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The Princess Alexandra Hospital NHS
NHS Trust

Public Meeting of the Board of Directors

AGENDA

Date and Time: Thursday 4 April 2019 from 09.00 - 12.00
Venue: Boardroom, The Princess Alexandra Hospital, Harlow.

Time	Item	Subject	Action	Lead	Page
01 OPENING ADMINISTRATION					
09.00	**1.1**	Apologies	-		
	1.2	Declarations of Interest	-	Chairman	
	1.3	Minutes from meeting on 07.03.19	Approve	Chairman	4
	1.4	Matters Arising and Action Log	Review	All	12
02 PATIENT STORY					
09.05	**2.1**	John's Story			
03 REPORT FROM CHIEF EXECUTIVE					
09.30	**3.1**	CEO's Report	Discuss/Approve	Chief Executive	13
04 RISK					
09.40	**4.1**	Board Assurance Framework	Approve	Head of Corporate Affairs	17
09.50	**4.2**	Significant Risk Register	Approve	Chief Medical Officer	33
05 PATIENTS					
10.00	**5.1**	Mortality Improvement Plan including: • Learning from Deaths (presentation by Surgery)	Discuss	Chief Medical Officer	37
10.20	**5.2**	Nursing, Midwifery and Care Staff Levels including Nurse Recruitment	Inform	Director of Nursing and Midwifery	50
10.30	**5.3**	Seven Day Services: Self Assessment	Approve	Chief Medical Officer	61
06 PEOPLE					
10.35	**6.1**	Staff Survey	Discuss	Director of People	66
10.50	**6.2**	People Strategy	Approve	Director of People	69
11.00	**6.3**	Gender Pay Gap	Approve	Director of People	90
BREAK - 10 minutes					
07 PERFORMANCE					
11.20	**7.1**	Integrated Performance Report	Inform	Executives	94
08 GOVERNANCE					
11.30	**8.1**	Strategic Objectives 2019/20	Approve	Chief Executive	122

11.40	**8.2**	Reports from Committees: • CFC.5.03.19 • Audit 6.03.19 including Terms of Reference • QSC.22.03.19 • PAF.25.03.19 • WFC.25.03.19 including Terms of Reference	Inform/ Approve	Chairs of Committees	125 126 127 134 135 136 137
11.45	**8.3**	Report from Senior Management Team	Inform	Chief Executive	141
11.50	**8.4**	Report from ICP Board	Inform	Chief Executive	142
09 QUESTIONS FROM THE PUBLIC					
11.55	**9.1**	Opportunity for Members of the Public to ask questions about the Board discussions or have a question answered.	Discuss	Chairman	
10 CLOSING ADMINISTRATION					
	10.1	Summary of Actions and Decisions	-	Chairman/All	
	10.2	New Issues/Risks	Discuss	All	
	10.3	Reflection on Meeting	Discuss	All	
12.00	**10.4**	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

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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)	Vacant	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
		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 7 March 2019 from 09:00 – 10:30 @ Leisure Zone, Harlow CM20 3DT

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)
Observing:	
Robbie Ayers	PAH
Janet Whybrow	Roydon Parish Council
A Edward	Harlow District Council
Ron Kingsmill	Hert 4 Harlow
Virginia D'Rose	PAH
Martyn Richardson	PAH
Nicholas Taylor	Member of Public
Alan Leverett	Member of Public
Janet Jackson	Harlow District Council
Piers Meyler	Harlow District Council
Charlotte Jefferson	PAH
Martin Smith	PAH
Laura Warren	PAH
Marcelle Michail	PAH
Diane D Bowers	PAH Patient Panel
Shahid Sardar	PAH
Chris Cook	PAH
Nikki Staines	PAH
Gagan Mohindra	Epping Forest District Councillor/Essex County Councillor
Apologies:	
None received	
Secretariat:	
Heather Schultz	Head of Corporate Affairs (HoCA)
Lynne Marriott	Board & Committee Secretary (B&CS)

01 OPENING ADMINISTRATION	
1.1	The Chairman welcomed all to the meeting, particularly members of the public and local stakeholders. He informed those present that an opportunity would be given after the discussion for questions to be raised. In addition some questions had also been received in advance and would be answered at the end of the discussion.
1.1 Apologies	
1.2	No apologies had been received.
1.2 Declarations of Interest	
1.3	No declarations were made.
1.3 Minutes of Meeting on 07.02.19	
1.4	The minutes of the meeting held on 07.02.19 were agreed as a true and accurate record of that meeting, with no amendments.

1.4 Matters Arising and Action Log	
1.5	The one open item on the action (not yet due) was noted.
1.6	In relation to the previous minutes, which had reported an HSMR of 127, the Chief Medical Officer (CMO) was able to update members that the figure had now been corrected by Dr. Foster to 123. Despite a slight reduction mortality still remained 'higher than expected'.
02 PLACES	
2.1 Our New Hospital: The Preferred Way Forward	
2.1	This item was introduced by the Chief Executive Officer (CEO). He informed those present that the decision to be made that day was to agree the preferred way forward in relation to plans for a new hospital in Harlow. The recommendation made in the paper was as a result of a whole system workshop held on 14.02.19. It was important to remember that a strategic outline case (SOC) still needed to be developed and additional processes worked through. The Board's decision therefore was based on information available to date. The move towards outline business case (OBC) would provide further detail with a decision taken at OBC stage on the preferred option at that time.
2.2	The recommendation presented in the paper was the result of many months of work with specialist advisors and discussion with Regulators/Commissioners and latterly the Department of Health (DoH) and Her Majesty's Treasury (HMT). The recommendation had also been aligned with local authority plans which were being reviewed at a national level. The above had all complied with new and complex HMT guidance (Green Book process) for any large capital schemes (£100m+). The CEO cautioned that funding was not yet approved for a new hospital so the recommendation to be agreed that day would be key to ongoing discussions. He also highlighted that the preferred way forward would not necessarily be the final decision. As more information was gathered for OBC stage and a full public consultation undertaken it might be that a different way forward became more preferable. The CEO noted that the physical location of the new hospital was obviously an area of focus for everyone but he emphasised that the preferred way forward required more than just a decision on the site.
2.3	As a final point the CEO flagged that the paper set out a range of options assessed by the Trust to identify a preferred way forward. It should be noted however that more than 20 other options had been considered in order to arrive at the short list. It should also be noted all options considered would deliver the same level of healthcare which was equivalent to the range of services and type of care currently provided at the Trust. He handed over to the Director of Strategy (DoS).
2.4	The DoS introduced himself. He informed those present that the Trust was working with a range of people in order to make an informed decision on the way forward. Those were: 1) Health Planners: to identify the demographics and service needs. 2) Architects: to support with 'fit to site'. 3) Contractors: to understand true costs. 4) Town Planners: to undertake traffic impact analysis and planning restrictions. 5) Finance Experts: to review funding structures and modelling.
2.5	The output from the above five work streams had culminated in the recommendation made at the aforementioned workshop.
2.6	<u>Assessment</u> The assessment of options was complex but the Trust's approach had been reviewed by the national team (who had written the Green Book guidance) and had been approved. Apart from Option 1 the same level of healthcare would be delivered in all cases whether on or off site. The options were: <u>Option 1 – Business As Usual</u> To continue to deliver services in the same way as currently and at the same time undertaking refurbishments and repairs to the estate for a period of ten years or more. This was a mandated option that had to be taken forward into the business case even if discounted.

	Option 2 – Do Minimum/Option 3 – Preferred Way Forward Options 2 and 3 were fundamentally the same in terms of funding, the difference was the site option. The site option would have a significant impact on the timeframe for completion of the new hospital. . Construction for an offsite option would be 3.5 years and onsite would be 5.5 years. The latter also required consideration of the impact of delivering the existing business during the building. Advice to date was that construction onsite would have a significant impact on delivery of existing services. Another consideration would be the value-for-money element (VfM). The longer a new hospital took to build, the longer it would take to deliver the clinical and financial benefits and the longer the borrowing period would be.
2.7	Options 4 (Short List Option) related to the option of building additional services on site e.g. a health campus and Option 5 (Do Maximum) was also a mandated option to be carried forward.
2.8	From the above options the preferred way forward had been recommended as a local acute hospital located on a greenfield site – East of Harlow (Junction 7a M11). It would be a new hospital build using off site construction via a contractual estate partnership within a 3.5 years construction timeframe and utilising a blended financing model.
2.9	In terms of next steps the key impact of the recommended preferred way forward would be moving the hospital to a new site. Before a final decision was reached a full public consultation would need to be undertaken. To enable a public consultation to commence a Pre-Consultation Business Case (PCBC) would need to be developed by West Essex CCG and East & North Herts CCG which would need approval by NHS England (NHSE) . A key element of that PCBC would be a full and comprehensive Equality Impact Assessment (EIA) to clearly establish the impact on the local population of the preferred way forward and the other viable options. Following consultation the Trust and its Commissioners would be required to update the PCBC with the outcome of the consultation for approval by NHSE. Following approval the Trust could update its SOC for approval. If agreed an announcement of funding would be made and an OBC developed. The final step would be development of a Full Business Case (FBC). The above process was nationally prescribed and timings were subject to change to reflect review and assurance by NHSE and NHSI. A high level indicative timeline had been included as Appendix 3 in the paper.
2.10	The CC opened up the item to questions.
2.11	In response to a question from Non-Executive Director Andrew Holden (NED-AH) it was confirmed that at OBC stage the possibility of building on the existing site would be revisited. All five options described above would be taken forward to OBC, at which point timeframes could change. In response to a second question from NED-AH it was confirmed that whilst the target date to Full Business Case (FBC) of 2021 would be challenging, it was felt it could be achieved. The DoS noted that work on the PCBC and SOC had started in parallel.
2.12	In response to a question from NED Helen Glenister (NED-HG) it was confirmed that following the event on 14.02.19 no specific questions or concerns had been raised by attendees. In response to a second question it was confirmed that the health needs assessment mentioned above would be undertaken for the whole of the hospital's catchment area.
2.13	The Chief Financial Officer (CFO) emphasised the recommendation being made that day was to identify a preferred way forward, not the only way forward; options would be taken forward for final consideration at OBC stage.
2.14	At this point in the meeting, following a request from a member of the public, it was agreed that the use of acronyms would be avoided.
2.15	Associate NED Helen Howe (ANED-HH) asked for assurance around the funding of a new hospital and whether the preferred way forward would attract the same amount of funding as for example, Option 5 (do maximum) would. In response the DoS confirmed the Trust was in discussion with both its Regulators and HMT around the different financing options but it would be HMT who would make the final decision.
2.16	In response to a question from the Director of Nursing & Midwifery (DoN&M) it was confirmed that in relation to the public consultation and capturing the voice of 'hard to

	reach' groups, a Public Health expert was currently a member of the Trust's Strategy Team and would support the development of a robust public consultation. Local authority partners were also facilitating links to those very groups.
2.17	In response to a question from NED Pam Court (NED-PC) in relation to anticipated growth it was confirmed that this had been taken into account in the planning stages. The hospital had been right-sized based on current information and all site options allowed an additional 20% of capacity to be built on. In response to a second question around the phasing of the funding the DoS confirmed that. Although the totality of any funding would be sought, it was likely it would be made available in tranches.
2.18	In response to a question from NED John Hogan (NED-JH) and the fact that the requirements for a new hospital should be future proofed based on local public health needs the DoS agreed and assured those present that one of the key design principles had been flexibility and the recognition that the model of care would change over time.
2.19	The Director of Quality Improvement (DoQI) noted that the new hospital presented a significant opportunity to transform services especially those currently constrained by the configuration of the current site. In particular the new build would address the issue of clinical adjacencies. In response the DoS stated that a new hospital on either site would be a great opportunity to transform clinical services and achieve those much sought after clinical adjacencies. It would also be an opportunity to transform other non-clinical services. The CMO agreed and added it was also an opportunity for the Trust to re-think its Clinical Strategy.
2.20	The CC thanked colleagues for the above update and reminded members that the decisions to be made that day were: 1. That the process followed above was deemed to be Green Book compliant and of sufficient detail to identify the preferred way forward for public consultation and SOC. 2. That a reasonable level of engagement with system stakeholders had been undertaken for a preferred way forward to be identified. 3. That the preferred way forward (a local acute hospital, located on a greenfield site – East of Harlow; a new hospital build using off site construction; via a contractual estate partnership; within a 3.5 years construction timeframe; utilising a blended financing model) should be taken forward to public consultation and, SOC development and, pending the result of the consultation, OBC.
2.21	The CC opened up the item to public questions.
2.22	**Questions from the public:** **Tony Edward (Harlow District Councillor)** stated it was not clear whether the Trust was seeking to develop a District General Hospital (DGH) or a DGH within a wider health campus. He was also not clear on the 20% growth being discussed and the 53k additional housing. He asked whether that 20% figure was included in that growth or was it anticipated that services would be provided for the current population plus an additional 53k plus 20%. Response from DoS: Growth had been taken into account in the design of the building but an additional 20% capacity over and above that could be taken on if required. All calculations had been based on planned housing growth for the area currently. A health campus was still the ambition i.e. the 'do maximum' option, however a significant amount of additional work would need to be undertaken alongside that and would be reliant on aligned business cases. Both the onsite and offsite options would allow for the 'do maximum' option.
2.23	**Member of Public (name not provided)** stated that concern had already been expressed about the relocation of the hospital to the boundary of the town and how patients would travel there. A key element of that would be the sustainable transport corridor, the cost of which had not been found in the local plan but was estimated at £161m. If work started today it would probably take around ten years to create that sustainable transport corridor. His concern therefore would be that a decision was made on a site option (offsite) assuming that the corridor would be funded and the outcome of that was a new hospital with no access.

	Response from DoS: The Trust was working closely with the local authorities on that. A hospital could not be built until there was assurance that the components were in place. There was funding for the Gilden Way improvement and Junction 7A. There were risks with the sustainable transport corridor however it was a core component of the Healthier Harlow Town and the traffic modelling had been undertaken without the corridor in place so would be an added bonus to the planned infrastructure for that site.
2.24	**Questions from Alan Leverett (Member of Public).** He stated he could see that much work had been done around the third option already. He asked whether it was wise to go down the route of the third option now when public/patients had not been consulted. He stated that he had only found out about the Board meeting two days ago and felt that many of the public would be working that day. In his view there would be much public interest in the work underway and public in the whole catchment area needed to be communicated with not just those in Harlow and Gilston. Response from DoS: There had to be an agreed preferred way forward before PCBC and the PCBC required funding. The expectation was that the consultation would be broader and the plan would be to visit a number of different venues at different times of the day. There was a requirement to look at the preferred way forward first but the consultation would guide the decision and feed into another business case which would address the outputs of the consultation – that would be a public document. *Will the Mental Health Unit remain in its current position?* Response from DoS: Discussions were underway with Essex University Partnership Trust (EPUT) who provided the Mental Health service and it would be down to them to consult on moving the unit should the hospital move offsite. *If the Mental Health Unit remains on site will that reduce the numbers for the local housing plan?* Response from DoS: 450 houses were planned if the Mental health Unit moved off the site and 400 if it remained. *It says 670 houses in the local plan?* Response from DoS: The plan was adjusted by the Planning Consultants. *Will the services at Epping and Bishop's Stortford remain?* Response from DoS: There were no plans currently to change those services.
2.25	**Member of Public (name not provided)** stated that she thought there had been a possible site option in the Gilston area. Response from DoS: There was an option in the Gilston area and it was one of the 20 site options considered but a planning application for housing was submitted which changed the planning position for the Trust and also the land value meaning a significant additional cost to purchase the land. There was a second site in Gilston but it transpired that circa £12m of retrospective works would need to be undertaken before building could start. Reasons for the dismissal of both sites would be included in the documentation. There were approximately 20 other site options which had also fallen away.
2.26	**Councillor Gagan Mohindra** expressed his thanks to the CEO and DoS for the great work so far. He said there was still a lot more to be done and the project had political support at all levels. Harlow & Gilston Garden Town (on whose Board he sat) would address the transport issues. He noted that flexibility and future-proofing had been built into the work the team were doing.

2.27	**Diane Deane-Bowers (Vice Chair of Patient Panel) (DDB-VCPP)** thanked the Board for undertaking the work. As a patient and volunteer she believed the prospect of a new hospital was hugely exciting. She stated that her concerns would be around transport (particularly for poorer members of the catchment population) and parking. In addition she drew members' attention to the fact that in recent years Papworth Hospital had moved to Addenbrooke's, a move which had been delayed for over 12 months due to issues with construction materials. She was reassured by the support the hospital had for its case from Robert Halfon MP and she added that the Patient Panel would be more than willing to support the Trust where it could. Response from DoS: Concerns around access would be addressed by the quality impact assessments and public consultation. 1750 parking spaces had been allocated for both of the site options. DDB-VCPP continued that she was hugely interested in any possible educational aspect of a new hospital. The area had local outstanding schools and the Education College at Stansted had been hugely successful. It would be wonderful, she felt, to train people in hospitality and domestic services. Response from DoS: Discussions were underway with organisations who may have an appetite for working in partnership with the Trust.
2.28	**Member of Public (name not provided)** asked whether there was an idea of the possible mix of public versus private funding for a new hospital. Response from DoS: This was still being worked through with Department of Health – indicative figures for the core funding were not yet available. *If the site at junction 7A is the chosen option there will be a time lag between moving from the current site to the new site. Do you envisage having to run two hospitals in parallel for a given time?* Response from the COO: The move would be undertaken in phases on a risk assessed basis with potentially lower risk services moving first. The Trust would take advice from other organisations who had experience of such a move. The public would be kept fully informed and other ways of communicating to the catchment population (other than by the website) would be explored and implemented.
2.29	**Written questions submitted prior to the meeting** H*ow can you justify spending £150m building a new hospital when you cannot staff the existing one?* Response from DoS/COO: The current hospital was not fit for purpose and was built for a 1960s model of care. A new hospital design would improve productivity and help attract and retain staff by offering state of the art working conditions designed to deliver best in class care. *Why does the hospital serve such a large area?* Response from DoS: The catchment population of circa 300k was relatively small for a district general hospital compared to other district general hospitals in the UK. The split between West Essex and East Hertfordshire patients was 60:40.
2.30	*Why can't you reinstate A&E departments at St. Margaret's and Herts & Essex Hospitals?* Response from COO: To run A&E departments would require a full set of supporting services e.g. theatres, surgery and diagnostics. The modelling for the catchment population did not indicate the need for three A&E departments and that would be difficult to staff and

	expensive to run. There was a Minor Injuries Unit at Herts & Essex Hospital.
2.31	*Why can't you continue to develop PAH as is still being done on the existing site?* Response from DoQI: Investment in the current site would continue to ensure services were safe and of high quality; some of that work was currently underway. It had been fully assessed as an option and the analysis showed that the investment required and the disruption to patients would be significant for over nine years. In addition it would not offer good value for money for tax payers compared to a new greenfield site.
2.32	The TC drew the Board's attention to the following recommendations which required agreement: 1) That the process followed to agree a way forward was deemed to be Green Book compliant and of sufficient detail to identify the preferred way forward for public consultation and SOC. 2) That a reasonable level of engagement with system stakeholders had been undertaken for a preferred way forward to be identified. 3) That the preferred way forward (a local acute hospital, located on a greenfield site – East of Harlow; a new hospital build using off site construction; via a contractual estate partnership; within a 3.5 years construction timeframe; utilising a blended financing model) should be taken forward to public consultation and, SOC development and, pending the result of the consultation OBC.
2.33	**Board Decision** • The Board agreed with point one above. • In relation to point two the Board agreed that, a reasonable level of engagement had been undertaken at the current stage. • In principle the Board agreed with point three. ANED-HH highlighted that she understood that a preferred way forward needed to be agreed at the current stage but acknowledged the benefit of the "Do Maximum" option which would include a Health and Social Care Campus (Education Hub, private patient hub, community and social care). Members agreed.
2.34	The TC thanked the DoS and his team for all the work undertaken to date.
03 GOVERNANCE	
3.1 Reports from Committees	
3.1	Quality & Safety Committee (QSC) – 22.02.19 – Chair NED John Hogan (NED-JH) **NED-JH highlighted the following areas in the report:** **Stillbirths:** A verbal update of the draft report had been shared by NHSI and the final report was now awaited. Some emerging themes had been identified in the Trust's internal reviews which had also been identified by NHSI. An action plan was in place and reports once finalised would be shared with staff as well as lessons learned. **Maternity Incentive Scheme**: An update was received on progress made to date in meeting the standards set out in the Maternity Incentive Scheme and in particular the development of an action plan for Standard 3. The Board agreed to grant delegated authority to the Chair of QSC, another Non-Executive Director member of QSC, the DoN&M and CMO to sign off the action plan supporting the standard. **Terms of Reference (ToR):** The Committee's ToR had been reviewed and were agreed at the meeting (to include two new Executive members).
3.2	The Board approved QSC's revised ToR.
3.3	Performance & Finance Committee (PAF) – 25.02.19 – Chair NED Andrew Holden The paper was taken as read. Key points to highlight were: **Bed Contract:** PAF agreed the contract but it required Board approval as lifetime costs were over £1m. **Revised Operating Plan:** Final submission would be presented to PAF.25.03.19 following anticipated commissioner contract sign-off on 21.03.19. PAF therefore agreed to request delegated authority for Trust Executives (CFO/CEO) to sign 2019/20 Commissioner contracts by 21.03.19 and for PAF to approve the final plan submission at its meeting on 25.03.19 ahead of submission deadline 04.04.19.

The Princess Alexandra Hospital NHS
NHS Trust

	Terms of Reference: The Committee's ToR had been reviewed and recommended to the Board for approval..
3.4	In response to a question from ANED-HH it was confirmed that an STP-wide bed contract had not been entered into at the current time as STP timeframes did not align with those of the Trust. Future work would ensure those became aligned.
3.5	In response to a question from NED-PC the CFO confirmed that the Trust's financial outturn remained in line with its control total and target for the year (£28.5m).
3.6	The Board approved the award of the Bed Contract and agreed the request for delegated authority in relation to submission of the Operating Plan. The revised ToR were also approved.
04 QUESTIONS FROM THE PUBLIC	
4.1	See above.
05 CLOSING ADMINISTRATION	
5.1 Summary of Actions and Decisions	
5.1	These are presented in the shaded boxes above.
5.2 New Issues/Risks	
5.2	No new risks or issues were identified.
5.3 Reflections on Meeting	
5.3	Members agreed there had been good discussion and strong public engagement and support.
5.4 Any Other Business (AOB)	
5.4	There were no items of AOB.

Signed as a correct record of the meeting:	
Date:	04.04.19
Signature:	
Name:	Steve Clarke
Title:	Trust Chairman

Trust Board Meeting in Public
Action Log - 04.04.19

Action Ref	Theme	Action	Lead(s)	Due By	Commentary	Status
TB1.07.02.19/14	BAF Risk 4.1	Discuss Risk 4.1 at PAF and agree whether some of the elements should be separate individual risks.	CFO/HoCA	PAF.25.03.19	Actioned.	Proposed for closure

No actions arising from TB1.07.03.19.

The Princess Alexandra Hospital NHS Trust

Trust Board – 4 April 2019

3.1

Agenda Item:	3.1
Presented by:	Lance McCarthy - CEO
Prepared by:	Lance McCarthy - CEO
Date prepared:	29 March 2019
Subject / Title:	CEO's Report

Purpose:	Approval		Decision		Information	x	Assurance	x

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 - New Hospital update - Your future, our Hospital - PAH 2030 - Market testing of domestic services
Recommendation:	The Trust Board is asked to note the CEO report.

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
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3.1

Chief Executive's Report
Trust Board: Part I – 4 April 2019

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

(1) Key performance headlines

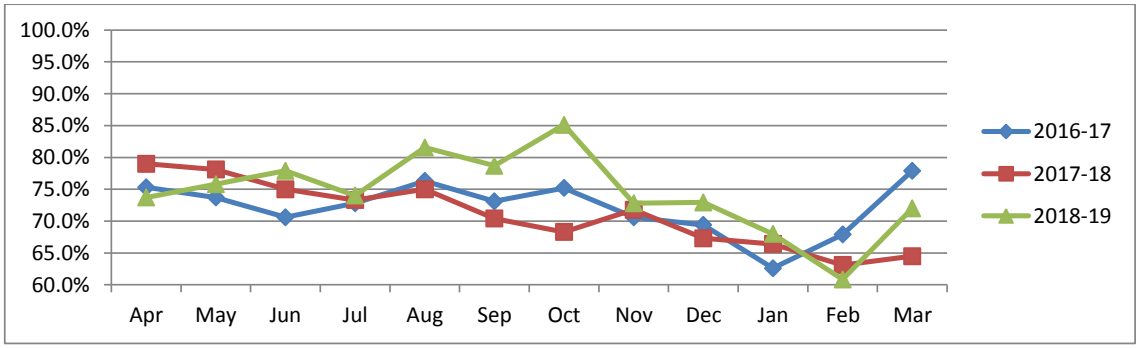
Some key summary performance headlines outlined below for the latest month. More detail on each of these and other key performance indicators are shown in the revised and updated Integrated Performance Report later on the agenda.

Key Performance Indicator	Actual performance for latest month (February)	Comparison to last report
ED 4-hour performance	60.6%	↓ (worse)
HSMR	116.7 (Oct 17 – Sep 18)	→ (NB: same data as last report)
CDiff numbers	0	↑ (better)
MRSA numbers	0	→
Never Events	0	→
Incidents reported	828	New indicator
No harm / minor harm incidents	96.9%	New indicator
RTT incomplete	92.5%	↓ (worse)
6-week diagnostic standard	99.7%	↑ (better)
Cash balance	£1,380k	↓ (worse)
Stat Man training	92.0%	↑ (better)
Vacancy rate	11.5%	↑ (better)

(2) Urgent care performance and flow

After much improved performance against the 95% 4-hour access target for urgent care in the summer, we have continued to struggle with to meet this standard through the winter. Performance remains significantly below where we would wish it to be.

Performance for all months over the last 3 financial years is shown in the chart below (the March position is a predicted position as at 28 March). Year to date (1 April 2018 – 28 March 2019) we have seen a 3.29% improvement in performance compared with the same period for 2017/18. We have had a 5.2% increase in attendances over the same time period.



Attendance numbers at our ED by month for the last 3 years are shown in the table below (note: the March 2019 figure is a predicted number, extrapolated from actuals for the first 28 days of the month).

Our drop in performance in recent months has been due in part to a significant rise in ED attendances – 8.6% increase over the last 5 months compared with the same period in 2018. The acuity of our patients over this period, as measured by the NEWS2 scores on arrival in ED, also continue to be significantly greater than last year..

Month	2016-17	2017-18	2018-19	% change
Apr	8,027	8,164	8,192	0.3%
May	8,931	8,649	8,829	2.1%
Jun	8,461	8,625	8,875	2.9%
Jul	9,108	8,794	9,226	4.9%
Aug	8,312	8,141	8,373	2.8%
Sep	8,385	8,328	8,678	4.2%
Oct	8,691	8,707	8,868	1.8%
Nov	8,533	8,767	9,296	6.0%
Dec	8,432	8,583	9,172	6.9%
Jan	8,076	8,419	9,149	8.7%
Feb	7,459	7,584	8,448	11.4%
Mar	8,737	8,547	9,425	10.3%
TOTAL	101,152	101,308	106,531	
Average	**8,429**	**8,442**	**8,878**	**5.2%**

We are continuing to work closely with primary care and CCG colleagues to determine the reasons for the changes in demand locally for our services and to predict future demand levels in the immediate and medium terms, so we can resource our services appropriately and ensure that our patients are receiving timely and safe care.

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

(3) CQC inspection

We are currently part way through our latest formal Care Quality Commission (CQC) inspection.

A range of Executive Directors and senior clinicians were interviewed by NHS Improvement and NHS England colleagues on 26 March 2019 in relation to our Use of Resources inspection date. We were then inspected on 27 March and 28 March by 25 CQC colleagues, looking at 6 of our core services (urgent and emergency care, medical care, surgery, children and young people, maternity and end of life care). The inspection went well with CQC colleagues identifying what they described as a real and significant change in the culture in the organisation with our people being very open and proud of the services they provide and care they deliver.

Our well-led interviews have been confirmed as 23 and 24 April, approximately 8 weeks after which we will receive a draft report. We expect the full report to be published at the end of July / early August.

I'd like to take this opportunity to thank the inspectors for the manner in which the inspection was undertaken to thank all of our amazing people at PAHT who engaged so fully with the inspection team and who were so proud to show off the amazing care that we provide on a daily basis.

(4) New Hospital update

Following the decision by the Trust Board on the Preferred Way Forward for a new hospital on 7 March, we continue to work hard to update our Strategic Outline Case and to work with our local commissioners to develop a Pre-Consultation Business Case. We remain in close contact with our regulators and key personnel, regionally and nationally, as they change as part of the NHSE/I reconfiguration to support a positive funding decision for the new hospital.

(5) Your Future, our Hospital – PAH 2030

Aligned with the NHS Long Term Plan, launched on 7 January 2019, we will be refreshing our strategy over the spring, developing an organisational plan for the next 10 years to support our drive towards delivering 'outstanding' services to our patients and secure our future with a new building.

Transformation and modernisation of our corporate services will be at the heart of this, supporting the clinical transformation work already in place, and Quality First remains our approach, putting Quality First in everything that we do and supported by our Quality First team.

Staff engagement sessions are being arranged for May and June to help develop the plan, aligned with our 5Ps, before it will be launched at the Leadership Conference at the end of July.

(6) Market testing of domestic services

We are currently in the first phase of the market testing process for our domestic services. This phase stops on 14 April with the receipt of any proposals. These will provide us with two important pieces of information; how the market can deliver high quality cleaning services and the costs to do this, including future innovation and the use of technology. Once we have this detailed information it will be fully evaluated and we will then determine whether our current services could match or adapt to meet or exceed these options.

Myself, the Director of People and the Director of Quality Improvement have meet regularly with our local and regional staff side representatives and also with our domestic staff and will continue to do so through the process.

There has been some concern raised by our regional UNISON officer and some local public figures about the outsourcing of our domestic services. We are in ongoing active dialogue with all concerned. They are aware that the process of market testing does not necessarily mean that our domestic services will be outsourced.

Author: **Lance McCarthy, Chief Executive**
Date: **29 March 2019**

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The Princess Alexandra Hospital
NHS Trust

Trust Board - 4 April 2019

4.1

Agenda Item:	4.1
Presented by:	Head of Corporate Affairs - Heather Schultz
Prepared by:	Head of Corporate Affairs - Heather Schultz
Date prepared:	26 March 2019
Subject / Title:	Board Assurance Framework 2018/19

Purpose:	Approval	x	Decision		Information		Assurance	

Executive Summary: [please don't expand this cell; additional information should be included in the main body of the report]	The Board Assurance Framework 2018/19 is presented for review. Changes to the BAF risks and risks closed (4 risks) during 2018/19 are reflected in Appendix A. Risks, risk ratings and outcomes of Committee reviews in month are summarised (Appendix B) and detailed BAF risks as at April 2019 are attached (Appendix C). There are no proposed changes to the risk scores this month but updates to controls, actions and target dates are reflected in red font.
Recommendation:	The Board is asked to approve the Board Assurance Framework and note the changes made during 2018/19 as reflected in Appendix A and the April position reflected in Appendix B.

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 28.03.19, PAF.25.03.19, WFC. 25.03.19 and QSC.22.03.19
Risk / links with the BAF:	As reflected in the attached BAF.
Legislation, regulatory, equality, diversity and dignity implications:	Compliance with national legislation and regulations and the Code of Governance.
Appendices:	Appendix A - 2018/19 Summary of BAF changes, Appendix B - Summary of Residual Risk Ratings and Appendix C - Board Assurance Framework 2018/19

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Summary of BAF risks amended/closed during 2018/19

Appendix A

5P	Executive Lead	BAF Risks	Outcome of Board and Committee reviews in 2018/19.
	Chief Finance Officer/DoI &IT	1.3 Coding Risk Coding issues (including clinical) within the Trust impacting on Patient Safety, Finance, Performance and Operational delivery	**CLOSED.** Reviewed at Board in February 2019 and risk rating reduced from 16 to 12 (target risk rating) and removed from BAF.
	DoP	2.1 Workforce Capacity Concerns around staffing capacity to manage workload, deliver services of high quality and maintain national performance requirements.	Reviewed at Board in November 2018 and risk rating reduced from 20 to 16. Risk remains on the BAF as 2.1 Nurse recruitment: Inability to recruit to critical nursing roles.
	Chief Nurse/Chief Medical Officer	2.2 Clinical Leadership and Engagement Inconsistent Clinical Leadership & Engagement in strategy, operations, performance and delivery which impairs Trusts reputation & sustainability.	**CLOSED.** Reviewed at Board in August 2018, risk rating reduced from 16 to 12 (target risk rating) and removed from BAF.
	DoP	2.4 Workforce Productivity Gaps in staff capability not being consistently addressed through available performance management and development processes	**CLOSED.** Reviewed at Board in November 2018, risk rating reduced from 9 to 6 and removed from BAF.
	DoS	3.2 Health Economy Stability & Joined up Approach Failure of the Accountable Care Partners to integrate and work effectively as an ACP and deliver demand management, productivity and efficiency targets, undermining both hospital and system sustainability.	**CLOSED.** Reviewed at Board in October 2018, risk rating reduced from 16 to 12 (target risk rating) and removed from BAF.
	CFO	5.1 Finance Concerns around failure to meet financial plan including cash shortfall.	Reviewed at Board in June 2018 and risk rating reduced from 20 to 15. Risk remains on the BAF.

5P	Executive Lead	BAF Risks April 2019	Current risk score	Designated Committee and outcome of Committee review.
	Chief Nurse/Chief Medical Officer	1.1 Outcomes:Variation in outcomes in clinical quality, safety, patient experience and 'higher than expected' mortality.	**16**	QSC Reviewed at QSC.22.03.19; risk rating confirmed and recommended that 'observation compliance reports' are included under controls.
	Chief Finance Officer/DoI&IT	1.2 EPR Concerns around availability of functionality for innovative operational processes together with data quality and compliance with system processes	**16**	PAF Reviewed at PAF.25.03.19. Risk rating confirmed.
	DoP	2.1 Nurse Recruitment Inability to recruit to critical nursing roles.	**16**	WFC reviewed on 25.03.19 Risk rating confirmed.
	DoP	2.3 Internal Engagement Failure to communicate key messages and organisational changes to front line staff.	**9**	WFC reviewed on 25.03.19. Risk rating confirmed.
	DQI	3.1 Estates & Infrastructure Concerns about potential failure of the Trust's Estate & Infrastructure and consequences for service delivery.	**20**	PAF Reviewed at PAF.25.03.19. Risk rating confirmed.
	DoS	3.3 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**	For review by Trust Board on 4.04.19
	DoS	3.4 Strategic Change and Organisational Structure Capacity & capability of senior Trust leaders to influence both internally and externally the required strategic changes.	**12**	For review by Trust Board on 4.04.19

	DoS	3.5 Sustainability of local services Failure to ensure sustainable local services whilst the new hospital plans are in development.	**16**	For review by Trust Board.4.04.19
	DCFO/DQI	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**	PAF Reviewed at PAF.25.03.19, risk rating confirmed.
	COO	4.2 4 hour Emergency Department Constitutional Standard Failure to achieve ED standard	**20**	PAF Reviewed at PAF.25.03.19, risk rating confirmed.
	CFO	5.1 Finance Concerns around failure to meet financial plan including cash shortfall.	**15**	PAF Reviewed at PAF.25.03.19, risk rating confirmed.

