The Princess Alexandra Hospital NHS Trust

AGENDA

Public Meeting of the Board of Directors

Date and time: Thursday 5 December 2019
09.30 – 12.30

Venue: Harlow LeisureZone, Second Avenue, Harlow CM20 3DT

	Item	Subject	Action	Lead	
01 Opening Administration					
09.30	1.1	Apologies	-		
	1.2	Declarations of Interest	-	Chairman	
	1.3	Minutes from Meeting held on	Approve	Chairman	4
	1.4	Matters Arising and Action Log	Review	All	12
02 Patient Story					
09.35	2.1	Patient Story	Inform	Director of Nursing & Midwifery	Verbal
03 Risk					
10.00	3.1	Significant Risk Register	Review	Chief Medical Officer	13
10.10	3.2	Board Assurance Framework 2019-20	Review	Head of Corporate Affairs	17
04 Chief Executive's Report					
10.15	4.1	CEO's Report	Discuss	Chief Executive	29
05 Patients					
10.30	5.1	Learning from Deaths Presentation (Surgery)	Discuss	Chief Medical Officer	To follow
10.45	5.2	Mortality Update	Assure	Chief Medical Officer	33
10.50	5.3	Nursing, Midwifery and Care Staff Levels including Nurse Recruitment	Discuss	Director of Nursing & Midwifery	40
11.00	5.4	Nursing Establishment Review	Approve	Director of Nursing & Midwifery	50
11.10	5.5	PAHT Clinical Strategy	Discuss	Director of Strategy	67
11.20	5.6	7 Day Services	Assure	Chief Medical Officer	71
11.25		**Break - 10 minutes**			
06 People					
11.35	6.1	Freedom to Speak Up – Self Assessment	Inform	Director of People	82
07 Performance and Places					
11.45	7.1	Integrated Performance Report (IPR)	Discuss	Executives	104
08 Governance					
11.55	8.1	NED Committee Membership Changes	Approve	Chairman	150

12.00	8.2	Reports from Committees: • QSC.22.11.19 including Safeguarding Children & Adults Annual Report • WFC.25.11.19 • PAF.28.11.19 • AC.04.12.19	Inform	QSC Chair WFC Chair PAF Chair AC Chair	152 153 188 189 Verbal
12.10	8.3	Report from Senior Management Team meetings: October/November 2019	Inform	Chief Executive	190
09 Questions from the Public					
12.15	9.1	Opportunity for Members of the Public to ask questions about the Board discussions or have a question answered.	Discuss	Chairman	
10 Closing Administration					
	10.1	Summary of Actions and Decisions	-	Chairman/All	
	10.2	New Risks and Issues Identified	Discuss	All	
	10.3	Any Other Business	Review	All	
12.30	10.4	Reflection on Meeting	Discuss	All	

Public Board Meeting Dates 2019/20

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

The Princess Alexandra Hospital NHS Trust

Board Purpose:

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.
Quoracy:
One third of voting members, to include at least one Executive and one Non-Executive (excluding the Chair). Each member shall have one vote and in the event of votes being equal, the Chairman shall have the casting vote.
Ground Rules for Meetings:
1. The purpose of the meeting should be defined on the day (set the contract). 2. Papers should be taken as read. 3. The purpose of a paper must be clearly explained and the decision/s to be made must be identified. 4. Members/attendees are encouraged to ask questions rather than make statements and are reminded that when attending meetings, it is important to be courteous and respect freedom to speak, disagree or remain silent. Behaviour in meetings should be in line with the Trust's Behaviour Charter. 5. Challenge should be constructive and a way of testing the robustness of information. 6. Members/attendees are encouraged to support the Chair of the meeting to ensure the meeting runs to time. 7. The use of mobile phones during meetings should be avoided; phones must be set to silent. 8. If the duration of a meeting is likely to exceed 2 hours a break should be taken at a convenient point.

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

The Princess Alexandra Hospital NHS
NHS Trust

Minutes of the Trust Board Meeting in Public
Thursday 3 October 2019 from 09:30 – 12:30 at
Herts & Essex Hospital, Haymeads Lane, Bishop's Stortford, Hertfordshire CM23 5JH

Present:	
Steve Clarke	**Trust Chairman (TC)**
Lance McCarthy	Chief Executive Officer (CEO)
Ogechi Emeadi (non-voting)	Director of People (DoP)
Helen Glenister	Non-Executive Director (NED-HG)
John Hogan	Non-Executive Director (NED-JH)
Andrew Holden	Non-Executive Director (NED-AH)
Helen Howe (non-voting)	Associate Non-Executive Director (ANED-HH)
John Keddie (non-voting)	Associate Non-Executive Director (ANED JK)
Stephanie Lawton	Chief Operating Officer (COO)
Jim McLeish (non-voting)	Director of Quality Improvement (DoQI)
Sharon McNally	Director of Nursing & Midwifery (DoN&M)
Michael Meredith (non-voting)	Director of Strategy (DoS)
Andy Morris	Chief Medical Officer (CMO)
Trevor Smith	Chief Financial Officer (CFO)
George Wood	Non-Executive Director (NED)
Staff Story:	
Kathy Joyce	Theatres
Learning from Deaths:	
Fiona Lodge	Head of Children's Services & Nursing
In attendance:	
n/a	
Apologies:	
Pam Court	Non-Executive Director (NED-PC)
Secretariat:	
Heather Schultz	Head of Corporate Affairs (HoCA)
Lynne Marriott	Board & Committee Secretary (B&CS)

01 OPENING ADMINISTRATION	
1.1	The Trust Chairman (TC) welcomed all to the meeting and reminded members that 'flu vaccinations were available for all members that day.
1.1 Apologies	
1.2	As above.
1.2 Declarations of Interest	
1.3	No declarations of interest were made.
1.3 Minutes of Meeting held on 01.08.19	
1.4	These were agreed as a true and accurate record of that meeting with the following amendment: Minute 2.6: The Director of Nursing & Midwifery (DoN&M) clarified that the Mental Health Liaison Service was currently **in the process of being implemented**.
1.4 Matters Arising and Action Log	
1.5	It was confirmed that open actions could either be closed or would be addressed during the course of the meeting.
02 STAFF STORY	
2.1 Staff Story *(37 minutes)*	
2.1	The Board heard a story from a member of staff who had transitioned from male to female (*see Private Board meeting note dated 03.10.19*).
03 RISK	
3.1 Significant Risk Register (SRR) *(7 minutes)*	
3.1	This item was presented by the CMO and the paper was taken as read. Four new risks had

	been raised and added since 01.08.19. Brief updates on those were provided as: 1) Failure to action incidents in FAWS promptly – work was already underway to address that. 2) Inconsistency of IV fluids (prescriptions on paper rather than electronic) – mitigation in place and updated software to be received in November. 3) Medicines storage – replacement air-conditioning unit planned for 30.09.19. 4) Increase in calls to Outpatient booking service – patients advised to phone after 17:00 when lines less busy. Patient experience being assessed.
3.2	In response to a question from NED Helen Glenister (NED-HG) it was confirmed that point number 4 above would be addressed by the Trust's Outpatient Transformation work and the specific work-stream allocated to access, automation and patient contact linking in with GPs.
3.3	In relation to the risk associated with the organisation's Chemotherapy Management System (CMS), and to provide assurance, Associate NED Helen Howe (ANED-HH) was able to update that the Quality & Safety Committee (QSC) had requested an unannounced visit to the area to check that the Standard Operating Procedure (SOP) was working and it was noted that it was.
3.4	In terms of patient complaints members were informed that the Audit Committee (AC) had requested QSC review the information it had received (Internal Audit Report) in relation to complaint response times. It had agreed to do that at its October meeting.
3.2 Board Assurance Framework (BAF) *(1 minute)*	
3.5	This paper was presented by the Head of Corporate Affairs (HoCA) and the report was taken as read. There were no proposed changes to the risk scores that month and no comments from members.
3.6	The Board approved the BAF.
04 CHIEF EXECUTIVE'S Report	
4.1 CEO's Report *(19 minutes)*	
4.1	The CEO presented his update and key highlights were as follows: <u>MRSA</u> There had been one bacteraemia, the first since 2014.
4.2	<u>ED Performance</u> Performance against the 95% 4-hour access standard remained significantly below where the organisation would wish to be. Numbers of attendances continued to increase however the new integrated GP and ENP service at the front of ED was functioning well and seeing 20% of total ED attendances, increasing physical and ED resource capacity.
4.3	<u>New Hospital</u> Funding had been announced the previous weekend for a new hospital and the CEO expressed a huge thank you to Robert Halfon for his support over previous years. He took the opportunity to reiterate that the Board's preferred way forward (agreed at its public meeting in March 2019) was for a new hospital on a greenfield site by the new junction 7A of the M11 motorway. He believed that centrally the expectation was for the new facility to be built by 2025.
4.4	<u>Visit by Prime Minister</u> The Trust had welcomed The Rt. Hon. Boris Johnson MP on 27.09.19 who had been able to see first-hand the need for a new hospital. He had made an announcement about government funding of £200m for additional scanners across 80 hospitals and for additional imaging support at PAH to help reduce waiting times for diagnostics.
4.5	<u>Development of Integrated Care Providers (ICP)</u> Work continued at pace with West Essex and East Hertfordshire health and care colleagues to develop system wide clinical pathways for the benefit of patients. The new five year contract as an Alliance with Essex Partnership University Trust (EPUT) and West Essex CCG, for the provision of integrated Musculoskeletal services for the local population was now in the early stages of its delivery phase and the Trust would continue to develop further plans for taking on the Lead Provider role for other services and pathways from April 2020.

4.6	Event in a Tent The CEO conveyed huge thanks to everyone involved in organising that year's events and to those who took part. It had been a great opportunity to not only thank but to also recognise staff for their hard work and commitment to the hospital. The CMO acknowledged the focus on mental health and the difference that was now starting to make in the organisation.
4.7	It was agreed that the slides from the 'Civility Saves Lives' session would be circulated to members.
ACTION **TB1.03.10/19/16**	**Circulate the slides from the Civility Saves Lives session at Event in a Tent.** **Lead: Director of People**
4.8	In response to a request from NED Andrew Holden (NED-AH) the CEO agreed to focus on 'temporary staffing percentage of pay bill' rather than 'agency percentage of pay bill' in his key performance headlines.
ACTION **TB1.03.10/19/17**	**Focus on 'temporary staffing percentage of pay bill' as a key performance headline in CEO report.** **Lead: CEO**
4.9	In response to a question from NED John Hogan (NED-JH) in relation to timeframes for more detail on the funding for a new hospital the CEO confirmed that he hoped to receive formal confirmation the following week. He cautioned the organisation would not have the required skillset for a project of such size and, on identification of the gaps, would need to buy-in additional resource.
4.10	In response to a question raised by NED-HG the CEO agreed this could be the opportune time to revisit the possibility of fundraising for part of the new hospital.
4.11	As a final point the TC confirmed he would personally write to Robert Halfon on behalf of the Board to thank him for his support to date.
ACTION **TB1.03.10/19/18**	**Write to Robert Halfon to thank him for his support with the case for a new hospital.** **Lead: Trust Chairman**
05 PATIENTS	
5.1 Learning from Deaths (FAWS) *(27 minutes)*	
5.1	The CMO introduced the item and welcomed the Head of Children's Services & Nursing (HoCS&N) who then relayed the following case: The baby had been born prematurely at PAH and had died at the Trust in April 2019. She had complex health needs (involving joint care with Addenbrooke's) and had been looked after by foster parents but with positive involvement from her birth mother. Both had felt that issues were well explained, the medical team were compassionate and at the point where the decision was made to withdraw care, there was support from the consultant involved.
5.2	From a professional perspective following the death the team were commended for being easy to work with. There had been good communication between all and the ward had been receptive to palliative care. There had been excellent liaison between acute, chronic and palliative care and staff had felt that her death had been the best possible – calm and peaceful with both foster parents and birth parents prepared, present and ready. Different teams had worked as a single virtual team with Skylar at the heart of all planning and discussions. Staff had felt supported by the senior nursing team at PAH and chaplaincy support had been significant.
5.3	Challenges for the family had been the birth mother's understanding of the treatment pros and cons and the decision-making about escalation of treatment and the birth mother had struggled with the involvement of Social Services and the legalities of the end of life decisions.
5.4	Some of the professional challenges which had come to light her death were that there was insufficient support for foster parents and a long drive to the hospice. The symptoms were extreme and she had responded to many conventional medications.
5.5	Recommendations going forward had been agreed as: • Use of the Recommended Summary Plan for Emergency Care and Treatment.

	(ReSPECT) and Children and Young Persons Advance Care Plan (CYPACP) • Regular meetings with each Symptom Management service for staff learning • Write a document for the withdrawal of non-invasive ventilation • Community Nursing Team need support in being able to provide more end of life support.
5.6	In relation to the final point made in minute 5.4 above and a question raised by the TC it was confirmed that there needed to be a named Lead responsible for care when care was being provided between two or more centres.
5.7	The CMO emphasised that the Chaplaincy Service needed to be used more than it was currently. NED-JH echoed the comments above in relation to spiritual care and also congratulated the team on the care they had provided in very difficult circumstances.
5.9	NED-GW highlighted the courage of her foster parents and the challenge faced by the distance to the hospice. In response it was confirmed the team had been in touch with three hospices but decisions were made on a case by case basis.
5.10	The Director of Nursing & Midwifery (DoN&M) reflected on the fact there had not been a death on Dolphin Ward for two years and how different care may have been for a child (teenager) who was transitioning from children's to adult services who may have found them self in an adult bed. In response the HoCS&N confirmed there had been two quite recent deaths of teenagers and it was agreed any learning would be taken from those two cases and shared.
5.11	ANED-JK reflected there should be some mechanism for the hospital to nominate people (in this case foster parents) for awards for the selfless work that they did. The TC agreed to take that away for further discussion.
ACTION **TB1.03.10/19/19**	**Discuss further a mechanism for nominating families/carers for awards.** **Lead: Executive Team**
5.12	As a final point the CEO congratulated the team on their work which made a huge difference to patients and their families and had also underpinned the recent transformation in the hospital's Paediatric Services as reflected in the outcome of the recent CQC inspection.
5.2 Mortality Improvement Board Progress Report *(5 minutes)*	
5.13	This item was presented by the CMO and the paper was taken as read. He had been updated the previous evening that SHMI had come down by a further point which now put it into the "as expected" range. In response to a question from NED-AH as to whether HSMR reduced as SHMI reduced, the CMO confirmed that did not necessarily follow.
5.14	The Director of Quality Improvement (DoQI) updated that QSC had been updated on proposed changes to the governance processes around the Mortality improvement programme which would be finalised shortly and reported back to QSC.
5.15	In response to a concern raised by NED-JH in relation to mortality for fractured neck of femur the CMO confirmed that mortality in June had been 8% (in-year) and in-month 14%. He agreed there was some more work to do around that.
5.3 Nursing, Midwifery and Care Staff Levels including Nurse Recruitment *(5 minutes)*	
5.16	This item was presented by the DoN&M and the headlines for August were the continued positive shift in terms of the fill position in line with the net addition of 35 RNs across the organisation in the financial year (63 starters v 28 leavers). The overall nursing vacancy position had reduced in August to 22.7% with the Band 5 rate at 34%. This was positive against the overall forecast but slightly behind the Band 5 planned forecast vacancy rate. The RAG rating remained green as the variance was less than 2% behind forecast and it was expected there would be a significant catch up the following month.
5.17	The DoN&M cautioned that some work had been done to take out the variation in pay rates for NHS-P and to drop the additional levy down at the end of August which could have an impact on fill rates. The recruitment trajectory was still on track for vacancies to be at 10% or lower by the end of the financial year and early figures were showing that the overall vacancy position had dipped below 20% for September. It was noted that action ref: TB1.01.08.19/11 would be discussed further at QSC.

5.18	In response to a question from ANED-HH it was confirmed there were currently circa 40 vacancies for Healthcare Support Workers. The DoN&M agreed that whilst that was not of particular concern the vacancies did need to be filled. In response to a second question in relation to the movement of staff she confirmed that whilst bank/agency staff were allocated to a particular ward (so were not included in the figures), the movement of substantive staff was known to have a detrimental effect on team-working and experience.
5.19	The TC acknowledged the reduction in the nurse vacancy rate.
5.4 Inpatient Survey Results *(3 minutes)*	
5.20	This paper was presented by the DoN&M and had been seen previously by QSC – the detail still needed to be worked through. Headlines were that there continued to be a significant improvement in a number of areas including significantly, doctors' communication was no longer as significant a concern as had historically been the case. It was acknowledged there needed to be further work around the delivery and choice of food and around discharge processes. The focus going forward would be to look at the results in conjunction with the results of the Friends & Family Test, incident reporting and SIs.
Members took a ten minute break	
06 PEOPLE	
6.1 Workforce Race Equality Standards (WRES) and Workforce Disability Equality Standards (WDES) *(12 minutes)*	
6.1	WRES This update was presented by the Director of People (DoP) who confirmed the paper had been reviewed and approved at WFC in order to meet the deadline for publication. She noted there had been improvements in seven of the nine indicators. Two key headlines were: • BME staff experiencing harassment, bullying and or abuse from the public had increased • Total number of non-clinical BME staff employed in band 8 and above had decreased in 2019.
6.2	In response to a concern raised by ANED-HH it was confirmed there had been a recent Trust focus on Unconscious Bias and Values & Behaviours training. In addition an 'In Your Shoes' pilot had been launched for areas where bullying/harassment was more prevalent.
6.3	The CEO acknowledged that whilst one third of staff had indicated in the Staff Survey they were being bullied, this issue was not being raised anywhere else (e.g. on the incident system). His concern was the organisational culture was not lending itself to staff feeling able to raise individual concerns. The DoP confirmed there was a bigger piece of work underway around bullying/harassment and a paper related to that would come to a future Workforce Committee (WFC).
6.4	WDES The DoP presented the key findings of the Trusts first Workforce Disability Equality Standard (WDES) report. Members were updated there was significant disparity with staff who declared their disability on Electronic Staff Record and those who completed the Staff Survey. Members were asked to note that there was no detailed action plan currently as the report was new. However, the Trust would pursue achieving Disability Confident Employer status.
6.5	In response to a question raised by ANED-JK the DoP agreed to clarify outside the meeting the data provided in response to question 10 in the table.
ACTION **TB1.03.10/19/20**	**Clarify the data provided in response to question 10 in the table in WDES paper.** **Lead: Director of People**
07 PERFORMANCE AND PLACES	
7.1 Integrated Performance Report (IPR) *(28 minutes)*	
7.1	This report was introduced by the COO and key headlines under the 5Ps were as follows:

	Patients Following a recent small cluster of falls a deep dive was currently underway with actions already in place. The recent case (first since 2014) of MRSA bacteraemia had been scrutinised at QSC and work was underway to understand why the Trust was a high reporter for post-partum haemorrhage (it was confirmed each case was scrutinised and currently there was no evidence of any patient harm).
7.2	Performance There had been a long discussion at PAF around ED performance and the team was presenting at a regional event that day on improvements to emergency care. Overall performance was showing signs of improvement and the next focus would be on recruitment, particularly medical staff. There were currently only three middle grade vacancies and one consultant vacancy. The new Associate Medical Director (AMD) was now in post and job plans/rotas were starting to be reviewed. Worked had started on the new Urgent Treatment Centre (UTC) which would provide pre-bookable appointments. There were also plans to be able to provide same day emergency care. Cancer: there had been good progress in terms of recovery of the 62 day target with current performance slightly above trajectory and full recovery predicated for November. Referral to Treatment/Diagnostics: standards achieved for both. Demand and capacity issues were being worked through. In relation to the above the CMO added the Trust was currently participating in a pilot to appoint medical students from Bulgaria (from GMC approved medical schools) which, if successful, would eliminate the requirement for bank/agency staff at FY1/FY2 level.
7.3	People Sickness rates for August had been slightly above the Trust target of 3.9% by 0.2%. In response to a question from NED-GW it was confirmed that data was collated from staff exit interviews and presented to the WFC.
7.4	Pounds Targets for M5 had been achieved but still left a deficit of £3m against plan year-to-date. The focus was on the recovery plan which would be discussed later that day in the private session and had already been discussed at PAF. PAF would have oversight of the trajectories and stretch targets to track delivery and there would be weekly oversight through the delivery group reporting into the Executive Team and Senior Management Team. Final bids for emergency capital were being made, they totalled circa £5m for around 18 different schemes. The CMO added as a final point that the East of England (EoE) region had been working together to try to address the issue of agency rates for doctors. A meeting was planned for the following week with EoE CEOs to request their support with that.
7.5	Places In terms of catering, food waste had reduced between August and September from 19% to 6% against a target of 3.5%. Standards for domestic services were being achieved and the modernisation programme continued. There had been a significant review of the capital plan in terms of prioritisation. The previous week's announcement of funding for a new hospital would have an impact on how capital was invested moving forward. NED-AH cautioned that investment in the current site should not cease or reduce until such time as the business case for the new hospital had been signed off. The CEO highlighted that linked with the importance of the five year plan (equipment/maintenance) and putting any unused capital towards the new hospital.
7.2 Emergency Preparedness, Resilience and Response Annual Report *(1 minute)*	
7.6	This item was introduced by the COO and had previously been presented to PAF. The report was taken as read and there were no questions from members.
7.7	The Board was assured of the work undertaken with regard to Emergency Preparedness and it approved the Annual EPRR Core Standards Assurance return.

08 GOVERNANCE	
8.1 Governance Manual (bi-annual review) *(1 minute)*	
8.1	This item was presented by the CFO who confirmed that the Manual had been considered by the Trust's Audit Committee and SMT. The bi-annual review brought the document up-to-date with technical guidance and in particular, controls around capital had been tightened.
8.2	The Board approved the proposed changes and content of the Manual which would now be circulated to staff.
8.2 Reports from Committees *(2 minutes)*	
8.3	Workforce Committee.23.09.19 – Chair NED-PC There were no further updates or questions from members.
8.4	Performance & Finance Committee.26.09.19 – Chair NED-AH It was reiterated that PAF had discussed at length the Trust's financial recovery plan.
8.5	Audit Committee.26.09.19 – Chair NED-GW (including Audit Committee Annual Report) There were no further updates or questions from members.
8.6	Quality & Safety Committee.27.09.19 – Chair NED-JH (including Infection Control Annual Report) Items to note that were not within the report were that work was ongoing to understand why the organisation was showing as an outlier in terms of post-partum haemorrhage (PPH) although no cases of patient harm had been identified and also that the birthing unit was currently closed which was impacting on patient choice.
8.3 Report from Senior Management Team Meetings (September 2019)	
8.7	This paper was presented by the CEO and key discussions from the meeting had been around the introduction of the talent management pilot, the CQC improvement plan and a deep dive presentation on SLR in Haematology.
09 QUESTIONS FROM THE PUBLIC	
9.1	There were no members of the public in attendance.
10 CLOSING ADMINISTRATION	
10.1 Summary of Actions and Decisions	
10.1	These are presented in the shaded boxes above.
10.2 New Issues/Risks	
10.2	The upcoming burden of work, particular on the Executive Team, was noted in terms of the new hospital, moving towards an integrated care system and the work around the PAHT 2030 strategy. Some thought would need to be given as to how the above would be appropriately resourced.
10.3 Reflections on Meeting	
10.3	Members agreed it had been useful to bring a positive story for the Learning From Deaths item. The CEO added that going forward, and with the recent appointment of a Lead Medical Examiner, the organisation would be able to review more deaths (target of 75% by December) and glean more and more learning.
10.4 Any Other Business (AOB)	
10.4	NED-HG requested that it be acknowledged whether a formal response (as had been requested) had gone out to the family in relation to the previous meeting's Patient Story. It was agreed that would be followed up after the meeting and the outcome provided in the minutes as below. ***Post Meeting Note:*** The HCG and Patient Experience team have continued to work and liaise with the family and the complaint process is now closed.

Signed as a correct record of the meeting:	
Date:	05.12.19

The Princess Alexandra Hospital NHS
NHS Trust

Signature:	
Name:	Steve Clarke
Title:	Trust Chairman

Trust Board Meeting in Public
Action Log - 05.12.19

Action Ref	Theme	Action	Lead(s)	Due By	Commentary	Status
TB1.03.10.19/16	Event in a Tent	Circulate the slides from the Civility Saves Lives session at Event in a Tent.	DoP	TB1.05.12.19	Actioned.	Closed
TB1.03.10.19/17	CEO Update	Focus on 'temporary staffing percentage of pay bill' as a key performance headline in CEO report.	CEO	TB1.05.12.19	Addressed at item 4.1.	Closed
TB1.03.10.19/18	Harlow MP	Write to Robert Halfon to thank him for his support with the case for a new hospital.	TC	TB1.05.12.19	Actioned.	Closed
TB1.03.10.19/19	Award Nominations	Discuss further a mechanism for nominating families/carers for awards.	Exec. Team	EMT.14.11.19	Actioned. Recommendations to be made to Patient Panel.	Proposed for closure
TB1.03.10.19/20	WDES Report	Clarify the data provided in response to question 10 in the table in WDES paper.	DoP	TB1.05.12.19	Actioned. Data has been verified but presentation is being amended.	Proposed for closure

The Princess Alexandra Hospital NHS Trust

Trust Board – 5 December 2019

3.1

Agenda item:	3.1
Executive Lead:	Dr Andy Morris – Chief Medical Officer
Prepared by:	Sheila O'Sullivan – Associate Director of Governance & Quality Lisa Flack - Compliance and Clinical Effectiveness Manager
Date prepared:	25 November 2019
Subject / title	Significant Risk Register

Purpose:	Approval		Decision		Information	√	Assurance	√

Key issues:	This paper presents the Significant Risk Register (SRR) and was produced from the Risk Assure system using the risk registers for all our services. There are a total of 81 risks with a score of greater then 15: • There are no risks with a score of 25 • There are 20 risks with a score of 20, increased from 16 on 25/9/19. A summary of each risk is detailed within section 2.5-2.9. • 18 risks have a score of 16, reduced from 20. • 43 risks have a score of 15, increased from 39 in 25/9/19. 2 new risks with a score of 15 have been raised over the last two months with details provided in section 3. 4 risks scoring 20 for theatres are detailed in section 2.5. 1 risk detailed in section 2.9 has been reassessed and the score increased during November 2019.
Recommendation:	Trust Board is asked to i) Note the content of the Significant Risk Register ii) Take assurance from the actions currently in place or planned

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

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

respectful | caring | responsible | committed

The Princess Alexandra Hospital NHS Trust

3.1

1.0 INTRODUCTION

This paper details the Significant Risk Register (SRR) across the Trust; the registers were pulled from the web based Risk Assure system on 25 November 2019. The Trust Risk Management Group meets monthly and reviews risks across the Trust, including significant risks. There is an annual work plan so each areas register can be reviewed in detail on a rotation.

2.0 CONTEXT

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

2.2 There are 81 (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	11 (9)	5 (6)	2 (2)	0 (0)	18 (17)
Estates & Facilities	3 (3)	0 (0)	0 (0)	0 (0)	3 (3)
Finance	0 (2)	0 (0)	2 (2)	0 (0)	2 (2)
Information Data Quality and Business Intelligence	1 (1)	0 (0)	0 (0)	0(0)	1 (1)
Non-Clinical Health & Safety	2(2)	0 (0)	0 (0)	0 (0)	2 (2)
Nursing	1 (0)	0 (1)	0 (0)	0 (0)	1 (1)
Operational	1 (1)	0 (0)	4 (4)	0 (0)	5 (5)
Research, Development & Innovation	0 (0)	1 (0)	0 (1)	0 (0)	1 (1)
Resilience	1 (1)	0(0)	0(0)	0(0)	1 (1)
Workforce	0 (0)	1 (1)	0 (0)	0 (0)	1 (1)
Child Health	1(2)	0 (0)	0 (0)	0(0)	1 (2)
Safeguarding Adults	1	0	0	0	1
Women's Health	4(3)	2(2)	0 (0)	0 (0)	6 (5)
Medicine	4 (4)	5 (6)	8 (7)	0 (0)	17 (17)
Surgery	13 (13)	4 (4)	4 (0)	0 (0)	21 (17)
Totals	43 (39)	18 (20)	20 (16)	0 (0)	81 (75)

(The scores from paper presented in October 2019 are in brackets)

2.3 The Trust has no risks scoring 25

2.4 There are 20 risks with a score of 20, raised since 26 September 2019; this has increased from 16 in the October 2019 paper. A summary of these risks and actions underway are:-

2.5 Patients:

2.5.1 EPMA system

- Dose reductions to be applied as directed by user and not incorrectly interpreted by the EPMA system (CMS/2019/360 on register since January 2019)
  Actions: This issue has been reported to the supplier with request for a bug fix to resolve. Anticipate this being amended in version 7, planned introduction by end of November 2019.
- Applying a dose reduction to oral chemotherapy on a different administration days needs to be correctly applied on EPMA (CMS/2019/383 on register since February 2019)
  Actions: Mitigating SOP developed and cascaded. Actions for prescribers and pharmacists detailed on the protocol. Nurses required to be vigilant for doses especially when dose reductions are applied. As risk CMS/2019/360 requested the supplier provide a remedy in the next version to be launched by end of November 2019. EPMA team are monitoring Datix incidents.

2.5.2 Frailty service

- Limited space for individual patient consultations could impact on patient experience. Prioritisation of diagnostics may lead to delays in flow.
  Actions: A system wide business case to develop frailty services has been completed and shared with system colleagues. Dedicated frailty space and facilities are part of the ward alignment. Transition of community resource into the frailty team is underway to support patient flow and experience.

2.5.3 Theatres

- Theatre 1 roof leaks (THE 006/2019, initially raised on 31/10/19).
- Theatre 6 as above (THE 007/2019, initially raised on 31/10/19).
- Theatre 7 as above (THE 008/2019, initially raised on 31/10/19).
  Actions: Staff remain vigilant for signs of water leaking, weather forecasts are checked for rain prior to starting a list.
  Lists are moved to another theatre if capacity allows and theatre lists do not start if a leak is apparent. Estates are aware of the concern with the roof and remedial work to repair the roof to be considered under capital projects with a deadline of 31/12/19.
- Roof leaks into the consumable/drape store resulting in water damage to stock (THE005/2019 initially raised on 31/10/19, linked to THE 006/2019 and 007/2019).
  Action: Keeping stock rooms lightly stocked with removal of some stock items to an alternative area. Vigilance regarding storage areas when significant rain falls, use of buckets and padding to catch the water are in place now. Estates team are assessing the roof with a contractor for possible remedial work to repair to be considered under capital projects, current deadline of 31/12/19.

2.6 People

2.6.1 Nursing staff numbers

- Registered Nurses – Harold (JS02), Fleming- MAU (03) and Saunders (Saun04).
  Actions: Recruitment and retention action plans are in place with daily reviews of staffing numbers and rotation of staff to ensure patient safety.

2.7 Performance

2.7.1 ED performance

- Statutory compliance risk for failure to deliver 4 hour ED standard (001/2017 on register since April 2014).
- Quality and safe care may be impacted by failure to deliver the 4 hour ED standard, on Medicine teams register (MED57, ED012on register since July 2016).
- **Actions:** Urgent care improvement programme established and in place across PAH and wider healthcare system. External support via ECIST and NHSI continues with

clear improvement plans and trajectories in place. Weekly assurance of surge plan and progress against the KPIs. Overall patient times are monitored through the improvement board, local meetings and into QSC and PAF.
Actions: Development of surge escalation plan. Improvement plan is in place across the patient pathway with trajectory set for compliance.

- Failure to achieve 85% of all patients referred by GP to receive treatment within the cancer 62 day standard (005/2016 on register since July 2016)
  Actions: A revised patient target list to ensure a granular oversight of individual patients on their cancer pathway against the cancer escalation triggers, a speciality level recovery plan with trajectories and mitigation are in place. Monitored at weekly tumour site and trust level meetings.

2.8 Places:

2.8.1 Endoscopy

- The unit requires an air handling unit following building work to comply fully with H&S requirements. (HTM03-01) (Endo 080719, on register since July 2019)
  Actions: Plans in place for air handling unit are in place and will be addressed in the financial year.

2.9 Pounds:

2.9.1 Delivery of Financial Targets

Medicine and Surgery HCGs due to temporary staffing costs and CIP shortfalls.
Action: Recruitment plans and temporary staffing controls. CIP assurance meetings and workshops, Delivery Group attendance. Weekly temporary staffing reviews, temporary staff group attendance, HCG vacancy control panels.

4.0 RECOMMENDATION

Trust board are asked to note the content of the SRR.

The Princess Alexandra Hospital NHS
NHS Trust

Trust Board - 5 December 2019

3.2

Agenda Item:	3.2
Presented by:	Heather Schultz - Head of Corporate Affairs
Prepared by:	Heather Schultz - Head of Corporate Affairs
Date prepared:	28 November 2019
Subject / Title:	Board Assurance Framework 2019/20

Purpose:	Approval	x	Decision		Information		Assurance	

Key Issues:	The BAF risks are presented for review. The risks have been reviewed with Executive leads and discussed at the relevant Committees in November. Appendix A provides an overview of all the risks and the proposed risk ratings. WFC considered a proposal to reduce Risk 2.1 (Nurse recruitment) from 16 to 12 and recommended the risk rating remain at 16 until January 2020 when progress against the target vacancy rate will be reviewed again. PAF Committee reviewed Risk 5.1 (Finance) at the meeting on 28.11.19 and recommended the risk rating is increased from 15 to 20.
Recommendation:	The Board is asked to approve the Board Assurance Framework and the increased risk rating for Risk 5.1.

