves engagement, recruitment and retention and results in further improvements in our staff survey results.													
BAF 2.2		**Internal Communication** Failure to communicate key messages and organisational changes to front line staff.	**Causes:** i) Change fatigue and 'regulation fatigue' ii) Increasing demand versus reducing resources iii) Lack of awareness around the organisation of strategic direction due to poor communication channels/tools iv) Poor attitude and behaviours v) Competing priorities vi) Challenged Provider status vii) Insufficient management time allocated to communication with staff	**4 X 4= 16**	Director of People **Workforce Committee**	i) Staff awards; ii) CEO blog & 'In Touch'; Ask Lance iii) Staff Briefing sessions iv) Staff, patients and carers involved in creation of values, standards & behaviours to ensure ownership; v) Sharing the Learning events to involve staff in safety improvements, which has included the Being Open/ Duty of Candour. viii) Quality Fellows programme ix) National Leadership Programmes for staff x) Staff Survey xi) Schwartz Rounds xii) Staff Council (being relaunched at EIAT) xiii) Quality Ist Communication Plan and Newsletter xiv) Event in Tent xv) People Strategy in development xvi) Printed magazine (quarterly) xvi) The Trusted Executive work in progress xvii) Associate Director of Comms appointed	i) PAF and Board meetings ii) QSC meetings iii) Staff Engagement Working Group iv) Workforce Committee	i) Staff survey results - showing signs of improvement ii) FFT for staff - improvements iii) Workforce reports to PAF and Workforce Committee iv) IPR to PAF and Board v) OD reports to WFC vi) Learning and Development reports to WFC.	~~3x3=9~~ 3x2=6	Clarity on timescales for change (PCBC, SOC approval). **Actions:** i) Review of Comms function completed and implementation to follow. ii) Relaunch of website iii) Staff app being developed			**Achieved target risk score and proposed for closure.**	**3x2=6 end of June 2019 (re-structure of Comms team and function)**
			Effects: i) Error omission ii) Poor reputation iii) Demoralised staff iv) Impact on sustainability v) Changes not embedded as business as usual vi) Disconnect between management and front line staff											

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The Princess Alexandra Hospital Board
Assurance Framework 2019-20

Risk No		PRINCIPAL RISKS				KEY CONTROLS	ASSURANCES ON CONTROLS	BOARD REPORTS						
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		What could prevent the objective from being achieved	What are the potential causes and effects of the risks		Which area within our organisation this risk primarily relate to	What controls or systems are in place to assist in securing the delivery of the objectives	Where we can gain evidence that our controls/systems, on which we are placing reliance, are effective	We have evidence that shows we are reasonably managing our risks and objectives are being delivered		Where are we failing to put controls/systems in place or where collectively are they not sufficiently effective.	Where are we failing to gain evidence that our controls/systems, on which we place reliance, are effective			
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	Strategic Objective 2: Our People – we will support and develop our people to deliver high quality care within a culture that improves engagement, recruitment and retention and results in further improvements in our staff survey results. **Strategic Objective 4: Our Performance - we will meet and achieve our performance targets, covering national and local operational, quality and workforce indicators**													
2.3		**Inability to recruit, retain and engage our people**	**Causes:** High vacancies in some critical areas/roles High turnover in some areas Capacity and capability of some managers and leaders Large cohort of new starters Inability to recruit from Europe due to uncertainty around Brexit Staff not fully enagaging in and understanding the modernisation agenda Trust's proximity to London Effects: Low staff morale, high temporary staffing costs, poor patient experience and outcomes/ increased mortality and impact on Trust's reputation	**4 X 4 =16**	Director of People, OD & Communications **Workforce Committee**	i) People strategy 'joy to work at PAHT' ii) Behaviour charter and vision and values iii) People management policies, systems, processes & training iv) Management of organisational change policies & procedures v) Freedom To Speak Up Guardian roles vi) Equality and inclusion champions vii) Event in a Tent held annually viii) Staff awards held locally and trust wide annually	i) WFC, QSC, SC, PAF, WFC, SMT, EMT. ii) People board iii) JSCC, JLNC iv) PRMs and health care group boards	i) Workforce KPIsreported to WFC bi-monthly ii) People strategy deliverables iii) Staff survey results and action plans (WFC May 19) iv) Staff friends and family results (WFC May 19) v) Medical engagement surveys and action plans (WFC November 2018)	**4 x3 = 12**	Pulse surveys targeted for all staff communications strategy Medical engagement Effective intranet/extranet for staff to access anywhere 24/7 Actions i) Behaviour workshops - Q2 implementation of communicaiton strategy - Q4 ii) recruitment plans for medical staff - Q2 iii) New consultant development programme - Q2 iv) Extranet for staff - Q1 20/21	None identified.	01/07/2019	**New risk**	**4 x2 = 8 (at end of 5 year People Strategy but to be reviewed in March 2020)**

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		Principal Risks		**RAG Rating (CXL)**	**Executive Lead and Committee**	**Key Controls**	**Sources of Assurance**	**Positive Assurances on the effectiveness of controls**	**Residual RAG Rating (CXL)**	**Gaps in Control**	**Gaps in Assurance**	**Review Date**	**Changes to the risk rating since the last review**	**Target RAG Rating (CXL)**
		What could prevent the objective from being achieved	What are the potential causes and effects of the risks		Which area within our organisation this risk primarily relate to	What controls or systems are in place to assist in securing the delivery of the objectives	Where we can gain evidence that our controls/systems, on which we are placing reliance, are effective	We have evidence that shows we are reasonably managing our risks and objectives are being delivered Evidence should link to a report from a Committee or Board.		Where are we failing to put controls/systems in place or where collectively are they not sufficiently effective.	Where are we failing to gain evidence that our controls/systems, on which we place reliance, are effective			
	Strategic Objective 3: Our Places – we will maintain the safety of and improve the quality and look of our places and work with our partners to develop an OBC for a new build, aligned with the further development of our local Integrated Care Alliance.													
BAF 3.1		**Estates & Infrastructure** Concerns about potential failure of the Trust's Estate & Infrastructure and consequences for service delivery.	**Causes:** i) Limited NHS financial resources (Revenue and Capital) ~~ii) Long periods of underinvestment in team and structure~~ iii) Lack of capital investment, iv) Current financial situation, v) Inherited aged estate in poor state of disrepair vi) No formal assessment of update requirements, vii) Failure to comply with estates refurbishment/ repair programme historically, viii) Under-investment in training of estate management & site development ix) Inability to undertake planned preventative maintenance x) Lack of decant facility to allow for adequate repair/maintenance particularly in wards areas. xi) Key workforce gaps in compliance, energy and engineering.	**5 X 4= 20**	Director of ~~Quality Improvement Strategy~~ **Performance and Finance Committee**	i) Schedule of repairs ii) Six-facet survey/ report received (£105m) iii) Potential new build/location of new hospital iv) Capital programme - aligned to red rated risks. v) STP Estate Strategy developed and approved. vi) Modernisation Programme for Estates and Facilities underway vii) Robust water safety testing processes viii) Annual asbestos survey –completed and red risks resolved. ix) Trust's Estate strategy being developed as part of Project Genesis (Our New Hospital) x) Annual fire risk assessment completed and final report received, compliance action plan being developed. xi) New estates and facilities leadership team in place	i) PAF and Board meetings ii) SMT Meetings iii) Health and Safety Meetings iv) Capital Working Group v) External reviews by NHSI and Environmental Agency vi) Water Safety Group vii) Weekly Estates and Facilities meetings ~~viii) First Impressions Count project group~~ ix) Project Genesis Steering Group	i) Reports to SMT (as required) ii) ~~Reports on testing for legionella, asbestos~~ iii) Signed Fire Certificate iv) Annual H&S reports to Trust Board and quarterly to PAF (July 19). v) Ventilation audit report vi) Water Safety Report (PAH site) vii) Annual and quarterly report to PAF: Estates and Facilities (July 19) viii) PLACE Assessments (Audit report May 18)	**5x4=20**	i) Planned Preventative Maintenance Programme (time delay) and amber backlog maintenance risks now emerging red risks ii) Ventilation systems iii) Sewage leaks and drainage iv) Electrical Safety/Rewiring (gaps) v) Maintaining oversight of the volume of action plans associated with compliance. ~~vi) Catering services modernisation completed~~ vii) Lack of authorised persons within estates and facilities teams. viii) Sustainability Management Group to be established (launch in April) and Sustainability manager ~~to be~~ recruited. **ACTIONS:** i) Backlog maintenance review underway ~~and Six Facet Survey completed.~~ ii) Recruitment of Sustainability Manager underway	i) Estates Strategy /Place Strategy developing within STP ii) Compliance with data collection and reporting iii) PPM data not as robust as required iv) PAM assurance not robustly updated.	02/07/2019	**Residual risk rating unchanged.**	**4 x 2 =8 (Rating which Trust aspires to achieve but will depend on relocating to new hospital site)**
			Effects: i) Backlog maintenance increasing due to aged infrastructure ii) Poor patient perception and experience of care due to aging facilities. iii) Reputation impact iv) Impact on staff morale v) Poor infrastructure, vi) Deteriorating building fabric and engineering plant, much of which was in need of urgent replacement or upgrade, vii) Poor patient experience, viii) Single sex accommodation issues in specific areas, ix) Out dated bathrooms, flooring, lighting – potential breach of IPC requirements, x) Ergonomics not suitable for new models of care. xi) Failure to deliver transformation project and service changes required for performance enhancement xii) Potential slips/trips/fall to patients, staff or visitors from physical defects in floors and buildings xiii) Potential non compliance with relevant regulatory agency standards such as CQC, HSE, HTC, Environmental Health.											

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Risk No		**PRINCIPAL RISKS**				**KEY CONTROLS**	**ASSURANCES ON CONTROLS**	**BOARD REPORTS**						
		Principal Risks		**RAG Rating (CXL)**	**Executive Lead and Committee**	**Key Controls**	**Sources of Assurance**	**Positive Assurances on the effectiveness of controls**	**Residual RAG Rating (CXL)**	**Gaps in Control**	**Gaps in Assurance**	**Review Date**	**Changes to the risk rating since the last review**	**Target RAG Rating (CXL)**
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BAF 3.2		**Financial and Clinical Sustainability across health and social care system** Capacity and capability to deliver long term financial and clinical sustainability across the health and social care system	**Causes:** i) The financial bridge is based on high level assumptions ~~ii) The development of QIPP and CIP programmes for 2017/18 has not followed a Footprint wide approach~~ iii) The Workstream plans do not have sufficient underpinning detail to support the delivery of the financial savings attributed to them iv) The resources required for delivery at a programme and workstream level have not been defined or secured v) The current governance structure is under development given the shift in focus from planning to delivery. vi) The collaborative productivity opportunities linked to new models of care require more joined-up ways of working, clear accountability and leadership, changes to current governance arrangements.	**4 X 4= 16**	DoS Strategy Committee	i) STP workstreams with designated leads ii) System leaders Group iii) New STP governance structure iv) STP priorities developed and aligned across the system. ~~v) STP PMO under development~~ vi) CEO's forum vii) Integrated Clinical Strategy in development viii) STP Estates Strategy being developed. ix) MSK contract ~~being developed with system partners and due diligence submission (9.01.19)~~ x) STP Clinical Strategy in place xi) STP wide Strategy Group implemented xii) Independant STP Chair and independant STP Director of Strategy appointed.	i) West Essex CCG review of local governance arrangements ii) Feedback from regulators iii) System leadership meetings iv) Proposals made around system dashboards and KPIs	i) Minutes and reports from system/partnership meetings/Boards ii) CEO reports to Board and STP updates iii) STP report to Strategy Committee July 2019	**4 X 4= 16**	Lack of STP demand and capacity modelling. **ACTIONS:** System agreement on governance and programme management System leadership capacity to lead STP-wide transformation Trust to nominate representatives on proposed STP/ACP workstreams		02/07/2019	**No changes to risk rating.**	**4x3=12** **Sept 2019** ~~**(new accountable officer to be appointed and a clear CCG strategy to be available).**~~
			Effects: i) Lack of system confidence ii) Lack of pace in terms of driving financial savings iii) Undermining ability for effective system communication with public iv) More regulatory intervention											

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BAF 3.3		**Strategic Change and Organisational Structure** Capacity & capability of senior Trust leaders to influence both internally and externally the required strategic changes.	**Causes:** i) Staff and stakeholders lack of awareness and/or understanding of drivers and issues cross the system ii) Change fatigue and continuous change in leadership iii) Scale, pace and complexity of change required. iv) Infrastructure (IT, buildings) not supportive of change v) Financial resources lacking to support change vi) Focus on immediate operational and financial priorities versus the longer term strategic planning vii) Lack of clarity regarding contracting and organisational models in support of ICP viii) Management resource and team to drive change and strategy development being built. ix) Lack of shared vision and key drivers for change xi) Internal programme for development and implementation of 5P plans.	**4 X 4= 16**	DoS Strategy Committee	i) SMT meetings ii) Clinical specialty meetings iii) Good relationships with key partner organisations iv) CEO chairing ICP Board v) Project Genesis Steering Group vi) CEO and Chair attending STP meetings vii) Programme plan in place - health planners engaged, transport study, strategic estates advisors engaged. viii) Clinical Strategy being developed. ix) Strategy Committee established ~~in April 2019~~ x) ~~New PAH Board Chairman appointed.~~ xi) Development of MSK service and engagement of senior clinicians.	i)Workshops with clinical leads ii) ICP and STP meetings including acute and back office workstream meetings iii) Project Genesis Steering Group	i) Reports to Strategy Committee ~~Board~~ on strategic developments and Our New Hospital ~~reports to PAF/Board.~~ (July 19) Ii) Board workshop sessions held in September: site options and clinical strategy. iii) System workshop held on new hospital design (Nov 18) ~~iv) Well led rating assigned by CQC - good~~ iv) Preferred Way Forward decision at Trust Board in March 2019 v) Board to Board with West Essex CCG held 4 July 2019. vi) STP update to Strategy Committee (July 2019)	**4x3=12**	i) Data quality impacting on business intelligence (SLR) **ACTIONS:** Trust's vision and mission statement being refreshed and 5P plans underway as part of Clinical Strategy work - to be agreed at Leadership event scheduled for July 2019 ~~Establishment of a 'Strategy Committee.~~ Strategy team being developed PAH long term strategy being developed	None identified.	02/07/2019	**Risk rating not changed.**	4 x 2= 8 September 2019
			Effects: i) Poor reputation ii) Increased stakeholder and regulator scrutiny iii) Low staff morale iv) Threatened stability and sustainability v) Restructuring fails to achieve goals and outcomes vi) Impact on service delivery and quality of care vii) Poor staff survey viii) Failure to fully implement the transformation agenda required e.g. increase in market share, following restructure ix) Undermines regulatory confidence to invest in hospital/system solutions											

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BAF 3.4		**Sustainability of local services** Failure to ensure sustainable local services continue whilst the new hospital plans are in development and funding is being secured.	**Causes:** i) Limited NHS financial resources (Revenue and Capital) ii) Long periods of underinvestment in backlog maintenance iii) Lack of capital investment, iv) Current financial situation, v) Inherited aged estate in poor state of disrepair vi) Complexity of STP vii) Insufficient quantity and expertise in workforce capability	**4 X 4= 16**	Director of Strategy **Trust Board**	i) Potential new build/location of new hospital ii) KPMG Review iii) STP Footprint and Estate Strategy developed. iv) Herts & West Essex STP Estates workstream v) Clinical Support Service workstream led by CEO vi) Estates and Facilities Infrastructure subgroup for West Essex vii) SOC affordability model viii) SOC approved and submitted to NHSI ~~and further financial analysis template submitted to DH~~ ix) Site analysis Phase I complete x) Detailed analysis of current site option commissioned ~~xi) Director of Strategy appointed~~ xii) Master planning work being aligned to Six Facet Survey and Health Planning, phasing of development on PAH site or off site. xiii) Alignment of strategic capital and tactical capital plans xiv) MSK service developments underway xv) Capital funding of £9.5m received	i) PAF and Board meetings ii) SMT Meetings iii) Capital Planning Group iv) Weekly Estates and Facilities meetings v) SOC Steering Group	i) STP reports to Strategy Committee and Board via CEO Report (July 2019) ii) Reports to SMT iii) STP work plans iv) Our New Hospital reports to Strategy Committee (July 2019) ~~PAF~~ and updates to Board. v) PAHT 2030 report to Strategy Committee (July 2019)	**4 x 4 = 16**	i) Balancing short term investment in the PAH site vs the required long term investment **ACTIONS:** Strategy being developed and underpinned by 5P plans Phase II work underway PCBC work commissioned Regular meetings held with regulators. Newly established Strategy Committee	i) Strategy in development	03/07/2019	**No change to residual risk rating.**	**4 x 3 =12** **Sept 2019**
			Effects: i) Failure to deliver strategy and transformation project and service changes required for service and performance enhancement ii) Poor patient perception and experience of care due to aging facilities. iii) Reputation impact iv) Impact on staff morale v) Poor infrastructure, vi) Deteriorating building fabric and engineering plant vii) Poor patient experience, viii)Backlog maintenance ix) Potential non compliance with relevant regulatory agency standards such as CQC, HSE, HTC, Environmental Health. x) Lack of integrated approach xi) Increased risk of service failure xii) Impact on throughput of patients												

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Low Risk		1-3												
Risk No		**PRINCIPAL RISKS**				**KEY CONTROLS**	**ASSURANCES ON CONTROLS**	**BOARD REPORTS**						
		Principal Risks		**RAG Rating (CXL)**	**Executive Lead and Committee**	**Key Controls**	**Sources of Assurance**	**Positive Assurances on the effectiveness of controls**	**Residual RAG Rating (CXL)**	**Gaps in Control**	**Gaps in Assurance**	**Review Date**	**Changes to the risk rating since the last review**	**Target RAG Rating (CXL)**
		What could prevent the objective from being achieved	What are the potential causes and effects of the risks		Which area within our organisation this risk primarily relate to	What controls or systems are in place to assist in securing the delivery of the objectives	Where we can gain evidence that our controls/systems, on which we are placing reliance, are effective	We have evidence that shows we are reasonably managing our risks and objectives are being delivered		Where are we failing to put controls/systems in place or where collectively are they not sufficiently effective.	Where are we failing to gain evidence that our controls/systems, on which we place reliance, are effective			
								Evidence should link to a report from a Committee or Board.						
	Strategic Objective 4: Our Performance - we will meet and achieve our performance targets, covering national and local operational, quality and workforce indicators													
BAF 4.1		**Supporting Functions (including Finance, IT and Estates and Facilities)** Capacity & capability of the business support functions including a requirement to continue to modernise systems, processes and structures.	Causes: i) Lack of automation and technology ii) Reliance on paper processes iii) Potential underinvestment in some corporate functions e.g. estates and facilities iv) Lack of standardised reporting mechanisms	**4x5=20**	**Exec lead**: Director of Quality Improvement. **Committee:** Performance and Finance Committee	i) Modernisation programme being launched; workstreams and leads identified ii) Realignment of executive director portfolios and leads iii) QI strategy supporting modernisation projects iv) Modernisation programme being aligned to work programme of ICA/ICP and developing PAHT Clinical Strategy	i) PAF, Audit and Board meetings ii) CQC/NHSI reviews/reports iii) ICT Programme Board iv) Transformation and QI Board being established (Oct 19) v) EMT/SMT meetings vi) System-wide Transformation Board	i) Outputs from NHSI deep dives Model Hospital data and reports to PAF (June 19) ii) Internal Audit and External Audit reports including Head of Internal Audit Opinion and VfM conclusion (Audit Committee May 19). iii) Modernisation presentation to PAF (June 19) iv) PAHT 2030 report to Strategy Committee (July 19)	**4x3=12**	i) Resourcing and funding for modernisation programme	None identified.	02/07/2019	Proposed for closure. The underlying issues are reflected in other BAF risks.	**4x3=12** **March 2020**
			Effects: i) Over reliance on manual processes and interventions ii) Labour intensive, error prone and time consuming processes iii) Ability to attract skilled staff and retention and morale (leading to reliance on temporary staff), iv) Reliance on key individuals and single points of failure v) Adequate value for money conclusions. vi) Inability to meet business partnering needs of organisation											

Risk Key														
Extreme Risk		15-25												
High Risk		8-12	**The Princess Alexandra Hospital Board Assurance Framework 2019-20**											
Medium Risk		4-6												
Low Risk		1-3												
Risk No		**PRINCIPAL RISKS**				**KEY CONTROLS**	**ASSURANCES ON CONTROLS**	**BOARD REPORTS**						
		Principal Risks		**RAG Rating (CXL)**	**Executive Lead**	**Key Controls**	**Sources of Assurance**	**Positive Assurances on the effectiveness of controls**	**Residual RAG Rating (CXL)**	**Gaps in Control**	**Gaps in Assurance**	**Review Date**	**Changes to the risk rating since the last review**	**Target RAG Rating (CXL)**
		What could prevent the objective from being achieved	What are the potential causes and effects of the risks		Which area within our organisation this risk primarily relate to	What controls or systems are in place to assist in securing the delivery of the objectives	Where we can gain evidence that our controls/systems, on which we are placing reliance, are effective	We have evidence that shows we are reasonably managing our risks and objectives are being delivered		Where are we failing to put controls/systems in place or where collectively are they not sufficiently effective.	Where are we failing to gain evidence that our controls/systems, on which we place reliance, are effective			
								Evidence should link to a report from a Committee or Board.						
	Strategic Objective 4: Our Performance - we will meet and achieve our performance targets, covering national and local operational, quality and workforce indicators													
BAF 4.2		**4 hour Emergency Department Constitutional Standard** Failure to achieve ED standard	**Causes:** i) Access to community and OOH services. ii) Change in Health Demography with increase in long term conditions. iii) Gaps in medical and nursing workforce iv) Lack of public awareness of emergency and urgent care provision in the community. vi Attendances continue to rise annually (5.1% over the last 2 years). viii) Changes to working practice and modernisation of systems and processes ~~viii) Attitude and behaviour challenges~~ ix) Delays in decision making, patient discharges and delays in social care and community impacting on flow x) Increases in minor attendances	**4 X 5 = 20**	Chief Operating Officer Performance and Finance Committee	i) Performance recovery plans in place ii) Regular monitoring and weekly external reports iii) Daily oversight and escalation iv) Robust programme and system management v) Daily call with ~~NHSI~~ CCG/~~NHSE~~, daily report on performance. vii) Work in progress to develop new models of care viii) Local Delivery Board in place ix) Daily specialty response times monitored x) System reviewing provision of urgent care xi) Exec attendance at safety huddles daily xii) ED action plan reported to PAF/Board xiii) Co-location of ENP's, GP's, Out of hours GP'S to support minor injuries ~~xiv) Daily review of Paeds by Clinical Lead and HoN~~ xv) Protection of assessment capacity work underway xvi) Additional capacity in place ~~xvii) Additional winter funding for social care~~ xviii) Weekly Urgent Care operational meetings and Urgent Care Board in place xix) On site support from ECIST and NHSI medical lead	i) Access Board meetings ii) Board, PAF and EMB meetings iii) Monthly Operational Assurance Meetings iv) Monthly Local Delivery Board meetings v) Weekly System review meetings vi) Daily system executive teleconference vii) Fortnightly escalation meetings with NHSI/NHSE viii) Weekly HCG reviews ix) System Operational Group	i) Daily ED reports to NHSI ii) Monthly escalation reports to NHSE iii) Monthly PRM reports from HCGS iv) Monthly IPR reported to PAF/QSC and Board reflecting ED performance. v) Presentation on ED performance and 'next steps' to PAF and Board (May/June 19)	**4 x 5 = 20**	i) Staffing (Trust wide) and site capacity ii) System Capacity iii) Leadership issues **Actions:** i) Local Delivery Board monitoring ED performance iii) Monthly Performance review meetings and weekly Urgent Care Board review	None noted.	02/07/2019		**4x3 =12 March 2020 (on delivery of standard - 95%)**
			Effects: i) Reputation impact and loss of goodwill. ii) Financial penalties. iii) Unsatisfactory patient experience. iv) Potential for poor patient outcomes v) Jeopardises future strategy. vi) Increased performance management vii) Increase in staff turnover and sickness absence levels												

Risk Key														
Extreme Risk		15-25												
High Risk		8-12	**The Princess Alexandra Hospital Board Assurance Framework 2019-20**											
Medium Risk		4-6												
Low Risk		1-3												
Risk No		**PRINCIPAL RISKS**				**KEY CONTROLS**	**ASSURANCES ON CONTROLS**	**BOARD REPORTS**						
		Principal Risks		**RAG Rating (CXL)**	**Executive Lead and Committee**	**Key Controls**	**Sources of Assurance**	**Positive Assurances on the effectiveness of controls**	**Residual RAG Rating (CXL)**	**Gaps in Control**	**Gaps in Assurance**	**Review Date**	**Changes to the risk rating since the last review**	**Target RAG Rating (CXL)**
		What could prevent the objective from being achieved	What are the potential causes and effects of the risks		Which area within our organisation this risk primarily relate to	What controls or systems are in place to assist in securing the delivery of the objectives	Where we can gain evidence that our controls/systems, on which we are placing reliance, are effective	We have evidence that shows we are reasonably managing our risks and objectives are being delivered		Where are we failing to put controls/systems in place or where collectively are they not sufficiently effective.	Where are we failing to gain evidence that our controls/systems, on which we place reliance, are effective			
								Evidence should link to a report from a Committee or Board.						
	Strategic Objective 5: Our Pounds – we will manage our pounds effectively and modernise our corporate services to achieve our agreed financial control total for 2019/20 and our local system control													
BAF 5.1		**Finance** Concerns around failure to meet financial plan including cash shortfall.	Causes: i) Operational performance impacting on financial performance including recovery of PSF/FRP ~~e.g. ED target~~, ii) CCG affordability and contractual disputes and challenges, iii) ability to deliver recurrent CIPs, iv) workforce shortages v) high levels of unplanned expenditure including maintenance of aging estate, vi) Capture and billing of activity. vii) Potential impact of pension changes ~~pay settlement~~	**5 X 4= 20**	**Exec leads :** CFO **Committee** : Performance and Finance Committee	i) Access to Interim Revenue Support loans ii) Cost Improvement Programme iii) Formal re-conciliation process with CCG iv) Internal and external Agency controls and reporting v) SMT, PAF and Audit Committee vi) Health Care Group Assurance meetings vii) Enhanced Performance Reviews viii) Regular Balance sheet reviews ix) Approved Governance Manual x) Budget sign off process xi) Enhanced financial reporting and controls xii) Regulatory returns required e.g. agency spend xiii) Increased frequency of reporting for selected HCGs xiv) Medical agency protocol xv) Financial Recovery Plan - due Sept 2019 xvi) Demand and Capacity planning xvii) ~~Revised forecast meetings with~~ HCGs year end forecast for M3 ~~and SMT. HCG's that are off trajectory are required to ensure full mitigation.~~ xviii) Use of resources assessment 26.03.19 iiixi) The Trust and CCG are jointly discussing system financial principles e.g. block payment or minimum guarantee payment ~~a potential year end settlement for 18/19.~~	i) Internal Audit & External Audit opinion. ii) External reviews iii) NHSI/E reporting iv) Internal Trust reporting v) Cash Management group vi) ~~Pay award steering group~~ vii) Joint meetings with CCG viii) Delivery Group - weekly ix) CQUIN Group	i) Monthly reports including bank balances and cash flow forecasts to PAF and Board ii) CIP reports iii) Internal Audit reports: Financial Reporting and Budget Monitoring (substantial assurance) Key Financial Systems (substantial assurance) Non-SLA Income (limited assurance) iv) Financial Recovery Plan v) FAM reports monthly vi) PRM packs monthly vii) Recovery plans and trajectories reported to Delivery Group (weekly)	**5x3=15**	i) Organisational and Governance compliance e.g. waivers ii) Activity and capacity planning iii) CIP delivery ~~eporting and run rate reductions~~ iv) CQUIN - risk of recovering full income v) Management of temporary staffing costs	PLICs Demand and Capacity ~~planning regularisation~~ Workforce planning	01/07/2019		To be reviewed following FOT discussion at PAF.
			Effects: i) Ability to meet financial control target ii) Potential delay to payment to creditor/ suppliers ii) Increased performance management iv) Going Concern status v) Risk to recovery of sustainability funding vi) Impact on capital availability vi) Unfavourable audit opinion (VfM,Section 30 Letter) vii) Restrictions on service development viii) Recruitment & retention ix) Increased likelihood of dispute/arbitration processes x)Reputational risks xi) Increase in agency temp staff costs xii) Impact of in year Commissioner QIPP plans								**ACTIONS:** Future,Modernisation Demand and Capacity Planning and Modelling to be regularised Clinical and operational forums in place to review QIPP schemes. Review of Capital reporting and planning for 19/20 underway.				

The Princess Alexandra Hospital NHS Trust

Trust Board (Public) – 1 August 2019

4.1

Agenda Item:	4.1
Presented by:	Lance McCarthy – CEO
Prepared by:	Lance McCarthy – CEO
Date prepared:	26 July 2019
Subject / Title:	CEO Update

Purpose:	Approval		Decision		Information		Assurance	

Key Issues: [please don't expand this cell; additional information should be included in the main body of the report]	This report updates the Board on key issues since the last public Board meeting: - Performance highlights - Urgent care and flow - CQC inspection - Political changes - Development of Integrated Care Provider - Consultant appointments
Recommendation:	The Trust Board is asked to note the CEO report and approve the recommendations of the AAC panels.

Trust strategic objectives: [please indicate which of the 5Ps is relevant to the subject of the report]	Patients	People	Performance	Places	Pounds
	x	x	x	x	x

Previously considered by:	n/a
Risk / links with the BAF:	CEO report links with all the BAF risks
Legislation, regulatory, equality, diversity and dignity implications:	None
Appendices:	None

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The Princess Alexandra Hospital NHS
NHS Trust

Chief Executive's Report
Trust Board: Part I – 1 August 2019

This report provides an update since the last Board meeting on the key issues facing the Trust.

(1) Key performance headlines

Some key summary performance headlines outlined below for the latest month. More detail on each of these and other key performance indicators are shown in the revised and updated Integrated Performance Report later on the agenda.

Key Performance Indicator	Actual performance for latest month (June)	Comparison to last report
ED 4-hour performance	78.2%	↑ (better); target = 95%
SHMI	113.7 (Feb 18 – Jan 19)	↓ (better); higher than expected
CDiff (hospital onset)	0	↓ (better)
MRSA	0	→
Never Events	0	→
Incidents reported	715	↓ (better)
No harm / minor harm incidents	97.0%	↑ (better)
Falls / 1,000 bed days	8.39	New indicator, lower than May
6-week diagnostic standard	99.1%	↓ (worse)
Stat Man training	90.0%	↓ (worse); on target of 90%
Agency % of paybill	7.2%	New indicator, target of 7.0%

NOTE: New indicators are in blue

(2) Urgent care performance and flow

Performance against the 95% 4-hour access target remains significantly below where we would wish it to be. Numbers of attendances continue to increase materially (6.98% increase (November 18 – June 19 when compared to November 17 – June 18)).

At the time of writing this paper, performance against the standard for July was 79.31%, the 4th consecutive month of improvement. The total number of attendances in July were looking to be as high as 9,900 in the month, which would make it our busiest month ever, 5.5% higher than in March 2019.

The new integrated GP and ENP service at the front of ED is bedding in well, seeing nearly 20% of total ED attendances, increasing physical and ED resource capacity. This is aligned with the ongoing work that we are undertaking with the Emergency Care Intensive Support Team and our local partners to improve access and flow for our urgent care patients. The key areas of focus remain:

- Medical staffing numbers in ED
- Provision of additional intermediate care capacity out of hospital
- Increased space for the assessment of medical patients
- Increased inpatient capacity

More detail on actions to support our urgent care patients will be picked up later in the agenda.

(3) CQC inspection

Following our most recent Care Quality Commission (CQC) inspection, CQC colleagues have completed their ratings approval process and have amended the draft report in light of our factual accuracy responses. The full report is planned to published on 31st July, the day before this Board meeting. At the time of writing this paper, the report is embargoed, so I will update Board members on the outcome during the meeting.

(4) Political changes

The appointment of The Rt Hon Boris Johnson MP as the Prime Minister has led to many and some significant changes to members of the cabinet.

The 2 key changes that affect us directly, in addition to the appointment of the new PM, are:

- The Rt Hon Sajid Javid MP appointed as the Chancellor of the Exchequer, replacing The Rt Hon Philip Hammond MP
- Chris Skidmore MP appointed as the Minister of State for Health, replacing Stephen Hammond MP

The Rt Hon Matt Hancock MP remains as the Secretary of State for Health and Social Care and Caroline Dinenage MP remains as the Minister of State for Care.

(5) Development of Integrated Care Providers (ICP)

We are continuing to work closely with our West Essex and East Hertfordshire health and care colleagues to develop system wide clinical pathways for the benefit of our patients.

As we develop our local Integrated Care Provider, we launched our One Health and Care Partnership Alliance on 17 June at the Harlow Civic Centre. It was well attended by representatives from all local health and care organisations as well as voluntary and third sector organisations and many members of the public. We have created a transition programme for the integration of clinical and non-clinical services on our way to formalising the ICP and enabling us to potentially transition towards a local system wide integrated care trust should this become possible.

Since the last Board meeting, we have also signed a 5-year contract as an Alliance with Essex Partnership University Trust (EPUT), with West Essex CCG, for the provision of integrated Musculoskeletal services for the local population.

(6) Consultant appointments

We have held 4 Consultant Advisory Appointments Committees since the last Board meeting. The AACs recommend to the Board the appointments of the following 6 consultants:

Consultant in Oral and Maxillofacial Surgery

- Elizabeth Gruber

Consultants in Urology

- Stella Ivaz
- Andrew Russell
- Ali Gharib

Consultant in Haematology

- Khaled Majadob

Consultant in Emergency Medicine
- Gnanavadivel Singaravadivel

The Board is asked to approve the AACs' recommendations.

Author: **Lance McCarthy, Chief Executive**
Date: **26 July 2019**

Trust Board - 1 August 2019

5.2

Agenda Item:	5.2
Executive Sponsor	Sharon McNally – Director of Nursing & Midwifery
Presented by:	Sharon McNally - Director of Nursing and Midwifery
Prepared by:	Andy Dixon - Matron for Quality Improvement Sarah Webb – Deputy Director of Nursing and Midwifery
Date prepared:	July 2019
Subject / Title:	Report on Nursing and Midwifery and Care Staff Levels (Hard Truths) and an Update to Nursing and Midwifery Workforce Position
Purpose:	Approval [ ] Decision [ ] Information [■] Assurance [■]
Executive Summary: [please don't expand this cell; additional information should be included in the main body of the report]	This paper sets out the regular nursing and midwifery retrospective staffing report for the month of June 2019 (part A), and provides an update to the workforce position (part B). Headlines: • The RN/M fill rate for days has decreased by 2.0% in month. The overall fill rate for RN/RM has decreased by 1.5% • There has been a decrease in NHSP demand in month and a slight dip in temporary staff fill rates. • The overall nursing vacancy position has remained unchanged in month to 24.6% and the Band 5 rate at 39.3%. This is positive against the overall forecast but is slightly behind the Band 5 planned forecast vacancy rate. The RAG rating remains green as the variance is less than 2% behind forecast and it is expected that there will be a significant catch up next month • An exception report detailing the analysis of the rota fill, any impact on quality and actions is included in appendix.2.
Recommendation:	The Board is asked to note the information within this report

Trust strategic objectives: [please indicate which of the 5Ps is relevant to the subject of the report]	 Patients	 People	 Performance	 Places	 Pounds
	■	■	■		■

Previously considered by:	WFC.20.05.19
Risk / links with the BAF:	BAF: 2.1 Workforce capacity All Health Groups have both recruitment and retention on their risk registers
Legislation, regulatory, equality, diversity and dignity implications:	NHS England and CQC letter to NHSFT CEOs (31.3.14): Hard Truths Commitment regarding publishing of staffing data. NHS Improvement letter: 22.4.16 NHS Improvement letter re CHPPD: 29/6/18
Appendices:	Appendix 1a: Ward level fill rates (including WMS and Supernummary staff hours) Appendix 1b: Ward level fill rates (excluding WMS and Supernummary staff hours) Appendix 2: Ward staffing exception reports

1.0 PURPOSE

To update and inform the Committee on actions taken to provide safe, sustainable and productive staffing levels for nursing, midwifery and care staff in June 2019. To provide an update to the nursing vacancy rate, that the plans to further reduce the vacancy rate over 2019.

2.0 BACKGROUND

The report is collated in line with The National Quality Board recommendations (July, 2016).

2.0 ANALYSIS

3.1 This report provides an analysis based on the planned versus actual coverage in hours for the calendar month of June 2019.

3.2 The report includes additional shifts that have been worked due to increased workload (activity, patient dependency and / or acuity) or 1:1 patient supervision (specialing). As the requirement for additional shifts is not static and fluctuates, these shifts are not planned in advance of the rota being published, it is possible for the rota to have > 100% fill.