The Princess Alexandra Hospital NHS
NHS Trust

The Princess Alexandra Hospital Board Assurance Framework

2018-19

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Risk Key														
Extreme Risk		15-25												
High Risk		8-12	**The Princess Alexandra Hospital Board Assurance Framework 2018-19**											
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 - continue to improve the quality of care we provide our patients, improving our CQC rating and exiting special measures **Strategic Objective 4: Our Performance - meet and achieve our performance targets, covering national and local operational, quality and workforce indicators**													
BAF 1.1		~~Inconsistent~~ Variation in outcomes in clinical quality, safety, patient experience and 'higher than expected' mortality.	Causes: i) Unwarranted variation in care ii) System wide flow ~~iii) Inconsistent patient feedback (including PALS) into service improvement and re design.~~ ~~iv) Failure to achieve sustainable improvements in national survey results~~ ~~v) Poor results in Inpatient Survey with areas for improvement identified~~	**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. 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 ~~viiiFour 'Big Dots' - AKI, Sepsis, Mortality and End of Life~~ xii) Risk Management Training Programme ~~xiii Monthly newsletters - Quality Matters, Pharmacy 5 Minutes~~ xiv) Escalation prescribing processes ~~for prescribing doctors and processes for non-medical prescribers~~ xv) Electronic handovers and E-Obs and observation compliance reports xvi) Schwartz Rounds xvii) NHSI/NHSE Oversight xvi) Red2 Green Board rounds supported by ECIST xx) ~~Improved reporting and review process for deaths and establishment of incident management group.~~ Implementation of Medical Examiners with reporting software and Board oversight xxi) Patient Experience Strategy xxii) NED lead appointed for Mortality xxiii) ~~Bundles of Care being implemented - Pneumonia.~~ xxiv) Mortality ~~Improvement Plan~~ 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) Four domains under the Mortality Improvement Strategy are: bundles of care, Hospital at night, achieving excellence every time and recording/reporting.~~ xxx) Robust management of periods orf increased incidences of Infection Control (MRSA/VRE) xxx) Robust management of variations in neonatal outcomes xxxi) Engagement in external reviews MBRRACE and LeDeR	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 vii) Infection Control Committee viii) Integrated Safeguarding meetings ix) Patient Panel meetings x) PLACE Inspections xi) Medicines Management Committee xii) CCG audits xiii) Monthly QA visits/inspections xiv) End of Life and Mortality Groups xv) AKI & Sepsis Group xvi) Urgent Care Improvement Board xvii) Mortality Surveillance Group xviii) Mortality Improvement Board	i) Improvement in some areas of the National Inpatient Survey and NACEL Survey ii) CQUIN reports to PAF/QSC iii) CEO Assurance Panels. iv) Reports to QSC on Patient Experience, Serious Incidents, Safer Staffing, Patient Panel, Safeguarding, Infection Control (top quartile) v) Reports to Board from QSC and reports on clinical issues for escalation, Mortality and CN/CMO reports vi) Dr Foster reports, CQC inspection reports and GIRFT reports vii) Sustained Increase in Datix reporting and reduced harm viii) Feedback from NHSI and Commissioners on harm reviews (positive) ix) Real time Dr Foster feedback and engagement ~~x) Water Safety testing across the Trust (SMH) - normal results~~ xi) GMC Trainee Results Report xii) Integrated Performance Report (IPR) ~~xiii) Outstanding NICU peer review~~ xiv) Clinical Audit report 18/19 - tiaa xv) Improved and sustained palliative care coding xvi) CMO/CFO Coding Meetings xvii) Positive staff survey outcomes measuring safety culture xviii) Freedom to Speak Up Guardians and Guardian of Safe Working reports. xix) Patient stories and learning from deaths presentations to Board	**4x4=16**	i) Internal/External Comms in development and improving (launch date to be agreed) ii) Evolving clinical audit approach- improved tracking of local audits and drive to improve collation and input of data for national audits iii) Disparity in local patient experience surveys versus inpatient survey iv) Staffing, site capacity and constraints **ACTIONS:** i) Website development ii) Inpatient Survey action plan in place and Staff Survey action plan in development iii) Maxwell Stanley and Dr Foster work commissioned in relation to mortality ~~iv) Software to support medical examiners procured~~	i) Clinical evidence of improvements made following compliance with national audits, NICE,NCEPOD. ~~i) Reporting on Learning from deaths~~ ~~ii) Medical examiners not operational (software in test phase)~~ ~~iv) Reporting to MIB on progress against workstreams identified in Mortality Improvement Strategy.~~ ii) Demonstrating an embedded learning programme from Board to ward.	12/03/2019	**Risk rating not changed.**	4x3 =12 (Target date July 2019 - to ~~achieve 'as expected' for mortality.~~ review progress against Mortality Improvement Strategy workstreams and following receipt of inpatient survey results in May)
			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 2018-19**											
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 - continue to improve the quality of care we provide our patients, improving our CQC rating and exiting special measures **Strategic Objective 5: Our Pounds – manage our pounds effectively to achieve our agreed financial targets and control totals**													
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) System fixes	**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 xiv) Link to Quality 1st being discussed. xv) New daily Cambio meetings/roadmap xvi) Internal 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	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	i) Weekly Data Quality reports to Access Board and EDB ii) Internal Audit reports to Audit Committee iii) External Audit reports to Audit Committee on Quality Account Indicators iv) DQ Report to PAF and roadmap report September 2017 v) 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) CCIO post out to advert. vii) Compliance with refresher training viii) 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.	Mar-19	Residual Risk rating unchanged	**4x3=12** ~~**March 2019**~~ **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) Recruitment of new CCIO - JD developed and recruitment in progress. v) Refresher training underway vi) Revised roadmap to incorporate new statutory/legal requirements i.e. 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 2018-19

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 – support our people to deliver high quality care within a culture that improves, engagement, recruitment and retention and improvements in our staff survey results													
	Strategic Objective 4: Our Performance - 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.	**Causes:** National shortages of appropriately qualified staff Competition from neighbouring hospitals National drive to increase nursing number leaving market shortfall (demand outstrips supply) **Effects:** i) Pressure on existing staff to cope with demand leading to overworked staff and increased sickness ii) Low staff morale 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	4 X 4 =16	Director of People **Workforce Committee**	i) Participation in local and regional job fairs ii) Targeted overseas recruitment activity iii) Apprenticeships and work experience opportunities iv) Use of new roles to bridge gaps 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	i) PAF, QSC, WFC, EMT, EMB, Workforce and Board meetings ii) Health Group Boards iii) Internal Audit report on Recruitment (substantial assurance) iv) Recruitment and Retention Group	i) Safer Staffing Reports (monthly to QSC and Board) ii) Workforce reports (progress on recruitment, retention, bank and agency) to PAF iii) Incident reporting and monthly SI reports to QSC	4 x 4 = 16	i) Dedicated nurse recruiter ii) Detailed pipeline and trajectory iii) Career escalator	None noted.	19/03/2019	**Risk rating not changed.**	**4 x 3 = 12 Nov 2019**

Risk Key														
Extreme Risk		15-25												
High Risk		8-12	**The Princess Alexandra Hospital Board Assurance Framework 2018-19**											
Medium Risk		4-6												
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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 – support our people to deliver high quality care within a culture that improves, engagement, recruitment and retention and improvements in our staff survey results													
BAF 2.3		**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**	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		19/03/2019	**No change to risk rating.**	**3x2=6 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											

Risk Key														
Extreme Risk		15-25												
High Risk		8-12	**The Princess Alexandra Hospital Board Assurance Framework 2018-19**											
Medium Risk		4-6												
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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)**
		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 – 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 a West Essex and East Hertfordshire Accountable Care Partnership													
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 **Performance and Finance Committee**	i) Schedule of repairs ii) Six-facet survey/ report received (£105m) iii) Potential new build/location of new hospital iv) Re-profiled 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.	i) PAF and Board meetings ii) EMB 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 ii) Reports on testing for legionella, asbestos iii) Signed Fire Certificate iv) Annual H&S reports to Trust Board and quarterly to PAF. v) Ventilation audit report vi) Water Safety Report (PAH site) vii) Annual and quarterly report to PAF: Estates and Facilities viii) PLACE Assessments	**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 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.	15/03/2019	**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.												

Risk Key														
Extreme Risk		15-25												
High Risk		8-12	**The Princess Alexandra Hospital Board Assurance Framework 2018-19**											
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 3: 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 a West Essex and East Hertfordshire Accountable Care Partnership													
BAF 3.3		**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 **Trust Board**	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	**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		15/03/2019	**No changes to risk rating.**	**4x3=12** **~~March~~ 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											

Risk Key														
Extreme Risk		15-25												
High Risk		8-12	**The Princess Alexandra Hospital Board Assurance Framework 2018-19**											
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			
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	Strategic Objective 3: 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 a West Essex and East Hertfordshire Accountable Care Partnership													
BAF 3.4		**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 **Trust Board**	i) SMT meetings ii) Clinical specialty meetings iii) Good relationships with key partner organisations iv) CEO chairing ICP Board v) SOC Steering Group vi) CEO 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 being 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) SOC Steering Group	i) Reports to Board on strategic developments and Our New Hospital reports to PAF/Board. 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	**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. Establishment of a 'Strategy Committee. Strategy team being developed PAH long term strategy being developed	None identified.	15/03/2019	**Risk rating not changed.**	**4 x 2= 8** **September 2019** ~~**March 2019 for engagement process with level of management below Board.**~~
			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											

Risk Key														
xtreme Risk		15-25												
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edium Risk		4-6												
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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)**
		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,			
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	Strategic Objective 3 : 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 a West Essex and East Hertfordshire Accountable Care Partnership													
BAF 3.5		**Estate** Failure to ensure sustainable local services continue whilst the new hospital plans are in development	**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 Board via CEO Report ii) Reports to EMB iii) STP work plans iv) Monthly Our New Hospital reports to PAF and updates to Board.	**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. Establishing a Strategy Committee	i) Strategy in development	15/03/2019	**No change to residual risk rating.**	~~**4 x 3 =12 March 2019 timeframe for completion of master planning work)**~~ **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												

Risk Key														
Extreme Risk		15-25												
High Risk		8-12	**The Princess Alexandra Hospital Board Assurance Framework 2018-19**											
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 4: Our Performance - 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) High volume of internal, regulatory and STP information requirements, ii) shortage of skill sets / specialist staff, iii) limited investment / availability of resources iv) reliance on outsourced contractors / systems and inflexible systems, v) historical systems which are not fully integrated (vi physical space and poor office accommodation and facilities to support integrated working. vii) Appetite for change management. viii) Existing finance systems provider has novated to SBS and SBS advised Trust that upgrades and improvements to current system will not be supported beyond contract expiry 2020.	**4x5=20**	**Exec leads** :- Chief Financial Officer, Chief Operating Officer and Director of Quality Improvement. **Committee:** Performance and Finance Committee	i) Continuous priority reviews and workload planning, ii) business partnering approach and performance reviews, iii) Recruitment exercises - successful reduction in temporary costs, iv) increase involvement in collaborative work e.g. STP, v) review of staffing structures and consultation / market testing, vi) modernisation groups and use of benchmarking to identify improvements e.g. Qlikview, EROS, Carter, GIRFT, model hospital, vii) system implementations / upgrades e.g. EROS, Qlikview and ledger upgrades, viii) staff surveys / appraisals ix) Mitre lease extended for 18 months. x) Procurement strategy	i) Internal and external Audit reports ii) PAF and Board meetings iii) NHSI reviews/reports iv) Business case approved for ICT restructure. v) ICT Programme Board vi) Audit Committee vii) NHSI review/visit re estate	i) Outputs from NHSI deep dives ii) Internal Audit and External Audit reports including Head of Internal Audit Opinion and VFM conclusion. iii) Estates Governance review reported to Audit Committee iv) Staff survey outcomes	**4x3=12**	i) Recruitment and retention. ii) Enhanced plans to realise full benefits of system implementation / upgrades. iii) Re-location of Corporate Staff to alternative office accommodation. iv) Trust will need to undertake an options appraisal to review finance systems.	i) Benefit realisation reviews	20/03/2019		**4x2=8 ~~March~~ Sept 2019**
			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) single failure points, v) adequate value for money conclusions.							**ACTIONS:** i) Recruitment plans for areas ii) Market testing iii) Income capture processes under review iv) Trust obtaining support from external supplier.					

Risk Key														
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High Risk		8-12	**The Princess Alexandra Hospital Board Assurance Framework 2018-19**											
Medium Risk		4-6												
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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)**
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								Evidence should link to a report from a Committee or Board.						
	Strategic Objective 4: Our Performance - 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) ~~Weekly meetings with ED team and all HCGs~~ xi) System reviewing provision of urgent care xii) Exec attendance at safety huddles daily xiii) ED action plan reported to PAF/Board xiv) Co-location of ENP's, GP's, Out of hours GP'S to support minor injuries xv) Daily review of Paeds by Clinical Lead and HoN xvi) Protection of assessment capacity work underway xvii) Additional capacity ~~handed over 20.12.18~~ in place xviii) Additional winter funding for social care xix) Weekly Urgent Care ~~Board~~ operational meetings and Urgent Care Board in place xx) On site support from ECIST	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 meetings	**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	None noted.	19/03/2019		4x3 =12 March ~~2019~~ 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														
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Medium Risk		4-6												
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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)**
		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 – manage our pounds effectively to achieve our agreed financial targets and control totals													
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 STF 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 pay settlement	5 X 4= 20	**Exec leads :** CFO/All Executives **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) Executive Management Board, PAF and Audit Committee vi) Health Care Group CIP 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) Internal special measures for selected HCG to remain xiv) New medical agency protocol xv) Financial Recovery Plan - Q1 xvi) Demand and Capacity planning xvii) Revised forecast meetings with HCGs and SMT. HCG's that are off trajectory are required to ensure full mitigation. xviii) Use of resources assessment 26.03.19 iixx) The Trust and CCG are jointly discussing a potential year end settlement for 18/19.	i) Internal Audit & External Audit opinion. ii) External reviews iii) NHSI reporting iv) Internal Trust reporting v) Cash Management group vi) Pay award steering group vii) Joint meetings with CCG	i) Monthly reports including bank balances and cash flow forecasts to PAF and Board ii) CIP Tracker reports iii) IA reports iv) Financial Recovery Plan	5x3=15	i) Organisational and Governance compliance e.g. waivers ii) Activity and capacity planning iii) CIP reporting and run rate reductions	PLICs Demand and Capacity planning regularisation Workforce planning	20/03/2019	**Risk rating not changed.**	**5x2=10 ~~March~~ June 2019**
			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. Focus on pay and non pay CIPs.Medical pay award being assessed. CCG triangulation. Model Hospital data 2017/18 under review. Trust reviewing 19/20 control total and impact assessment of tariff.				

The Princess Alexandra Hospital NHS
NHS Trust

TRUST BOARD - 4 APRIL 2019

4.2

Agenda Item:	4.2
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:	22 March 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 registers on 21 March 2019. There are a total of 74 risks with a score of 15 or more. • There are no risks with a score of 25 • 18 risks score 20 (↓ from 20 in February 19) A summary of each risk and the actions planned to manage and mitigate them is detailed • 23 risks with a score of 16, (↑22 risks in February 19) • 33risks with a score of 15, (↓37 risks in February 19) 1 new risk (score 15) raised since 1 February 2019 about security of the OPD at St Margaret's Hospital out of hours
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:	
Appendices:	Nil

The Princess Alexandra Hospital NHS
NHS Trust

4.2

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 21 March 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

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.

There are 74 significant risks on our risk register. The breakdown by service is detailed in the table below.

	Risk Score				
	15	16	20	25	Totals
CCCS	4 (4)	5 (4)	0 (1)	0 (0)	9 (9)
Estates & Facilities	6 (6)	0 (1)	3 (3)	0 (0)	9 (9)
Finance	2 (2)	0 (0)	0 (0)	0 (0)	2 (2)
IM&T and IG	0 (0)	3 (3)	0 (0)	0 (0)	3 (3)
Information Data Quality and Business Intelligence	0(2)	0(0)	0(0)	0(0)	0(2)
Non-Clinical Health & Safety	1 (2)	1 (0)	0 (0)	0 (0)	2 (2)
Nursing	0 (0)	1 (1)	0 (0)	0 (0)	1 (1)
Operational	1 (0)	0 (1)	4 (4)	0 (0)	5 (5)
Resilience	1 (0)	0(0)	0(0)	0(0)	1 (0)
Workforce	0 (0)	1 (1)	0 (0)	0 (0)	1 (1)
Child Health	1(2)	0 (0)	0 (0)	0(0)	1 (2)
Safeguarding Children	0 (0)	0 (1)	0 (0)	0 (0)	0(1)
Women's Health	2 (1)	2(1)	0 (0)	0 (0)	4 (2)
Medicine	2 (2)	8 (10)	7 (8)	0 (0)	17 (20)
Surgery	13 (14)	2 (1)	4 (4)	0 (0)	19 (19)
Totals	33 (37)	23 (22)	18 (20)	0 (0)	74 (79)

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

The Trust does not have any risks scoring 25.

There are 18 risks with a score of 20; the key areas are detailed below.

Patients:

- No electronic monitoring of urinary stent insertion and removal, risk to patient treatment (URO004/2018 on register since June 2018).
  Action: Aiming to developing an electronic stent register, information team and surgery are working to create this. Until an electronic solution the register will need to be completed manually and we anticipate an administrator starting to oversee this work from February 2019.

- Reduction in flexible cystoscopy sessions leading to patients being overdue a re-scope (URO010/2018)
  Action: Plan in place, the current backlog is six weeks. External provider Alliance is working with our team to undertake 10 sessions scoping 24 patients per session. This will clear the backlog by end of Feb 19.

People

- Four clinical areas have insufficient numbers of Registered Nurses - Harold (JS02), MAU (Fleming03) and Saunders (04) and Tye Green (Harold02), 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 sick leave and removal of junior staff from rotation (URO001/2015 on register since June 2015)
  Action: Rolling recruitment in place to fill the Consultant vacancies, working with agencies to fill substantively the 4 that remain. 4 middle grades interviewed via agencies and staff planned to start in March and April. Service is developing 3 advanced nurse practitioners posts.

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 Operational 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: Improvement plan in place across the emergency care pathway with trajectory set for continuous improvement. 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)
- No ED patient to wait for longer than 12 hours to be admitted (003/2016 on register since July 16)
  Action: Improvement plan in place across all ED pathways.

- Failure to meet the cancer 62 day standard (005/2016 on register since July 2016), Linked to the urology (URO001/2015):
  Action: Recovery plan with trajectories and mitigation are in place.

- Endoscopy patients have interrupted service as result of decontamination washer failure which will impact JAG accreditation (Endo002 on register since October 2017).
  Action: As an interim measure decontamination unit used in Colposcopy. The awarding of the tender to undertake the complete refurbishment of the endoscopy unit and the installation of new washers is being imminently awarded. A project installation

group is planned to oversee work. Deadlines not finalised but expected during April 19.

Places:

- Medical gas pipeline is failing and obsolete (EFM013 on register since May 2018).
  Action: For failing pipes: A staff member is being trained to undertake the work experience element of the role to be an Authorised Engineer. They have started undertaking low hazard work from Nov 18 with planned completion by April 19. High hazard work continues to be undertaken by an external Authorised Engineer. Drawing of Trust pipeline commenced 25 October, will conclude by April 19

- Frequent failure of the chiller plant (EFM014 on register since February 2018).
  Action: Plan to replace the highest risk plan failure first with the replacement programme working over two years up to March 20. Inspection, assessment and replacement (if needed) of lower risk plant will be completed between April 19 to March 20.

- Effective lifts (EFM015 on register since June 2018).
  Action: Remedial work is part of backlog maintenance programme with prices for work received. Work to start April 19 and conclude by March 20. The statutory compliance mechanical LOLER work will be completed first.

- Robust IT system interface between Cosmic and Infoflex to enable development of a stent register (URO007/2018 on register since April 2018 linked to URO004/2018).
  Action: Register is being developed manually currently until an electronic solution is identified

Pounds: Nil

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

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5.1

Agenda Item:	5.1
Presented by:	Dr. Andy Morris – Chief Medical Officer
Prepared by:	Quality First Triumvirate
Date prepared:	14th March 2019
Subject / Title:	Mortality Improvement Programme

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]	The Princess Alexandra Hospital NHS Trust established a Mortality Improvement Board in December 2018 to strengthen governance, reporting, focus and delivery in efforts to improve mortality rates. This paper outlines the progress that has been made by the Mortality Improvement Board as means of information and assurance.
Recommendation:	For the Board to approve the focus of Mortality Improvement Board.

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

Previously considered by:	QSC.22.03.19
Risk / links with the BAF:	Quality Improvement has the potential to support the mitigation of a number of risks in the organisation, but to highlight two specifically: 3.4 Strategic Change and Organisational Structure 1.1 Inconsistent Outcomes
Legislation, regulatory, equality, diversity and dignity implications:	
Appendices:	Mortality Improvement Programme Update – App 1: Mortality Dashboard – App 2: Mortality Tracker

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5.1

1. Introduction

The Trust's mortality markers remain a concern. A mortality dashboard is being developed to provide up to date information for the Sub Committees of and the Trust Board. Five programmes of work have been identified to drive quality improvements forward which are monitored via the newly formed Morality Improvement Board.

The overarching 'success measure' for the Mortality Improvement Board has been agreed as:

> *Achieve 'as expected' mortality rates (HSMR) across all specialities, with no more than two outlier alerts over a 12 month rolling period by March 2021 and to be sustained thereafter.*

2. Purpose

The purpose of this paper is to outline the progress made by the Mortality Improvement Board as well as giving an overview of next steps.

3. Progress since last report

3.1 Leading Change and Leading Projects development session delivered to nine project leads and programme triumvirate members with further sessions booked.

3.2 Aims, measures and ideas for change have now been agreed for all programmes and there projects, which further ensures that we embed our quality improvement (QI) methodology into practice (*figure 1*).

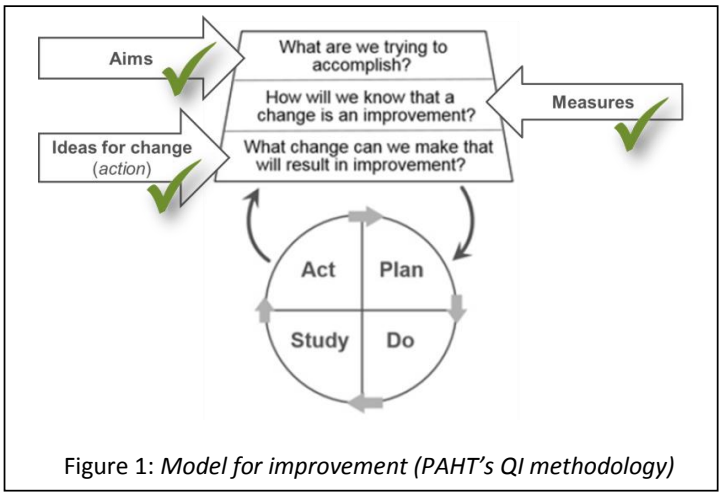

Figure 1: *Model for improvement (PAHT's QI methodology)*

3.3 Equality, Quality & Privacy impact assessments have now all been submitted for all programmes and projects and with key individuals for sign off.

3.4 In addition to the Trust Board of Director's Mortality Dashboard (see appendix 1) the Quality First Team are developing a Mortality Improvement Board progress and performance tracker, which will track the performance against the success measures for each project as outline in the table in section 4 of the paper. Targets and trajectories are being established once data sources have been identified. The timescales for delivering the progress and performance tracker are outline in appendix 2.

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4. Programmes, projects, aims, success measures and change ideas (*initial areas of focus/action*)

Programme	Project	Aim	Success measures	Change ideas *(initial areas of focus/action)*
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)	#NOF mortality rate (% of patients who died) % #NOF patients admitted to Tye Green (NOF ward) % of #NOF patients in theatres within 36 hours of arrival at A&E % #NOF patients admitted into Tye Green within 4 hours of ED attendance	• Focus on time to theatre and time to specialised ward from ED • Fracture pain blocks and documentation • Consultant anaesthetist presence in theatre
	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)	Emergency laparotomy mortality rate (% of patients who died) Case ascertainment in NELA Arrival in theatre within a timescale appropriate for urgency % of Em Lap patients admitted to ICU (with Ppossom >5) post operatively Consultant anaesthetist present in theatre	• Agreement with ED Clinical Lead to establish Acute Abdomen Pathway to expedite investigation and treatment of patients in ED who may need emergency laparotomy. • Agreement with Lead Consultant for Radiology to perform (wherever possible) CT scans for Acute Abdomen patients within 1hr of request and report immediately. • Agreement that Surgical SpR will redesign emergency laparotomy booking form • Agreement with Care of the Elderly team that ALL emergency laparotomy patients should be reviewed by a geriatrician within 72hrs of admission (Main challenge to this at present is acute staffing shortage of Consultant Geriatricians) • Highlighted that data input to NELA database needs to be 100% (currently >1/3 patients have incomplete datasets) and agreement is required on how to achieve this
	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)	COPD mortality rate (% of patients who died) COPD patients receive specialist input to their care within 24 hours of admission Administer nebuliser and steroids within 4 hours of admission	• Internal best practice - Review process for patients recorded as COPD/Pneumonia • Capture COPD diagnosis on electronic database • Links with local Health economy oversight group • Review routes for patients to come in - education and training in primary care • Improve recording of DNACPR and Treatment Escalation Plans (TEP) for patients

				• Recording of comorbidities
	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)	Pneumonia mortality rate (% of patients who died) Aspiration pneumonia mortality rate (%of patients who died) Oxygen prescribed within 1 hours of admission CURB-65 score in ED for all patients presenting with DIB Chest x-ray within 4 hours of admission	• Patients on antibiotics to be transferred to patient at home • Refresh and re-launch Community Acquired Pneumonia (CAP) pathway • Explore implementation of delirium care bundle to reduce risk of aspiration pneumonia • Deep dive into aspiration pneumonia and improve recording of DNACPRs and TEPs
	Sepsis	5% reduction in Sepsis mortality by March 2020	Sepsis mortality rate (% of patients who died) 95% of all patients admitted to ED with a NEWS score of 3 are screened for sepsis by May 2019 % sepsis patients receiving treatment within one hour (ED)	• Sepsis champions - implement locally • Communication and engagement • Lead nurse for sepsis • Blood culture analyser to be embedded in ED • Explore funding for Procalcitonin test in ED and Critical Care
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	% of Observations on patients with a EWS ≥5 within 30 minutes of due time	• To improve compliance with timely vital signs observation leading to early detection and escalation of deteriorating patient % of Observations on patients with a EWS ≥5 within 30 minutes of due time • Timely observations should promote early detection and escalation for appropriate management. • Review process for escalation to Critical Care Outreach Team (CCOT)
	Vital Signs: *Standardised escalation process and effective decision making following escalation*		Number of Datix level of harm incidents associated with deteriorating patients (level of harm reduction)	
	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	% of completed fluid balance charts	• To improve compliance with fluids & electrolytes management with early detection and treatment leading to reduction in harm caused by fluid and electrolytes imbalance • Accurate completion of fluid balance charts are a national challenge. Baseline audit data suggests very poor compliance at PAHT. PDSA cycle commenced on two pilot wards, which include changing start time and introduction of two charts i.e. acute and basic
	Fluids & Electrolytes: *Management of Acute Kidney Injuries (AKI)*		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	• Prescribe fluids on JAC • Administer fluids via pumps • Redesign of green intravenous fluid prescription charts • Redesign of AKI Alerts • AKI alerts to GPs

			reporting period Nov17-Oct18)	• AKI Tea Trolley (awareness and education campaign) • Patient information leaflet
			Number of AKI alerts	
			Number of patients with alerts that have remained the same or improved during their admission	
			Number of drug reviews for AKI patients	
			AKI Mortality Rate (% of patients who died, based on Dr Foster data for renal disease comorbidity)	
	Fluids & Electrolytes: *Management of Diabetic Emergencies*		Reduction in harm incidents related to DKA (not able to pull off datix)	• Reduction in harm incidents related to DKA • Compliance with the DKA protocol • Agree pathway measures and develop communication and education plan
			Delays in insulin administration (suggested by Sarah Webb, deputy chief nurse)	
			Compliance with the DKA protocol (look at one element as a surrogate, otherwise requires audit)	
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	Antibiotic usage (per 1000 admissions)	• 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 • Looking at the possibility to develop JAC to better enforce 'review dates' and 'indication' compliance. • Gain consensus for Antibiotic Stewardship amongst surgeons • Improve compliance with antibiotic stewardship by following best practice and the Trust policy by ensuring that antibiotic prescriptions are reviewed within 72 hours by an appropriate clinician with a documented outcome and patients • Ensure that antibiotics are switched from IV to oral unless clinically required • Implement an antibiotic App (micro guide) at PAHT
			% of antibiotic prescriptions having an indication documented	
			% of antibiotics prescribed with a review date or stop date documented	
			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	
			LoS for patients who have antibiotics during their admission (non-elective and elective)	
	Timely Decision Making	95% Compliance with completion of TEP for all	% compliance with completion of TEP forms for all patients over 16 years old	• To ensure that TEP forms are completed for all patients over 16 years old. • To ensure that an EDD is entered on all electronic and paper mediums for all patients within 14

		adult (>16yrs) in-patients		hours of admission is provided
		Right patient, right ward - first time	100% of EDD on Cosmic for all patients within 14 hours of admission.	• Document a preferred ward for all patients. • All inpatient referrals will be reviewed by senior decision maker within 24 hours of referral being sent
			100% Preferred ward documented for all patients.	• All inpatient referrals to be electronic
Reporting and recording	**Medical Examiners**	100% adult deaths (>16yrs) reviewed by ME and evidence of shared learning against reviews	% of completed Mortality Reviews including evidence of shared learning	• ME role commenced with an initial aim of 25% of deaths being reviewed. • Working group to include coders, junior doctors, MEs and PS&Q leads • Communication strategy to raise awareness of role • Process to ensure learning from every death developed and embedded
	Documentation (meeting standards, recording care accurately and communicating management plans)	Every entry in the patient notes are compliant with GMC and NMC standards	% compliance with GMC standards % compliance with NMC standards	• This project aims to improve compliance against minimum key GMC and NMC documentation standards, specific to improving communication between teams to ensure greater continuity of care. Specific tests for change (as of 4th March) include: - A new proforma for ward rounds - GMC stamps for Doctors - Discharge summaries to contain mandatory 'responsible consultant' field • PDSA cycle for nursing assessments to be recorded electronically to commence on Medical Assessment Unit
	Coding	Accurately capture the patient pathway delivered during an episode of care in nationally reported data sets (SUS and HES).	Total number of co-morbidities recorded trust wide Depth of co-morbidities Data protection and security tool kit Charlson Co-morbidity index	• This project aims to improve the capture of comorbidities and care delivered during an episode of care by educating and engaging clinical staff in coding and good documentation. Specific tests for change include: - Engaging educational sessions for clinicians - Dr Foster educational sessions for clinicians - Mandatory selection on co-morbidities on discharge summaries - Engagement Assurance Triangles PDSA cycle
Hospital at Night	**Doctor Handover**	Implementation of structured handover of patients for all specialities out of hours	Number of unexpected escalations to critical care (excluding ED) Percentage of unexpected return to theatres (excluding ED) Attendance at handover recorded - % of full H@N clinical team (required vs actual)	• Structured and consistent approach to Doctor Handover for all specialties • Generation of policies and procedures to support process change
	Electronic Handover	Implementation of	Number of hard copy handover sheets with	• Enhance and embed existing electronic handover

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		electronic handover	patient details found Implementation of an electronic handover	tool • Generation of policies and procedures to support process change • Generation of user guide to support teams • Targeted training provided to teams
	Hospital at night (task allocation)	Implementation of Hospital at Night software	Reduction in incidents associated with delay in clinician attending/responding to care need	• Hospital at Night application rolled out • Generation of policies and procedures to support process change • Generation of user guide to support teams • Targeted training provided to teams

5. Recommendations

Mortality improvement board progress and performance tracker will be reviewed monthly at Mortality Improvement Board. Trust Board of Director's Mortality Dashboard (see appendix 1) to be submitted to Q&SC monthly by the Trust's Information Team.