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:	WFC 25 November, PAF 28 November and QSC 22 November 2019.
Risk / links with the BAF:	As indicated in the attached BAF
Legislation, regulatory, equality, diversity and dignity implications:	Compliance with the Code of Governance, CQC Well - led Framework.
Appendices:	Appendix A - summary of risks

5P	Executive Lead	Committee	BAF Risks August 2019	Current risk score	Trend
	Chief Nurse/Chief Medical Officer	QSC	1.1 Outcomes:Variation in outcomes in clinical quality, safety, patient experience and 'higher than expected' mortality.	16	
	Chief Finance Officer/DoI&IT	PAF	1.2 EPR Concerns around availability of functionality for innovative operational processes together with data quality and compliance with system processes	16	
	DoP/DoN	WFC	2.1 Nurse Recruitment Inability to recruit to critical nursing roles.	16	
	DoP	WFC	2.3 Workforce: Inability to recruit, retain and engage our people	12	
	DoS	PAF	3.1 Estates & Infrastructure Concerns about potential failure of the Trust's Estate & Infrastructure and consequences for service delivery.	20	
	DoS	Trust Board/ Strategy Committee	3.2 Financial and Clinical Sustainability across health and social care system Capacity and capability to deliver long term financial and clinical sustainability across the health and social care system.	16	
	DoS	Trust Board/ Strategy Committee	3.3 Capacity & capability of senior Trust leaders to work in partnership to develop an Integrated Care Trust.	12	
	DoS	Trust Board/ Strategy Committee	3.4 Sustainability of local services Failure to ensure sustainable local services continue whilst the new hospital plans are in development and funding is being secured.	16	
	COO	PAF	4.2 4 hour Emergency Department Constitutional Standard Failure to achieve ED standard	20	
	CFO	PAF	5.1 Finance Concerns around failure to meet financial plan including cash shortfall.	20	

The Princess Alexandra Hospital NHS
NHS Trust

The Princess Alexandra Hospital Board Assurance Framework

2019-20

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

Risk Key														
Extreme Risk		15-25												
High Risk		8-12	**The Princess Alexandra Hospital Board Assurance Framework 2019-20**											
Medium Risk		4-6												
Low Risk		1-3												
Risk No		**PRINCIPAL RISKS**				**KEY CONTROLS**	**ASSURANCES ON CONTROLS**	**BOARD REPORTS**						
		Principal Risks		**RAG Rating (CXL)**	**Executive Lead and Committee**	**Key Controls**	**Sources of Assurance**	**Positive Assurances on the effectiveness of controls**	**Residual RAG Rating (CXL)**	**Gaps in Control**	**Gaps in Assurance**	**Review Date**	**Changes to the risk rating since the last review**	**Target RAG Rating (CXL)**
		What could prevent the objective from being achieved	What are the potential causes and effects of the risks		Which area within our organisation this risk primarily relate to	What controls or systems are in place to assist in securing the delivery of the objectives	Where we can gain evidence that our controls/systems, on which we are placing reliance, are effective	We have evidence that shows we are reasonably managing our risks and objectives are being delivered		Where are we failing to put controls/systems in place or where collectively are they not sufficiently effective.	Where are we failing to gain evidence that our controls/systems, on which we place reliance, are effective			
								Evidence should link to a report from a Committee or Board.						
	Strategic Objective 1: Our Patients - we will continue to improve the quality of care and experiences that we provide our patients and families, integrating care with our partners and improving our CQC rating													
BAF 1.1		Variation in outcomes in clinical quality, safety, patient experience and 'higher than expected' mortality.	Causes: i) Unwarranted variation in care ii) System wide flow	**4 X 5= 20**	Director of Nursing/ Chief Medical Officer **Quality and Safety Committee**	i) Robust quality and safety governance structures in place including infection control ~~ii) Performance management of unacceptable behaviour and revised Accountability Framework~~ iii) Robust Appraisal/ medical revalidation process (2 positive peer reviews) - 360° feedback and Fitness to Practice process in nursing iv) RCA methodology workshops v) End of Life and deteriorating patient simulation programme for all staff. and Whole System Steering Group vi) Mandated & focused education & training in communication skills such as breaking bad news training. vii) Sharing the Learning Programme ~~and acrbaddad.~~ viii) Monthly Commissioner reviews of quality and Safety xii) Risk Management Training Programme xiv) Escalation prescribing processes xv) Electronic handovers, Hospital at Night and E-Obs and observation compliance reports xvi) Schwartz Rounds xviii) NHSI/NHSE Oversight xix) Red2 Green Board rounds supported by ECIST ~~xx) Implementation of Medical Examiners with reporting software and Board oversight.~~ xxi) Patient Experience Strategy xxii) NED lead appointed for Mortality xxiv) Mortality Strategy including dashboard, tracker, updates on workstreams and learning from deaths. xxv) Introducing '15 steps' walkabouts from January 2019 xxvi) Nursing Establishment review (bi-annually) and succesful nursing recruitment campaign xxvii) Safer Staffing policy xxviii) Real time patient feeback implemented across all wards xxix) Robust management of periods onf increased incidences of Infection Control (MRSA/VRE and Pseudemonas) xxxi) Robust management of variations in neonatal outcomes xxxii) Engagement in external reviews MBRRACE,HSIB and LeDeR and Healthcare Safety Investigation Branch (maternity) xxxiii) Medical examiners (MEs) and Lead ME appointed and Mortality Surveillance Group established xxxiii) Complaints workshops held xxxiv) Joint GIRFT and Model Hospital quality improvement programme	i) National Survey ii) Cancer Survey iii) CEO Assurance Panels iv) SIG meetings v) QSC, PAF, Risk Management Group and Board meetings vi) Patient Safety and Quality meetings, PRMs and Patient Experience meetings vii) Infection Control Committee viii) Integrated Safeguarding meetings ix) Patient Panel meetings x) PLACE Inspections xi) Medicines Management Committee ~~xii) CCC audits~~ xiii) End of Life and Mortality Surveillance Group xiv) AKI & Sepsis Group xv) Urgent Care Improvement Board xvi) ~~Mortality Review Group~~ ~~xvii) Mortality Improvement Board~~ xvi) Deteriorating Patient Group xvii) Cardiac arrest review panels	i) Improvement in some areas of the National Inpatient Survey and NACEL Survey ii) CQUIN reports to SMT/PAF~~QSC~~ (September 2019). iii) CEO Assurance Panels (as required) iv) Reports to QSC on Patient Experience November 19, monthly Serious Incidents, monthly Safer Staffing, Patient Panel November 19, Safeguarding, monthly Infection Control v) Monthly Mortality Improvement report to QSC and monthly IPR report vi) Dr Foster reports, CQC inspection reports (March 18 and draft June 19) and GIRFT reports vii) Real time Dr Foster reports and engagement viii) GMC Survey results (July 2019) ix) Clinical Audit report 18/19 - tiaa (limited assurance) v) CMO/CFO Coding Meetings and quarterly Coding reports to PAF (June 19) vi) Positive staff survey outcomes (2018) measuring safety culture and engagement vii) Freedom to Speak Up Guardians quarterly reports to WFC (Nov 19) and Guardian of Safe Working reports to Trust Board (Dec18). viii) Patient stories and learning from deaths presentations to Public Board meetings (bi-monthly) ix) Internal Audit reports tiaa 2019: Safeguarding (substantial assurance) and Complaints (reasonable assurance) x) International Nurse Recruitment business case to SMT/PAF and Board (June/July 19)	**4x4=16**	Lack of modernisation in some reporting processes including: i) Clinical audit plan developed and to be implemented - improved tracking of local audits and drive to improve collation and input of data for national audits ii) Disparity in local patient experience surveys versus inpatient survey iii) Staffing, site capacity and constraints iv) Access to Qlikview v) NICE - oversight of guidance that Trust has decided not to implement **ACTIONS:** i) Inpatient Survey action plan in place and Staff Survey action plan in place iii) Ongoing work with Dr Foster in relation to mortality iv) Review of quality/safety and risk leadership structure v) NHS Patient Safety Strategy 2019 published. Trust to review and align to best practice	i) Clinical evidence of improvements made following compliance with national audits, NICE,NCEPOD. ii) Demonstrating an embedded learning programme from Board to ward.	04/11/2019	Risk rating not changed	4x3 =12 (Target date ~~Dec 2019~~ March 2020 - to review progress against Mortality Improvement Strategy workstreams
			Effects: i) Increase in complaints/ claims or litigation ii) Persistent poor results in National Surveys iii) Poor reputation iv) Recurrent themes in complaints involving communication failure v) Loss of confidence by external stakeholders vi) Higher than expected Mortality rates											

Risk Key														
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High Risk		8-12	**The Princess Alexandra Hospital Board Assurance Framework 2019-20**											
Medium Risk		4-6												
Low Risk		1-3												
Risk No		**PRINCIPAL RISKS**				**KEY CONTROLS**	**ASSURANCES ON CONTROLS**	**BOARD REPORTS**						
		Principal Risks		**RAG Rating (CXL)**	**Executive Lead and Committee**	**Key Controls**	**Sources of Assurance**	**Positive Assurances on the effectiveness of controls**	**Residual RAG Rating (CXL)**	**Gaps in Control**	**Gaps in Assurance**	**Review Date**	**Changes to the risk rating since the last review**	**Target RAG Rating (CXL)**
		What could prevent the objective from being achieved	What are the potential causes and effects of the risks		Which area within our organisation this risk primarily relate to	What controls or systems are in place to assist in securing the delivery of the objectives	Where we can gain evidence that our controls/systems, on which we are placing reliance, are effective	We have evidence that shows we are reasonably managing our risks and objectives are being delivered		Where are we failing to put controls/systems in place or where collectively are they not sufficiently effective.	Where are we failing to gain evidence that our controls/systems, on which we place reliance, are effective			
								Evidence should link to a report from a Committee or Board.						
	Strategic Objective 1: Our Patients - we will continue to improve the quality of care and experiences that we provide our patients and families, integrating care with our partners and improving our CQC rating **Strategic Objective 5: Our Pounds - we will manage our pounds effectively and modernise our corporate services to achieve our agreed financial control total for 2019/20 and our local system control total**													
BAF 1.2		**EPR** Concerns around availability of functionality for innovative operational processes together with data quality and compliance with system processes.	Causes: i) Poor engagement with the system, usability, time/skills ii) Timely system fixes/enhancements	**5 X 4= 20**	Chief Financial Officer/Chief Operating Officer/Chief Medical Officer **Performance and Finance Committee**	i) Weekly DQ meetings held at ADO level ii) Programme management arrangements established with Data Quality Recovery Programme to 'Health Group Challenge' meetings, EMB and Trust Board. Governance via Performance and Finance Committee to Trust Board. iii) Increased training application support, mobile training support, RTT validators & staff awareness sessions. iv) Performance Mgt Framework in place. v) Training programme. vi) Super users in place to deliver focused support. vii) 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 viii) Access Policy ix) Functionality enhanced through deployment of alternate solutions (e-Obs, Portal, Meds management) x) Development of capacity planning tools/information xi) PWC review and actions identified xii) ICT Newsletter issued xiii) Daily ICT/COSMIC meetings ongoing xiv) Real time data now available xv) CDS 011 now live xvi) Maternity MDS configuration completed. xvii) Monthly Contract Performance monitoring meeting with supplier established.	i) Access Board ii) ICT Programme Board (chaired by CFO) iii) Board and PAF meetings iv) Weekly meetings with Cambio vi Weekly DQ meetings vi) Monthly performance reviews vii) Monthly EPR Board to Board meetings viii) Exec to Exec meeting on 25.11.19	i) Weekly Data Quality reports to Access Board and EDB ii) External Audit reports to Audit Committee on Quality Account Indicators (July 19 - adverse conclusion) iii) Monthly DQ reports to PAF (September 19) and quarterly ICT updates (July 19) iv) EPR outline business case developed and presented to SMT and PAF September 19.	**4 X 4= 16**	i) Continue to develop 'usability' of EPR application to aid users ii) Resource availability iii) Capacity within operational teams iv) Elements of system remain onerous (completion of discharge summaries) v) External system support vi) Compliance with refresher training vii) Cambio delivery schedule slippage	Reporting mechanism on compliance of new staff/interims/junior doctors with the system and uptake of refresher training - monitoring process being developed. Responsiveness and quality of delivery of PFM - testing processes and actions identified by tiaa internal audit (limited assurance).	Nov-19	Risk rating unchanged	**4x3=12** **~~December 2019~~ end of March 2020 (subject to monthly review of progress)**
			Effects: i)Patient safety if data lost, incorrect, missing from the system. ii) National reporting targets may not be met/ missed. iii) Financial loss to organisation through non-recording of activity, coding of activity and penalties for not demonstrating performance iv) Inability to plan and deliver patient care appropriately							**ACTIONS:** i) Ongoing training and support ~~ii) Restructure of IT team (resourcing)~~ iii) Re-establishing relationship/engagement with Cambio iv) Refresher training underway v) Revised roadmap to incorporate new statutory/legal requirements e.g GDPR				

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

The Princess Alexandra Hospital Board
Assurance Framework 2019-20

Risk No		PRINCIPAL RISKS				KEY CONTROLS	ASSURANCES ON CONTROLS	BOARD REPORTS						
		Principal Risks		RAG Rating (CXL)	Executive Lead and Committee	Key Controls	Sources of Assurance	Assurances on the effectiveness of controls	Residual RAG Rating (CXL)	Gaps in Control and Actions	Gaps in Assurance	Review Date	Changes to the risk rating since the last review	Target RAG Rating (CXL)
		What could prevent the objective from being achieved	What are the potential causes and effects of the risks		Which area within our organisation this risk primarily relate to	What controls or systems are in place to assist in securing the delivery of the objectives	Where we can gain evidence that our controls/systems, on which we are placing reliance, are effective	We have evidence that shows we are reasonably managing our risks and objectives are being delivered		Where are we failing to put controls/systems in place or where collectively are they not sufficiently effective.	Where are we failing to gain evidence that our controls/systems, on which we place reliance, are effective			
								Evidence should link to a report from a Committee or Board.						
	Strategic Objective 2: Our People – we will support and develop our people to deliver high quality care within a culture that improves engagement, recruitment and retention and results in further improvements in our staff survey results. **Strategic Objective 4: Our Performance - we will meet and achieve our performance targets, covering national and local operational, quality and workforce indicators**													
BAF 2.1		**Nurse Recruitment** Inability to recruit sufficient numbers of registered nurses.	**Effects:** Reputation impact and loss of goodwill. i) Financial penalties. ii) Unsatisfactory patient experience. iii) Potential for poor patient outcomes iv) v) Jeopardises future strategy. vi) Increased performance management vii) Increase in staff turnover and sickness absence levels	**5 X 4 =20**	Director of People and Director of Nursing **Workforce Committee**	i) Participation in local and regional job fairs ii) Targeted overseas recruitment activity and proactive recruitment campaigns iii) Apprenticeships and work experience opportunities iv) Use of new roles in line with national direction v) Use of recruitment and retention premia as necessary vi) Use of TRAC recruitment tool vii) Use of a system to recruit pre-qualification students viii) Working in collaboration with STP and LWAB ix) Lead Nurse for Recruitment and Retention appointed	i) PAF, QSC, WFC, EMT, SMT, Workforce and Board meetings ii) PRMs and Health Group Boards iii) Recruitment and Retention Group iv) People Board	i) Safer Staffing Reports (monthly to QSC, WFC and bi-monthly to Board) ii) Workforce report (progress on recruitment, retention, bank and agency) to WFC 25.11.19 iii) Incident reporting and monthly SI reports to QSC iv) Internal Audit report 18/19 on Recruitment (substantial assurance) v) International Nurse recruitment business case to SMT, PAF (June 2019) and Board (July 2019) vi) Monthly IPR report	**4 x 4 = 16**	i) Limited ability to influence some of the pre-employment timeframes due to external requirements e.g. NMC registration Actions: Registered nurse vacancy rate to be included in IPR Ongoing monitoring of pre-employment phase of recruitment process to minimise delays	None noted.	18/11/2019	**Risk rating to remain at 12 following discussion at WFC on 25.11.19**	**4 x 3 = 12** **January 2020**
			Effects: i) Pressure on existing staff to cope with demand leading to overworked staff and increased sickness ii) Low staff morale and impact on engagement iii) Shortcuts and failure to follow processes and procedures due to workload and fatigue leading to higher chances of patient safety errors occurring iv) Lower staff retention rates v) Reduced attendance at training courses vi) Impact on patient experience										

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

The Princess Alexandra Hospital Board
Assurance Framework 2019-20

Risk No		PRINCIPAL RISKS				KEY CONTROLS	ASSURANCES ON CONTROLS	BOARD REPORTS						
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								Evidence should link to a report from a Committee or Board.						
	Strategic Objective 2: Our People – we will support and develop our people to deliver high quality care within a culture that improves engagement, recruitment and retention and results in further improvements in our staff survey results. **Strategic Objective 4: Our Performance - we will meet and achieve our performance targets, covering national and local operational, quality and workforce indicators**													
2.3		**Workforce:** Inability to recruit, retain and engage our people	**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	**4 X 4 =16**	Director of People, OD & Communications **Workforce Committee**	i) People strategy 'joy to work at PAHT' ii) Behaviour charter and vision and values iii) People management policies, systems, processes & training iv) Management of organisational change policies & procedures v) Freedom To Speak Up Guardian roles vi) Equality and inclusion champions vii) Event in a Tent held annually viii) Staff recognition awards held locally and trust wide annually ix) Enhanced controls around temporary staffing x) Line Manager development programme underway xi) Behaviour workshops held	i) WFC, QSC, SC, PAF, WFC, SMT, EMT. ii) People board iii) JSCC, JLNC iv) PRMs and health care group boards	i) Workforce KPIs reported to WFC bi-monthly and IPR (monthly) ii) People strategy deliverables iii) Staff survey results and action plans (WFC Sept 19) iv) Staff friends and family results (WFC Sept19) v) Medical engagement surveys, action plans and GMC surveys (WFC November 2019)	**4 x3 = 12**	Pulse surveys targeted for all staff Communications strategy Medical engagement Effective intranet/extranet for staff to access anywhere 24/7 Actions ~~i) Behaviour workshops - Q2~~ ii) Implementation of communication strategy - Q4 iii) Recruitment plans for medical staff - ~~Q2~~ iv) New consultant development programme - Q3 v) Extranet for staff - Q1 20/21	None identified.	04/11/2019	**Risk score not changed.**	**4 x2 = 8 (at end of 5 year People Strategy but to be reviewed in March 2020)**
			Effects: Low staff morale, high temporary staffing costs, poor patient experience and outcomes/ increased mortality and impact on Trust's reputation											

Risk Key														
Extreme Risk		15-25												
High Risk		8-12	**The Princess Alexandra Hospital Board Assurance Framework 2019-20**											
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Risk No		**PRINCIPAL RISKS**				**KEY CONTROLS**	**ASSURANCES ON CONTROLS**	**BOARD REPORTS**						
		Principal Risks		**RAG Rating (CXL)**	**Executive Lead and Committee**	**Key Controls**	**Sources of Assurance**	**Positive Assurances on the effectiveness of controls**	**Residual RAG Rating (CXL)**	**Gaps in Control**	**Gaps in Assurance**	**Review Date**	**Changes to the risk rating since the last review**	**Target RAG Rating (CXL)**
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								Evidence should link to a report from a Committee or Board.						
	Strategic Objective 3: Our Places – we will maintain the safety of and improve the quality and look of our places and work with our partners to develop an OBC for a new build, aligned with the further development of our local Integrated Care Alliance.													
BAF 3.1		**Estates & Infrastructure** Concerns about potential failure of the Trust's Estate & Infrastructure and consequences for service delivery.	**Causes:** i) Limited NHS financial resources (Revenue and Capital) ii) Lack of capital investment, iii) Current financial situation, iv) Inherited aged estate in poor state of disrepair v) No formal assessment of update requirements, vi) Failure to comply with estates refurbishment/ repair programme historically, vii) Under-investment in training of estate management & site development viii) Inability to undertake planned preventative maintenance ix) Lack of decant facility to allow for adequate repair/maintenance particularly in ward areas. x) Key workforce gaps in compliance, energy and engineering.	**5 X 4= 20**	Director of Strategy **Performance and Finance Committee**	i) Schedule of repairs ii) Six-facet survey/ report received (£105m) iii) Potential new build/location of new hospital iv) Capital programme - aligned to red rated risks. v) STP Estate Strategy developed and approved. vi) Modernisation Programme for Estates and Facilities underway vii) Robust water safety testing processes viii) Annual asbestos survey –completed and red risks resolved. ix) Trust's Estate strategy being developed as part of Project Genesis (Our New Hospital) x) Annual fire risk assessment completed and final report received, compliance action plan being developed. xi) New estates and facilities leadership team in place x) Sustainability Manager in post	i) PAF and Board meetings ii) SMT Meetings iii) Health and Safety Meetings iv) Capital Working Group v) External reviews by NHSI and Environmental Agency vi) Water Safety Group vii) Weekly Estates and Facilities meetings viii) Project Genesis Steering Group	i) Reports to SMT (as required) ii) Signed Fire Certificate iii) Annual H&S reports to Trust Board and quarterly to PAF (Oct 19). v) Ventilation audit report vi) Water Safety Report (PAH site) vii) Annual and quarterly report to PAF: Estates and Facilities (July 19) viii) PLACE Assessments (Audit report May 18) ix) IPR monthly x) Sustainability report to PAF (Oct 19)	**5x4=20**	i) Planned Preventative Maintenance Programme (time delay) and amber backlog maintenance risks now emerging red risks ii) Ventilation systems iii) Sewage leaks and drainage iv) Electrical Safety/Rewiring (gaps) v) Maintaining oversight of the volume of action plans associated with compliance. viii) Sustainability Management Group to be established **ACTIONS:** i) Backlog maintenance review underway and alignment of capital to identified risks with business cases to support investments. ii) EBME review underway	i) Estates Strategy /Place Strategy developing within STP ii) Compliance with data collection and reporting iii) PPM data not as robust as required iv) PAM assurance not robustly updated.	09/11/2019	**Residual risk rating unchanged.**	**4 x 2 =8 (Rating which Trust aspires to achieve but will depend on relocating to new hospital site)**
			Effects: i) Backlog maintenance increasing due to aged infrastructure ii) Poor patient perception and experience of care due to aging facilities. iii) Reputation impact iv) Impact on staff morale v) Poor infrastructure, vi) Deteriorating building fabric and engineering plant, much of which was in need of urgent replacement or upgrade, vii) Poor patient experience, viii) Single sex accommodation issues in specific areas, ix) Out dated bathrooms, flooring, lighting – potential breach of IPC requirements, x) Ergonomics not suitable for new models of care. xi) Failure to deliver transformation project and service changes required for performance enhancement xii) Potential slips/trips/fall to patients, staff or visitors from physical defects in floors and buildings xiii) Potential non compliance with relevant regulatory agency standards such as CQC, HSE, HTC, Environmental Health.											

Risk Key														
Extreme Risk		15-25												
High Risk		8-12	**The Princess Alexandra Hospital Board Assurance Framework 2019-20**											
Medium Risk		4-6												
Low Risk		1-3												
Risk No		**PRINCIPAL RISKS**				**KEY CONTROLS**	**ASSURANCES ON CONTROLS**	**BOARD REPORTS**						
		Principal Risks		**RAG Rating (CXL)**	**Executive Lead and Committee**	**Key Controls**	**Sources of Assurance**	**Positive Assurances on the effectiveness of controls**	**Residual RAG Rating (CXL)**	**Gaps in Control**	**Gaps in Assurance**	**Review Date**	**Changes to the risk rating since the last review**	**Target RAG Rating (CXL)**
		What could prevent the objective from being achieved	What are the potential causes and effects of the risks		Which area within our organisation this risk primarily relate to	What controls or systems are in place to assist in securing the delivery of the objectives	Where we can gain evidence that our controls/systems, on which we are placing reliance, are effective	We have evidence that shows we are reasonably managing our risks and objectives are being delivered		Where are we failing to put controls/systems in place or where collectively are they not sufficiently effective.	Where are we failing to gain evidence that our controls/systems, on which we place reliance, are effective			
								Evidence should link to a report from a Committee or Board.						
	Strategic Objective 3: Our Places – we will maintain the safety of and improve the quality and look of our places and work with our partners to develop an OBC for a new build, aligned with the further development of our local Integrated Care Alliance.													
BAF 3.2		**Financial and Clinical Sustainability across health and social care system** Capacity and capability to deliver long term financial and clinical sustainability across the health and social care system	**Causes:** i) The financial bridge is based on high level assumptions ii) The Workstream plans do not have sufficient underpinning detail to support the delivery of the financial savings attributed to them iii) The resources required for delivery at a programme and workstream level have not been defined or secured iv) The current governance structure is under development given the shift in focus from planning to delivery. v) The collaborative productivity opportunities linked to new models of care require more joined-up ways of working, clear accountability and leadership, changes to current governance arrangements.	**4 X 4= 16**	DoS Strategy Committee	i) STP workstreams with designated leads ii) System leaders Group iii) New STP governance structure iv) STP priorities developed and aligned across the system. v) CEO's forum vi) Integrated Clinical Strategy in development vii) STP Estates Strategy being developed. viii) STP Clinical Strategy in place ix) STP wide Strategy Group implemented x) Independant STP Chair and independant STP Director of Strategy appointed.	STP CEO's meeting (fortnightly) Transformation Group meetings Joint CEO/Chairs STP meetings (quarterly) Clinical leaders group (meets monthly) STP Estates, Finance meetings	i) Minutes and reports from system/partnership meetings/Boards ii) CEO reports to Board and STP updates iii) STP report to Strategy Committee (Oct 2019) iv) STP lead's presentation to Trust Board (Aug '19).	**4 X 4= 16**	Lack of STP demand and capacity modelling. **ACTIONS:** System agreement on governance and programme management System leadership capacity to lead STP-wide transformation Trust to nominate representatives on proposed STP/ACP workstreams		19/11/2019	**No changes to risk rating.**	**4x3=12 March 2020**
			Effects: i) Lack of system confidence ii) Lack of pace in terms of driving financial savings iii) Undermining ability for effective system communication with public iv) More regulatory intervention											

Risk Key														
Extreme Risk		15-25												
High Risk		8-12	**The Princess Alexandra Hospital Board Assurance Framework 2019-20**											
Medium Risk		4-6												
Low Risk		1-3												
Risk No		**PRINCIPAL RISKS**				**KEY CONTROLS**	**ASSURANCES ON CONTROLS**	**BOARD REPORTS**						
		Principal Risks		**RAG Rating (CXL)**	**Executive Lead and Committee**	**Key Controls**	**Sources of Assurance**	**Positive Assurances on the effectiveness of controls**	**Residual RAG Rating (CXL)**	**Gaps in Control**	**Gaps in Assurance**	**Review Date**	**Changes to the risk rating since the last review**	**Target RAG Rating (CXL)**
		What could prevent the objective from being achieved	What are the potential causes and effects of the risks		Which area within our organisation this risk primarily relate to	What controls or systems are in place to assist in securing the delivery of the objectives	Where we can gain evidence that our controls/systems, on which we are placing reliance, are effective	We have evidence that shows we are reasonably managing our risks and objectives are being delivered		Where are we failing to put controls/systems in place or where collectively are they not sufficiently effective.	Where are we failing to gain evidence that our controls/systems, on which we place reliance, are effective			
								Evidence should link to a report from a Committee or Board.						
	Strategic Objective 3: Our Places – we will maintain the safety of and improve the quality and look of our places and work with our partners to develop an OBC for a new build, aligned with the further development of our local Integrated Care Alliance.													
BAF 3.3		**Strategic Change and Organisational Structure** Capacity & capability of senior Trust leaders to work in partnership to develop an Integrated Care Trust.	**Causes:** i) Staff and stakeholders lack of awareness and/or understanding of drivers and issues cross the system ii) Scale, pace and complexity of change required. iii) Infrastructure (IT, buildings) not supportive of change iv) Financial resources lacking to support change v) Focus on immediate operational and financial priorities versus the longer term strategic planning vi) Lack of clarity regarding contracting and organisational models in support of ICP vii) Management resource and team with relevant capability and skills to drive change and strategy development to be developed. viii) Uncertainty around future CCG structure and relationships	**4 X 4= 16**	DoS Strategy Committee	i) Good relationships with key partner organisations ii) CEO chairing ICP Board iii) CEO and Chair attending STP meetings iv) Clinical Strategy being developed. v) Strategy Committee established vi) Development of MSK service and engagement of senior clinicians. vii) One Health and Care Partnership established viii) Financial principles for integrated working developed	i) ICP and STP meetings ii) Expert Oversight Groups and workstreams (finance,people, IT) iii) ICP senior leaders meetings	i) ICP Reports to Strategy Committee ii) CEO report to Board (bi-monthly) iii) Joint Executive meeting held with West Essex CCG 12.09.19 and 21.11.19	**4x3=12**	i) Data quality impacting on business intelligence (SLR) **ACTIONS:** Trust's vision and mission statement being refreshed and 5P plans underway Strategy team being developed PAH long term strategy being developed	Reporting from EOGs/workstreams to be established Development of governance structures for integration	19/11/2019	**Risk rating not changed.**	4 x 2= 8 **March 2020**
			Effects: i) Poor reputation ii) Increased stakeholder and regulator scrutiny iii) Low staff morale iv) Threatened stability and sustainability v) Restructuring fails to achieve goals and outcomes vi) Impact on service delivery and quality of care vii) Poor staff survey viii) Failure to fully implement the transformation agenda required e.g. increase in market share, following restructure ix) Undermines regulatory confidence to invest in hospital/system solutions											

Risk Key														
xtreme Risk		15-25												
High Risk		8-12	**The Princess Alexandra Hospital Board Assurance Framework 2019-20**											
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 – we will maintain the safety of and improve the quality and look of our places and work with our partners to develop an OBC for a new build, aligned with the further development of our local Integrated Care Alliance.													
BAF 3.4		**Sustainability of local services** Failure to ensure sustainable local services continue whilst the new hospital plans are in development and funding is being secured.	**Causes:** i) Limited NHS financial resources (Revenue and Capital) ii) Long periods of underinvestment in backlog maintenance iii) Lack of capital investment, iv) Current financial situation, v) Inherited aged estate in poor state of disrepair vi) Complexity of STP vii) Insufficient quantity and expertise in workforce capability	**4 X 4= 16**	Director of Strategy **Trust Board**	i) Potential new build/location of new hospital ii) STP Footprint and Estate Strategy developed. iii) Herts & West Essex STP Estates workstream iv) Pathology workstream led by CEO v) Estates and Facilities Infrastructure subgroup for West Essex vi) SOC affordability model vii) SOC approved and submitted to NHSI viii) Detailed analysis of current site option commissioned ix) Master planning work being aligned to Six Facet Survey and Health Planning, phasing of development on PAH site or off site. x) Alignment of strategic capital and tactical capital plans xi) MSK service developments underway xii) Capital funding of £9.5m received	i) PAF and Board meetings ii) SMT Meetings iii) Capital Planning Group iv) Weekly Estates and Facilities meetings	i) STP reports to Strategy Committee ~~and Board via CEO Report (August 2019)~~ ii) Reports to SMT iii) STP work plans iv) Our New Hospital reports to Strategy Committee (Oct 2019 ~~and September 2019) PAF~~ and updates to Board. v) PAHT 2030 report to Strategy Committee (Oct 2019) vi) PCBC approved at Trust Board (September 2019) vii) MAU business case approved at Trust Board September 2019	**4 x 4 = 16**	i) Balancing short term investment in the PAH site vs the required long term investment **ACTIONS:** Strategy being developed and underpinned by 5P plans Phase II work underway	i) Strategy in development	19/11/2019	**No change to residual risk rating.**	**4 x 3 =12** **March 2020**
			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 2019-20**											
Medium Risk		4-6												
Low Risk		1-3												
Risk No		**PRINCIPAL RISKS**				**KEY CONTROLS**	**ASSURANCES ON CONTROLS**	**BOARD REPORTS**						
		Principal Risks		**RAG Rating (CXL)**	**Executive Lead**	**Key Controls**	**Sources of Assurance**	**Positive Assurances on the effectiveness of controls**	**Residual RAG Rating (CXL)**	**Gaps in Control**	**Gaps in Assurance**	**Review Date**	**Changes to the risk rating since the last review**	**Target RAG Rating (CXL)**
		What could prevent the objective from being achieved	What are the potential causes and effects of the risks		Which area within our organisation this risk primarily relate to	What controls or systems are in place to assist in securing the delivery of the objectives	Where we can gain evidence that our controls/systems, on which we are placing reliance, are effective	We have evidence that shows we are reasonably managing our risks and objectives are being delivered		Where are we failing to put controls/systems in place or where collectively are they not sufficiently effective.	Where are we failing to gain evidence that our controls/systems, on which we place reliance, are effective			
								Evidence should link to a report from a Committee or Board.						
	Strategic Objective 4: Our Performance - we will meet and achieve our performance targets, covering national and local operational, quality and workforce indicators													
BAF 4.2		**4 hour Emergency Department Constitutional Standard** Failure to achieve ED standard	**Causes:** i) Access to community and OOH services. ii) Change in Health Demography with increase in long term conditions. iii) Gaps in medical and nursing workforce iv) Lack of public awareness of emergency and urgent care provision in the community. v) Attendances continue to rise annually (5.1% over the last 2 years). vi) Changes to working practice and modernisation of systems and processes vii) Delays in decision making, patient discharges and delays in social care and community impacting on flow viii) Increases in minor attendances	**4 X 5 = 20**	Chief Operating Officer Performance and Finance Committee	i) Performance recovery plans in place ii) Regular monitoring and weekly external reports iii) Daily oversight and escalation iv) Robust programme and system management v) ~~Daily call with NHSI/ CCG/NHSE, daily report on performance.~~ Escalation calls with NHSI vii) Work in progress to develop new models of care viii) Local Delivery Board in place ix) ~~Daily specialty response times monitored~~ x) System reviewing provision of urgent care xi) Exec attendance at safety huddles ~~daily.~~ xii) ED action plan reported to PAF/Board xiii) Co-location of ENP's, GP's, Out of hours GP'S to support minor injuries xv) Protection of assessment capacity work underway ~~xvi) Additional capacity in place~~ xvii) Weekly Urgent Care operational meetings and Urgent Care Board in place xix) On site support from ECIST and NHSI medical lead xx) Focus on length of stay in ED for all patients xxi) Focus on improving assessment capacity	i) Access Board meetings ii) Board, PAF and EMB meetings iii) Monthly Operational Assurance Meetings iv) Monthly Local Delivery Board meetings v) Weekly System review meetings ~~vi) Daily system executive teleconference~~ vii) Fortnightly escalation meetings with NHSI/NHSE viii) Weekly HCG reviews ix) System Operational Group	i) Daily ED reports to NHSI ii) Monthly escalation reports to NHSE iii) Monthly PRM reports from HCGS iv) Monthly IPR reported to PAF/QSC and Board reflecting ED performance. v) Presentation on ED performance and 'next steps' to PAF and Board (May/June 19)	**4 x 5 = 20**	i) Staffing (Trust wide) and site capacity ii) System Capacity iii) Leadership issues **Actions:** i) Local Delivery Board monitoring ED performance iii) Monthly Performance review meetings and weekly Urgent Care Board review	None noted.	20/09/2019		**4x3 =12 March 2020 (on delivery of standard - 95%)**
			Effects: i) Reputation impact and loss of goodwill. ii) Financial penalties. iii) Unsatisfactory patient experience. iv) Potential for poor patient outcomes v) Jeopardises future strategy. vi) Increased performance management vii) Increase in staff turnover and sickness absence levels												

The Princess Alexandra Hospital NHS Trust

Trust Board (Public) – 05.12.19

4.1

Agenda item:	4.1
Presented by:	Trevor Smith – Deputy CEO
Prepared by:	Trevor Smith – Deputy CEO
Date prepared:	29.11.19
Subject / title:	CEO Update

Purpose:	Approval		Decision		Information	x	Assurance	

Key issues:	This report updates the Board on key issues since the last public Board meeting: - Performance Highlights - STP/ICP - Ward Refurbishment - International Men's Day - Library Team Winners - Nursing Times Shortlist - Diabetes Medals Presented - Black History Month - Children and Young People's Patient Experience Survey 2018
Recommendation:	The Trust Board is asked to note the CEO report.

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

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

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The Princess Alexandra Hospital NHS
NHS Trust

Chief Executive's Report
Trust Board: Part I – 5 December 2019

This report provides an update on the key issues facing the Trust and events that have taken place since the last public Board meeting.

1. Key Performance Headlines

Some key summary performance headlines are 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	October	September
ED 4-hour performance	74.18%	74.98%
SHMI	111.8 (June)	111.44 (May)
CDiff (hospital onset)	1	1
MRSA	0	1
Never Events	0	0
Incidents reported	932	947
No harm / minor harm incidents	906	910
Falls / 1,000 bed days	7.5	6.6
6-week diagnostic standard	99.46%	99.64%
Stat Man training	91%	92%
Temporary staffing % of total pay bill	18.7%	18.4%

2. Urgent Care Performance and Flow

Performance against the 95% 4-hour access target remains significantly below where we would wish it to be. The number of patients attending continues to increase materially with over 7% increase November 18 to October 19 (110,332 attends) when compared to November 17 to October 18 (102,957 attends).

The new integrated GP and ENP service at the front of ED continues to function well, seeing circa 90 patients per day recently. This is aligned with the ongoing work that we are undertaking with the Emergency Care Intensive Support Team and our local partners to improve access and flow for our urgent care patients. The key areas of focus remain:

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

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

The month of November has seen very high patient numbers, regularly over 300-400 attends per day with increasing demand on our emergency department, wards and services throughout the hospital. Our people have responded tremendously to meet the needs of our patients and to ensure they have received compassionate and safe care.

STP/ICP

Paul Burstow, the Independent Chair of our STP visited the Trust on 28th and was provided with a tour of the site; Paul appreciated the time and welcome he received from all concerned.

As part of the STP ongoing OD programme a conference was held for NEDs and Lay Members to explore their contribution to our emerging system of ICPs and ICS. Following that session it has been agreed to establish a network of NEDs and Lay members, providing a voice and a route for further OD for NED and lay members of our Boards.

The appointment process for the STP CEO post has been deferred into January.

The Trust continues to work closely with partners within both STP and ICP across a number of clinical and non-clinical workstreams. A number of joint Executive Team meetings have taken place and a Board to Board meeting with WECCG will be held after our Board meeting today.

Ward Refurbishment
We know that many of our people are working in some of the older parts of the Princess Alexandra Hospital and whilst we know that in the not too distant future we will have a new hospital, I am pleased to let you know that our ward refurbishment programme is underway. Lister Ward has been repatriated after refurbishment and early informal feedback has been positive. Ray ward is currently undergoing the same level refurbishment and is due to be completed by mid-December. We hope that the refresh of the wards will make these areas feel better for both our patients and our people. Our estates team are working to ensure that the disruption is kept to a minimum as the areas are improved and the refurbishment programme progresses.

Children and Young People's Patient Experience Survey 2018
I am delighted to let you know that the hard work, professionalism and commitment to delivering the very best experience for patients has earnt our children and young people's team an improved rating by the Care Quality Commission (CQC) in their children and young people's survey. The results have exceeded previous ratings and included results that put PAHT ahead of the majority of trusts in six of the key questions.

The rating is a credit to the team and a reflection of their ongoing focus on improving the experience of children and young people.

Library Team Winners
The library management team for the Harlow Healthcare Library have won a coveted award in recognition of their contribution to modernising the library services available to staff on the hospital site. Liz Hunwick, library services manager and Sarah Lanney, library resources manager at Basildon Healthcare Library were selected as joint winners of the 2019 Information Manager of the Year Award for the Knowledge and Information Management Awards 2019.

The library team provide an excellent service to our clinical teams and through this an improvement in the care they are able to provide and should be congratulated on their success.

Nursing Times Shortlist
The recent annual Nursing Times Awards included PAHT being shortlisted in three categories, a great recognition of the very high standards of care being provided by our specialist teams and volunteers. The competition was tough and although we were not winners this time congratulations go to Caroline Ashton-Gough, dementia specialist nurse, the tissue viability team and Shahid Sardar, associate director of patient experience and the Butterfly Volunteers from the Anne Robson Trust.

Our local media have been keen to share the news of our people making the final of the Awards and this coverage has included an interview on BBC Essex radio with Caroline.

Diabetes Medals Presented
Two patients were presented with medals to mark more than 50 years of safely and successfully self-managing their diabetes at a special event at the Princess Alexandra Hospital. The event was hosted by our diabetes team and Dr Andy Morris, chief medical officer to mark World Diabetes Day on 14 November. Both patients received medals for 50 years of self-managing diabetes with the support of the team. This is a fantastic achievement for those receiving their medals and also a great example of supporting our patients to be more independent through self-care and reducing the likelihood of patients developing complications as a result of diabetes or needing to attend hospital in an emergency.

Funding for a New CT Scanner Announced
We were very pleased to learn that PAHT is to receive funding for a new replacement CT scanner for our hospital. This is great news for our patients as modern up-to-date scanners are more time efficient and able to scan and construct images more quickly and will mean that we have two modern scanners to use to care for our patients. We will have the new scanner in 2020-21.

Black History Month
To finish our celebration of Black History Month, the fabulous voices of a children's choir entertained our people, visitors and patients with a range of seasonal songs. The choir's performance was just one of many events that took place across the month. The members of the choir were all children of some of our international nurses with a great community spirit and sense of family.

International Men's Day
International Men's Day is commemorated worldwide to shine a spotlight on men who are making a positive and valued difference, and to raise awareness of issues that men face on a global scale. I am pleased that PAHT people were able to be part of this international celebration based on a theme of making a difference for men and boys. Two interactive sessions titled Head Strong took place and were open to all staff as an opportunity to encourage open and honest discussions and a chance find out more about the support available for individuals, or a friend or family member.

Other Matters
The staff survey has recently closed.

The Trust continues to progress on the flu vaccination programme with over 50% of staff having now received the vaccine.

The need to increase our IG training levels continues to be promoted through staff brief and key meetings with our people.

Author: **Trevor Smith, Deputy Chief Executive**
Date: **28 November 2019**

The Princess Alexandra Hospital NHS Trust

Trust Board – 05.12.19

5.2

Agenda item:	5.2
Presented by:	Dr Andy Morris/Jim McLeish
Prepared by:	Quality First Triumvirate
Date prepared:	13th November 2019 (reporting on October 2019 performance/progress)
Subject / title:	Mortality Improvement (Improving Patient Outcomes)

Purpose:	Approval		Decision		Information	✓	Assurance	✓

Key issues:	The Trust is a national outlier as it has a significantly high Hospital Standardised Mortality Ratio (HSMR).
Recommendation:	For the Board to review progress and performance of the Mortality Improvement (Improving Patient Outcomes) work and associated measures for assurance and information purposes.

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

Previously considered by:	QSC.22.11.19
Risk / links with the BAF:	Quality Improvement has the potential to support the mitigation of a number of risks in the organisation, but to highlight two specifically: 3.4 Strategic Change and Organisational Structure 1.1 Inconsistent Outcomes
Legislation, regulatory, equality, diversity and dignity implications:	
Appendices:	1. Mortality Improvement Performance and Progress Tracker

1.0 Purpose/issue

The Trust is a national outlier as it has a significantly high Hospital Standardised Mortality Ratio (HSMR). Quality and Safety Committee are asked to review progress and performance of the Mortality Improvement (Improving Patient Outcomes) work and associated measures for assurance and information purposes.

2.0 Progress updates (exception reporting only)

Care Bundles

1. **Fractured Neck of Femur:** of the 4 measures within this project, two have met the trajectory in the most recent reported month, including '% #NOF patients admitted to Tye Green (NOF ward)' and '% of #NOF patients in theatres within 36 hours of arrival at A&E'.

- The 12 month rolling mortality rate has continued to decrease (improve) from February 2019. May and June 2019 hit trajectory and the mortality rate did not deteriorate in July.

  The actions being taken to address performance:
  - A workshop was held on October 22nd with ED where a root cause analysis was completed to inform actions and quality improvement tests of change.
  - Going forward regular meetings are being held between ED and Tye Green staff to agree the quality improvement focus.
  - An ED coordinator will play an enhanced role in navigating fractured neck of femur (#NOF) patients through the ED efficiently.
  - Priority list for trauma has been developed.
  - Golden patient concept (first patient on list) to be enhanced and enforced.

2. **Acute Abdomen:** The 12 month rolling mortality rate for Intestinal obstruction has increased in the last two months reported, however we are still meeting trajectory.
   - A workshop is being held on 13th November between the surgical team and the quality first team to review and discuss the next steps in this project.

3. **COPD:** The 12 month rolling mortality rate is still not meeting trajectory, and has increased on the previous month.
4. **Pneumonia:** Of the 4 measures within this project, the most recent data shows none have met the trajectory**.** The 12 month rolling rate for both Pneumonia and Aspiration pneumonia are not meeting trajectory.