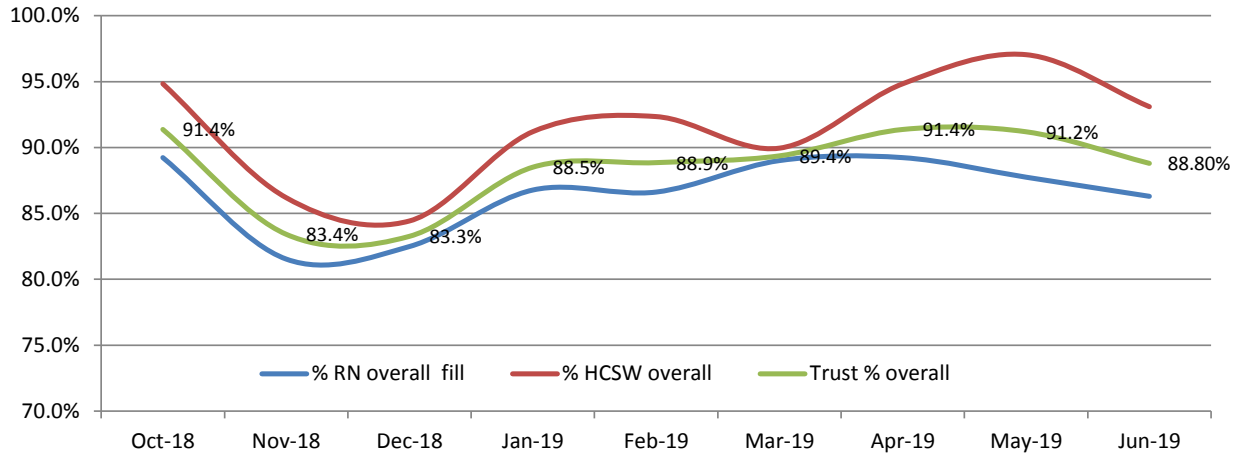
3.3 Care Hours per Patient Day* (CHPPD) has been confirmed as the national principle measure of nursing, midwifery and healthcare support worked deployment on inpatient wards (NHSI, 2018). From September 2018, publication of CHPPD replaced the actual v's fill dataset on My NHS and NHS Choices. CHPPD is reported under section 3.8.

3.4 The summary position for the Trust Safer Staffing Fill rates for June 2019 is included in the table below with a comparison with May.

3.4.1 In addition, the final row shows the Trust average excluding Ward Manager Supervisory (WMS) hours along with Supernumerary staff hours, which historically have been included in the submission.

Trust average	Days RM/RN	Days Care staff	Nights RM/RN	Nights care staff	Overall RM/RN	Overall care staff	Overall ALL staff
Trust average June (including WMS and Sup)	82.7%	82.5%	91.5%	111.6%	86.3 %	93.1 %	88.8 %
Trust average May ((including WMS and Sup)	84.7%	85.3%	92.1%	117.4%	87.8%	97.0%	91.2%
Change against May	↓2.0%	↓2.8%	↓0.6%	↓5.8%	↓1.5%	↓3.9%	↓2.4%

3.5 Fill rate: the rolling 9 month data is included in the table below:

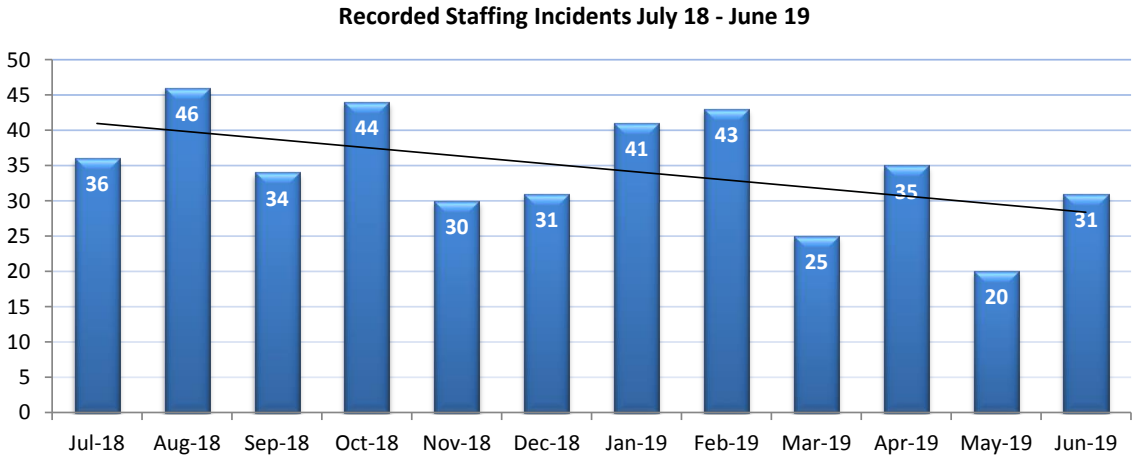


3.6 Exception reporting: Appendix 2 shows the exception report for the wards. The report includes analysis of the position, impact on quality, safety or experience and details actions in place to mitigate and improve the position where safe staffing is of concern.

3.6.1 National reporting is for inpatient areas, and therefore does not include areas including the emergency department or day units. To ensure the Board is sighted to the staffing in these areas, the data for these areas is included below using the same methodology as the full UNIFY report:

	Day		Night	
Ward name	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)
A&E Nursing	97.85%	194.7%	105.2%	110.1%
PAH Theatres	79.1%	94.0%	79.7%	103.3%
Endoscopy Nursing	117.0%	103.1%	-	-

3.7 Datix reports: The trend in reports completed in relation to nursing and midwifery staffing is included below and shows a downward trend over the 12 months reporting period. All incidents continue to be reviewed by the safety and quality review process.



3.8 There were no beds closed as a result of staffing concerns during June 2019.

3.9 Care Hours per Patient Days (CHPPD) the table below shows data calculated using the Model Hospital methodology. Model hospital data for national median has not been updated since February 2019.

	June 2019 data	National Median (Feb 2019)	Variance against national median
CHPPD Total	7.3	7.9	-0.5
CHPPD RN	4.5	4.6	-0.1
CHPPD HCA	2.8	3.2	-0.4

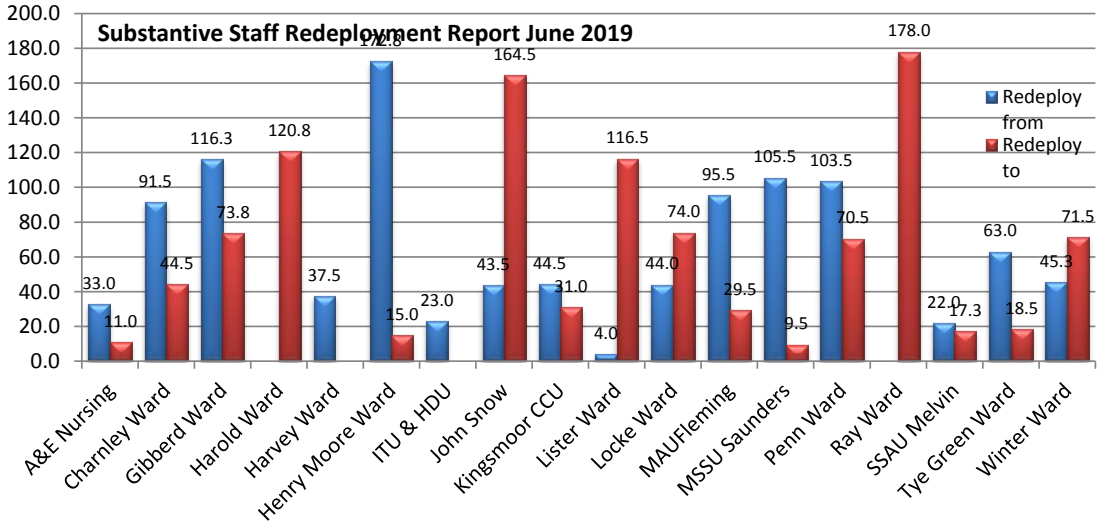
3.10 Mitigation:

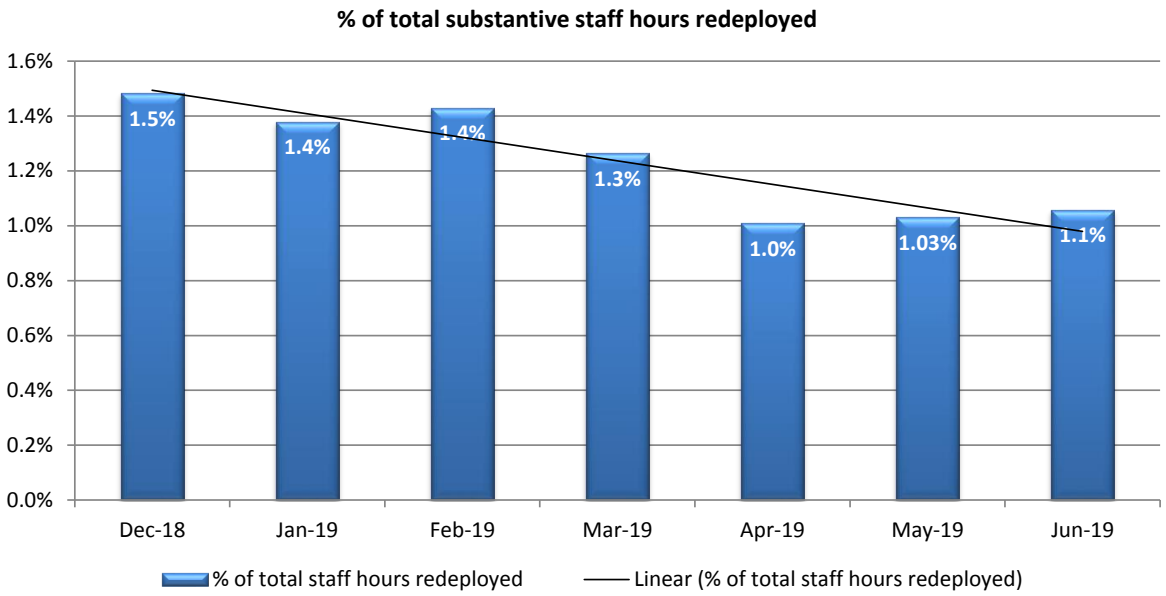
The day to day management of safer staffing across the organisation is managed through the daily staffing huddles and information from SafeCare to ensure support is directed on a shift: shift basis as required in line with actual patient acuity and activity demands. Ward managers support safe staffing by working in the numbers which continues to compromise their ability to work in a supervisory capacity.

3.11 Redeployment of staff:

The 2 graphs below show how the Trust is supporting safe staffing through redeployment of staff to meet acuity and dependency. The graph only shows the redeployment of substantive Trust staff and does not capture the moves of bank or agency staff. The maternity wards and Dolphin have been excluded from this report as they flex staff across the whole service dependant on patient and service needs.

The first graph shows the number of hours of staff redeployed from and to the adult inpatient ward to support safe staffing while the second graph shows the percentage of the total number of staff hours that are redeployed which shows a reducing trend of 0.4% over the past 12 months.





The accuracy of these reports continues to be dependent on the wards and site team redeploying staff, capturing and recording these moves in real-time in the e-Roster or SafeCare system.

While essential to ensure the safe staffing across the Trust moving substantive staff can impact on staff satisfaction and retention rates and therefore is monitored closely to minimise the impact on staff.

3.12 Bank and Agency fill rates:

The use of NHSP continues to support the clinical areas to maximise safer staffing. The Trust has worked with NHSP to increase the availability of resource, and are working in partnership to improve this further. The table below shows that there was a decrease in registered demand (↓92 shifts) in June. There was a decrease in NHSP and agency fill for RN, resulting in an overall reduction in fill rate for RNs in month but an increase compared to the same time period in 2018. The HCSW demand shows a small increase (↑78 shifts) with the overall fill rate down against May.

RN/M temporary staffing demand and fill rates:

Last YTD Month & Year	Shifts Requested	NHSP Filled Shifts	% NHSP Shift	Agency Filled Shifts	% Agency Filled Shifts	Overall Fill Rate	Unfilled Shifts	% Unfilled Shifts
March 2019	5,303	2,208	41.6%	1,387	26.2%	67.8%	1,708	32.2%
April 2019	4,382	1,652	37.7%	1,407	32.1%	69.8%	1,323	30.2%
May 2019	4,610	1,771	38.4%	1,251	27.1%	65.6%	1,588	34.4%
June 2019	4,518	1,718	38.0%	1,204	26.6%	64.7%	1,596	35.3%
June 2018	4,149	1,321	31.8%	1,090	26.3%	58.1%	1,738	41.9%

HCA temporary staffing demand and fill rates:

Last YTD Month & Year	Shifts Requested	NHSP Filled Shifts	% NHSP Shift	Agency Filled Shifts	% Agency Filled Shifts	Overall Fill Rate	Unfilled Shifts	% Unfilled Shifts
March 2019	2,762	1,951	70.6%	0	0%	70.6%	811	29.4%
April 2019	2,214	1,707	77.1%	0	0%	77.1%	507	22.9%

May 2019	2,275	1,854	81.5%	0	0%	81.5%	421	18.5%
June 2019	2,353	1,841	78.2%	0	0%	78.2%	512	21.8%
June 2018	1,782	1,203	67.5%	0	0%	67.5%	579	32.5%

The December 2018 bank staffing initiative continues to be in place, and was further extended until the end of August 2019. The impact will continue to be reviewed and assessed. Review of temporary staffing process has identified that we could potentially improve the fill rate by increasing the number of shifts being sent to NHSP at time of confirming the roster. Ward managers and matrons have been reminded of the process.

B: Workforce:

Nursing Recruitment Pipeline

The nurse vacancy rate remains one of the Trusts biggest challenges. The vacancy rate in June remained static at 24.6% which is slightly below the forecast rate which was 25.4%.

Band 5 posts make up the bulk of the vacancy rate and in June the vacancy rate remained static at 39.3% against the previous month and slightly behind the forecast rate of 38.1%. There were fewer starters in month than expected due to delays with the Home Office visa process. The trajectory remains green due to a less than 2% variance against the plan which we are confident will be corrected next month.

The following table shows confirmed recruitment figures (in green) against the planned trajectory.

Establishment V Staff in Post												
Funded Establishment WTE	942.61	942.61	942.61	942.61	942.61	942.61	942.61	942.61	942.61	942.61	942.61	942.61
Actual RN Vacancy Rate	25.3%	24.7%	24.6%	23.2%	21.8%	18.4%	15.3%	12.3%	9.9%	8.9%	8.6%	8.4%
Forcast Vacancy Rate in Business Plan	26.8%	26.9%	25.4%	24.0%	22.7%	19.3%	16.2%	13.1%	10.8%	9.7%	9.4%	9.3%

Band 5 Establisment V Staff in Post	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
Funded Band 5 Establisment WTE	487.93	487.93	487.93	487.93	487.93	487.93	487.93	487.93	487.93	487.93	487.93	487.93
Actual Band 5 Vacancy Rate	40.8%	39.7%	39.3%	36.7%	34.0%	27.4%	21.5%	15.6%	11.1%	9.0%	8.4%	8.2%
Forcast Vacancy Rate in Business Plan	40.8%	41.0%	38.1%	35.4%	32.8%	26.2%	20.3%	14.3%	9.8%	7.8%	7.2%	7%

Projected Starters Pipeline	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
RNs (not Band 5)	1	1	2	1	1	1	1	1	1	1	1	1
Band 5 Newly Qualified + Local	3	2	0	0	0	6	0	0	10	0	0	0
Band 5 International Recruitment	6	5	7	19	19	32	35	35	18	16	9	7
Band 5 Starters	**6**	**7**	**7**	**19**	**19**	**38**	**35**	**35**	**28**	**16**	**9**	**7**
Total Starters	10	8	9	20	20	39	36	36	29	17	10	8
Planned Starters	**6**	**5**	**20**	**19**	**19**	**38**	**35**	**35**	**28**	**16**	**9**	**7**

Projected Leavers WTE	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
RNs (not Band 5) Leavers	2	3	3	1	1	1	1	1	1	1	1	1
Band 5 Leavers	3	2	5	6	6	6	6	6	6	6	6	6
Total Leavers	**5**	**5**	**8**	**7**	**7**	**7**	**7**	**7**	**7**	**7**	**7**	**7**

Weekly planned skype interviews and offers	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
Planned Skype Interviews	50	50	50	50	50	50	50	50	50	51	52	53
Skype Offers	25	25	31									

The focus of our nursing recruitment remains international recruitment. There are 159 nurses who have offers made either during the overseas recruitment campaigns from 2018 or from weekly Skype interviews. The offer holders are at various stages in the process of completing the necessary

documentation and tests required for NMC registration and Home Office approval and the forecast of when we are expecting them to commence forms the pipeline in the table above. The forecast for June was for 20 offer holders to commence in June at Band 5 however there were only 5 starters due to the current delays in the Home Office processing visa applications which is currently sitting at 6-9 weeks (previously this was at 7 days for a priority application). We work closely with the agencies and new starters to ensure we are reducing the time from offer to starting in post as far as possible but various factors such as visa applications are outside our control.

Work continues to ensure we maximise both the international pipeline and local recruitment. An overseas recruitment campaign to India was held in early July and 132 offers were made to nurses including 12 ED nurses, 14 ITU, 13 scrub nurses and 11 theatre staff for PACU as well as general nurses. The team used this as an opportunity to refresh the recruitment brochure tailored to international nurses to ensure we sell the benefits of working at PAH and living in Harlow to overseas nurses.

An STP recruitment event was held at Watford Football Stadium in June who was represented by the practice development team who spoke to some potential candidates on the day.

A new senior nursing post to lead on recruitment and retention has been advertised. This post will pick up and accelerate the recruitment activity already in place and focus on the retention strategy for the Trust.

4.0 RECOMMENDATION

The Board is asked to receive the information describing the position regarding nursing and midwifery recruitment, retention and vacancies, along with sickness rates, and note the plan to review and make further recommendations to improve the trajectory.

Author: Andy Dixon. Matron for Quality Improvement,
Sarah Webb, Deputy Director of Nursing and Midwifery

Date: 17th July 2019

Appendix 1.

Ward level data: fill rates June 2019. (Including Ward Manager Supervisory and Supernummary Staff hours)

	Day		Night				
Ward name	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	% RN overall fill rate	% overall HCSW fill rate	% Overall fill rate
Dolphin Ward	87.90%	69.60%	94.20%	133.40%	90.3%	85.7%	89.0%
Kingsmoor CCU	83.40%	80.40%	97.30%	107.30%	89.1%	89.9%	89.4%
MAU Fleming	55.60%	64.20%	64.30%	93.10%	59.0%	73.8%	64.9%
Tye Green Ward	85.50%	117.90%	79.20%	118.40%	83.1%	118.1%	97.4%
Harvey Ward	79.40%	81.10%	86.70%	96.00%	82.3%	86.5%	84.0%
ITU & HDU	93.0	276.2%	97.0%	127.8%	94.9%	191.0%	103.0%
John Snow	71.20%	75.30%	86.80%	105.80%	77.1%	86.6%	80.9%
Charnley Ward	103.70%	90.60%	117.50%	145.60%	108.5%	107.5%	108.1%
Lister Ward	98.30%	80.20%	106.60%	149.70%	101.5%	99.5%	100.5%
Locke Ward	105.00%	107.50%	89.30%	135.50%	98.6%	117.6%	105.5%
Neo-Natal Unit	81.90%	57.40%	80.70%	56.70%	81.3%	57.1%	74.3%
Penn Ward	82.90%	96.70%	106.80%	135.60%	90.9%	110.8%	98.5%
Ray Ward	95.00%	73.10%	125.90%	156.10%	105.3%	100.4%	102.8%
MSSU Saunders	77.20%	81.20%	88.20%	91.00%	81.6%	85.0%	83.1%
Harold Ward	66.60%	86.70%	120.60%	164.70%	82.2%	111.4%	94.6%
Henry Moore Ward	89.00%	64.90%	92.10%	60.00%	90.2%	63.6%	79.3%
Gibberd Ward	88.30%	90.40%	113.50%	103.30%	97.7%	96.1%	96.8%
Winter Ward	68.10%	104.70%	104.50%	161.00%	79.7%	125.0%	96.8%
Chamberlen Ward	58.00%	31.70%	63.40%	63.30%	60.5%	45.6%	56.7%
Labour Ward	81.00%	59.00%	82.70%	61.70%	81.8%	60.2%	77.4%
Samson Ward	112.20%	67.40%	100.50%	86.70%	106.6%	74.2%	91.3%
Birthing Unit	92.70%	80.00%	79.00%	93.60%	86.3%	86.4%	86.3%
Trust total	82.7%	82.5%	91.5%	111.6%	86.3%	93.1%	88.8%

Appendix 2

Ward staffing exception reports
Reported where the fill is < 85% during the reporting period, or where the ADoN has concerns re: impact on quality/ outcomes

	Report from the Associate Director of Nursing for the HCG		
Ward	Analysis of gaps	Impact on Quality / outcomes	Actions in place
Fleming	Low RN and HCSW fill rates	Nil reported complaints of Red Flag incidents	
Harvey	Low RN and HCSW fill rates	Nil reported complaints of Red Flag incidents	
Saunders	Low RN and HCSW fill rates	Nil reported complaints of Red Flag incidents	
John Snow	Fill rates for RN and HCA below 85% threshold	Nil reported	X3 safe staffing reviews per day.
Henry Moore	Significant reduction in template and fill rate for HCA impacting on overall fill rate	Nil as bed reduction and good skill mix	Nil
Chamberlin	We utilise the staff to where the workload is increased in busy periods and we have been below template for parts of the month of June as it is indicating	We have closed the birthing unit to ensure staff are all in the appropriate areas on 4 occasions in June when the staff have needed to be on labour ward but have opened as soon as we can so as to avoid low risk women delivering on the Consultant led Labour ward. At no time in month has the unit been unsafe or care compromised, the managers on call have been called in during June particularly overnight to work.	The staffing is reviewed on a daily basis as is the workload, sickness is still higher than normal in maternity but we are working with HR and adherence with attendance policy

Labour	See above		
Neo Natal	RN and HCSW low	Nil as activity also dipped in month	Rota templates to be updates to reflect changes in planned Care Hours

The Princess Alexandra Hospital NHS Trust

Trust Board (Public) – 1 August 2019

5.3

Agenda Item:	5.3
Presented by:	Lance McCarthy – CEO
Prepared by:	Lance McCarthy – CEO
Date prepared:	26 July 2019
Subject / Title:	Pathology Services update

Purpose:	Approval		Decision		Information		Assurance	

Key Issues:	This report updates the Board on progress with the procurement of an STP wide pathology service. Four Supplier Questionnaire responses have been received from NHS and non-NHS organisations and will be evaluated during August. A process of competitive dialogue will be undertaken over the winter and spring with a preferred bidder identified in April 2020. Assuming sovereign Board approvals, the contract will be awarded in June / July 2020.
Recommendation:	The Trust Board is asked to note the progress made with the STP wide pathology procurement.

Trust strategic objectives: [please indicate which of the 5Ps is relevant to the subject of the report]	Patients	People	Performance	Places	Pounds
	x	x	x	x	x

Previously considered by:	n/a
Risk / links with the BAF:	Links to the BAF risks on service delivery and estate.
Legislation, regulatory, equality, diversity and dignity implications:	TUPE regulations will apply to Pathology staff in scope Public Sector procurement Regulations
Appendices:	Report attached.

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The Princess Alexandra Hospital NHS
NHS Trust

Pathology services update
Trust Board: Part I – 1 August 2019

This report provides an update on progress with the STP wide procurement of pathology services and their move towards being part of a pathology network.

(1) Background

1.1 Aligned with NHS Improvement's push in summer 2017 for all pathology services to be arranged across the country in 27 networks, all organisations individually, and the STP as a whole, approved OBCs in the winter to go out to procurement for an STP wide pathology service.

1.2 All organisations agreed that they are supporters of clinical networks generally, and for pathology in particular, given the benefits they can bring to our patients, our people and our finances.

(2) Progress

2.1 We have had a project team in place since March 2019 to support the procurement.

2.2 Reporting to an STP wide Pathology Networking Board, with representatives from all 3 acute Trusts and all 3 CCGs in the STP, there are a number of key workstreams with relevant representation, including:

- Clinical and operational
- Financial and contractual
- Workforce
- IM&T
- Data
- Communications

2.3 An OJEU notice and Supplier Questionnaire (SQ) was issued at the start of June, with a draft service specification. The SQ timeframe has completed and we have received 4 responses, from both NHS and non-NHS organisations.

2.4 The evaluation of the SQ responses will be undertaken in August in parallel with the ongoing development of the service specification.

2.5 All pathology staff across all organisations are either directly involved with the procurement or kept updated by their local leads and a regular fortnightly progress update.

(3) Competitive Dialogue

3.1 The procurement methodology approved for this is one of competitive dialogue. Therefore post the SQ valuation and approval of the evaluation report, the competitive dialogue phase will begin.

3.2 Working through the winter and spring months, it is planned that the recommendation of the preferred bidder will be made to the Pathology Networking Board in April 2020, with a subsequent recommendation made to sovereign CCG and Trust Boards in May 2020.

3.3 A contract award is expected to be made in June / July 2020 for a 10-15 year contract.

The Board is asked to note the good progress with the STP wide pathology procurement.

Lance McCarthy - Chief Executive Officer

The Princess Alexandra Hospital NHS Trust

Trust Board - 1 August 2019

5.4

Agenda Item:	5.4
Presented by:	Sharon McNally - Director of Nursing and Midwifery
Prepared by:	Jacqui Featherstone/Paula Hollis - Deputy Head of Midwifery
Date prepared:	17.07.2019
Subject / Title:	Maternity incentive scheme: year 2 – 10 maternity safety actions

Purpose:	Approval		Decision		Information		Assurance	

Key Issues: [please don't expand this cell; additional information should be included in the main body of the report]	This is the second year that NHS Resolution are operating the Clinical Negligence Scheme for Trusts (CNST) to support the delivery of safer maternity care. The Trust must demonstrate achievement of all the 10 safety actions to recover the element of the CNST maternity incentive fund contribution as of August 2019. This paper outlines the requirements of the scheme, the assurance framework and provides a summary of the evidence of achievement against all 10 standards.
Recommendation:	The Board is asked to receive the paper as assurance that maternity services have demonstrated all the requirements of the Maternity Incentive Scheme and recommend the Board approves the submission of the Board declaration form.

Trust strategic objectives: [please indicate which of the 5Ps is relevant to the subject of the report]	Patients	People	Performance	Places	Pounds
	x		x		

Previously considered by:	QSC on 26 July 2019
Risk / links with the BAF:	BAF risk 1.1 Variation in clinical outcomes
Legislation, regulatory, equality, diversity and dignity implications:	NHS Resolution Maternity Incentive Scheme
Appendices:	Action plan in resources area of Diligent

The Princess Alexandra Hospital NHS Trust

5.4

PURPOSE

This paper outlines the requirements required to achieve the NHS Resolution Maternity Incentive Scheme payment for 2019/20 and provides evidence that all ten safety actions have been achieved. The Maternity Incentive Scheme requires the Board to declare that they are satisfied with the evidence provided to NHS Resolution meets the required standards as set out in the guidance. This report provides a summary of the evidence which is further detailed in the action plan in Appendix 1. Maternity services are confident that the evidence compiled meets all the standards required.

1.0 BACKGROUND

This is the second year that NHS Resolutions are operating the Maternity Incentive Scheme to support the delivery of safer maternity care. Under the Clinical Negligence Scheme for Trusts only trusts that meet all 10 maternity safety actions will be eligible for a partial refund of approx. 10% of their the initial contribution. For PAH this equate to approx. £0.5M. In 2018/19 the Trust were able to evidence 9 out of the 10 and did not receive the rebate.

The maternity service have been working towards achievement of all 2019/20 safety actions and meeting the evidence submission requirements so that we qualify for the rebate. The FAWS (Family and Womens) Health Group meet twice a month to update the action plan with support from Trust Executives and monthly reporting at Health Group Performance Review Meeting.

Due to the importance of delivering the safety elements for our mothers and babies as well as achieving the rebate, the oversight of delivery was undertaken by Quality and Safety Committee (QSC) on behalf of the Board.

3.0 MATERNITY INCENTIVE SCHEME

The 10 maternity safety actions are framed as questions:

1. Are you using the National Perinatal Mortality Tool to review perinatal deaths to the required standard
2. Are you submitting data to the Maternity Services Data Set to the required standard?
3. Can you demonstrate that you have transitional care services to support the Avoiding Term Admissions into Neonatal units Programme?
4. Can you demonstrate an effective system of medical workforce planning to the required standard?
5. Can you demonstrate an effective system of midwifery workforce planning to the required standard?
6. Can you demonstrate compliance with all four elements of the Saving Babies' Lives care bundle?
7. Can you demonstrate that you have a patient feedback mechanism for maternity services and that you regularly act on feedback?
8. Can you evidence that 90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session within the last training year?
9. Can you demonstrate that the trust safety champions (obstetrician and midwife) are meeting bimonthly with Board level champions to escalate locally identified issues?
10. Have you reported 100% of qualifying 2018/19 incidents under NHS Resolution's Early Notification scheme?

Each question has a required standard and minimal evidential requirement to demonstrate compliance. The document also details and assurance framework with timescales on the evidential standards that require Board sign off. These are detailed below.

3.1 Key timelines

Date Board approval required by	Element	Evidence	Board or Trust Committee
10th March 2019	3	Action plan for delivery of transitional care services	Trust Board
30th April 2019	1	Q4 report on progress against perinatal deaths and any actions required	QS&C
19th May 2019	3	Update on progress with agreed action plans on delivery of transitional care services	QS&C
31st July 2019	4	Report on any medical education concerns raised in GMS national survey and an action plan to address any concern's raised	QS&C/Trust Board
31st July 2019	5	Report on maternity staffing and safety issues including update on Birthrate Plus information	QS&C/Trust Board
31st July 2019	6	Report proving assurance that the Trust is meeting all 4 elements of Saving Babies Lives Care Bundle	QS&C/Trust Board
15th August 2019	All	Final paper. Oversight and sign off of completion of evidence of all 10 elements. Agenda with Trust Board on 1st August 2019.	Trust Board

4. Oversight

The report details the actions that have been taken to achieve the requirements set out in the Maternity Incentive Scheme. The maternity management team have worked collaboratively on each element to ensure that the safety actions are achieved which has had joint oversight by the Director of Nursing and Midwifery and Deputy Director of Nursing and Midwifery at monthly oversight meetings.

5. Compliance

The following describe each of the ten elements of the incentive schemes, the standards require and a summary of the evidence of compliance.

Safety Action 1 – Are you using the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard?

Required Standard

a) A review of 95% of all deaths of babies suitable for review using the Perinatal Mortality Review Tool (PMRT) occurring from Wednesday 12 December 2018 have been started within four months of each death.

b) At least 50% of all deaths of babies who were born and died in your trust (including any home births where the baby died) from Wednesday 12 December 2018 will have been reviewed, by a multidisciplinary review team, with each review completed to the point that a draft report has been generated, within four months of each death.

c) In 95% of all deaths of babies who were born and died in your trust (including any home births where the baby died) from Wednesday 12 December 2018, the parents were told that a review of their baby's death will take place and that their perspective and any concerns about their care and that of their baby have been sought.

d) Quarterly reports have been submitted to the trust Board that include details of all deaths reviewed and consequent action plans.

Minimum evidential requirement for trust Board

A report has been received by the trust Board each quarter from Wednesday 12 December 2018 until Thursday 15 August 2019 that includes details of the deaths reviewed and the consequent actions plans. The report should evidence that the required standards a) to c) above have been met.

Evidence

The Perinatal mortality review processes have been embedded within the service since March 2018 and are compliant with all the detailed elements.

A monthly multi-disciplinary Perinatal Mortality Review Team (PMRT) meeting is held on the 1st Friday of the month at which all cases that meet the criteria are reviewed.

The parents are informed the PMRT meeting will take place and feedback is shared with them either at face to face meeting or at the Sensitive clinic meeting. Parents concerns are sought and these are addressed at the PMRT.

100% of deaths that meet the criteria have been reviewed within the timeframe required.

A quarterly report was sent to the trust Board on 22.04.2019 giving details of 4 deaths and associated action plans that occurred between December 2018 and 31st March 2019. This is 100% of deaths that meet the criteria and within the timescale

A report on 5 deaths which occurred in Quarter 1 that meet the criteria has been prepared and will be reviewed at QSC on the 26.07.2019

Recommendation: Standard Met

Safety Action 2 - Are you submitting data to the Maternity Services Data Set to the required standard?

Required Standard

This relates to the quality, completeness of the submission to the Maternity Services Data Set (MSDS) and readiness for implementing the next version of the dataset (MSDSv2).

Minimum evidential requirement for trust Board

NHS Digital will issue a monthly scorecard to data submitters (trusts) that can be presented to the Board.
The scorecard will be used by NHS Digital to assess whether each MSDS data quality criteria has been met and whether the overall score is enough to pass the assessment. It is necessary to pass all three mandatory criteria and 14 of the 19 other criteria (please see table below for details).

Evidence

All requirements relating to the submission of the quarterly maternity minimum data set have been achieved to date.

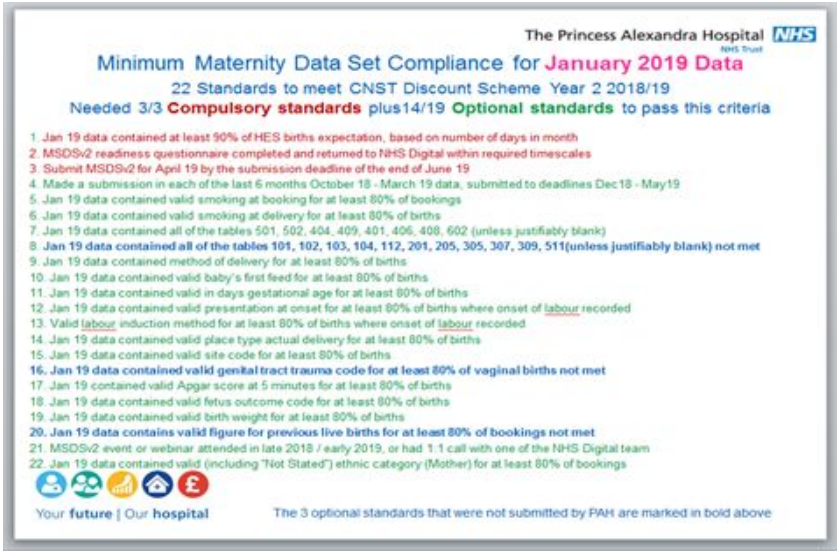
Monthly scorecards have been issued by NHS Digital for the Trust which demonstrates compliance with the standard.

The scorecard is reported at the monthly performance review meeting with the trust Executive team.

January 2019 Data Submission

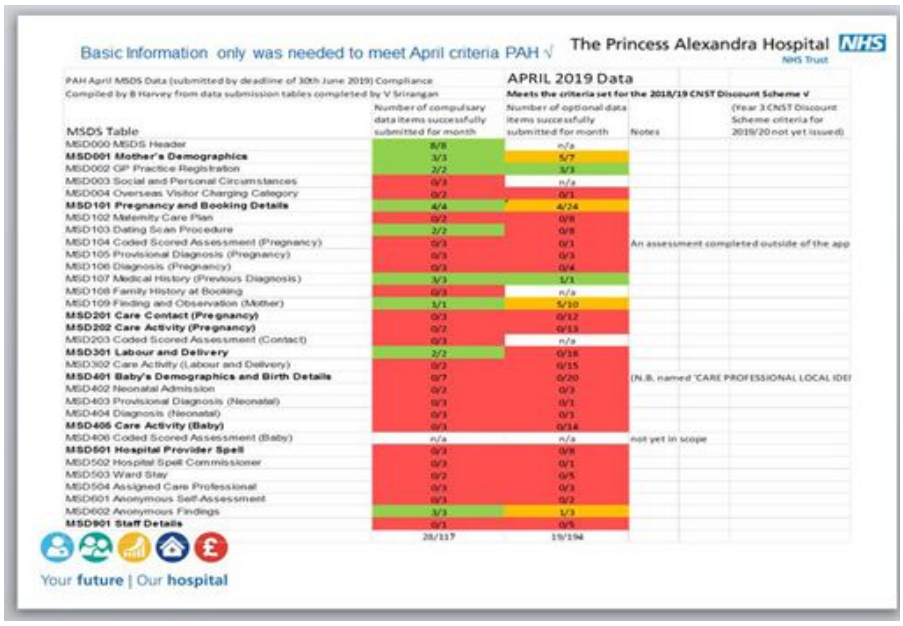
MSDS version 1.5 data for January 2019 required 3/3 Compulsory standards plus14/19 Optional standards (specific to version 1.5) to be met as the pass criteria

PAH achieved this standard



April 2019 Data Submission

In April the criteria changed as MSDSv2 was introduced. The mandatory elements only (Basic information) needed to be submitted as a minimum to pass MSDS (version 2) April 2019 standard (PAH achieved √)



Recommendation: Standard Met

Safety Action 3 – Can you demonstrate that you have transitional care services to support the Avoiding Term Admissions into Neonatal units Programme?

Required Standard

a) Pathways of care for admission into and out of transitional care have been jointly approved by maternity and neonatal teams with neonatal involvement in decision making and planning care for all babies in transitional care.
b) A data recording process for transitional care is established, in order to produce commissioner returns for Healthcare Resource Groups (HRG) 4/XA04 activity as per Neonatal Critical Care Minimum Data Set (NCCMDS) version 2.
c) An action plan has been agreed at Board level and with your Local Maternity Systems (LMS) and Operational Delivery Network (ODN) to address local findings from Avoiding Term Admissions Into Neonatal units (ATAIN) reviews.
d) Progress with the agreed action plans has been shared with your Board and your LMS & ODN

Minimum evidential requirement for trust Board

Local policy available which is based on principles of British Association of Perinatal Medicine (BAPM) transitional care where:
1. There is evidence of neonatal involvement in care planning
2. Admission criteria meets a minimum of HRG XA04 but could extend beyond to BAPM transitional care framework for practice
3. There is an explicit staffing model
4. The policy is signed by maternity/neonatal clinical leads

Data is available (electronic or paper based) on transitional care activity which has been recorded as per XA04 2016 NCCMDS.

An audit trail providing evidence and a rationale for developing the agreed action plan to address local findings from ATAIN reviews.

Evidence of an action plan to address identified and modifiable factors for admission to transitional care.
Action plan has been signed off by trust Board, ODN and LMS and progress with action plan is documented within minutes of meetings at Board ODN/LMS.

Evidence

There is a local policy in place which is based on the British Association of Perinatal Medicine principles regarding transitional care.
Data is available on transitional care activity which is reviewed monthly at the performance meetings with the neonatal team.
An action plan for delivery of the staffing and environmental aspects of transitional care has been developed and approved by Trust Board and the LMS.
The Operational Delivery Network has reviewed the plan which has previously been presented to the Quality and Safety Committee in April 2019.