Authors: **Dr. Andy Morris, Jim McLeish, Lindsay Hanmore, Robert Ayers and Helen Pardoe**

Date: **14th March 2019**

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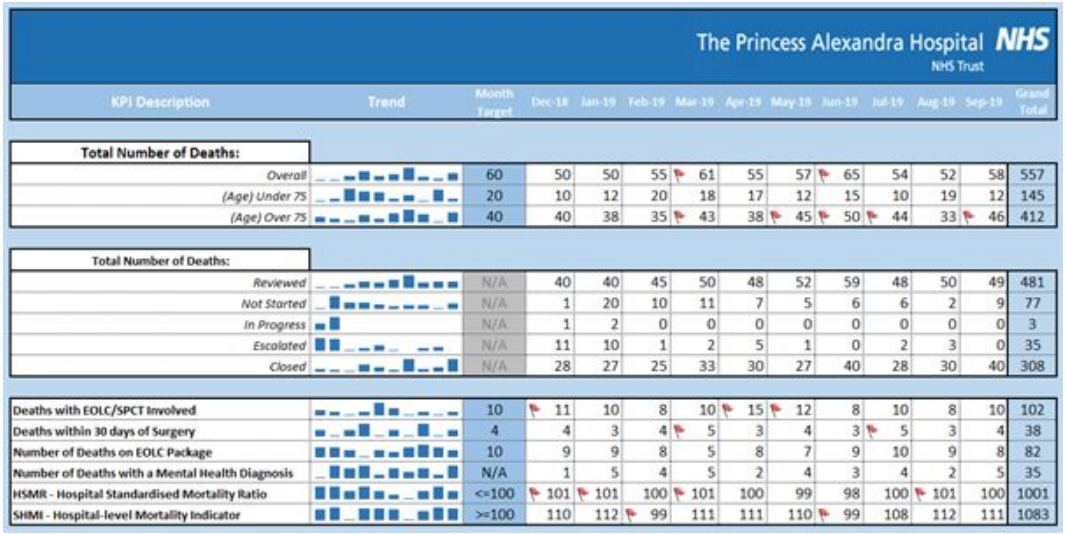
5.1

Appendix 1: *Board of Directors Mortality Dashboard (this data does not reflect actual performance – it is there to show what the dashboard will look like when presented)*



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KPI Description	Trend	Month Target	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Grand Total
Total Number of Deaths:													
Overall		60	50	50	55	61	55	57	65	54	52	58	557
(Age) Under 75		20	10	12	20	18	17	12	15	10	19	12	145
(Age) Over 75		40	40	38	35	43	38	45	50	44	33	46	412
Total Number of Deaths:													
Reviewed		N/A	40	40	45	50	48	52	59	48	50	49	481
Not Started		N/A	1	20	10	11	7	5	6	6	2	9	77
In Progress		N/A	1	2	0	0	0	0	0	0	0	0	3
Escalated		N/A	11	10	1	2	5	1	0	2	3	0	35
Closed		N/A	28	27	25	33	30	27	40	28	30	40	308
Deaths with EOLC/SPCT Involved		10	11	10	8	10	15	12	8	10	8	10	102
Deaths within 30 days of Surgery		4	4	3	4	5	3	4	3	5	3	4	38
Number of Deaths on EOLC Package		10	9	9	8	5	8	7	9	10	9	8	82
Number of Deaths with a Mental Health Diagnosis		N/A	1	5	4	5	2	4	3	4	2	5	35
HSMR - Hospital Standardised Mortality Ratio		<=100	101	101	100	101	100	99	98	100	101	100	1001
SHMI - Hospital-level Mortality Indicator		>=100	110	112	99	111	111	110	99	108	112	111	1083

Appendix 2: *Mortality Improvement Board progress and performance tracker delivery plan*

Task	Lead	Start	End	% Done
Mortality Improvement Board (MIB) programme management				
Establish MIB Programme Tracker	**Quality First**	06/11/2019	05/01/2019	
Define tracker measures (KPIs)	Programme Triumvirates		28/02/2019	100%
Sign off measures with programme triumvirates and Exec Sponsors	Programme Triumvirates & Exec Sponsors	28/02/2019	08/03/2019	60%
Establish and agree data sources & Leads for provision of data	Quality First Team		28/02/2019	80%
Populate baseline data (current performance) against agreed Programme Tracker	Quality First Team	04/02/2019	28/06/2019	5%
30% of data populated	Quality First Team	Milestone	29/03/2019	
60% of data populated	Quality First Team	Milestone	26/04/2019	
80% of data populated	Quality First Team	Milestone	31/05/2019	
100% of data populated	Quality First Team	Milestone	28/06/2019	
Set and agree targets and delivery dates	Programme Triumvirates & Exec Sponsors	29/03/2019	26/04/2019	5%
Set and agree trajectories	Programme Triumvirates & Exec Sponsors	29/03/2019	31/05/2019	5%
Submit tracker at MIB (as work-in-progress)	Quality First Team	02/04/2019	28/06/2019	

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Learning from Deaths

Surgery and Critical Care Health Care Group

March 2019

Patient JC

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- 69 yr old gentleman with Past Medical History - cerebral palsy, left hemiplegia, learning disabilities, ischaemic heart disease, epilepsy and a longstanding history of bladder and kidney stones and was wheelchair bound. He lived in a care home since 1998.
- Referred by GP in December 2014 with difficulty urinating and microscopic haematuria. He was diagnosed with a urinary tract infection and prescribed antibiotics.
- February 2015 - Urology OPA - flexible cystoscopy showed bladder stones. CT scan confirmed bilateral renal calculi. Listed for removal of stones and TURP in July 2015.
- July 2016 - Urology follow-up and diagnostic tests arranged to review his kidney function which showed bilateral kidney stones
- July 2017- Bilateral stents inserted. He had an extended hospital stay following the procedure due to sepsis. He was planned to have the stents removed in 6 weeks.
- May 2018 - Admitted for Cystoscopy and change of stents.

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Patient JC

- Procedure took place 29th May 2018
- Found that the patient had large stones and pus in the kidneys.
- Found to be septic and his clinical condition intra operatively was unstable
- Transferred to the recovery post operatively where he continued to deteriorate
- A decision was made that this was un-survivable sepsis and the treatment plan was for end of life care.
- The patient died a short time later believed to be sepsis related.
- A Post Mortem was carried out and the findings were:

Cause of death un-natural relating to a surgical procedure carried out on 29/5/18

1a: Retroperitoneal haemorrhage with left renal haematoma

1b: Left renal vein damage (Bilateral renal stones and stent change procedure 29/5/18)

Part 2: Urinary sepsis with renal stones (Escherichia Coli and Enterococcus Faecium Cultured 29/5/18)

Ischemic heart disease

Cerebral palsy

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Review

- Serious Incident and external review undertaken
- Coroners Inquest took place 22/3/19

Findings

- The patient died from a retroperitoneal haemorrhage with left haematoma which was undetected.
- The patient did have cardiovascular instability but was known to have urinary sepsis so this was assumed be due to this rather than a sign of retroperitoneal haemorrhage post operatively.
- There is evidence that identifies delays in treatment and procedure and a delay in managing a deteriorating patient post operatively.

Coroners Conclusion

- The deceased died as a result of a recognised complication of a necessary medical procedure.

Learning and actions

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- **Delays in pathway**
  - A register for patients who have had a stent inserted to be set up to ensure that there is accurate and appropriate management of the patient pathway for removal.
  - The booking processes for stent removals to be reviewed with clear reporting to identify patients that have fallen out of the appropriate pathway.
- **Delays in escalating deteriorating pt**
  - Standard operating procedures to be developed for PACU in regard to handover, escalation of and management of post-operative patients. These are to include documentation and escalation of the deteriorating patient.
  - Training and education needs to be directed at all staff with regard to correct documentation in patient records of the reviews and actions agreed.
  - Implementation of NEWS2 in line with national guidance.
- **Poor documentation**
  - Surgeons and Anaesthetists to ensure that detailed post-operative instructions are handed over and documented clearly in the patient records.
  - A review an update of the anaesthetic paperwork and to include clearer post-operative instructions.

Report on Nursing and Midwifery and Care Staff Levels (Hard Truths) and an Update to Nursing and Midwifery Workforce Position.

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 Sharon McNally – Director of Nursing and Midwifery
Date prepared:	15.03.2019
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 February 2019 (part A), and provides an update to the workforce position (part B). Headlines: • The overall fill rate (RN/M and HCA) for the ward areas shows a small increase, 94.2% in February and 93.4% in January 2019. • This is in line with an improved fill of bank and agency to support safe staffing. • The nursing vacancy position remains broadly unchanged. However, there is a drive and focus to significantly improve the vacancy position over 2019 which can be seen in the forecast position (page 7) . • 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:	QSC.22.03.19 WFC.25.03.19
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 1: Ward level fill rates Appendix 2: Ward staffing exception reports

Trust Board – 4 April 2019

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 February 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).

3.0 ANALYSIS

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

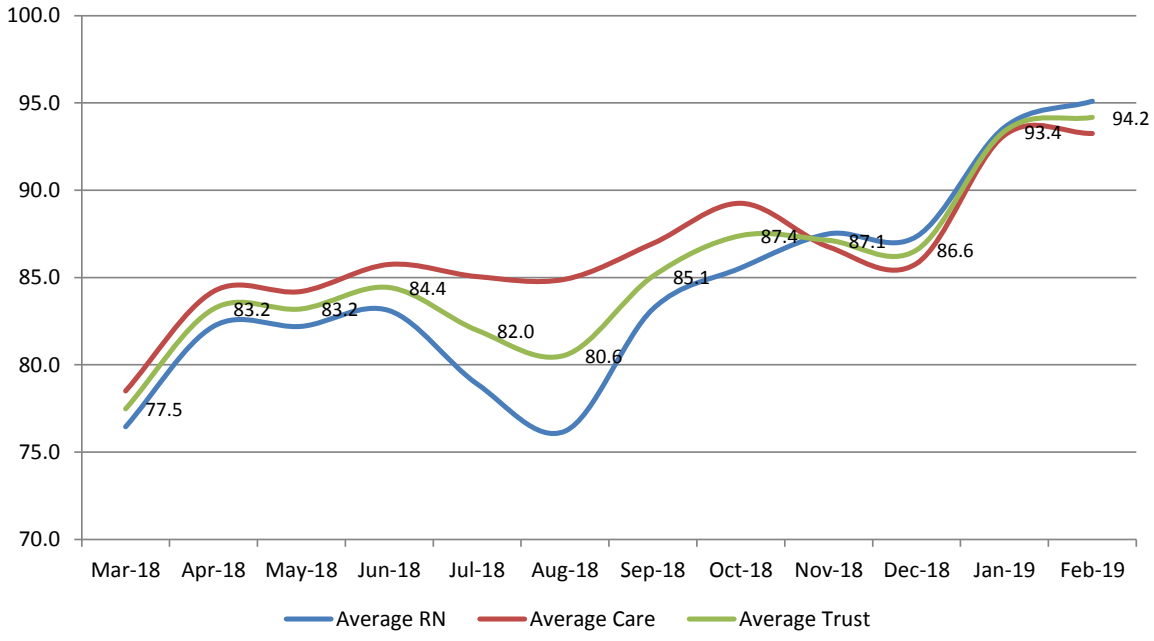
3.3 Care Hours per Patient Day* (CHPPD) has been confirmed as the national principle measure of nursing, midwifery and healthcare support worked deployment on inpatient wards (NHSI, 2018). From September 2018, publication of CHPPD replaced the actual v's fill dataset on My NHS and NHS Choices. CHPPD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

3.4 The summary position for the Trust Safer Staffing Fill rates for February 2019 is included in the table below (January 19 in brackets):

Trust average	Days RM/RN	Days Care staff	Nights RM/RN	Nights care staff	Av RM/RN	Av care staff	Av ALL staff
Trust average	80.7% (83.2%)	84.9% (84%)	109.5% (104.6%)	101.6% (102.3%)	95.1% (93.6%)	93.3% (93.2%)	94.2% (93.4%)
Change	↓2.5%	↑0.9%	↑4.9%	↓0.7%	↑1.5%	↑0.1%	↑0.8%

* *CHPPD is the total number of hours worked on the roster (clinical staff), divided by the bed state captured at 23.59 each day. For the purposes of reporting, this is aggregated into a monthly position.*

3.5 Fill rate: the rolling 12 month data is included in the table below:



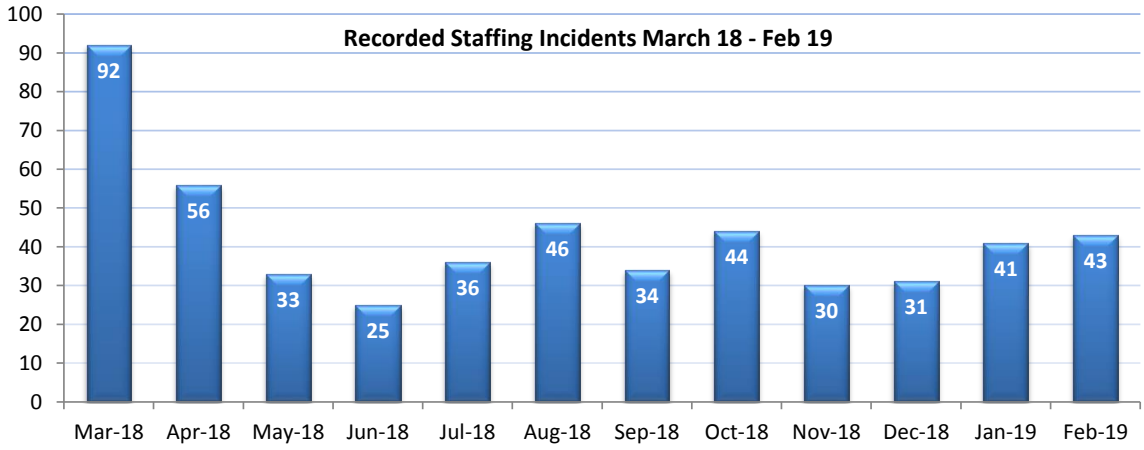
3.6 Exception reporting: Appendix 2 shows the exception report for the wards. The report includes analysis of the position, impact on quality, safety or experience and details actions in place to mitigate and improve the position where safe staffing is of concern.

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 the following areas is included below:

	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	83.4%	127.5%	93.1%	91.3%
PAH Theatres	89.0%	70.8%	99.6%	100.0%
Endoscopy Nursing	115.1%	99.9%	-	-

The above data has been calculated using the same methodology as the full UNIFY report

3.7 Datix reports: The trend in reports completed in relation to nursing and midwifery staffing is included below. All incidents continue to the reviewed by the safety and quality review process.

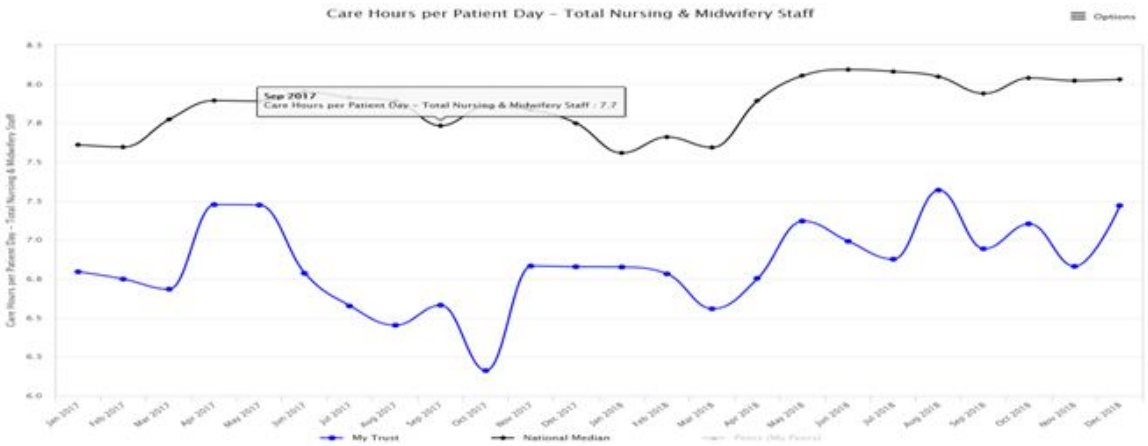


3.7.1 The Deputy Director of Nursing led a meeting in February to address the process for taking forward how the Trust will use and record Red Flags. This will develop further over the coming months and be incorporated in this report.

3.8 Care Hours per Patient Days (CHPPD): Data from the Model Hospital Dashboard (updated December 2018 data). PAH November data in brackets:

	December 2018 data	National Median	Variance against national median
CHPPD Total	7.2 (6.8)	8.0	0.8
CHPPD RN	4.3 (4.0)	4.8	0.5
CHPPD HCA	2.9 (2.8)	3.2	0.4

The graph below shows Care Hours per Patient Day (total Nursing and Midwifery Staff) taken from the Model Hospital site (data December 2018) showing PAH against the national median. While a CHPPD of 7.2 total staff and 4.3 RN is in the lowest quartile nationally, the data also shows that PAH has made an improvement in the CHPPD it provides.
A reduction in the vacancy rate would have a positive impact on the CHPPD.



3.9 Quality & Safety: The Trust started holding monthly nursing workforce meetings, which will provide an opportunity to review the shift templates, vacancies, skill mix, roster KPIs and nurse sensitive indicators including red flags. There will also be a corresponding move to undertake 'deep dives' in areas where there is concern, and provide a summary position in this report. The first meeting took place on the 5th March chaired by the Director of Nursing. The format of these meetings going forward will be formalised

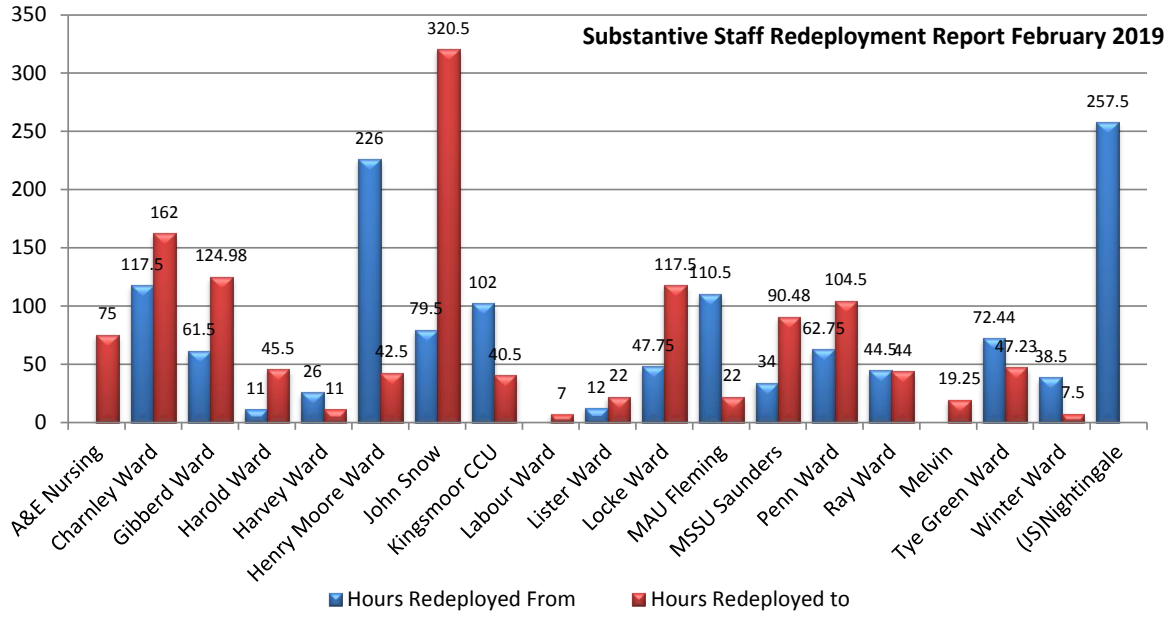
There were no beds closed as a result of staffing concerns during February 2019.

3.10 Mitigation: The day to day management of safer staffing across the organisation is managed through the operational huddles and use of SafeCare to ensure support is directed on a shift: shift basis as required in line with 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.

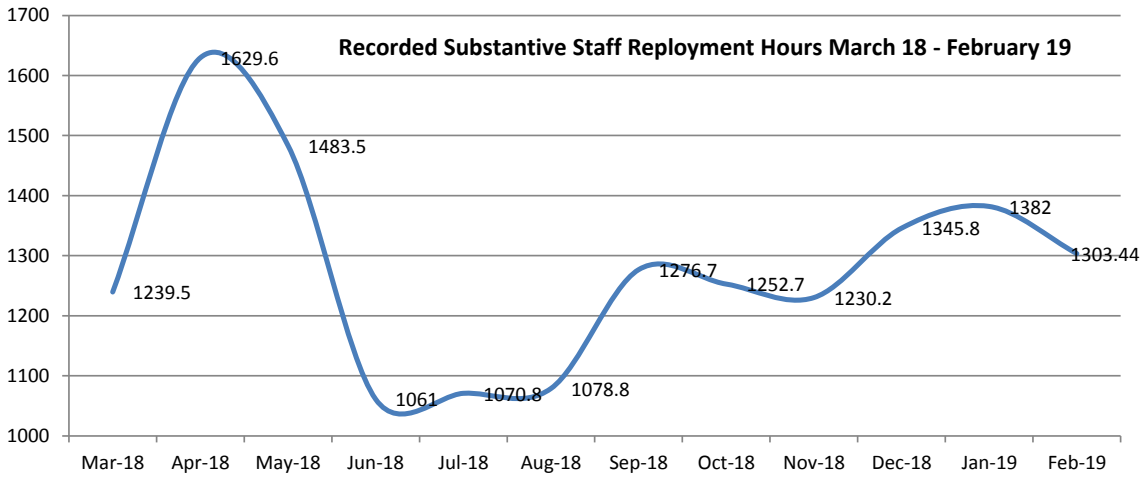
In order to support the safer staffing processes further, the Director of Nursing has requested the senior nursing team develop a safer staffing policy. The policy was reviewed and approved at the Nursing, Midwifery and Allied Health Professional Senior Leadership Team meeting in March, and will commence implementation.

The Trust continues to develop a "specialist pool" of HCAs to be used when vulnerable patients require close observation (patients with dementia, learning disabilities or those at high risk of falling). A study day regarding this took place in February and the Matron for Quality is currently fine tuning the process and writing the SOP.

3.11 Redeployment of staff: the following graph shows the redeployment of substantive Trust staff by hours and does not capture the moves of bank or agency staff.



The graph shows each of the Safer Staffing Wards and the number of hours of staff redeployed from the ward to support safe staffing and the number of hours of staff received. The maternity wards have been excluded from this report as they flex staff across the whole service dependant on patient and service needs.



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.

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 an increase in registered demand (113 shifts) in February, and the total number of shifts filled has sustained its improved position remains improved. The HCSW demand also increased (217 shifts) and the

actual number of shifts filled is the highest ever, the impact of the Bank Pool on this continues to be monitored.
The impact of staff taking year end leave needs to be assessed on the increased demand.

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
November 2018	3,524	1,496	42.5 %	1,060	30.1 %	72.5 %	968	27.5 %
December 2018	3,622	1,490	41.1 %	982	27.1 %	68.2 %	1,150	31.8 %
January 2019	3,934	1,832	46.6 %	1,074	27.3 %	73.9 %	1,028	26.1 %
February 2019	4,047	1,824	75.1%	1,123	27.7%	72.8%	1,100	27.2%
February 2018	4,265	1,340	31.2%	1,019	23.7%	54.9%	1,936	45.1%

5.2

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
November 2018	2,029	1,455	71.7 %	0	0.0 %	71.7 %	574	28.3 %
December 2018	2,099	1,528	72.8 %	0	0.0 %	72.8 %	571	27.2 %
January 2019	2,132	1,663	78.0 %	0	0.0 %	78.0 %	469	22.0 %
February 2019	2,349	1,723	73.4%	0	0%	73.4%	626	26.6%
February 2018	1,980	1,159	58.5%	0	0%	58.5%	821	41.5%

In order to support safe staffing, in December 2018 the Trust launched an initiative aimed at increasing the bank fill rates.
This has been a success, with NHSP stating that there has been an increase in recruitment to NHSP from all avenues along with an increase in fill rate during the time the initiative has been running. EMT reviewed the impact of the incentives, and have agreed continuation over April.

B:

Workforce:

Nursing Recruitment Pipeline

The registered nursing vacancy rate (currently at 26%) remains one of the organisations biggest challenges. The bulk of this sits within the band 5 nursing establishment where 37% of the posts are vacant. The trust seeks to significantly reduce the vacancy position for band 5 nurses throughout 2019, with a concerted overseas recruitment campaign that will implement a programme of international nurse recruitment over the next financial year and into 2020/21.

The focus of our nursing recruitment campaigns is to employ band 5 registered nurses. Whilst we seek to do this nationally, UK supply is severely limited resulting with an increase drive to recruit internationally.

The table below highlights our band 5 nursing establishment and the corresponding recruitment pipeline. As at end of February 2019, there were 181 WTE vacant band 5 posts, the trajectory of the plan effectively reduces this by 70% (52 WTE vacancies) by the end of 2019.

Establishment V Staff in Post													
Funded Establishment WTE	919.88	919.88	919.88	939.88	939.88	939.88	939.88	939.88	939.88	939.88	939.88	979.88	
Staff in Post WTE	681.57	681.57	687.57	687.57	703.57	734.57	765.57	798.57	837.57	869.57	902.57	944.57	
Vacancy WTE	238.31	238.31	232.31	252.31	236.31	205.31	174.31	141.31	102.31	70.31	37.31	35.31	Vacancy Rate
Forecast RN Vacancy Rate	25.9%	25.9%	25.3%	26.8%	25.1%	21.8%	18.5%	15.0%	10.9%	7.5%	4.0%	3.6%	3.60
Band 5 Establisment V Staff in Post													
	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	
Funded Band 5 Establisment WTE	486.19	486.19	486.19	506.19	506.19	506.19	506.19	506.19	506.19	506.19	506.19	546.19	
Band 5 Staff in Post WTE	307.83	304.83	311.83	312.83	311.83	317.83	317.83	333.83	370.83	401.83	434.83	493.83	
Band 5 Conversion	1		8	5	3	10	4	20	35	35	37	53	
Vacancy Band 5 WTE	178.36	181.36	174.36	193.36	194.36	188.36	188.36	172.36	135.36	104.36	71.36	52.36	Vacancy Rate
Forecast Band 5 Vacancy Rate	36.7%	37.3%	35.9%	38.2%	38.4%	37.2%	37.2%	34.1%	26.7%	20.6%	14.1%	9.6%	9.59

Starters Pipeline												
	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19
RNs	5	3	2	2	2	2	2	2	2	2	2	2
Newly Qualified/ Pre Reg Nurses	1	0	3	0	0	0	0	0	6	0	0	10
International Recruitment												
Skype Recruitment	2	2	6	3	16	30	30	30	30	30	30	30
India Campaign (July 18)	2	1	1	1	2	1	2	2	2	2	2	2
Philipines Campaign (Dec 18)	0	0	0	0	2	4	3	5	5	4	5	4
Provisional Starters	**10**	**6**	**12**	**6**	**22**	**37**	**37**	**39**	**45**	**38**	**39**	**48**
Confirmed Starters	**10**	**6**										

Weekly planned skype interviews and offers												
	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19
Planned Skype Interviews	26	26	50	50	50	50	50	50	50	50	50	50
Planned Skype Offers	13	11										

Average Band 5 Leavers WTE												
	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19
Projected Band 5 RN Leavers	6	6	6	6	6	6	6	6	6	6	6	6
Confirmed Band 5 RN Leavers	5	4										

The above demonstrates that international recruitment is fundamental towards aiding the reduction of our vacancy rate;

- This is a two-pronged approach recruiting either 'in country' interviewing face to face or online via Skype. We have consulted with a number of recruitment agencies to provide candidates towards our skype recruitment programme. Skype interviews are conducted weekly, and allow candidates to start in post quicker than via campaign.
- From the above, we average approximately 6 WTE registered nurse leavers a month; work will continue to embed the nursing retention plan to reduce this figure.

Attraction & Retention

- Utilising LinkedIn & twitter to promote our vacancies, using imagery to portray the staff experience

- Nursing recruitment open days to be held through the remainder of 2019 (April, June, September & November), with varied promotion on social media, trust website and Heart Radio campaigns.

- Periodic 'post induction check-ins' for our recent starters (held at 3, 6, 9 months - linked to career clinics) and for any themes raised to inform initiatives and plans to aid retention;

- International recruitment buddies/network, to formalise the integration of our international recruits with existing overseas nurses. This will include;
    - Buddying for new employees
    - 'Itchy feet' coaching for those employees who are looking for their next step
    - Career development coaching

- We also seek to maximising on the apprenticeship and graduate schemes to support staff development

Effective rostering and efficient use of resources:

- The rostering policy is under review to ensure this is aligned to NHSI e-rostering good practice guidance (2018), which will include rota KPIs in line with national guidance. The E Roster Manager is meeting with the Director of Nursing to finalise the policy prior to the ratification process.
- Roster Perform, which provides an accessible retrospective and prospective view of rostering metrics, will be made visible and used to demonstrate performance and drive forward improvements. Importantly, the system will enable a prospective view of rota fill, and identify areas that can be actioned in advance to improve availability (peaks in annual leave, study leave). The E Roster team continues the roll out training on this.

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
Sharon McNally – Director of Nursing and Midwifery

Date:

Appendix 1.

Ward level data: fill rates February 2019.

Ward name	DAY				NIGHT			
	Registered midwives/nurses		Care Staff		Registered midwives/nurses		Care Staff	
	Average fill rate	*ind*	Average fill rate	*ind*	Average fill rate	*ind*	Average fill rate	*ind*
Dolphin Ward	80.4%	▼	81.2%	▼	92.3%	▲	173.3%	▼
Kingsmoor CCU	81.0%	▲	92.5%	▲	97.3%	▲	108.5%	▲
MAUFleming	57.1%	▲	60.2%	▼	74.9%	▲	90.1%	▼
Tye Green	95.5%	▲	118.0%	▲	155.8%	▲	118.7%	▲
Harvey Ward	79.7%	▼	115.0%	▼	134.3%	▲	105.6%	▲
ITU & HDU	85.7%	▼	29.2%	▲	88.8%	▼	-	▶
John Snow	88.4%	▼	100.9%	▲	98.2%	▲	111.5%	▲
Charnley Ward	75.4%	▼	88.1%	▼	111.6%	▲	92.8%	▼
Lister Ward	95.4%	▲	97.7%	▲	142.9%	▲	99.5%	▼
Locke Ward	79.7%	▼	105.2%	▼	125.1%	▲	162.3%	▲
Neo-Natal Unit	93.8%	▲	50.2%	▼	91.9%	▲	50.2%	▼
Penn Ward	70.6%	▼	95.7%	▼	162.5%	▲	98.2%	▼
Ray Admissions Unit	95.1%	▲	80.3%	▼	160.1%	▲	100.6%	▼
MSSU Saunders	86.2%	▼	109.7%	▲	164.4%	▲	98.9%	▲
Harold Ward	57.4%	▼	99.3%	▲	130.3%	▲	108.4%	▲
Henry Moore Ward	84.9%	▲	73.8%	▲	96.7%	▲	45.2%	▼
Gibberd Ward	65.0%	▲	98.6%	▲	65.3%	▲	111.7%	▼
Winter Ward	70.9%	▲	106.5%	▲	97.8%	▼	178.4%	▲
Chamberlen Ward	79.7%	▼	71.0%	▼	76.5%	▼	67.9%	▼
Labour Ward	78.5%	▼	49.7%	▼	75.5%	▼	56.3%	▼
Birthing Unit	80.9%	▼	66.7%	▼	83.8%	▼	78.6%	▲
Samson Ward	93.1%	▼	78.5%	▲	83.5%	▼	78.0%	▲
TRUST	80.7%	▼	84.9%	▲	109.54%	▲	101.65%	▼

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

Feb 19

	Report from the Associate Director of Nursing for the HCG		
Ward	Analysis of gaps	Impact on Quality / outcomes	Actions in place
MAU Fleming	Vacancies affecting the overall fill rate.	No measurable increase in patient experience concerns, or incident severity noted.	Proactive recruitment and retention campaign in place, support and oversight from senior nursing team.
Henry Moore	Ward hasn't been working to full patient capacity and so staffing appropriate for the period	No impact noted.	Staff have been moved to other areas to support safe staffing (see section 3.11)
Gibberd	Vacancies affecting the overall fill rate. Overall improving trajectory of staffing vacancies.	There has been an increase in incidence relating to management of pressure areas, which is being supported by the senior nursing team and the Tissue Viability Team. No measurable increase in patient experience concerns, or incident severity noted.	Improvement plan in place, including proactive recruitment and retention campaign in place, support and oversight from senior nursing team. New ward leadership in place (following secondment of current ward manager).
Winter	Vacancies affecting the overall fill rate, along with other leave (maternity)	No measurable increase in patient experience concerns, or incident severity noted. Dip in hand hygiene compliance – being addressed by the ward manager.	Proactive recruitment and retention campaign in place, support and oversight from senior nursing team.
Neo Natal Unit	Current vacancies are being used in the reconfiguration of staffing to meet BAPM recommendations in order to create Band 5 QIS roles. Ongoing work	No direct impact on quality or safety noted. Good skill mix and improved ratios across the team	Oversight and proactive management of vacancies.
Chamberlen / Labour/ Birthing Unit	Long term sickness within maternity, there is a plan for all staff to return to work, also	No direct impact on quality or safety noted.	Absence policy is adhered to. On-going monitoring and proactive recruitment to vacancies.

/ Samson	Maternity leave has increased . Staffing managed and flexed across the maternity service.	Core compliance for FAWs 90%	

The Princess Alexandra Hospital NHS Trust

Trust Board (Public) – 4 April 2019

5.3

Agenda Item:	5.3
Presented by:	Dr Andy Morris
Prepared by:	Andy Morris, Julie Matthews, Alan Zeller
Date prepared:	20/03/19
Subject / Title:	7 Day Services at PAH

Purpose:	Approval	x	Decision		Information	x	Assurance	

Key Issues: [please don't expand this cell; additional information should be included in the main body of the report]	The Trust is required by NHSI to self-assess its services against 4 key indicators. NHSI also require this to be reported and approved by the Trust board. The Trust is compliant with all 4 of them but there is some variation within these at the weekends.
Recommendation:	Trust Board is asked to note the report.