- **The actions being taken to address performance of COPD and Pneumonia:**
  - A successful workshop was held on Friday 25th October. Led by speciality lead consultants, Quality First Team and wider pathway stakeholders. An extensive root cause analysis allowed better understanding of the underlying problems.
  - Going forward regular meetings are being held to develop driver diagrams, project plans and discuss the quality improvement focus.
  - There is an understanding the work that is commencing with the Reporting and Recording Programme will aim to address weaknesses in coding and recording of the 'first episode of care'.

- There is recognition that work is required that wider system partners need to be involved in the development and delivery of tests of change to improve mortality rates for COPD and Pneumonia.

5. **Sepsis:** Although it is widely recognised that there has been significant and sustained improve for Sepsis mortality rates the 3 most recent months show a slight increase in the crude mortality. Although an increase there is no statistical variance in HSMR.
   - Sepsis is in the process of being handed over to business as usual meaning that the healthcare group and specialty teams will be leading governance and reporting plus any associated quality improvement activities (with the support of the Quality First Team where required). There is work underway to have a wider focus on the 'deteriorating patient', which will further enhance any work related to improving sepsis mortality rates.

Excellence Every Time Group 1

- **Vital Signs:** the most recent month for this measure shows a slight improvement in performance.
  - Actions to improve compliance are held locally within Healthcare Groups.
  - Handover to business as usual has been commenced.
- **Fluid Balance Charts:** the measure of this projects shows an increase in compliance in the most recent month and has exceeded trajectory.
- **AKI:** Out of the 3 measures within this project, none have not met trajectory for the most recently reported month.
- The 12 month rolling mortality rate for Renal disease comorbidity is showing minor improvements however it is not meeting trajectory.
  - There are plans to hold a World Kidney event, increase medical education, hold a champions programme and find Dr. Parsons' project with an aim to improve outcomes.
  - The trust is currently in the testing phase to implement fluid prescribing on JAC.
- **Diabetic Emergencies:** the measure for this project has increased in the most recent month, however we need further data before this is statistically significant. A new 'hypo box' was implemented in August and our next steps will be to monitor the impact as well as develop new tests of change.

Excellence Every Time Group 2

- **Antibiotics Stewardship:** For the most recent month, we have seen a decrease in LoS for patients on antibiotics. There were 37 additional downloads of the app in October and 1370 page hits. We hope to see support to increase compliance against antibiotic policy and improve stewardship practice.

Reporting and Recording

- **Medical Examiners:** This measure has dramatically increased in October with 97.3 % of all cases being reviewed and is above trajectory. The process and focus for the project is being reviewed by the Deputy Chief Medical Officer and Lead Medical

Examiner who has recently started at PAH. This part of the project can be handed over to 'business as usual' and the outstanding action is to implement a process to ensure a minimum of 25% of deaths receive a structured judgement review (SJR).

- **Documentation:** Compliance with documentation standards (Perfect ward) against trajectory has been met. The 'first episode of care' will be an initial focus going forwards as there is understanding that if we get diagnosis recorded well as the beginning of care in hospital will inform better clinical decision making and care planning.
    - The team are focusing on working to revise the 'Specialty Assessment Tool' used for the initial diagnosis and recording of care.

Hospital at Night

- There has been an increase in number of escalations to critical care (excluding ED), this could have links with the seasonal variation; however we have seen a decrease in number of calls to the 2222 number out of hours.
- 15th July hospital at night was successfully implemented and sustained through the introduction of junior doctors.
- The team are now focussing on Electronic Handover, removing the need for paper handover sheets.

Authors: Dr. Andy Morris, Jim McLeish, Robbie Ayers, Lindsay Hanmore & Miss Helen Pardoe

Date: 13th November 2019

The Princess Alexandra Hospital NHS Trust

5.2

APPENDIX 1: Mortality Improvement Performance and Progress Tracker

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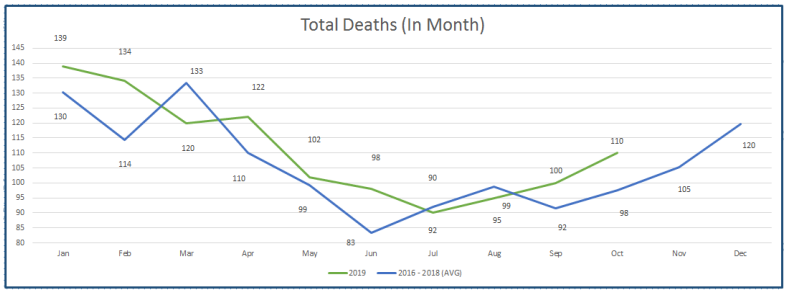
Mortality improvement progress and performance tracker (our goal)

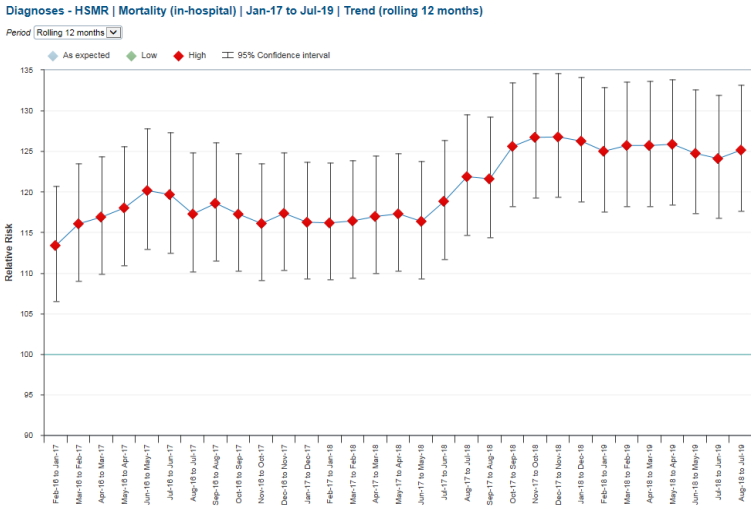
Our goal

Achieve 'as expected' across all specialities, with no more than two outlier alerts over a 12 month rolling period by March 2021 and to be sustained.

Our progress & performance



Dec 18 | Aug 19
Jan 19 | Sep 19
Feb 19 | Oct 19
Mar 19 | Nov 19
Apr 19 | Dec 19
May 19 | Jan 20
Jun 19 | Feb 20
Jul 19 | Mar 20



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5.2

Programme	Project	Aim		Success measures: Measure	Trajectory Vs Actual	Performance and progress tracker: Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Trend
Care Bundles	Fractured Neck of Femur	Reduce mortality to expected level i.e. from 8.5% to 6% by March 2020 (based on Dr Foster Data from reporting period Nov17-Oct18)	1	#NOF mortality rate (% of patients who died - 12 months rolling) - via Dr Foster	Trajectory	8.3%	8.2%	8.0%	7.9%	7.8%	7.6%	7.5%	7.4%	7.2%	7.1%	7.0%	6.8%	6.7%	
					Actual	8.3%	8.7%	7.9%	8.2%	9.4%	8.8%	8.1%	7.4%	7.2%	7.2%				
				#NOF HSMR (relative risk 12 month rolling) via Dr Foster		148.4	157.0	149.3	155.7	179.6	165.4	162.1	154.0	148.7	143.5				
				#NOF mortality rate (% of patients who died - 12 months rolling) - via Paul Esq		9.0%	9.0%	8.5%	8.1%	8.7%	8.6%	8.2%	7.8%	8.0%	7.9%	7.8%	7.7%	8.3%	
			2	% #NOF patients admitted to Tye Green (NOF ward)	Trajectory	90%	90%	90%	90.0%	90.0%	90.0%	90.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	
					Actual	79.0%	97.0%	85.0%	100.0%	89.0%	89.5%	83.3%	88.5%	91.4%	93.5%	88.9%	100.0%	100.0%	
			3	% of #NOF patients in theatres within 36 hours of arrival at A&E	Trajectory	77%	79%	74%	78.6%	79.6%	80.7%	81.7%	82.7%	83.8%	84.8%	85.9%	86.9%	87.9%	
					Actual	77.0%	79.0%	74.0%	78.6%	70.0%	82.9%	73.0%	67.6%	72.7%	83.3%	75.8%	82.0%	92.3%	
			5	% #NOF patients admitted into Tye Green within 4 hours of ED attendance	Trajectory	73%	42%	31%	46.4%	49.5%	53.3%	56.8%	60.3%	63.8%	67.2%	70.7%	74.2%	77.6%	
					Actual	73.0%	42.0%	31.0%	46.4%	12.5%	40.0%	27.0%	38.2%	72.7%	53.3%	54.5%	42.0%	34.6%	
	Acute Abdomen	Reduce mortality to expected level i.e. from 8.7% to 7.1% by March 2020 (intestinal obstruction, based on Dr Foster Data from reporting period Nov17-Oct18)	6	Intestinal obstruction mortality rate (% of patients who died - 12 months rolling) - via Dr Foster	Trajectory	8.60%	8.51%	8.42%	8.34%	8.25%	8.16%	8.07%	7.98%	7.89%	7.81%	7.72%	7.63%	7.54%	
					Actual	8.60%	8.3%	6.3%	6.8%	6.8%	7.1%	6.3%	5.3%	6.2%	6.6%				
				Intestinal Obstruction HSMR (relative risk 12 month rolling) via Dr Foster		123.8	119.4	91.2	97.3	93.9	101.0	98.2	90.8	95.4	96.4				
			7	Case ascertainment in NELA	Trajectory		66.0%			72.8%			79.6%			86.4%		93.2%	
					Actual		66.0%			99.0%			100.0%						
			8	Arrival in theatre within a timescale appropriate for urgency	Trajectory		82.0%			83.5%			85.0%			86.6%		88.2%	
					Actual		82.0%			96.0%			65.0%						
			9	% of Em Lap patients admitted to HDU/ITU (with NELA risk score >5) post operatively	Trajectory		77.0%			78.6%			80.2%			81.8%		83.4%	
					Actual		77.0%			64.0%			80.0%						
			10	Consultant anaesthetist and surgeon present in theatre if NELA risk score >5%	Trajectory		83.0%			86.4%			89.8%			93.2%		96.6%	
					Actual		83.0%			93.0%			89.0%						
	COPD	Reduce mortality to expected level i.e. from 6.6% to 4.1% by March 2020 (based on Dr Foster Data from reporting period Nov17-Oct18)	11	COPD mortality rate (% of patients who died - 12 months rolling) - via Dr Foster	Trajectory	6.4%	6.3%	6.1%	6.0%	5.8%	5.7%	5.6%	5.4%	5.3%	5.1%	5.0%	4.8%	4.7%	
					Actual	6.4%	7.2%	6.8%	6.6%	6.4%	5.9%	6.0%	6.0%	5.9%	6.2%				
				COPD HSMR (relative risk 12 month rolling) via Dr Foster		162.2	175.5	170.2	163.1	158.8	149.6	147.5	142.6	140.1	143.8				
			12	Administer nebuliser and steroids within 4 hours of attendance	Trajectory														
					Actual					6.3%	15.2%	13.8%	38.5%	27.3%	28.6%	30.0%	13.3%		
	Pneumonia	Reduce mortality to expected level i.e. from 19.6% to 15.3% by March 2020 (based on Dr Foster Data from reporting period Nov17-Oct18)	13	Pneumonia mortality rate (% of patients who died)	Trajectory	16.1%	16.0%	15.8%	15.7%	15.5%	15.4%	15.2%	15.1%	14.9%	14.8%	14.6%	14.5%	14.3%	
					Actual	16.1%	16.3%	16.2%	15.7%	16.1%	16.0%	16.8%	16.5%	16.4%	16.2%				
				Pneumonia HSMR (relative risk 12 month rolling) via Dr Foster		119.8	121.1	123.5	120.5	123.6	124.0	130.0	127.6	125.9	124.6				
			14	Aspiration pneumonia mortality rate (%of patients who died - 12 months rolling) - via Dr Foster	Trajectory	47.0%	46%	45%	44.0%	43.0%	42.0%	41.0%	40.0%	39.0%	38.0%	37.0%	36.0%	35.0%	
					Actual	47.0%	43.7%	42.9%	42.8%	44.3%	45.2%	43.4%	45.1%	45.3%	46.3%				
				Aspiration Pneumonia HSMR (relative risk 12 month rolling) via Dr Foster		155.7	152.0	149.4	144.4	147.5	154.0	148.2	149.0	147.6	148.7				
			15	Oxygen prescribed within 1 hour of attendance	Trajectory					10.00%	20.00%	30.00%	40.00%	50.00%	60.00%	70.00%			
					Actual					0.0%	4.80%	0.0%	9.1%	0.00%	0.00%	0.00%	0.00%	0.00%	
			16	Chest x-ray within 4 hours of attendance	Trajectory	84.6%	82.6%	83.3%	80.0%	42.9%	61.1%	67.9%	74.7%	81.5%	88.3%	95.0%	95.0%	95.0%	
					Actual	84.6%	82.6%	83.3%	80.0%	42.9%	64.0%	82.4%			81.8%	80.7%			
	Sepsis	5% reduction in Sepsis mortality by March 2020	17	Sepsis mortality rate (% of patients who died - 12 months rolling) - via Dr Foster	Trajectory	20.5%	20.2%	19.9%	19.6%	19.3%	19.0%	18.7%	18.4%	18.2%	17.9%	17.6%	17.3%	17.0%	
					Actual	20.5%	20.0%	19.3%	17.6%	16.1%	15.9%	15.6%	16.0%	16.9%	17.0%				
				Sepsis HSMR (relative risk 12 month rolling) via Dr Foster		131.7	192.0	129.1	120.4	113.4	111.9	107.3	105.1	107.9	107.6				

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5.2

Programme	Project		Aim		Success measures		Performance and progress tracker												Trend
					Measure	Trajectory Vs Actual	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	
Excellence Every Time group 1	Vital Signs	Timely recording of vital signs observation and adequate & effective equipment for undertaking and recording vital signs	To improve compliance with timely vital signs observation leading to early detection and escalation of deteriorating patient	20	% of Observations on patients with a NEWS ≥5 within 30 minutes of due time	Trajectory				70.0%	75.0%	80.0%	85.0%	90.0%	95.0%	95.0%	95.0%	95.0%	95.0%	
						Actual				63.2%	69.0%	72.2%	75.3%	76.4%	81.5%	81.6%	86.0%	83.6%	84.6%	
	Fluids & Electrolytes	Accurate input/ output Fluid Balance chart	To improve compliance with fluids & electrolytes management with early detection and treatment leading to reduction in harm caused by fluid and electrolytes imbalance	21	% of completed fluid balance charts	Trajectory				0.0%					40.0%	45.5%	51.1%	56.6%	62.2%	
						Actual				0.0%			28.0%	51.8%	47.2%	61.4%	60.0%	47.5%	66.1%	
		Management of Acute Kidney Injuries (AKI)		22	Renal disease comorbidity mortality rate (% of patients who died - 12 months rolling) - via Dr Foster	Trajectory	10.5%	10.4%	10.2%	10.0%	9.9%	9.8%	9.7%	9.6%	9.5%	9.3%	9.2%	9.1%	9.0%	
						Actual	10.5%	10.4%	10.2%	9.8%	10.2%	10.2%	10.0%	9.5%	9.4%	9.6%				
					Renal Disease HSMR (relative risk 12 month rolling) via Dr Foster		127.7	128.6	128.8	128.2	134.1	136.6	135.1	132.2	128.6	130.2				
				23	Number of patients with Multiple AKI alerts	Trajectory				98	105	101	100	98	95	95	90	90	85	
						Actual				98	105	101	100	98	110	121	117	111	133	
				24	Percentage of patients with alerts that have remained the same or improved during their admission	Trajectory	86%	85.0%	89.0%	87.0%	91.0%	88.5%	89.8%	91.1%	92.4%	93.7%	95.0%	95.0%	95.0%	
						Actual	86.0%	85.0%	89.0%	87.0%	91.0%	88.5%	88.0%	89.8%	87.3%	87.5%	98.0%	84.0%	74.4%	
		Diabetic Emergencies		26	Number of hypos	Trajectory	878	852	711	765	751	738	724	710	697	683	669	656	642	
						Actual	howe	852	711	765	544	501	607	460	533	740	690	515	695	
	Antibiotics Stewardship		Correct antibotic use for patient need (right drug, right patient, right time, right route)	31	LoS for patients who have antibiotics during their admission (non elective and elective)	Trajectory	8.13	8.44	8.52	8.90	8.38	7.97	8.39	8.31	8.22	8.12	8.03	7.94	7.85	
						Actual	8.13	8.44	8.52	8.90	8.38	8.43	8.03	8.40	8.08	8.42	8.52	7.26	6.51	
Reporting and recording	Medical Examiners		100% adult deaths (>16yrs) reviewed by ME and evidence of shared learning against reviews	35	% of completed Mortality Reviews by an ME	Trajectory							25.0%	25.0%	30.0%	40.0%	50.0%	60.0%	70.0%	
						Actual							17.8%	19.0%	24.0%	28.4%	23.0%	56.7%	97.3%	
					Number of completed reviews	Actual							22	18	28	25	21	55	107	
	Documentation (meeting standards, recording care accurately and communicating mangement plans)		Every entry in the patient notes are compliant with GMC and NMC standards	36	Compliance with documentation standards in Perfect Ward Audit tool	Trajectory						95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	
						Actual						95.0%	98.0%	95.0%	97.0%	91.9%	92.1%	92.3%	95.6%	
				38	Depth of coding (Dr Foster)	Trajectory														
						Actual				3.10	3.20	3.10	3.40	3.20	3.30	3.40				
Hospital at Night	Doctor Handover		Implementation of structured handover of patients for all specialities out of hours	39	Number of unexpected escalations to critical care (excluding ED)	Trajectory	3	13	4	5	11	8	7	6	6	6	6	6	6	
						Actual	3	13	4	5	11	8	3	6	8	4	6	7	12	
				40	Percentage of unexpected return to theatres (excluding ED)	Trajectory	0.93%	0.93%	0.93%	0.93%	0.93%	0.93%	0.93%	0.93%	0.90%	0.90%	0.90%	0.90%	0.90%	
						Actual	0.53%	0.55%	1.15%	1.45%	0.95%	0.96%	0.99%	0.58%	0.94%	0.64%	0.40%	1.00%	0.76%	
	Electronic Handover		Implementation of electronic handover	42	% of tasks allocated and succesfully closed by the following day	Trajectory										30%	39%	48%	56%	
						Actual										98.07	97.02	96.5	95.8	
				43	Implementation of an electronic nighttime handover	Trajectory										100%	100%	100%	100%	
						Actual										100%	100%	100.0%	100.0%	
	Hospital at night (task allocation)		Implementation of Hospital at Night software	44	Maximum number of calls to the 2222 number out of hours	Trajectory														
						Actual						53		63	54	65	72	44	36	

The Princess Alexandra Hospital NHS Trust

Trust Board – 05.12.19

5.3

Agenda item:	5.3
Presented by:	Sharon McNally – Director of Nursing & Midwifery
Prepared by:	Andy Dixon - Matron for Quality Improvement Sarah Webb – Deputy Director of Nursing and Midwifery
Date prepared:	November 2019
Subject / title:	Report on Nursing and Midwifery and Care Staff Levels (Hard Truths) and an Update to Nursing and Midwifery Workforce Position

Purpose:	Approval		Decision		Information	x	Assurance	x

Key issues:	This paper sets out the regular nursing and midwifery retrospective staffing report for the month of October 2019 (part A), and provides an update to the workforce position (part B). Headlines: • Fill rate has increased for overall RN/RM in month to 97.4% which is an increase of 7.6%. • The overall nursing vacancy position reduced in October to 17.9% and the Band 5 rate to 25.4%. This is slightly behind the Band 5 planned forecast vacancy rate for M7 which was 20.3%. The RAG rating remains green as the number of confirmed starters for November and December. The Trust saw the highest number of domestic new starters in September with 7 nurses 6 of whom had completed their top up from Assistant Practitioner to Registered Nurse in month. • Data quality review: The Maternity Service wards have been reported as a single unit rather than individual wards this month. • For the first time since reporting began there were no wards this month who had an overall registered nurse fill rate of less than 75%
Recommendation:	The committee is asked to note the information within this report

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

Previously considered by:	QSC.22.11.19 WFC.25.11.19
Risk / links with the BAF:	BAF: 2.1 Workforce capacity All Health Groups have both recruitment and retention on their risk registers
Legislation, regulatory, equality, diversity and dignity implications:	NHS England and CQC letter to NHSFT CEOs (31.3.14): Hard Truths Commitment regarding publishing of staffing data. NHS Improvement letter: 22.4.16 NHS Improvement letter re CHPPD: 29/6/18
Appendices:	Appendix 1: Ward level fill rates Appendix 2: Registered fill rates by month. RAG rated Appendix 3: Ward staffing exception reports

The Princess Alexandra Hospital NHS Trust

5.3

1.0 PURPOSE

To update and inform the Committee on actions taken to provide safe, sustainable and productive staffing levels for nursing, midwifery and care staff in October 2019. To provide an update to the nursing vacancy rate, that the plans to further reduce the vacancy rate over 2019/20.

2.0 BACKGROUND

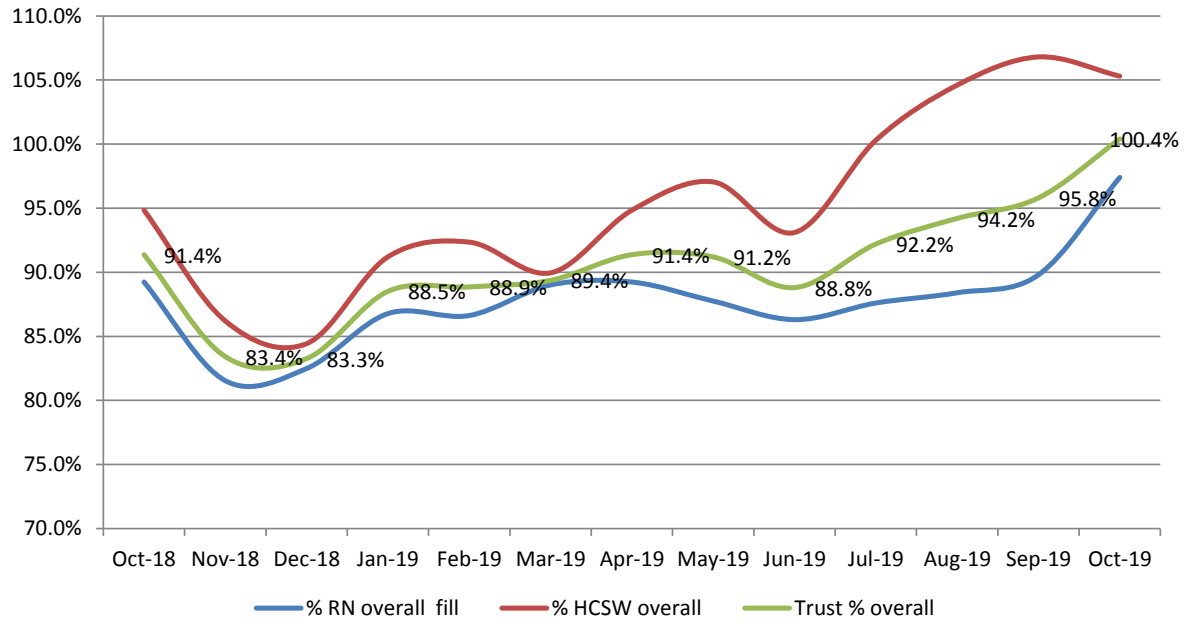
The report is collated in line with The National Quality Board recommendations (June, 2016).

3.0 ANALYSIS

3.1 This report provides an analysis based on the actual coverage in hours against the agreed static demand templates for the calendar month of October 2019.

3.2 The summary position for the Trust Safer Staffing Fill rates for October 2019 is included in the table below with a comparison with September 2019. Fill rate has increased for overall RN/RM in month to 96.6% which is an increase of 6.8%

Trust average	Days RM/RN	Days Care staff	Nights RM/RN	Nights care staff	Overall RM/RN	Overall care staff	Overall ALL staff
Trust average October (excluding WMS and Sup)	99.2%	104%	95%	107.1%	97.4%	105.3%	100.4%
Trust average September (excluding WMS and Sup)	93.1%	101.3%	85.3%	115.3%	89.8%	106.8%	95.8%
Change against September	↑6.1%	↑2.7%	↑9.7%	↓8.2	↑7.6%	↓1.5%	↑4.6%



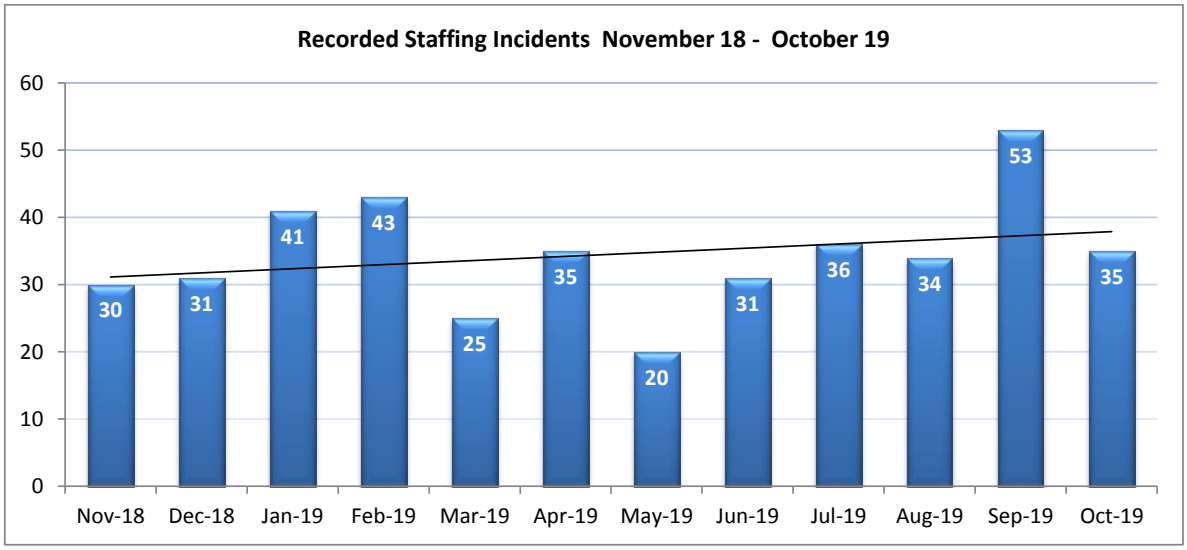
3.4 Exception reporting: Appendix 4 shows the exception report for the wards where the fill rate is less than 75%The report includes analysis of the position, impact on quality, safety or experience and details actions in place to mitigate and improve the position where safe staffing is of concern**.** Following benchmarking with other acute Trusts in the STP the threshold for the RAG rating has been adjusted this month with the following thresholds applied.

Red <75%	Amber 75 – 95%	Green >95%

3.4.1 National reporting is for inpatient areas, and therefore does not include areas including the emergency department or day units. To ensure the Board is sighted to the staffing in these areas, the data for these areas is included below using the same methodology as the full UNIFY report. It is noted that the fill rate is significantly reduced for theatres; this was due to decreased activity during planned estates works and reduction in some lists due to medical annual leave.

	Day		Night	
October 2019	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)
A&E Nursing	99.9%	96.7%	94.5%	92.3%
PAH Theatres	87.7%	61.3%	77.6%	16.1%
Endoscopy Nursing	73.8%	85.1%	-	-

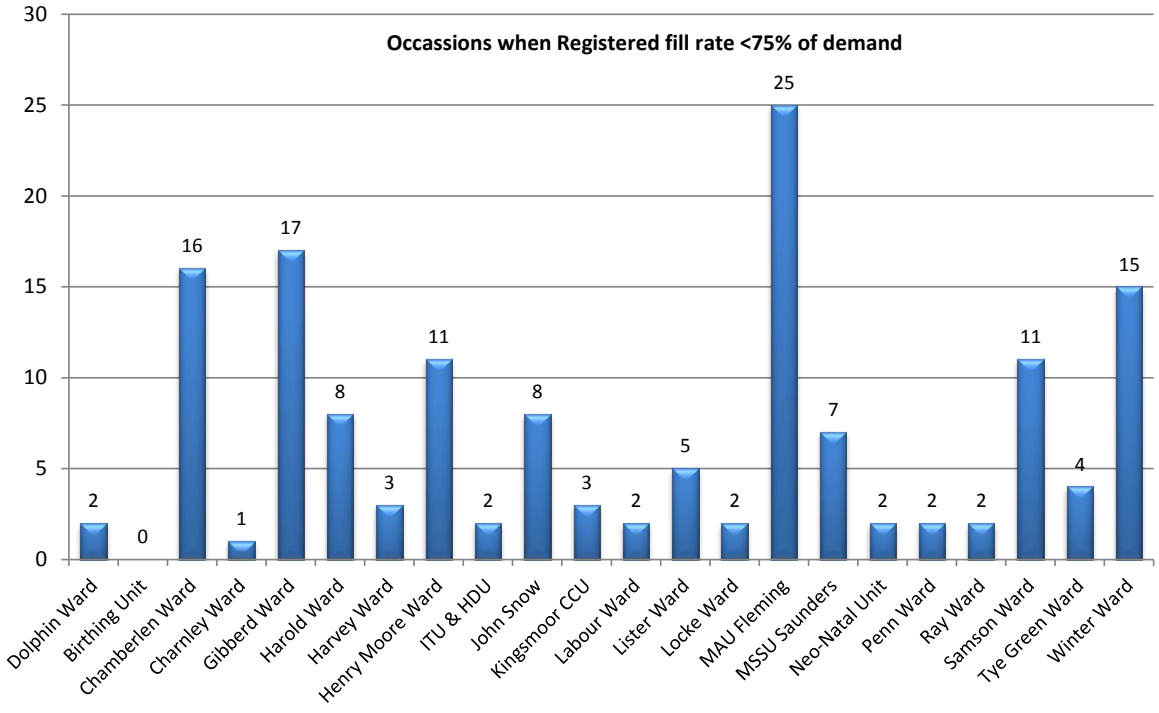
3.5 Datix reports: The trend in reports completed in relation to nursing and midwifery staffing is included below and shows a substantive increase in September, against a previous downward trend over the 12 months reporting period. All incidents continue to be reviewed by the safety and quality review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



3.6 There were no beds closed as a direct result of safer staffing concerns during October 2019,

3.7 Red flag data: The Trust has commenced collating and validating red flag events. A red flag event occurs when registered nurse fill rate drops below 75% of the planned demand.

The graph below demonstrates the number of occasions/shifts where the reported fill rate has fallen below 75% by ward. The change of report is enabling Associate Directors of Nursing to undertake a deeper dive of underlying data and identified that some staff moves and alternative measures to support staffing such as redeploying community or non-clinical staff are not being captured. This is particularly relevant to maternity services who redeploy staff across all the maternity areas to ensure patient safety.



3.8 Care Hours per Patient Day* (CHPPD) has been confirmed as the national principle measure of nursing, midwifery and healthcare support worked deployment on inpatient wards (NHSI, 2018). The table below shows data calculated using the Model Hospital methodology. Current model hospital data for national median is based on latest available data.

	October 2019 data	National Median (July 2019)	Variance against national median
CHPPD Total	7.7	8.2	↓0.5
CHPPD RN	4.75	4.8	↓0.05
CHPPD HCA	2.95	3.3	↓0.35

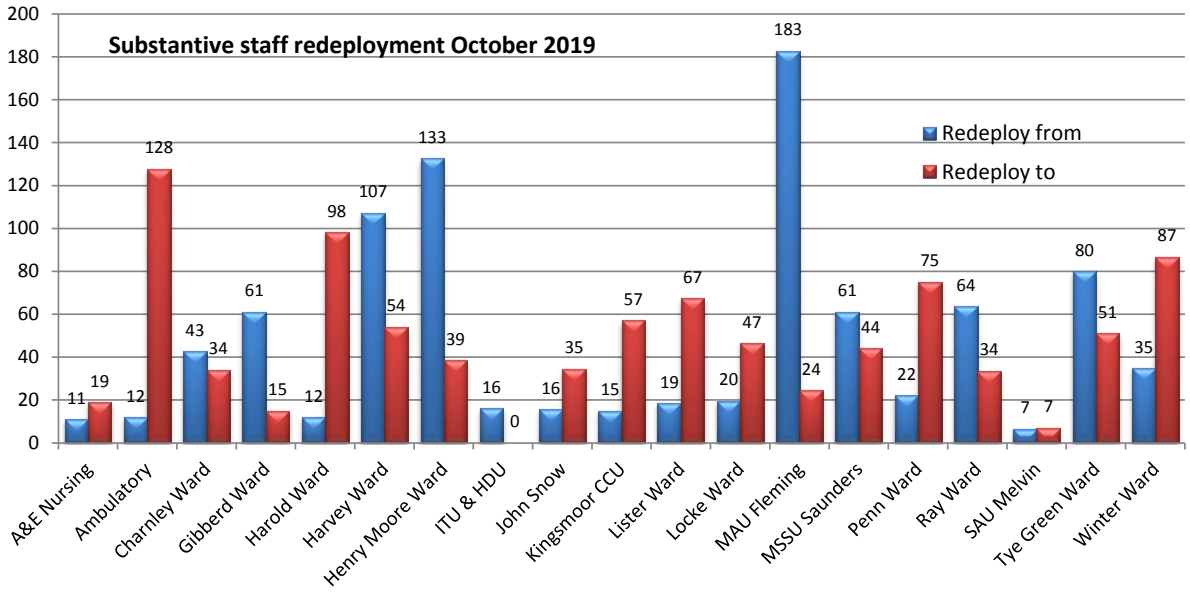
3.9 Mitigation:

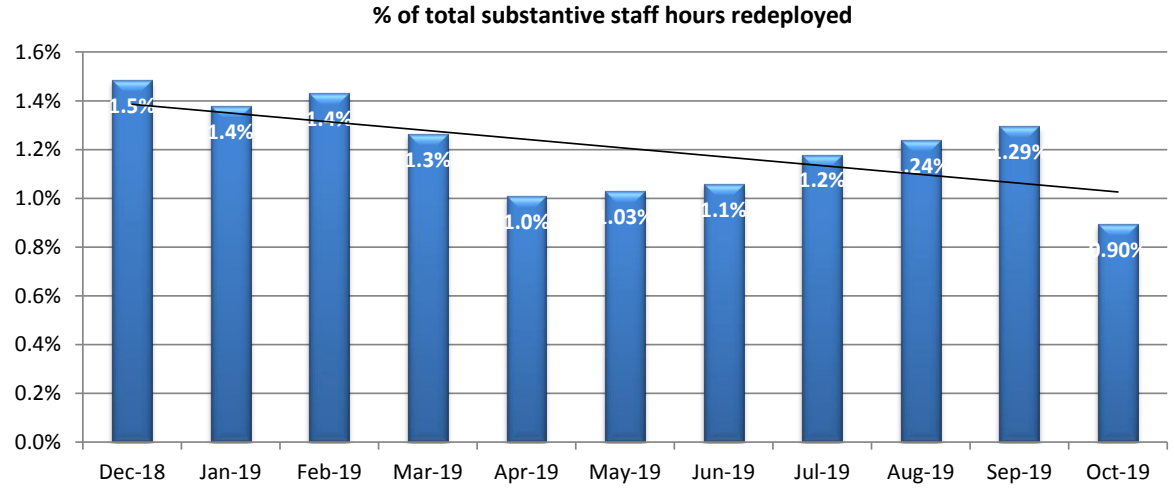
The day to day management of safer staffing across the organisation is managed through the daily staffing huddles and information from SafeCare to ensure support is directed on a shift: shift basis as required in line with actual patient acuity and activity demands. Ward managers support safe staffing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

3.10 Redeployment of staff:

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

The first graph shows the number of hours of staff redeployed from and to the adult inpatient ward to support safe staffing while the second graph shows the percentage of the total number of staff hours that are redeployed which shows a reduction against the previous 3 months.





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

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

3.11 Bank and Agency fill rates:

The use of NHSP continues to support the clinical areas to maximise safer staffing. The Trust has worked with NHSP to increase the availability of resource, and are working in partnership to improve this further. The table below shows that there was a reduction in registered demand (↓192 shifts) in October. There was an increase in NHSP and agency fill for RN, resulting in an overall increase in fill rate for RNs (3.1%) in month.

The HCSW demand shows a decrease (↓80 shifts) with the overall fill rate down by 0.9% against September.

RN/M temporary staffing demand and fill rates:

Last YTD Month & Year	Shifts Requested	NHSP Filled Shifts	% NHSP Shift	Agency Filled Shifts	% Agency Filled Shifts	Overall Fill Rate	Unfilled Shifts	% Unfilled Shifts
July 2019	3,560	1,698	47.7%	1158	32.5%	80.2%	704	19.8%
August 2019	3,865	1,652	42.7%	1071	27.7%	70.4%	1141	29.6%
September 19	4,348	1,770	40.7%	1031	23.7%	64.4%	1547	35.6%
October 2019	4,156	1,777	42.8%	1029	24.8%	67.5%	1350	32.5%
October 2018	3,805	1,605	42.2%	1004	26.4%	68.6%	1196	31.4%

HCA temporary staffing demand and fill rates:

Last YTD Month & Year	Shifts Requested	NHSP Filled Shifts	% NHSP Shift	Agency Filled Shifts	% Agency Filled Shifts	Overall Fill Rate	Unfilled Shifts	% Unfilled Shifts
July 2019	2,534	1988	78.5%	0	0%	78.5%	546	21.5%
August 2019	2,590	1964	75.8%	0	0%	75.8%	626	24.2%
September 19	2,613	1956	74.9%	0	0%	74.9%	657	25.1%
October 2019	2,533	1,874	74.0%	0	0%	74.0%	659	26.0%
October 2018	2,034	1,483	72.9%	0	0%	72.9%	551	27.1%

B: Workforce:

Nursing Recruitment Pipeline

The nurse vacancy rate has been reducing since April with significant falls in the last few months. The overall nursing vacancy rate in October fell to 17.9 % from 25.3% in April. Although this is slightly behind the forecast rate of 16.2% the Trust remains on track to achieve the overall target of <10% by March 2020.

Band 5 posts continue to make up the bulk of the vacancy rate and in October the vacancy rate fell further to 25.49% slightly behind the forecast rate of 26.2%. The trajectory remains green as the number of starters planned for November and December will keep us on track to meet forecast outturn position. The recruitment pipeline has over 180 nurses who are holding offers of employment and there is confidence that sufficient number of offer holders will convert into starters by the end of March to achieve the trajectory.

The Recruitment and Retention Nurse has been focussing on the targeting skype interviews with candidates for areas where we have specialist skills including ED and NICU. The retention strategy is being refreshed however significant progress has been made in year with the overall nursing and midwifery.

The following table shows confirmed recruitment figures (in green) against the planned trajectory. turnover rate falling from 15.81% to 11.31% over the last 12 months.