Recommendation: Standard Met

Safety Action 4 – Can you demonstrate an effective system of medical workforce planning to the required standard?

Required Standard

a) Formal record of the proportion of obstetrics and gynaecology trainees in the trust who 'disagreed/strongly disagreed' with the 2018 General Medical Council National Training Survey question: 'In my current post, educational/training opportunities are rarely lost due to gaps in the rota.' In addition, a plan produced by the trust to address lost educational opportunities due to rota gaps.
b) An action plan is in place and agreed at Board level to meet Anaesthesia Clinical Services Accreditation (ACSA) standards 1.2.4.6, 2.6.5.1 and 2.6.5.6.

Minimum evidential requirement for trust Board

a) Proportion of trainees formally recorded in Board minutes and the action plan to address lost educational opportunities should be signed off by the trust Board and a copy submitted to the Royal College of Obstetricians and Gynaecologists (RCOG) at workforce@rcog.org.uk

b) Board minutes formally recording the proportion of ACSA standards 1.2.4.6, 2.6.5.1 and 2.6.5.6 that are met.

Where trusts did not meet these standards, they must produce an action plan (ratified by the Board) stating how they are working to meet the standards

Evidence

A Training Evaluation Report for Obstetrics and Gynaecology at PAH has been completed and a gap analysis has been undertaken. Ten trainees completed the survey, out of these five disagreed with the question '*In my current post, educational/training opportunities are rarely lost due to gaps in the rota'* and two strongly disagreed. The Clinical Lead has completed an action plan to address lost educational opportunities.
A meeting was held to discuss training needs with the trainees and a plan for redeploying staff to allow for more educational activities is being developed, after the recent redesign of consultant job

plans. In conclusion significant progress has been and is being made in recruiting and retaining staff to ease the pressures on the rota that have been compromising training opportunities. There is a clear plan for recruiting more staff as well as using the ones we have, more effectively. To date the board have not received this information however these are the correct figures and were submitted to the RCOG and the Deanery.

In order to comply with the three standards detailed in section B (ASCA standards 1.2.4.6, 2.6.5.1, 2.6.5.6) the Head of Midwifery reviewed the ACSA standards with the Lead Anaesthetist and has confirmed compliance evidenced through the staff rotas.

1.2.4.6 - Elective LSCS lists have a dedicated rota and workforce of obstetricians, anaesthetists and midwifery staff to support this service.
2.6.5.2 - The anaesthetic rota also demonstrates 24 hour cover for obstetrics which includes an epidural service.
2.6.5.6 The labour ward rounds are multi-disciplinary and include anaesthetists.

To date the board has not seen oversight of the compliance of the ACSA standards however this paper provides this assurance.

Recommendation: Standard Met

Safety Action 5 – Can you demonstrate an effective system of midwifery workforce planning to the required standard?

Required Standard

a) A systematic, evidence-based process to calculate midwifery staffing establishment has been done.
b) The obstetric unit midwifery labour ward coordinator has supernumerary status (defined as having no caseload of their own during that shift) to enable oversight of all birth activity in the service
c) Women receive one-to-one care in labour (this is the minimum standard that Birthrate+ is based on)
d) A bi-annual report that covers staffing/safety issues is submitted to the Board

Minimum evidential requirement for trust Board

A bi-annual report that includes evidence to support a-c being met. This should include:

- *A clear breakdown of BirthRate+ or equivalent calculations to demonstrate how the required establishment has been calculated.*
- *Details of planned versus actual midwifery staffing levels.*
- *An action plan to address the findings from the full audit or table-top exercise of BirthRate+ or equivalent undertaken. Where deficits in staffing levels have been identified, maternity services should detail progress against the action plan to demonstrate an increase in staffing levels and any mitigation to cover any shortfalls.*
- *The midwife: birth ratio.*
- *The percentage of specialist midwives employed and mitigation to cover any inconsistencies. BirthRate+ accounts for 9% of the establishment which are not included in clinical numbers. This includes those in management positions and specialist midwives.*
- *Evidence from an acuity tool (which may be locally developed) and/or local dashboard figures demonstrating 100% compliance with supernumerary labour ward status and the provision of one-to-one care in active labour and mitigation to cover any shortfalls*
- *Number of red flag incidents (associated with midwifery staffing) reported in a consecutive six month time period within the last 12 months, how they are collected, where/how they are reported/monitored and any actions arising (Please note: it is for the trust to define what red flags they monitor. Examples of red flag incidents are provided in the technical guidance).*

Evidence

A bi-annual nursing and midwifery workforce report is presented to Quality Safety Committee and trust Board which includes an overview of the maternity workforce. This was most recently in May 2019. The next update is due in October 2019.

There are currently ten whole time equivalent vacancies for midwives however six posts have been appointed to and are in the recruitment process.

Maternity Services have recently completed a Birthrate Plus review in partnership with the LMS. This identified that within the service we have an additional deficit of 7.98 WTE midwives and 3.2 WTE MCAs. The BR+ model recommended the overall ratio for PAH to be 23 births to 1 WTE however this currently sits 29.5 births to 1 WTE. The ratios are based on extensive data from Birthrate Plus studies and whilst published seen as 'up to date', more recent studies in the past 3 years are indicating that these ratios may not be appropriate to use for comparison, mainly due to increase in acuity of mothers and babies and subsequent care required. These factors have changed the overall and, indeed, individual ratios. Therefore, Birthrate + advise to use own ratios calculated from a detailed assessment for workforce planning purposes.
There is an additional non-clinical midwifery WTE based on 9% (national recommendations). At PAH there is a slight surplus of 0.13 WTE but the actual percentage to apply is a local decision and is reflective of the needs of the service.

Daily Red Flag Safety Huddles were commenced 29th March 2019. Senior midwifery managers and PS&Q team attend. Red Flag incidents are reviewed to allow time for appropriate actions to be undertaken. Red flags include the supernummary status of the midwife in charge of the labour ward and also the provision of one to one care of women in labour. Trends from Red Flag incidents are fed back through divisional PS&Q forum.

Recommendation: Standard Met

Safety Action 6 – Can you demonstrate compliance with all four elements of the Saving Babies' Lives care bundle?

Required Standard

Board level consideration of the Saving Babies' Lives (SBL) care bundle (Version 1 published 21 March 2016) in a way that supports the delivery of safer maternity services.

Each element of the SBL care bundle implemented or an alternative intervention in place to deliver against element(s)

Minimum evidential requirement for trust Board

Board minutes demonstrating that the SBL bundle has been considered in a way that supports delivery and implementation of each element of the SBL care bundle or that an alternative intervention put in place to deliver against element(s).

Evidence

The SBL care bundle has been discussed previously at QSC and is regularly reviewed at the monthly performance review meetings and PS&Q. There are four elements of the bundle; decreasing smoking in pregnancy, monitoring fetal growth restriction, monitoring reduced fetal movements and effective fetal monitoring in labour. All elements have
been implemented into the maternity care pathway and compliance audits have been undertaken to review the ongoing effectiveness. The required survey (12) has been completed and submitted and further comments have been received by NHSI. There was a robust discussion at QS&C last year

regarding implementation of a recommended tool for monitoring fetal growth. A population growth chart has been subsequently implemented which is one of the recommended tools.

Recommendation: Standard Met

Safety Action 7 – Can you demonstrate that you have a patient feedback mechanism for maternity services and that you regularly act on feedback?

Required Standard

User involvement has an impact on the development and/or improvement of maternity services.

Minimum evidential requirement for trust Board

Evidence should include:
Acting on feedback from, for example a Maternity Voices Partnership.
User involvement in investigations, local and or Care Quality Commission (CQC) survey results.
Minutes of regular Maternity Voices Partnership and/or other meetings demonstrating explicitly how a range of feedback is obtained, the action taken and the communications to report this back to women.

Evidence

Various recommended feedback tools have been utilised to achieve a robust and equitable patient feedback. These have included hosting a Whose Shoes events which involved stakeholders and commissioners, and engaged board members directly, monthly Maternity Voices Partnership meetings, maternity patient safety thermometer and the Maternity Survey results. Findings from all these have been shared with staff through FAWS board PS&Q and at the Trust board Performance Review meetings. Maternity survey results have been reviewed and presented to PS&Q with associated recommendations

Recommendation: Standard Met

Safety Action 8 – Can you evidence that 90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session within the last training year?

Required Standard
90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session within the last training year.

Minimum evidential requirement for trust Board
Evidence that 90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session within the last training year through Board sight of a staff training database or similar.

Evidence
Weekly oversight of training compliance is undertaken by the ADoN/M for FAWS and the Practice Development Midwife. All staff groups have now achieved > 90% compliance. This has been achieved by weekly MDT ‘skills and drills’ scenario training and also by MDT attendance and facilitation on PROMT. This continues to be an ongoing process to ensure that targets are maintained and compliance levels are sustained. This will be included in the maternity dashboard to ensure there is monthly oversight of compliance

Safety Action 9 – Can you demonstrate that the trust safety champions (obstetrician and midwife) are meeting bimonthly with Board level champions to escalate locally identified issues?

Required Standard

a) The Executive Sponsor for the Maternal and Neonatal Health Safety Collaborative (MNHSC) is actively engaging with supporting quality and safety improvement activity within: i. the trust ii. the Local Learning System (LLS)

b) The Board level safety champions have implemented a monthly feedback session for maternity and neonatal staff to raise concerns relating to relevant safety issues

c) The Board level safety champions have taken steps to address named safety concerns and that progress with actioning these are visible to staff

Minimum evidential requirement for trust Board

Evidence of executive sponsor engagement in quality improvement activities led by the trust nominated Improvement Leads for the MNHSC as well as other quality improvement activity for trusts in waves one and three
• Evidence that the trust Board have been sighted on the local improvement plan, updated on progress, impact and outcomes with the quality improvement activities being undertaken locally
• Evidence of attendance at one or more National Learning Set or the annual national learning event
• Evidence of engagement with relevant networks and the collaborative LLS
• Evidence of a safety dashboard or equivalent, visible to staff which reflects action and progress made on identified concerns raised by staff
• Evidence that safety concerns raised by staff feedback sessions are reflected in the minutes of Board meetings and include updates on progress, impact and outcomes relating to the steps and actions taken to address these concerns

Evidence

Monthly Safety walkabouts and feedback sessions are undertaken by the DoN&M and Medical Director who are current Board Level Safety Champions. Findings and actions arising from the walkabouts and feedback sessions are disseminated to staff via the monthly PS&Q newsletter.
Trust Board Champions (CMO and DoNM) have overseen the immediate action plan arising from the verbal feedback from the CQC inspection in March 2019 which will be updated when the full report is published.
Consideration has been given to whether in future a Non-Executive Director should fulfil the role of Board Safety Champion as discussed by NHSI.
Local Learning Set (LLS) meeting will be attended by Board Level Safety Champions (29th July) following advice from NHSI that national LLS was not appropriate to meet this recommendation.
The DoN&M currently sits as the Trust's nominated Improvement Lead for the Maternal and Neonatal Health Safety Collaborative (MNHSC).

Recommendation: Standard Met

Safety Action 10 – Have you reported 100% of qualifying 2018/19 incidents under NHS Resolution's Early Notification scheme?

Required Standard

Reporting of all qualifying incidents that occurred in the 2018/19 financial year to NHS Resolution under the Early Notification scheme reporting criteria.

Minimum evidential requirement for trust Board

Trust Board sight of trust legal services and maternity clinical governance records of qualifying Early Notification incidents and numbers reported to NHS Resolution Early Notification team.

Evidence

There is a process in place for ensuring every baby that meets qualifying incidents is referred to the NHS Resolution Early Notification Scheme. There have been three cases having been identified since Dec 2018 which have been referred. These are reported at the monthly PS&Q meetings. Legal Services also disseminate this data to Trust PS&Q.

Recommendation: Standard Met

6.0 RECOMMENDATION

It is requested that the Trust Board accepts the report and the evidence that has been submitted to demonstrate compliance with the ten Maternity Safety Actions.

Author: P Hollis
Date: 18.07.2019

Trust Board - 1 August 2019

Agenda Item:	5.5
Executive Sponsor	Sharon McNally Director of Nursing and Midwifery
Prepared by:	Jacquelyn .Featherstone Associate Director of Nursing and Midwifery
Date prepared:	16.07.19
Subject / Title:	Maternity Serious Incident Cluster - Progress report

Purpose:	Approval		Decision		Information		Assurance	x
Executive Summary: [please don't expand this cell; additional information should be included in the main body of the report]	Between December 2017 and December 2018 within maternity at Princess Alexandra Hospital there had been 8 Serious Incidents (SIs) relating to perinatal deaths. In December, an overview of themes across all the cases was undertaken and a thematic action plan developed. Furthermore, to ensure transparency, support was sought from NHSI to undertake an external review which was finalised in February 2019. The action plan has had oversight of the Director of Nursing and the Chief Medical Officer, with additional oversight by the wider executive team through the Performance Review Meetings. A CEO assurance panel was held on 4.04.2019 with external partners and stakeholders. Duty of candour letters have been sent out to each family with regard to the NHSI report with a copy of an individualised report made available to each family.							
Recommendation:	For Board to be assured by findings and actions in this report							

Trust strategic objectives: [please indicate which of the 5Ps is relevant to the subject of the report]	Patients	People	Performance	Places	Pounds

Previously considered by:	Quality and Safety Committee 26/7/19
Risk / links with the BAF:	NA
Legislation, regulatory, equality, diversity and dignity implications:	
Appendices:	Appendix.1: Action plan.

PURPOSE

This paper is to provide assurance to the Trust Quality Safety Committee that following the incidents in Maternity, the service has taken appropriate action to review the incidents, identified the immediate actions required, identify any learning, and ensure the service is safe.

1.0 BACKGROUND

Over a period of 13 months between December 2017 and December 2018 within maternity at Princess Alexandra Hospital (PAH) there has been 8 serious incidents (SIs) relating to perinatal deaths; this is higher than the expected.
Each one was immediately escalated and presented at the daily Serious Incident Group (SIG) meeting as per normal practice and each one was declared a serious incident with an investigation and root cause analysis undertaken. Three cases were also subject to external expert review to inform the SI process. Following the 8th case in December 2018, a 'step back' approach was adopted to understand if there were themes emerging from the cohort of cases.

It was agreed to inform the CCG and our regulators, and to ask for an external review to enable and ensure transparency of an overarching investigation into the themes of all the cases and ensure an open and learning culture. NHSI agreed to undertake the external review. This review of all 8 cases was undertaken in January 2019 and finalised in February 2019
The main findings of the report support the findings that had been identified by the 'step back' approach highlighted above. The two organisation areas were:

'*The two (2) organisational areas seen to be trending had already been identified by the Trust and actions were being taken to move both issues forward. The areas are the first two (2) elements of the 'Saving Babies' Lives' care bundle (2107):*

- ***Use of antenatal growth charts*** *(customised growth charts or population-based charts) - The ability to recognise risk factors during the antenatal period was significantly reduced during the period that most of these women where undergoing antenatal care as the chart used for the plotting of growth was a separate insert to the notes and was not being used consistently. This meant that the opportunity to recognise reduced fetal growth during this period was limited. This issue trended across five (5) of the cases reviewed. For some of these women the failure to recognise that the fetus was small for gestational age may have placed them on the wrong antenatal pathway and in the wrong place for birth as they could have benefited from continuous fetal monitoring in labour on the Labour ward rather than intermittent auscultation in the Midwifery Led Birthing Unit (MLBU).*
  Management of smoking cessation*- There was evidence that the Trust had not fully implemented the monitoring of carbon monoxide monitoring in line with national recommendations. The guidelines have now been reviewed and are in the process of being re-launched with all staff.'*

In addition:

'The remaining two (2) elements of the care bundle, raising awareness of reduced fetal movement and effective fetal monitoring during labour, also featured in the cases reviewed however this appeared to be related to clinicians not following guidelines rather than organisational issues.

During the review of medical records, it was noted that the Trust are not always following NICE guidelines. Whilst this did not always impact on the outcome for the women the Trust is encouraged to ensure that there has been robust governance around the decision not to implement the national best practice guidance.

Where concerns regarding individual practice was recognised the Trust were able to provide reassurance that educational support had been provided to address the concern. It is recommended that there is an audit of the clinicians practice relating to the area of concern to assure the Trust that the clinicians have embedded the practice changes.

Whilst the review has highlighted areas for the Trust to take forward there were no major issues identified that the Trust had not already identified and had either already actioned or were in the process of moving forward. It should provide assurance that the PAH Clinical governance processes are robust, and the Trust escalates to the regulators and requests support from the NHSI quality team appropriately.

*(*NHSI review of fetal / early neonatal deaths February 2019)

2.0 NEXT STEPS

A CEO assurance panel was held on 2 April 2019 with external stakeholders present including the CCG, CQC, an external Obstetric Consultant and an external Head of Midwifery. The actions were added to the overarching action plan (See Appendix 1)

A communication plan has been devised covering all eventualities as the Duty of Candour letters were sent out to each individual family, offering them an opportunity to meet with the senior team and receive an individualised copy of the NHSI report. At the time of the report two families have been in contact and copies of their individualised report have been sent to them

4.0 RECOMMENDATIONS

- To continue to have oversight and executive support to ensure momentum of the completion of the action plan
- To present at monthly HCG Performance Review Meeting
- To share action plan and lessons learned with all staff at open meeting in July 2019

5.0 RISKS

Reputation - The Trust have been open and honest throughout with all external agencies and duty of candour with all families involved.

5.0 RECOMMENDATION

For Board to be assured by findings and actions in this report

Author: Jacquelyn Featherstone Associate Director of Nursing and Midwifery

Date: 16 July 2019

Working Action Plan following review by NHSi: series of fetal/early neonatal deaths for PAH *(updated: July 2019)*

Green – Actions Completed	Amber – On-track, not yet completed	Red - Insufficient progress to meet planned timeframe

Following an External review of incidents by the NHSI
There were two main themes identified throughout the cases reported.

- **Regarding the use of antenatal growth charts, it was identified that these were not an integral part of the maternity hand held notes.**
- **The second theme related to the appropriate management of smoking cessation. There was evidence that the Trust had not fully implemented the monitoring of carbon monoxide monitoring in line with national recommendations. The guidelines have now been reviewed and are in the process of being re-launched with all staff.**

Detailed below will highlight the recommendations as set out following the external review together with progress, actions and evidence of progress.

Theme / Action	Recommendations made by NHSI review	Action	Lead	Progress	Evidence	Completion date	RAG
		ORGANISATIONAL					
(Theme) 1. ,	**Use of antenatal growth charts** The Trust should ensure that there is a fetal growth chart which is either customised to the woman or population based in line with the 'Saving babies lives' initiative. This should be given priority within any action planning.	Population charts to be integral in maternity handheld notes	**Antenatal Matron/ Smoking Cessation Midwife**	Interim, paper copies have been attached to all handheld notes.	Evidence email trail and information disseminated	August 2018	
				Notes have been peer reviewed	Email trail within evidence folder	February 2019	
				New notes with population charts implemented across service for all bookings	Arrived and circulated to community teams. Women now being booked on new notes	June 2019	
		Real time audit of notes and compliance		Register and commence audit of new hand held notes from September 2019-November 2019	Registered and available on allocate.	December 2019	

		To have viewpoint or a similar software program available on all scanning computers	**Associate Director of Operations**	Software available on two computers (high risk and smoking), option appraisal (procurement process) for final decision - meeting planned for 19 July	Viewpoint software on the two main machines in Maternity Ultrasound all pregnant smoking women are being offered 32,36 and 39-40 week growth scans	July 2019	
(Theme) 2.	**Management of smoking cessation** The Trust is currently strengthening the CO monitoring and the smoking cessation pathway as it was found to be difficult to understand. The new pathway should be commented on by newly qualified midwives so that the Trust are assured that the pathway is presented in a way which is understood by all. All midwives working in the community should have training or updates on the pathway.	CO monitoring and the smoking cessation pathway to be part of the induction for newly qualified midwives	**Practice Development Midwife /Smoking Cessation Midwife**	Smoking Cessation Midwife to present to preceptorship in April 2019	Email in evidence Folder	April 2019	
		To share with 3rd year student Midwives, obtain feedback for understanding	**ARU midwifery Course leader**	Feedback from students and shared with Smoking cessation Midwife	Email in evidence folder.	March 2019 Feedback May 2019	
		Discuss CO monitoring and smoking cessation pathway at the MDT morning meeting		Discussed at MDT meeting 07.03.2019 Discussed at community team leaders meeting	Held in Morning meeting book	March 2019	

	Audit of compliance to the pathway should be undertaken once the reinforced pathway has had the opportunity to take effect. Mandatory field for CO monitoring on COSMIC	Audit to be registered, presented when completed, report and action plan completed.	**Smoking Cessation Midwife**	Audit registered 05.02.2019, baseline undertaken in March 19 – with quarterly audit cycle established (next audit July).	Presented at MDT Audit Presentation in evidence folder	May 2019	
			Director of Nursing	To establish mandatory recording of CO monitoring on cosmic.	Mandatory field in Cosmic	September 2019	
		Recommendations and learning from the audit to be shared with all FAWS staff All smokers must be offered 39-40 week scans to monitor fetal growth.	**Smoking Cessation Midwife** **Associate Director of Operations**	Bereavement midwife performed deep dive into compliance of CO Monitoring as part of Saving Babies Lives care bundle. Commenced 01.05.2019	Saving babies lives care bundle deep dive report within evidence folder.	May 2019	
(Theme) 3.	New theatre in Obstetric area being built now.	New obstetric theatre to be opened		New theatre opened February 2019	Up and running daily	February 2019	

Theme/ Action	Recommendations made by NHSI review	Action	Lead	Progress	Evidence	Completion date	RAG
			COMPLIANCE				
(Theme) 4.	The trust should review the guideline 'Induction and Augmentation of Labour including the use of syntocinon' (2018) with a view to strengthening the observation of high-risk women and their fetus' during induction of labour.	Guideline peer review.	**Lead Consultant for Labour Ward**	Roundtable discussion with Consultants to clarify variation in pathway and NICE / RCOG discrepancies and agree a way forward to inform revised guideline. *	Email trail in evidence folder Revised guideline published*	November 2019	
	The Trust should ensure that the induction of labour guideline is unambiguous prior to relaunch and monitoring of implementation	Guideline peer review.	**Lead Consultant for Labour Ward**	Roundtable discussion with Consultants to clarify variation in pathway and NICE / RCOG discrepancies and agree a way forward to inform revised guideline.	Email trail in evidence folder Revised guideline published	November 2019	
	The Trust should assure themselves that the clinicians understand the need to respond to hyperstimulation of the uterus when syntocinon is being used	Discuss management of hyperstimulation and use of syntocinon at MDT morning meeting	**Lead Consultant for Labour Ward**	Discussed 13.01.2019	Morning MDT book held on Labour Ward	January 2019	

	The Trust should ensure that they remind midwives that Terbutaline should be considered for women who have spontaneous hypercontractility in labour.	Discussion re terbutaline usage/hyperstimulation benefits and contraindications at Thursday morning doctors training This is a medical intervention and is currently under review in the Induction of Labour guideline.	**CSG Lead Consultant**	15.03.2019 Emailed Consultant 09.05.2019 Emailed to follow up.	Email in evidence folder	June 2019	
				See above *	See above *	November 2019	
		To be discussed at Morning MDT meeting and within Midwifery mandatory training session	**Practice Development Midwife/ Lead Consultant for Labour Ward**	Discussed 13.01.2019	Email in evidence folder	February 2019	
	Undertake an undergoing a second cycle of prostin IOL to ensure that the Trust guidelines are being followed with regard to decision making of the use of a second cycle in prostin.	Undertake audit for induction of labour Sharing the learning with FAWS staff	**Audit lead for women's health** **FAWS PSQ**	Review undertaken of practice, compliant with national guidance. No change in practice anticipated. Not applicable at the present time Request	Email in evidence folder	July 2019	
(Action) 5.	The use of fetal blood sampling should be audited to ensure there is appropriate use of this surveillance method in the unit.	Assign member of staff to complete the audit for the use of FBS. Share recommendations with all FAWS staff and share the learning	**Labour Ward Manager**	Audit completed, for audit meeting presentation in September and discussion regarding pathway.	Email in evidence folder Once completed	September 2019	

(Action) 6.	The trust should audit intermittent monitoring of the fetal heart rate using auscultation to ensure that it is being applied in an effective way. This should include a review of the way that midwives document the method of auscultation being utilised.	Register audit for intermittent monitoring of the fetal heart using auscultation. Share the learning with FAWS staff	**Birthing Unit Manager**	Audit data collection complete (July 19), presentation to audit meeting September.	Evidence folder	September 2019	
		Introduce Fresh ears to the birthing unit.		Fresh Ears stickers implemented in April 19. Audit scheduled August 19, with quarterly audit cycle.	Email trail in evidence folder Audit programme demonstrates compliance	April 2019 August 2019	
(Theme) 7.	There was no guidance on the urgent escalation to a consultant at the time of incident. There is now a new Standard Operating Procedure in place. This should be audited to ensure it is embedded.	Escalation Standard Operating Procedure (SOP) has been written and published on the intranet. Global email sent all maternity staff with SOP attachment	**FAWS PSQ team**	Available on the Intranet. Sent to all staff 05.02.2019	SOP attached to Evidence folder	November 2018 February 2019	
		Complete spot audits to ensure SOP is embedded in practice	**FAWS PSQ Team**		Signature sheet in evidence folder Spot audit programme demonstrates compliance	May 2019	

		Present audit when completed within Trust PSQ meeting	**FAWS PSQ Team**	Audit completed. Added to Agenda for July PSQ 15.07.2019		July 2019	
	The escalation process if the first line medical responder is not available should be explicit and audited.	Trigger List to escalate to Paediatric Consultant to be reviewed.	**CSG Lead Consultant**	Revised escalation process in place, noting at Trust policy group August 2019.	Revised escalation process in place	August 2019	
(Action) 8.	The Trust should assure itself that there is robust antenatal planning which is documented and executed. An audit of the handheld held records will provide the Health Group with this assurance. (see point 10 regarding audit)	Maternity handheld health care records have been reviewed and out for per review. Antenatal pathways are within these and previous records and have been used by the maternity team caring for these women, whether low or high risk	**Community, Birthing Unit and Antenatal Matron**	Healthcare records were sent for peer review. New Notes have Care pathway integrated within. New notes received and circulated to community teams New handheld notes embedded across the service for new bookings. Monthly audit programme in place	Copy of notes within evidence folder Audit results demonstrate compliance	June 2019	
(Action) 9.	The Trust should consider looking at all components of the 'Saving babies lives care bundle' when undertaking any review of management of pregnant women.	Any cases of stillbirths or neonatal deaths are reviewed using the PMRT template from MBRRACE this incorporates the care bundles from saving babies lives	**Lead Midwife for PSQ Bereavement Midwife**	PMRT minutes of meetings (monthly)	Minutes from January 2019, February 2019 and March 2019 within evidence folder.	On-going	

(Action) 10	The hand-held records of woman should hold all relevant information regarding the care and planning of care of women. It is recommended that the Trust undertake a robust audit of the hand-held records to assure themselves that correct antenatal pathways are being used and documentation is robust.	Current health care records are under review and currently out for peer review. They provide information for antenatal pathways.		See action 8,	.	June 2019	
		Record keeping audit within Mandatory training to commence		Re-registered February 2019 and commenced June 2019. On Audit schedule to be presented September 2019	Copy of audit registration and audit tool within evidence folder	September 2019	
(Action) 11.	The Trust should ensure that the guidelines on use of the pool are robust and that all midwives are aware that there are safe temperatures of the pool and that these should be monitored and documented whilst the woman is in the pool (NICE 2007)	Water birth guideline is currently under review For peer review, ratification, TPG and posting on the intranet Disseminate to staff once posted	**Deputy manager Birthing Unit**	Benchmarking with another hospital, guidelines under review.	Revised guidelines published	September 2019	
				Ensure guideline is in line with NICE CG(190) 2014 (NICE has no lower temperature for waterbirth but advises should be no higher than 37.5C)	Revised guidelines published	September 2019	
(Action) 12.	The Trust appear to use Syntometrine for the initial management of the 3rd stage of labour. This is not in line with NICE guidelines. The Trust should ensure that where they have guidelines which are not in line with national recommendations that there	Review of current practice and research to inform practice.	**Senior Management teams Consultants and matrons**	Benchmarking with 6 other organisations. Discussion at April audit meeting to review assessment tool (see below). Agreed no change in practice – evidence for decision making collated.	CSG lead presented at April Audit. Minutes attached.	June 2019	

	have been appropriate governance conversations and risk register entries.	Not on midwives exemptions and would need to be prescribed for every woman by the medical team. PGD to be developed if change in practice is agreed by all parties			No change in practice anticipated. Not applicable at the present time		
		Complete a baseline assessment tool for Nice Guidance Intrapartum care for healthy women and babies CG190	**Lead Midwife Quality and Compliance/ Obstetric PSQ lead Consultant**	Meeting 25.06.2019	Base line assessment tool for the third stage of labour and post-partum haemorrhage completed. In evidence folder. Evidence from CSG lead from Cochrane report attached.	25 June2019	
THEME	**Recommendations made by NHSI review**	**Action**	**Lead**	**Progress**	**Evidence**	**Completion date**	**R A G**
EDUCATION AND TRAINING							
(Theme) 13.	The Trust should ensure that the guideline relating to raised blood pressure in pregnancy is unambiguous and relaunch the guideline ensuring that all midwives and medical staff understand the pathway. Audit would provide assurance that the pathway is being followed.	Hypertension in pregnancy guidelines has been reviewed and posted on the intranet.	**FAWS PSQ Team**	Guideline posted to intranet.	Version of guideline in evidence folder	March 2019	
		Training in the Thursday morning doctors training day re management of pre-eclampsia and	**CSG Lead**	Email to request date to perform update.	Email in evidence folder	May 2019	

		pregnancy induced hypertension					
				Register audit for compliance with guidance, and audit data to be collected August 2019 for reporting to audit meeting October	Audit demonstrating compliance	October 2019	
(Action) 13.	Ensure that all aspects of concern highlighted in internal and SI reports are explored using root cause methodology so that all lessons are appropriately recognised, and learning occurs as a result.	All staff who undertake RCAs are trained externally before being allocated investigation. All lessons learnt, change of practice and recommendations are disseminate to all FAWS staff by: Email Newsletter Morning MDT meeting Mandatory training Thursday morning doctors training This is evidenced on the Datix system	**Lead Midwife for PSQ**	Authorised RCA trained staff held within central PSQ team records	List of all staff trained in the last twelve months included within evidence folder Evidence in folder	March 2019	
(Action) 14	The Trust should assure itself that the management of reduced fetal movements is in line with the RCOG recommendations.	Revised guideline for management of reduced fetal movements to be ratified at FAWS PSQ meeting. Inform all maternity and obstetric staff of revised guideline	**Lead Midwife for Quality and Compliance**	Peer review (January 19) Audit incorporated in the revised record keeping audit cycle.	Copy of up to date guideline within Evidence Folder	March 2019	

THEME	Recommendations made by NHSI review	Action	Lead	Progress	Evidence	Completion date	RAG
			STAFFING				
(Action) 15.	The Trust should review the medical staffing requirements of the maternity unit using the RCOG guidelines as the standard.	Job plans under review & to start working to new job plans as of 13.05.2019 Workforce gap analysis undertaken	**Associate Director of Operations FAWS**	Business case to be completed to meet service demand in line with guidelines (90 hours) – completed and approved (2019/20 budgets) Locum Consultant started 25.03.2019	Currently on risk register Business case approved Rota available for evidence	April 2019	
(Action) 16	Staffing of second obstetric theatre should be reviewed and a mechanism to ensure that there is always the ability to open a second theatre put into place.	Currently the on-call consultant will attend out of hours Surgery health care group to support FAWS with elective caesarean sections	**Lead Midwife for PSQ**	In place	Second theatre in use Review of any incidents raised re delay (0 in 19/20 YTD)	March 2019	
		Business plan for second senior house officer for night shift.	**Associate Director of Operations FAWS**	Business case for 3 more SHOs in development	Business case tabled and agreed way forward documented	September 2109	
THEME	**Recommendations made by NHSI review**	**Action**	**Lead**	**Progress**	**Evidence**	**Completion date**	**RA**

							G
Communication							
(Action) 16	Duty of Candour to be undertaken to all families who have been part of the NSHI review	Communication plan to be implemented and letters to be sent to all families	Communications Manager	Discussions and engagement with stakeholders. Communications to be sent to families July 19.	Letters by recorded delivery Communications plan in place	July 2019	

All staffing issues highlighted within the external report have been addressed with their individual line managers. Any care or service issues have been included within a separate action plan and this is being monitored closely. All evidence for this action plan is included within the folder.

The Princess Alexandra Hospital NHS Trust

Trust Board – 1 August 2019

6.1

Agenda Item:	6.1
Presented by:	Dr Andy Morris, Responsible Officer
Prepared by:	Jane Bryan, Medical Resourcing Manager
Date prepared:	24/07/19
Subject / Title:	Annual Board report for Appraisal and Revalidation

Purpose:	Approval		Decision		Information	x	Assurance	
Key Issues:	The report gives a summary of Appraisal & Revalidation and relates to the completed round of appraisal for 2018/19 for the permanent medical staff of The Princess Alexandra Hospital NHS Trust (PAHT). The paper sets out a summary of the process for the Annual appraisal, compliance data, and how this is monitored and assessed to ensure it is quality assured.							
Recommendation:	For information and sign off of statement of compliance (Appendix1)							

Trust strategic objectives:	Patients	People	Performance	Places	Pounds
	x	x	x		

Previously considered by:	N/A
Risk / links with the BAF:	N/A
Legislation, regulatory, equality, diversity and dignity implications:	It is a legal requirement that the Trust facilitates an enhanced annual appraisal for these grades of doctors.
Appendices:	Appendix 1: Annexe D - Statement of compliance for signature (NHS England)

1. Introduction

1.1. This report gives a summary of Revalidation and relates to the completed round of appraisal for 2018/19 for the medical staff of The Princess Alexandra Hospital NHS Trust (PAHT). This includes all Consultant staff, SAS Grades, Trust Doctors and the Locum Doctors employed directly by the Trust. It is a legal requirement that the Trust facilitates an enhanced annual appraisal for these grades of doctors.

1.2. Revalidation was introduced by the GMC in 2012 to strengthen the way that doctors are regulated with the aim of improving the quality of patient care provided, improving patient safety and increasing public trust in the system. Previously GMC registration was issued at the point of qualification and remained current unless it was removed. Now doctors are only granted a GMC licence to practice for five years and consequently every 5 years each licence must be revalidated. For this to happen the GMC must be assured that the doctor is up to date and safe to practice and this should be evidenced through a history of strengthened annual appraisals which measures both conduct and performance.

1.3. Each practicing doctor should have a prescribed connection to a Designated Body (DB). This includes all Consultant staff, SAS Grades, Trust Doctors and Locum Doctors employed directly by the Trust. During the revalidation cycle the RO of that body is charged with making a recommendation to the GMC as to whether or not a doctor should have their licence renewed. Revalidation depends on satisfactory engagement in annual appraisal, including submission of a portfolio of defined supporting Information, and a sign off from the DB with whom the doctor has a 'prescribed connection' as defined by the General Medical Council (GMC).

1.4. It is the Trust's statutory obligation to ensure an appraisal is facilitated but it is the personal responsibility of the doctor to ensure it is undertaken. Within each appraisal they must discuss their practice and performance with their appraiser ensuring that they meet the guidance set by the GMC in 'Good Medical Practice'.

1.5. The paper sets out the process for the annual appraisal, and how it is monitored and assessed to ensure it is quality assurance.

2. Appraisal & Revalidation

2.1. The Appraisal and Revalidation Team consists of the RO, Deputy RO, Medical Resourcing Manager and Medical Resourcing Officer. Alongside are a team of trained medical appraisers.

2.2. PAHT is a DB and has a prescribed connection with 263 medical staff i.e. all doctors employed directly by the Trust, excluding those in training as at 31st March 2019. In order to revalidate their licence to practice with the General Medical Council, all Doctors must undertake an annual appraisal.

2.3 2 6 1 appraisals took place between 1st April 2018 and 31st March 2019 and were submitted to the RO for approval, providing a 99.21% completion rate. The appraisals have been undertaken in an electronic format (provided by Clarity Informatics Ltd) since 2011. The appraisal feedback suggests that there has been an

increase in the level of satisfaction with the appraisal scheme year on year and is high.

2.4 The compliance rate for completed appraisals at 31/3/2019 was 99%. This was an increase from 98% in 2018/96% in 2017 and 80% in 2016. PAHT were the highest comparator within the Region (range of 80% to 94%)

2.5 During the same period, RO made 71 recommendations for revalidation to the GMC based on the evidence that is gathered from a history of annual appraisals. All recommendations were submitted to the GMC on time. Of those 71 recommendations, 1 doctor was deferred due to non–engagement and the matter referred to the GMC.

3. Responsible Officer (RO)

3.1 As RO the CMO attended regular RO network support meetings during the year (locally and nationally) provided by NHSE in conjunction with the GMC. This is a statutory obligation of all ROs.

3.2 The RO has a prescribed connection to the regional RO for NHSE, Midlands and East and is appraised by an RO appraiser from a neighbouring Trust.

4. Medical Appraisal and Revalidation Committee

The Medical Appraisal and Revalidation Committee (MARC) RO, Deputy RO, Medical Resourcing Manager and Medical Resourcing Officer meet on a monthly basis to discuss and assess forthcoming revalidation decisions, outliers of appraisal, clinical governance issues related to doctors which may have an impact on the revalidation recommendation status, quarterly reporting figures and any other issues which may arise related to appraisal and revalidation.

5. Policy and Guidance

Version 2.0 of the '*NHS England Medical Appraisal Policy'* was published in May 2015 and included some amendments and updates. The trust has a medical Appraisal & Revalidation policy on the trust Intranet.

