The Princess Alexandra Hospital NHS Trust

Meeting of the Board of Directors

AGENDA

Date and Time: Thursday 4 October 2018 August 2018 from 10.00 to 13.30
Venue: Boardroom, The Princess Alexandra Hospital, Harlow.

Time	Item	Subject	Action	Lead	Page
01 OPENING ADMINISTRATION					
10.00	**1.1**	Apologies	-		
	1.2	Declarations of Interest	-	Chairman	
	1.3	Minutes from Meeting on 02.08.18	Approve	Chairman	4
	1.4	Matters Arising and Action Log	Review	All	15
02 STAFF STORY					
10.10	**2.1**	A Junior Doctor Staff Story			
03 REPORT FROM CHIEF EXECUTIVE					
10.40	**3.1**	CEO's Report	Discuss	Chief Executive	16
04 RISK					
11.00	**4.1**	Board Assurance Framework	Approve	Chief Medical Officer	25
11.10	**4.2**	Significant Risk Register	Discuss	Chief Medical Officer	44
05 QUALITY					
11.20	**5.1**	Mortality Update	Discuss	Chief Medical Officer	47
11.30	**5.2**	Nursing, Midwifery and Care Staff Levels	Inform	Chief Nurse	96
06 PERFORMANCE					
11.40	**6.1**	Integrated Performance Report	Inform	Executives	101
07 PLACES					
12.00	**7.1**	Our New Hospital	Approve	Director of Strategy	146
12.20	**7.2**	Hertfordshire and West Essex STP Estates Plan	Approve	Director of Quality of Improvement	149
08 PEOPLE					
12.30	**8.1**	Training and Continued Professional Development Funding 2018/19	Discuss	Director of People	215
12.40	**8.2**	Health Care Worker Flu Vaccination: Self Assessment	Approve	Director of People	219
09 GOVERNANCE					
12.55	**9.1**	West Essex Integrated Care Partnership (ICP) Governance Model	Approve	Chief Executive	222
13.05	**9.2**	Annual Report on Emergency Preparedness and Business	Approve	Chief Operating Officer	238

		Continuity and Forward Plan			
13.15	**9.3**	Reports from Committees: • Audit Committee 05.09.18 including Terms of Reference • CFC.3.10.18 • QSC.26.09.18 including Terms of Reference • WFC.24.09.18 including Terms of Reference • PAF.24.09.18 including Committee review and Terms of Reference	Inform/ Approve	Chairs of Committees	250 Verbal 258 265 271
10 QUESTIONS FROM THE PUBLIC					
13.25	**10.1**	Opportunity for Members of the Public to ask questions about the Board discussions or have a question answered.	Discuss	Chairman	
11 CLOSING ADMINISTRATION					
	11.1	Summary of Actions and Decisions	-	Chairman/All	
	11.2	New Issues/Risks	Discuss	All	
	11.3	Reflection on Meeting	Discuss	All	
13.30	**11.4**	Any Other Business	Review	All	

TRUST BOARD 2018/19

Meetings, Purpose, Membership and Quoracy

24th May 2018 (ETB)	4th October 2018
7th June 2018	6th December 2018
2nd August 2018	7th February 2019

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.

Board Membership and Attendance – 2018/19			
Non-Executive Director Members of the Board (voting)		**Executive Members of the Board (voting)**	
Title	**Name**	**Title**	**Name**
Trust Chairman	Alan Burns	Chief Executive	Lance McCarthy
Chair of Audit Committee (AC)	Steve Clarke	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	Chief Medical Officer	Andy Morris
Chair of the Workforce Committee (WFC)	Pam Court	Director of Nursing & Midwifery	Sharon McNally
Chair of Charitable Funds Committee (CFC)	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 2 August from 10:00 – 12:30
Boardroom, Princess Alexandra Hospital, Harlow

Present:

Alan Burns	Trust Chairman (TC)
Lance McCarthy	Chief Executive Officer (CEO)
Stephen Bright	Non- Executive Director (NED-SB)
Steve Clarke (non-voting)	Associate Non-Executive Director (ANED-SC)
Sharon Cullen	Acting Chief Nurse
Ogechi Emeadi (non-voting)	Director of People
John Hogan	Non-Executive Director (NED-JH)
Andrew Holden	Non-Executive Director
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)
Andy Morris	Chief Medical Officer (CMO)
Trevor Smith	Chief Financial Officer (CFO)

In attendance:

Sharon McNally	Incoming Chief Nurse (ICN)

Members of the Public/Observers

Darren Hobbs	Associate Director of Operations – CCCS
Lynsey Rowe	Head of Marketing and Communications
Hannah Hobbs	Communications Assistant
Chetna Patel	Associate Director – Quality First
Shahid Sardar (for part)	Associate Director – Patient Engagement
Ann Nutt (for part)	Chair of Patient Panel
Piers Mercer	Essex Live

Apologies

Michael Meredith (non-voting)	Director of Strategy (DoS)
Helen Glenister	Non-Executive Director (NED-HG)
Pam Court	Non-Executive Director (NED-PC)
Heather Schultz	Head of Corporate Affairs (HoCA)

Secretariat:

Lynne Marriott	Board & Committee Secretary (B&CS)

01 OPENING ADMINISTRATION	
1.1	The Trust Chairman (TC) welcomed all to the meeting, particularly Gech Emeadi, the new Director of People (DoP), Sharon Cullen, Acting Chief Nurse (ACN), Sharon McNally, Incoming Chief Nurse (ICN) and Helen Howe, new Associate Non-Executive Director (ANED-HH).
1.1 Apologies	
1.2	As above.
1.2 Declarations of Interest	
1.3	No declarations were made.
1.3 Minutes of Meeting on 07.06.18	
1.4	The minutes of the meeting held on 07.06.18 were agreed as a true and accurate record of that meeting with no amendments.
1.4 Matters Arising and Action Log	
1.5	There were no matters arising and no comments on the action log. Action ref: 29.03.18/94 would be dealt with under item 6.1 below.

02 PATIENT STORY	
2.1	Item deferred due to staff absence.
03 REPORT FROM CHIEF EXECUTIVE	
3.1 CEO's Report	
3.1	The CEO introduced his report and drew members' attention to the key performance indicators detailed on page one. On the whole performance had improved during the month of June for all but two of the indicators. There had been one case of C-diff in the month and cancer performance (62 day standard) had struggled and would be discussed in more detail at item 5.1.
3.2	In relation to ED performance the organisation continued to improve its performance against the 95% 4-hour access target although performance levels remained significantly below where they should be. June's performance had improved for the fourth consecutive month (the first time this had happened for more than five years) and at 77.93% was the third highest monthly performance since December 2015. It was however below trajectory (80%) for the month. The volume of patients attending the ED had continued to rise with 2.8% more attendances year to date compared with the same period the previous year. There had been 8,885 attendances in June, the busiest month for two years and 6,974 patients had been seen in the ED in the first 23 days of July - 7% more than for the same period the previous year. It was highly likely that July 2018 would be the busiest ever month for ED attendances at the Trust and possibly as high as 9,400. The significant rise in activity in recent months had put pressure on the department and on the flow of patients through the hospital. Recent weeks had also seen the impact of the sustained period of warm weather on the local population with increased numbers of non-elective admissions, particularly amongst older people. Currently it was looking as if July performance would be circa 74% which was disappointing given the improved performance over the previous five months.
3.3	It would be discussed further during the private session later that day but the CEO updated that additional inpatient capacity had now been commissioned with building due to start imminently. That would provide an additional 27 inpatient beds on the site by Christmas to support flow through the winter and would be in addition to more community capacity in the immediate term to support patients being discharged more effectively to reduce inpatient bed occupancy rates. The organisation continued to work closely with its health and care partners to ensure the right community capacity was in place to best meet the needs of patients and continue to develop plans for further inpatient bed capacity on the site in 2019/20 to support reducing bed occupancy further and to meet the increasing demand for services.
3.4	In response to a concern raised by the TC in relation to the staffing of any new areas the CEO confirmed a piece of work would be completed that week which had reviewed the configuration of beds by specialty. Once that had been finalised there would be a greater understanding of role/skillset requirements with a view to then undertaking a focussed recruitment campaign starting in September.
3.5	In relation to the new hospital development the CEO was pleased to report that progress continued to be made at pace. The Trust was now in a clear capital approvals and assurance process with NHS England (NHSE) and NHS Improvement (NHSI). The first phase of that was to build on its Strategic Outline Case (SOC) submitted the previous year and West Essex CCG's previous system wide clinical service planning and public engagement to develop a Pre-Consultation Business Case (PCBC) by the end of September. The PCBC would be considered by the Essex Health and Overview Scrutiny Committee before being recommended to NHSE colleagues.
3.6	Running in parallel with the development of the PCBC was the work required to underpin a decision on a preferred site for the new hospital; one of two off-site options and the potential to rebuild on the current site. The long term revenue implications of each option and a range of other evaluation criteria would be reviewed by the Board over the coming two months to determine a preferred site. Once there was PCBC approval and a decision on

	the preferred site, there would be a move to an NHSI assurance process, requiring a revised SOC, an Outline Business Case (OBC) and a Full Business Case (FBC) requiring national NHSI Resources Committee, Department of Health and Social Care and HM Treasury approvals. The target would be summer 2020 for final FBC approval.
3.7	In relation to new consultant appointments the CEO updated that five Consultant Advisory Appointments Committees had been held during June and July across a range of specialties. The quality of the applicants applying continued to rise with increasingly difficult decisions having to be made by the Committees. The Board approved the six recommended appointments.
3.8	The CEO also formally welcomed the Trust's new Director of People (DoP), Associate NED (ANED) and incoming Chief Nurse (ICN). In relation to the latter he thanked the Acting Chief Nurse (ACN) for covering that role until October.
3.9	As a final point the CEO highlighted that following Jeremy Hunt MP's appointment to the role of Secretary of State for Foreign and Commonwealth Affairs in July, Matt Hancock MP had been appointed Secretary of State for Health and Social Care.
3.10	NED John Hogan (NED-JH) asked what it would take for ED performance to return to trajectory and hit 90% by September. In response the CEO stated that performance had been on trajectory in April and May but had missed trajectories in June and July. August too was unlikely to hit trajectory. There were a number of elements which he hoped would improve performance over the next few months. All the senior ED nursing posts had now been recruited to and those new staff would take up their positions over the coming six weeks. A new 'front door' model would begin the following week which would relieve pressure and stream patients away. Improvements in community and ambulance services were also starting to take effect. What had not helped were the recent increased attendances and higher than normal sickness for medical staff in the ED. He added that apart from the ED, other operational performance was good and amongst some of the best in the country.
3.11	The TC stated that the additional capacity for winter would provide an opportunity to maximise elective capacity through the winter. The CEO agreed and stated that there needed to be further discussions in relation to the realignment of wards to achieve physical adjacencies but agreed that some of the additional capacity would indeed be for elective surgical patients. He added that criteria-led discharge had recently been successfully implemented on one surgical ward and would now be rolled out to the rest over the coming six weeks. That would help reduce length of stay (LOS) and increase surgical bed capacity.
04 RISK	
4.1 Board Assurance Framework (BAF)	
4.1	This item was presented by the CMO who highlighted that the organisation's top three risks remained the same (all scoring 20) and were workforce capacity, estate and infrastructure and four hour ED target. He drew members' attention to two points: 1) The recommendation by QSC to reduce the rating of risk 2.2 (medical engagement) from 16 to 12 2) The four risks around 'places' (3.2, 3.3. 3.4 and 3.5) which were noted for 'Board review'.
4.2	In response to point 1 above NED-JH confirmed that the reduction of the risk rating had been discussed in detail at QSC and with a request for additional evidence. That evidence had been provided and highlighted that the Medical Engagement Survey had shown improvements in all domains with scoring now better than the national average. The Board was happy to approve the reduction in the rating of risk 2.2 and noted the four risks around 'places'.
4.2 Significant Risk Register (SRR)	
4.3	This update was presented by the CMO and key points were: • 76 risks scoring 15 and above (29 scoring 20, 24 scoring 16 and 23 scoring 15). • 19 risks overdue a review • 16 new risks raised since 30.05.18

	He cautioned that of the 16 new risks only six were scoring over 15, the remainder therefore should not have formed part of the update. Of those new risks (and scoring 20) he highlighted the cashing-up of all virtual and telephone clinics to ensure all follow-up activities were booked/planned and the monitoring/tracking of patients who had undergone a stent insertion in urology. There were pieces of work underway to address both those risks and mitigation in place.
4.4	The CMO further updated that of the 19 risks overdue for review he was not unduly concerned as review dates had only expired by two/three months. Despite the Risk Management Group (RMG) meeting on a monthly basis it did not undertake a complete review of the SRR at each meeting. Recommendations were made but took time to feedback to the relevant teams.
4.5	In response to the above ANED Steve Clarke stated that overdue dates did concern him and asked whether the process for setting those needed to be reviewed. In response the CMO stated that the process for review was robust and dynamic. The electronic system being used was new so was still work in progress but progress had been good over the previous 18 months. The Chief Financial Officer (CFO) added that the transparency of reporting from the RMG was good but suggested that system was somewhat clunky and the reporting cycle probably needed refining to fit with Committee and Board reporting schedules. In response to a question from the TC the CMO agreed to reinforce greater rigour around setting realistic review dates and challenging back when those were not achieved.
4.6	NED Stephen Bright (NED-SB) stated he felt lots of good work was being done but asked whether that was being embedded. In response the CMO stated that he felt it was. The RMG had opened up Trust-wide discussion around risk and there were solid escalation processes in place for high scoring risks. He agreed there was work to do around reporting but felt there were good examples of where process was already embedded. In addition the CEO stated that the process for the management of clinical risks in the organisation was strong and had been recognised externally. In relation to non-clinical risk the RMG was starting to address that now to combine both clinical and non-clinical risk management.
4.7	In response to a concern raised by ANED-SC in relation to the review date (March 2019) of the risk around electricity generators, the Director of Quality Improvement (DoQI) was able to confirm that the risk was currently under review and a plan was in place to mitigate that as part of the capital programme. A second generator would be installed and additional works were also being undertaken.
4.3 Risk Management Strategy (RMS)	
4.8	The CMO updated that the RMS presented was an update of the previous strategy and had been updated to reflect the organisation's strategic changes e.g. Your Future, Our Hospital, the 5Ps and the push to move to outstanding. In relation to page 40 of the report (Good Governance Institute Risk Appetite for NHS Organisations) he asked members to consider the organisation's current risk appetite and where it might want that to be going forward.
4.9	In response to a question from the CEO the CMO confirmed that organisations could have different levels of risk based on the different elements i.e. it could be more risk averse in some areas and less so in others depending on current organisational issues.
4.10	ANED-SC stated he would agree there needed to be some differentiation – lower in relation to the clinical domain and higher for innovation – although the scale of that differentiation would not be huge. In relation to innovation the CMO flagged the example of sepsis where there was lots of very successful work currently underway in the organisation with strong project management, robust leadership and national reporting. NED-SB added that in order to exit special measures the organisation had had to have a minimal/cautious risk appetite in order to achieve that.
4.11	The Acting Chief Nurse (ACN) stated it was interesting how the culture in an organisation helped determine its risk appetite. When the culture was open and people felt safe to express themselves that appetite would be strong with potential to mature further. Where an organisation had been rated inadequate it took time for confidence to be rebuilt. The CEO added that the transition towards a new hospital would provide an opportunity to make

	radical changes and in order to glean the maximum benefit from public investment it would need its appetite to be moving towards the 'seek'/'mature' end of the scale.
4.12	After further discussion it was agreed the Board should continue its discussion around risk appetite at its Development Session in September and should use some very different but relevant examples in order to learn how to be confident in handling risk.
ACTION **TB1.02.08.18/06**	**Continue the discussion around the organisation's risk appetite at the Board Development Day on 06.09.18.** **Lead: The Board**
4.13	The Board approved the RMS and noted it would be reviewed annually.
05 PERFORMANCE	
5.1 Integrated Performance Report (IPR)	
5.1	This item was introduced by the Chief Operating Officer who updated that the document now included the position in relation to the previous month's performance. A deep dive was planned against all trajectories and objectives for Q1/Q2 which would be reported via the Performance & Finance Committee (PAF).
5.2	PATIENTS The CMO updated that compliance with DNACPR remained a challenge. Performance in month had been 44% against a trajectory of 88% but the audit was small so compliance had a greater impact. The main issue with compliance related to MCA2 completion however in July the organisation had rolled out a new DNACPR with the MCA2 assessment forming part of that. It was expected that compliance would improve as a result.
5.3	The ACN continued there had also been poor compliance with the use of liquid medications, however only two wards had been audited. It was agreed that was indefensible in light of the fact the issue had already been raised as a concern by the CQC and immediate actions taken at the time. Going forward responsibilities would be shared between nursing staff and Pharmacy. In response to a question from NED-JH in relation to ward pharmacists the CMO updated that a joint business case (ward based pharmacists/anticoagulation services) would be coming back to the Executive Management Board (EMB) but cautioned it would be a cost pressure although the clinical and safety benefits had been clearly evidenced during the recent pilot. ANED-HH added the introduction of a ward based pharmacist programme also reduced LOS; medicines reconciliation at the front door was another possible opportunity.
5.4	The ACN continued that complaints had been lower in month but it was still a struggle to capture compliments. That was being addressed as it was starting to distort patient feedback. Incident reporting remained good with the majority being minor or low harm.
5.5	Performance **RTT** – trajectory achieved for the third consecutive month and the organisation would be back on national reporting at 92% by the end of July. **Neurology** – decision taken (due to capacity challenges) to suspend the service to new referrals until a substantive appointment could be made. **52 week breaches** – of 18, four had been validated and patients no longer required for treatment. The remainder were in Paediatric Urology with seven left to be treated and all clinically reviewed and support available from Addenbrooke's. **Urology** – two Consultant Urologists and one Locum Urologist appointed all to start mid-October. **Cancer** – standards in Urology and Lower GI (Endoscopy) not achieved but plans in place to address. Currently a backlog of 20 patients awaiting surgery at UCLH and an update in relation to additional capacity expected later that day. In relation to the Urology pathway and following the appointment of new staff, work had been undertaken with the team and the clinical lead to review the front end of the pathway. Assurance had been provided that that was now back on track with recovery forecast for August. There were also capacity constraints within Endoscopy due to increased demand and as of that day a ten week project was underway with NHSI to review services – recovery was expected in August. All other Cancer performance remained strong. **Emergency Department** – two candidates to be interviewed the following week for the GP

	Clinical Lead position in the Urgent Care Centre. The service would operate seven days per week (07:00-22:00) with a plan to extend that to overnight. **Paediatric ED** – performance had achieved 94.64% for the month with the hope of securing a new consultant at a Panel to be held on 15.08.18 bringing the total number of consultants to nine. In relation to middle grade appointments the position was strong going into August with only three gaps in the rota.
5.6	That week the team had met the CEO from the East of England Ambulance Service and it had been agreed to dedicate the next Local Delivery Board (LDB) to a workshop to focus on opportunities for joint working on admission avoidance and support with conveyancing and learning from other systems. Updates on the agreed Improvement Plan continued to be provided to the Trust's Regulators and there would be a visit from NHSE the following week to review the position.
5.7	**Diagnostics** – performance remained strong and continued to deliver against the standard as it had done for the previous three years. **Bed capacity and LOS** – improvements had been seen in the LOS programme with good clinical engagement and a focus on Cardiology and Respiratory and the criteria-led discharge work. There was support from ECIP and workshops scheduled over coming weeks to embed processes. There would be interviews the following week for a System Lead post in the Integrated Discharge Team. **Outpatients and Clinic Cancellations** – these were a focus for EMB and the weekly Access Board with deep dives undertaken into both reasons for and numbers of affected patients. A programme of work was about to be launched to improve Outpatient Services.
5.8	In response to a question from ANED-HH it was confirmed there had been discussions around the Hospital at Home Service which would continue at the workshop mentioned above.
5.9	In response to a question from NED-JH in relation to issues with endoscopy washers assurance was provided that the Trust was in discussion with JAG and there were plans for four new machines in addition to an external capital bid made to the STP for the upgrading of Day Care Stay Services.
5.10	PEOPLE The DoP reported good news in relation to vacancy rates, sickness absence and Friends & Family Test (FFT). Areas to focus on going forward would be statutory/mandatory training and appraisal compliance. Going forward there would be a focus on those staff with the most training outstanding and visibility of Exec/Senior Manager compliance. The new agenda for change pay deal would help support compliance in that staff would not be entitled to an increment if training or appraisals were outstanding. The TC added that incoming staff from other NHS organisations should not have to repeat training if it was still in date.
5.11	The CMO flagged that the Executive team had discussed and agreed that sanctions should be in place for staff (including doctors) for non-compliance in relation to appraisals and training. He felt that that should now start to take effect. ANED-SC added that the Workforce Committee (WFC) had discussed it would be important to have carefully written policies which could be applied to both encourage and discipline in relation to failure to achieve compliance with training/appraisal.
5.12	NED-SB congratulated the organisation on the improvements in scoring for FFT which he hoped would be reflected in the next Staff Survey.
5.13	In relation to sanctions NED-JH cautioned that before those were applied the organisation must be sure it had provided every opportunity to support staff in achieving compliance. In response the CEO agreed and said that there should be a targeted approach to training and a balance in relation to any sanctions but also, an acknowledgement that it was there for the safety of both staff and patients.
5.14	PLACES The DoQI reported a recent increase in disruption due to estates issues such as blockages, drainage and the management of air handling units – the heatwave had not helped. The local risk register had been reviewed to align with that. There was significant mechanical and engineering input in the capital plan and the organisation was now out to tender for the

	majority of works. A Six Facet Survey had been commissioned which would provide a much more up to date view of the estate and plant.
5.15	The DoQI continued there had been improvements in cleaning following the raising of some concerns and HCGs were supporting the management of equipment. On-site smoking was being managed and reduced and there would be a focus on advice and support for inpatients towards the end of the summer.
5.16	There had been disappointing results in relation to feedback on the new menu which related to unauthorised changes – that had been addressed. Phase 2 of the menu would be launched at the end of September which would see the introduction of choices for snacks/breakfast.
5.17	In response to two questions from the TC it was confirmed the catering specification was being finalised and would be out to tender over winter and hopefully resolved in Q4. Although cleaning standards were improving, the organisation still lacked a decant facility.
5.18	POUNDS In M3 the Trust had incurred a deficit of £2.4m, £50k better than planned with a Q1 cumulative deficit of £9.1m, £150k ahead of plan. Q1 activity/income over-performance £0.65m (elective, maternity pathway, diagnostic and direct access) offset by £0.5m expenditure overspends (temporary and medical staffing, unplanned maintenance and utility expenditure). Key risks included CIP/QIPP delivery, containing temporary staffing costs and the potential impact of the new pay settlement. The Trust continued to target delivery/improvement of the agreed control total.
5.19	In response to a question from the TC it was confirmed that in relation to the pay award NHSI had acknowledged it would be a cost pressure for the organisation. The CFO confirmed that exact figures needed to be confirmed, after which the Trust would present its case, if required.
5.20	As a final point the TC stated that he welcomed the improved presentation which facilitated a robust discussion on the chosen KPIs at Board level, but with the finer detail left to its Committees.
5.2 Sustainable Health Care Strategy 2018-2022	
5.21	This item was presented by the DoQI who updated that the Trust's Strategy had not been updated in circa five years and was now due for renewal. As a result the revised Strategy was a combination of the work done to date to demonstrate key successes over the past five years in addition to the setting out of a challenging plan to take the organisation forward into 2020 to ensure it delivered against that sustainability agenda.
5.22	The Strategy had been discussed in detail at PAF the previous week with two key issues to note: 1) There was now a requirement to have a Sustainability Lead at Board level and that proposed lead was the DoQI (subject to agreement by the Board), 2) Sustainability had to be taken out of the carbon footprint and into the environment and society and although there had been progress in relation to the carbon footprint work there was more to be done in terms of engaging the wider organisation and system. However there was a plan which clearly set out how to achieve that over the coming two years and that work would start with the establishment of a Sustainability Steering Group which would be chaired by the DoQI.
5.23	The Board approved the Strategy and the Sustainability Development Management Plan 2018-20 and agreed with the proposal that the DoQI should be the Trust's Sustainability Lead.
06 QUALITY	
6.1 Nursing, Midwifery and Care Staff Levels	
6.1	This item was presented by the ACN who reminded members that the paper was a summary of a more detailed report which had been presented to the Quality & Safety Committee (QSC). She highlighted it was the third consecutive month where the organisation had seen more starters than leavers. The overall registered nurse vacancy position had risen to 26% but that was directly attributable to a workforce uplift for the ED, Surgical Assessment Unit and Short Stay Medical Ward. There had been little change in the number of safety incidents reported for safer staffing areas. The Trust was on track to

	deliver a zero vacancy ambition for Healthcare Support Workers by December 2018.
6.2	The TC flagged that although the organisation had 42 fewer RN vacancies compared with the same period the previous year, at that rate it would take circa six years to reach full establishment. He asked for the view of QSC. In response NED-JH stated that QSC agreed it was the organisation's biggest risk and whilst monthly reports provided assurance that everything that could be done was being done, he saw the issue as mirroring that in the ED – a huge amount of effort for minimum return.
6.3	The TC reminded members that it had previously discussed ways to encourage recruitment and retention of nursing staff and he would like to revisit that in the autumn once new directors had had time to settle in.
6.4	The CEO cautioned that the negative impact of being in special measures should not be underestimated. Once out, it took time for confidence to be rebuilt but now was the 'golden period' for recruitment and the organisation should endeavour to maximise on that. He also flagged there had been conversations around packages, rewards and recognition for staff and those needed to be rapidly enhanced if the organisation was going to attract the staff it needed.
6.5	In response to a question from ANED-HH it was confirmed that the organisation currently used NHS Professionals (NHSP) for its temporary/bank staff. The TC stated that he felt not every stone had been left unturned and he would welcome revisiting the 'nurse recruitment' discussion in October.
ACTION **TB1.02.08.18/07**	**Re-open the discussion around nurse recruitment at October Board.** **Lead: Director of People/Director of Nursing**
6.2 Mortality Update	
6.6	The TC introduced the item and asked the CMO to take members' through the report in some detail to ensure its content was properly understood.
6.7	In response the CMO stated that he would start with the data. He reminded members that the organisation had struggled with its internal reporting via Dr. Foster and indeed the previous month's Board report had been delayed until the present month to ensure that the data was real. In addition he added that it had recently come to light that if mortality statistics were applied to incomplete data that would generate an inaccurate figure for HSMR (hospital standardised mortality ratio) and would also flag different mortality alerts. He also highlighted that in relation to the alerts indicated in the report that day, the one relating to cancer of the ovary was not real and was down to a coding error.
6.8	The TC asked the CMO to remind members of the definition of HSMR. In response the CMO confirmed that HSMR looked at 56 of the most common HRG (Healthcare Resource Group) codes. It did not take into account the patient's background meaning that of the four boroughs comprising the Trust's catchment population, Central Harlow was very different from the other three i.e. with a higher number of smokers/teenage pregnancies. That meant that the data for that one borough distorted the Trust's overall data and contributed to its higher than expected mortality rate.
6.9	The CMO continued that what was also interesting about Harlow was that it was a new town (70 years old the previous year) as was Basildon (of similar age). Harlow now had a resident population which was elderly and from a deprived background (formerly residents of East London who were moved out after WWII bombings). In relation to comorbidities for the over 85s Harlow fell outside by two standard deviations compared to the rest of the country – so had a population with a higher than national average for comorbidities.
6.10	The CMO reminded members that HSMR was dependant on coding. If an organisation's coding for comorbidities was robust (i.e. a patient was expected to die) then its HSMR would come down. A neighbouring trust had set a trajectory to reduce its HSMR by upping its palliative care coding and its HSMR had come down. The Trust's palliative care coding had seen a step-change in Spring/Summer 2017 and then again in the autumn but there was still more to be done.
6.11	In response to the above the TC cautioned that it was important to recognise what was real. To use the argument around comorbidities/palliative care coding an organisation needed to be satisfied it was addressing both and could provide evidence of a clear plan for the latter.

6.12	In response to the above the CMO highlighted the recent external review of coding and the Charlson measurement – the Trust had come out average. But what had been seen were improvements nationally elsewhere whilst the Trust's performance had remained fairly static.
6.13	The CMO continued that HSMR had now been higher than expected for the previous 15 months. Six months ago he had undertaken a three year review of mortality. What that had shown was that mortality was not impacted by nursing numbers or acuity. Where there was a link (and there was accompanying evidence) was with patient flow through the organisation. When ED performance was around 70% HSMR started to rise and when performance improved (as it had recently) HSMR dropped.
6.14	The CMO drew members' attention to the fact that although the rolling 12 month HSMR had been higher than expected for the previous 15 months, the in-month data was better news and had been 'as expected' for eight of last 12 months. At this point he highlighted the example of Milton Keynes Trust (also a new town) whose mortality profile mirrored that of the Trust's, albeit their baseline was lower.
6.15	The CMO went on to outline the process for outlier alerts. Once received an alert would be subject to a coding check. Errors were in the order of 10%-30% and were down to the interface between the coding and the doctors. A new process had therefore been introduced whereby codes (admission/diagnosis/death) would now be confirmed between the teams the day after death with the coders attending the ward areas in order to achieve that.
6.16	After the coding check if the alert appeared to be real the relevant clinician would be written to with a request for an audit. The results of that audit would then be taken to the Trust's Patient Safety & Quality Group (PSQ Group) and could lead to changes such as a new pathway. Once embedded a re-audit would then take place. He highlighted that the CQC also picked up on outlier alerts for which they had a rigorous review process including terms of reference.
6.17	In relation to SMR, the CMO confirmed that alerts were different to those associated with HSMR in that they involved the patient pathway in primary care too. He confirmed discussions were underway with Primary Care to identify a mortality lead.
6.18	The CMO confirmed that SHMI was reported quarterly.
6.19	The CMO continued that the organisation's Mortality Surveillance Group (MSG) had been running since December 2017. It was well attended by a range of disciplines but there were challenges with the reporting dashboard which he was addressing with the IT team. He added that the Trust was a leader in terms of the new Medical Examiner role although the previous Secretary of State for Health had changed the remit of that on his last day in office and the role now required the incumbent to be 1 WTE with admin' support and reviewing deaths in another trust, not their own. He felt that would now make it challenging to appoint to that role.
6.20	In relation to mortality reviews the organisation was using the process used by Essex hospitals and the Royal College of Physicians' review form. He would be taking a case for some mortality software (circa £10k-£20k) to EMB. He also flagged the previous Secretary of State's edict that all Boards should be able to demonstrate their learning from deaths. To that end he highlighted the Trust's two recent Bereavement Surveys and its robust processes for the review of patient deaths.
6.21	NED-JH highlighted the variation in the Trust's outlier alerts. The CMO agreed and added that over the past four years alerts had risen from circa one to two per year to 12 already in the current year. That could be down to better reporting or alternatively a growing issue that was causing mortality to rise. In response to the above and a request from NED-JH it was agreed that the CMO would provide mortality data for each of the HCGs to encourage personal ownership (rather than Exec. ownership) and that that data could be presented on the HCGs' dashboards at their monthly performance reviews.
ACTION **TB1.02.08.18/08**	**HCGs to provide their HSMR data (on their dashboards) as part of their monthly Performance Review.** **Lead: Chief Medical Officer/HCGs**
6.22	The TC asked the CEO for his own views on Trust mortality. In response the CEO stated

	the issue was complex. The current governance in place was robust (Mortality Surveillance Group, Outlier Reviews, Serious Incident Group) but he felt there was a definite underreporting of the complexity of the hospital's core patients which was impacting on its HSMR. He drew members' attention to page 7 of the report which detailed "% of spells with an observed death" and "% of spells with an expected death". For the latter many trusts in the region had a higher percentage however for the former, the Trust was nearly the highest. For him that related to issues with coding but also with other influencing factors such as lower ED performance, environmental issues, lack of clinical adjacencies and higher than average length of stay. In his view there needed to be a re-think on the quality of coding and also in terms of the relationship between coders and clinicians. As a final point NED-JH stated that if clinicians became responsible for HSMR then figures would improve.
6.23	The CFO highlighted that both himself and the CMO were overseeing the Trust's Coding Improvement Plan which was presented regularly to PAF, further external support from Dr Fosters was being engaged and progress was being made.
6.24	In response to a question from ANED-HH in relation to mortality reviews referring back into primary care, the CMO confirmed they did not currently. There had been conversations around that with Commissioners and the identification of a nurse to undertake that but to date there had been no real drive to take that forward.
6.25	The TC thanked members for a very detailed discussion.
6.3 Research & Development Annual Report	
6.26	This item was also presented by the CMO who confirmed that the report had been to QSC and was now in line with the organisation's 5Ps. R&D was a huge success story for a hospital the Trust's size and the team at PAH was lucky to have a very dynamic leader. Trials had overachieved on patient recruitment meaning an additional £20k of income over the previous three years. The extra monies had meant the team were now able to 'grow their own' researchers and was a leader in the field.
6.27	The TC thanked the CMO for the report and highlighted that R&D remained a consistently good news story.
07 GOVERNANCE	
7.1 Medical Appraisal and Revalidation	
7.1	This item was introduced by the CMO as another good new story for the organisation. Compliance with medical appraisal was 98% and the Trust was on time with its recommendations for revalidation. There had been a small number of deferrals but the CMO was aware of the reasons against each individual case and most pertained to lack of evidence rather than lack of engagement. He added that the second Peer Review by the East of England had been very positive.
7.2	In line with the recommendation it was agreed that the Statement of Compliance at Appendix E would be signed off.
7.2 Reports from Committees	
7.3	Charitable Funds Committee (CFC) – 04.07.18 The CFO drew the Board's attention to the fact that the Committee had agreed a small group would meet to discuss the approach to fund-raising going forward. The Board noted the Committee Review and approved its Terms of Reference for 2018/19.
7.4	Quality & Safety Committee (QSC) – 25.07.18 Assurance had been provided by Mr Wee on the reasons for the Trust opting out of the GROW element of the Saving Babies Care Bundle. The Medicine HCG had flagged an issue in relation to Endoscopy washers which had reached end of life – that was being addressed in the capital plan. The report on discharges before midday had been received but further clarity had been requested particularly where patients had been discharged from a ward in a timely manner but had then spent a period of time in the Discharge Lounge. The Patient Panel had requested permission for some of its members to see/hear records of complaints which had not been anonymised – that would be discussed further with the

	Trust's Information Governance Team. The CMO had provided assurance on the organisation's processes in relation to opiate usage in light of recent coverage around deaths at two hospitals.
7.5	Workforce Committee (WFC) – 23.07.18 There had been a significant improvement in the results from Q1 of the Friends and Family Test. There had also been a conversation around compliance with appraisal and statutory/mandatory training with further discussions to now take place at EMB. The volunteer establishment had increased from 82 to 237 in the preceding ten months and the Committee had also heard from the Trust's two Freedom to Speak Up Guardians who confirmed they would be encouraging local resolution of cases and supporting teams in changing behaviours.
7.6	Performance & Finance Committee (PAF) – 23.07.18 No additional comments.
08 QUESTIONS FROM THE PUBLIC	
8.1	There were no questions from the Public.
09 CLOSING ADMINISTRATION	
9.1 Summary of Actions and Decisions	
9.1	These are presented in the shaded boxes above.
9.2 New Issues/Risks	
9.2	No new risks or issues were identified.
9.3 Reflections on Meeting	
9.3	Not undertaken at this point.
9.4 Any Other Business (AOB)	
9.4	The TC highlighted to members that his term as Chairman at the Trust would end in November 2018 and the process of recruiting for his replacement would begin within the next few weeks. In response the CEO thanked the TC for his commitment over the past two years particularly in relation to being a good advocate for patients, holding the Executive Team to account to ensure patients came first and supporting the Trust externally so that its profile remained high.
9.5	As a final point the CEO added that he had received confirmation the previous day that the Trust had been successful in its bid for capital monies for Cancer Care (£700k) which would be used to upgrade its MRI scanner.

Signed as a correct record of the meeting:	
Date:	04.10.18
Signature:	
Name:	Alan Burns
Title:	Chairman

Trust Board Meeting in Public
Action Log - 04.10.18

Action Ref	Theme	Action	Lead(s)	Due By	Commentary	Status
TB1.02.08.18/06	Risk Appetite	Continue the discussion around the organisation's risk appetite at the Board Development Day on 06.09.18.	The Board	~~BD.06.09.18~~ BD.01.11.18	Deferred due to annual leave. Item not yet due.	Open
TB1.02.08.18/07	Nurse Recruitment	Re-open the discussion around nurse recruitment at October Board.	The Board	~~TB1.04.10.18~~ BD.01.11.18	Deferred until new Director of Nursing & Midwifery established in post. Item not yet due.	Open
TB1.02.08.18/08	HCG HSMR Data	HCGs to provide their HSMR data (on their dashboards) as part of their monthly Performance Review.	CMO/HCGs	TB1.04.10.18	Actioned.	Closed

The Princess Alexandra Hospital NHS
NHS Trust

Trust Board (Public) – 4 October 2018

3.1

Agenda Item:	3.1
Presented by:	Lance McCarthy - CEO
Prepared by:	Lance McCarthy - CEO
Date prepared:	28.09.1
Subject / Title:	CEO Report

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 updates the Board on key issues since the last public Board meeting.
Recommendation:	The Trust Board is asked to note the CEO report and to agree the AACs' recommendations to appoint 1 new consultant.

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

respectful | caring | responsible | committed

The Princess Alexandra Hospital NHS
NHS Trust

Chief Executive's Report
Trust Board: Part I – 4 October 2018

3.1

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 Integrated Performance Report later on the agenda.

Key Performance Indicator	Actual performance for latest month (August)	Comparison to last report
ED 4-hour performance	81.56%	↑ (better)
HSMR	116.7 (Jun 17 – May 18)	↓ (worse)
CDiff numbers	1	→
MRSA numbers	0	→
Never Events	0	→
RTT incomplete	92.1%	↑ (better)
Cancer 62 day standard	80.2% (July)	↑ (better)
6-week diagnostic standard	99.2%	↓ (worse)
Cash balance	£3,531k	n/a
Vacancy rate	12.9%	n/a

(2) Urgent care performance and flow

We continue to improve our performance against the 95% 4-hour access target for urgent care, although performance levels remain significantly below where we would wish them to be.

August's performance was 81.56%, the first time since December 2015 that performance has been better than 80%.

As at 27 September, performance for the month was 78.68%. We have made a good recovery in improving the flow provided in the latter half of the month, with performance at 71% after the first 11 days as a result of a significant increase in paediatric and older people with complex conditions. The new frailty assessment unit based in ED has significantly improved the care and experiences of our frail patients, with an average of 3 per day being treated and returned to their normal place of residence rather than being admitted. Those that are admitted through the unit into the hospital are also seeing a reduction in their length of stay.

Good progress is being made with the building of a new 27 bedded inpatient ward. The foundations have been dug and good progress is being made with the building of the facility off site. We remain on track for the new ward to be handed over to us on 17 December, in time for it to be open to support flow through the winter months. Recruitment for the new facility is underway as are plans to relocate other services within the hospital to maximise the benefit of having the right and most productive clinical adjacencies. We continue to work closely with heath and care partners to ensure the right amount of the right type of capacity is available in the community for the winter. We are also continuing to work closely with the East of England ambulance service to reduce conveyances to the hospital where appropriate and to ensure speedy transfer and handover of patients. We also continue to develop plans for further inpatient bed capacity on the PAH site in 2019/20 to support reducing our bed occupancy further and meeting the increasing demand for our services.

We remain on regular system wide escalation working closely with NHS England and NHS improvement to try to reduce blockages in the wider system.

(3) Event in a Tent

Building on the success of our Event in a Tent in 2017, we ran a very successful 3-day Event in a Tent between 25 and 27 September to celebrate, support and recognise our staff and their achievements. More than 1,000 people came to the tent over the three days and the feedback that I have received from our people has been universally positive. We will continue to run this as an annual event.

Each day started with a **strategy briefing**, outlining our plans to develop a 10-year Clinical Strategy and link this strongly with the new hospital development and each evening saw a celebration of our people, through **Our Amazing People Awards, Long Service Awards** and a **quiz night**.

On the 25th, we had a fantastic **poster celebration**, displaying 70 of the most inspiring and innovative quality improvement and research and development programmes in place within the organisation over the last 12 months. All parts of the organisation were represented and they showed the enormous amount of ongoing change, innovation and improvement being made for our patients. Colleagues voted for their favourite, the winners of which will be presented with their prizes this week. The **Chairman's QI fund** was also launched; an opportunity for colleagues to bid for up to £50k to support further improvements and innovations

Our **AGM** was also hosted in the tent on the 25th and was attended by 120 people, including staff, health and care colleagues, local authority partners, current patients and members of the public. As well as the review of the year and of our finances for 2017/18, we also had presentations on the new hospital and on our new frailty unit and pathways. There was very good engagement with and questions from the audience.

The other two days were themed, the 26th for staff health and wellbeing and the 27th for recruitment and community engagement, which saw us recruit a further 10 registered nurses. Within these, we took the opportunity to launch a number of initiatives to support our people better, including:

- Our **Behaviour Charter**, aligning behaviours to our 4 values and supporting the ongoing change in culture to become increasingly open, trusting and challenging
- Our **staff app, myPAHT**, to support our people with useful information to hand
- Our new **employee assistance programme**, providing all of our people and members of their direct family access to help and support for a wide range of issues from legal support to mental health support
- Relaunch of our **staff council** and **equality and inclusion programme**
- Our **5 o'clock leadership club**, with a fantastic talk from Jason Todd from the *Art of Brilliance*

Thanks to the Charitable Funds for funding most of the cost of the Event in a Tent and thanks to the whole HR team (Ellie Manlove and Martin Smith in particular) and Quality First team for their organisation of what was a very successful and fun 3 days.

(4) Consultant appointment

We held a Consultant Advisory Appointments Committee during August for an oncoplastic breast surgeon. The AAC recommends to the Board the appointment of:

- Bijan Ansari

The Board is asked to approve the AACs' recommendations.

(5) The New UK Code of Governance

The new UK Corporate Governance Code will come into force on 01.01.19 and will be of interest to Trust Board members as a benchmark of good corporate governance. The relevance of the new Code to the NHS is:

1) It represents the latest thinking on the application of good corporate governance for the direction of UK organisations.
2) The Code of Governance for NHS Foundation Trusts (last revised in 2014) has been based on the UK Code and has traditionally been revised with each new iteration of the UK Code.

The key changes to the updated Code include:

Workforce/Stakeholders: The promotion of greater Board engagement with the workforce so the Board can describe how it has considered stakeholder interests when it is promoting the success of the organisation.

Culture: A greater emphasis on the need for Boards to align an organisation's values with its strategy so the Board can assess how it leads in generating and preserving value over the long-term rather than the short-term.

Succession/Diversity: An emphasis on Boards having the right combined experience to ensure constructive challenge and promotion of diversity. The requirement for robust succession-planning and consideration to the length of term that Chairs remain in post. A strengthening of the role of the Remuneration Committee and an emphasis on the importance of external Board evaluation.

Remuneration: A requirement for Remuneration Committees to take into account workforce remuneration when setting Director remuneration.

The view of NHS Providers is that the new Code represents significant change that should have a positive impact on corporate governance in the UK. Discussions will be underway soon with NHSI around the prospect of updating the code for Foundation Trusts, thereby making it relevant for NHS Trusts.

(6) STP Leader's Update

Attached to this report is the latest STP Leader's Update shared on behalf of Deborah Fielding. The update is designed to:

- Keep staff informed about the progress of the ongoing work to draft the STP's integrated health and care strategy
- Promote the first joint winter plan for STP organisations
- Highlight some recent success stories from across the STP and introduce new team members.

(7) Chairman recruitment

The recruitment process for the Chairman, led by NHS Improvement, is in train. To date there has been interest shown in the role by 7 individuals. The closing date is 24 October with the interviews scheduled for 14 November.

I'd like to take this opportunity to thank Alan Burns on behalf of the Board for his energy, passion and commitment to the Trust over the last 2 years and his clear direction and drive for improvements to the care and experiences that our patients have.

(8) Executive Director change

I'd like to take this opportunity to welcome Sharon McNally as our new Director of Nursing and Midwifery. Sharon joined us on 1 October from Cambridge University Hospitals NHS FT where she has been the Deputy Chief Nurse for the last 6 years. Sharon brings with her over 30 years of acute

nursing experience, including 6 years as Deputy Chief Nurse, and is passionate about ensuring staff are empowered and engaged to enable great, compassionate care to flourish.

I'd like to extend my thanks again to Sharon Cullen, who pushed back her planned retirement date to act in to the role during August and September to provide us with continuity.

Author: **Lance McCarthy, Chief Executive**
Date: **28 September 2018**

October 2018

A Healthier Future

Hertfordshire and west Essex STP

Deborah Fielding: Leader's Update

Hello,

There's a lot to update you on in this edition of the Leader's Update, which comes at a crucial period in the development of the Hertfordshire and west Essex Sustainability and Transformation Partnership (STP). Please help to keep your colleagues updated by **circulating this newsletter** to anyone who is interested in improving health and care in our area.

Integrated health and care strategy and 10-year financial plan

In recent weeks, colleagues from across the STP have been working together intensively to develop an overarching integrated health and care strategy for Hertfordshire and west Essex, supported by a 10-year financial plan.

Drawing heavily on expertise from within our organisations, our cross-organisational improvement 'workstreams' and supported by the recommendations and findings of advisers Carnall Farrar and Newton Europe, the draft strategy and financial plan are shaping up well.

Frontline clinicians from across all health providers, social care representatives and commissioning organisations have all been involved and committed to pushing forward this important work.

On Thursday (4 October), key clinical and professional leaders, together with representatives of patient groups, are reviewing our developing strategy and financial plan. We aim to get these plans onto the agenda of each of the STP's governing organisations later in the autumn.

Working together to tackle winter

Meanwhile, last Tuesday (25 September), colleagues involved in urgent and emergency care met to formulate a single winter plan for our area for the first time. Leaders of our three urgent and emergency care systems have committed to providing mutual aid to each other in times of increased pressure and demand.

To support this, a new 'dashboard' that brings together information about the three urgent and emergency systems in our area has been developed by the STP's technology workstream, funded by NHS England.

The dashboard will display urgent care information, such as ambulance handover times and A&E waits, in as near 'real time' as possible. This will help staff across the whole of Hertfordshire and west Essex to quickly identify pressures and work together to take prompt action, heading-off problems at an early stage.

Welcome to the team

I'm delighted to welcome some new faces to the STP team, supporting the development of an improved, integrated health and care system for our population.

Our Director of Strategy, **Harper Brown** started in post at the end of July. Harper has taken a secondment from his Director of Commissioning role at East and North Hertfordshire CCG, initially working part-time, but now full-time for 18 months. He has a wealth of experience in health service management and has worked internationally for several charities.

Head of Programme Management, **Dennis Carlton**, started last week. A physio by training, most recently he has been working for NHS Improvement on a London-wide transformation programme, and is looking forward to working at a system-wide level to improve health and care for local people.

We are looking forward to being joined by an Independent Chair later this autumn. Responsible for holding the system to account and keeping the STP focused on the task in hand; the chair will also act as an ambassador for our STP, building and enhancing relationships with a wide range of stakeholders locally, regionally and nationally. I'll let you know who's appointed to this role when I can.

Some success stories…

The planned care workstream has been singled out for national praise recently for its results in a national NHS '100 day challenge', which has tested new ways of working in **three** different speciality areas:

- A new referral management system for respiratory services at West Hertfordshire NHS Hospitals Trust, aimed at improving the quality and relevance of referrals to specialist services, should result in a 40% reduction in avoidable face-to-face appointments.
- A pilot project which dedicates operating theatre time to gall bladder removal (cholecystectomies) at Princess Alexandra Hospital has seen waiting times for patients with gallbladder disease halved.
- A first contact practitioner service for urogynaecology, initially tested in East and North Hertfordshire, with the aim of reducing avoidable referrals to secondary care and ensuring women start treatment at the earliest opportunity, is now being trialled by Herts Valleys CCG and West Herts NHS Hospitals Trust. Watch this space for the results.

Cancer funding

The STP has been allocated just over £4m as its share of the East of England Cancer Alliance transformation funding bid. Our implementation plan includes projects to improve a number of cancer treatment pathways in line with national best practice, including increasing early diagnosis of high-risk prostate cancers, improving patient experience and supporting cancer patients after treatment by ensuring they have full access to a recovery package.

National profile for our medicines optimisation work

NHS England has announced that our STP will be one of only seven nationally to take part in a programme exploring how pharmacy and medicines optimisation can be embedded into the breadth of work across our STP.

www.healthierfuture.org.uk

Our area was chosen because of the "maturity of the local system and existing leadership for pharmacy and medicines in the area". Research published in February estimated 237 million medication errors occur in the NHS in England every year with 28% causing moderate or serious harm.

For these reasons, STPs and Integrated Care Systems (ICS) can benefit from considering medicines optimisation and pharmacy activities in every aspect of their work, rather than as a standalone item or as 'medicines management'.

Workstream SRO changes

We've had a couple of changes of senior responsible officer (SRO) across the workstreams, with Andrew Geldard, interim Chief Officer of West Essex CCG, taking on Technology and Beverley Flowers, Chief Executive of East and North Hertfordshire CCG, as interim SRO for Urgent and Emergency Care.

You can keep up-to-date with progress from the different workstreams online, as they are starting to publish regular updates on our website, A Healthier Future. **Take a look here**

Mental health nurses trial a success

Community psychiatric nurses have been supporting patients in GP surgeries in Watford, Hertford and Stevenage, in a Mental Health workstream trial.

The new service has been very well received by patients and carers. More than 100 people gave feedback and 95% said they had a positive experience. Making mental health help available in a convenient and familiar setting, with reduced waiting times, is a big step forward in improving care.

Improving the hospital discharge process

The Urgent and Emergency Care workstream held a whole-system workshop in the summer, with all STP organisations asking what can be done differently to help to get people home or into a nursing or care home, when they are ready to leave hospital.

Speakers, including representatives from NHS Improvement and senior 'Allied Health Professionals', gave examples of best practice and successful initiatives. Some of the key themes the group agreed to develop included: an STP-wide roll-out of 'Discharge to Assess', to engage GPs in supporting out-of-hospital interventions, to increase third sector and charity involvement throughout the patient pathway and for all multidisciplinary teams to receive Health Coaching.

Good luck for awards season

It's good to see work across the STP being short-listed for the highly regarded Health Service Journal (HSJ) Awards.

Herts Valleys CCG's Kathryn Magson is in the running for Chief Executive of the Year, a title currently held by HPFT's Tom Cahill. It would be wonderful to keep that prestigious title in our STP! Other award nominees from across our STP are:

Innovation in Mental Health: Hertfordshire Partnership University Foundation Trust, for the 'May Contain Nuts' Theatre Group;

Optimisation of Medicines Management: Central London Community Healthcare Trust and Herts Valley CCG, 'an integrated approach to optimise home oxygen';

Patient Digital Participation: West Hertfordshire Hospitals Trust, 'iSeeU Baby';

System Led Support for Carers:
Hertfordshire and West Essex STP Partnership, 'A Healthier Future for Carers: integrating vision, pathways and support';

Workforce: East and North Hertfordshire CCG, 'Tackling the workforce crisis: empowering and inspiring our primary care staff'.

I look forward to hearing how we get on at the awards ceremony in November, good luck all,

Deborah

Your future | Our hospital

NHS
The Princess Alexandra Hospital
NHS Trust

Trust Board - 4 October 2018

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 September 2018
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. The risks, risk ratings and outcomes of Committee reviews in month are summarised in Appendix A and the BAF is attached as Appendix B. There is one proposed change to the risk ratings: Risk 3.2 (ICP) Health Economy Stability and Joined Up Approach: Following review at EMT on 27.09.18 it is proposed to reduce the risk rating from 16 to 12 (the target risk rating). A verbal update on the rationale for the reduction will be provided at the meeting.
Recommendation:	The Board is asked to approve the Board Assurance Framework and the reduction of the risk score for Risk 3.2 from 16 to 12.

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 27.09.18, PAF.24.09.18, WFC. 24.09.18 and QSC.28.09.18
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 - Summary of Residual Risk Ratings Appendix B - Board Assurance Framework 201/18

5P	Executive Lead	BAF Risks	Current risk score	Designated Committee and outcome of Committee review.
	Chief Nurse/Chief Medial Officer	1.1 Outcomes: Inconsistent outcomes in clinical quality, safety, patient experience and 'higher than expected' mortality.	16	QSC Reviewed at QSC.28.09.18; risk rating confirmed.
	Chief Finance Officer/DoI& IT	1.2 EPR Concerns around data quality including misuse and compliance with system and system resilience as well as forward compatibility as Trust moves towards having Integrated Care Records	16	PAF Reviewed at PAF.24.09.18. Risk rating confirmed.
	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	16	PAF Reviewed at PAF.24.09.18. Risk rating confirmed.
	IDoP	2.1 Workforce Capacity Concerns around staffing capacity to manage workload, deliver services of high quality and maintain national performance requirements.	20	WFC reviewed on 24.09.18 Risk rating confirmed.
	IDoP	2.3 Internal Engagement Failure to communicate key messages and organisational changes to front line staff.	9	WFC reviewed on 24.09.18. Risk rating confirmed.
	IDoP	2.4 Workforce Productivity Gaps in staff capability not being consistently addressed through available performance management and development processes	9	WFC reviewed on 24.09.18. 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.24.09.18. Risk rating confirmed.

	DoS	3.2 Health Economy Stability & Joined up Approach Failure of the Integrated Care Partnership to integrate and work effectively as an ICP and deliver demand management, productivity and efficiency targets, undermining both hospital and system sustainability.	**12**	**For review by Trust Board on 4.10.18. (proposed reduction of risk rating from 16 to 12)**
	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.4.10.18.
	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.4.10.18.
	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.4.10.18.
	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.24.09.18, risk rating confirmed.
	COO	4.2 4 hour Emergency Department Constitutional Standard Failure to achieve ED standard	**20**	PAF Reviewed at PAF.24.09.18, risk rating confirmed.

	CFO	5.1 Finance Concerns around failure to meet financial plan including cash shortfall.	**15**	PAF Reviewed at PAF.24.09.18, and risk rating confirmed.

The Princess Alexandra Hospital NHS
NHS Trust

The Princess Alexandra Hospital Board Assurance Framework

2018-19

Your future | Our hospital

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 outcomes in clinical quality, safety, patient experience and 'higher than expected' mortality.	Causes: i) Inconsistent treatment stratification ii) Failure to incorporate patient feedback (including PALS) into service improvement and re-design. iii) Failure to achieve sustainable improvements in national survey results iv) Poor results in 2016 Inpatient Survey	**4 X 5= 20**	Chief Nurse/ 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 which includes patient feedback - 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 viii) Monthly Commissioner reviews of quality and Safety xi)Four 'Big Dots' - AKI, Sepsis, Mortality and End of Life xii) Risk Management Training Programme xiii) Monthly newsletters - Quality Matters, Pharmacy 5 Minutes xiv) Escalation processes for prescribing doctors and processes for non-medical prescribers xv) Electronic handovers and E-Obs xvi) Schwartz Rounds xvii) Redesign of ED xviii) NHSI/NHSE Oversight xix) Red2 Green Board rounds xx) Improved reporting and review process for deaths and establishment of incident management group. xxi) Patient Experience Strategy xxii) NED lead appointed for Mortality	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) Executive Assurance meetings with ED, Critical care, End of Life, Urology and General Surgery. xvi) AKI and Sepsis merged with Q1st and NED lead	i) Improvement in some areas of the National Inpatient 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) Increase in Datix reporting and reduced harm over approx. last 18 months viii) Feedback from NHSI and Commissioners on harm reviews (positive) ix) Real time Dr Foster feedback x) Arthoplasty infections (monitoring) xi) Water Safety testing across the Trust (SMH) - normal results xiii) Local Delivery Board (LDB) xiv) GMC Trainee Results Report xv) Integrated Performance Report (IPR) xvi) Mock CQC Inspection Report xvii) Learning from deaths reports and dashboard, Mortality Presentation to Board (Oct 17) and HSMR improved to 114. xviii) Outstanding NICU peer review xix) Clinical Audit report - tiaa xx) Enable East Review (Oct 17) xxi) Improved palliative care coding	**4x4=16**	i) Real time patient safety feedback ii) Internal/External Comms in development iii) Evolving clinical audit approach iv) Real time patient feedback system in procurement phase v) Disparity in local patient experience surveys versus inpatient survey vi) Staffing and site capacity **ACTIONS:** i) Website development ii) Inpatient Survey action plan in place iii) Medical Examiners being appointed - implementation September 2018 iv) Real time patient feedback (anonymised) live in 11 area- roll out scheduled for completion by October 2018.	i) Clinical evidence of improvements made following Compliance with national audits, NICE,NCEPOD.	07/09/2018	**Risk rating not changed.**	4x3 =12 (Target date ~~Sept~~ 2018 May 2019 - to achieve 'as expected' for mortality and for patient experience, 5 personal care indicators in Quality Account in top 20% - 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											

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 data quality including misuse and compliance with system and system resilience as well as forward compatibility as Trust moves towards having Integrated Care Records	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 ~~weekly~~ Cambio meetings/roadmap xvi) Internal daily ICT/COSMIC meetings ongoing xvii) 7.7 in development and expected in test environment by end of May ~~9.02.18~~ xviii) Real time data now available xix) Exec to Exec meetings every 2 weeks xx) Cambio to attend ICT Steering Group xxi) OBS requirements being reviewed to assess gaps xxii) Contract review - completed xxiii) ~~External Support - PWC~~. 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) Executive to raise profile & awareness of implementation/ transformation opportunities with clinical leaders/consultants. vii) CCIO post now vacant viii) Compliance with refresher training ix) CDS 011 issue identified with diagnosis qualifier currently in test an requires resolution before 7.7 can go into test environment. ix) Cambio delivery schedule slippage, 7.4 HF04 and HF05 to go Live 19/09/18, then PFM to go into Test by 28/09/2018	Reporting mechanism on compliance of new staff/interims/junior doctors with the system and uptake of refresher training - monitoring process being developed.	Sep-18	Residual Risk rating unchanged	**4x3=12 (~~Sept~~ December 18)**
			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) Establishing benefits realisation programme v) Recruitment of new CCIO - in mitigation each ICT Project Board has a clinical member and AMD Q1st engaged in projects. vi) Refresher training underway vii) 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	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** **Strategic Objective 5: Our Pounds – manage our pounds effectively to achieve our agreed financial targets and control totals**													
BAF 1.3		**Coding Risk** Coding issues (including clinical) within the Trust impacting on Patient Safety, Finance, Performance and Operational delivery	**Causes:** ~~i) Clinical staff not fully, accurately capturing information required in a timely manner~~ i) Liaison and education between coders and clinicians not optimal. ii) Failure to capture and code activity by national submission deadlines such as flex and freeze dates. iii) EPR issues - clinical engagement with COSMIC iv) Inconsistent engagement by HGs in addressing data completeness and clinical coding issues v) Poor notes and record keeping vi) Human element with some junior doctors not providing definitive diagnosis to facilitate coding vii) Ongoing COSMIC development/fixes viii) SOPs not in place and inconsistent compliance ix) Maintaining alignment with information systems to ongoing changes in operating models x) Capacity and capability within training team **Effects**: i) Loss of income ii) Incorrect triggering in external reports such as Dr Foster and impact on HSMR and SHMI iii) Negative impact on reputation iv) Potential safety issues v) Capacity planning and operational performance vi) Pathway and Collaboration implications vii) Costs for overtime and agency staff	5 X 4= 20	Director of IT **Performance and Finance Committee**	i) DQ Improvement Plan ii) Weekly Access Board meetings iii) Data quality dashboards developed iv) MediCode implemented and maintained v) Clinical lead for coding identified vi) Meetings/workshops with clinical leads on coding vii) Clinical coding pilot by clinicians viii) Additional coders employed/targeted to areas of risk ix) Weekly Specialty meetings x) CMO monthly meetings with coding re mortality xi) IM&T Programme Board xiii) Coding action plan xiv) Presentations to CWG and MAC xv) Business case for additional resource now approved xvi) Outsourcing to improve coding backlog and percentage coded by flex date. xvii) External review completed and final report received and presented to EMT; further actions identified and to be incorporated into coding improvement framework. xviii) Recruiting to new structure (ongoing) xix) Weekly clinical coding quality audit for the insourced/outsourced coding resource xx) Mortality validation work underway and linking with Medical Examiners Trainee coders in place xxi) Plans underway to relocate off site team members back on site to unify the team	i) Internal Audit (DQ/coding and ED) ii) Annual clinical coding audit for IG Toolkit iii) Dr Foster reports iv) Mortality reviews v) External Audit (Quality Account indicators) vii) PAF meetings	i) Internal Audit reports to Audit Committee ii) External audit report to Audit Committee (Quality Account indicators) iii) DQ Recovery Plan (PAF) iv) Monthly DQ reports (PAF) v) Weekly reports and HG dashboards to EDB and Access Board vi) Maxwell Stanley report on clinical coding	4 X 4= 16	i) Need to increase direct clinical coding particularly for outpatients ii) Management and quality of content of medical notes and timely availability of notes iii) Continue to develop 'usability' of EPR application to aid users iv) Capacity within operational teams v) Elements of system remain onerous (completion of discharge summaries) vi) External system support vii) Recruitment and retention within coding team and 2 coders on long term sickness absence **ACTIONS:** Recruitment to posts EPR meetings/negotiations Recruitment of CCIO Coding improvement framework following external review ~~and bid to NHSI for funding to support improvements.~~ Guidance for coders updated in respect of co-morbidities from discharge summaries. Coding using electronic systems e.g. radiology, theatres Maxwell Stanley project launching in August.	Current concern around timely completeness of coding has been addressed since April 17 and the focus is shifting to maintain the position and address the secondary issues endorsed by external review. Quality of outsourced coding under review and being monitored with feedback provided to close the loop. (Gaps to be addressed by coding improvement framework)	19/09/2018	No change to risk ratings.	4x3=12 ~~August~~ December 2018 - embedding actions in Coding Improvement Framework)

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		**Workforce Capacity** Concerns around staffing capacity to manage workload, deliver services of high quality and maintain national performance requirements.	**Causes:** i) National hotspots (Acute physicians, Stroke consultants, ED consultants, Pathologists and Care of elderly staff and registered nurses and midwives). ii) Geographical location of the Trust, close to London but without the HCA weighting. iii) Proximity to teaching hospitals which are attractive to some staff iv) Lack of focus on active talent management v) High turnover of nursing, biomedical scientists and AHP staff vi) Rewards currently available for agency working	**4 X 4 =16**	Interim Director of People **Workforce Committee**	i) National representation to increase international supply and supportive immigration policies. ii) Recruitment processes refreshed (TRAC, benefits package, Vacancy Review Panel, Social Media and Recruitment Campaign) iii) Clear SP Strategy and direction iv) Succession planning introduced and part of appraisal v) Talent Management Plan features as a component of new People Strategy and Operating Plan 18/19. vi) Turnover of Nursing, Biomedical Scientists and AHPs ~~at 13.3%~~ below STP average of 16%. vii) Agency controls in place having met regulator set target in 17/18 and improved use of bank.. viii) Improved use of technology and monitoring of time to hire KPIs ix) Leadership and Development Programmes underway	i) PAF, QSC, WFC, EMT, EMB, Workforce and Board meetings ii) Health Group Boards iii) Internal Audit report on Recruitment (substantial assurance)	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 5 =20**	Inability to influence supply. Action: Continue to work with HEE to influence national policies Implement a workforce planning cycle	Director of People to review incidents and monthly SI reports.	17/09/2018	**No change to residual risk rating.**	**4x4=16 ~~Oct~~ December 2018**
			Effects: i) Pressure on existing staff to cope with demand leading to overworked staff 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) Staff retention and succession planning issues											

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 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 Engagement** 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) Collaboration with Lister, development of ACO and uncertainty about STP plan vii) Challenged Provider status viii) Insufficient management time allocated to communication with staff	**4 X 4= 16**	Director of HR **Workforce Committee**	i) Staff awards; ii) CEO ~~weekly~~ 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. vi) ~~Development and Deployment Strategy~~ ~~vii) Great Leaders Programme~~ viii) Quality Fellows programme ix) National Leadership Programmes for staff x) Staff Survey xi) Schwartz Rounds ~~xii) CQC QIP~~ xiii) Staff Council (being relaunched at EIAT) xiv) Quality Ist Communication Plan and Newsletter xvii) Event in Tent xv) People Strategy in development xvi) Printed magazine (quarterly) xviii) The Trusted Executive work in progress	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). ~~and the future of the Trust.~~ **Actions:** i) Monthly updates to Board on strategic developments ii) Sustaining engagement activities following Event in a Tent iii) Recruitment to Associate Director of Communications role. Structure of Comms team and recruitment pending - ~~awaiting start of new DoF and Comms~~ iv) Review of Comms function completed and implementation to follow. v) Relaunch of website vi) Staff app being developed		17/09/2018	**No change to risk rating.**	3x2=6 (~~September~~ November 2018 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
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	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 2.4		**Workforce Capability** Gaps in staff capability not being consistently addressed through available performance management and development processes	**Causes:** i) Managers not prioritising performance management and development issues ii) Historic lack of management and leadership development training iii) Historic view that appraisals and performance management are not important iv) Lack of a systematic approach to determining organisational, business unit and individual objectives and development plans	**3 X 4 =12**	Interim Director of People	i) Capability Policy in place ii) Training for Managers, Band 5, 6 and 7 leadership training programmes including 'Leading difficult conversations' sessions. External funding in place. iii) HR support for managers in managing underperformance iv) Leadership development and action learning sets in place v) People Strategy vi) New appraisal system vii) Data on Informal Dispute Resolution viii) NHS Staff Survey and action plan ix) Manager training workshops in progress. x) Medical appraisals and revalidation processes xi) GMC referrals and MHPS process xii) GMC Survey	i) Board and WFC meetings	i) Employee Relations reports to WFC ii) Workforce KPIs and IPR iii) MHPS reports to Board iv) Training and development updates to WFC.	**3 x 3 = 9**	Talent management framework identifying key roles, individuals and gaps. Actions: i) Talent Management and Succession Planning in development ii) Leadership and Management development framework (key behaviours) in development iii) Managers Induction being developed	Confidential staff survey results via staff mobile app and outputs to be included	17/09/2018	No change to risk rating	**3 x 2 = 6 (January 2019 pending results of 2018 Staff Survey/ Organisational design review)**
			Effects: i) Impact on staff morale of perceived acceptance of underperformance ii) Impact on staff retention iii) Perpetuating cycle of overworked staff compensating for capability gaps. iv) Potential impacts on workforce productivity and income. v) Disengaged workforce.											