Establishment V Staff in Post												
Funded Establishment WTE	942.61	942.61	942.61	942.61	942.61	942.61	942.61	942.61	942.61	942.61	942.61	942.61
Staff in Post WTE	704	710.00	711.00	716.00	737.00	759.00	774.00	797.00	829.00	849.00	862.00	863.00
Vacancy WTE	238.61	232.61	231.61	226.61	205.61	183.61	168.61	145.61	113.61	93.61	80.61	79.61
Actual RN Vacancy Rate	25.3%	24.7%	24.6%	24.0%	21.8%	19.5%	17.9%	15.4%	12.1%	9.9%	8.6%	8.4%
Forcast Vacancy Rate in Business Plan	26.8%	26.9%	25.4%	24.0%	22.7%	19.3%	16.2%	13.1%	10.8%	9.7%	9.4%	9.3%

Band 5 Establisment V Staff in Post												
	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
Funded Band 5 Establisment WTE	487.93	487.93	487.93	487.93	487.93	487.93	487.93	487.93	487.93	487.93	487.93	487.93
Actual Band 5 Vacancy Rate	40.8%	39.7%	39.3%	38.1%	34.0%	28.9%	25.4%	20.9%	14.3%	10.2%	7.6%	7.4%
Forcast Vacancy Rate in Business Plan	40.8%	41.0%	38.1%	35.4%	32.8%	26.2%	20.3%	14.3%	9.8%	7.8%	7.2%	7%

Projected Starters Pipeline												
	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
RNs (not Band 5)	1	1	2	2	4	1	2	2	1	1	1	1
Band 5 Newly Qualified + Local	3	2	0	1	1	3	7	3	10	0	0	0
Band 5 International Recruitment	6	5	7	7	21	26	13	25	28	26	19	7
Band 5 Starters	**9**	**7**	**7**	**8**	**22**	**29**	**20**	**28**	**38**	**26**	**19**	**7**
Total Starters	10	8	9	10	26	30	22	30	39	27	20	8
Planned Overseas Nurse starters as per B/C	6	5	20	19	19	32	35	35	18	16	9	7
Planned Band 5 Starters (domestic and overseas)	**6**	**5**	**20**	**19**	**19**	**38**	**35**	**35**	**28**	**16**	**9**	**7**
Revised Overseas Nurse starters Plan rephased @ M5	**6**	**5**	**7**	**7**	**21**	**25**	**35**	**35**	**28**	**26**	**19**	**7**

Projected Leavers WTE												
	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
RNs (not Band 5) Leavers	2	3	3	3	3	4	4	1	1	1	1	1
Band 5 Leavers	3	2	5	2	2	4	3	6	6	6	6	6
Total Leavers	**5**	**5**	**8**	**5**	**5**	**8**	**7**	**7**	**7**	**7**	**7**	**7**

4.0 RECOMMENDATION

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

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

Date: 11th November 2019

The Princess Alexandra Hospital NHS Trust

Appendix 1.

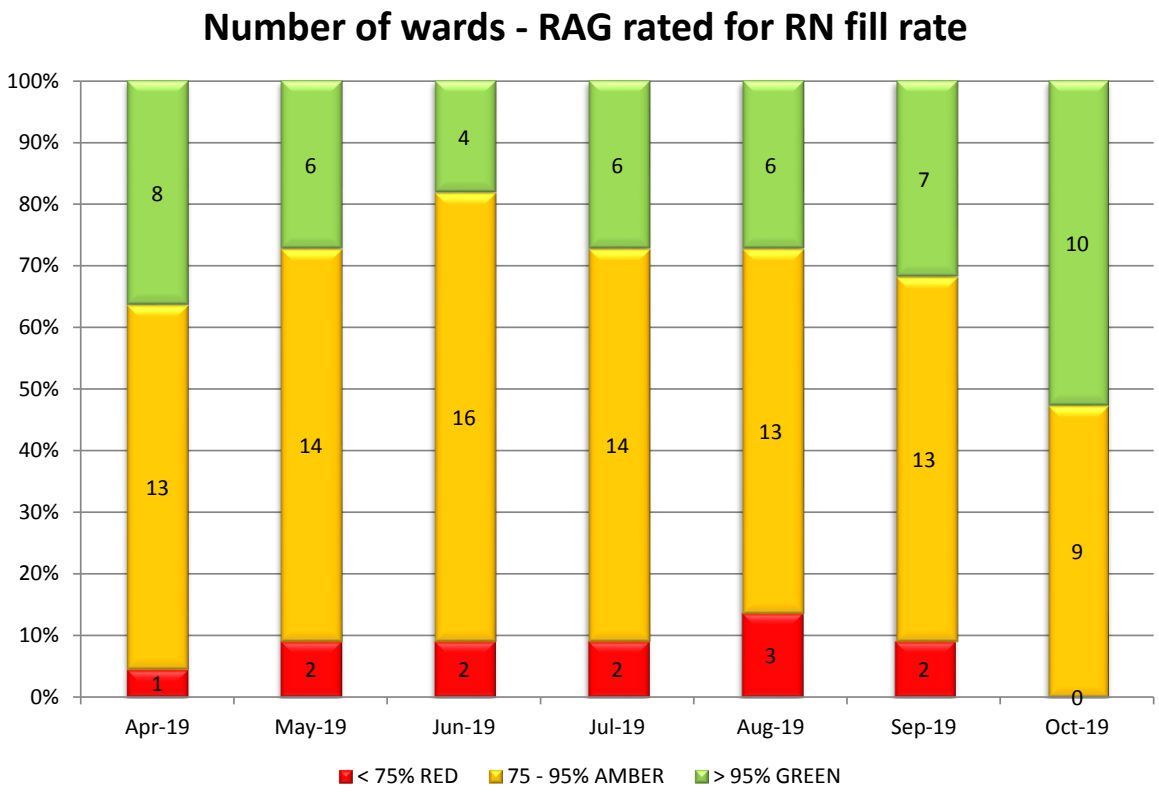
Ward level data: fill rates October 2019.

Please note due to a data quality review: Maternity Service Wards are presented as a single unit.

	Day		Night				
Ward name	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	% RN overall fill rate	% overall HCSW fill rate	% Overall fill rate
Dolphin Ward	130.1%	111.4%	94.2%	100.8%	114.1%	107.8%	112.5%
Kingsmoor CCU	89.7%	107.4%	108.9%	114.1%	96.5%	110.0%	101.7%
MAU Fleming	92.2%	109.7%	76.9%	82.8%	85.2%	96.2%	89.9%
Tye Green Ward	109.7%	164.7%	124.3%	104.2%	115.5%	134.4%	123.9%
Harvey Ward	100.5%	100.6%	124.3%	104.2%	109.5%	102.0%	105.8%
ITU & HDU	114.0%	107.4%	100.0%	166.4%	107.7%	125.9%	116.8%
John Snow	100.8%	110.8%	101.7%	117.2%	101.2%	113.3%	105.5%
Charnley Ward	92.3%	130.7%	87.7%	119.4%	90.0%	125.0%	95.9%
Lister Ward	100.2%	100.0%	110.1%	129.7%	103.7%	111.2%	106.6%
Locke Ward	111.9%	94.9%	119.4%	147.8%	114.9%	111.5%	113.4%
Neo-Natal Unit	86.1%	123.4%	94.6%	168.7%	89.1%	140.6%	108.9%
Penn Ward	97.2%	111.0%	99.9%	134.5%	98.2%	119.9%	106.5%
Ray Ward	91.7%	105.0%	84.8%	97.9%	88.9%	101.6%	95.7%
MSSU Saunders	92.2%	109.7%	76.9%	82.8%	85.2%	96.2%	89.9%
Harold Ward	86.0%	86.3%	84.1%	94.7%	85.2%	89.7%	87.2%
Henry Moore Ward	81.1%	80.7%	94.1%	89.7%	86.0%	83.4%	85.0%
Gibberd Ward	93.6%	88.5%	97.9%	100.9%	95.3%	93.2%	94.4%
Winter Ward	87.0%	110.6%	98.5%	115.9%	91.9%	112.6%	99.3%
Maternity Services	110.4%	86.9%	92.5%	81.7%	101.9%	84.6%	96.9%
Trust total	99.2%	104.0%	95.0%	107.1%	97.4%	105.3%	100.4%

The Princess Alexandra Hospital NHS Trust

Appendix 2



The Princess Alexandra Hospital NHS Trust

Appendix 3

Ward staffing exception reports
Reported where the fill is < 75% during the reporting period, or where the ADoN has concerns re: impact on quality/ outcomes

	Report from the Associate Director of Nursing for the HCG		
Ward	Analysis of gaps	Impact on Quality / outcomes	Actions in place

The Princess Alexandra Hospital NHS Trust

Trust Board – 05.12.19

5.4

Agenda Item:	5.4
Presented by:	Director of Nursing, Midwifery and AHPs
Prepared by:	Associate Directors of Nursing , Medicine, Surgery and Critical Care, Cancer Cardiology and Clinical Support, Family and Women's
Date prepared:	18th September 2019
Subject / Title:	Nursing and Midwifery Establishment Review

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]

In line with national reporting and best evidence, the nursing and midwifery establishment review was undertaken in July 2019.

The outcome of the establishment review recommends a net increase in establishment of 10.5 WTE across adult medical inpatient areas. In addition following the Birthrate+ review of maternity services and in line with increasing complexity and acuity, there is a recommendation of an uplift of 8 WTE midwifes and 3.2 WTE maternity support workers. The gross annual budget increase is £945k. However, this is offset by reductions to non-nursing roles in 20/21 and further reductions in 21/22 reducing the requirement to £670k and £312k respectively as per below:

	£000'ks
Nursing establishment budget increase	945
Reduction in non nursing roles (PYE)	(276)
Net budget increase 20/21	670
FYE of incremental reduction in non nursing roles	(358)
Net budget increase 21/22	312

The paper has been to both Workforce and PAF Committees. At PAF it was supported and agreed that the costs associated with the recommended uplifts to establishments would be considered as part of the budget setting process which will be reported to PAF in January 2020 and then Board for Budget 2020/21.

Recommendation: The Board are asked to support the outcome and recommendations of the July 2019 nursing and midwifery establishment review.

Trust strategic objectives: [please indicate which of the 5Ps is relevant to the subject of the report]

Patients	People		Places	Pounds
■	■	■		■

Previously considered by:	19th September 2019 EMT: to work though the financial modelling, part year and full year effect. 23rd September 2019 WFC: methodology and recommendations noted and supported. Committee noted the financial modelling required further focus. WFC.23.09.19 WFC.25.11.19 PAF.28.11.19
Risk / links with the	BAR Risk 2.1 Nurse Recruitment

Legislation, regulatory, equality, diversity and dignity implications:	NHSE: How to ensure the right people with the right skills in the right place at the right time (2014). Expectation one. NQB guidance (2013, 2016)
Appendices:	Appendix 1: Nurse sensitive indictors Appendix 2: Summary of new roles and ward/ department reviews Appendix 3: Nurse to bed ratios Appendix 4: Acuity and Dependency Tools for calculating Nursing and Midwifery staffing Appendix 5: Nursing Workforce Intentions 2020/21

1.0 PURPOSE

This report provides assurance that mechanisms are in place to review nursing and midwifery establishments in line with regulatory requirements. It details the outcome and recommendations following the review of establishments undertaken in July 2019.

The NQB guidance (2013, 2016) and NICE set out clear expectations for boards in relation to staffing: *Boards are required to take full responsibility for the quality of care provided to patients, and as a key determinant of quality, take full and collective responsibility for nursing, midwifery and care staffing capacity and capability. Boards are required to ensure there are robust systems in place to assure themselves that there is sufficient capacity and capability to provide high quality care to patients on all wards, departments, services or environments day or night, every day of the week.*

2.0 BACKGROUND AND NATIONAL CONTEXT

Post publication of the Francis Report 2013 and Safe Staffing in Adult inpatient wards in acute hospital (NICE, 2014) the National Quality Board (NQB July 2016) has defined a framework and set of expectations (July 2016) to achieve the "right staff, with the right skills, in the right place at the right time", including the responsibilities of Trust Boards.

NHS organisations have a responsibility to undertake an annual comprehensive nursing and midwifery skill mix review to ensure that there are safe staffing levels and to provide assurance to the Board and stakeholders. The yearly skill mix review should be "followed with a comprehensive staffing report to the board after six months to ensure workforce plans are still appropriate" (NQB 2016).

Lord Carter's report, *Operational Productivity and Performance in English Acute Hospitals: Unwarranted variations (revised February 2016)*, identified efficiency opportunities and the requirement for organisations to meet the challenges of maintaining and improving quality, operational performance, finance and efficiency. The latest CQC Consultation document outlines how effectively a provider uses its resources is one of the factors that determines the quality and responsiveness of its care.

The data collection for this nursing and midwifery establishment review was commenced in July 2019 utilising the Safer Nursing Care Tool (SNCT) for adult ward areas, the Baseline Emergency Staffing Tool (BEST) for the Emergency department, Safer Nursing Care Tool (SNCT) for children inpatient wards for Dolphin, Birthrate plus for the maternity department and Dinning's Tool for Neonatal Unit.

Whilst the establishment reviews focus on the acuity/dependency results, these are not reviewed in isolation. Experience and best practice identifies that a wider suite of quality indicators must be considered to allow more informed approaches in respect of assuring the Trust that staff are in place to provide high quality, safe and compassionate care. A review of the nurse sensitive indicators are included in Appendix.1. The quality indicators were reviewed when considering the SNCT findings. Additional local information related to the ward layout, and professional judgement supplements the outcome of the SNCT findings.

Nursing Red Flags (NICE, 2014) should also be analysed, to understand the frequency and incidence within the clinical areas. A refresh of Nursing Red Flags in line with national guidance has been undertaken to inform safe staffing and future establishment reviews. Red flags will be reported in the Hard Truths paper each month from September 2019 where there has been a:

- Shortfall of 25% or 8 hours (whichever is reached first) in RN availability on a shift
- Less than 2 RNs on a shift.

2.1 Review methodology

The SNCT multipliers are incorporated into the Safecare module of Allocate Healthroster, this is completed three times per day for each area by the nurse in charge. During the Census period, results were validated on a daily basis by Matrons with additional validation by the Heads of Nursing and Associate Directors of Nursing. This validation showed that on average the acuity accuracy was at 96% across the trust, for the purpose of this review only the late census data was used.

The BEST data collection was completed on an hourly basis, 24 hours per day for a week as stipulated in the audit process.

The SNCT calculation is based upon a funded headroom allowance of 22% (leave allowance including annual, study, sickness etc.), our trust allowance is currently 20%, it should be noted that the Royal College of Nursing (RCN) recommends 25%.

The Ward Manager role has 22.5hours per week supervisory time built in however achievement of compliance with supernumerary time is inconsistent across all areas due to the vacancy rate.

It should be noted that although there has been considerable national debate on the subject of skill mix and nurse to patient ratio, to date no national standards for staffing levels in inpatient areas have been mandated in England, although a minimum Registered Nurse to patient ratio of 1:8 in the day and 1:11 at night is supported by professional organisations such as the Royal College of Nursing and the Safe Staffing Alliance. The nurse to patient ratio is currently mandated in Scotland and Wales and the RCN is campaigning for legislation to guarantee nurse staffing levels in England across all sectors and settings.

In addition to the above, professional judgement, peer group validation, review of e roster data and nurse sensitive indicators were incorporated into the review process.

The previous establishment review was competed in November 2018; in line with best practice, the July 2019 data collection period will therefore reflect seasonal variations.

2.0 Workforce Intentions 2020/21

The Trust has had a high vacancy rate (27%) for Registered Nurses for some time. There is a focussed programme of work to reduce the vacancy rate to less than 10% by March 2020 supported by a business case for overseas recruitment. The programme is currently on track to achieve the March 2020 target and reduce reliance on temporary staffing and high bank and agency costs.

1. Further reduce the vacancy rate to less than 5% over 2020/21.
2. Strengthen the ward leader's role uplifting the ward manager role to supernumerary, enabling them to demonstrate and use their transformational leadership skills. Evidence shows where this happens wards have fewer safety incidents, less staff absence and lower turnover
3. Recruit 5 Clinical Practice Educators and an additional 1WTE PDT Nurse to support development of skills and capability of nursing workforce and mentors and apprenticeships within the workplace

In response to the nursing vacancy position across the trust the following support roles were introduced to enable nurses to focus on essential care delivery:

- Ward Coordinators – clerical support to the Ward Manager to support daily running of ward.
- Patient Journey Coordinator – support to nursing teams to facilitate patient pathways and discharge planning.

As the vacancy position improves there will be a phased approach to disestablishing these posts with staff redeployed to alternative vacant administration posts which will releasing savings circa £500k in 2020/21 and provide a full year effect of circa £1m which will offset the costs of these changes.

Full nursing workforce intentions for 2020/21 are found in Appendix 5.

Findings:

A full breakdown of the findings from the establishment review can be found in Appendix 2. Wards which require a change in establishment are as follows:

Lister ward: 2 consecutive reviews have identified the need to uplift the establishment to meet patient acuity by 5 WTE. Lister ward are currently supporting the new Nursing Associate role therefore the recommendation is that the uplift is 5 WTE Band 4 Nursing Associate posts.

Ray ward: 2 consecutive reviews have demonstrated the requirement to increase the establishment by 5WTE band 5 RN uplifting the skill mix ratio to meet the requirements of the ward.

Harold ward: 2 consecutive reviews have demonstrated the requirement to increase the establishment by 3 WTE Band 5 and 2 WTE Band 2 to increase the skill mix to 60/40.

Saunders ward: The budgeted establishment exceeds the template requirement therefore a reduction of 4.5WTE posts is required.

Maternity: Following analysis of Birth Rate Plus (BR+) Data, there is a recommendation to increase the establishment by 7.98 WTE Midwives and 3.20 WTE Maternity Care Assistants.

Summary table of findings:

Healthcare Group	Ward	Tool	Recommendation	Full Year 2020/21 Budget Changes	Full Year 2021/22 Budget Changes
Total Medicine			Increase by 10.5 WTE	£431,780	£431,780
Total FAWS			Increase by 11.2 WTE	£513,588	£513,588
Across HCG			Uplift Ward Managers to supernumeracy status	£108,591	£246,798
			Clinical Practive Educators	£115,698	£262,950
			Nursing support roles reduction	(£500,000)	(£1,143,091)
Less Changes to Workforce				(£275,711)	(£633,343)
Total Budget increase				**£669,657**	**£312,025**

* Current in year run rate impact of £36k, will be covered nursing underspends across the HCG

Emerging questions

The data from this establishment review has identified a number of areas which require further review over the next 6 months where changes may be recommended. These areas will be therefore under 'watch'.

Trend data is suggestive of a change in rota template with a **reduction** in required establishment in the following areas:

Harvey Trend data is suggestive of a change in rota template with a reduction in required establishment.

Locke Trend data is suggestive of a change in rota template with a reduction in required establishment however the service model is to increase acuity and deliver NIV service through the acute respiratory unit located on Locke ward, the staffing model is supportive of this development

John Snow Trend data suggests there could be a decrease the establishment. However, applying professional judgement, the recommendation is to review the impact of the increase in the funded and recruited establishment and review the establishment against the next data set in 6 months in line with future service developments.

Paediatrics Trend data suggests there could be a decrease the establishment however paediatric acuity and demand is highly seasonal and monthly data for full 12 months should be reviewed.

Trend data is suggestive of a change in rota template with an **increase** in required establishment in the following areas:

Gibberd Trend data is suggestive of a change in template with an increase in establishment. However the service model for this ward is currently under review.

Increased skill mix. There are currently 7 wards where the skill mix of qualified to unqualified staff is less than 60:40. In line with evidence of the impact of poor skill mix on nurse led outcomes including mortality a shift to a minimum 60:40 ratio on all inpatient wards will be phased into future reviews.

RECOMMENDATIONS

- To note the recommendations within this report, and the methodology used to inform the establishment setting process:
    - Medicine HCG will increase the establishment for Lister, Ray and Harold Wards by 5 RN, 5 Nursing Associates and 5 HCSW, which will partially be offset by realigning of establishments across the HCG.
    - Increase Maternity Services establishment by 8 WTE Midwives and 3.20 WTE Maternity Care Assistants
    - Harold Ward are already working on higher rotas, with a run rate impact of £36k in 19/20
- To approve the net budget increase in 20/21 of £670k which reduces to £312k in 21/22.
- It is recommended that the staffing templates are uplifted in the adult inpatient areas in line with the recommendations with immediate effect to support safe staffing and for maternity services from 1st April 202/21.
- Given the current vacancy across nursing it is anticipated that recruitment to substantive posts will be phased throughout the remainder of the current financial year and therefore budgets would be realigned with effect from April 2020/21
- Nurse Sensitive Indicators will be reviewed by exception reports on a monthly basis to ensure safe staffing levels
- A further establishment review will be completed in February 2020 and report to Board in May.

Appendix.1: Summary of Nurse Sensitive Indicators for each in-patient area

Nurse Sensitive Indicators July 2019												
HCG	Ward	PALS (inc bereavement / GP queries)	PALS Queries referred to Complaints	Open PALS at month end	Compliments	New Complaints	Open complaints at month end	Pressure Ulcers Cat 2/3	Falls	SI	Staffing Levels	Medication Errors
MHCG	A&E	19	0	17	63	2	11	0	1	0	1	2
	MAU Fleming	5	0	9	10	0	0	0	4	1	0	3
	Gibberd	5	0	8	10	0	4	5	9	0	0	2
	Harold	0	0	4	11	0	1	1	13	0	2	0
	Harvey	1	0	6	5	1	1	2	9	0	0	3
	Lister	3	0	2	26	0	1	3	14	0	1	1
	Locke	5	0	4	4	0	2	2	4	0	0	5
	Ray	3	0	7	1	0	0	2	13	0	1	4
	Saunders MSSU	0	0	10	13	0	1	0	8	0	0	2
	Tye Green	1	0	4	15	0	0	1	6	0	5	2
	Winter	2	0	7	11	0	2	0	10	0	0	2
SHCG	Chamley	3	0	3	36	0	1	0	3	0	1	1
	Penn	2	0	9	29	0	0	1	1	0	5	5
	HDU/ ITU	3	0	5	0	0	0	1	1	0	0	2
	John Snow	5	0	17	2	0	0	0	1	0	1	4
	Henry Moore	2	0	3	6	0	0	0	3	0	0	0
CCCS	Kingsmoor CCU	4	0	2	1	1	1	1	8	0	0	3
FAWS	NICU	0	0	0	0	0	0	0	0	0	0	4
	Dolphin	0	0	1	1	0	0	0	0	1	0	0
	Samson	0	0	1	0	0	0	0	0	0	2	0
	Chamberlen	0	0	0	0	0	0	0	0	0	2	0
	Birth Unit	2	0	2	0	0	0	0	0	0	6	1
	Labour	0	0	0	0	0	0	0	0	1	8	0

Appendix.2: Summary of new roles and ward/ department reviews.

New roles to support the RN workforce:

Nursing Associates – A new clinical role regulated by the NMC which supports the delivery of clinical care and underpinned by a foundation degree at Band 4. There are 3 newly registered Nursing Associates working on Lister Ward with a plan to uplift the establishment to 4.72 to provide 1 NA per shift. Introduction of the NA role on Lister will improve the skill mix which is currently 50/50 to 60/40. The Trust is currently supporting 13 Trainee Nursing Associates Apprenticeships across the clinical areas.

Assistant Practitioners – An unregistered clinical role trained to foundation degree level working under the supervision of nursing staff responsible for a group of patients. The Trust is supporting 16 Assistant Practitioner Apprenticeships and there are 23 Assistant Practitioners in nursing wards and departments all of whom are undertaking the top up course to become Registered Nurses.

Exclusions

Due to recent service changes in the acute pathway areas the following areas have been excluded and remain under review (Fleming, Ambulatory Care Unit).

Medicine Health Care Group including Urgent and Emergency Services

A summary of the MHCG identifies change in establishment across 4 wards: Lister, Ray, Harold and Saunders, with a net total increase of 10 WTE using the outcome of SNCT, professional judgement

and knowledge of developments both in terms of patient pathways and workforce developments such as the Nursing Associate Role.

Harvey Ward

Recommendation: Based on SNCT data an increase in establishment is not required at present. As the current establishment meets the acuity and dependency requirements further recruitment to this area will be currently suspended and redirected to areas of greatest need across the healthcare group.

20 bedded Gastroenterology/Haematology Ward which has 10 individual side rooms. This ward has one of the largest compliments of side rooms, one of which is larger and is used to accommodate bariatric patients and equipment and because on the increased number of side rooms is also the ward of choice for patients with special needs such as learning disabilities. It should be noted that staff from this area are regularly redeployed to support other areas across the healthcare group and trust. During the month of July there was a reduction in bed capacity to 16 to support the critical care refurbishment. The data collected has been extrapolated to reflect the increase to 20 beds and demonstrates the same outcome. During the month of July a total of 89 hours were redeployed from this area.

Winter Ward

Recommendation: Based on SNCT data an increase in establishment is not required at present a further review of establishment should be completed in six months.

28 bedded Endocrinology Ward which has four individual side rooms, in line with best practice this ward specialises in the treatment of patients with Diabetic Ketoacidosis (DKA) who have a higher turnover in terms of length of stay.

Lister Ward

Recommendation: To increase by 5 WTE Band 4 Nursing Associate Roles and complete a further review in 6 months once the impact of the Nursing Associate role has been evaluated.

28 bedded Complex Care of the Elderly Ward which has achieved the Quality Mark for the delivery of Elder Friendly Care. This ward has four individual side rooms. Nurse sensitive indicators show that the ward has the highest number of falls across the healthcare group and trust, the patient acuity data shows over 60% are level 1B therefore requiring a high level of essential care. During the last 6 months the ward has had a higher number of MRSA transmissions a quality improvement plan which is being monitored weekly is in place to address this.

The SNCT data identified a requirement to increase the staff establishment by 10 WTE. This WTE figure is aligned to the findings from the November 2018 SNCT data which identified the requirement to increase the establishment by 9 WTE. The recommendation at this time was not to increase the establishment and repeat the data collection therefore capturing possible variations, as this was the first formal establishment review utilising the SNCT. To further support this rationale it was recognised that the current establishment had not been achieved and that the introduction of new roles such as the Associate Nurse would further impact on the establishment requirement. The Nursing Associate role is a Band 4 role and as a registered practitioner will support the skill mix for the ward to meet 60/40 ratio. Taking this into account and utilising professional judgement and knowledge of the ward the decision has been made to increase by 5WTE Band 4 Nursing Associate roles and complete a further review in 6 months to access the impact.

Locke Ward

Recommendation: The recommendation of this establishment review is not to make any further changes to the establishment and complete a further review in six months.

27 bedded Respiratory Ward which in September 2018 as part of service improvements opened a three bedded Acute Respiratory Unit (ARU). Locke Ward has had their establishment increased to open and recruit to the ward including ARU. Further plans are in place to repatriate the Non Invasive Ventilation (NIV) service from Critical Care to Medicine in the latter part of 2019.

Based on SNCT data alone a decrease in establishment is suggested by 6 WTE. However, there is seasonal variation of the patient group within this speciality and the establishment has been set to reflect a fully functioning ARU which has not yet been realised. The healthcare groups recommendation is not to change the current establishment and complete a further review in six months when the NIV service will be in place alongside a full years SNCT review data to allow for seasonal variation.

Ray Ward

Recommendation: Based on SNCT data an increase in establishment by 5 WTE Band 5 RN is recommended with a further establishment review in six months. This will ensure that the skill mix ratio meets a 60:40 split.

28 bedded Complex Care of the Elderly Ward which has achieved the Quality Mark for the delivery of Elder Friendly Care. This ward has four individual side rooms. Ray ward has had a marked increase in the incidence of pressure ulcers, fall and medication errors along with an increase in MRSA transmissions. The ward has an improvement action plan in place which is being monitored weekly. The patient acuity data shows over 70% are level 1B therefore requiring a high level of essential care.

Based on the SNCT data alone the establishment is required to be increased by 8 WTE. Compared to the findings from the November 2018 SNCT data which identified the requirement to increase the establishment by 12 WTE both data collections demonstrate the requirement to increase the establishment. Applying professional judgement to this ward area and patient group, it is recommended that an increase of 5WTE band 5 RN will be appropriate to adjust the skill mix ratio to meet the requirements of the ward.

Harold Ward

Recommendation: Based on SNCT data an increase in establishment by 3 WTE Band 5 and 2 WTE Band 2 is recommended with a further establishment review in six months.

This ward is the specialist Frailty ward with an expected patient length of stay up to 72 hours. This ward relocated and increased the bed base by 5 beds in February 2019. The findings from the November 2018 SNCT data identified the requirement to increase the establishment by 7 WTE. The recommendations from this were to review the acuity and dependency data following the move and amalgamations of the team.

Nurse sensitive indicators show that this ward as a high number of falls which reflects the patient cohort. The patient acuity data shows over 67% are level 1B therefore requiring a high level of essential care. The ward has 12 individual side rooms which impacts on the ability to cohort patients at higher risk of falls.

The latest data collection has demonstrated the requirement to increase the establishment. A considered approach to increasing WTE should be taken with the recommendation to increase the establishment by 3 WTE Band 5 and 2 WTE Band 2 to increase the skill mix to 60/40. The current roster usage template and ward spending has shown that this increase is currently being used within the ward area.

There are future developments planned in the rapid access frailty service assessment with focus on increasing the use of frailty assessment admission avoidance and admission for up to 72 hour length of stay and there will be further amalgamation of the frailty team and the ward based team.

Saunders Ward

Recommendation: A realignment of funds across the HCG is recommended with a further review in 6 months

28 bedded short stay admission ward, aiming to have a length of stay up to 72 hours. This operational model is linked to developments on Fleming and the Ambulatory Care Unit which are in the initial stages implementation. As a result the SNCT establishment review will not be reflective of the planned operational model, the current data analysis identifies that the establishment is slightly over the acuity and dependency requirements for the ward however a further review should be completed in in line with future pathway developments and reviews of the Fleming and Ambulatory Care Unit establishments.

Applying professional judgement to the currently model and template figures a realignment of over establishment from Saunders to Harold is recommended.

Tye Green

Recommendation: No further changes required at present however the previously agreed establishment uplift will now be realised following the reduction in overall vacancy position. A further review will be completed in 6 months.

This ward is the specialist Fractured Neck of Femur ward. The ward has a total bed base of 31 beds 2 of which are used as assessment beds to support achievement of best practice pathways for patients. This ward relocated in January 2019 and increased the bed base by 5 beds at this time.

Due to the patient group this areas has high numbers of patients who have been assessed as high risk of falls. The ward environment lends itself to cohort nursing utilising two 5 bedded bays for patients at high risk of falls requiring closer levels of observation. The patient acuity data shows over 75% are level 1B therefore requiring a high level of essential care.

The latest SNCT data collection has demonstrated the requirement to increase the establishment. This is in line with the previous SNCT review which also recommended an increase in the nursing establishment of 4.29WTE band 5 RN. This was agreed but not yet realised due to the overall vacancy position
However, applying professional judgement alongside this, the recommendation is to review the impact of the increase in the funded and recruited establishment and review the establishment against the next data set in 6 months.

Gibberd Ward

Recommendation: No changes required at present due to service review.

This ward is a 27 bed ward that specialising in end of life care and dementia care.
The latest SNCT data collection has demonstrated the requirement to increase the establishment by 7 WTE. This data is supported by the current roster usage template and ward spending which shows that this is the establishment that is currently being used within the ward area.

At present the ward is undergoing a service review and the outcome of this will determine the establishment required. It is recommended that the ward continue to run the same roster template and spend whilst this review is undertaken.

Emergency Department

Recommendation: The recommendation following completion of the BEST audit is not to make any further changes to the establishment that were approved in the October 2019 establishment review and to complete a further review in six months in line with future service developments.

The Emergency Department is a Level 1 Consultant Led department that sees approximately 110,000 patients per year. The outcome of the previous establishment provided investment of circa £500,000 which supported increase staffing to the Rapid Assessment and Treatment area, opening of the Clinical Decision Unit 24 hrs per day and the introduction of the streaming role.

The Trust is working with the Emergency Care Intensive Support Team to improve pathways of care for patients. Future developments include the opening of an Urgent Care Treatment facility planned for December 2019. In addition the Trust has submitted a Full Business Case (FBC) for a 28 bedded assessment area.

The BEST audit currently does not demonstrate a need to increase the ED establishment. As future developments are likely to reduce the number of patients being seen in the department the recommendation from the healthcare group is not to increase the establishment currently, implement changes to pathways and complete a further BEST audit in six months

Endoscopy
Recommendation: An increase in establishment is not required at present.

The Endoscopy staff establishment in place is in line with JAG recommended levels. Future service developments will see this service grow from 6 to 7 days however this was already factored into the business and recruitment is underway. Therefore the HCG recommends no further changes to the current establishment and for a further review in 6 months.

Areas Excluded:

Fleming Ward & Ambulatory Care Unit

A medical assessment ward with mixed capacity for beds chairs and trolleys up to a maximum of 26 patients. The staffing establishment for this area includes staff for the Ambulatory Care Unit which is open 7 days a week 08.00 to 20.00 and sees on average 40 patients per day. The operational model for Fleming is rapid assessment, discharge or admission with a length of stay no longer than 24 hours.
A full business case (FBC) has been prepared by the Trust for capital investment to provide a new medical assessment unit which includes a revised operational model and staffing requirements. Consequently the decision was made to exclude the SNCT data for this establishment review period whilst the business case is under review.

Surgery and Critical Care Health Care Group

Henry Moore Ward

Recommendation: Based on SNCT data an increase in establishment is not required at present.

19 bedded elective orthopaedic surgical ward which cares for patient's pre and post-operative from elective care bad patients who are having planned trauma surgery. The ward's patient capacity fluctuates at times and as such this and following a review of the SNCT data there is a suggestion that the establishment is high for the ward. However, data has not factored the requirement of the pre admission nurse daily. All pre-operative orthopaedic patients arrive on the ward pre surgery for admission. This was not captured in the SNCT data. It should be noted that staff from this area are regularly redeployed to support other areas across the healthcare group and trust. During the month of July a total of 173 hours were redeployed from this area.

Moving into the winter period, there are plans to utilise the ward in a different way to facilitate manging the expected increase in patient capacity. The current funded nursing establishment will be required to support this way of working.

John Snow Ward

Recommendation: Based on SNCT data an increase in establishment is not required at present.

This ward is the female gynaecology and surgical ward, which until the ward realignment in February 2019 had 18 inpatient beds. Following the ward realignment the bed base has increased to 22 inpatient beds. The previous establishment review in November 2018 agreed to increase the number of HCA's by 1 per shift.
The latest SNCT data collection has demonstrated the requirement to decrease the establishment. However, applying professional judgement alongside this, the recommendation is to review the impact of the increase in the funded and recruited establishment and review the establishment against the next data set in 6 months in line with future service developments.

Penn Ward

Recommendation: Based on SNCT data an increase in establishment is not required at present.

This is a 28 bedded surgical ward which is looking to achieve the Quality Mark for the delivery of Elder Friendly Care. This ward has four individual side rooms. Based on SNCT data a change in establishment is not required at present.

Charnley Ward

Recommendation: Based on SNCT data an increase in establishment is not required at present.

This ward is a 27 bedded ward and was opened on the 2nd January 2019. Based on SNCT data a change in establishment is not required at present.

SAU (Melvin) Ward

Recommendation: No change to the establishment required.

A surgical assessment unit with capacity for chairs and trolleys up to a maximum of 14 patients. The staffing establishment for this area allows for the unit to open 7 days a week 08.00 to 22.00 and sees on average 180 patients per week. The operational model for SAU is rapid assessment, discharge or admission for surgical patients. A change in the establishment is not required at present.

Intensive care unit / High Dependency Unit (Critical Care)

Recommendation: No change to the establishment required.

This is 10 bedded unit (5 ITU and 5 HDU beds). The Intensive Care Society Guidelines for Provision of Intensive Care Services (GPICS) were applied in the review of the establishment within critical care. These ensure that level 3 patients are nursed on a 1:1 basis, level 2 patients on a 1:2 basis and provide a supernumerary nurse in charge with a dedicated Clinical Nurse Educator. The current funded establishment meets the requirements of the GPICS.

Theatres

Recommendation: No change to the establishment required.

The standards from the Association of Perioperative Practice (AfPP) were applied in reviewing the theatre establishment. This was based on the new revised theatres schedules and shift pattern recently introduced in April 2019. There was an increase in establishment following the SNCT review in November 2018. This alongside the changes in theatre schedules and shift pattern show that the current funded establishment meets the requirements of the service.

Recovery (PACU)

Recommendation: No change to the establishment required.

The standards from the Association of Perioperative Practice (AfPP) and British Anaesthetic & Recovery Nurses Association (BARNA) were applied in reviewing this establishment. This was based on the new revised theatres schedules and shift pattern recently introduced in April 2019. There was an increase in establishment following the SNCT review in November 2018. This alongside the changes in theatre schedules and shift pattern show that the current funded establishment meets the requirements of the service.

Day Stay Unit (ADSU)

Recommendation: No change to establishment.

This service underwent a review 18 months ago with an increase in the establishment to facilitate later opening times and weekend working. There was an increase in the staffing establishment at this time. The current funded establishment meets the requirements of the service.

Oak Unit

Recommendation: No change to establishment.

This is a day unit which carries out a range of urology procedures. This service has recently moved to the HCG. At present, there is not a requirement to amend this establishment. Any recommendations will be made as part of a service review and business planning.

Eye Unit

Recommendation: No change to establishment.

Following a review of the services delivered with the Eye unit, a review of the nursing and administrative establishment was undertaken and changes have been implemented within a cost neutral adjustment for the Health Care Group. The current funded establishment meets the requirements of the service.

Family and Women services Health Group

Paediatric Emergency Department and Paediatric Ambulatory Unit (PAU)

Recommendation: Based on the BEST and RCN Children's nursing guidelines, no change to establishment.

The Children's Emergency Department and PAU relocated and opened co-located in December 2017 with an accompanying staffing uplift reflecting this change. The staff are utilised flexibly to meet nursing and activity demand. The department have recruited to some of the vacant posts and all the Nurses on maternity leave will be back by mid-September and we have continued to staff the department at all times with children trained staff only. We have now fully recruited to the reception team and Health care support worker roles and plan to undertake BEST Audit in September

Maternity Services

Recommendation: Based on Birth Rate Plus (BR+) Data, there is a recommendation to increase the establishment by 7.98 WTE Midwives and 3.20 WTE Maternity Care Assistants. It is recommended for the 3.20 WTE MCAs to be costed in current year however to phase the Midwives, 4wte this current full year and the 3.98 WTE next financial year

The maternity services consist of a Consultant led high risk labour ward with 9 delivery rooms 1 maternity theatre with the second theatre just waiting to be handed over following completion, plus a three bedded recovery room.

Antenatal inpatient services include a 15 bedded ward with 1 bereavement suite. The postnatal inpatient ward has 22 beds.

There is a co-located birthing unit for low risk women to access midwifery led care. The birthing unit has 3 delivery rooms all with the provision for water births, there are 12 post natal beds on the birthing unit.

The SNCT is not utilised within maternity, the workforce tool used is Birthrate plus (BR+). This is a framework for workforce planning and strategic decision - making. BR+ is based upon an understanding of the total midwifery time required to care for women and providing 1:1 care by the midwife throughout established labour. The principles behind the BR+ methodology are consistent with the recommnedations in the NICE safer staffing guideline for midwives in maternity settings, and has been validated by the RCM and RCOG.