6. Appraisers & Appraisals

Appraisers are selected by a formal interview and have undertaken enhanced Appraiser training. The Appraisers receive a stringent check list of the mandatory documentation that must be presented by the doctors for Appraisal without which the appraisal meeting will not take place. Appraisers meetings are held monthly, appraisers are required to attend at least four in-house Appraiser meetings a year to provide a support mechanism and to exchange and discuss issues and developments associated with appraisal as well as attend annual top up training to maintain their skills. All are also Quality Assured by the Deputy RO. Appraisers have been awarded 0.25 SPA per week to recognise the time required for the role.

7. Appraisals

The 6 key elements as set out by the GMC are as follows:

- Continuing professional development
- Quality improvement activity
- Significant events
- Feedback from colleagues
- Feedback from patients
- Review of complaints and compliments

PAHT provides a 360 degree feedback process from patients and colleagues for doctors using the Clarity Informatics Toolkit at least once in every 5 year revalidation cycle. The doctor receives a benchmarked reported with comparisons to their practice based on a self-assessment, national average, organisational average and against the doctors own specialty.

8. Compliance to GMC requirements

All Trusts are required to provide Quality Assurance to NHS England about both the quality of appraisers work and the quality of the appraisal inputs/outputs to ensure that compliance to GMC requirements are being met.

9. Quality Assurance

The Deputy RO undertakes a Quality Assurance check on all appraisals that are due for revalidation within 120 days of the due date of the recommendation for the individual doctor.

10.External Peer review of appraisal and revalidation processes

The '*Framework of Quality Assurance (FQA) for R.O.s and Revalidation'* published in April 2014 was produced to provide assurance and oversight that DBs are discharging their statutory duty.

PAHT was the subject of a review of its appraisal and revalidation processes in April 2018 by the Revalidation Team from NHSE Midlands and East and received very positive feedback.

11. Monitoring Performance

The CMO/RO and Medical Resourcing Manager meet on a quarterly basis with the GMC Employment Liaison Adviser (ELA) to discuss and review any GMC investigations and to provide the ELA with details of any local investigations or concerns.

Currently any appraisal that has been reported as a concern by an appraiser is counter checked by the Deputy RO for quality assurance who initiates actions as appropriate.

The Deputy RO undertakes a Quality Assurance check on all appraisals that are due for revalidation within 120 days of the due date of the recommendation for the individual doctor. This process ensures that:

- The full scope of practice has been described
- Patient feedback and MSF have been completed
- Complaints and significant incidents are included

- There is evidence of self-reflection
- The CPD plan is appropriate, in line with Trust and personal objectives
- The appraisal meeting discussion is evidenced
- The appraisal outcomes are robust

12. Responding to Concerns and Remediation

The Trust has developed a remediation policy to support doctors in difficulty. This policy is part of the framework for Maintaining High Professional Standards. Other local Trust policies including sickness management are used as part of the remediation and rehabilitation programme that may be required for any doctor in difficulty.

13. Risk and Issues

There are no appraisal and revalidation issues currently on the Trust's risk register. The Board can take assurance that the controls upon which the organisation relies to manage the appraisal process are suitably designed, consistently applied and are in line with the National Framework for Revalidation.

14. Recommendations

By implementing the GMC's regulatory process, the Trust can be assured the doctors that are employed are fit to practice and improving patient care and safety.

It is requested that the Board accepts this report and is able to sign off the statement of compliance set out in **Appendix I (Annex E)**. This is a Quality Assurance framework set out by the department of health for responsible officers and revalidation.

NHS England and NHS Improvement

Annex D – Annual Board Report -Statement of Compliance.

[APPENDIX 1)

The Board / executive management team of Princess Alexandra Hospital NHS Trust has reviewed the content of this report and can confirm the organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013).

Signed on behalf of the designated body

[(Chief executive or chairman (or executive if no board exists)]

Official name of designated body: _ _ _ _ _ _ _ _ _ _ _

Name: _ _ _ _ _ _ _ _ _ _ _ Signed: _ _ _ _ _ _ _ _ _ _

Role: _ _ _ _ _ _ _ _ _ _ _

Date: _ _ _ _ _ _ _ _ _ _

A Framework of Quality Assurance for Responsible Officers and Revalidation

Annex D – Annual Board Report and Statement of Compliance.

NHS England and NHS Improvement

A Framework of Quality Assurance for Responsible Officers and Revalidation

Annex D – Annual Board Report and Statement of Compliance.

Publishing approval number: **000515**

Version number: 3.0

First published: 4 April 2014

Updated: February 2019

Prepared by: Lynda Norton, Claire Brown, Maurice Conlon

This information can be made available in alternative formats, such as easy read or large print, and may be available in alternative languages, upon request. Please contact Lynda Norton on England.revalidation-pmo@nhs.net.

Contents

Introduction:

The Framework of Quality Assurance (FQA) for Responsible Officers and Revalidation was first published in April 2014 and comprised of the main FQA document and annexes A – G. Included in the seven annexes is the Annual Organisational Audit (annex C), Board Report (annex D) and Statement of Compliance (annex E), which although are listed separately, are linked together through the annual audit process. To ensure the FQA continues to support future progress in organisations and provides the required level of assurance both within designated bodies and to the higher-level responsible officer, a review of the main document and its underpinning annexes has been undertaken with the priority redesign of the three annexes below:

- **Annual Organisational Audit (AOA):**

  The AOA has been simplified, with the removal of most non-numerical items. The intention is for the AOA to be the exercise that captures relevant numerical data necessary for regional and national assurance. The numerical data on appraisal rates is included as before, with minor simplification in response to feedback from designated bodies.

- **Board Report template:**

  The Board Report template now includes the qualitative questions previously contained in the AOA. There were set out as simple Yes/No responses in the AOA but in the revised Board Report template they are presented to support the designated body in reviewing their progress in these areas over time.

  Whereas the previous version of the Board Report template addressed the designated body's compliance with the responsible officer regulations, the revised version now contains items to help designated bodies assess their effectiveness in supporting medical governance in keeping with the General Medical Council (GMC) handbook on medical governance[1]. This publication describes a four-point checklist for organisations in respect of good medical governance, signed up to by the national UK systems regulators including the Care Quality Commission (CQC). Some of these points are already addressed by the existing questions in the Board Report template but with the aim of ensuring the checklist is fully covered, additional questions have been included. The intention is to help designated bodies meet the requirements of the system regulator as well as those of the professional regulator. In this way the two regulatory processes become complementary, with the practical benefit of avoiding duplication of recording.

[1] Effective clinical governance for the medical profession: a handbook for organisations employing, contracting or overseeing the practice of doctors GMC (2018) [https://www.gmc-uk.org/-/media/documents/governance-handbook-2018_pdf-76395284.pdf]

The over-riding intention is to create a Board Report template that guides organisations by setting out the key requirements for compliance with regulations and key national guidance, and provides a format to review these requirements, so that the designated body can demonstrate not only basic compliance but continued improvement over time. Completion of the template will therefore:

a) help the designated body in its pursuit of quality improvement,

b) provide the necessary assurance to the higher-level responsible officer, and

c) act as evidence for CQC inspections.

- **Statement of Compliance:**

The Statement Compliance (in Section 8) has been combined with the Board Report for efficiency and simplicity.

Designated Body Annual Board Report

Section 1 – General:

The board / executive management team – [*delete as applicable*] of [*insert official name of DB*] can confirm that:

1. The Annual Organisational Audit (AOA) for this year has been submitted.

Date of AOA submission:**15th May 2019**
Action from last year**: None**
Comments**: None**
Action for next year: **None**

2. An appropriately trained licensed medical practitioner is nominated or appointed as a responsible officer.

Action from last year: **None**
Comments: **None**
Action for next year: **None**

3. The designated body provides sufficient funds, capacity and other resources for the responsible officer to carry out the responsibilities of the role.

Yes
Action from last year: **None**
Comments: **None**
Action for next year: **None**

4. An accurate record of all licensed medical practitioners with a prescribed connection to the designated body is always maintained.

Action from last year: **None**
Comments: **None**
Action for next year: **None**

5. All policies in place to support medical revalidation are actively monitored and regularly reviewed.

Action from last year: **None**
Comments: **None**
Action for next year: **Due for review**

6. A peer review has been undertaken of this organisation's appraisal and revalidation processes.

Action from last year: **None**
Comments: **None**
Action for next year: **None**

7. A process is in place to ensure locum or short-term placement doctors working in the organisation, including those with a prescribed connection to another organisation, are supported in their continuing professional development, appraisal, revalidation, and governance.

Action from last year: **None**
Comments: **None**
Action for next year: **None**

Section 2 – Effective Appraisal

1. All doctors in this organisation have an annual appraisal that covers a doctor's whole practice, which takes account of all relevant information relating to the doctor's fitness to practice (for their work carried out in the organisation and for work carried out for any other body in the appraisal period), including information about complaints, significant events and outlying clinical outcomes.

Action from last year: **None**
Comments: **None**
Action for next year: **To continue to maintain high compliance level**

2. Where in Question 1 this does not occur, there is full understanding of the reasons why and suitable action is taken.

Action from last year: **N/A**
Comments:
Action for next year:

3. There is a medical appraisal policy in place that is compliant with national policy and has received the Board's approval (or by an equivalent governance or executive group).

Action from last year: **None**
Comments: **None**
Action for next year: **None**

4. The designated body has the necessary number of trained appraisers to carry out timely annual medical appraisals for all its licensed medical practitioners.

Action from last year: **None**
Comments: **None**
Action for next year: **None**

5. Medical appraisers participate in ongoing performance review and training/ development activities, to include attendance at appraisal network/development events, peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers[2] or equivalent).

Action from last year: **None**
Comments: **None**
Action for next year: **None**

6. The appraisal system in place for the doctors in your organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group.

Action from last year: **None**
Comments: **None**
Action for next year: **None**

Section 3 – Recommendations to the GMC

1. Timely recommendations are made to the GMC about the fitness to practise of all doctors with a prescribed connection to the designated body, in accordance with the GMC requirements and responsible officer protocol.

Action from last year: **None**
Comments: **None**
Action for next year: **None**

2. Revalidation recommendations made to the GMC are confirmed promptly to the doctor and the reasons for the recommendations, particularly if the recommendation is one of deferral or non-engagement, are discussed with the doctor before the recommendation is submitted.

Action from last year: **None**
Comments: **None**
Action for next year: **None**

[2] http://www.england.nhs.uk/revalidation/ro/app-syst/
[2] Doctors with a prescribed connection to the designated body on the date of reporting.

Section 4 – Medical governance

1. This organisation creates an environment which delivers effective clinical governance for doctors.

Action from last year:
Comments:
Action for next year:

2. Effective systems are in place for monitoring the conduct and performance of all doctors working in our organisation and all relevant information is provided for doctors to include at their appraisal.

Action from last year:
Comments:
Action for next year:

3. There is a process established for responding to concerns about any licensed medical practitioner's[1] fitness to practise, which is supported by an approved responding to concerns policy that includes arrangements for investigation and intervention for capability, conduct, health and fitness to practise concerns.

Action from last year:
Comments:
Action for next year:

4. The system for responding to concerns about a doctor in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group. Analysis includes numbers, type and outcome of concerns, as well as aspects such as consideration of protected characteristics of the doctors[3].

Action from last year:
Comments:
Action for next year:

5. There is a process for transferring information and concerns quickly and effectively between the responsible officer in our organisation and other responsible officers (or persons with appropriate governance responsibility) about a) doctors connected to your organisation and who also work in other

[4]This question sets out the expectation that an organisation gathers high level data on the management of concerns about doctors. It is envisaged information in this important area may be requested in future AOA exercises so that the results can be reported on at a regional and national level.

places, and b) doctors connected elsewhere but who also work in our organisation[4].

Action from last year: Comments: Action for next year:

6. Safeguards are in place to ensure clinical governance arrangements for doctors including processes for responding to concerns about a doctor's practice, are fair and free from bias and discrimination (Ref GMC governance handbook).

Action from last year: Comments: Action for next year:

Section 5 – Employment Checks

1. A system is in place to ensure the appropriate pre-employment background checks are undertaken to confirm all doctors, including locum and short-term doctors, have qualifications and are suitably skilled and knowledgeable to undertake their professional duties.

Action from last year: Comments: Action for next year:

Section 6 – Summary of comments, and overall conclusion

Please use the Comments Box to detail the following:

- **General review of last year's actions – None to review**
- **Actions still outstanding – None**
- **Current Issues- None**
- **New Actions: The Medical Revalidation Policy is due for review**

Overall conclusion:

There is a robust system for Appraisal and revalidation within PAHT, the aim is to continue to maintain the high level of compliance. There was a higher level responsible officer visit by NHS England in April 2018, which received very

[4] The Medical Profession (Responsible Officers) Regulations 2011, regulation 11: http://www.legislation.gov.uk/ukdsi/2010/9780111500286/contents

positive feedback for our processes.

Section 7 – Statement of Compliance:

The Board / executive management team – [*delete as applicable*] of [*insert official name of DB*] has reviewed the content of this report and can confirm the organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013).

Signed on behalf of the designated body

[(Chief executive or chairman (or executive if no board exists)]

Official name of designated body: _ _ _ _ _ _ _ _ _ _ _

Name: _ _ _ _ _ _ _ _ _ _ _ Signed: _ _ _ _ _ _ _ _ _ _ _

Role: _ _ _ _ _ _ _ _ _ _ _

Date: _ _ _ _ _ _ _ _ _

OFFICIAL

Victoria House
Capital Park
Fulbourn
Cambridge CB21 5XB
Telephone Number: 0113 825 4659
E-mail: england.revalidation-midlandsandeast@nhs.net

1st April 2019

To: All Responsible Officers / Designated Bodies

Dear Responsible Officer

Framework of Quality Assurance – Annual Organisational Audit (Annex C)

By the middle of June 2018, all responsible officers had completed the **Annual Organisational Audit** on behalf of their designated bodies. I would like to thank you for your efforts in making the audit a great success, both in terms of the number of returns received (100% for the second year running) and in ensuring the increase in the overall appraisal rate each year.

Since the AOA was first introduced in 2014, we have completed the first cycle of medical revalidation and it now feels the right time to update the FQA and its underpinning annexes. We have started this work by reviewing the AOA and in response to feedback from designated bodies, we have produced a slimmed down questionnaire for responsible officers to compete for the 2018/19 exercise, which includes simplified appraisal categories.

This slimmed down AOA concentrates primarily on the quantitative measures of previous AOAs, the numbers of doctors with a prescribed connection and their appraisal rates. As the systems and processes that support medical revalidation are established, we have moved the emphasis to reporting on how these should be developed year on year through a new version of the board report (Annex D) instead of through the AOA. The new board report, which now also includes **the statement of compliance**, has been designed to cover the remaining requirements of the RO regulations. The board report template, a component of the FQA, will be available from the end of **June 2019** on the NHS England webpages:

http://www.england.nhs.uk/revalidation/qa/.

High quality care for all, now and for future generations

As your Higher-Level Responsible Officer, I am writing to request that you complete and submit the mandatory return, the 2018/19 **Annual Organisational Audit** (AOA), for the period 1 April 2018 to 31 March 2019. The deadline for submission is **Friday 7 June 2019**. All responsible officers are also asked to present an **annual report** (FQA annex D) to their Board or equivalent management team. Following this, the completed report and the **statement of compliance** with the regulations (FQA annex E) should then be signed off by the Chairman or Chief Executive Officer of the designated body's Board or management team and submitted to me by **September 27, 2019**.

In the accompanying email, there is a link to the electronic version of the **AOA**. Once the 'submit' button has been pressed, the information will be sent to a central database. The information you provide is collated by NHS England and following analysis of the data, a national report is produced. Individual designated bodies are not identified.

Each higher-level responsible officer will receive a detailed report for those designated bodies connected to them and each designated body will receive an individual comparator report personalised to them, indicating their return benchmarked against others in their sector and all designated bodies nationally.

Please note, in terms of the e-form:

- You should only use the link received from NHS England in today's email, as it is unique to your organisation. The link opens an electronic version of the AOA for completion.
- Once the link is opened, you will be presented with two buttons; one to download a blank copy of the AOA for reference; the second button will take you to the electronic form for submission.
- Submissions can only be received electronically via the link. Please do not complete hard copies, or email copies of the document.
- The form must be completed in its entirety prior to submission; it cannot be part-completed and saved for later submission.
- Once the 'submit' button has been pressed, the information will be sent to a central database, collated by NHS England.
- A copy of the completed submission will be sent to the responsible officer.

Further detailed guidance on completion and submission is available within the AOA form.

In summary, please may I ask that you:

1. Complete and return the **Annual Organisational Audit** by **Friday 7 June 2019** for your 2018-19 year-end position.

2. Arrange for an **annual report** (FQA Annex D) to be submitted to your Board or equivalent governance body.

High quality care for all, now and for future generations

3. Return a copy of your board report, complete with a signed **Statement of Compliance** (FQA Annex D) to me by **September 27, 2019**

Kind regards

Dr Nigel Sturrock

Higher-Level Responsible Officer
NHS England - Midlands
NHS England - East of England

Regional Medical Director
NHS England - Midlands

CC: Chairs and Chief Executives of Designated Bodies

Trust Board – 01.08.19

Agenda Item:	7.1
Presented by:	Stephanie Lawton – Chief Operating Officer
Prepared by:	Information Team, Executive Directors
Date prepared:	18 July 2019
Subject / Title:	Integrated Quality and Performance Report

Purpose:	Approval		Decision		Information	✓	Assurance	✓

Executive Summary: [please don't expand this cell; additional information should be included in the main body of the report]	**Patients:** Good progress on reducing outstanding incidents. Continued progress on mortality improvements. **Performance:** Access standards achieved. Areas of ongoing focus are emergency care and cancer. **People:** Successful overseas recruitment campaign underway. **Pounds**: The Trusts YTD deficit is £10.5m, £2.8m worse than plan. Reductions in agency spend and improved CIP delivery has improved the rate of variance. In accordance with National and STP requirements the Trust is currently reviewing its capital programme requirements for 19/20. **Places**: Work underway on the Fracture Clinic, Antenatal and MAFU successfully completed.
Recommendation:	The Board is asked to discuss the report and note the current position and further action being taken in areas below agreed standards.

Trust strategic objectives: [please indicate which of the 5Ps is relevant to the subject of the report]	 Patients	 People	 Performance	 Places	 Pounds
	x	x	x	x	x

Previously considered by:	Executive Management Team Senior Management Team	PAF.25.07.19 QSC.26.07.19
Risk / links with the BAF:		
Legislation, regulatory, equality, diversity and dignity implications:	No regulatory issues/requirements identified.	
Appendices:		

7.1

The Princess Alexandra Hospital NHS Trust

Integrated Performance Report

June 2019

The purpose of this report is to provide the Board of Directors with an analysis of quality performance.
The report covers performance against national and local key performance indicators.

Your future | Our hospital

Contact:

Lance McCarthy, Chief Executive Officer
Andy Morris, Chief Medical Officer
Sharon McNally, Director of Nursing
Trevor Smith, Deputy CEO & Chief Financial Officer
Stephanie Lawton, Chief Operating Officer
Jim McLeish, Director of Quality Improvement
Ogechi Emeadi, Director of People
Michael Meredith, Director of Strategy

respectful | caring | responsible | committed

Trust Objectives

NHS
The Princess Alexandra Hospital
NHS Trust

Our Patients
Continue to improve the quality of care we provide **our patients**, improving our CQC rating.

Our People
Support **our people** to deliver high quality care within a culture that improves engagement, recruitment and retention and improvements in our staff survey results.

Our Places
Maintain the safety of and improve the quality and look of **our places** and work with our partners to develop an OBC for a new build, aligned with the development of our local Integrated Care Alliance.

Our Performance
Meet and achieve **our performance** targets, covering national and local operational, quality and workforce indicators.

Our Pounds
Manage **our pounds** effectively to achieve our agreed financial control total for 2019/20.

Your future | Our hospital

respectful | caring | responsible | committed

5Ps

In this month

The Princess Alexandra Hospital NHS Trust

Patients

Performance

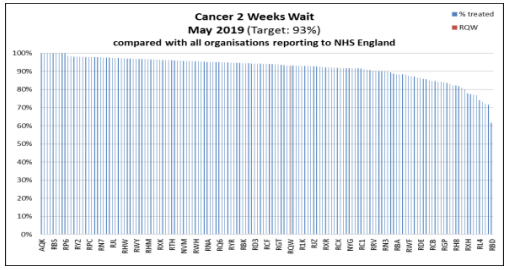
People

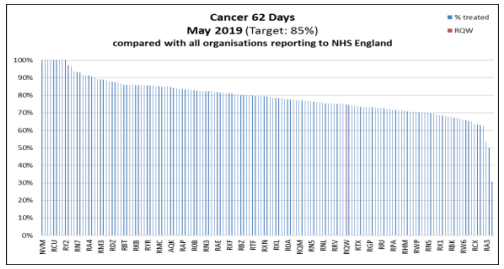
Pounds

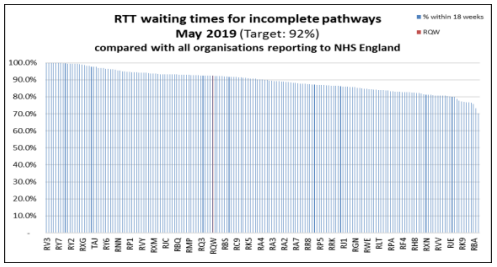
Places

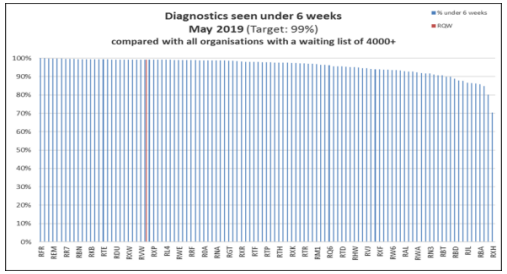
National Benchmarking
Compared with all organisations reporting to NHS England

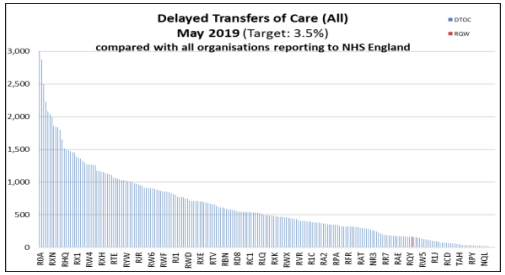
NHS
The Princess Alexandra Hospital
NHS Trust

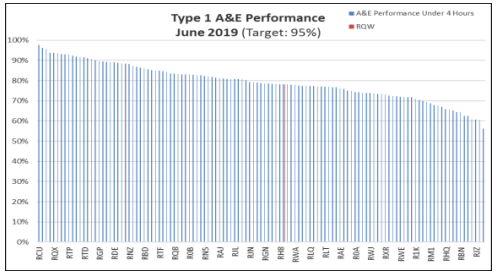


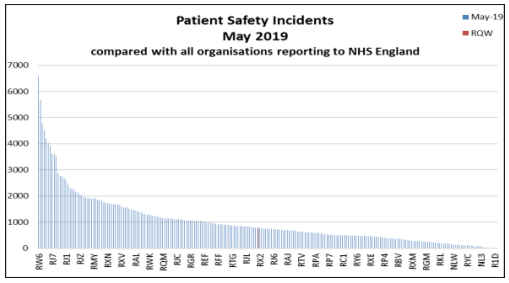


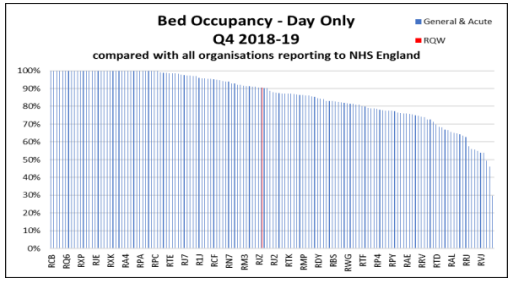


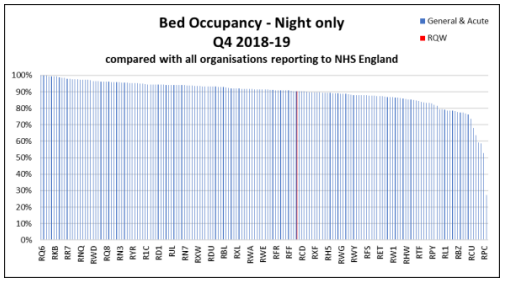












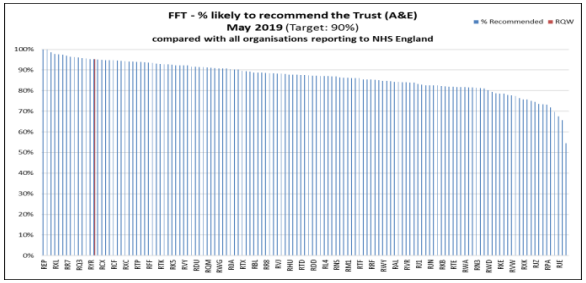
Your future · Our hospital

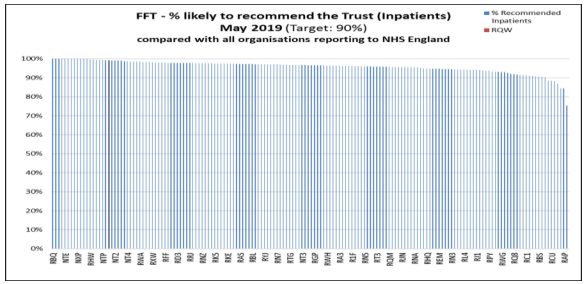
Data Source: NHS England Statistics/Public Health England/Dr Foster

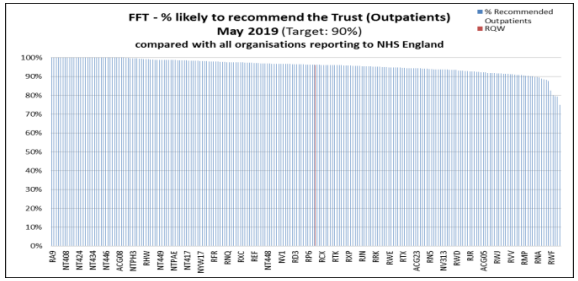
respectful | caring | responsible | committed

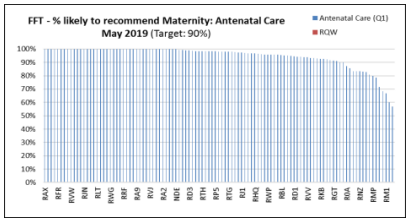
National Benchmarking
Compared with all organisations reporting to NHS England

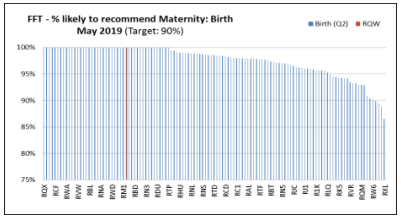
NHS
The Princess Alexandra Hospital
NHS Trust

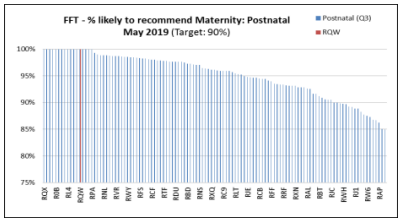


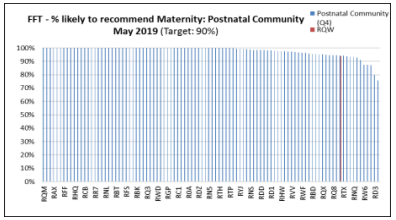


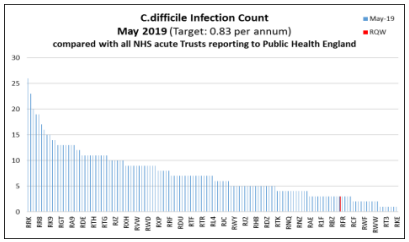


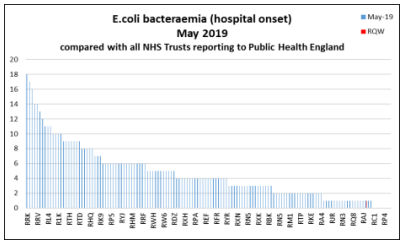


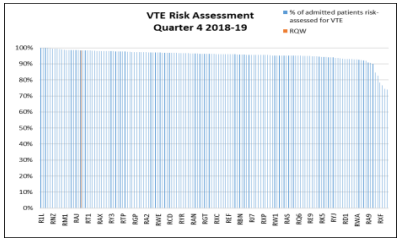


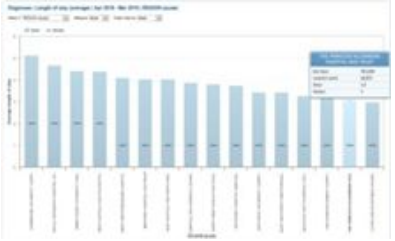












Your future · Our hospital

Data Source: NHS England Statistics/Public Health England/Dr Foster

respectful | caring | responsible | committed

Executive Summary Our Patients

The Princess Alexandra Hospital NHS Trust

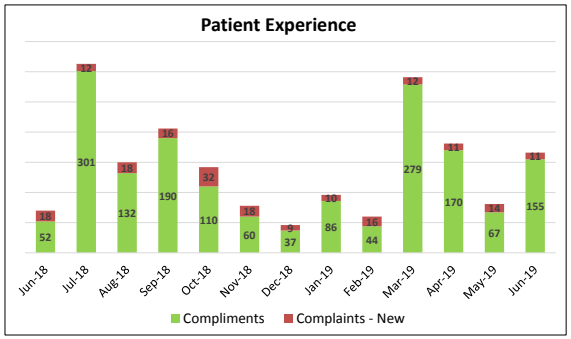
There are no significant changes reported in month in relation to the quality KPIs.

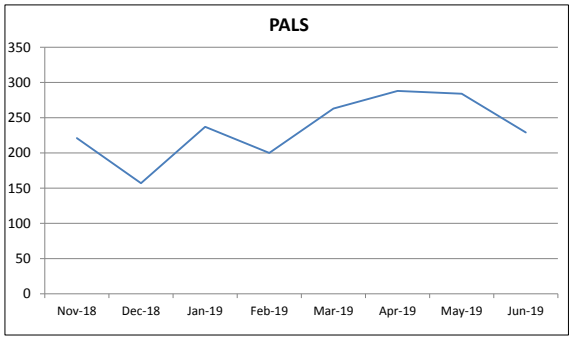
Patient Experience

1 Our Patients Summary 1.1 Patient Experience

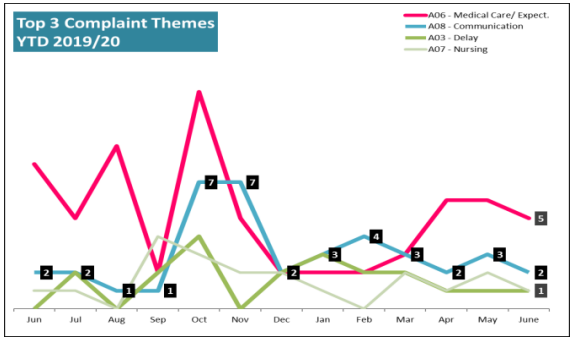
The Princess Alexandra Hospital NHS Trust

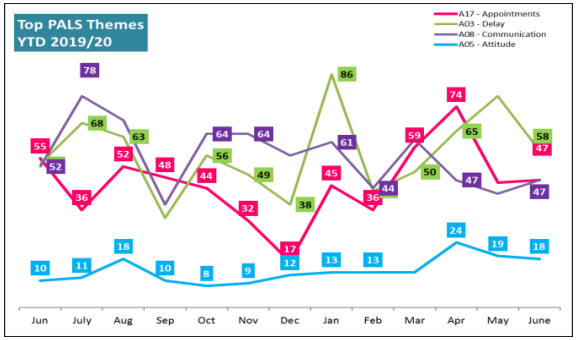
There are no significant changes in the data this month from patient experience. The number of people who responded to the Friends and Family Test question in A&E (sampling) is lower than the same month last year, but continues to be well above the average for all Trusts nationally.

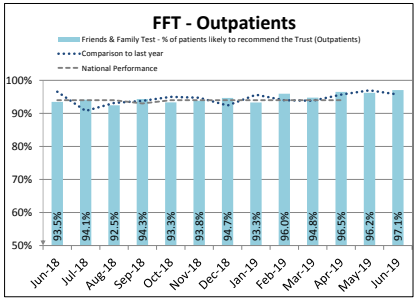


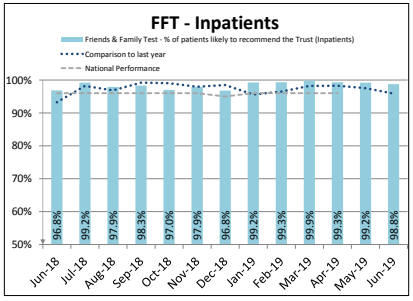


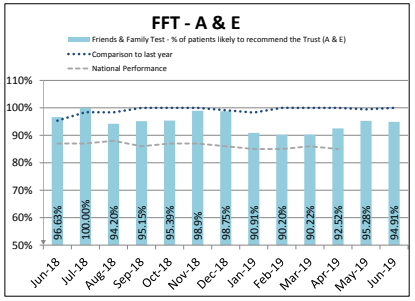
PALS converted to Complaints	
Jun-18	0
Jul-18	3
Aug-18	2
Sep-18	3
Oct-18	6
Nov-18	4
Dec-18	1
Jan-19	2
Feb-19	2
Mar-19	0
Apr-19	1
May-19	2
Jun-19	2

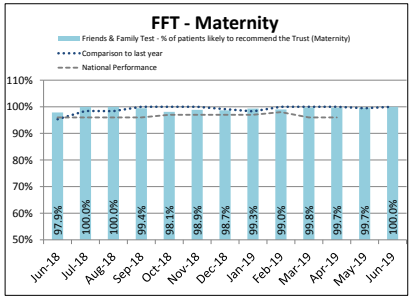












Patient Safety

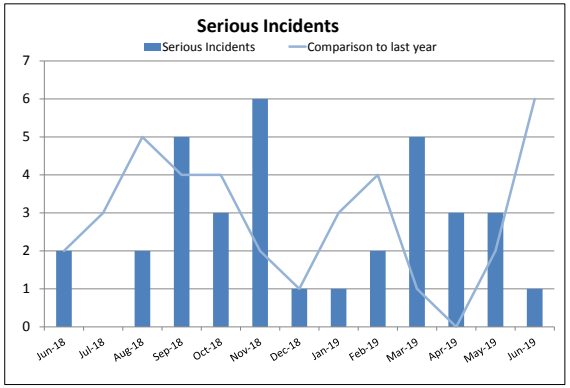
1 Our Patients Summary 1.2 Patient Safety

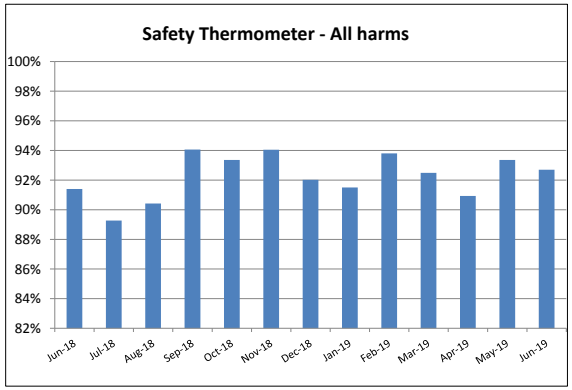
NHS The Princess Alexandra Hospital NHS Trust

There were 949 incidents in total reported in June 2019.
715 incidents were PAH, comprising of 491 no harm & 202 minor harm (97%), 21 moderate harm (2.9%) and 1 severe harm incident (0.1%).

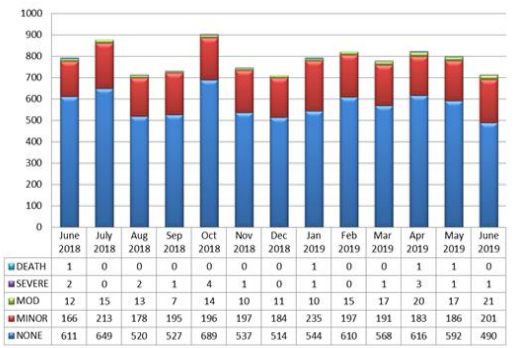
Severe Harm Incidents
There was 1 severe graded incident reported in June:
• Failure to report a CT chest in 2017, this has been discussed at SIG & is for an internal RED investigation

Serious Incident
There was 1 incident meeting the Serious Incident criteria declared in June 2019:
• Suboptimal care of a deteriorating patient leading to admission to Critical Care.

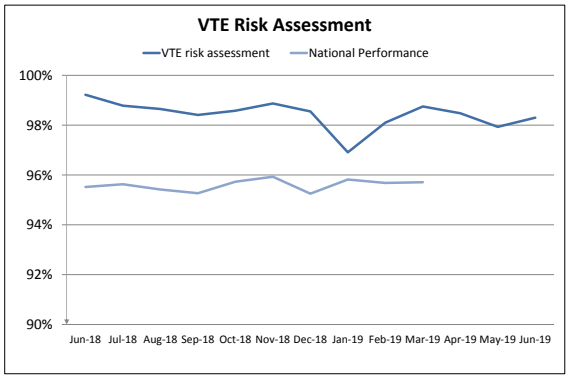


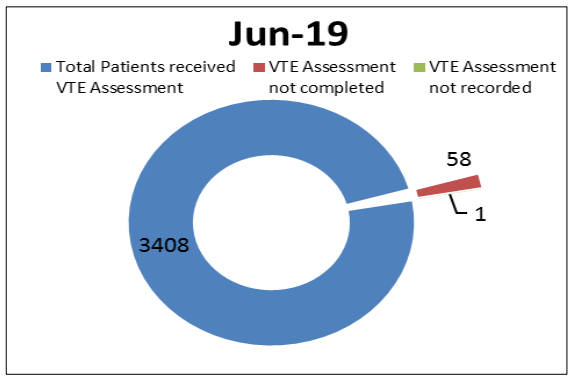


Severity of reported Incidents on Datix (June 2018 – June 2019)



	June 2018	July 2018	Aug 2018	Sep 2018	Oct 2018	Nov 2018	Dec 2018	Jan 2019	Feb 2019	Mar 2019	Apr 2019	May 2019	June 2019
DEATH	1	0	0	0	0	0	0	1	0	0	1	1	0
SEVERE	2	0	2	1	4	1	0	1	0	1	3	1	1
MOD	12	15	13	7	14	10	11	10	15	17	20	17	21
MINOR	166	213	178	195	196	197	184	235	197	191	183	186	201
NONE	611	649	520	527	689	537	514	544	610	568	616	592	490





Infection Control

1 Our Patients Summary 1.3 Infection Control

The Princess Alexandra Hospital NHS Trust

MRSA There have been no cases of Trust-apportioned MRSA bacteraemia in the Trust since 2014.