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 3.1		**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. iii) Project Board established to review Capital requirements. iv) Potential new build/location of new hospital v) Re-profiled Capital programme - aligned to red rated risks. vi) STP Strategy being developed and being submitted to Board in October 2018 vii) Clinical Infrastructure Risk review underway viii) Central returns Steering Committee ix) Modernisation Programme for Estates and Facilities x) NHSI support and application to NHSI Resources Committee (for funding) xi) Robust water safety testing processes xii) Annual asbestos survey -completed and red risks resolved. xiii) Associate Director of Estates and Facilities appointed xiv) External fire risk assessments completed following Grenfell fire. Action plan developed. xv) Trust's Estate strategy being developed as part of Project Genesis (Our New Hospital) xvi) SDMP plan approved at Board in August 2018	i) PAF and Board meetings ii) EMB Meetings iii) Health and Safety Meetings iv) Capital Planning 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.	i)Letter from HSE - no regulatory concern raised ii) Reports to EMB iii) Fire Safety report iv) Reports on testing for legionella, asbestos v) Signed Fire Certificate vi) Annual H&S reports to Trust Board and bi-monthly to QSC vii) Ventilation audit report viii) Water Safety Report (PAH site) ix) Annual and quarterly report to PAF: Estates and Facilities x) PLACE Assessments	**5x4=20**	ii) Planned Preventative Maintenance Programme (time delay) and amber backlog maintenance risks now emerging red risks iii) Ventilation systems iv) Sewage leaks and drainage v) Electrical Safety/Rewiring (gaps) vi) SDMP Plan vii) Maintaining oversight of the volume of action plans associated with compliance. viii) Catering services modernisation ix) Lack of authorised persons within estates and facilities teams. **ACTIONS:** i) Review of Estates and Facilities infrastructure - consultation in Q1. ii) Backlog maintenance review iii) Business cases being developed Combined Heat and Power (in 18/19) iv) Applying for distressed Capital funding to mitigate areas of risk. v) Review of Catering infrastructure Consultation in Q1 ~~vi) SDMP plan to be included in OBC work.~~ vii) Estates and facilities management re-structure viii) Capital Programme realigned to address red risks	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. Design phase for sewage and plumbing work tendered.	07/09/2018	**Residual risk rating unchanged.**	**4 x 2 =8 (Rating which Trust aspires to achieve but will depend on relocating to new hospital site) and:** **Target rating to be confirmed once the design and technical surveys are completed.**
			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			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 3.2		**Health Economy Stability & Joined up Approach** Failure of the Integrated Care Partnership to integrate and work effectively as an ICP and deliver demand management, productivity and efficiency targets, undermining both hospital and system sustainability.	**Causes:** i) ~~Lack of clarity re leadership and governance~~ ii) Failure to align incentives and rewards across all partners iii) Poor IT connectivity essential for sharing of clinical information iv) Organisational sovereignty hindering joint workforce arrangements and new ways of working v) System capacity and capability to deploy population health management systems to risk stratify populations	**4 X 4= 16**	DoS **Trust Board**	i) System Leadership in place ii) CCG ~~proposing~~ new system governance arrangements (ICP within STP footprint which in turn reports to West Essex Partnership Board) iii) ~~Accountable~~ Integrated Care Partnership meetings iv) ICP developing project management arrangements v) PAH/CCG proposal for developing a new financial and contracting model using microsimulation of respiratory services vi) Neighbourhood approach being developed by system vii) CCG reviewing commissioning options for out of hospital services viii) CCG and system agreement on actuarial modelling with Centene and Ribera Salud. ix) CEO chairing ACP Board ~~for next 6 months.~~ x) ACP collaborative agreement signed. ~~xi) Actuarial study completed by Milliman (delayed and impacting on OBC).~~ ~~xii) Board to Board held 30.11.17~~ xiii) CCG reviewing Urgent Care arrangements xiv) Clinical Oversight Groups established for Respiratory, MSK and Urgent Care xv) Contracting and payment reform workshop to be held in October 2018. xvi) MSK contract being developed (for sign off by April 2019)	i) ~~Outline business case by BCG and KPMG~~ ii) Chairs/ CEO group meetings iii) ~~Accountable Care Provider Board~~ iv) ~~System leadership meetings~~	i) Minutes and reports from system/partnership meetings/Boards ii) ~~BCG business case and KPMG report~~ iii) Memorandum of Understanding RS/WECCG and PAH ~~iv) STP governance proposals~~	**~~4 X 4= 16~~** **4 x 3 = 12**	i) STP footprint includes whole of Herts & West Essex therefore potential for lack of focus on West Essex/East Herts system. ii) Underpinning assumptions of STP to be tested. iii) Potential £50m risk across system iv) Lack of demand and capacity modelling at ACP and STP levels v) Dashboard for delivery/performance of GPs to be developed. **ACTIONS:** Revised internal and external governance arrangements Commissioning intentions concerning future provision of out of hospital STP finance leaders reviewing financial controls to mitigate financial risk. Developing new service models and ~~reviewing~~ contracts for MSK, Respiratory and Urgent Care (Completion by October 2018).	None identified.	26/09/2018	**Risk rating reduced to 12 meeting target risk rating.**	**4x3=12** **~~March~~ October 2018)**
			Effects: i) No clear authority for strategic prioritisation and deployment of system resources ii) Partner organisations seeking approval for decisions from their sovereign organisation iii) Failure of other partners to take on and share risk iv) Fragmentation of provision of care v) Duplication of effort and cost vi) Capacity and capability of already overstretched system workforce not being optimised vii) Hindering introduction of new models of care viii) Potential £50m system-wide STP risk in 2017/18											

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) Limited input from clinicians and other key stakeholders into STP strategy ii) The financial bridge is based on high level assumptions iii) The development of QIPP and CIP programmes for 2017/18 has not followed a Footprint-wide approach iv) The Workstream plans do not have sufficient underpinning detail to support the delivery of the financial savings attributed to them v) The resources required for delivery at a programme and workstream level have not been defined or secured vi) The current governance structure is under development given the shift in focus from planning to delivery. vii) 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 prioritisation under review with workstream leads being nominated. v) STP PMO under development vi) CEO's forum vii) Integrated Clinical Strategy in development viii) STP Estates Strategy being developed.	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 iii) PWC report on governance arrangements iv) Presentation to EMB on new STP governance structures v) STP paper on system working	**4 X 4= 16**	Lack of STP demand and capacity modelling. STP Clinical Strategy being developed and demand assumptions to be considered to ensure achievable cost savings **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 Escalation to CEO forum and West Essex actuarial piece to be shared.	Proposed governance structures to be tested.	26/09/2018	**No changes to risk rating.**	**4x3=12** **~~Sept 2018~~** **March 2019**
			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) ~~Undermining political support for Capital programme~~ v) 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			
								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 3.4		**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) Inability to recruit and retain innovative leaders in the Trust~~ vii) Focus on immediate operational and financial priorities versus the longer term strategic planning viii) Lack of clarity regarding contracting and organisational models in support of ICP ix) ~~Lack of dedicated~~ Management resource and team to drive change and strategy development being built. x) Lack of shared vision and key drivers for change xi) ~~Launched 5Ps at Event in Tent and~~ internal programme for development and implementation of 5P plans. ~~xii) Lack of clarity on capital prioritisation process at national level.~~	**4 X 4= 16**	DoS **Trust Board**	i) SMT meetings ii) Clinical specialty meetings ~~iii) Quality 1st Improvement Board~~ ~~iv) Deputy CMO appointed~~ v) Good relationships with key partner organisations vi) CEO chairing ICP Board ~~vii) Legal advice taken on potential organisational/contractual models~~ ~~viii) PAH/ENHT Working Group established~~ ix) SOC Steering Group x) CEO attending STP meetings ~~xi) DoPP actively engaged with Harlow Gilston Garden Town planning~~ ~~xii) PAH attended meeting with Centre on 24 April re OBC~~ xi) Director of Strategy appointed. xii) Programme plan in place - health planners engaged, transport study, strategic estates advisors engaged. xiii) Clinical Strategy being developed. xiv) Strategy Committee being established.	i)Workshops with clinical leads ii) ICP and STP meetings including acute and back office workstream meetings iii) SOC Steering Group iv) Harlow/Gilston Garden Town Co-op.	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.	**4x3=12**	i) Financial analytical support for programme ii) Capacity and capability to develop LEAN process mapping iii) Embedding the programme iv) External training required to develop internal capacity v) Data quality impacting on business intelligence (SLR) **ACTIONS:** Trust's vision and mission statement being refreshed and 5P plans underway. Establishment of a 'Strategy Committee. Clinical Strategy review underway. Strategy team being developed.	None identified.	26/09/2018	**Risk rating not changed.**	**4 x 2= 8** ~~October~~ Dec 2018)
			Effects: i) Poor reputation ~~ii) Imposed strategy not compatible with resources and organisational aim~~ iii) Increased stakeholder and regulator scrutiny iv) Low staff morale v) Threatened stability and sustainability vi) Restructuring fails to achieve goals and outcomes vii) Impact on service delivery and quality of care viii) Poor staff survey ix) Failure to fully implement the transformation agenda required e.g. increase in market share, following restructure x) Undermines regulatory confidence to invest in hospital/system solutions												

Risk Key														
xtreme Risk		15-25												
High Risk		8-12	**The Princess Alexandra Hospital Board Assurance Framework 2018-19**											
edium 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,			
								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 3.5		**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 being 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 capital plans	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) KPMG Report~~ iv) STP work plans v) 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 ~~Prep for meeting on 24 April 2018.~~ Capital Plan submission for PAH prioritised. PCBC work commissioned Regular meetings held with regulators. Establishing a Strategy Committee	i) Strategy in development	26/09/2018	**No change to residual risk rating.**	**4 x 3 =12** **~~December 2018~~ March 2019 timeframe for completion of master planning work)**
			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) Trust has been given notice to vacate Mitre Buildings by November 2018 and this is a risk to continuity. The Trust has received a verbal offer to extend this period for a short period and is negotiating the length of this period although discussions have not yet concluded.	**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	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.	i) Benefit realisation reviews	07/09/2018		**4x2=8 March 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) ICT re-structure, iv) Alternative office accommodation options v) Income capture processes				

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**	**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 4.2		**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) ~~Increased turnover and lack of qualified workforce.~~ 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) Poor flow out of ED x) Delay in decision making	**4 X 5 = 20**	Chief Operating Officer	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 established 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) Establishment of Urgent Care team xviii) Development of additional capacity to support flow	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) Twice weekly reports to NHSE on DToCs iii) Escalation reports weekly to NHSE iv) Monthly PRM meetings	**4 x 5 = 20**	i) Staffing (Trust wide) and site capacity ii) System Capacity iii) Leadership issues **Actions:** i) ~~D&D Strategy and recruitment/retention action plan~~ ii) Local Delivery Board monitoring ED performance iii) Monthly Performance review meetings ~~iv) Actions being taken in relation to Pauline Phillips letter~~	None noted.	17/09/2018		4x3 =12 ~~September 2018~~ March 2019 (on delivery of standard - 95%)
			Effects: i) Reputation impact and loss of goodwill. ii) Financial penalties. iii) Unsatisfactory patient experience. iv) Potential for poor patient outcomes v) Jeopardises future strategy. vi) Increased performance management vii) Increase in staff turnover and sickness absence levels												

Risk Key														
Extreme Risk		15-25												
High Risk		8-12	**The Princess Alexandra Hospital Board Assurance Framework 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 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	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	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	Service Line Reporting Demand and Capacity planning Workforce planning	07/09//2018	**Risk rating not changed.**	**5x2=10 Sept Dec 2018**
			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 Alternative accommodation for corporate staff being sought. Clinical and operational forums in place to review QIPP schemes. Improved FOT process. Review of Capital reporting. Focus on pay and non pay CIPs.				

The Princess Alexandra Hospital NHS
NHS Trust

TRUST BOARD - 4 OCTOBER 2018

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:	28 September 2018
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 latest Significant Risk Register (SRR) across the Trust. This was produced from the web based Risk Assure system. There are: 75 significant risks with a score of 15 and above. Of these: 1 risk for urology staffing scores 25, this has increased since August 2018 25 risks score 20 30 risks are overdue their review in this period No new risks have been raised scoring 15 plus (since 26.7.18)
Recommendation:	The Trust Board is asked to i) Note 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 risk and SRR according to its 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:	

The Princess Alexandra Hospital NHS
NHS Trust

4.2

1.0 INTRODUCTION

This paper details the Significant Risk Register (SRR) across the Trust; it was prepared on 24 September 2018 and produced from the web based Risk Assure system. 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 75 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)	3 (3)	1 (0)	0 (0)	8 (7)
Estates & Facilities	6 (3)	1 (1)	3 (4)	0 (0)	10 (8)
Finance	2 (1)	0 (0)	0 (1)	0 (0)	2 (2)
IM&T and IG	0 (1)	3 (3)	3 (3)	0 (0)	6 (7)
Non-Clinical Health & Safety	1 (1)	0 (0)	0 (0)	0 (0)	1 (1)
Nursing	0 (0)	1 (1)	0 (0)	0 (0)	1 (1)
Operational	0 (0)	1 (1)	3 (3)	0 (0)	4 (4)
Patient Safety & Quality	0 (0)	0 (0)	0 (0)	0 (0)	0 (0)
Workforce	0 (0)	1 (1)	0 (0)	0 (0)	1 (1)
Child Health	3 (1)	1 (1)	0 (1)	(0)	4 (3)
Safeguarding Adults	0 (0)	0 (2)	0 (0)	0 (0)	0 (2)
Safeguarding Children	0 (0)	1 (1)	0 (0)	0 (0)	1 (1)
Women's Health	1 (1)	1 (2)	0 (1)	0 (0)	2 (4)
Medicine	2 (2)	7 (6)	11 (12)	0 (0)	20 (20)
Surgery	9 (9)	1 (2)	4 (4)	1 (0)	15 (15)
Totals	28 (23)	21 (24)	25 (29)	1 (0)	75 (76)

The scores from the August paper are in brackets

There is one risk scoring 25:

- People; relates to the depleted workforce in the Urology service.

There are 25 risks with a score of 20; the key areas are detailed below with full details of each risks and controls in place in appendix 1.

- Patients: Risks for endoscopy equipment, placing patients in post anaesthetic care unit (overnight), cashing up virtual clinics, ophthalmology care for neonates and tracking patients after a stent insertion.
- People: Staff vacancies and workforce planning, staff competencies against various statutory mandatory training topics and compliance with IG training.
- Performance: Delivery of ED four hour standard and 62 day cancer standard
- Places: electrical back-up systems, medical gas pipeline, environmental temperature controls, fire suppression for IT equipment, lifts meeting LOLER regulations, doors not secure allowing access, lack of CCTV, Williams Day unit.
- Pounds: Nil

Most Trust risks are reviewed within the allocated timeframe. However there are 30 risks scoring 15 and above that are overdue their review date, see appendix 2. These will continue to appear on relevant risk leads 'To do' list (created by RiskAssure) until updated.
Details of all risks are also published on the Trust intranet.

No new risks scoring 15 plus have been recorded on RiskAssure between 26/07/18 and 21/09/18.

The Risk Management Group continues to meet on a monthly basis, working through the annual work plan however the dates have recently changed and the September meeting was cancelled. Those risks that were due to be reviewed at this meeting will be carried forward.

The Compliance and Clinical Effectiveness Manager continues to support colleagues with the risk management process and use of RiskAssure and this month supported the AD for Governance with Risk Assessment training on the Band 7 programme.

3.0 RECOMMENDATION

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

The Princess Alexandra Hospital NHS
NHS Trust

Trust Board (Public) – 04.10.18

5.1

Agenda Item:	5.1
Presented by:	Dr Andy Morris, CMO
Prepared by:	Dr Andy Morris, CMO
Date prepared:	12/09/18
Subject / Title:	Mortality Report September 2018

Purpose:	Approval		Decision		Information	x	Assurance	

Executive Summary:	The 12 month rolling HSMR for June 2017 to May 2018 is 116.7 and statistically "higher than expected"'. This is the 17th consecutive month of reporting for a "higher than expected". The in-month HSMR is as expected and has been for 8 of the last 12 months. There are 4 confirmed diagnostic outliers: septicaemia, aspiration pneumonitis, intestinal obstruction and COPD. The palliative care coding rate is 3.87%% v national of 4.03% and the stillbirth rate remains below the national average but 3 deaths in the last month. Also included in the report is new data for specialities and a report from Dr Foster.
Recommendation:	The Board is asked to note the report and the concerns raised.

Trust strategic objectives:	Patients	People	Performance	Places	Pounds
	x		x		

Previously considered by:	PQSG, MSG QSC.28.09.18
Risk / links with the BAF:	BAF risk 1.1 Inconsistent outcomes in clinical quality, safety, patient experience and 'higher than expected' mortality (CxL=16)
Legislation, regulatory, equality, diversity and dignity implications:	
Appendices:	Dr Foster report Summary report

Mortality report September 2018

Guidance for Trust and Boards

https://www.england.nhs.uk/wp-content/uploads/2017/03/nqb-national-guidance-learning-from-deaths.pdf

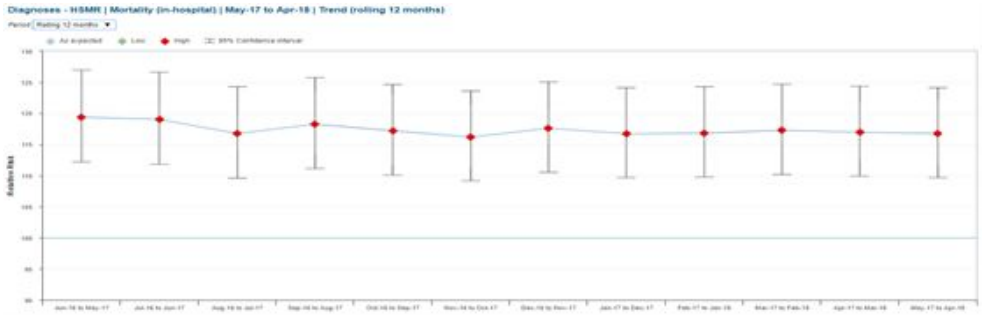
https://improvement.nhs.uk/uploads/documents/170720_Implementing_LfD_-_information_for_boards_proofed_v2.pdf

Mortality dashboard

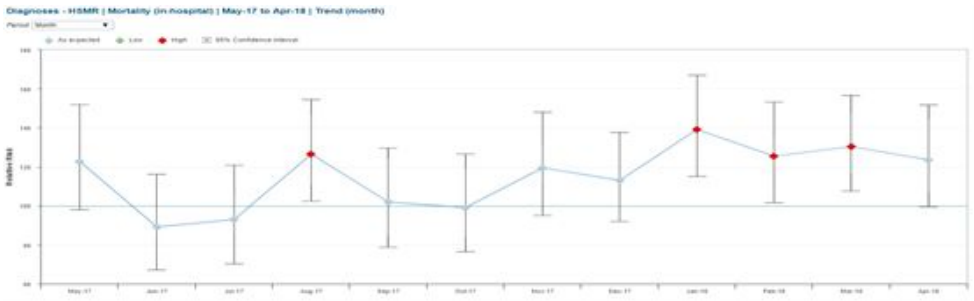
This **c**an be found on Qlikview on the QIP icon.

HSMR

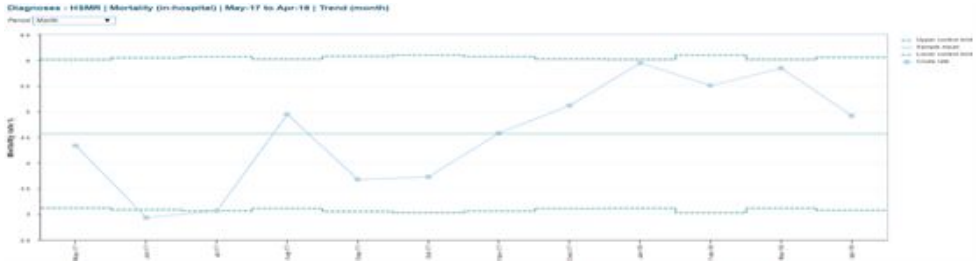
The validated12 month rolling HSMR for June 2017 to May 2018 is 116.7 and statistically "higher than expected"'. This is the 17th consecutive month of reporting for a "higher than expected".



The corrected in-month HSMR is as expected and has been for 8 of the last 12 months:



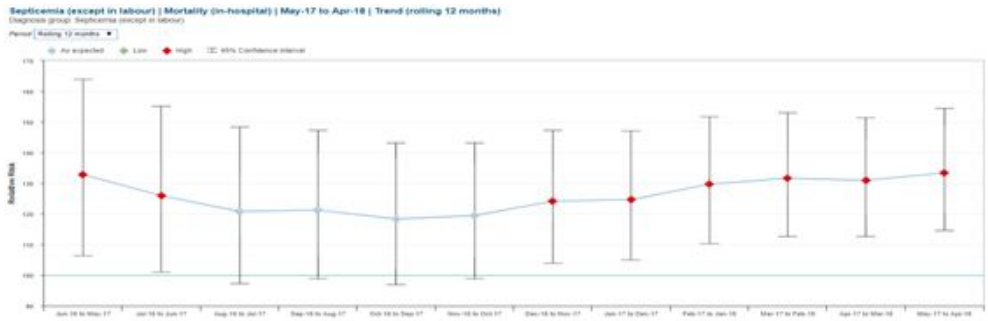
The 12 month rolling crude death rate within the HSMR basket has fallen:

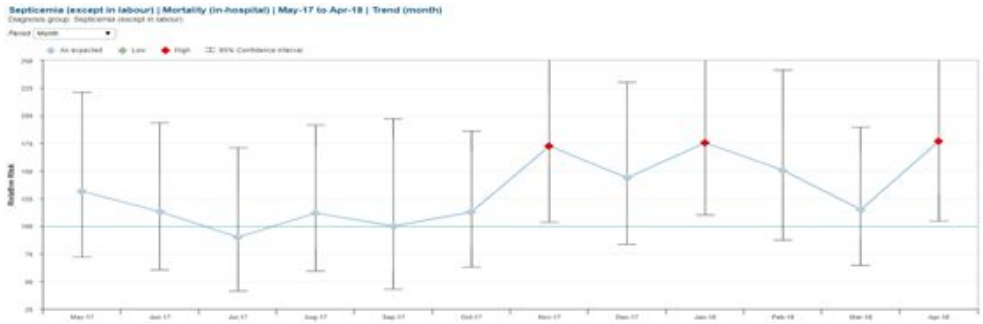


In the 12 month period there are a total of 147 deaths over and above those expected. This has increased from last month.

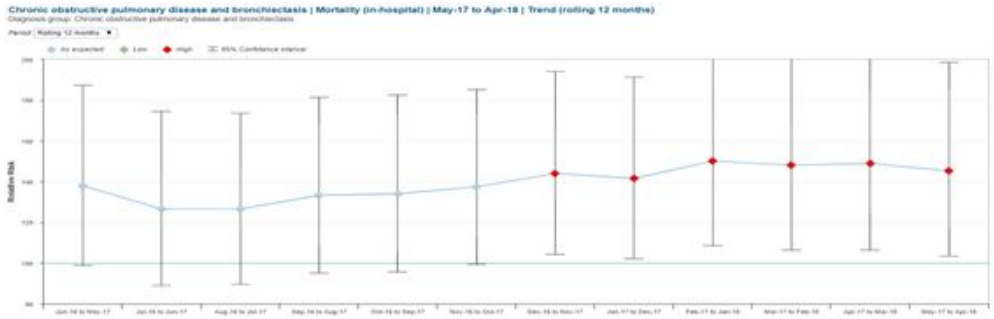
There are 4 diagnostic outliers:

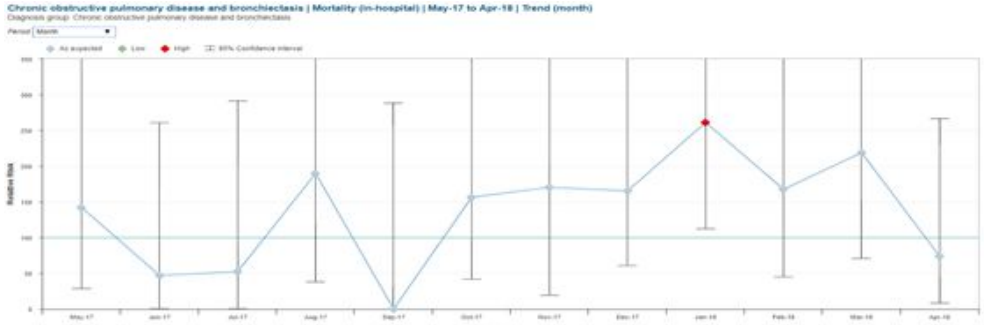
1) Septicaemia, 180 deaths vs. 135 expected.
The rolling 12 month and in-month HSMR are higher than expected and rising:



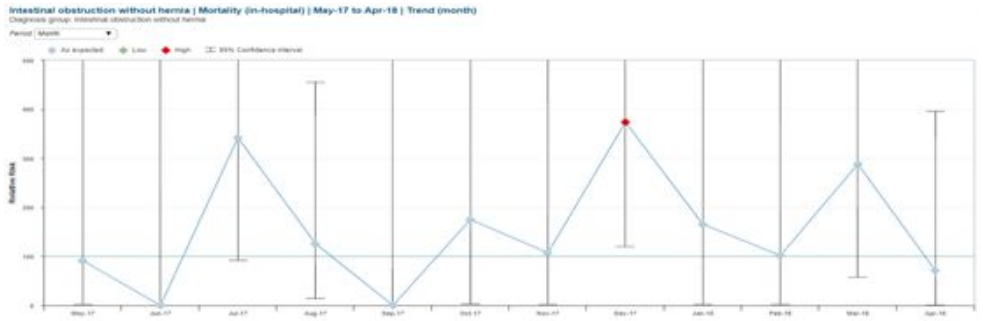


2) COPD and bronchiectasis, 39 deaths vs. 26 expected.
The 12 month rolling HSMR is higher than expected but falling and the in-month HSMR is as expected and also falling:





3) Intestinal obstruction without hernia, 20 deaths vs. 11 expected.
This is a recurring alert. The 12 month rolling HSMR is higher than expected but the in-month HSMR is as expected:



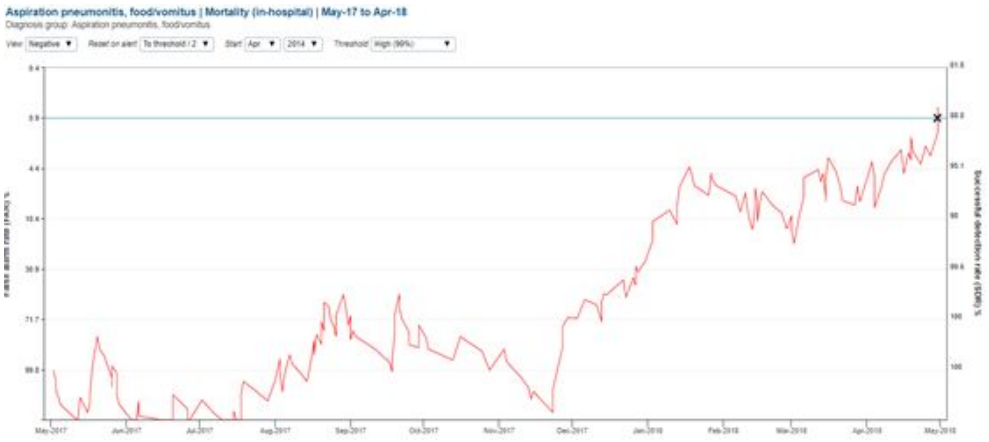
4) Aspiration pneumonitis, 78 deaths vs. 62 expected.

This is a new alert and is being queried with Dr Foster.

Palliative care coding
The palliative care coding rate is 3.87% versus the national rate of 4.03%. This has risen.

SMR
All diagnosis SMR for June 2017 to May 2018 was 116.3 and statistically “higher than expected”. This has risen.
There are 8 alerts in total but 4 of these are very low numbers. Those remaining are the same as the HSMR alerts.
As of this month, we are now able to report SMR by selected services:
General surgery, as expected
Geriatric medicine, higher than expected
Respiratory medicine, higher than expected
Cardiology, as expected
Gastroenterology, as expected.

CUSUM alerts
There is 1 alert this month:
Aspiration pneumonitis



This will need further review.

SHMI
The SHMI for January 2107 to December 2017 was 112.3 and is “as expected”.

Stillbirths
The stillbirth rate for September 2017 to August 2018 is 2.43 per 1000 births adjusted for termination of pregnancy. The national rate is 3.93 per 1000.
To note, there were 3 stillbirths in August, all of which are now SIs.

Matters to note:
HSMR and SMR remain higher than expected for the rolling 12 month period.

The in-month HMSR is as expected.
Palliative care coding continues to improve.
The stillbirth rate is well below the national average but there has been a cluster of 3 which are being investigated as SIs.
A meeting with Dr Foster, the CMO and CFO was held in August to discuss the data quality of the reports and to explore any other avenues worthy of investigation. This concluded that further work with the Maxwell-Stanley team would be worthwhile.
A joint meeting with EN&H reviewed a mortality software tool that the Execs have now agreed should be pursued.

Summary
The statistical markers for mortality remain a significant concern.

THE PRINCESS ALEXANDRA HOSPITAL NHS TRUST

HSMR ANALYSIS (FY 17/18)

August 2018

HEALTH | dr foster®

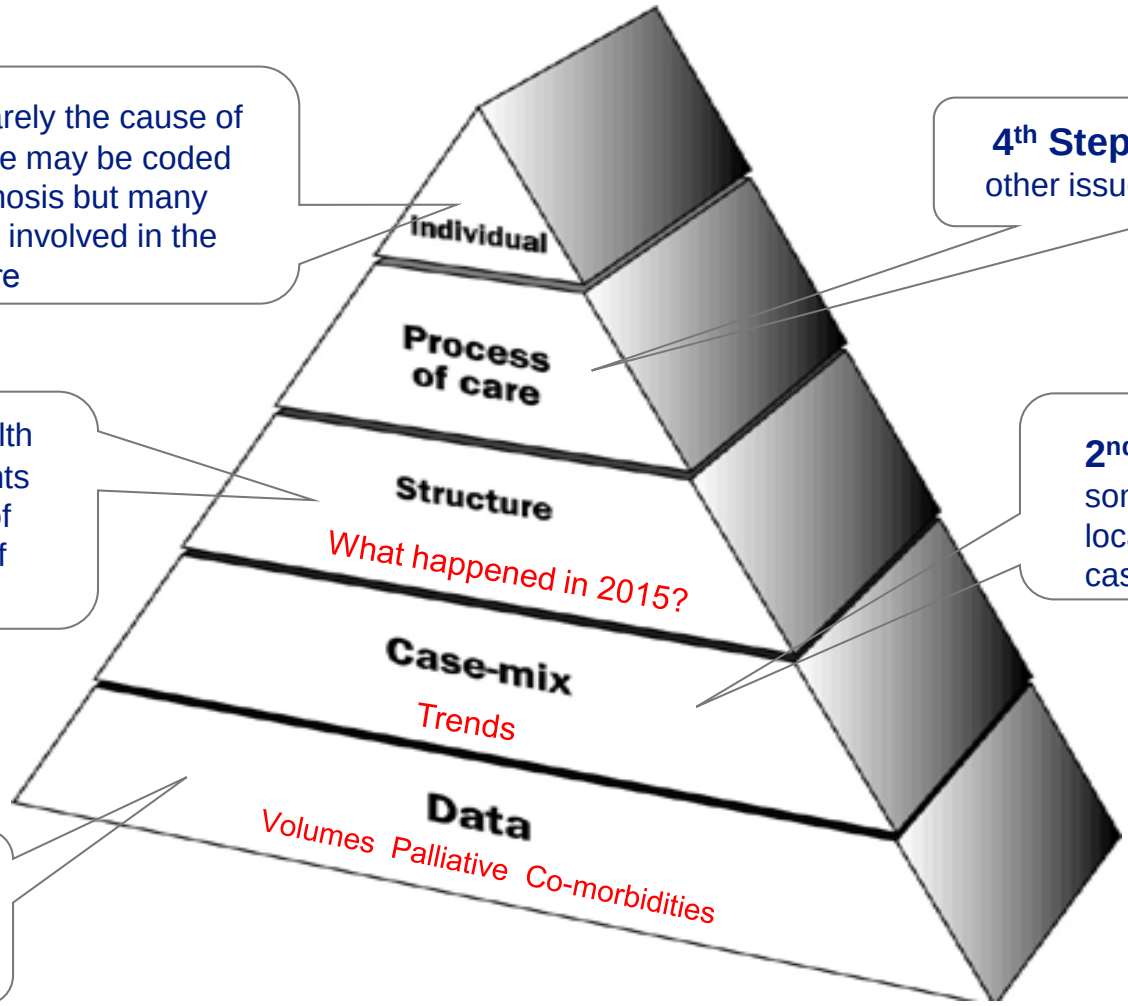
Overview

- Objective is to try and understand what is driving the high HSMR at PAH
- Marianne has been working with the trust providing reports and attending mortality meetings
- Alerts have been highlighted and investigated but no change in overall trajectory
- SHMI is also trending up
- Matthew has undertaken an independent review and will present his opinion
- Present results and identify next steps

Pyramid Model Of Investigation To Find Credible Cause For……..

Finally: An individual is rarely the cause of an alert. A Consultant name may be coded against the primary diagnosis but many individuals and teams are involved in the patient's care

4th Step: Examine when other issues have occurred



3rd Step: The Local Health Economy may treat patients differently than the rest of England e.g. provision of hospices, etc

2nd Step: Has something occurred locally to affect your casemix

1st Step: Does the coding reflect what happened to the patient

Lilford et al. Lancet 2004; **363:** 1147-54

Summary and Conclusions

Focus on 1+ Day LOS

- Marginally high proportion of 0 day Non-elective LOS, proportionately similar to 15/16
- Material increase in crude rate across the 3 year period against a reducing expected rate
- 17/18: 1+ LOS (HSMR) Non-elective, 3rd highest crude rate nationally and a significantly high SMR
- 15/16: 1+ LOS (HSMR) Non-elective, 72nd highest crude rate nationally and a significantly low SMR
- SHMI continues to increase although remains “a expected” using over dispersion
  - Common key diagnosis groups with DF SMR
- Case-mix changes include ACD (significant reduction), UTI (stable, compared to a national fall), Pneumonia (stable, compared to a national fall)
- COPD and Septicemia: Significantly high and high crude rates (Septicemia 6th highest nationally)

SHMI – December 2017

3yr HSMR trend

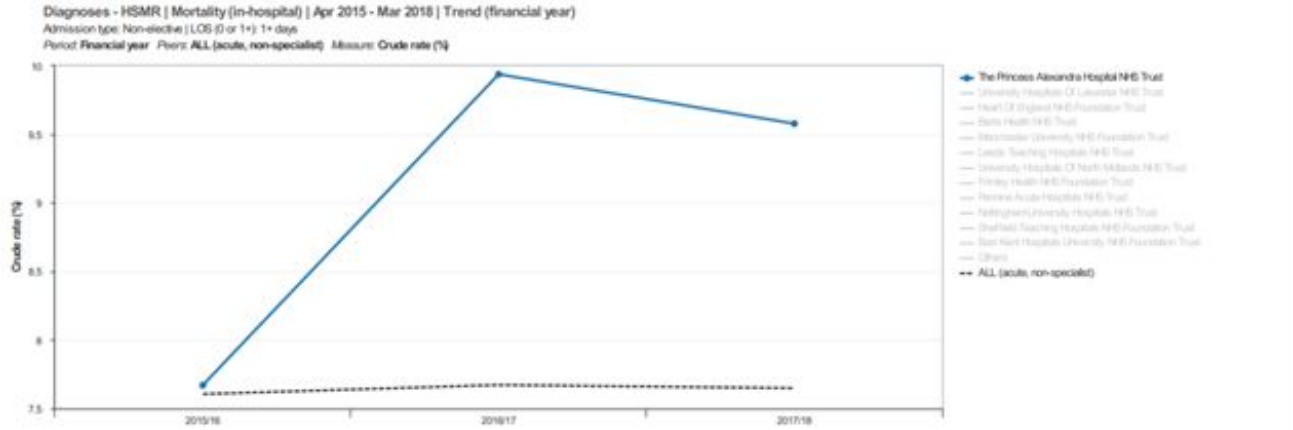
Admission type	LOS (0 or 1+)	Trend (financial year)	Superspells	% of All	Spells	Observed	Crude rate (%)	Expected	Expected rate (%)	Observed-expected	Relative risk	95% lower confidence limit	95% upper confidence limit
Elective	Day Case	2015/16	7979	12.03	7979	1	0.01	0.00	0.00	****	****	****	****
		2016/17	8029	12.10	8029	0	0.00	0.00	0.00	****	****	****	****
		2017/18	7995	12.05	7995	0	0.00	0.00	0.00	****	****	****	****
	0 days	2015/16	348	0.52	348	0	0.00	1.12	0.32	-1.12	0.00	0.00	326.15
		2016/17	499	0.75	500	0	0.00	1.50	0.30	-1.50	0.00	0.00	244.92
		2017/18	411	0.62	411	0	0.00	1.08	0.26	-1.08	0.00	0.00	340.69
	1+ days	2015/16	969	1.46	969	5	0.52	6.18	0.64	-1.18	80.88	26.06	188.74
		2016/17	868	1.31	872	4	0.46	4.69	0.54	-0.69	85.28	22.94	218.34
		2017/18	674	1.02	675	3	0.45	5.14	0.76	-2.14	58.33	11.72	170.43
Non-elective	0 days	2015/16	2882	4.34	2884	38	1.32	58.84	2.04	-20.84	64.58	45.70	88.65
		2016/17	2572	3.88	2572	43	1.67	52.97	2.06	-9.97	81.17	58.74	109.34
		2017/18	3081	4.64	3083	40	1.30	52.83	1.71	-12.83	75.72	54.09	103.11
	1+ days	2015/16	10211	15.39	10292	781	7.65	860.70	8.43	-79.70	90.74	84.49	97.33
		2016/17	9645	14.54	9705	960	9.95	796.39	8.26	163.61	120.54	113.04	128.42
		2017/18	10182	15.35	10237	976	9.59	829.70	8.15	146.30	117.63	110.37	125.25

3 Year HSMR trend Non-Elective Age

Trend (financial year)	Age (10-year)	Superspells	% of All	Spells	Observed	Crude rate (%)	Expected	Expected rate (%)	Observed-expected	Relative risk	95% lower confidence limit	95% upper confidence limit
2014/15	0-4	758	1.42	760	3	0.40	6.26	0.83	-3.26	47.92	9.63	140.01
	5-14	191	0.36	191	0	0.00	0.29	0.15	-0.29	0.00	0.00	1269.02
	15-24	616	1.15	617	0	0.00	0.56	0.09	-0.56	0.00	0.00	651.58
	25-34	734	1.37	736	0	0.00	2.69	0.37	-2.69	0.00	0.00	136.22
	35-44	754	1.41	754	1	0.13	4.74	0.63	-3.74	21.09	0.28	117.34
	45-54	1043	1.95	1045	15	1.44	19.85	1.90	-4.85	75.57	42.26	124.65
	55-64	1335	2.50	1338	61	4.57	51.70	3.87	9.30	117.99	90.25	151.56
	65-74	2073	3.88	2081	119	5.74	116.13	5.60	2.87	102.47	84.89	122.62
	75-84	3256	6.09	3272	304	9.34	306.76	9.42	-2.76	99.10	88.27	110.89
	85+	2770	5.18	2791	411	14.84	421.01	15.20	-10.01	97.62	88.41	107.53
2015/16	0-4	814	1.52	821	2	0.25	5.57	0.68	-3.57	35.90	4.03	129.62
	5-14	185	0.35	185	0	0.00	0.34	0.18	-0.34	0.00	0.00	1076.11
	15-24	553	1.03	553	1	0.18	1.78	0.32	-0.78	56.26	0.74	313.00
	25-34	687	1.29	688	3	0.44	3.14	0.46	-0.14	95.43	19.18	278.84
	35-44	684	1.28	687	9	1.32	5.20	0.76	3.80	173.23	79.05	328.87
	45-54	985	1.84	986	12	1.22	17.29	1.76	-5.29	69.40	35.82	121.24
	55-64	1268	2.37	1277	48	3.79	53.43	4.21	-5.43	89.83	66.23	119.11
	65-74	2032	3.80	2049	114	5.61	122.34	6.02	-8.34	93.18	76.86	111.94
	75-84	3050	5.71	3071	244	8.00	280.83	9.21	-36.83	86.89	76.32	98.50
	85+	2831	5.30	2859	386	13.63	418.96	14.80	-32.96	92.13	83.17	101.80
2016/17	0-4	940	1.76	943	5	0.53	6.23	0.66	-1.23	80.32	25.88	187.43
	5-14	181	0.34	182	1	0.55	0.29	0.16	0.71	347.31	4.54	1932.37
	15-24	419	0.78	419	0	0.00	1.35	0.32	-1.35	0.00	0.00	272.30
	25-34	538	1.01	538	5	0.93	1.88	0.35	3.12	265.66	85.61	619.96
	35-44	614	1.15	617	10	1.63	5.25	0.86	4.75	190.31	91.11	350.01
	45-54	911	1.70	911	16	1.76	20.18	2.22	-4.18	79.27	45.28	128.73
	55-64	1256	2.35	1257	63	5.02	49.80	3.96	13.20	126.52	97.21	161.87
	65-74	1946	3.64	1956	147	7.55	121.01	6.22	25.99	121.48	102.63	142.78
	75-84	2736	5.12	2753	302	11.04	259.69	9.49	42.31	116.29	103.55	130.18
	85+	2679	5.01	2701	454	16.95	395.69	14.77	58.31	114.74	104.42	125.79
2017/18	0-4	966	1.81	972	2	0.21	7.62	0.79	-5.62	26.24	2.95	94.75
	5-14	223	0.42	223	0	0.00	0.24	0.11	-0.24	0.00	0.00	1514.48
	15-24	466	0.87	467	2	0.43	0.99	0.21	1.01	201.45	22.62	727.34
	25-34	716	1.34	717	5	0.70	1.64	0.23	3.36	304.87	98.25	711.45
	35-44	686	1.28	687	3	0.44	7.56	1.10	-4.56	39.66	7.97	115.89
	45-54	944	1.77	946	18	1.91	19.87	2.11	-1.87	90.58	53.65	143.16
	55-64	1338	2.50	1343	53	3.96	45.82	3.42	7.18	115.67	86.64	151.31
	65-74	2094	3.92	2101	120	5.73	116.68	5.57	3.32	102.84	85.27	122.98
	75-84	2896	5.42	2903	319	11.02	251.21	8.67	67.79	126.99	113.43	141.71
	85+	2937	5.50	2961	496	16.89	415.30	14.14	80.70	119.43	109.15	130.42
2018/19	0-4	90	0.17	90	1	1.11	0.67	0.74	0.33	149.96	1.96	834.35
	5-14	14	0.03	14	0	0.00	0.01	0.08	-0.01	0.00	0.00	30975.04
	15-24	48	0.09	48	0	0.00	0.03	0.06	-0.03	0.00	0.00	12856.42
	25-34	73	0.14	73	0	0.00	0.10	0.13	-0.10	0.00	0.00	3819.45
	35-44	71	0.13	71	0	0.00	0.36	0.51	-0.36	0.00	0.00	1014.45
	45-54	85	0.16	85	1	1.18	1.68	1.97	-0.68	59.68	0.78	332.07
	55-64	147	0.28	148	7	4.76	4.90	3.33	2.10	142.91	57.25	294.46
	65-74	209	0.39	211	24	11.48	15.65	7.49	8.35	153.40	98.26	228.26
	75-84	313	0.59	313	46	14.70	27.35	8.74	18.65	168.16	123.10	224.31
	85+	286	0.54	286	70	24.48	41.91	14.65	28.09	167.02	130.19	211.02

ALTH | dr foster®

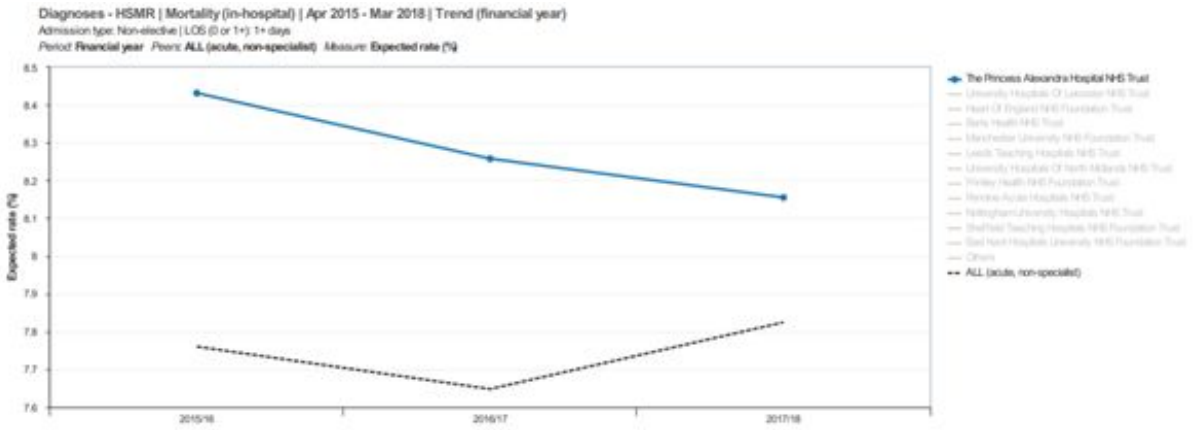
3 Year HSMR trend – Non-Elective 1+ LOS



1+ LOS crude rate

Trend (financial year)	Crude rate (%)	The Princess Alexandra Hospital NHS Trust	University Hospitals Of Leicester NHS Trust	Heart Of England NHS Foundation Trust	Barts Health NHS Trust	Manchester University NHS Foundation Trust	Leeds Teaching Hospitals NHS Trust	University Hospitals Of North Midlands NHS Trust	Frimley Health NHS Foundation Trust	Pennine Acute Hospitals NHS Trust	Nottingham University Hospitals NHS Trust	Sheffield Teaching Hospitals NHS Foundation Trust	East Kent Hospitals University NHS Foundation Trust	Others
All	7.6%	9.0%	6.5%	7.2%	6.5%	5.8%	7.1%	8.3%	7.3%	7.5%	8.3%	7.7%	8.4%	7.7%
2015/16	7.6%	7.7%	6.5%	7.5%	6.7%	5.6%	7.1%	8.0%	7.3%	7.9%	8.6%	7.6%	8.1%	7.7%
2016/17	7.7%	9.9%	6.8%	7.0%	6.5%	6.0%	6.9%	8.2%	7.2%	7.6%	7.7%	7.9%	8.4%	7.7%
2017/18	7.6%	9.6%	6.2%	7.2%	6.3%	5.6%	7.3%	8.7%	7.5%	7.1%	8.5%	7.7%	8.8%	7.7%

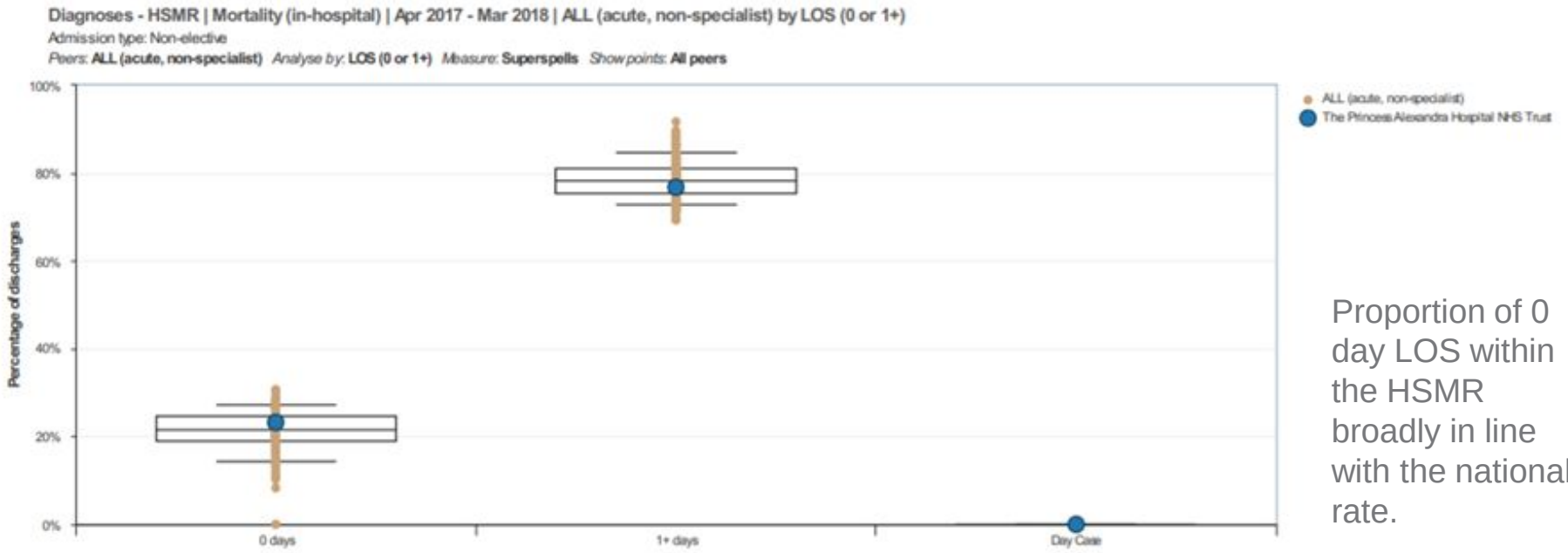
1+ LOS expected rate



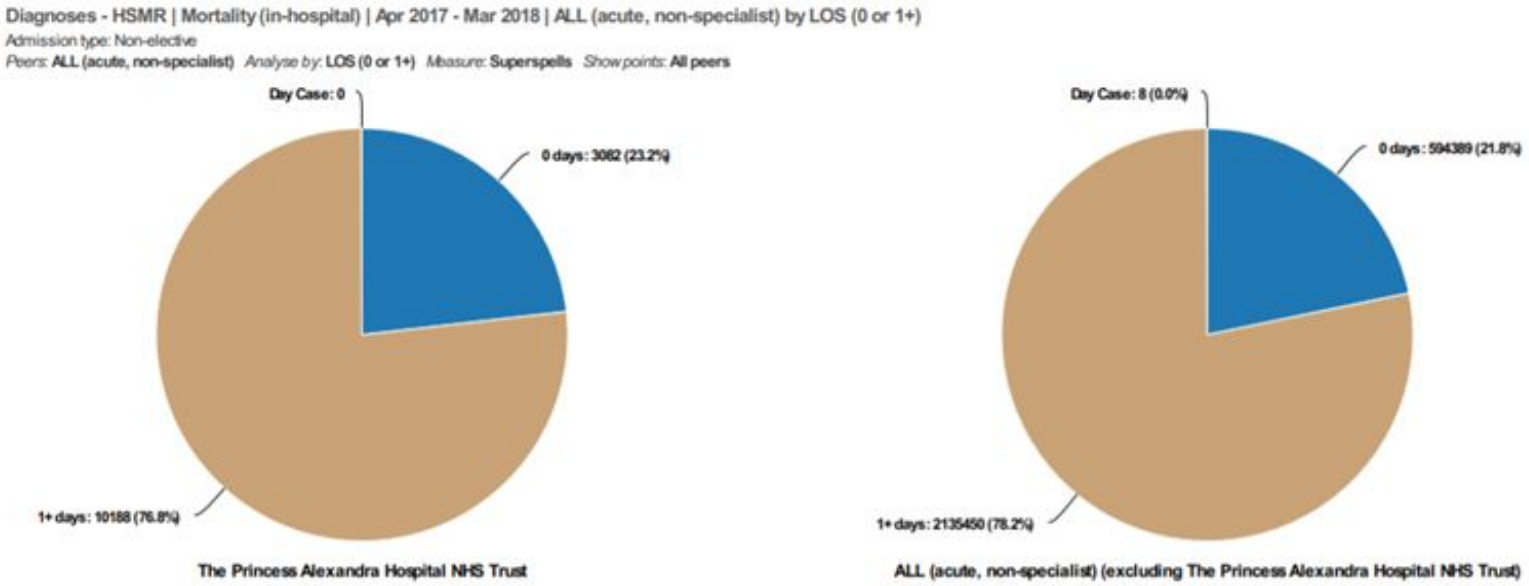
Trend (financial year)	Expected rate (%)	The Princess Alexandra Hospital NHS Trust	University Hospitals Of Leicester NHS Trust	Heart Of England NHS Foundation Trust	Barts Health NHS Trust	Manchester University NHS Foundation Trust	Leeds Teaching Hospitals NHS Trust	University Hospitals Of North Midlands NHS Trust	Frimley Health NHS Foundation Trust	Pennine Acute Hospitals NHS Trust	Nottingham University Hospitals NHS Trust	Sheffield Teaching Hospitals NHS Foundation Trust	East Kent Hospitals University NHS Foundation Trust	Others
All	7.7%	8.3%	7.0%	7.0%	6.9%	6.3%	7.2%	8.5%	8.1%	7.4%	7.6%	7.5%	9.0%	7.8%
2015/16	7.8%	8.4%	7.0%	7.4%	6.6%	5.8%	7.2%	8.7%	8.2%	7.6%	7.8%	7.7%	9.0%	7.8%
2016/17	7.6%	8.3%	6.8%	6.9%	7.1%	6.2%	7.3%	8.4%	8.0%	7.3%	6.8%	7.6%	8.8%	7.7%
2017/18	7.8%	8.2%	7.1%	6.7%	7.1%	6.8%	7.1%	8.4%	8.1%	7.4%	7.8%	7.2%	9.3%	7.9%

7 Year HSMR trend – Non-Elective 1+ LOS Crude Rate Rolling 12 month

0 Day Non-Elective LOS



Proportion of 0 day LOS within the HSMR broadly in line with the national rate.



HSMR Non-Elective Casemix changes

	Diagnosis group	Pneumonia			Urinary tract infections			Septicemia (except in labour)		
				National			National			National
Trend (financial year)	Total	Superspells	%	%	Superspells	%	%	Superspells	%	%
2015/16	13093	1483	11.33	9.00	948	7.24	6.80	318	2.43	2.4
2016/17	12220	1698	13.90	9.70	972	7.95	6.90	287	2.35	2.7
2017/18	13266	1531	11.54	8.90	955	7.20	5.30	829	6.25	6.6

All

Key Diagnosis groups Requiring further investigation

- COPD
- Septicemia
- Obstruction without Hernia.
- Fluid & Electrolyte disorders

1+ LOS

	Diagnosis group	Pneumonia		Urinary tract infections		Chronic obstructive pulmonary disease and		Septicemia (except in labour)	
Trend (financial year)	Total	Superspells	%	Superspells	%	Superspells	%	Superspells	%
All	30070	4453	14.81	2387	7.94	1640	5.45	1401	4.66
2015/16	10220	1384	13.54	798	7.81	553	5.41	311	3.04
2016/17	9660	1626	16.83	840	8.70	555	5.75	279	2.89
2017/18	10190	1443	14.16	749	7.35	532	5.22	811	7.96

1+ LOS

Admission type	Diagnosis group	Trend (financial year)	Superspells	% of All	Spells	Observed	Crude rate (%)	Expected	Expected rate (%)	Observed-expected	Relative risk	95% lower confidence limit	95% upper confidence limit
Non-elective	Acute cerebrovascular disease	2015/16	413	3.35	418	48	11.62	74.98	18.15	-26.98	64.02	47.20	84.88
		2016/17	61	0.49	61	12	19.67	13.91	22.80	-1.91	86.29	44.54	150.74
		2017/18	56	0.45	56	15	26.79	15.05	26.87	-0.05	99.67	55.75	164.41
	Chronic obstructive pulmonary disease and bronchiectasis	2015/16	554	4.49	556	29	5.23	27.20	4.91	1.80	106.63	71.40	153.15
		2016/17	555	4.50	555	40	7.21	24.35	4.39	15.65	164.30	117.36	223.73
		2017/18	532	4.31	532	38	7.14	25.91	4.87	12.09	146.66	103.77	201.31
	Fluid and electrolyte disorders	2015/16	119	0.96	119	6	5.04	5.20	4.37	0.80	115.31	42.11	250.98
		2016/17	102	0.83	103	3	2.94	3.93	3.85	-0.93	76.40	15.36	223.24
		2017/18	152	1.23	153	14	9.21	7.00	4.61	7.00	199.97	109.23	335.53
	Fracture of neck of femur (hip)	2015/16	347	2.81	347	24	6.92	21.70	6.25	2.30	110.60	70.84	164.57
		2016/17	349	2.83	350	36	10.32	21.33	6.11	14.67	168.76	118.18	233.64
		2017/18	382	3.10	382	33	8.64	23.05	6.03	9.95	143.17	98.54	201.08
	Intestinal obstruction without hernia	2015/16	155	1.26	155	14	9.03	10.33	6.66	3.67	135.55	74.05	227.45
		2016/17	151	1.22	152	15	9.93	9.80	6.49	5.20	153.10	85.62	252.53
		2017/18	156	1.26	156	19	12.18	11.24	7.21	7.76	168.99	101.69	263.91
	Pneumonia	2015/16	1387	11.24	1402	210	15.14	270.86	19.53	-60.86	77.53	67.40	88.76
		2016/17	1628	13.20	1634	310	19.04	270.91	16.64	39.09	114.43	102.04	127.90
		2017/18	1445	11.71	1452	239	16.54	211.43	14.63	27.57	113.04	99.16	128.32
	Septicemia (except in labour)	2015/16	312	2.53	315	42	13.46	48.16	15.44	-6.16	87.20	62.84	117.88
		2016/17	279	2.26	279	60	21.51	45.12	16.17	14.88	132.99	101.48	171.19
		2017/18	812	6.58	814	174	21.43	135.70	16.71	38.30	128.23	109.88	148.76
	Urinary tract infections	2015/16	799	6.48	805	36	4.51	33.38	4.18	2.62	107.86	75.53	149.33
		2016/17	841	6.82	842	47	5.59	34.80	4.14	12.20	135.05	99.22	179.59
		2017/18	750	6.08	752	32	4.27	23.82	3.18	8.18	134.35	91.88	189.67

Peer Analysis – COPD

Diagnosis group: Chronic obstructive pulmonary disease and bronchiectasis

Admission type: Non-elective

LOS (0 or 1+): 1+ days

Patients: 409
Superspells: 532 (130.1)
First / Last: Apr 2017 / Mar 2018
Deaths: 38 (7.1%)
LOS: 6.7

REGION (acute non-specialist)	Superspells	% of All	Spells	Observed	Crude rate (%)	Expected	Expected rate (%)	Observed-expected	Relative risk	95% lower confidence limit	95% upper confidence limit
All	11858	100.00	11883	675	5.69	602.49	5.08	72.51	112.03	103.74	120.82
North West Anglia NHS Foundation Trust	1283	10.82	1286	68	5.30	78.49	6.12	-10.49	86.64	67.27	109.83
Southend University Hospital NHS Foundation Trust	985	8.31	985	66	6.70	50.97	5.18	15.03	129.48	100.13	164.73
Norfolk and Norwich University Hospitals NHS Foundation Trust	930	7.84	936	36	3.87	46.45	4.99	-10.45	77.51	54.28	107.31
Colchester Hospital University NHS Foundation Trust	840	7.08	840	66	7.86	46.07	5.49	19.93	143.25	110.78	182.25
Basildon and Thurrock University Hospitals NHS Foundation Trust	771	6.50	772	39	5.06	39.99	5.19	-0.99	97.52	69.33	133.31
Luton and Dunstable University Hospital NHS Foundation Trust	748	6.31	749	44	5.88	36.38	4.86	7.62	120.94	87.87	162.36
The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust	734	6.19	734	48	6.54	31.66	4.31	16.34	151.59	111.76	201.00
Cambridge University Hospitals NHS Foundation Trust	718	6.05	718	29	4.04	37.69	5.25	-8.69	76.95	51.52	110.52
East and North Hertfordshire NHS Trust	714	6.02	725	43	6.02	37.21	5.21	5.79	115.56	83.62	155.66
Ipswich Hospital NHS Trust	662	5.58	663	30	4.53	30.40	4.59	-0.40	98.67	66.56	140.87
West Hertfordshire Hospitals NHS Trust	657	5.54	657	29	4.41	31.18	4.75	-2.18	93.02	62.28	133.59
James Paget University Hospitals NHS Foundation Trust	632	5.33	632	35	5.54	27.41	4.34	7.59	127.70	88.93	177.61
Bedford Hospital NHS Trust	586	4.94	586	42	7.17	27.85	4.75	14.15	150.82	108.68	203.87
Mid Essex Hospital Services NHS Trust	551	4.65	553	37	6.72	28.52	5.18	8.48	129.75	91.34	178.85
The Princess Alexandra Hospital NHS Trust	532	4.49	532	38	7.14	25.91	4.87	12.09	146.66	103.77	201.31
West Suffolk NHS Foundation Trust	515	4.34	515	25	4.85	26.31	5.11	-1.31	95.04	61.49	140.30

- High crude rate, low volume

Peer Analysis - Septicaemia

Diagnosis group: Septicemia (except in labour)

Admission type: Non-elective

LOS (0 or 1+): 1+ days

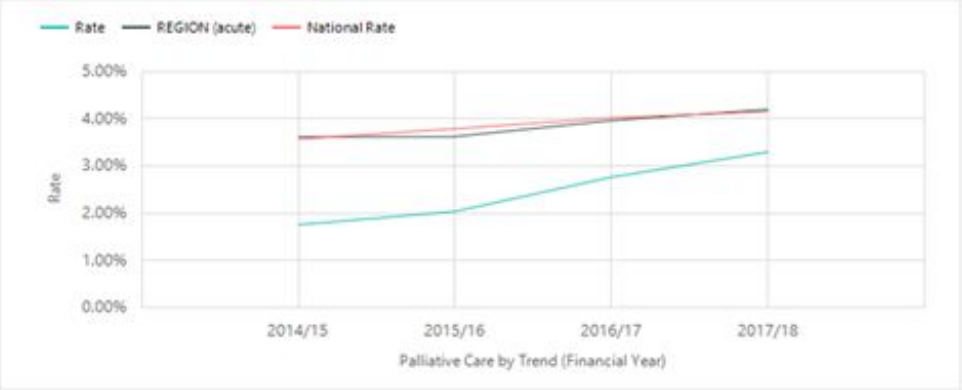
Patients: 748
Superspells: 814 (108.8)
First / Last: Apr 2017 / Mar 2018
Deaths: 175 (21.5%)
LOS: 11.0

REGION (acute non-specialist)	Superspells	% of All	Spells	Observed	Crude rate (%)	Expected	Expected rate (%)	Observed-expected	Relative risk	95% lower confidence limit	95% upper confidence limit
All	21230	100.00	21290	3545	16.70	3674.62	17.31	-129.62	96.47	93.32	99.70
Norfolk and Norwich University Hospitals NHS Foundation Trust	2110	9.94	2116	412	19.53	393.01	18.63	18.99	104.83	94.95	115.46
North West Anglia NHS Foundation Trust	1941	9.14	1941	280	14.43	343.41	17.69	-63.41	81.54	72.26	91.67
Basildon and Thurrock University Hospitals NHS Foundation Trust	1822	8.58	1823	292	16.03	329.02	18.06	-37.02	88.75	78.86	99.54
Cambridge University Hospitals NHS Foundation Trust	1650	7.77	1661	195	11.82	250.46	15.18	-55.46	77.86	67.31	89.58
West Suffolk NHS Foundation Trust	1637	7.71	1641	233	14.23	285.33	17.43	-52.33	81.66	71.51	92.84
Mid Essex Hospital Services NHS Trust	1512	7.12	1512	285	18.85	267.54	17.69	17.46	106.53	94.52	119.64
Colchester Hospital University NHS Foundation Trust	1435	6.76	1437	255	17.77	258.23	18.00	-3.23	98.75	87.00	111.64
West Hertfordshire Hospitals NHS Trust	1430	6.74	1439	287	20.07	262.17	18.33	24.83	109.47	97.17	122.90
The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust	1281	6.03	1284	171	13.35	227.81	17.78	-56.81	75.06	64.23	87.19
East and North Hertfordshire NHS Trust	1215	5.72	1233	243	20.00	206.50	17.00	36.50	117.68	103.34	133.44
Luton and Dunstable University Hospital NHS Foundation Trust	1158	5.45	1160	174	15.03	182.09	15.72	-8.09	95.56	81.88	110.86
Ipswich Hospital NHS Trust	915	4.31	915	133	14.54	154.72	16.91	-21.72	85.96	71.97	101.87
Bedford Hospital NHS Trust	893	4.21	897	161	18.03	155.37	17.40	5.63	103.62	88.23	120.92
The Princess Alexandra Hospital NHS Trust	814	3.83	814	175	21.50	136.25	16.74	38.75	128.44	110.11	148.94
Southend University Hospital NHS Foundation Trust	767	3.61	767	133	17.34	118.26	15.42	14.74	112.46	94.16	133.28
James Paget University Hospitals NHS Foundation Trust	650	3.06	650	116	17.85	104.44	16.07	11.56	111.06	91.77	133.21

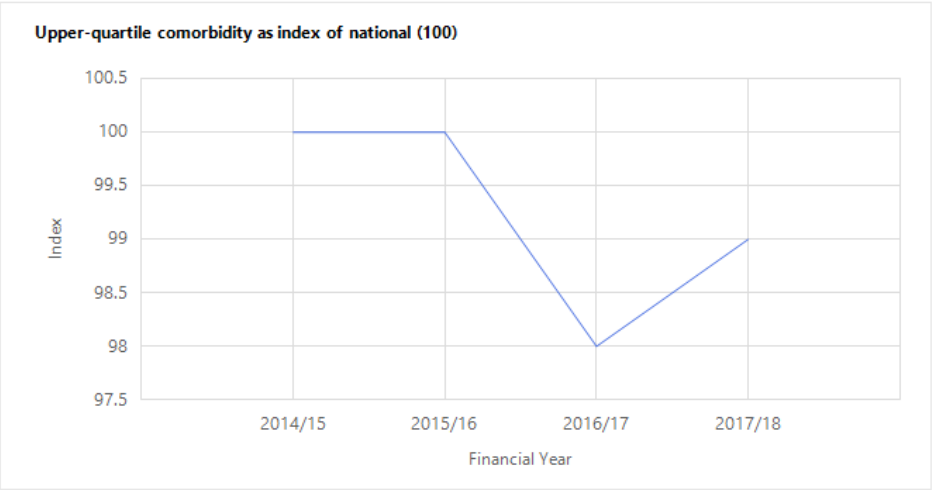
- High crude rate both regionally and nationally (6th highest)

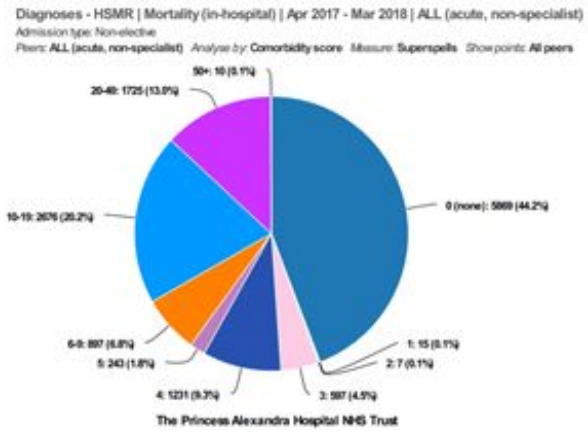
Palliative Care & Comorbidity coding

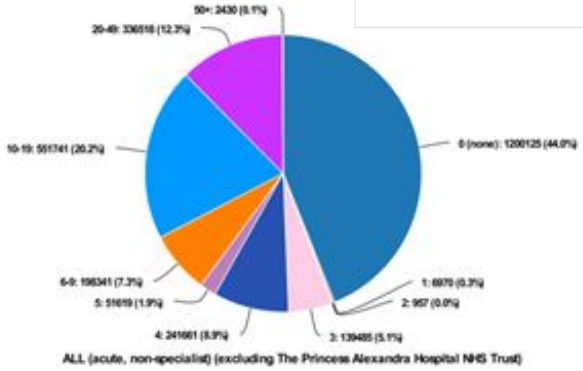
Trend (Financial Year)	Non-elective spells	Palliative care	Rate	National Rate	Peer Group Rate
2014/15	13,585	239	1.76%	3.57%	3.63%
2015/16	13,176	269	2.04%	3.79%	3.63%
2016/17	12,277	340	2.77%	4.03%	3.97%
2017/18	13,320	440	3.30%	4.16%	4.20%



	2014/15	2015/16	2016/17	2017/18
Upper-quartile comorbidity	25.0%	24.9%	24.4%	24.7%
as index of national (100)	100	100	98	99







HEALTH | dr foster®

THANK YOU

HEALTH | dr foster®

MORTALITY SUMMARY REPORT

THE PRINCESS ALEXANDRA HOSPITAL NHS TRUST

TRUST LEVEL – SEPTEMBER 2018

Report Date	4th September 2018
Healthcare Intelligence Specialist	Marianne Tankard
Area	East of England
Contact details	07738 028 185
Data Period	June 2017 to May 2018 (1 month lag applied = May17 to Apr18)

HEALTH | dr foster

TABLE OF CONTENTS

EXECUTIVE SUMMARY

Data Period: June 2017 to May 2018 (1 month lag applied, data = May 17 to Apr 18)

Metric	Result
HSMR	**116.7** 'higher than expected' range
HSMR position vs. peers	PAH is 1 of 6 Trusts within the peer group of 16 that sit within the 'higher expected' range. Crude rate within HSMR basket = 4.6% (Peer group rate = 3.6%)
HSMR outlying groups	There are 4 outlying groups attracting significantly higher than expected deaths (2 new groups this month): • Septicaemia (except in labour) – continues to alert • Chronic obstructive pulmonary disease and bronchiectasis – continues to alert • Intestinal obstruction without hernia– NEW ALERT THIS MONTH • Aspiration pneumonitis, food/vomitus – NEW AERT THIS MONTH
Coding analysis	• The Trust has a palliative care coding rate of 4.03% vs. national rate of 3.87% (NB: for 18/19 = only 2 months data so far) • The Trust codes 24.7% of spells within the upper quartile Charlson co-morbidity vs. 25% nationally
SMR by service	SMR split by service: • General Surgery = 111.9 'as expected' • General Medicine = 119.7 'higher than expected' • Geriatric Medicine = 119.8 'higher than expected' • Respiratory Medicine = 116.4 'higher than expected' • Gastroenterology = 107.4 'as expected' • Cardiology = 105.1 'as expected'
All Diagnosis SMR	All Diagnosis SMR is **116.3** 'higher than expected' range There are 8 outlying groups attracting significantly higher than expected deaths (3 new groups this month): • Joint disorders and dislocations, trauma-related – NEW ALERT THIS MONTH • Intestinal obstruction without hernia– NEW ALERT THIS MONTH • Aspiration pneumonitis, food/vomitus – NEW AERT THIS MONTH

New CUSUM alerts this month	There is 1 new CUSUM alerts this month: • Aspiration pneumonitis, food/vomitus – triggered May 18
SHMI (Jan 17 to Dec 17)	SHMI = 112.13 'as expected' (band 2) • 4 outlying groups

REPORT OUTLINE

Background

The report provides an overview of mortality using the Hospital Standardised Mortality Ratio, the Standardised Mortality Ratio, Summary-level Hospital Mortality Index and Crude rates. The report presents intelligence with potential recommendations for further investigation. This report should be used as an adjunct to supplement other pieces of work completed within the Trust and not used in isolation.