This is the first time the establishmnet has been reviewed within maternity for a number of years and the changes since the last review is the acuity of the women not the increase in capacity. The results showed that the maternity unit is above the average of women requiring more clincial input, which included obseity related problems, mental health and a high incidence of complex safguarding issues.

Dolphin

Recommendation: Based on the SNCT for Children and RCN guidelines, no change to establishment

Dolphin ward is a 16 bedded childrens ward who have additional 4 beds that are utilised for day case activity. Due to the flutuating seasonal inpatient bed requiremetns for paediatrics in winter and during peak activity the additional 4 besds are utilised for inpatient admissions.

The SNCT for Children was licensed for use in 2018. The Dolphin team capture the acutiy and dependancy of children using the childrens mulptipliers on Safecare.

NICU

Recommendation: Based on the Dinning's Workforce calculator for Neonatal care no changes to the establishment

The neonatal unit has 16 cots in total. 2 Intensive care 4 High dependancy and 10 Special Care. Recommended staffing levels for neonatal units are set by the Neonatal Clinical Reference Group and entered in the neonatal data information system BadgerNet. Bed occupancy and cot levels are entered daily and inform the workforce calculator known as Dinning's tool. As part of the monitoring of the workforce it was recognised that the numbers of Qualified in Speciality Nurses at Band 5 level was slightly lower than recommended so some minor alterations to the establishment have been made within the existing budgettary envelope.

Cancer, Cardiology and Clinical Support, Health Care Group

Kingsmoor Ward

Recommendation: Based on SNCT data an increase in establishment is not required at present.

30 bedded acute cardiology ward including 6 coronary care beds for patients requiring Level 2 cardiac care and 24 acute cardiology beds. The coronary care beds are incorporated into 2 separate bays to ensure mixed sex breaches do not occur. The SNCT establishment recommends a slight decrease in establishment of RNs but does not take into account the layout of Kingsmoor Ward and the fact that Level 2 patients can be in different bays. Therefore the recommendation is for staffing levels to remain the same on Kingsmoor Ward and review again in 6 months' time.

Outpatients

Recommendation: based on Professional Judgement and activity templates, no change to establishment

There is not a recognised tool to calculate the recommended nursing staffing levels for Outpatients. The current method of operation is that if a clinic requires medication or a procedure (minor operative) is being carried out, we have a registered nurse within the clinic. All other clinics have a minimum of a healthcare assistant but there is always a registered nurse on duty for the department. We review the acuity of the clinic to assess the requirements for example, a two doctor fracture clinic will have two members of staff supporting, but a two doctor general surgery clinic will only require one member of staff. On days where there is a reduced need for nurses within Outpatients staff are re-deployed to work across the in-patient ward areas.

Cardiac Cath Lab

Recommendation: based on professional judgement and activity templates, no change to establishment

The service runs 5 days a week and undertakes cardiac diagnostic procedures and cardiac pacemaker insertions for both in-patients and outpatients. The nursing establishment has been reviewed and has been calculated based on the number of nurses required to support with procedures and in the recovery of patients post procedure based on current and predicted levels of activity. The recommendation is that staffing levels remain the same and are reviewed in 6 months' time.

William's Day Unit

Recommendation: based on Professional Judgement and activity templates, no change to establishment

The unit is open 5.5 days per week and provides day case chemotherapy and supportive treatments for oncology patients. The nursing levels are reviewed every 6 months and are calculated based on the number of patients attending for treatment over the preceding 6 months. The recommendation at present is that the nursing establishment remains the same and is reviewed again in 6 months.

Appendix.3: Proposed rota template and nurse:bed ratio Oct 19.

	Proposed Template following review October 2019									
Ward	Day		Night		Number of beds	Day		Night		Skill Mix Ratio (% of qualified staff)
	RN	HCA	RN	HCA		Patient to RN ratio	Patient to all staff ratio	Patient to RN ratio	Patient to all staff ratio	
MAU Fleming	10	6	7	4	26	2.6	1.6	3.7	2.4	63%
Gibberd	4	4	3	4	27	6.8	3.4	9.0	3.9	47%
Harold	5	4	3	3	27	5.4	3.0	9.0	4.5	53%
Harvey	4	3	3	3	20	5.0	2.9	6.7	3.3	54%
Lister	5	4	4	3	28	5.6	3.1	7.0	4.0	56%
Locke	5	3	4	2	27	5.4	3.4	6.8	4.5	64%
Ray	5	4	4	2	28	5.6	3.1	7.0	4.7	60%
Saunders MSSU	5	4	4	3	28	5.6	3.1	7.0	4.0	56%
Tye Green	5	4	4	3	31	6.2	3.4	7.8	4.4	56%
Winter	5	3	3	2	28	5.6	3.5	9.3	5.6	62%
ED	17	10	16	9						63%
Charnley	5	3	3	2	27	5.4	3.4	9.0	5.4	62%
Henry Moore	3	2	2	1	19	6.3	3.8	9.5	6.3	63%
John Snow	4	3	3	2	22	5.5	3.1	7.3	4.4	58%
Penn	5	3	3	2	28	5.6	3.5	9.3	5.6	62%
ITU/HCU	9	1	9	1	10	1.1	1.0	1.1	1.0	90%
Kingsmoor	5	3	4	2	30	6.0	3.8	7.5	5.0	64%
NICU	5	1	5	1	16	3.2	2.7	3.2	2.7	83%
Dolphin	5	2	4	1	16	3.2	2.3	4.0	3.2	75%

Appendix 4: Acuity and Dependency Tools for calculating Nursing and Midwifery staffing

The Safer Nursing Care Tool (SNCT) is a nationally recommended tool for measuring the acuity and dependency of patients in adult ward areas to determine establishments (NICE, 2014). This tool is widely accepted by Chief Nurses as the tool of choice used to inform ward establishment requirements.

BEST has been designed by the Royal College of Emergency Medicine to demonstrate Emergency Department (ED) nursing workload based on a combination of the number of patients attending the department, a measure of the patients nursing dependency and length of stay.

Birthrate plus is a framework for workforce planning based on the time required to care for women based on a minimum standard of providing one to one care throughout established labour, intrapartum care of both mother and baby. The principles underpining the birthrate plus methodology are consistent with the recommnedations from NICE safer staffing guidelines for midwives and has been validated by the Royal Colege of Midwives (RCM) and Royal College of Obstetricians and Gyanecologists (RCOG).
Nationally agreed guidelines and standards have been applied in areas where these are recommended such as Critical Care and Theatres.

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Appendix 5 Nursing Workforce Intentions 2020/21

Priority	Intention	Rationale	Estimated Cost
1.	Uplift nursing and midwifery establishment in line with Autumn establishment review	Uplift required to support acuity and dependency as evidenced by validated safe staffing process	£662,453
2.	Reduce and maintain nurse vacancy of less than 1% in 2020/21. To meet this it is anticipated that approx. 106 international nurses will be required to supplement domestic recruitment	Improve patient outcomes reducing mortality and better patient flow	£1,197,800 based on £11,300 per nurse exc offset of B&A spend
3.	Recruit 5 Clinical Practice Educators and Additional WTE PDT Nurse	Make posts from overseas business case substantive to support development of skills and capability of nursing workforce and mentors and apprenticeships within the workplace Increase capacity of PDT team to support improvements in nursing practice including discharge planning across the Trust	£312,950
4.	Uplift Band 5 establishment to enable Ward Managers to be fully supervisory	Strengthen the ward leader's role, enabling them to demonstrate and use their transformational leadership skills. Evidence shows where this happens wards have fewer safety incidents, less staff absence and lower turnover.	5.6 WTE £246,798
5.	Review Band 6 WTE establishment	Ensure equity across similar profiled wards whilst ensuring succession planning and adequate scope for career progression within nursing workforce	Adjustments within establishment – no anticipated cost
6	Recruit x10 Apprentice Degree Nurses on 4 year programme	Grow our own nursing workforce	No additional costs in Year 1 as recruit to Band 2 vacancy.

Reducing in non-clinical support roles of ward co-coordinator and patient journey co-ordinator which were introduced to meet shortfall in nursing posts following consultation would release circa £1m (NB redundancy costs may apply if redeployment is not possible.)

The Princess Alexandra Hospital NHS Trust

Meeting title and date here

5.5

Agenda item:	5.5
Presented by:	Michael Meredith, Director of Strategy & Estates
Prepared by:	Chloe Atkinson, Strategy & Development Manager
Date prepared:	27th November 2019
Subject / title:	PAHT Clinical Strategy Update

Purpose:	Approval		Decision		Information	X	Assurance	

Key issues:	• The position of the PAHT Clinical Strategy within the wider national and local strategic framework. • Development process for the PAHT Clinical Strategy • Segmentation & content of the PAHT Clinical Strategy • Timelines and Next Steps
Recommendation:	To note the progress in developing the PAHT Clinical Strategy.

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

Previously considered by:	Strategy Committee Expert Oversight Groups SRO input by Dr Andy Morris & Dr Marcelle Michail
Risk / links with the BAF:	This paper relates to risks: 3.2: Financial and Clinical Sustainability across health and social care system 3.3: Capacity & capability of senior Trust leaders to work in partnership to develop an Integrated Care Trust.
Legislation, regulatory, equality, diversity and dignity implications:	None confirmed yet
Appendices:	None

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5.5

1.0 Purpose/issue

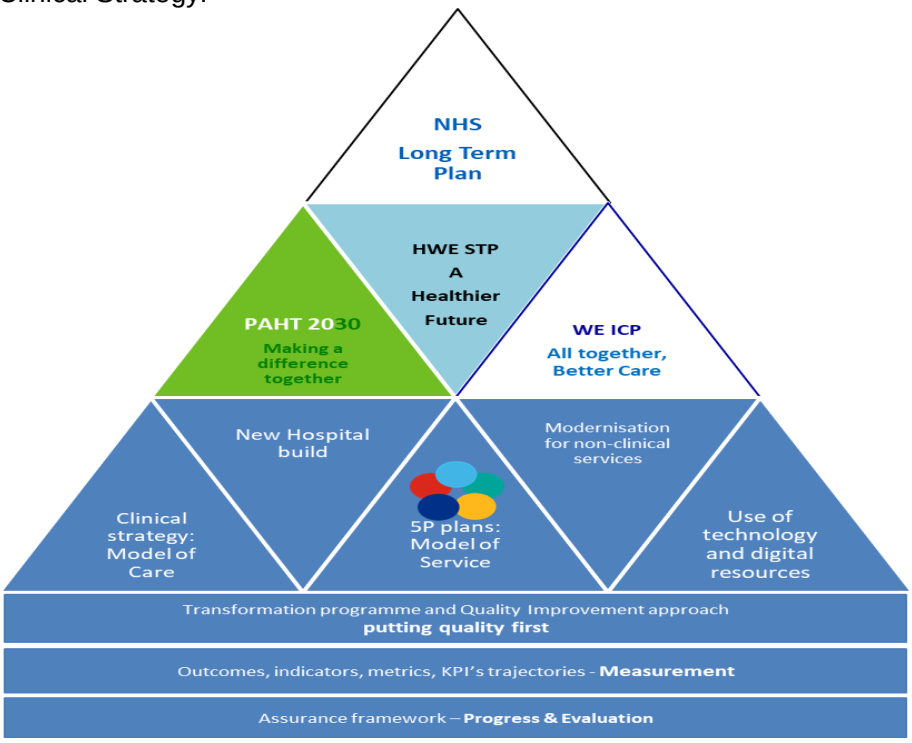
The purpose of this paper is to provide the Board with an update on the development of the PAHT 2030 Clinical Strategy.

2.0 Background

In June 2019 PAHT launched the development of the PAHT2030 Strategy. Underpinned by the PAHT 1 Vision, 3 Goals and 5 P's framework, PAHT2030 aims to describe our

- future model of care in response to the NHS Long Term Plan and our position within the One Health & Care Partnership and HWE STP
- our future estates requirements
- our modernisation plans
- our digital requirements over the next 10 years.

This paper outlines our approach and progress in the development of the PAHT2030 Clinical Strategy.



3.0 Proposal

The development of the PAHT Clinical Strategy is set around the following set of principles:

- Based upon the PAHT 2030 Framework
- Led & owned by the clinical teams

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- Includes SMART objectives based upon PAHT 5P's
- Based upon reliable & up to date data sets
- Underpinned by Population Health Management

It is proposed that the PAHT 2030 Clinical Strategy will provide a clear vision and model of care at speciality, health group and trust levels. The Clinical Strategy will outline the clinical roles and responsibilities PAHT has within the emerging ICP along with our opportunities to work across clinical networks with our STP partners.

Each sub section of the Clinical Strategy includes:

- A concise narrative which illustrates clear drivers for change and supports clinical teams in designing their future model of care based upon areas of predicted growth and demand, along with known national priorities and requirements and/or changes in practice.
- A speciality/Health Care Group Vision and set of 3 Courageous Goals developed with the entire clinical team and set upon the PAHT2030 organisational Goals of being Integrated, Modern and Outstanding.
- A clear depiction of what will be achieved over the next 10 years through defined objectives and outcomes developed through the PAHT 2030 5 P's Framework.
- A timeline for transformative change which outlines our priorities over 1-2 years, 3-5 years and 5+ years.

As illustrated in *Figure 1*, The Clinical Strategy is being built in tiers with clinical teams leading each part of the process through ½ day workshops and various working groups. As the speciality and disease pathway strategies are built, trends and highlights are identified at Health Care Group level to allow us to begin understanding our workforce, facilities and estates requirements over the next 10 years.

Each step of the process is undertaken with our partners from the One Health & Care Partnership to ensure the PAHT strategies align with and support the current strategic drivers outlined in the One Health & Care Partnership and STP Strategies, as well as focussing on the development of our internal core services and organisational drivers.

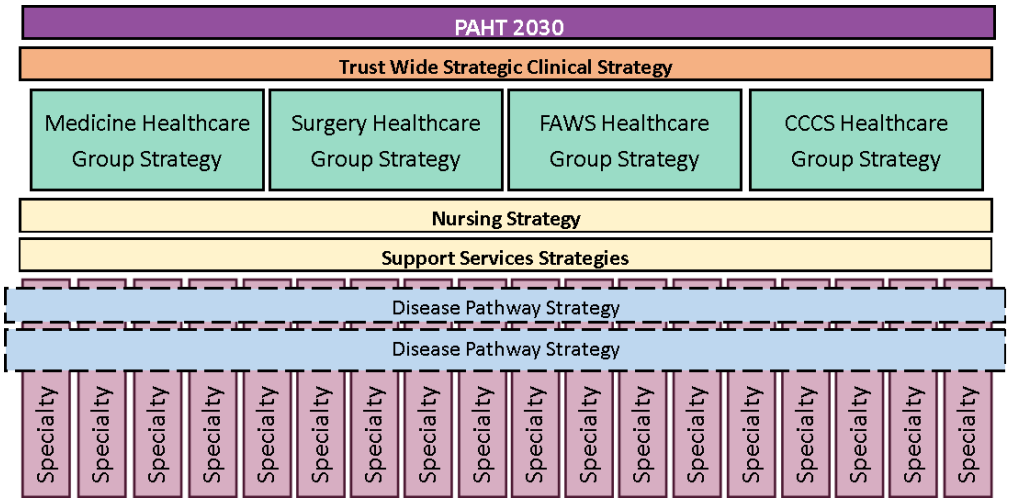

Figure 1: Tiered development of PAHT Clinical Strategy

Through facilitation by the Strategy Team, the clinical teams are taken through the process of developing a strategy fit for the next 10 years. This includes identifying changes in medical practice, workforce requirements and estates and facilities requirements to meet the demand predicted over the next 10 years.

As we move through the development process, each new model of care will be evaluated by a cross organisational group to confirm the overall impacts to finance, demand, workforce and estates. This will, in turn, begin to feed into the demand & capacity, CIP and operational planning cycles to provide the Trust and wider One Health & Care Partnership with an evidenced based foundation which should underpin all planning approaches.

4.0 Next steps or timeline

The original timeline for completion (*table 1*) is still on track to be achieved, with the final PAHT Clinical Strategy being presented to the PAH Trust Board in September 2020.

Table 2 displays the latest position for speciality team strategy development. The teams marked as green have either completed their Clinical Strategy Development Workshops, or have them scheduled within the next few weeks.

28.2.20	Phase 1 Completed
31.3.20	Phase 2 Completed
31.5.20	1st Draft of Clinical Strategy Completed
30.6.20	Clinical Team Agreement
30.6.20	Expert Oversight Group Agreement
31.7.20	Healthcare Group Agreement
31.7.20	EMT/SMT Agreement
30.9.20	Present final Clinical Strategy to PAHT Trust Board
30.9.20	Present final Clinical Strategy to ICP Board
30.9.20	Present final Clinical Strategy to STP Board

Table 1: Timeline for completion

Phase 1	Phase 2
October 19—February 2020	*December 2019—March 2020*
Maternity	Therapies
Paediatrics	T&O (inc. IMSKS)
Ophthalmology	Theatre Utilisation
Gastroenterology	Trauma
General Surgery	EOL
Urology	Haematology
Dermatology	Neurology
Care of the Elderly	Radiology
Frailty	Breast Surgery
Respiratory	Audiology/ENT/H&N
Cardiology	Patient @ Home
Outpatient Modernisation	Pharmacy
Pathology	Gynaecology
Urgent Care / Emergency Medicine	Critical Care
Diabetes & Endocrinology	Anaesthetics

Table 2: Latest position

4.0 Recommendation

We recommend that the Clinical Strategy Development Process continue as set out in this paper with regular updates to the Trust Board.

Author: Chloe Atkinson, Strategy & Development Manager
Date: 27th November 2019

The Princess Alexandra Hospital NHS
NHS Trust

Trust Board – 05.12.19

Agenda Item:	5.6
Presented by:	Chief Medical Officer – Andy Morris
Prepared by:	AD Operations – Surgery - Julie Matthews
Date prepared:	21st November 2019
Subject / Title:	Board Assurance 7 day services (7DS)

Purpose:	Approval		Decision		Information		Assurance	x

Key Issues: [please don't expand this cell; additional information should be included in the main body of the report]	In March 2019 NHS Improvement / England introduced a self-assessment process using a Board Assurance Framework (BAF) to monitor compliance with the NHS Clinical Standards for 7 Day services on a twice yearly basis. This BAF is the second formal submission. The priority standards which all Trusts are measured against are Standard 2: **Time to initial consultant review** •Standard 5: **Access to diagnostics** •Standard 6: **Access to consultant-led interventions** •Standard 8: **Ongoing daily consultant-directed review** Providers of acute services have previously completed a bi annual survey self-assessment Survey which was submitted to NHSI and then published the results. This assessment measured progress against the four priority standards through a combination of case note reviews and self-assessment. This new measurement system replaces the previous self-assessment survey and consists of a standard measurement and reporting template, which all providers of acute services will complete with self-assessments of their delivery of the 7DS clinical standards. The self-assessment template is attached for the Board to review and the completed template submitted to regional 7DS leads to enable measurement against the national ambitions for 7DS.
Recommendation:	The Trust Board is asked to approve the Board Assurance Framework for submission to the 7 Day Services Regional Team by the deadline of Friday 29 November 2019.

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

Previously considered by:	Executive Committee
Risk / links with the BAF:	None
Legislation, regulatory, equality, diversity and dignity implications:	Principles 1, 4, 5 and 7
Appendices:	Appendix 1 - Self – assessment template , sample rota's

1.1 Introduction

The Seven Day Hospital Services Programme aims to ensure that patients requiring emergency treatment receive high quality, consistent care every day of the week. Ten clinical standards for seven-day services (7DS) were developed in 2013 through the 7-Day Services Forum, of which four were identified as national priorities on the basis of their potential to positively affect patient outcomes. These are:

Clinical Standard 2 - Time to first consultant review

All emergency admissions must be seen and have a clinical assessment by a suitable consultant as soon as possible, but at the latest within 14 hours from the time of admission to hospital.

Clinical Standard 5 – Access to diagnostic tests

Hospital inpatients must have scheduled 7-day access to specialist diagnostic services.

Clinical Standard 6 – Access to consultant-directed interventions

Hospital inpatients must have timely 24-hour access, seven days a week, to key consultant-directed interventions, either on-site or through formally agreed networked arrangements. These interventions include interventional radiology, interventional endoscopy, emergency renal replacement therapy, urgent radiotherapy, stroke thrombolysis, percutaneous coronary intervention, cardiac pacing.

Clinical Standard 8 – Ongoing review by consultant twice daily if high dependency patients, daily for others

All patients identified with high dependency needs should be seen and reviewed by a consultant twice daily. Once a clear pathway of care has been established, patients should be reviewed by a consultant at least once every day, seven days a week, unless it has been determined that this would not affect the patient's care pathway.

1.2 Background

Prior to 2019, providers completed a bi-annual self-assessment survey, measuring progress against the four priority standards through a combination of case note reviews and self-assessment. PAH has performed well against the standards during the previous submissions and was subsequently invited to speak a 7DS conference on the implementation of the standards.

To provide direct oversight of progress of performance against 7DS Standards, from 2019 the Trust will be measured and reported through a Trust Board assurance framework that is to be submitted to regional and national 7DS teams. PAH has continued to undertake the bi annual case note audit as well as other supporting evidence part of the assurance to the Board. The audit was completed during October 2019 a sample size of 119 patients were reviewed, this is a calculation derived from the take for the hospital over the 7 day period of the review as designated by the 7DS audit. The local case note audit results the percentage of responses by specialty are detailed in the table below. The top three specialities included we acute medicine, paediatrics and General surgery, this is representative of admissions profile for the Trust across the week. A random sample of the responses were included in the audit. The table below shows the speciality split contained within the audit and the percentage.

Specialty	Number of Patients	Percentage of Patients
Acute Internal Medicine	**21**	**17.65**
Cardiology	**4**	**3.36**
Diabetes and Endocrinology	**2**	**1.68**
Emergency Medicine	**15**	**12.61**
Gastroenterology	**3**	**2.52**
General Surgery	**14**	**11.76**
Geriatric Medicine	**12**	**10.08**
Obstetrics and Gynaecology	**7**	**5.88**
Ophthalmology	**1**	**0.84**
Paediatric Medicine	**24**	**20.17**
Paediatric Surgical Wards	**1**	**0.84**
Trauma and Orthopaedic Surgery	**7**	**5.88**
Urology	**5**	**4.20**
Other	**3**	**2.52**

1.3 Supporting information

1.3.1 Clinical Standard 2 - Time to first consultant review

All emergency admissions must be seen and have a clinical assessment by a suitable consultant as soon as possible, but at the latest within 14 hours from the time of admission to hospital. There are sources of evidence provided for the assurance around this standard, namely Results of the 7DS clinical audit, Job plans and rota's.

Seen and Assessed within 14 hours of admission (compliance 90%)

	Admission Day						
	Monday	**Tuesday**	**Wednesday**	**Thursday**	**Friday**	**Saturday**	**Sunday**
Within 14 hours	15	9	12	20	11	11	11
% Within 14 hours	**93**	**52**	**92**	**68**	**78**	**73**	**73**
Outside of 14 hours	1	8	1	9	3	4	4
% Outside of 14 hours	6	47	7	31	21	26	26

The results of the October 2019 audit show that for weekdays the average percentage of patients seen within 14 hours was 75% and at the weekends was slightly lower at 73%. The previous audit of April 2019 of 72% on weekdays and 78% at weekends.

Patient made aware of diagnosis, management plan & prognosis within 48 hours of admission

	Admission Day						
	Monday	**Tuesday**	**Wednesday**	**Thursday**	**Friday**	**Saturday**	**Sunday**
Within 48 hours	15	14	12	27	13	11	14
% Within 48 hours	**93**	**82**	**92**	**93**	**92**	**73**	**93**
Outside of 48 hours	1	3	1	2	1	4	1
% Outside of 48 hours	6	17	7	6	7	26	6

The performance over weekdays was 91% and at weekends was 83%.

Sample rotas in appendix 2 provides evidence of rotas with Consultant cover at the weekends which would facilitate the above and clinical standard 2 and 8.

The deterioration in the results could related to the poor documentation in the patients notes, as this was is a retrospective audit undertaken by a notes review by a member of the audit team. Documentation was highlighted in the latest CQC report as an area of improvement required and the actions to improve this is detailed in the CQC action plan. The Mortality improvement board has a work stream dedicated to improving the documentation contained within the notes.

1.3.2 Clinical Standard 5 – Access to diagnostic tests

Hospital inpatients must have scheduled 7-day access to specialist diagnostic services including Computerised Tomography (CT), ultrasound, magnetic resonance imaging (MRI), microbiology, echocardiography and endoscopy. Consultant –directed diagnostic test are completed and reporting will be available 7 days a week within 1 hour for critical patients and within 12 hours for urgent patient

The Trust meets this standard overall. However, areas of non-compliance to the standard are access to endoscopy and echocardiography's at weekends. The staffing levels and difficulty in recruiting echocardiographers has resulted in a 5-day service for routine inpatients. The CCSS HCG has produced a paper and workforce plan to move to a 6 days service this year and progress to 7 days in 20/21. Cardiology Registrars on over a weekend perform any clinically urgent referrals if required. The current demand for this service at a weekend is low. Informal arrangements in place to provide weekend cover via alternative routes for patients who may require interventional endoscopy.

1.3.3 Clinical Standard 6 – Access to consultant-directed interventions

Hospital inpatients must have timely 24-hour access, seven days a week, to key consultant-directed interventions, either on-site or through formally agreed networked arrangements.

These interventions include interventional radiology, interventional endoscopy, emergency renal replacement therapy, urgent radiotherapy, stroke thrombolysis, percutaneous coronary intervention, cardiac pacing.

The Trust meets the standard for this on weekdays across all elements. The only areas of non-compliance to the standard are endoscopy and interventional radiology at weekends. Informal arrangements in place to provide weekend cover via alternative routes for patients who may require interventional endoscopy, this is reflective of the national picture for these specialities. Discussions are underway around Network arrangements for both services across 7 days with our STP partners. Interventional radiology cover over 7 days for vascular interventions will form part of the hub and spoke model for vascular emergencies across the STP and discussion are underway to find an STP wide solution to this non-compliance against the 7DS for this consultant directed intervention.

1.3.3 Clinical Standard 8 – Ongoing review by consultant twice-daily if high dependency patients, daily for others

All patients identified with high dependency needs should be seen and reviewed by a consultant twice daily. Once a clear pathway of care has been established, patients should be reviewed by a consultant at least once every day, seven days a week, unless it has been determined that this would not affect the patient's care pathway.

The Trust meets the standard for patients identified with high dependency needs should be seen and reviewed by a consultant twice daily as demonstrated by the results of the audit detailed below. This is the second consecutive audit were this standard has been achieved following a change made within the critical care team. Prior to the April 2019 survey, the Trust failed to meet this standard.

Patients requiring twice-daily reviews (90%)

	Review Day						
	Monday	**Tuesday**	**Wednesday**	**Thursday**	**Friday**	**Saturday**	**Sunday**
Number of patients requiring twice daily reviews	3	3	2	3	2	2	4
Number of patients receiving twice daily reviews	3	3	2	3	2	2	4
Number of patients excluded	0	0	0	0	0	0	0
% of patients receiving twice daily reviews	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**

The rota detailed in appendix show that Consultant and registrar cover provided 7 days per week in critical care. Any patient within the Trust identified as requiring high dependency care are located in the critical care areas.

Patients requiring once daily reviews (90%)

	Review Day						
	Monday	**Tuesday**	**Wednesday**	**Thursday**	**Friday**	**Saturday**	**Sunday**
Number of patients requiring once daily reviews	52	55	42	39	50	38	45
Number of patients receiving once daily review	51	53	42	39	44	31	36
Number of patients excluded	0	0	0	0	0	0	0
% of patients receiving once daily review	**98%**	**96%**	**100%**	**100%**	**88%**	**81%**	**80%**

The Trust fails to meet the standard for this at the weekends achieving 80% and but achieves the standard at 96% during the weekdays.

There are systems in place to allow review of all patients every day, and within 14 hours of admission for the primary admitting this can be evidenced through the rota's and job plan although the audit revealed that this is not always consistently documented. A review of the datix incident reported at the weekends does not appear to show an increase in the number of patient safety incidents reported at the weekends, the number are shown on sheet 2 in the appendices. This triangulates with the CQC report and the mortality improvement work stream on documentation improvements. There are actions in place under these work steams to improve documentation and therefore no further actions proposed because of this audit.

1.4 Summary

- Standard 2: Time to initial consultant review –Overall Standard not achieved
- Standard 5: Access to diagnostics – Overall standard achieved consistently
- Standard 6: Access to consultant-led interventions – Overall standard not achieved because of non-compliance in Interventional radiology and interventional endoscopy at weekends only. The Trust is in discussion with STP partners to scope potential solutions, and is representative of the national picture for these areas.
- Standard 8: Ongoing daily consultant-directed review – Twice daily reviews standard consistently achieved. Once daily reviews standard was not achieved in the last two audits and this is a deterioration from the previous achievement in this area. The

audit allowed areas for improvement to be identified to improve Trust performance against the standard. The Trust as implemented hospital at night in the intervening period between the spring and autumn audits of 2019 and work is underway to roll this programme across the weekends in the future.

1.5 Recommendations

The Trust Board is asked to approve the Board Assurance Framework for submission to the 7 Day Services Regional Team by the deadline of Friday 29 November 2019.

7 Day Hospital Services Self-Assessment

Organisation	**The Princess Alexandra Hospital NHS Trust**
Year	**2019/20**
Period	**Autumn/Winter**

The Princess Alexandra Hospital NHS Trust: 7 Day Hospital Services Self-Assessment - Autumn/Winter 2019/20

Priority 7DS Clinical Standards

Clinical standard	Self-Assessment of Performance	Weekday	Weekend	Overall Score
Clinical Standard 2: All emergency admissions must be seen and have a thorough clinical assessment by a suitable consultant as soon as possible but at the latest within 14 hours from the time of admission to hospital.	The results of the October 2019 audit show that for weekdays the average percentage of patients seen within 14 hours was 75% and at the weekends was slightly lower at 73%. The previous audit of April 2019 of 72% on weekdays and 78% at weekends. There are processes in place to allow review of all patients every day, and within 14 hours of admission for the primary admitting this can be evidenced through the rota's and job plan although the audit revealed that this is not always consistently documented. This triangulates with the CQC report and the mortality improvement work stream on documentation improvements.	No, the standard is not met for over 90% of patients admitted in an emergency	No, the standard is not met for over 90% of patients admitted in an emergency	Standard Not Met

Clinical standard	Self-Assessment of Performance		Weekday	Weekend	Overall Score
Clinical Standard 5: Hospital inpatients must have scheduled seven-day access to diagnostic services, typically ultrasound, computerised tomography (CT), magnetic resonance imaging (MRI), echocardiography, endoscopy, and microbiology. Consultant-directed diagnostic tests and completed reporting will be available seven days a week: • Within 1 hour for critical patients • Within 12 hour for urgent patients • Within 24 hour for non-urgent patients	Q: Are the following diagnostic tests and reporting always or usually available on site or off site by formal network arrangements for patients admitted as an emergency with critical and urgent clinical needs, in the appropriate timescales?	Microbiology	Yes available on site	Yes mix of on site and off site by formal arrangement	Standard Met
		Computerised Tomography (CT)	Yes available on site	Yes mix of on site and off site by formal arrangement	
		Ultrasound	Yes available on site	Yes available on site	
	Areas of non compliance to the standard are Endoscopy and Echo's at weekends. The staffing levels and difficulty in recruiting Echocardiographers has meant that we do not to provide a 7 day service for routine inpaients. THe HCG has produced a paper and workforce plan to move to a 6 days service this year and progress to 7 days in 20/21. Cardiology Registrars on over a weekend perform Echos on any clinically urgent referrals . Current demand for this service at a weekend is low . Informal arrangements in place to provide weekend cover via alternative routes for patients who may require	Echocardiography	Yes available on site	No the test is not available	
		Magnetic Resonance Imaging (MRI)	Yes available on site	Yes mix of on site and off site by formal arrangement	
		Upper GI endoscopy	Yes available on site	No the test is only available on or off site via informal arrangement	

Clinical standard	Self-Assessment of Performance		Weekday	Weekend	Overall Score
Clinical Standard 6: Hospital inpatients must have timely 24 hour access, seven days a week, to key consultant-directed interventions that meet the relevant specialty guidelines, either on-site or through formally agreed networked arrangements with clear written protocols.	Q: Do inpatients have 24-hour access to the following consultant directed interventions 7 days a week, either on site or via formal network arrangements?	Critical Care	Yes available on site	Yes available on site	Standard Not Met
		Interventional Radiology	Yes available on site	No the intervention is not available	
		Interventional Endoscopy	Yes available on site	No the intervention is only available on or off site via informal arrangement	
		Emergency Surgery	Yes available on site	Yes available on site	
	This standard is met on weekdays across all elements. Areas of non compliance to the standard are Endoscopy and interventional radiology at weekends. Informal arrangements in place to provide weekend cover via alternative routes for patients who may require interventional endoscopy. Discussions are underway around Network arrangements for both services across 7 days with our STP partners	Emergency Renal Replacement Therapy	Yes available on site	Yes available on site	
		Urgent Radiotherapy	Yes available off site via formal arrangement	Yes available off site via formal arrangement	
		Stroke thrombolysis	Yes available off site via formal arrangement	Yes available off site via formal arrangement	
		Percutaneous Coronary Intervention	Yes available on site	Yes available off site via formal arrangement	
		Cardiac Pacing	Yes available on site	Yes available off site via formal arrangement	

Clinical standard	Self-Assessment of Performance	Weekday	Weekend	Overall Score
Clinical Standard 8: All patients with high dependency needs should be seen and reviewed by a consultant TWICE DAILY (including all acutely ill patients directly transferred and others who deteriorate). Once a clear pathway of care has been established, patients should be reviewed by a consultant at least ONCE EVERY 24 HOURS, seven days a week, unless it has been determined that this would not affect the patient's care pathway.	The Trust fails to meet the standard for once daily reviews at the weekends achieving 80% and but achieves the standard at 96% during the weekdays. There are systems in place to allow review of all patients every day, and within 14 hours of admission for the primary admitting this can be evidenced through the rota's and job plan although the audit revealed that this is not always consistently documented. This triangulates with the CQC report and the mortality improvement work stream on documentation improvements. There are actions in place under these work steams to improve documentation and therefore no further actions are proposed as a result of this audit The Trust achevies the standard for twice daily reviews on across the week and weekends.	Once daily: Yes the standard is met for over 90% of patients admitted in an emergency	Once Daily: No the standard is not met for over 90% of patients admitted in an emergency	Standard Not Met
		Twice daily: Yes the standard is met for over 90% of patients admitted in an emergency	Twice daily: Yes the standard is met for over 90% of patients admitted in an emergency	

7DS Clinical Standards for Continuous Improvement

Self-Assessment of Performance against Clinical Standards 1, 3, 4, 7, 9 and 10
From 2015 - early 2019 Princess Alexandra NHS trust has achieved 90% plus in the four priority clinical standards CS2 74% 2016 - 90% 2018 , CS5 93% 2016-2018, CS6 94% 2016-2018, CS8 83% - 2016 90% - 2018 Some of the main drivers behind this improvement are the introduction of professions clinical standards, using Urgent care board and Senior management team meeting to monitor the standards.we have weak spots in Endoscopy, IR and Consultant reviews at the weekend reviews and reviews within 14 hours of admission. The drivers for this is beleived to be poor documentation and this is being actioned through work streams under mortiality and the CQC must and shoulds. The Trust as implemented hospital at night in the intervening period between the spring and autumn audits of 2019 and work is underway to roll this programme across the weekends in the future.

7DS and Urgent Network Clinical Services

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

Assessment of Urgent Network Clinical Services 7DS performance (OPTIONAL)
The Trust does not supply services for hyperacute strolke Paediatric intensice care STEMI heart Attack or Major trauma. The trust is currently part of the Essex network for emergency vascular services but is currently working with STP partners move to an STP delivered hub and spoke model for all vascualr activity.

Template completion notes

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

The Princess Alexandra Hospital NHS Trust

Trust Board – 5 December 2019

6.1

Agenda item:	6.1
Presented by:	Ogechi Emeadi, Director of People, OD & communications
Prepared by:	Ogechi Emeadi, Director of People, OD & communications
Date prepared:	28 November 2019
Subject / title:	Freedom to Speak Up Trust Self-Assessment

Purpose:	Approval	X	Decision		Information	X	Assurance	

Key issues:	The freedom to speak up trust self-assessment is attached. The self-assessment reflects where the Trust has met/partially met or not met the expectations along with the supporting evidence and actions since its last review in May 2019. The partially or not met expectations relates largely to ensuring that cases are regularly audited or peer reviewed. Having a positive raising concerns culture does not lie with any single part of the trust and therefore this self-assessment should be read as part of trusts overall organisational culture specifically how the trust engages with and supports its people.
Recommendation:	The Board is asked to discuss and approve the self-assessment.

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

Previously considered by:	Remuneration Committee on 7 November 2019 (partially considered)
Risk / links with the BAF:	2.3 inability to attract, recruit and retain
Legislation, regulatory, equality, diversity and dignity implications:	
Appendices:	

Your future | Our hospital

respectful | caring | responsible | committed

National Guardian
Freedom to Speak Up

NHS
Improvement

Freedom to Speak Up self-review tool for NHS Trusts and Foundation Trusts

~~May 2019~~ November 2019

How to use this tool

Effective speaking up arrangements help to protect patients and improve the experience of NHS workers. Having a healthy speaking up culture is evidence of a well-led Trust.

NHS Improvement and the National Guardian's Office have published a guide setting out expectations of boards in relation to Freedom to Speak Up (FTSU) to help boards create a culture that is responsive to feedback and focused on learning and continual improvement.

This self-review tool accompanying the guide will enable boards to carry out in-depth reviews of leadership and governance arrangements in relation to FTSU and identify areas to develop and improve.

The Care Quality Commission (CQC) assesses a Trust's speaking up culture during inspections under key line of enquiry (KLOE) 3 as part of the well-led question. This guide is aligned with the good practice set out in the well-led framework, which contains references to speaking up in KLOE 3 and will be shared with Inspectors as part of the CQC's assessment framework for well-led.

Completing the self-review tool and developing an improvement action plan will help Trusts to evidence their commitment to embedding speaking up and help oversight bodies to evaluate how healthy a Trust's speaking up culture is.

Self review indicator (Aligned to well-led KLOEs)	To what extent is this expectation being met?	What are the principal actions required for development?	How is the board assured it is meeting the expectation? Evidence
Our expectations			
Leaders are knowledgeable about FTSU			
Senior leaders are knowledgeable and up to date about FTSU and the executive and non-executive leads are aware of guidance from the National Guardian's Office.	Fully met	Report to Board sub committees three times a year. Attendance at the Trust Board as required. This self review tool is presented annually.	FTSUG attend the Workforce Board Sub Committee to present their report three times a year. FTSUG are members of the people board. FTSUG staff stories and discussion at Trust Board June 2018 Regular and individual meetings with the CEO, director of people and non-executive director lead for FTSU.