MSSA The Trust continues to have low numbers of MSSA bacteraemia and remains in the top quarter of best performing hospitals nationally. During June there was one Trust-apportioned case; the source of the bacteraemia was not known in this case.

C.difficile In March 2018, NHS Improvement outlined the intention to review the reporting and classification of Clostridium difficile (CDI) for 2019/20. There are four new definitions, but the two that will apply to the Trust are:

Healthcare onset healthcare associated (HOHA): cases detected three or more days after admission
Community onset healthcare associated (COHA): cases detected within two days of admission where the patient has been an inpatient in the Trust reporting the case in the previous four weeks.

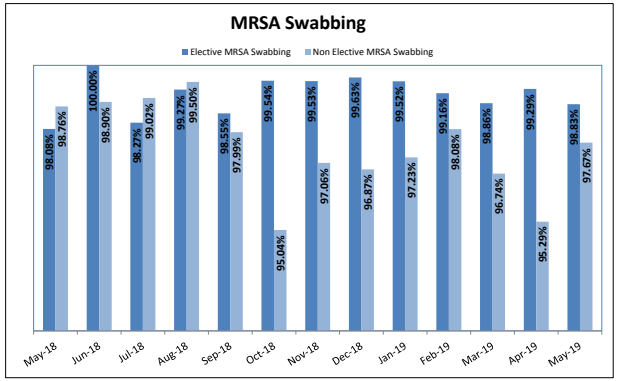
The reporting period has decreased from **72 to 48 hours**. This means that all patients that are tested after 48 hours will be assigned to the Trust. The consequence of this is that all cases which meet the definitions of HOHA and COHA, will be assigned to the acute Trust. This will significantly increase the cases assigned to acute providers, this has been reflected within the new objectives (**27 for PAH**). These cases will undergo the same robust Root Cause Analysis (RCA) and Multi-disciplinary team (MDT) process as the previous post 72 hour cases required.

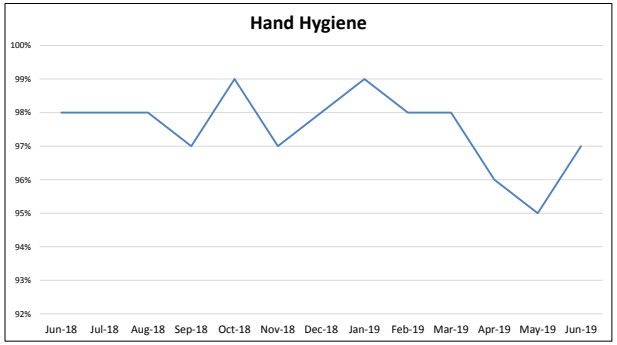
There was one COHA case of C.difficile under the new definitions in June (plus two GP cases). The RCA for the COHA case, along with the April and May cases will be held as a joint RCA and appeals panel with West Essex CCG and East and North Herts CCG present. This will take place at the end of July/beginning of August.

Gram Negative Blood Stream Infections (GNBSIs) The Trust remains in a good position when compared nationally with other hospitals (in the top performing quarter) and we have a collaborative approach to tackling GNBSIs across the health care economy.

MRSA screening The Trust has consistently met its trajectory of over 95% compliance for non-elective MRSA screening. Latest data available is for May and both elective and non-elective were above 95%.

Hand Hygiene Audits All wards/clinical department are expected to participate in monthly audits and these are undertaken as 'cross-over' audits, meaning staff do not audit themselves. The expectation is that 100% of clinical areas participate and the performance standard is 95% compliance. During June there was one area that did not undertake audits for their allocated areas. Six areas scored less than the expected standard of 95%. Wards/departments are expected to discuss their results and agree appropriate actions within their Health-Care Group.





MSSA	
Jun-18	1
Jul-18	1
Aug-18	3
Sep-18	0
Oct-18	0
Nov-18	0
Dec-18	0
Jan-19	0
Feb-19	1
Mar-19	2
Apr-19	0
May-19	1
Jun-19	1

C-DIFF Total (to March 2019)	
Jun-18	1
Jul-18	1
Aug-18	1
Sep-18	0
Oct-18	1
Nov-18	0
Dec-18	1
Jan-19	3
Feb-19	0
Mar-19	1

C-DIFF (New categories including community from April 2019)					
Month	Hospital Responsible		Community Responsible		Total
	Hospital onset healthcare associated	Community onset healthcare associated (Acute Admission within last 4 wks)	Community onset indeterminate association (Acute Admission within last 12 wks)	Community onset community associated (No acute contact within 12 wks)	
Apr-19	1	2	1	0	4
May-19	1	1	1	0	3
Jun-19	0	1	0	2	3

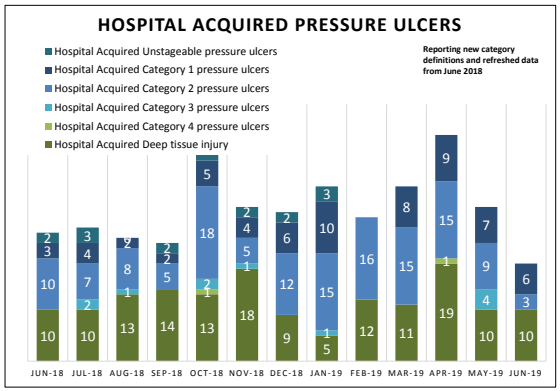
E Coli	
Jun-18	1
Jul-18	2
Aug-18	1
Sep-18	1
Oct-18	1
Nov-18	1
Dec-18	1
Jan-19	1
Feb-19	2
Mar-19	1
Apr-19	2
May-19	1
Jun-19	2

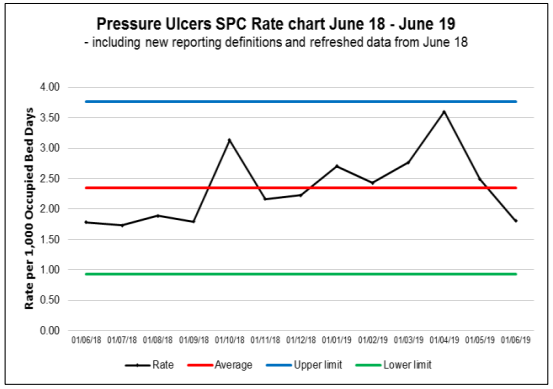
Klebsiella	
Jun-18	2
Jul-18	1
Aug-18	1
Sep-18	0
Oct-18	0
Nov-18	0
Dec-18	1
Jan-19	2
Feb-19	0
Mar-19	0
Apr-19	0
May-19	0
Jun-19	1

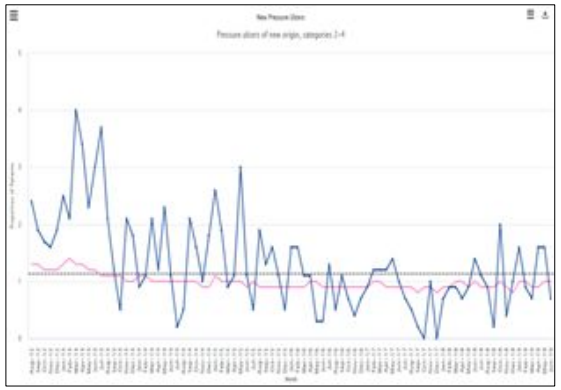
Pseudomonas	
Jun-18	0
Jul-18	0
Aug-18	0
Sep-18	0
Oct-18	1
Nov-18	0
Dec-18	0
Jan-19	0
Feb-19	0
Mar-19	0
Apr-19	0
May-19	0
Jun-19	0

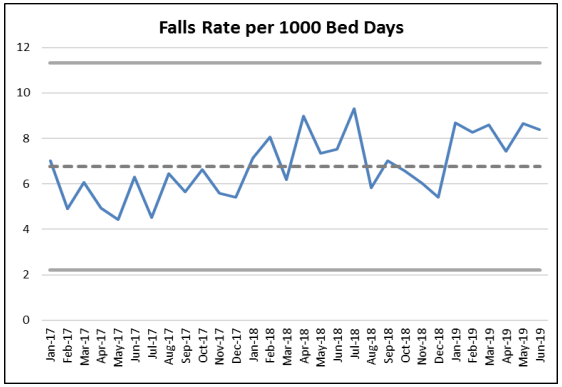
Falls in June saw a very slight decrease in the absolute number of falls to 107, down from 111 in May. This was accompanied by a decrease in the number of falls per 1000 OBD (occupied bed days) to 8.39, down from 8.65 in May. Year on year this is an increase when compared with the June 2018 rate of 7.53 falls per 1000 OBD. As a Trust we aim to ensure our levels of harm remain low and this is still the case with 98%+ PAH falls recorded as low or minor harm in June.

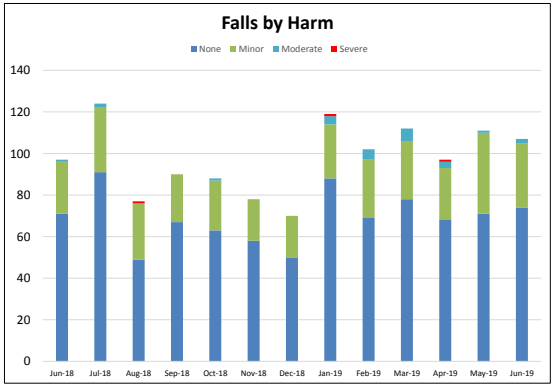
There has been a reduction in the number of pressure ulcers reported in the month of June as demonstrated in the charts.

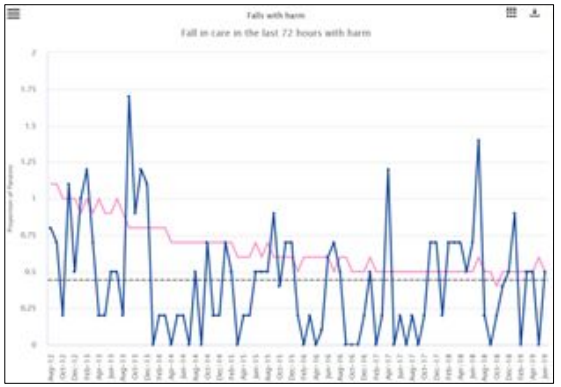






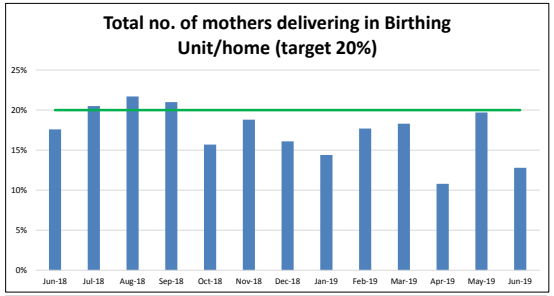


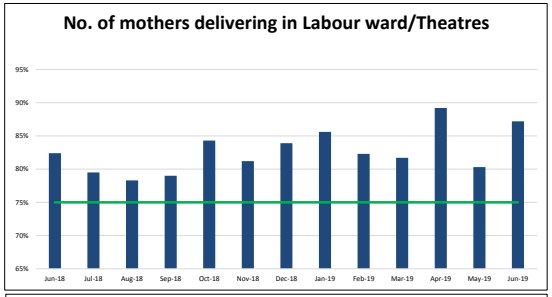


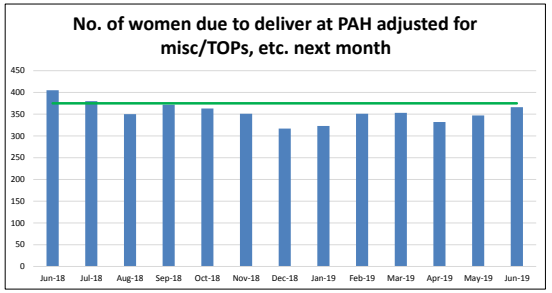


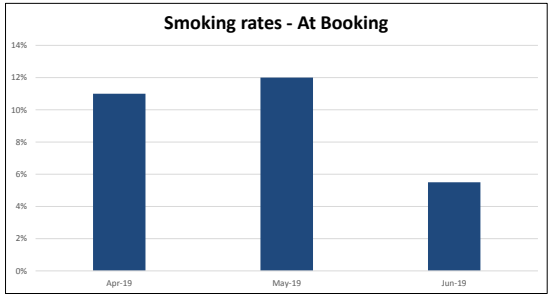
Family & Women's Service

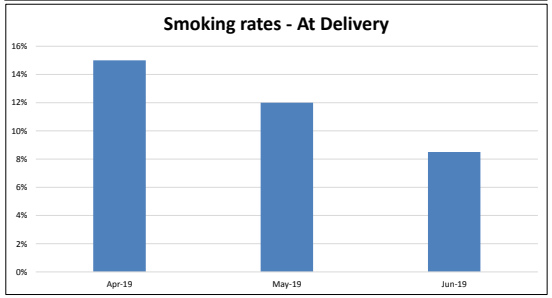
All midwives and medical staff whose CTG training needs updating have been informed that their K2 programme needs completing by the end of the month.

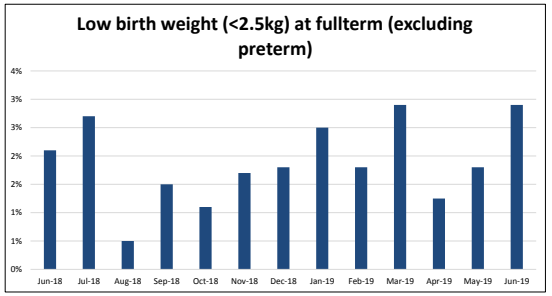


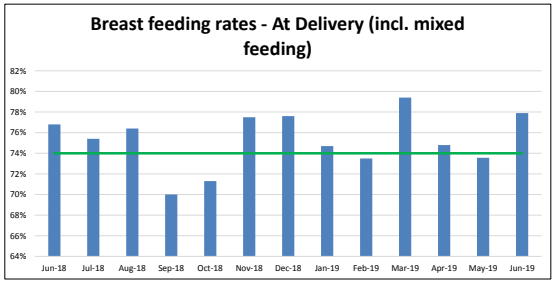


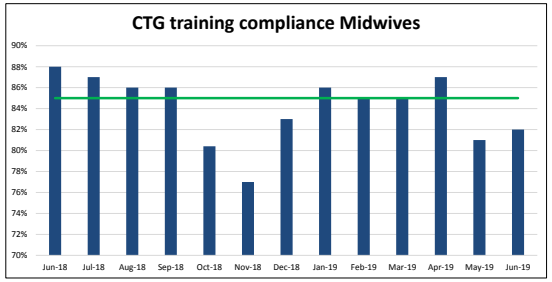


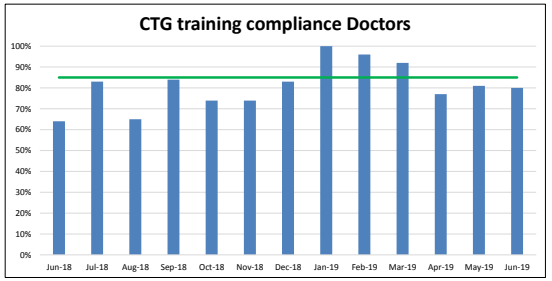










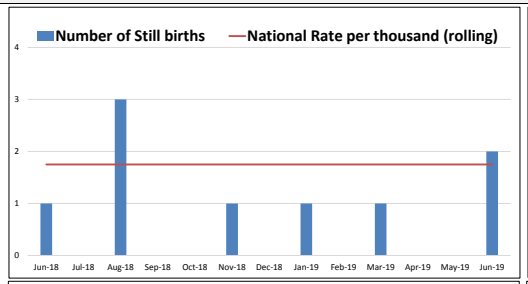


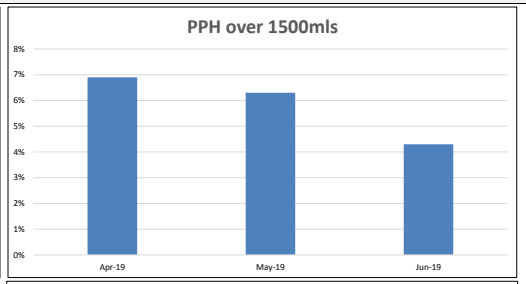
Family & Women's Service

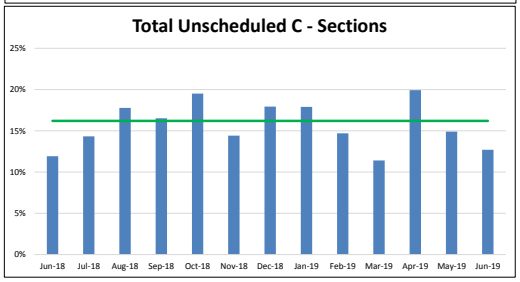
2 Our Patients Summary 1.6 Family & Women's Service

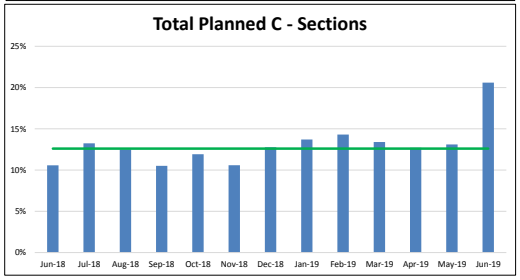
The Princess Alexandra Hospital NHS Trust

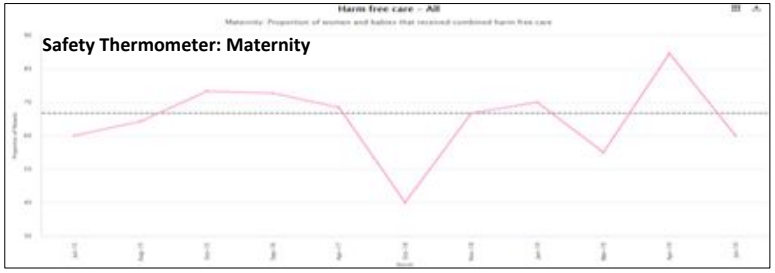
We have adjusted the Caesarean section target rates using the HES National Maternity Statistics (2017/18) with an overall rate of 28.8%.
There were 2 stillbirths in June, both babies were 24 weeks with one having a known abnormality.

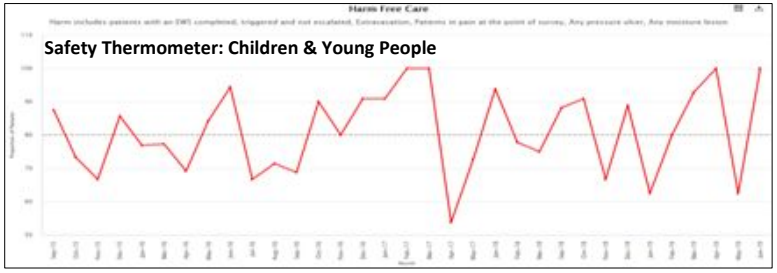






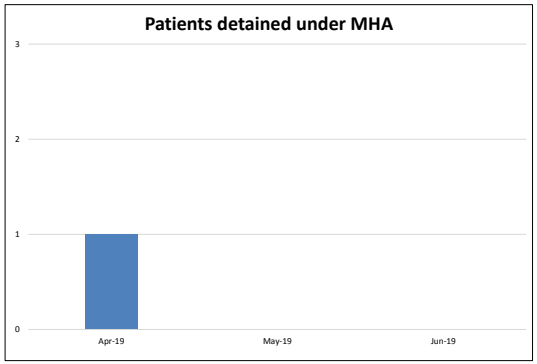


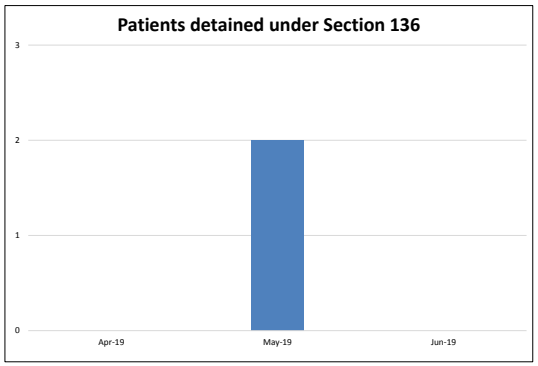


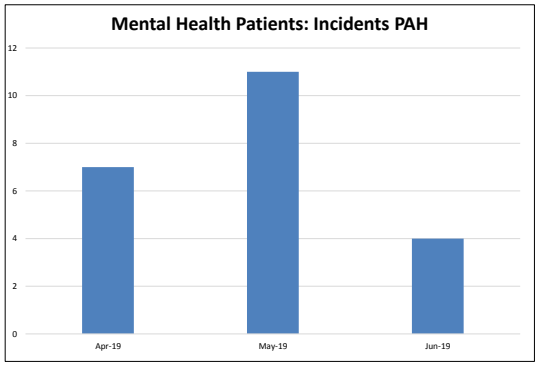


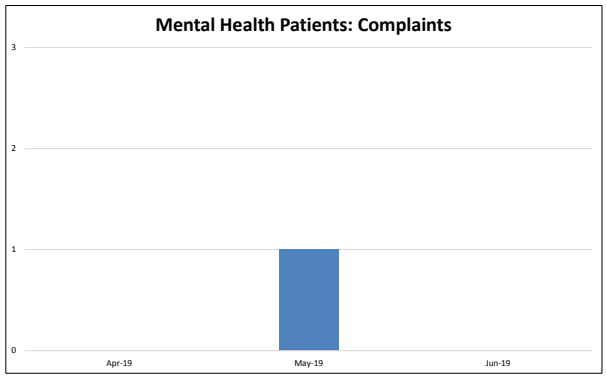
Mental Health

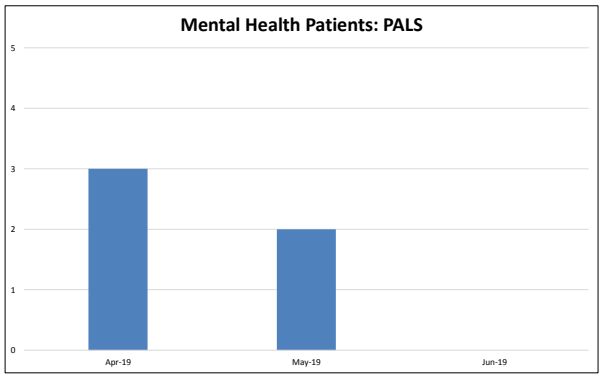
The newly established Mental Health Quality Forum is taking forward improvement work in relation to the care and management of mental health patients.











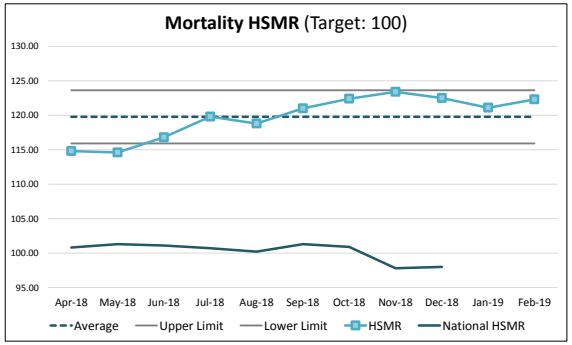
Mortality

1 Our Patients Summary 1.8 Mortality

The Princess Alexandra Hospital NHS Trust

The HSMR for the 12 month period March 18 to February 19 is 121.9 and higher than expected.
There are 8 outlier alerts:
Pneumonia
COPD
UTI
Senility
Aspiration pneumonia
Renal failure
Fracture neck of femur
Implanted devices

The SHMI for the same period is 113.66 and higher than expected.
There are 3 outlier alerts:
UTI
COPD
Senility



Mortality SHMI	
Jun-18	
Jul-18	
Aug-18	
Sep-18	116.7
Oct-18	
Nov-18	
Dec-18	114.1
Jan-19	113.7
Feb-19	
Mar-19	
Apr-19	
May-19	
Jun-19	

Mortality Outlier Alerts (QA)	
May 17 - Apr 18	4
Jun 17 - May 18	4
Jul 17 - Jun 18	4
Aug 17 - Jul 18	6
Sep 17-Aug 18	6
Oct 17 - Sep 18	9
Nov 17 - Oct 18	8
Jan 18 - Dec 18	7
Feb 18 - Jan 19	6
Mar 18 - Feb 19	8

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Mortality Improvement progress and performance tracker (project level)

The Princess Alexandra Hospital NHS Trust

Populated measures: 100% of 44

Programme	Project		Aim		Success measures: Measure	Type of Measure	Trajectory Vs Actual	Performance and progress tracker: Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
Care Bundles	Fractured Neck of Femur		Reduce mortality to expected level i.e. from 8.5% to 6% by March 2020 (based on Dr Foster Data from reporting period Nov17-Oct18)	1	#NOF mortality rate (% of patients who died)	Outcome	Trajectory	8.3%	8.2%	8.0%	7.9%	7.8%	7.6%	7.5%	7.4%	7.2%	7.1%	7.0%	6.8%	6.7%	6.5%	6.4%	6.3%	6.1%	6.0%
							Actual	8.3%	8.4%	7.6%	8.0%	9.1%													
				2	% #NOF patients admitted to Tye Green (NOF ward)	Process	Trajectory	90%	90%	90%	90.0%	90.0%	90.0%	90.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	98.0%	98.0%	98.0%	98.0%	98.0%
							Actual	79.0%	97.0%	85.0%	100.0%	89.0%	89.5%	83.3%											
				3	% of #NOF patients in theatres within 36 hours of arrival at A&E	Process	Trajectory	77%	79%	74%	78.6%	79.6%	80.7%	81.7%	82.7%	83.8%	84.8%	85.9%	86.9%	87.9%	89.0%	90.0%	90.0%	90.0%	90.0%
							Actual	77.0%	79.0%	74.0%	78.6%	70.0%	82.9%	73.0%	67.6%	72.7%									
				4	% of #NOF patients in theatres within 36 hours of arrival at A&E (excluding DOAC patients)	Process	Trajectory	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%	81.7%	83.3%	85.0%	86.7%	88.3%	90.0%	91.7%	93.3%	95.0%	95.0%	95.0%	95.0%
							Actual	94.4%	88.2%	85.3%	91.7%	84.8%	93.5%	77.1%	88.5%	80.0%									
				5	% #NOF patients admitted into Tye Green within 4 hours of ED attendance	Balance	Trajectory	73%	42%	31%	46.4%	49.9%	53.3%	56.8%	60.3%	63.8%	67.2%	70.7%	74.2%	77.6%	81.1%	84.6%	88.0%	91.5%	95.0%
							Actual	73.0%	42.0%	31.0%	46.4%	12.5%	40.0%	27.0%	38.2%	72.7%									
	Acute Abdomen		Reduce mortality to expected level i.e. from 8.7% to 7.1% by March 2020 (intestinal obstruction, based on Dr Foster Data from reporting period Nov17-Oct18)	6	Intestinal obstruction mortality rate (% of patients who died)	Outcome	Trajectory	8.60%	8.51%	8.42%	8.34%	8.25%	8.16%	8.07%	7.98%	7.89%	7.81%	7.72%	7.63%	7.54%	7.45%	7.37%	7.28%	7.19%	7.10%
							Actual	8.60%	8.3%	6.3%	6.8%	6.8%													
				7	Case ascertainment in NELA	Process	Trajectory	66.0%		66%		72.8%			79.6%			86.4%			93.2%			100.0%	
							Actual	66.0%				99.0%													
				8	Arrival in theatre within a timescale appropriate for urgency	Process	Trajectory	82.0%		82%		83.6%			85.2%			86.8%			88.4%			90.0%	
							Actual	82.0%				96.0%													
				9	% of Em Lap patients admitted to HDU/ITU (with NELA risk score >5) post operatively	Process	Trajectory	77.0%		77%		78.6%			80.2%			81.8%			83.4%			85.0%	
							Actual	77.0%				64.0%													
				10	Consultant anaesthetist and surgeon present in theatre if NELA risk score >5%	Process	Trajectory	83.0%		83%		86.4%			89.8%			93.2%			96.6%			100.0%	
							Actual	83.0%				93.0%													
	COPD		Reduce mortality to expected level i.e. from 6.6% to 4.1% by March 2020 (based on Dr Foster Data from reporting period Nov17-Oct18)	11	COPD mortality rate (% of patients who died)	Outcome	Trajectory	6.4%	6.3%	6.1%	6.0%	5.8%	5.7%	5.6%	5.4%	5.3%	5.1%	5.0%	4.8%	4.7%	4.6%	4.4%	4.3%	4.1%	4.0%
							Actual	6.4%	7.2%	6.8%	6.6%	6.4%													
				12	Administer nebuliser and steroids within 4 hours of attendance	Process	Trajectory																		
							Actual					6.3%	15.2%	13.8%											
	Pneumonia		Reduce mortality to expected level i.e. from 19.6% to 15.3% by March 2020 (based on Dr Foster Data from reporting period Nov17-Oct18)	13	Pneumonia mortality rate (% of patients who died)	Outcome	Trajectory	16.1%	16.0%	15.8%	15.7%	15.5%	15.4%	15.2%	15.1%	14.9%	14.8%	14.6%	14.5%	14.3%	14.2%	14.0%	13.9%	13.8%	13.6%
							Actual	16.1%	16.3%	16.2%	15.8%	16.0%													
				14	Aspiration pneumonia mortality rate (%of patients who died)	Outcome	Trajectory	47.0%	46%	45%	44.0%	43.0%	42.0%	41.0%	40.0%	39.0%	38.0%	37.0%	36.0%	35.0%	34.0%	33.0%	32.0%	31.0%	30.4%
							Actual	47.0%	44.0%	43.2%	43.0%	44.6%													
				15	Oxygen prescribed within 1 hour of attendance	Process	Trajectory																		
							Actual					0.00%	4.76%	0.00%											
				16	Chest x-ray within 4 hours of attendance	Process	Trajectory	84.6%	82.6%	83.3%	80.0%	42.9%	61.1%	67.9%	74.7%	81.5%	88.3%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%
							Actual	84.6%	82.6%	83.3%	80.0%	42.9%	64.0%	82.4%											
	Sepsis		5% reduction in Sepsis mortality by March 2020	17	Sepsis mortality rate (% of patients who died)	Outcome	Trajectory	20.5%	20.2%	19.9%	19.6%	19.3%	19.0%	18.7%	18.4%	18.2%	17.9%	17.6%	17.3%	17.0%	16.7%	16.4%	16.1%	15.8%	15.5%
							Actual	20.5%	19.9%	19.1%	17.5%	16.0%													
				18	95% of all patients admitted to ED with a NEWS score of 3 are screened for sepsis by May 2019	Outcome	Trajectory	82.0%	82.0%	82.0%	84.6%	87.2%	89.8%	92.4%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%
							Actual	85.0%	76.0%	84.0%	84.0%	84.0%	86.0%												
				19	% sepsis patients receiving treatment within one hour (ED)	Process	Trajectory	87.0%	87.0%	87.0%	89.0%	90.0%	92.0%	93.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%
							Actual	91.0%	83.0%	88.0%	89.0%	94.0%	94.0%												
Excellence Every Time group 1	Vital Signs	Timely recording of vital signs observation and adequate & effective equipment for undertaking and recording vital signs	To improve compliance with timely vital signs observation leading to early detection and escalation of deteriorating patient	20	% of Observations on patients with a EWS ≥5 within 30 minutes of due time	Process	Trajectory				70.0%	75.0%	80.0%	85.0%	90.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%
							Actual				63.2%	69.0%	72.2%	75.3%	76.4%	81.5%									
	Fluids & Electrolytes	Accurate input/ output Fluid Balance chart	To improve compliance with fluids & electrolytes management with early detection and treatment leading to reduction in harm caused by fluid and electrolytes imbalance	21	% of completed fluid balance charts	Process	Trajectory			0%	0.0%					40.0%	45.5%	51.1%	56.6%	62.2%	67.7%	73.3%	78.8%	84.4%	90.0%
							Actual			0%	0.0%			28.0%	51.8%	47.2%									
		Management of Acute Kidney Injuries (AKI)		22	Reduce mortality to expected level i.e. from 10.9% to 8.5% by March 2020 (based on Dr Foster data for renal disease comorbidity, from reporting period Nov17-Oct18)	Outcome	Trajectory	10.5%	10.4%	10.2%	10.0%	9.9%	9.8%	9.7%	9.6%	9.5%	9.3%	9.2%	9.1%	9.0%	8.9%	8.7%	8.6%	8.5%	8.4%
							Actual	10.5%	10.4%	10.1%	9.8%	10.1%													
				23	Number of patients with AKI alert	Outcome	Trajectory				98	105	101	100	98	95	95	90	90	85	85	80	80	75	75
							Actual				98	105	101	100	98	110									
				24	Percentage of patients with alerts that have remained the same or improved during their admission	Process	Trajectory	86%	85.0%	89.0%	87.0%	91.0%	88.5%	89.8%	91.1%	92.4%	93.7%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%
							Actual	86.0%	85.0%	89.0%	87.0%	91.0%	88.5%	88.0%	89.8%										
				25	Number of drug reviews for AKI patients	Process	Trajectory	75.0%										95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%
							Actual	75.0%																	
		Diabetic Emergencies		26	Number of hypos	Process	Trajectory	878	852	711	765	751	738	724	710	697	683	669	656	642	628	615	601	587	574
							Actual	879	852	711	765	544	501	607	460	533									
Excellence Every Time group 2	Antibiotics Stewardship		Correct antibiotic use for patient need (right drug, right patient, right time, right route) and a reduction in overall antibiotic use (and associated cost) move to middle quartile (national) by March 2020	27	Antibiotic usage (per 1000 admissions)	Outcome	Trajectory		5838			5602			5482			5304			5126			4948	
							Actual		5838			5803													
				28	% of antibiotic prescriptions having an indication documented	Process	Trajectory	15.0%										50.0%	55.0%	60.0%	65.0%	70.0%	75.0%	80.0%	85.0%
							Actual	15.0%																	
				29	% of antibiotics prescribed with a review date or stop date documented	Process	Trajectory	52%										71.0%	73.7%	76.4%	79.1%	81.9%	84.6%	87.3%	90.0%
							Actual	52.0%																	
				30	Number of the antibiotic prescriptions submitted that had evidence of review between 24 and 72 hours PLUS reviewed by an appropriate clinician PLUS a documented IV rationale	Process	Trajectory		71.0%			74.0%			77.0%			80.0%			85.0%			90.0%	
							Actual		71.0%			96.0%													
				31	LoS for patients who have antibiotics during their admission (non elective and elective)	Balance	Trajectory	8.13	8.44	8.52	8.90	8.38	7.97	8.39	8.31	8.21	8.12	8.03	7.94	7.85	7.76	7.67	7.58	7.49	7.50
							Actual	8.13	8.44	8.52	8.90	8.38	7.97	7.60	7.55	5.23									
	Timely Decision Making		95% Compliance with completion of TEP for all adult (>16yrs) in-patients	32	% compliance with completion of TEP forms for all patients over 16 years old	Outcome	Trajectory							43.0%	58.0%	61.7%	65.4%	69.1%	72.8%	76.5%	80.2%	83.9%	87.6%	91.3%	95.0%
							Actual							43.0%	58.0%	48.8%									
			Right patient, right ward - first time	33	100% of EDD on Cosmic for all patients within 14 hours of admission.	Process	Trajectory												72.8%	76.5%	80.2%	83.9%	87.6%	91.3%	95.0%
							Actual						1.5%												
				34	100% Preferred ward documented for all patients.	Process	Trajectory												72.8%	76.5%	80.2%	83.9%	87.6%	91.3%	95.0%
							Actual						50.7%												
Reporting and recording	Medical Examiners		100% adult deaths (>16yrs) reviewed by ME and evidence of shared learning against reviews	35	% of completed Mortality Reviews by an ME	Outcome	Trajectory							25.0%	25.0%	30.0%	40.0%	50.0%	60.0%	70.0%	80.0%	90.0%	100.0%	100.0%	100.0%
							Actual							17.8%	19.0%	24.0%									
					Number of completed reviews	Process	Trajectory																		
							Actual							22	18	28									
	Documentation (meeting standards, recording care accurately and communicating mangement plans)		Every entry in the patient notes are compliant with GMC and NMC standards	36	Compliance with documentation standards in Perfect Ward Audit tool	Process	Trajectory						95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%
							Actual						95.0%	98.0%	95.0%	97.0%									
				37	Depth of coding (NHS Digital - non-elective)	Process	Trajectory																		
							Actual		3.80			3.80													
				38	Depth of coding (Dr Foster)	Process	Trajectory																		
							Actual				3.10	3.20	3.10												
Hospital at Night	Doctor Handover		Implementation of structured handover of patients for all specialities out of hours	39	Number of unexpected escalations to critical care (excluding ED)	Balance	Trajectory	3	13	4	5	11	8	7	6	6	6	6	6	6	5	5	5	5	5
							Actual	3	13	4	5	11	8	7	6	8									
				40	Percentage of unexpected return to theatres (excluding ED)	Process	Trajectory	0.93%	0.93%	0.93%	0.93%	0.93%	0.93%	0.93%	0.93%	0.90%	0.90%	0.90%	0.90%	0.90%	0.80%	0.80%	0.80%	0.80%	0.80%
							Actual	0.53%	0.55%	1.15%	1.45%	0.95%	0.96%	0.99%	0.58%	0.94%									
				41	Attendance at handover recorded - % of full H@N clinical team (required vs actual)	Process	Trajectory										75.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%
							Actual																		
	Electronic Handover		Implementation of electronic handover	42	% of tasks allocated and succesfully closed by the following day	Process	Trajectory										30%	39%	48%	56%	65%	74%	83%	91%	100%
							Actual																		
				43	Implementation of an electronic nighttime handover	Outcome	Trajectory										100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
							Actual																		
	Hospital at night (task allocation)		Implementation of Hospital at Night software	44	Maximum number of calls to the 2222 number out of hours	Balance	Trajectory																		
							Actual						53		63	54									
					Percentage of tracker data populated		Trajectory						30.0%	50.0%	80.0%	100.0%									
							Actual						39.0%	61.0%	82.0%	100.0%									

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7.1

Executive Summary Our Performance

The Princess Alexandra Hospital NHS Trust

Planned care (Diagnostics, RTT and Cancer Standards)

Performance against the RTT and Diagnostic Standards has been sustained.