Methods

Using routinely collected hospital administrative data derived from Hospital Episode Statistics (HES) and analysing in the Quality Investigator tool, this report examines in-hospital mortality, for all inpatient admissions for the 12 month time period June 2017 to May 2018 (1 month lag).

HOSPITAL STANDARDISED MORTALITY RATIOS (HSMR) ANALYSIS

Key Highlights:

- HSMR = **116.7** 'higher than expected' range
- Crude rate within HSMR basket = 4.6% (Peer group rate = 3.6%)
- There are 4 outlying groups attracting significantly higher than expected deaths (2 new groups this month):
  - Septicaemia (except in labour) – continues to alert
  - Chronic obstructive pulmonary disease and bronchiectasis – continues to alert
  - Intestinal obstruction without hernia– NEW ALERT THIS MONTH
  - Aspiration pneumonitis, food/vomitus – NEW AERT THIS MONTH

Figure 1 – HSMR Monthly Trend

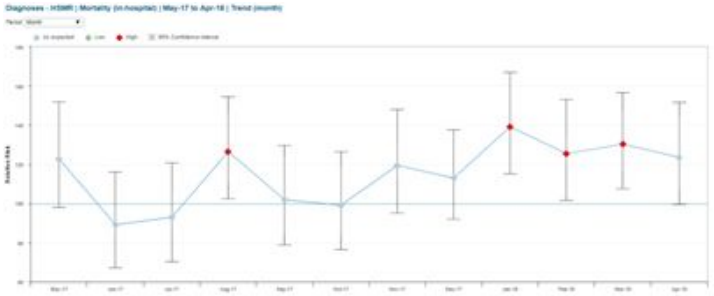
HSMR = **116.7** 'higher than expected' range.

Diagnoses - HSMR | Mortality (in-hospital) | May-17 to Apr-18 | Trend (month)

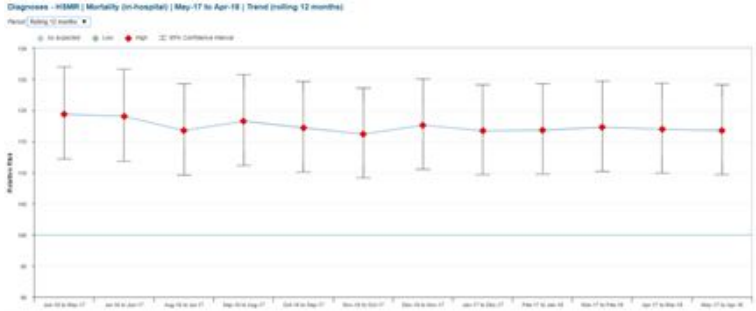
Period: Month

Trend (month)	Superspells	% of All	Spells	Observed	%	Expected	%	O-E	RR	LO	HI
All	22,382	100.0%	22,430	1,022	4.6%	875.5	3.9%	146.5	116.7	109.7	124.1
May-17	1,960	8.8%	1,961	85	4.3%	69.3	3.5%	15.7	122.7	98.0	151.8
Jun-17	1,875	8.4%	1,879	55	2.9%	61.7	3.3%	-6.7	89.2	67.2	116.0
Jul-17	1,825	8.2%	1,834	56	3.1%	60.2	3.3%	-4.2	93.0	70.3	120.8
Aug-17	1,942	8.7%	1,944	96	4.9%	75.9	3.9%	20.1	126.5	102.4	154.4
Sep-17	1,795	8.0%	1,801	66	3.7%	64.7	3.6%	1.3	101.9	78.8	129.7
Oct-17	1,744	7.8%	1,749	65	3.7%	65.6	3.8%	-0.6	99.1	76.5	126.3
Nov-17	1,812	8.1%	1,813	83	4.6%	69.5	3.8%	13.5	119.4	95.1	148.0
Dec-17	1,934	8.6%	1,940	99	5.1%	87.6	4.5%	11.4	113.1	91.9	137.7
Jan-18	1,951	8.7%	1,955	116	5.9%	83.4	4.3%	32.6	139.1	115.0	166.9
Feb-18	1,743	7.8%	1,748	96	5.5%	76.5	4.4%	19.5	125.4	101.6	153.2
Mar-18	1,951	8.7%	1,954	114	5.8%	87.5	4.5%	26.5	130.3	107.5	156.6
Apr-18	1,850	8.3%	1,852	91	4.9%	73.6	4.0%	17.4	123.6	99.5	151.7

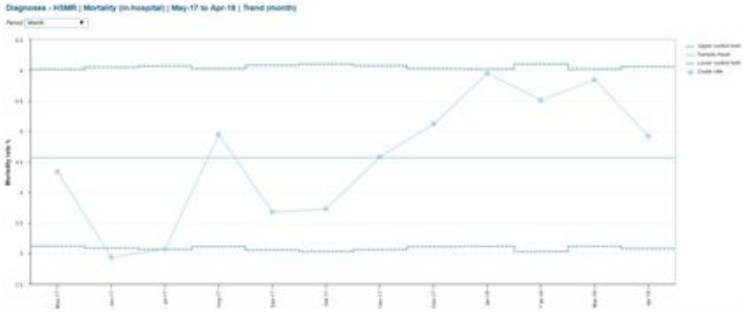
HSMR Trend (month)



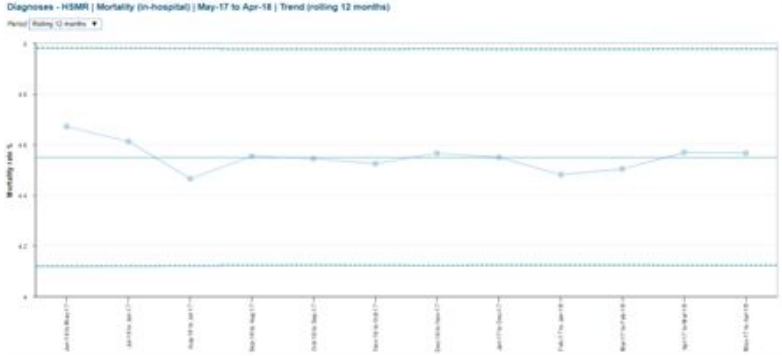
HSMR Trend (rolling 12 months)



Crude rate Trend (month) - HSMR Basket



Crude rate Trend (rolling 12 months) - HSMR Basket



HEALTH | dr foster®

Figure 2 – HSMR 12 Month's Peer Comparison

The Trust is 1 of 6 Trusts (within the peer group of 16) with an HSMR within the 'higher expected' range. The crude rate is 4.60% (vs 3.6% for the peer group).

Diagnoses - HSMR | Mortality (in-hospital) | May-17 to Apr-18 | REGION (acute, non-specialist)

Peers: REGION (acute, non-spe ▼ Measure: Relative risk ▼ Show: All ▼

REGION (acute, non-specialist)	Code	Superspells	% of All	Spells	Observed	%	Expected	%	O-E	RR	LO	HI
All		567,118	100.0%	571,809	20,686	3.6%	20329.0	3.6%	357.0	101.8	100.4	103.2
James Paget University Hospitals NHS Foundation Trust	RGP	20,422	3.6%	20,513	1,114	5.5%	894.2	4.4%	219.8	124.6	117.4	132.1
The Princess Alexandra Hospital NHS Trust	RQW	22,382	3.9%	22,430	1,022	4.6%	875.5	3.9%	146.5	116.7	109.7	124.1
Mid Essex Hospital Services NHS Trust	RQ8	30,500	5.4%	30,652	1,240	4.1%	1072.9	3.5%	167.1	115.6	109.2	122.2
Colchester Hospital University NHS Foundation Trust	RDE	36,268	6.4%	36,423	1,541	4.2%	1376.2	3.8%	164.8	112.0	106.5	117.7
Southend University Hospital NHS Foundation Trust	RAJ	41,210	7.3%	41,288	1,439	3.5%	1324.2	3.2%	114.8	108.7	103.1	114.4
Ipswich Hospital NHS Trust	RGQ	35,927	6.3%	36,050	1,204	3.4%	1132.7	3.2%	71.3	106.3	100.4	112.5
Bedford Hospital NHS Trust	RC1	18,744	3.3%	18,891	751	4.0%	703.4	3.8%	47.6	106.8	99.3	114.7
Luton and Dunstable University Hospital NHS Foundation Trust	RC9	32,736	5.8%	32,849	1,099	3.4%	1051.1	3.2%	47.9	104.6	98.5	110.9
The Queen Elizabeth Hospital, King's Lynn, NHS Foundation Trust	RCX	29,444	5.2%	29,574	1,042	3.5%	1000.0	3.4%	42.0	104.2	98.0	110.7
East and North Hertfordshire NHS Trust	RWH	45,745	8.1%	46,266	1,499	3.3%	1481.0	3.2%	18.0	101.2	96.2	106.5
West Hertfordshire Hospitals NHS Trust	RWG	30,064	5.3%	30,199	1,316	4.4%	1313.1	4.4%	2.9	100.2	94.9	105.8
Norfolk and Norwich University Hospitals NHS Foundation Trust	RM1	68,731	12.1%	69,499	2,262	3.3%	2344.3	3.4%	-82.3	96.5	92.5	100.5
Basildon and Thurrock University Hospitals NHS Foundation Trust	RDD	35,534	6.3%	36,583	1,416	4.0%	1455.1	4.1%	-39.1	97.3	92.3	102.5
North West Anglia NHS Foundation Trust	RGN	45,607	8.0%	45,856	1,584	3.5%	1753.7	3.8%	-169.7	90.3	85.9	94.9
Cambridge University Hospitals NHS Foundation Trust	RGT	52,972	9.3%	53,756	1,258	2.4%	1465.6	2.8%	-207.6	85.8	81.2	90.7
West Suffolk NHS Foundation Trust	RGR	20,812	3.7%	20,980	899	4.3%	1085.9	5.2%	-186.9	82.8	77.5	88.4

support@drfoster.com

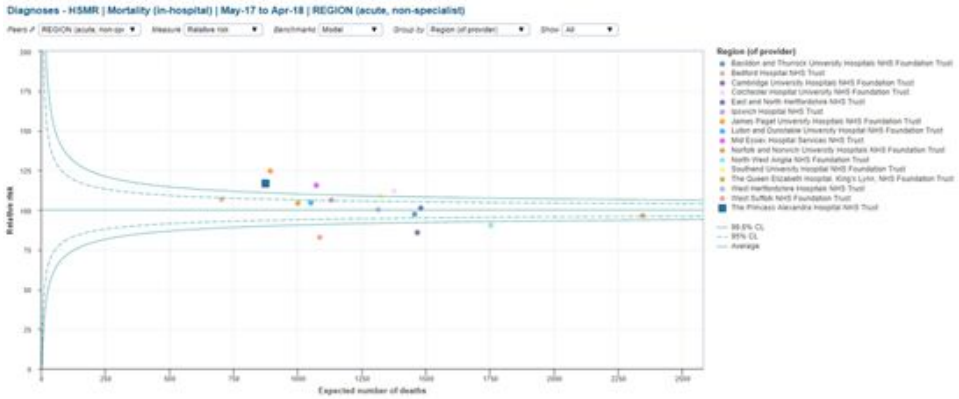


Figure 3 – HSMR by diagnosis group

There are 4 outlying groups - 2 new alerts this month:

- Septicaemia (except in labour) – continues to alert
- Chronic obstructive pulmonary disease and bronchiectasis – continues to alert
- Intestinal obstruction without hernia– NEW ALERT THIS MONTH
- Aspiration pneumonitis, food/vomitus – NEW AERT THIS MONTH

HEALTH | dr foster®

Diagnoses - HSMR | Mortality (in-hospital) | May-17 to Apr-18 | Diagnosis group

Analyse by: Diagnosis group | Measure: Relative risk | Show: All

Diagnosis group	Superspells	% of All	Spells	Observed	%	Expected	%	O-E	RR	LO	HI
All	22,382	100.0%	22,430	1,022	4.6%	875.5	3.9%	146.5	116.7	109.7	124.1
Septicemia (except in labour)	807	3.6%	811	179	22.2%	134.1	16.6%	44.9	133.5	114.7	154.5
Chronic obstructive pulmonary disease and bronchiectasis	639	2.9%	639	39	6.1%	26.8	4.2%	12.2	145.3	103.3	198.6
Intestinal obstruction without hernia	172	0.8%	172	20	11.6%	11.8	6.9%	8.2	169.1	103.3	261.2
Aspiration pneumonitis, food/vomitus	186	0.8%	193	78	41.9%	60.7	32.6%	17.3	128.5	101.5	160.3
Pneumonia	1,518	6.8%	1,526	234	15.4%	206.0	13.6%	28.0	113.6	99.5	129.1
Fracture of neck of femur (hip)	387	1.7%	387	34	8.8%	23.9	6.2%	10.1	142.3	98.5	198.9
Senility and organic mental disorders	109	0.5%	109	15	13.8%	8.5	7.8%	6.5	175.9	98.4	290.1
Fluid and electrolyte disorders	206	0.9%	209	13	6.3%	7.6	3.7%	5.4	171.0	91.0	292.4
Urinary tract infections	1,051	4.7%	1,054	33	3.1%	25.8	2.5%	7.2	127.9	88.0	179.6
Congestive heart failure, nonhypertensive	430	1.9%	430	55	12.8%	48.1	11.2%	6.9	114.5	86.2	149.0

Link to patient records: Intestinal obstruction without hernia:

https://one.drfoster.com/Query/?id=963013

Link to patient records: Aspiration pneumonitis, food/vomitus:

https://one.drfoster.com/Query/?id=963019

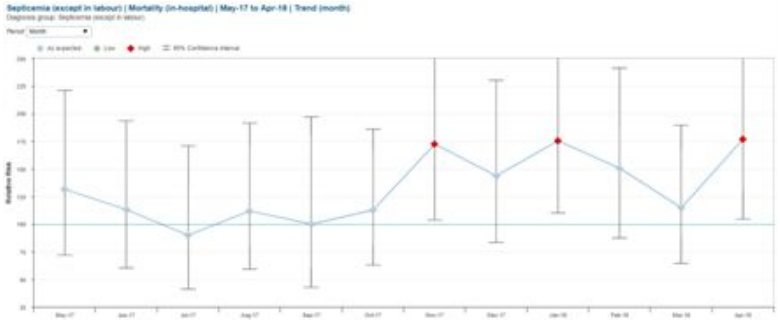
Figure 3.1 Tracking of outlying groups: **Septicaemia (except in labour)**

Septicemia (except in labour) | Mortality (in-hospital) | May-17 to Apr-18 | Trend (month)

Diagnosis group: Septicemia (except in labour)

Period: Month

Trend (month)	Superspells	% of All	Spells	Observed	%	Expected	%	O-E	RR	LO	HI
All	811	100.0%	811	180	22.2%	135.0	16.6%	45.0	133.4	114.6	154.4
May-17	71	8.8%	71	14	19.7%	10.6	15.0%	3.4	131.6	71.9	220.9
Jun-17	68	8.4%	68	13	19.1%	11.5	16.9%	1.5	113.1	60.2	193.4
Jul-17	71	8.8%	71	9	12.7%	10.0	14.1%	-1.0	90.0	41.1	170.9
Aug-17	71	8.8%	71	13	18.3%	11.6	16.4%	1.4	111.9	59.5	191.4
Sep-17	68	8.4%	68	8	11.8%	8.0	11.8%	0.0	100.0	43.1	197.1
Oct-17	68	8.4%	68	15	22.1%	13.3	19.6%	1.7	112.8	63.1	186.1
Nov-17	58	7.2%	58	19	32.8%	11.0	19.0%	8.0	172.4	103.8	269.3
Dec-17	69	8.5%	69	17	24.6%	11.8	17.1%	5.2	143.7	83.7	230.2
Jan-18	65	8.0%	65	22	33.8%	12.5	19.3%	9.5	175.4	109.9	265.6
Feb-18	67	8.3%	67	17	25.4%	11.3	16.8%	5.7	150.6	87.7	241.1
Mar-18	82	10.1%	82	15	18.3%	13.1	15.9%	1.9	114.9	64.2	189.4
Apr-18	53	6.5%	53	18	34.0%	10.2	19.2%	7.8	176.9	104.8	279.5



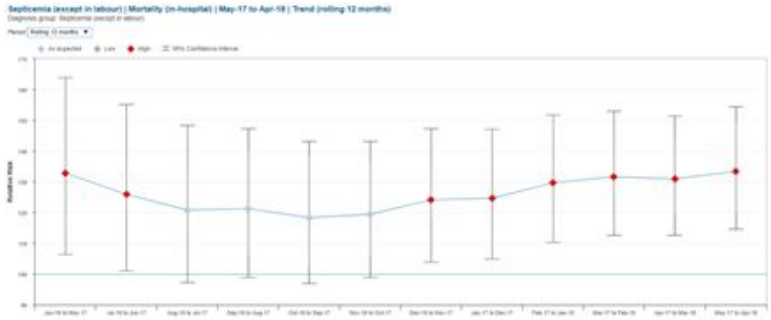


Figure 3.2 Tracking of outlying groups: **Chronic obstructive pulmonary disease and bronchiectasis:**

Chronic obstructive pulmonary disease and bronchiectasis | Mortality (in-hospital) | May-17 to Apr-18 | Trend (month)

Diagnosis group: Chronic obstructive pulmonary disease and bronchiectasis

Period: Month

Trend (month)	Superspells	% of All	Spells	Observed	%	Expected	%	O-E	RR	LO	HI
All	639	100.0%	639	39	6.1%	26.8	4.2%	12.2	145.3	103.3	198.6
May-17	53	8.3%	53	3	5.7%	2.1	4.0%	0.9	141.9	28.5	414.6
Jun-17	51	8.0%	51	1	2.0%	2.1	4.2%	-1.1	46.8	0.6	260.5
Jul-17	48	7.5%	48	1	2.1%	1.9	4.0%	-0.9	52.3	0.7	291.1
Aug-17	50	7.8%	50	3	6.0%	1.6	3.2%	1.4	189.7	38.1	554.1
Sep-17	41	6.4%	41	0	0.0%	1.3	3.1%	-1.3	0.0	0.0	287.7
Oct-17	45	7.0%	45	4	8.9%	2.6	5.7%	1.4	156.2	42.0	400.0
Nov-17	33	5.2%	33	2	6.1%	1.2	3.6%	0.8	170.2	19.1	614.4
Dec-17	76	11.9%	76	6	7.9%	3.6	4.8%	2.4	165.2	60.3	359.6
Jan-18	72	11.3%	72	8	11.1%	3.1	4.3%	4.9	260.9	112.3	514.0
Feb-18	57	8.9%	57	4	7.0%	2.4	4.2%	1.6	167.4	45.0	428.6
Mar-18	52	8.1%	52	5	9.6%	2.3	4.4%	2.7	218.7	70.5	510.3
Apr-18	61	9.5%	61	2	3.3%	2.7	4.4%	-0.7	73.7	8.3	266.3

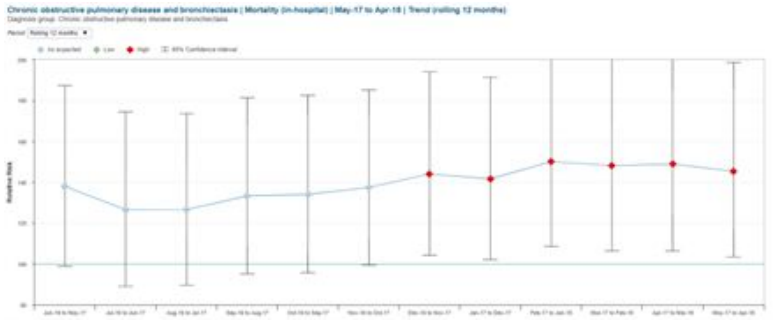


Figure 3.3 Tracking of outlying groups: **Intestinal obstruction without hernia**

Intestinal obstruction without hernia | Mortality (in-hospital) | May-17 to Apr-18 | Trend (month)

Diagnosis group: Intestinal obstruction without hernia

Period: Month

Trend (month)	Superspells	% of All	Spells	Observed	%	Expected	%	O-E	RR	LO	HI
All	172	100.0%	172	20	11.6%	11.8	6.9%	8.2	169.1	103.3	261.2
May-17	25	14.5%	25	1	4.0%	1.1	4.4%	-0.1	91.0	1.2	506.5
Jun-17	11	6.4%	11	0	0.0%	0.5	4.9%	-0.5	0.0	0.0	676.0
Jul-17	17	9.9%	17	4	23.5%	1.2	6.9%	2.8	341.6	91.9	874.6
Aug-17	14	8.1%	14	2	14.3%	1.6	11.3%	0.4	125.9	14.1	454.6
Sep-17	9	5.2%	9	0	0.0%	0.5	6.0%	-0.5	0.0	0.0	674.2
Oct-17	6	3.5%	6	1	16.7%	0.6	9.5%	0.4	174.9	2.3	973.2
Nov-17	15	8.7%	15	1	6.7%	0.9	6.2%	0.1	107.0	1.4	595.4
Dec-17	20	11.6%	20	5	25.0%	1.3	6.7%	3.7	373.6	120.4	871.7
Jan-18	9	5.2%	9	1	11.1%	0.6	6.7%	0.4	165.2	2.2	919.1
Feb-18	13	7.6%	13	1	7.7%	1.0	7.6%	0.0	101.6	1.3	565.2
Mar-18	20	11.6%	20	3	15.0%	1.0	5.2%	2.0	288.1	57.9	841.7
Apr-18	13	7.6%	13	1	7.7%	1.4	10.8%	-0.4	71.1	0.9	395.8

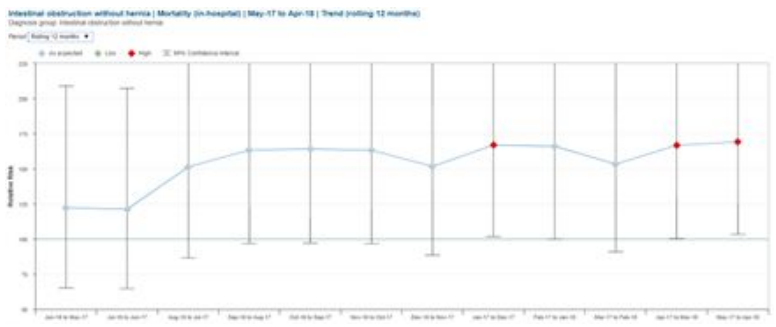


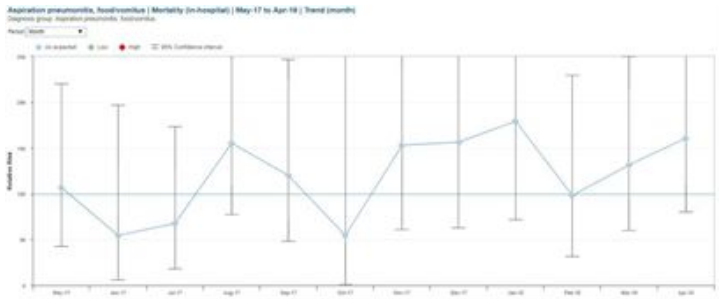
Figure 3.4 Tracking of outlying groups: **Aspiration pneumonitis, food/vomitus**

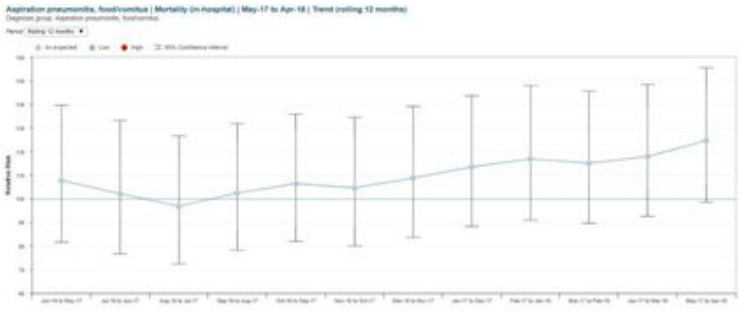
Aspiration pneumonitis, food/vomitus | Mortality (in-hospital) | May-17 to Apr-18 | Trend (month)

Diagnosis group: Aspiration pneumonitis, food/vomitus

Period: Month

Trend (month)	Superspells	% of All	Spells	Observed	%	Expected	%	O-E	RR	LO	HI
All	191	100.0%	193	78	40.8%	62.6	32.8%	15.4	124.6	98.5	155.5
May-17	22	11.5%	22	7	31.8%	6.6	29.8%	0.4	106.8	42.8	220.0
Jun-17	11	5.8%	11	2	18.2%	3.7	33.3%	-1.7	54.5	6.1	196.8
Jul-17	17	8.9%	17	4	23.5%	5.9	34.7%	-1.9	67.7	18.2	173.4
Aug-17	25	13.1%	25	11	44.0%	7.1	28.3%	3.9	155.3	77.4	277.9
Sep-17	17	8.9%	17	7	41.2%	5.8	34.3%	1.2	119.9	48.0	247.1
Oct-17	6	3.1%	7	1	16.7%	1.8	30.6%	-0.8	54.5	0.7	303.4
Nov-17	12	6.3%	12	7	58.3%	4.6	38.1%	2.4	153.0	61.3	315.2
Dec-17	15	7.9%	16	7	46.7%	4.5	29.8%	2.5	156.5	62.7	322.4
Jan-18	13	6.8%	13	7	53.8%	3.9	30.0%	3.1	179.3	71.8	369.5
Feb-18	15	7.9%	15	5	33.3%	5.1	33.9%	-0.1	98.3	31.7	229.4
Mar-18	19	9.9%	19	9	47.4%	6.8	36.0%	2.2	131.6	60.1	249.9
Apr-18	19	9.9%	19	11	57.9%	6.8	36.0%	4.2	160.7	80.1	287.6





HSMR trend April 14 to March 18

Fig 4: HSMR – quarterly trend

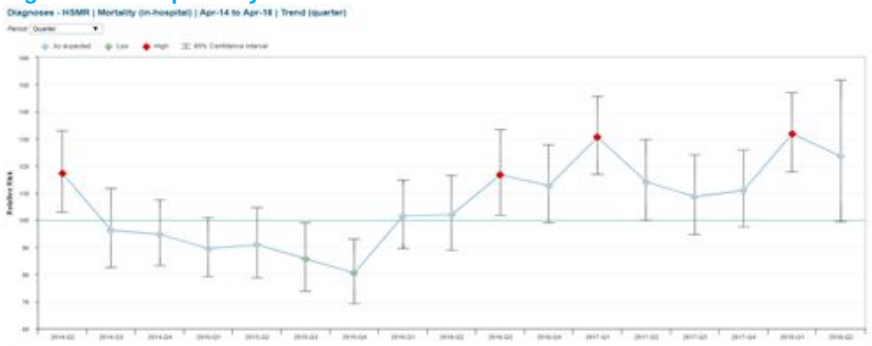


Fig 5: HSMR – Rolling 12 month trend

TRENDS IN CODING

Key Highlights:

- The Trust has a palliative care coding rate of 4.03% vs. national rate of 3.87% (NB: for 18/19 = only 2 months data so far)
- The Trust codes 24.7% of spells within the upper quartile Charlson co-morbidity vs. 25% nationally

Figure 6 – Palliative Care Coding Rate Vs National (HSMR Basket)

Palliative Care Profile

Organisation: **The Princess Alexandra Hospital NHS Trust** *Report Date:* **14 August 2018**

Basket: **Diagnoses - HSMR** *Peer group:* **REGION (acute)**

Trend (Financial Year)	Non-elective spells	Palliative care	Rate	National Rate	Peer Group Rate
2014/15	13,585	239	1.76%	3.57%	3.63%
2015/16	13,176	269	2.04%	3.79%	3.63%
2016/17	12,277	340	2.77%	4.03%	3.97%
2017/18	13,320	440	3.30%	4.17%	4.21%
2018/19	1,339	54	4.03%	3.87%	4.06%

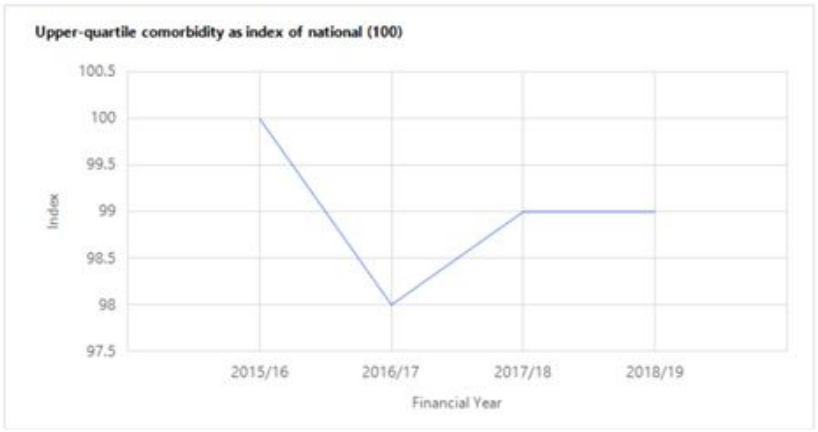
Figure 7 – Charlson Index Co-morbidity Coding Rates Vs National

Comorbidity Profile

Organisation: **The Princess Alexandra Hospital NHS Trust**

Report Date: **14 August 2018**

	2015/16	2016/17	2017/18	2018/19
Upper-quartile comorbidity	24.9%	24.4%	24.7%	24.7%
as index of national (100)	100	98	99	99

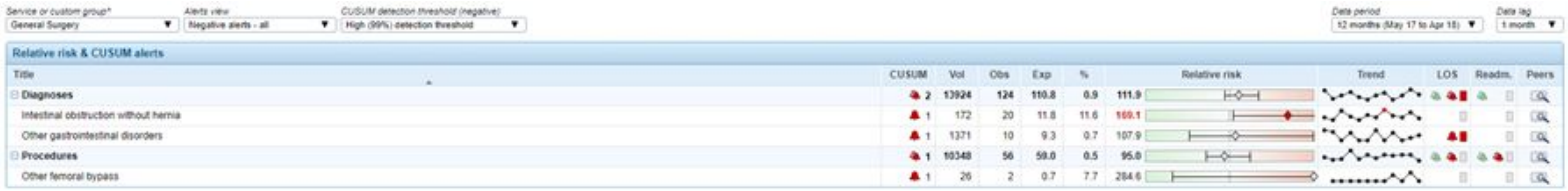


SMR BY SERVICE

SMR split by service:

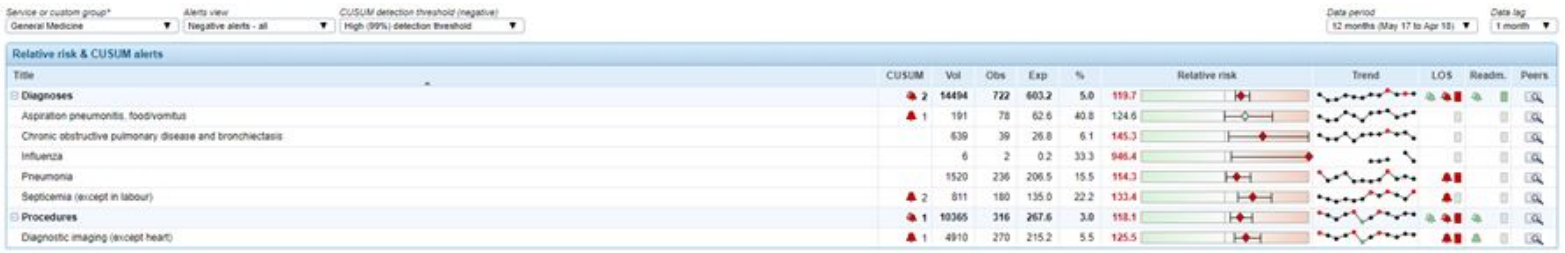
- General Surgery = 111.9 'as expected'
- General Medicine = 119.7 'higher than expected'
- Geriatric Medicine = 119.8 'higher than expected'
- Respiratory Medicine = 116.4 'higher than expected'
- Gastroenterology = 107.4 'as expected'
- Cardiology = 105.1 'as expected'

General Surgery



Title	CUSUM	Vol	Obs	Exp	%	Relative risk	Trend	LOS	Readm.	Peers
Diagnoses	2	13924	124	110.8	0.9	111.9				
Intestinal obstruction without hernia	1	172	20	11.8	11.6	169.1				
Other gastrointestinal disorders	1	1371	10	9.3	0.7	107.9				
Procedures	1	10348	56	59.0	0.5	95.0				
Other femoral bypass	1	26	2	0.7	7.7	284.6				

General Medicine



Title	CUSUM	Vol	Obs	Exp	%	Relative risk	Trend	LOS	Readm.	Peers
Diagnoses	2	14494	722	603.2	5.0	119.7				
Aspiration pneumonitis, food/vomitus	1	191	78	62.6	40.8	124.6				
Chronic obstructive pulmonary disease and bronchiectasis		639	39	26.8	6.1	145.3				
Influenza		6	2	0.2	33.3	946.4				
Pneumonia		1520	236	206.5	15.5	114.3				
Septicemia (except in labour)	2	811	180	135.0	22.2	133.4				
Procedures	1	10365	316	267.6	3.0	118.1				
Diagnostic imaging (except heart)	1	4910	270	215.2	5.5	125.5				

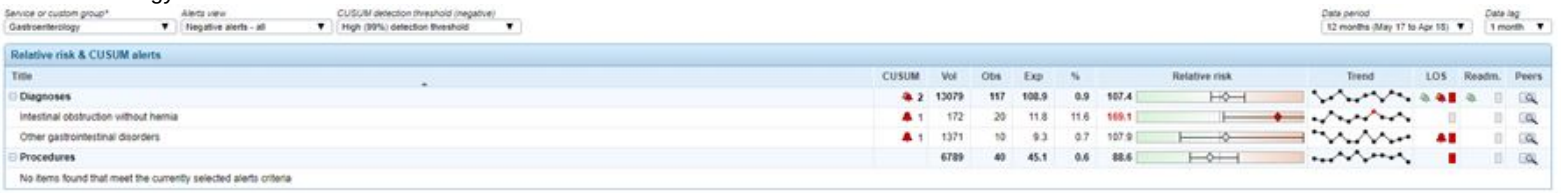
Geriatric Medicine

Title	CUSUM	Vol	Obs	Exp	%	Relative risk	Trend	LOS	Readm.	Peers
Diagnoses	2	2589	407	339.8	15.8	119.8				
Aspiration pneumonitis, food/vomitus	1	191	78	62.6	40.8	124.6				
Fracture of neck of femur (hip)	1	387	34	23.9	8.8	142.3				
Pneumonia		1520	236	206.5	15.5	114.3				
Procedures		1	0	0.0	0.0	0.0				
No items found that meet the currently selected alerts criteria										

Respiratory Medicine

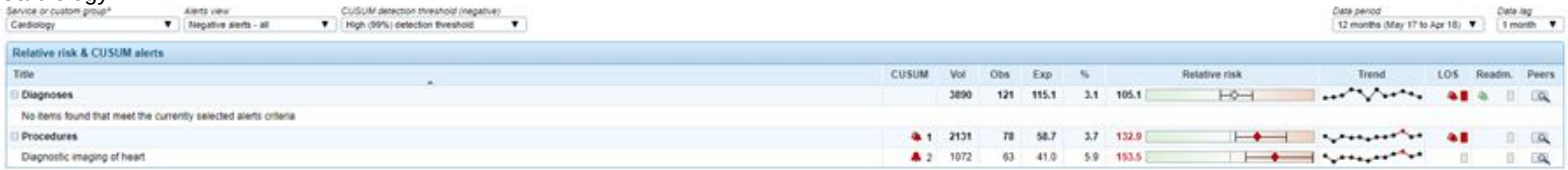
Title	CUSUM	Vol	Obs	Exp	%	Relative risk	Trend	LOS	Readm.	Peers
Diagnoses	1	3970	402	345.3	10.1	116.4				
Aspiration pneumonitis, food/vomitus	1	191	78	62.6	40.8	124.6				
Chronic obstructive pulmonary disease and bronchiectasis		639	39	26.8	6.1	145.3				
Influenza		6	2	0.2	33.3	966.4				
Pneumonia		1520	236	206.5	15.5	114.3				
Procedures		1017	80	106.2	7.9	75.3				
No items found that meet the currently selected alerts criteria										

Gastroenterology



Title	CUSUM	Vol	Obs	Exp	%	Relative risk	Trend	LOS	Readm.	Peers
Diagnoses	2	13079	117	108.9	0.9	107.4				
Intestinal obstruction without hernia	1	172	20	11.8	11.6	169.1				
Other gastrointestinal disorders	1	1371	10	9.3	0.7	107.9				
Procedures		6789	40	45.1	0.6	88.6				
No items found that meet the currently selected alerts criteria										

Cardiology



Title	CUSUM	Vol	Obs	Exp	%	Relative risk	Trend	LOS	Readm.	Peers
Diagnoses		3890	121	115.1	3.1	105.1				
No items found that meet the currently selected alerts criteria										
Procedures	1	2131	78	58.7	3.7	132.9				
Diagnostic imaging of heart	2	1072	63	41.0	5.9	153.5				

STANDARDISED MORTALITY RATIOS (SMR) ANALYSIS

Key Highlights:

- SMR = **116.3** 'higher than expected' range
- There are 8 outlying groups attracting significantly higher than expected deaths (3 new groups this month):
  - Joint disorders and dislocations, trauma-related – NEW ALERT THIS MONTH
  - Intestinal obstruction without hernia– NEW ALERT THIS MONTH
  - Aspiration pneumonitis, food/vomitus – NEW AERT THIS MONTH

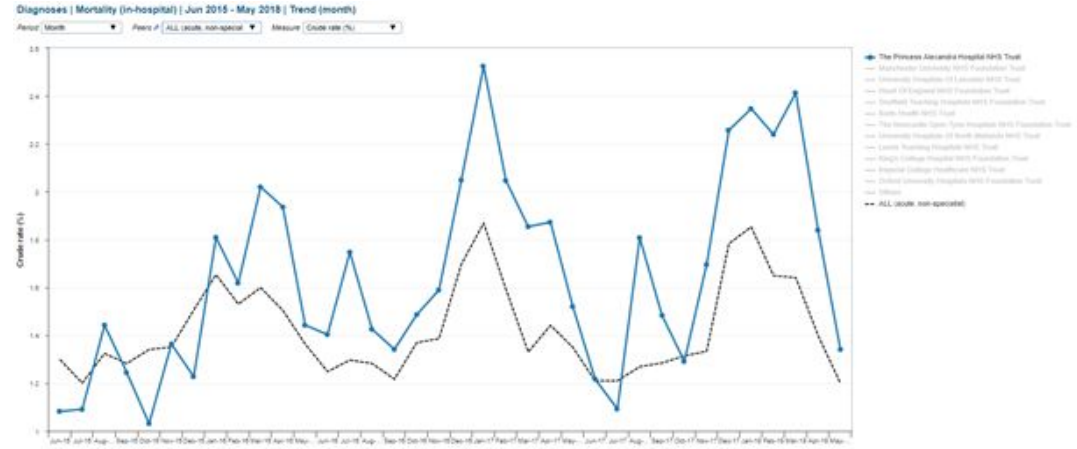
Figure 8 – SMR All Diagnosis trend month: All diagnosis SMR = 116.3 'higher than expected' range

Diagnoses | Mortality (in-hospital) | May-17 to Apr-18 | Trend (month)

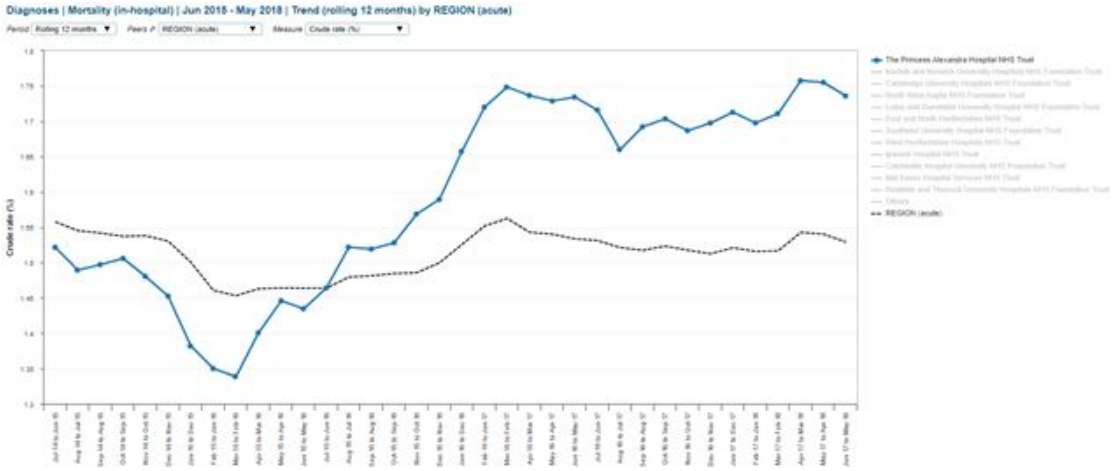
Period Month

Trend (month)	Superspells	% of All	Spells	Observed	%	Expected	%	O-E	RR	LO	HI
All	67,124	100.0%	67,240	1,178	1.8%	1012.9	1.5%	165.1	**116.3**	109.8	123.1
May-17	6,127	9.1%	6,134	95	1.6%	79.8	1.3%	15.2	119.0	96.3	145.5
Jun-17	5,837	8.7%	5,846	71	1.2%	70.9	1.2%	0.1	100.1	78.2	126.3
Jul-17	5,859	8.7%	5,877	64	1.1%	72.9	1.2%	-8.9	87.8	67.7	112.2
Aug-17	5,920	8.8%	5,932	107	1.8%	85.6	1.4%	21.4	**125.0**	102.4	151.1
Sep-17	5,528	8.2%	5,542	82	1.5%	76.6	1.4%	5.4	107.1	85.2	132.9
Oct-17	5,576	8.3%	5,588	72	1.3%	75.2	1.3%	-3.2	95.7	74.9	120.6
Nov-17	5,545	8.3%	5,551	94	1.7%	81.2	1.5%	12.8	115.8	93.6	141.7
Dec-17	5,228	7.8%	5,236	118	2.3%	99.7	1.9%	18.3	118.3	97.9	141.7
Jan-18	5,539	8.3%	5,548	130	2.3%	96.7	1.7%	33.3	**134.4**	112.3	159.6
Feb-18	4,867	7.3%	4,876	109	2.2%	85.4	1.8%	23.6	**127.6**	104.8	153.9
Mar-18	5,553	8.3%	5,560	134	2.4%	101.0	1.8%	33.0	**132.7**	111.2	157.1
Apr-18	5,545	8.3%	5,550	102	1.8%	87.9	1.6%	14.1	116.0	94.6	140.8

Figure 9 – All diagnosis SMR Crude rate trend vs. National Average (last 36 months)



Monthly trend



Rolling 12-month trend

Figure 10 – All diagnosis SMR diagnosis group

There are 8 outlying groups attracting significantly higher than expected deaths which it would be prudent to investigate further: 3 new alerts this month

- Joint disorders and dislocations, trauma-related – NEW ALERT THIS MONTH
- Cancer of head and neck – continues to alert
- Infective arthritis and osteomyelitis – continues to alert
- Septicaemia (except in labour) – continues to alert
- Influenza – continues to alert
- Chronic obstructive pulmonary disease and bronchiectasis – continues to alert
- Intestinal obstruction without hernia – NEW ALERT THIS MONTH
- Aspiration pneumonitis, food/vomitus – NEW ALERT THIS MONTH

Diagnoses | Mortality (in-hospital) | May-17 to Apr-18 | Diagnosis group

Analyse by Diagnosis group ▼ *Measure* Relative risk ▼ *Show* All ▼

Diagnosis group	Superspells	% of All	Spells	Observed	%	Expected	%	O-E	RR	LO	HI
All	67,124	100.0%	67,240	1,178	1.8%	1012.9	1.5%	165.1	116.3	109.8	123.1
Joint disorders and dislocations, trauma-related	251	0.4%	251	3	1.2%	0.4	0.2%	2.6	794.2	159.6	2320.6
Cancer of head and neck	25	0.0%	25	3	12.0%	0.4	1.8%	2.6	682.5	137.2	1994.2
Infective arthritis and osteomyelitis	104	0.2%	106	10	9.6%	3.5	3.4%	6.5	282.8	135.4	520.0
Septicemia (except in labour)	807	1.2%	811	179	22.2%	134.1	16.6%	44.9	133.5	114.7	154.5
Influenza	6	0.0%	6	2	33.3%	0.2	3.5%	1.8	946.4	106.3	3416.8
Chronic obstructive pulmonary disease and bronchiectasis	639	1.0%	639	39	6.1%	26.8	4.2%	12.2	145.3	103.3	198.6
Intestinal obstruction without hernia	172	0.3%	172	20	11.6%	11.8	6.9%	8.2	169.1	103.3	261.2
Aspiration pneumonitis, food/vomitus	185	0.3%	193	78	42.2%	60.3	32.6%	17.7	129.4	102.3	161.4
Pneumonia	1,514	2.3%	1,526	234	15.5%	205.2	13.6%	28.8	114.0	99.9	129.6
Fracture of neck of femur (hip)	387	0.6%	387	34	8.8%	23.9	6.2%	10.1	142.3	98.5	198.9

Link to patient records (joint disorders and dislocations, trauma related):

https://one.drfoster.com/Query/?id=963170

CUSUM ALERTS

Key Highlights:

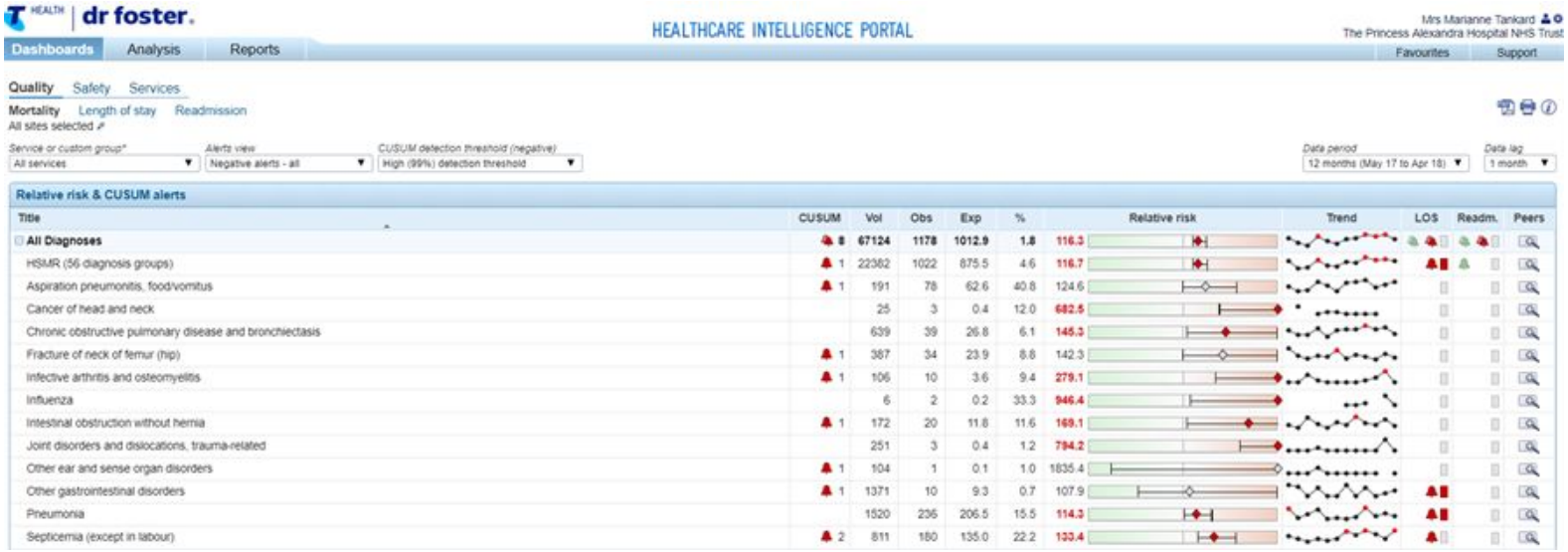
1 new CUSUM diagnosis group alerts this month – Aspiration pneumonitis, food/vomit – alert triggered May 18

(6 additional CUSUM diagnosis group alerts in last 12 months)

- Infective arthritis and osteomyelitis – alert triggered Mar 18
- Intestinal obstruction without hernia – alert triggered Mar 18
- Fracture of neck of femur (hip) – alert triggered Jul 17
- Other ear and sense organ disorders – alert triggered Aug 17
- Other gastrointestinal disorders – alert triggered Jul 17
- Septicaemia (except in labour) – triggered x 2 Jan 18, Feb 18

Figure 11 – Relative Risk and CUSUM Alerts

HEALTH | dr foster®



Title	CUSUM	Vol	Obs	Exp	%	Relative risk	Trend	LOS	Readm.	Peers
All Diagnoses	8	**67124**	**1178**	**1012.9**	**1.8**	116.3				
HSMR (56 diagnosis groups)	1	22362	1022	875.5	4.6	116.7				
Aspiration pneumonitis, food/vomitus	1	191	78	62.6	40.8	124.6				
Cancer of head and neck		25	3	0.4	12.0	682.5				
Chronic obstructive pulmonary disease and bronchiectasis		639	39	26.8	6.1	145.3				
Fracture of neck of femur (hip)	1	387	34	23.9	8.8	142.3				
Infective arthritis and osteomyelitis	1	106	10	3.6	9.4	279.1				
Influenza		6	2	0.2	33.3	946.4				
Intestinal obstruction without hernia	1	172	20	11.8	11.6	169.1				
Joint disorders and dislocations, trauma-related		251	3	0.4	1.2	794.2				
Other ear and sense organ disorders	1	104	1	0.1	1.0	1835.4				
Other gastrointestinal disorders	1	1371	10	9.3	0.7	107.9				
Pneumonia		1520	236	206.5	15.5	114.3				
Septicemia (except in labour)	2	811	180	135.0	22.2	133.4				

CUSUM DETAIL

Fig 11.1: Aspiration pneumonitits, food/vomit – alert triggered May 18

link to patient records: https://one.drfoster.com/Query/?id=963180

SHMI (DATA PERIOD: (JAN 17 TO DEC 17)

Key Highlights:

- SHMI = 112.13 'as expected' (band 2)
- 4 outlying groups
  - Fracture of neck of femur (hip)
  - Pneumonia
  - Septicaemia (except in labour)
  - Chronic obstructive pulmonary disease and bronchiectasis

Figure 12 – SHMI value and position vs. peers

SHMI - Published (With Over Dispersion): (Jan 17 - Dec 17)

	Provider	Denominator	Obs	Exp	Obs-Exp	SHMI	Low	High
RDD	Basildon And Thurrock University Hospitals NHS Foundation Tr	64,972	2,269	2,096	173	108.26	89.19	112.12
RGT	Cambridge University Hospitals NHS Foundation Trust	75,065	2,338	2,703	-365	86.51	89.35	111.91
RDE	Colchester Hospital University NHS Foundation Trust	54,957	2,473	2,164	309	114.27	89.22	112.09
RGQ	Ipswich Hospital NHS Trust	51,980	2,037	1,940	97	105.01	89.14	112.19
RGP	James Paget University Hospitals NHS Foundation Trust	31,136	1,636	1,390	246	117.68	88.84	112.57
RQ8	Mid Essex Hospital Services NHS Trust	57,674	2,013	1,847	166	108.99	89.10	112.24
RM1	Norfolk And Norwich University Hospitals NHS Foundation Trust	87,814	3,520	3,306	214	106.47	89.46	111.78
RGN	North West Anglia NHS Foundation Trust	77,356	2,806	2,602	204	107.85	89.33	111.94
RAJ	Southend University Hospital NHS Foundation Trust	55,404	2,382	2,136	246	111.52	89.21	112.10
RQW	The Princess Alexandra Hospital NHS Trust	47,352	1,600	1,427	173	112.13	88.86	112.53
RCX	The Queen Elizabeth Hospital, King'S Lynn, NHS Foundation Tr	47,672	1,769	1,801	-32	98.22	89.08	112.26
RGR	West Suffolk NHS Foundation Trust	36,926	1,476	1,667	-191	88.53	89.01	112.35

Figure 13 – SHMI trend

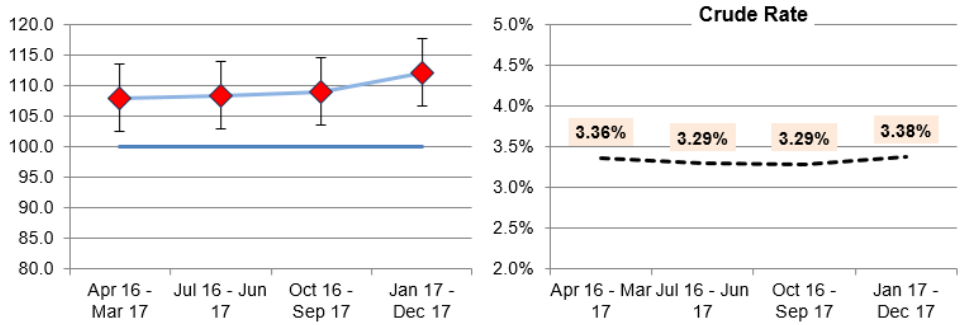


Figure 14 – SHMI outlying groups

SHMI Group - With 95% CI: (Jan 17 - Dec 17)

SHMI Group #	Obs	Exp	SHMI	Low	High
(120) Fracture of neck of femur (hip)	46	31	147.63	108.07	196.92
(73) Pneumonia	352	300	117.24	105.31	130.15
(75) Chronic obstructive pulmonary disease and bronchiectasis	61	45	135.20	103.41	173.68
(2) Septicemia (except in labour), Shock	176	148	118.77	101.87	137.67

REFERENCES

SMR

A calculation used to monitor death rates. The standardised mortality ratio is the ratio of observed deaths to expected deaths, where expected deaths are calculated for a typical area with the same case-mix adjustment. The SMR may be quoted as either a ratio or a percentage. If the SMR is quoted as a percentage and is equal to 100, then this means the number of observed deaths equals that of expected. If higher than 100, then there is a higher reported mortality ratio.

HSMR

The Hospital Standardised Mortality Ratio is the ratio of observed deaths to expected deaths for a basket of 56 diagnosis groups, which represent approximately 80% of in hospital deaths. It is a subset of all and represents about 35% of admitted patient activity. Further information can be found at http://www.drfoster.com/about-us/our-approach/metrics-methodologies-and-models-library/

Benchmark

The benchmark used in this analysis is the monthly benchmark available within the Quality Investigator tool.

CUSUM

A cumulative sum statistical process control chart plots patients' actual outcomes against their expected outcomes sequentially over time. The chart has upper and lower thresholds and breaching this threshold triggers an alert. If patients repeatedly have negative or unexpected outcomes, the chart will continue to rise until an alert is triggered. The line is then reset to half the starting position and plotting of patients continues.

HSMR Comparison

In order to give an indication of how performance for the current incomplete year compares to the national average we show a rebased HSMR for the current year. This is estimated for each of the 56 diagnoses by dividing the trust's SMR (using the existing benchmark) by the national SMR and multiplying by 100. The 56 rebased SMRs are then aggregated to produce the estimated rebased HSMR.

Charlson Index of Comorbidities

The original Charlson weights were derived 25 years ago in the USA. We have updated them (e.g. HIV had the highest weight then but its mortality has fallen greatly since) and calibrated them on English data due to differences in coding practice and hospital patient population characteristics. We had advice from some clinical coders on current English coding practice and, where possible, also assessed the consistency of comorbidity recording among admissions for the same patient.

Charlson Upper-Quartile Rate

For each financial year we calculate the proportion of a trust's HSMR spells where the Charlson index for the diagnosis-dominant episode is in the national upper quartile for that diagnosis and admission type, this is the observed value. The expected value is the equivalent proportion nationally i.e. 25%. The trust's index value is calculated as the observed/expected x 100.

Palliative Care Coding Rate

For each financial year we calculate the proportion of a trust's HSMR superspells excluding day cases which are coded as having palliative care, this is the observed value shown. The expected value is the proportion nationally for the equivalent mix of diagnosis and admission type. The trust's index value is calculated as observed/expected x 100

The Princess Alexandra Hospital NHS
NHS Trust

TRUST BOARD 4 October 2018

5.2

Agenda Item:	5.2
Presented by:	Sharon McNally Executive Director of Nursing and midwifery
Prepared by:	Sharon Cullen Deputy Chief Nurse
Date prepared:	27 September 2018
Subject / Title:	Report on Nursing, Midwifery and care staff levels

Purpose:	Approval		Decision		Information	✓	Assurance	✓

Executive Summary:	This is a summary report of the Trust's position in relation to nursing, midwifery and care staff data; in summary, the Trust has successfully uploaded the required data submission without exception. Fill rates across the peak summer months of July and August were affected by reduced temporary staff availability and higher annual leave profiling. The Trust is on track to achieve a zero vacancy ambition for HCSW by December 2018. The percentage RN vacancy has risen in light of additional funded posts; the report describes plans to introduce new roles in the bands 1-4 category which will lead to adjustments in the number of RN posts. There was a significant drop in the number of reported falls in August.
Recommendation:	The Trust Board is asked to receive the summary of information related to national submission of nursing, midwifery and care staff data and progress against vacancy, recruitment and retention plans.

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:	The detailed monthly report of Nursing, Midwifery and Care staff levels (hard Truths) was presented to the Quality and Safety Committee on 28 September 2018. And the Workforce committee received a report on nursing, midwifery, AHP and care staff recruitment and retention on 24 September 2018. This report to Trust Board is a summary of the 2 reports.
Risk / links with the BAF:	
Legislation, regulatory, equality, diversity and dignity implications:	This report to the Trust Board meets the national recommendations from the National Quality Board (July 2016).
Appendices:	**Appendix A: Patient safety incidents**

The Princess Alexandra Hospital NHS
NHS Trust

TRUST BOARD 04 October 2018
NURSING, MIDWIFERY AND CARE STAFF LEVELS

1.0 PURPOSE

1.1 To provide Trust Board with oversight of safer staffing and CHPPD national data submission.

2.0 BACKGROUND

2.1 This summary report is provided to the Trust Board in line with the National Quality Board (NQB) recommendations (updated in July 2016).

3.0 ANALYSIS

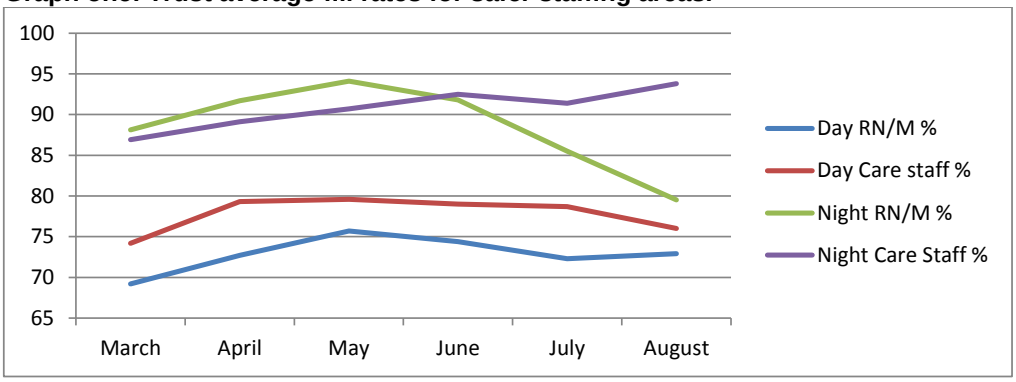
3.1 Safer Staffing data submission

Planned and actual nurse, midwifery and care staff levels have been successfully submitted to the NHS database (Unify) on a monthly basis without exception.

3.2 Fill Rates

Graph 1 shows the average fill rate for the safer staffing areas over the last 6 months. Fill rate is dependent upon both substantive staff and temporary workers. The Trust utilises a rapid response pool to optimise night shift fill rate; agencies are given the opportunity to fill 10 night shifts each day in advance. The early notification of shift availability had yielded an improved fill rate. In the two peak summer holiday months however fill rates dropped; this is demonstrated in the drop in fill rate for night shifts shown in graph 1. Annual leave profiling exceeded the standard of no greater than 17% in 11 safer staffing wards; some of this is directly linked to low numbers of substantive staff in post as the percentage on leave is associated with actual numbers in post rather than funded establishment.

Graph one: Trust average fill rates for safer staffing areas.



3.3 Care Hours Per Patient Days (CHPPD)

Data from the model hospital was updated in June 2018 (Table 1)

Table 1 (National median in brackets)	June 2018	Variance against national median
CHPPD Total	**7 (8.1)**	**-1.1**
CHPPD RN	**4.3 (4.8)**	**-0.5**
CHPPD HCSW	**2.7 (3.2)**	**-1.1**

3.4 Recruitment and turnover

3.41 **Table 2** shows an increase to vacancy rates for Nursing, Midwifery, Care Staff and AHPs for August 2018; this is directly attributable to increases in funded RN posts There are likely to be further adjustments to RN funded posts (and therefore RN vacancy percentage) as we create different non nursing roles to support different ways of working.

Table 2: Vacancy rates for Nursing, Midwifery, Care Staff and AHPs August 2018.

	Funded WTE	Contracted WTE	Vacancy WTE	Vacancy %
Nurses	919.2 (909.85)	659.54 (664.65)	259.65 (239.53)	28.24% (26.32)
Midwifes	144.06 (144.06)	147.12 (147.12)	-3.06 (-3.06)	-2.12(-2.12)
Care Staff	439.85 (444.51)	403.31 (401.38)	36.53 (39.99)	8.3% (8.99)
AHP's	55.60 (54.80)	50.38 (48.41)	5.21 (6.38)	9.3% (11.64)

(July 2018 position in brackets)

3.42 In August there were more RN leavers than starters; net loss of 4.54 WTE. The reasons for leaving in July and August are displayed in table 3; greater interrogation of the detail behind the reasons would be useful to understand if there were any missed opportunities to retain the staff members. In particular where staff have left to pursue further education or promotion and where staff have identified a lack of opportunity at the Trust.

Table 3: Reasons for leaving, July and August 2018

No.	Reason
15	Relocation
5	Work life balance
2	Promotion
2	Early retirement
2	Retirement
2	Dismissal
1	Further education
1	Lack of opportunities

3.43 The registered nurse and midwife pipeline is yielding 15-30 new starters per month.
September: 33 starters (27 external)
October: 14 confirmed and predicted starters (12 external)
November: 26 predicted (22 external)

3.44 Changes to Skill-mix

A different approach is being taken to staff the additional beds and the Frailty service for Winter 2018/19; we are seeking an Allied Health Professionals to lead both units in light of the case mix. The agreed cohort of patients for the additional bed capacity includes patients who are medically optimised with clear therapy goals, those on a frailty pathway and those medically optimised with a delayed transfer of care. Based on lower acuity and higher dependency the new staffing model has been calculated to support a workforce that is less reliant on Registered Nurses and more reliant on therapists and nursing and therapy assistants to support essential patient care and achievement of rehabilitation goals. Initially there will be a minimum requirement of 2RNs per shift to support the administration of medications but opportunities to strengthen pharmacy roles will be pursued.

3.45 Bands 1-4

Opportunities to adapt and create new roles are being pursued as well as continuing to recruit to all HCSW vacancies.

- Health Care support worker (HCSW) recruitment has been successful; the current vacancy is 8% (36 WTE) and the recruitment pipeline already has 30 starters due to in post by the end of November 2018.

- Since January 2018 31 new HCSW's have completed the Care Certificate and a further 50 are in the process of completing.
- The Trust has 26 (headcount) Assistant Practitioners (band 4) 3 of whom are within the Allied Health Professional workforce.

Table 4: Current Apprenticeships

Name of Apprenticeship	Numbers	Commence	Complete
Senior Healthcare Support Workers Apprenticeship Level 3	4	September 2018	12-24 months
Assistant Practitioner Level 5	7 2	January 2018 September 2018	July 2019 February 2020
Assistant Practitioner Level 5 (Allied Health Professionals)	2	October 2018	October 2020
Nursing Associate Level 5	3 7	May 2017 May 2018	May 2019 May 2020
RN Top Up	10	April 2018	February 2020

3.46 **Direct entry to apprenticeships:**

The Trust aims to scope the possibility of targeting 6th form and college leavers onto a recruitment initiative that sees them join as HCSW to complete the Care Certificate as a stepping stone to Trainee Nurse Associate or Assistant Practitioner. The premise would be 2 cohorts per year; January start for September level 5 study and September start for January level 5 study.

3.5 PATIENT SAFETY INCIDENTS

The month on month trend for safety incidents on the safer staffing areas is displayed in Appendix A. There was a decrease in the number of reported falls in August 2018; the numbers were in line with the same positon last year. The detailed report submitted to the Quality and Safety Committee includes "deep dive" review of specific clinical areas each month.

4.0 RECOMMENDATION

The Trust Board is asked to receive the summary of information related to national submission of nursing, midwifery and care staff data alongside information on the current recruitment and retention challenges.

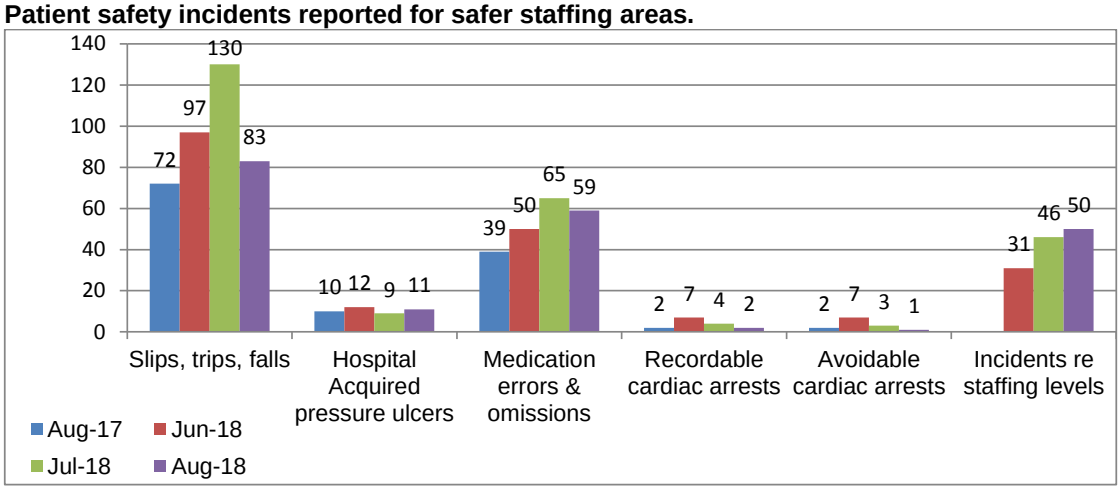
Author: Sharon Cullen, Interim Chief Nurse
Date: 27 September 2018

The Princess Alexandra Hospital NHS
NHS Trust

Appendix A

Patient safety incidents

Patient safety incidents reported for safer staffing areas.



5.2

respectful | caring | responsible | committed

NHS
The Princess Alexandra Hospital
NHS Trust

Integrated Performance Report

August 2018

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

Your future | Our hospital

Contact:

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

respectful | caring | responsible | committed

Trust Objectives

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.