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:	BAF risk 1.1 Outcomes
Legislation, regulatory, equality, diversity and dignity implications:	This is a requirement set down by NHSI
Appendices:	7 Day self-assessment

respectful | caring | responsible | committed

7 Day Hospital Services Self-Assessment

Organisation	**The Princess Alexandra Hospital NHS Trust**
Year	**2018/19**
Period	**Autumn/Winter**

The Princess Alexandra Hospital NHS Trust: 7 Day Hospital Services Self-Assessment - Autumn/Winter 2018/19

Priority 7DS Clinical Standards

Clinical standard	Self-Assessment of Performance	Weekday	Weekend	Overall Score
Clinical Standard 2: All emergency admissions must be seen and have a thorough clinical assessment by a suitable consultant as soon as possible but at the latest within 14 hours from the time of admission to hospital.	Provide a brief summary of performance against this standard, highlighting any areas for improvement in the case of non-compliance	Yes, the standard is met for over 90% of patients admitted in an emergency	Yes, the standard is met for over 90% of patients admitted in an emergency	Standard Met

Clinical standard	Self-Assessment of Performance		Weekday	Weekend	Overall Score
Clinical Standard 5: Hospital inpatients must have scheduled seven-day access to diagnostic services, typically ultrasound, computerised tomography (CT), magnetic resonance imaging (MRI), echocardiography, endoscopy, and microbiology. Consultant-directed diagnostic tests and completed reporting will be available seven days a week: • Within 1 hour for critical patients • Within 12 hour for urgent patients • Within 24 hour for non-urgent patients	Q: Are the following diagnostic tests and reporting always or usually available on site or off site by formal network arrangements for patients admitted as an emergency with critical and urgent clinical needs, in the appropriate timescales?	Microbiology	Yes available on site	Yes available on site	Standard Not Met
		Computerised Tomography (CT)	Yes available on site	Yes available on site	
		Ultrasound	Yes available on site	Yes available on site	
	This standard is met on weekdays across all elements. Areas of non compliance to the standard are Endoscopy and Echo's at weekends. Informal arrangements in place to provide weekend cover. Scoping exercise being undertaken to to calculate resources required to provide weekend cover.	Echocardiography	Yes available on site	No the test is not available	
		Magnetic Resonance Imaging (MRI)	Yes available on site	Yes available on site	
		Upper GI endoscopy	Yes available on site	No the test is not available	

Clinical standard	Self-Assessment of Performance		Weekday	Weekend	Overall Score
Clinical Standard 6: Hospital inpatients must have timely 24 hour access, seven days a week, to key consultant-directed interventions that meet the relevant specialty guidelines, either on-site or through formally agreed networked arrangements with clear written protocols.	Q: Do inpatients have 24-hour access to the following consultant directed interventions 7 days a week, either on site or via formal network arrangements?	Critical Care	Yes available on site	Yes available on site	Standard Met
		Interventional Radiology	Yes available off site via formal arrangement	No the intervention is only available on or off site via informal arrangement	
		Interventional Endoscopy	Yes available on site	Yes available off site via formal arrangement	
		Emergency Surgery	Yes available on site	Yes available off site via formal arrangement	
	No formal networks in place for IR, discussions underway with STP for network solution moving forward	Emergency Renal Replacement Therapy	Yes available on site	Yes available off site via formal arrangement	
		Urgent Radiotherapy	Yes available off site via formal arrangement	Yes available off site via formal arrangement	
		Stroke thrombolysis	Yes available off site via formal arrangement	Yes available off site via formal arrangement	
		Percutaneous Coronary Intervention	Yes available on site	Yes mix of on site and off site by formal arrangement	
		Cardiac Pacing	Yes available on site	Yes mix of on site and off site by formal arrangement	

Clinical standard	Self-Assessment of Performance	Weekday	Weekend	Overall Score
Clinical Standard 8: All patients with high dependency needs should be seen and reviewed by a consultant TWICE DAILY (including all acutely ill patients directly transferred and others who deteriorate). Once a clear pathway of care has been established, patients should be reviewed by a consultant at least ONCE EVERY 24 HOURS, seven days a week, unless it has been determined that this would not affect the patient's care pathway.	Very low number of patients requiring twice daily reviews on weekends are affecting the data as only 5 patients required twice daily reviews and 2 were not seen Overall position was 90% compliance with 96% of weekday patients seen and 60% at weekend	Once daily: Yes the standard is met for over 90% of patients admitted in an emergency	Once daily: Yes the standard is met for over 90% of patients admitted in an emergency	Standard Not Met
		Twice daily: Yes the standard is met for over 90% of patients admitted in an emergency	Twice Daily: No the standard is not met for over 90% of patients admitted in an emergency	

7DS Clinical Standards for Continuous Improvement

Self-Assessment of Performance against Clinical Standards 1, 3, 4, 7, 9 and 10
Provide a brief overall summary of performance against these standards Since 2015 Princess Alexandra NHS trust has achieved 90% plus in the four clinical standards CS2 74% 2016 - 90% 2018 , CS5 93% 2016-2018, CS6 94% 2016-2018, CS8 83% - 2016 90% - 2018 Some of the main drivers behind this improvement are the introduction of professions clinical standards, using Urgent care board and Senior management tream meeting to monitor the standards. There is more work to be done on understanding our situation and we have weak spots in Endoscopy, IR and Consultant reviews at the weekends. All are being review and risk assessed.

7DS and Urgent Network Clinical Services

	Hyperacute Stroke	Paediatric Intensive Care	STEMI Heart Attack	Major Trauma Centres	Emergency Vascular Services
Clinical Standard 2	N/A - service not provided by this trust	N/A - service not provided by this trust	N/A - service not provided by this trust	N/A - service not provided by this trust	N/A - service not provided by this trust
Clinical Standard 5	N/A - service not provided by this trust	N/A - service not provided by this trust	N/A - service not provided by this trust	N/A - service not provided by this trust	N/A - service not provided by this trust
Clinical Standard 6	N/A - service not provided by this trust	N/A - service not provided by this trust	N/A - service not provided by this trust	N/A - service not provided by this trust	N/A - service not provided by this trust
Clinical Standard 8	N/A - service not provided by this trust	N/A - service not provided by this trust	N/A - service not provided by this trust	N/A - service not provided by this trust	N/A - service not provided by this trust

Assessment of Urgent Network Clinical Services 7DS performance (OPTIONAL)
Provide a brief summary of issues in cases where not all standards are met.

Template completion notes

Trusts should complete this template by filling in all the yellow boxes with either a free text assessment of their performance as advised or by choosing one of the options from the drop down menus.

The Princess Alexandra Hospital NHS
NHS Trust

Trust Board – 4 April 2019

Agenda Item:	6.1
Presented by:	Ogechi Emeadi – Director of People
Prepared by:	Charlotte Jefferson, Head of Staff Engagement
Date prepared:	27 March 2019
Subject / Title:	Staff Survey 2018 Response Plan

Purpose:	Approval		Decision		Information	x	Assurance	

Executive Summary: [please don't expand this cell; additional information should be included in the main body of the report]	The NHS Staff Survey 2018 closed on 30 November 2018, giving us a final 40% response rate. Picker, our survey provider, has since issued a series of internal benchmarking reports, and national benchmarking reports are now available published via the Survey Coordination Centre (www.nhsstaffsurveys2018.com). Workshops have been held throughout January, February and March with each of our Health Care Groups (HCGs), to support them in developing action plans. Specific areas of focus have also been identified for centrally coordinated improvement work. All progress against action plans will be monitored on an ongoing basis by the Staff Engagement Steering Group.
Recommendation:	To note.

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

Previously considered by:	
Risk / links with the BAF:	BAF 2.2 – Clinical Leadership and Engagement BAF 2.3 – Internal Engagement BAF 2.4 – Workforce Capability
Legislation, regulatory, equality, diversity and dignity implications:	
Appendices:	

The Princess Alexandra Hospital NHS
NHS Trust

NHS Staff Survey 2018 – Response Plan

Background

The NHS Staff Survey 2018, managed through Picker, launched on 5th October 2018 and closed on 30th November 2018. Our closing response rate was 40%, an increase from the previous year.

Reports

The following reports have been received and requested from The Picker Institute Europe, our survey provider, and the Survey Coordination Centre, the national body providing survey benchmarking data across all participating NHS organisations.

Received	Further requested
• Picker - management report • Picker – RAG report (by HCG, division & team) • Picker – locality reports (by HCG, division & team) • Picker – free text report (by HCG & division) • Picker – staff engagement report (by HCG, division & team) • Survey Coordination Centre – national benchmarking report • Survey Coordination Centre – directorate comparison report	• Survey Coordination Centre – detailed benchmarking data (due end of March 2019 • Picker – free text analysis report (due April 2019)

Key themes

Key themes can be identified by making comparisons to our results from the previous year's survey, and by comparing our results against the national average for acute trusts.

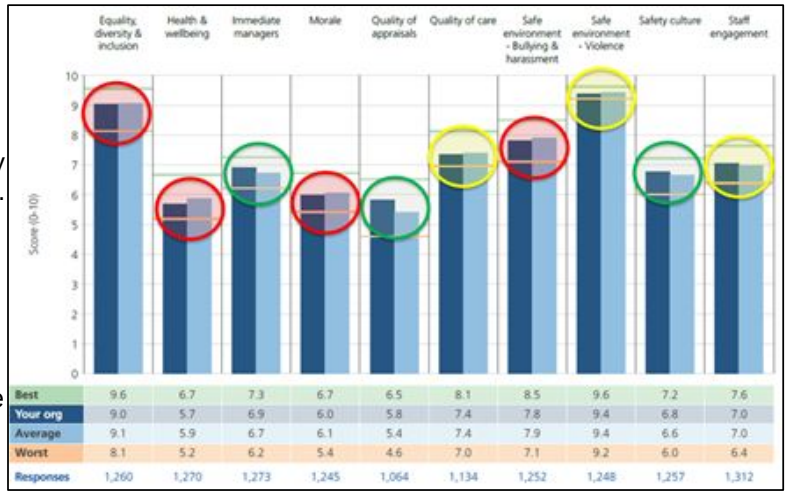
Internal benchmarking

There are 90 questions in total within the survey. Compared to results from the previous year, we have demonstrated significant improvement in 15 questions, notable improvement in a further 29 questions, and no change in the remaining questions. We have not seen any significant deterioration in responses to any question. Our most and least improved questions are below:

	Most improved from last survey		Least improved from last survey
57%	Would recommend organisation as place to work	67%	Last experience of physical violence reported
56%	Satisfied with recognition for good work	77%	In last month, have not seen errors/near misses/incidents that could hurt staff
34%	Satisfied with level of pay	67%	In last month, have not seen errors/near misses/incidents that could hurt patients
46%	Have adequate materials, supplies and equipment to do my work	80%	Not experienced harassment, bullying or abuse from other colleagues
46%	Satisfied with extent organisation values my work	71%	Immediate manager can be counted on to help with difficult tasks

National benchmarking

Nationally, the results are broken down into 10 key themes. The Trust is amongst the best in the country for immediate line manager, quality of appraisals and safety culture. We rank below average (by between 0.1-0.2 points) for the following areas: equality, diversity and inclusion, health and wellbeing, morale and safe environment: bullying and harassment, and rank the same as average in quality of care, safe environment: violence and staff engagement.



Response plan overview

Timescale	Actions
January	• Initial management report & RAG report received from Picker • Results discussed at SMT • Workshop held with representatives Trust-wide
February	• Locality reports received from Picker • HCG workshops held - Estates & Facilities 4/2/19 - CCCS 5/2/19 - Corporate 8/2/19 - Surgery 18/2/19
March	• HCG workshops held - Medicine 7/3/19 - FAWS 15/3/19 • Local engagement in creating action plans
April	• All local action plans to be returned by 5/4/19 • Local staff experience groups set up
May onwards	• Progress against action plans reviewed at Staff Engagement Steering Group & local Staff Experience Groups • Staff Friends & Family Test feedback also used to bolster review of progress & identification of achievements and/or concerns

Trust-wide actions
Each HCG is currently developing an overarching action and communications plan in response to the top five concerns and the top five achievements identified in the survey results. These plans will detail where a particular department/team is particularly noted as requiring improvement.

Themes that are identified as having notable impact across the Trust are being prioritised for improved work coordinated by the Head of Staff Engagement with support and input from the Staff Engagement Steering Group. To date, the key themes prioritised for focus Trust-wide improvement work are bullying harassment from managers and colleagues, and physical violence from managers and colleagues. These two themes identify wholly unacceptable behaviours, and require a further deep-dive to understand the issues. The numbers of staff reporting experiencing these behaviours far outweigh the number of cases reported to our Human Resources team, and furthermore the survey results confirm that a vast majority of staff didn't report the incident(s).

A number of pieces of work focused on values and culture are also currently in development that will further support improvement in staff experience, including Values and Behaviours Workshops, Unconscious Bias training, Bullying & Harassment training, and Induction for Managers.

Monitoring
All HCG action plans will be reviewed and monitored at the Staff Engagement Steering Group, chaired by the Head of Staff Engagement. Local staff experience groups are in the process of being set up, and will monitor progress against action plans and make any required updates to action plans locally.

Author: Charlotte Jefferson, Head of Staff Engagement
Date: 27/3/19

The Princess Alexandra Hospital NHS
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Trust Board – 4 April 2019

6.2

Agenda Item:	6.2
Presented by:	Ogechi Emeadi, Director of People, OD & Communications
Prepared by:	Ogechi Emeadi, Director of People, OD & Communications
Executive Director Sponsor	Ogechi Emeadi, Director of People, OD & Communications
Subject / Title:	People Strategy 2019 to 2024

Purpose:	Approval	X	Decision		Information		Assurance	

Executive Summary: [please don't expand this cell; additional information should be included in the main body of the report]	The People Strategy-on- a- Page was developed in May 2018 following a workshop. The current director of people, OD & communications has expanded the strategy to provide greater detail and context to its vison of making it a joy to work at the Trust. Key stakeholders have contributed to the detailed strategy. The committee approved the people strategy subject to clarification that our specific people measures will be set in the trust's annual operating plan and adding "registered nurse vacancies" as a weakness to the SWOT analysis
Recommendation:	The committee is asked to approve the people strategy – Joy to Work at The Princess Alexandra Hospital NHS Trust. .

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:	Executive Management Team People Board Joint Consultative Committee
Risk / links with the BAF:	2.1 Workforce capacity 2.3 Internal engagement 2.4 Workforce capabilities
Legislation, regulatory, equality, diversity and dignity implications:	CQC – Well led
Appendices:	Appendix 1 - People Strategy

The Princess Alexandra Hospital NHS Trust

PEOPLE STRATEGY AND PLAN UPDATE

1.0 PURPOSE

The People Strategy-on- a- Page was developed in May 2018 following a workshop. The current director of people, OD & communications has expanded the strategy to provide greater detail and context to its vison of making it a joy to work at the Trust. Key stakeholders have contributed to the detailed strategy. The committee is asked to approve the people strategy.

2.0 PEOPLE STRATEGY ENGAGEMENT PLAN

Below are details of the key stakeholder groups that contributed to the detailed people strategy.

		Dates
Communication Channels	Survey monkey	March 2019 - completed
	In Touch	March 2019 - completed
	Staff brief	March 2019 - completed
Key stakeholders and committees	Executive Management team	Dec 18 – Mar 19 - completed
	People Board	Jan 19 – Mar 19 - completed
	Joint Staff Consultative Committee	Jan 19 – Mar 19 - completed
	Medical Advisory Committee	February 19 – Mar 19 - completed
	Staff Council	February 2019 - completed
	Workforce Committee	Nov 18, Jan 19

3.0 NEXT STEPS

Work will now be undertaken to describe and implement a people plan with deliverables for 2019/20. Monitoring and progress of the deliverables will be presented at future workforce committees.

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4.0 RECOMMENDATION

The committee is asked to approve the people strategy – Joy to Work at The Princess Alexandra Hospital NHS Trust.

Author: Ogechi Emeadi, Director of people, OD & communications
Date: 19th March 2019

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Appendix 2

People Pillar	Summary of actions for Q3
Culture	**Employer Based Awards** • Process launched in September, applications/invites have been sent out and process in line with agreed published timelines. • The panel meet on February 2019 after which time, the award holders will be published in (In touch/ circulated to MAC and JLNC) • **Staff Council** • Relaunch of Staff Council • February 2019 Staff Council agenda agreed and circulated. Invitations and communication sent. **Staff App** • Group established to take the Staff App forward **Staff Survey 2018** • Themed "you said, we did" feedback released weekly (x8) at Exec briefing leading up to and during the 2018 Staff Survey **Staff Survey 2018** • Draft Picker report presented at January Senior Management Team meeting • Workshops and Action Planning sessions held in each HCG • HCG Action Plans to be monitored by HRBP's and at PRM's **Talent Management** • New incremental progression framework and appraisal policy produced. • TM guidance, and processes in development **Equality and Inclusion** • 5 staff members completed the ILM level 4 Award in E&D • Application for 2 members of staff submitted to commence in Dec 18 • Steering group meets monthly • E&I forums established for LGBT+ and BAME

	• Greater promotion of the inclusion champions • Equality and Inclusion Annual Report **Leadership** • Our Behaviour Charter sessions in development • Staff Engagement forum established
Health and Wellbeing	**Health and Wellbeing Day as part of EIAT:** • Successful launch of 2018 Flu campaign with circa 70 % front line staff vaccinated to date • Launch of Shaw Newsletter and updated intranet pages • Increased Twitter presence to inform staff • Mental Health Aid Training for managers held. • Mental Health Awareness days supported by literature and support via Healthy minds • Mental Health First Aider training commissioned for over 20 staff • Employee Assistance Programme tendered and launch with Health Assured as provider. • Evaluation of anonymous feedback from staff counsellor, shared with EAP provider • Increased offer of Gym membership and external classes • Stop smoking and healthy lifestyles clinics held • Increased workplace screening for high risk staff groups
Workforce Planning and Resourcing	Q3 has seen a bank rise in fill due to external recruitment and demand management work with E Rostering. Currently at M9 we are reaching 50% or above fill on bank (in line with the contract KPIs) except in qualified nursing which is currently at 41% (an increase by 10% since M1) At the end of Q3 agency spend is below the M9 target of £5.1M
Learning Leadership and Team Development	**Staff Appraisal** • Ongoing support to help ensure compliance • Managers Appraisal training ongoing • Introduced Managers Appraisal recording confirmations via ESR • New paperwork being considered as part of talent management and Pay Progression **Leadership and Team Development** • All offerings on Alex intranet 'Learning Zone' pages • Team Development sessions now widely offered – take up very good • Coaching training sessions and coaching offer widely available • The Trusted Executive commenced Coaching Board members following launch event in July

	• Mary Seacole and other Leadership Academy offerings available as released by HEE
Optimising Technology -MyESR	**Q3 Completed Actions** • Ongoing promotion of MyESR to all domestics and facilities staff • Successful completions of drop in session for all domestic and facilities staff – 90% attendance with a further weekend drop-in session due at the end of the month • Trust Communications to switch off paper pay slips will commence on 1st December 2018 • The final paper payslips will be distributed across the Trust on 28th March 2019

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People strategy 2019 - 2024

A joy to work at The Princess Alexandra Hospital NHS Trust

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Lance McCarthy
Chief executive

"Our ambition is clear – to deliver outstanding care to our local community. Our patients deserve this and should be demanding it. It is also clear that our people, our biggest asset, are key to achieving this ambition. Outstanding care and patient experiences will only be achieved if our people also have outstanding experiences and joy at work on a daily basis. This means having a supportive culture with consistent values and behaviours aligned with this, always feeling supported and having the opportunity to develop personally and professionally and working in a modern, technologically enabled organisation. Our People Strategy is focussed on making PAHT the best hospital in the NHS in which to work, making it a joy to work to here, and enabling our local community to consistently receive outstanding care."

"We have a lot to celebrate. Our people are talented and dedicated. They are passionate about what they do and the many thousands of patients they care for. Without their dedication we could not deliver our diverse range of services and they are key to designing how we will deliver our future services which will provide excellence in patient care. Ensuring they have joy at work through how they are recruited, developed, supported, engaged and valued is critical to our success."

Ogechi Emeadi
Director of people, organisational development and communications

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The Princess Alexandra Hospital NHS Trust

Background

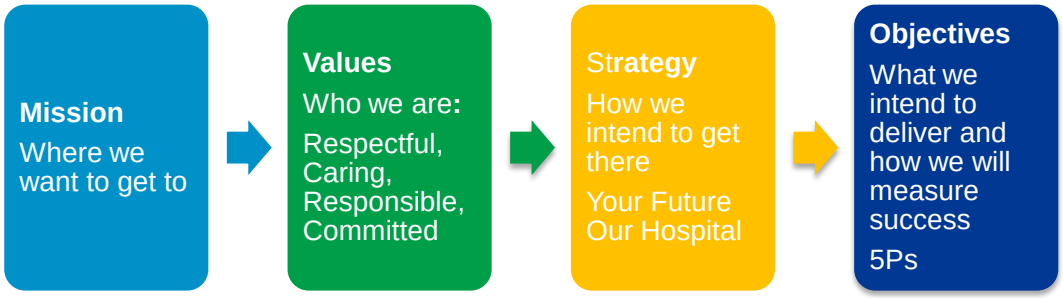
The Princess Alexandra Hospital NHS Trust plays a huge part in west Essex and east and north Hertfordshire's way of life.

The trust runs a busy hospital, The Princess Alexandra Hospital, and provides services at St. Margaret's Hospital, Epping and Herts and Essex Hospital. Together we serve a population of around 350,000 people.

We are dedicated to providing our patients with the right care, at the right time, in the right place; providing a wide range of services including: emergency, maternity, cancer and elderly care.

The trust constantly strives to improve services to give our patient safe care of the highest quality putting our community, people and partners at the heart of everything we do.

People strategy: in context



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Mission

The Trust's vision is to deliver outstanding healthcare to the local community and the Trust's mission is to put quality first in everything that is done.

Values and behaviours

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Our values, standards and behaviours were developed with staff and patients through our In Your Shoes programme and through staff workshops. They guide us as to how we can give better care, act with compassion and protect the most vulnerable people in our society and in our community, when they need us most.

The behaviours and standards help us to transform the care experiences we deliver and the support we give our people

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Our strategy

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- ✓ Providing outstanding healthcare and a first choice for patients
- ✓ Sustainable workforce, proud of The Princess Alexandra Hospital NHS Trust
- ✓ Well networked and sustainable services operating as part of an accountable care system
- ✓ First class clinical services – new hospital (2025)
- ✓ Financial sustainability across the local health system

Our objectives: 5 Ps

Underpinning the Trust's ambition to achieve outstanding healthcare is the five Ps. The trust board set five strategic objectives focussed on delivering the five Ps:

Five Ps	Trust objectives
	Our patients We will continue to improve the quality of care we provide our patients, improving our CQC rating and coming out of special measures.
	Our people Our people will deliver high quality care within a culture that improves engagement, recruitment and retention reinforced by improvements in our staff survey results.
	Our performance We will meet and achieve our performance standards, covering national and local operational, quality and workforce indicators.
	Our places We will maintain the safety of our places and improve the quality of our environment, whilst working with our partners to develop a strong case for a new build. This will be aligned with the development of a West Essex and East Hertfordshire Accountable Care Partnership.
	Our pounds We will manage our pounds and resources effectively to achieve our financial targets and control totals.

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Strategic context

The drive to develop integrated and new models of care continues. In this context, collaboration with partners across health and social care has taken a significant step forward across Hertfordshire and West Essex Integrated Care System (ICS).

Organisations have come together with a redefined purpose of bridging the gaps associated with care and quality, health and well-being and finance and sustainability.

In addition we are also working in greater partnership at a place based level with our health and social care partners. This is the West Essex Integrated Care Partnership (ICP). These strategic approaches will have important implications for how we work and therefore our people.

The people strategy therefore addresses our immediate and ongoing organisational challenges and needs but also the changing strategic landscape as we move towards greater system working.

Other factors that shape the people strategy are detailed on the page below.

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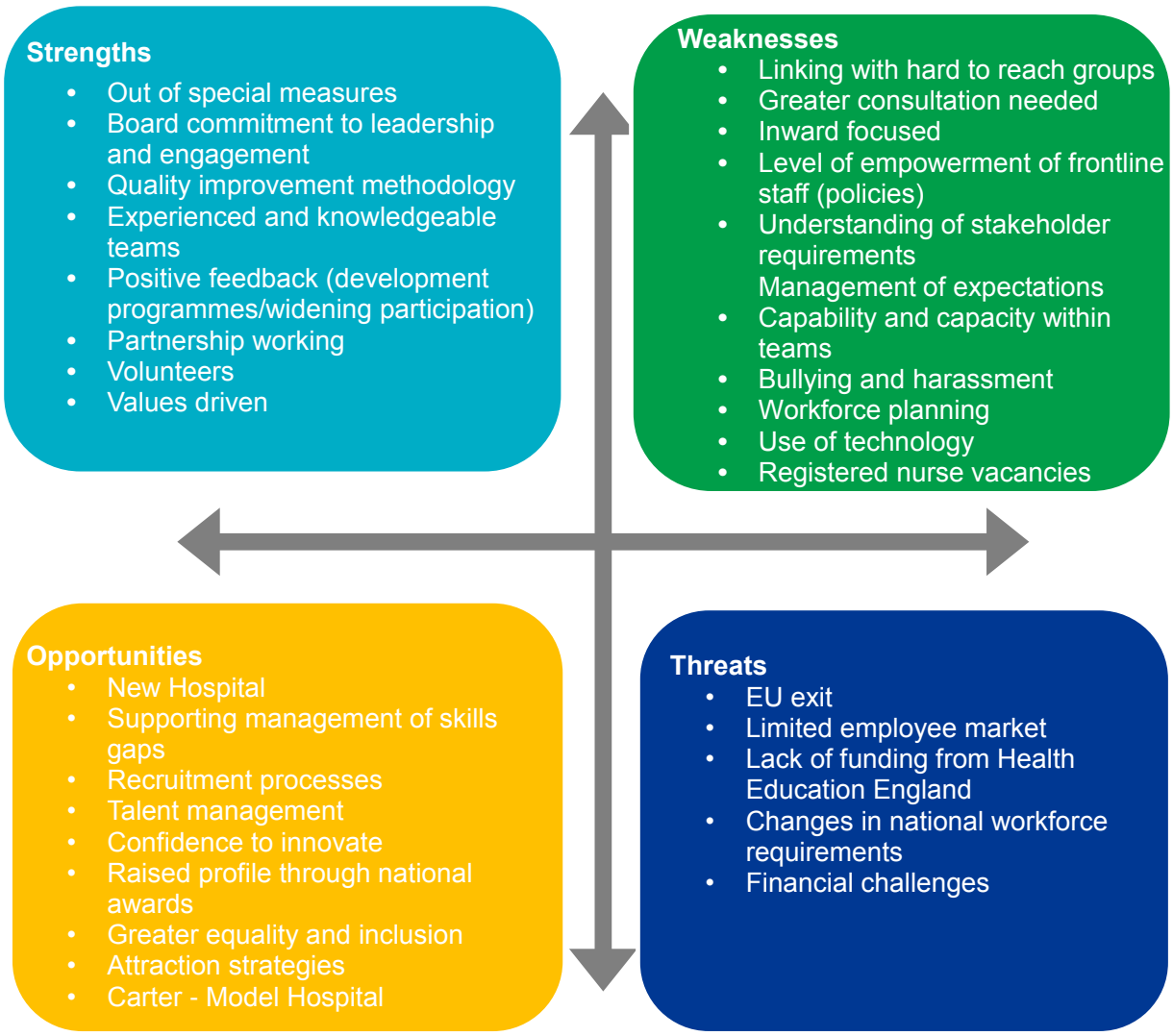

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Where we are now: facts and figures

Appraisal rate 88%	Nurses and midwives 826 WTE	Staff engagement score 7.0	Sickness absence 4.1%	Agency % of paybill 3.7%
Staff recommend trust as place to receive treatment 62%	Statutory and mandatory training 92%	Turnover 13.6%	Doctors 443 WTE	Bank spend 13.1%
Allied health professionals 132 WTE	No. of volunteers over 250	Apprentices 46	Staff recommend trust as a place to work - 57%	Vacancy rate 12.6%

Our people vision

Where people love coming to work and are highly productive on a daily basis. Our aim is to make work exciting, rewarding, stimulating, and enjoyable

Our people strategy

A workforce which is flexible and fully equipped with the appropriate skills, knowledge and resources to deliver highly effective evidence based treatments across our services. Collective leadership and devolution are at the heart of what we will do and how we will work.

We will take a strategic approach to talent management and talent is identified and individuals are developed, engaged and retained with the organisation.
All our people will show high levels of engagement and are committed to the Trust and its values and feel a sense of job satisfaction. They are involved in decision making and have the freedom to voice ideas and opportunities to develop their services.

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Our people will be empowered to maintain their own wellbeing while continuously improving the way in which care is delivered ensuring best quality outcomes for those using our services.

Our specific people measures will be set in the trust's annual operating plan.

Our people strategy: pillars

Our people strategy has five strategic objectives, the pillars, which are core to its delivery.

These are:

- **One.** Align and embed a health and wellbeing culture which is consistent with our vision, values and corporate goals
- **Two.** Develop and implement a workforce and resourcing plan which celebrates our employer brand and diversity
- **Three.** Invest appropriately in leadership and team development to attract and retain talent
- **Four.** Co-design and implement new service and workforce models across the STP and ACS
- **Five.** Maximise the use of technology to support professionals, productivity and efficiency

Implementation of the people strategy will contribute to fulfilling the commitments made in the Trust's overall vision and its success will be measured in terms of the outcomes it achieves across all aspects of the Trust.

Our approach to achieving these objectives within the People Strategy is to build on the progress made to date. The key actions to be taken are set out below under each of the five objectives listed, and supported by the people plan.

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People pillars

Pillar one

Align and embed a health and wellbeing culture which is consistent with our vision, values and corporate goals

This pillar seeks to help us move to a place where we can deliver even better care by taking better care of each other. This may mean changes to the way we lead, develop and support people.

- ✓ Ensuring our values and standards shape everything we do by continue to be embedded in our induction programmes, appraisal processes , recruitment and retention and education will be rolled out to all our people
- ✓ Develop our people to be to be highly engaged, motivated, calm, health and energised where they take ownership for their own health and wellbeing
- ✓ Provide our people with skills and access to high quality care and expertise to prevent harm and promote long term health
- ✓ Develop and prioritise facilities and services to help manage work and home more easily
- ✓ Physical and psychological safety (no harm) – our people will feel safe to raise concerns, encourage each other to do so and suffer no ill consequence as a result
- ✓ Fairness and equity for improving enjoyment
- ✓ Wellness, resilience, participative management, recognition, reward and feedback mechanism
- ✓ Health promotion events

Measures

- ➢ National staff survey results
- ➢ GMC survey results
- ➢ Staff Friends and Family Test – place to work
- ➢ Staff Friends and Family Test – place to be treated
- ➢ Sickness rates/themes
- ➢ Flu vaccination take up

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Pillar two

Develop and implement a workforce and resourcing plan which celebrates our employer brand and diversity

- ✓ Workforce transformation plan (new roles and ways of working – including apprenticeships) – build internal capacity and a capability to engage teams to redesign their people and plan for the future
- ✓ Conversion of students and trainee pipeline
- ✓ Employer brand and compelling proposition – be recognised as an employer of choice with exemplar attraction and recruitment strategies
- ✓ Entrepreneurial resourcing plan – develop tailored innovative strategies to attract and recruit 'hard to recruit' roles
- ✓ Recognition and reward schemes – reward and recognise individual and team contribution which supports the Trust's values and help deliver our corporate objectives and the best experience for
- ✓ Simplified and streamlined recruitment processes and systems – create an agile flexible attraction and recruitment framework which helps to deliver excellent candidates experience at every stage of the attraction, selection and onboarding process

Measures

- Vacancies
- New roles within the trust
- Bank and agency usage
- Exception reports
- Time to hire and join
- Staff awards – national and local
- Number of apprenticeships

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Pillar three

Invest appropriately in leadership and team development to attract and retain talent.

- ✓ Shared career and skills framework – design and develop an internal development framework for all staff so career ladders are easily identifiable for all staff groups
- ✓ Distributed leadership commitment framework
- ✓ Flexible learning delivery (including e-learning)
- ✓ Talent management – develop a comprehensive talent and succession strategy that operates at every stage of the employee journey and grows a leadership team
- ✓ Succession planning
- ✓ Appraisal supplemented by 360 – continue to embed effective e-appraisal throughout the organisation
- ✓ Apprenticeships to widen access to employment and higher level apprenticeships to support career pathways
- ✓ Strengthening innovation and leadership capabilities alongside critical technological skills
- ✓ Make talent and capabilities management a priority

Measures

- ➢ Statutory and mandatory training compliance
- ➢ Appraisal and 360
- ➢ Stability and turnover
- ➢ Internal promotions

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Pillar four

Co-design and implement new service and workforce models across the Hertfordshire and West Essex (H&WE) STP and Accountable Care System

- ✓ Maximise the attraction and retention of staff across H&WE
- ✓ Develop approaches to understand current and future workforce requirements
- ✓ Ensure the development and design of existing and new roles to meet the needs of
- ✓ the public
- ✓ Develop leadership capabilities to meet the needs of the evolving system
- ✓ Develop approaches to maximise efficiency and effectiveness of workforce processes and support eg temporary staffing; organisational development; mandatory training
- ✓ Support the development of a H&WE STP talent academy

Measures

- ➢ New roles across the ACS and ICP
- ➢ Joint roles with partner organisations
- ➢ Increase in workforce supply
- ➢ Number of work experience placements
- ➢ Number of active health/STEM (science, technology, engineering and maths) ambassadors

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Pillar five

Maximise the use of technology to support professionals, productivity and efficiency

- ✓ Implement and embed apps and other technology – to enable productive working and connections between and within our people groups providing electronic flows of demand data
- ✓ Utilising and maximising workforce systems to eliminate or reduce manual processes including:
  - ESR
  - e-learning
  - Self e-rostering to include best practice rostering
  - Staff extranet and website
  - Staff app
  - Use of digital messaging screens
  - Staff bank management model

Measures

- ➢ Staff App analytics
- ➢ e-learning take up
- ➢ Self-service rostering to include best practice rostering
- ➢ Enable a streamlined service provided by the people teams across our multiple sites by enhancing productivity and enable a focus on more value added tasks

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Our strategy in practice

Monitoring and review

Every year a set of key workforce deliverable will be developed and agreed and then progress against these will be tracked and monitored. This will ensure that progress against the workforce strategy is made. This monitoring and tracking will take place via:

- **Trust board:** they will receive regularly reports on progress against our annual objectives and key performance indicators on workforce within the performance dashboard.
- **Workforce committee:** will oversee the development of annual action plans and track progress in details against these.
- **Senior management team via people board and performance review meetings:** through the annual business planning round, workforce objectives will be developed by the divisions and progress against these will be tracked.

Associated trust documents

- 10-year clinical strategy
- Quality strategy
- Quality improvement strategy
- Quality accounts; annual operational business plans; health care group business plans
- Organisational development strategy
- Recruitment strategy
- Talent management strategy
- Health and wellbeing strategy

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Trust Board – 01.04.2019

6.3

Agenda Item:	6.3
Presented by:	Ogechi Emeadi, Director of People
Prepared by:	Nathaniel Williams, Workforce Information & Systems Manager
Date prepared:	01.03.2019
Subject / Title:	Gender Pay Gap Reporting 2019

Purpose:	Approval	x	Decision	x	Information	x	Assurance	x

Executive Summary: [please don't expand this cell; additional information should be included in the main body of the report]	The PAHT gender pay gap as at 31 March 2018 snapshot date report average mean hourly rate of 29% lower for women (no change form 2017) and average median hourly rate of 23% lower for women (an increase from 2017). If we exclude Medical and Dental staff group, the mean pay gap is 2% lower for women and women get paid more than men by 8% on median pay gap. Bonuses (Consultants Clinical Excellence Awards) were paid to more men than women consultants. Mean average bonus payment is 28% lower for women (4.9% decrease from 2017) and Median average bonus payment is 20% lower for women (13% decrease from 2017). The 4 pay quartiles show more women than men in each of the quartiles. WFC approved following clarity to section 8 bullet point 4
Recommendation:	The report is presented for information and discussion

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:	Workforce Committee
Risk / links with the BAF:	BAF Risk 2.1 Workforce Capacity
Legislation, regulatory, equality, diversity and dignity implications:	The Trust is required by law to publish the gender pay gap report by 30th March 2019
Appendices:	Appendix -1 Gender Pay Gap 2018

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1. Introduction

This is the second Gender Pay Gap Report from The Princess Alexandra Hospital NHS Trust (PAH Trust). The gender pay reporting legislation requires all organisations employing more than 250 people to publish their gender pay report on the government website by 30 March 2019, based on a gender profile of 77% women and 23% men employees at PAH Trust and earnings as at 31 March 2018.