Delivery of the key cancer standards continues to be challenging. The Trust achieved five out of the nine standard, although nationally only one standard was met. The issues contributing to this underperformance have been identified as;

Tumour Group	Issues
Gynae	Diagnostic capacity, retirement of MDT co-ordinator
Head & Neck	Complex pathways, Co-ordinator issues at RFH (RFH senior management team aware and working with PAH), poor pathway across multiple centres, pregnancy of patient.
Urology	PAH Nuclear Medicine Scanner out of action, patients referred to Queens. Trans-perineal biopsies and histology delays. Locum clinician not adhering to clinical pathways (no longer at Trust)
Breast	Delays to treatment at Broomfield. Breast outpatient capacity. Complexity of patients.
Lower GI	Colonoscopy capacity, CPET capacity, high number of patients with multiple co-morbidities requiring high level care after surgery.
Generic Issues	Staffing in MDT team Endoscopy: failure of water system to provide cleansing

Predicted standards for the period June- August has been set out below.

		Predicted month		
Type	**Target**	Jun-19	Jul-19	Aug-19
2 Week Wait	**93%**	90.90%	93.00%	93.00%
2 Week Wait (Breast Symptoms)	**93%**	76.50%	93.00%	93.00%
31 Day First Treatment	**96%**	97.70%	97.70%	98.08%
62 Day Standard	**85%**	79.00%	82.00%	81.90%
62 Day Screening	**90%**	86.40%	90.00%	100.00%
62 Day Upgrade	**90%**	90.00%	90.00%	90.00%
31 Day Surgery	**94%**	100.00%	100.00%	100.00%
31 Day Drugs	**98%**	100.00%	100.00%	100.00%

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Executive Summary Our Performance Continued

The Princess Alexandra Hospital NHS Trust

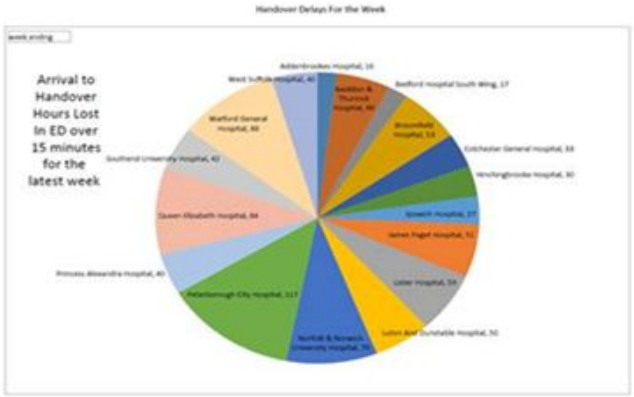
Urgent Care Standard

Whilst our performance against the 4 hour standard improved in June, it was still significantly below the 95% standard, however, we improved compared to May by 4%. The main reasons for the performance were gaps in the medical rota in the Emergency Department which led to delays in patients being seen, and a reduction in patients being seen by the primary care service. Our minors performance improved significantly, and was the best it has been since October 2018

Recruitment plans are in progress for appointing to the vacant posts, with two middle grade doctors commencing in June, and Consultant interviews scheduled for July with two candidates

Our length of stay reduced in June to the lowest level this year, and our Golden Patient implementation has improved our discharges before 12pm by 40%

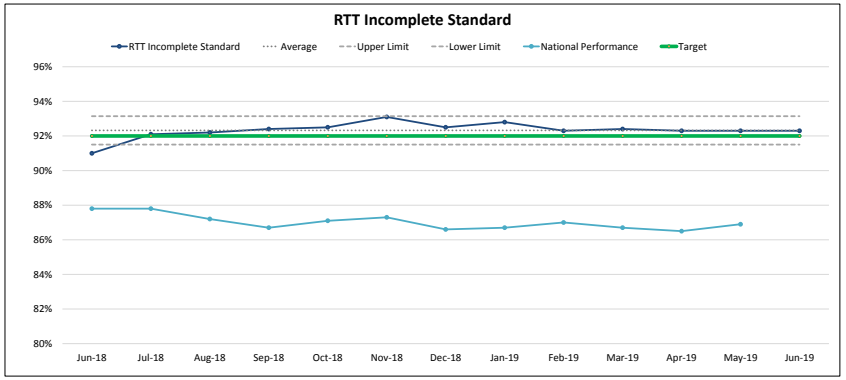
We have continued to see improvements in our ambulance handover times, with a significant improvement in our ability to take patients within the 15 minute standard. This has contributed to a reduction in the longer delays of ambulance handovers, and we continue to be one of the best performing hospitals in the region for handover delays. In June we only reported one handover delay over 60 minutes all month

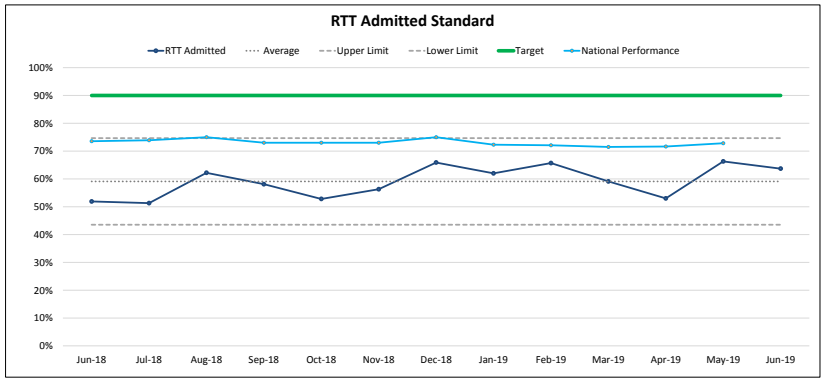


Your future. Our hospital

respectful | caring | responsible | committed

RTT


RTT Incomplete Standard
RTT Incomplete Standard
Average
Upper Limit
Lower Limit
National Performance
Target
96%
94%
92%
90%
88%
86%
84%
82%
80%
Jun-18
Jul-18
Aug-18
Sep-18
Oct-18
Nov-18
Dec-18
Jan-19
Feb-19
Mar-19
Apr-19
May-19
Jun-19


RTT Admitted Standard
RTT Admitted
Average
Upper Limit
Lower Limit
Target
National Performance
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
Jun-18
Jul-18
Aug-18
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Oct-18
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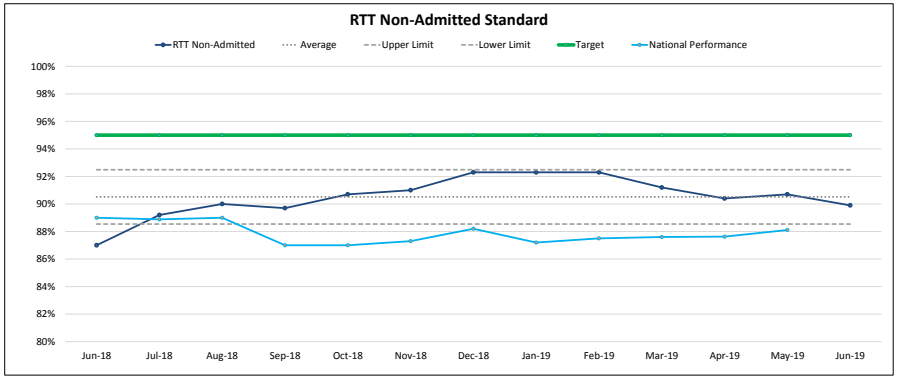
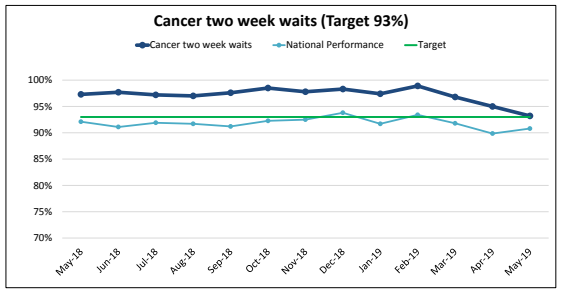
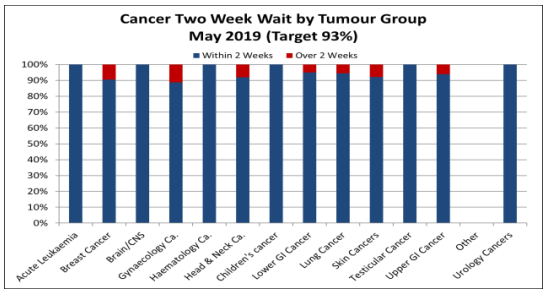
Jan-19
Feb-19
Mar-19
Apr-19
May-19
Jun-19


RTT Non-Admitted Standard
RTT Non-Admitted
Average
Upper Limit
Lower Limit
Target
National Performance
100%
98%
96%
94%
92%
90%
88%
86%
84%
82%
80%
Jun-18
Jul-18
Aug-18
Sep-18
Oct-18
Nov-18
Dec-18
Jan-19
Feb-19
Mar-19
Apr-19
May-19
Jun-19

	Cancer 2 week waits - breast symptomatic	Cancer 31 Day First	Cancer 31 Day Subsequent Drug	Cancer 31 Day Subsequent Surgery
May-18	97.70%	97.40%	100.00%	100.00%
Jun-18	97.70%	100.00%	100.00%	100.00%
Jul-18	98.70%	98.90%	100.00%	N/A
Aug-18	99.40%	95.20%	100.00%	100.00%
Sep-18	99.20%	97.70%	100.00%	100.00%
Oct-18	98.80%	96.70%	100.00%	100.00%
Nov-18	97.30%	96.70%	100.00%	100.00%
Dec-18	96.90%	100.00%	100.00%	100.00%
Jan-19	97.40%	97.00%	100.00%	100.00%
Feb-19	96.70%	97.30%	100.00%	100.00%
Mar-19	86.90%	96.90%	100.00%	100.00%
Apr-19	91.00%	100.00%	100.00%	100.00%
May-19	92.60%	97.80%	92.90%	75.00%

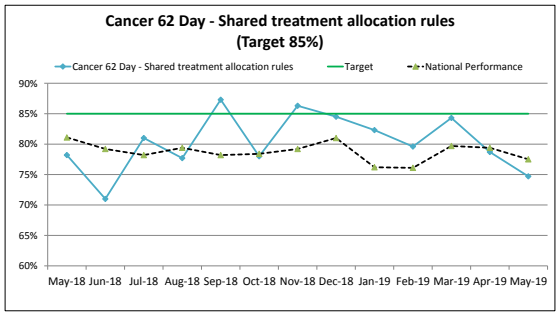
Note: Above heat map colour scale based on green = highest performance to red = lowest performance.

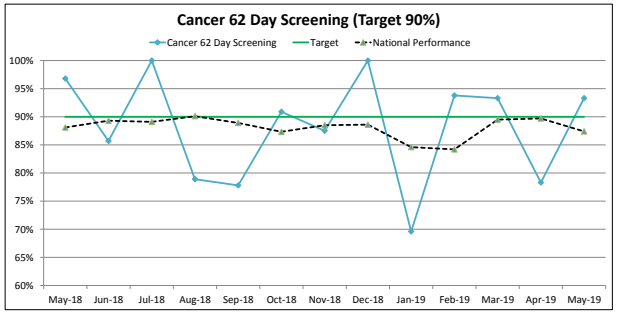


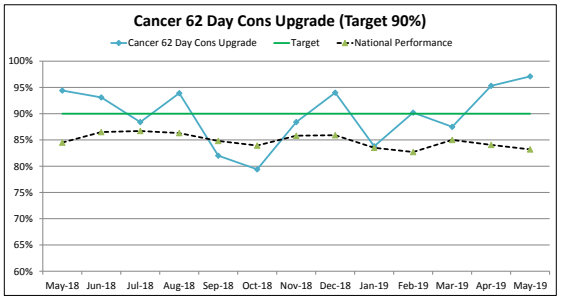


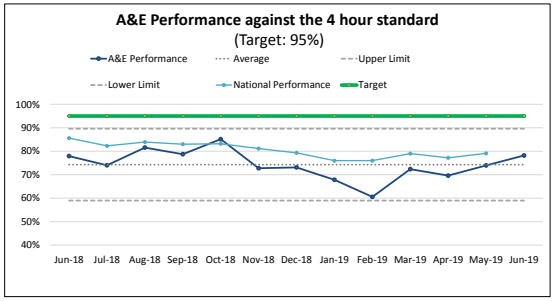
May performance by tumour group

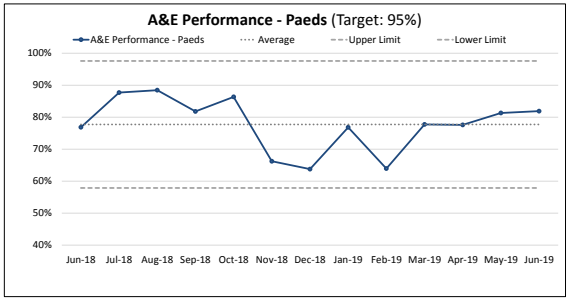
Target Wait Group	14 day target performance %	31d day first seen performance %	62 day standard performance %	62 day Screening performance %	62d CU performance %	31d day subsequent drugs performance %	31d day subsequent surgery performance %
Acute Leukaemia	100.0%						
Breast Cancer	90.5%	91.7%	100.0%	91.7%			100.0%
Brain/CNS	100.0%						
Gynaecology Ca.	88.7%	100.0%	14.3%		88.9%		
Haematology Ca.	100.0%	100.0%	100.0%		100.0%	100.0%	
Head & Neck Ca.	91.8%	100.0%	0.0%		100.0%		
Children's cancer	100.0%						
Lower GI Cancer	94.9%	94.1%	50.0%	100.0%	91.7%	100.0%	0.0%
Lung Cancer	94.4%	100.0%	60.0%		100.0%	100.0%	
Skin Cancers	92.0%	100.0%	100.0%		100.0%		
Testicular Cancer	100.0%	100.0%	100.0%				
Upper GI Cancer	93.9%	100.0%	66.7%		100.0%	100.0%	
Other		100.0%	0.0%		100.0%		
Urology Cancers	100.0%	100.0%	76.9%		100.0%	88.9%	
Total performance	93.2%	97.8%	74.7%	93.3%	97.1%	92.9%	75.0%
Symptomatic Breast Referrals (non Cancer)	92.6%						

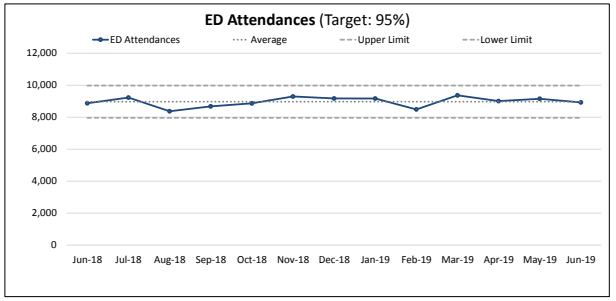


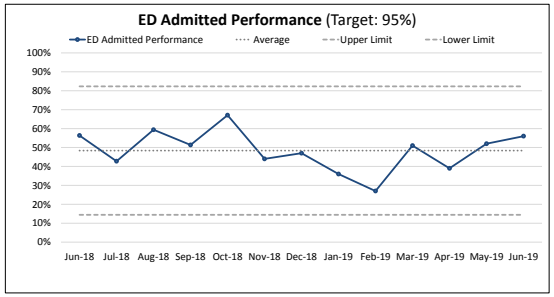


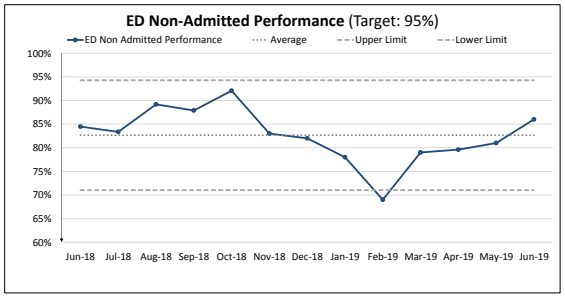






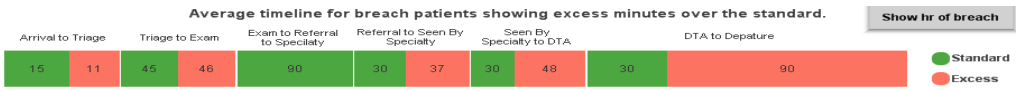


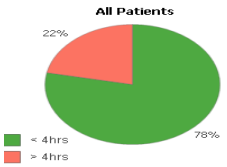




ED Internal Professional Standards

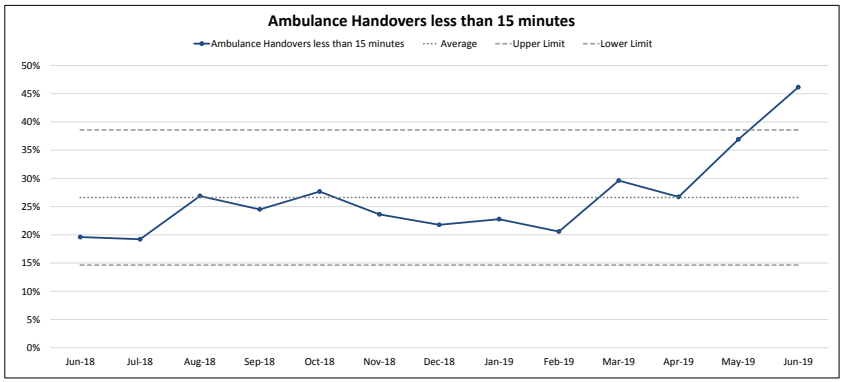
	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19
Arrival to Triage - Average Wait (Minutes)	32	32	28	31	29	36	34	37	43	35	38	33	26
Triage to Exam - Average Wait (Minutes)	98	98	79	82	74	91	94	106	118	106	99	99	91
Exam to Referral to Specialty - Average Wait (Minutes)	75	79	74	78	72	80	83	85	97	81	82	80	82
Referral to Seen by Specialty - Average Wait (Minutes)	66	74	70	69	68	83	82	84	85	73	75	69	67
Seen by Specialty to DTA - Average Wait (Minutes)	87	91	77	86	77	94	97	105	109	82	93	72	78
DTA to Departure - Average Wait (Minutes)	160	201	119	161	123	223	209	312	308	171	197	147	120

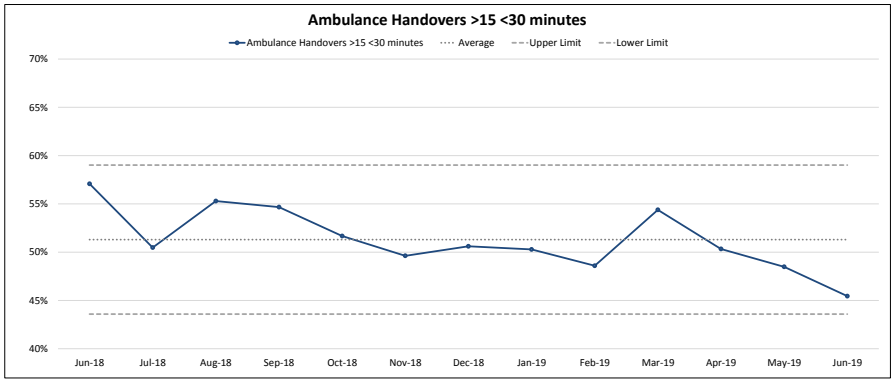


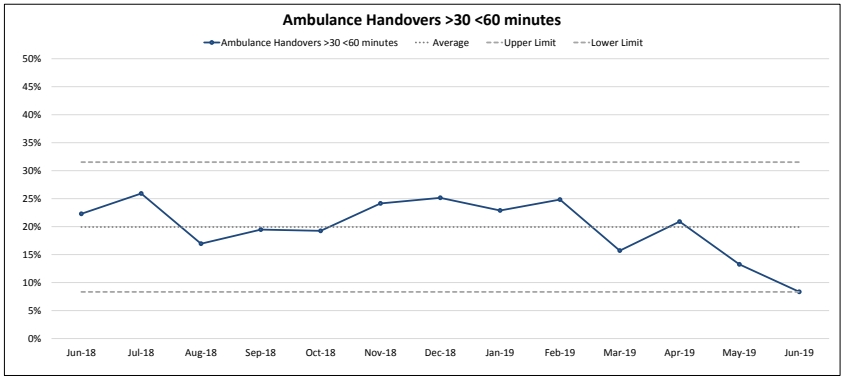


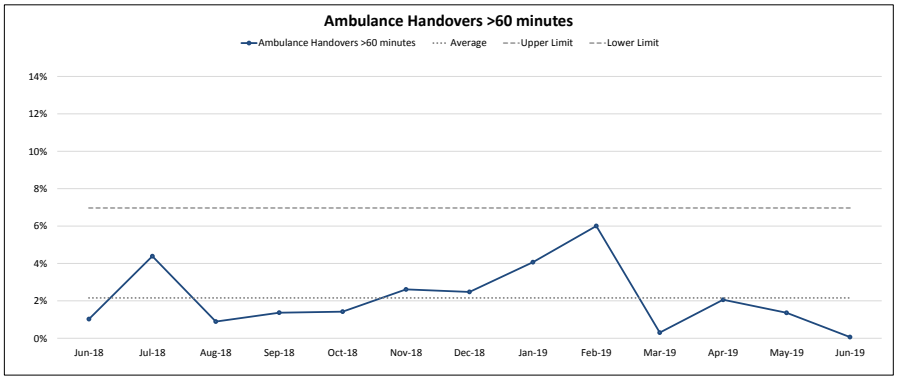
Measure	Standard	Average	Excess	Patients with Timestamp	Patients Who Breached	% Breached	Patients Who Breached Rank
Arrival to Triage	15	26	11	8,660	4,550	53%	
Triage to Exam	45	91	46	7,724	4,374	57%	
Exam to Referral to Specialty	90	82	0	2,526	452	18%	
Referral to Seen by Specialty	30	67	37	2,697	1,693	63%	
Seen by Specialty to DTA	30	78	48	1,606	839	52%	
DTA to Depature	30	120	90	2,335	1,266	54%	

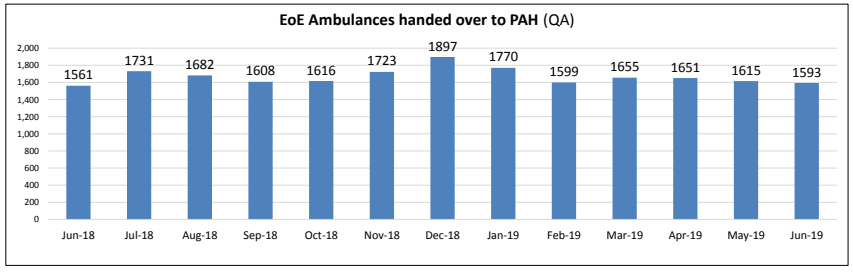
Ambulance


Ambulance Handovers less than 15 minutes
Ambulance Handovers less than 15 minutes
Average
Upper Limit
Lower Limit
50%
45%
40%
35%
30%
25%
20%
15%
10%
5%
0%
Jun-18
Jul-18
Aug-18
Sep-18
Oct-18
Nov-18
Dec-18
Jan-19
Feb-19
Mar-19
Apr-19
May-19
Jun-19

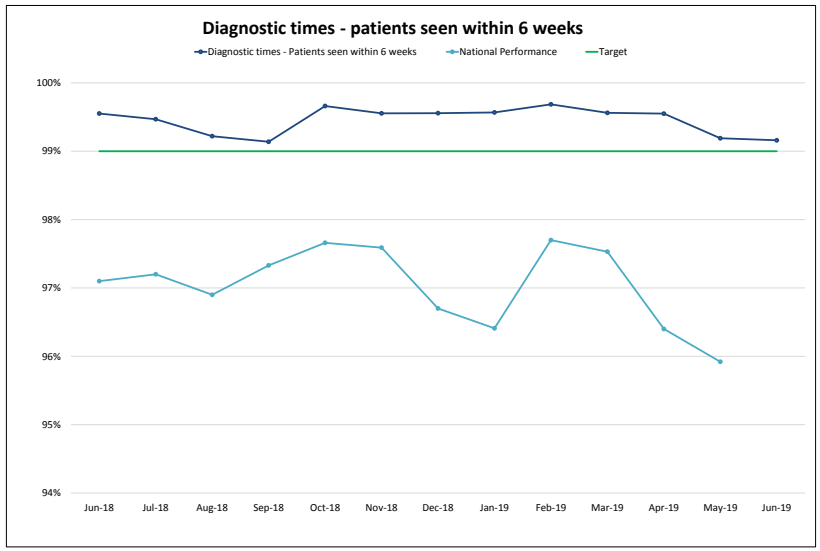

Ambulance Handovers >15 <30 minutes
Ambulance Handovers >15 <30 minutes
Average
Upper Limit
Lower Limit
70%
65%
60%
55%
50%
45%
40%
Jun-18
Jul-18
Aug-18
Sep-18
Oct-18
Nov-18
Dec-18
Jan-19
Feb-19
Mar-19
Apr-19
May-19
Jun-19

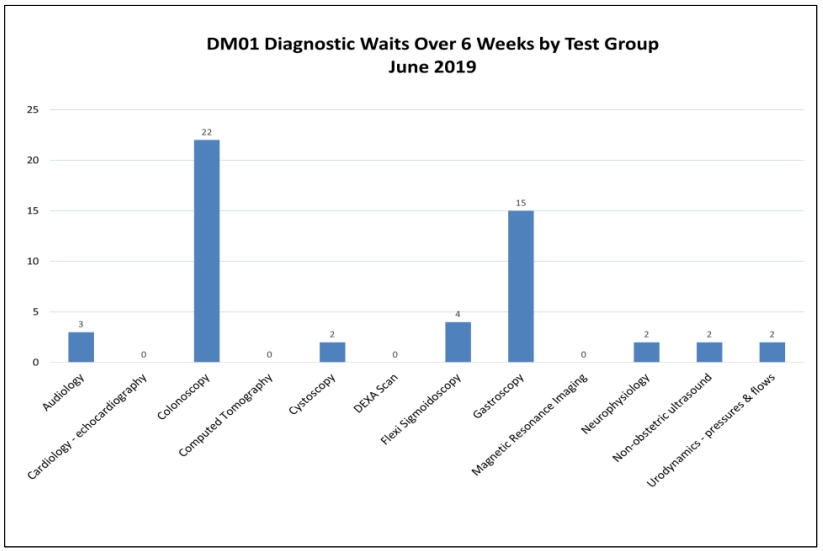

Ambulance Handovers >30 <60 minutes
Ambulance Handovers >30 <60 minutes
Average
Upper Limit
Lower Limit
50%
45%
40%
35%
30%
25%
20%
15%
10%
5%
0%
Jun-18
Jul-18
Aug-18
Sep-18
Oct-18
Nov-18
Dec-18
Jan-19
Feb-19
Mar-19
Apr-19
May-19
Jun-19


Ambulance Handovers >60 minutes
Ambulance Handovers >60 minutes
Average
Upper Limit
Lower Limit
14%
12%
10%
8%
6%
4%
2%
0%
Jun-18
Jul-18
Aug-18
Sep-18
Oct-18
Nov-18
Dec-18
Jan-19
Feb-19
Mar-19
Apr-19
May-19
Jun-19


EoE Ambulances handed over to PAH (QA)
2,000
1,800
1,600
1,400
1,200
1,000
800
600
400
200
0
1561
1731
1682
1608
1616
1723
1897
1770
1599
1655
1651
1615
1593
Jun-18
Jul-18
Aug-18
Sep-18
Oct-18
Nov-18
Dec-18
Jan-19
Feb-19
Mar-19
Apr-19
May-19
Jun-19

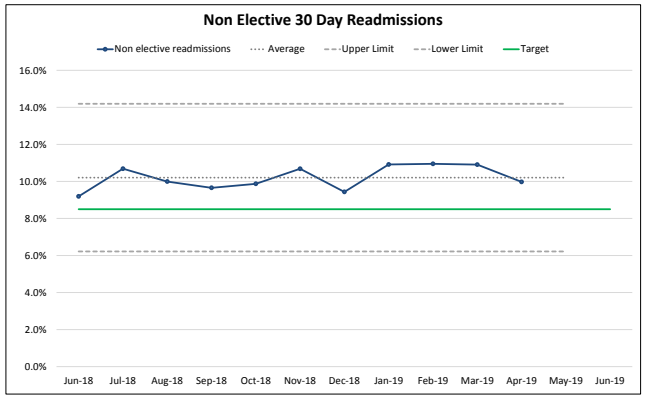
Diagnostics

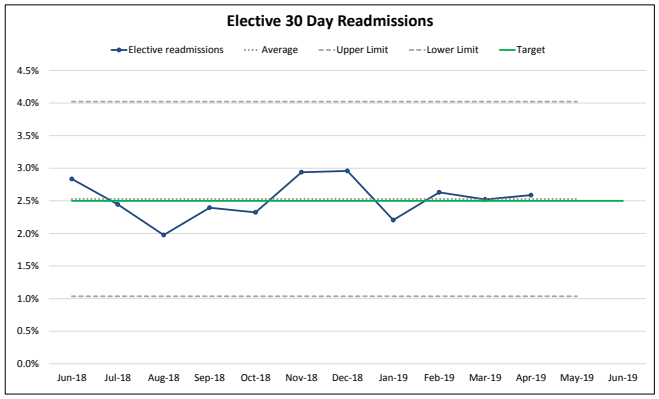


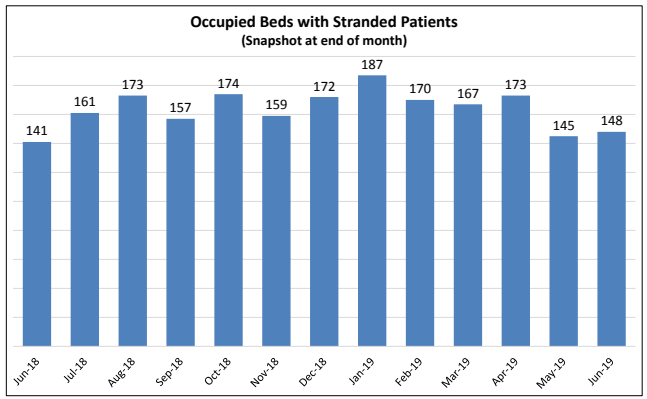


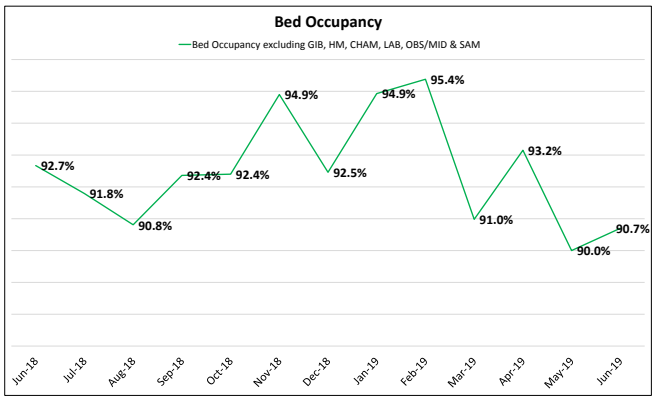
Test	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19
Magnetic Resonance Imaging (MRI)	99.72%	100%	100%	100%	100%	100%	100%	100.00%	100.00%	99.92%	100.00%	99.77%	100.00%
Computed Tomography (CT)	99.41%	100%	99.84%	99.84%	100%	100%	100%	99.51%	99.70%	99.85%	99.73%	99.32%	100.00%
Non-Obstetric Ultrasound	99.96%	99.96%	99.92%	99.92%	99.71%	100%	100%	99.84%	99.66%	100.00%	99.76%	99.92%	99.92%
DEXA	100%	99.28%	100%	100%	100%	100%	100%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
Audiology - Audiology Asessments	98.70%	100%	100%	100%	100%	99%	100%	97.51%	99.04%	98.18%	99.58%	98.50%	98.80%
Cardiology - Echocardiography	100%	98.48%	95.01%	98.20%	100%	100%	100%	100.00%	100.00%	100.00%	99.75%	100.00%	100.00%
Neurophysiology	100%	100%	100%	100%	93.33%	100%	100%	100%	100%	100%	100%	100%	83.33%
Urodynamics	100%	88.89%	96.36%	74.47%	92.68%	57%	80%	70.37%	82.35%	90.00%	86.84%	89.66%	92.59%
Colonoscopy	98.53%	94.97%	97.87%	89.16%	97.35%	99%	96%	98.45%	98.16%	95.24%	96.76%	90.71%	88.11%
Flexi Sigmoidoscopy	100%	100%	95.12%	97.37%	96.97%	98%	96%	97.06%	100.00%	90.91%	97.67%	90.00%	93.10%
Cystoscopy	66.67%	75.00%	100%	96.30%	100%	100%	100%	100.00%	100.00%	94.74%	100.00%	90.91%	92.31%
Gastroscopy	96.40%	93.67%	94.87%	95.19%	97.41%	98%	92%	98.51%	100.00%	95.00%	95.35%	92.52%	88.46%