In this month

The Princess Alexandra Hospital NHS Trust

Perfomance:

We received:	
Referrals from GPs	4564 ↓
Urgent cancer referrals	1203 ↓
We treated:	
A&E attendances	8373 ↓
Non-elective admissions	2936 ↑
Outpatient attendances	28570 ↓
Day cases	1776 ↓
Elective inpatients	331 ↓

People:

Starters	99.94 ↑
Leavers	49.13 ↓
Vacancy	12.9% ↑
Turnover	14% ↓
Stat Mand	0.88 ↑
FFT(Care & Treatment)	77% ↑
FFT(Place to Work)	64% ↑

Places:

Priority 1 Response	99% ↓
Catering Patient Satisfication	78% ↑
Meals served	43025 ↕
Food Waste	7% ↓
PLACES Score	90% →

Patients:

Compliments	132 ↓
Complaints	18 ↑
FFT Inpatients	97.91% ↓
FFT Outpatients	92.46% ↓
FFT A&E	94.20% ↓
FFT Maternity	100.00% →

Pounds:

YTD Deficit	-£13,487,520 ↓
Agency Target £s	-£4,023,994 ↓
Nursing Agency Target	6% ↓
Capital Expenditure	£1,382,600 ↑
BPPC Volume	64% ↓
BPPC - £s	75% ↓
Cash Balance	£3,531,000 ↓
Income & Expenditure: In month	No data ↑

←→↑↓ = comparison with previous month

Your future | Our hospital

respectful | caring | responsible | committed

6.1

Navigation Appendix 1

Our Patients
Our People
Our Performance
Our Places

Your future | Our hospital

Key

The table below identifies the 2018/19 KPI target, current performance and then sets a trajectory for the year. The different coloured boxes indicate the individual month's trajectory and in which month the target will be met as follows:
RED: Starting point
AMBER: Moving towards meeting the target
GREEN: The month when the trust is expected to meet the target

IPR = Integrated Performance Report (the trust wide dashboard)

		Executive LEAD	MUST / SHOULD	2018 / 19 Target	Compliance Data Source	Baseline performance (Feb 2018)	Expected Monthly Performance (July18)	Performance in April 18	Performance in May 18	Performance June 18	Performance July 18	Trajectory Aug 18	Trajectory Sept 18	Trajectory Oct 18	Trajectory Nov 18	Trajectory Dec 18	Trajectory Jan 19	Trajectory Feb 19	Trajectory March 19
Patients	** (Trust) Review DNARCPR forms to ensure completed fully in line with Trust Guidelines and National Policy	Director of Nursing	MUST	95%	Audit of DNARCPR forms	82% Dec 17	60%	52%		44%	44%	56%	70%	80%	90%	90%	90%	90%	90%
	** (Trust) Review MCA & DOLS and how this is documented within patient notes	Director of Nursing	MUST	90%	Audit of medical records every 2 months		No Audit planned		55%		87%	63%	75%		85%		90%		90%
	(Trust) Fridge temperatures are regularly checked and acted upon if temperatures are outside the normal range	Director of Nursing	MUST	98%	Ward Accreditation Audit	95%	98%	99%	87%	97%	99%	98%	98%	98%	98%	98%	98%	98%	98%
	** (Trust) must ensure that bottles of liquid medications are dated, signed on opening and do not exceed the expiry date	Director of Nursing	SHOULD	90%	Pharmacy Audit & Clinical Wednesday Audit	80%	70%	Planned audit 4/4 not completed	Planned audit 2/5 not completed. Changed to DOLS	25%	70%	70%	80%	90% embedded	90%	90%	90%	90%	90%
	** (Urgent Care) Medical records contain a complete and contemporaneous record in respect of each patient and that appropriate risk assessments are completed and documented	Director of Nursing	MUST	90%	ED Documentation audit	NA	70%	Embed ED documentation	Embed ED documentation	Embed ED documentation	20%	70%	80%	90%	90%	90%	90%	90%	90%
	(Urgent Care) Conduct hourly observations - comfort	Director of Nursing	SHOULD	95%	Audit documentation	NA	Care rounds implemented 90%	Care rounds being implemented	Care rounds implemented	Care rounds implemented	Care rounds implemented, 82%	Care rounds implemented 90%	Care rounds implemented 95%	Care rounds implemented 95%	Care rounds implemented 95%	Care rounds implemented 95%	Care rounds implemented 95%	Care rounds implemented 95%	Care rounds implemented 95%
	** (Urgent Care) Conduct Emergency Care Safety Checklists	Director of Nursing	SHOULD	90%	Weekly audit in ED		90%	Implement new documentation	Embed ED documentation	Embed ED documentation Audit Results: 78%	98%	100%	90%	90%	90%	90%	90%	90%	90%
	(CCCS) Ensure there is a planned preventative maintenance programme in place for all the equipment in the Mortuary	Director of Nursing	SHOULD	100%	Evidence of appropriate documentation	Improved documentation of maintenance commenced Feb 18	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
	(Critical Care) Introduce disposable washing bowls for patients	Director of Nursing	SHOULD	100%	Evidence of disposable bowls in use in Critical Care	None	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
	** (Paediatrics) Improve transition arrangements for adolescent patients	Director of Nursing	MUST	Transition arrangements in place & embedded	Transition audit / Patient Survey	Limited arrangements in place	Transition policy to be implemented	Transition Policy being developed	Transition Policy consultation in progress	Transition policy for further amendment after consultation	Transition policy has been delayed. Will be discussed at TPG in September	Transition policy has been delayed. To be approved during September	Transition Policy embedded	Transition Policy	Transition Lead in post	Transition policy fully embedded	Transition policy fully embedded	Transition policy fully embedded	Transition policy fully embedded
	** (Paeds) Consent should be consistently documented	Director of Nursing	SHOULD	90%	Documentation & notes audit	Not audited	60%	Align with GDPR process	Align with GDPR process Audit planned end June	Audit tool developed First audit to be completed July	40%	60%	70%	80%	90%	90%	90%	90%	90%
	** (Paeds) Enhance communication with patients to ensure they have all the information they need (give ward leaflet to all children)	Director of Nursing	SHOULD	100% leaflets given to patient and parents	NA	Review in progress	60%	Audit to be developed	Audit to be developed	Audit tool developed First audit to be completed July	40%	60%	70%	80%	90%	95%	100%	100%	100%
	** (Paeds) Ensure records are complete and comprehensive, in particular the documentation of conversations with parents	Director of Nursing	SHOULD	90%	Documentation & notes audit	ED document being revised	60%	Audit to be developed	Audit to be developed	Audit tool completed and first audit will be completed in July	80%	60%	3 Staff to attend me First workshop Audit: 70%	Rollout of Me First Workshop to staff Audit: 80%	90%	90%	90%	90%	90%
People	** (Trust) Appraisals	Director of People	MUST	90%	Appraisal records	86%	80%	78%	77%	76%	83%	81%	85%	90%	90%	90%	90%	90%	90%
	** (Trust) Stat/Man Training (inc: safeguarding, Fire, Infection Control, Life Support - Core 8 Topics)	Director of People	MUST	90%	Training records	84%	87%	84%	86%	86%	89%	87%	88%	90%	90%	90%	90%	90%	90%

Key

The table below identifies the 2018/19 KPI target, current performance and then sets a trajectory for the year. The different coloured boxes indicate the individual month's trajectory and in which month the target will be met as follows:
RED: Starting point
AMBER: Moving towards meeting the target
GREEN: The month when the trust is expected to meet the target

IPR = Integrated Performance Report (the trust wide dashboard)

	Executive LEAD	MUST / SHOULD	2018 / 19 Target	Compliance Data Source	Baseline performance (Feb 2018)	Expected Monthly Performance (July18)	Performance in April 18	Performance in May 18	Performance June 18	Performance July 18	Trajectory Aug 18	Trajectory Sept 18	Trajectory Oct 18	Trajectory Nov 18	Trajectory Dec 18	Trajectory Jan 19	Trajectory Feb 19	Trajectory March 19
** (Trust) Paediatric Life Support Training Compliance	Director of People	MUST	90%	Training records	80%	84%	75%	78%	80%	97%	84%	86%	88%	90%	90%	90%	90%	90%
** (Trust) Adult Life Support Training (level 2)	Director of People	MUST	90%	Training records	77%	70%	65%	65%	68%	69%	70%	74%	78%	80%	84%	88%	90%	90%
** (Trust) Adult Safeguarding Training (Levels 1 & 2)	Director of People	MUST	90%	Training records	L1 - 92% L2 - 78%	L1 - 90% L2 - 86%	L1 - 93% L2 - 79%	L1 - 94% L2 - 83%	L1 - 94% L2 - 84%	L1 - 95% L2 - 88%	L1 - 90% L2 - 86%	L1 - 90% L2 - 90%	L1 - 90% L2 - 90%	L1 - 90% L2 - 90%	L1 - 90% L2 - 90%	L1 - 90% L2 - 90%	L1 - 90% L2 - 90%	L1 - 90% L2 - 90%
** (Trust) Safeguarding Children Training (levels 1, 2 & 3)	Director of People	MUST	90%	Training records	L1 - 92% L2 - 85% L3 - 62%	L1 - 90% L2 - 90% L3 - 78%	L1 - 92% L2 - 85% L3 - 63%	L1 - 93% L2 - 87% L3 - 70%	L1 - 94% L2 - 87% L3 - 72%	L1 - 94% L2 - 90% L3 - 77%	L1 - 90% L2 - 90% L3 - 78%	L1 - 90% L2 - 90% L3 - 80%	L1 - 90% L2 - 90% L3 - 85%	L1 - 90% L2 - 90% L3 - 90%	L1 - 90% L2 - 90% L3 - 90%	L1 - 90% L2 - 90% L3 - 90%	L1 - 90% L2 - 90% L3 - 90%	L1 - 90 % L2 - 90% L3 - 90%
** (Trust) Recruit Registered Nurses (RNs) to ensure adequate numbers of RN's in line with national guidance	Director of People	SHOULD	18%	Vacancy Data	24.0%	24%	26%	25%	26%	26%	24%	22.0%	20.0%	19.5%	19%	19%	18.5%	18%
** (Urgent Care) Staff are competent including: Fire Safeguarding L.2 / 3 Infection Control L2	Director of People	MUST	90%	Training records	81% (medical HCG)	84%	F: 74% SA: 77% SC-2: 83% SC-3: 61% IC: 74%	F: 81% S.A: 86 % S.C-2: 91% SC-3: 63% IC: 77%	[illegible] S.A2: 86% S.C.2: 96% S.C.3: 78% IC: 73%	F: 94% SA2: 89% SC2: 91% SC3: 76% IC:78%	84%	88%	89%	90%	90%	90%	90%	90%
** (Surgery) There must be a Paediatric trained nurse in theatres at all times - Working with FAWS	Director of People	MUST	100%	Staff Roster	0%	0%	0%	0%	0%	0%	0%	0%	25%	50%	75%	100%	100%	100%
** (Paeds) Recruit Registered Paediatric Nurses to ensure compliance with RCN standards regarding staffing & competences on Dolphin Ward	Director of People	MUST	14%	Staff Roster / Shelford Acuity Model & Safer Staffing	22.9%	30%		RN: 68% Establishment filled 32% Vacant	RN: 68% Establishment filled 32% Vacant	RN: 71% Establishment 29% Vacancy	30%	28%	26%	24%	22%	20%	18%	16%
(Urgent Care) Ambulance patients are appropriately assessed & triaged in a timely manner in accordance with RCEM guidelines	Chief Operating Officer	MUST	<30mins - 80% 30-60mins - 20% IPR		<30mins - 66% 30-60mins - 26% >60mins - 8%	<30 - 77% 30-60 - 28.5% >60 - 1.5%	<30: 75% 30-60 min: 21% >60 : 4.2%	<30: 83% 30-60: 16% >60 : 1%	<30: 76.7% 30-60: 22.3% >60: 1%	<30: 70.1% 30-60:25.6% >60 - 4.3%	<30 - 82.2% 30-60 - 16.9% >60 - 0.9%	<30 - 80% 30-60 - 20%	<30 - 80% 30-60 - 20%	<30 - 80% 30-60 - 20%	<30 - 80% 30-60 - 20%	<30 - 80% 30-60 - 20%	<30 - 80% 30-60 - 20%	<30 - 80% 30-60 - 20%
(Trust) Reduce the number of late discharges (22.00-08.00hrs)	Chief Operating Officer	SHOULD	Zero	IPR	3.0%	4.5%	4.8%	5.2%	9.7%	8.3%	6.5%	4.0%	3.0%	2.0%	1.5%	1.0%	0.5%	0%
** (Trust) Reduce the number of bed moves between (22.00-08.00hrs)	Chief Operating Officer	SHOULD	Zero	IPR	3.0%	11.0%	17.7% 143 Pts	17.9% 170 Pts	17.5% 211 Pts	20.8% 266 Pts (this includes moves MAU)	16.71% 200 Pts (this includes moves from assessment areas)	8.0%	5.0%	3.0%	1.5%	1.0%	0.5%	0%
(Trust) Reduce the number of delayed discharges from HDU to the wards	Chief Operating Officer	SHOULD	4-24hrs=12 >24hrs = 2	IPR	4-24hrs=21 >25hrs=12	4-24hrs:19 >24hr: 16	4-24hrs: 23 >24hr: 17	4-24hrs: 21 >24 hr: 10	4-24hrs: 18 >24hr: 11	4-24hrs: 16 >24hr= 13	4-24hrs=22 >24hr=16	4-24hrs=18 >24hr=14	4-24hrs=17 >24hr=12	4-24hrs=16 >24hr=10	4-24hrs=15 >24hr=8	4-24hrs=14 >24hr=6	4-24hrs=13 >24hr=4	4-24hrs=12 >24hr=2
(Trust) To monitor trends in delayed discharges to identify trends / areas for improvement	Chief Operating Officer	SHOULD	Trends monitored & acted upon	Audit data	Trends not monitored	Trends monitored and acted upon	Trends monitored and acted upon	Trends monitored and acted upon	Trends monitored and acted upon	Trends monitored and acted upon	Trends monitored and acted upon	Trends monitored and acted upon	Trends monitored and acted upon	Trends monitored and acted upon	Trends monitored and acted upon	Trends monitored and acted upon	Trends monitored and acted upon	Trends monitored and acted upon
(Surgery) Reduce the use of PACU for inappropriate patients (DSU etc.) late at Night	Chief Operating Officer	SHOULD	Extend DSU opening hours to 22.00hrs / Zero	IPR	DSU closes at 18.00hrs	Extend opening to 22.00 Zero DSU pts in PACU	Recruit additional staff	Recruit additional staff	Recruit additional staff	Extend opening to 21.00hrs. 5 pts moved to PACU	Extend opening to 21.00hrs. 1 DSU pts moved to PACU	Extend opening to 22.00hrs. Zero DSU pts in PACU	Extend opening to 22.00hrs. Zero DSU pts in PACU	Extend opening to 22.00hrs. Zero DSU pts in PACU	Extend opening to 22.00hrs. Zero DSU pts in PACU	Extend opening to 22.00hrs. Zero DSU pts in PACU	Extend opening to 22.00hrs. Zero DSU pts in PACU	Extend opening to 22.00hrs. Zero DSU pts in PACU
** (HDU) Reduce the number of mixed sex breaches	Chief Operating Officer	MUST	Zero	IPR	5	4	8	2	5	4	8	2	1	0	0	0	0	0

Key

The table below identifies the 2018/19 KPI target, current performance and then sets a trajectory for the year. The different coloured boxes indicate the individual month's trajectory and in which month the target will be met as follows:
RED: Starting point
AMBER: Moving towards meeting the target
GREEN: The month when the trust is expected to meet the target

IPR = Integrated Performance Report (the trust wide dashboard)

		Executive LEAD	MUST / SHOULD	2018 / 19 Target	Compliance Data Source	Baseline performance (Feb 2018)	Expected Monthly Performance (July18)	Performance in April 18	Performance in May 18	Performance June 18	Performance July 18	Trajectory Aug 18	Trajectory Sept 18	Trajectory Oct 18	Trajectory Nov 18	Trajectory Dec 18	Trajectory Jan 19	Trajectory Feb 19	Trajectory March 19
Places	(HDU) When refurbishing, consider the position of the sink area in HDU, moving it so that staff do not have to pass through a bed area to wash their hands	Director of Strategy	SHOULD	Review space & identify a new design. Submit business case.	NA	NA	If approved go out to tender	not in capital plan 18/19	not in capital plan 18/19	not in capital plan 18/19	not in capital plan 18/19	not in capital plan 18/19							
	(HDU) When refurbishing, consider the space required to provide safe movement around bed spaces	Director of Strategy	SHOULD	Review space & identify a new design. Submit business case.	NA	NA	If approved go out to tender	not in capital plan 18/19	not in capital plan 18/19	not in capital plan 18/19	not in capital plan 18/19	not in capital plan 18/19							
	(CCCS) Ensure there is a planned preventative maintenance programme in place for all the equipment in the Mortuary	Director of Strategy	SHOULD	100%	NA	Improved documentation of maintenance commenced Feb 18	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

6.1

NB. Data extracted from IPR unless otherwise stated.

Measure	SOF Data Frequency	IPR Monthly Standard	Apr	May	Jun	Q1 17-18	Jul	Aug	Sep	Q2 17-18	Oct	Nov	Dec	Q3 17-18	Jan	Feb	Mar	Q4 17-18	Apr	May	Jun	Q1 18-19	Jul	Aug	Sep	Q2 18-19	Oct	Nov	Dec	Q3 18-19	Jan	Feb	Mar	Q4 18-19
Quality of Care																																		
Written complaints	Quarterly	25	13	17	15	**45**	22	25	21	**68**	18	28	13	**59**	22	21	23	**66**	23	23	19		12	18										
Staff Friends & Family Test % recommended - care	Quarterly	67%				**73%**				**75%**								**70%**				77%												
Occurrence of any Never Event	Monthly (6-month rolling)	0	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0		0	0										
Patient Safety Alerts not completed by deadline	Monthly	-																		0														
Mixed-sex accommodation breaches	Monthly	0	9	5	5	**19**	3	2	2	**7**	11	3	1	**15**	11	5	11	**27**	8	2	5		0	0										
Inpatient scores from FFT - % positive	Monthly	90%	93%	98%	97%	**96%**	99%	99%	98%	**99%**	98%	96%	96%	**97%**	98%	98%	98%	**98%**	96%	98%	97%		99%	98%										
A&E scores from FFT - % positive	Monthly	90%	91%	95%	89%	**92%**	89%	96%	92%	**92%**	97%	96%	89%	**94%**	90%	95%	95%	**93%**	95%	88%	97%		94%	94%										
Maternity scores from FFT - % positive	Monthly	90%	95%	98%	98%	**97%**	100%	100%	100%	**100%**	99%	98%	100%	**99%**	100%	100%	99%	**100%**	100%	100%	98%		100%	100%										
Emergency C-section rate	Monthly	-	64	67	58		44	49	56		51	56	46		62																			
CQC inpatient survey	Annual	-																																
VTE risk assessment	Quarterly	95%	98%	98%	99%		99%	98%	99%		99%	98%	98%		99%	99%	98%		99%	98%	99%		99%	99%										
C-diff plan: actual variance from plan	Monthly	-	1	0	1		4	0	3		0	1	0		2	0	2		2	2	1													
C-diff - infection rate	Monthly (12-month rolling)	0.83	1	0	1	**2**	4	0	3	**7**	0	1	0	**1**	2	0	0	**2**	2	2	1		1	1										
MRSA bacteraemia infection rate	Monthly (12-month rolling)	-	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0		0	0	0													
MSSA bacteraemias	Monthly (12-month rolling)	0	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	1		1	3										
E. coli bacteraemia bloodstream infection	Monthly (12-month rolling)	-	13	10	13	**36**	11	25	13	**49**	15	20	19	**54**	15	14	9	**38**	17	10	11	**38**												
Hospital Standardised Mortality Ratio	Quarterly	100	114	116	118		116	118	117		116	116	115		115	114.8	114.6																	
Summary Hospital-Level Mortality Indicator	Quarterly	100			109				109				112																					
Potential under-reporting of patient safety incidents	Monthly (6-month rolling)	-	No data	437	541		579	855	471		493	829	335		897	621	684		704	709	548		833											

NB. Data extracted from IPR unless otherwise stated.

Measure	SOF Data Frequency	IPR Monthly Standard	Apr	May	Jun	Q1 17-18	Jul	Aug	Sep	Q2 17-18	Oct	Nov	Dec	Q3 17-18	Jan	Feb	Mar	Q4 17-18	Apr	May	Jun	Q1 18-19	Jul	Aug	Sep	Q2 18-19	Oct	Nov	Dec	Q3 18-19	Jan	Feb	Mar	Q4 18-19
Operational Performance																																		
A&E max. waiting time of 4 hours from arrival to admission/ transfer/ discharge	Monthly	95%	79%	78%	75%		73%	75%	70%		68%	72%	67%		66%	63%	65%		74%	76%	78%		74%	82%										
Max. time of 18 weeks from point of referral to treatment (RTT) - patients on an incomplete pathway	Monthly	92%	94%	94%	93%		93%	93%	92%		92%	92%	92%		89%	89%	88%		89%	90%	91%		92%											
Max. 62-day wait for first treatment from urgent GP referral for all suspected cancer	Monthly	85%	91%	93%	91%		85%	85%	87%		85%	90%	97%		94%	86%	79%		83%	76%	81%													
Max. 62-day wait for first treatment from NHS cancer screening service referrals	Monthly	90%	100%	92%	97%		100%	100%	100%		100%	91%	92%		79%	100%	97%		88%	94%	100%													
Max. 6-week wait for diagnostic procedures	Monthly	99%	100%	99%	99%		100%	99%	99%		100%	100%	99%		100%	99%	99%		99%	99%	99%		99%											
Dementia assessment & referral: the no. & proportion of patients aged 75 & over admitted as an emergency for more than 72 hours:	Quarterly																																
a. who have a diagnosis of dementia or delirium or to whom case finding is applied		90%	96%	95%	97%		97%	99%	99%		99%	96%	97%		98%	99%	98%		96%	96%	99%													
b. who, if identified as potentially having dementia or delirium, are appropriately assessed		90%	100%	100%	100%		100%	100%	100%		100%	100%	100%		100%	100%	100%		100%	100%	100%													
c. where the outcome was positive or inconclusive, are referre on to specialist services		90%	93%	98%	98%		100%	98%	88%		100%	88%	100%		96%	91%	96%		88%	100%	100%													
Organisational Health																																		
Staff sickness	Monthly	3.50%	2.8%	3.7%	3.5%		3.7%	3.5%	3.2%		4.0%	4.3%	4.2%		4.2%	3.8%	3.9%		3.9%	3.4%	3.3%		3.2%	3.2%										
Staff turnover	Monthly	12%	15%	15%	15%		15%	15%	14%		14%	14%	14%		13%	13%	13%		13%	13%	13%		14%	14%										
NHS Staff Survey	Annual																	3.58 for 2017															
Proportion of temporary staff (agency costs)	Monthly	-													8.13%	6.58%	6%		7.43%	6.46%	6.6%		4.5%											
Financial Health																																		
Financial Metrics	Quarterly	-																																

Performance Overview

The Princess Alexandra Hospital NHS Trust

External views of the Trust

This section provides details of the ratings & scores published by the Care Quality Commission (CQC) & NHS Choices. A breakdown of the currently published score is provided, along with details of the scoring system.

Care Quality Commission

NHS Choices

The NHS Choices website has a 'Services Near You' page, which lists the nearest hospitals for a location you enter. This page has ratings for hospital (rather than Trusts) based upon a range of data sources.

Site	NHS Choices Users Rating	Recommended by Staff	Mortality Rate	Food: Choice & Quality
The Princess Alexandra Hospital	4 stars	OK	OK	✓ 80.87%
St Margaret's Hospital	3.5 stars	OK	OK	No relevant data available

Stars - maximum 5

OK = Within expected range

✓ = Among the best (top 20%)

! = Among the worst

Executive Summary Our Patients

The Princess Alexandra Hospital NHS Trust

From the 12 objectives in Our Patients, this month 6 (50%) are performing within the expected range. Six areas are not achieving the expected monthly performance standard, these are:

DNACPR compliance: In month the score for actual performance against the six Trust resuscitation standards was 44% (against trajectory plan of 88%). The monthly audit was small; therefore poor compliance has a greater impact. The main issue for non-compliance is that we did not complete MCA2 as part of the DNACPR assessment.
Within our improvement plan the Trust will roll out the new DNACPR form which has the MCA2 assessment as part of the form, this will ensure improvement. The roll out took place across June & July and teaching is well underway in all clinical areas. The planned trajectory for this objective has been amended with a gradual phased increase now planned.

The Fridge temperature compliance has achieved an Amber rating at 97%. All clinical areas submitted their data but there were gaps in compliance in three day care areas and one assessment ward.

Use of liquid medications being dated, signed and not used after expiry was audited on just two wards in month. The actual performance was poor with compliance of 25% (planned trajectory was 84%). With just two wards audited, poor compliance takes on a greater significance. On both wards the Ward Manager took immediate action after the audit results were shared. The Associate Director for Governance & Quality has shared the results with all nursing leaders to ensure each ward area develops a plan to undertake spot checks and reviews regularly. The planned trajectory for this objective has been amended and a phased increase is now detailed.

Paediatrics:
The Transition from children to adult services policy was completed and submitted to the Trust policy group in Augus

The paediatric audits for Dolphin ward: three audits were developed during June and will be audited in July. In collaboration with the FAWS team the trajectory plan has been amended to include a phased trajectory. The audits to be undertaken in month include:-
• Consent with treatment being documented
• Monitoring the use of communication leaflet to patients about admission to hospital
• Review of documentation detailing conversations with parents
The team have secured three places on the National Workshops - Me First Masterclass, the first session to be held locally this financial year is planned for 27 September 2018. Three senior staff will attend and then lead on cascade training to their colleagues to cover the content of the training and how to use the tools that will be shared. There were a total of 913 incidents reported in August 2018 with 711 of these being PAH.
Of the PAH incidents 671 (94%) were 'no harm' or 'minor harm' incidents. 34 (4.8%) were rated as moderate harm. 6 (0.84%) incidents were severe harm and death.

30 incidents meeting moderate, severe and death harms was discussed at the Serious Incident Group in month.
The grading of each incident is subject to change after discussions and decisions on each incident.

During August 2018, 2 Serious Incidents were raised: the first incident was for a maternity case with baby death and the second was a ward fall that resulted in a cerebral bleed and the patient died.

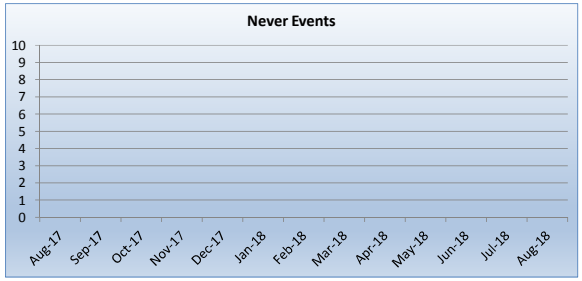
1 Our Patients Summary 1.1 Patient Safety - incident reporting

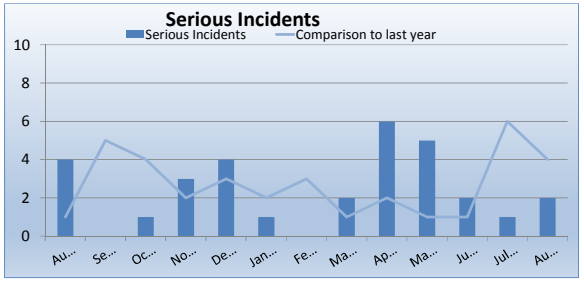
The Princess Alexandra Hospital NHS Trust

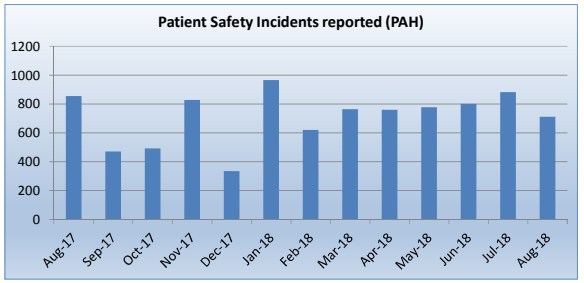
Incidents: There were a total of 913 incidents reported in August 2018 with 711 of these being PAH. Of the PAH incidents during August 2018, approx. 94% were 'no harm' or 'minor harm' incidents while 6% rated as moderate, severe harm & death. The moderate & severe incidents have been reviewed and/or discussed at oversight and/or Serious Incident Group & grading may be subject to change. The number of incidents reported month on month has increased overall in comparison to when the paper based system was in place.

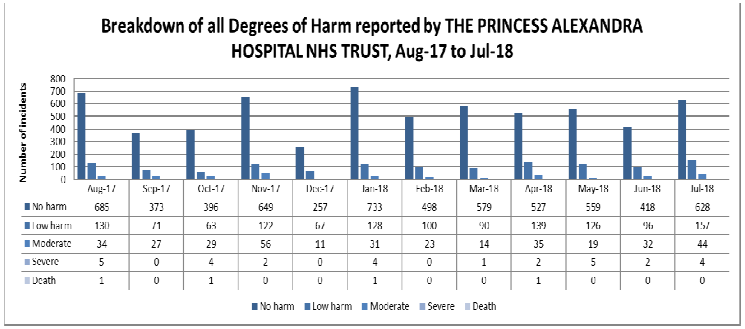
During August 2018 there were 2 Serious Incidents:
Slip Trip and Fall meeting SI threshold
Maternity/Obstetric incident meeting SI criteria: mother and baby

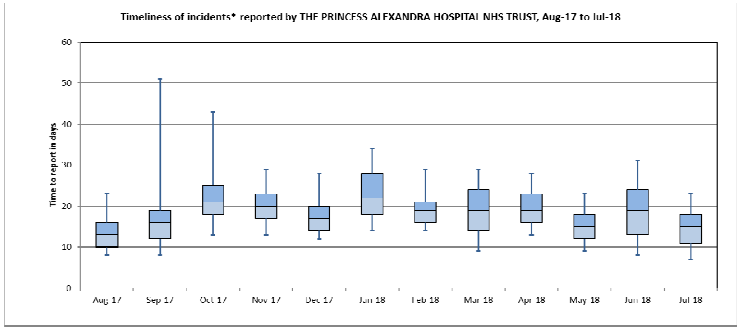
Safety Thermometer: 90.42% of the incidents reviewed were reported as no harm, 53 patients are recorded as having 1 or more harm. The data shows that of these patients 6 were recorded as having hospital acquired harms.
NB: The information collected during the Monthly Patient Safety Thermometer is a point prevalence audit and as such only provides us with snap shot of information relating to all inpatients on the one audit day of the month.
The accuracy cannot be completely validated in each case – this is currently being reviewed as to how best we can be confidant of the accuracy of this element in the survey.











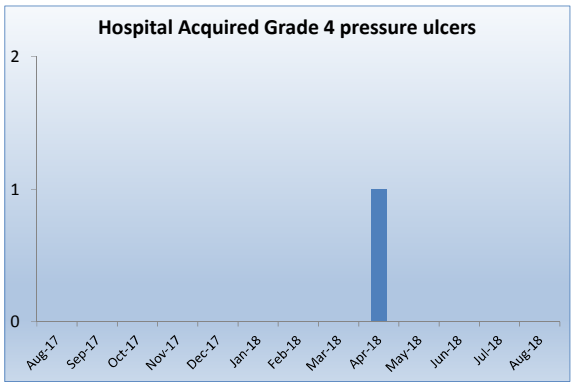
Your future | Our hospital

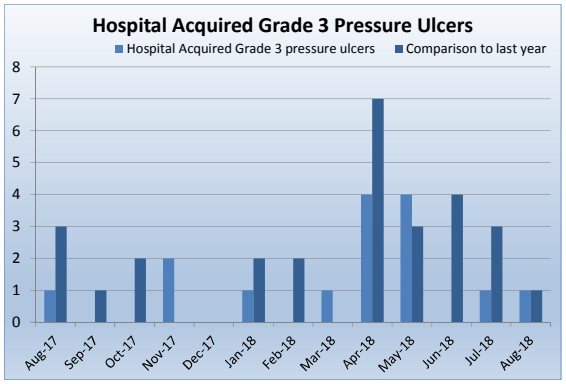
respectful | caring | responsible | committed

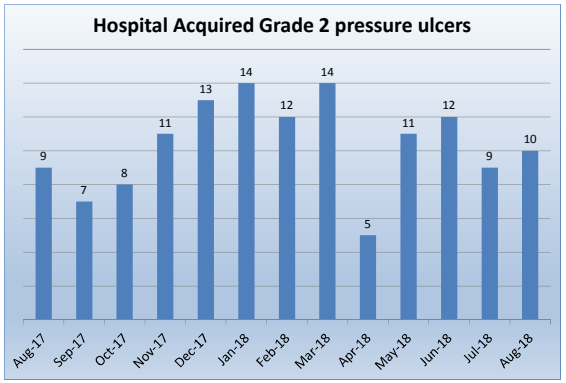
1 Our Patients Summary 1.2 Patient Safety - harm-free care

The Princess Alexandra Hospital NHS Trust

The Trust successfully have not had any Grade 4 Pressure Ulcers for August. Two of the grade 2 pressure ulcers have been to scrutiny panel and were deemed unavoidable. The other pressure ulcer cases are awaiting review at scrutiny panel so we are unable to confirm at this time whether avoidable or not.



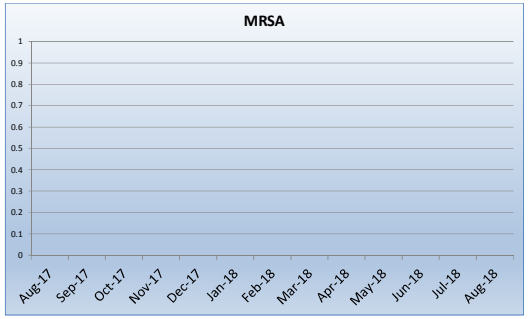


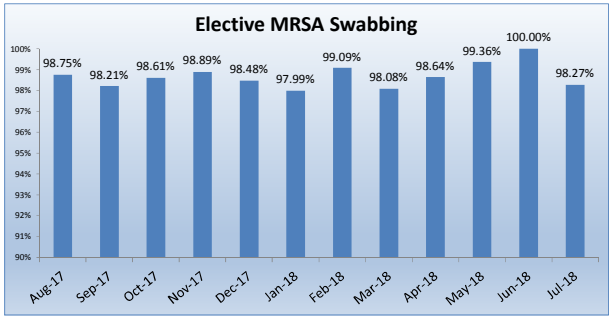


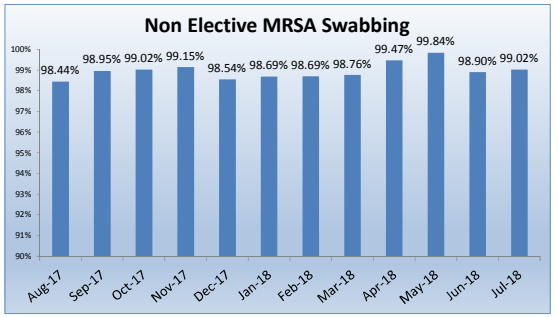
Your future | Our hospital

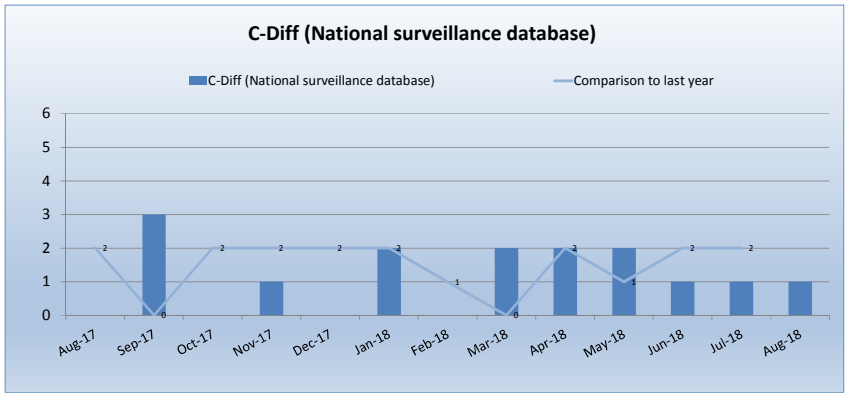
respectful | caring | responsible | committed

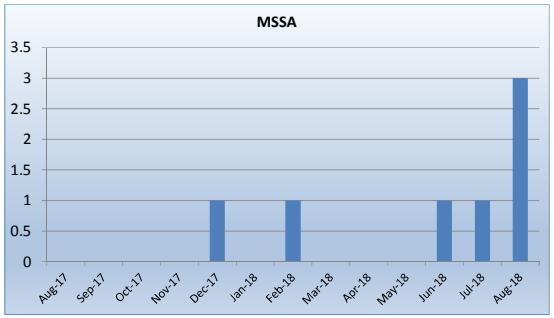
MRSA bacteraemia: There have been no cases of Trust-apportioned MRSA to date for 2018-19
MRSA Screening: Over 98% compliance was achieved for both elective & non-elective screening in July (the most recent data available).
Clostridium difficile: The trajectory for 2018-19 is nine cases for the year. There was one case of C.difficile in August; the RCA panel has not yet been held.
MSSA: There were three Trust apportioned cases in August – currently being investigated to identify the source. There is no trajectory in place for MSSA, but we continue to monitor and report cases.











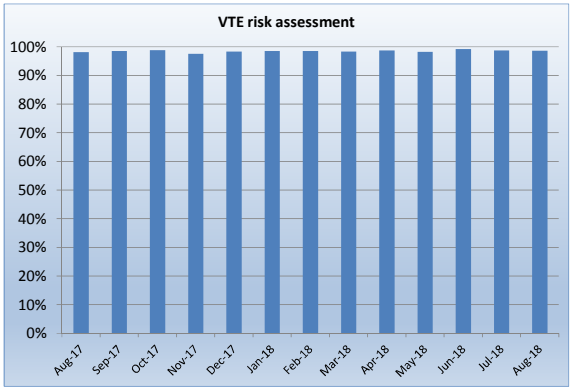
Your future | Our hospital

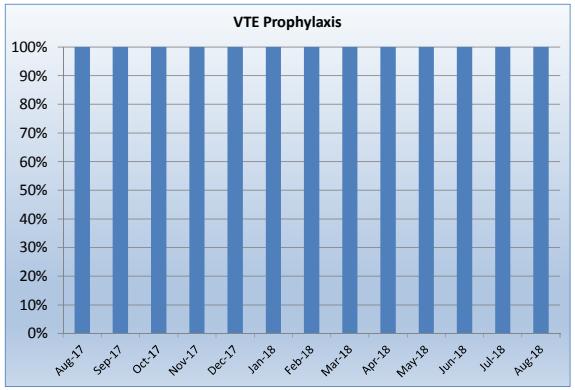
respectful | caring | responsible | committed

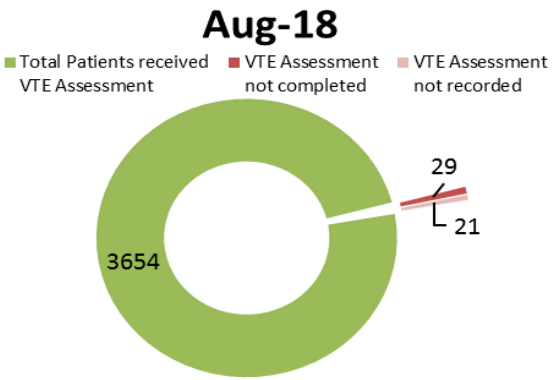
1 Our Patients Summary 1.4 Screening on admission

The Princess Alexandra Hospital NHS Trust

The Trust is currently above target for VTE Assessments for August as at 12th September 2018.
All non-compliant VTE assessments are scrutinised by the VTE leads and reported monthly through PSQ. Any incidents are recorded on DATIX and are reported through the daily incident group. All prophylaxis doses missed are escalated immediately to the Nurse in charge and the patient receives prescribed anticoagulation.





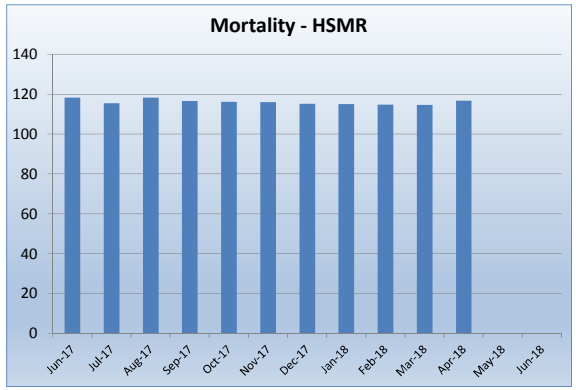


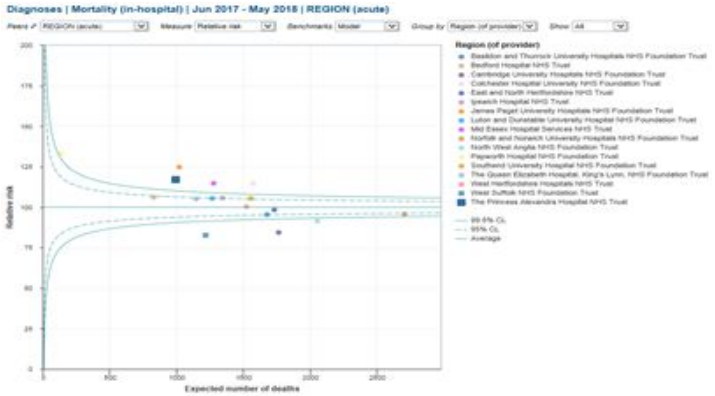
Your future | Our hospital

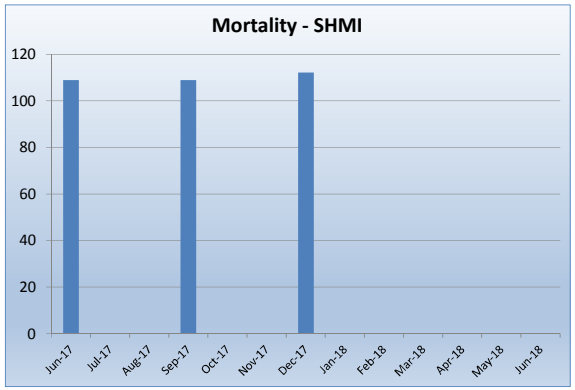
respectful | caring | responsible | committed

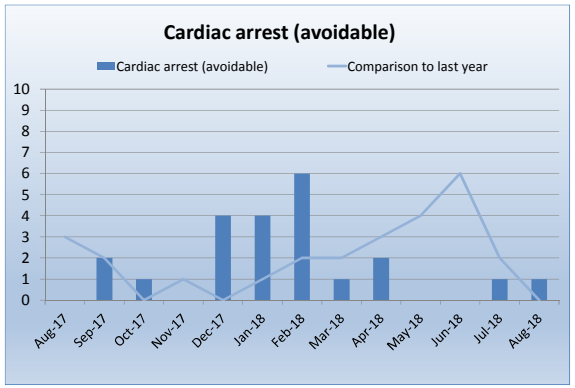
Mortality HSMR: The validated rolling HSMR for June 2017 to May 2018 is 116.7 and statistically "higher than expected". This is the 16th consecutive month of reporting for a "higher than expected". There are 4 diagnostic outliers; septicaemia, COPD, intestinal obstruction and aspiration pneumonitis. The SHMI is as expected.

Cardiac Arrest: The cardiac arrest potentially avoidable incidents are reported as potentially avoidable pending investigation, and are then reviewed by the healthcare groups. The incidence of potentially avoidable cardiac arrests for failures to rescue and failures to consider DNACPR have continued to reduce over the last 3 years. There is one potentially avoidable cardiac arrest this month pending investigation.









Your future | Our hospital

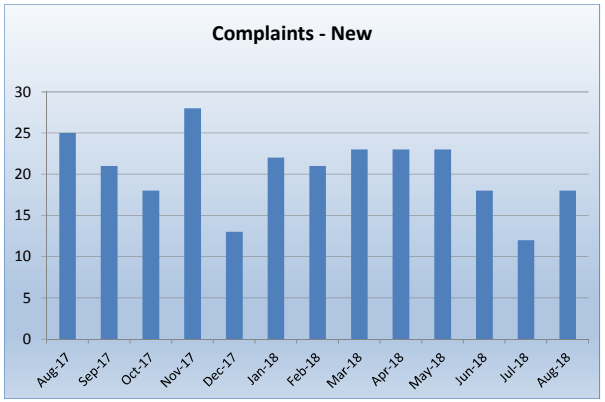
respectful | caring | responsible | committed

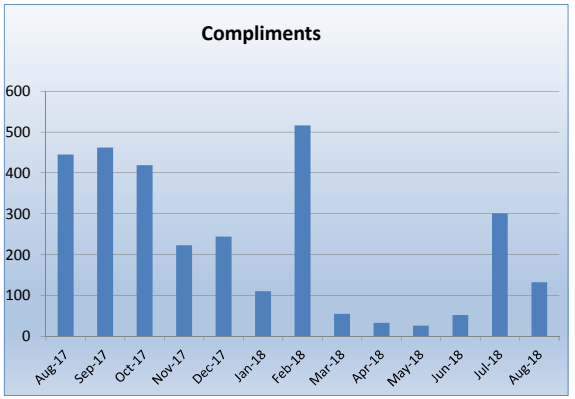
15

1 Our Patients Summary 1.6 Complaints & Compliments

The Princess Alexandra Hospital NHS Trust

The evidence from Patient Experience Metrics for August 2018 is positive for not just one metric, but consistent across the board, a rare occurrence and may be evidence of improvement in operational delivery, consistent with lower than usual complaints and a high level of PALS local resolutions which reached an annual high at 254.

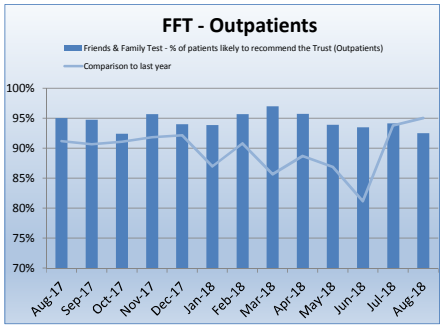


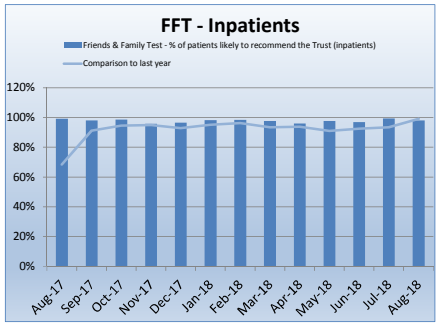


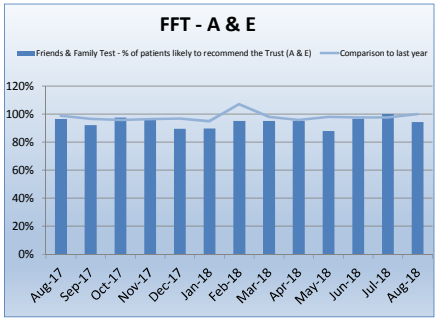
Your future | Our hospital

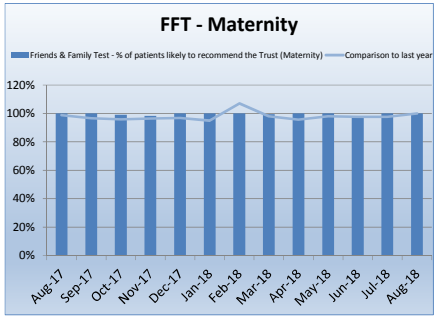
respectful | caring | responsible | committed

As above.









Friends & Family Test Results		Positive & Negative Response Total						Total Responses								
Friends & Family Test Return		Likely	%	Unlikely	%	Neither / Don't Know	%	Extremely Likely	Likely	Neither	Unlikely	Extremely Unlikely	Don't Know	Total Responses	Total Eligible Patients	Response Rate
Maternity	Q1 Antenatal Care	14	100.00%	0	-	0	-	**14**	**0**	**0**	**0**	**0**	**0**	**14**	-	-
	Q2 Birth	127	100.00%	0	0.00%	0	0.00%	**127**	**0**	**0**	**0**	**0**	**0**	**127**	365	34.79%
	Q3 Care on postnatal ward	127	100.00%	0	0.00%	0	0.00%	**127**	**0**	**0**	**0**	**0**	**0**	**127**	362	35.08%
	Q4 Postnatal community provision	35	100.00%	0	0.00%	0	0.00%	**32**	**3**	**0**	**0**	**0**	**0**	**35**	347	10.09%
	Total excluding Q3	176	100.00%	0	0.00%	0	0.00%	**173**	**3**	**0**	**0**	**0**	**0**	**176**	712	24.72%
A&E		715	94.20%	3	0.40%	41	5.40%	**611**	**104**	**31**	**1**	**2**	**10**	759	4374	17.35%
Acute Inpatients		610	97.91%	7	1.12%	6	0.96%	**570**	**40**	**4**	**3**	**4**	**2**	623	1811	34.40%
Total exl. Outpatients		**1501**	**96.34%**	**10**	**0.64%**	**47**	**3.02%**	1354	147	35	4	6	12	**1558**	**6897**	**22.59%**
Outpatients		2184	92.46%	70	2.96%	108	4.57%	**1624**	**560**	**79**	**28**	**42**	**29**	2362	27209	8.68%
Total incl. Outpatients		**3685**	**94.01%**	**80**	**2.04%**	**155**	**3.95%**	2978	707	114	32	48	41	**3920**	**34106**	**11.49%**

Executive Summary Our Performance

The Princess Alexandra Hospital NHS Trust

From the 7 objectives in Our Performance, this month 2 (29%) are performing better than expected; Assessment and Triage and Discharges from Critical Care. (2) are within the expected range, (3) (43%) are not achieving the expected monthly performance - late discharges, overnight bed moves and
Actions taken to address under performance are:
Refresher training on Red 2 Green, Board Rounds supported by Quality First Team and ECIP Lead. Understanding of discharge planning and discharge processes across all multi disciplinary teams. Introduction of a standardised approach to board rounds and information required. Discharge planning to begin at the point of admission to be more visible and the application of quality standards to all wards for discharge processes is to be increased. This will ensure the patient journey co-ordinators work seamlessly with all ward teams to support the senior nursing and medical teams.
Data cleansing is underway to look at all ward moves out of core hours. An audit is planned to be undertaken throughout October which will capture all moves, reasons and decision making.

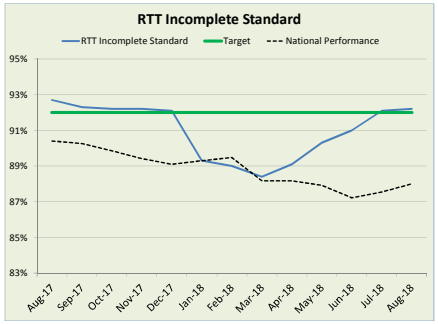
The Quality First team are working with the specialities of cardiology, respiratory and general surgery teams to deliver the model pathway project. The aim is to bring down length of stay to meet national benchmarks by end of financial year. This project will also seek to achieve 35% of discharges before 12MD. Criteria led discharge projects are beginning to be implemented into clinical areas.

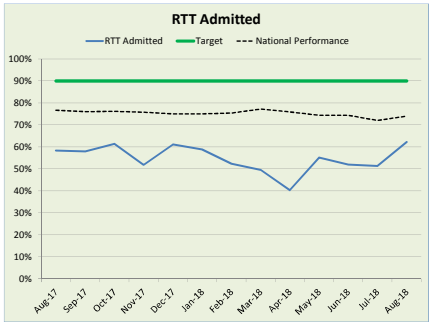
Mixed sex breaches HDU: Five breaches occurred in month (against a trajectory of 2). This does fluctuate month on month. The ability to prevent breaches is linked with early ward discharges and therefore the actions detailed previously will bring about a continued improvement for this group of patients. The critical care team have a standard operating procedure, which they implement on a daily basis to minimise the number of breaches that occur.

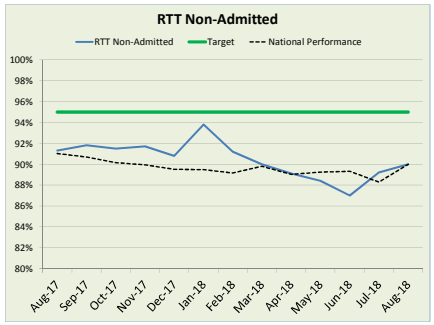
Overnight Stays in PACU: This is not on this action plan but was reviewed by the CQC so will be reported each month. During August 10 patients had overnight stays on PACU; this is the lowest number since January 2018. Again the work being undertaken to manage flow through the hospital will have a positive impact in reducing overnight stays in PACU.

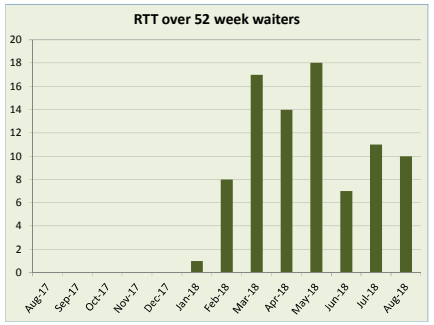
Delivery of the national constitutional standard for RTT (18 weeks) has continued with 92% Incomplete Performance achieved in July and August. Trajectory to improve admitted performance has been agreed with the clinical and operational teams. Delivery of the 4 hour Emergency Care standard improved in August from 74% in July to 81% in August. Minors and Paediatric performance continued to improve. The establishment and opening of the Urgent Care Centre completed in August with both operational and clinical leads being appointed. Mobilisation of the whole team is now well underway. The Trust continues to experience variation in performance on a daily basis, however detailed breach analysis and focus from the senior teams is starting to address these issues. Reduction in the Length of Stay (LOS) and greater discharge planning are critical factors to achieving sustained flow and continuing to improve overall patient experience and flow. Delivery of the Diagnostic Standard remains strong with 99% achieved again in month. Cancer performance improved in month, however, remains fragile. The trajectory to return to delivery of national standard is the end of September.

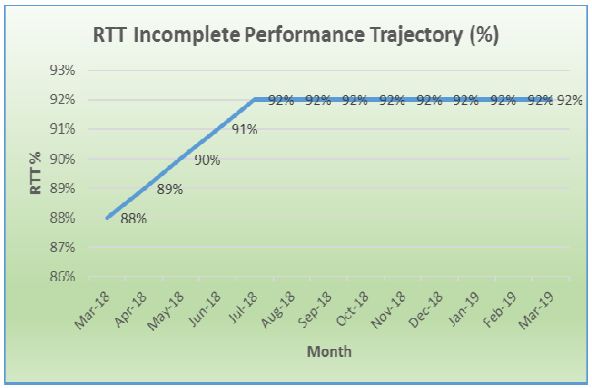
RTT performance has delivered above the national standard for the second month and there is a plan in place to ensure that the 52wk patients are treated. These are paediatric patients who have all undergone a clinical harm review. No issues have been identified. The Trust continue to receive support from Addenbrookes in this specialty.

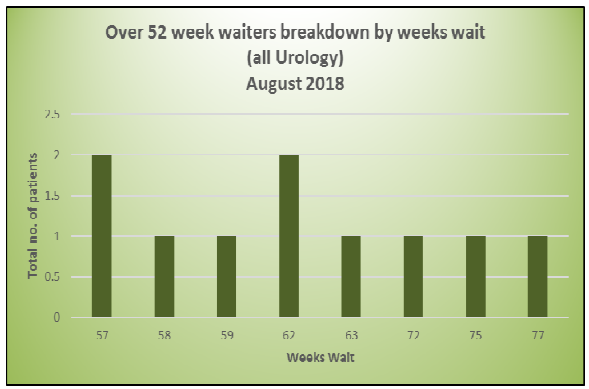


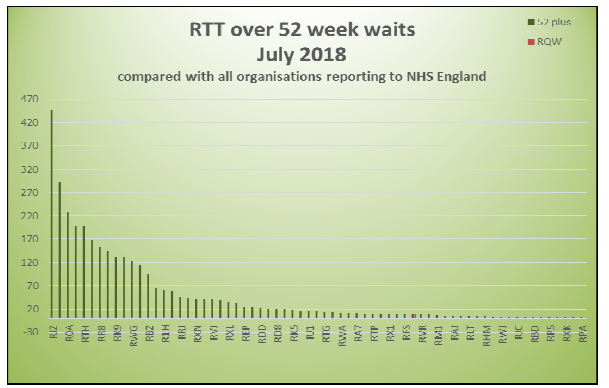












2 Our Performance Summary — 2.2 Responsive - Cancer performance

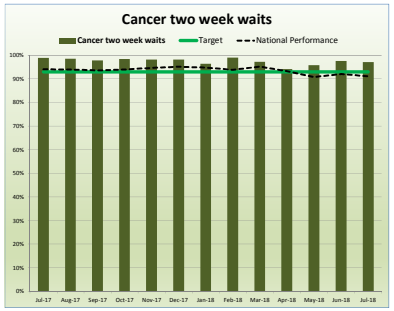
The Princess Alexandra Hospital NHS Trust

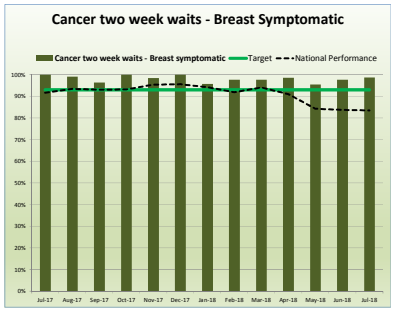
62 day standard

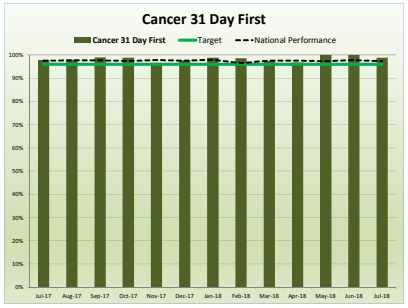
• 2 x Breast patients: Due to clinical complexity and patient choice, these patients would always be within the 15% tolerance allowable. • Head and Neck patient: Delay for diagnostics at PAH and biopsy. The ENT team are due to meet with the Chief Operating officer to review the issues within the Head and Neck Pathway and establish solutions. • Colorectal patient: The patient was referred to the Royal Free hospital on day 25 which is well within the expected timeframe, however the patient required discussion through the hepatobiliary MDT which caused delays at their end and prevented the patient being treated until day 81. • Urology 9 patients: There were issues with Urology capacity, pathology capacity and turnaround times as well as MRI reporting. The MRI reporting is being reviewed and overseen on a daily basis to minimise further delays.

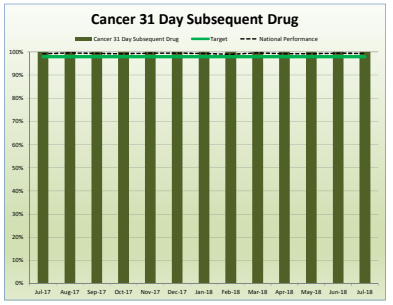
62 day Consultant Upgrade

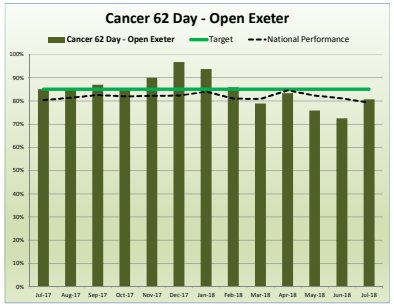
• 3 Urology patients delayed through lack of capacity causing disjointed pathway. Further delays were caused by the clinician not informing the co-ordinator that the patient had been upgraded (1 case). • 2 Skin patients breached due to delays at Mid Essex (2 cases). • 1 Upper GI and 1 Lung failed through the complexity of the patient.

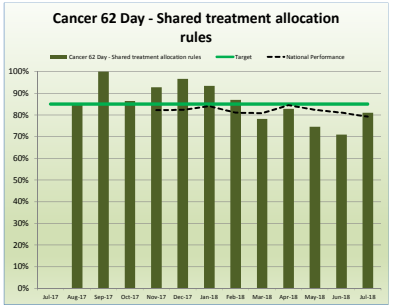


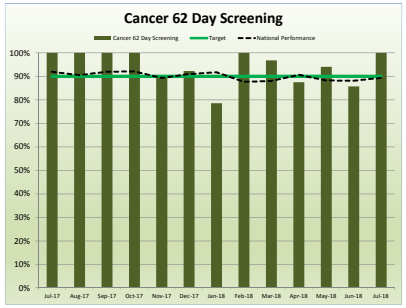


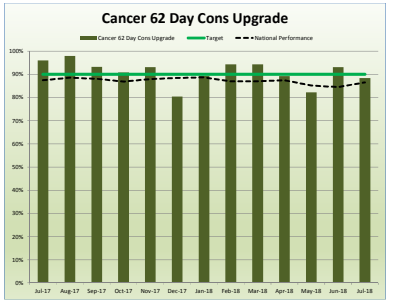


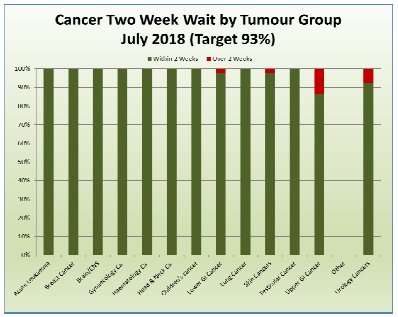


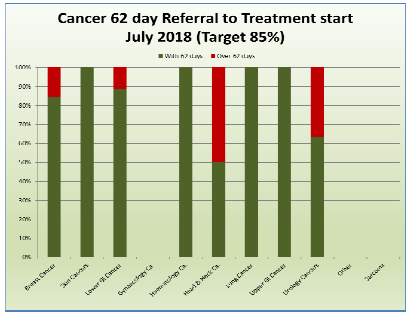












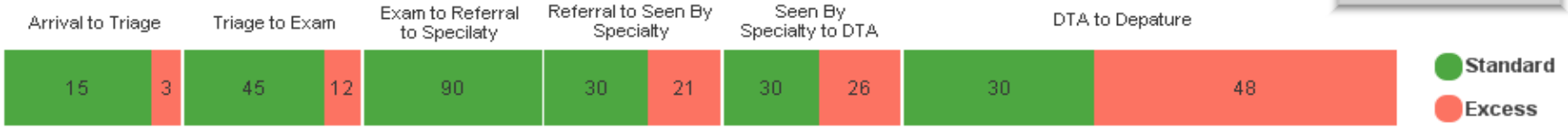
Your future | Our hospital

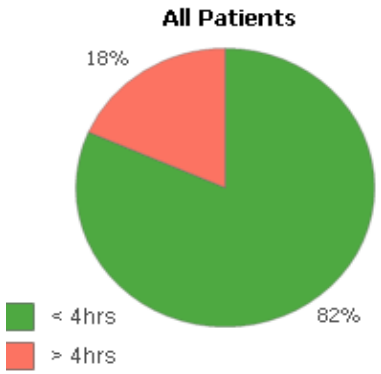
respectful | caring | responsible | committed

20

Median timeline for breach patients showing excess minutes over the standard.

Show hr of breach





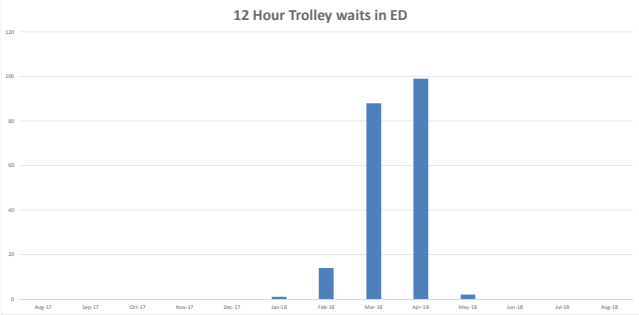
Measure	Standard	Median	Excess	Patients with Timestamp	Patients Who Breached	% Breached	Patients Who Breached Rank
Arrival to Triage	00:15:00	00:18:00	00:03:00	8,291	4,601	55%	
Triage to Exam	00:45:00	00:57:00	00:12:00	7,376	3,339	45%	
Exam to Referral to Specialty	01:30:00	00:58:00	00:00:00	2,435	434	18%	
Referral to Seen by Specialty	00:30:00	00:51:00	00:21:00	2,593	1,658	64%	
Seen by Specialty to DTA	00:30:00	00:56:00	00:26:00	1,600	856	54%	
DTA to Depature	00:30:00	01:18:00	00:48:00	2,143	1,068	50%	

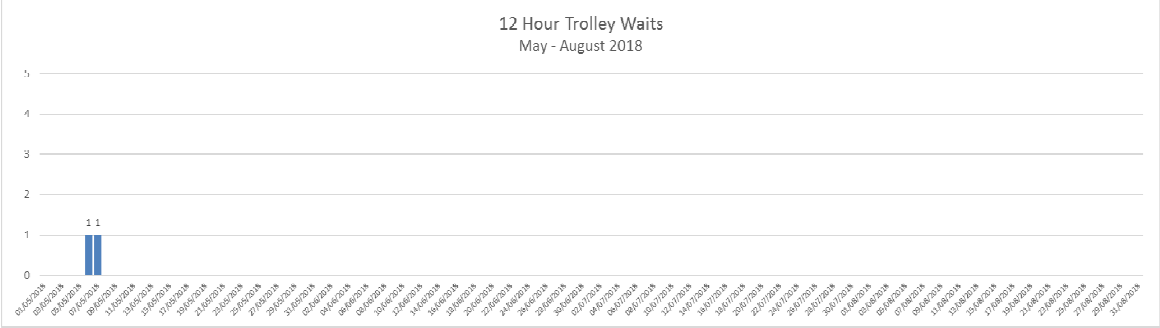
2 Our Performance Summary — 2.4 Responsive - Ambulance & ED

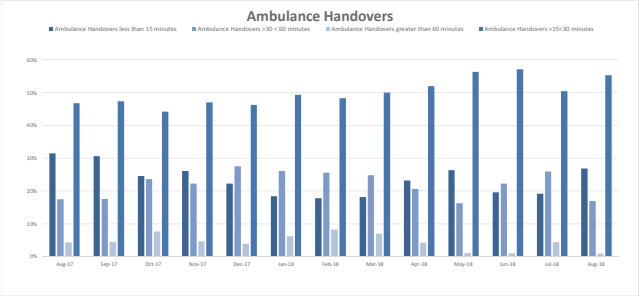
The Princess Alexandra Hospital NHS Trust

12 hour trolley waits: Zero tolerance of 12 hour trolley waits continues and teams work collaboratively to ensure that plans are in place and early escalation of risks are highlighted to senior managers to ensure compliance and patient safety/experience.

Ambulance Handovers: An improvement in performance correlates with an enhanced focus on the RAT process including the ability to provide additional resources during times of surge. This is owing to a slight improvement in workforce numbers both medical and nursing which will continue into the Autumn.