Senior leaders can readily articulate the Trust's FTSU vision and key learning from issues that workers have spoken up about and regularly communicate the value of speaking up.	Fully met	Embed into leadership and communications activities as 'business as usual'	Regular CEO communications Posters publicising the philosophy, structures, roles and responsibilities
They can provide evidence that they have a leadership strategy and development programme that emphasises the importance of learning from issues raised by people who speak up.	Fully met	Promote FTSU within the new Behavioural Charter & Leading yourself & Team framework	Feedback from Staff FFT, Staff & behavioural surveys
Senior leaders can describe the part they played in creating and launching the Trust's FTSU vision and strategy.	Fully met		CEO personally led the appointment, promotion and development of the FTSUG FTSUGs shared their experience at the June 2018 Trust Board
Leaders have a structured approach to FTSU			
There is a clear FTSU vision, translated into a robust and realistic strategy that links speaking up with patient safety, staff experience and continuous improvement.	Partially met	Consideration by the Quality & Safety committee &	Review of any external whistleblowing cases (CQC insight report) to

		underpinning governance	the current internal FSUG policies and procedures
There is an up-to-date speaking up policy that reflects the minimum standards set out by NHS Improvement.	Fully met	Continue to promote the policies	FTSUG & Whistleblowing policy updated in 2018.
The FTSU strategy has been developed using a structured approach in collaboration with a range of stakeholders (including the FTSU Guardian) and it aligns with existing guidance from the National Guardian.	Fully met	Consideration of a separate strategy and plan in 2019/20	FTSUGs joined Heads of professions in January 2018 to design and develop the new People Strategy and plan for 2018/19. A comprehensive strategy was approved at Trust Board in March 2019.
Progress against the strategy and compliance with the policy are regularly reviewed using a range of qualitative and quantitative measures.	Fully/partially met	As above	People metrics qualitative and quantitative aligned to people strategy and plan
Leaders actively shape the speaking up culture			

All senior leaders take an interest in the Trust's speaking up culture and are proactive in developing ideas and initiatives to support speaking up.	Fully met	Create more consistency in developing ideas and initiatives to support speaking up at every level of leadership	Board setting the style and tone through a focus on culture and behaviours include board development, TTEF observations at exec meetings and senior management meetings. NHSI board/sub board committee observation
They can evidence that they robustly challenge themselves to improve patient safety, and develop a culture of continuous improvement, openness and honesty.	Partially met	As above in relation to a culture of continuous improvement, openness and honesty	CEO leading by example and recruiting leaders accordingly. Challenging coaching training delivered to all senior managers. Behaviour charter Etiquette rules in meetings
Senior leaders are visible, approachable and use a variety of methods to seek and act on feedback from workers.	Fully met	Ongoing programme of targeted walkabouts	Weekly staff brief, Board buddying system, staff and culture surveys, Ask Lance, 15 steps

			programme, ad hoc visits to departments
Senior leaders prioritise speaking up and work in partnership with their FTSU Guardian.	Fully met	Extend relationship of FTSUGs with leaders and staff representatives at all levels	CEO, director of people, deputy director of people, and head of staff engagement engage FTSUG in opportunities for partnership working eg equality and inclusion group, staff engagement group, staff council, event in a tent, mental health awareness days, staff health and wellbeing (SHaW) events
Senior leaders model speaking up by acknowledging mistakes and making improvements.	Partially met	Integrate into the CEOs new OD programme (due to be launched on 5 July with the Trust Board and top 100 leaders on 9 July 2018)	Feedback from staff, patient and cuture culture surveys and The Trusted Executive Foundation (TTEF) survey due in July 2019. Continuous improvement.

The board can state with confidence that workers know how to speak up; do so with confidence and are treated fairly.	Partially met	Continue to promote through existing communications channels	See above
Leaders are clear about their role and responsibilities			
The Trust has a named executive and a named non-executive director responsible for speaking up and both are clear about their role and responsibility.	Fully met	Confirm NED and exec	Member of the patient safety and quality committee is the named NED. Director of people is the named Executive Director CEO meets with F2SUG regularly
They, along with the chief executive and chair, meet regularly with the FTSU Guardian and provide appropriate advice and support.	Fully met	See above	See above
Other senior leaders support the FTSU Guardian as required.	Fully met	Extend relationship of FTSUGs with leaders at all levels	Deputy director of people, members of the Workforce sub committee

Leaders are confident that wider concerns are identified and managed			
Senior leaders have ensured that the FTSU Guardian has ready access to applicable sources of data to enable them to triangulate speaking up issues to proactively identify potential concerns.	Fully met	Invite the FTSUG to identify any additional sources of data and/or insights to identify potential concerns	As members of the Workforce Committee, FTSUG receive monthly reports on key workforce performance indicators, ER activity, staff surveys
The FTSU Guardian has ready access to senior leaders and others to enable them to escalate patient safety issues rapidly, preserving confidence as appropriate.	Fully met	Ensure that FTSUGs are incorporated into the induction meetings for all new senior leaders	FTSUG have confirmed that they have a positive relationship with and ready direct access to senior leaders for any matter
Leaders receive assurance in a variety of forms			
Workers in all areas know, understand and support the FTSU vision, are aware of the policy and have confidence in the speaking up process.	Partially met	Audit/ survey workers	Widespread communication of FTSUG through induction, policies & communications (leaflets, screensavers, Intranet, etc), banners,

			regular visits
Steps are taken to identify and remove barriers to speaking up for those in more vulnerable groups, such as Black, Asian or minority ethnic (BAME), workers and agency workers	Fully met	Continue to work with the Equality &Inclusion group Members of the staff engagement group	Agendas items, notes of E & I Group
Speak up issues that raise immediate patient safety concerns are quickly escalated	Fully met	Continue to review effectiveness of escalation arrangements	Confirmed by the FTSUG
Action is taken to address evidence that workers have been victimised as a result of speaking up, regardless of seniority	Fully met	Continue to review effectiveness of actions taken to address workers who have spoken up	Confirmed by the FTSUG
Lessons learnt are shared widely both within relevant service areas and across the Trust	Partially met	Report to workforce sub committee in Q4 of 2018/9	Lessons learnt have been used to form part of the delivery of unconscious bias training. shared with a small select set of individuals due to maturity of the model

			FTSUG now report to HCG boards. Themes to be discussed at PRMs
The handling of speaking up issues is routinely audited to ensure that the FTSU policy is being implemented	Partially met	Report to workforce sub board committee	Reports are presented to workforce committee three times a year.
FTSU policies and procedures are reviewed and improved using feedback from workers	Fully met	See above	Policy committee
The board receives a report, at least every six months, from the FTSU Guardian.	Fully met	See above (through the Workforce Committee)	See above
Leaders engage with all relevant stakeholders			
A diverse range of workers' views are sought, heard and acted upon to shape the culture of the organisation in relation to speaking up; these are reflected in the FTSU vision and plan.	Fully met	Continue to ensure that a range of workers' views are sought, heard and acted upon to shape the culture of the organisation in relation to speaking up with the E & I Group.	People strategy, plan 19/20 and underpinning governance arrangements including people board, equality and inclusion group, staff engagement group
Issues raised via speaking up are part of the performance data discussed openly with commissioners, CQC and NHS Improvement.	Fully met	Review with CEO and Executive Team.	Themes discussed at CQC well led inspection and use of resources in

			March and April 2019. Specific issues form part of CQC quality meetings (insight report) and NHSI/E performance report meetings
Discussion of FTSU matters regularly takes place in the public section of the board meetings (while respecting the confidentiality of individuals).	Partially met	Schedule regular staff stories at the Trust Board	Commenced in June 2018
The Trust's annual report contains high level, anonymised data relating to speaking up as well as information on actions the Trust is taking to support a positive speaking up culture.	Partially met	Integrate to plan for development of next year's annual report	Published annual report
Reviews and audits are shared externally to support improvement elsewhere.	Partially met	Develop audit tool	Detailed quarterly report shared with NGO.
Senior leaders work openly and positively with regional FTSU Guardians and the National Guardian to continually improve the Trust's speaking up culture	Partially met as it is the FTSUG's who work with other regional Guardians and the NGO.	Include in inaugural report to workforce committee in Q4 for 2018/19	N/A
Senior leaders encourage their FTSU Guardians to develop bilateral relationships with regulators,	Fully met	Integrate into the regulatory timetable	Met with CQC inspectors in April 2019

inspectors and other local FTSU Guardians			
Senior leaders request external improvement support when required.	Fully met	Inform FTSUG of external improvement support.	External improvement support obtained in numerous areas eg ECIST, AHSNs etc
Leaders are focused on learning and continual improvement			
Senior leaders use speaking up as an opportunity for learning that can be embedded in future practice to deliver better quality care and improve workers' experience.	Fully met	Integrate learning into the communications aligned to the continuous improvement cycle	Examples form the Quality Improvement team
Senior leaders and the FTSU Guardian engage with other Trusts to identify best practice.	Fully met	Continue to network with Trusts and FTSUGs	Confirmed by FTSUG
Executive and non-executive leads, and the FTSU Guardian, review all guidance and case review reports from the National Guardian to identify improvement possibilities.	Fully met	Extend to include the new Director of People, OD & Communications	Achieved by FTSUG meetings with CEO meetings and director of people
Senior leaders regularly reflect on how they respond to feedback, learn and continually improve and encourage the same throughout the organisation.	~~Partially~~ Fully met	Integrate into the CEOs new OD programme	Numerous diagnostic reports received by senior leaders. The Trusted executive

			survey to top 100 leaders outcome presented in August 2019 Staff friends and family test now include additional questions to track senior leaders behaviour 360 feedback part of appraisal for senior leaders
The executive lead responsible for FTSU reviews the FTSU strategy annually, using a range of qualitative and quantitative measures, to assess what has been achieved and what hasn't; what the barriers have been and how they can be overcome; and whether the right indicators are being used to measure success.	Partially met	Ensure the report to workforce committee in Q4 is robust	Currently achieved through review of people strategy and plan (pillar 1 culture & well being) 2018/19
The FTSU policy and process is reviewed annually to check they are fit for purpose and realistic; up to date; and takes account of feedback from workers who have used them.	Fully met	N/A	Business as usual for the Policy committee

A sample of cases is quality assured to ensure: • the investigation process is of high quality; that outcomes and recommendations are reasonable and that the impact of change is being measured • workers are thanked for speaking up, are kept up to date though out the investigation and are told of the outcome • Investigations are independent, fair and objective; recommendations are designed to promote patient safety and learning; and change will be monitored	Not met	Consider formal peer review for QA purposes	Reviewed informally by CEO & Head of HR with FTSUG A formal peer review to be undertaken in Q4.
Positive outcomes from speaking up cases are promoted and as a result workers are more confident to speak up.	Partially met	Consider methodology for determining if there is link between the promotion of positive outcomes and confidence of workers to speak up	Achieved through existing communication channels -New communications team will support targeted communications and will feature in the communications strategy.

Individual responsibilities			
Chief executive and chair			
The chief executive is responsible for appointing the FTSU Guardian.	Fully met	N/A	Achieved in November 2017
The chief executive is accountable for ensuring that FTSU arrangements meet the needs of the workers in their Trust.	Fully met	N/A	See above
The chief executive and chair are responsible for ensuring the annual report contains information about FTSU.	Fully met (with support from HR)	N/A	Contained in annual report
The chief executive and chair are responsible for ensuring the Trust is engaged with both the regional Guardian network and the National Guardian's Office.	Fully met	N/A	Achieved
Both the chief executive and chair are key sources of advice and support for their FTSU Guardian and meet with them regularly.	Fully met	N/A	Confirmed by FTSUGs regularly meet CEO and have met new chairman.
Executive lead for FTSU			

Ensuring they are aware of latest guidance from National Guardian's Office.	Fully met	Continue to review latest guidance from the National Guardian's Office at CEO meetings	Achieved through regular director of people meetings and CEO meetings
Overseeing the creation of the FTSU vision and strategy.	Fully met	N/A	People Strategy and plan 2019/20 (pillar 1: Culture & well being)
Ensuring the FTSU Guardian role has been implemented, using a fair recruitment process in accordance with the example job description and other guidance published by the National Guardian.	Fully met	N/A	Achieved in November 2018 by the CEO & Head of HR
Ensuring that the FTSU Guardian has a suitable amount of ring fenced time and other resources and there is cover for planned and unplanned absence.	Fully met	Review annually	See above including the recruitment of F2SUG champions.

Ensuring that a sample of speaking up cases have been quality assured.	Partially met	Consider as part of peer review (see above)	N/A
Conducting an annual review of the strategy, policy and process.	Not met (due)	Plan an annual review in December 2019	Integral to review of people plan 201~~98~~/~~19~~120 Q4
Operationalising the learning derived from speaking up issues.	Partially ~~Not~~ met	Consider how to operationalise the learning from speaking up issues	~~N/A~~Learning forms part of the unconscious bias training for managers and the introduction of am I a bully training. Specific area have piloted 'in your shoes' intervention
Ensuring allegations of detriment are promptly and fairly investigated and acted on.	Fully met	Publicise anonymised allegations, investigations and actions	Confirmed by FTSUG

Providing the board with a variety of assurance about the effectiveness of the Trusts strategy, policy and process.	Fully met	Continue to integrate assurance through existing governance arrangements	Integral to review of people plan 2018/19
Non-executive lead for FTSU			
Ensuring they are aware of latest guidance from National Guardian's Office.	Fully met	a named NED to review with the FTSUG.	Named NED regularly meets with F2SUG
Holding the chief executive, executive FTSU lead and the board to account for implementing the speaking up strategy.	Fully met	See above	Named NED raises any issues with with the CEO or director of people
Robustly challenge the board to reflect on whether it could do more to create a culture responsive to feedback and focused on learning and continual improvement.	Fully met	Propose 'reflections and review' as a regular agenda item at Board and/or sub committee meetings	Standing item at Board and sub committee meetings
Role-modelling high standards of conduct around FTSU.	Fully met	Consider incorporating a review of role modelling high standards of conduct as part of the new 360 tool	NEDs at workforce committee receive positive feedback on role modelling high standards of conduct

			Named NEDs appraisal
Acting as an alternative source of advice and support for the FTSU Guardian.	Fully met	See above	Named NED meets regularly with F2SUGs and provides a coaching and mentoring support
Overseeing speaking up concerns regarding board members.	Fully met	Continue to oversee speaking up concerns	Confirmed by FTSUG
Human resource and organisational development directors			
Ensuring that the FTSU Guardian has the support of HR staff and appropriate access to information to enable them to triangulate intelligence from speaking up issues with other information that may be used as measures of FTSU culture or indicators of barriers to speaking up.	Fully met	Continue to triangulate insights together (FTSUG and HRBPs)	Regular meetings deputy director of people and HR business partners
Ensuring that HR culture and practice encourage and support speaking up and that learning in relation to workers' experience is disseminated across the Trust.	Fully met	Continue to audit and develop a positive people culture and practice which is based on the TTEF methodology	Evidenced via corporate staff and culture surveys and local HCG surveys

Ensuring that workers have the right knowledge, skills and capability to speak up and that managers listen well and respond to issues raised effectively.	Fully met	Roll out the new behavioural charter, leading self and teams framework	Robust recruitment and appraisal (including development) processes and systems
Medical director and director of nursing			
Ensuring that the FTSU Guardian has appropriate support and advice on patient safety and safeguarding issues.	Fully met	Arrange induction meeting with FTSUGs and new Director of Nursing & Midwifery	FTSUG confirmed that they are able to discuss with medical director and nursing director
Ensuring that effective and, as appropriate, immediate action is taken when potential patient safety issues are highlighted by speaking up.	Fully met	See above	See above
Ensuring learning is operationalised within the teams and departments that they oversee.	Partially met	Produce reports for operational teams to ensure learning has been shared as appropriate	Demonstrated at PS&Q meetings through reports

The Princess Alexandra Hospital NHS Trust

Trust Board – 05.12.19

Agenda item:	7.1
Presented by:	Stephanie Lawton – Chief Operating Officer (COO)
Prepared by:	Information Team, HealthCare Groups & Corporate Teams
Date prepared:	22 November 2019
Subject / title:	M7 Integrated Performance Report (IPR)

Purpose:	Approval		Decision		Information	x	Assurance	x

Key issues:	**Patients:** A new approach to the management of complaints timelines to be introduced. Proposal to be shared with EMT, SMT and QSC before implementation in the new year. **People:** Registered nurse vacancy improving. Retention improving. Focus on appraisals and statutory and mandatory training. **Performance:** Emergency care remains challenging. Ambulance handovers significantly improved. Recruitment ongoing. Cancer and RTT on trajectory for improvement. **Pounds:** The in-month deficit (excluding PSF). **Places:** Significant progress on the annual capital backlog programme. Ward refurbishment programme underway.
Recommendation:	The Board is asked to discuss the report and note the current position and further action being taken in areas below agreed standards.

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

Previously considered by:	QSC.22.11.19 PAF.28.11.19
Risk / links with the BAF:	
Legislation, regulatory, equality, diversity and dignity implications:	No regulatory issues/requirements identified.
Appendices:	M7 IPR

7.1

Your future | Our hospital

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The Princess Alexandra Hospital NHS Trust

Integrated Performance Report

October 2019

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

Your future | Our hospital

Contact:

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

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Trust Objectives

The Princess Alexandra Hospital NHS Trust

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

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

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

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

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

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5Ps

In this month

The Princess Alexandra Hospital NHS Trust

Patients

Performance

People

Pounds

Places

7.1

Executive Summary Our Patients

The Princess Alexandra Hospital NHS Trust

Patient Experience

A new approach to the management of complaints timelines is to be introduced on receipt of a complaint. This will be changing from the new year with a proposal being shared with relevant committees for discussion before implementation at EMT, SMT and QSC.

Incidents

There were 1168 (1170) incidents in total reported in October 2019. 932 (947) incidents were PAH, comprising of 717 (700) no harm, 189 (217) minor harm (97.2%), 24 (28) moderate harm (2.6%), 2 (2) severe harm (0.2%). The percentage spread is consistent with previous months.

Infection Control

The IC metrics remain stable.

Maternity Data Set

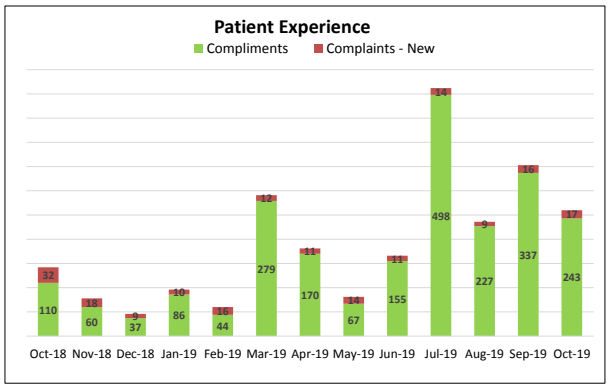
The total number of mothers delivering in Birthing Unit/home in October was less than 1%, as the Birthing Unit was closed throughout the month due to water quality issues. This is being reviewed under the SI process. The Birthing Unit re-opened during November 2019.
The Planned C Section rate was higher than usual, therefore an audit of the indications for C Sections is planned in order to understand the themes for indications for C sections and determine if these are always appropriate and how we can address this.

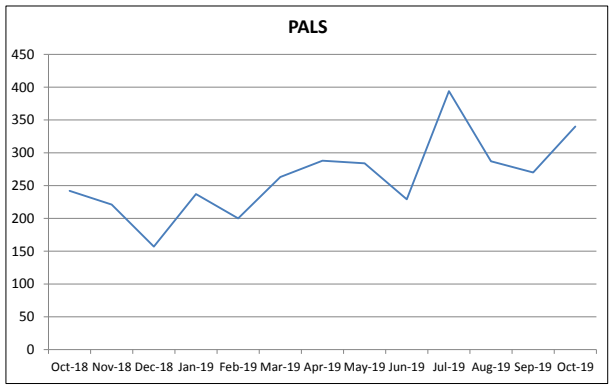
Patient Experience

1 Our Patients Summary 1.1 Patient Experience

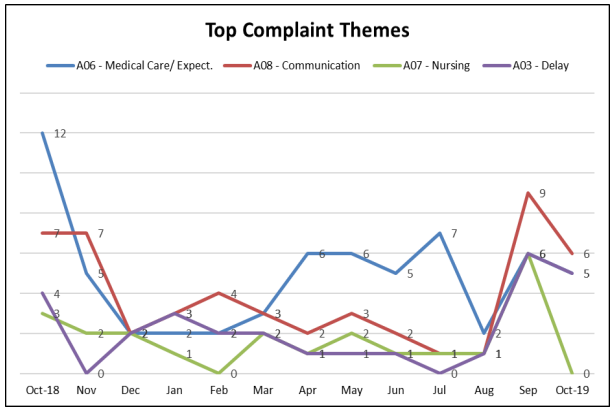
The Princess Alexandra Hospital NHS Trust

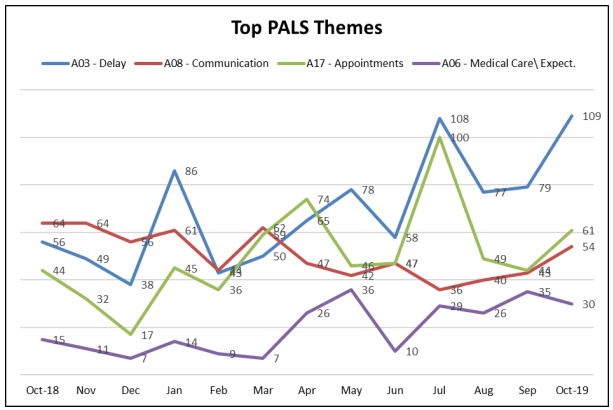
Of new PALS concerns 68 relate to Outpatients Department (OPD) treatment delays and appointment issues. No significant changes in complaint evidence, with medical care expectations the most frequently occurring theme with one case partially upheld by the Ombudsman since April 2019.

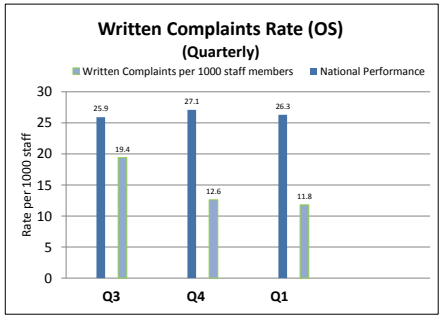




PALS converted to Complaints	
Oct-18	6
Nov-18	4
Dec-18	1
Jan-19	2
Feb-19	2
Mar-19	0
Apr-19	1
May-19	2
Jun-19	2
Jul-19	1
Aug-19	1
Sep-19	4
Oct-19	2





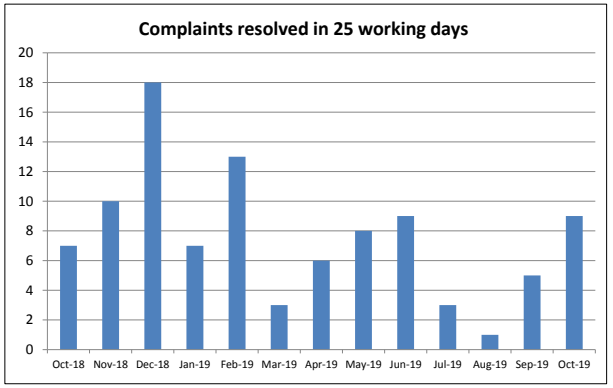


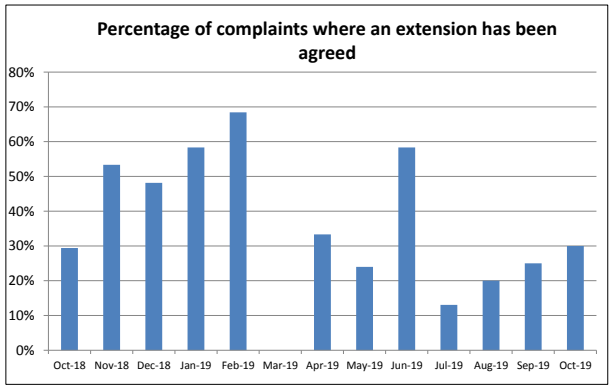
Patient Experience

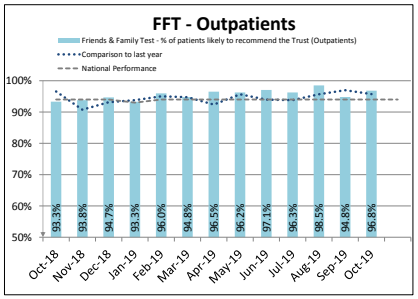
1 Our Patients Summary 1.2 Patient Experience

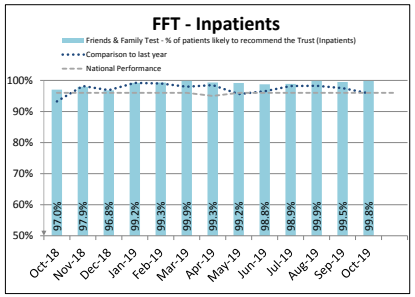
The Princess Alexandra Hospital NHS Trust

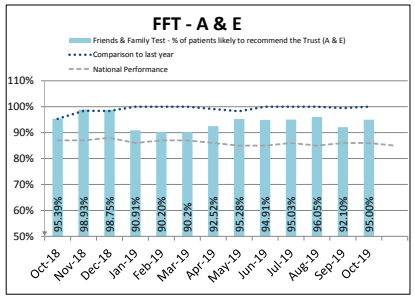
Corporate: 100% of new complaints were acknowledged and escalated within 3 working days against a target of 100%, we have achieved this every month since April 2018. 97% of PALS cases were shared or escalated to a complaint within 3 working days against a target of 95%.
HCG level KPIs: 13 of 67 complaints were outside of deadline at the time of reporting and all teams have been reminded to update complainants and bring these cases back into time. 77% of PALS cases received in October were closed by the time of reporting. A new approach to the management of complaints timelines is to be introduced on receipt of a complaint. This will be changing from the new year with a proposal being shared with relevant committees for discussion before implementation at EMT, SMT and QSC.

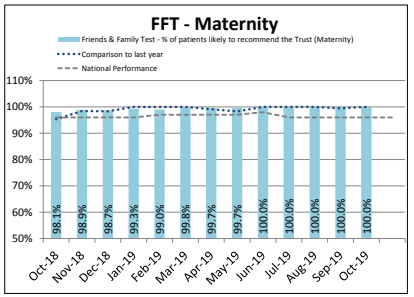












Patient Safety

1 Our Patients Summary 1.3 Patient Safety

NHS The Princess Alexandra Hospital NHS Trust

Incidents: There were 1168 (1170) incidents in total reported in October 2019. 932 (947) incidents were PAH, comprising of 717 (700) no harm, 189 (217) minor harm (97.2%), 24 (28) moderate harm (2.6%), 2 (2) severe harm (0.2%). The percentage spread is consistent with previous months.
There were two incidents meeting the Serious Incident criteria and declared externally in October 2019:
- Maternity / Obstetric incident affecting mother and baby: due to lack of escalation for a pathological cardiotocography (CTG).
- Incident preventing an organisation's ability to continue to deliver an acceptable quality of service: this is due to the Birthing Unit closure.

There were 1168 (1170) incidents in total reported in October 2019. 932 (947) incidents were PAH, comprising of 717 (700) no harm, 189 (217) minor harm (97.2%), 24 (28) moderate harm (2.6%), 2 (2) severe harm (0.2%). The percentage spread is consistent with previous months.

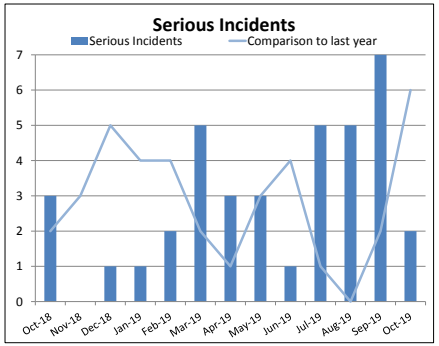
Patient Safety Incidents uploaded to NRLS
The trust uploads no harm and minor incidents monthly to NRLS. Incidents where patients have moderate, severe and death harm grading are uploaded when the harm grading is confirmed, which is on conclusion of the investigation.

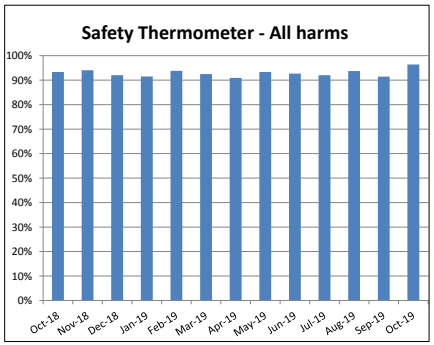
PAH data on NRLS
- PAH data on patient safety incidents taken from NRLS for the period 1/10/2018 to 31/09/2019 has 6168 incidents
- PAH data taken from Datix on patient safety incidents for the period 1/10/2018 to 31/09/2019 has 6827 incidents.

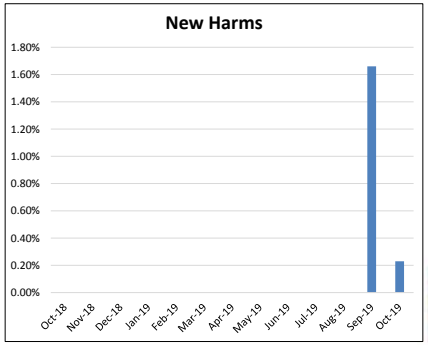
This is a variation of 659 incidents which is a total of 10.7%
During November the Trust will re-upload all of our safety incident data to NRLS to ensure PAH Datix and the NRLS systems are alligned.

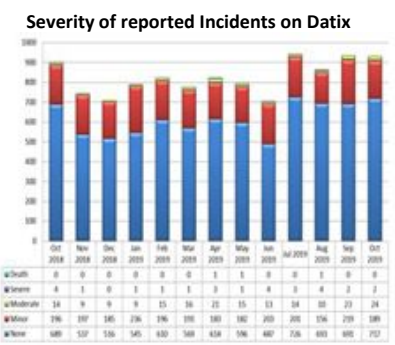
National Safety Alerts
The breached alert is for Anti-Ligature Curtain Rail Systems, due for completion by 11/09/2019. This alert is specifically aimed at mental health trusts, however as we do treat mental health and vulnerable patients we are looking to applying the relevant sections of the alert to PAH.
We have completed:
- A full site survey of all trust curtain rails
- Have a list of side rooms across the trust that have the required collapsible anti-ligature curtain rails
- Have an anti-ligature policy to inform our staff in the management of this group of patients

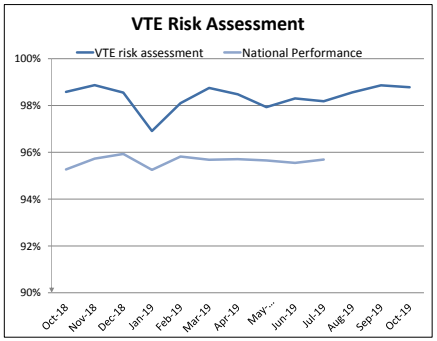
Actions to be completed
- A simplified risk assessment for use in our high risk areas
- Mental Health Quality group will consider the wider issues of mental health care in a general setting.

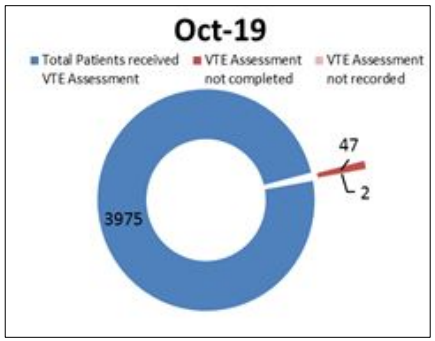


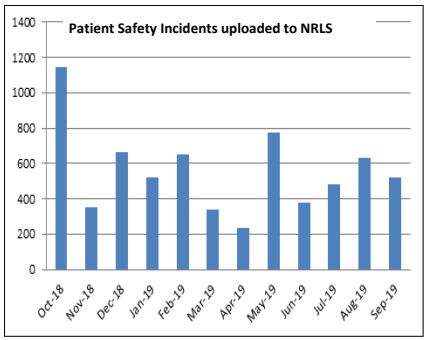


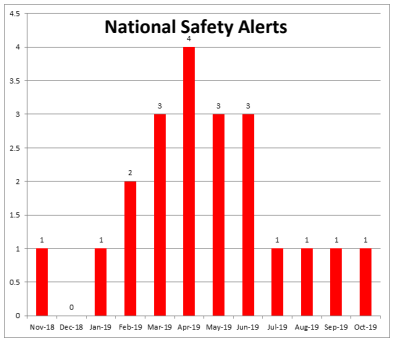












Infection Control

MRSA - No MRSA bacteraemia cases in October. Total of two cases for the year (one of these was not Trust-attributable, but allocated to the Trust due to timing of the blood cultures being taken more than 48 hours after admission).

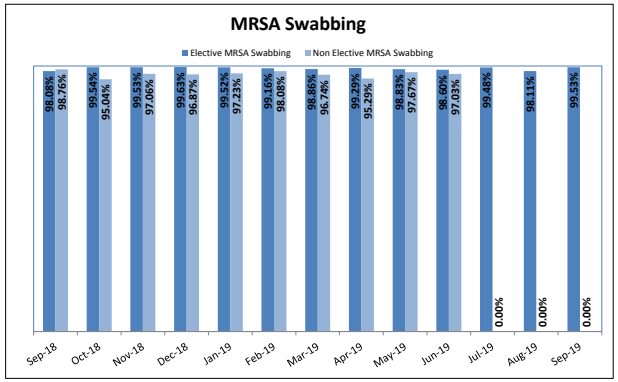
MSSA - The Trust continues to have low numbers of MSSA bacteraemia and remains in the top quarter of best performing hospitals nationally. During October there were no Trust cases.

C.difficile - There have been a total of 12 cases year to date; under new definitions these are classified as eight hospital onset cases and four community onset cases.
During October, the Trust presented three cases to the C.difficile Appeals Panel, chaired by West Essex and East and North Herts CCGs. All three cases were upheld successfully. This therefore means the appealed cases will not be included in final number (in terms of contractual arrangements with the CCG, although they are still recorded on the national database).

Gram Negative Blood Stream Infections (GNBSIs) - The Trust remains in a good position when compared nationally with other hospitals (in the top performing quarter) and we have a collaborative approach to tackling GNBSIs across the health care economy. The Trust has been recognised nationally for reducing our GNBSIs and we have been asked to share how this was achieved. This month there were two GNBSI cases.

MRSA screening – The Trust has consistently met its trajectory of over 95% compliance for MRSA screening. However, the most recent data for non-elective screening is still awaiting validation from the Health Care groups and we are reviewing with the Information Team how this process can be improved upon.

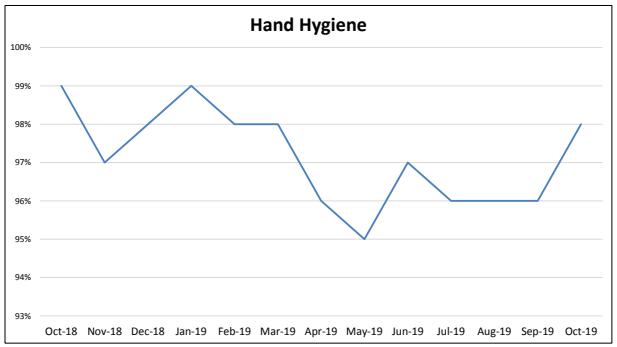
Hand Hygiene Audits – All wards/clinical department are expected to participate in monthly audits and these are undertaken as 'cross-over' audits, meaning staff do not audit themselves. The expectation is that 100% of clinical areas participate and the performance standard is 95% compliance. During October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



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

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

C-DIFF (New categories including community from April 2019)					
Month	Hospital Responsible		Community Responsible		Total
	Hospital onset healthcare associated	Community onset healthcare associated (Acute Admission within last 4 wks)	Community onset indeterminate association (Acute Admission within last 12 wks)	Community onset community associated (No acute contact within 12 wks)	
Apr-19	2	1	1	0	4
May-19	1	1	1	0	3
Jun-19	0	1	0	2	3
Jul-19	1	0	0	5	6
Aug-19	0	0	1	2	3
Sep-19	1	1	0	0	2
Oct-19	1	1	1	1	4



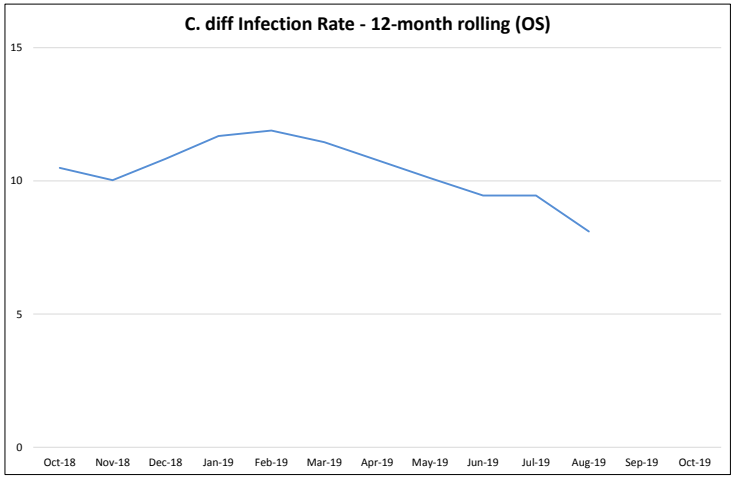
E Coli	
Oct-18	1
Nov-18	1
Dec-18	1
Jan-19	1
Feb-19	2
Mar-19	1
Apr-19	2
May-19	1
Jun-19	2
Jul-19	0
Aug-19	2
Sep-19	3
Oct-19	0

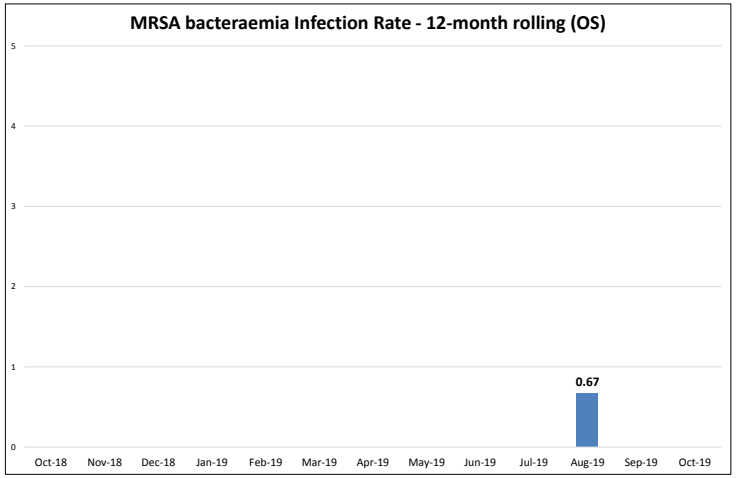
Klebsiella	
Oct-18	0
Nov-18	0
Dec-18	1
Jan-19	2
Feb-19	0
Mar-19	0
Apr-19	0
May-19	0
Jun-19	1
Jul-19	0
Aug-19	0
Sep-19	0
Oct-19	0

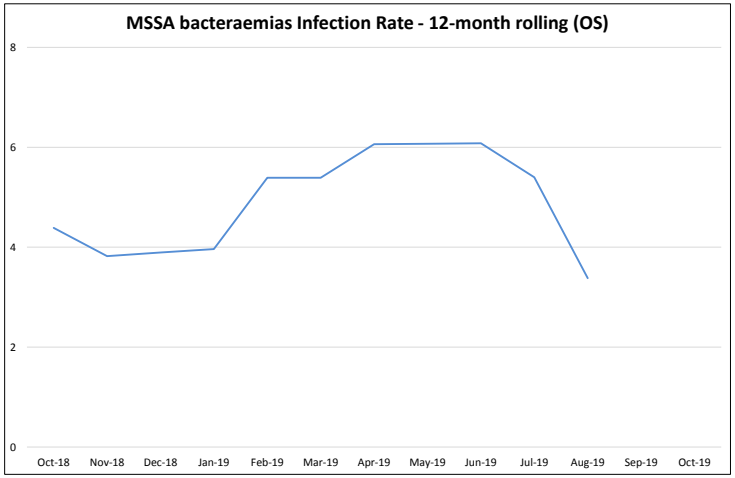
Pseudomonas	
Oct-18	1
Nov-18	0
Dec-18	0
Jan-19	0
Feb-19	0
Mar-19	0
Apr-19	0
May-19	0
Jun-19	0
Jul-19	0
Aug-19	0
Sep-19	1
Oct-19	2

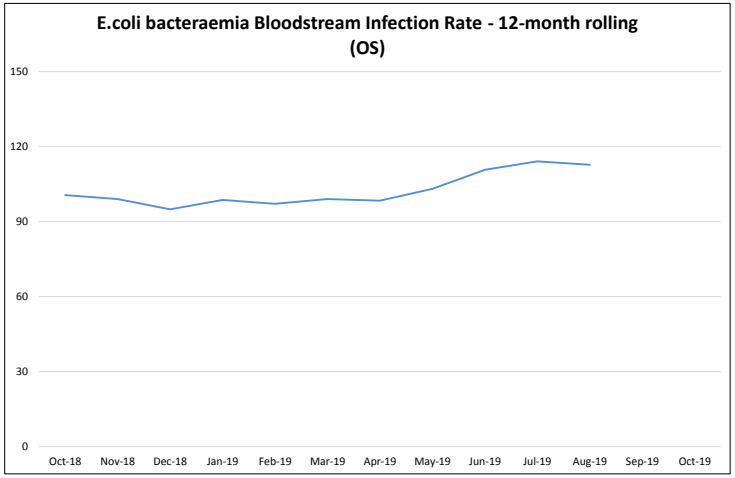
Infection Control

The following are the latest published data available.