Readmissions & Stranded Patients

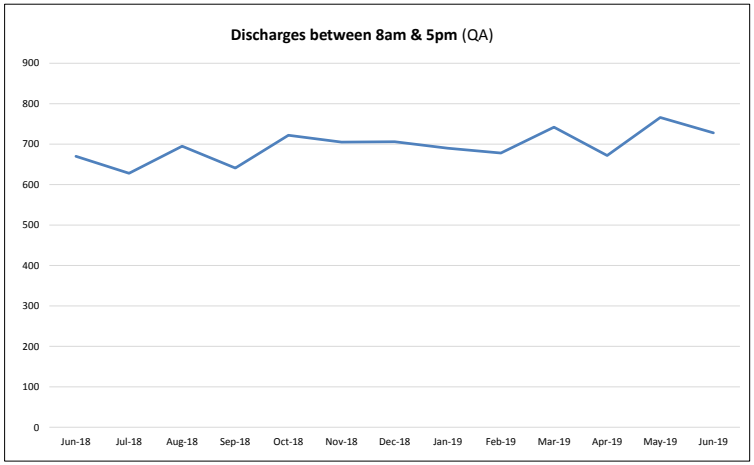


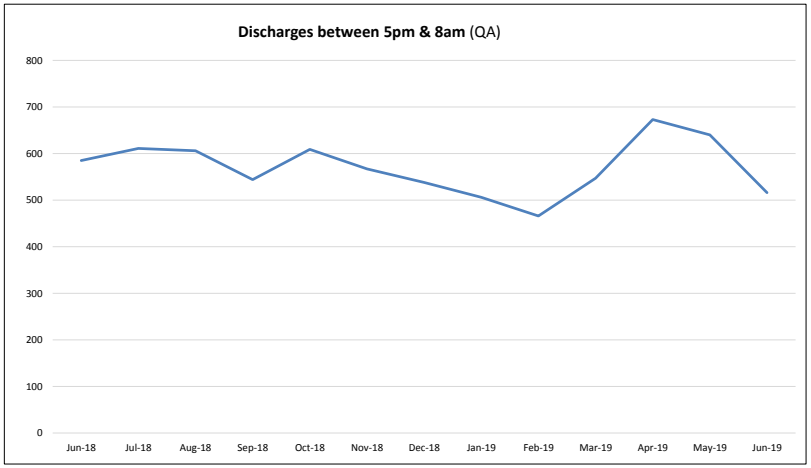


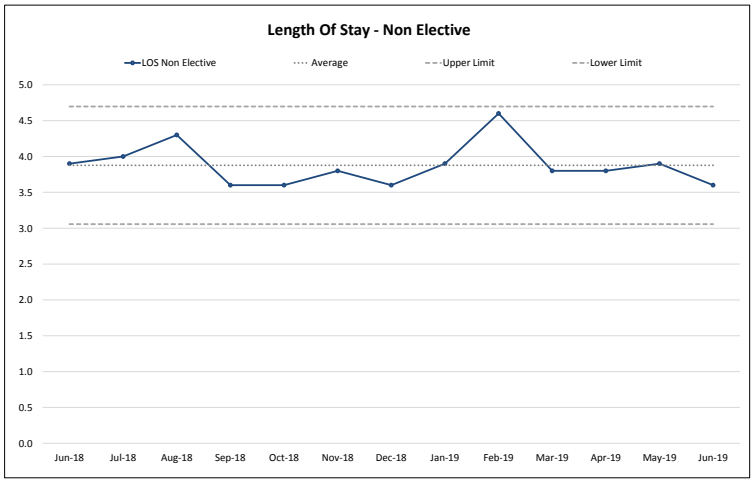


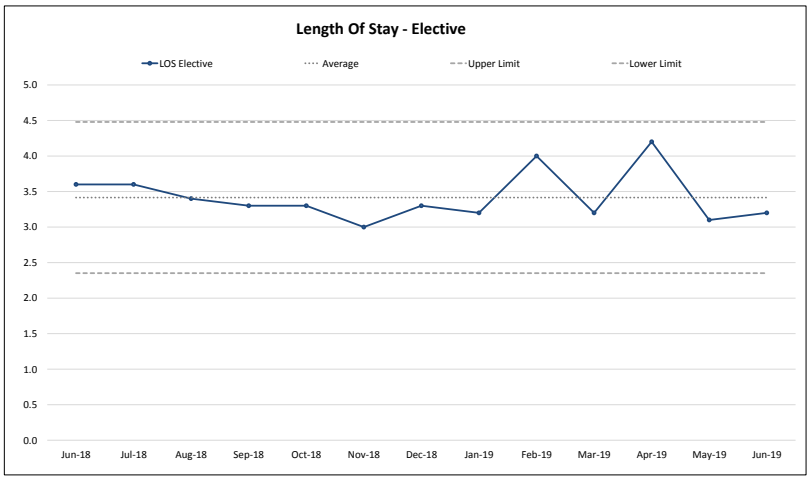


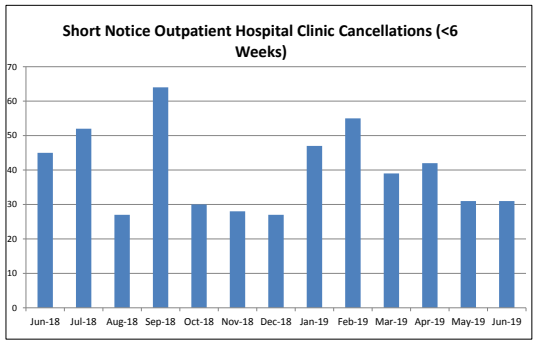
Discharges & LOS

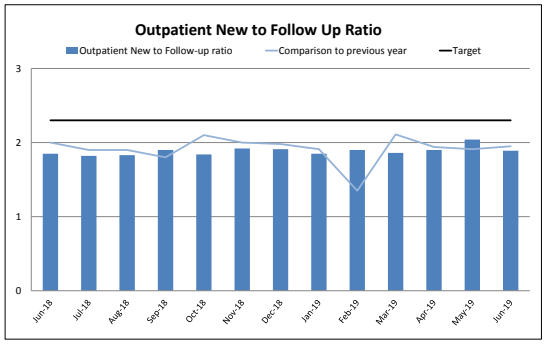


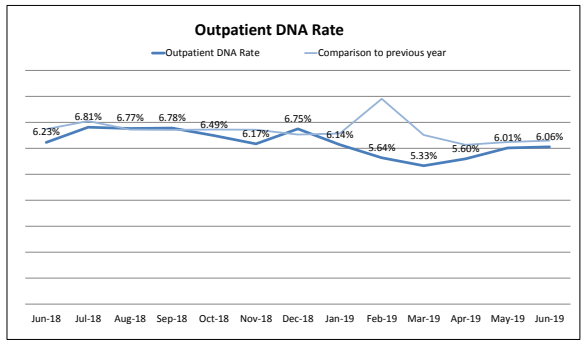


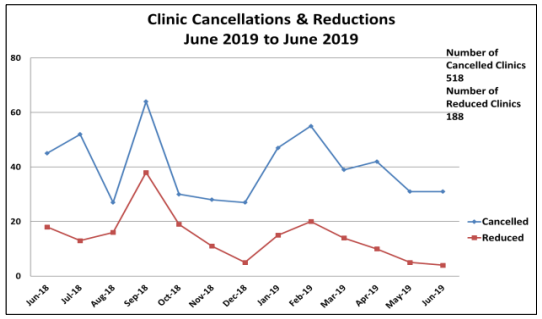


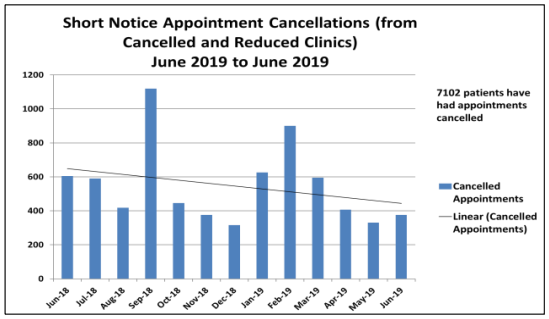


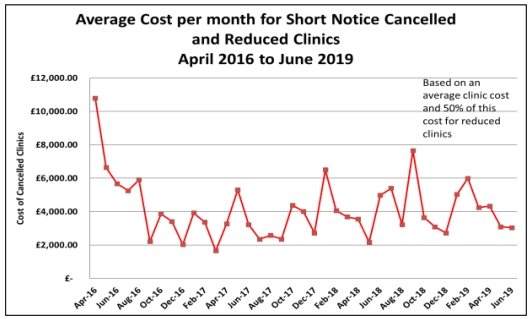












DNA Rate for Follow Up Appointments per Specialty for June

Specialty & Performing Unit	AHP Episode	Anaesthetics	Anticoagulant Service	Breast Surgery	Cardiology	Chemical Pathology	Clinical Haematology	Clinical Oncology	Colorectal Surgery	Community Midwifery	Dermatology	Diabetic Medicine	Dietetics	Endocrinology	ENT	Gastroenterology	General Medicine	General Surgery	Gynaecology	Haematology	Medical Oncology	Medicine for the Elderly	Neonatology	Neurology	Obstetrics	Ophthalmology	Optometry	Oral Surgery	Orthoptics	Paediatric Diabetic Medicine	Paediatrics	Physiotherapy	Respiratory Medicine	Rheumatology	Trauma & Orthopaedics	Urology	Vascular Surgery	Well Baby	Total
DNA Rate	0.00%	0.00%	13.16%	7.65%	5.42%	13.10%	21.05%	1.39%	4.55%	5.19%	5.97%	4.62%	8.82%	5.00%	6.03%	9.43%	0.19%	5.22%	3.66%	4.47%	0.19%	3.23%	3.57%	3.93%	4.10%	9.45%	3.91%	9.05%	5.66%	19.44%	7.64%	8.50%	3.86%	3.92%	8.71%	5.17%	5.36%	3.13%	5.60%

Cancelled Operations	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19
Cancelled Operations for Non Clinical reasons	7	22	17	21	14	8	29	43	39	24	14	22	TBC
Cancelled Operations - breach of 28 day standard	0	0	0	1	2	0	0	3	0	1	1	0	TBC
Urgent operations cancelled (Non Medical)	1	5	0	0	1	0	0	0	0	0	0	0	0
Urgent operations cancelled for a second or more time (Non medical)	0	0	0	0	0	0	0	0	0	0	0	0	0

Figures unavailable at time of publication.

Executive Summary Our People

The Princess Alexandra Hospital NHS Trust

RN recruitment remains an ongoing priority, with rolling adverts for RN Band 5 and HCA.

International Recruitment continues with weekly Skype interviews and the Trust has plan for concerted overseas campaigns over the financial year and into 2020/21 with the focus on reducing the Band 5 vacancy rate to less than 10%.

The Trust attends external events at local Schools, Colleges and Universities, not only to get the name of the Trust known to the public but also as our plan for immediate and long term recruitment.

Mitigation is managed through the daily operational huddles and use of SafeCare. Ward Managers support staffing by working in the numbers which compromises their ability to work in a supervisory capacity.

Redeployment of staff continues to keep all clinical areas safe.

The nursing retention plan continues and key measures are now embedded.

We have increased the promotion of staff health and wellbeing through the use of our app to detail the employee assistance programme and are promoting staff benefits.

Workforce Indicators Summary

Agency Spend 7.07%
Bank Spend 12.36%

Staff In Post
3096
WTE

Training
90%

Sickness
3.4%

13.4%

Medical 95%
Non-Medical 92%

Turnover
13%

Scorecard

Workforce Measures as at 30th June 2019	Trust Target	Trust	CCCS	FAWS	Medicine HCG	Surgery HCG	Estates & Facilities	Corporate	People	Finance
Funded Establishment- WTE		3602.92	864.32	462.45	890.67	756.35	279.18	137.32	56.68	155.95
Vacancy Rate	8.0%	13.37%	5.41%	8.60%	20.96%	19.10%	7.94%	4.40%	14.13%	18.08%
Agency % of paybill	7.0%	7.2%	2.8%	2.7%	17.1%	6.9%	0.0%	0.0%	0.0%	0.0%
Bank Usage - Cost	n/a	£1,954,648	£143,038	£177,118	£950,255	£533,292	£49,844	£33,087	£17,545	£50,470
Agency Usage -Cost	£858,000	£1,119,059	£89,460	£53,119	£758,369	£236,274	£0	£0	£0	£0
Sickness Absence	3.7%	3.4%	3.2%	4.4%	3.2%	2.9%	6.5%	2.4%	2.8%	0.6%
Long Term Sickness	1.85%	1.6%	1.3%	2.5%	1.4%	1.3%	2.9%	1.4%	2.1%	0.0%
Short Term Sickness	1.85%	1.9%	1.9%	2.0%	1.8%	1.7%	3.7%	1.0%	0.7%	0.6%
Rolling Turnover (voluntary)	12%	13.2%	12.2%	14.1%	14.9%	12.5%	9.6%	15.5%	15.7%	15.1%
Statutory & Mandatory Training	90%	93%	97%	90%	90%	91%	93%	97%	94%	97%
Appraisal	90%	92%	95%	82%	93%	92%	91%	97%	88%	92%
FFT (care of treatment) Q2	70%	76%	76%	82%	74%	68%	85%	74%	n/a	n/a
FFT (place to work) Q2	61%	61%	59%	73%	62%	54%	55%	69%	n/a	n/a
Active Job Plans (first sign off)	90%						n/a	n/a	n/a	n/a
Time to hire (Advert to formal offer made)	31Days	46	41	76	49	46	62	41	n/a	n/a

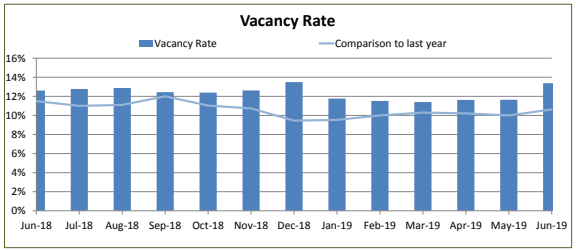
Above target	
provement from last month/above or below target	
Underachieving target	

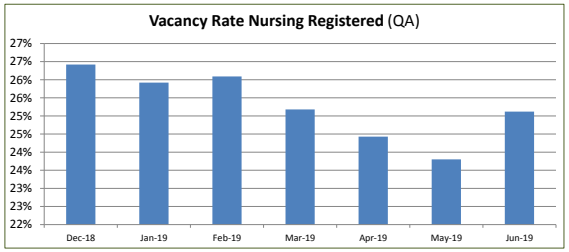
Workforce Indicators

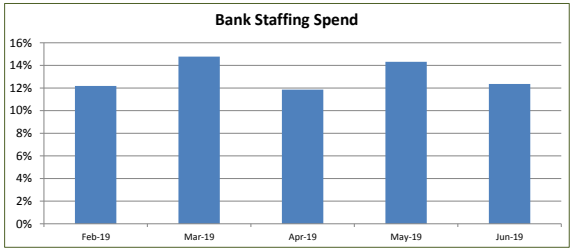
3 Our People Summary

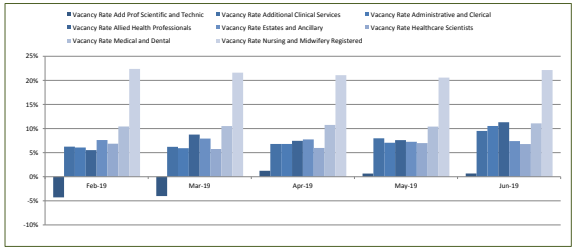
3.3 Well Led

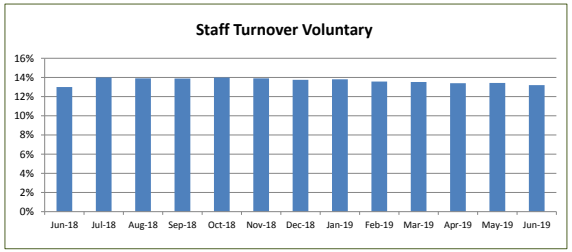
NHS The Princess Alexandra Hospital NHS Trust

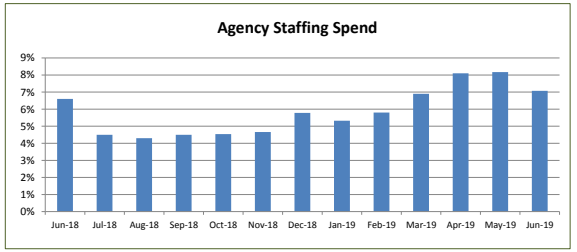


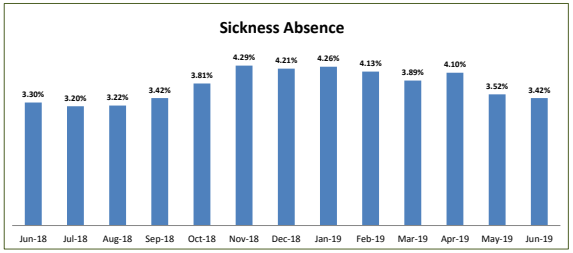


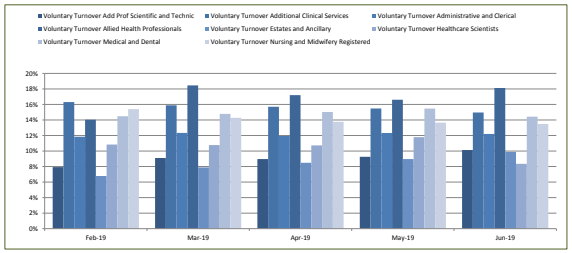


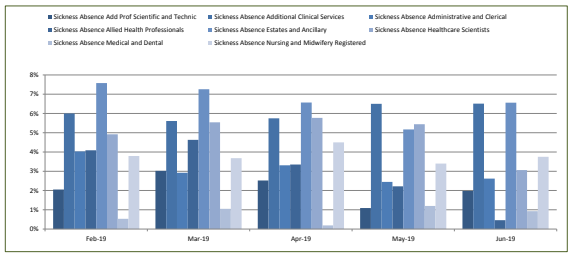




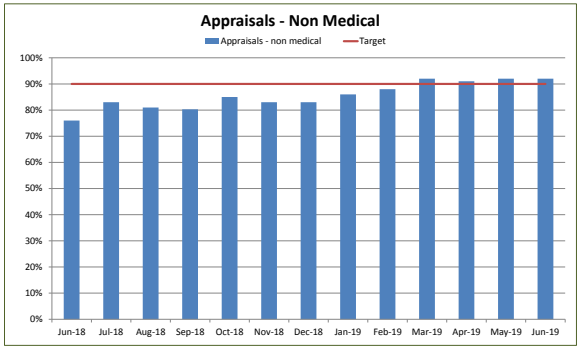


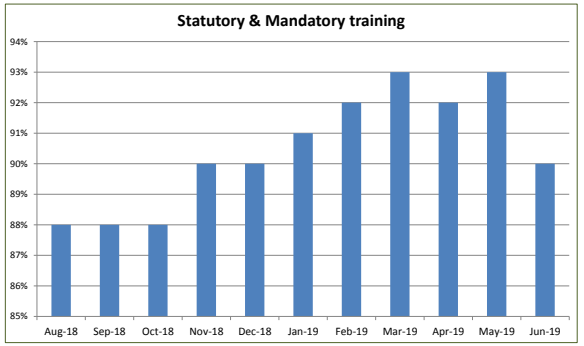


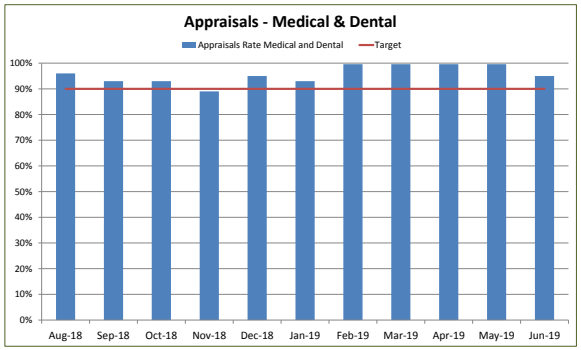


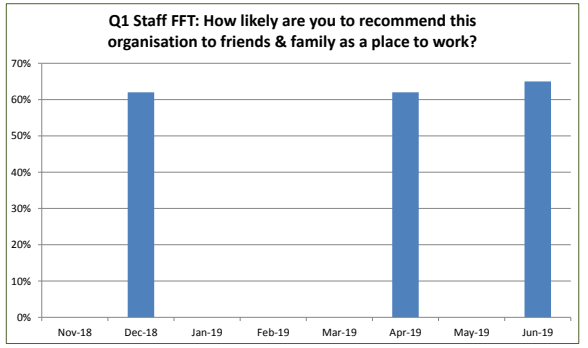


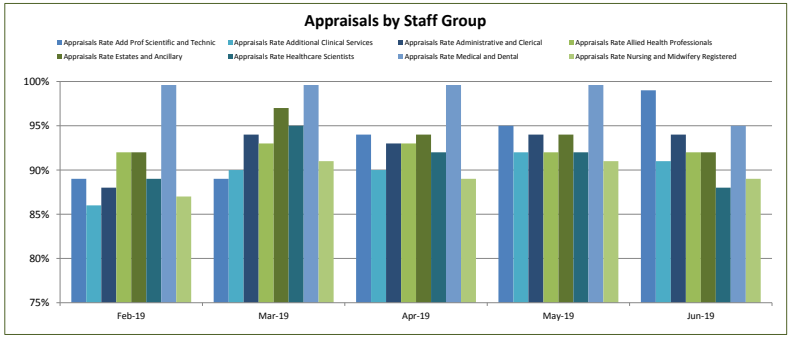
Workforce Indicators

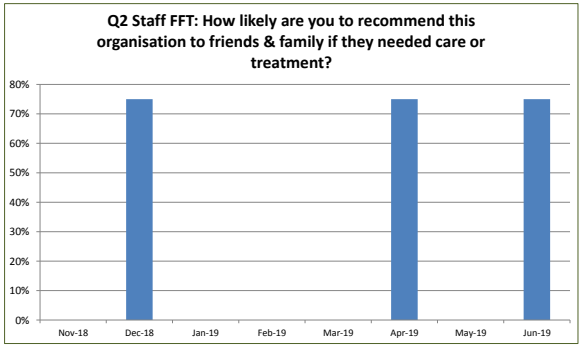












Executive Summary Our Places

The Princess Alexandra Hospital NHS Trust

Domestic Services – All very high and high risk wards and clinic area have been audited this period, together with the continued increased scrutiny on our wards has seen higher standards being sustained regularly. Whilst the number of audits has increased, the number of escalations reduced which has had a very positive impact on the patient care environment, however, it has been necessary to increase staffing levels to achieve this. In July the modernisation of the domestic services will commence, with an anticipated 3 month programme of consultation. In preparedness for the review, it has been necessary to appoint a facilities compliance manager which will realise improved scrutiny across the healthcare groups.

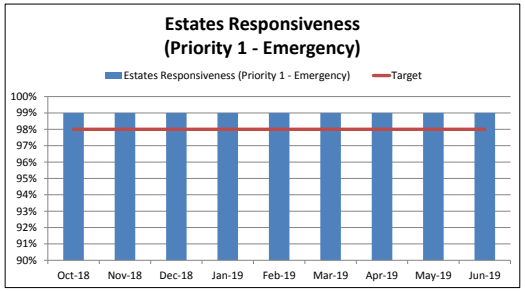
Catering Services – This month has seen an increase of 1,000 meals ordered at ward level and other patient areas, e.g. emergency department, following engagement at ward level with clinical and non-clinical staff we have witnessed a significant reduction in food waste, achieving our target set in April 2019 to reduce waste by a further 3%, which was necessary to achieve national standards. The refinement of the retail offer to visitors and staff has been presented to our executive for amendment, subject to further refinement, it is expected that these changes will take effect in August 2019.

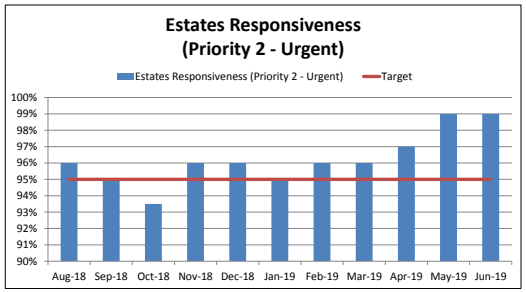
Capital Services – The approved capital programme for 2019/20 is underway, which includes the later phases of the schemes carried forward over two years. In this period works have been ongoing to replace the north-side generator, scheduled for completion in July, however, the installation realised the need to replace the fuel tanks which on inspection by our engineers revealed a fracture. The installation will be completed in September 2019. Other backlog maintenance schemes include the replacement of the air handling units and chiller units in main theatres, which are scheduled for completion in August 2019 and the refurbishment of the Intensive Care Unit which has been delayed because if the need to replace the ventilation system, something which had not been factored in when the scheme was identified. The refurbishment will address the environmental and care environment and create capacity for an additional isolation pod. Enabling works commenced for the repatriation of the fracture clinic from Herts and Essex hospital. The build programme will commence in mid-July and is expected to be completed in 2020.
Furthermore, planning is underway for the development of the investment business cases for a new urgently needed medical assessment unit, urgent care centre, cancer unit and training and administration block. Each of the schemes will be delivered to RIBA level 2, prior to formal submission to the STP as part of wider regional bid for capital investment schemes.

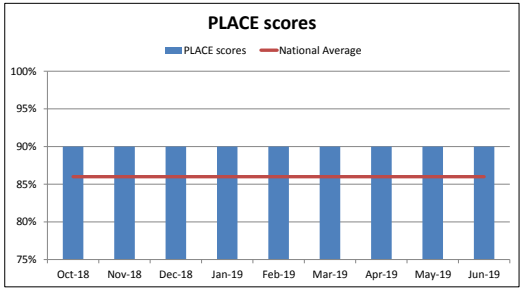
Restructuring – In this period, the strategic head of facilities took up her new position, whose primary role will be to lead on the cost improvement programme, sustainability of services and modernisation programme within the facilities services structure.

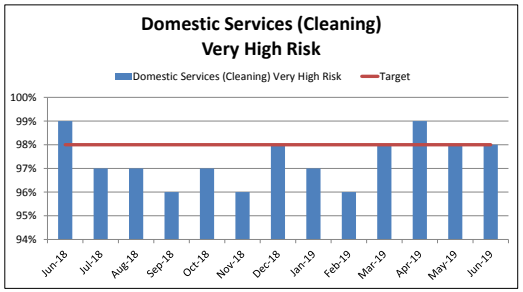
Mandatory Training and Appraisals – for five consecutive months estates and facilities have met the trust's targets for training and appraisals, and in June achieving an average of 93% across both areas of compliance.

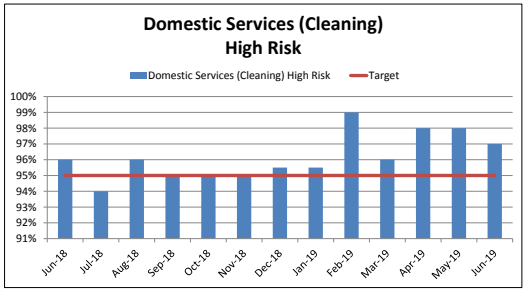
Places

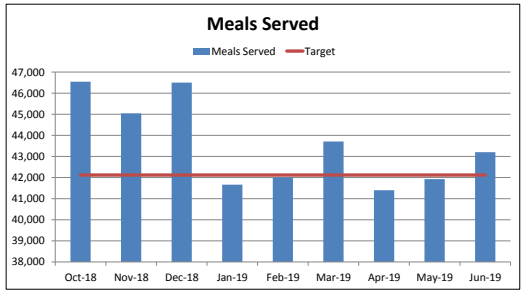

Estates Responsiveness (Priority 1 - Emergency)
Estates Responsiveness (Priority 1 - Emergency)
Target
100%
99%
98%
97%
96%
95%
94%
93%
92%
91%
90%
Oct-18
Nov-18
Dec-18
Jan-19
Feb-19
Mar-19
Apr-19
May-19
Jun-19

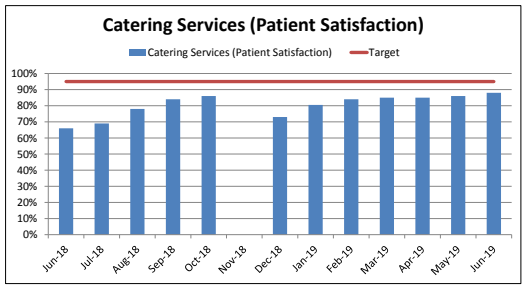

Estates Responsiveness (Priority 2 - Urgent)
Estates Responsiveness (Priority 2 - Urgent)
Target
100%
99%
98%
97%
96%
95%
94%
93%
92%
91%
90%
Aug-18
Sep-18
Oct-18
Nov-18
Dec-18
Jan-19
Feb-19
Mar-19
Apr-19
May-19
Jun-19

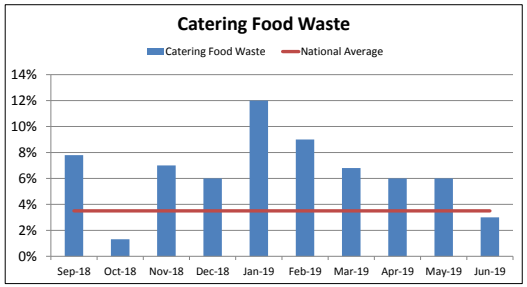

PLACE scores
PLACE scores
National Average
100%
95%
90%
85%
80%
75%
Oct-18
Nov-18
Dec-18
Jan-19
Feb-19
Mar-19
Apr-19
May-19
Jun-19


Domestic Services (Cleaning) Very High Risk
Domestic Services (Cleaning) Very High Risk
Target
100%
99%
98%
97%
96%
95%
94%
Jun-18
Jul-18
Aug-18
Sep-18
Oct-18
Nov-18
Dec-18
Jan-19
Feb-19
Mar-19
Apr-19
May-19
Jun-19


Domestic Services (Cleaning) High Risk
Domestic Services (Cleaning) High Risk
Target
100%
99%
98%
97%
96%
95%
94%
93%
92%
91%
Jun-18
Jul-18
Aug-18
Sep-18
Oct-18
Nov-18
Dec-18
Jan-19
Feb-19
Mar-19
Apr-19
May-19
Jun-19


Meals Served
Meals Served
Target
47,000
46,000
45,000
44,000
43,000
42,000
41,000
40,000
39,000
38,000
Oct-18
Nov-18
Dec-18
Jan-19
Feb-19
Mar-19
Apr-19
May-19
Jun-19


Catering Services (Patient Satisfaction)
Catering Services (Patient Satisfaction)
Target
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
Jun-18
Jul-18
Aug-18
Sep-18
Oct-18
Nov-18
Dec-18
Jan-19
Feb-19
Mar-19
Apr-19
May-19
Jun-19


Catering Food Waste
Catering Food Waste
National Average
14%
12%
10%
8%
6%
4%
2%
0%
Sep-18
Oct-18
Nov-18
Dec-18
Jan-19
Feb-19
Mar-19
Apr-19
May-19
Jun-19

Executive Summary Our Pounds

The Princess Alexandra Hospital NHS Trust

The Trust's YTD deficit is £10.5m, £2.8m worse than plan. Reductions in agency spend and improved CIP delivery has improved the rate of variance. Key drivers of the position are CIP under delivery, temporary staffing costs and under performance in elective and day case activity. As the Trust has not delivered the planned deficit it is not eligible to record YTD Financial recovery or Provider Support funding of a further £3m. In accordance with National and STP requirements the Trust is currently reviewing its capital programme requirements for 19/20.

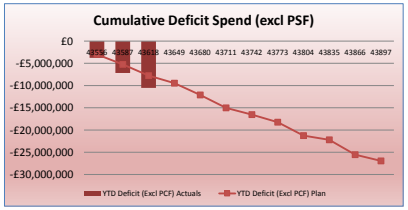
Pounds

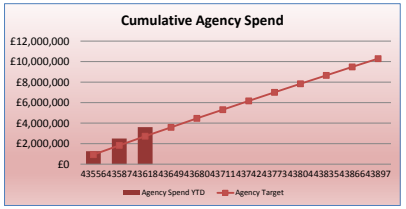
5 Our Pounds Summary

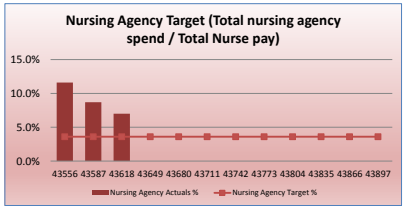
5.1 Overall financial position

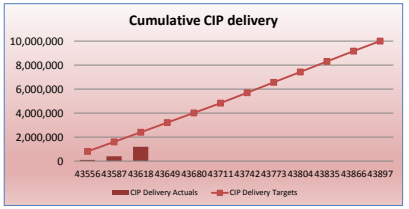
The Princess Alexandra Hospital NHS Trust

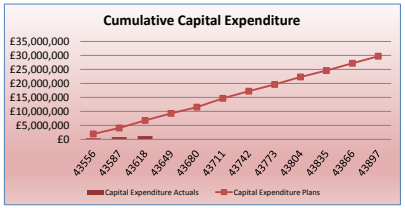
OUR POUNDS		
Metric	Annual Plan (Standard)	Latest Month
YTD Deficit (Excl. PSF)	-£26,942,000	-£10,514,380
Cumulative Agency Spend £s	-£10,292,000	-£3,613,997
Nursing Agency Target (Total nursing agency spend / Total Nurse pay)	3%	7%
Cumulative Capital Expenditure	£29,714,000	£1,184,000
BPPC Volume	95%	85%
BPPC - £s	95%	81%
Cash Balance	£1,000,000	£922,000

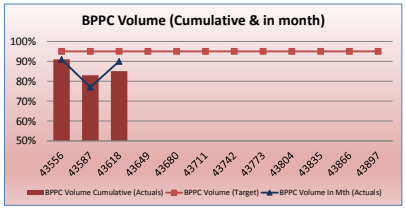


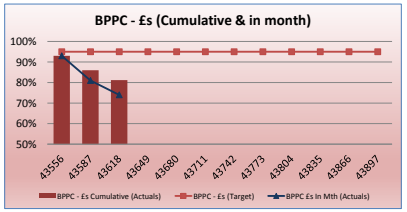


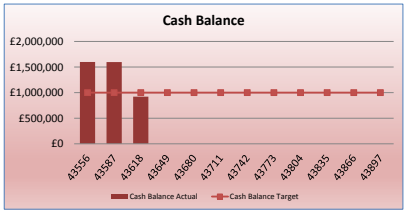












respectful | caring | responsible | committed

Commissioning for Quality and Innovation (CQUIN)

2019/20 CQUIN Performance forecast

			Current Trajectory				
	Scheme	Target	Q1	Q2	Q3	Q4	Max FY Value
CCG1a	Antimicrobial Resistance - Lower Urinary Tract Infections in Older People	90%	0%	61%	75%	90%	244,128
CCG1b	Antimicrobial Resistance - Antibiotic Prophylaxis in Colorectal Surgery	90%	0%	0%	65%	90%	244,128
CCG2	Staff Flu Vaccines	80%				80%	488,257
CCG3a	Alcohol and Tobacco - Screening	80%	80%	80%	80%	80%	162,752
CCG3b	Alcohol and Tobacco - Tobacco Brief Advice	90%	80%	85%	90%	90%	162,752
CCG3c	Alcohol and Tobacco - Alcohol Brief Advice	90%	50%	65%	80%	90%	162,752
CCG7	Three High Impact actions to Prevent Hospital Falls	80%	0%	26%	80%	80%	488,257
CCG11a	Pulmonary Embolus	75%	0%	65%	75%	75%	162,752
CCG11b	Tachycardia with Atrial Fibrillation	75%	75%	75%	75%	75%	162,752
CCG11c	SDEC - Community Acquired Pneumonia	75%	0%	60%	65%	75%	162,752
							2,441,283

CQUIN

The Princess Alexandra Hospital NHS
NHS Trust

Trust Board – 01 August 2019

Agenda Item:	8.1
Presented by:	Chief Executive/Director of Strategy
Prepared by:	Colin Forsyth, Head of Financial Services
Date prepared:	24 July 2019
Subject / Title:	Capital Reprioritisation

Purpose:	Approval		Decision		Information	✓	Assurance	
Executive Summary:	The purpose of this paper is to update the Board on the local impact of the recent national exercise to reprioritise and reduce the 19/20 Capital programme.							
Recommendation:	The Board is asked to note and discuss the proposed 19/20 capital programme following the reprioritisation exercise.							

Trust strategic objectives: [please indicate which of the 5Ps is relevant to the subject of the report]	Patients	People	Performance	Places	Pounds
	✓	✓	✓	✓	✓

Previously considered by:	Executive Team, STP and PAF (July 25)
Risk / links with the BAF:	BAF: 5.1 Concerns around meeting financial plan and cash shortfall.
Legislation, regulatory, equality, diversity and dignity implications:	Statutory requirement to breakeven
Appendices:	Appendix A – Revised 5 yr Capital Programme Appendix B – Capital Letter

8.1

The Princess Alexandra Hospital NHS
NHS Trust

Capital Reprioritisation

1. Purpose

The purpose of this report is to update the Board on the local impact of the National requirement to reduce 19/20 capital spend by at least 20%. In response to this request the STP has co-ordinated an exercise and the Trust has reviewed its schemes to establish which schemes can be deferred into future years.

2. Background

The Trust's opening 2019/20 capital programme totalled **£29.7m**.

The opening Capital programme was comprised of £10.3m of schemes funded by internal capital and £19.4m of scheme intended to be funded by additional Public Dividend Capital PDC and subject to business case approvals. The most significant of the PDC schemes were Additional Capacity £7.5m, Emergency Capital £5m, SOC development £2.8m and STP ICT schemes £3.7m.

The Trust has reviewed the schemes both from an implementation and risk basis. Following this review it is proposed that **£8.2m** of original schemes have been deferred into 20/21. The main schemes deferred are those which remain subject to PDC approvals including £3.5m of the Additional Capacity, £2.8m SOC and £1.8m ICT / STP schemes.

The revised capital programme is therefore **£21.5m**. Of this programme £10.3m remains funded from internal resources and with a revised £11.2m of schemes subject to additional PDC funding and business case submissions.

In addition to the above the Trust has updated the total build PDC requirement relating to the SOC totalling £480m. As part of the PCBC further work continues to agree the phasing of these costs in future years.

Revised Plan	Original Plan £000s	To be Deferred £000s	Revised Investment £000s
SOC	3,210.0	2,800.0	410.0
Additional Capacity (STP Wave 4)	7,414.0	3,534.0	3,880.0
Backlog Maintenance and Estates - General	5,676.0		5,676.0
Backlog Maintenance - Emergency	5,000.0		5,000.0
Equipment Replacement	2,269.0		2,269.0
ICT - General	2,456.0		2,456.0
ICT - STP	3,689.0	1,831.0	1,858.0
	29,714.0	**8,165.0**	**21,549.0**
Funded By			
Internal funding			
Internal Resources (as per original plan)	10,300.0		10,300.0
Donated Assets	105.0		105.0
External Funding			
Wave 4 STP Additional Capacity	7,500.0	3,534.0	3,966.0
Emergency Capital	5,000.0		5,000.0
IT STP	3,534.0	1,831.0	1,703.0
SOC	2,800.0	2,800.0	0.0
LED	475.0		475.0
Total Funding	**29,714.0**	**8,165.0**	**21,549.0**

This impact on the 5 year plan is in appendix A

3. Recommendation

The Board are asked to note the revised 19/20 capital programme and note that 50% of the planned programme is still subject to funding approval.

The Princess Alexandra Hospital NHS
NHS Trust

Appendix 1

The Princess Alexandra Hospital NHS Trust
Capital Programme: 2019/20 to 2023/24

	Original Plan 2019/20	Deferral	Revised Plan 2019/20	2020/21	2021/22	2022/23	2023/24
	£000s	£000s	£000s	£000s	£000s	£000s	£000s
Central							
SOC	**3,210**	2,800	410	2,800	81,429	132,857	265,714
	3,210	**2,800**	**410**	**2,800**	**81,429**	**132,857**	**265,714**
Estates							
Dedicated Space For Fracture Clinic	**2,183**		2,183				
Additional Capacity	**7,414**	3,534	3,880	5,534			
Training/Corporate Centre	**1,800**		1,800				
LED Lighting	**509**		509				
	11,906	**3,534**	**8,372**	**5,534**	**0**	**0**	**0**
Backlog Maintenance							
Backlog maintenance - unassigned	**(197)**		(197)	6,300	6,300	6,300	6,300
Obsolete Electrical Switchgear Replacement	**122**		122				
Chiller Replacement	**155**		155				
AHU Repairs and Replacement	**95**		95				
Lift LOLER Repairs	**104**		104				
Main Lift door repairs all four floors	**364**		364				
ADU Laser Compliant Doors	**30**		30				
Main Theatre Flooring	**49**		49				
ITU / HDU - Minor Works	**70**		70				
Water Safety Remedial Works - MRI	**10**		10				
Waste Compound	**17**		17				
Main Theatres Refurbishment	**36**		36				
Operational Room	**8**		8				
Harold Ward 5 Bed Bay	**17**		17				
North Side Generator	**140**		140				
Upgrade Main ITU	**164**		164				
	1,184	**0**	**1,184**	**6,300**	**6,300**	**6,300**	**6,300**
2019/20 Backlog - Emergency Monies (£5m)							
Emergency Monies (future years)	**0**		0	5,000	5,000	5,000	5,000
Cancer Services - William's Day Unit	**1,800**		1,800				
Plumbing and Sewerage (main block)	**1,000**		1,000				
Heating and Hot Water (statutory)	**500**		500				
St Margaret's OPD Compliance	**500**		500				
Flat Roof (ADSU and Maternity)	**900**		900				
Fire Compartmentalisation(Zone A) and Ventilation	**300**		300				
	5,000	**0**	**5,000**	**5,000**	**5,000**	**5,000**	**5,000**
Wave 5 STP Bids							
Backlog Maintenance				77,700	6,300	6,400	2,100
Outpatient Services				1,100	1,100	1,100	1,100
Transformation of Day Case Services				4,600	5,400	0	0
Frailty Assessment Unit				6,000	0	0	0
Electronic patient Record (EPR)				30,000	0	0	0
Aseptic Unit replacement				1,200	0	0	0
Realignment of surgical services				3,800	1,500	0	0
Transitional Care Unit				2,000	0	0	0
Pathology Acute service reconfiguration				25,500	0	0	0
	0	**0**	**0**	**151,900**	**14,300**	**7,500**	**3,200**
Equipment							
CCCS	**1,628**		1,628				
FAWS	**95**		95				
Medicine	**330**		330				
Surgery	**205**		205				
Other	**11**		11	2,000	2,000	2,000	2,000
	2,269	**0**	**2,269**	**2,000**	**2,000**	**2,000**	**2,000**
ICT - Internal							
IT general	**0**		0	1,800	2,000	2,000	2,000
NHS mail	**132**		132	0			
HSCN	**24**		24				
End User Device Replacement	**250**		250				
Replacement Switchboard	**300**		300				
Digital Messaging (ISOLON)	**400**		400				
Windows 10 Upgrade	**150**		150				
Ardentia Data Warehouse	**200**		200				
network Data Storage	**500**		500				
EPR Business Case Development	**500**		500				
	2,456	**0**	**2,456**	**1,800**	**2,000**	**2,000**	**2,000**
ICT - STP wide							
EPR Development	**811**	411	400	961			
My Care Record	**366**	182	184	432			
Medicine Management	**585**	128	457	278			
Interoperability	**1,927**	1,110	817	2,547			
	3,689	**1,831**	**1,858**	**4,218**	**0**	**0**	**0**
	29,714	**8,165**	**21,549**	**179,552**	**111,029**	**155,657**	**284,214**

8.1

To:
Provider Chief Executives
Provider Finance Directors

Julian Kelly

Chief Financial Officer

NHS England & NHS Improvement
Skipton House
80 London Road
SE1 6LH

England.chieffinancialofficer@nhs.net

Date 7 May 2019

Dear Colleagues

Capital Planning 2019/20

I am writing, as the new NHSE/I Chief Financial Officer, to ask for your support in helping to collectively manage capital expenditure across the NHS in 2019/20. I recognise the very significant pressures providers are facing in terms of the need to spend capital to ensure the provision of safe and high quality patient care and the amount of pent up demand for capital spending we now have throughout the provider sector.