2. Background & context

2.1 The legislation framework can be referenced to the Equality Act 2010 -Specific Duties and Public Authorities - Regulations 2017.

2.2 It is important to note that the gender pay gap reporting legislation is distinct from equal pay. Equal pay is concerned with men and women earning equal pay for the same or similar work. The gender pay gap is about the difference between men and women's average pay within an organisation.

2.3 The gender pay gap is not the same as equal pay. The NHS has a national pay structure, job evaluation system and contractual terms and conditions for medical and non-medical staff which have been developed in partnership with trade unions. This national framework provides a robust set of arrangements for pay determination.

2.4 The Gender Pay reporting requirements have been introduced to make the differences in pay between men and women more transparent across all industry sectors, enabling employers to consider the reasons for any differences and to take any corresponding action.

3. Requirements

The report is based on earnings as at 31 March 2018 and provides analysis on the following:

- Mean pay gap – the difference between the mean (average hourly earnings, excluding overtime) of men and women employees
- Median pay gap – the difference between the median (the difference between the midpoints of hourly rates of earnings, excluding overtime) of men and women employees
- Pay distribution by gender – the proportion of men and women employees in the lower, lower middle, upper middle and upper quartile pay bands
- Mean bonus gap – the difference between the mean bonus paid to men and women employees (bonus pay exclusively made up of local and national Consultant clinical excellence awards and discretionary points)

4. Gender Profile by Staff Group

This report is based on a gender staff profile of 77% Women and 23% men employees at the Princess Alexandra Hospital as at 31 March 2018 in the following staff groups:

	Headcount		%	
Staff Group	**Women**	**Men**	**Women**	**Men**
Add Prof Scientific and Technic	72	24	75%	25%
Additional Clinical Services	526	74	88%	12%
Administrative and Clerical	587	136	81%	19%
Allied Health Professionals	104	35	75%	25%

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Estates and Ancillary	225	121	65%	35%
Healthcare Scientists	58	29	67%	33%
Medical and Dental	177	288	38%	62%
Nursing and Midwifery Reg	837	71	92%	8%

5. **Mean and Median Ordinary pay gap**

Mean Avg Hourly Rate		
£22.32	29% Difference ↔ from 2017	£15.80

Median Avg Hourly Rate		
£17.99	23% Difference ↑ 4% from 2017	£13.85

In aggregate the mean gender pay gap indicates that women earned 29% less than men no change from 2017 report whilst the median pay gap indicates for the reporting period that women earn 23% less than men an increase of 4% from the 2017 report.

6. **Mean and Median Bonus pay gap**

At The Princess Alexandra Hospital NHS Trust, the only staff group in receipt of bonuses during the reporting period were consultants in accordance with the NHS national terms and conditions for medical staff. Bonus pay is exclusively made up of local and national Consultants Clinical Excellence Awards and discretionary points. In section 4 of this report, the gender breakdown for medical staff shows that this is the only staff group which employs more men (62%) than women (38%). The mean and median difference in bonus payments for medical staff during the reporting period is as follows:

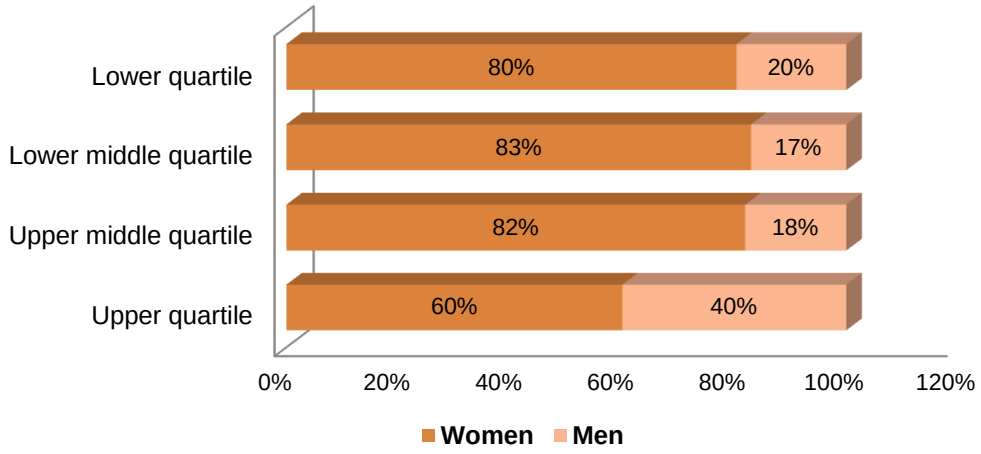
Mean Avg Bonus Payment		
£13,032.16	28% Difference ↓ 4.9% from 2017	£9,418.75

Median Avg Bonus Payment		
£9,417.50	20% Difference ↓ 13.3% from 2017	£7,535.52

In aggregate women average mean bonus payment were 28% lower than men a decrease of 4.9% from 2017 whilst women average median bonus payment were 20% less than men a decrease of 13.3% from 2017.

7. **Pay distribution by gender**

The table below shows the proportion of men and women employees in each quartile (the lower being lowest paid and upper being the highest paid staff). Quartiles are calculated by ranking the pay for each employee from lowest to highest.



8. **What are we doing about it?**

The Equality and Inclusion Steering Group recommend the following:

- Review flexible working policy across all areas
- Raising awareness on shared parental leave
- Unconscious bias training
- Consultants Clinical Excellence Awards are carried out once a year
- Ensure Consultants clinical excellence awards decision panel is gender equitable
- Widely publicising the Consultants Clinical Excellence awards cycle with additional workshops

The Equality and Inclusion Steering Group will monitor delivery of these actions

The Princess Alexandra Hospital NHS
NHS Trust

Trust Board - 4 April 2019

Agenda Item:	7.1
Presented by:	Stephanie Lawton – Chief Operating Officer
Prepared by:	Information Team, HealthCare Groups & Corporate Teams
Date prepared:	20 March 2019
Subject / Title:	Integrated 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 – Mortality Improvement Board established, 5 workstreams underway. Training in place for medical examiners. Work underway to decant HDU/ITU and undertake minor repairs and deep clean. People – On trajectory to achieve the appraisal target by the end of March. Sustained improvement in statutory and mandatory training. Recruitment trajectories are agreed with healthcare groups for the year ahead. Performance – Achievement of national standards in RTT and Diagnostics with an improving position in Cancer. ED 4 hour standard remains challenging with ongoing support from the ECIST. Pounds - The In month deficit (excluding PSF) was £2.6m, £0.1m behind plan. The YTD deficit is £27.2m compared to the control total of £28.5m. Places – Significant progress on the annual capital backlog programme, with 87% of the capital spend achieved. The remaining schemes will be completed by March 2019.
Recommendation:	The Committee are 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

Previously considered by:	PAF.25.03.19
Risk / links with the BAF:	
Legislation, regulatory, equality, diversity and dignity implications:	No regulatory issues/requirements identified.
Appendices:	IPR

7.1

The Princess Alexandra Hospital NHS Trust

Integrated Performance Report

February 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.

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

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Trust Objectives

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 2018/19.

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5Ps

In this month

The Princess Alexandra Hospital NHS Trust

Patients

Performance

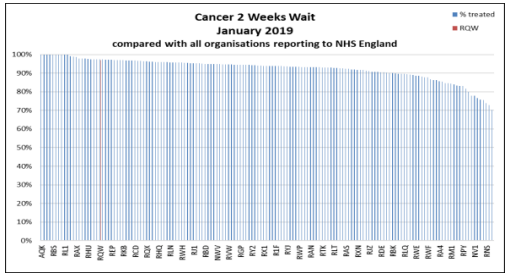
People

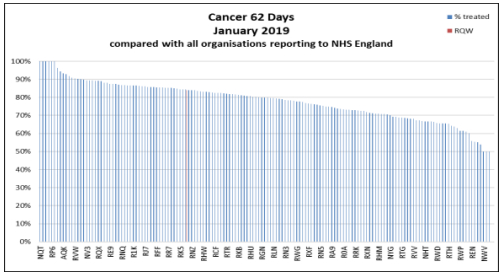
Pounds

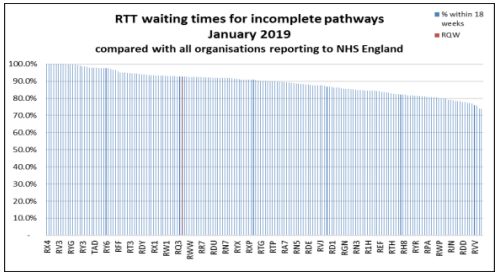
Places

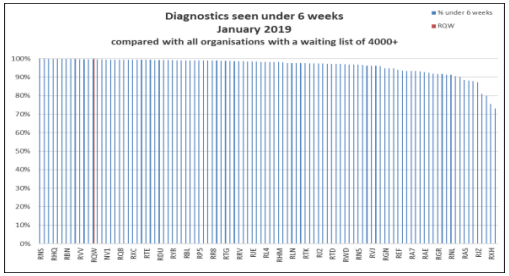
National Benchmarking
Compared with all organisations reporting to NHS England

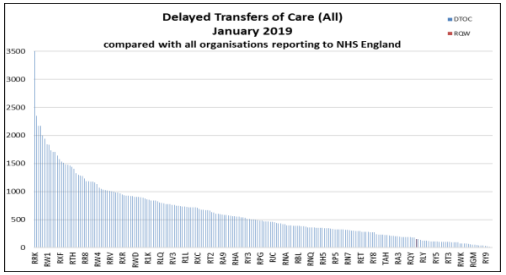
NHS
The Princess Alexandra Hospital
NHS Trust

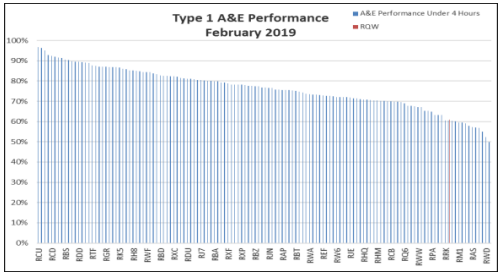


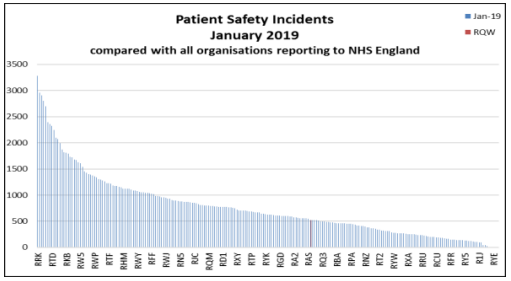


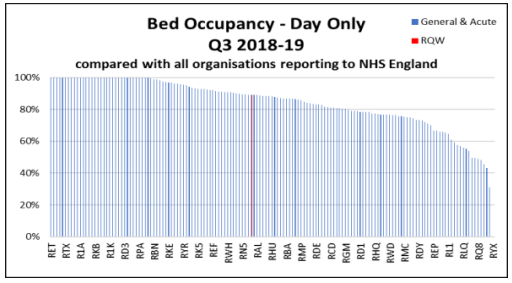


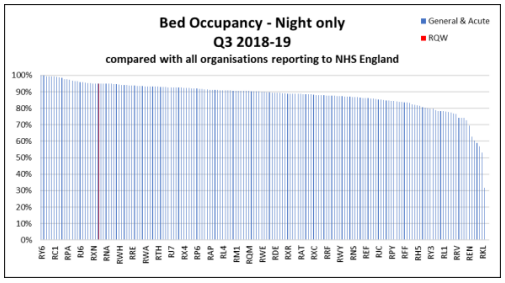












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Data Source: NHS England Statistics/Public Health England/Dr Foster

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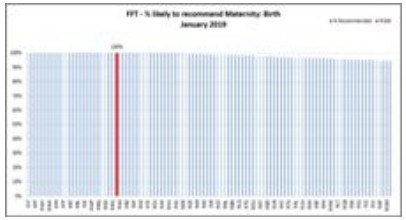
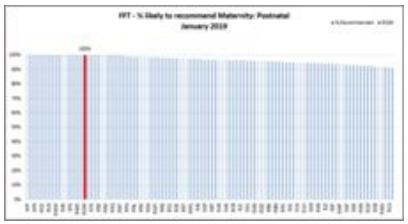
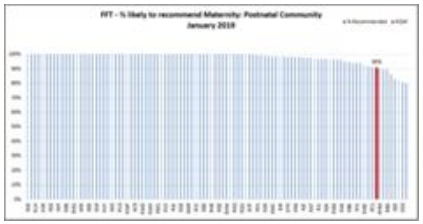
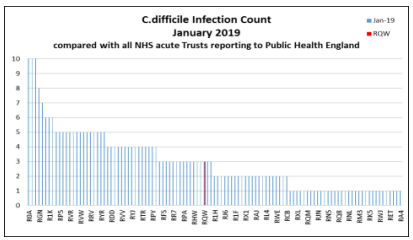
National Benchmarking
Compared with all organisations reporting to NHS England

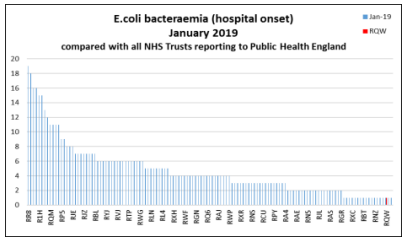
NHS
The Princess Alexandra Hospital
NHS Trust

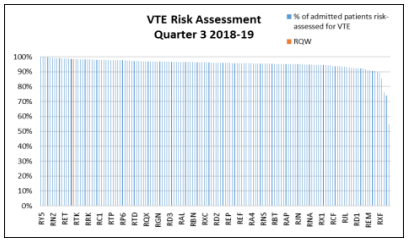


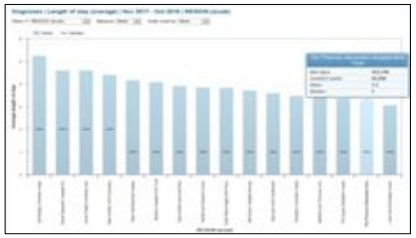












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Data Source: NHS England Statistics

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Executive Summary Our Patients

The Princess Alexandra Hospital NHS Trust

Quality Compliance:
Performance has improved in month, with three additional objectives signed off as practice embedded into everyday practice.
From the 13 objectives in Our Patients:
Seven (54%) are achieved & signed off as embedded.
Four (31%) of objectives were achieved in month.
Two (15%) objectives have not achieved the expected monthly trajectory.

The objectives that have not achieved the monthly trajectory are:-
a) MUST improve the Emergency Care Medical records to demonstrate complete, contemporaneous records with appropriate risk assessments documented.
b) SHOULD conduct hourly comfort rounds the team will:

There were a total of 1021 incidents reported in month, of which 828 of these were PAH incidents.
Of the PAH incidents 96.9% were 'no harm' or 'minor harm' incidents.
2.9% were 'moderate harm'.
1 incident 'severe harm'
1 incident 'a death'
2 incidents met the Serious Incident criteria & were declared externally

HSMR: One of our priority responsibilities is to improve outcomes, as well as the experience, for our patients. A key measure for success will be to achieve 'as expected' mortality rates across all specialities by March 2021. To this end, the Mortality Improvement Board (MIB) has been established and is chaired by our Chief Executive, in recognition that this is our highest immediate priority. Five programmes of work have been established; led by senior doctors, nurses and managers.

Falls: Falls in February saw an absolute decrease in the number of falls to 102, down from 119 in January. This was accompanied with a decrease in the number of falls per 1000 OBD (occupied bed days) to 7.89 down from 9.21 in January. Year on year this is a reduction on the 2018 Feb figure of 8.05 falls per 1000 OBD. However, 7.89 per 1000 OBD is still higher than published national averages (6.6 per 1000 OBD) for acute providers. However, by way of explanation we have been making efforts as a Trust to ensure patients are more active more often, & the literature will support that this has a tendency to increase the total amount of falls. As a Trust we need to ensure our total levels of harm remain within national parameters & this is still the case (96% no/low harm across Jan and Feb 2019). From the qualitative falls data from February, which suggest falls indicative of syncope, & 2019/20 CQUIN - we will be working to improve rates of assessment of lying /standing BPs.

PU: analysis of the data has shown that of the 29 pressure ulcers that were reported - of the 29 pressure ulcers, 4 were device related pressure ulcers.
One case was deemed avoidable at scrutiny panel was found initially to be moisture incontinence related, all other cases are awaiting scrutiny.

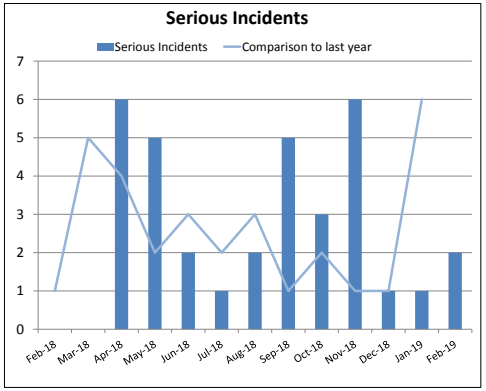
Safety Thermometer: We had 93.86% harm free care as captured by the national safety thermometer audit (Feb 19), with a 1.54% urinary tract infection & 4.39% pressure ulcer prevalence.

Patient Safety & Experience

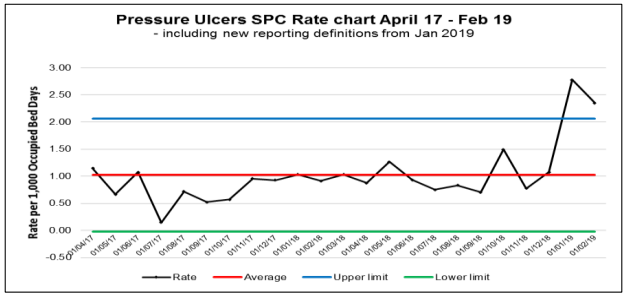
1 Our Patients Summary 1.1

The Princess Alexandra Hospital NHS Trust

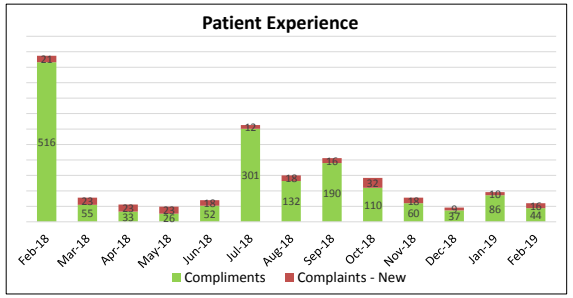
Serious Incidents



Pressure Ulcers SPC Rate chart April 17 - Feb 19
- including new reporting definitions from Jan 2019



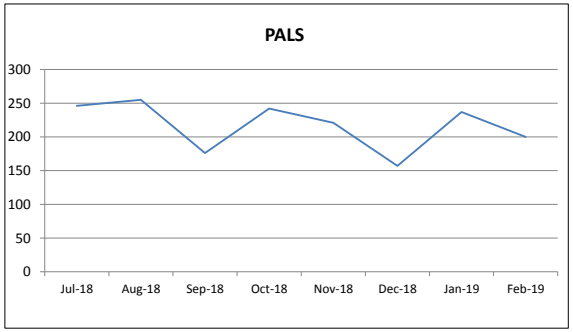
Patient Experience



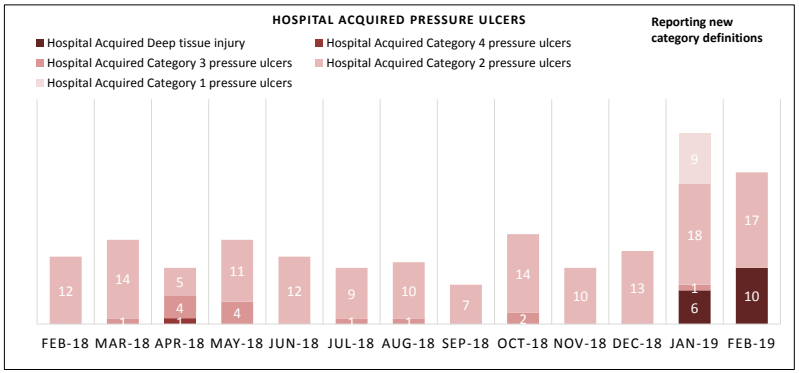
Unstageable pressure ulcers	
Jan-19	4
Feb-19	2

PALS converted to Complaints	
Apr-18	3
May-18	0
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	

PALS

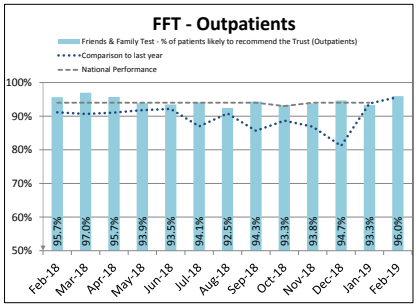


HOSPITAL ACQUIRED PRESSURE ULCERS

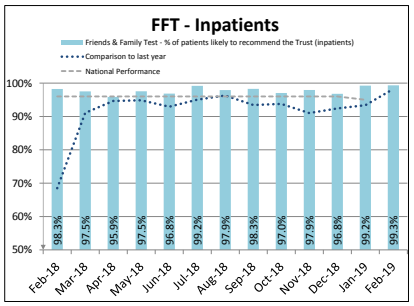


Complaints by Theme (QA)	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
Complaints - Care & Treatment	0	0	6	5	12	0
Complaints - Staff Attitude & Behaviour	0	0	0	0	0	0

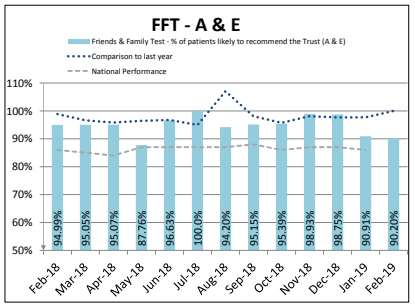
FFT - Outpatients



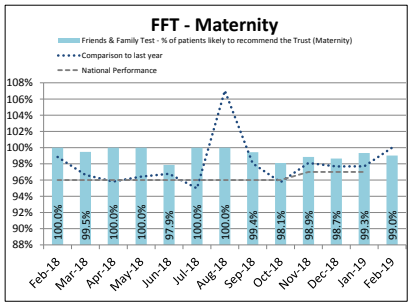
FFT - Inpatients



FFT - A & E



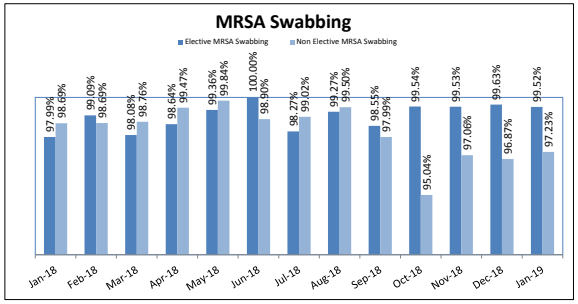
FFT - Maternity



7

7.1

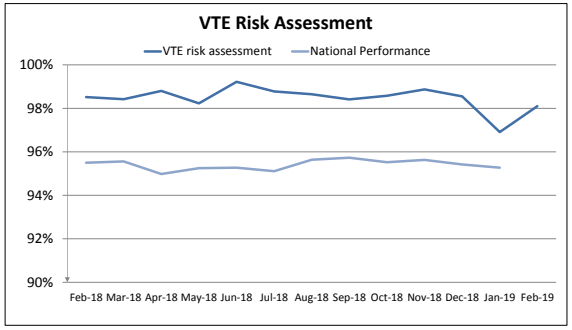
Infection Control, VTE & Mortality

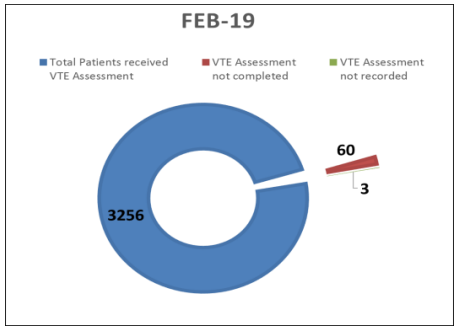


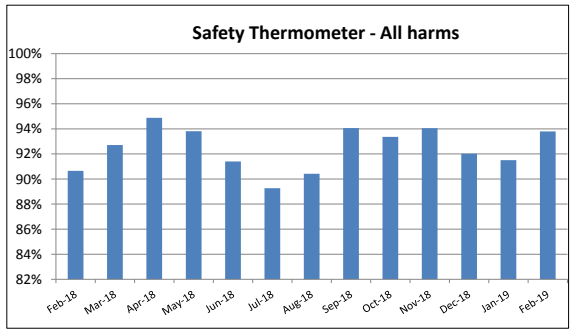
MSSA	
Apr-18	0
May-18	0
Jun-18	1
Jul-18	1
Aug-18	3
Sep-18	0
Oct-18	0
Nov-18	0
Dec-18	0
Jan-19	0
Feb-19	1

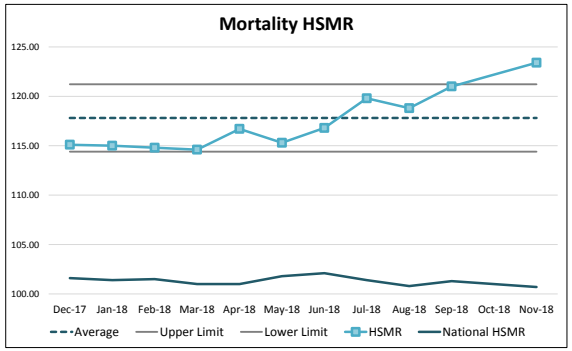
C-Diff (National surveillance database)	
Feb-18	0
Mar-18	2
Apr-18	2
May-18	2
Jun-18	1
Jul-18	1
Aug-18	1
Sep-18	0
Oct-18	1
Nov-18	0
Dec-18	1
Jan-19	3
Feb-19	0

E Coli	
Feb-18	0
Mar-18	0
Apr-18	3
May-18	0
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







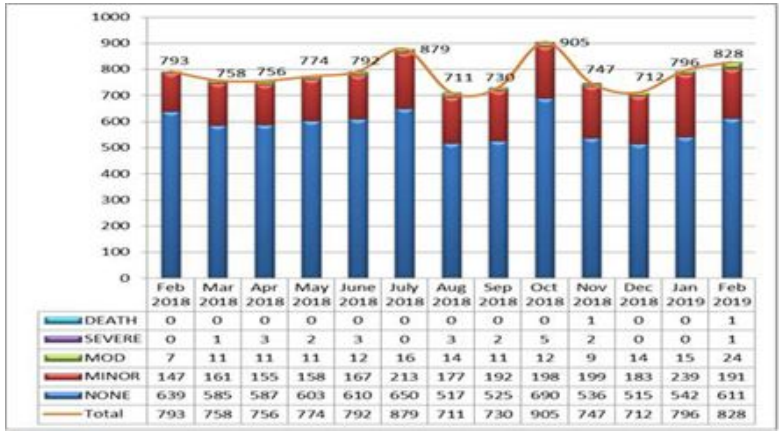


Mortality SHMI	
Dec-17	112.1
Jan-18	
Feb-18	
Mar-18	113.7
Apr-18	
May-18	
Jun-18	
Jul-18	
Aug-18	
Sep-18	116.7
Oct-18	
Nov-18	
Dec-18	

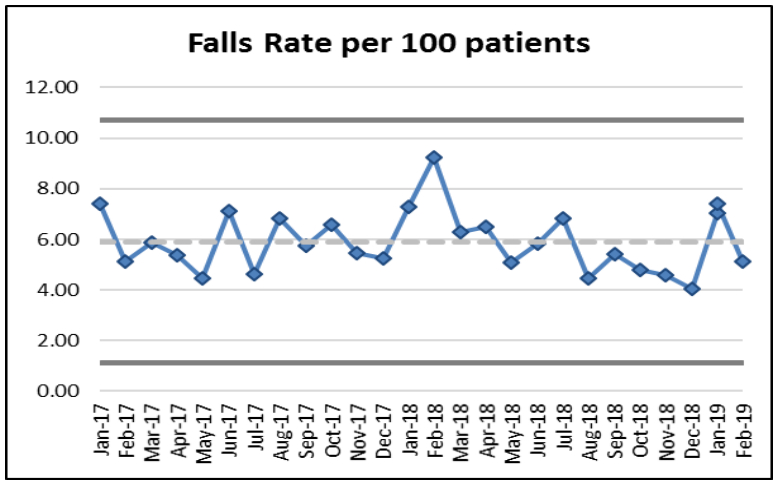
Mortality Outlier Alerts (QA)	
Aug-18	No data
Sep-18	4
Oct-18	4
Nov-18	No data
Dec-18	6
Jan-19	No data
Feb-19	8

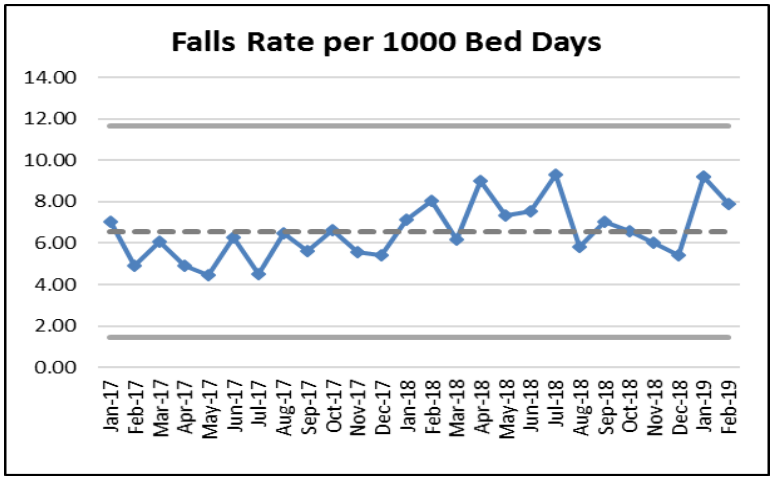
Sepsis, Harm & Deaths

Severity of Reported Incidents on Datix (Feb 18 - Feb 19)



	Feb 2018	Mar 2018	Apr 2018	May 2018	June 2018	July 2018	Aug 2018	Sep 2018	Oct 2018	Nov 2018	Dec 2018	Jan 2019	Feb 2019
DEATH	0	0	0	0	0	0	0	0	0	1	0	0	1
SEVERE	0	1	3	2	3	0	3	2	5	2	0	0	1
MOD	7	11	11	11	12	16	14	11	12	9	14	15	24
MINOR	147	161	155	158	167	213	177	192	198	199	183	239	191
NONE	639	585	587	603	610	650	517	525	690	536	515	542	611
Total	793	758	756	774	792	879	711	730	905	747	712	796	828





Executive Summary Our Performance

The Princess Alexandra Hospital NHS Trust

Operational performance

Planned Care Standards

This remains strong in RTT achieving the national incomplete standard. This has consistently been achieved since July 2018. Diagnostics teams have delivered outstanding performance again in month which places the Trust in the top performing Trusts for achievement of this standard. Cancer performance has improved with detailed recovery plans in place and a clear trajectory to return to national standard in March. Despite not achieving the 62 day standard, the team have shown good grip and control in the oversight of all cancer pathways and performance remains above national performance levels.

Urgent care Standards

Achievement of the 4 hour standard proved extremely challenging in month. However, the team have shown resilience and determination to build upon the work streams and continue to focus on 4 key actions. Performance is expected to improve in March. With support from the Emergency Care Intensive Support Team (ECIST), work is focussed on streaming, RAT/Ambulance and Acute Assessment.

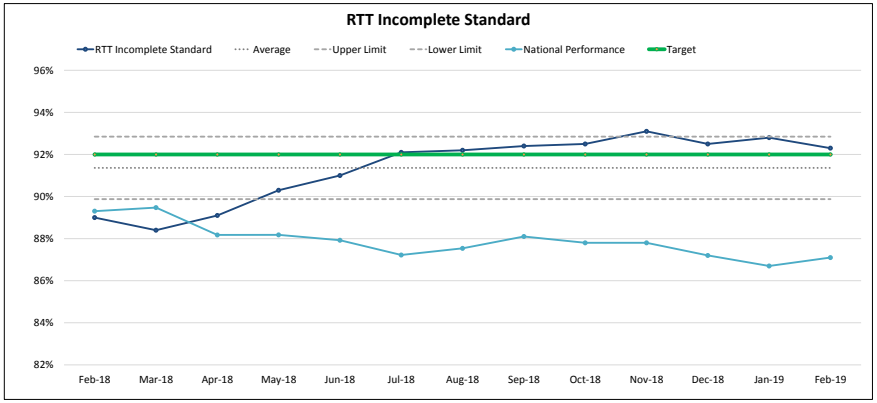
- Attendances above 300 patients in February continued, however, it is predicted that this will stabilise next month.
- The Trust has seen an increase with over 10% more minors' patients attending the emergency department.
- Performance has declined for non-admitted patients, primarily due to increase in volumes and lack of space and capacity to see and treat patients.

The CCG have commenced work to looking at demand analysis at both GP practice level and presenting condition. This will be presented and discussed at the Local Delivery Board over the next month.

Work has commenced on the redesign of acute assessment capacity with a view to having a draft business case in place by May 2019. Performance in paediatric emergency care has shown signs of improvement with staffing levels improving and sustainability of Paediatric Ambulatory Care opening hours.

The Urgent Care Improvement Board continues to meet weekly with good attendance and commitment from all healthcare teams. Length of stay has increased in February with a number of complex long stay patients over 21 days. System discussions regarding additional support and capacity are being led by the Local Delivery Board.