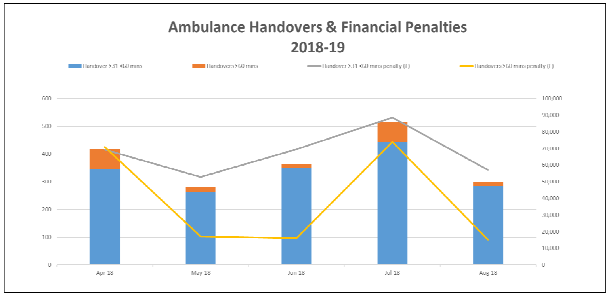




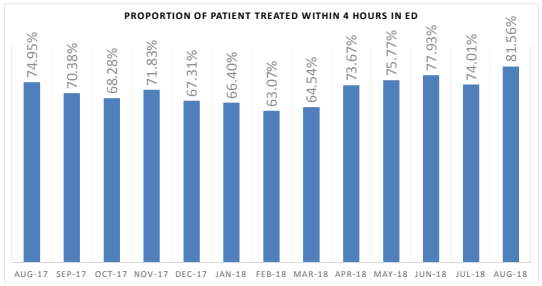
Ambulance Handovers 18/19

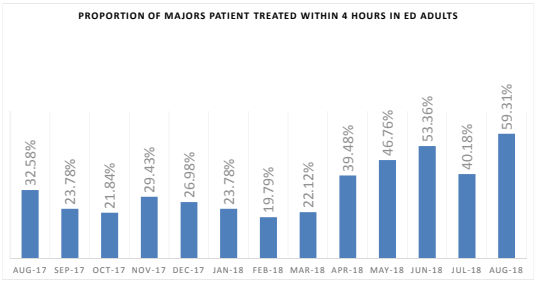
Suspended as part of Sustainability and Transformation Fund, but previously penalised as per contract ref E.B.S.7a/b (pg65)
Ambulance handovers should be within 15 minutes with none waiting more than 30 minutes
£200 per service user waiting over 30 minutes and £1,000 waiting over 60 minutes (in total, not aggregated with 30 minutes penalty)
Handover figures provided by Information

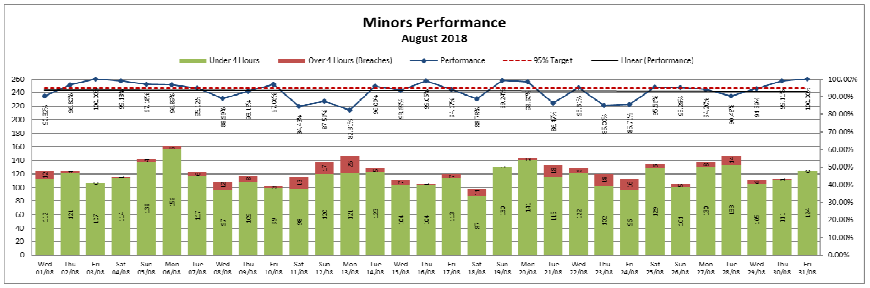
	Penalty per SU	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	YTD
Handover >31 <60 mins		347	264	348	443	285								1687
Handovers >60 mins		71	17	16	74	15								193
Handover >31 <60 mins penalty (£)	200	69,400	52,800	69,600	88,600	57,000	0	0	0	0	0	0	0	337,400
Handovers >60 mins penalty (£)	1,000	71,000	17,000	16,000	74,000	15,000	0	0	0	0	0	0	0	193,000
Total Penalties (£)		140,400	69,800	85,600	162,600	72,000	0	0	0	0	0	0	0	530,400

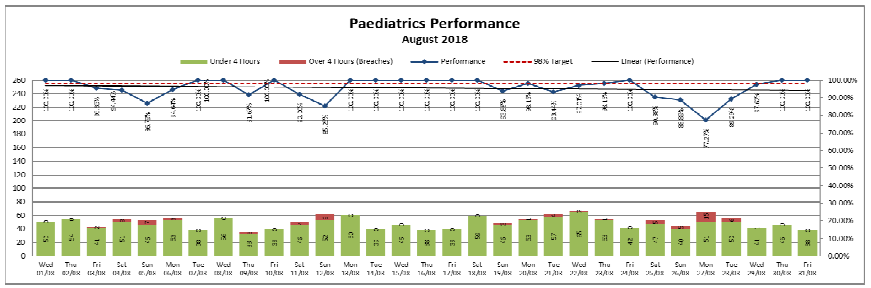


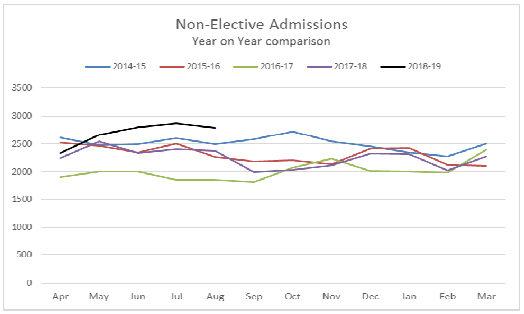
We have continued to see an improvement against 4 hour standard which is encouraging and is the direct result of improved patient flow and clinical ownership and oversight in ED. However, there remains daily variation which the clinical and operational teams are working hard to correct.











2 Our Performance Summary — 2.6 Responsive - Diagnostics, Readmissions, Caesarean Sections

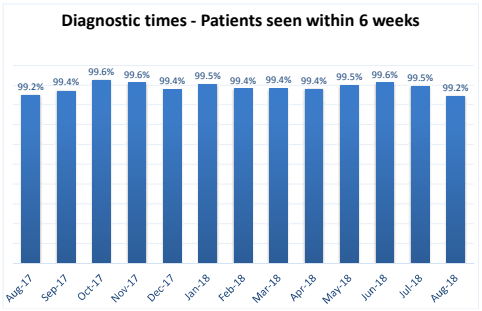
The Princess Alexandra Hospital NHS Trust

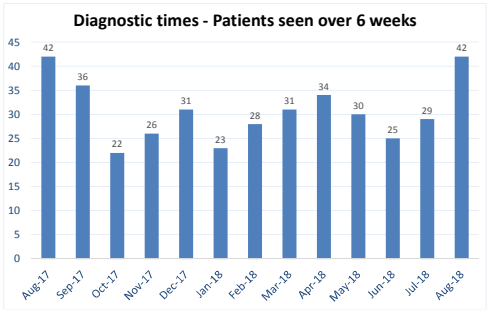
Diagnostics: Patients seen within 6 weeks: We have achieved this target every month for the last 3 and a half years with an average performance of 99.4% over the last 12 months. Nationally, the UK have not met this target for over 2 and a half years with an average performance of 97.2%. Below is the graph to show the month on month performance when compared to the national position.

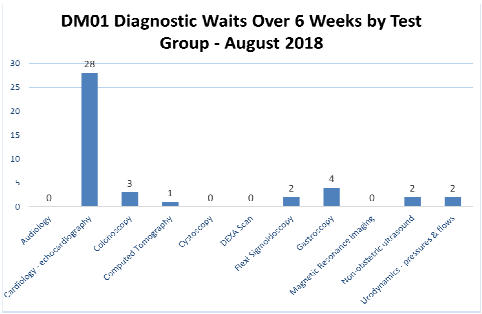
Patients seen over 6 weeks: The number of 6 week breaches fluctuates by month but is predictable year on year with the number increasing in the three key periods of Easter, summer and Christmas. The threshold for breaches for PAH is dependent on activity but is circa 50 breaches per month tolerance. PAH average around 28 breaches per month so have an adequate buffer to allow for unexpected scanner breakdowns, etc.

Over 6 weeks by Test: The graph below shows the breakdown per test over the last 6 months. Yellow areas are where the performance is below the required 99%, but the total numbers performed are relatively low that it is accepted (both locally and nationally) that it is extremely difficult to achieve 99% in those specialties and the numbers of breaches are not a concern.

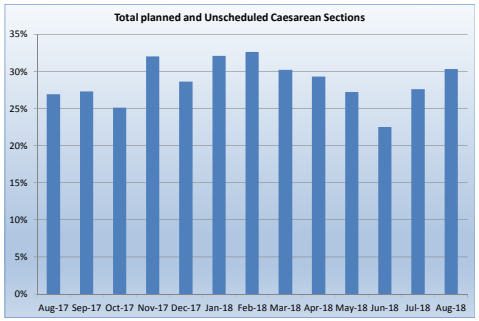
Total Planned & Unscheduled Caesarean Sections: (1) The Labour Ward Consultant is liaising with a hospital with a lower C Section rate in order to determine if any lessons could be learned and translated to PAH.
(2) The Labour Ward Team is planning to review the way the Consultant cover on Labour Ward is organised in order to see if changes may be beneficial. Longer blocks of cover may be conducive to new clinical initiatives.

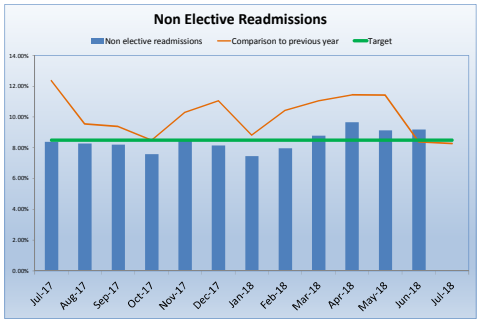


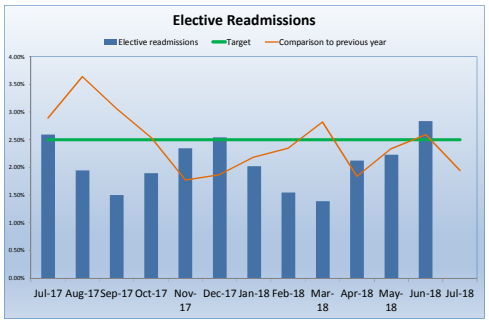




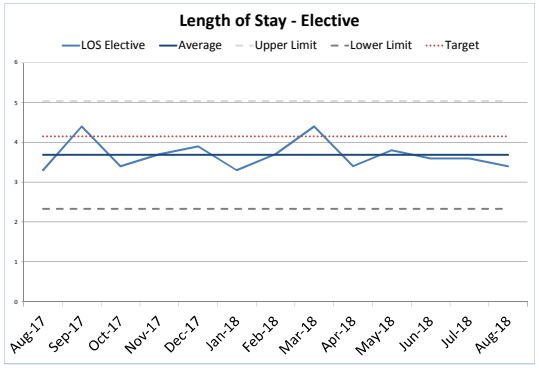
Test	Target	Apr-18	May-18	Jun-18	Jul-18	Aug-18
Magnetic Resonance Imaging (MRI)	99%	99.91%	99.82%	99.72%	100.00%	100.00%
Computed Tomography (CT)	99%	99.37%	99.22%	99.41%	100.00%	99.84%
Non-Obstetric Ultrasound (Non-Obs US)	99%	99.92%	99.81%	99.96%	99.96%	99.92%
DEXA	99%	97.06%	100.00%	100.00%	99.28%	100.00%
Audiology - Audiology Assessments	99%	99.16%	99.25%	98.70%	100.00%	100.00%
Cardiology - Echocardiography	99%	99.37%	99.85%	100.00%	98.48%	95.01%
Neurophysiology	99%	100.00%	100.00%	100.00%	100.00%	100.00%
Urodynamics	99%	100.00%	95.65%	100.00%	88.89%	96.96%
Colonoscopy	99%	96.32%	97.66%	98.53%	94.97%	97.87%
Flexi Sigmoidoscopy	99%	97.37%	96.36%	100.00%	100.00%	95.12%
Cystoscopy	99%	77.78%	95.45%	66.67%	75.00%	100.00%
Gastroscopy	99%	91.75%	95.36%	96.40%	96.67%	94.87%
PAH PERFORMANCE	99%	99.40%	99.48%	99.60%	99.45%	99.22%

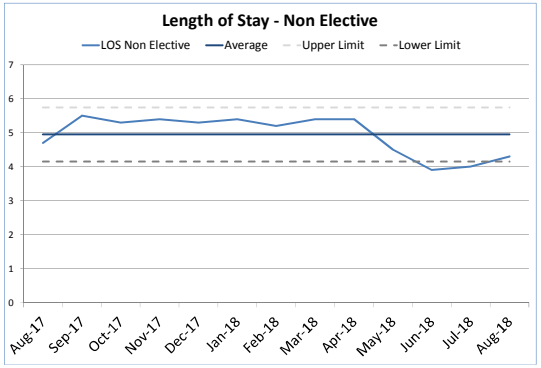


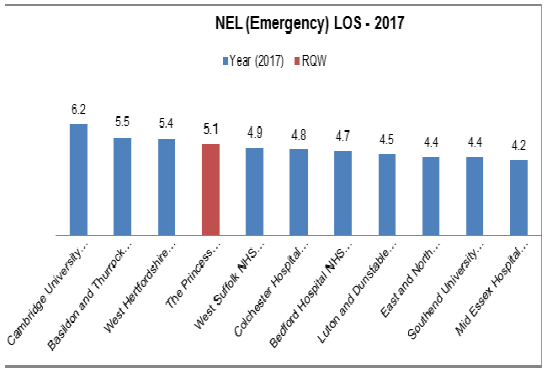


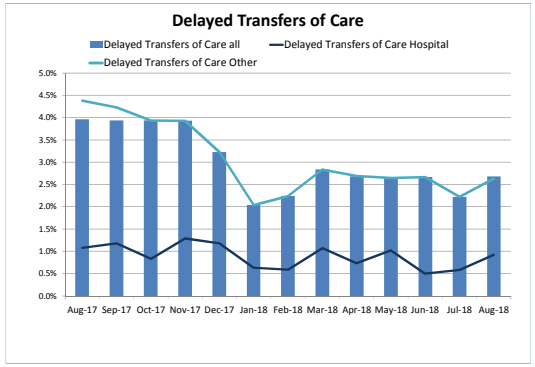


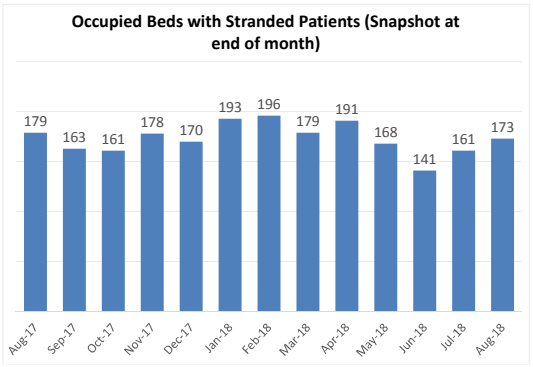
Your future | Our hospital

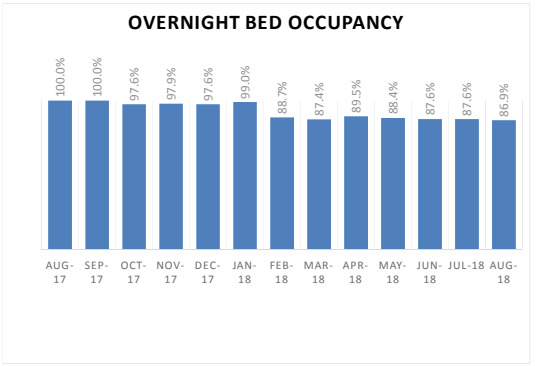










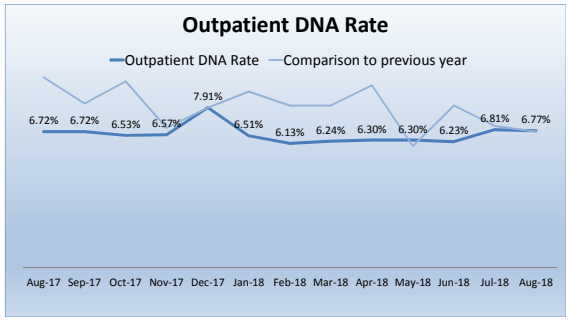


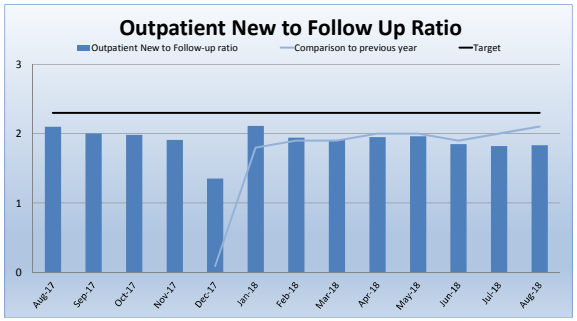
2 Our Performance Summary — 2.8 Outpatient Management

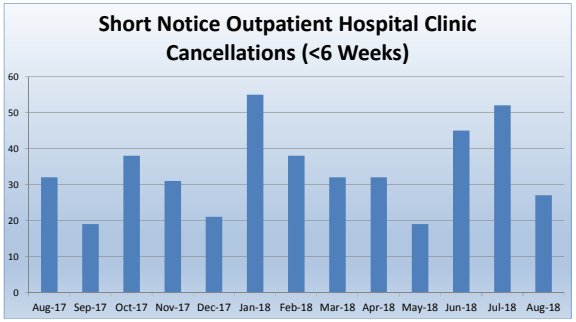
The Princess Alexandra Hospital NHS Trust

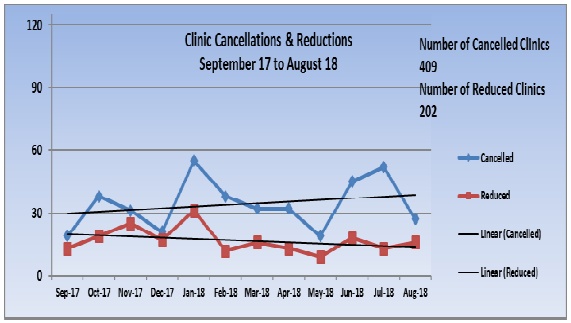
Outpatients: Outpatient DNA rates remain constant under 7% which is below the national average – this places the Trust near the upper quartile of all Trusts in England. Some focus work has commenced on individual specialties where the rate is above 7% in order to further improve overall rates. Outpatient new to follow up rates remain constant & in line with contractual requirements.

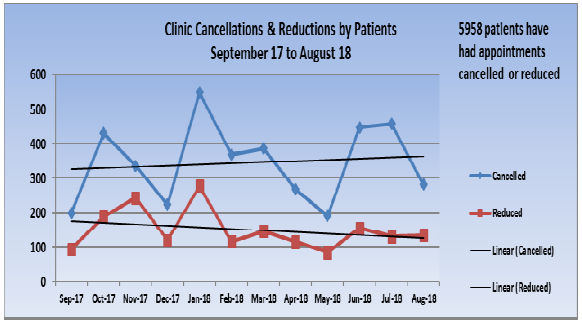
Short Notice Outpatient Hospital Clinic Cancellations: The number of Outpatient Clinics cancelled at short notice for August has reduced since July, with numbers of patients affected significantly lower. Themes for cancellations and reductions continue to be mainly due to locum unavailability (21%) and Rota/Staffing Issues (Doctors 26%, Nurses 12%) predominantly in the specialties of Ophthalmology and Urology. There is significant focus at senior level to address the issue of being able to secure sufficient consultant locum cover to minimize patient cancellations and operational teams are adhering to local short notice cancellation process to clinically prioritise available capacity. Careful weekly monitoring continues to be carried out with escalation to Access Board and then to the Executive Management board. All cancellations must be verified and authorised by a senior member of the HCG management team.

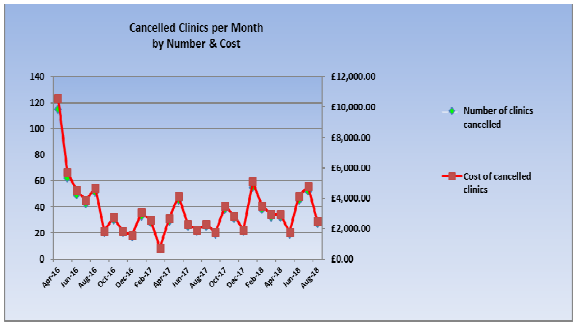












Executive Summary Our People

The Princess Alexandra Hospital NHS Trust

From the 10 objectives in Our People, this month 2 (20%) are performing within the expected range, these are Statutory mandatory training compliance and Safeguarding Adults training rates. Eight objectives (80%) are not achieving the expected monthly performance, these are:-

Appraisal compliance was 76% (except doctors) against trajectory plan of 89%. The medical staff appraisal rate was 92% in month.
All line managers are asked to prioritise the planning and updating of appraisals to ensure they are planned in a timely way. All staff receive a personal email from Leadership & Management Development Facilitator, 3 months before the expiry of their appraisal as a prompt to start completing their personal review and to plan a meeting with the line manager. HCG leadership teams receive summary reports for their areas and this is discussed at the monthly performance reviews. The planned trajectory for this objective has been amended and a phased increase is now planned.

Statutory mandatory training: Performance in month was 86% against a trajectory plan of 87%
Paediatric Life support was 80% (against a planned trajectory of 89%)
Adult life support compliance was 68% (against a plan of 89%)
Safeguarding Children achieved compliance for level 1. The level 2 compliance is 87% (against a plan of 90%); level 3 compliance was 72% (against trajectory plan of 78%).
The remaining topics are within their expected compliance standard.

A training plan is in place with sufficient places available, however there continues to be a shortfall in attendance. Clinical staff non-compliant with four of the level 2 training topics received an email from Chief Nurse and Chief Medical Officer requesting they plan their training. Healthcare group managers are allocating staff onto training dates. The Trust training programme is planned and to address specific training needs for doctors a single days mandatory training will commence from July onwards, this will cover the majority of face to face training topics e.g. safeguarding level 2, fire delivered as class room sessions. Additional topics will need to be attended separately where practical participation is needed in small group's e.g. manual handling and life support.
Further discussion is planned to take place at the executive management board about how to bring about a significant improvement to compliance rates. The planned trajectory for this objective has been amended and a phased increase is now planned. Statutory mandatory training: Performance in month was 86% against a trajectory plan of 87%
Paediatric Life support was 80% (against a planned trajectory of 89%)
Adult life support compliance was 68% (against a plan of 89%)
Safeguarding Children achieved compliance for level 1. The level 2 compliance is 87% (against a plan of 90%); level 3 compliance was 72% (against trajectory plan of 78%).
The remaining topics are within their expected compliance standard.
Information governance will need to be completed on-line by all staff going forward. The statutory mandatory training booklet implemented in September 2017 ensured many staff gained IG compliance. There is concern that the Trusts compliance with the 95% standard required for Information Governance will be impacted from September onwards.
Trust Registered Nurse (RN) vacancy rate is 26% (against a trajectory of 21%). From May to June, the Trust has had more starters then leavers. The rolling recruitment for the year shows uplift in numbers of people in post.
The increase in vacancy rate is as a result in June of an increased the numbers of funded RN posts in ED, Saunders ward (short stay); Melvin (surgical assessment unit) and Kingsmoor ward (cardiology) as they have been repositioned into a larger ward.
The planned trajectory for this objective has been amended and a phased increase is now planned.
Registered Nurse recruitment remains an ongoing priority, the Trust attends job fairs, university recruitment fairs and we have open days and focused advertising. Rolling adverts for RN band 5 and HCA are ongoing with bespoke recruitment for specific clinical areas undertaken as needed. The Trust has successfully recruited 60 nurses from India, which we expect to start coming into post from November 2017.
The nursing retention plan continues and key measures are to extend the preceptorship programme to 18 months and itchy feet programme is now embedded.

To maintain safety: thrice a day 8am, 11.30 and 16.00 meetings between CSM and Matrons to review staffing across the Trust. Safe Care is the primary decision making tool in determining evidence acuity and dependency based staff redeployment. As part of the staffing review the non-nursing staff such as ward co-ordinator, ward clerks, ward assistants are taken into consideration.

Urgent Care training: Compliance rates are variable. Fire and Safeguarding children level 2 achieve the monthly planned trajectory of 87%. Safeguarding adults is almost at trajectory, short by 1%. Safeguarding children level 3 and infection control training rates are lower than expected. This is improving overall with the nursing teams in particular showing an improvement. The ED team are organising for the subject matter experts to deliver specific training to the ED over the summer months to ensure improvement. The planned trajectory for this objective has been amended and a phased increase is now planned.

Children's trained nurses in Recovery: The Surgery and Children's teams are working together to develop the plan for paediatric trained nurses to be working in the theatre recovery (PACU) areas. Paediatrics are advertising for additional band 6 nurses to allow rotation posts to commence with staff working in PACU during the 8am to 8pm period initially. In addition surgery will undertake specific recruitment for recovery to have duel trained nurses. The PACU team will develop a training programme for the paediatric nurses. The surgical teams are ensuring all paediatric patients have their extended recovery period in the paediatric bay in Day Surgery unit up to 8pm. The planned trajectory for this objective has been amended with a gradual phased increase now planned.
Paediatric RN: The ongoing recruitment of paediatric nurses will cover the staffing shortfall for Dolphin our paediatric ward. The Trust already use the Shelford acuity tool (Safecare) and the CQC recommended compliance with the RCN guidance. Safecare tool has been relaunched with the team reinforcing the need to input dependency data daily and for validation by the Ward Manager and Matron. This gives an accurate reflection of the patient's acuity and level of care requirements. Our paediatric team will have discussions with the RCN to capture some specific areas we need to monitor to deliver compliance against both sets of standards. The ward is currently supporting the paediatric emergency department as they have a combination of staff vacancies and maternity leave shifts to be covered. 2.6 WTE Registered nurses have been recruited and expected to start work in the Trusts from September 2018.

3 Our People Summary

3.1 Well Led - Workforce Indicators - Summary

The Princess Alexandra Hospital NHS Trust

Agency Spend 4.3%
Bank Spend 11%

Staff In Post
3007
WTE

Training
88%

Vacancy Rate
12.9%

Sickness
3.2%

Turnover
14%

Medical 96%
Non-Medical 81%

Your future | Our hospital

respectful | caring | responsible | committed

28

The Princess Alexandra Hospital NHS Trust

HCG	Trust Target	Trust & West Essex STP average benchmarking data June 2018	Trust	CCCS	FAWS	MedicineHCG	Surgery HCG	Estates & Facilities	Corporate	HR Workforce	Finance
Funded Establishment- WTE			3478	847.57	483.18	868.15	684.72	270.53	123.27	54.16	146.95
Vacancy Rate	8.0%	13.6%	12.9%↑	4.5%↓	11.4%↑	21.8%↓	17.8%↑	7.4%↑	0.0%	15.9%↑	15.6%↑
Agency % of paybill	7.0%	5.3%	4.3%↓	2.3%↓	4.1%↑	8.1%↑	5.2%↓	1.1%↑	0%↓	4%↓	3.4%↓
Bank Usage – Cost	n/a		£1,501,937	£87,952	£213,539	£908,662	£344,388	£138	£14,873	£7,341	£68,381
Agency Usage -Cost	£858,000		£598,005	£73,213	£84,641	£317,782	£159,849	£8,001	£0	£6,910	£19,643
Sickness Absence	3.5%	3.0%	3.2%↔	2.9%↓	3.3%↓	3.1%↓	3.0%↑	6.8%↑	1.6%↓	0.2%↓	2.4%↓
Long Term Sickness	1.75%		1.8%	1.8%	1.9%	1.4%	1.5%	5.0%	0.0%	0.0%	1.4%
Short Term Sickness	1.75%		1.4%	1.1%	1.5%	1.7%	1.5%	1.6%	1.5%	0.2%	1.0%
Turnover (voluntary)	12%	16%	13.91%↓	13.8%↑	12.5%↓	16.0%↓	14.1%↑	9.3%↓	11.0%↑	13.0%↓	18.6%↑
Stability	90%	82%	88.04%↑	91.7%↑	90%↑	84.6%↓	86%↔	83%↓	87.1%↓	89%↑	89%↓
Statutory & Mandatory Training	90%	88%	88%↓	93%↔	85%↑	83%↓	83%↓	95%↔	94%↔	95.1%↓	97.9%↓
Appraisal	90%	81%	81%↓	84%↓	81%↑	78%↓	81%↓	80%↓	80%↑	87%↔	72%↓
FFT (care of treatment) Q1	70%		78%↑	tbc	tbc	tbc	tbc	tbc	tbc	n/a	n/a
FFT (place to work) Q1	61%		65%↑	tbc	tbc	tbc	tbc	tbc	tbc	n/a	n/a
Active Job Plans (first sign off)	90%		73.0%	86.0%	95.0%	67.0%	70.0%	n/a	n/a	n/a	n/a
Electronic Rosters (Medical staff)	100%		83%↑	56%↑	100%↔	100%↔	75%↑	n/a	n/a	n/a	n/a
Exception Reports (junior doctors)	3		20↑	12↑	0↓	3↑	5↑	n/a	n/a	n/a	n/a
Time to hire (Advert to formal offer made)	31Days		49↑	47↑	48↑	46↑	67↑	n/a	n/a	n/a	n/a

Above target	
Exceeding or below target	
underachieving target	

Patient at home is within Medicine HCG
Increase in Establishment for FAWS and Surgery
↔ ↓↑ Comparison from previous month

Staff Group	Trust Target	Add Prof Scientific and Technic	Additional Clinical Services	Administrative and Clerical	Allied Health Professionals	Estates and Ancillary	Healthcare Scientists	Medical & Dental	Nursing Registered	Midwifery Registered
Funded Establishment – WTE		98.72	574.38	713.17	136.37	303.14	94.83	492.06	919.2	144.1
Vacancy Rate	8.0%	2.2%	6.6%	8.1%	11.2%	7.1%	16.1%	8.4%	28.2%	0.0%
Bank Usage – Cost	n/a	£62,666	£280,464	£125,840	£0	£1,963	£0	£668,451	£347,587	
Agency Usage -Cost	£860,938	£88,909	£0	£25,613	£0	£0	£0	£251,095	£234,387	
Sickness Absence	3.5%	1.1%	4.3%	2.5%	3.9%	6.4%	7.1%	0.4%	3.1%	4.3%
Long Term Sickness	1.75%	0.0%	1.6%	1.5%	2.9%	4.8%	4.5%	0.3%	1.4%	3.2%
Short Term Sickness	1.75%	1.1%	2.6%	0.9%	1.0%	1.6%	2.6%	0.2%	1.6%	1.1%
Turnover (voluntary)	12%	6.6%	16.2%	13.6%	16.5%	7.2%	12.8%	13.6%	17.0%	9.7%
Stability	90%	79.2%	86.4%	90.9%	83.5%	87.6%	87.0%	89.6%	83.5%	89.8%
Statutory & Mandatory Training	90%	93.0%	98.0%	97.0%	94.0%	94.0%	97.0%	62.0%	90.0%	
Appraisal	90%	89.0%	81.0%	78.0%	83.0%	81.0%	86.0%	96.0%	82.0%	

3 Our People Summary — 3.3 Well Led - Workforce Indicators (a)

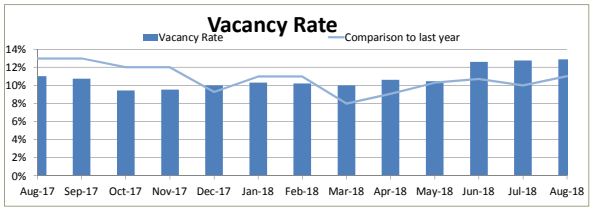
The Princess Alexandra Hospital NHS Trust

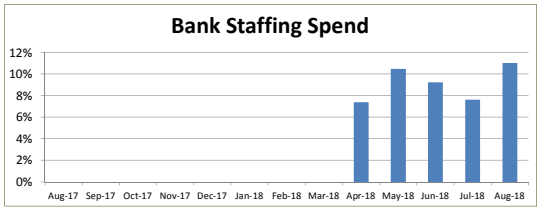
Vacancy Rate: The Trust vacancy rate of 12.87% has increased marginally from last month (up 0.10%) This is following the establishment increases across the Trust. The largest vacancy rate remains within our nursing staff group (22.4%) and is being addressed though a number of initiatives; weekly Skype interviews for both national and international candidates, month recruitment days; the next as part of the Event in a Tent, attending external events at local colleges and universities. We are also preparing for our next international recruitment campaign to the Philippines later this year which will add to the recruitment pipeline.

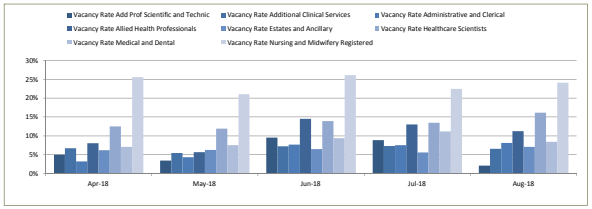
Bank Staffing Spend: Bank spend has increased from the previous month; this increase is in line with a number of retrospective doctors shifts being added in August. Bank usage continues to be in line and monitored against the new NHSP contract. The ongoing effort is to increase bank fill rates and reduce agency spend. The Chief Nurse and Contingent Labour Manager meet fortnightly with NHSP to discuss new incentives, proposals to increase bank fill. Nurses and doctors who are not on bank have been written to individually by the Trust, highlighting the benefits of working shifts via NHSP. It is hoped this will capture staff who have not worked shifts recently. Ward walks will also take place daily by NHSP to the areas with the biggest unfilled rates and work with the teams to try and increase these by agency migration.

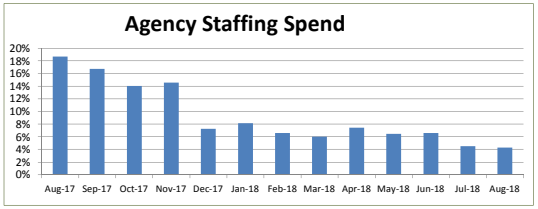
Agency Staffing Spend: Our % of agency has decreased from the previous month and is still below the % threshold. Spend continues to be monitored with medical and AHP supply authorised and reviewed daily between CMO and Contingent Labour Manager. Nursing continues to be authorised by Chief Nurse. Non Medical continues to be authorised by Executive Lead as per temporary staffing policy and countersigned by Director of People. Bank migration continues with NHSP now being monitored under the new contract to increase bank fill rates. Monthly stakeholder review meetings with NHSP continue to take place, as well as weekly reviews with Contingent Labour Manager.

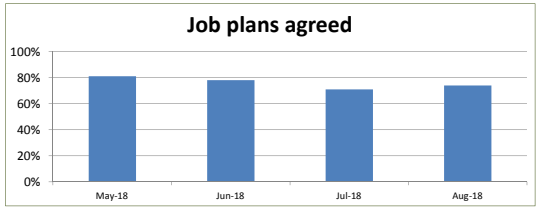
Job plans agreed: These figures indicate that job plans have been submitted (not signed off at final agreement stage). Although job plans are being submitted and signed off by leads, many of these are not correct/in line with guidance and are therefore being reverted back to discussion stage, so these figures may decrease/fluctuate. There are numerous meetings/discussions taking place with AMDS/leads to ensure the information in job planning is correct. The final deadline for submission to 3rd stage is 14th September 2018 at which point they will be reviewed by CMO before final sign off.











Your future | Our hospital

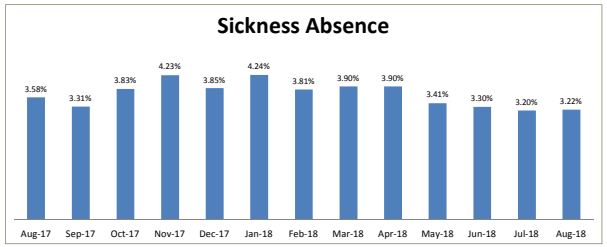
respectful | caring | responsible | committed

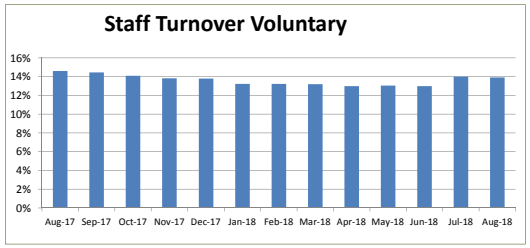
3 Our People Summary — 3.4 Well Led - Workforce Indicators (b)

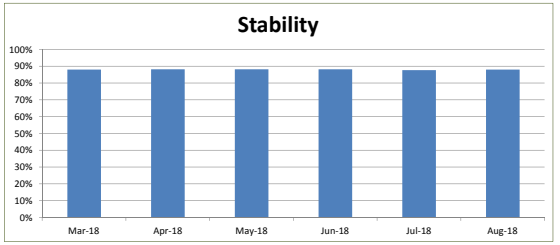
The Princess Alexandra Hospital NHS Trust

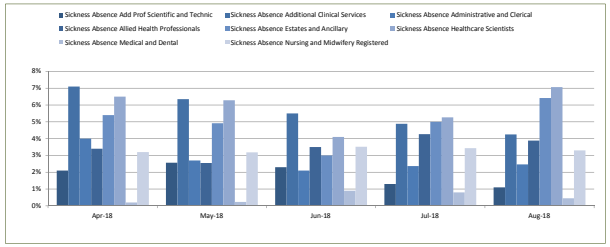
Staff Voluntary Turnover: Voluntary Turnover has remained relatively stable since the start of the year; still above target rate of 12%. An improvement from the previous 12 months.
High turnover rate among employees with less than 24 months' service.

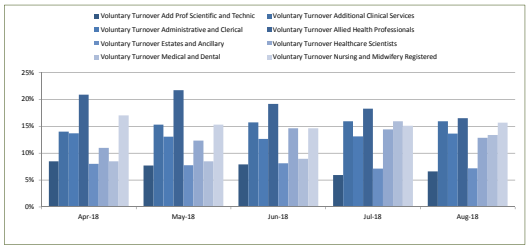
Stability: Overall Stability continues to improve indicating the Trust is retaining its experienced workforce.

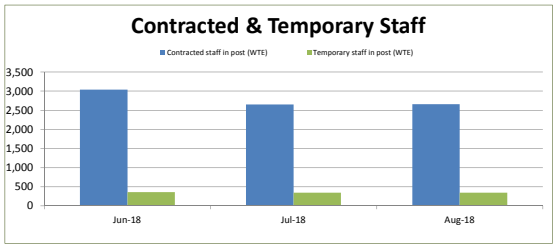












Your future | Our hospital

respectful | caring | responsible | committed

3 Our People Summary

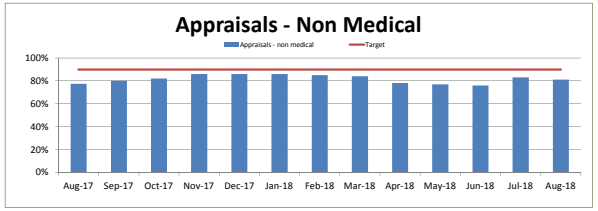
3.5 Well Led - Workforce Indicators (c)

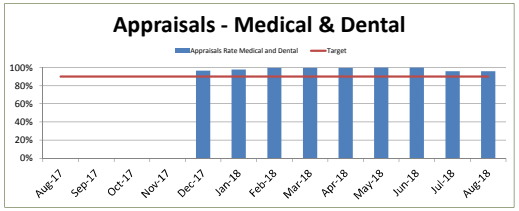
NHS The Princess Alexandra Hospital NHS Trust

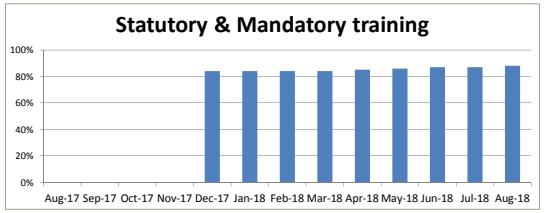
Appraisals – Non Medical: RAG prediction for the next month: Amber. Actions are being taken to bring about an improvement in the RAG prediction for next month:
Implementation of ESR Self-Service functionality
Reminder emails sent to outstanding staff
Deep-Dive meetings
Continue targeted compliance emails to leadership teams highlighting areas below trajectory
1-1 support offered to managers to work through appraisal compliance figures if discrepancies between central and local data are reported
Continued offer of training including in local departments
Explanation for the RAG prediction: Requirement of a 9% improvement in the next 4 weeks. Despite highlighting the requirement for improvement in appraisal completion and a high focus on appraisal completion, recent months (as shown below) have produced only a typical 3% improvement month on month. The progression with compliance decreased by 6%. Without significant effort from those HCGs with the lowest compliance, 90% compliance is unlikely to be achieved.

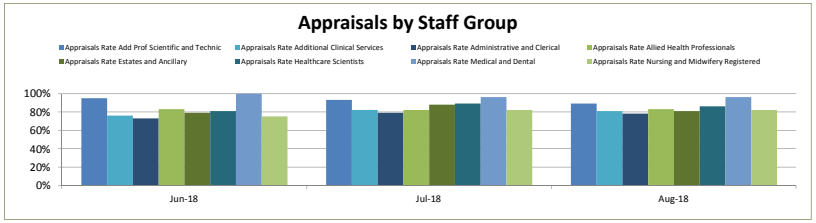
Statutory & Mandatory Training: Overall compliance for August is at 88% with a 2% variance to achieve our organisational target of 90% by September 2018.
Attendance at classroom sessions continues to be patchy, however, enrolment, last minute staff cancellations, DNA's on booked sessions, and session cancellations due to operational pressures, sickness and absence still causing concern. This month we had 229 staff that enrolled onto a class but did not attend. It's anticipated that the newly ratified pay deal which links requirements to pay progression with full compliance with Core training and Appraisal will push staff to full compliance, improve attendance and reduce DNA to training.

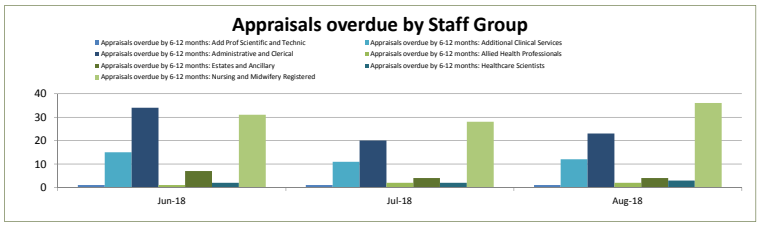
Actions
- Additional Classroom sessions are being provided each month for individual topics at various time slots including out of hours and weekends.
- A special Consultants and Dr's Refresher study days was held in early Sept but attendance was very poor.
- We continue to attend healthcare group board meeting to discuss other measures to increase compliance
- A new Core Training Steering Meeting with all Subject Matter Experts chaired by the People Director started in June to discuss ways to improve compliance
- Mobile sessions continue to be offered at offsite venues and in clinical areas.
- We are working with HCG's and Departments in carrying out 'deep dives', to ensure data accuracy and staff competency profile accuracy.
- The ESR monitoring system sends regular reminders to staff when staff are approaching renewal, and after compliance has lapsed.
- Reminders are sent to all staff who are non-compliant in certain areas to remind them to complete all outstanding training.
- In terms of governance, we continue to advise managers to offer staff Time of in Lieu or additional hours to complete learning if required
- This month, we have auto enrolled all staff that are non-compliant with Level 2 Training in Safeguarding Adults, Safeguarding Children and Infection Prevention & Control advising staff to simply log on and complete training
- In planning for the expected dip in compliance for Fire and Information governance Training in Sept – November largely due to the introduction of the core Training booklet in 2017, we have emailed all staff who will running out of compliance at these period encouraging them to update their compliance before expiration.
- The training team continue to ensure the provision of adequate training sessions and flexible delivery options including improved monitoring and reporting.
- The responsibility to ensure that staff participate in training remains with all staff, their managers and Executive Directors





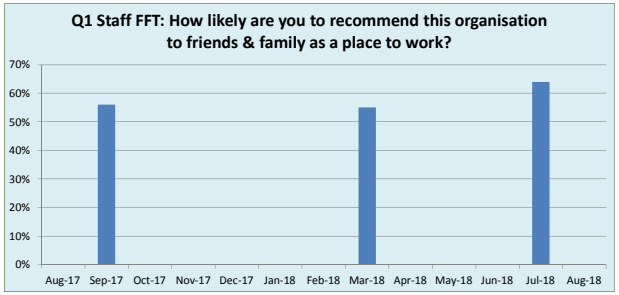


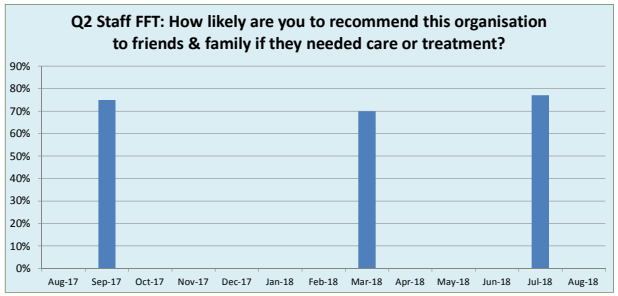




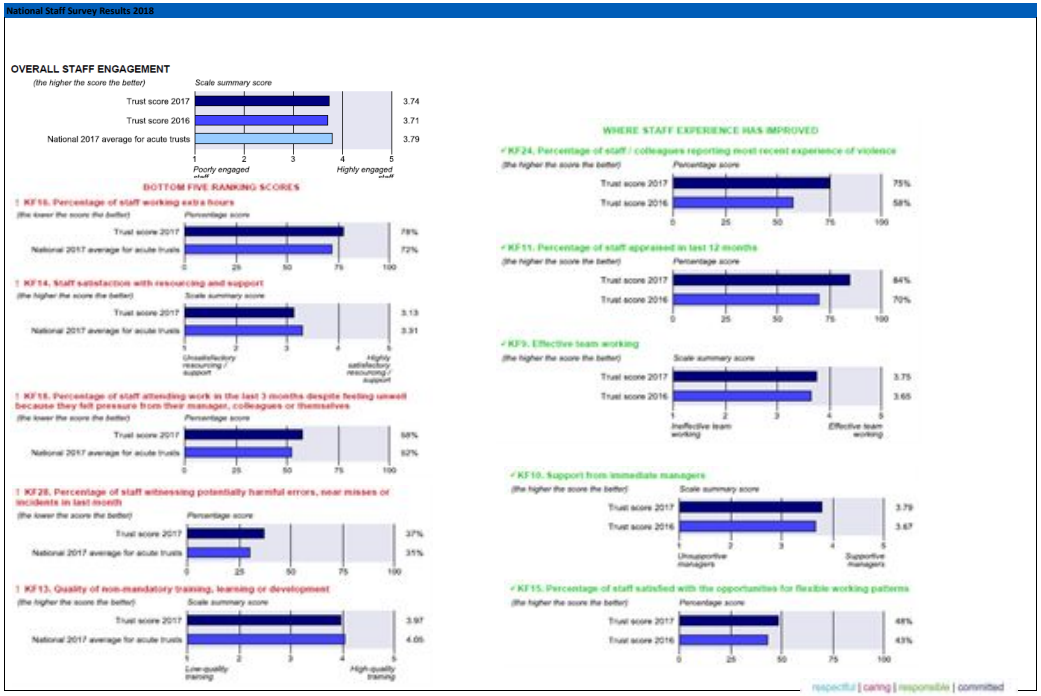
Your future | Our hospital

respectful | caring | responsible | committed





Your future | Our hospital



Executive Summary Our Places

The Princess Alexandra Hospital NHS Trust

Estates and Facilities Structure: A fully developed consultation proposal was presented to the Director of Quality Improvement for assurance, costs and workforce impact. This proposal to restructure facilities management services is developed to fully align with the objectives outlined in the 'Model Hospital' program for meeting national and regional metrics around best use of our estate, and importantly to strengthen its business focus on delivering strategic objectives for this Trust. From the 3 objectives in Our Places, this month the planned preventative maintenance programme is in place.

Refurbishment of HDU: The Trust is not intending to undertake refurbishment work this financial year to review space in the high dependency unit. To mitigate the concerns raised by the CQC, the critical care and estates teams are looking at the possibility of putting in additional sinks or to look at use of portable hand washing facilities in the high dependency unit. Hand Hygiene is a priority on the unit; staff has high compliance with use of hand gels at the bed spaces. The infection control rates on the critical care unit are good.

This proposal addresses the urgent need to realign the estates and facilities team structures to improve the leadership, accountability and governance, and importantly are cost neutral. These proposed changes principally affect the senior leadership team and administrative and clerical roles. It will be necessary to manage these changes in accordance with the Trust's Management of Change Policy.

Catering Consultation: Staff consultation on new catering structure and improved ways of working was formally launched on Friday 10 August, during this period staff have welcomed the opportunity to engage in the process with meaningful dialogue with the senior facilities team. The consultation period has been extended by a further week to provide staff an opportunity to properly present their 'flexible working' applications. It was encouraging to receive positive feedback on the quality and clarity provided in the consultation documentation by staff-side, and recognition of the key objectives to provide assurance to the Board on food standards, growing sustainability needs and ensuring that the services continue to remain flexible and centred on the needs of our patients.

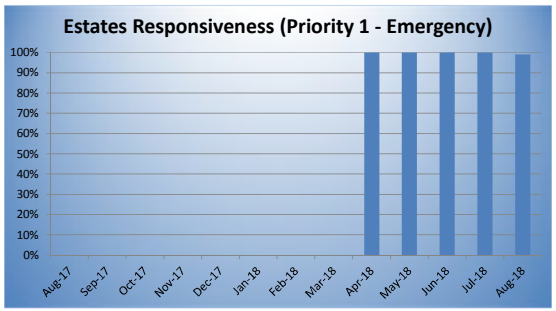
Patient Led Assessment of the Care Environment (PLACE): Following the official release of the Trust's results in August 2018 by NHS Digital, the Trust embarked on a comprehensive programme of change across the six domains, to address areas on improvement necessary to achieve 'upper quartile' national assessment status. These improvements include targeting first impressions on our main wards, e.g. clutter, the labelling on cleaned equipment (Green labels) and protected mealtimes.

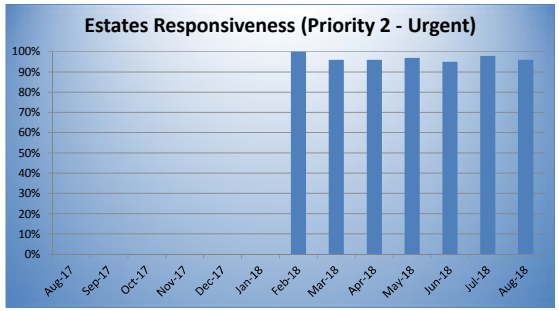
Estates and Facilities Market Testing: The market testing of domestic and estates services is now being progressed as a result of securing a dedicated procurement specialist to undertake a comprehensive tendering exercise, which when complete is expected to deliver higher levels of compliance to engineering, building standards and cleanliness within the Trust. The plan is developed based on estates and facilities management expertise and insight into current market trends. This also aligns with the model hospitals and the need to improve our core standards linked to the Estates & Facilities functions of an acute hospital.

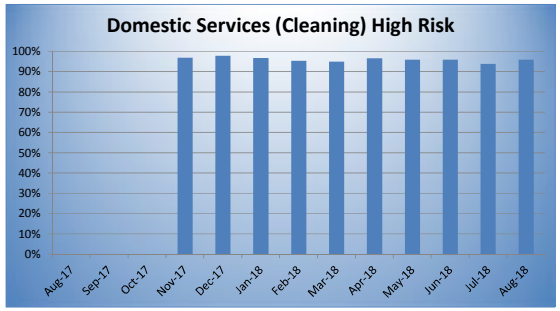
Capital Projects: Significant progress on the annual capital backlog and investment programme has been made with all schemes approaching RIBA level 4 status (full design and build specifications). The majority of the identified backlog maintenance schemes are in the procurement tendering platform. The 27 bedded ward development has advanced and is scheduled for completion in December 2018.

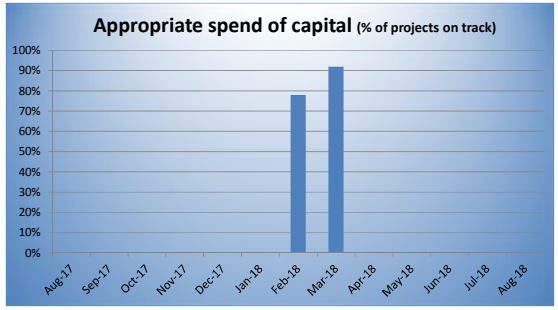
The Princess Alexandra Hospital NHS Trust

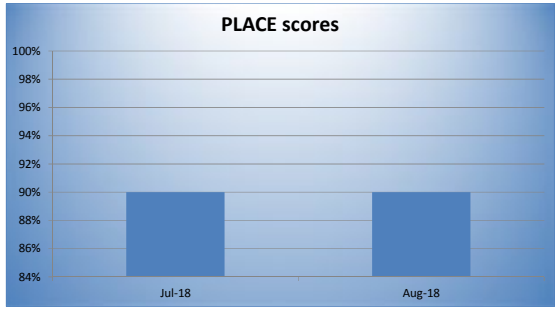
Domestic Services (Cleaning) Very High Risk: Inability to sustain services during the school holiday period.
Catering Services (Patient Satisfaction): Unable to fully quantify satisfaction as the patient surveys were removed from the trays when served.
PLACE scores: Part of a national annual assessment and therefore fixed for the assessment period.





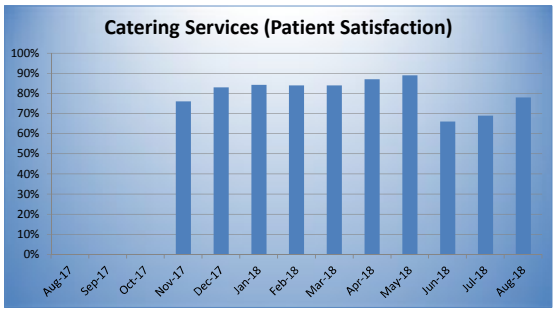


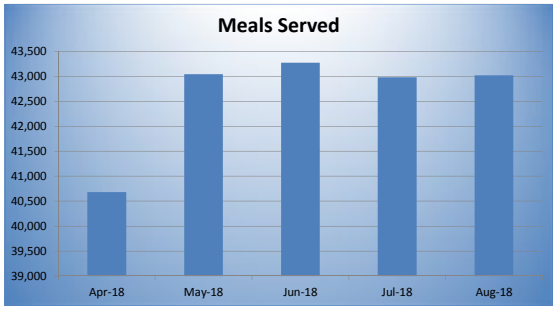




Your future | Our hospital

respectful | caring | responsible | committed


Catering Services (Patient Satisfaction)
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
Aug-17
Sep-17
Oct-17
Nov-17
Dec-17
Jan-18
Feb-18
Mar-18
Apr-18
May-18
Jun-18
Jul-18
Aug-18


Meals Served
43,500
43,000
42,500
42,000
41,500
41,000
40,500
40,000
39,500
39,000
Apr-18
May-18
Jun-18
Jul-18
Aug-18


Catering Food Waste
9%
8%
7%
6%
5%
4%
3%
2%
1%
0%
Mar-18
Apr-18
May-18
Jun-18
Jul-18
Aug-18

Executive Summary Our Pounds

The Princess Alexandra Hospital NHS Trust

The M5 in month was £1.7m, £0.1m behind plan. YTD deficit £13.5m, £0.1m better than plan. Activity and income underperformance in-month was offset by expenditure underspends. Agency costs reduced further and remain within national target.

The key risks to delivery of financial plan are:

a) The potential impact of Commissioner QIPP schemes and associated impact on Trust income levels.
b) Maintaining temporary staff cost management.
c) The impact of pay settlement.
d) Delivery of ED Trajectories to secure PSF funding.

The Trust has developed a number of mitigations, enhanced financial controls remain in place and the Trust is forecasting delivery of its revenue control target and maximisation of its capital resource limit.

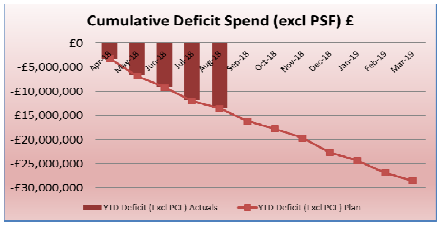
5 Our Pounds Summary

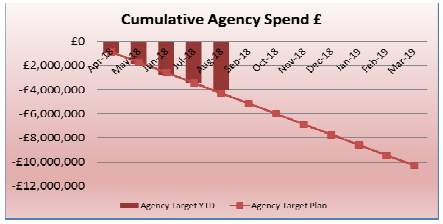
5.1 Overall financial position

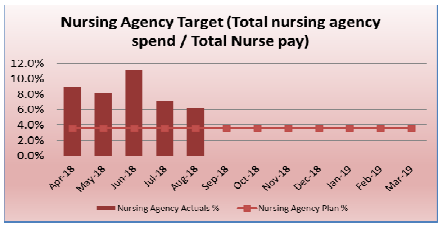
NHS
The Princess Alexandra Hospital
NHS Trust

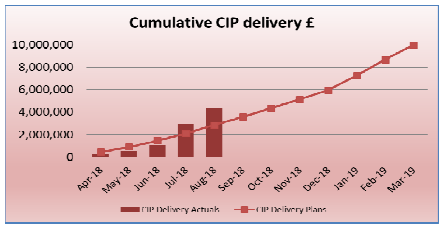
OUR POUNDS

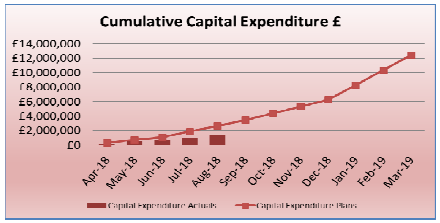
Metric	Annual Plan (Standard)	Previous Month	Latest Month
YTD Deficit (Excl. PSF)	-£28,471,000	-£11,822,867	-£13,487,520
Cumulative Agency Spend £s	£10,300,000	£3,464,000	£4,023,994
Nursing Agency Target (Total nursing agency spend / Total Nurse pay)	3%	7%	6%
Cumulative Capital Expenditure	£12,834,000	£1,055,000	£1,382,600
BPPC Volume	95%	67%	64%
BPPC - £s	95%	79%	75%
Cash Balance	£1,000,000	£4,062,000	£3,531,000

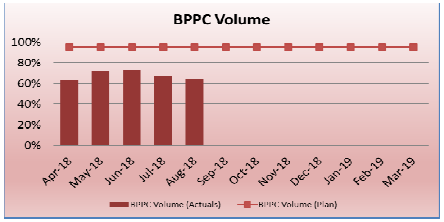


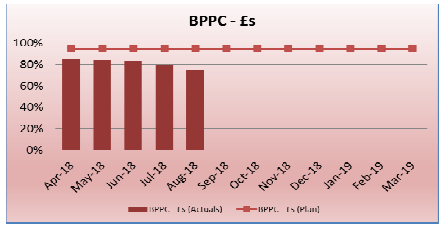


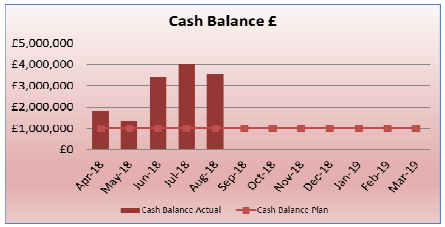










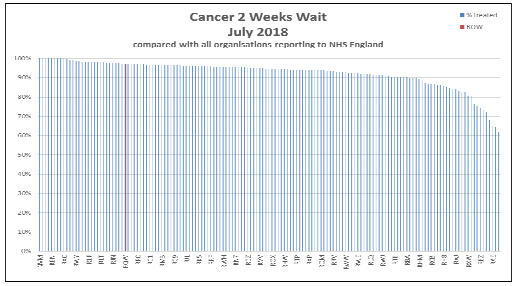


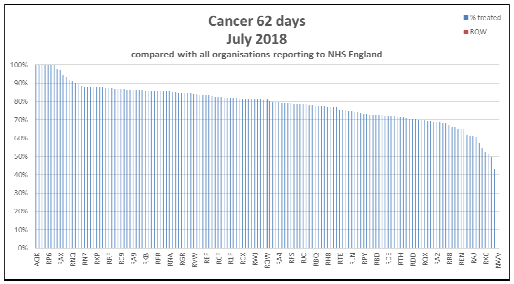
Your future | Our hospital

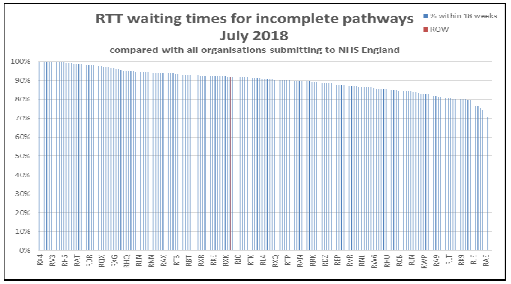
respectful | caring | responsible | committed

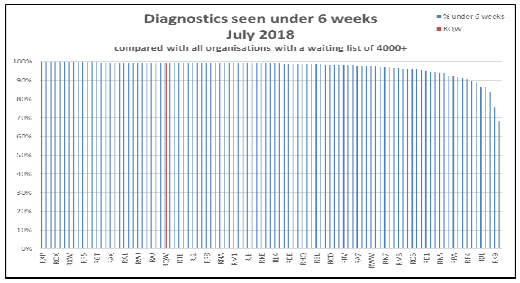
National Benchmarking
Compared with all organisations reporting to NHS England

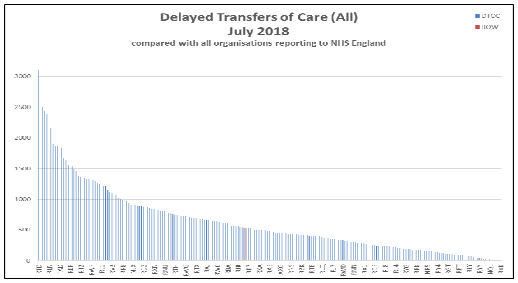
The Princess Alexandra Hospital NHS Trust

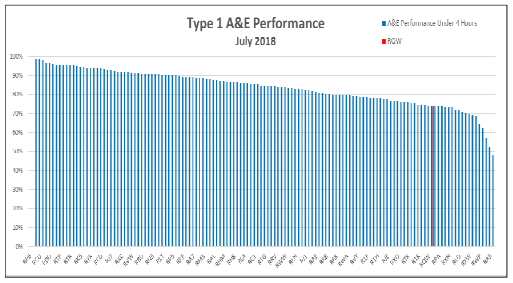


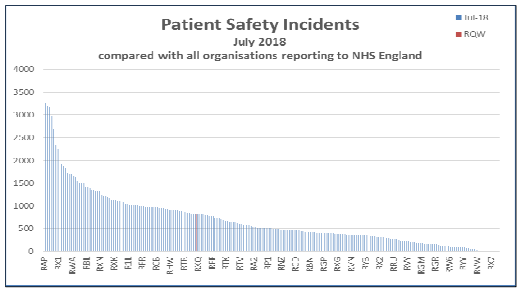


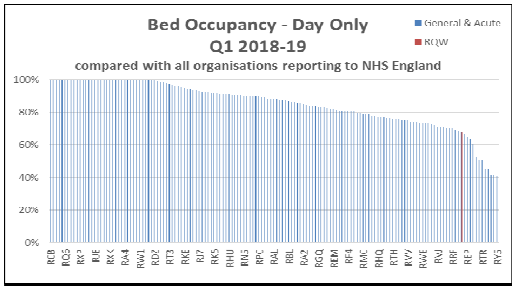


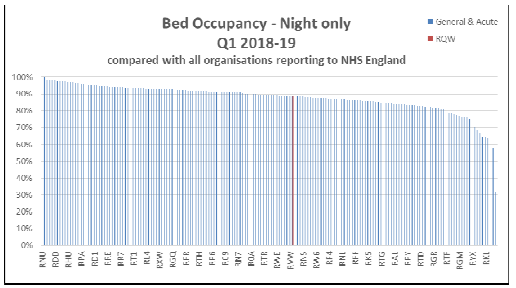












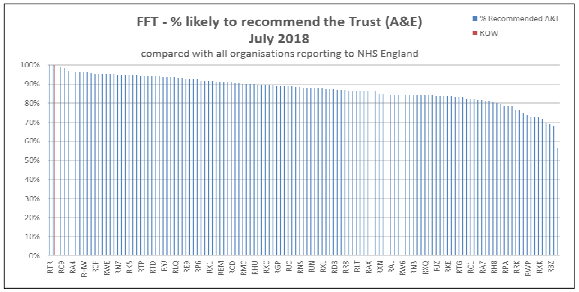
Your future | Our hospital

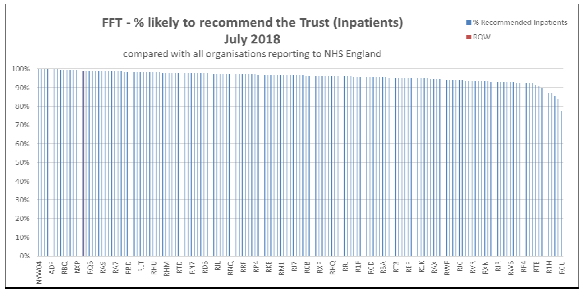
Data Source: NHS England Statistics/Public Health England/Dr Foster

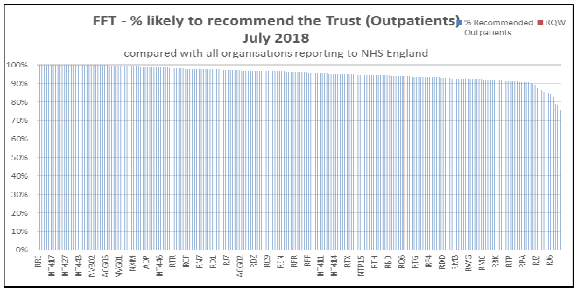
respectful | caring | responsible | committed

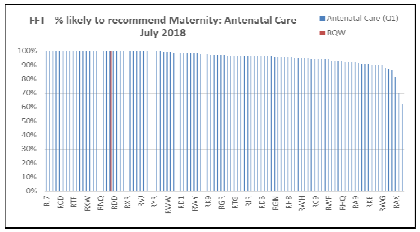
National Benchmarking
Compared with all organisations reporting to NHS England

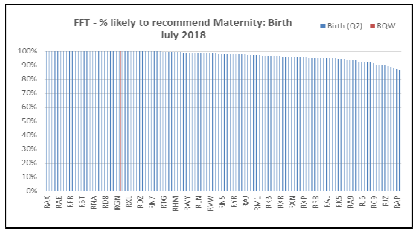
NHS
The Princess Alexandra Hospital
NHS Trust

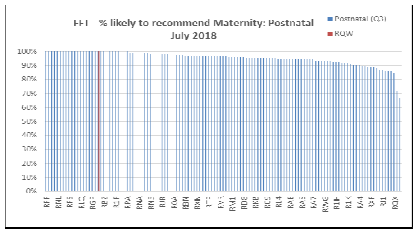


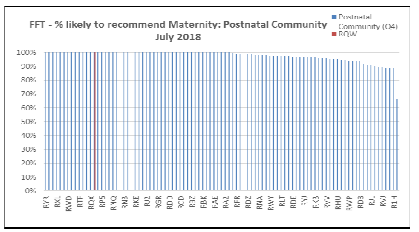


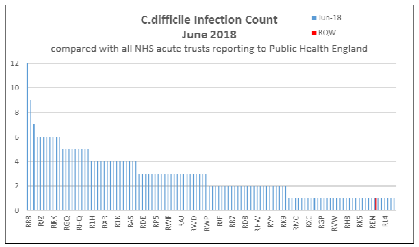


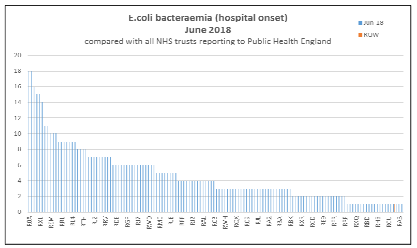


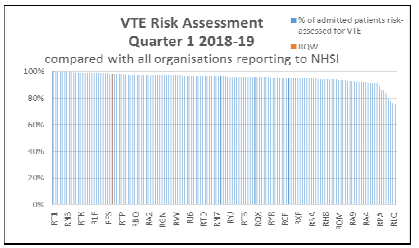


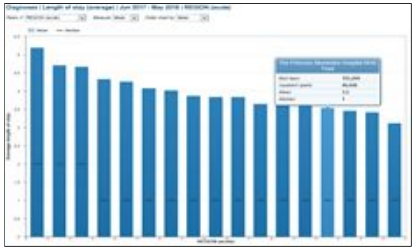












Your future | Our hospital

Data Source: NHS England Statistics

respectful | caring | responsible | committed

Health Care Group Management Priorities

HCG: Surgery & Critical Care

	Our Patients	Our People	Our Performance	Our Process	Our Property
Key Management Priorities 2018-2019	1. Ensure that our patients are safe and protected from harm whilst in our care. Achievement of all CQC Must and Should requirements. 2. Patients are kept well informed about every aspect of their hospital experience. 3. Patients are well cared for and treated with dignity, respect and compassion in a clean and well managed environment.	1. Ensure staff are involved, informed and listened to and ensure staff are supported and confident to do their jobs. 2. Ensure staff receive appropriate education and training to enable them to practice safely. 3. Maintain a turnover rate below 10%.	1. Achieving national performance targets for Cancer Wait Times, Diagnostic standards & RTT. 2. Focus on ensuring all quality standards are met, including the Trusts internal professional standards for response times to ED. 3. Reduce Non elective length of stay.	1. Assess all areas as for 'fit for purpose' to deliver safe care and working environment. 2. Progress Fracture clinic relocation to PAH site. 3. Review eye unit patient flow and clinical space.	1. Deliver Health care groups financial balance 2. Deliver health care group CIP target 3. Reduce agency expenditure by 10% from 2017-18

Quality Dashboard Performance

- 2 SI closed in August and none reported.
- Datix - 101 reported with 93.7% as no or minor harm
- Medication - 16 reported in month all were no or minor harm
- Pressure ulcers - No avoidable pressure ulcers.
- VTE risk assessment- 99% compliant.
- Complaints 4 New with 12 closed in month.
- PALS - 95 New - 115 Open

Concerns

- Urology staffing - new risk- following the loss of 2 appointed Consultants and the further resignation of 2 part time Consultants, both with specialist interest in prostate. This is compounded by the high demand nationally for short and longer term temporary medical staff. A recruitment plan and re advertisement of key posts is underway.
- Anaesthetics staffing - Deanery gap in the trainee rota which has been mitigated though temporary staffing until the new intake of trainees takes place.
- Environment of Penn Ward and HDU require refurbishment on risk register. This is part of a wider capital programme which the teams are aware of.
- Recruitment and retention of staff with main ward areas
- Availability of theatre sessions for new consultants - theatre utilisation programme underway led by Mr Refson Clinical lead General Surgery.

Requires Support

Issue	Action Required	Who by	Domain List
Paediatric Services (all Specialties) remains fragile and is under review.	Full review of all Paediatric services	Full review of all Paediatric services	Full review of all Paediatric services
Support required for recruitment into difficult to fill positions within the HCG	HR support to facilitate other avenues for recruitment	HR support to facilitate other avenues for recruitment	HR support to facilitate other avenues for recruitment

Action Log from previous months

Item	Actions Completed/Outstanding
Repatriation of medical patients into the most appropriate wards & the protection of the surgical bed base in times of increased pressure. Repatriation of Surgical patients from Medicine back into surgical specialties.	review of LOS and bed base required to deliver activity plan.
Support from procurement to maximise STP opportunities.	
Re-location of Urology invasive procedures to PAH site from STM.	
Disaggregation of pre-assessment and admissions and Oak Unit (Invasive Urology procedures).	