(Rolling 12-month count/rolling 12-month average occupied bed days per 100,000 beds.)

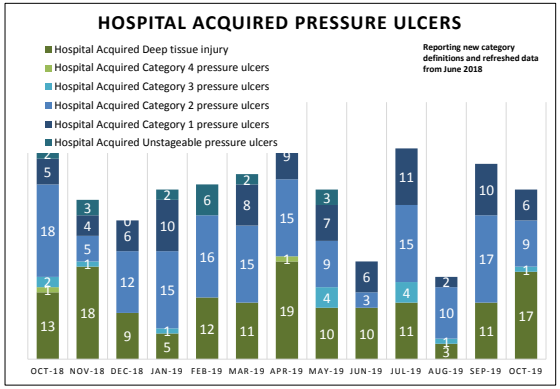
Pressure Ulcers

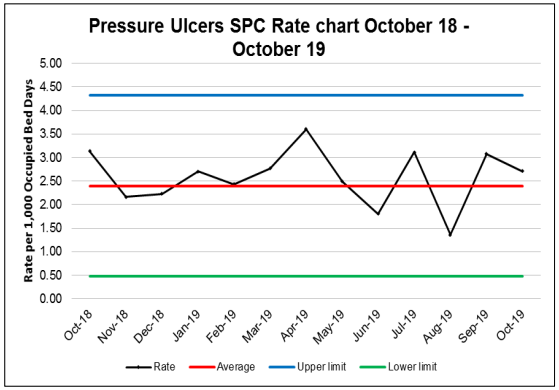
There were a total of 36 Pressure Ulcers in October as opposed to 39 in September with 1 Grade 3. Five of the pressure ulcers were medical device related from oxygen device, nasogastric tube and stockings and actions to reduce device related damage is an area of focus for the improving Essential Care group. Seven were related to patients on EOL pathway, with no omissions in care identified.

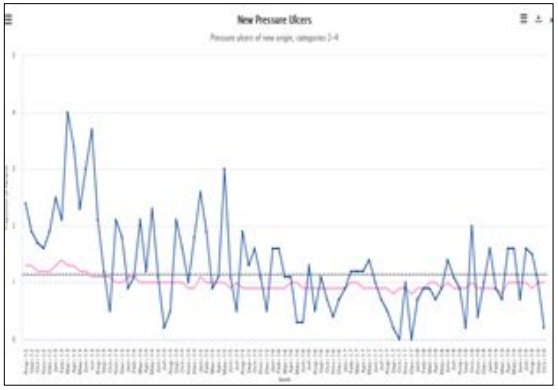
After providing intensive support on Ray Ward, the number of pressure ulcers have decreased from 10 to 4 this month which is positive improvement. Gibberd Ward had the highest number of PUs (5), which correlates with the safety thermometer data in CQC Insight report, however, all of them were EOL patients with no omissions in care.

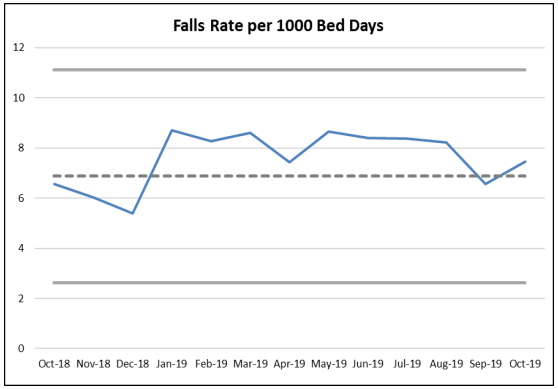
Falls

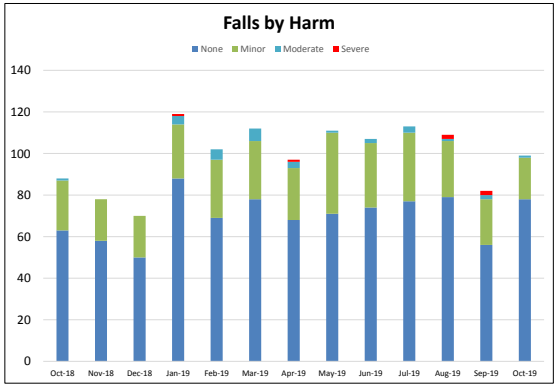
Overall falls rates remains broadly unchanged. Falls with harm were 22 one of which was a moderate harm. The Improving Essential Care Group for falls are focused on continuing to embed the deconditioning work but also reviewing our processes for identifying in-patients who have a known increased risk to reduce the overall harm rates with improved care planning to management the risk.

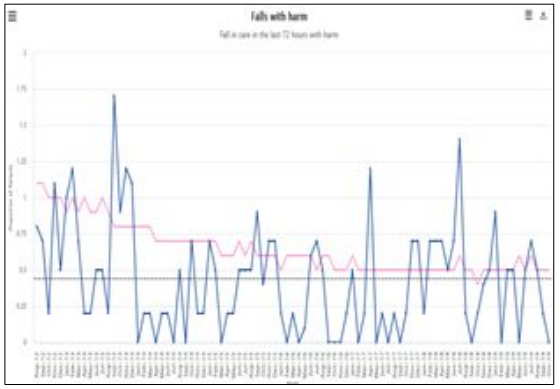












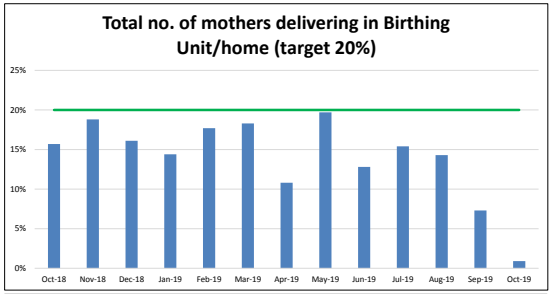
Family & Women's Service

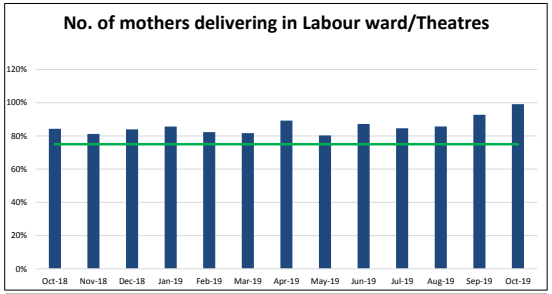
2 Our Patients Summary 1.7 Family & Women's Service

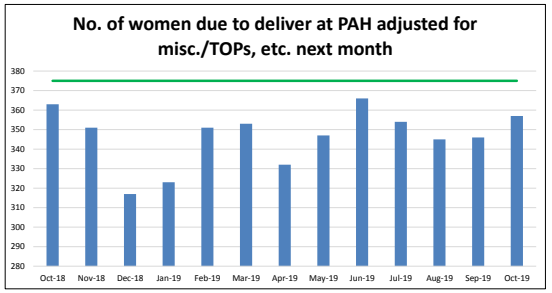
The Princess Alexandra Hospital NHS Trust

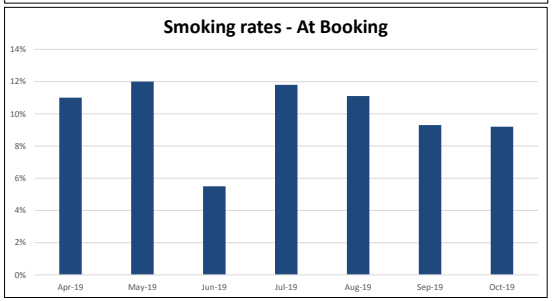
The total number of mothers delivering in Birthing Unit/home in October was less than 1%, as the Birthing Unit was closed throughout the month. The Birthing Unit has recently re-opened for postnatal women and with plans to be fully re-open, including for women in labour, in the near future.
'Smoking at delivery' rates are higher than 'smoking at booking'. This is partly because these are two different cohorts of women but an audit has indicated that a significant number of women state they are ex-smokers at booking but then are recorded as 'smokers' at the time of delivery. Further audits are planned to determine what can be put in place to assist these women to maintain the effectiveness of smoking cessation advice.

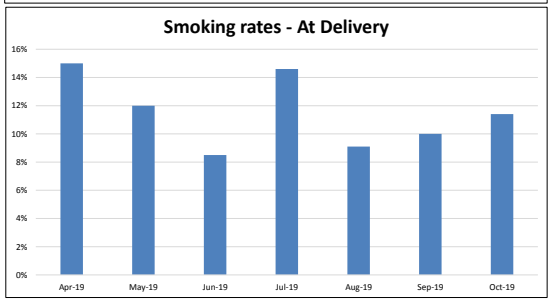
The Planned C Section rate was higher than usual, therefore an audit of the indications for C Sections is planned in order to understand the themes for indications for C sections and determine if these are always appropriate and how we can address this.

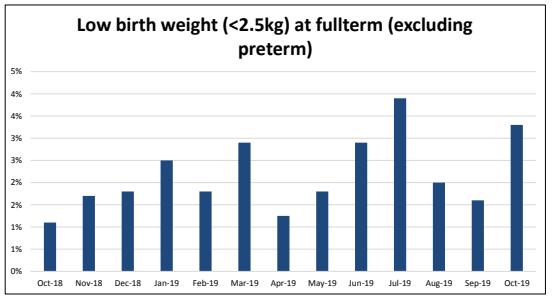


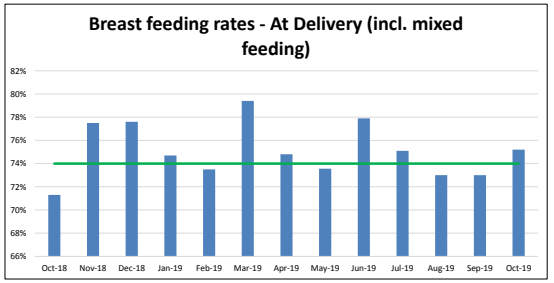


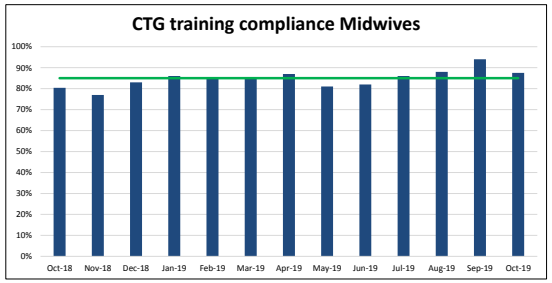


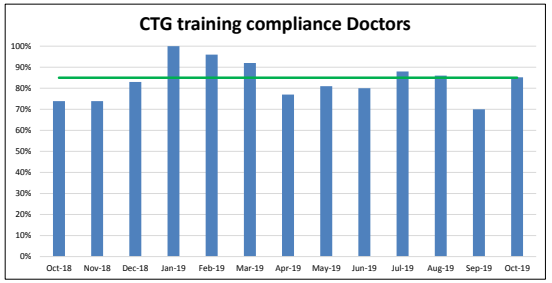












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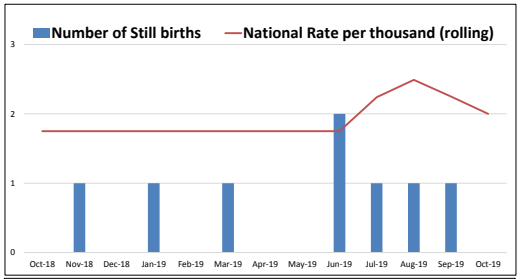
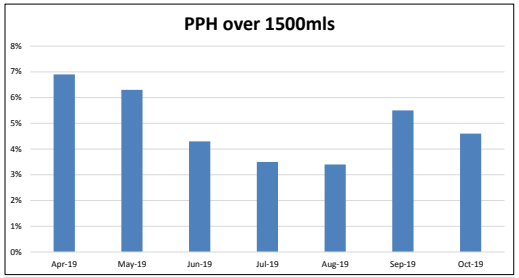
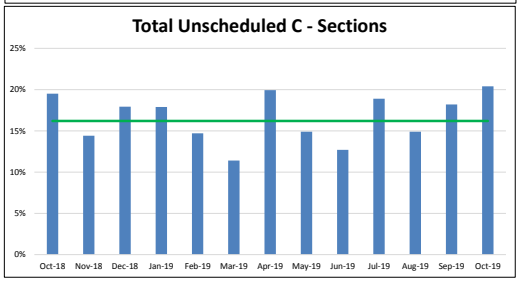
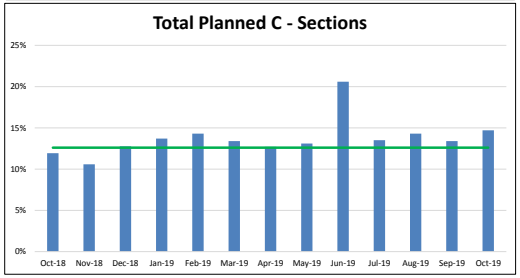
7.1

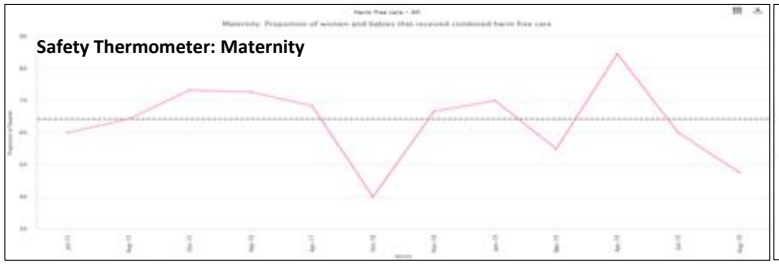
Family & Women's Service

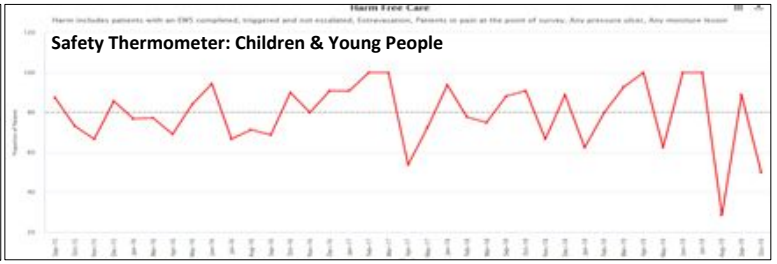






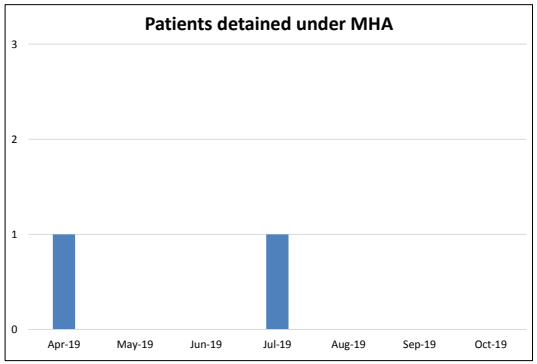


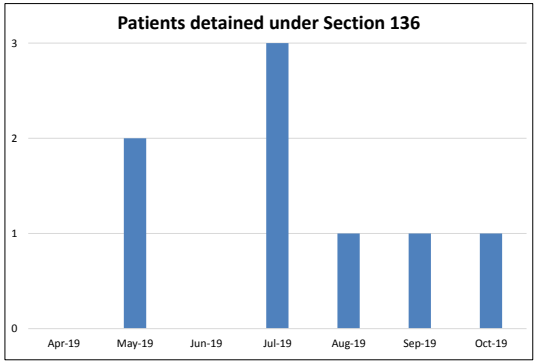


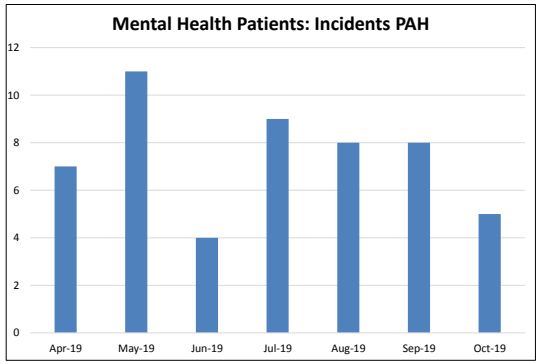


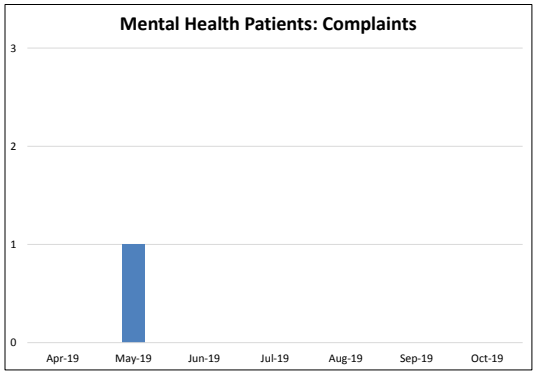
Mental Health

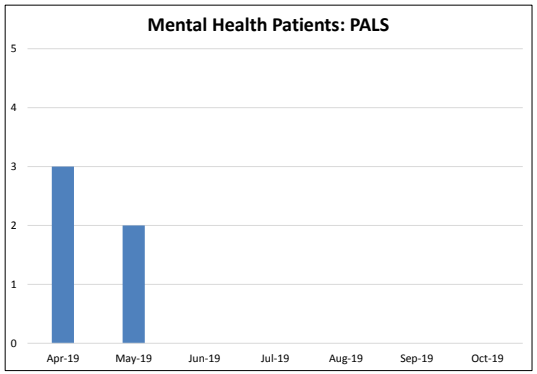
Improvement work continues via the newly established Mental Health Quality Forum, which includes representation from our mental health partners at EPUT and NELFT.

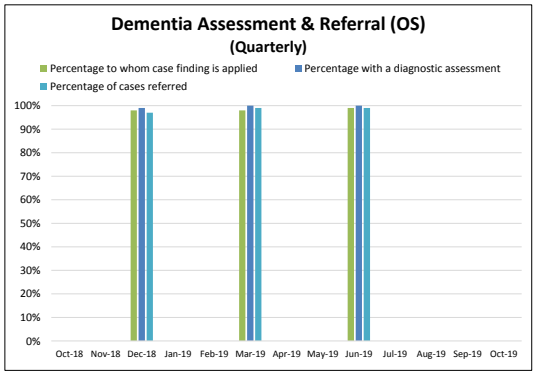




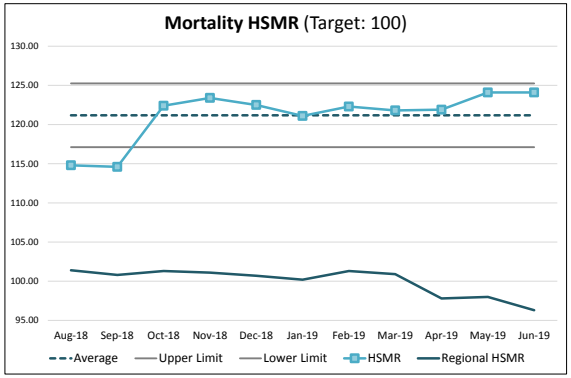


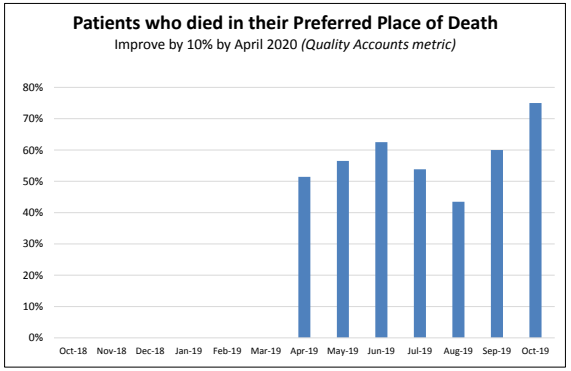






Mortality





Mortality SHMI	
Oct-18	
Nov-18	
Dec-18	114.1
Jan-19	114.3
Feb-19	113.6
Mar-19	
Apr-19	113.0
May-19	111.4
Jun-19	111.8
Jul-19	
Aug-19	
Sep-19	
Oct-19	

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

Programme	Project	Aim		Success measures: Measure	Trajectory Vs Actual	Performance and progress tracker: Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Trend
Care Bundles	Fractured Neck of Femur	Reduce mortality to expected level, i.e. from 8.5% to 6% by March 2020 (based on Dr Foster Data from reporting period Nov17-Oct18)	1	#NOF mortality rate (% of patients who died - 12 months rolling) - via Dr Foster	Trajectory	8.3%	8.2%	8.0%	7.9%	7.8%	7.6%	7.5%	7.4%	7.2%	7.1%	7.0%	6.8%	6.7%	
					Actual	8.3%	8.7%	7.9%	8.2%	9.4%	8.8%	8.1%	7.4%	7.2%	7.2%				
				#NOF HSMR (relative risk 12 month rolling) via Dr Foster		148.4	157.0	149.3	155.7	179.6	165.4	162.1	154.0	148.7	143.5				
				#NOF mortality rate (% of patients who died - 12 months rolling) - via Paul Esq		9.0%	9.0%	8.5%	8.1%	8.7%	8.6%	8.2%	7.8%	8.0%	7.9%	7.8%	7.7%	8.3%	
			2	% #NOF patients admitted to Tye Green (NOF ward)	Trajectory	90%	90%	90%	90.0%	90.0%	90.0%	90.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	
					Actual	79.0%	97.0%	85.0%	100.0%	89.0%	89.5%	83.3%	88.5%	91.4%	93.5%	88.9%	100.0%	100.0%	
			3	% of #NOF patients in theatres within 36 hours of arrival at A&E	Trajectory	77%	79%	74%	78.6%	79.6%	80.7%	81.7%	82.7%	83.8%	84.8%	85.9%	86.9%	87.9%	
					Actual	77.0%	79.0%	74.0%	78.6%	70.0%	82.9%	73.0%	67.6%	72.7%	83.3%	75.8%	82.0%	92.3%	
			5	% #NOF patients admitted into Tye Green within 4 hours of ED attendance	Trajectory	73%	42%	31%	46.4%	49.9%	53.3%	56.8%	60.3%	63.8%	67.2%	70.7%	74.2%	77.6%	
					Actual	73.0%	42.0%	31.0%	46.4%	12.5%	40.0%	27.0%	38.2%	72.7%	53.3%	54.5%	42.0%	34.6%	
	Acute Abdomen	Reduce mortality to expected level, i.e. from 8.7% to 7.1% by March 2020 (intestinal obstruction, based on Dr Foster Data from reporting period Nov17-Oct18)	6	Intestinal obstruction mortality rate (% of patients who died - 12 months rolling) - via Dr Foster	Trajectory	8.60%	8.51%	8.42%	8.34%	8.25%	8.16%	8.07%	7.98%	7.89%	7.81%	7.72%	7.63%	7.54%	
					Actual	8.60%	8.3%	6.3%	6.8%	6.8%	7.1%	6.3%	5.3%	6.2%	6.6%				
				Intestinal Obstruction HSMR (relative risk 12 month rolling) via Dr Foster		123.8	119.4	91.2	97.3	93.9	101.0	98.2	90.8	95.4	96.4				
			7	Case ascertainment in NELA	Trajectory		66.0%			72.8%			79.6%			86.4%		93.2%	
					Actual		66.0%			99.0%			100.0%						
			8	Arrival in theatre within a timescale appropriate for urgency	Trajectory		82.0%			83,5%			85.0%			86.6%		88.2%	
					Actual		82.0%			96.0%			65.0%						
			9	% of Em Lap patients admitted to HDU/ITU (with NELA risk score >5) post operatively	Trajectory		77.0%			78.6%			80.2%			81.8%		83.4%	
					Actual		77.0%			64.0%			80.0%						
			10	Consultant anaesthetist & surgeon present in theatre if NELA risk score >5%	Trajectory		83.0%			86.4%			89.8%			93.2%		96.6%	
					Actual		83.0%			93.0%			89.0%						
	COPD	Reduce mortality to expected level, i.e. from 6.6% to 4.1% by March 2020 (based on Dr Foster Data from reporting period Nov17-Oct18)	11	COPD mortality rate (% of patients who died - 12 months rolling) - via Dr Foster	Trajectory	6.4%	6.3%	6.1%	6.0%	5.8%	5.7%	5.6%	5.4%	5.3%	5.1%	5.0%	4.8%	4.7%	
					Actual	6.4%	7.2%	6.8%	6.6%	6.4%	5.9%	6.0%	6.0%	5.9%	6.2%				
				COPD HSMR (relative risk 12 month rolling) via Dr Foster		162.2	175.5	170.2	163.1	158.8	149.6	147.5	142.6	140.1	143.8				
			12	Administer nebuliser & steroids within 4 hours of attendance	Trajectory														
					Actual					6.3%	15.2%	13.8%	38.5%	27.3%	28.6%	30.0%	13.3%		
	Pneumonia	Reduce mortality to expected level, i.e. from 19.6% to 15.3% by March 2020 (based on Dr Foster Data from reporting period Nov17-Oct18)	13	Pneumonia mortality rate (% of patients who died)	Trajectory	16.1%	16.0%	15.8%	15.7%	15.5%	15.4%	15.2%	15.1%	14.9%	14.8%	14.6%	14.5%	14.3%	
					Actual	16.1%	16.3%	16.2%	15.7%	16.1%	16.0%	16.8%	16.5%	16.4%	16.2%				
				Pneumonia HSMR (relative risk 12 month rolling) via Dr Foster		119.8	121.1	123.5	120.5	123.6	124.0	130.0	127.6	125.9	124.6				
			14	Aspiration pneumonia mortality rate (%of patients who died - 12 months rolling) - via Dr Foster	Trajectory	47.0%	46%	45%	44.0%	43.0%	42.0%	41.0%	40.0%	39.0%	38.0%	37.0%	36.0%	35.0%	
					Actual	47.0%	43.7%	42.9%	42.8%	44.3%	45.2%	43.4%	45.1%	45.3%	46.3%				
				Aspiration Pneumonia HSMR (relative risk 12 month rolling) via Dr Foster		155.7	152.0	149.4	144.4	147.5	154.0	148.2	149.0	147.6	148.7				
			15	Oxygen prescribed within 1 hour of attendance	Trajectory					10.00%	20.00%	30.00%	40.00%	50.00%	60.00%	70.00%			
					Actual					0.0%	4.80%	0.0%	9.1%	0.00%	0.00%	0.00%	0.00%	0.00%	
			16	Chest x-ray within 4 hours of attendance	Trajectory	84.6%	82.6%	83.3%	80.0%	42.9%	61.1%	67.9%	74.7%	81.5%	88.3%	95.0%	95.0%	95.0%	
					Actual	84.6%	82.6%	83.3%	80.0%	42.9%	64.0%	82.4%			81.8%	80.7%			

7.1

	Sepsis		5% reduction in Sepsis mortality by March 2020	17	Sepsis mortality rate (% of patients who died - 12 months rolling) - via Dr Foster	Trajectory	20.5%	20.2%	19.9%	19.6%	19.3%	19.0%	18.7%	18.4%	18.2%	17.9%	17.6%	17.3%	17.0%	
						Actual	20.5%	20.0%	19.3%	17.6%	16.1%	15.9%	15.6%	16.0%	16.9%	17.0%				
					Sepsis HSMR (relative risk 12 month rolling) via Dr Foster		131.7	192.0	129.1	120.4	113.4	111.9	107.3	105.1	107.9	107.6				
Excellence Every Time group 1	Vital Signs	Timely recording of vital signs observation & adequate & effective equipment for undertaking & recording vital signs	To improve compliance with timely vital signs observation leading to early detection & escalation of deteriorating patient	20	% of Observations on patients with a NEWS ≥5 within 30 minutes of due time	Trajectory				70.0%	75.0%	80.0%	85.0%	90.0%	95.0%	95.0%	95.0%	95.0%	95.0%	
						Actual				63.2%	69.0%	72.2%	75.3%	76.4%	81.5%	81.6%	86.0%	83.6%	84.6%	
	Fluids & Electrolytes	Accurate input/ output Fluid Balance chart	To improve compliance with fluids & electrolytes management with early detection & treatment leading to reduction in harm caused by fluid & electrolytes imbalance	21	% of completed fluid balance charts	Trajectory				0.0%					40.0%	45.5%	51.1%	56.6%	62.2%	
						Actual				0.0%			28.0%	51.8%	47.2%	61.4%	60.0%	47.5%	66.1%	
		Management of Acute Kidney Injuries (AKI)		22	Renal disease comorbidity mortality rate (% of patients who died - 12 months rolling) - via Dr Foster	Trajectory	10.5%	10.4%	10.2%	10.0%	9.9%	9.8%	9.7%	9.6%	9.5%	9.3%	9.2%	9.1%	9.0%	
						Actual	10.5%	10.4%	10.2%	9.8%	10.2%	10.2%	10.0%	9.5%	9.4%	9.6%				
					Renal Disease HSMR (relative risk 12 month rolling) via Dr Foster		127.7	128.6	128.8	128.2	134.1	136.6	135.1	132.2	128.6	130.2				
				23	Number of patients with Multiple AKI alerts	Trajectory				98	105	101	100	98	95	95	90	90	85	
						Actual				98	105	101	100	98	110	121	117	111	133	
				24	Percentage of patients with alerts that have remained the same or improved during their admission	Trajectory	86%	85.0%	89.0%	87.0%	91.0%	88.5%	89.8%	91.1%	92.4%	93.7%	95.0%	95.0%	95.0%	
						Actual	86.0%	85.0%	89.0%	87.0%	91.0%	88.5%	88.0%	89.8%	87.3%	87.5%	98.0%	84.0%	74.4%	
		Diabetic Emergencies		26	Number of hypos	Trajectory	878	852	711	765	751	738	724	710	697	683	669	656	642	
						Actual	howe	852	711	765	544	501	607	460	533	740	690	515	695	
Excellence Every Time group 2	Antibiotics Stewardship		Correct antibotic use for patient need (right drug, right patient, right time, right route) & a reduction	31	LoS for patients who have antibiotics during their admission (non elective and elective)	Trajectory	8.13	8.44	8.52	8.90	8.38	7.97	8.39	8.31	8.22	8.12	8.03	7.94	7.85	
						Actual	8.13	8.44	8.52	8.90	8.38	8.43	8.03	8.40	8.08	8.42	8.52	7.26	6.51	
Reporting and recording	Medical Examiners		100% adult deaths (>16yrs) reviewed by ME and evidence of shared learning against reviews	35	% of completed Mortality Reviews by an ME	Trajectory							25.0%	25.0%	30.0%	40.0%	50.0%	60.0%	70.0%	
						Actual							17.8%	19.0%	24.0%	28.4%	23.0%	56.7%	97.3%	
					Number of completed reviews	Actual							22	18	28	25	21	55	107	
	Documentation (meeting standards, recording care accurately & communicating management plans)		Every entry in the patient notes are compliant with GMC & NMC standards	36	Compliance with documentation standards in Perfect Ward Audit tool	Trajectory						95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	
						Actual						95.0%	98.0%	95.0%	97.0%	91.9%	92.1%	92.3%	95.6%	
				38	Depth of coding (Dr Foster)	Trajectory														
						Actual				3.10	3.20	3.10	3.40	3.20	3.30	3.40				
Hospital at Night	Doctor Handover		Implementation of structured handover of patients for all specialities out of hours	39	Number of unexpected escalations to critical care (excluding ED)	Trajectory	3	13	4	5	11	8	7	6	6	6	6	6	6	
						Actual	3	13	4	5	11	8	3	6	8	4	6	7	12	
				40	Percentage of unexpected return to theatres (excluding ED)	Trajectory	0.93%	0.93%	0.93%	0.93%	0.93%	0.93%	0.93%	0.93%	0.90%	0.90%	0.90%	0.90%	0.90%	
						Actual	0.53%	0.55%	1.15%	1.45%	0.95%	0.96%	0.99%	0.58%	0.94%	0.64%	0.40%	1.00%	0.76%	
	Electronic Handover		Implementation of electronic handover	42	% of tasks allocated and succesfully closed by the following day	Trajectory										30%	39%	48%	56%	
						Actual										98.07	97.02	96.5	95.8	
				43	Implementation of an electronic nighttime handover	Trajectory										100%	100%	100%	100%	
						Actual										100%	100%	100.0%	100.0%	
	Hospital at night (task allocation)		Implementation of Hospital at Night software	44	Maximum number of calls to the 2222 number out of hours	Trajectory														
						Actual						53		63	54	65	72	44	36	

Your future | Our hospital

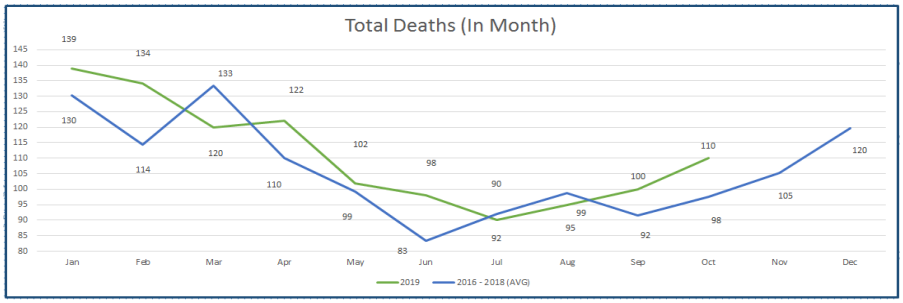
The Princess Alexandra Hospital NHS Trust

Mortality improvement progress and performance tracker (our goal)

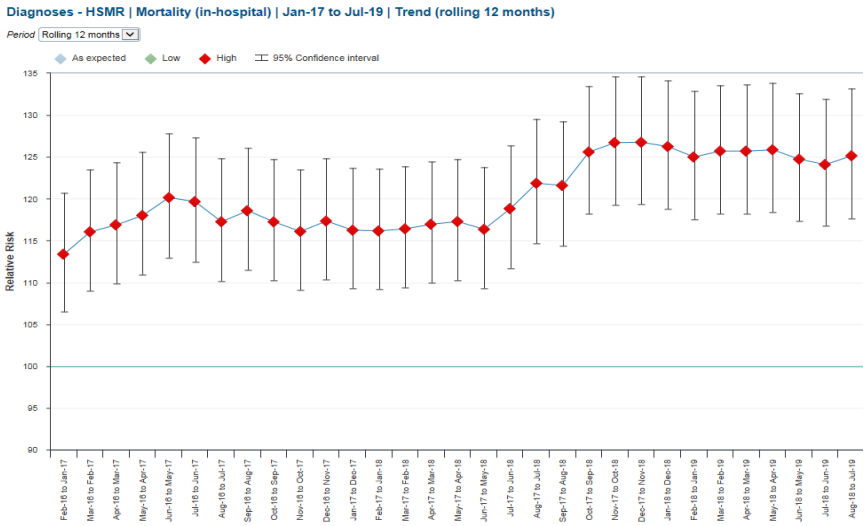
Our goal

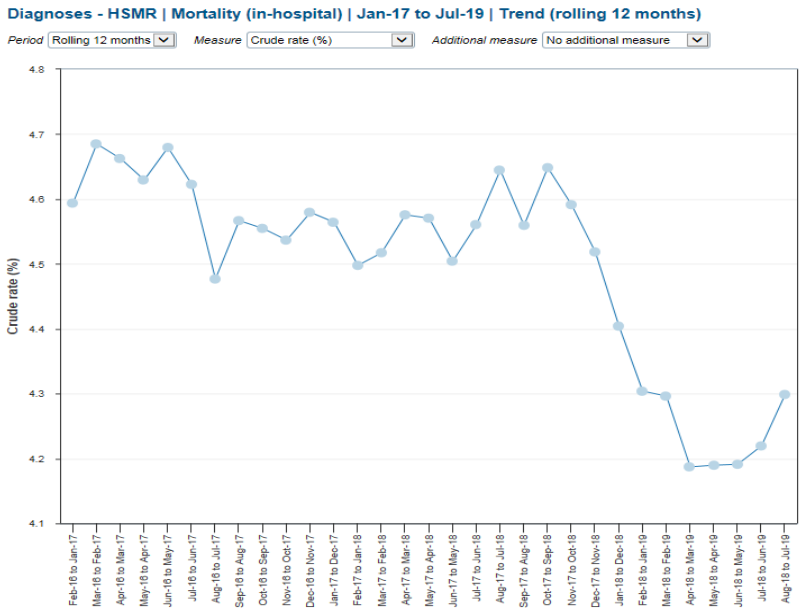
Achieve 'as expected' across all specialities, with no more than two outlier alerts over a 12 month rolling period by March 2021 & to be sustained.