RTT


RTT Incomplete Standard
RTT Incomplete Standard
Average
Upper Limit
Lower Limit
National Performance
Target
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94%
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Feb-18
Mar-18
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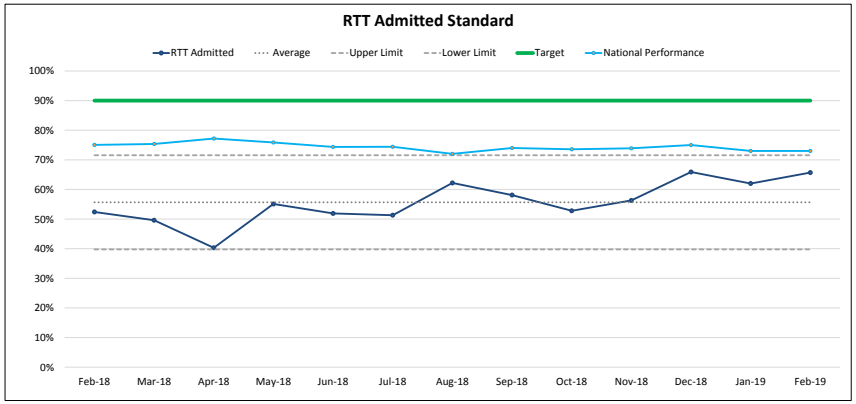
Jan-19
Feb-19


RTT Admitted Standard
RTT Admitted
Average
Upper Limit
Lower Limit
Target
National Performance
100%
90%
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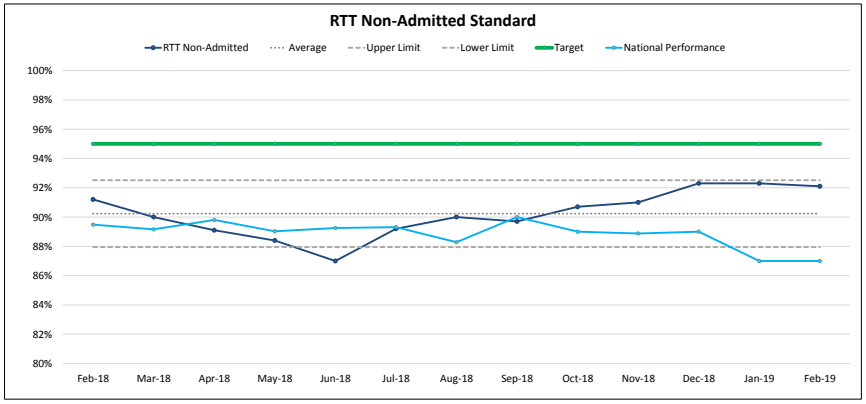
RTT Non-Admitted Standard
RTT Non-Admitted
Average
Upper Limit
Lower Limit
Target
National Performance
100%
98%
96%
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92%
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Feb-18
Mar-18
Apr-18
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Jul-18
Aug-18
Sep-18
Oct-18
Nov-18
Dec-18
Jan-19
Feb-19

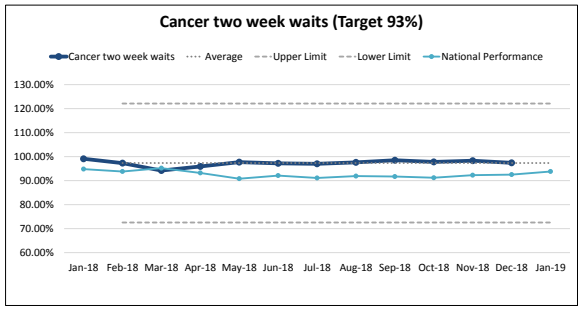
2 Our Performance Summary

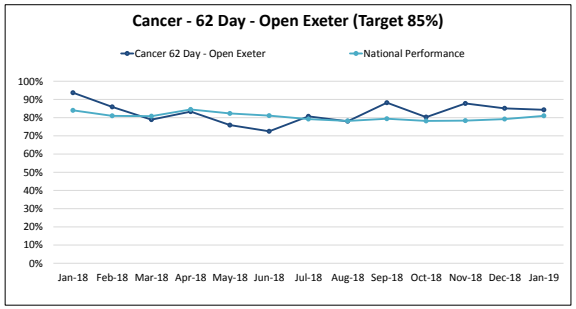
2.2 Responsive

The Princess Alexandra Hospital NHS Trust

	Cancer 2 week waits - breast symptomatic	Cancer 31 Day First	Cancer 31 Day Subsequent Drug	Cancer 31 Day Subsequent Surgery
Jan-18	95.80%	98.90%	100.00%	100.00%
Feb-18	97.70%	98.60%	100.00%	100.00%
Mar-18	97.70%	97.40%	100.00%	100.00%
Apr-18	98.60%	96.80%	100.00%	100.00%
May-18	95.50%	100.00%	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%

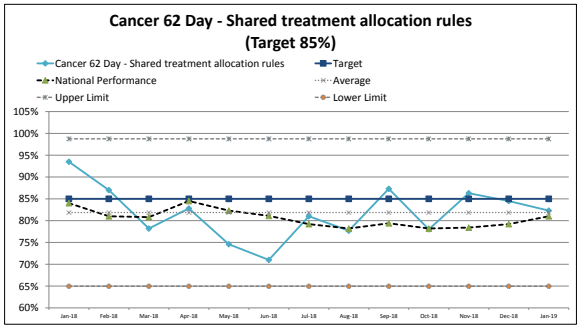
Note: Above heat map colour scale based on green = highest performance to red = lowest performance.

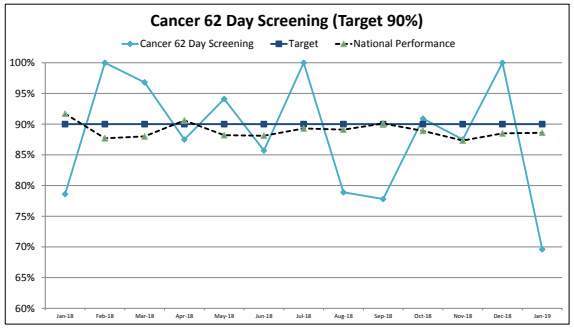


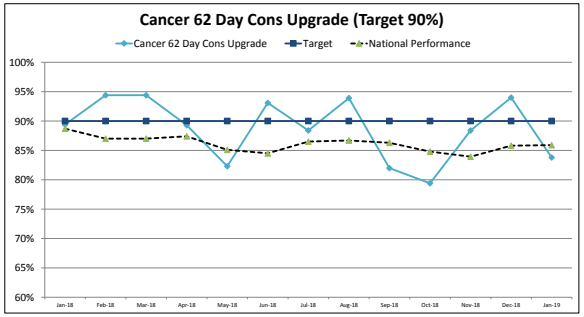


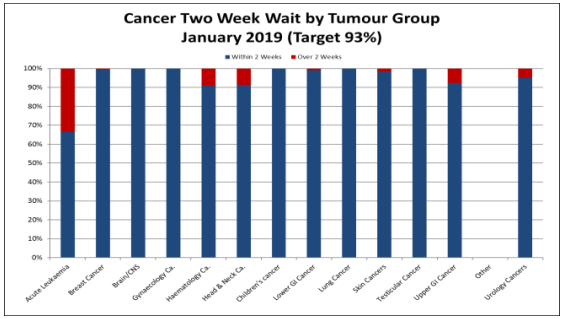
January performance by tumour group

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	66.7%						
Breast Cancer	99.5%	92.6%	100.0%	72.7%			
Brain/CNS	100.0%						
Gynaecology Ca.	100.0%	100.0%	100.0%		0.0%		
Haematology Ca.	90.9%	100.0%	50.0%		100.0%		
Head & Neck Ca.	91.4%		100.0%				
Children's cancer	100.0%						
Lower GI Cancer	99.2%	100.0%	66.7%	0.0%	100.0%		
Lung Cancer	100.0%	88.9%	90.0%		86.7%		
Skin Cancers	98.4%	100.0%	86.4%		100.0%		100.0%
Testicular Cancer	100.0%	100.0%	100.0%				
Upper GI Cancer	92.4%	100.0%	100.0%		90.0%		
Other		100.0%	-		100.0%		
Urology Cancers	95.2%	100.0%	84.6%		57.1%	100.0%	
Total performance	97.4%	97.0%	84.3%	69.6%	83.8%	100.0%	100.0%
Symptomatic Breast Referral	97.4%						

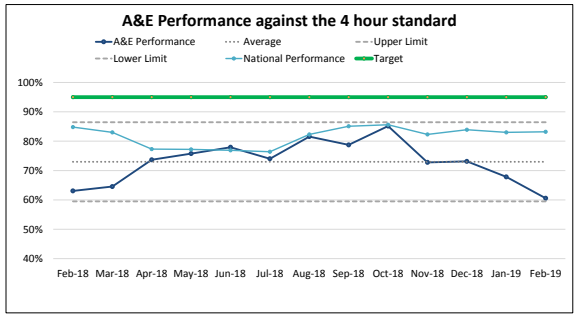


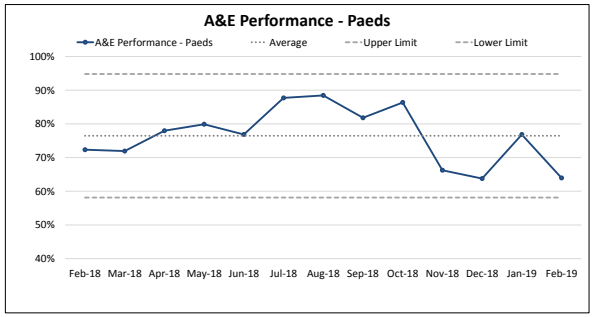


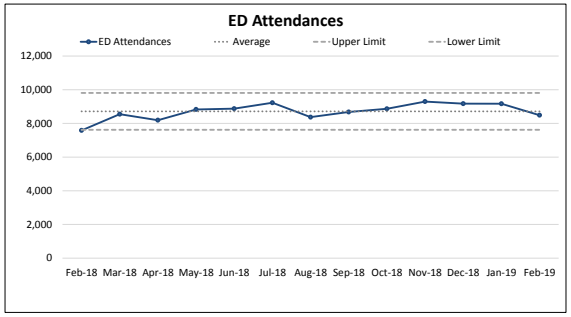


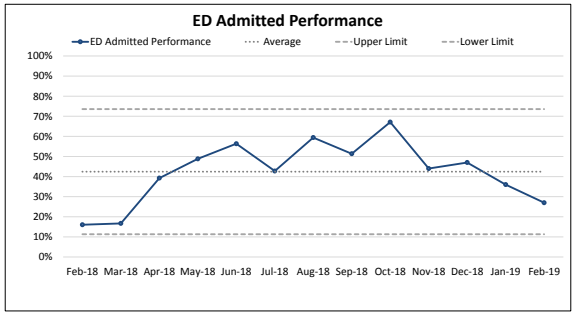


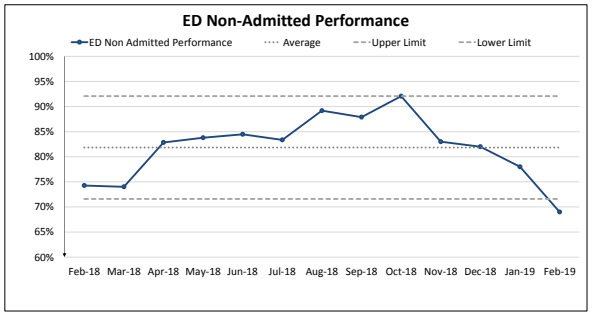
ED





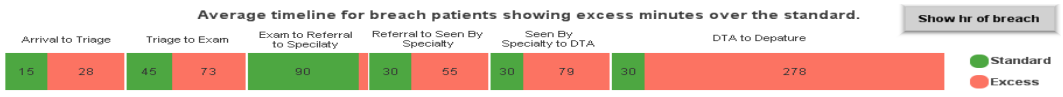


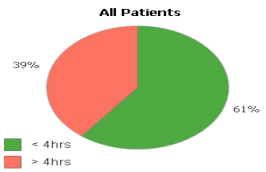




ED Internal Professional Standards

	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19
Arrival to Triage - Average Wait (Minutes)	35	37	31	32	32	32	28	31	29	36	34	37	43
Triage to Exam - Average Wait (Minutes)	111	111	100	92	98	98	79	82	74	91	94	106	118
Exam to Referral to Specialty - Average Wait (Minutes)	99	99	87	82	75	79	74	78	72	80	83	85	97
Referral to Seen by Specialty - Average Wait (Minutes)	85	83	79	69	66	74	70	69	68	83	82	84	85
Seen by Specialty to DTA - Average Wait (Minutes)	132	121	105	91	87	91	77	86	77	94	97	105	109
DTA to Departure - Average Wait (Minutes)	391	416	381	219	160	201	119	161	123	223	209	312	308





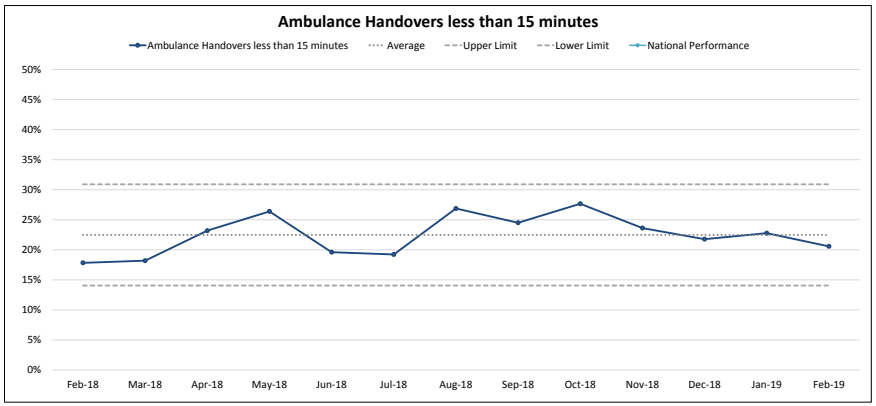
Measure	Standard	Average	Excess	Patients with Timestamp	Patients Who Breached	% Breached	Patients Who Breached Rank
Arrival to Triage	15	43	28	8,300	5,769	70%	
Triage to Exam	45	118	73	7,460	4,297	58%	
Exam to Referral to Specialty	90	97	7	2,689	580	22%	
Referral to Seen by Specialty	30	85	55	2,780	1,936	70%	
Seen by Specialty to DTA	30	109	79	1,502	910	61%	
DTA to Depature	30	308	278	1,798	1,266	70%	

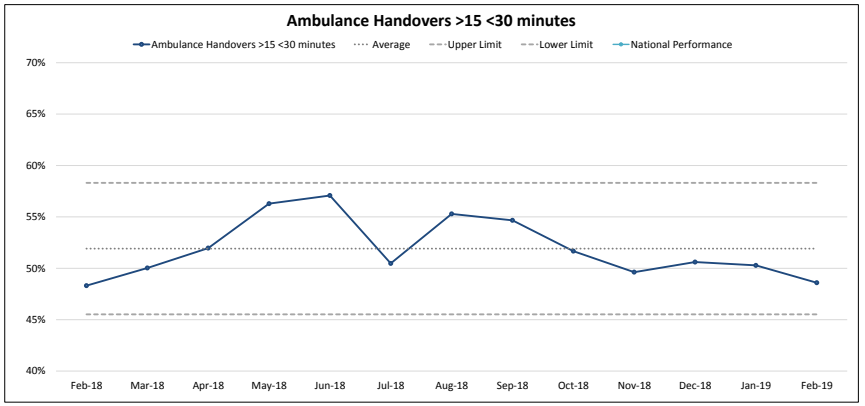
Ambulance

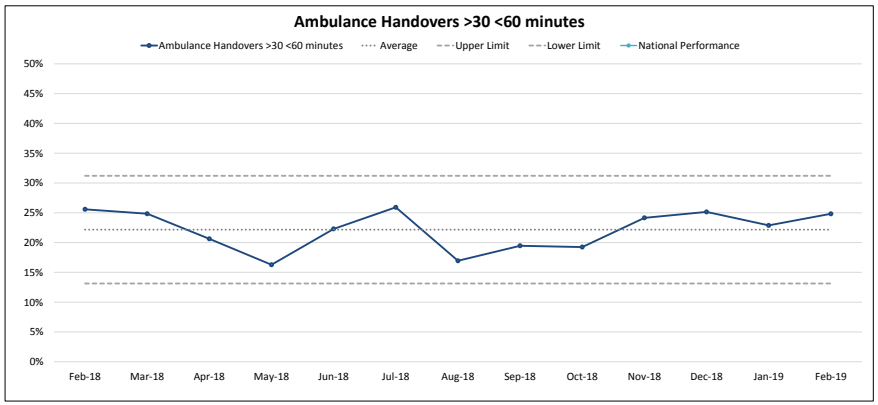
2 Our Performance Summary

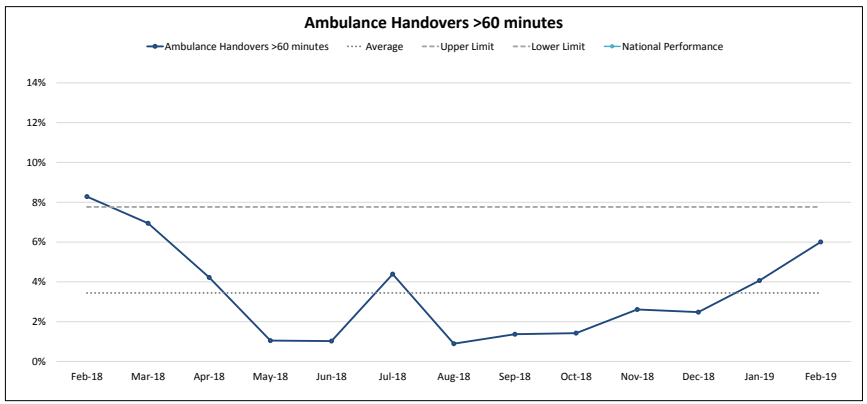
2.4 Responsive

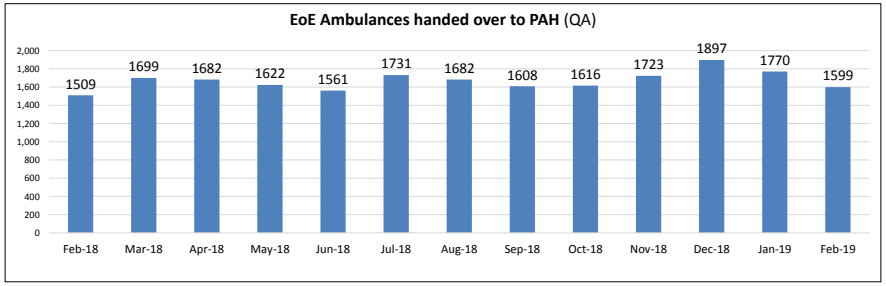
The Princess Alexandra Hospital NHS Trust



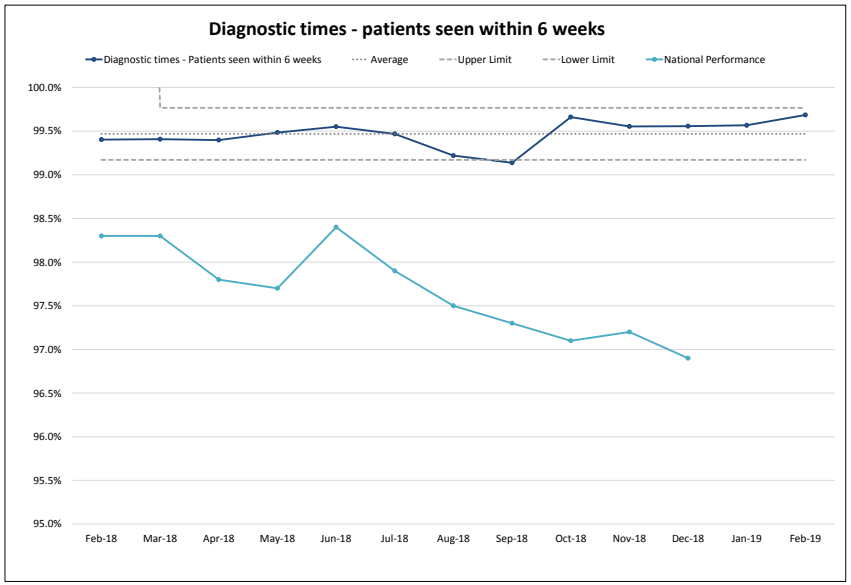


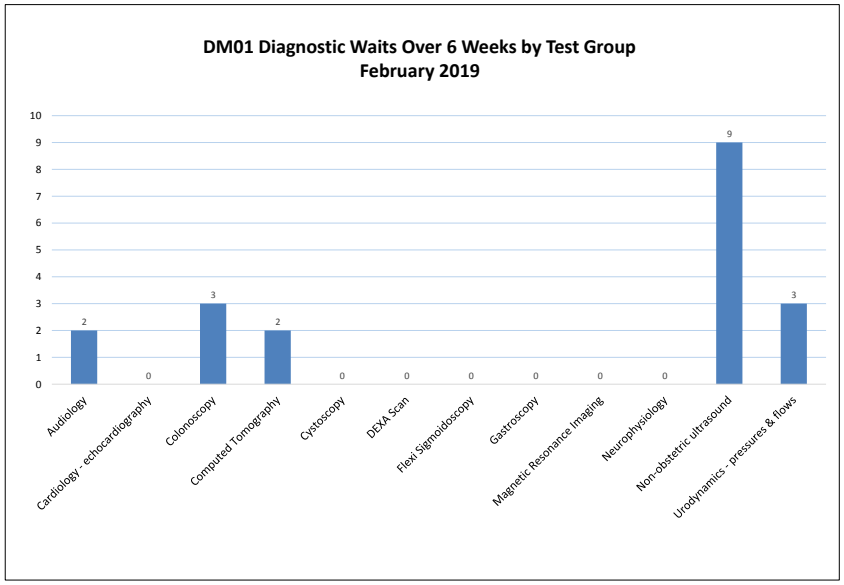






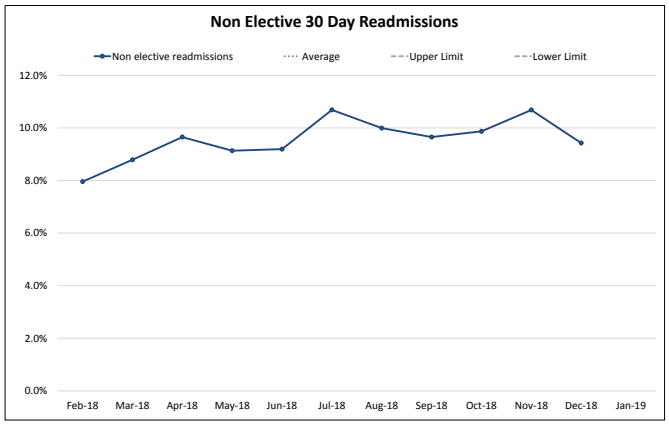
Diagnostics

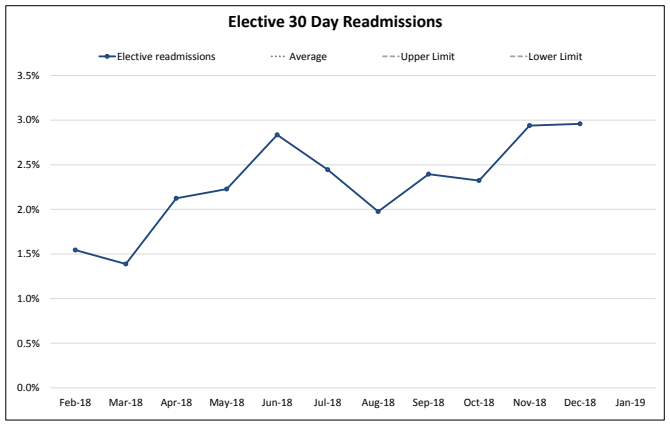


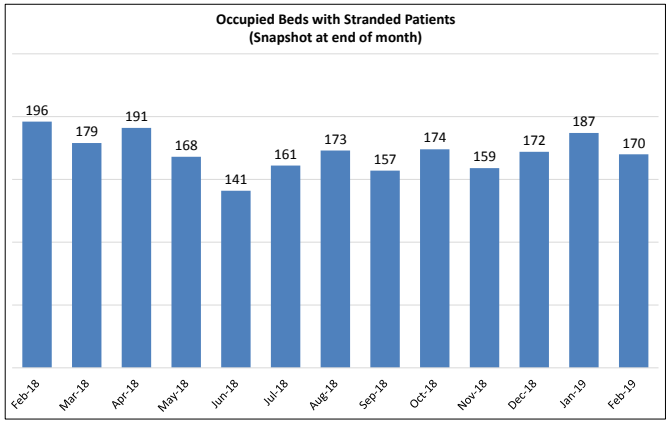


Test	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
Magnetic Resonance Imaging (MRI)	99.91%	99.82%	99.72%	100%	100%	100%	100%	100%	100%	100.00%	100.00%	
Computed Tomography (CT)	99.37%	99.22%	99.41%	100%	99.84%	99.84%	100%	100%	100%	99.51%	99.70%	
Non-Obstetric Ultrasound	99.92%	99.81%	99.96%	99.96%	99.92%	99.92%	99.71%	100%	100%	99.84%	99.66%	
DEXA	97.06%	100%	100%	99.28%	100%	100%	100%	100%	100%	100.00%	100.00%	
Audiology - Audiology Asessments	99.16%	99.25%	98.70%	100%	100%	100%	100%	99%	100%	97.51%	99.04%	
Cardiology - Echocardiography	99.37%	99.85%	100%	98.48%	95.01%	98.20%	100%	100%	100%	100.00%	100.00%	
Neurophysiology	100%	100%	100%	100%	100%	100%	93.33%	100%	100%	100%	100%	
Urodynamics	100%	96%	100%	88.89%	96.36%	74.47%	92.68%	57%	80%	70%	82%	
Colonoscopy	96.32%	97.66%	98.53%	94.97%	97.87%	89.16%	97.35%	99%	96%	98.45%	98.16%	
Flexi Sigmoidoscopy	97.37%	96.36%	100%	100%	95.12%	97.37%	96.97%	98%	96%	97.06%	100.00%	
Cystoscopy	77.78%	95.45%	66.67%	75.00%	100%	96.30%	100%	100%	100%	100.00%	100.00%	
Gastroscopy	91.75%	95.36%	96.40%	93.67%	94.87%	95.19%	97.41%	98%	92%	98.51%	100.00%	

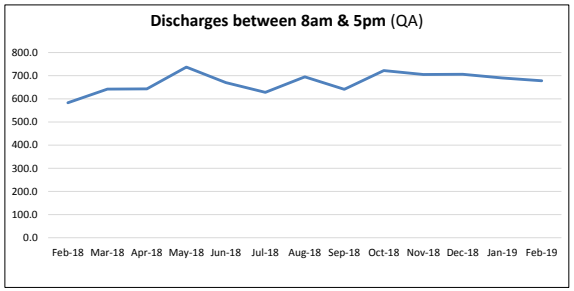
Readmissions & Stranded Patients

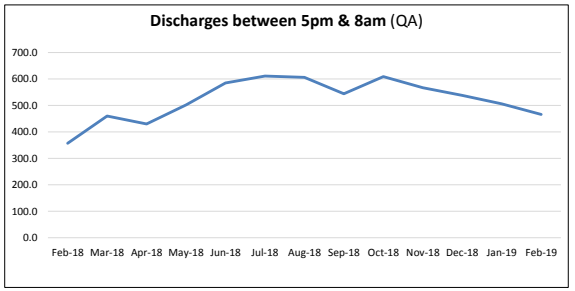


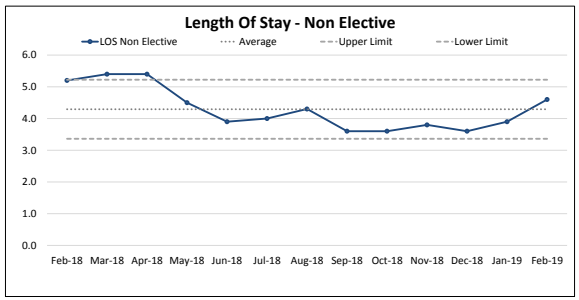


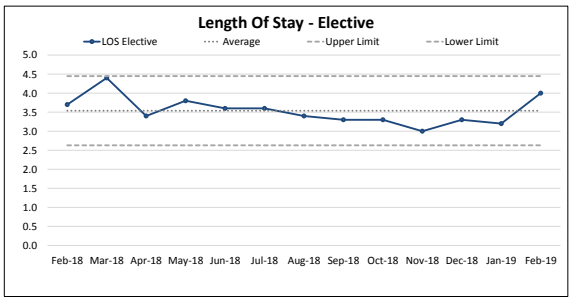


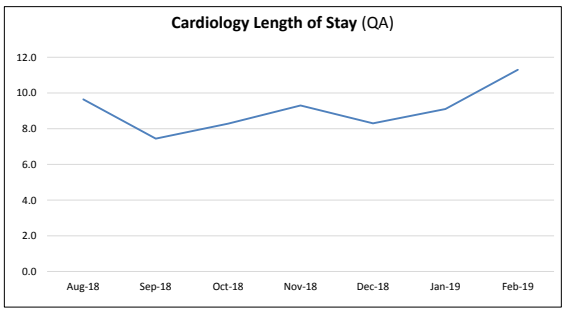
Discharges & LOS

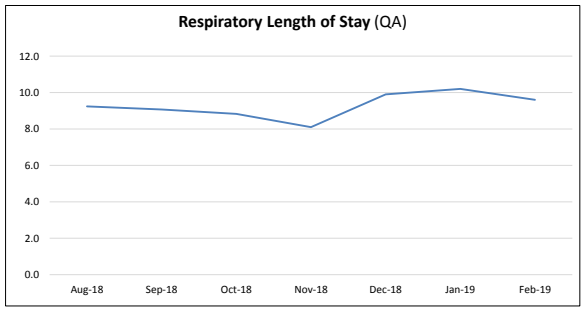


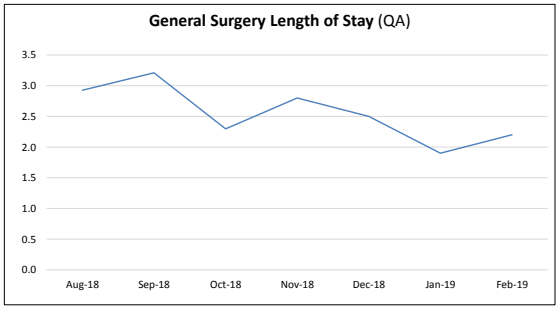




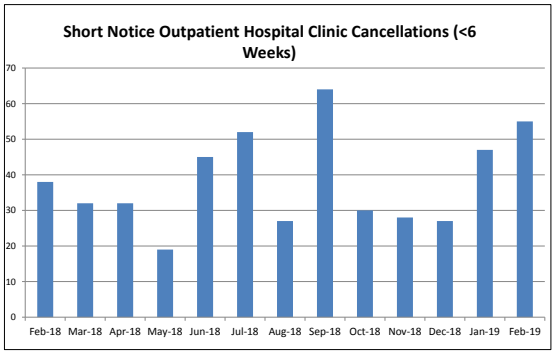


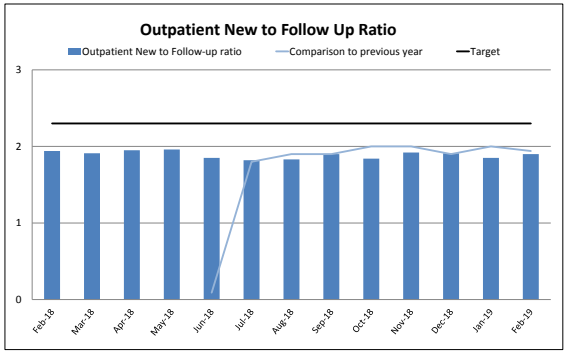


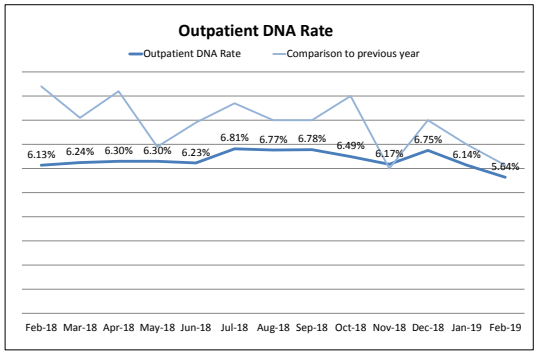


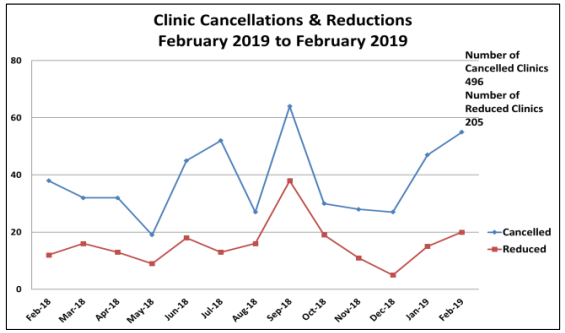


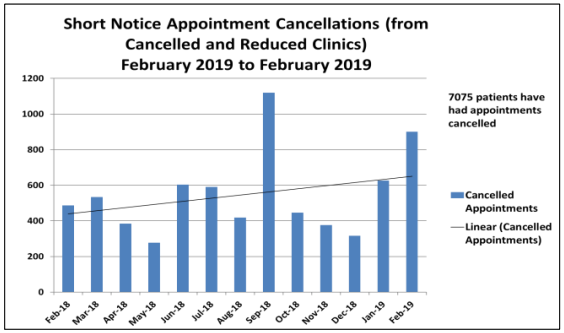
Outpatients & Cancelled Operations

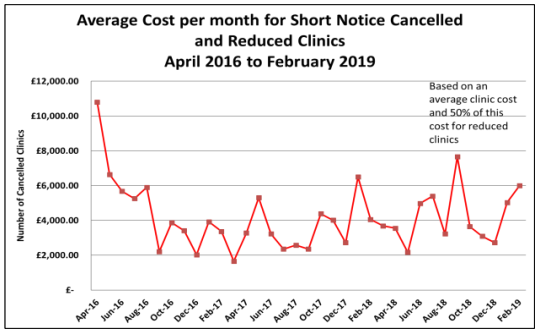












Cancelled Operations	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19
Cancelled Operations for Non Clinical reasons	18	41	61	27	7	22	17	21	14	8	29	43	39
Cancelled Operations - breach of 28 day standard	3	5	2	1	0	0	0	1	2	0	0	3	0
Urgent operations cancelled (Non Medical)	0	0	0	2	1	5	0	0	1	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

Executive Summary Our People

The Princess Alexandra Hospital NHS Trust

Performance has dipped in month for the 10 objectives in Our People, in month:
Four (40%) have achieved the planned monthly trajectory.
Six (60%) have not achieved the expected monthly trajectory standards. These are:
•MUST improve appraisal compliance
•MUST improve Adult and paediatric life support training
•MUST improve compliance with safeguarding adults and children (level 2)
•MUST improve Emergency Care teams level 2 training compliance
The mitigating actions to bring about an improvement in the non-compliant areas are:
a) **Appraisal**:
•Managers will receive reports detailing future appraisal dates and list of staff who are out of date, to assist in identifying areas with poor compliance
•Continual support for managers to improve use of ESR Self-Service, to engage with the Workforce teams and make corrections to data held in ESR.
•Detailed data validation exercise to be undertaken with FAWS HCG in month
•Individuals who are out of date are sent an individual email, this appears to have had a positive effect in the last few months.
•To reach 90% by end of March, 48 expired appraisals and the 43 due to expire in March need to be completed.
•We are anticipating achieving the 90% standard for the end of March 2019.