HCG: Cancer, Cardiology & Clinical Support Services

	Our Patients	Our People	Our Performance	Our Places	Our Pounds
Key Management Priorities 2018-2019	Achieve a minimum of a 'Good Rating' from the areas that are to be inspected at the next CQC inspection.	Provide the general management tier with leadership and management training	Achieving national performance targets for Cancer Wait Times, Diagnostic standards & RTT.	Confirm direction of travel for future of pathology services	Deliver Health care groups financial (forecasted) out turn position
	Working collaboratively with all HCGs to improve patient pathways through the Quality First Programme.	Implement 7-day working in Therapies, Cardiology & Pathology.	Focus on ensuring all quality standards are met, including the Trusts internal professional standards.	Improve the fabric and infrastructure of cancer services and the Williams day unit	Deliver health care group CIP target
	Improved level of patient compliments and reduced patient complaints	Support Pathology staff through the proposed hub and spoke changes outlined by NHSI	Reduce backlog of Data quality errors across all areas, and work to prevent their creation	Begin the outpatient reconfiguration of services to create a Paeds OPD	Production and utilisation of accurate reference costs and PLIC data

Quality Dashboard Performance

Getting the basics right: 98% compliance with Resus Trolley checks, 100% Compliance with CD checks, 100% Compliance with Fridge Temperature checks across CCCS.
Agency Nurse Checklist: 78% compliance with agency nurse checklist on Kingsmoor Ward this is an increase in compliance.
Nurse/AHP Vacancy: 18% RN on Kingsmoor Ward with active recruitment on going. WDU has 10% RN vacancy and it has proved difficult to recruit competent chemotherapy trained nurses. Recruitment in therapies has significantly improved the vacancy rate.
PALS and Complaints: 1 new complaint in August. 0 ongoing complaints. 24 Negative PALS received aim for local resolution of PALS within 48hrs.
Incident Reporting: 103 incidents reported. 19 minor harm,4 moderate harm,0 Serious Incident, 1 Red incident investigation.
Mortality Meetings: All specialities holding regular mortality reviews and cardiology moving towards morbidity review meetings.
Policies and Guidelines: 9 under review and 1 out of date (awaiting formatting prior to approval).
Clinical Effectiveness: Results from local and national audits including MINAP and the NHFA to be shared at CCCS PS&Q with updated action plans. CCCS are review all local and national audits undertaken by the HCG and are monitoring the results and action plans to ensure they are effective.
Infection Control: Hand hygiene audits > 95% across most areas. Any areas falling below this standard have an action plan in place. 0 MRSA Transmissions, 0 C.Diff cases across the HCG in June.
DNACPR: Maintained compliance with DNACPR Audit.
Pharmacy: Medical Gasses Training for designated nursing officers and Train the trainer training completed. Electronic prescribing system implementation across clinical areas commenced
Regular Heads of Nursing meeting with Chief Pharmacist to ensure communication of medications safety agenda with agreed actions.
End of Life Care: 6 day service has maintained 98% of patients being seen within 48 hours of referral to SPCT.

Concerns

Radiology: The process for our current Consultant Radiologist to obtain an ARSAC license to enable us to continue to provide Nuclear Medicine Services is taking longer than expected. Our current license holder has now retired so there is a period of around 6 months where the Trust will not have a fully registered ARSAC license holder. Conversations underway with East & North Herts Trust for them to temporarily share there Consultant ARSAC license holder with PAH until our own consultant is fully registered. Current Risk Register score of 12.

Cancer: The total number of patients being tracked on pathways with suspected cancer has significantly increased since December 2017. The Cancer Tracking team now have circa 1,340 patients to track at any given time compared to 800 just 6 months ago. The biggest area of increase has been seen in Lower GI so the current capacity issues in Endoscopy is contributing to an ever increasing gap in resources putting the Trust cancer Target at risk for beyond Q1. Plans have been put in place in both urology and Lower GI to recover, but the impact of these changes will take a couple of months to take hold, still leaving the cancer target a risk at this time.

Requires Support

Issue	Action Required	Who by	Domain List
Radiology: The process for our current Consultant Radiologist to obtain an ARSAC license to enable us to continue to provide Nuclear Medicine Services is taking longer than expected. Our current license holder has now retired so there is a period of around 6 months where the Trust will not have a fully registered ARSAC license holder. Current risk register score of 12.	Conversations underway with East & North Herts Trust for them to temporarily share there Consultant ARSAC license holder with PAH until our own consultant is fully registered.	AMD for CCCS	Business Continuity

Action Log from previous months

Item	Actions Completed/Outstanding
Cancer: The total number of patients being tracked on pathways with suspected cancer has significantly increased since December 2017. The Cancer Tracking team now have circa 1,340 patients to track at any given time compared to 800 just 6 months ago. The biggest area of increase has been seen in Lower GI so the current capacity issues in Endoscopy is contributing to an ever increasing gap in resources putting the Trust cancer Target at risk for beyond Q1. Plans have been put in place in both urology and Lower GI to recover, but the impact of these changes will take a couple of months to take hold, still leaving the cancer target a risk at this time.	Data being analysed (specifically for 2 week wait performance) in both these areas and evidence that urology is starting to improve is evident. So the expectation is that Urology should be in a position to deliver their cancer target from September onwards. There still remains some doubt over Lower GI due to endoscopy capacity as data does not show any improvement at this stage.

HCG: Family & Women Services

	Our Patients	Our People	Our Performance	Our Places	Our Pounds
Key Management Priorities 2018-2019	Improve on incidence reporting in order to improve services	Safeguarding, Appraisal & Mandatory Training for all staff	Achieving an improved CQC Outcome for Child Health	Maternity theatres - to comply with statutory requirements.	Achieve on all CIP
	Improve patient experience, safety & outcome	Nursing Midwifery & Medical Staff Recruitment	Maintain all NHS performance standards in RTT, Cancer & Diagnostics.	Ensure all areas are adequately equipped to meet activity needs in order to achieve excellent patient outcomes & experience.	Achieve our financial forecast outturn
	Improve on patient complaint & feedback platform	Improve on staff engagement	Focus on achieving the 95% 4hrs paediatric ED wait standard	PAAU opened to help achieve paediatric ED standard	Thorough look at SLR with Head of Finance to optimise spend and reporting.
		Staff to be fully involved in all service plans/development		On-going planning with Capital & Estates Team on all capital works.	
		All staff to have clear objectives & PDP			

Quality Dashboard Performance	Missing outcomes codes	FAWS had 5 missing outcomes on 10/08/18 (4 Paediatrics and 1 Gynaecology). This is well within the target to keep the number of outstanding to <30. Daily emails are sent of all outstanding appointments to named clinic Consultants to complete. A few community midwives do not have remote access signals and therefore the outcome of appointments are completed later.
	Invalid Source of Referral	This has been reduced down to 115 outstanding in total. There is a plan in place to correct all these which is on target. Currently the highest numbers are on Dolphin ward & EPU referrals from A & E
	Missing or incomplete discharge summaries	There has been a small increase since last month but the rate of increase is reducing. 10% of all the FAWS missing discharge summaries have been audited. An ongoing 3 month rolling audit is presented and discussed at every FAWS Board Meeting and new processes are being put in place to reduce this further.
	National & Access Target Performance	FAWS delivered against all Cancer and RTT national targets. Paeds - 98.9%, Gynae - 95.6% Paeds ED - 95%, Gynae CWT (2WW - 100%, 62D - 100%, 31D - 100%)
	Patients unarrived or DNA list	There are 9 (down from 31 last month) outstanding for FAWS. This is within our target to maintain the number of outstanding to <30

Concerns	Medical, midwifery & nursing staff shortages & the difficulty with recruiting to these posts.
	Contract issues regarding Maternity pathways, but now in discussions with East and North Herts to agree the Maternity Antenatal Lead provider status correctly going forward.
	LSCS - 30.7% in August 2018. This is above our target of 25%. There will be clinical review of this.
	Achieving and maintaining the 95% national target for paediatric ED
	Medical staffing, out of hours is not compliant with statutory recommendation for O&G department
	Transitional care on the postnatal ward – this has increased workload and prolonged the LOS in hospital for mothers and babies
	There is currently only 1 Labour Ward theatre while the second Labour Ward theatre starts refurbishment

	Issue	Action Required	Who by	Domain List
Requires Support	The second Labour Ward Theatre does not meeting the Capacity & National Standard and is not yet completed	**High Impact -** Building work has commenced on the second theatre - expected completion by Sept 2018 Meeting with Estates on the 19th September for update and confirmation that work is on target for completion date as set.	Capital Board	Project & Business Constraints
	Medical staffing, out of hours not compliant with statutory recommendation.	**High Impact** - The Business case completed. Agreed way forward for this was to add this to factored in as a budget cost pressure for 2018/2019 to ensure adequate staff to meet National standards recommended in Safer Childbirth. These posts are out for advert but we have been unable to recruit to the posts to date. Meeting with HR on the 19th to review advert.	HG Lead, EMB	Statutory Compliance, Operational Development
	Continued difficulty in recruitment of specialist staff throughout the HG.	**High Impact** - Recruitment systems & processes being streamlined to meet Health Group requirements.	HR, HG Leads	Workforce & Operational Development
	A Service development to match the activity and capacity with the suggested requirement of a second clinical room and couch for Women's Health OP i.e. Hysteroscopy, Colposcopy, Myosure services	**Medium Impact** - To review current services and offices co-located in this area and develop the business/service plan to create a second clinical room to allow for the increase in activities in Gynae oncology. Timeline to be worked up and presented at Performance review in November 2019 .	HG Leads, Capital Board	Project & Business Constraints
	Space to increase our ANC bookings	**Medium Impact** - To review use of HEH & SMH.	HG Leads	Project & Business Constraints

	Item	Actions Completed/Outstanding
Action Log from previous months	Recruitment of Nursing staff for Nightingale ward	Outstanding – Recruitment has been very positive for Nightingale Ward. There are still 1 WTE Band 6 and 10 WTE B5 post and 1.6 WTE HCA posts vacant with further interview dates agreed and set.
	Maternity theatres build - to ensure the building programme of works is completed on time.	Outstanding - Build programme agreed, building works have commenced, 2nd theatre build commenced
	Location for the development of a Paeds Assessment & Ambulatory Unit	Completed - PAAU opened and running Monday - Friday
	Data Quality & Maternity Pathway inconsistencies.	Outstanding - on-going work to improve DQ, DQ Manager working with HG & Information team

HCG: Medicine

	Our Patients	Our People	Our Performance	Our Places	Our Pounds
Key Management Priorities 2018-2019	Improve patient safety, outcomes & experience.	Improve staff wellbeing, engagement & involvement.	Achieve greater grip on performance including the ED 4 hour performance.	Ensure full utilisation on ambulatory in particular GP Assessment patients to ensure the best experience for patients on a consistent basis.	Achieve greater grip on aspects of finance, management of budgets and income against plan.
	Achieve greater integration, which for us means patient centred, well coordinated & sustainable care.	Recruitment & retention of medical & nursing staff across key specialties & wards.	Improving patient flow, reducing patient delays, reducing ED crowding, removing exit block from ED & improvement against the four hour standard.	Ensure consistent use of Medical Assessment space, to take patients directly from ED Streaming & RAT.	Delivery CIP savings and a sustainable reduction in temporary staff expenditure
	Non Invasive Ventilation (NIV) Service to start on Locke Ward.	Develop strategy based upon staff feedback from quality framework analysis (enablers) & performance captured in our balanced scorecard (results).	Embed the Rapid Access & Treatment process.	Embed the End of Life & Dementia service on Gibberd Ward.	Delivery of agreed forecast out turn.

Quality Dashboard Performance

Safe:

Risk Register August 2018

1. A&E 4 hour target (20)
2. Band 5 vacancies across the healthcare group (inc ED) (20)
3. Endoscopy Washers (20)
4. Nursing and Medical vacancies P@H (20)

Incidents August 2018
Serious Incidents
New: 0
Closed: 1
Deescalated: 1
Open: 5 at month end. (including 1 which is sitting with Radiology,
Internal Reds
New: 20
Closed: 0

Quality Audits August 2018
95.31% Compliance with Pressure Ulcer Standards
98.57% Compliance with Vital Sign Observation
93.72% Compliance with Falls Standards
96% Compliance with Hand Hygiene
98.95% Compliance with Medicines Management
100% Compliance with Admin. of critical Medicines
94.58% Compliance with Oral Hygiene Standards
96.47% Compliance with Pain Standard
95.11% Compliance with Nutrition Standards

CAS Alerts
1 Chief Medical Officer Alert received and actioned.
0 Medical Device Alert
0 PSA new
2 PSA outstanding. 1 overdue.
3 ISBs received in August

NICE Guidance (All)
12 received in August 2018

36 Total
2 x Not implemented
8 x Mostly Implemented
26 x under review -

Caring:

Complaints - August 2018
9 complaints received.
13 Complaints closed.
21 open complaints at month end.
Themes: Nursing care, failure to follow procedure,

PHSO
0 new PHSO
7218 – await final report from PHSO
8868 – await review by PHSO
8923 – await review by PHSO

PALS August 2018
77 received.
70 PALS closed .
186 PALS open at month end.

CQC enquiry
0 received for August 2018.

Compliments
37 compliments received and logged on Datix for Healthcare

Well- Led:

Vacancy position **21.8%**
New starters **38**, leavers **16** (WTE)
Sickness **3.1,** last month **3.4**
Appraisal rates (central data) **78%** compliance

Concerns

- ED current performance against national target. ED - Need to improve streaming processes at the front door and ambulance handover times.
- The number of ongoing medical and nursing vacancies and the impact that this has on retention, staff morale, reliance on temporary workforce.
- Financial gap against plan, specifically concerning non elective admissions. Understanding of gap is underway to enable remedial plans to be developed
- Endoscopy capacity is limited for planned activity. Remedial actions plans are being implemented

Requires Support

Issue	Action Required	Who by	Domain List
ED Performance and Patient Flow	Engagement from all operational & site teams to sustained delivery of improved communications both in & out of hours. Reset of capacity to make create space for the medical assessment unit. Q1st working with the Emergency department to improve the ABC within the department.	Site Team, Surgery, MHG, FAW's	Quality
Financial gap against plan, specifically concerning non elective admissions. Understanding of gap is underway to enable remedial plans to be developed	Understanding of development of plan and assumptions made	Finance, Information	Finance
Medical staffing - ongoing number of consultant vacancies in Medicine which is being mirrored nationally is impacting on the ability to deliver & sustain performance.	Exploration of alternative recruitment initiatives to assist in the appointment of suitably qualified staff to support delivery of the service. Middle Grade posts advertised.	Recruitment	Workforce & Operational Development

Action Log from previous months

Item	Actions Completed/Outstanding
Engagement from all operational & site teams to sustain delivery of improved communications both in & out of hours. Attendance by all health groups at the Urgent care programme board and the daily 1pm huddle	A meeting with the Site Team will be arranged with the DOP /Deputy COO.
Exploration of alternative recruitment initiatives to assist in the appointment of suitably qualified staff to support delivery of the service.	Ongoing recruitment into medical and nursing vacancies required

CQUIN

CQUIN schemes 2017-2019

For the first time NHS England have published a 2 year scheme which is aimed at providing greater certainty & stability on the CQUIN goals, leaving more time for health communities to focus on improvement initiatives.

There are no locally derived CQUIN schemes for 2017-2019. The value of the CQUINs is approximately 2.5% of the value of contracts held by PAHT.

The national CQUIN schemes are:

- Improving staff health & wellbeing
- Reducing the impact of serious infections (antimicrobial usage & sepsis)
- Improving services for people with mental health needs who present to A&E
- Offering advice & guidance (hospital clinicians to GPs)
- NHS e referrals
- Supporting proactive & safe discharge
- Preventing ill health by risky behaviours – alcohol & tobacco (2018/19)

Monitoring arrangements:

- The Trust has identified individuals to lead each of the CQUIN schemes.
- A schedule for monthly monitoring meetings is in place, chaired by the Deputy Chief Nurse who is supported by a Trust Income & Contracts Manager. The purpose of the monthly meeting is to review progress against the agreed quarterly milestones for each scheme, to identify any risks to achievement for appropriate escalation.
- Monthly meetings with the lead commissioner also take place to ensure early recognition of any challenges or obstructions which may affect successful achievement of milestones.
- Monitoring performance against CQUIN schemes will be undertaken by the Service Performance Quality Review Group (SPQRG) which has attendance from East & North Hertfordshire & West Essex Clinical Commissioning Groups & PAHT (chaired by West Essex Clinical Commissioning Group (WECCG).

Reporting process:

- Progress Reports & Evidence of delivery of CQUIN will be submitted to commissioners on a quarterly basis.
- A progress report on CQUIN achievement will be submitted to the Trust Performance & Finance Committee in April, September & December 2017 & to the Quality & Safety Committee bi-annually.

Schemes 2017-18	Goal weighting (1.5% total)	Milestone	Milestone weighting	Milestone weighting (as proportion of goal weighting)	Forecast acheivement	Actual Acheivement	Forecast delivery	Total contract value combined (WE & ENH CCG)	Contract value (WECCG)	Contract value (ENHCCG)	Actual Total Achievement by Quarter
								£167,885,000	£107,706,000	£60,179,000	
1) NHS Staff Health and Wellbeing	0.0834%	Q1	0%	0.0000%	0%	n/a	0.0000%	£0.00	£0.00	£0.00	N/A
(a) Introduction of health and wellbeing		Q2	0%	0.0000%	0%	n/a	0.0000%	£0.00	£0.00	£0.00	N/A
initiatives		Q3	0%	0.0000%	0%	n/a	0.0000%	£0.00	£0.00	£0.00	N/A
		Q4	100%	0.0834%	0%		0.0000%	£140,016.09	£89,826.80	£50,189.29	
Total								**£140,016.09**	**£89,826.80**	**£50,189.29**	
1) NHS Staff Health and Wellbeing	0.0833%	Q1	0%	0.0000%	0%	n/a	0.0000%	£0.00	£0.00	£0.00	N/A
(b) Healthy food for NHS staff, visitors and		Q2	0%	0.0000%	0%	n/a	0.0000%	£0.00	£0.00	£0.00	N/A
patients		Q3	0%	0.0000%	0%	n/a	0.0000%	£0.00	£0.00	£0.00	N/A
		Q4	100%	0.0833%	100%		0.0833%	£139,848.21	£89,719.10	£50,129.11	
Total								**£139,848.21**	**£89,719.10**	**£50,129.11**	
1) NHS Staff Health and Wellbeing	0.0833%	Q1	0%	0.0000%	50%	n/a	0.0000%	£0.00	£0.00	£0.00	N/A
(c) Improving the uptake of flu		Q2	0%	0.0000%	50%	n/a	0.0000%	£0.00	£0.00	£0.00	N/A
vaccinations for front line staff		Q3	0%	0.0000%	50%	n/a	0.0000%	£0.00	£0.00	£0.00	N/A
		Q4	100%	0.0833%	100%		0.0833%	£139,848.21	£89,719.10	£50,129.11	
Total								**£139,848.21**	**£89,719.10**	**£50,129.11**	
2) Reduction in impact of serious infections	0.0625%	Q1	25%	0.0156%	70%	68%	0.0109%	£26,232.03	£16,829.06	£9,402.97	£17,837.78
(a) Identification of sepsis in ED and		Q2	25%	0.0156%	70%	40%	0.0109%	£26,232.03	£16,829.06	£9,402.97	£10,492.81
inpatient settings		Q3	25%	0.0156%	70%	40%	0.0109%	£26,232.03	£16,829.06	£9,402.97	£26,232.03
		Q4	25%	0.0156%	70%		0.0109%	£26,232.03	£16,829.06	£9,402.97	
Total								**£104,928.13**	**£67,316.25**	**£37,611.88**	
2) Reduction in impact of serious infections	0.0625%	Q1	25%	0.0156%	70%	68%	0.0109%	£26,232.03	£16,829.06	£9,402.97	£17,837.78
(b) Treatment of sepsis in ED and inpatient		Q2	25%	0.0156%	70%	70%	0.0109%	£26,232.03	£16,829.06	£9,402.97	£18,362.42
settings		Q3	25%	0.0156%	70%	70%	0.0109%	£26,232.03	£16,829.06	£9,402.97	£26,232.03
		Q4	25%	0.0156%	70%		0.0109%	£26,232.03	£16,829.06	£9,402.97	
Total								**£104,928.13**	**£67,316.25**	**£37,611.88**	
2) Reduction in impact of serious infections	0.0625%	Q1	25%	0.0156%	100%	100%	0.0156%	£26,232.03	£16,829.06	£9,402.97	£26,232.03
(c) Antibiotic review		Q2	25%	0.0156%	0%	100%	0.0000%	£26,232.03	£16,829.06	£9,402.97	£26,232.03
		Q3	25%	0.0156%	0%	100%	0.0000%	£26,232.03	£16,829.06	£9,402.97	£26,232.03
		Q4	25%	0.0156%	0%		0.0000%	£26,232.03	£16,829.06	£9,402.97	
Total								**£104,928.13**	**£67,316.25**	**£37,611.88**	
2) Reduction in impact of serious infections	0.0625%	Q1	0%	0.0000%	100%	n/a	0.0000%	£0.00	£0.00	£0.00	£0.00
(d) Reduction in antibiotic consumption per		Q2	0%	0.0000%	100%	n/a	0.0000%	£0.00	£0.00	£0.00	£0.00
1,000 admissions		Q3	0%	0.0000%	100%	n/a	0.0000%	£0.00	£0.00	£0.00	£0.00
		Q4	33.4%	0.0209%	100%		0.0209%	£35,045.99	£22,483.63	£12,562.37	
			33.3%	0.0208%	100%		0.0208%	£34,941.07	£22,416.31	£12,524.75	
			33.3%	0.0208%	100%		0.0208%	£34,941.07	£22,416.31	£12,524.75	
Total								**£104,928.13**	**£67,316.25**	**£37,611.88**	
3) Improving services for people with MH	0.2500%	Q1	10%	0.0250%	100%	0%	0.0250%	£41,971.25	£0.00	£0.00	£0.00
needs who present to A&E		Q2	40%	0.1000%	80%	100%	0.0800%	£167,885.00	£107,706.00	£60,179.00	£167,885.00
		Q3	10%	0.0250%	80%	100%	0.0200%	£41,971.25	£26,926.50	£15,044.75	£41,971.25
		Q4	40%	0.1000%	75%		0.0750%	£167,885.00	£107,706.00	£60,179.00	
Total								**£419,712.50**	**£242,338.50**	**£135,402.75**	
4) Offering Advice and Guidance	0.2500%	Q1	25%	0.0625%	50%	50%	0.0313%	£104,928.13	£67,316.25	£37,611.88	£52,464.06
		Q2	25%	0.0625%	100%	100%	0.0625%	£104,928.13	£67,316.25	£37,611.88	£104,928.13
		Q3	25%	0.0625%	80%	92%	0.0500%	£104,928.13	£67,316.25	£37,611.88	£104,928.13
		Q4	25%	0.0625%	80%		0.0500%	£104,928.13	£67,316.25	£37,611.88	
Total								**£419,712.50**	**£269,265.00**	**£150,447.50**	
5) NHS e-referrals	0.2500%	Q1	25%	0.0625%	100%	100%	0.0625%	£104,928.13	£67,316.25	£37,611.88	£104,928.13
		Q2	25%	0.0625%	80%	50%	0.0500%	£104,928.13	£67,316.25	£37,611.88	£52,464.06
		Q3	25%	0.0625%	70%	50%	0.0438%	£104,928.13	£67,316.25	£37,611.88	£104,928.13
		Q4	25%	0.0625%	70%		0.0438%	£104,928.13	£67,316.25	£37,611.88	
Total								**£419,712.50**	**£269,265.00**	**£150,447.50**	
6) a) Supporting Proactive and Safe Discharg	0.1000%	Q1	0%	0.0000%	0%	0%	0.0000%	£0.00	£0.00	£0.00	£0.00
		Q2	100%	0.1000%	100%	100%	0.1000%	£167,885.00	£107,706.00	£60,179.00	£167,885.00
		Q3	0%	0.0000%	0%	n/a	0.0000%	£0.00	£0.00	£0.00	£0.00
		Q4	0%	0.0000%	0%	n/a	0.0000%	£0.00	£0.00	£0.00	
Total								**£167,885.00**	**£107,706.00**	**£60,179.00**	
6) b) Supporting Proactive and Safe Discharg	0.0500%	Q1	75%	0.0375%	100%	100%	0.0375%	£52.506	£33.685	£18.821	£62,956.88
		Q2	0%	0.0000%	0%	n/a	0.0000%	£0.00	£0.00	£0.00	£0.00
		Q3	25%	0.0125%	0%	0%	0.0000%	£17.50	£11.23	£6.27	£20,985.63
		Q4	0%	0.0000%	0%	n/a	0.0000%	£0.00	£0.00	£0.00	
Total								**£70.01**	**£44.91**	**£25.09**	
6) c) Supporting Proactive and Safe Discharg	0.1000%	Q1	0%	0.0000%	0%	n/a	0.0000%	£0.00	£0.00	£0.00	£0.00
		Q2	0%	0.0000%	0%	n/a	0.0000%	£0.00	£0.00	£0.00	£0.00
		Q3	0%	0.0000%	0%	n/a	0.0000%	£0.00	£0.00	£0.00	£0.00
		Q4	100%	0.1000%	50%		0.0500%	£139.85	£89.72	£50.13	
Total								**£139.85**	**£89.72**	**£50.13**	
Total	1.5%			1.5%			74.23%	**£2,266,447.50**	**£1,427,104.50**	**£797,371.75**	**£1,182,015.33**
Engagement with STP	0.5%					0.50%		£839,425.00	£538,530.0	£300,895.0	
Local schemes (risk reserve)	0.5%					0.50%		£839,425.00	£538,530.0	£300,895.0	

The Princess Alexandra Hospital NHS Trust

TRUST BOARD 4 OCTOBER 2018

Agenda Item:	7.1							
Presented by:	Michael Meredith - Director of Strategy							
Prepared by:	Michael Meredith - Director of Strategy							
Date prepared:	27 September 2018							
Subject / Title:	Our New Hospital							
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 paper is to update the Board on the ongoing development of the case for a new hospital and specifically the selection of an off-site location.							
Recommendation:	The Trust Board is asked to: - Delay the off-site evaluation until the detailed analysis and supporting information is complete. - Evaluate the 3 site options together in a public Board meeting on 7 March 2019, rather than the previously agreed 2-stage evaluation process.							

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:	N/A
Legislation, regulatory, equality, diversity and dignity implications:	N/A
Appendices:	N/A

respectful | caring | responsible | committed

The Princess Alexandra Hospital NHS Trust

Trust Board 4 October 2018

Our New Hospital Update

1. PURPOSE

This paper is to update the Board on the ongoing development of the case for a new hospital and specifically the selection of an off-site location.

2. UPDATE: OFF SITE OPTIONS

The Board is considering three options for location of the new hospital. They are:

- Redeveloping the existing site (on-site option)
- North of Harlow in Gilston Village (off-site option 1)
- East of Harlow at Junction 7A of the M11 (off-site option 2)

The plan for deciding on the preferred site was that we would take a 2-stage approach. Against the criteria, discussed with our health and local authority partners through the new hospital steering group and agreed by the Trust Board on 2 August 2018 that we would:

- Evaluate and agree the preferred off site option today (4 October)
- Evaluate this with the on-site option and agree the preferred site option (7 March 2019).

The decision would be pending final commercial negotiation with land owners.

Unfortunately we do not have the level of information at this stage required for us to make a fully informed decision on our preferred off-site option.

The choice of preferred site is a very significant and very important decision for the Trust, for our people and most importantly for all of the local residents who currently use or may use our services in the future. It is imperative that we have all of the right information to the detail that we feel comfortable with to be able to make a fully informed decision.

The recent pausing of the Gilston Village Master Plan and the further detailed traffic modelling required with regard to the impact of a new hospital at Junction 7A of the M11 mean we are do not yet have the full and complete information that we expected to at this stage (we should note that Essex County Council has been extremely helpful working with our modelling team to give the level of assurance needed to reach a decision).

It is expected that the detailed traffic modelling output will be available in November 2018.

3. UPDATE – on-site option

The Trust is currently working with both health planners and master planners to complete a thorough and detailed analysis of the future demand for acute services, in conjunction with our integrated care plans with our health and care partners. These will, in turn, lead to a detailed requirement for hospital space including wards, diagnostics and consulting rooms.

Alongside the health planning work we are also undertaking a more detailed analysis of the cost, phasing and 'fit to site' of redeveloping the existing PAH site. This is a very technical exercise that will require a number of months to complete. It is an important piece of work to

enable us to evaluate the viability of redeveloping the existing site and the timing and financial impact of this, to enable a full evaluation of the patient, clinical and financial benefits of either remaining or moving off site.

It is expected that this work will have been fully completed by early February 2019.

4. PROPOSAL

The earliest that we will have sufficiently detailed information about some of the evaluation for the criteria for the preferred off-site option is November 2018. Given the proximity in timing to the completion of the information required to fully evaluate the on-site option (February 2019), it is proposed that we move from a 2-stage evaluation process (as outlined above) to a single evaluation process on 7 March 2019.

This would be an evaluation of all 3 sites at the same time and would allow a single position to be set out, giving complete clarity with regard to the Trust's preferred option.

It is also proposed that we undertake this meeting as a full Trust Board meeting in public.

It is important to note, that this change to a single staged process will not delay our planned timeframe of making a final preferred site option by March 2018, and therefore will not delay our capital assurance process with NHS England. We are still on track to meet with their regional team with the relevant documentation, including a pre-consultation business case and a revised Strategic Outline Case in the spring.

5. RECOMMENDATION

The Trust Board is asked to:

- Delay the off-site evaluation until the detailed analysis and supporting information is complete.
- Evaluate the 3 site options together in a public Board meeting on 7 March 2019, rather than the previously agreed 2-stage evaluation process.

Author: Michael Meredith, Director of Strategy
Date: 27 September 2018

Your future | Our hospital

The Princess Alexandra Hospital NHS Trust

Trust Board - 4 October 2018

Agenda Item:	7.2
Presented by:	Director of Quality Improvement - Jim Mc Leish
Prepared by:	STP authors
Date prepared:	26 September 2018
Subject / Title:	

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 attached STP Estates plan is presented to Board for noting. This submission is currently being considered by NHSE and the STP awaits feedback on the content of the submission including expected confirmation of successful wave 4 bids. Feedback is expected in November 2018.
Recommendation:	The Board is asked to review and note the STP Estates Plan.

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:	N/A
Legislation, regulatory, equality, diversity and dignity implications:	N/A
Appendices:	

7.2

respectful | caring | responsible | committed

Trust Board Meeting
05 July 2018

Title of the paper	**Hertfordshire and West Essex STP Estates Plan**
Agenda Item	
Lead Executive	Helen Brown, Acting Chief Executive
Author(s)	STP estates and capital workstream.
Executive Summary	The STP estates plan was completed for submission in draft to NHS England in July 2018. A standard template was provided with mandated data collection. The workbook template reflected the priorities set out within the Governments response to the Naylor Review of NHS Estates – "NHS property and estates; why the estate matters for patients'. www.gov.uk/government/publications/naylor-review-government-response The plan sets out the scale of the estates challenge across the STP and the key role that estate transformation needs to contribute to the overall service transformation strategy of the STP. It identifies a series of estate improvement metrics that the STP needs to deliver over the next three to five years and sets out actions that need to be taken collectively across the STP partner organisations as well as actions to be taken by individual constituent organisations. These are summarised in section A8: critical decisions and road map. One of the key requirements of the process was the identification and prioritisation of a future pipeline of capital projects across the STP, together with a pipeline of future disposal opportunities (with sale proceeds contributing to the cost of delivering identified priorities). All organisations submitted a list of future capital schemes; providers also submitted details about current capital schemes funded via internal capital allocations. The total estimated capital requirement for the STP equates to between £1.7 and £2.1 bn – the range reflecting upper and lower range costs of the two major acute redevelopments at West Hertfordshire Hospitals NHS Trust and Princess Alexandra Hospital, Harlow. The STP FD led the prioritisation process on behalf of STP organisations; the key focus of the prioritisation process was the identification of schemes that the STP wished to put forward for capital funding via the STP 'wave 4' capital bidding process. There were 2 linked but separate submissions for projects / bids with a value of >£100m and projects / bids with a value of <£100m. The STP undertook a full evaluation of a long list of projects submitted by STP member organisations to identify a short list of projects for submission to the national bidding round. Bid evaluation criteria were set out nationally and the local prioritisation process used the same criteria to evaluate submissions from STP organisations. Following the prioritisation process the HWE STP submitted bids to the national review process for the major acute redevelopment programmes at West Hertfordshire Hospitals NHS Trust and Princess Alexandra Hospital, Harlow. In addition the following 7<£100m estate relate bids were submitted: 1. Additional Bed Capacity PAH

7.2

	2. WHHT Emergency Care Transformation WGH 3. ENHT Creation of Herts and West Essex Vascular Hub 4. ENH Luton and Dunstable Renal Dialysis Unit Relocation 5. WHHT Planned Care Transformation (Phase 1) 6. PAH Transformation of Day Case Services 7. ENH Satellite Radiotherapy - North Herts & Stevenage The wave 4 bidding process also allowed for IT bids to be submitted – at the request of NHS Improvement a bid was also submitted for £7m capital funding to address ongoing issues with the implementation / functionality of the Lorenzo EPR (electronic patient record) at East and North Herts NHS Trust. Sections A4 to A7 and section B of the workbook set out the project and disposals pipeline in more detail. The plan / workbook and project pipeline will need to be regularly up dated and mechanisms put in place to track progress against KPI and action delivery. It is anticipated that the workbook will be updated on an annual basis and that the project pipeline and prioritisation will be regularly reviewed. Future waves of capital funding are expected to be released at a national level although this has not yet been confirmed. The STP estates and capital group will co-ordinate work over the next six months to ensure that the STP is well positioned to bid against any future capital bidding processes. The overall programme will be overseen by the estates and capital group, working closely with the STP FDs group. Governance arrangements are set out in section A of the workbook.
Where the report has been previously discussed, i.e. Committee/ group	STP CEOs, FDs and Estates and Capital Group.
Action required:	The Board is asked to approve the STP estates plan.
Links to the board assurance framework	☐ **PR1** Failure to provide safe, effective, high quality care ☐ **PR2** Failure to recruit to full establishments, retain and engage workforce ☒ **PR3** Current estate and infrastructure compromises the ability to deliver safe, responsive and efficient patient care ☐ **PR4a** Underdeveloped informatics infrastructure compromises ability to deliver safe, responsive and efficient patient care – IM&T ☐ **PR4b** Underdeveloped informatics infrastructure compromises ability to deliver safe, responsive and efficient patient care – Information and information governance ☐ **PR5a** Inability to deliver and maintain performance standards for Emergency Care ☐ **PR5b** Inability to delivery and maintain performance standards for Planned Care(including RTT, diagnostics and cancer) ☐ **PR7a** Failure to achieve financial targets, maintain financial control and realise and sustain benefits from CIP and Efficiency programmes ☐ **PR7b** Failure to secure sufficient capital, delaying needed improvements in the patient environment, securing a healthy and safe infrastructure

	☐ **PR8** Failure to engage effectively with our patients, their families, local residents and partner organisations compromises the organisation's strategic position and reputation. ☒ **PR9** Failure to deliver a long term strategy for the delivery of high quality, sustainable care ☐ **PR10** System pressures adversely impact on the delivery of the Trust's aims and objectives PR6 – business continuity has been closed (incorporated into PR1)
Trust objectives	☒ To deliver the best quality care for our patients ☒ To be a great place to work and learn ☒ To improve our finances ☒ To develop a strategy for the future

Hertfordshire and West Essex STP Estates plan

July 2018

Version must be submitted to nhsi.strategicfinance@nhs.net by 16 Monday July 2018

DRAFT

Disclaimer

The options set out in this document are for discussion purposes. The involved NHS bodies understand and will comply with their statutory obligations when seeking to make decisions over estate strategies which impact on the provision of care to patients and the public. The options set out do not represent a commitment to any particular course of action on the part of the organisations involved.

In respect of any request for disclosure under the FoIA: This is a confidential document for discussion purposes and any application for disclosure under the Freedom of Information Act 2000 should be considered against the potential exemptions contained in s.22 (Information intended for future publication), s.36 (Prejudice to effective conduct of public affairs) and s.43 (Commercial Interests). Prior to any disclosure under the FoIA the parties should discuss the potential impact of releasing such information as is requested.

DOCUMENT CONTROL

Owner	**Helen Brown, SRO STP Estates and Capital Group**
Status	VERSION 0.12 0807CE version

Version	Date	Description
V0-1 to 0.6	June 2018	Working drafts iterated by STP estates project team
V0-7	18/06/18	Initial draft for STP estates and capital group review
V0-8	22/06/18	draft for NHS E and I regional team review
V0-9	25/06/18	Resubmitted for NHS E and I regional team review
V0.10	26/06/18	Circulation draft for comments - STP CEOs, FDs , Strategy and Estates leads
V0-11	29/06/18	Updated draft for circulation to STP prioritisation panel on 3rd July.
V0-12	06/07/18	Final draft for CEO meeting 10th July
V1.0	16/07/18	Final draft for submission

Document sign-off

Name	Date
ENHCCG	Formal approval through all organisations Boards by end September 2018.
HVCCG	Formal approval through all organisations Boards by end September 2018.
WECCG	Formal approval through all organisations Boards by end September 2018.
ENHT	Formal approval through all organisations Boards by end September 2018.
EPUT	Formal approval through all organisations Boards by end September 2018.
HCT	Formal approval through all organisations Boards by end September 2018.
HPFT	Formal approval through all organisations Boards by end September 2018.
PAHT	Formal approval through all organisations Boards by end September 2018.
WHHT	Formal approval through all organisations Boards by end September 2018.

DRAFT

STP Estate Strategy - Contents

DRAFT

Glossary

BAU	Business as Usual	NHSE	National Health Service England
CIP	Cost Improvement Plans	NHSI	National Health Service Improvement
ED	Emergency Department	OBS	Outline Business Case
ENHCCG	East & North Herts CCG	OCH	Our Changing Hospitals
ENHT	East & North Herts Hospital Trust	OPE	One Pubic Estate
EPR	Electronic Patient Record	PAH	Princess Alexandra Hospital
EPUT	Essex Partnership University NHS Foundation Trust	PCBC	Pre-Consultation Business Case
ETTF	Estates & Technology Transformation Fund	PMO	Programme Management Office
FBC	Final Business Case	RFL	Royal Free London
GIA	Gross Internal Area	RHIC	Regional Estates Infrastructure Company*
HCC	Hertfordshire County Council	SOC	Strategic Outline Case
HCT	Hertfordshire Community NHS Trust	SRO	Senior Responsible Officer
HPFT	Hertfordshire Partnership University NHS Foundation Trust	STP	Sustainability & Transformation Partnership
HVCCG	Herts Valley CCG	UCC	Urgent Care Centre
HWE	Hertfordshire & West Essex (STP)	UTC	Urgent Treatment Centre
ITFF	Independent Trust Finance Facility	WECCG	West Essex CCG
LIFT	Local Improvement Finance Trust	WHHT	West Hertfordshire Hospital Trust
NHS PS	NHS Property Services		

** Potential new funding route subject to HM Treasury approval and procurement process.*

Scope

Herts and West Essex STP organisations.

Aggregate STP data comprises 3 CCGs, 5 Trusts excluding EPUT (with EPUT specific examples included where relevant).

Executive Summary (1 of 6)

Overview of STP:

- HWE STP covers three CCG areas – East & North Herts CCG, Herts Valley CCG and West Essex CCG.
- 1.5m population, high growth area (c 10% growth projected to 2024) including a 33% increased in people aged over 75
- Life expectancy in HWE is above the national average

Providers

- 164 GP practices, 301 community pharmacies
- 1 community trust (Hertfordshire Community Trust), 1 mental health trust (Hertfordshire Partnership NHS FT) and 1 combined community and mental health trust (Essex Partnership University Trust)
- 3 acute trusts (East and North Herts Trust, West Hertfordshire Hospitals NHS Trust, Princess Alexandra Hospital, Harlow).

Key STP Service Strategy Themes:

- Living well and preventing ill health by changing the model of care
- Transforming primary care, community and mental health services
- Improving urgent and hospital services
- Providing health and care more efficiently and effectively

Priority workstreams:

Prevention & Primary care	Integrated place based care	Urgent care	Planned care
Mental Health & Learning Disability	Women & Children	Frailty	Cancer

Enablers:

- Workforce, Estates, integrated care system redesign (ICS/ICO)

Estates Priorities:

1. Collaborative use of facilities to promote integration of care and new care models
2. Improve quality of estate (primary, community, mental health and acute)
3. Engage with local councils to identify opportunities for collaboration (one public estate)
4. Optimise the use of healthcare estate across the STP footprint and match capacity to future demand.
5. Identify surplus estate, realising its value and how this can improve housing provision locally
6. Drive operational efficiencies through collaboration across all sectors

Executive Summary (2 of 6)

Current Estate :

- 352 properties, GIA 413,019 m^2
- Total Estate Cost of Overall = £ 117.5m p.a. of which £14.4m Primary Care (GP premises)
- £139.5m backlog maintenance
- £79.8m high-risk backlog maintenance
- *Condition
  - > 60% of total acute estate in condition C or D
  - > 60% of primary estate assessed as amber or red (3% red)
  - > 20% of community/Mental Health estate in condition C or D
- *Functional suitability
  - 35% of acute total estate functionally unsuitable
  - 32% of acute clinical areas unsuitable
- 24.7% non-clinical space
- Utilisation data not available but clear evidence of variability – some elements of the estate highly pressurised but with under utilisation / mothballed estate in places. 5% of the estate us currently unoccupied (including c 8000m2 GIA at Hemel Hempstead Hospital)

Planned Estate – target KPI improvement :

- Planned reduction in high risk back-log maintenance by 2023
- Reduce non-Primary Care annual costs by 3% (£3.3m) by March 2023.
- Average £/m2 reduced to £289 (a £9/GIA m^2 reduction)
- Reduce non-clinical by 1% of GIA i.e. 3544 m^2 by March 2023
- Reduce % of estate at condition C or below to 18% by March 2023 *(further reduction can only be achieved in longer term linked to major acute redevelopment plans)*
- Reduce unoccupied floor space by 2.5% i.e. 9261.50 m^2 by March 2023

- ** See appendix two and three for detailed calculations*
- ** Based on data from Eric return 18/19, all other data 17/18 to be updated.*

The **acute estate** in HWE is particularly challenged, especially at PAHT & WHHT – both Trusts have developed SOCs for major redevelopment of their sites.

- > 85% of estate condition C or D (95% at PAHT, 80% at WGH)
- > 50% functionally unsuitable / non complaint with modern standards (64% at WHHT, 22% at PAHT)
- £130.3m backlog maintenance
- Clinical adjacencies poor

Watford General Hospital (WGH)

Princess Alexandra Hospital (PAHT) Harlow

The Lister Hospital, Stevenage

Mount Vernon Cancer Centre (MVCC) Northwood

ENHT has some good quality estate (QE2) however elements of the Lister Hospital estate remain un-modernised & Mount Vernon Cancer Centre is in poor condition and requires redevelopment .

Executive Summary (3 of 6)

Our project pipeline includes:

- 18 small / medium sized ETTF* projects approved in principle
- 8 primary / community / MH integrated care projects in progress (self funded through internal capital and disposals)
- 1 mental health estate transformation (HPFT) in final stages of implementation – rationalisation of small sites and major investment in acute inpatient facilities (funded via disposals and internal capital).
- An additional 12 new primary and integrated care schemes in development, funding sources to be confirmed (disposals, 3PD*, RHIC*)
- An STP wide ICT interoperability programme to support information sharing and a number of smaller system IT schemes to support service transformation.
- 4 major long term acute transformation schemes (PAHT and WHHT acute redevelopments, phase 3 OCH (Our Changing Hospitals) at the Lister Hospital, redevelopment of Mount Vernon Cancer Centre). (5-10 year + delivery timeline)
- A range of 'interim' acute estate capacity and transformation schemes to support service delivery over the next 5-10 years pending the longer term redevelopments / on retained estate not planned for redevelopment. 8 Wave 4 bids submitted to address highest priority areas.
- In addition there is a requirement for on-going acute backlog / compliance / medical equipment and provider IT investment: £174m funded internally, additional £39m funded through private finance, and £118.9m required to maintain safety and business continuity.

Disposals: 15 sites identified for disposal with a total potential capital contribution of £87.7m

Executive Summary (4 of 6)

Capital Investment Summary:

Total HWE Capital requirement is c.£1.7bn-£2.1bn (the range reflecting the two major redevelopments at PAHT and WHHT). This includes:

- Wave 4 bids totalling c.£70m which are our immediate priority schemes that we believe best fit the criteria set out for wave 4. These have been shortlisted and prioritized from a longer list of requirements.
- Primary/community/mental health schemes funded through ETTF (£35m) and disposals (11.5m)
- We also have other STP priorities (not included in wave 4), funded through internally generated resources of £174m (through depreciation (£149m) plus disposals (£11m) and other funding sources (£14m));
- c.£877m-£1,306m for 2 major acute redevelopments at PAHT and WHHT (upper and lower end estimates), including disposal proceeds of £47m. PAHT and WHHT acute redevelopment capital requirements and potential funding sources subject to further work as SOC / PCBC and OBCs are developed. Lower range estimated pending more detailed work.

After deducting these schemes, this leaves £511m of schemes, made up of £80m of outstanding backlog maintenance, £81m for ENHT final phase OCH and redevelopment of Mount Vernon and £351m of other schemes. It is expected that there will be £18.7m of disposals and c£51m of schemes funded through private finance (PFI, etc.) leaving the balance of £442m to potentially be required through wave 5 and other future processes.

	Net capital	Disposals	Gross capital
Total Capital	**2,021**	**87.7**	**2,109**
Less: Wave 4	70.10	-	**70.1**
Less: Primary/Community and MH funded through ETTF and disposals	35.09	11.45	**46.5**
Less: Trust BAU	163.85	10.50	**174.3**
Less: Trust SOC	1,259.28	47.00	**1,306.3**
Total Capital (after removing the above)	**493.19**	**18.70**	**511.89**

In submitting the wave 4 bids and the draft strategy, we have assumed the following:

- That BAU capital funding for CCGs (covering GPIT etc) will continue as currently.
- That recent clarification on the status of digital funding scheme means that provider digitisation schemes are not included within this workbook but that the advice provided previously by NHSI regarding Lorenzo being required to be submitted to access funding in 18/19 as part of wave 4 still stands.

Executive Summary (5 of 6)

Summary Conclusions:

HWE STP has an ambitious transformation strategy (A Healthier Future) to improve health outcomes and develop new models of care delivery to transform care for our residents. Estate transformation is a critical enabler to the STPS overall transformation strategy:

- Additional capacity is required in primary care to support population growth and new models of care. GP practices are increasingly working together to deliver services at greater scale and the estate will need to adapt to support this.

- System partners are working to integrate care and redesign care pathways – greater collaboration and new ways of working will support more efficient use of the estate. However some additional capacity will be required and some buildings are not fit for purpose. Development of integrated care hubs serving populations of 100-150k are a key part of our strategy. Plans are already in place / in development in HVCCG and ENHCCG although progress needs to be accelerated. WECCG plans are at an earlier stage of development.

- The acute estate in HWE is urgent need of improvement. PAHT and WHHT have developed strategic outline cases for major redevelopments of their hospitals which need to be urgently progressed – the challenge of capital availability and affordability is acknowledged; however doing nothing is not an option. ENHT has some excellent modern facilities (QE2 Hospital in Welwyn Garden City, maternity and planned surgery facilities at the Lister) however substantial investment is still required to bring unmodernised elements of the estate at the Lister Hospital up to standard. Urgent investment is required to address backlog maintenance, compliance, capacity and key business continuity risks.

- Mount Vernon Cancer Centre (MVCC) is in very poor condition and accessibility is poor for large parts of the catchment area it serves. Plans are in place to develop a satellite radiotherapy service in East Hertfordshire, subject to capital being made available (Wave 4 bid). A broader review of cancer services to support redevelopment plans for MVCC is required.

- Our estate is an expensive resource that needs to be optimised through new ways of working and estates rationalisation. Estate modernisation can reduce running costs, although given the scale of investment required in new facilities it is unlikely that the overall estate cost base will reduce. However estate transformation is a key enabler to the overall STP efficiency programme and will support service transformation and delivery efficiencies.

Executive Summary (6 of 6)

Summary of key next steps and critical decisions:

- Our STP service transformation and medium term financial strategy requires updating. A detailed view of activity and capacity by care setting is required to underpin the detailed business cases that will be needed to support delivery of the STP estate strategy. This work has commenced and is due to complete in the autumn.
- Long term estate redevelopment plans for PAHT and WHHT need to be confirmed and the business case process expedited to ensure that long term sustainable solutions can be implemented as soon as possible. Interim investment is also required to address critical risks within the current estate.
- ENHT are developing a new 5 year strategy. Investment is required at the Lister Hospital to bring the 'un-modernised' elements of the estate up to standard (phase 3 OCH - tower block wards, main theatres and paediatrics).
- A service strategy / option appraisal to support planning for the redevelopment of Mount Vernon Cancer Centre is required.
- CCG 'local estates forums' need to be re-invigorated, clear milestones developed and additional capacity / capability deployed to ensure delivery of primary and integrated care schemes.
- HCT and HPFT are developing a joint estates strategy with a view to identifying opportunities to improve integration of care and optimise estate utilisation.
- Engagement and input from NHS PS needs to be strengthened.
- Links to local authorities and 'One Public Estate' programmes in Hertfordshire and Essex need to be strengthened & further opportunities for collaboration explored.

Note: Hertfordshire County Council has developed a joint venture trading company (Herts Living Limited) to deliver property development services which can be accessed by STP members to support the objectives of the STP.

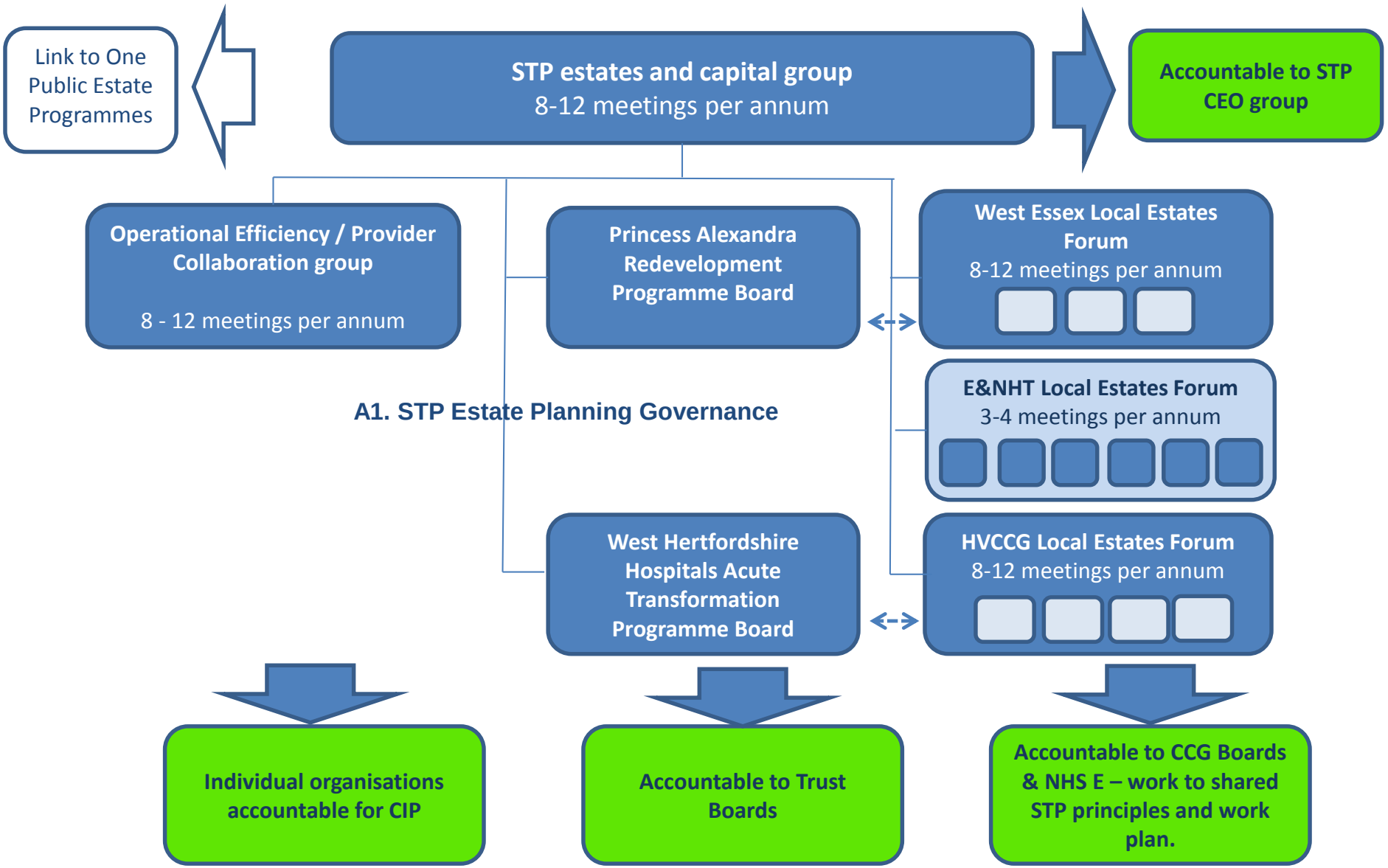
Section A – STP Estate Strategy

DRAFT

A1. STP Estate Planning Governance (1)

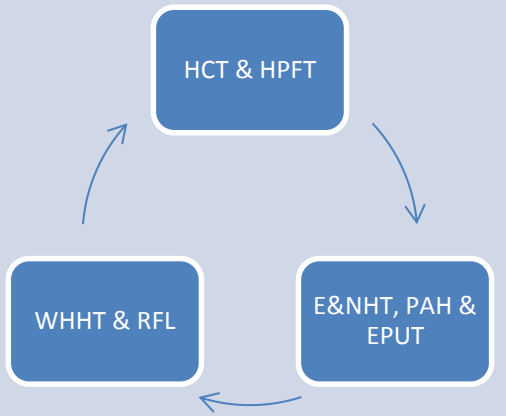
Progress made / current activities	Commentary
Estate SRO	Helen Brown, Deputy CEO, West Hertfordshire Hospitals NHS Trust
Lead Strategic Estates Adviser	Ian Greggor
Form of estates governance model established	See slide 14. Estates and Capital Group established within STP Governance structure. 3 x Local Estates Forums Operational efficiency sub group established – key providers working together to share best practice and identify opportunities to collaborate (e.g. joint procurements).
Status of resource delivery plan to support STP estate transformation initiatives	Herts and West Essex STP have resourced enabling work streams with funded Project Manager posts and expert external advisors. Transformation initiative within estates are supported by a strong cross section of stakeholders to supplement specific focus on subject matter as required and to reflect local opportunities, priorities, and available resources. Use of Provider team resource is planned to deliver key next steps but this will evolve as plans become more firm over the coming months and initiatives are finalised/ The STP will assess and access resource through available infrastructure funding routes which will include the LIFT Co, Regional Health Investment Companies (as they are developed), and existing initiatives to establish development vehicles.
Estate Planning resources supporting the STP and partner organisations	Diane Brent - HCT / HPFT Director of Estates providing expert advice to the STP estates and capital group. (c 0.1 wte) 0.4 wte project management support via STP PMO. External advisory support commissioned to support development of STP estate strategy.

A1. STP Estate Planning Governance (2)



DRAFT

A1. STP Estate Planning Governance (3)

STP estates and capital	Local Estate Forums	Operational Efficiencies / provider collaboration
- Set strategy - Assurance re delivery of strategy on behalf of STP CEOS - Oversight and prioritisation of project pipeline - Prioritisation / oversight of bids for STP capital - Review business cases > £5m and make recommendations to STP CEOs - Advise re estates aspects of Integrated Care System / Integrated care alliance transition - Links to County Councils and One Public Estate	- Local delivery of strategy - Assurance re delivery of strategy - Detailed development of local pipeline and priority schemes - Oversight of local approval processes for pipeline projects - Make recommendations to STP estates and capital group re. approval of schemes - Detailed development / delivery of estates aspects of integrated care alliance transition - Links to District Borough Councils	- Provider collaboration & oversight of provider CIP estates and facilities  - Share best practice and benchmarking - Joint procurements where added value from scale and timelines align - Back office opportunities

DRAFT

A1. STP Estate Planning Governance (4)

Links to partner organisation estate strategies

Name of STP partner organisations	Estate Strategy (Yes / No)	Status (Live / Draft / expired)	Date of last Board Approved Estate Strategy	Comments
East and North East Herts CCG	Yes	Live	June 2016	
West Essex CCG	Yes	Live	June 2016	In the process of update. Due October 2018
Herts Valley CCG	Yes	Live	July 2016	
West Hertfordshire Hospital Trust	Yes	Live	Feb 2017	This is an interim strategy to optimise the estate pending the long term redevelopment.
Princess Alexandra Hospital	Yes	Expired	May 2013	Due for review and update. Due March 2019. This will be an interim strategy to optimise the estate pending the long term redevelopment.
Hertfordshire Community Trust	Yes	Live	November 2016	HCT and HPFT have established a shared estates service under a singe lead Director and plan to develop a joint estates strategy. Due March 2019.
Hertfordshire Partnership Foundation Trust	Yes	Expired	November 2006	
East and North Hertfordshire Trust	Yes	Expired	2011	Due for review and update, expected March 2019. This will be an interim strategy to optimise the estate pending the long term redevelopment.
Essex Partnership University Trust	Yes	Live	2017	Approved November 2017

A2 STP Service Strategy & Implications (1)

Key STP Service Strategy Themes:

1. Living well and preventing ill health by changing the model of care :
   - Moving to a population health model.
   - Focusing on self-management
   - Preventing ill-health in the community

2. Transforming primary care, community and mental health services:
   - Primary care transformation and extended hours
   - Implementing new models of joined-up care in communities ~ place-based care
   - Redesign frailty pathway – focus on older adults with complex needs.
   - Reducing in A&E demand - right care, right place, right time – 111/ UTC roll out / admission prevention / post acute care.
   - Incorporating psychological therapies into treatment pathways for people with long term conditions
   - Cancer pathways including screening / early detection
   - Workforce development – Primary Care & Mental Health priorities

Enabling Implications for Future Estate:

1. Collaborative use of facilities to promote integration of care and new care models
   (eg Marlowes Health and Well Being Centre, Hemel Hempstead)

2. Improve quality of estate (primary, community, mental health and acute)
   - Reduce backlog maintenance, improve compliance and address highest risks
   - Improve functional suitability and privacy and dignity.

   (e.g immediate: fire compliance programmes in place across all providers, long term: PAHT and WHHT redevelopment SOCs).

3. Engage with HCC and local councils to identify opportunities for co-location/ spare capacity, including further developing the OPE/health collaboration.
   (e.g. Borehamwood, Stevenage)

DRAFT

A2 STP Service Strategy & Implications (2)

Key STP Service Strategy Themes (cont'd):

3. Improving urgent and hospital services:
   - Improving emergency care pathway – admission prevention, ambulatory models patient flow, bed capacity and discharge (improved performance ambulance handovers and ED standards)
   - Redesign planned care pathways
   - Reducing or stopping activity which has limited clinical effectiveness
   - Cancer access - Improved 62 day and 2 week wait standards & improved access to satellite radiotherapy
   - Improving the sustainability and affordability of fragile services
   - Expanding access to mental health services in acute (hospital) settings.
   - Transforming the hospital estate & digital infrastructure

4. Providing health and care more efficiently and effectively
   - Medium term financial strategy and activity / capacity plan
   - Modernising Pathology services
   - Right care / Carter / Model Hospital.

Enabling Implications for Future Estate (cont'd):

4. Optimise the use of healthcare estate across the STP footprint and match capacity to future demand.
   - Assess use of spare capacity in acute, primary care and community facilities for services and staff to fully utilise existing estate prior to developing new builds
   - Maximise utilisation of our estate and reduce our estate footprint through digital transformation, flexible working and extended hours
   - Reduce non clinical estate footprint through modernising working practices and consolidating / shared back office

   (e.g. QE2 utlisation, HPFT and HCT joint estate strategy, WHHT back office).

5. Identify surplus estate, realising its value and how this can improve housing provision locally.
   (e.g. Harpenden Memorial Hospital, Danestrete Clinic Stevenage)

6. Drive operational efficiencies through collaboration across all sectors
   (e.g. linen and laundry, non patient transport services, WHHT / RFL partnership).

DRAFT

A2. STP Service Strategy & Implications (3)

Estates progress against key service strategies and programmes:

#	Progress made / current activities	Issues and barriers
1	Primary care transformation. Primary care transformation strategy including extended hours making good progress. Increased collaboration between practices and a number of mergers proposed. Changes to the estate will be required to facilitate new models of care and provide additional capacity. 19 ETTF schemes approved in principle / in progress. 3 new primary care schemes identified (Borehamwood, Hertford and Letchworth) and part of pipeline - aiming for wave 5 submissions. *(note *primary care transformation also included in integrated care schemes)*	A number of schemes are delayed pending revised premises cost directions & release of funds from NHS E. Capacity and capability within CCGs to progress these schemes is a risk to delivery. West Essex schemes (Saffron Walden, North Weald, Old Harlow, Chigwell and Dunmow) at earlier stage of development and need to be accelerated – capacity and capability within the CCG is a risk to delivery. Re-procurement of community services by HVCCG & potential transfer of estates to a new provider / NHS PS presents a risk to delivery of schemes in West Hertfordshire. Complexity of negotiations & regulations / funding streams can be a barrier to achieving primary care integration into locality schemes. Engagement with NHS PS needs to be strengthened. Poor IT infrastructure in providers and interoperability.
2	Integrated care HCT and HPFT joint estates director in place and developing a joint estates strategy. Joint development of new integrated and community health facility in Hemel Hempstead (The Marlowes, opened April 2018). Business case approved and scheme now in implementation phase for new health facility within St Alban's Civic Centre. (Due to complete early 2019). OBC approved for the new community hub in Harpenden – linked to the disposal of Harpenden Memorial Hospital. Business cases in progress for community hub developments in Borehamwood, Hoddesdon & Stevenage. WECCG estate strategy and population growth planning has confirmed requirements for additional capacity in key population centres – detailed business cases to be developed.	

DRAFT

A2. STP Service Strategy & Implications (4)

Estates progress against key service strategies and programmes:

#	Progress made / current activities	Issues and barriers
3	**Cancer** *Significant work across the STP to develop plans to ensure implementation of* • *nationally agreed rapid assessment and diagnostic pathways for lung, prostate and colorectal cancers, ensuring that patients get timely access to the latest diagnosis and treatment* • *the implementation of FIT testing* • *stratified follow up strategies, improved cancer care in the community and cancer recovery packages* *Working to ensure estate and infrastructure support pathway development with respect to timely access for PET CT, and urgent one-stop clinics such as in urology.* Wave 4 bid submitted for satellite radiotherapy service in East Hertfordshire to improve access. Bids submitted via Cancer Transformation Fund process – primarily equipment and IT related.	Service strategy / option appraisal required to support redevelopment planning for Mount Vernon Cancer Centre (current estate not fit for purpose). Complex service (crosses two networks / STP areas) and political environment.
4	**Mental Health** Significant Mental Health service and estate transformation has been delivered across Hertfordshire since 2012 including reconfiguration of community services in a hub and spoke model to improve equity of access across Hertfordshire and substantial investment in and rationalisation of acute inpatient mental health Investment of >£70m in the programme funded through internal capital and c 40 disposals of small sites. Final phases of inpatient improvement programme to complete by 2020. EPUT have invested £20m on the development of the Derwent Centre to improve mental health facilities in Harlow.	

DRAFT

A2. STP Service Strategy & Implications (5)

Estates progress against key service strategies and programmes:

#	Progress made / current activities	Issues and barriers
5	**Urgent and Emergency Care** Performance against 4 hour ED standard across the STP areas is consistently below the national standard, and below the national average. (84.9% May 2018). Improving emergency care is a key priority for the STP and a comprehensive suite of improvement plans are in place across HWE to support this. Poor estate infrastructure presents a challenge in both acute and out of hospital settings and investment is also required in primary and community care settings to support extended access and urgent treatment models. **HVCCG / WHHT**: Hemel urgent care centre upgraded to urgent treatment centre in December 2017. WHHT opened a new 8 bedded clinical decision unit adjacent to ED in December 2017. ED department under capacity and poorly configured – wave 4 bid submitted. Bed capacity also a risk and options currently being reviewed to provided additional surge capacity. **ENCCG/ ENHT**: 'our changing hospitals' (OCH) programme upgraded emergency care facilities at the Lister Hospital in 2014 and new QE2 Hospital in Welwyn Garden City includes urgent care centre (opened 2015). **WECCG/PAHT:** PAHT invested £2m to reconfigure the ED, create a new paediatric ED and improve flow out of ED in to assessment facilities. Inpatient bed capacity remains a significant constraint. Implementation of extended hours in primary care ongoing – estates a constraint in some localities. Wave 4 bids submitted for additional non elective bed capacity at PAHT and redevelopment of WHHT ED to provide additional capacity and improved configuration.	Requirement for long term redevelopment of the PAHT and WHHT sites adds complexity to planning processes and makes demonstrating ROI difficult as investments only have a maximum 10 year life cycle. Existing sites / configuration and condition of buildings limits potential options to improve in the short to medium term.

DRAFT

A2. STP Service Strategy & Implications (6)

Estates progress against key service strategies and programmes:

#	Progress made / current activities	Issues and barriers
6	**Short to medium term acute Transformation (to 2023)** All three acute providers have significant estate infrastructure and IT challenges in terms of their estate. PAHT and WHHT are developing major redevelopment plans to provide long term solutions; however the current estate needs significant investment to address critical compliance and capacity issues in the short to medium term and elements of the ENHT estate also require significant investment to modernise. Internally generated capital is limited and has to meet critical backlog, compliance, equipment replacement, IT and capacity / (essential) service improvement priorities. All 3 Trusts have taken forward estate improvements over the past 3-5 years. ENHT has made significant investments in improving the estate via the first 2 phases of the 'Our Changing Hospitals' programme. WHHT has addressed key compliance and backlog issues in the estate (e.g. asbestos, fire safety, cardiology centre) and has also invested in expanded endoscopy capacity and bowel screening facilities to address rising demand. PAHT has addressed its top clinical and backlog risks, redesigning its ED, adding a new paediatric Emergency department , creating a new minor injuries unit and addressing some critical infrastructure issues including generator back up, fire safety compliance and modernising electrical wiring. The trust has also mitigated some of its key clinical quality issues by redeveloping maternity theatres and our orthopaedic clean surgical unit to address rising demand. This extensive programme was not possible without a level of risk, and it has been necessary to carry over schemes falling within the estates backlog programme into the following financial year (2018/19).	Internally generated (depreciation) capital is limited at c.£30m per annum across the 5 year period (c.£10m p.a. at PAHT, c.£8m p.a. at ENHT, c.£5m p.a. at WHHT, c.£3m p.a. at HCT and c.£4m p.a. at HPFT at after loan repayments). The Trust's existing internal capital funding plans of £174m are funded through the depreciation noted above and disposals and other funding proceeds (c.£25m). Both WHHT and PAHT redevelopment SOCs are pending approval and more detailed work is required to determine the preferred option for the longer term (ie OBCs to be completed) – this makes strategic estates planning in the short term more challenging. Political / stakeholder context in WHHT an additional challenge in relation to rationalising services between sites and making decisions about where to prioritise investment.

DRAFT

A2. STP Service Strategy & Implications (7)

Estates progress against key service strategies and programmes:

#	Progress made / current activities	Issues and barriers
7	**Acute Transformation (2023+)** PAHT and WHHT have both submitted SOCs for major redevelopment of their hospitals. NHS I and NHS E have provided preliminary feedback and set out additional work required prior to approval. WHHT to update SOC to address feedback received and PAHT developing a pre consultation business case.	Delays in approval process and lack of clarity re respective decision making responsibilities of different parts of the system (although progress now being made). Risk of conflicting expectations of wave 4 bidding process vs 'green book' requirements and potential risk of stakeholder challenge. Clarity of expectations re new service change guidance / consultation requirements & timing of any PCBC (PAHT/ WECCG) Capital availability, uncertainty about PF2 and concerns re affordability to the system. Commissioning assumptions and system wide activity and capacity modelling is required at a sufficiently granular level to support OBC development and provide assurance that hospital infrastructure will be 'right sized' to meet future needs. Potential for differences in view about what is an achievable level of change and therefore what the 'right size' is for future hospital provision.