Overall, the NHS capital expenditure limit for 2019/20 is higher than last year. Provider self-financed capital expenditure, including that financed through borrowing from DHSC or externally, scores against this limit as well as spending funded through central DHSC grants and centrally run programmes. The most recent provider plans, somewhat understandably, include a significant increase in forecast capital expenditure compared to last year funded by trust cash balances as well as emergency loan requests. This level of capital spend would lead to the NHS unacceptably breaching its capital spending limit.

NHS England & NHS Improvement and DHSC are currently revisiting all capital budgets, including those held centrally, to ensure we identify all of the flexibility available to us nationally. However, as the majority of NHS capital is spent in the provider sector, we will also need your support and help to ensure we stay within the NHS capital limit – a particularly important requirement in a Spending Review year when future capital spending limits are likely to be agreed with the Treasury.

As a first step we want to work with you to ensure that provider capital plans are both affordable – within the limit set by the Treasury and Parliament – and robust. This will need a more planned, proactive and collaborative approach to managing capital spending than we have had before.

As a starting point we would like to ensure that, together, we create a realistic opening plan position for each provider that has been carefully reviewed by each provider leadership team, supported as needed by NHSE/I regional teams. It's vital that these plans are realistic and deliverable and only contain expenditure based on defined funding sources that have already received approval. Any additional requirements for external borrowing, including DHSC borrowing, should be minimised to absolutely urgent and critical expenditure that needs to be incurred in 2019/20, with a clear view on why this cannot be provider self-financed.

If we are to keep to the capital limit set for the NHS, we will need to carefully prioritise the capital that we do spend. I would therefore like to ask that you consider deferring expenditure which is not deemed to be essential or already contractually committed into future years. We will need to recognise where spending is deferred so that we can take account of it in discussions with DHSC and HMT on future capital spending.

I want to avoid continuous, unnecessary, resubmission of planning spreadsheets as each one will require significant work at your end, but we do need all providers to resubmit their 2019/20 capital plans on 15 May 2019 as part of the agreed final operational plan resubmission:

- Please submit your updated operating financial planning template incorporating the revised capital plans (or resubmit your financial planning template confirming that no changes have been made).
- As part of this plan resubmission process we are unable to accept plans with deteriorations to the financial position submitted on 4 April 2019. We are also unable to accept plans that increase capital expenditure.
- Please submit revised activity, workforce and triangulation operating plan templates to reflect all impacts of revised capital plans (or resubmit your activity, workforce and triangulation planning templates confirming that no changes have been made).

We will obviously welcome any reduction in planned levels of capital expenditure and I want to reinforce that, should you make such a reduction, no adverse judgement will be made on the quality or accuracy of the original plan.

We are hoping that these resubmitted plans will significantly close the current gap between the allocated NHS capital limit and current plans, but the current gap is sufficiently large that we suspect there will still be further work to do. If this is the case we are, following provider feedback on how to proceed, likely to ask providers to work together across their STP to prioritise the most important and urgent capital needs in their local health systems. We are keen to avoid imposition of a top down set of capital controls. Asking you to work together to make the best use of available capital to serve the needs of your local populations feels a much more preferable option. But we need this approach to work, and at rapid pace. If necessary, further

information on this will be set out in due course. We will also consider whether, on the basis of your revised capital plans, further short-term in-year control measures are necessary.

I know you will want as much certainty on what capital you will able to spend in 2019/20 as quickly as possible. But, until we have been able to complete this exercise, providers should not commence spending on capital schemes in advance of having a secured funding source for that scheme or an approved business case.

More widely I recognise the need, as set out in the Long Term Plan, to develop a new capital and associated cash support and control regime as an urgent priority. I am very keen to work collaboratively with you and other stakeholders on a new regime. We will therefore be engaging with you on this work over the next few months.

I would also like to thank you and your teams for all the work on 2019/20 plans. I look forward to working closely with you, on this and a range of other issues, as I take up my new role.

Please let me know if you have any thoughts or input on the above approach.

Yours sincerely,

Julian Kelly

Chief Financial Officer
NHS England & NHS Improvement

Cc:
Simon Stevens, Chief Executive, NHSE
Lord David Prior, Chair, NHSE
Ian Dalton, Chief Executive, NHSI
Baroness Dido Harding, Chair, NHSI
Regional Finance Directors, NHSE/I
David Williams, Director General, DHSC

The Princess Alexandra Hospital NHS Trust

BOARD OF DIRECTORS

MEETING DATE: 01/08/19 **AGENDA ITEM NO: 9.1**

REPORT TO THE BOARD FROM:	Workforce Committee
REPORT FROM:	Pam Court – Committee Chair
DATE OF COMMITTEE MEETING:	22/07/019

SECTION 1 – MATTERS FOR THE BOARD'S ATTENTION
The following are highlighted for the Board to note or to take action:
• Statutory and mandatory training compliance and appraisal rates continue to be above 90%. • The NHSP contract was reviewed; further discussion will take place following PAF's review of the contract. • Communications plan received and progress noted. • BAF risks 2.1, 2.2 and 2.3 were discussed: WFC agreed the risk score for 2.1 Nurse Recruitment (16), agreed the closure of Risk 2,2 Internal Communication following review of the Communication update and action plan, and agreed the new risk 2.3 Inability to recruit, retain and engage our people. The risk score is 12 and WFC suggested that medical vacancies are highlighted in the detail of the risk. • The NHS People Strategy and Plan was discussed and the reporting structure was approved. • The Committee discussed the outcome of the annual effectiveness review; improvements in attendance as well as the workforce dashboard were noted. The overall scoring reflects that the Committee is effective (all questions were assigned a score of 2 (good).
SECTION 2 – ITEMS FOR THE BOARD'S INFORMATION AND ASSURANCE
The following are highlighted for the Board's awareness and/or assurance:
The committee also received the following reports: Workforce Report (Targets and Performance), Temporary Staffing, Safer Staffing, Training and Education, Voluntary Services Update, Medical Revalidation report and a report from the People Board.
SECTION 3 – PROGRESS AGAINST THE COMMITTEE'S ANNUAL WORK PLAN
The Committee's progress against its Annual Work Plan is set out below:
The Committee is making good progress against the work plan and agreed to receive the next Nursing Establishment review in September 2019.

9.1

The Princess Alexandra Hospital NHS
NHS Trust

BOARD OF DIRECTORS

MEETING DATE: 1 August 2019 **AGENDA ITEM NO: 9.1**

REPORT TO THE BOARD FROM: Performance and Finance Committee (PAF)
REPORT FROM: Andrew Holden - PAF Chairman
DATE OF COMMITTEE MEETING: 25.07.19

SECTION 1 – MATTERS FOR THE BOARD'S ATTENTION
The following are highlighted for the Board to note or to take action:
• Finance - Q1 results were discussed; year to date the deficit is £10.5m which is £5.8m worse than plan. £3m relates to PSF/FRP and £2.8m to pay and shortfall on CIP delivery. Capital reprioritisation has occurred and takes the plan from £29.7m to £21.5 with majority of deferred schemes relating to schemes where funding has not yet been secured. A recovery plan is being developed and PAF has requested a forecast outturn following which scoring of the finance BAF risk will be reviewed (currently scoring 15). • PAF received an update on the New Hospital and PCBC; this will be discussed at Board. • PAF discussed the EPR outline business case and agreed that some further work was needed in terms of costs. Further updates will be presented to PAF going forward. • PAF supported the changes to the BAF risks and closure of Risk 4.1 Supporting functions. • The Committee's annual effectiveness review was discussed; areas requiring improvement (timely despatch of papers and rationalisation of length of papers) will be addressed on an ongoing basis.
SECTION 2 – ITEMS FOR THE BOARD'S INFORMATION AND ASSURANCE
In addition to the above, PAF received reports on the following agenda items: Data Quality, IM&T report, Health and Safety report, STP Wave 4 Capital update, Estates and Facilities update, Procurement update
SECTION 3 – PROGRESS AGAINST THE COMMITTEE'S ANNUAL WORK PLAN
The Committee continues to make good progress against the workplan.

9.1

The Princess Alexandra Hospital NHS
NHS Trust

BOARD OF DIRECTORS

MEETING DATE: 1 August 2019 **AGENDA ITEM NO: 9.1**

REPORT TO THE BOARD FROM:	Quality & Safety Committee (QSC)
REPORT FROM:	John Hogan
DATE OF COMMITTEE MEETING:	26 July 2019

SECTION 1 – MATTERS FOR THE BOARD'S ATTENTION

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

Items for escalation to the Board:

QSC reviewed the Maternity Incentive Scheme and action plan and recommended it to Board for approval (Board agenda item 5.4).

QSC discussed the Maternity SIs and accompanying action plan and noted this would be discussed further at Board on 01.08.19.

QSC discussed the Committee's annual effectiveness review and identified the following areas for improvement: length of the agendas, rationalising the number of attendees, the volume and length of papers as well as implementation of actions within agreed target dates. A review of the groups reporting to PS&Q and QSC will be undertaken and additional actions to address areas of improvement were agreed.

QSC received the R&D annual report which is attached as Appendix A.

BAF risk 1.1 was reviewed by QSC and members agreed the scoring should remain at 16.

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

Other items discussed:

QSC also received the following reports: Healthcare Group Quarterly Performance Report – Surgery M3 Integrated Performance Report (IPR), Mortality Improvement Programme, Safer staffing (Hard Truths), Monthly Quality, Safety & Effectiveness Report, Monthly Report from Patient Safety & Quality Group, Nutrition & Hydration Update, Patient Experience Report, Update from Patient Panel, 15 Steps Update (6 monthly), Research & Development Annual Report, Clinical Compliance Readiness 2018/19, CQC Insight Report, Draft Infection Control Annual Report (for Board in September 2019).

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

The Committee is making good progress against its work plan.

Trust Board (Public) – 01.08.19

Agenda Item:	9.1
Presented by:	Chris Cook – Head of Research, Development & Innovation
Prepared by:	Chris Cook – Head of Research, Development & Innovation
Date prepared:	Monday 15th July, 2019
Subject / Title:	R&D Annual Report

Purpose:	Approval		Decision		Information	X	Assurance	X

Executive Summary: [please don't expand this cell; additional information should be included in the main body of the report]	This paper is an annual report for the Quality & Safety Committee, giving an overview of the activity for 2018/2019 at both local and national level.
Recommendation:	The Board is assured of Research Delivery, Governance, Activity and Financial Probity.

Trust strategic objectives: [please indicate which of the 5Ps is relevant to the subject of the report]	Patients	People	Performance	Places	Pounds
	X	X	X		X

Previously considered by:	The Research, Development & Innovation Group QSC.26.07.19
Risk / links with the BAF:	A Trust that is not research active will not attract the staff required to sustain the existing Principles, Value and Objectives of both the Trust and the NHS. Non participation in research could lead to a loss in reputation and commercial income and therefore impact on future opportunities.
Legislation, regulatory, equality, diversity and dignity implications:	All research involving patients must be National Research Ethics Service (NRES) and Health Research Authority (HRA) approved prior to consideration at the Trust and MHRA approved if the trial involves medicinal products. All staff must be GCP (Good Clinical Practice) trained if involved in Clinical Trials involving Medicinal Products, or if they are research naïve.
Appendices:	APPENDIX A – Research, Innovation & Development Annual Report for 2018/2019 APPENDIX B – Quarterly Report – Medicine Healthcare Group

1.0 PURPOSE/ISSUE

For the Quality & Safety committee to be informed of Research delivery, governance activity and financial probity.

2.0 BACKGROUND

Health research is highly regulated. Clinical trials, medical device studies, use of patient data, professional qualifications, access to and treatment of NHS patients and other aspects of research studies are regulated by EU Directives, UK Legislation and Professional standards of good practice. The Medicines for Human use Regulations Authority (MHRA) regulate trials of medicines for example. The Department of Health's UK Policy Framework Research sets out principles of good practice in the management and conduct of health and social care research that take appropriate account of legal requirements and other standards. These principles protect and promote the interest of patients, service users and the public in health and social care research, by describing ethical conduct and proportionate, assurance-based management of health and social care research, so as to support and facilitate high-quality research in the UK that has the confidence of patients, service users and the public.

A quality research culture, where excellence is promoted with strong research leadership and expert management, is essential to understand, apply standards, principles and requirements correctly.

The Trust currently participates in National Institute for Health Research (NIHR) portfolio adopted research as well as non-portfolio activity, which may consist of direct links to pharmaceutical companies, or as part of staff programmes of education. The Trust are members of the North Thames Clinical Research Network (NT CRN), who support the Trust with essential funding to make research happen, monitoring the activity within the Trust and benchmarking against co-members and national metrics.

PAHT also have links with University College London Partnership (UCLP), who support research at the Trust via NT CRN. There are further opportunities for commercial trials through direct contact with Industry and IQVIA (formerly Quintiles), a provider of Biopharmaceutical and commercial outsourcing for Clinical Trials.

R&D generates income from NT CRN. This provides income for year on year fixed term contracts for the research workforce, as well as funding for support services.

3.0 PROPOSAL

The Quality and Safety Committee to have information available to them regarding the activity and progress of Research & Innovation activities across the Trust during the period 2018/2019. Please see Appendix A

4.0 ADDITIONAL HEADINGS (IF REQUIRED)

Risks

A Trust that is not research active will not attract the staff required to sustain the existing Principles, values and Objectives of both the Trust and the NHS.

Non-participation in research could lead to a loss in reputation and therefore impact on future opportunities.

Resources Required

Research Workforce, Network Funding, Commercial Funding and the support of the Trust Board.

Next Steps or Timeline

Continue to work to national regulatory standards and metrics, whilst continuing to adapt with the national research agenda.

The 5 Ps of Research

Our Patients – for the local population to have access to new, innovative treatment and for every patient to have the opportunity to participate in a research trial.

Our People – to work together and with the extended team(s) across the Trust to deliver new, innovative, quality treatment to patients.

Our Performance – to grow research year on year, to achieve a growth in funding and enable further studies to be delivered to the local population.

Our Places – to work together to develop one clinical trials unit, where patients and research staff can work together and have access to clinical space.

Our Pounds – to deliver high quality research time to target, attracting commercial sponsors to the Trust, sharing the proceeds according to the Research Strategy.

5.0 RECOMMENDATION

For the Board to be assured that:-

- RD&I Group is functioning appropriately
- Research activity continues to grow
- Funding secured and utilised appropriately
- R&D function has a visible role within the Network and theTrust.

Author: ***Chris Cook – Head of Research, Development & Innovation***
Date: ***15th July, 2019***

APPENDIX A

The Princess Alexandra Hospital NHS Trust
Research, Development & Innovation Annual Report for 2018/2019

Summary of Performance

The Princess Alexandra Hospital NHS Trust (PAHT) continues to support its staff when undertaking research. Its main research activity is recruiting patients into high quality National Institute for Health Research (NIHR) portfolio adopted Multi-centre studies for which we receive funding from the North Thames Clinical Research Network (NT CRN) hosted at Barts Health.

PAHT are active in all Healthcare Groups and cover most specialties; to this end, we are now producing quarterly reports for Healthcare Groups, and have started in Medicine. Please See **Appendix B**

During 2018/2019 9 commercial studies and 30 Academic studies were recruited to.

The target for recruitment into studies for 2017/2018 was 590 patients with the actual number of patients recruited being 1001.

There is no target for 2019/2020 due to the impact of the budget cut of 8%, however the department has every intention to at least meet and if possible exceed last year's final figure.

Research Income 2018/2019

The Research funding from NT CRN is based on the previous year's research activity, targeted investment and an allowance for research data management. Funding for 2018/2019 was reduced by 5.5%, therefore 0.5 w.t.e. of one of the Research Nurse Vacancies at February, 2018 was funded from commercial activity.

Research Income from NT CRN 2018/2019

Date	**Amount (£)**	
Q1	30 June 2018	£107,180.00
Q2	30 September 2018	£107,180.00
Revised Q3	31 December 2018	£112,523.09
Revised Q4	08 March 2019	£110,189.22
Y/E Adjustment	**08 May 2019**	**£497.77**
Total 2018/19		**£437,570.08**

Funding for the coming financial year has been reduced by 8% due to the cut to NT CRN overall budget, leading to PAHT opting out of the membership for Health Enterprise East and having to pull back some of the commercial funding from the Research Strategy financial agreement.

Successful Business Case Bid to NT CRN
Two members of the Breast Unit Team left the Trust in January, 2019. A business case was submitted to the network for 1.0 w.t.e. Band 4 Clinical Trials Practitioner and 1.0 Band 5 Trainee Research Nurse, which was successful and the posts currently being recruited to.

Research Capability Funding (RCF)

The Trust met the qualifying criteria to receive RCF of £20,000 for achieving the recruitment of patients in excess of 500 between October, 2017 and October, 2018. RCF is allocated to research active NHS organisations in England to enable them to maintain capacity and capability. The use of these funds is prescriptive and must be evidenced at the end of the Financial Year; this may only be

used to support costs not met from other sources which are salary based and not for the purchase of equipment

A decision has been made to recruit a Band 3 Research Administrative Assistant into post for 12 months, taking on the more administrative elements of the Research Nurses and Clinical Trials Practitioners, in turn keeping them in the clinic recruiting patients into studies.

Performance in Initiating and Delivering Clinical Research (PID)

The PID quarterly report represents the data submitted by providers of NHS Services for Performance in Initiating clinical research. Each clinical trial record submitted is assessed on data completeness, compatibility of durations between Valid Research Application (VRA), NHS Permissions and first Patient Recruited and the attributed reasons and sources of delay to clinical trial initiation.

Failure to meet these High Level Objectives can result in a financial penalty as and when Research Capability Funding is awarded.

The Trust is mandated to display this data on the Trust website and can incur a financial penalty if this process is not followed.

Commercial Activity

The Trust continues to work directly with various pharmaceutical companies, including Roche, Pfizer, Gilead and GSK as well as closely with IQVIA & PRA Health Sciences – both Clinical Research Organisations. 9 commercial studies have been recruited to in the last 12 months, compared to 27 for the last financial year. This drop is due to two factors – many commercial studies are now in the follow up phase but also one of the commercial studies was in A&E and required the time of all of the clinic staff at one time or another.

Income from Commercial Activity

Income Generated to 2014/2015	**£120,912.98**
Income Generated in 2015/2016	**£93,962.64**
Total Commercial Income Generated	**£214,875.62**
Commercial Income Reported in 2015/2016	**£143,250.43**
Carried Forward to 2016/2017 for Pump Priming	**£71,625.19**
Income Generated in 2016/17	**£97,657.58**
Carried Forward to 2017/2018 for Pump Priming	**£169,282.77**
Income Generated in 2017/2018	**£153,185.08**
Carried Forward to 2018/2019 for Pump Priming	**£156,048**
Income Generated in 2018/2019	**102,001**
Carried Forward to 2019/2020 for Pump Priming	**130,125**

Currently the Research Strategy, ratified in January, 2019, outlines the division of net profit from commercial activity as a three way split – Specialty/R&D Pump Priming/Trust budget.

Commercial funding from the R&D Pump Priming element of the strategy split is utilised for:-

- 1.0 w.t.e. Band 6 Pharmacy Technician
- 0.67 w.t.e. Band 5 Clinical Trials Practitioner
- 0.5 w.t.e. Band 6 Research Nurse (see above NT CRN income)
- 0.2 w.t.e. Band 7 Optometrist

£20k Funding Initiative – 2018/2019

The following quality improvement projects were awarded funding from the pump priming funding element of the commercial activity:-

- Essential equipment to support rapid discharges for End of Life patients wishing to go home to die - **Julie Cattermole – Senior Oncology Palliative Care Occupational Therapist – not utilised – See below 2019/2020**
- Fit for Frailty Screening Project – **Janice Bernardo & Shirley Halewood, Frailty Lead Practitioner and Senior Sister Patient at Home – not utilised – service changed.**
- Engage with patients and carers in West Essex and parts of Hertfordshire. To establish a user/carer forum to engage with GP's (survey) and primary care patients – **Anne Nutt – Chair of Patient Panel – project delivered**
- Delirium – **Caroline Ashton – Clinical Nurse Specialist – Project delivered**
- Diabetes App – **Dr D. Sennik – not utilised – IT element could not be overcome within the one year funding period**

£20k Funding Initiative – 2019/2020

The following quality improvement projects were awarded funding from the pump priming funding element of the commercial activity and are on track to be delivered by April, 2020.

- **Gill Hutchinson** – Clinical Lead Specialist – Palliative Care – Butterfly Tote Bags
- **Caroline Ashton** – Clinical Nurse Specialist – Frailty & Dementia – RITA Therapy
- **Alice Jones** – Occupational Therapist – End of Life Care – Essential Equipment to support rapid discharges
- **Chris Tuckett** – Falls Prevention Practitioner & Physiotherapist – Perceived Barriers to Greater Mobility on a Hospital Ward

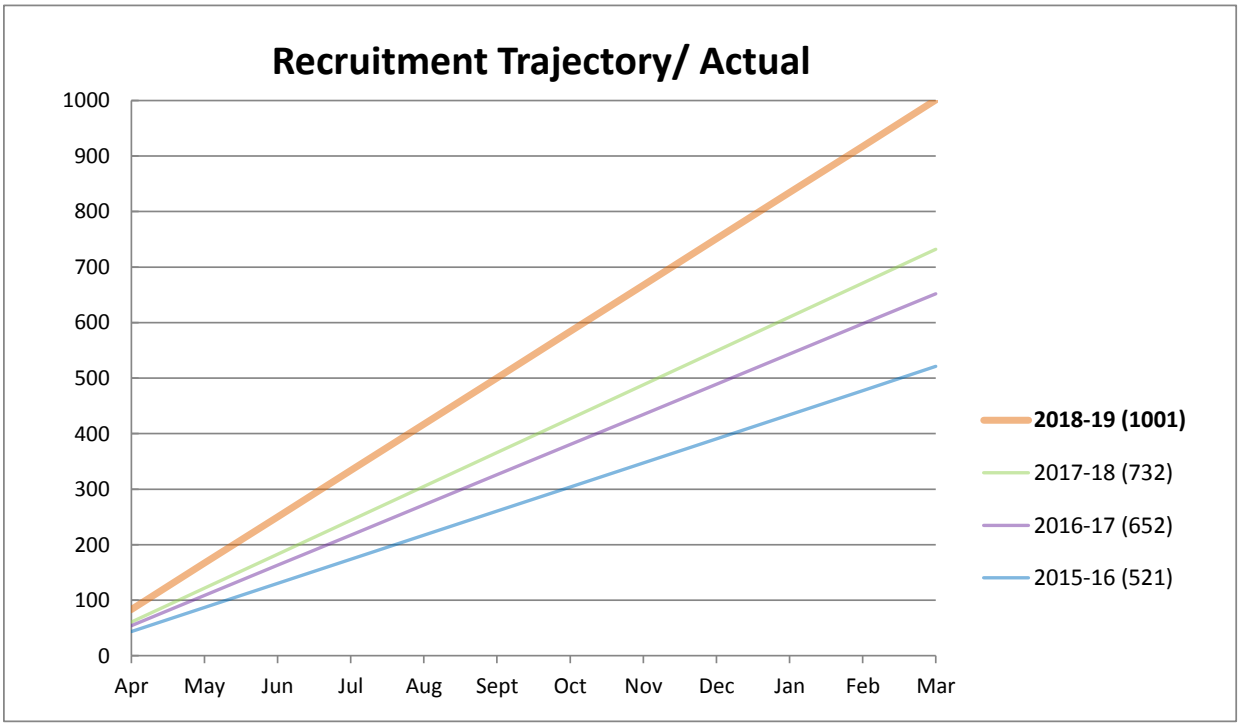
Research Activity

Health Group	Specialty	Recruitment into Trials
Medical	Rheumatology	29
	Dermatology	6
	Respiratory	20
	Gastroenterology	454
	Neurology/Ageing	59
	Diabetes	1
	Emergency	198
Cancer, Cardiology & Clinical Support Services	Cancer (including Haematology)	62
	Cardiology	19
Surgery & Critical Care	Ophthalmology	3

	Orthopaedics	2
	Surgical	98
Women & Child Health	Obstetrics	18
Other	Staff Surveys	32

Year End Recruitment Performance

At the beginning of 2018/2019 the target for recruitment of patients into studies by NT CRN was to be 590 into National Institute for Health Research (NIHR) portfolio adopted trials. The final number of patients recruited into research for the last financial year is 1001. Below is a Trajectory to show growth over the last four years.



Local Own Account Research and Non-Portfolio Studies

Study Name	Brief Description	Academic
Midwives perceptions of the potential use of mobile health technology to deliver lifestyle interventions to prevent excessive gestational weight gain – Kate Hucknell	To explore the views and opinions of midwives regarding the implementation of a mobile health technology (mHealth) aimed at assisting women to eat healthily, being physically active and gaining healthy amounts of weight during pregnancy.	Masters
EHAAT Dr Sarah McLachlan - Research Fellow in Health Services Research - Anglia	The evaluation of a need for night operations by Essex & Herts Air Ambulance Trust (EHAAT) to deliver critical care to patients in Essex and	Masters

Ruskin University	Hertfordshire.	
UK survey of current cough augmentation management in patients with motor neurone disease - **Mrs Rachel Szczepanski** **Sheffield Hallam University**	To provide evidence of any variation in practice, identify priorities for development, provide information to prompt more rigorous research and understand clinician perceived barriers and facilitators to practice.	Masters

Staff Undertaking research, as part of their education programme, are asked to attend the RD&I Group to present their findings, but also to develop action plans so that their research can be translated into practice.

Good News Stories

- **Recruitment of patients** into studies was up by 38.5% compared to the previous year
- **International Clinical Trials Day** saw 100 members of the public visiting stands in the hospital and the Harvey Centre.
- **QFiT Study** – PAHT were the second highest recruiters across the UK of this UCLH based study. This testing kit for potential colo-rectal cancer patients has now translated into practice and is widely available for standard use.
- **NOAC** - The evaluation of a virtual patient programme to teach pharmacists NOAC counselling in atrial fibrillation– PAHT were the highest recruiters for this Pharmacy based study.
- **ISCOMAT Study** - This study involves 42 hospitals across the country. Half the hospitals will provide help with managing medicines in a new way, the other half will continue to deliver care as usual. This is the first NIHR Portfolio study to have a Clinical Nurse Specialist as Principal Investigator at PAHT.

Patient & Public Involvement

The Research illustration for PAH has now been completed, and is being shown in designated areas across the Trust and various social media.

PAH has a Patient Research Ambassador – Cyril Cleary who is setting up a support group for Barretts Oesophagus. Claire Unwins has recently joined the Patient Research Ambassador Scheme and is helping to bring awareness of research to GP Surgeries and other primary care facilities.

The Trust again took part in the annual national Patient Research Engagement Survey and have agreed to be part of a 9 month rolling programme of surveys for 2019/2020.

Annual Delivery Plan

The Trust's Annual Delivery Plans usually follow those of NT CRN and with change to the national high level objectives (HLO's), below is the Trust's delivery plans in line with those HLO's.

- Deliver significant levels of participation in CRN portfolio studies
- Deliver NIHR CRN Portfolio studies to recruitment target within the planned recruitment period.
- Increase the number of studies delivered for the commercial sector with support from the NIHR Clinical Research Network
- Widen participation in research by enabling the involvement of a range of health and social care providers
- Deliver significant levels of participation in NIHR CRN Portfolio Dementia and Neurodegeneration (DeNDRoN)

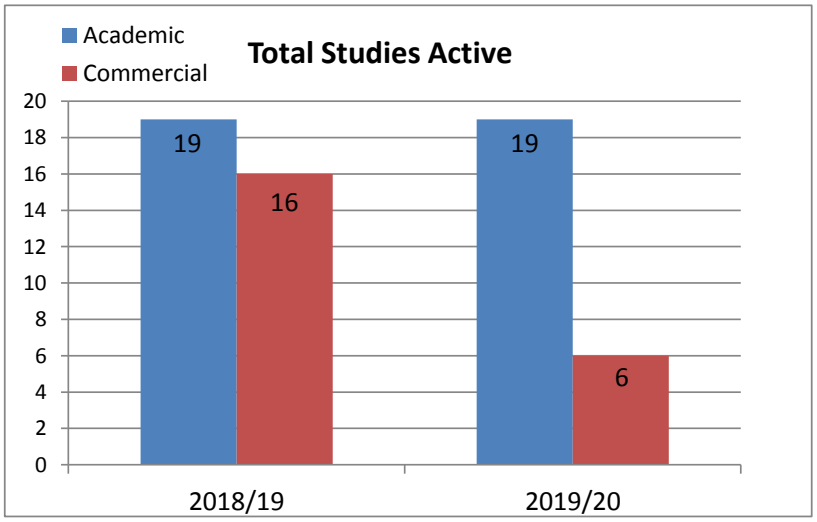
- Reduce study site set up times for NIHR CRN studies by 5%
- Demonstrate to people taking part in health and social care research studies that their contribution is valued.

APPENDIX B

MEDICINE Quarterly Report 2019/20

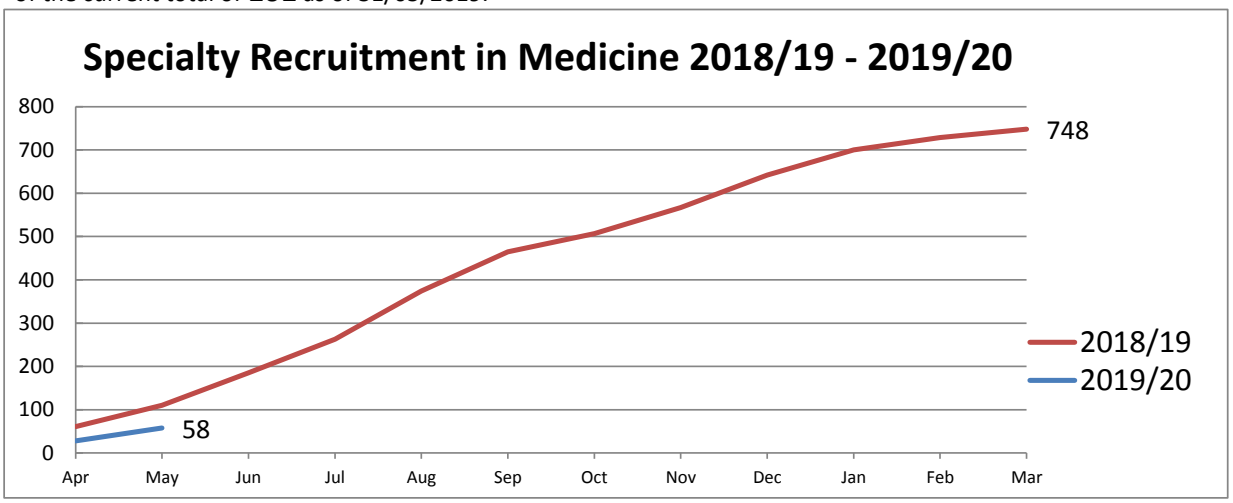
Research, Development & Innovation

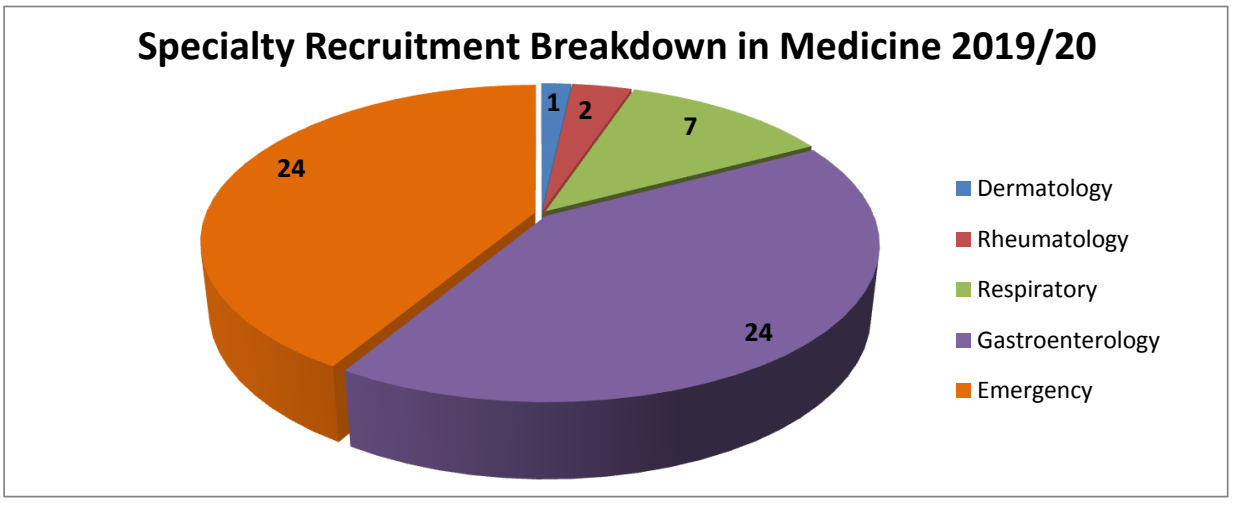
Active Studies 2019/20	
COMMERCIAL	**ACADEMIC**
6	19



Recruitment 2019/20

The number of participants recruited into research studies in the **Medicine** clinical group is currently **58** out of the current total of **101** as of 31/05/2019.





9.1

The Princess Alexandra Hospital NHS Trust

BOARD OF DIRECTORS

MEETING DATE: 01.08.19 **AGENDA ITEM NO:** 9.1

REPORT TO THE BOARD FROM: CHARITABLE FUNDS COMMITTEE (CFC)

REPORT FROM: Helen Glenister

DATE OF COMMITTEE MEETING: 25.07.19

SECTION 1 – MATTERS FOR THE BOARD'S ATTENTION
The following are highlighted for the Board to note or to take action:
The Trust Board is asked to note the following: : • The General Fund balance is c. £37k. Total fund balances at 30 June 2019 total £617k, a reduction from 1 April of £39k. During this period the charity received income totalling £156k and incurred expenditure of £195k. • The draft Annual report and accounts were considered and will be presented to the next meeting of CFC for approval. • CFC discussed the request to raise funds in the sum of £139k, excluding VAT for a Mobile Breast Screening Van. Members agreed that fundraising should proceed. CFC had been asked to consider whether the van could bear the name of an individual and following advice received from NHS Digital this request was declined; other ways of acknowledging the individual were recommended instead. The provision of equipment for the screening trailer will be funded from Capital via a separate business case. • CFC received a presentation outlining new arrangements and plans for fundraising.
SECTION 3 – PROGRESS AGAINST THE COMMITTEE'S ANNUAL WORK PLAN
The CFC is generally making good progress against its 2019/20 annual work plan.

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The Princess Alexandra Hospital NHS
NHS Trust

BOARD OF DIRECTORS

MEETING DATE: 01.08.19 **AGENDA ITEM NO: 9.2**

REPORT TO THE BOARD FROM: Senior Management Team
REPORT FROM: Lance McCarthy - Chairman
DATES OF MEETINGS (Fortnightly): 2 July and 16 July 2019.

ITEMS FOR THE BOARD'S INFORMATION AND ASSURANCE

SMT meetings took place on 2 and 16 July 2019.

The following items were discussed at the meetings:

2 July 2019:

- Overseas Nurses - Business Case. The Business Case was supported by SMT. Following further discussion it was suggested that all gateway reviews would be reported back to SMT in line with suggested timescales.
- Proposal for Quality Compliance Improvement Workshop. Outputs from the group discussion/workshop were recorded under separate cover and will be shared following approval by DoN.

16 July 2019:

- Geriatric Medicine presentations – Model Hospital: A detailed summary was presented to SMT on the work to date following a deep dive of Model Hospital data and saving efficiencies to be made.
- External attendance by WECCG on the role of 'Primary Care Networks'.
- Modernisation of the ICT Strategy.
- EPR Business case. The 'Clinical Modernisation Group' led by the CCIO will take this forward in order to 'check and challenge' that the I.T. platforms will meet the needs of the organisation.
- Finance month 3 update/STP Capital Submission.