b) **Statutory Mandatory training topics**:
•Individuals with the most outstanding numbers of statutory mandatory training or who have the longest duration of non-compliance are asked to attend one to one meetings with the Director for People.
•HCG have developed detailed plans and trajectory for their team's compliance. This is discussed with the executives at the monthly performance review meetings.
•Use of audit days or individual HCG team days to complete training for groups
•Using e-roster to schedule time for staff to complete on line training
•Strengthening use of e-roster to block study leave if staff are not compliant with statutory mandatory training
•Providing additional support for staff to access and use e-learning modules
•Looking to reintroduce the single day for statutory mandatory training updates
•Developing pre-induction support for new starters
•Streamlining the approach to carrying forward training undertaken at other NHS organisations
•Single day training sessions are in place from January 2019 which is hoped will assist staff attendance.

c) For ED, in addition to the actions detailed above the Practice Development lead will ensure all individuals non-compliant have training dates planned.

d) MUST objective to have a paediatric trained RN in Recovery (PACU) at all times, the Trust does not meet this recommendation. To mitigate this risk we have undertaken the following:-
•We have staff trained the adult nursing team to ensure they have the skills required to manage all patients in the immediate post-operative period. To address the CQC concerns the PACU staff have the necessary skills to care for children immediately post operatively as they have undergone:-
•A competency package for care of children and young people in PACU is developed and staff are being assessed against it. By end of March 15 RNs (100% of appropriate staff) will have completed this. The reaming 3 new staff are undertaking their adult PACU compete assessment
•Completed Paediatric Life Support (PILs) training and an assessment and airway management. 75% compliant currently with remaining staff completing the training during March and April.
•100% are compliant with the annual Safeguarding Children level 3 training.
•Staff attend the Children's Acute Transport Service study day on the stabilisation and management of the critically unwell child.
•Staff are encouraged to attend the Paediatric HDU study day.
•When staff have a specific concern about a child they contact the in-patient ward team, Paediatric HDU facilitator or matron in Paediatrics for support.
•Staff working with children are compliant with the guidelines of the Association of Anaesthetists of Great Britain and Ireland- as described in the document - Immediate Post Recovery Guidelines (2013)

Workforce Indicators Summary

Agency Spend 5.80%
Bank Spend 12.18%

Staff In Post
3068
WTE

Training
92%

Sickness
4.1%

11.5%

Turnover
13%

Medical 100%
Non-Medical 88%

Scorecard

Workforce Measures as at 28th February 2019	Trust Target	Trust	CCCS	FAWS	Medicine HCG	Surgery HCG	Estates & Facilities	Corporate	People	Finance
Funded Establishment- WTE		3496.65	847.39	454.83	872.03	728.25	270.53	122.51	54.16	146.95
Vacancy Rate	8.0%	11.5%	3.2%	7.8%	20.5%	16.3%	7.5%	0.0%	8.6%	16.3%
Agency % of paybill	7.0%	5.7%	2.9%	3.2%	8.7%	8.5%	3.4%	3.6%	0.2%	0.0%
Bank Usage - Cost	n/a	£1,860,668	£100,971	£215,119	£1,029,099	£336,545	£62,200	£29,425	£11,123	£75,733
Agency Usage -Cost	£858,000	£809,575	£88,203	£64,818	£344,395	£269,794	£22,512	£19,531	£321	£0
Sickness Absence	3.5%	4.1%	3.5%	4.7%	3.8%	3.9%	8.2%	3.7%	0.6%	3.1%
Long Term Sickness	1.75%	1.6%	1.1%	2.4%	1.0%	1.3%	4.9%	0.8%	0.0%	1.1%
Short Term Sickness	1.75%	2.5%	2.3%	2.3%	2.8%	2.6%	3.3%	2.9%	0.6%	2.1%
Rolling Turnover (voluntary)	12%	13.57%	13.20%	16.30%	15.19%	12.74%	6.90%	12.96%	12.44%	16.82%
Stability	90%	88.4%	89.6%	86.1%	86.4%	91.2%	85.4%	90.1%	100.0%	86.7%
Statutory & Mandatory Training	90%	92%	95%	90%	89%	89%	94%	97%	96%	98%
Appraisal	90%	88%	92%	81%	88%	85%	92%	88%	91%	79%
FFT (care of treatment) Q2	70%	76%	tbc	tbc	tbc	tbc	tbc	tbc	n/a	n/a
FFT (place to work) Q2	61%	61%	tbc	tbc	tbc	tbc	tbc	tbc	n/a	n/a
Flu Vaccination(Front Line)	75%	77%	71.0%	70.5%	75.0%	66.4%	71.4%	82.8%	90.9%	n/a
Active Job Plans (first sign off)	90%						n/a	n/a	n/a	n/a
Electronic Rosters (Medical staff)	100%	91%	64%	100%	100%	100%	n/a	n/a	n/a	n/a
Exception Reports (junior doctors)	3	14	1	2	11	0	n/a	n/a	n/a	n/a
Time to hire (Advert to formal offer made)	31Days								n/a	n/a

Above target	
Improvement from last month/below target	
Underachieving target	

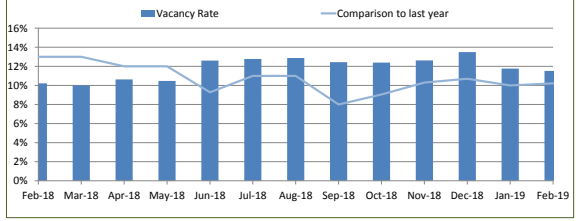
Workforce Indicators

3 Our People Summary

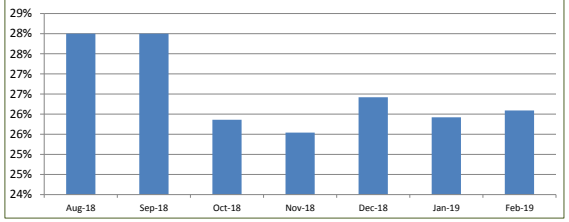
3.3 Well Led

The Princess Alexandra Hospital NHS Trust

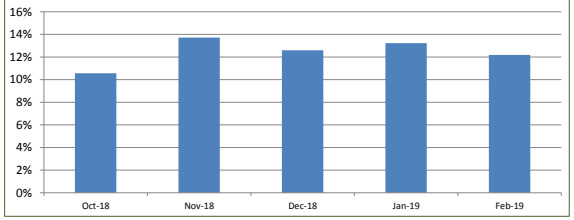
Vacancy Rate

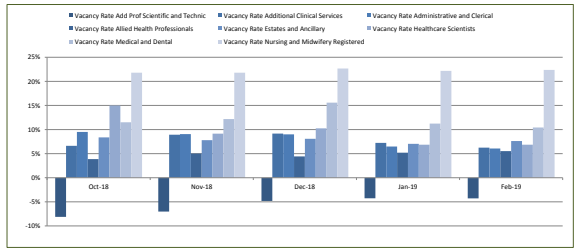


Vacancy Rate Nursing Registered (QA)

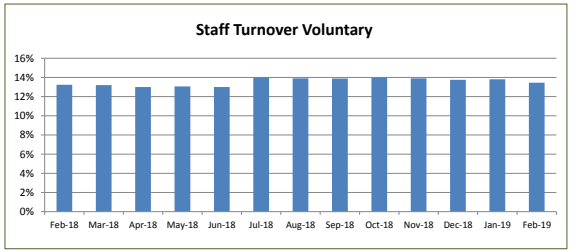


Bank Staffing Spend

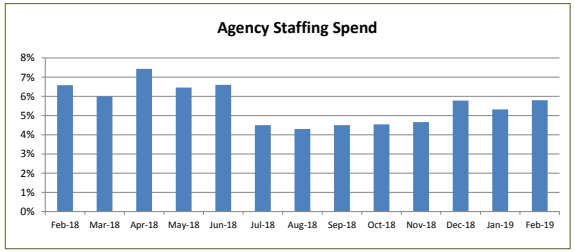




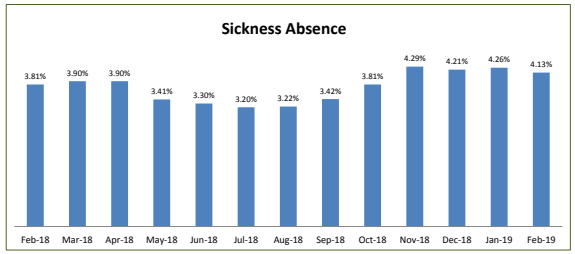
Staff Turnover Voluntary

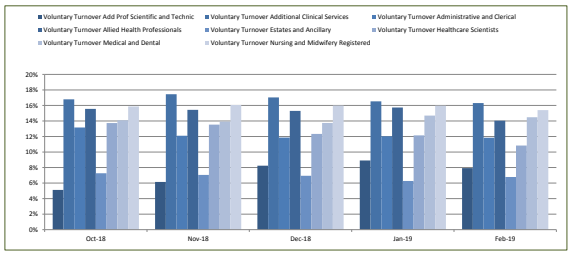


Agency Staffing Spend

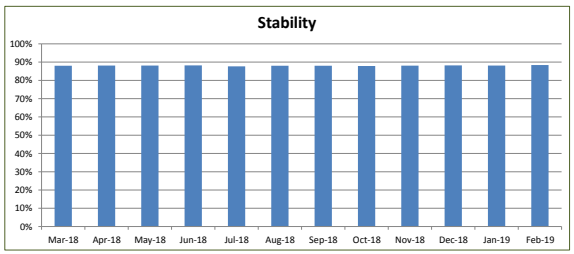


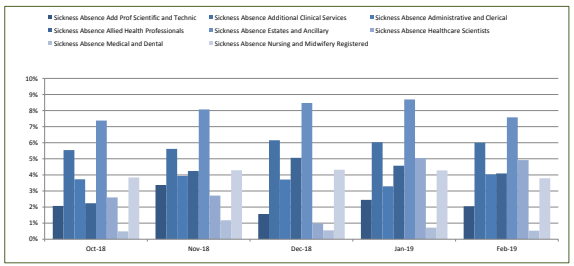
Sickness Absence



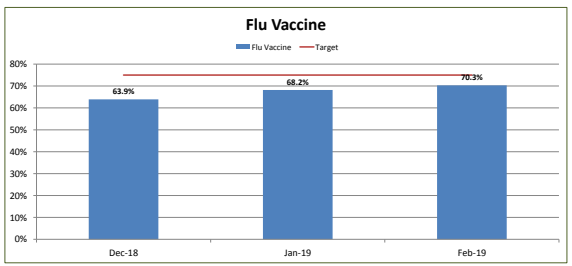


Stability

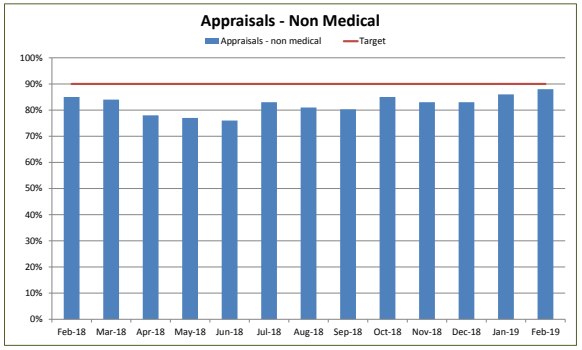


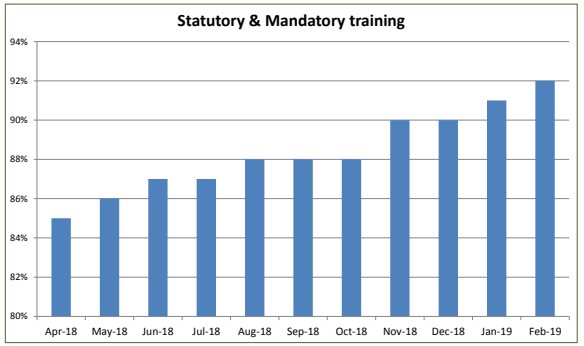


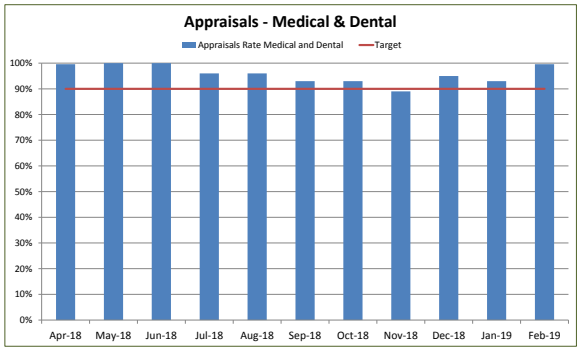
Flu Vaccine

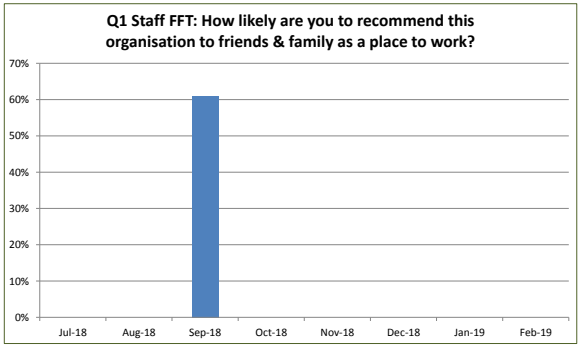


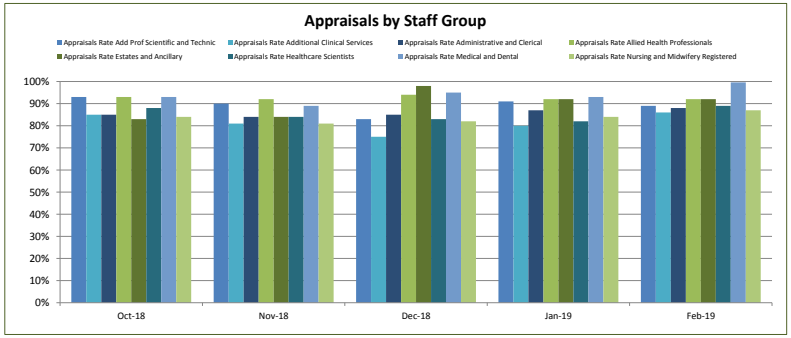
Workforce Indicators

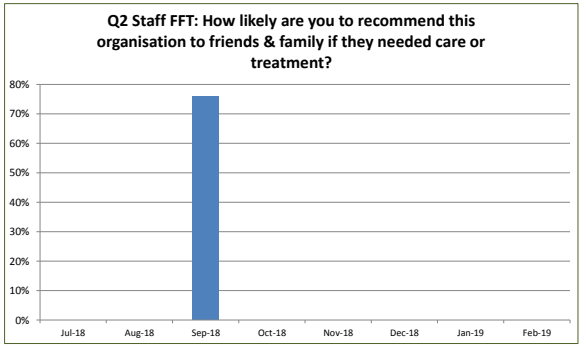












Executive Summary Our Places

The Princess Alexandra Hospital NHS Trust

Key Performance Indicators (Reporting by Exception)
Patient satisfaction (Catering Services)has continued to improve (currently 84%) following the introduction of the new menus. In February 2019, whole plate food waste has reduced by 3%, which is attributable to the collaborative approach by the senior leaders within the catering and domestic services team, with stricter controls applied for portion control and patient ordering.

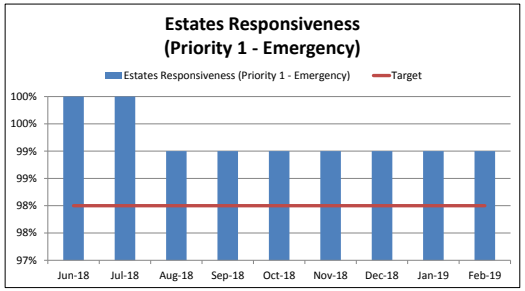
Domestic Services – This period has seen an improvement in the cleaning standards which is attributable to the increased monitoring across the Trust in preparedness for the forthcoming CQC inspection.
This period results are now aligned to a revised audit monitoring programme, which no longer includes recheck scores and are only assessed against the initial inspections. However, whilst the number of high and low risk clinical areas missing their cleanliness performance target has improved this period the high levels of sickness and absenteeism, vacancies and leave commitments have hindered ability to achieve the target. The oversight measures applied by the senior team in the previous period will continue until performance target is sustainable.

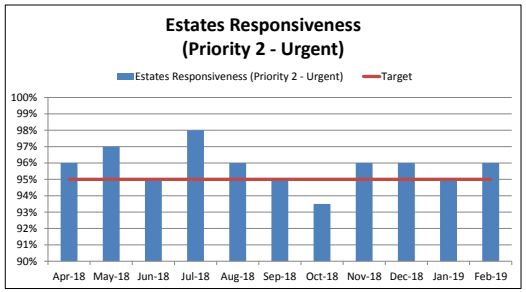
Market Testing of Services – The domestic services programme commenced in January 2019, with a comprehensive employee engagement programme. All domestic services staff have been briefed on the purpose of this initiative , specifically to current business continuity issues the service has experienced over recent months.
The tender returns are expected back in April 2019, which will then be subjected to a comprehensive review, which will include Infection Preventions, operational teams, nursing and finance.
The programme will take three months to conclude, with an anticipated decision on the process in June 2019.

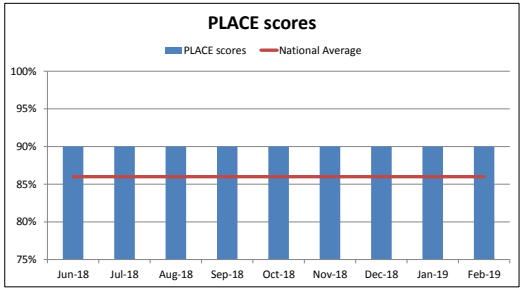
Further development taking place to initiate similar changes with estates and grounds and gardens which is being worked on with procurement with the aim of a 'mini competition' framework, against competitively tendered rates for the main estates contract and a 'direct award' for grounds and gardens. A similar approach will be applied at the launch of each 'market test' to explain the rationale for change and the potential impact of the potential changes. The process is expected to take 3 months to complete and final Board approval papers expected to commence in May 2019.

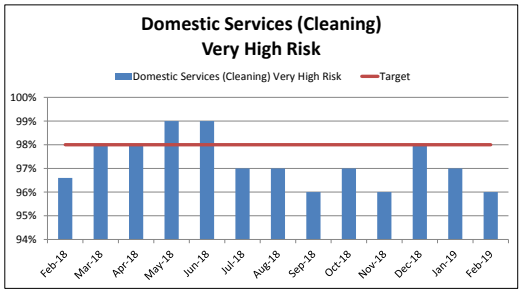
Capital Projects – Significant progress on the annual capital backlog programme, with 87% of the capital spend achieved, the majority of which were completed in February 2019. The remaining schemes will be completed by March 2019.
The backlog maintenance (12 in total) will address some of the Trusts highest estates risks, including, basement fire stopping, AHU repairs to Theatres, water ingress, lift repairs following insurance failures, site wide CCTV monitoring, etc.
Further development of schemes which were planned over two years, including plumbing and sewerage, main lift refurbishment, fracture clinic tender award are on schedule for completion in 2019.

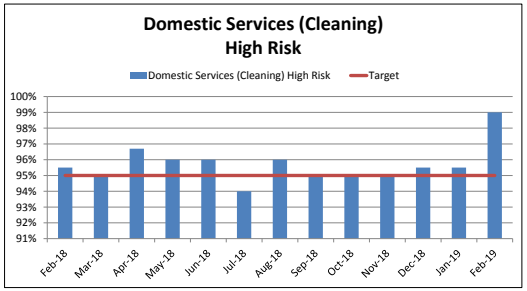
Places

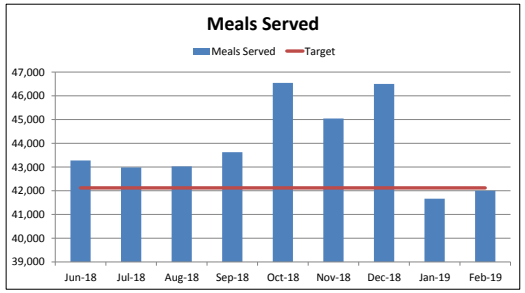

Estates Responsiveness (Priority 1 - Emergency)
Estates Responsiveness (Priority 1 - Emergency)
Target
100%
100%
99%
99%
98%
98%
97%
Jun-18
Jul-18
Aug-18
Sep-18
Oct-18
Nov-18
Dec-18
Jan-19
Feb-19

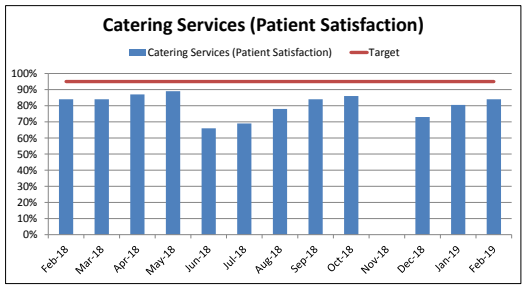

Estates Responsiveness (Priority 2 - Urgent)
Estates Responsiveness (Priority 2 - Urgent)
Target
100%
99%
98%
97%
96%
95%
94%
93%
92%
91%
90%
Apr-18
May-18
Jun-18
Jul-18
Aug-18
Sep-18
Oct-18
Nov-18
Dec-18
Jan-19
Feb-19

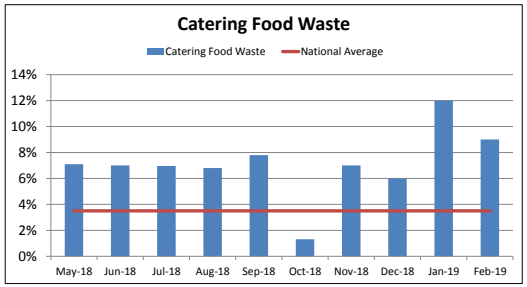

PLACE scores
PLACE scores
National Average
100%
95%
90%
85%
80%
75%
Jun-18
Jul-18
Aug-18
Sep-18
Oct-18
Nov-18
Dec-18
Jan-19
Feb-19


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


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


Meals Served
Meals Served
Target
47,000
46,000
45,000
44,000
43,000
42,000
41,000
40,000
39,000
Jun-18
Jul-18
Aug-18
Sep-18
Oct-18
Nov-18
Dec-18
Jan-19
Feb-19


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


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

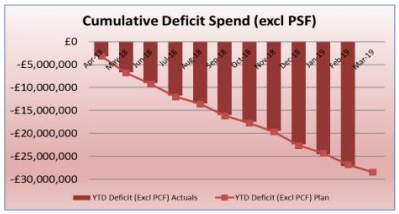
Executive Summary Our Pounds

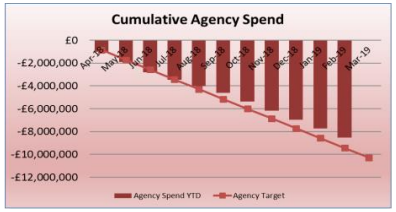
The Princess Alexandra Hospital NHS Trust

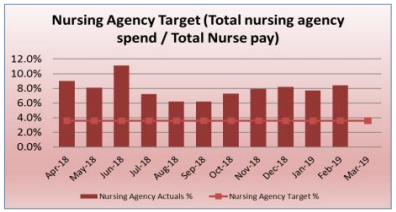
The In month deficit (excluding PSF) was £2.6m, £0.1m behind plan. The YTD deficit is £27.2m compared to the control total of £28.5m. The Trust continues to negotiate settlements to support delivery of the control total. The Trust temporary staffing costs in m11 totalled £2.7m (£32m annualised). The Trust continues to agree contract values and terms with Commissioners for 19/20 contracts which are required to be signed by 21 March 2019. As part of the CQC inspection a Use of Resources assessment will be underaken on 26th March 2019. The Trust is also preparing for the year end Accounts process and finalising contract negotiations and budget setting for 2019/20.

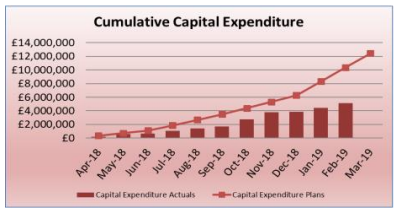
Pounds

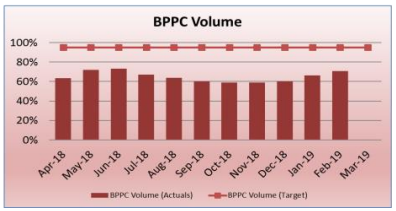
OUR POUNDS			
Metric	Annual Plan (Standard)	Previous Month	Latest Month
YTD Deficit (Excl. PSF)	-£28,471,000	-£24,580,418	-£27,167,652
Cumulative Agency Spend £s	£10,300,000	£7,739,633	£8,549,208
Nursing Agency Target (Total nursing agency spend / Total Nurse pay)	3%	8%	8%
Cumulative Capital Expenditure	£12,834,000	£4,427,800	£5,126,000
BPPC Volume	95%	66%	71%
BPPC - £s	95%	76%	87%
Cash Balance	£1,000,000	£1,252,000	£1,380,000

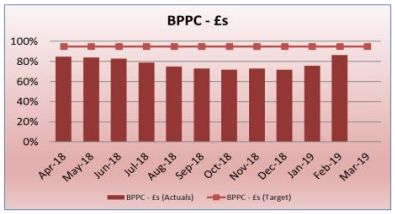












The Princess Alexandra Hospital NHS Trust

Trust Board – 4 April 2019

Agenda Item:	8.1
Presented by:	Lance McCarthy - CEO
Prepared by:	Lance McCarthy - CEO
Date prepared:	29 March 2019
Subject / Title:	Strategic Objectives 2019/20

Purpose:	Approval	x	Decision		Information	x	Assurance	

Key Issues: [please don't expand this cell; additional information should be included in the main body of the report]	The Trust Board is asked to discuss and approve the proposed strategic objectives for the organisation for 2019/20. They are based on the 5Ps, progress against them is proposed to be monitored by the Strategy Committee and risks to their achievement will tracked through the Board Assurance Framework. A review mid-year is proposed in light of the development of 'Your future; our hospital - PAH 2030', our 10-year organisational plan.
Recommendation:	The Trust Board is asked to approve: • The 5 proposed Strategic Objectives for the Trust for 2019/20 • Reviewing them in October • That progress against their achievement is overseen and monitored by the Strategy Committee of the Trust Board

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:	The Strategic Objectives and the BAF are fundamentally linked, with the BAF identifying the risks to the non-delivery of the Strategic Objectives.
Legislation, regulatory, equality, diversity and dignity implications:	None
Appendices:	None

8.1

respectful | caring | responsible | committed

The Princess Alexandra Hospital NHS
NHS Trust

Strategic Objectives for 2019/20
Trust Board – 4 April 2019

1.0 PURPOSE

1.1 The Trust Board is asked to discuss and approve the proposed strategic objectives for the organisation for 2019/20.

2.0 BACKGROUND

2.1 The Trust's strategic objectives underpin the working of the organisation for the year.

2.2 From the strategic objectives the Health Care Group objectives and individual objectives are set, ensuring they are aligned with the direction of the Trust.

2.3 The strategic objectives need to reflect the key risks faced by the organisation.

2.4 The Trust Board agreed, in June 2017, 5 Strategic Objectives, based around our 5Ps, and supporting our ambition to provide outstanding care for our local population. The Board agreed to maintain the strategic objectives for 5 years to ensure consistency of direction.

2.5 Our Board Assurance Framework (BAF), reviewed at every Board meeting, will identify the risks, and mitigations in place, of achieving our strategic objectives.

8.1

3.0 5Ps

3.1 We will be developing *'Your future; our hospital - PAH 2030'*, over the spring. This will be an organisational plan for the next 10 years, aligned with the NHS Long Term Plan, to support our drive towards delivering 'outstanding' services to our patients and secure our future with a new building.

3.2 It will be focussed around the 5 'Ps' of:

- Patients
- People
- Places
- Performance
- Pounds

and will be underpinned by working in partnership with all our health and social partners.

3.3 This will likely set some courageous goals for each of the 5Ps that build upon the proposed strategic objectives for 2019/20 in section 4.2. I'd recommend that we review the strategic objectives themselves in light of this in October 2019.

3.4 The 5P plans will continue to be delivered by a Quality First approach, putting Quality First in everything that we do and supported by our Quality First team.

3.5 All Healthcare Groups have developed a 5P plan of their own, interlinked with each other and supporting the delivery of the Trust wide 5P plan. Over 2019/20, all specialties, clinical departments and corporate department will also develop a 5P plan of their own, linked with the transformation and modernisation agenda across the whole organisation. These will be interlinked with the actions from the Getting it Right First Time (GiRFT) programme and our Model Hospital data, supporting the improved use of our resources.

3.6 The 5P plans will have clear milestones identified for delivery within each specific year. Achievement of the 2019/20 milestones within the 5P plans will support the achievement of the Trust's 2019/20 strategic objectives.

4.0 PROPOSAL

4.1 Some minor amendments have been made for 2019/20 to reflect the move in to the new financial year. The changes are highlighted in red below.

4.2 The 5 proposed objectives for approval are outlined below:

- Our Patients – we will continue to improve the quality of care and experiences that we provide **our patients**, integrating care with our partners and improving our CQC rating
- Our People – we will support **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
- 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 a ~~our~~ local Integrated Care Alliance
- 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 for ~~2018/19~~ 2019/20 and our local system control total

4.3 It is proposed that the Strategy Committee of the Trust Board oversees and monitors progress throughout the year against the strategic objectives on a 2-monthly basis and reports progress in to the Trust Board.

5.0 RECOMMENDATION

5.1 The Trust Board is asked to:

- approve the 5 proposed strategic objectives for the Trust for 2019/20
- approve the recommendation of reviewing them in October in line with the development of *'Your future; our hospital - PAH 2030'*
- approve the proposal that progress against their achievement is overseen and monitored by the Strategy Committee of the Trust Board

Author: **Lance McCarthy, Chief Executive**
Date: **29 March 2019**

The Princess Alexandra Hospital NHS Trust

BOARD OF DIRECTORS

MEETING DATE: 04.04.19 **AGENDA ITEM NO:** 8.2

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

REPORT FROM: Helen Glenister

DATE OF COMMITTEE MEETING: 05.03.19

SECTION 1 – MATTERS FOR THE BOARD'S ATTENTION
The following are highlighted for the Board to note or to take action:
The Board is asked to note the following: : • The meeting took place with the new committee membership which included the Director of People (Executive Lead) and Director of Strategy. . • An outline fundraising risk register was received. A formal risk register will be developed and reviewed by the Risk Management Group within Princess Alexandra Hospital NHS Trust with the highest scoring risks discussed at CFC. • The committee agreed the annual accounts timetable. • Work is ongoing to develop a clear strategy and plan for Charity Fundraising. . The following reports were received: • Breast Fund activities including research activities and patient impact of Charitable activities. • General fundraising update. • Charity Finance - income remained stable. A plan of action had not been received for a number of dormant funds (despite foloow-up communications), therefore it was agreed that fund managers would receive formal communications to note that funds would be transferred to the general fund if plans were not produced with two weeks • Budgets and plans for 2019/20 .
SECTION 2 – ITEMS FOR THE BOARD'S INFORMATION AND ASSURANCE (To include an update on delivery of each performance trajectory – ED, RTT, Cancer, 30 Day Re-admissions, 52 week breaches and Stroke)
The following are highlighted for the Board's awareness and/or assurance:
Section 2 is not applicable to the Charitable Funds Committee
SECTION 3 – PROGRESS AGAINST THE COMMITTEE'S ANNUAL WORK PLAN
The CFC is generally making good progress against its 2018/19 annual work plan. The Charitable Funds Strategy and Action Plan had not been reviewed partly due to changes in Executive Lead for the Charitable Funds Committee. The work plan for 2019/20 was agreed..

8.2

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The Princess Alexandra Hospital NHS Trust

BOARD OF DIRECTORS

MEETING DATE: 04.04.2019 **AGENDA ITEM NO: 8.2**

REPORT TO THE BOARD FROM: Audit Committee (AC)

REPORT FROM: Andrew Holden – Chair of Audit Committee

DATE OF COMMITTEE MEETING: 06/03/2019

SECTION 1 – MATTERS FOR THE BOARD'S ATTENTION
The following are highlighted for the Board to note or to take action:
The following areas are highlighted to the Board: 1. The revised terms of reference were considered following amendments to the committee membership and an update to include reference to section 24 of the NHS standard contract in relation to Counter Fraud. The terms of reference (**Appendix A)** are recommended to the Board for approval. 2. Three Internal Audit reports were discussed; financial reporting and budget monitoring which received substantial assurance, key financial systems which received substantial assurance and overseas/RTA and private patient income which received limited assurance. 3. The Draft Head of Internal Audit Opinion providing a reasonable assurance opinion was noted and the committee received the draft Annual Governance Statement for comment. It was noted that this year there were fewer limited assurance opinions and there were substantial assurance opinions compared to the previous reasonable opinions. 4. The Counter Fraud plan for 2019/20 was approved. 5. The committee received the report on waivers, losses and special payments: losses and special payments for the period 01.04.18-31.01.19 totalled £62.5k. Waivers for the period 01.04.18-31.01.19 totalled £4.4m. A contract had since been agreed for the non-emergency patient transport waiver. 6. A private session was also held to review the external audit contract and it was agreed the external audit contract would be extended for a further year.
SECTION 3 – PROGRESS AGAINST THE COMMITTEE'S ANNUAL WORK PLAN
The Committee's progress against its Annual Work Plan is set out below:
The AC is making good progress against its annual work plan and meets again on Thursday 23 May 2019.

8.2

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The Princess Alexandra Hospital NHS Trust

AUDIT COMMITTEE

TERMS OF REFERENCE 2019/20

PURPOSE:

The Audit Committee (the Committee) shall provide the Board of Directors with an independent and objective review of financial and corporate governance, assurance processes and risk management across the whole of the Trust's activities (clinical and non-clinical) both generally and in support of the Annual Governance Statement. In addition, it shall oversee the work programmes for external and internal audit and receive assurance of their independence and monitor the Trust's arrangements for corporate governance.

For the purposes of procuring the Trust's External Auditor, the Trust Board has nominated the Audit Committee to acts as its Auditor Panel in line with Schedule 4, paragraph 1 of the Local Audit and Accountability Act 2014.