DRAFT

A3. Performance Indicators: Success Metrics to 2022/23

Indicator	Current	Planned	Progress against targets
Estate Running Costs (£/m2)	£ **117.5**m p.a. comprised of: £14.4m of Primary Care costs • *Primary Care, equivalent to £244 per m² based on 59,049 GIA* m² £103.1m of Non-Primary Care costs • *Non-Primary Care, equivalent to £291 per* m² *based on 354,470* m² *GIA*	• The Primary Care contribution to running costs reduction is under discussion • Reduce non-Primary Care annual costs by 3% (£3.3m) by April 2023. • Average £/m² for non-primary care reduced to £289 (a £2/GIA m² reduction)	All providers have annual CIP and estate efficiency programmes at minimum 4% and an STP wide estate group has been established to support greater collaboration and scale benefits. WHHT delivered a 0.75m per annum reduction in soft FM contract via a recent retendering exercise.
Non-Clinical Space (%) (Carter Metric max 35%)	87477m², equivalent to 24.7 %	Reduce by 1% of GIA i.e. 875m² by April 2023	19 ETTF schemes and current programme of mental health improvement / integrated care hubs is on track to deliver improvement in 'out of hospital estate'. Acute hospital estate very challenged and major redevelopment will be required to address the significant issues – SOCs for PAHT and WHHT have been submitted and active dialogue with NHSE/I to agree way forward. ENHT updating 5 year strategy and expect to bid via future STP capital wave (wave 5 or 6) to secure support to complete the required improvements at the Lister Hospital.
Unoccupied Floor Space (%) (Carter Metric Max 2.5%)	18,523m², equivalent to 5%	Reduce by 2.5% i.e. 9261.50m² equivalent to by April 2023	
Functional Suitability	(Acute only) 35% of Acute site as a whole are functionally unsuitable (64% at WHHT, 22% at PAHT) 32% of Clinical areas of Acute sites are functionally unsuitable (62% at WHHT, 18% at PAHT)	*Significant improvement will only be delivered with major capital investment as per the WHHT and PAHT SOCs.* 5% improvement in primary / community over the next 3 years *(significant improvement won't be delivered in acute until long term transformation secured)* All High Risk Backlog Maintenance to be eradicated by 2023, equivalent to £41.3m	
Condition	Estate in condition C or D > 60% of acute estate > 60% of primary estate < 25% of community/Mental Health (1% unknown) Back-log maintenance of £76.57m		
Naylor benchmarks	Release 117,047 GIA m² for housing	potential additional 170,888m² GIA identified subject to further planning and enabling investment to release land?	

DRAFT

Section A4

DRAFT

A4. Sustainability & Transformation Initiatives

In order of priority. Key strategy and programmes (subset projects in the next section as appropriate) where implementation required to enable wider STP strategy

STP initiative	Estates Impact and Enablers	Est. Net Revenue Benefits (£m pa)	Project Status / Funding Strategy	Est. Deliver Year	Gross Capital Required (£m)	Disposal receipts (£m)	Comments and Interdependencies
Improving primary care	Improve primary care estate, additional capacity and larger scale	TBC	**18 approved ETTF projects**	11 – 18/19 6 – 19/20 1 – ongoing	£23.4	0	Awaiting premises costs directions for some schemes. New projects Borehamwood, Hertford and Letchworth.
Integrated care	'hub' developments to integrate care at locality level and provide additional capacity to deliver STP strategy	TBC	**16 schemes** Various stages and funding strategies (including 3 ETTF schemes totalling £9.5m)	3 – 19/20 6 -20/21 3 – 21/22 4 – ongoing	£121.63m	£28m (including 3 ETTF disposals totalling £10m)	Enabler for acute transformation programme ('right sizing hospital capacity').
Acute Transformation (1) short to medium term priorities	Address backlog compliance and align capacity to demand and new models of care	TBC	**38 schemes** Various stages and funding strategies	1 -18/19 7 – 19/20 14 - 20/21 5 - 21/22 6 – 22/23 5 – ongoing	£403.45m	£47.7m	Key priorities to address critical backlog, compliance and capacity. over and above that which can be internally generated. For PAHT and WHHT this investment is required to maintain safety and business continuity ahead of the full redevelopment programme.
Mental health	Improve inpatient MH facilities	TBC	**5 approved projects**	2 – 18/19 2 – 19/20 1 - 20/21	£13.6	£1.4m	Programme nearing completion – has delivered substantial improvements to MH facilities in Hertfordshire.

DRAFT

A4. Sustainability & Transformation Initiatives

In order of priority

Key strategy and programmes (subset projects in the next section as appropriate) where implementation required to enable wider STP strategy

STP initiative	Estates Impact and Enablers	Est. Net Revenue Benefits (£m pa)	Project Status / Funding Strategy	Est. Deliver Year	Gross Capital Required (£m)	Disposal receipts (£m)	Comments and Interdependencies
Acute Transformation (2) long term redevelopment	Full redevelopment of PAHT and WHHT hospitals	TBC	Both WHHT and PAHT schemes at SOC stage – wave 4 bids to be submitted.	Dependent on preferred options & approvals – c. 2024 / 2025	£1306.3m (this is the higher end estimate of £657m for PAH and £649m for West Herts)	£47.0m (based on higher end estimate of capital)	SOCs under review by NHS E & I. Further work to assess redevelopment and phased options to be completed. PCBC required for PAHT. WHHT SOC to be updated with more detail on phased & redevelopment options.
Cancer	Mount Vernon Cancer Centre East Herts Satellite radiotherapy service	TBC	Pre SOC stage – potential to be funded via RHIC. Satellite Radiotherapy funding to be bid for in next wave of ETTF funding	22/23 21/22	£65.7m	0m	Service strategy required to support options appraisal.
Trust BAU	N/a	TBC	Various	ongoing	£174.35m	£10.5m	Various internally generated schemes
TOTAL		TBC			**£2,108.4m**	**£87.7m**	

Note: £46.9m of primary care (£23.4m), Integrated care (£9.5m) and Mental Health (£13.6m), funded through ETTF (£35m) and disposals (£11.5m).

DRAFT

A5. Progress of approved estate projects

Approved at FBC or allocated STP capital only

Project / Location	CCG / Trust	Strategic Objective	Status Update	Est Revenue impact £m (+/-)	Net Capital impact £M (+/-)	Project Milestone	Estimated Delivery Year	Funding route	Business Case Status
St Albans	HCT		OBC December 2017 - scheme will not require FBC	£0m	£0m	Building work to commence September 2018.	March 2019	Disposal	Approved OBC

DRAFT

A6. Prioritised Estate Projects Pipeline

Capital investment pipeline – listed in priority order (summary of section B)

Project / Location	CCG / Trust	Strategic Objective	Priority / Importance (Critical, High/Essential, Desirable) Incl. links to capital schemes listed in Section B	Est Revenue impact £m (+/-)	Net Capital impact £M (+/-)	Project Milestone	Estimated Delivery Year	Proposed Funding route – Incl. links to capital schemes listed in Section B	Business Case Status
1 Primary and Integrated care = tranche A	• ENH CCG • HV CCG • WE CCG • HCT • HPFT	• Estate subject to ETTF funding • Mental Health/ Integrated Care	• Critical • High • Desirable	TBC	35.1		18/19- 20/21	ETTF, Provider own capital, Disposals	2 OBC approved, 1 OBC, 1 FBC, 1 SOC, rest Business cases at various stages
2 Acute BAU - (critical schemes) tranche A	• ENHT • WHHT • PAH • HCT	• Provider own capital	• Critical	TBC	163.8		22/23	Internal, private, loans	BAU
3 Acute capacity and transformation schemes - tranche A (Wave 4 bids)	• ENHT • WHHT • PAH	• Acute Services reconfiguration / consolidation • Acute Trusts 'Business as Usual'		-7.5	70.1		19/20- 20/21	STP Wave 4 Capital	SOC Q2 18/19

Note1: Primary and Integrated Care includes disposals of £11.5m, giving a gross capital of £46.8m (with balance of £35m funded through ETTF).
Note 2: Acute BAU capital includes disposals of £11m giving a gross capital of £174m

DRAFT

A6. Prioritised Estate Projects Pipeline

Capital investment pipeline – listed in priority order (summary of section B)

Project / Location	CCG / Trust	Strategic Objective	Priority / Importance (Critical, High/Essential, Desirable) Incl. links to capital schemes listed in Section B	Est Revenue impact £m (+/-)	Net Capital impact £M (+/-)	Project Milestone	Estimated Delivery Year	Proposed Funding route – Incl. links to capital schemes listed in Section B	Business Case Status
4 PAHT acute redevelopment	PAH	Acute Services reconfiguration / consolidation	Critical	TBC	618.3		23/24	SOC based on PDC - mix of PDC and private finance anticipated	SOC approved by local partners and submitted to NHSI June 2017. OBC 19/20 and FBC 20/21
4 WHHT acute redevelopment	WHHT	Acute Services reconfiguration / consolidation	Critical	TBC	641.0		28/29	SOC based on PDC - refreshed SOC likely to recommend mix of PDC and private finance	SOC submitted to NHSI in Jun17. Following engagement with NHSI Trust will update SOC by Dec 18. OBC planned for late 2019, FBC late 2020
6 ENHT final phase OCH improvements at Lister	ENHT	Acute Services reconfiguration / consolidation	Desirable	TBC	30.5		22/23	STP Capital / ITFF	SOC 19/20
7 Mount Vernon Cancer Centre redevelopment	ENHT	Acute Services reconfiguration / consolidation	High	TBC	50.0		22/23	Mix of PDC and private finance anticipated.	SOC 19/20

DRAFT

A6. Prioritised Estate Projects Pipeline

Capital investment pipeline – listed in priority order (summary of section B)

Project / Location	CCG / Trust	Strategic Objective	Priority / Importance (Critical, High/Essential, Desirable) Incl. links to capital schemes listed in Section B	Est Revenue impact £m (+/-)	Net Capital impact £M (+/-)	Project Milestone	Estimated Delivery Year	Proposed Funding route – Incl. links to capital schemes listed in Section B	Business Case Status
8 Acute BAU (high priority schemes) - tranche B	• ENHT • WHHT • PAH	• Acute Trusts 'Business as Usual' • High risk back-log maintenance programme • Other - Medical	• Critical • High	TBC	130.8		18/19-25/26	Trust capital, STP Capital	1 OBC Approved 17/18, 1 OBC aim 19/20, 1 within PAH Soc, Individual Business cases for trust own capital
9 Primary and Integrated care = tranche B (expected wave 5 bids)	• HCT • HV CCG • WE CCG	• Community Service re-configuration/ consolidation • Estate subject to ETTF funding • Primary Care Service reconfiguration / consolidation	• Critical • High	TBC	42.7				
10 STP ICT interoperability scheme	STP	Other - IT	High	TBC	39.7		25/26	STP Capital	Business Case complete

DRAFT

A6. Prioritised Estate Projects Pipeline

Project / Location	CCG / Trust	Strategic Objective	Priority / Importance (Critical, High/Essential, Desirable) Incl. links to capital schemes listed in Section B	Est Revenue impact £m (+/-)	Net Capital impact £M (+/-)	Project Milestone	Estimated Delivery Year	Proposed Funding route – Incl. links to capital schemes listed in Section B	Business Case Status
11 Acute capacity and transformation - tranche B (high priority schemes)	• ENHT • WHHT • PAH	• Acute Services reconfiguration / consolidation • Acute Trusts 'Business as Usual'	• Critical • High	TBC	74.9		19/20-22/23	Mix of Trust capital, STP Capital, Private Finance	1 OBC 18/19, 1 SOC 18//19, 3 SOC 19/20, Rest Business cases being progressed
12 Primary and Integrated care = tranche C (expected wave 6 bids)	• ENH CCG • WE CCG	• Acute Services reconfiguration / consolidation • Primary Care Service reconfiguration / consolidation	• Critical • High • Desirable	TBC	49.5		20/21-21/22	Mix of STP Capital, RHIC, Private	1 SOC, 2 OBC, 2 Business cases being developed
13 Pathology modernisation	• ENHT • WHHT • PAH	• Acute Services reconfiguration / consolidation • Acute Trusts 'Business as Usual'	• Critical • High	TBC	66.6		18/19-22/23	Mix of Trust capital, STP Capital, Private Finance	1 SOC approved, 1 OBC, 3 Business cases to be developed
Total					**2,013.0**				

Note: The net capital above is after the deduction of disposals (£87.7m from the gross capital requirements. This priority capital listed above excludes "acute capacity and transformation tranche C" (£6.2m) and "System IT" (£2.3m). Taking account of the disposals and excluded schemes gives a gross capital requirement of £2,108m.

DRAFT

A7. Headline Financial Impacts:

Capital investment pipeline summary

Capital investment pipeline summary

Investment requirement (strategic objective)	Estimated investment capital £m	Funding Strategy Source / Capital allocated £m	Committed (OBC stage)	Uncommitted (Pre OBC)	Estimated timeline	Capital Proceeds £m	Impact on Gross Estate Running Cost (+ / -) £m pa	Service savings £m pa
High risk back-log maintenance programme	79.8	• STP Capital £78.3m, Internal Funds £1.5m	14.5	65.3	Ongoing - up to 22/23	-	TBC	TBC
Acute Trusts 'Business as Usual'	332.1	This includes: • Provider internally funded capital of £174m (Depreciation £149, disposals £11m and £14m) • Other acute capital note funded total £157.9m (STP Capital required £118.9m,Private Finance £39m)	-	332.1	Various - up to 28/29	10.5	TBC	TBC
Acute Services reconfiguration / consolidation	1,529.2	• STP Capital £211m, Disposals £59m, PAHT and WHHT transformation mixture of PDC and Private Finance	-	1,529.2	Ongoing - up to 25/26	59.7	TBC	TBC
Community Service re-configuration/ consolidation	12.0	• Private Finance £10m, Disposals £2m	-	12.0	On-going up to 20/21	2.0	TBC	TBC
Primary Care Service reconfiguration / consolidation	51.6	• STP Capital £46.1m, Private Finance £1.5m, Disposals £4m	-	51.6	Ongoing up to 21/22	4.0	TBC	TBC
Estate subject to ETTF funding	23.8	• STP Capital £0.4m, Already funded £23.4m (ETTF)	23.4	0.4	On-going up to 20/21	-	TBC	TBC
Other	79.7	This includes: • integrated care (£9.5m) and mental health (£13.6m) funded through disposals of £11m and ETTF £12m • With balance funded through STP Capital, disposals and private finance	21.6	58.1	Ongoing up to 25/26	11.5	TBC	TBC
Totals	**2,108.4**		**59.5**	**2,048.9**		**87.7**		

Note: £46.9m of primary care (£23.4m), Integrated care (£9.5m) and Mental Health (£13.6m), funded through ETTF (£35m) and disposals (£11.5m).

A7. Headline Financial Impacts:

Provider own-Capital Position

Trust / FT Name	Own estates capital forecast over the next 5 years to 2022/23 (£m)	Proposed main strategy proposals (> £10m) of own generated capital	CURRENT Backlog Maintenance		FORECAST Backlog Maintenance at end of 5 year period 2022/23	
			All categories (£m)	High / significant (£m)	All categories (£m)	High / significant (£m)
ENHT	32.3	Critical backlog & compliance schemes, medical equipment replacement, IT investments and essential capacity and service transformation schemes. No individual schemes > £10m funded. Only 2 schemes > 10m within acute programme, both at PAHT - cancer centre / fracture clinic & IT investment.	30.6	18.5	31.6	11.4
WHHT	40.4		71.2	32.5	69.3	13.8
PAH	48.5		28.8	28.8	26.5	16.1
HPFT	31.6	Critical backlog and compliance (including fire safety). Final phases of IP improvement programme.	6	-	0.5	-
HCT	21.5	Critical backlog and compliance. Integrated care schemes funded from disposals.	3.2	-	0.4	-
Totals	**174.3**		**139.8**	**79.8**	**128.4**	**41.3**
difference					- 11.4	- 38.5

NOTE 1: Trust BAU capital represents ccritical backlog & compliance schemes, medical equipment replacement, IT investments and essential capacity and service transformation schemes. No individual schemes > £10m funded, except for cancer centre/ fracture clinic & IT investment at PAHT.

NOTE 2: The Backlog maintenance numbers are currently under further detailed review with the Trusts.

DRAFT

A7. Headline Financial Impacts

Surplus Land & Housing

Disposal Opportunities

Disposal Status	No. of Sites	Land Area (Ha)	GIA (m)	Estimated disposal value £m	Total # Estimated Housing Units	# Housing Units for NHS Staff	Gross Running Cost reduction £m	Cost to Achieve Vacant Possession (where known) £m
1. Vacant and Declared Surplus and disposal transaction in progress [A1]	3	0.287	1068	4.75	50	10	0.033	0.1
2.Vacant and Declared Surplus/ disposal subject to marketing [A1]	0	0	0	0	0	0	0	0
3.Vacant but not yet Declared surplus [A2]	1	0.04	232	0.3	10	0	0.02	0
4.Site occupied but OBC approved to achieve vacant possession and dispose [B, C ,D]	3	0.98	2847	10.4	67	7	0.06	10.7
5.Future opportunity subject to strategy/ feasibility including Trust Own Capital [B, C ,D]	8	20.623	167082	72.2	1171	60	0.03	TBC
Totals	**15**	**21.93**	**171229**	**87.65**	**1298**	**77**	**0.143**	**TBC**

Summary by Financial Year (estimated year of disposal completion)

Deliverable / Financial Year	2017 – 18	2018 – 19	2019 – 20	2020 – 21	Remaining Years
Land Area (Ha)	TBC	0.167	0.16	0.98	20.623
Estimated disposal value £m	TBC	2.75	4	15.9	65
Estimated Housing Units	TBC	40	40	67	1151
Gross Running Cost reduction £m	**TBC**	0.023	0.03	0.06	0.03

DRAFT

A7. Headline Financial Impacts

Surplus Land Disposals (by named site)

Site	Current status of disposal	Land Area (Ha)	GIA (m)	Estimated disposal value £m
Principal Health Centre, St Albans	1. Vacant and Declared Surplus and disposal transaction in progress [A1]	0.12	727	Redacted – commercially sensitive
305 Ware Road	1. Vacant and Declared Surplus and disposal transaction in progress [A1]	TBC	0	
Hydebrook House, Old QEII	1. Vacant and Declared Surplus and disposal transaction in progress [A1]	0.167	341	
HCT	1. Vacant and Declared Surplus and disposal transaction in progress [A1]	TBC	0	
Sub-total				
Other opportunities (11)	Disposals to be finalised			
Total				**87.7**

Note: The above analysis only presents finalised disposals. The balance reflects site disposal opportunities, not yet finalised. Dependent on acute redevelopments & significant enabling capital investment – some options require purchase of alternative site

DRAFT

A8. Road Map: Critical Decisions & Activities

Decision/ Activity Required	Significance/ impact on STP strategic objectives	Timeline	Owner	Action By:
STP activity model to support 'right sizing' of acute hospital footprints and confirm 'out of Hospital' capacity requirements	Critical input to optimisation of STP estate, to confirm capacity for acute transformation OBCs and requirement for 'out of hospital' integrated care capacity.	October 2018	STP FDs	STP FD
Fragile services review – determine whether any reconfiguration required across acute footprints to ensure clinical and financial sustainability.	To ensure sustainable future model & determine clinical model for acute redevelopments	March 2019	STP Planned care workstream	Deborah Fielding (STP CEO)
Cancer strategy and options appraisal - Mount Vernon Cancer Centre and satellite radiotherapy.	Critical input to MVCC redevelopment SOC	September 2019	STP Cancer workstream	Kate Lancaster (STP Cancer SRO)
Confirm preferred option PAHT redevelopment / develop PCBC (if required) & OBC	Essential to secure fit for purpose / 'right sized' capacity for West Essex acute services.	March 2019	PAHT Programme Board	Lance McCarty – CEO PAHT
Confirm preferred option WHHT redevelopment - SOC update	Essential to secure fit for purpose / 'right sized' capacity for Herts Valley acute services.	December 2018	WHHT Programme Board	Helen Brown- acting CEO WHHT
ENHT update 5 year strategy and supporting estate strategy; agree forward plan for development of supporting business cases	Essential to secure fit for purpose / 'right sized' capacity for East and North Herts acute services.	March 2019	ENHT Board	Kate Lancaster – Director of Strategy ENHT
Secure funding to address critical backlog and compliance issues on acute sites	Essential to ensure able to maintain delivery of safe and effective acute hospital care for local residents.	March 2019	Provider estate directors	Providers

DRAFT

A8. Road Map: Critical Decisions & Activities

Decision/ Activity Required	Significance/ impact on STP strategic objectives	Timeline	Owner	Action By:
Establish programme milestones for primary care and integrated care developments, ensure adequate resourcing to deliver and reinvigorate governance – HVCCG	Essential to deliver fit for purpose / 'right sized' primary and integrated care capacity in Herts Valley.	September 2018	HVCCG LEF	Caroline Hall – FD HVCCG
Establish programme milestones for integrated care developments, ensure adequate resourcing to deliver and reinvigorate governance - ENHCCG	Essential to deliver fit for purpose / 'right sized' primary and integrated care capacity in East and North Herts	September 2018	ENHCCG LEF	Alan Pond – FD ENHCCG
Establish programme milestones for integrated care developments, ensure adequate resourcing to deliver and reinvigorate governance - WECCG	Essential to deliver fit for purpose / 'right sized' primary and integrated care capacity in West Essex.	September 2018	WECCG LEF	Dean Westcott – FD WECCG
HCT & HPFT update estate strategies and identify whether any further opportunities for integration / rationalisation.	Essential enabler to HV CCG and ENHCCG 'out of hospital' / integrated care estate planning, support financial sustainability and contribute to housing targets.	December 2018	HCT & HPFT	Diane Brent – Director of Estates HCT & HPFT
Establish programme to optimise utilisation of key sites (e.g. QE2 hospital WGC).	Essential enabler to right sizing estate and support disposals and cost savings plans.	September 2018	STP Estates and capital group / LEFs	Helen Brown – SRO STP estates and capital
Build stronger links with NHS PS and input to STP estates and capital group / LEFs.	Ensure all elements of the estate included in planning process. (e.g. Saffron Walden).	July 2018	CHP / NHS PS	Ian Greggor – strategic estates advisor.
Update estates data to reflect 2018 ERIC returns and fill gaps / ensure robust data to track performance against KPIs	Essential enabler to estates improvement and efficiency programme	December 2018	STP Estates and capital group / STP PMO	Helen Brown – SRO STP estates and capital

DRAFT

Section B – STP capital prioritisation

DRAFT

B1. Introduction

- Section B requires your STP to **identify and then explicitly prioritise its capital schemes**.
- NHS capital more generally remains constrained: any STP capital available must be targeted towards those STPs for which it will demonstrably deliver the greatest benefits in terms of clinical and financial sustainability.
- In order to prioritise funding, therefore, NHSI, NHSE and the DHSC have agreed that the STP capital bidding approach is the single route towards accessing capital for service change.
- We understand this may mean some difficult decisions being made at an STP level, but in the context of capital constraint STPs should be focusing on those schemes which will deliver the greatest benefits in terms of clinical and financial sustainability.
- Please note that whilst STPs' own prioritisation of schemes will be a key factor, in order to access public funding schemes must score well against the six DHSC/Treasury criteria: transformation, patient benefit including demand management and delivery of core targets, value for money, financial sustainability, alignment with estate strategy, and deliverability.
- **Three tables must be completed**:
  - B2) List any small-medium sized capital schemes (with a value under £100m) which require STP capital funding:
    - Only include those schemes within the STP which are planned to deliver over the next five years, and for which STP capital funding is being sought
    - You do not need to include schemes where STP capital funding is not required
    - We anticipate that successful bidders will be announced in Autumn 2018.
  - B3) List all large capital schemes (with a value in excess of £100m):
    - Please include all large capital schemes within the STP that will likely be realised over the next 10 years, irrespective of whether central funding is required. THIS COULD BE A NIL RETURN.
    - This will include: large schemes already submitted in earlier STP capital waves; those schemes known to DHSC, NHSE and NHSI for which funding has not yet been secured (includes schemes approved by the ITFF but not yet approved for funding release by DHSC); and those large schemes known to DHSC, NHSE and NHSI which are yet to apply for public funding.
    - Large schemes which require public funding will be assessed to a different timetable, likely specific to each scheme. It is highly unlikely any schemes will be announced as part of this wave of funding.
  - B4) Ranked in order of priority, any small-medium and large capital schemes which require STP capital funding:
    - Please include all small-medium schemes from B2, and any large schemes from B3 for which you are bidding for STP capital in this round, listed in order of priority.
- **Finally, STP leads must complete the 'sign-off' slide to confirm their support**.

DRAFT

B2. STP capital schemes below £100m

List (1 of 6)

Please identify all schemes under £100m which are planned to deliver over the next five years, for which STP capital funding is requested. Note, this section should also include 'non estates' bids (e.g. fleet, equipment).

Note the below table shows net capital

STP scheme name and lead organisation	18/19 (£m)	19/20 (£m)	20/21 (£m)	21/22 (£m)	22/23 (£m)	23/24 (£m)	Total STP capital funding requested (£m)	Effect on backlog maintenance (£m)	Value of land disposals (£m)
Primary care / Integrated care							0		
ENHCCG Hertford Primary Care Hub			2.9				2.9		
ENHCCG Letchworth Primary Care Hub							0		
HCT Hoddesdon Local Health Hub			1				1		
HCT Stevenage Health & Wellbeing Hub		4.5	4.5				9		
HVCCG Borehamwood (GP)			6.725				6.725		
HVCCG St Albans (GP)							0		
WECCG Chigwell		2	2				4		
WECCG Dunmow			10				10		
WECCG North Weald			4	4			8		
WECCG Old Harlow			5				5		
WECCG Saffron Walden Community Hospital		2	5	4			11		
WHHT Hemel Hempstead/ Dacorum Local Hospital Project	0	1	15	16.5	2.1		34.6		

Work in progress

Redacted – commercially sensitive

Please note the details in this table must agree to the details in individual STP capital Bid Templates

DRAFT

B2. STP capital schemes below £100m

List (2 of 6)

Please identify all schemes under £100m which are planned to deliver over the next five years, for which STP capital funding is requested. Note, this section should also include 'non estates' bids (e.g. fleet, equipment).

Note the below table shows net capital (including Wave 4 capital, highlighted in yellow)

STP scheme name and lead organisation	18/19 (£m)	19/20 (£m)	20/21 (£m)	21/22 (£m)	22/23 (£m)	23/24 (£m)	Total STP capital funding requested (£m)	Effect on backlog maintenance (£m)	Value of land disposals (£m)
Acute compliance							0		
ENHT High risk backlog maintenance (LISTER)	0	2	4	6	6.5		18.5		0
ENHT High Risk Fire Compliance (LISTER)		1	1	1			3		0
PAHT Backlog Maintenance	0	10.6	8.6	5.8	3.8		28.8		0
WHHT Backlog Maintenance & Compliance (WHHT)	0	4.32	3	3	3	4.68	18		0
WHHT Theatre Development WGH		7.5	7	0	0		14.5		0

Work in progress

Please note the details in this table must agree to the details in individual STP capital Bid Templates

DRAFT

B2. STP capital schemes below £100m

List (3 of 6)

Please identify all schemes under £100m which are planned to deliver over the next five years, for which STP capital funding is requested. Note, this section should also include 'non estates' bids (e.g. fleet, equipment).

Note the below table shows net capital (including Wave 4 capital, highlighted in yellow)

STP scheme name and lead organisation	18/19 (£m)	19/20 (£m)	20/21 (£m)	21/22 (£m)	22/23 (£m)	23/24 (£m)	Total STP capital funding requested (£m)	Effect on backlog maintenance (£m)	Value of land disposals (£m)
Acute other							0		
ENHT Back office consolidation and reduction of estates costs (LISTER)	0	0.5	0	0	0		0.5		0
ENHT Hertfordshire and West Essex STP Vascular Surgery Reconfiguration	0	3.8	3.4	0	0		7.2		0
ENHT Luton and Dunstable Renal Dialysis Unit Relocation		4.2	0	0	0		4.2		0
ENHT Main Entrance - Lister	0	1	3	0	0		4		0
ENHT Planned Care Pathway Redesign (LISTER	0	0.5	3.5	0	0		4		0
ENHT Reprovision of Lister Theatres and Children's Unit not addressed through OCH [OCH Phase5] (LISTER)	0	0.5	3	13	14		30.5		0
ENHT Ward and Patient Accommodation quality and compliance alterations (LISTER)	0	4	4	4	4	12	28		0
PAHT Additional Bed Capacity	0	7.5	2	0	0		9.5		0
PAHT Aseptic Unit replacement		1.2					1.2		0
PAHT Development of Hybrid Interventional Theatres Suites	0	2.2	0	0	0		2.2		0

Work in progress

Please note the details in this table must agree to the details in individual STP capital Bid Templates

DRAFT

B2. STP capital schemes below £100m

List (4 of 6)

Please identify all schemes under £100m which are planned to deliver over the next five years, for which STP capital funding is requested. Note, this section should also include 'non estates' bids (e.g. fleet, equipment).

Note the below table shows net capital (including Wave 4 capital, highlighted in yellow)

STP scheme name and lead organisation	18/19 (£m)	19/20 (£m)	20/21 (£m)	21/22 (£m)	22/23 (£m)	23/24 (£m)	Total STP capital funding requested (£m)	Effect on backlog maintenance (£m)	Value of land disposals (£m)
Acute other (cont.)							0		
PAHT Paediatric Outpatient Services	0	1.1	1.1	1.1	1.1		4.4		0
PAHT Realignment of surgical services	0	3.8	1.5	0	0		5.3		0
PAHT Transformation of Day Case Services	0	0	4.6	5.4	0		10		0
WHHT Bed Capacity & Configuration	0	10	0	0	0		10		0
WHHT Delivery Suite	0	0	1.5	0	0		1.5		0
WHHT Emergency Care Transformation WGH		5	6	0	0		11		0
WHHT Neonatal Unit		1.5	0	0	0		1.5		0
WHHT Planned Care Transformation (Phase 1)	0	4	1.5	0	0		5.5		0
WHHT Endoscopy SACH	0	0	0	0	5		5		0
WHHT Breast Unit SACH	0	1.5	0	0	0		1.5		0

Work in progress

Please note the details in this table must agree to the details in individual STP capital Bid Templates

DRAFT

B2. STP capital schemes below £100m

List (5 of 6)

Please identify all schemes under £100m which are planned to deliver over the next five years, for which STP capital funding is requested. Note, this section should also include 'non estates' bids (e.g. fleet, equipment).

Note the below table shows net capital (including Wave 4 capital, highlighted in yellow)

STP scheme name and lead organisation	18/19 (£m)	19/20 (£m)	20/21 (£m)	21/22 (£m)	22/23 (£m)	23/24 (£m)	Total STP capital funding requested (£m)	Effect on backlog maintenance (£m)	Value of land disposals (£m)
Acute medical equipment	5	6	6	6.5	5		28.5		0
Car parking	0	30	5	5	0		40		0
Pathology	0.05	1.4	39.6	14.1	1.85	1.1	58.1		0
ICT							0		
ENHT Lorenzo EPR Implementation & Benefits Realisation	7	0	0	0	0	0	7		
Risk Stratification - Hertfordshire & West Essex		1	0.9				1.9		
STP IT interoperability		3.7	7.7	7.6	6.9	13.8	39.7		
Frailty Digital Technology Bid		0.36					0.36		
Cancer							0		
ENHT Redevelopment of Mount Vernon Cancer Centre	0	0	0.5	0.5	19	30	50		0
ENHT Satellite Radiotherapy - North Herts & Stevenage	0	7	8.7	0	0		15.7		0
TOTAL	**12.05**	**136.68**	**183.225**	**97.5**	**72.25**	**61.58**	**563.285**		**18**

Work in progress

DRAFT

B2. STP capital schemes below £100m

List (6 of 6)

Please identify all schemes under £100m which are planned to deliver over the next five years, for which STP capital funding is requested. Note, this section should also include 'non estates' bids (e.g. fleet, equipment).

The below tables reconciles to total capital shown in section A. Total net capital of £2,021m plus disposals of £87m give the total capital of £2,108m

STP scheme name and lead organisation	18/19 (£m)	19/20 (£m)	20/21 (£m)	21/22 (£m)	22/23 (£m)	23/24 (£m)	Total STP capital funding requested (£m)	Value of land disposals (£m)	Total (£m)
STP capital schemes below £100m	12.05	136.68	183.225	97.5	72.25	61.58	563.285	18	581.285
STP capital schemes above £100m	4.03	17.00	6.75	236.00	417.20	578.30	1259.277	47.70	1306.277
ETTF schemes (including Mental Health)	8.838	22.65	3.6	0	0	0	35.088	11.45	46.538
Trust own capital	46.22	37.72	27.92	25.67	26.32		163.85	10.50	174.349
Total	71.13	214.047	221.499	359.171	515.772	639.88	2021.499	87.65	2108.449
Memo line: Wave 4 bids (included within "STP schemes below £100m")	*7*	*31.5*	*26.2*	*5.4*	*0*	*0*	*70.1*	*0*	*70.1*

The £581m represents the gross capital for all schemes less than £100m which require STP capital. This includes the wave 4 capital if £70.1m.

After adjusting for Wave 4 capital it leaves ££511m, of which there it is expected that there will be £18m of disposals and c£51m of schemes funded through private finance (PFI, etc.) leaving the balance of £442m to potentially be required through wave 5 and other future processes.

Please note the details in this table must agree to the details in individual STP capital Bid Templates

DRAFT

B3. STP capital schemes over £100m

List (1 of 1)

Please all large capital schemes within the STP which will likely be required over the next 10 years, irrespective of whether public funding is required. THIS COULD BE A NIL RETURN.
Large schemes which require public funding will be assessed to a different timetable, likely specific to each scheme. It is highly unlikely any schemes will be announced as part of this wave of funding.

Higher end range of capital (with net capital presented)

STP scheme name	18/19 (£m)	19/20 (£m)	20/21 (£m)	21/22 (£m)	22/23 (£m)	23+ (£m)	Total (£m)	Of which public funding requested (£m)	Effect on backlog maintenance (£m)	Value of land disposals (£m)
WHHT – Acute transformation project (Development phase)	0.75	13.4	4.35	41.6	93.2	487.7	**649.0**	TBC	TBC	**8.0**
PAHT Acute Healthcare Estate Transformation Project	3.3	3.6	2.4	194.4	324.0	129.6	**657.3**	n/a	94.8	**39.0**

Lower end range of capital (with net capital presented)

STP scheme name	18/19 (£m)	19/20 (£m)	20/21 (£m)	21/22 (£m)	22/23 (£m)	23+ (£m)	Total (£m)	Of which public funding requested (£m)	Effect on backlog maintenance (£m)	Value of land disposals (£m)
WHHT – Acute transformation project (Development phase)	0.75	4.6	11.3	13.7	64.1	346.3	**440.8**	TBC	TBC	**20.0**
PAHT Acute Healthcare Estate Transformation Project	3.3	3.6	2.4	86.6	86.6	253.8	**436.3**	206.0	94.8	**39.0**

Notes:

1) WHHT acute redevelopment – figures in the higher end range table above represent preferred way forward as per 2017 SOC. Following feedback from NHS I / E plan is to refresh SOC and resubmit. Phased redevelopment option to be reviewed in more detail. Costs quoted above include 25% optimism bias and VAT on 100% of build cost. The lower end is an estimate
2) PAHT acute redevelopment – figures in the higher end range table above represent preferred way forward as per 2017 SOC. Costs quoted above include 10% optimism bias and VAT on 100% of build cost.
3) NB acute SOC £ estimates at 2017/2018 prices, all other £ estimates at 18/19 prices.

DRAFT

B4. Prioritisation

All schemes requesting public STP capital

Ranked in order of priority, please list any schemes from B2 and B3, whether small-medium or large, for which STP capital bid templates are being submitted.

STP scheme name and lead organisation	18/19 (£m)	19/20 (£m)	20/21 (£m)	21/22 (£m)	22/23 (£m)	Total STP capital funding requested (£m)	Effect on backlog maintenance (£m)	Value of land disposals (£m)
(Ranking N/A) - ENH Lorenzo EPR Implementation & Benefits Realisation	7	-	-	-	-	7.0	-	-
1. Additional Bed Capacity PAH	-	7.5	2	-	-	9.5	0.7	-
2. WHHT Emergency Care Transformation WGH	-	5	6	-	-	11	0.7	-
3. ENHT Creation of Herts and West Essex Vascular Hub	-	3.8	3.4	-	-	7.2	0.3	-
4. ENH Luton and Dunstable Renal Dialysis Unit Relocation	-	4.2	-	-	-	4.2	-	-
5. WHHT Planned Care Transformation (Phase 1)	-	4	1.5	-	-	5.5	0.3	-
6. PAH Transformation of Day Case Services	-	-	4.6	5.4	-	10.0	6.8	-
7. ENH Satellite Radiotherapy - North Herts & Stevenage	-	7	8.7	-	-	15.7	-	-
Total	**7**	**31.5**	**26.2**	**5.4**	**0**	**70.1**	**8.8**	**-**

DRAFT

B4. Prioritisation (1/2)

Supporting Narrative

- To support our understanding of this prioritisation table, please provide a narrative explanation setting out:
  - How the higher priority schemes support delivery of your STP's estate strategy (which in turn will support delivery of the STP's strategy for clinical and financial sustainability)
  - How you plan to prioritise your own capital funding to deliver these schemes (e.g. provider self-generated capital, land disposals).
- An STP capital bidding template ("Bid Template") must be completed for each individual scheme.

How the higher priority schemes support delivery of your STP's estate strategy (which in turn will support delivery of the STP's strategy for clinical and financial sustainability)

There is a golden thread between delivering clinical and financial sustainability, the STP estates strategy and the wave 4 bids, with the prioritised bids supporting:

- Acute transformation.
- Improved performance
- Improved system financial sustainability
- Reduction in backlog maintenance
- Addressing priority service needs

How you plan to prioritise your own capital funding to deliver these schemes (e.g. provider self-generated capital, land disposals)

- Self generated capital has been prioritised by Trusts to meet priority backlog, equipment and IT requirements not eligible for wave 4 bids.
- The STP Estates Programme has undertaken a comprehensive review of disposal opportunities, linked to delivery of STP and organisational aims.
- All disposals are being re-invested in key priorities as set out in the STP draft estates strategy, and the STP has confirmed that there isn't a contribution possible for these schemes.
- The detail of disposals and the proposed identified application of receipts is set out within the HWE STP estates workbook.
- WHHT and PAHT have identified potential land disposals as part of their major acute redevelopment schemes – however these are subject to decision making on the final preferred option and again are linked to the redevelopment schemes (ie not realisable without associated investment to support rationalisation of the estate).

DRAFT

B4. Prioritisation (2/2)

Supporting Narrative

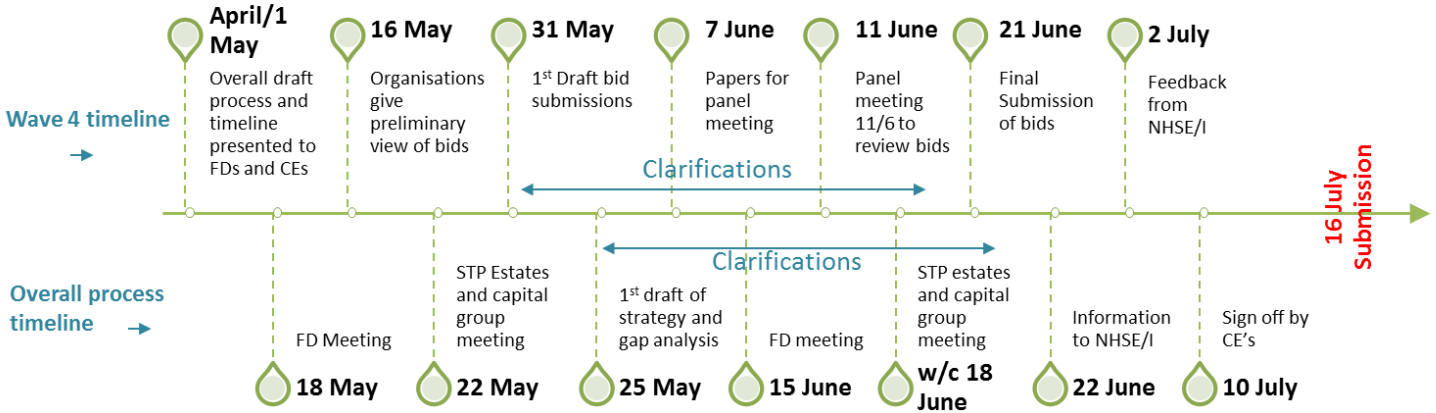
- To support our understanding of this prioritisation table, please provide a narrative explanation setting out:
  - How the higher priority schemes support delivery of your STP's estate strategy (which in turn will support delivery of the STP's strategy for clinical and financial sustainability)
  - How you plan to prioritise your own capital funding to deliver these schemes (e.g. provider self-generated capital, land disposals).
- An STP capital bidding template ("Bid Template") must be completed for each individual scheme.

Process

- Wave 4 capital bids assessed through a 2 stage review and prioritisation process overseen by STP finance director with expert advisory support from Arcadis and Deloitte. Criteria aligned with national criteria as per wave 4 bid template. Particular focus on expected transformation benefits, deliverability and VFM.

- Prioritisation panel chaired by STP chief executive with representation from CCGs, Trusts and strategic estates advisor.

- Prioritisation process undertaken during June/July as per timeline below



DRAFT

B5. STP lead Sign Off

I confirm that we have discussed and prioritised our capital projects at an STP level, and the tables in Section B reflect this discussion.

This is the current view of the STP . [This remains a [draft] strategy subject to further work and engagement.]

STP lead signature	Date 12th July 2018

STP lead name- Deborah Fielding, STP CE

STP lead organisation / address details

Herts and West Essex STP
James Taylor House
Hatfield

DRAFT

Annex 1: STP Estates Data Summary

DRAFT

Portfolio Summary

Estates Composition (1 of 3)

Portfolio	No. Properties	Footprint Size (Ha)	Size (sqm)	Percentage Tenure split Freehold / Leasehold	Estate Running costs pa (£m) (rent, s'charge, FM)	Back-log Maintenance £m
GP owned	231	Not known	59,049 (GIA)*	34% Freehold, 59% Leasehold 7% Not Known	£14.4m ❖	TBC
NHS PS	9	Not known	10,527 (GIA)	56% Freehold, 44% Leasehold	£3.4m	TBC
CHP (LIFT) ⌘	1	Not known	8,542 (GIA)		£4.0m	TBC
Provider estate	81	Not known	329,278 (GIA)	69% freehold, 31% Leasehold	£93.3m	See A7 (Provider own-Capital Position)
Public Health Estate	1	Not known	550 (GIA)	100% Leasehold	£0.2m	TBC
Other (PFI) ⌘	1	Not known	5073 (GIA)		£2.2m #	TBC
Totals	**324**	**Not known**	**413,019 (GIA)**	**43% Freehold** **52% Leasehold** **5% unknown (GP's)** **(not including LIFT/PFI)**	**£117.6**	**TBC**

* 63 properties are 'not known' ❖ 27 Properties are 'not known' ⌘ Shown in figures on slide 3 of 3 below # Approximate figure which will be confirmed for July submission

Functional Use Summary

Functional Uses	No. Properties	Footprint Size (Ha)	Size GIA (sqm)	Percentage Tenure split Freehold / Leasehold	Estate Running costs pa (£m)	Back-log Maintenance £m
Clinical/clinical support						
Back Office (self contained unit)						
Other (eg w'house or workshop)						
Totals						

data used to produce the statistics shown in these tables is based on FY18 ERIC data. To be updated in September following FY19 submissions. Hectare data not currently available for majority of sites, to be sourced for September update.

DRAFT

Estates Composition (2 of 3)

High Cost Sites: Estate Running Costs

Highest Cost Sites	Footprint Size (Ha)	Size GIA (sqm)	Freehold / Leasehold	Estate Running costs pa (£m)	Back-log Maintenance £m	Cost per sqm	Current Site Strategy
Watford General Hospital	Not known	58,339	Freehold	£24.3m	TBC	£417	
Lister Hospital ❖	Not known	81,216	Freehold	£22.2m	TBC	£273	
Princess Alexandra Hospital	Not known	54,182	Freehold	£22.2m	£28.8m	£410	
St Albans City Hospital	Not known	18,518	Freehold	£6.0m	TBC	£324	
Hemel Hempstead Hospital ❖	Not known	32,195	Freehold	£4.0m	TBC	£124	

❖ Checking data on these two sites – potential mismatch between GIA and running costs

Highest Cost Locations : Per m^2

Excludes LIFT and PFI

Highest Cost Sites	Footprint Size (Ha)	Size GIA (sqm)	Freehold / Leasehold	Estate Running costs pa (£m)	Back-log Maintenance £k	Cost per sqm	Current Site Strategy
4 Bowlers Green*	Not known	604	Freehold	£0.3m	TBC	£560	
The Civic Centre (Hertsmere)	Not known	550	Leasehold	£0.2m	TBC	£431	
Watford General Hospital	Not known	58,339	Freehold	£24.3m	TBC	£417	
Princess Alexandra Hospital	Not known	54,182	Freehold	£22.2m	£28.8m	£410	

* Non Clinical premises

DRAFT

Estates Composition (3 of 3)

PFI and LIFT Utilisation (Top 5)

Highest Cost Sites	Footprint Size (Ha)	Size GIA (sqm)	Estimated Utilisation (%)	Estate Running costs pa (£m)	Cost per sqm (GIA)	Proposed STP Site Strategy	Actions taken to address under-utilised space
New QEII (LIFT)	Not known	8,542	100%	£4.0m	£464		N/A
Hertford County Hospital (PFI)	Not known	5,073	100%	£2.2m #	£442		N/A
No other PFI/LIFT schemes							

 # TBC

DRAFT

2. Other STP Estates Information

Appendices

Appendix no.	Details
1	Members of the STP Estates and Capital group
2	Estate condition calculations
3	Functional suitability calculations

DRAFT

Appendix 1 – Members of the STP Estates and Capital group

NAME	ORGANISATION	NAME	ORGANISATION
Ian Greggor	Community Health Partnerships	**Trudi Mount**	Herts Valley CCG
Riana Relihan	Community Health Partnerships	**Jim McLeish**	Princess Alexandra Hospital NHS Trust
Alan Pond	East & North Herts CCG	**Marc Davis**	Princess Alexandra Hospital NHS Trust
Dean Goodrum	East & North Herts NHS Trust	**Geoff Roberts**	West Essex CCG
Sarah Brierley	East & North Herts NHS Trust	**Peter Wightman**	West Essex CCG
Sue Fogden	East & North Herts NHS Trust	**Helen Brown**	West Hertfordshire NHS Trust
Ian Crockett	Essex Partnership University NHS Trust	**Patrick Hennessy**	West Hertfordshire NHS Trust
Mike Evans	Hertfordshire County Council	**Tim Duggleby**	West Hertfordshire NHS Trust
Andrew Boasman	Hertfordshire Partnership NHS Trust	**Peter Cutler**	STP PMO Hertfordshire Partnership NHS Trust
Jim Naughton	Hertfordshire Partnership NHS Trust	**Shirley Potter**	STP PMO Hertfordshire Partnership NHS Trust
Diane Brent	Herts Community NHS Trust		
Caroline Hall	Herts Valley CCG		

DRAFT

Appendix 2 – Estate condition calculations (1 of 2)

Acute - Condition of Estate by Site (Based on 2012 data)

	Site	GIA 2012/13 m^2	% A	GIA 2012/13 m^2	% B	GIA 2012/13 m^2	% C	GIA 2012/13 m^2	% D	GIA 2012/13 m^2	% awaiting disposal	GIA 2012/13 m^2
ENHT	Hertford County Hospital (PFI)	5,073	100	5,073	0	0	0	0	0	0	0	
	Lister Hospital	67,876	21	14,254	23	15,611	45	30,544	11	7,466	0	
	Mount Vernon Cancer Centre		0	0	89	0	11	0	0	0	0	
	New QEII (LIFT)	32,020	100	32,020	0	0	0	0	0	0	0	
WHHT	HHH	22,004	2	440	47	10,342	16	3,521	0	0	35	7,701
	SACH	19,911	0	0	25	4,978	45	8,960	30	5,973	0	
	WGH	62,249	0	0	15	9,337	80	49,799	1	622	4	2,489
PAHT	The Princess Alexandra Hospital	56,846	0	0	2	1,137	95	54,004	3	1,705	0	0
Totals		265,979		51,787		41,405		146,828		15,768		10,191.36

Overall condition A (%)	19		
Overall condition B (%)	16	Total condition C and D	61
Overall condition C (%)	55		
Overall condition D (%)	6		
Awaiting disposal (%)	4		

DRAFT

Appendix 2 – Estate condition calculations (2 of 2)

CCG Condition (estate as a whole)

CCG	Green	Green %	Amber	Amber %	Red	Red %	Unknown	Unknown %	Total properties
E&N Herts CCG	13	15	69	78		0	6	7	88
Herts Valley CCG	22	22	62	63	1	1	13	13	98
West Essex CCG	26	58	11	24	5	11	3	7	45
Grand Total	61	26	142	61	6	3	22	10	231

Total number of Amber and Red properties	148	Total number of Green properties	61
Total % of Amber and Red properties	64	Total % of Green properties	26

Community and M/H condition (estate as a whole)

HPFT/HCT	Green	Green%	Amber	Amber%	Red	Red%	unknown	Unknown %	Total properties
	65	79	14	17	3	4	1	1	82

Total number of Amber and Red properties	17	Total number of Green properties	65
Total % of Amber and Red properties	21	Total % of Green properties	79

DRAFT

Appendix 3 – Functional Suitability calculations (1 of 3)

WHHT					
Areas	**RWG02**	**RWG03**	**RWG08**	**Total GIA**	**Comment**
Not functionally suitable - occupied floor area	85.0%	59%	28%		
GIA	65,265.0	19853.0	35849.0	**120,967.0**	
Total unsuitable for site	**55,475**	**11,713**	**10,038**	**77226**	Equates to 64%
Not functionally suitable - patient areas	78	52	20		
GIA	**51487**	**15944**	**15779**	**83210**	
Total unsuitable for patient areas	**40159.86**	**8291**	**3156**	**51607**	Equates to 62%

Appendix 3 – Functional Suitability calculations (2 of 3)

ENHT				
Areas	**RWH01**	**RWH04**	**Total GIA**	**Comment**
Not functionally suitable - occupied floor area	0.0%	39%		
GIA	81,216.0	14061.0	95277	
Total unsuitable for site	**0**	**5484**	**5484**	**Equates to 6% across the two sites**
Not functionally suitable - patient areas	0.0%	22%		
GIA	58601.00	9524	68125	
Total unsuitable for patient areas		**2095**	**2095**	**Equates to 3% across the two sites**

Appendix 3 – Functional Suitability calculations (3 of 3)

PAH	
Areas	**RQWG0**
Not functionally suitable - occupied floor area (%)	**22.9**
GIA m2	51,752
Total unsuitable for site m2	**11,866**
Not functional suitable - patient areas	**17.7**
GIA	35,017.0
Total unsuitable for patient areas	**6,194.51**

Totals				
Site	**Whole site total GIA**	**Whole site functionally unsuitable**	**Clinical areas GIA**	**Clinical areas functionally unsuitable**
WHHT	120967	77226	83210	51607
ENHT	95277	5484	68125	2095
PAH	51752	11866	35017	6195
Totals m2	**267996**	**94576**	**186352**	**59897**
Totals %	**35**		**32**	

The Princess Alexandra Hospital NHS Trust

TRUST BOARD – 4th October 2018

Agenda Item:	8.1
Presented by:	Ogechi Emeadi, Director of People, OD and Communications
Prepared by:	Martin Smith, AD for Training, Education and Development
Date prepared:	26th September 2018
Subject / Title:	Non-Medical CPD (Continued Professional Development) 2018/19

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]	This paper explains the Trust's position with non-medical CPD funding, and how it is used to help drive recruitment, support retention and staff engagement, and fund priority areas of practice development related to or derived from the changing nature of service needs and/or new models of care. It gives a background to HEE (Health Education England) non-medical CPD funding to explain the context, provides an update on the Trust's current position, and identifies the need for new processes and updated policies/procedures to ensure improved, equitable and robust systems are introduced to allow for the identification of CPD funding required, and the fair and targeted distribution of these funds across the Trust.
Recommendation:	It is recommended that Trust Board note the contents of this paper, and tasks EMB to ensure that non-medical CPD provision is provided for the remainder of 2018/19.It is also recommended that Trust Board further reviews the position of non-medical CPD is 4 months to take assurance that the Trust has the necessary educational governance in place.

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

Previously considered by:	EMB
Risk / links with the BAF:	BAF2.1: Workforce Capability
Legislation, regulatory, equality, diversity and dignity implications:	
Appendices:	

8.1

respectful | caring | responsible | committed

1.0 PURPOSE/ISSUE

This paper explains the Trust's position with non-medical CPD funding, and how it is used to help drive recruitment, support retention and staff engagement, and fund priority areas of practice development related to or derived from the changing nature of service needs and/or new models of care. It gives a background to HEE (Health Education England) non-medical CPD funding to explain the context, provides an update on the Trust's current position, and identifies the need for new processes and updated policies/procedures to ensure improved, equitable and robust systems are introduced to allow for the identification of CPD funding required, and the fair and targeted distribution of these funds across the Trust.

2.0 BACKGROUND

2.1 Non-medical CPD funding has been provided by Health Education England (HEE) since 2007 to spend primarily on a range of accredited courses, modules and workshops to support staff development and ensure the workforce is adequately trained to fulfil their roles.

2.2 This investment has been used to fund priority areas of practice/workforce development. It has also been used to maintain a workforce with the requisite qualifications as set out by a range of professional bodies, and to support staff recruitment and retention. PAHT's annual funding allocation has been historically overseen and allocated by the Director of Nursing, following a detailed Training Needs exercise, and goes primarily to nursing, midwifery, AHP, pharmacy and healthcare scientist staff.

2.3 Each year when providing funding, HEE as the Commissioners put in place contractual arrangements referred to as Learning and Development Agreements (LDA's) which set out certain limitations of how funding could be spent by Practice Providers (Trusts). Whilst this criteria was restrictive, the Trust has broadly been able to support Trust staff to achieve required qualifications and work in line with the various requirements stipulated by professional staffing bodies.

2.4 HEE funding has now undergone major changes, which substantially reduces PAHT's CPD funding allocation.

2.5 Organisations within the STP footprint across Hertfordshire and West Essex will now be required to put in place arrangements at both local and system-wide levels, in response to these HEE funding changes. The intention is to work collaboratively with STP partners where possible to identify educational priorities, that are both essential to service requirements and transformation changes proposed within the STP's. A new process of needs identification, calculation of funding required, and the allocation of funding needs to be established in readiness for 2019/20.

2.6 The withdrawal of CPD funding also coincides with the introduction of the Apprenticeship Levy, however it is important to specify that the Levy cannot be used to purchase short courses/accredited modules with the Universities which CPD/LBR has been used for previously, and hence the withdrawal of CPD funding has created a potential gap in meeting staff educational needs.

3.0 ANALYSIS

3.1 HEE CPD funding ceased for 2017/18, but was replaced by LBR (Learning Beyond Registration) funding. The amounts provided by HEE for LBR were substantially

reduced from the previous CPD allocations, although these amounts were being reduced year on year. For 2015/16 PAHT received £200k CPD, in 2016/17 £187k CPD, and in 2017/18 £63k LBR. However, for 2017/18 PAHT received an extra CPD allocation from HEE of £182k, in recognition of the Trust being in 'special measures'. For 2018/19 PAHT has only received £57k LBR. In recognition of a potential shortfall, PAHT allocated £92,885 to support CPD, plus a further £50,000 from the general training budget for 2018/19, totalling £142,885.

3.2 A Trust-wide Training Needs Analysis was used to identify and request CPD requirements for 2018/19. Courses, modules and workshops totaling almost £550k were requested, and the HCG ADoN's prioritised their needs down to approximately £450k. With the allocation of the £57k LBR, and some other requests attracting alternative external HEE funding, we are left with a potential CPD funding requirement of approximately £350k (in should be noted that in previous years not all requests are agreed, and during the year requests change due to staff leaving/joining, or changing roles). 2018/19 funding allocated and committed so far:

- £30,300 for mentorship modules for nurses and midwives
- £40,980 for modules for staff on existing Degree, Masters or Doctorate pathways.
- £34,721 for commitments and payments since 1/4/18

The budget remaining is £36,884, with our outstanding needs totaling over £200k for the rest of 2018/19 for modules, short courses, workshops and accredited programmes of study.

3.3 Following discussion at EMB on 4th September:

- It can be confirmed that the Apprenticeship Levy funding cannot we used to support our current CPD requirements.
- A review of corporate training budgets has been undertaken, and due to alternative funding being provided, and an expected expenditure not now being required, a further £89k can be made available to support CPD in 2018/19 from corporate training budgets.
- A meeting with the Interim DoN and ADoNs, has identified potential funding within HCG's that is to be investigated, and ADoNs have also been tasked to review and re-prioritise their HCG CPD needs to ensure that are still required.
- A review of the mentorship modules will be carried out in light of the NMC changes to determine whether they are still required.

4.0 NEXT STEPS

4.1 Following the ADoNs review, there is a need to decide with some urgency which CPD requirements are to be supported for the rest of 2018/19.

4.2 In future, new processes and updated policies/procedures to ensure improved, equitable and robust systems will be introduced to allow for the identification of non-medical CPD funding required, and for the fair and targeted distribution of funds across the Trust. HCG Managers will be required to identify training needs and prepare business cases to include; training needs analysis, risks if funding is not secured, spend against allocation and consideration of alternative funding sources. Compliance with Core (Statutory/Mandatory) training, and an up-to-date Staff Appraisal will be pre-requisites for staff receiving CPD funding and/or support.

4.3 An improved system of Educational Governance, with robust reporting lines will be introduced that align with all Trust requirements, and HEE Education Risk and Quality Governance arrangements and Quality Framework Standards. With these new assurance processes in place at local, corporate and external levels, the Trust can ensure that CPD governance and risk arrangements are robust and are regularly evaluated and reviewed.

5.0 RISKS

5.1 If the Trust fails to invest in CPD for its staff there are a number of inherent risks to service provision, staff engagement, recruitment and retention.

5.2 The purchasing of education through HEI's will no longer be covered by national contracts, and purchase orders in excess of £7.5k with any one supplier will require waivers or preferred supplier status or pan provider agreements across the STP footprint, to ensure there is no breach of policy.

6.0 RECOMMENDATION

6.1 It is recommended that Trust Board note the contents of this paper, and tasks EMB to ensure that non-medical CPD is being provided for the remainder of 2018/19.

6.2 It is also recommended that Trust Board further reviews the position of non-medical CPD is 4 months to take assurance that the Trust has the necessary educational governance in place.

Author: **Martin Smith, AD for Training, Education and Development**
Date: **26th September 2018**

The Princess Alexandra Hospital NHS Trust

Trust Board 4 October 2018

Agenda Item:	8.2
Presented by:	Ogechi Emeadi -Director of People, OD & Communications
Prepared by:	Ellie Manlove – Head of HR
Date prepared:	24 September 2018
Subject	Healthcare worker flu vaccination best practice management checklist

Purpose:	Approval	x	Decision		Information		Assurance	

Executive Summary:	On 7 September 2018 national clinical and staff side professional leaders wrote to Chief Executives requesting that the best practice management checklist for healthcare worker vaccination was completed. It is a requirement that the self-assessment against these measures is published in Trust Board papers before the end of 2018 for public assurance
Recommendation:	For Trust Board to approve the Self-Assessment

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:	n/a
Risk / links with the BAF:	n/a
Legislation, regulatory, equality, diversity and dignity implications:	n/a
Appendices:	n/a

8.2

Healthcare worker flu vaccination best practice management checklist

A	**Committed leadership** (number in brackets relates to references listed below the table)	**Trust self-assessment**
A1	Board record commitment to achieving the ambition of 100% of front line healthcare workers being vaccinated, and for any healthcare worker who decides on the balance of evidence and personal circumstance against getting the vaccine should anonymously mark their reason for doing so.	All staff member are now required to complete a consent form, if they wish to opt out the need to mark why and tick to say they understand the risk of flu and take full responsibility if they then get the flu.
A2	Trust has ordered and provided the quadrivalent (QIV) flu vaccine for healthcare workers (1).	This has been ordered and delivered into the Trust as of 14/9/18
A3	Board receive an evaluation of the flu programme 2017-18, including data, successes, challenges and lessons learnt (2,6)	To be written and sent to EMT by Soofiya address for October Board
A4	Agree on a board champion for flu campaign (3,6)	Sharon McNally & Ogechi Emeadi
A5	Agree how data on uptake and opt-out will be collected and reported	This information is being collated by the
A6	All board members receive flu vaccination and publicise this (4,6)	Board members are booked to have flu jabs and photos on 26 September in the Event in a Tent – health and Wellbeing Day
A7	Flu team formed with representatives from all directorates, staff groups and trade union representatives (3,6)	Flu champions have all been trained
A8	Flu team to meet regularly from August 2018 (4)	Monthly meeting next meeting 04/10/18
B	**Communications plan**	
B1	Rationale for the flu vaccination programme and myth busting to be published – sponsored by senior clinical leaders and trade unions (3,6)	Posters, regarding why you should get the flu vaccination posted around the hospital in staff area. Myth busting facts to be placed on Septembers payslips
B2	Drop in clinics and mobile vaccination schedule to be published electronically, on social media and on paper (4)	To be published on Alex by the end of September. Plus to be attached to Octobers SHaW newsletter, with physical copies taken round the hospital.

B3	Board and senior managers having their vaccinations to be publicised (4)	Board members are booked to have flu jabs and photos on 26 September in the Event in a Tent – health and Wellbeing Day. Senior consultants have also agreed to be photographed
B4	Flu vaccination programme and access to vaccination on induction programmes (4)	Booked for all induction sessions from October 2018
B5	Programme to be publicised on screensavers, posters and social media (3, 5,6)	Flu plan agreed with communications to include screensavers, posters, social media and internal communications
B6	Weekly feedback on percentage uptake for directorates, teams and professional groups (3,6)	New excel flu uptake now in use, Weekly flu uptake to be publicised via coms/ Alex page/ Staff briefing and SHaW newsletter.
C	**Flexible accessibility**	
C1	Peer vaccinators, ideally at least one in each clinical area to be identified, trained, released to vaccinate and empowered (3,6)	40 plus flu champions trained this year.
C2	Schedule for easy access drop in clinics agreed (3)	Roaming clinic times to be advertised. All drop ins welcome during SHaW working hours
C3	Schedule for 24 hour mobile vaccinations to be agreed (3,6)	Night and weekend clinics, date to be publicised. Outpatient nurse at Herts and Essex and St Margaret's trained as flu champions and have agreed to take responsibility of vaccinating all staff based there.
D	**Incentives**	
D1	Board to agree on incentives and how to publicise this (3,6)	Week one incentive for a free tea or coffee and the canteen, other weeks to include, pens, sweets, free back massage, Harlow theatre tickets.
D2	Success to be celebrated weekly (3,6)	Via InTouch, weekly briefing

Your future | Our hospital

NHS
The Princess Alexandra Hospital
NHS Trust

Trust Board - 4 October 2018

Agenda Item:	9.1
Presented by:	Chief Executive - Lance McCarthy/ James Roach - ICP Programme Director
Prepared by:	
Date prepared:	28 September 2018
Subject / Title:	West Essex Integrated Care Partnership (ICP) Governance Model

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 ultimate aim of the Proposed ICP Governance model is to reduce duplication and create single routes for system decision making and enhance these through associated schemes of delegation. The aim would be to launch the ICP Governance Model from 1st November 2018 with delegation in identified areas being fully in place from 1st April 2019.
Recommendation:	The Board is asked to approve the proposed changes to the ICP Governance model, review and advise on proposed schemes of delegation.

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:	N/A
Legislation, regulatory, equality, diversity and dignity implications:	Code of Governance.
Appendices:	Proposal for West Essex Integrated Care Partnership (ICP) Governance Model

9.1

respectful | caring | responsible | committed

Developing an Integrated Governance Framework

Proposal for the West Essex Integrated Care Partnership

Section 1 - Introduction and Background

The emerging ICP Governance model was developed following a mapping session held with system partners in July with the ICP Board in August approving the roll out of the model subject to

- Each individual Partner Governing Body approving development of the proposed Governance Model
- Legal advice being sought in relation to the levels of delegated authority sort.

The aim would be to launch the ICP Governance Model from 1st November 2018 with delegation in identified areas being fully in place from 1st April 2019.

The ultimate aim of the Proposed ICP Governance model is to reduce duplication and create single routes for system decision making and enhance these through associated schemes of delegation.

The CCG Governing Body is asked to;

- Approve the proposed ICP Governance Model to launch in Shadow form from the 1st November.
- Support the transition from Shadow ICP Governance to full delegated authority in identified areas from 1st April 2018. Transition will include formalising the role of each forum, implementation in a timely way , gaining the relevant legal advice in relation to delegations and permissions and requesting Regulator support in relation to the proposed direction of travel
- Endorse the development of a formal Alliance Agreement (in line with NHS England guidance) to underpin the ICP and its Governance model

Section 2 - Key strategic priorities and how the West Essex ICP Programme will enable delivery

Strategic Priorities	**The ICP Programme will;**
1.Collaboration	Bind system organisations together to deliver key services under an Integration agreement.
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 initially in the 3 priority areas and jointly 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.
6. Measure what matters	Use data and evidence to identify system priorities underpinned by system wide population health and analysis.

7.Transparency	• Developing a joint financial plan • Launch of an integrated performance dashboard • Sharing of data and intelligence
8.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.
9.Sustainability	A joint focus on the future and ensuring 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.
10. System Leadership	Ensuring a system wide implementation plain which delivers the key strategic objectives of the system underpinned by an effective pan system Organisational Development Plan.

It is intended that the Integrated Care Partnership covers all aspects of Health and Care in the West Essex area, specifically

- ✓ Public health (defining strategic and tactical)
- ✓ Social care (as above)
- ✓ Primary Care (through the integrated Neighbourhood model)
- ✓ Community services
- ✓ Mental health services

- ✓ Acute services
- ✓ Specialised services (this may well link to the development of the Integrated Care System across the current Herts and West Essex STP Footprint)
- ✓ Health education, innovation and R&D
- ✓ Governance, Assurance and regulation
- ✓ Resources and finance
- ✓ Capital and estate
- ✓ Information sharing and digital integration
- ✓ Workforce
- ✓ Communication and engagement

To enable effective ICP Governance the following **enablers** will be put in place across the system;

- ✓ Appropriate system wide governance and regulation
- ✓ Empowered System Leadership
- ✓ Delegation of resources in line with delegation of statutory functions (role of CCGs where ICPs are established)
- ✓ Access to fiscal and regulatory levers that drives the improvement of health and wellbeing across the West Essex Health and Care System
- ✓ A shared strategic approach to capital and estates planning

- ✓ A shared strategic approach to communications and engagement
- ✓ A shared strategic approach to workforce planning (clinical and non-clinical)
- ✓ Development of new payment mechanisms
- ✓ Development of new information sharing system /process

Section 3- Key Governance Milestones

- By **October 31st[h] 2018** – we will have approval to roll out the system wide governance model with system wide responsibilities and authority to instruct for legal clarification over where delegated authority can be implemented within the parameters of compliance.
- During **October 2018** we will scope and agree a new single oversight and assurance framework for the ICP (This we will scope in the System wide planning workshop on the 8th October)
- By **November 2018** – Shadow capitated contract in place for the 3 priority areas
- By **end of November 2018** we will agree an ICP Delivery Plan working as one in the key priority areas underpinned by a single contracting and assurance framework for the ICP. In particular we jointly publish set of ICP Delivery intentions for 2018/19
- By **December 2018** we will have established the process and plan for the West Essex ICP Medium Term Financial Plan (to launch formally on the 1st April 2019) and with it an approach for agreeing and monitoring investment decisions within the ICP
- By **January 2018** we will have in place an ICP Alliance Agreement to bind the partnership in real terms providing the framework to work as one system to develop an integrated care partnership in West Essex.
- By **November 2018**, taking staff and public feedback into account we will refresh and rebrand the ICP from a communications and engagement perspective.
- By **January 2018** determine the future role of the CCG in relation to strategic and tactical commissioning as the ICP becomes more established including putting in place system and place commissioning responsibilities.