DUTIES:

The following comprise the Committee's main responsibilities:

Annual Work Plan and Committee Effectiveness

Agree an annual work plan with the Trust Board based on the Committee's purpose (above) and conduct an annual review of the Committee's effectiveness and achievement of the Committee work plan for consideration by the Trust Board.

Governance, Internal Control and Risk Management

The Committee shall review the establishment and maintenance of an effective system of integrated governance, internal control and risk management across the whole of the Trust's activities (both clinical and non-clinical) that supports the achievement of the Trust's objectives. In particular, the Committee shall:

1. Review the risk and control related disclosure statements prior to endorsement by the Board; this shall include the Annual Governance Statement, Head of Internal Audit opinion, External Audit opinion and/or other appropriate independent assurances.
2. Ensure the provision and maintenance of an effective system of financial risk identification and associated controls, reporting and governance structure.
3. Maintain an oversight of the Trust's general risk management structures, processes and responsibilities especially in relation to the achievement of the Trust's corporate objectives.
4. Receive reports from other assurance committees of the Board regarding their oversight of risks relevant to their activities and assurances received regarding controls to mitigate those risks; this shall include Clinical Audit programme overseen by the Trust's Quality & Safety Committee.
5. Review the adequacy and effectiveness of policies and procedures:
   a. by which staff may, in confidence, raise concerns about possible improprieties or any other matters of concern
   b. to ensure compliance with relevant regulatory, legal and conduct requirements.

Internal Audit

The Committee shall ensure that there is an effective internal audit function that meets mandatory standards and provides appropriate independent assurance to the Committee, Chief Executive and the Board of Directors. It shall achieve this by:

1. Reviewing and approving the Internal Audit Strategy and annual Internal Audit Plan to ensure that it is consistent with the audit needs of the Trust (as identified in the Assurance Framework).
2. Considering the major findings of internal audit work, their implications and the management's response and the implementation of recommendations and ensuring co-ordination between the work of internal audit and external audit to optimise audit resources.
3. Conducting a regular review of the effectiveness of the internal audit function.
4. Periodically consider the provision, cost and independence of the internal audit service (not more than every five years unless circumstances require otherwise).

External Audit

The Committee shall review the findings of the external auditors and consider the implications and management's response to their work. In particular the Committee shall:

1. Discuss and agree with the external auditor, before the audit commences, the nature and scope of the external audit as set out in the annual plan and ensure coordination with other external auditors in the local health economy, including the evaluation of audit risks and resulting impact on the audit fee.
2. Review external audit reports including the report to those charged with governance and agree the annual audit letter before submission to the Board;
3. Agree any work undertaken outside the annual external audit plan (and consider the management response and implementation of recommendations).
4. Ensure the Trust has satisfactory arrangements in place to engage the external auditor to support non-audit services which do not affect the external auditor's independence.
5. Review the performance of the external audit service and report to the Public Sector Audit Appointments Ltd (PSAA) on any matters relating to the external audit service.

Annual Report and Accounts Review

The Committee shall ensure that the systems for financial reporting to the Board, including those of budgetary control, are subject to review as to the completeness and accuracy of the information provided to the Board. The Committee shall review the annual report and financial statements before submission to the Board, particularly focusing on:

1. The wording of the Annual Governance Statement and any other disclosures relevant to the terms of reference of the Committee.
2. All narrative sections of the Annual Report to satisfy itself that a fair and balanced picture is presented which is neither misleading nor consistent with information presented elsewhere in the document.
3. Changes in, and compliance with, accounting policies, practices and estimation techniques.
4. The meaning and significance of the figures, notes and significant changes.

5. Areas where judgement has been exercised and any qualitative aspects of financial reporting.
6. Explanation of estimates or provisions having material effect.
7. The schedule of losses and payments.
8. Any unadjusted (mis)statements.
9. Any reservations and disagreements between the external auditors and management which have not been satisfactorily resolved.
10. The letter of representation.

Annual Quality Account

The Committee shall seek assurance that:

1. The reporting in the Trust's Quality Account is in line with the Trust's quality priorities and performance and consistent with other sources of assurance on quality available to the Committee
2. The Quality Account presents a fair and balanced representation of the Trust's quality performance
3. The priorities for quality focus concur with those of the Trust's patients and its plans
4. External audit opinion confirms that the Quality Account meets statutory guidelines.

Governance Manual

1. On behalf of the Board of Directors, review the operation of and proposed changes to the standing orders, standing financial instructions, codes of conduct, standards of business conduct and the maintenance of registers.
2. Examine any significant departure from the requirements of the foregoing, whether those departures relate to a failing, overruling or suspension.
3. Review the schemes of delegation and authority.

Management

The Committee shall request and review reports and positive assurance from directors and managers on the overall arrangements for governance, risk management and internal control and may also request specific reports from individual functions within the Trust as necessary.

Counter Fraud/Bribery/Corruption Arrangements

The Committee shall ensure that the Trust has in place:

1. Adequate measures to comply with ~~the Directions to NHS Bodies on Counter Fraud Measures 2004.~~ Section 24 of the NHS Standard Contract]
~~1.~~2. ~~___~~
~~2.~~3. Appropriate arrangements to implement the requirements of the Bribery Act 2010.
~~3.~~4. A means by which suspected acts of fraud, corruption or bribery can be reported.

The Committee shall review the adequacy and effectiveness of policies and procedures in respect of counter fraud, bribery and corruption.

The Committee shall formally receive an annual report summarising the work conducted by the Local Counter Fraud Specialist for the reporting year in line with Section 24 of the NHS Standard Contract]
~~the Secretary of State's Directions on Fraud and Corruption~~.

The following comprise the Auditor Panel's main responsibilities:

Procurement of External Audit
In its capacity as Auditor Panel, the Committee shall:
1. Agree and oversee a robust process for selecting the external auditors in line with the Trust's procurement processes and rules.
2. Advise the Board on the selection and appointment of the External Auditor.
3. Ensure that any conflicts of interest are dealt with effectively.
4. Advise the Board on the maintenance of an independent relationship with the appointed External Auditor.
5. Advise the Board on whether or not any proposal from the External Auditor to enter into a liability limitation agreement as part of the procurement process is fair and reasonable.
6. Approve the Trust's policy on the purchase of non-audit services from the appointed external auditor.
7. Advise the Board on any decision about the resignation or removal of the External Auditor.

ACCOUNTABLE TO: Trust Board.

REPORTING ARRANGEMENTS: A regular written report from the Committee shall be produced for the Board of Directors by the Committee Chairman and Lead Executive. It shall highlight areas of focus from the last meeting and demonstrate progress against the Committee annual work plan.

The Committee shall report to the Board of Directors at least annually:

- on its work in support of the Annual Governance Statement, (specifically commenting on the fitness for purpose of the Assurance Framework)
- the extent to which risk management processes are embedded within the organisation
- the integration of governance arrangements
- the appropriateness of evidence compiled to demonstrate fitness to register with the Care Quality Commission
- the robustness of the processes behind the Quality Account and the development of the Quality Report through a report from the Quality & Safety Committee.

The Chair of the Auditor Panel shall produce a report from the Panel outlining how it has discharged its duties.

CHAIRMAN Non-Executive Director.

COMPOSITION OF MEMBERSHIP: Members of the Committee shall be appointed from amongst the Non-Executive Directors and shall consist of not less than three members including the Committee Chairman, at least one of whom shall have recent and relevant financial experience. The Trust Chairman will not be a member of the Committee. Members of the Performance & Finance Committee and the Quality & Safety Committee shall be among the members of the Audit Committee.

The Auditor Panel shall comprise the entire membership of the Audit Committee. All members of the Auditor Panel will be independent Non-Executives Directors.

ATTENDANCE

Members are expected to make every effort to attend all meetings of the Committee and it is expected that they shall attend the majority of Committee meetings within each reporting year. An attendance record will be held for each meeting and an annual register of attendance will be included in the Committee's annual report to the Board.

In addition to the members of the Committee, the following will be invited to attend each Committee meeting:

- Chief Financial Officer and Deputy Chief Financial Officer
- Executive Lead for Risk Management
- Representatives from Internal Audit, External Audit and the Local Counter Fraud Service.

At least once a year, the Committee shall meet privately with the internal and external auditors.

The Chief Executive shall be invited to attend the Committee at least annually to discuss the process for assurance that supports the Annual Governance Statement. This shall be when the Committee formally considers the annual reports and accounts prior to Board approval.

To ensure appropriate accountability, other Executive Directors and, if required, members of the management team will be invited to attend when the Committee is discussing areas of risk or operation that are their responsibility.

The Chair of the Auditor Panel may invite Executive Directors and others to attend meetings of the Panel. However, these attendees will not be members of the Auditor Panel.

DEPUTISING ARRANGEMENTS

In the absence of the Committee Chairman, the Audit Committee shall be chaired by one of the Non-Executive Director members of the Committee.

Other deputies may attend but must be suitably briefed and designated and notified in advance, where possible.

QUORUM:

The quorum for any meeting of the Committee shall be the attendance of a minimum of two members. Each member shall have one vote and in the event of votes being equal, the Chairman of the Committee shall have the casting vote.

The quorum for any meeting of the Auditor Panel shall be the attendance of a minimum of two members.

DECLARATION OF INTERESTS

All members, ex-officio members and those in attendance must declare any actual or potential conflicts of interest; these shall be recorded in the minutes. Anyone with a relevant or material interest in a matter under consideration must be excluded from the discussion.

MEETING FREQUENCY:

There shall be four meetings of the Committee each year with additional meetings where necessary. This includes a meeting to focus on the pre-Board consideration of the Annual Reports and Accounts which will only consider usual business by exception.

The Auditor Panel shall consider the frequency and timing of meetings needed to allow it to discharge its responsibilities but as a general rule will

meet on the same day as the Committee.

MEETING ORGANISATION

Audit Committee

- Meetings of the Committee shall be set before the start of the financial year.
- The meeting shall be closed and not open to the public.
- The Head of Corporate Affairs shall ensure there is appropriate secretarial and administrative support to the Committee.
- The agenda and supporting papers shall be forwarded to each member of the Committee and planned attendees not less than five clear days* before the date of the meeting.

Auditor Panel

- The meeting shall be closed and not open to the public.
- The Head of Corporate Affairs shall ensure there is appropriate secretarial and administrative support to the Committee.
- The agenda and supporting papers shall be forwarded to each member of the Committee and planned attendees not less than five clear days* before the date of the meeting.
- The agenda items for discussion by the Auditor Panel shall be clearly distinguished from the items for discussion by the Committee.
- The minutes of the Auditor Panel shall be separate from the minutes of the Committee.

*'clear day' means any day which is not a Saturday or Sunday or a public or bank holiday.

AUTHORITY

The Committee is constituted as a Committee of the Trust Board. Its constitution and terms of reference shall be as set out above, subject to amendment by the Board as necessary.

The Committee and the Auditor Panel are authorised by the Board of Directors to investigate any activity within these terms of reference. They are authorised to seek any information they require from any employee, and all employees are directed to co-operate with any request made by the Committee and Auditor Panel.

The Committee and the Auditor Panel are authorised by the Trust Board to request the attendance of individuals and authorities from outside the Trust with relevant experience and expertise if they consider this necessary and to seek advice and support from the Head of Corporate Affairs and external experts as required.

TERMS OF REFERENCE

The terms of reference of the Committee shall be reviewed at least annually and approved by the Trust Board.

DATE APPROVED

By Committee: 6 March 2019
By Trust Board:

TO BE REVIEWED ANNUALLY

Next review due: March 2020

The Princess Alexandra Hospital NHS Trust

AUDIT COMMITTEE2019/20: MEMBERSHIP

Membership and Those in Attendance	
Members	
Vacant	**Non-Executive Director and Committee Chair**
Helen Howe	Associate Non-Executive Director
Andrew Holden	Non-Executive Director
In Attendance (Board)	
Trevor Smith	Chief Financial Officer (Lead Exec)
Lance McCarthy	Chief Executive Officer
Andy Morris	Chief Medical Officer
In Attendance (Internal & External Audit)	
Thanzil Khan	tiaa
Kevin Limn	tiaa
Gareth Robins	tiaa
Debbie Hanson	Ernst & Young
Kay Storey	Ernst & Young
Invited	
Simon Covill	Deputy Chief Finance Officer
Nick Ryan	Deputy Chief Finance Officer
Secretariat	
Heather Schultz	Head of Corporate Affairs
~~Esther Kingsmill~~	~~Corporate Governance Officer~~

8.2

The Princess Alexandra Hospital NHS
NHS Trust

BOARD OF DIRECTORS

MEETING DATE: 4 April 2019 **AGENDA ITEM NO: 8.2**

REPORT TO THE BOARD FROM: Quality & Safety Committee (QSC)

REPORT FROM: Helen Glenister

DATE OF COMMITTEE MEETING: 22 March 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: • **Stillbirths:** Assurance provided to the Committee that following receipt of the report from NHSI, there were no new concerns in addition to those already identified by the Trust. CEO Assurance Panel to take place on 02.04.19 after which a decision will be taken on whether a further external review is required. • **Maternity Incentive Scheme**: Delegated authority was granted by the Board for the Chair of QSC, another Non-Executive Director member of QSC, the Director of Nursing & Midwifery and the Chief Medical Officer to sign off the action plan in relation to Standard 3. Action plan was duly signed off under delegated authority and submitted by deadline of 10.03.19. • **Infection Control:** The Vancomycin Resistant *Enterococcus* (VRE) outbreak on ITU/HDU continues to be monitored and managed. QSC was assured that control measures were robust and the Committee would be updated again in April.
SECTION 2 – ITEMS FOR THE BOARD'S INFORMATION AND ASSURANCE
Other items discussed: QSC also received the following reports: Quarterly Performance Report (Surgery), M11 Integrated Performance Report, Mortality Improvement Programme, Patient Experience Report, Update from Patient Panel, Report on Nursing, Midwifery and Care Staff Levels, Monthly Quality, Safety & Effectiveness Report, Monthly Report from Patient Safety & Quality Group, Quality Compliance Readiness 2018/19, CQC Insight Report and BAF Risks Review.
SECTION 3 – PROGRESS AGAINST THE COMMITTEE'S ANNUAL WORK PLAN
The Committee is making good progress against its work plan.

8.2

The Princess Alexandra Hospital NHS
NHS Trust

BOARD OF DIRECTORS

MEETING DATE: 04 April 2019 **AGENDA ITEM NO: 8.2**

REPORT TO THE BOARD FROM: Performance and Finance Committee (PAF)
REPORT FROM: Andrew Holden - PAF Chairman
DATE OF COMMITTEE MEETING: 25.03.19

SECTION 1 – MATTERS FOR THE BOARD'S ATTENTION

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

- Month 11: PAF discussed the Month 11 financial results in detail. The year to date deficit is £27.2m against the year-end target of £28.5m. Delivery of the control total is being supported through non-recurrent measures including release of winter monies, cancer funds, rental incomes and contingency. PAF questioned whether the control total of £28.5m would be delivered, noting that the full amount of PSF (£5.6m) would be at risk if the Trust did not achieve the control total. PAF discussed the continued increase in temporary staffing costs and ongoing discussions with the CGG regarding the year end position. The Committee was assured that the Trust would achieve the gross control total although it would be challenging.

- ED Standard: PAF discussed ED performance and the current challenges to delivering the standard. A number of initiatives are already underway and were discussed but PAF focussed on further initiatives and areas that will be progressed. These include investing in additional assessment spaces, introducing Hospital at Night, strengthening the frailty service, streaming to Herts Urgent Care Centre, encouraging appropriate behaviours by leadership teams and finally, reviewing the number of inpatient beds taking into account ECIST's views and mindful of the revenue and staffing implications associated with creating additional capacity.

- Operating Plan and Budget: Under delegated authority granted by the Board on 7 March 2019, PAF approved the interim budget with the final budget to be presented to PAF in April and Board in May 2019.

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

In addition to the above, PAF received reports on the following agenda items:

- MSK Contract, Core Contract and COPD
- Data Quality and Coding Updates
- Carter Work Streams/Model Hospital Update
- Use of Resources assessment
- BAF risks

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

The Committee is making good progress against its work plan. The 2019/20 workplan is being developed to enable a deep dive approach on specific areas on alternate months.

The Princess Alexandra Hospital NHS Trust

BOARD OF DIRECTORS

MEETING DATE: 04/04/19 **AGENDA ITEM NO: 8.2**

REPORT TO THE BOARD FROM:	Workforce Committee
REPORT FROM:	Pam Court – Committee Chair
DATE OF COMMITTEE MEETING:	25/03/2019

SECTION 1 – MATTERS FOR THE BOARD'S ATTENTION
The following are highlighted for the Board to note or to take action:
• The committee received and approved the Gender Pay Gap report in advance of the publication deadline of 31 March 2019. • The staff survey results were received and discussed in detail; year on year improvements were noted and 4 areas/themes will be addressed in the action plans being developed by the Health Care Groups and Corporate departments. • The People Strategy was reviewed and recommended to the Board for approval subject to the inclusion of a reference to the Trust's annual Operating Plan where workforce and targets are detailed. • The revised Terms of Reference were considered and are recommended to Board for approval (Appendix 1).
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) 2018/19, Temporary Staffing, Safer Staffing, Training and Education, People Board Report and BAF risks.
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 considered the 2019/20 workplan.

8.2

The Princess Alexandra Hospital NHS Trust

WORKFORCE COMMITTEE

TERMS OF REFERENCE

PURPOSE:

The purpose of the Workforce Committee:

- Maintain oversight of the development and design of the Workforce and ensure it is aligned with the strategic context within which the Trust is required to operate.
- Assure the Board on all aspects of Workforce and Organisational Development and provide leadership and oversight for the Trust on workforce issues that support delivery of the Trust's annual objectives.
- Assure the Board that the Trust has adequate staff with the necessary skills and competencies to meet both the current and future needs of the Trust and ensure delivery of efficient services to patients and service users.
- Assure the Board that legal and regulatory requirements relating to workforce are met.

DUTIES:

The following comprise the Workforce Committee's main duties as delegated by the Board of Directors:

1. To promote the trust's values and behaviours
2. Provide assurance on the development and delivery of a people and OD strategy that supports the Trust plans and ensure an appropriate workforce culture is in place and monitor their implementation.
3. Keep under review the Trust's plans in relation to its workforce including recruitment and retention of staff, Organisational Development, learning, and employee engagement and wellbeing.
4. Review workforce performance and oversee the development of a balanced scorecard for all workforce indicators.
5. Review the outcomes of national and local staff surveys and monitor the progress of action plans.
6. Monitor staff engagement initiatives and outcomes
7. Ensure the Trust meets its statutory obligations regarding Diversity and Inclusion.
8. Oversee the Trust's relationship with educational partners to maximise the benefits of these relationships to the Trust.
9. Review and monitor workforce, organisational development and education and training risks including those reflected on the Board Assurance Framework and seek assurance that plans/actions are in place to mitigate identified risks.
10. The Committee shall request and review reports from other sub groups as deemed necessary
11. Other Workforce/OD/Training activity as requested by the Board.
12. Keep under review the development of a Communications Strategy and monitor its implementation.
13. Review and monitor the portfolio of volunteer activities and services. Provide assurance to the Board that there are mechanisms in place to allow staff to raise concerns and that these are dealt with in policy and national guidance including receiving regular reports from the Freedom to Speak up Guardians.

WORKPLAN:

Annual Work Plan and Committee Effectiveness

Every year, set an Annual Work Plan and conduct an effectiveness review (which will include the achievement of the Annual Work Plan and a review of the terms of

reference) and report this to the Board.

ACCOUNTABLE TO: Trust Board.

REPORTING A Committee report shall be provided to the next meeting of the Board of Directors. The report shall set out areas requiring the Board's attention and report on the level of assurance provided by the Workforce Committee and advise of progress against the Annual Work Plan.

CHAIRMAN: Non-Executive Director.

COMPOSITION OF MEMBERSHIP: The Workforce Committee is comprised of Executive and Non-Executive Directors appointed by the Board. The agreed membership is:

- Chair - Non-Executive Director
- Non-Executive Director
- Director of People, Organisational Development & Communications
- Director of Nursing and Midwifery
- Chief Operating Officer
- Director of Medical Education

The Chairman of the Workforce Committee shall be appointed by the Chairman of the Trust Board; s/he shall have recent and relevant finance or business or workforce experience.

If not already a member of the Workforce Committee, the Audit Committee Chairman may attend any meeting.

The Chairman and Chief Executive of the Board reserve the right to attend meetings and will attend alternate meetings of the Committee.

All members will have one vote. In the event of votes being equal, the Chairman will have the casting vote. Deputies attending the meeting on behalf of a member of the Committee are not entitled to exercise a vote.

ATTENDANCE: Members are expected to attend all meetings of the Committee. An attendance register shall be taken at each meeting and an annual register of attendance included in the Trust's annual report.
In addition to the members of the Board, the following shall be expected to attend each meeting:

- Deputy Director of People
- Associate Director of Learning and OD
- Associate Director of Communications
- Medical Education Manager

To ensure appropriate accountability, others will be invited to attend where areas of risk or operation are being discussed within their areas of responsibility.

Where considered appropriate and necessary, the Internal Auditors may be invited to attend meetings to present reports of any audits conducted by them in respect of issues within the scope of the Committee.

DEPUTISING ARRANGEMENTS In the absence of the Committee Chairman, another Non-Executive Director member of the Workforce Committee will chair the meeting.
Other deputies may attend but must be suitably briefed and, where possible, designated and notified in advance. In the absence of an Executive member

his/her designated deputy may attend with the permission of the Chief Executive Officer.

QUORUM: The quorum for any meeting shall be the attendance of a minimum of one Non-Executive member, and one other Executive member.

DECLARATION OF INTERESTS: All members and those in attendance must declare any actual or potential conflicts of interest; these shall be recorded in the minutes. Anyone with a relevant or material interest in a matter under consideration must be excluded from the discussion.

LEAD EXECUTIVES: Director of People, OD and Communications

MEETING FREQUENCY: Meetings of the Workforce Committee shall be bi-monthly.

MEETING ORGANISATION:

- Meetings of the Committee shall be set before the start of the financial year.
- The meeting will be closed and not open to the public.
- The Head of Corporate Affairs shall ensure there is appropriate secretarial and administrative support to the Committee.
- All final Committee reports must be submitted six clear days* before the meeting.
- The agenda and supporting papers shall be forwarded to each member of the Committee and planned attendees five clear days* before the date of the meeting and not less than three clear days* before the date of the meeting.

*'clear day' is a day which is not a Saturday or Sunday or a public or bank holiday.

AUTHORITY The Workforce Committee is constituted as a Committee of the Trust Board. Its constitution and terms of reference shall be as set out above, subject to amendment by the Board as necessary.

The Workforce Committee is authorised by the Board of Directors to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee, and all employees are directed to co-operate with any request made by the Workforce Committee.

The Workforce Committee is authorised by the Trust Board to request the attendance of individuals and authorities from inside or outside the Trust with relevant experience and expertise if it considers this necessary.

TERMS OF REFERENCE: The terms of reference of the Workforce Committee shall be reviewed at least annually and presented to the Trust Board.

DATE APPROVED: By Workforce Committee: 25 March 2019
By Trust Board:

The Princess Alexandra Hospital NHS Trust

MEMBERSHIP

Membership and Those in Attendance	
Members	
Chair: Non-Executive Director	Pam Court
Non-Executive Director	Helen Howe
Non-Executive Director	Vacant
Director of People, OD and Communications	Ogechi Emeadi
Chief Operating Officer	Stephanie Lawton
Director of Nursing and Midwifery	Sharon McNally
Director of Medical Education	Jonathan Refson
In Attendance	
Associate Director of Learning and OD	Martin Smith
Medical Education Manager	Margaret Short
Deputy Director of People	Beverley Watkins
Associate Director of Communications	Laura Warren
In Attendance (right to attend reserved)	
Trust Chairman	Steve Clarke
Chief Executive	Lance McCarthy
Secretariat	
Head of Corporate Affairs	Heather Schultz

8.2

The Princess Alexandra Hospital NHS
NHS Trust

BOARD OF DIRECTORS

MEETING DATE: 04.04.19 **AGENDA ITEM NO: 8.3**

REPORT TO THE BOARD FROM: Senior Management Team
REPORT FROM: Lance McCarthy - Chairman
DATES OF MEETINGS: 5th and 19th March 2019.

ITEMS FOR THE BOARD'S INFORMATION AND ASSURANCE
SMT meetings took place on 5 March and 19 March 2019. The following items were discussed at the meeting on 5th March: • Finance - Month 10 results • CIP sign off • Job planning • Understanding the nurse fill rates on the Safer Staffing Report • Feedback from The Trusted Executive Foundation following questionnaire 22.01.2019 and the Challenging Coaching Masterclasses. • EU Exit • Medical Advisory Committee Terms of Reference and guidance for the election of MAC leadership The meeting on 19th March 2019 focussed on CQC preparedness and members of SMT visited clinical areas across the Trust to talk to staff about the forthcoming CQC inspection and encouraged staff to talk about areas they are proud of and improvements being made.

8.3

The Princess Alexandra Hospital NHS
NHS Trust

Trust Board (Public) – 4 April 2019

Agenda Item:	8.4
Presented by:	Lance McCarthy - CEO
Prepared by:	Lance McCarthy - CEO
Date prepared:	27.03.19
Subject / Title:	Report from the ICP Board

Purpose:	Approval	x	Decision		Information		Assurance	

Executive Summary: [please don't expand this cell; additional information should be included in the main body of the report]	This report provides an update of the progress with developments to care pathways across the West Essex ICP, the pipeline of activity and the work to formalise the ICP as a delivery vehicle of the Hertfordshire and West Essex STP / ICS.
Recommendation:	The Trust Board is asked to note progress and developments across the local ICP.

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:	1.1 outcomes 3.3 financial and clinical sustainability across the health and care system 3.5 sustainability of local services
Legislation, regulatory, equality, diversity and dignity implications:	None
Appendices:	None

8.4

respectful | caring | responsible | committed

West Essex Integrated Care Programme

Delivery Plan August 1st – 31st March 2019.

West Essex CCG Board – March 2019

Section 1 - Overview

This paper provides a summary of the proposed ICP Delivery Plan for the rest of 2018/19; the key actions are outlined below and will be overseen by the ICP Delivery Board with regular updates and areas for approval continuing to be presented to individual Governing Bodies at each key decision making stage. A more detailed action plan is held centrally by the Programme Team.

This paper includes an overview of

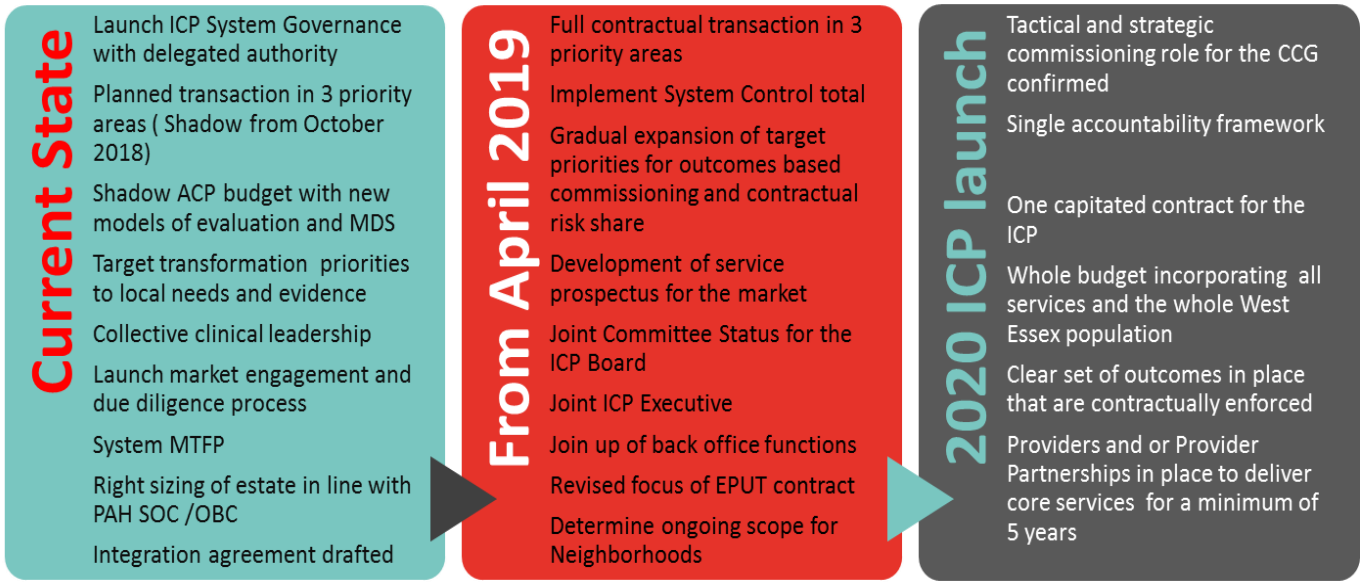
- Key strategic priorities
- Key delivery actions
- The proposed due diligence Process for MSK and COPD services
- Proposed levels of delegated authority for the ICP Programme

Section 2- Key strategic priorities

Strategic Priorities	The ICP Programme will;
1.Collaboration	Bind system organisations together to deliver key services under an Integration agreement/ MOU.
2. Tackling Local variation	Develop one consistent approach to identifying and addressing variation in our system according to local needs and operational realities.

3. Co –production and partnership	Set the framework for co-production and oversee the implementation of integrated clinical pathways and services.
4. Deliver	Ensure the system transacts in the 3 priority areas and develops a pipeline for joint service development and identifies new clinical priorities for integration and capitation.
5. Adoption and spread of innovation	Ensure that we develop a system wide platform for innovation through the Transformation Board and adopt and spread best practice and innovation.
6. Join up clinical and managerial leadership	Develop a framework for system clinical leadership through the Senate and Expert Oversight Groups. Through the ICP Board develop a Joint Executive for the oversight and leadership of the ICP and wider system.
7.Measure what matters	Use data and evidence to identify system priorities underpinned by system wide population health and analysis (such as the vital few).
8.Transparency	Join up of financial position Transparent review of costs and spend Sharing data and intelligence
9.Accountability	Develop a culture of holding each other to account for transformation and service change and ensure there is clarity on system wide roles and responsibilities.
10.Sustainability	Look forward and ensure we have a long term strategy for sustainable change through forums such as the System Transformation Board, System Finance Directors Group and the Strategic Estates Group.

Section 3 - Delivery strategy



Section 4 - Action plan 2018/19

The information below is a summary of the key delivery actions that the ICP Programme will take forward for the rest of 2018/19

Reference	Key area of focus	Start date	End Date	On track
1	**Pre mobilisation**			
1.1	Gain approval from ICP Board for service specifications (COPD and MSK)	1st August	18th August	Delivered
1.2	Finalise legal and procurement position (received)	18th August	31st August	Delivered
1.3	Commence ICP Provider Due diligence process for MSK and COPD	1st September	30thh October	Process completed. 5 year contract to commence during Q1
1.4	Draft Commissioning Intentions for ICP	1ST October	31st October	Finalised at 08/10/18 planning event.

1.5	In line with NHS Long Term Plan –outline ICP Future state 2019-2022	1st February 2019	31st March 2019	Outlined shared with local providers. March ICP Board to sign off priorities
Reference	**Key area of focus**	**Start date**	**End Date**	**On track**
2.	**Establish Programme Governance and Leadership**			
2.1	Sign off ICP governance model and with associated levels of delegated authority (all aspects of the governance model)	24th July	1st September	Full launch 1st April 2019
2.2	Governance model to be approved by individual Governing Bodies in September	1st September	30th September	Completed
2.3	Draft Formal Integration Agreement (all partners) for date effective launch of 1st April 2019. Potentially will need Governing Body sign off in January and then shadow implementation to the end of March 2019	1st September	January 2019	On track for April 1st Launch
2.4	Develop Communication and lead Stakeholder Engagement Plan	1st August	1st December 2019	CCG comms strategy approved

2.5	Launch new branding of the West Essex ICP	1S January 2019	31st March	Established and to launch 1st April
2.6	Development of the Medium Term Financial Plan for the West Essex system and put in place a supporting delivery and assurance mechanism	1st January 2019	31st March 2019	In line with local and national planning timetable
2.7	Develop and Implement a Single Accountability Framework for the ICP	1st October	31st March 2019	On track for 1st April 2019 launch

Reference	Key area of focus	Start date	End Date	On track
3.	**Launching local care models**			
3.1	Front Door Model (Shadow with agreed MDS and payment terms)	1st August	31st/3/2019	Currently under evaluation
3.2	MSK service launch (shadow with agreed MDS and payment terms)	1st October	31st/3/2019	Due diligence process has been completed
3.3	COPD service launch (Shadow with agreed MDS and payment terms)	1st October	31st /3/2019	Financial envelope and service spec for approach ICP Board 28/1
3.4	Transformation Board (working in partnership with Expert Oversight Groups) to recommend new clinical priority areas for the ICP	1st September	31st October	Completed – now part of ICP Transformation Plan

Reference	Key area of focus	Start date	End Date	On track
4.	**Developing the outcomes framework**			
4.1	Commence monitoring of revised outcome measures for MSK/COPD and Front Door Model	1st October	31 / 3/ 19	Outcomes drafted
4.2	Design and approve ICP Reporting Architecture	1st September	1st November	Completed
4.3	Launch system wide Population Health Framework	1st October	1st December	Launched
5.	**Developing the contractual and financial framework**			

5.1 **5.2**	Define and agree via System FDS a detailed contracting strategy for 2019/20 and 2020/21 to include budget modelling, scenarios and the framework approach for risk and gain share. Develop financial report and templates to support the revised contract model	1st September 1st September	31st /3 /2019 1st November	In progress – need to be refreshed due to national planning round and MTFP refresh end of June 2019 On track and in line with local planning framework
Reference	**Key area of focus**	**Start date**	**End Date**	**On track**
6.	**Workforce and system development**			
6.1 **6.2**	Develop a workforce strategy following local needs analysis Launch Integrated Care System KLOE review and audit	1st November From 1st October r	30th January 19 November 30th	This will be led by System HR Directors In progress
7.	**Communications and engagement**			
7.1	Produce Patient Engagement Plan	3rd September		Commenced

7.2	Produce Staff Engagement Plan	3rd September		Commenced
7.3	Commence Public Engagement on ICP vision	1st November		Approach approved at ICP Board on 100918

Section 5 – Key Strategic Imperatives Quarter 4 2018/19

Deliver

- Transact new models of care MSK and COPD
- Agree negotiated position for front door and assessment space
- Launch system wide outpatients strategy
- Set framework for Diabetes , CVD , Transfer of care system wide pathways
- Establish the framework for the delivery of the Medium Term Financial Plan
- Launch new governance model
- Commence delivery of ICP Transformation Plan

James Roach

Programme Director West Essex Integrated Care Programme