Section 4 - Description of the Proposed Governance Model

4.1 Principles

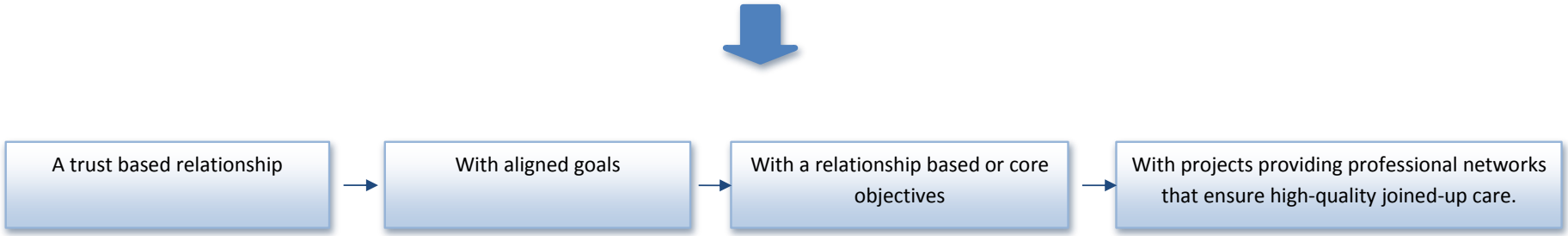
The revised Governance framework and the proposed West Essex ICP Alliance Agreement does not replace the legal framework or regulatory duties of our statutory organisations as they are currently constituted but instead sits alongside the defined framework to complement and enhance it

4.2 "Give and get "

The approach and subsequent agreements will include NHS England and NHS Improvement with the Alliance agreement being flexible enough (using NHS England template) to achieve the right level of delegated authority in areas such as

- Financial
- Capacity
- Devolved freedoms and flexibilities

In return the intention would be to move away from a purely transactional approach to improved performance and transformation change



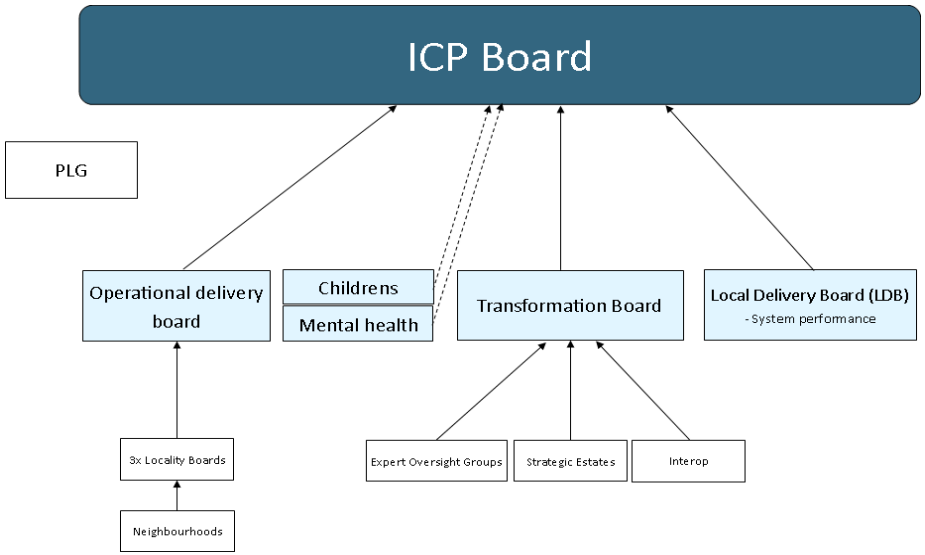
- As the ICP is not yet a legal entity (as defined by NHS England) , The ICP Board through its governance process and delegated authority will continue to engage closely and work in partnership with Boards , Governing Bodies and Councils throughout the development of the ICP

- The development of the ICP during 2018/19 will establish how individual organisations will be held to account for their contribution to the delivery of NHS Constitution and Mandate arrangements in full and remain part of the of the wider NHS system ICP. The ultimate aim is for the ICP to be assured once as a place for delivery of core local, regional and national priorities

The proposed Governance changes will ensure that we develop effectively as an ICP which will include collective decision making , governance and a single accountability framework to the delivery of the West Essex plan

4.3 The Proposed Governance Model

What we are proposing is the development of collaborative ICP Governance (as outlined below) which recognises the statutory governance of member organisations but at the same times begins to accelerate the development of the ICP and bind it in real terms



- This model of system wide governance will remain in place between 2018 and 2020 and during this time it is intended that the West Essex ICP will work with Department of Health , NHS England and NHS Improvement to establish the governance model that will enable the system to develop into an independent fully functional ICP by 2020 (the Current West Essex ICP vision)
- CCGs and Local Authorities will continue to receive their respective health and care funding and be statutorily responsible for their allocation.
- To act as an initial structure, it is proposed the Leadership and Management Team Terms of Reference, devised in Schedule 3 Part 1 on the NHS E template Alliance Agreement is used. These terms can be adapted, but provide a base. It is suggested that any recommendation surrounding delegation are made with the support of legal advice, as whilst the CCG and Trust will have statutory and regulatory duties, other collaborating members may also have terms defined by statutory or held within other constitutional documentation.

4.4 Summary of key meetings

West Essex ICP Board

The ICP Delivery Board will have system wide overview and accountability. It will develop an Alliance Agreement and a Terms of Reference for the Board to adopt; it will also lead the way in developing the Alliance Contract. It will ultimately oversee the delivery of all core programme objectives ensuring key issues addressed and any delegated authority is used appropriately in delivery terms.

The ICP Board has agreed that Primary Care should be represented on a locality basis. These will be specifically to represent the strengths and concerns of the Locality they represent from a general practice perspective though they should be also able to represent the wider Neighbourhood issues within their localities from a population health needs perspective. Board GPs as Locality leads is already understood and established.

The ICP Board will also have clinical/professional representation from other providers specifically PAH, EPUT, ECC and when appropriate from Hertfordshire.

Local Delivery Board

It has been agreed that LDB is formally connected into ICP Governance Structure Formerly connecting the LDB into the ACP Governance structure, which covers Urgent Care, DTOC and winter planning. The ICP Delivery Board will also have overall delegated responsibility and sign off for decisions made by the LDB. This will establish the clinical pathway and single control total position for urgent care.

Existing Children's and Mental Health Boards

These will have a direct linkage to the ICP Delivery Board

Transformation Board
This Board will take the lead for innovation and transformation across the system and focus on areas such as progress population health service alignment, delivery of core transformation priorities, and development of the ICP Workforce model. It will also take responsibility for aligning system efficiency plans. The following key sub groups will link into the Transformation Board;

(a)Strategic estates group – maximise use of estate for current and future service needs.

(b)IT Interoperability – covering shared care record, interoperability and data sharing, it will also look to mainstream the integration of data, move towards single care record and align our analysis.

(C) Expert Oversight Groups – Joint clinical expert groups leading the development of Integrated Care Pathways in a range of clinical specialties

Operational Delivery Board

The Board will oversee all programme delivery, performance management, financial leadership (Single Control Total and MTFP), development of new contracting and currency models and take responsibility for aligning CIP, QIPP and Cost improvement.

In the future it is hoped we will move all existing contracting and finance functions into one system Board meeting and develop a Single Accountability Framework for the ICP .There will also linkage into the work that is being undertaken at Neighbourhood and locality levels giving neighbourhoods a seat at the table and an opportunity to influence decision making across the ICP.

CCG Governance

CCG Governing Bodies are required by statute to have 2 committees both of which should be chaired by lay members:

1. Audit Committee and
2. Remuneration Committee

3. In addition, the CCG has taken on delegated responsibility for primary care commissioning and has established a Primary Care Commissioning Committee.

4. Quality Committee

These committees would remain in place in the future for the CCG and all Provider Organisations.

Section 5- Future Roles of CCGs where ICP has been developed

5.1 – Key messages

Recent guidance from NHS England advised on the future role of CCGs where ICPs have been developed in the context of the Draft Integrated Care Provider Contract /Consultation package. This will be considered in more detail at the CCG Board Development Session in October, key messages are summarised below.

- CCGs will continue to be responsible for the delivery of their functions, although it is recognised that they may also require through contract provisions an ICP to take action to support the function of certain CCG functions.
- CCGs functions can't be delegated
- CCGs and ICPs should maximise opportunities for making shared use of administrative resources
- The establishment of ICPs will require providers to deploy integrated budgets flexibly. To enable this CCGs may wish to pool budgets with other commissioners
- The draft ICP contract developed by NHS England stipulates some requirements of ICPs which will subject to statutory constraints include
    - Requirement to conduct a population health needs assessment and to develop strategies to improve health and wellbeing of the population
    - The requirement to seek to address underlying health inequalities
    - The need to put in place information systems and risk stratification

- Obligation to offer patient choice , including choice of primary care provider

. ***5.2 – Future Opportunities***

Activity function CCG is responsible for	Description	How can ICP support delivery
Population needs assessment	• CCGs are obliged to deliver JSNA • Local analysis of demand, population needs and expectations	• Join up assessment • Use data to determine future priorities and allocation of resource • Needs analysis to deliver current and future contracture obligations
Commissioning	Commission health services to meet needs of service	The ICP cannot directly commission services but would be able to sub contract services within the scope of what it has been commissioned to provide
Managing and developing the supply chain for services provided across the CCG (including across the ICP)	Stimulating the market to ensure there are a number of high quality options for patients available when commissioning service	Yes the ICP should stimulate the market to ensure there are a number of high quality options available when it is sub-contracting services
Demand management across the CCG	Putting in place actions across the CCG to control levels of demand on particular services	Yes the ICP should create and manage demand management plans for their populations to enable patients to make appropriate choices

Engagement and consultation on service change proposals	Section 142 – CCG	Yes ICPs should develop new ways to involve their population in the design and use of services
Integrating the Provision of services across the CCG	CCG has a duty to exercise its functions with a view to ensuring that health services are delivered in an integrated way where it considers that this would improve the quality of those services	ICP should lead on the development of integrated provider pathways ICP will hold responsibility for a wide range of services itself , organisational barriers will be removed and the ICP will put in place smooth , seamless pathways between services provided by the ICP
Addressing health inequalities	CCG obliged under Section 141	The Draft national ICP contract raises a specific obligation on the ICP to reduce health inequalities when performing its obligations
Planning and implementation of cost improvement schemes	Yes	Yes – ICPs are well placed to deliver these in a sustainable way
Decision making relating to funding routes	Yes	Yes where service and contractually appropriate
Contract management for services within outside of ICP scope	Yes in the normal	ICP would be responsible for managing any contracts it has with sub-contractors.

Quality monitoring	Yes	Yes quality monitoring of services being delivered through a sub contract should be carried out by an ICP
Oversight and management of system performance	Taking responsibility as the system leader for the overall performance of whole local health system	ICP wide performance management of services it delivers and sub contracts
Oversight of risk and reward mechanisms	Using the contract to put in place mechanisms between CCG and ICP a	Not appropriate for ICP to have oversight of reward mechanisms but can influence them through contract negotiations

Section 6 -Binding the partnership in real terms

NHS England Alliance Agreement

This emerging agreement (when drafted) will develop and embed the framework by which all partners will come together working as one in identified areas in 2019/20 to establish how we will develop as an integrated care partnership. We will agree together the delegated powers and new relationships we develop across organisations to deliver on this ambition and bind the partnership in real terms

This alliance agreement will be developed in November.

Section 7 -Proposed scheme of delegation

The information below represents current thinking on proposed scheme of delegation for the ICP Programme, a more detailed proposal will be provided to the relevant Governing Bodies for sign off in September. Any suggestions below will be subject to receipt of external legal advice:

Major Programme Decision Areas	Remains with individual Boards	Delegated to ICP Board
Agreement to Overarching ICP Plan and investment requirements and underpinning Governance	✓	
Agreement on formal ICP Board , levels of delegated authority and MOU	✓	
Agreement on the assurance process	✓(CCG)	
Agreement of the decision to proceed with most capable lead providers approaches or proceed to competitive market procurement		✓(agree)
Contract award recommendations for Governing Body Ratification	✓(agree)	✓(Recommend)
Define the responsibilities and accountability of the Lead Provider		✓
Agreement on the mobilisation of resources required to deliver the programme and its objectives		✓
Day to day direction and leadership of the programme		✓
Recommendations and agreement on readiness to go live in April 2019	✓(agree)	✓(Recommend)

Section 8 -Next steps /key decisions required

Governing Body are asked to

- Approve the proposed ICP Governance Model to launch in Shadow form from the 1st November
- Support the transition from Shadow ICP Governance to full delegated authority in identified areas from 1st April 2018. Transition will include formalising the role of each forum, implementation in a timely way , gaining the relevant legal advice in relation to delegation and permission and requesting Regulator support in relation to the proposed direction of travel
- Endorse the development of a formal Alliance Agreement (in line with NHS England guidance) to underpin the ICP and its Governance model

James Roach

ICP Programme Director

September 2018

The Princess Alexandra Hospital NHS
NHS Trust

Trust Board
04th October 2018

Agenda Item:	9.2
Presented by:	Stephanie Lawton – Chief Operating Officer / Accountable Emergency Officer
Prepared by:	Chris Allen – Emergency Planning and Resilience Manager
Date prepared:	10th September 2018
Subject / Title:	NHS England Emergency Planning, Resilience and Response (EPRR) Core Standards Annual Return

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 attached report and appendix outlines the Trusts response to the Annual NHS England EPRR Core Standards. This year the Trust has achieved a Substantially Compliant rating, this was reviewed as part of a validation meeting with NHS England and Mid Essex CCG (as lead CCG for EPRR) who agreed with the Trust assessment of its scoring. Whilst direct comparison with the previous year is difficult due to the question sets changing yearly, there is an improvement in the position from the previous year. The committee are asked to take the report as assurance prior to approval at Trust board for submission to the Local Health Resilience Partnership as per the NHS England requirements.
Recommendation:	To approve this paper and submission of the core standards to the Local Health Resilience Partnership.

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:	NHS England / Mid Essex CCG Validation Panel – 6th September 2018 Performance and Finance Committee – 24th September 2018 PAF.24.09.18
Risk / links with the BAF:	Non-compliance may result in legal and regulatory action BAF 2.3 – Internal Engagement
Legislation, regulatory, equality, diversity and dignity implications:	Civil Contingencies Act 2004 Health and Social Care Act 2012 NHS England EPRR Core Standards NHS England EPRR Framework 2015 NHS Standard Contract
Appendices:	Copy of Core Standards for EPRR Return

The Princess Alexandra Hospital NHS
NHS Trust

0.1 PURPOSE

1.1 This paper provides a report on the Trust's self-assessment against the NHS England Core Standards for Emergency Planning, Resilience and Response.

2.0 BACKGROUND

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

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

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

2.3 The NHS England Core Standards are used to ensure compliance with the requirements of the Civil Contingencies Act (2004) along with the requirements laid down by the NHS Standard Contract, and the requirements of NHS England and the Department of Health.

9.2

3.0 ANALYSIS

3.1 As an organisation the Trust scored substantially compliant, based on 72 standards, the Trust was fully compliant in 69 of the standards, and partially compliant in 3 of the standards.

3.2 Where we have scored partially compliant actions plans will be developed to obtain compliance, with these plans monitored via the Local Health Resilience Partnership.

3.3 There were no standards showing as non-compliant.

3.4 The EPRR Core Standards document defines compliance levels as:

i. Non-Compliant - Not compliant with core standard and not in the EPRR work plan within the next 12 months.
ii. Partial Compliance - Not compliant but evidence of progress and in the EPRR work plan for the next 12 months.
iii. Fully Compliant - Fully compliant with core standard.

4.0 Areas of partial compliance

4.1 Below is a breakdown of the standards which were scored as partially compliant with an overview of actions to be taken and any feedback provided from the NHS England / Mid Essex CCG Validation Meeting.

4.1.1 Core Standard 38 – Warning and Informing – *"The organisation has processes for warning and informing the public and staff during major incidents, critical incidents or business continuity incidents"*.

Whilst there are clear processes in place for warning and informing staff members to multiple incident types, there are clear gaps in out processes in terms of communication with the wider public. In particular, gaps are recognised out of hours and at weekends, when there is no dedicated communications team support. Whilst the executive director on call will manage media enquires out of hours, there are limitations to their abilities to manage this specialist area of work, and this will become increasingly limited if they are strategically managing the Trust response to an incident. The work plan will reflect the need for an updated media relations policy that includes warning and informing arrangements, and protocols for management of emergency communications.

4.1.2 Core Standard 39 – Media Strategy – *"The organisation has a media strategy to enable communication with the public. This includes identification of and access to a trained media spokespeople able to represent the organisation to the media at all times"*.

Whilst there is a media relations policy in place, this does not reflect the specialist needs for communication in an emergency, or contain specific information related to the communications team response arrangements for an emergency. Additionally, there are a very limited number of staff who have undertaken training for the management of the media or spokesperson training. The work plan will reflect the need for an updated media relations policy that includes identification and training of spokes persons, and protocols for management of emergency communications.

4.1.3 Core Standard 40 – LHRP Attendance – "*The Accountable Emergency Officer, or an appropriate director, attends (no less than 75%) of Local Health Resilience Partnership (LHRP) meetings per annum*".

The Trust has had representation at all LHRP meetings, however, the attendance by the Accountable Emergency Officer or appropriate director does not meet 75%. The guidance provided at the validation meeting by NHS England is that if the Accountable Emergency Officer is happy for the Emergency Planning and Resilience Manager to attend on their behalf, a letter of delegated authority should be provided by the Accountable Emergency Officer, which would then count as attendance for future meetings.

5.0 RECOMMENDATION

1. To approve this paper and submission of the core standards to the Local Health Resilience Partnership.

Author: Chris Allen – Emergency Planning and Resilience Manager
Date: 11th September 2018

Please select type of organisation: **Acute Providers**

Core Standards	Total standards applicable	Fully compliant	Partially compliant	Non compliant
Governance	6	6	0	0
Duty to risk assess	2	2	0	0
Duty to maintain plans	14	14	0	0
Command and control	2	2	0	0
Training and exercising	3	3	0	0
Response	7	7	0	0
Warning and informing	3	1	2	0
Cooperation	4	3	1	0
Business Continuity	9	9	0	0
CBRN	14	14	0	0
Total	64	61	3	0

Deep Dive	Total standards applicable	Fully compliant	Partially compliant	Non compliant
Incident Coordination Centres	4	4	0	0
Command structures	4	4	0	0
Total	8	8	0	0

Overall assessment:	Substantially compliant

Instructions:
Step 1: Select the type of organisation from the drop-down at the top of this page
Step 2: Complete the Self-Assessment RAG in the 'EPRR Core Standards' tab
Step 3: Complete the Self-Assessment RAG in the 'Deep dive' tab
Step 4: Ambulance providers only: Complete the Self-Assessment in the 'Interoperable capabilities' tab
Step 5: Click the 'Produce Action Plan' button below

Ref	Domain	Standard	Detail	Acute Providers	Evidence - examples listed below
1	**Governance**	**Appointed AEO**	The organisation has appointed an Accountable Emergency Officer (AEO) responsible for Emergency Preparedness Resilience and Response (EPRR). This individual should be a board level director, and have the appropriate authority, resources and budget to direct the EPRR portfolio. A non-executive board member, or suitable alternative, should be identified to support them in this role.	Y	• Name and role of appointed individual
2	**Governance**	**EPRR Policy Statement**	The organisation has an overarching EPRR policy statement. This should take into account the organisation's: • Business objectives and processes • Key suppliers and contractual arrangements • Risk assessment(s) • Functions and / or organisation, structural and staff changes. The policy should: • Have a review schedule and version control • Use unambiguous terminology • Identify those responsible for making sure the policies and arrangements are updated, distributed and regularly tested • Include references to other sources of information and supporting documentation.	Y	Evidence of an up to date EPRR policy statement that includes: • Resourcing commitment • Access to funds • Commitment to Emergency Planning, Business Continuity, Training, Exercising etc.
3	**Governance**	**EPRR board reports**	The Chief Executive Officer / Clinical Commissioning Group Accountable Officer ensures that the Accountable Emergency Officer discharges their responsibilities to provide EPRR reports to the Board / Governing Body, no less frequently than annually. These reports should be taken to a public board, and as a minimum, include an overview on: • training and exercises undertaken by the organisation • business continuity, critical incidents and major incidents • the organisation's position in relation to the NHS England EPRR assurance process.	Y	• Public Board meeting minutes • Evidence of presenting the results of the annual EPRR assurance process to the Public Board
4	**Governance**	**EPRR work programme**	The organisation has an annual EPRR work programme, informed by lessons identified from: • incidents and exercises • identified risks • outcomes from assurance processes.	Y	• Process explicitly described within the EPRR policy statement • Annual work plan
5	**Governance**	**EPRR Resource**	The Board / Governing Body is satisfied that the organisation has sufficient and appropriate resource, proportionate to its size, to ensure it can fully discharge its EPRR duties.	Y	• EPRR Policy identifies resources required to fulfill EPRR function; policy has been signed off by the organisation's Board • Assessment of role / resources • Role description of EPRR Staff • Organisation structure chart • Internal Governance process chart including EPRR group
6	**Governance**	**Continuous improvement process**	The organisation has clearly defined processes for capturing learning from incidents and exercises to inform the development of future EPRR arrangements.	Y	• Process explicitly described within the EPRR policy statement
7	**Duty to risk assess**	**Risk assessment**	The organisation has a process in place to regularly assess the risks to the population it serves. This process should consider community and national risk registers.	Y	• Evidence that EPRR risks are regularly considered and recorded • Evidence that EPRR risks are represented and recorded on the organisations corporate risk register

8	Duty to risk assess	Risk Management	The organisation has a robust method of reporting, recording, monitoring and escalating EPRR risks.	Y	• EPRR risks are considered in the organisation's risk management policy • Reference to EPRR risk management in the organisation's EPRR policy document
9	Duty to maintain plans	Collaborative planning	Plans have been developed in collaboration with partners and service providers to ensure the whole patient pathway is considered.	Y	Partners consulted with as part of the planning process are demonstrable in planning arrangements
11	Duty to maintain plans	Critical incident	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to a critical incident (as per the EPRR Framework).	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required
12	Duty to maintain plans	Major incident	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to a major incident (as per the EPRR Framework).	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required
13	Duty to maintain plans	Heatwave	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to the impacts of heat wave on the population the organisation serves and its staff.	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required
14	Duty to maintain plans	Cold weather	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to the impacts of snow and cold weather (not internal business continuity) on the population the organisation serves.	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required
15	Duty to maintain plans	Pandemic influenza	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to pandemic influenza as described in the National Risk Register.	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required
16	Duty to maintain plans	Infectious disease	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to an infectious disease outbreak within the organisation or the community it serves, covering a range of diseases including Viral Haemorrhagic Fever. These arrangements should be made in conjunction with Infection Control teams; including supply of adequate FFP3.	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required

17	**Duty to maintain plans**	**Mass Countermeasures**	In line with current guidance and legislation, the organisation has effective arrangements in place to distribute Mass Countermeasures - including the arrangement for administration, reception and distribution, eg mass prophylaxis or mass vaccination. There may be a requirement for Specialist providers, Community Service Providers, Mental Health and Primary Care services to develop Mass Countermeasure distribution arrangements. These will be dependant on the incident, and as such requested at the time. CCGs may be required to commission new services dependant on the incident.	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required
18	**Duty to maintain plans**	**Mass Casualty - surge**	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to mass casualties. For an acute receiving hospital this should incorporate arrangements to increase capacity by 10% in 6 hours and 20% in 12 hours.	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required
19	**Duty to maintain plans**	**Mass Casualty - patient identification**	The organisation has arrangements to ensure a safe identification system for unidentified patients in emergency/mass casualty incident. Ideally this system should be suitable and appropriate for blood transfusion, using a non-sequential unique patient identification number and capture patient sex.	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required
20	**Duty to maintain plans**	**Shelter and evacuation**	In line with current guidance and legislation, the organisation has effective arrangements in place to place to shelter and / or evacuate patients, staff and visitors. This should include arrangements to perform a whole site shelter and / or evacuation.	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required
21	**Duty to maintain plans**	**Lockdown**	In line with current guidance and legislation, the organisation has effective arrangements in place safely manage site access and egress of patients, staff and visitors to and from the organisation's facilities. This may be a progressive restriction of access / egress that focuses on the 'protection' of critical areas.	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required
22	**Duty to maintain plans**	**Protected individuals**	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to manage 'protected individuals'; including VIPs, high profile patients and visitors to the site.	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required

23	**Duty to maintain plans**	**Excess death planning**	Organisation has contributed to and understands its role in the multiagency planning arrangements for excess deaths, including mortuary arrangements.	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required
24	**Command and control**	**On call mechanism**	A resilient and dedicated EPRR on call mechanism in place 24 / 7 to receive notifications relating to business continuity incidents, critical incidents and major incidents. This should provide the facility to respond or escalate notifications to an executive level.	Y	• Process explicitly described within the EPRR policy statement • On call Standards and expectations are set out • Include 24 hour arrangements for alerting managers and other key staff.
25	**Command and control**	**Trained on call staff**	On call staff are trained and competent to perform their role, and are in a position of delegated authority on behalf on the Chief Executive Officer / Clinical Commissioning Group Accountable Officer. The identified individual: • Should be trained according to the NHS England EPRR competencies (National Occupational Standards) • Can determine whether a critical, major or business continuity incident has occurred • Has a specific process to adopt during the decision making • Is aware who should be consulted and informed during decision making • Should ensure appropriate records are maintained throughout.	Y	• Process explicitly described within the EPRR policy statement
26	**Training and exercising**	**EPRR Training**	The organisation carries out training in line with a training needs analysis to ensure staff are competent in their role; training records are kept to demonstrate this.	Y	• Process explicitly described within the EPRR policy statement • Evidence of a training needs analysis • Training records for all staff on call and those performing a role within the ICC • Training materials • Evidence of personal training and exercising portfolios for key staff
27	**Training and exercising**	**EPRR exercising and testing programme**	The organisation has an exercising and testing programme to safely test major incident, critical incident and business continuity response arrangements. Organisations should meet the following exercising and testing requirements: • a six-monthly communications test • annual table top exercise • live exercise at least once every three years • command post exercise every three years. The exercising programme must: • identify exercises relevant to local risks • meet the needs of the organisation type and stakeholders • ensure warning and informing arrangements are effective. Lessons identified must be captured, recorded and acted upon as part of continuous improvement.	Y	• Exercising Schedule • Evidence of post exercise reports and embedding learning
28	**Training and exercising**	**Strategic and tactical responder training**	Strategic and tactical responders must maintain a continuous personal development portfolio demonstrating training in accordance with the National Occupational Standards, and / or incident / exercise participation	Y	• Training records • Evidence of personal training and exercising portfolios for key staff
30	**Response**	**Incident Co-ordination Centre (ICC)**	The organisation has a preidentified an Incident Co-ordination Centre (ICC) and alternative fall-back location. Both locations should be tested and exercised to ensure they are fit for purpose, and supported with documentation for its activation and operation.	Y	• Documented processes for establishing an ICC • Maps and diagrams • A testing schedule • A training schedule • Pre identified roles and responsibilities, with action cards • Demonstration ICC location is resilient to loss of utilities, including telecommunications, and external hazards
31	**Response**	**Access to planning arrangements**	Version controlled, hard copies of all response arrangements are available to staff at all times. Staff should be aware of where they are stored; they should be easily accessible.	Y	Planning arrangements are easily accessible - both electronically and hard copies

32	**Response**	**Management of business continuity incidents**	The organisations incident response arrangements encompass the management of business continuity incidents.	Y	• Business Continuity Response plans
33	**Response**	**Loggist**	The organisation has 24 hour access to a trained loggist(s) to ensure decisions are recorded during business continuity incidents, critical incidents and major incidents.	Y	• Documented processes for accessing and utilising loggists • Training records
34	**Response**	**Situation Reports**	The organisation has processes in place for receiving, completing, authorising and submitting situation reports (SitReps) and briefings during the response to business continuity incidents, critical incidents and major incidents.	Y	• Documented processes for completing, signing off and submitting SitReps • Evidence of testing and exercising
35	**Response**	**Access to 'Clinical Guidance for Major Incidents'**	Emergency Department staff have access to the NHSE 'Clinical Guidance for Major Incidents' handbook.	Y	Guidance is available to appropriate staff either electronically or hard copies
36	**Response**	**Access to 'CBRN incident: Clinical Management and health protection'**	Clinical staff have access to the PHE 'CBRN incident: Clinical Management and health protection' guidance.	Y	Guidance is available to appropriate staff either electronically or hard copies
37	**Warning and informing**	**Communication with partners and stakeholders**	The organisation has arrangements to communicate with partners and stakeholder organisations during and after a major incident, critical incident or business continuity incident.	Y	• Have emergency communications response arrangements in place • Social Media Policy specifying advice to staff on appropriate use of personal social media accounts whilst the organisation is in incident response • Using lessons identified from previous major incidents to inform the development of future incident response communications • Having a systematic process for tracking information flows and logging information requests and being able to deal with multiple requests for information as part of normal business processes • Being able to demonstrate that publication of plans and assessments is part of a joined-up communications strategy and part of your organisation's warning and informing work
38	**Warning and informing**	**Warning and informing**	The organisation has processes for warning and informing the public and staff during major incidents, critical incidents or business continuity incidents.	Y	• Have emergency communications response arrangements in place • Be able to demonstrate consideration of target audience when publishing materials (including staff, public and other agencies) • Communicating with the public to encourage and empower the community to help themselves in an emergency in a way which compliments the response of responders • Using lessons identified from previous major incidents to inform the development of future incident response communications • Setting up protocols with the media for warning and informing
39	**Warning and informing**	**Media strategy**	The organisation has a media strategy to enable communication with the public. This includes identification of and access to a trained media spokespeople able to represent the organisation to the media at all times.	Y	• Have emergency communications response arrangements in place • Using lessons identified from previous major incidents to inform the development of future incident response communications • Setting up protocols with the media for warning and informing • Having an agreed media strategy which identifies and trains key staff in dealing with the media including nominating spokespeople and 'talking heads'
40	**Cooperation**	**LRHP attendance**	The Accountable Emergency Officer, or an appropriate director, attends (no less than 75%) of Local Health Resilience Partnership (LHRP) meetings per annum.	Y	• Minutes of meetings
41	**Cooperation**	**LRF / BRF attendance**	The organisation participates in, contributes to or is adequately represented at Local Resilience Forum (LRF) or Borough Resilience Forum (BRF), demonstrating engagement and co-operation with other responders.	Y	• Minutes of meetings • Governance agreement if the organisation is represented
42	**Cooperation**	**Mutual aid arrangements**	The organisation has agreed mutual aid arrangements in place outlining the process for requesting, co-ordinating and maintaining resource eg staff, equipment, services and supplies. These arrangements may be formal and should include the process for requesting Military Aid to Civil Authorities (MACA).	Y	• Detailed documentation on the process for requesting, receiving and managing mutual aid requests • Signed mutual aid agreements where appropriate
46	**Cooperation**	**Information sharing**	The organisation has an agreed protocol(s) for sharing appropriate information with stakeholders.	Y	• Documented and signed information sharing protocol • Evidence relevant guidance has been considered, e.g. Freedom of Information Act 2000, General Data Protection Regulation and the Civil Contingencies Act 2004 'duty to communicate with the public'.
47	**Business Continuity**	**BC policy statement**	The organisation has in place a policy statement of intent to undertake Business Continuity Management System (BCMS).	Y	Demonstrable a statement of intent outlining that they will undertake BC - Policy Statement

48	**Business Continuity**	**BCMS scope and objectives**	The organisation has established the scope and objectives of the BCMS, specifying the risk management process and how this will be documented.	Y	BCMS should detail: • Scope e.g. key products and services within the scope and exclusions from the scope • Objectives of the system • The requirement to undertake BC e.g. Statutory, Regulatory and contractual duties • Specific roles within the BCMS including responsibilities, competencies and authorities. • The risk management processes for the organisation i.e. how risk will be assessed and documented (e.g. Risk Register), the acceptable level of risk and risk review and monitoring process • Resource requirements • Communications strategy with all staff to ensure they are aware of their roles • Stakeholders
49	**Business Continuity**	**Business Impact Assessment**	The organisation annually assesses and documents the impact of disruption to its services through Business Impact Analysis(s).	Y	Documented process on how BIA will be conducted, including: • the method to be used • the frequency of review • how the information will be used to inform planning • how RA is used to support.
50	**Business Continuity**	**Data Protection and Security Toolkit**	Organisation's IT department certify that they are compliant with the Data Protection and Security Toolkit on an annual basis.	Y	Statement of compliance
51	**Business Continuity**	**Business Continuity Plans**	The organisation has established business continuity plans for the management of incidents. Detailing how it will respond, recover and manage its services during disruptions to: • people • information and data • premises • suppliers and contractors • IT and infrastructure These plans will be updated regularly (at a minimum annually), or following organisational change.	Y	• Documented evidence that as a minimum the BCP checklist is covered by the various plans of the organisation
52	**Business Continuity**	**BCMS monitoring and evaluation**	The organisation's BCMS is monitored, measured and evaluated against the Key Performance Indicators. Reports on these and the outcome of any exercises, and status of any corrective action are annually reported to the board.	Y	• EPRR policy document or stand alone Business continuity policy • Board papers
53	**Business Continuity**	**BC audit**	The organisation has a process for internal audit, and outcomes are included in the report to the board.	Y	• EPRR policy document or stand alone Business continuity policy • Board papers • Audit reports
54	**Business Continuity**	**BCMS continuous improvement process**	There is a process in place to assess and take corrective action to ensure continual improvement to the BCMS.	Y	• EPRR policy document or stand alone Business continuity policy • Board papers • Action plans
55	**Business Continuity**	**Assurance of commissioned providers / suppliers BCPs**	The organisation has in place a system to assess the business continuity plans of commissioned providers or suppliers; and are assured that these providers arrangements work with their own.	Y	• EPRR policy document or stand alone Business continuity policy • Provider/supplier assurance framework • Provider/supplier business continuity arrangements

Ref	Domain	Standard	Detail	Acute Providers	Evidence - examples listed below	Self assessment RAG Red = Not compliant with core standard. In line with the organisation's EPRR work programme, compliance will not be reached within the next 12 months. Amber = Not compliant with core standard. The organisation's EPRR work programme demonstrates evidence of progress and an action plan to achieve full compliance within the next 12 months. Green = Fully compliant with core standard.	Action to be taken	Lead	Timescale	Comments
Deep Dive - Command and control										
Domain: Incident Coordination Centres										
1	Incident Coordination Centres	Communication and IT equipment	The organisation has equipped their ICC with suitable and resilient communications and IT equipment in line with NHS England Resilient Telecommunications Guidance.	Y		Fully compliant				Multipe systems in place: Standard Trust Analogue Phone System Non-Geographic number with ability to divert as required including to mobiles Independent BT Line Independent Wifi connection outside of N3 network
2	Incident Coordination Centres	Resilience	The organisation has the ability to establish an ICC (24/7) and maintains a state of organisational readiness at all times.	Y	Up to date training records of staff able to resource an ICC	Fully compliant				ICC is located within hospital operations centre, this area is used continually by the Site Management Team and On Call Teams 24/7
3	Incident Coordination Centres	Equipment testing	ICC equipment has been tested every three months as a minimum to ensure functionality, and corrective action taken where necessary.	Y	Post test reports Lessons identified EPRR programme	Fully compliant				ICC is located within hospital operations centre, this area is used continually by the Site Management Team and On Call Teams 24/7
4	Incident Coordination Centres	Functions	The organisation has arrangements in place outlining how it's ICC will coordinate it's functions as defined in the EPRR Framework.	Y	Arrangements outline the following functions: Coordination Policy making Operations Information gathering Dispersing public information.	Fully compliant				Within Major and Critical Incident Plan
Domain: Command structures										
5	Command structures	Resilience	The organisation has a documented command structure which establishes strategic, tactical and operational roles and responsibilities 24 / 7.	Y	Training records of staff able to perform commander roles EPRR policy statement - command structure Exercise reports	Fully compliant				Training in place for commanders
6	Command structures	Stakeholder interaction	The organisation has documented how its command structure interacts with the wider NHS and multi-agency response structures.	Y	EPRR policy statement and response structure	Fully compliant				Within Major and Critical Incident Plan and Trust On-Call Pack
7	Command structures	Decision making processes	The organisation has in place processes to ensure defensible decision making; this could be aligned to the JESIP joint decision making model.	Y	EPRR policy statement inclusive of a decision making model Training records of those competent in the process	Fully compliant				Decision making model used in plans and training
8	Command structures	Recovery planning	The organisation has a documented process to formally hand over responsibility from response to recovery.	Y	Recovery planning arrangements involving a coordinated approach from the affected organisation(s) and multi-agency partners	Fully compliant				Within Major and Critical Incident Plan and Trust On-Call Pack

Overall assessment:			Substantially compliant						
Ref	**Domain**	**Standard**	**Detail**	Evidence - examples listed below	**Self assessment RAG** Red = Not compliant with core standard. In line with the organisation's EPRR work programme, compliance will not be reached within the next 12 months. Amber = Not compliant with core standard. The organisation's EPRR work programme demonstrates an action plan to achieve full compliance within the next 12 months. Green = Fully compliant with core standard.	**Action to be taken**	**Lead**	**Timescale**	**Comments**
38	**Warning and info**	**Warning and informing**	The organisation has processes for warning and informing the public and staff during major incidents, critical incidents or business continuity incidents.	• Have emergency communications response arrangements in place • Be able to demonstrate consideration of target audience when publishing materials (including staff, public and other agencies) • Communicating with the public to encourage and empower the community to help themselves in an emergency in a way which compliments the response of responders • Using lessons identified from previous major incidents to inform the development of future incident response communications • Setting up protocols with the media for warning and informing	Partially compliant	Media Relations Policy is currently under review by the Trust Communications Team, to include details on warning / informing as currently focus is on responding to media enquiries, also to provide more details on out of hours enquiries / warning / informing	Trust Communications Team	Feb-19	Active campagins to communicate with public such as Keep Warm Keep Well, Heatwave, National Campaigns
39	**Warning and info**	**Media strategy**	The organisation has a media strategy to enable communication with the public. This includes identification of and access to a trained media spokespeople able to represent the organisation to the media at all times.	• Have emergency communications response arrangements in place • Using lessons identified from previous major incidents to inform the development of future incident response communications • Setting up protocols with the media for warning and informing • Having an agreed media strategy which identifies and trains key staff in dealing with the media including nominating spokespeople and 'talking heads'	Partially compliant	Media Relations Policy is currently under review by the Trust Communications Team, which will then include specifics regarding training of key staff and more detail on management of both enquires out of hours and warning / informing	Trust Communications Team	Feb-19	Media Relations Policy
40	**Cooperation**	**LRHP attendance**	The Accountable Emergency Officer, or an appropriate director, attends (no less than 75%) of Local Health Resilience Partnership (LHRP) meetings per annum.	• Minutes of meetings	Partially compliant	Earler dates in diary will enable AEO or executive director to attend	Accountable Emergency Officer	Sep-19	Attendance by AEO at 50% (1 of 2) previous LHRP Meetings, meetings attended by EP&R Manager who has full authority to make decisions in absence of AEO

The Princess Alexandra Hospital NHS Trust

BOARD OF DIRECTORS

MEETING DATE: 04/10/2018 **AGENDA ITEM NO: 9.3**

REPORT TO THE BOARD FROM: Audit Committee (AC)

REPORT FROM: Stephen Bright – Chair of Audit Committee

DATE OF COMMITTEE MEETING: 05/09/2018

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 committee undertook the annual committee effectiveness review and recommended the ToR to the Trust Board for approval. Areas highlighted to the Committee from the effectiveness review were discussed and actions agreed. A summary of the effectiveness review and the revised TOR are attached as Appendix A. The TOR were updated to reflect changes to the membership. 2. Internal Audit had finalised the review of **Pharmacy Stock Management** which received reasonable assurance, **GDPR Compliance** which received reasonable assurance and **HR, Recruitment and Payroll** which received substantial assurance. Members congratulated the HR team for the improvements demonstrated since the last audit. 3. The External Audit annual audit letter was received and noted. 4. The report on Waivers Losses and Special Payments detailed the following: losses and special payments for the period April 2018-July 2018 - £24.4k. Waivers for the period April 2018-July 2018 - £1,820k. Waivers were being actively monitored. Members expressed the view that there is a need for PMO support for the Capital Programme and requested clarification on the private ambulance waiver. 5. Three counter fraud cases remained open, with four closed since the committee meeting in May. There had not been any new referrals received in this period. 6. The committee received the annual review of Risk Management and the BAF and noted good progress had been made. 7. A private session was also held to review the service provided by internal and external audit; members were content with the services being provided.
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 Friday 21 December 2018.

Your future | Our hospital

The Princess Alexandra Hospital NHS Trust

AUDIT COMMITTEE

TERMS OF REFERENCE

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.
2. Appropriate arrangements to implement the requirements of the Bribery Act 2010.
3. 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 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

Audit Committee

ORGANISATION

- 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: ~~17 October 2017~~5 September 2018
By Trust Board: ~~30 November 2017~~

TO BE REVIEWED ANNUALLY

Next review due: ~~October 2017~~September 2019

The Princess Alexandra Hospital NHS Trust

AUDIT COMMITTEE 2017~~8~~/1~~8~~9: MEMBERSHIP

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

9.3

The Princess Alexandra Hospital NHS
NHS Trust

BOARD OF DIRECTORS

MEETING DATE: 4 October 2018 **AGENDA ITEM NO: 9.3**

REPORT TO THE BOARD FROM: Quality & Safety Committee

REPORT FROM: John Hogan

DATE OF COMMITTEE MEETING: 28 September 2018

SECTION 1 – MATTERS FOR THE BOARD'S ATTENTION
The following are highlighted for the Board to note or to take action:
Items for escalation to the Board: • QSC received an update on the procurement and replacement of endoscopy washers and suggested that the issue is escalated to the next SMT for a discussion on ways of expediting the process to mitigate further cancellation and re-scheduling of appointments. • Mortality (higher than expected) was discussed in detail and QSC remains concerned. Monthly monitoring at QSC will continue. • The stillbirth rate has increased to 2.43 per 1000 births which is still below the national average but is drawn to the attention of the Board. • QSC received assurance on the Trust's processes for sharing the learning as well as how the learning is embedded in the HCGs and shared across HCGs. • The annual review of the Committee and the revised TOR (**Appendix 1**) were discussed and recommended to the Board for approval. Areas for improvement identified in the review included reducing the length of papers presented to the Committee and ensuring that a clear executive summary is available to cover the key headlines in the reports. The Committee requested that each paper has an executive lead/sponsor.
SECTION 3 – PROGRESS AGAINST THE COMMITTEE'S ANNUAL WORK PLAN
The Committee is making good progress against its work plan.

9.3

The Princess Alexandra Hospital NHS
NHS Trust

QUALITY & SAFETY COMMITTEE

TERMS OF REFERENCE 2018/19

PURPOSE:

The Quality & Safety Committee (QSC) functions as the Trust's umbrella clinical governance committee. It enables the Board to obtain assurance that high standards of care are provided by the Trust and that adequate and appropriate governance structures, processes and controls are in place throughout the Trust to enable it to deliver a quality service according to each of the dimensions of quality set out in *High Quality Care for All* and enshrined through the Health & Social Care Act 2012:

- **Clinical Effectiveness** – consistently achieving good clinical outcomes and high levels of productivity through evidence-based clinical practice.
- **Safety** – achieving high and improving levels of patient and staff safety and identifying, prioritising and managing risk arising from the delivery of clinical care.
- **Patient Experience** – promoting safety and excellence to deliver an excellent patient experience as measured by direct interaction with, and feedback from, those using the Trust's services.

DUTIES:

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

Evidence-Based Clinical Practice

1. To receive assurance on action taken to improve mortality rates as part of the Trust's mortality review process and to receive a monthly update on Learning From Deaths.

2. To ensure there is a well-functioning and effective process for considering and implementing guidance from the National Institute for Health and Clinical Excellence (NICE) and National Service Frameworks, recommendations from the National Confidential Enquiry into Patient Outcome and Death (NCEPOD) and responding to National Patient Safety Agency (NPSA) Alerts.

3. To receive assurance in respect of the delivery of any action plans arising from reviews or investigations into safety and or quality by healthcare regulators, inspectorates, accrediting bodies or Royal Colleges.

Compliance

1. ~~To monitor the Trust's compliance against regulatory and statutory requirements excluding any regulation relating to Estates and Facilities (reported to PAF).~~

2. To monitor the Trust's compliance with the Care Quality Commission's (CQC) registration criteria and oversee any remedial action required

3. To ensure the Trust complies with the NHS Litigation Authority (NHSLA) risk management standards and the Clinical Negligence Scheme for Trusts (CNST) maternity standards.

4. To undertake ~~monthly~~ quarterly "deep-dives" ~~review~~ into the work of each Healthcare Group via a Quality & Safety Performance Report to review quality and safety performance according to the CQC domains with both AMD and ADoN in attendance for their presentation.

5. ~~To ensure there is a well-functioning process for Health & Safety in place which includes radiation use and protection guidelines (IR(ME)R), fire safety and decontamination.~~ From July 2018 this will fall under the remit of the Performance & Finance Committee.

6. To ensure the Trust complies with recommendations from the National Quality Board.

7. To receive regular reports on the Trust's infection control arrangements and receive assurance on remedial measures taken to handle the outbreak of infection.

8. To receive regular reports on the Trust's compliance with Safeguarding requirements and matters concerning Deprivation of Liberty and Mental Capacity Act.

9. To receive recommendations on the Trust's annual Quality Account priorities and monitor their in-year progress.

Audit

1. To receive the annual Clinical Audit Programme and ensure that it is in line with the audit needs of the Trust prior to commending it for approval by the Board. Monitor its in-year progress including actions taken to address audit concerns.

2. To make recommendations concerning the annual programme of Internal Audit work to the extent that it applies to matters within the remit of the QSC and consider the major findings of quality related Internal Audit reports (including the management response).

3. To be assured that recommendations from all clinical audits are robustly implemented in practice and desired outcomes are achieved.

Research and Development

1. To ensure the Trust has an effective Research and Development Strategy in place and produces an annual Research and Development Report to the Trust Board.

2. To review governance arrangements for Research and Development activity within the Trust including Clinical Ethics.

3. To receive six monthly reports from the Research & Development Group.

Learning when Things Go Wrong

1. To review the risks allocated to the QSC from the Board Assurance Framework ~~or Trust Significant Risk Register~~ and receive assurance that actions are in place to effectively manage and control the risks identified.

2. To ensure there are clearly defined and well understood processes for escalating safety and quality issues and meeting the Trust's obligations in respect of Duty of Candour with patients and families.

3. To consider regular reports identifying the trends and themes arising from claims, litigation, incidents (including SIs) and complaints and the management actions being taken to reduce risks and learn lessons.

Records and Confidentiality

1. To oversee the Trust's policies and procedures in respect of the use of clinical data and patient identifiable information to ensure that this is in accordance with all relevant legislation and guidance including the Caldicott Guidelines and the Data Protection Act.

2. To review, on an annual basis, the Trust's systems for the Management of Medical Records.

Patient Experience

1. To review the Trust's arrangements for managing complaints and PALS contacts.

2. To ensure the Trust has an effective system for patient feedback (including Friends and Family Test, patient environment and amenities) and patient involvement.

3. To undertake a review of the findings of any national patient surveys including any relevant action plans.

General Governance

1. To consider matters referred to the QSC by the Board or by the groups which report to it.

2. Every year, to set an annual Work Plan and conduct a review of the Committee's effectiveness (including the achievement of the Work Plan and a review of the Committee's terms of reference) and report this to the Board.

3. To ensure a system is in place to review and approve relevant policies and procedures that fall under the Committee's areas of interest.

4. As required, to review any relevant Trust strategies relevant to the Committee's terms of reference (e.g. those associated with clinical quality, clinical effectiveness, health and safety, patient experience) prior to approval by the Board and monitor their implementation and progress.

5. To consider the arrangements for the assessment by the Chief Medical Officer and ~~Chief Nurse~~ Director of Nursing & Midwifery on the safety and quality impact of the schemes within the Trust's Cost Improvement and Transformation Programme.

6. On behalf of the Performance & Finance Committee, to consider the clinical and safety aspects of all business cases worth more than £1m prior to their consideration by the Trust Board.

ACCOUNTABLE TO: Trust Board.

REPORTING: A highlight report prepared by the QSC Chairman supported by the Chief Medical Officer and ~~Chief Nurse~~ Director of Nursing & Midwifery will be presented to the next meeting of the Board. The report shall set out areas requiring the Board's attention and report on the level of assurance provided by the QSC meeting; it shall also demonstrate progress against the QSC Annual Work Plan.

The Princess Alexandra Hospital NHS
NHS Trust

CHAIRMAN: Non-Executive Director.

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

- Chair - Non-Executive Director
- Non-Executive Director
- Associate Non-Executive Director
- Chief Medical Officer
- Chief Nurse.

The Chairman of the QSC shall be appointed by the Chairman of the Trust Board; ideally s/he shall have recent and relevant experience of NHS quality and safety.

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

The Chairman and Chief Executive of the Trust shall be ex officio members and will be invited to all meetings.

One of the NED members of QSC shall also be a member of the Trust's Audit Committee.

Other members of the Executive Team or management may be called to attend the meeting if required.

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

ATTENDANCE: Members are expected to make every effort to attend all meetings of the QSC and it is expected that they will attend nine out of eleven Committee meetings within each reporting year. An attendance register shall be taken at each meeting and an annual register of attendance will be included in the QSC's annual report to the Board.

The Chair of the Patient Panel will be a lay member of the QSC. In addition to the members of the Board, the following will be expected to attend each QSC meeting:

- Chief Operating Officer or a designated deputy
- Associate Medical Directors
- Associate Directors of Nursing
- Deputy Chief Nurse
- Associate Director of Governance & Quality
- Associate Director, Patient Engagement & Experience Team
- ~~A member of the Quality 1st team, in rotation~~
- AMD for Quality First

To ensure appropriate accountability, other managers or clinicians will be invited to attend when the QSC is discussing areas of risk or operation that fall 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 QSC.

The Princess Alexandra Hospital NHS
NHS Trust

DEPUTISING ARRANGEMENTS:	In the absence of the Chair of the Committee, another Non-Executive Director appointed by the members of the Committee will chair the meeting. Other deputies may attend but must be suitably briefed and, where possible, designated and notified in advance.
QUORUM:	The quorum for any meeting of the QSC shall be the attendance of a minimum of two members of which one shall be a Non-Executive Director and one shall be either the Chief Medical Officer or the ~~Chief Nurse~~ Director of Nursing & Midwifery.
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.
LEAD EXECUTIVES	Chief Medical Officer and ~~Chief Nurse~~ Director of Nursing & Midwifery.
MEETING FREQUENCY:	Meetings of the QSC shall be held: • Monthly • Usually on the ~~third~~ fourth Friday of Board cycle from 09.30 to 12.30 • At such other times as the Chairman of the QSC shall require.
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 (though lay members will be permitted to attend). • The Head of Corporate Affairs shall ensure there is appropriate secretarial and administrative support to the Committee. • A draft agenda shall be developed by the Head of Corporate Affairs and Lead Executives and agreed by the Committee Chair at least ten clear days* before the next Committee meeting. • 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 three clear days* before the date of the meeting. *'clear day' means any day which is not a Saturday or Sunday or a public or bank holiday.
AUTHORITY:	The QSC 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 QSC 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 QSC. The QSC is authorised by the Trust Board to request the attendance of individuals and authorities from inside and outside the Trust with relevant experience and expertise if it considers this necessary.

The Princess Alexandra Hospital NHS
NHS Trust

TERMS OF REFERENCE:	The terms of reference of the QSC shall be reviewed at least annually and presented to the Trust Board for approval.
DATE APPROVED:	By QSC: 28.09.18 By Trust Board: 04.10.18

The Princess Alexandra Hospital NHS Trust

BOARD OF DIRECTORS

MEETING DATE: 04/10/18 **AGENDA ITEM NO: 9.3**

REPORT TO THE BOARD FROM:	Workforce Committee
REPORT FROM:	**Pam Court – Committee Chair**
DATE OF COMMITTEE MEETING:	**24/09/18**

SECTION 1 – MATTERS FOR THE BOARD'S ATTENTION

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

- There were no changes to the BAF risks. Workforce capacity remained the most significant risk, with a rating of 20. Culture of Engagement and Workforce Capability both had a risk rating of 9. Controls, actions and target dates had been updated.
- The committee undertook the annual review of committee effectiveness and recommended the ToR to the Trust Board for approval. Areas highlighted to the Committee from the effectiveness review were discussed and actions agreed including amendments to the committee membership (reflected within the amended ToR), the potential for Health Care Group representation and an extension of the committee remit to include FTSU and Voluntary services. The committee also considered how it could improve member attendance. The ToR were updated to include the review and management of the voluntary services portfolio, reporting from the FTSUG's and the development of a communications strategy in addition to membership changes. The revised TOR are attached as Appendix A.
- The committee received the results from the GMC survey and were concerned to note there were 44 areas with 'red flags' and only 17 'green flag' areas. An action plan is being developed to address each of the areas of concern.

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

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

Statutory and Mandatory Training Compliance: Core training compliance had deteriorated by 1%, to 88% in September 2018. The committee was content that staff were given every opportunity possible to complete training and it was proposed a move to sanctions was necessary to improve staff training compliance.

Education Update: There was a shortfall in CPD funding of approx. £200,000 therefore budgets were under review to identify how to support CPD requirements with limited funding. The Resuscitation Training team had progressed to offer advanced courses such as Advanced Life Support (ALS) and the European Paediatric Advanced Life Support (EPALS) which would provide some additional income for the Trust.

Workforce Race Equality Standard: The WRES submission indicated an improvement in diversity with some areas of concern. Areas which showed deterioration were the likelihood of BME staff being appointed from shortlisting, the likelihood of BME individuals entering into a formal investigation process, percentage of BME staff experiencing harassment, bullying or abuse and the number of BME staff reporting discrimination. The committee was particularly concerned regarding BME representation on the Board which accounted for 0% of voting members of the Executive Team and 0% of Non-Executive Directors.

People Strategy: The committee received an update on the development of a five year people strategy. Following further engagement a finalised version would report to the committee in January 2019 for approval.

The committee also received the following reports: Communications Update, People Strategy and Plan Update, Workforce Report, Report on Nursing, Midwifery, AHP and Care Staff Levels, OD Update and Appraisal Update.
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 work plan was agreed with some minor amendments.

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 ~~and information~~ 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 on all aspects of recruitment, retention, staff experience and engagement~~
- ~~Assure the Board that the Trust's structures and systems support the delivery of inter-professional training and development~~ 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. ~~Develop and~~K~~ k~~eep under review the Trust's plans in relation to its workforce including recruitment and retention of staff, Organisational Development, learning ~~and Training~~, and employee engagement and wellbeing.
4. Review workforce performance and oversee the development of a balanced scorecard for all workforce indicators.
5. ~~Oversee the development of the Trust's People, Development and Deployment and OD Strategies and monitor their implementation.~~
6. Review the outcomes of national and local staff surveys and monitor the progress of action plans.
7. Monitor staff engagement initiatives and outcomes
8. ~~Ensure systems are in place to ensure the Trust meets the relevant HR legislation and best practice guidance~~Ensure the Trust meets its statutory obligations ~~including legislation~~ regarding Diversity and Inclusion.
9. Oversee the Trust's relationship with educational partners to maximise the benefits of these relationships to the Trust.
10. 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.
11. The Committee shall request and review reports from other sub groups as deemed necessary
12. Other Workforce/OD/Training activity as requested by the Board.
13. ~~Oversee~~ Keep under review the development of a Communications Strategy and monitor its implementation.

9.3

The Princess Alexandra Hospital NHS Trust

~~10.~~
11. ~~Review~~ Review and monitor the portfolio of volunteer activities and services.
13. Provide assurance to the Board that there are mechanisms in place to allow staff to raise concerns and that these are dealt within policy and national guidance including receiving ~~Receive~~ regular reports from the Freedom to Speak up Guardians.

WORKPLAN: **Annual Work Plan and Committee Effectiveness**

1. 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
- ~~Chief Nurse~~ Director of Nursing and Midwifery
- Chief Operating Officer
- Director of Medical Education
- ~~Deputy Chief Financial Officer~~
-

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.

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
- ~~Director of Medical Education/~~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 ~~HR and Chief Nurse~~

MEETING FREQUENCY:

Meetings of the Workforce Committee shall be bi-monthly~~held 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 Princess Alexandra Hospital NHS Trust

	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: September 2018 By Trust Board:

MEMBERSHIP

Membership and Those in Attendance	
Members	
Chair: Non-Executive Director	~~James Anderson~~Pam Court
Non-Executive Director	~~Pam Court~~Steve Clarke
Deputy Chief Financial Officer	Simon Covill
Director of ~~HR~~ People, OD and Communications	~~Liz Booth~~Raj ~~Bhamber~~ Gech Emeadi
Chief Operating Officer	Stephanie Lawton
~~Chief Nurse~~ Director of Nursing and Midwifery	~~Nancy Fontaine~~ Sharon McNally
In Attendance	
~~Clinical Tutor (Consultant General & Vascular)~~	~~Jonathan Refson~~
~~Head of Staff Engagement~~	~~Charlotte Hazelton~~
~~Head of Education and Training~~ Associate Director of Learning and OD	Martin Smith
~~Head of Human Resources~~	~~Soofiya Idrees~~
~~Head of Human Resources~~	~~Ellie Manlove~~
~~Head of Workforce Information and Systems Manager~~	~~Nathaniel Williams~~
Medical Education Manager	Margaret Short
Deputy Director of People	Beverley Watkins
Associate Director of Communications	TBC
In Attendance (right to attend reserved)	
Trust Chairman	Alan Burns
Chief Executive	Lance McCarthy
Secretariat	
Head of Corporate Affairs	Heather Schultz
Esther Kingsmill	Corporate Governance Officer

9.3

The Princess Alexandra Hospital NHS
NHS Trust

BOARD OF DIRECTORS

MEETING DATE: 04.10.18 **AGENDA ITEM NO: 9.3**

REPORT TO THE BOARD FROM:	Performance and Finance Committee
REPORT FROM:	Andrew Holden - PAF Chairman
DATE OF COMMITTEE MEETING:	24.09.18

SECTION 1 – MATTERS FOR THE BOARD'S ATTENTION

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

Committee Effectiveness Review: The annual Committee review was discussed and it was agreed that meeting papers needed to be produced in a more timely manner. Terms of Reference were discussed and revised (see attached for approval).

Our New Hospital: Additional and more detailed work has been requested in relation to the traffic survey and as a result the decision to agree the off-site option may take place in March 2019.

Emergency Department Performance: August had seen the Trust's best position for two and a half years at 81% which, although below trajectory, showed the improvement was continuing. All band 6 and 7 posts now filled but just under 20 band 5 vacancies due to the recent increase in establishment. New Paediatric ED consultant who had started at the end of August was already making an impact. Performance for September was predicted to be around 79%.

Integrated Performance Report: The report was noted and is included within the Board papers for discussion.

Data Quality: Very positive meeting of Executive and senior clinical staff held to discuss the issue of ED discharge letters. Agreement that paper recording will cease as of 1st October and only COSMIC will be used.

Coding: Improvements continue with the hope that outsourcing can stop (or significantly reduce) by the end of the calendar year.

Month 5 Finance Report: In-month deficit £1.7m - £0.1m behind plan. Year-to-date deficit £13.5m - £0.1m ahead of plan.

Carter: NHSI deep dive had commended how far the Trust had come with the management and coordination of CIPs and with the use of Carter in identifying CIP schemes. It had also recognised the steady work around the GiRFT programme.

Workforce Update: Request from NHSI for a deep dive around agency spend. Plans to be part of a shared bank with East & North Herts and West Herts.

Estates & Facilities Annual Report: Very positive PLACE assessment with the Trust exceeding national averages in a number of areas.

BAF Risks: No change to any of the risk ratings.

Temporary Ward: In line with Trust Board approval a pre-fabricated building is being constructed to increase capacity, enable improvement in clinical adjacencies and optimise patient flow. The estimated timescale for completion is December 2018. The clinical and operational model for the ward has been proposed and approved by the Associate Directors of Nursing. Recruitment for posts has commenced. Under delegated authority from the Board, PAF considered and approved the additional capacity to support emergency flow over winter.

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

The Princess Alexandra Hospital NHS
NHS Trust

In addition to the above, PAF received reports on the following agenda items: • Medium Term Planning (on private Board agenda) • Health & Safety Update • Annual Report on Emergency Preparedness, Business Continuity and Forward Plan (recommended to Board for approval)
SECTION 3 – PROGRESS AGAINST THE COMMITTEE'S ANNUAL WORK PLAN
The Committee is making good progress against its work plan.

The Princess Alexandra Hospital NHS
NHS Trust

PERFORMANCE AND FINANCE COMMITTEE

TERMS OF REFERENCE 2018/19

PURPOSE:

The purpose of the Performance and Finance Committee (PAF):

- Consider, challenge and recommend the Trust's Operating Plan to the Board.
- Scrutinise operational and financial performance and monitor achievement of national and local targets and recommend any re-basing or re-forecasting of operational and financial performance trajectories to the Board;
- Assure the Board of Directors that the Trust has robust processes in place to prioritise its finance and resources and make decisions about their deployment to ensure that they best meet patients' needs, deliver best value for money and are efficient, economical, effective and affordable.
- Recommend the Trust's Cost improvement programme to the Board and monitor its delivery including investigating reasons for variance from plan and recommend any re-basing or re-forecasting of the Plan to the Board;
- Monitor the management of the Trust's asset base and the implementation of the Trust's enabling strategies in support of the Trust's clinical strategy and clinical priorities;
- Review and monitor the management of finance, performance and contracting risks.

DUTIES:

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

Financial Management and Strategy

1. Consider the content of, planning assumptions, key risks and principles underpinning the Operating Plan prior to submission to the Board for approval.
2. Where there is variance against plan, agree any re-base or re-forecast and ensure appropriate actions are put in place for recovery.
3. Approve the Capital Programme as part of the budget setting process and monitor progress against the plan.
4. Approve the process for the submission of the National Reference Cost Return prior to submission and review the results.
5. Review the implementation of the Trust's plans for Service Line Management.
6. Review compliance with agency cap and spend.
7. Review financial performance and forecast against income, expenditure, working capital and capital and seek assurance that the position is in line with approved plans, targets and milestones and that any corrective measures that are being taken are effective
8. Review significant risks associated with the forecast outturn.
9. Review the Treasury Management Policy, receive reports in accordance with the Policy and approve institutions.
10. Review arrangements for effective compliance reporting in respect of loans and other requirements

Operational Performance

1. Agree the annual operational performance plan including annual trajectories for each local and national target, including CQUINs.
2. Scrutinise operational performance and including the investigation of

reasons for variance from plan.
3. Recommend any re-basing or re-forecasting of annual performance trajectories to the Board.
4. Advise the Board of any penalties likely/due to be incurred as a result of performance variance.
5. Monitor the strategic and operational systems and processes to ensure the competent performance management of the organisation

Cost Improvement

1. Agree the level of the Cost Improvement Programme and recommend the /Cost Improvement Programme to the Board.
2. Monitor delivery of the Trust's Cost Improvement Programme including the investigation of reasons for any variance from plan.
3. Recommend any re-basing or re-forecasting of the Programme to the Board and advise of the reasons why this is necessary;
4. Provide the Board with assurance on the progress and delivery of the programme.

Contract Management

1. Review the Trust's negotiating position prior to annual contracting round with commissioners.
2. Review financial and performance activity against contracts and if corrective action is required, receive assurance that the measures being taken are effective.
3. Consider any tender opportunities with an annual income value exceeding £1m.

Workforce

1. Maintain oversight of expenditure on temporary staffing.

Procurement

1. Oversee the implementation of the Trust's Procurement Strategy.
2. Receive an annual report in respect of the Annual Procurement Plan.
3. Receive regular updates on the Procurement pipeline

Business Cases, Benefits Realisation and Return on Investment

On behalf of the Board:

1. Undertake a robust appraisal of new business cases and re-investment business cases valued at over £1m, ensuring that the outcomes and benefits are clearly defined, measurable, support the delivery of key objectives for the Trust and that they are affordable.
2. Review benefits realisation and return on investment of major projects.

Capex

1. Consider any significant infrastructure investment prior to proposals being put to the Board for consideration/approval.
2. Monitor the implementation of the Trust's Information Technology strategy and Estates Strategy.
3. Consider any estate disposal, acquisition or estate change of use in accordance with the Trust's Strategy and recommend to the Board.

Estates, Facilities & Sustainability

1. Oversee the implementation of the Trust's Carbon Reduction and Sustainability Strategy.

2. Receive an annual report in respect of the Trust's Sustainable Development Management Plan.

3. Review the Trust's arrangements for estates and facilities management

Health and Safety:
Maintain oversight of Health & Safety including radiation use and protection guidelines (IR(ME)R), fire safety and decontamination

Information Management, Data Quality and Coding

1. Oversee the Trust's information management, coding and data quality arrangements and review progress against key metrics.
2. Monitor the implementation of the annual Information Management Plan.

Resilience & Business Continuity

1. Undertake an annual review of the Trust's resilience & business continuity arrangements,
2. On behalf of the Board, review how the Trust is upholding its duties to fulfil its duties as a Category 1 responder under the Civil Contingencies Act 2004 and recommend a report to the Board in respect of these.

Risk

1. Monitor and review any risks allocated to the PAF.
2. Review and monitor finance, performance and contracting risks and seek assurance that plans/actions are in place to mitigate identified risks.

Annual Work Plan and Committee Effectiveness

1. 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 PAF meeting and advise of progress against the PAF's Annual Work Plan.

CHAIRMAN: Non-Executive Director.

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

- Chair - Non-Executive Director
- Non-Executive Directors/Associate Non-Executive Directors
- Chief Financial Officer
- Chief Operating Officer
- Director of Strategy
- ~~Director of People, OD and Communications~~
- ~~Deputy Chief Nurse~~ Director of Nursing & Midwifery
- Director of ~~Business Delivery~~Quality Improvement

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

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

At least one of the Non-Executive Director/ members of the PAF shall also be a member of the Trust's Audit Committee.

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

All members will have one vote. In the event of votes being equal, the Chairman of the PAF will have the casting vote. Deputies attending the PAF 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 PAF. An attendance register shall be taken at each meeting and an annual register of attendance included in the PAF's annual report to the Board.

In addition to the members of the Board, the following shall be expected to attend each PAF meeting:

- Deputy Chief Finance Officers
- Director of Information & IT
- ~~Associate Director of Procurement~~

To ensure appropriate accountability, others will be invited to attend when the PAF is discussing areas of risk or operation that are their responsibility.

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

DEPUTISING ARRANGEMENTS

In the absence of the Committee Chairman, another Non-Executive Director member of the PAF 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 of the PAF shall be the attendance of a minimum of two Non-Executive members and two Executive members or their deputies (who may attend with the permission of the Chief Executive Officer).

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:

Chief Financial Officer and Chief Operating Officer.

The Princess Alexandra Hospital NHS
NHS Trust

MEETING FREQUENCY:	Meetings of the PAF shall be held 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 ~~Corporate Secretary~~ 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 PAF 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 PAF 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 PAF. The PAF 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 PAF shall be reviewed at least annually and presented to the Trust Board.
DATE APPROVED:	By PAF: 24.09.18 By Trust Board: 04.10.18

9.3

The Princess Alexandra Hospital NHS
NHS Trust

PERFORMANCE & FINANCE 2018/19 MEMBERSHIP

Membership and Those in Attendance	
Members	
Chairman - Non-Executive Director	Andrew Holden
Non-Executive Director	~~Stephen Bright~~ Steve Clarke
Non-Executive Director	Vacant
Chief Financial Officer	Trevor Smith (Lead Exec)
Chief Operating Officer	Steph Lawton
Director of Strategy	Michael Meredith
~~Director of~~ ~~People, OD and Communications~~	~~Gech Emeadi~~
~~Deputy Chief Nurse~~ Director of Nursing & Midwifery	~~Sharon Cullen~~ Sharon McNally
Director of Quality Improvement	Jim McLeish
In Attendance	
Director of People, OD & Comms (as required)	Ogechi Emeadi
Deputy Chief Financial Officer	Simon Covill
Deputy Chief Financial Officer	Nick Ryan
Associate Director of Procurement	Michael Stone
Director of Information and IT	Lynne Fenwick
In Attendance (right to attend reserved)	
Trust Chairman	Alan Burns
Chief Executive	Lance McCarthy
Secretariat	
Head of Corporate Affairs	Heather Schultz
Board & Committee Secretary	Lynne Marriott

9.3