Our progress & performance



Dec 18 | Aug 19
Jan 19 | Sep 19
Feb 19 | Oct 19
Mar 19 | Nov 19
Apr 19 | Dec 19
May 19 | Jan 20
Jun 19 | Feb 20
Jul 19 | Mar 20





respectful | caring | responsible | committed

7.1

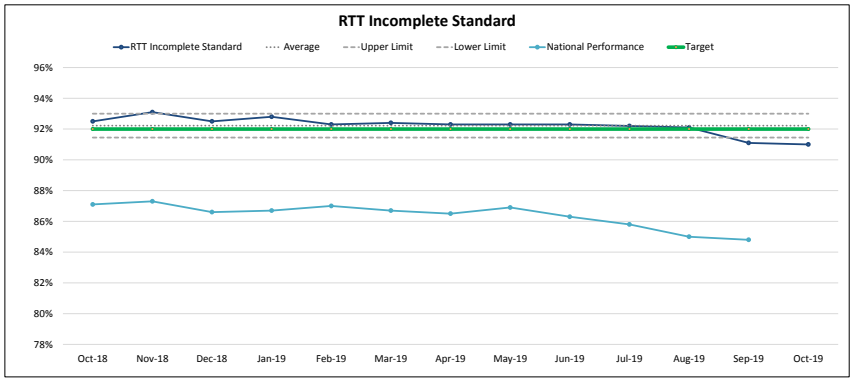
Executive Summary Our Performance

The Princess Alexandra Hospital NHS Trust

Cancer recovery achieved ahead of trajectory. Diagnostics no areas of concern to escalate. RTT recovery continues. Detailed demand and capacity work underway due for completion end of November. Risk stratification of patients in each speciality underway. Review list clearance on trajectory. Outpatient transformation programme is progressing well with a number of specialties reviewing technology and digital solutions to supporting new ways of working. Good clinical engagement to modernise and improve patient experience. Emergency Care failed to achieve the national standard in October. Performance saw 74% of patients seen, treated, transferred or discharged within 4 hours. The Trust continued to see a significant increase in patients presenting at ED, with over 9500 being seen and treated. This is the second busiest months in over 4 years. The increase in numbers was felt predominantly in majors and paediatrics, with both areas seeing significant increases and both areas above agreed activity plan. The CCG are working on a number of demand management schemes with trajectories in place to reduce patients presenting for minor injuries in ED. The increase in major patients also correlated with an increase in admissions which impacted on our bed occupancy and inability to achieve adequate flow through the hospital. The national GIRFT team have completed their analysis of emergency care performance and presented to executive colleagues in November. The work streams in place which focus on triage times, overall time spent in ED and flow through to assessment areas were confirmed to be the right areas to focus on. Workforce challenges continue with middle grade and consultants across both ED and Acute Medicine. Whilst recruitment has been successful, the GMC process is protracted and start dates are slow to be agreed as a result of this. There are 3 doctors joining the team before end of December with a further 3 in January and 8 more in February and March. HR and workforce colleagues are in continuous dialogue with doctors in relation to the onboarding process. Recruitment continues with advertisements reviewed and renewed on a rolling basis. Winter planning is well underway with detailed plans and operational processes being approved across all healthcare groups. National standards are expected to be released early in 2020 with full go live from April.

Our ambulance conveyance performance continues to be consistently good, with only 9 ambulances being delayed more than 6 minutes, and we continue to be one of the top hospitals in the region for ambulance handovers.

RTT


RTT Incomplete Standard
RTT Incomplete Standard
Average
Upper Limit
Lower Limit
National Performance
Target
96%
94%
92%
90%
88%
86%
84%
82%
80%
78%
Oct-18
Nov-18
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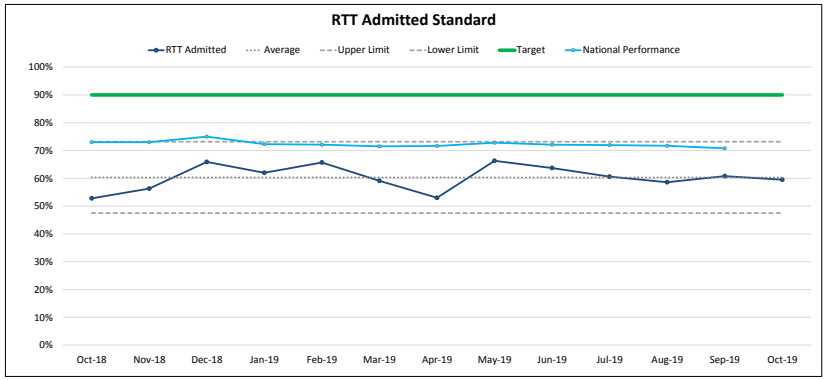
May-19
Jun-19
Jul-19
Aug-19
Sep-19
Oct-19


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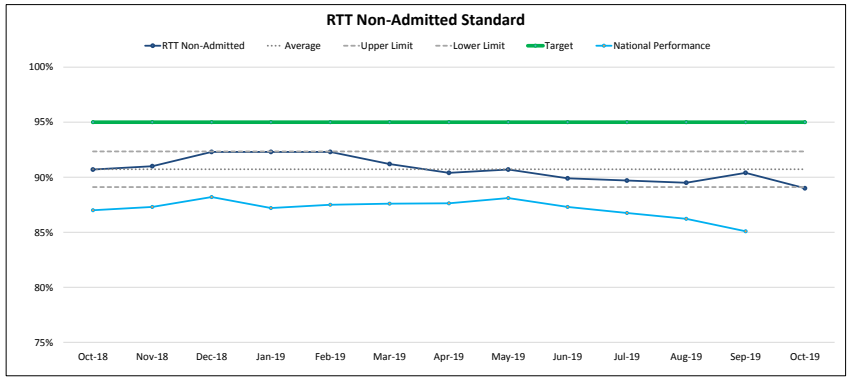
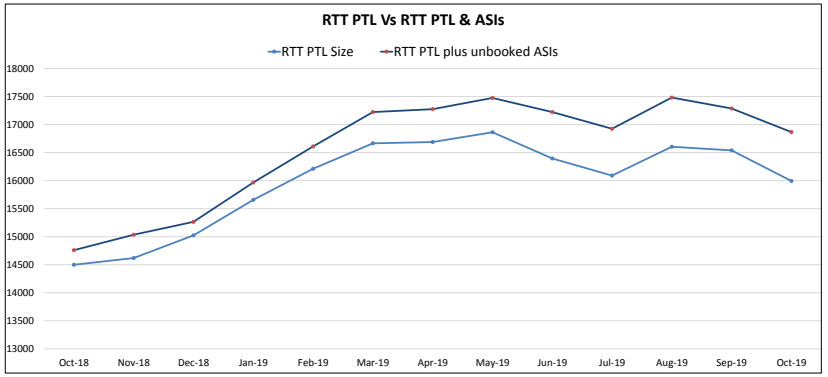
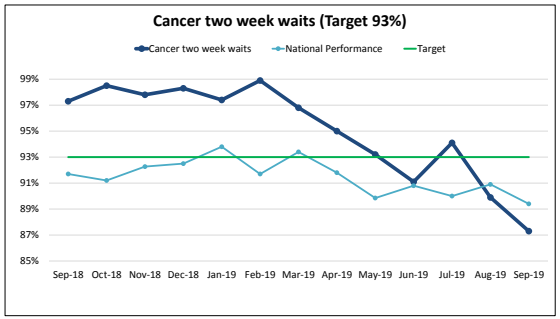
May-19
Jun-19
Jul-19
Aug-19
Sep-19
Oct-19

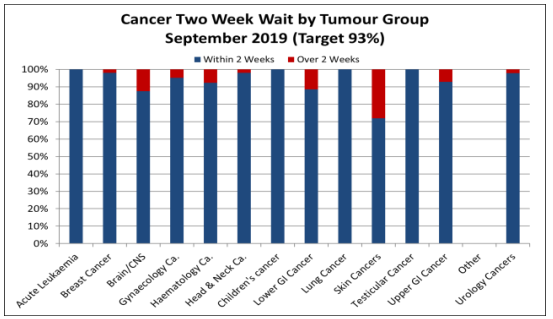

RTT Non-Admitted Standard
RTT Non-Admitted
Average
Upper Limit
Lower Limit
Target
National Performance
100%
95%
90%
85%
80%
75%
Oct-18
Nov-18
Dec-18
Jan-19
Feb-19
Mar-19
Apr-19
May-19
Jun-19
Jul-19
Aug-19
Sep-19
Oct-19

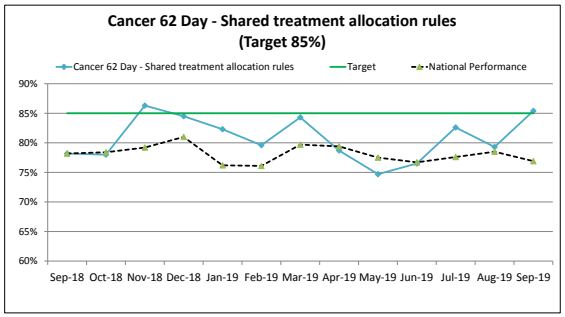

RTT PTL Vs RTT PTL & ASIs
RTT PTL Size
RTT PTL plus unbooked ASIs
18000
17500
17000
16500
16000
15500
15000
14500
14000
13500
13000
Oct-18
Nov-18
Dec-18
Jan-19
Feb-19
Mar-19
Apr-19
May-19
Jun-19
Jul-19
Aug-19
Sep-19
Oct-19

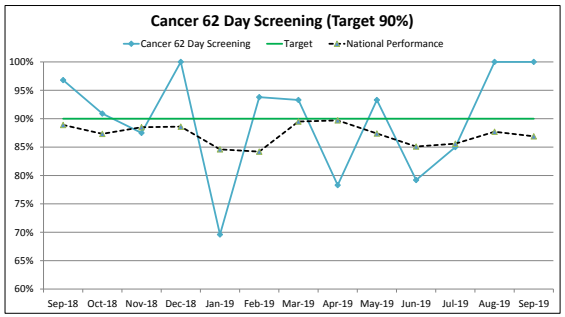
	Cancer 2 week waits - breast symptomatic	Cancer 31 Day First	Cancer 31 Day Subsequent Drug	Cancer 31 Day Subsequent Surgery
Sep-18	97.70%	97.40%	100.00%	100.00%
Oct-18	98.80%	96.70%	100.00%	100.00%
Nov-18	97.30%	96.70%	100.00%	100.00%
Dec-18	96.90%	100.00%	100.00%	100.00%
Jan-19	97.40%	97.00%	100.00%	100.00%
Feb-19	96.70%	97.30%	100.00%	100.00%
Mar-19	86.90%	96.90%	100.00%	100.00%
Apr-19	91.00%	100.00%	100.00%	100.00%
May-19	92.60%	97.80%	92.90%	75.00%
Jun-19	76.10%	98.10%	100.00%	100.00%
Jul-19	95.70%	99.00%	100.00%	100.00%
Aug-19	97.50%	98.90%	100.00%	100.00%
Sep-19	99.10%	99.10%	100.00%	100.00%

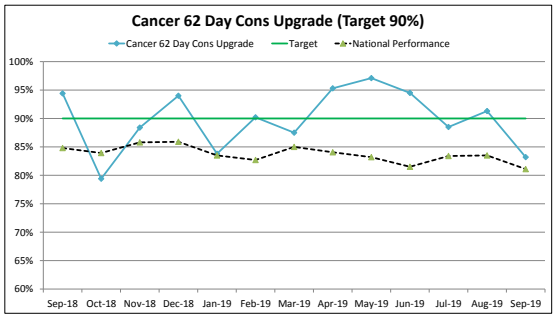
Note: Above heat map colour scale based on green = highest performance to red = lowest performance.



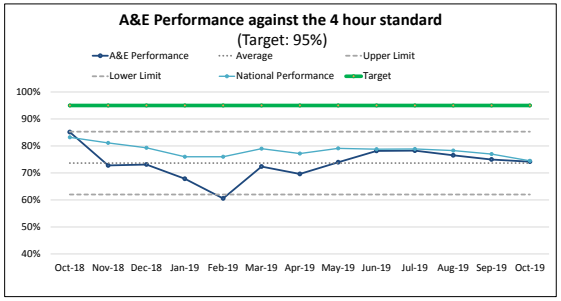


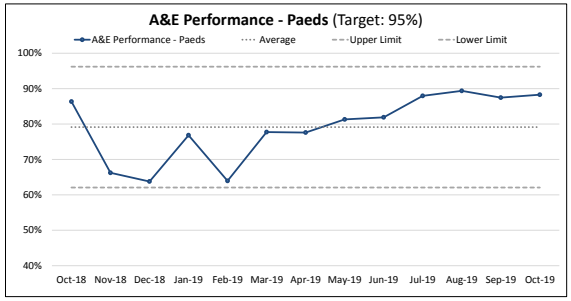


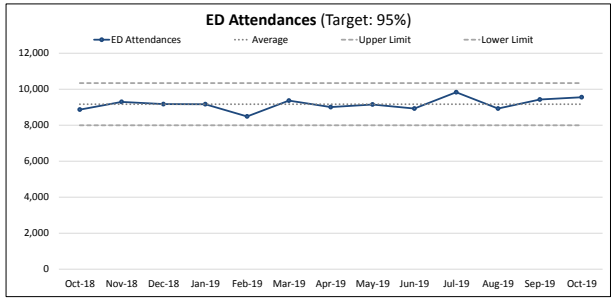


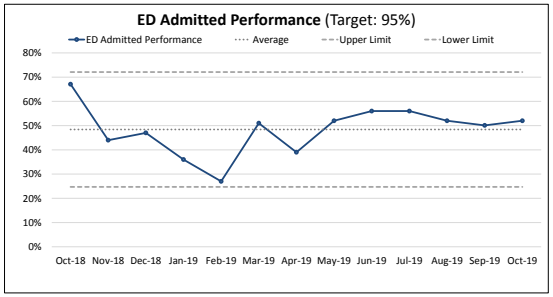


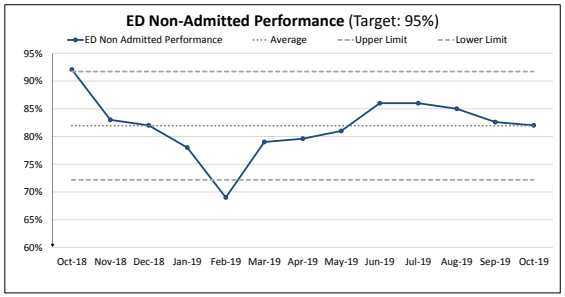
ED





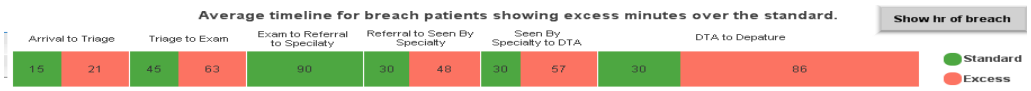


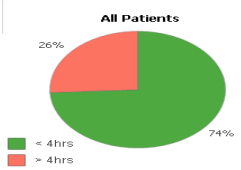




ED Internal Professional Standards

	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19
Arrival to Triage - Average Wait (Minutes)	29	36	34	37	43	35	38	33	26	46	34	39	35
Triage to Exam - Average Wait (Minutes)	74	91	94	106	118	106	99	99	91	90	93	102	108
Exam to Referral to Specialty - Average Wait (Minutes)	72	80	83	85	97	81	82	80	82	81	83	84	88
Referral to Seen by Specialty - Average Wait (Minutes)	68	83	82	84	85	73	75	69	67	65	79	70	78
Seen by Specialty to DTA - Average Wait (Minutes)	77	94	97	105	109	82	93	72	78	73	74	84	87
DTA to Departure - Average Wait (Minutes)	123	223	209	312	308	171	197	147	120	115	108	120	116

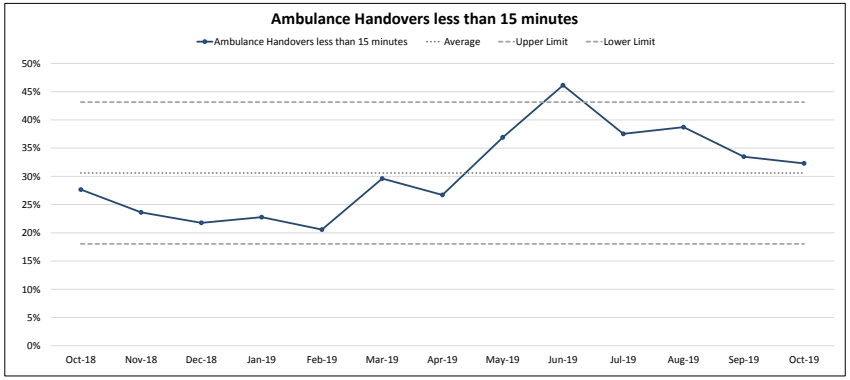




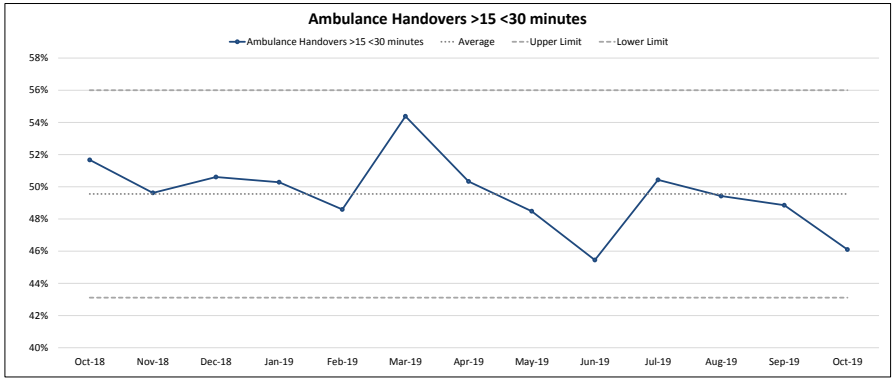
Measure	Standard	Average	Excess	Patients with Timestamp	Patients Who Breached	% Breached	Patients Who Breached Rank
Arrival to Triage	15	36	21	8,931	5,514	62%	
Triage to Exam	45	108	63	8,097	4,700	58%	
Exam to Referral to Specialty	90	88	0	2,742	494	18%	
Referral to Seen by Specialty	30	78	48	2,893	1,914	66%	
Seen by Specialty to DTA	30	87	57	1,743	861	49%	
DTA to Depature	30	116	86	2,497	1,251	50%	

Ambulance

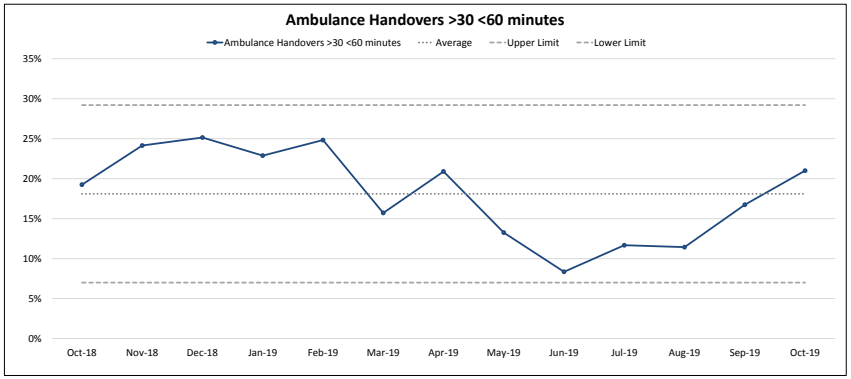
Ambulance Handovers less than 15 minutes



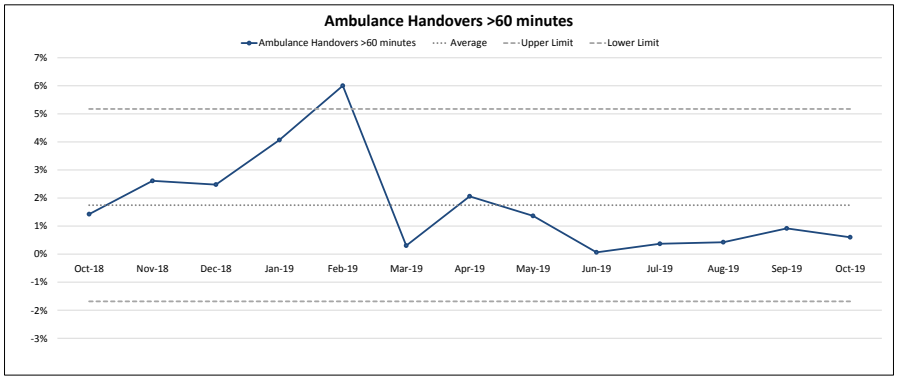
Ambulance Handovers >15 <30 minutes



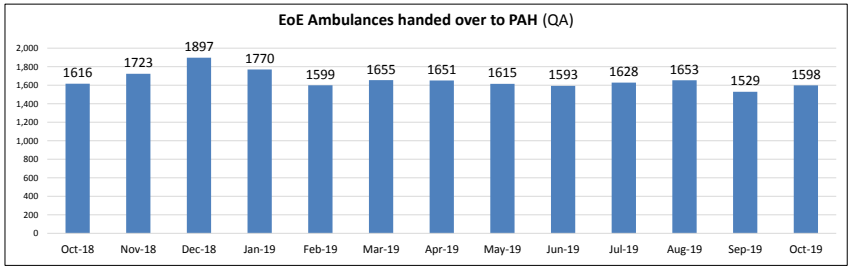
Ambulance Handovers >30 <60 minutes



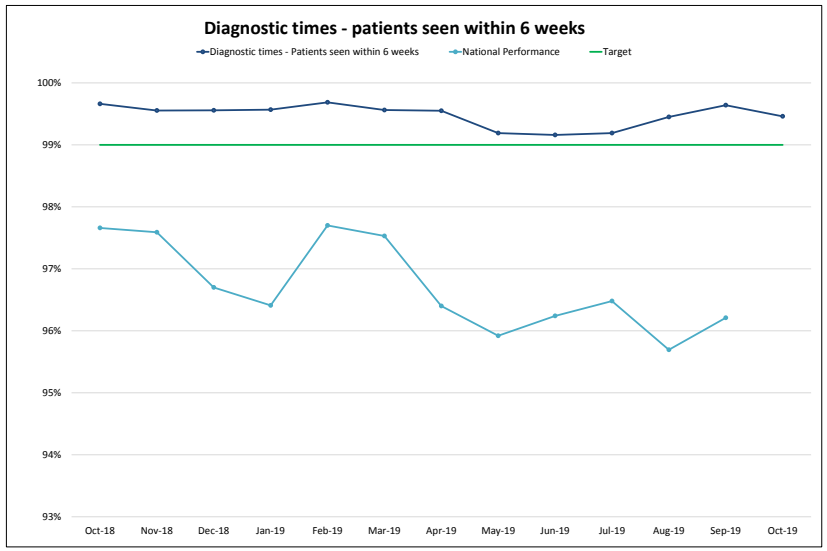
Ambulance Handovers >60 minutes

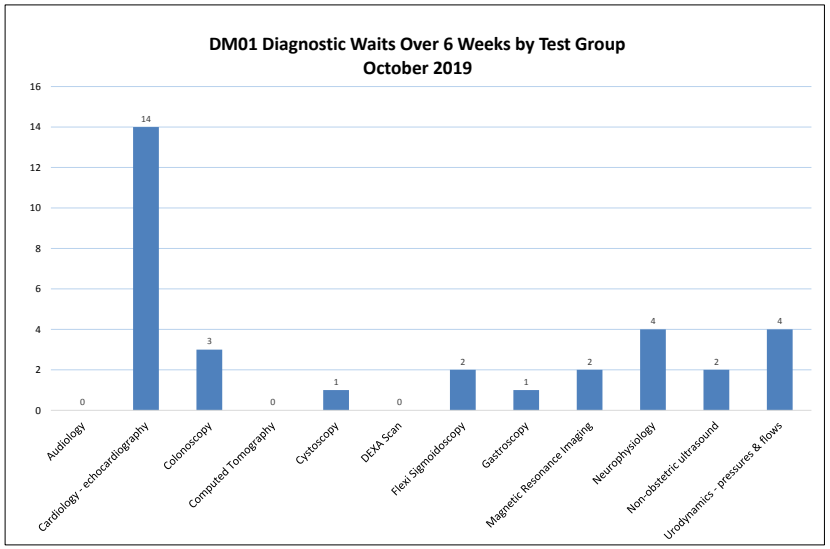


EoE Ambulances handed over to PAH (QA)



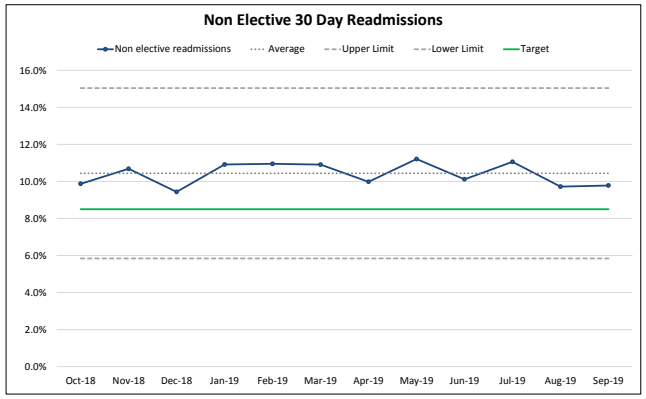
Diagnostics

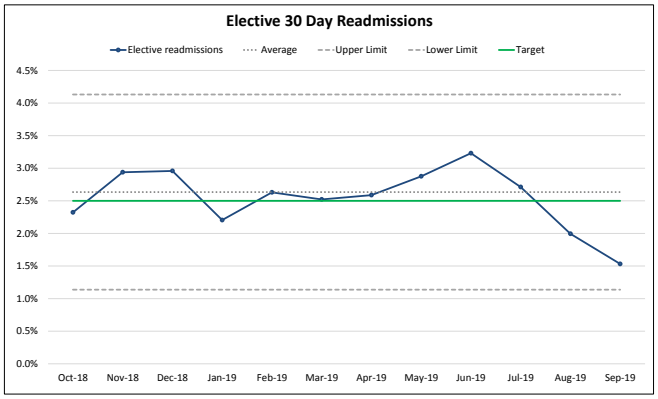


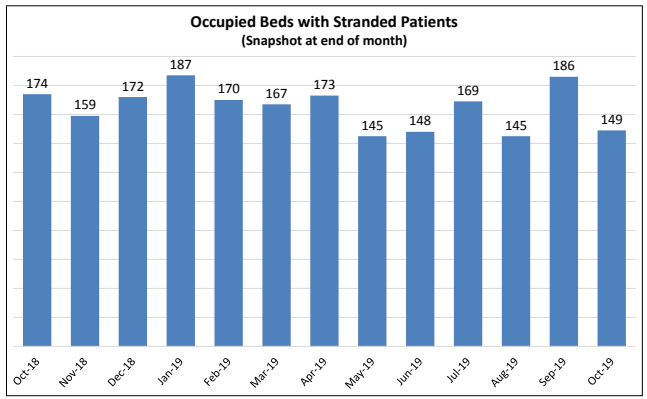


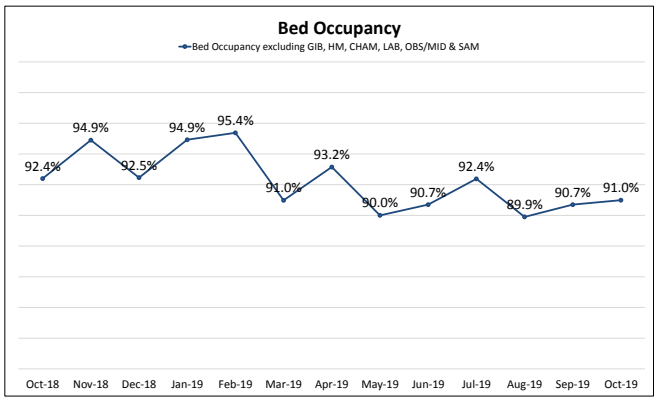
Test	% of Total Cohort - Oct 19	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19
Magnetic Resonance Imaging (MRI)	22.6%	100.00%	100%	100%	100%	100%	100%	100%	99.77%	100.00%	100.00%	100.00%	100.00%	99.86%
Computed Tomography (CT)	10.0%	100.00%	100%	100.00%	99.51%	100%	100%	100%	99.32%	100.00%	100.00%	99.09%	99.83%	100.00%
Non-Obstetric Ultrasound	40.5%	99.71%	99.92%	99.96%	99.84%	99.66%	100%	100%	99.92%	99.92%	100.00%	99.86%	99.96%	99.92%
DEXA	1.7%	100%	100.00%	100%	100%	100%	100%	100%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
Audiology - Audiology Asessments	3.9%	100.00%	99%	100%	98%	99%	98%	100%	98.50%	98.80%	100.00%	99.51%	100.00%	100.00%
Cardiology - Echocardiography	13.7%	100%	100.00%	99.53%	100.00%	100%	100%	100%	100.00%	100.00%	100.00%	99.86%	99.74%	98.34%
Neurophysiology	0.5%	93%	100%	100%	100%	100.00%	100%	100%	100%	83%	50%	67%	67%	85.71%
Urodynamics	0.6%	93%	56.76%	80.00%	70.37%	82.35%	90%	87%	89.66%	92.59%	90.00%	95.24%	94.74%	89.19%
Colonoscopy	3.7%	97.35%	98.61%	95.93%	98.45%	98.16%	95%	97%	90.71%	88.11%	84.62%	94.81%	99.24%	98.68%
Flexi Sigmoidoscopy	0.6%	97%	98%	95.56%	97.06%	100.00%	91%	98%	90.00%	93.10%	89.66%	92.86%	100.00%	94.29%
Cystoscopy	0.4%	100.00%	100.00%	100%	100.00%	100%	95%	100%	90.91%	92.31%	95.65%	93.55%	100.00%	96.30%
Gastroscopy	1.8%	97.41%	98.20%	92.38%	98.51%	100.00%	95%	95%	92.52%	88.46%	88.79%	96.83%	98.81%	99.07%

Readmissions & Stranded Patients

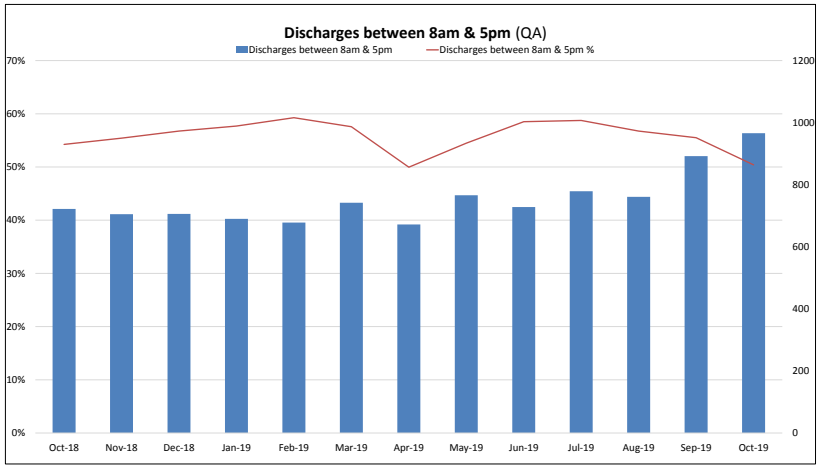


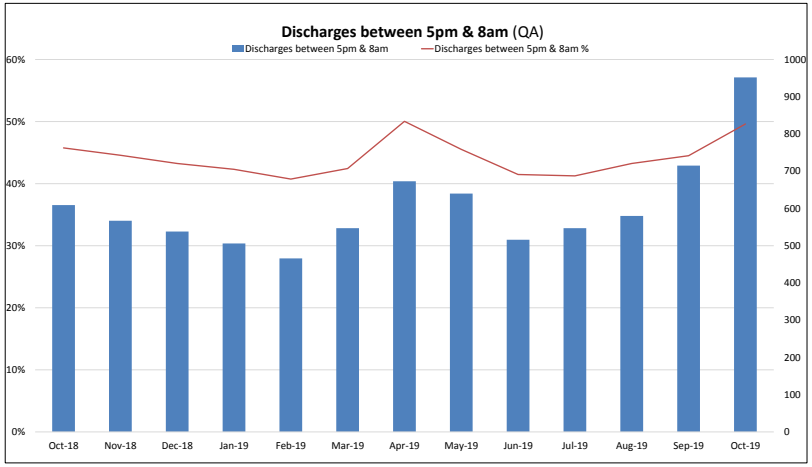


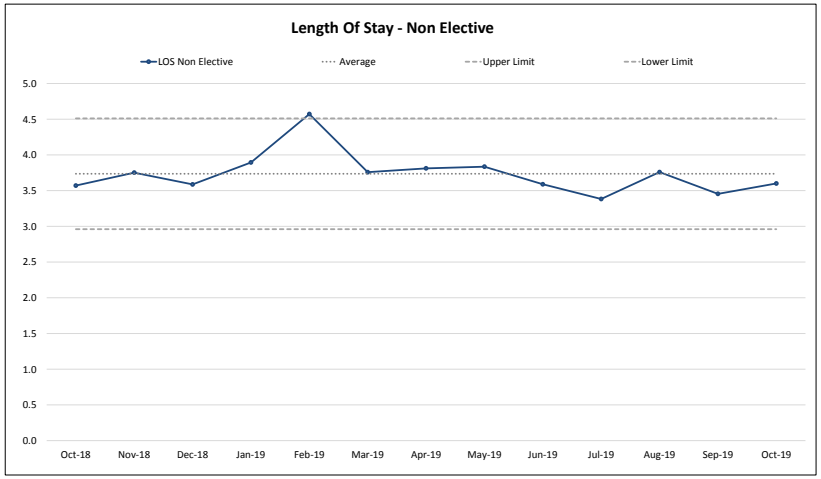


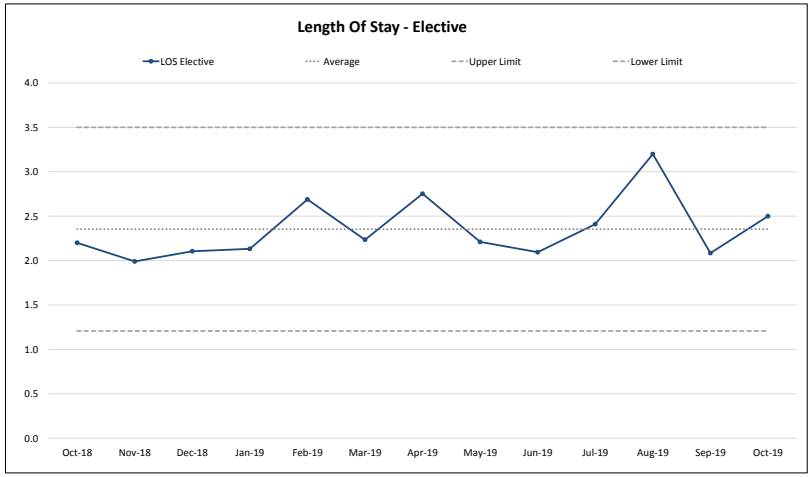


Discharges & LOS

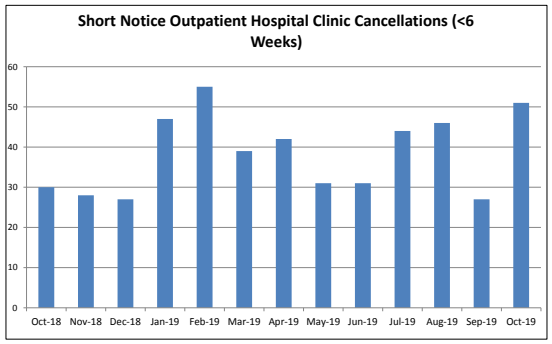


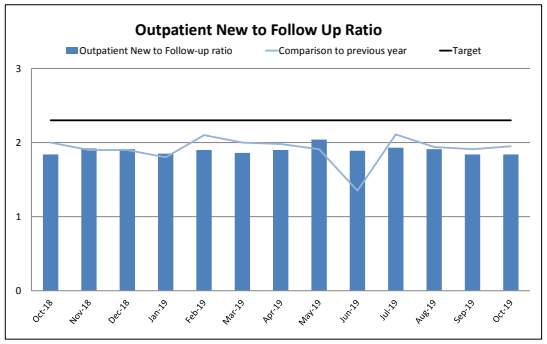


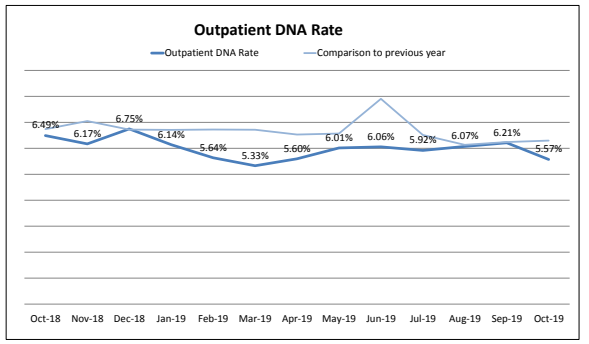


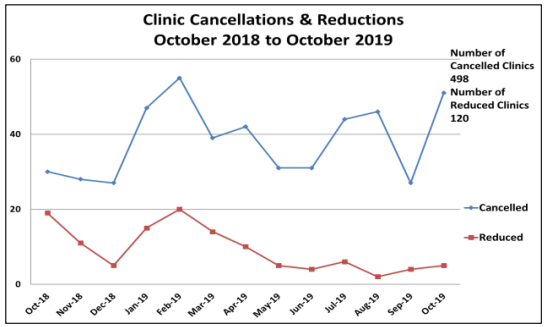


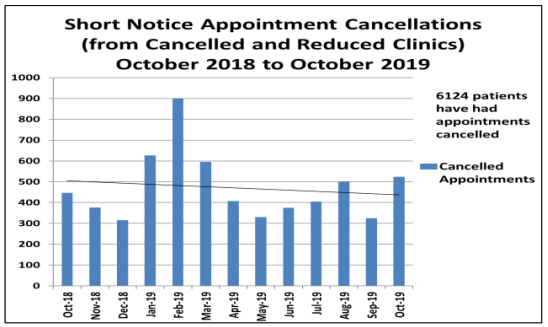
Outpatients & Cancelled Operations

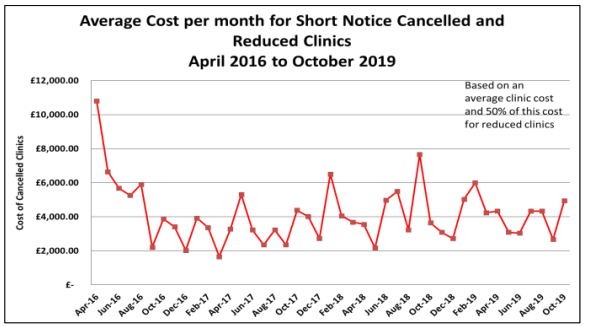












DNA Rate for Follow Up Appointments per Specialty for October

Specialty & Performing Unit	Accident & Emergency	AHP Episode	Anaesthetics	Anticoagulant Service	Breast Surgery	Cardiology	Chemical Pathology	Clinical Haematology	Clinical Oncology	Colorectal Surgery	Community Midwifery	Dermatology	Diabetic Medicine	Dietetics	Endocrinology	ENT	Gastroenterology	General Medicine	General Surgery	Gynaecology	Haematology	Medical Oncology	Medicine for the Elderly	Neonatology	Neurology	Obstetrics	Ophthalmology	Optometry	Oral Surgery	Orthoptics	Paediatric Diabetic Medicine	Paediatrics	Physiotherapy	Respiratory Medicine	Rheumatology	Trauma & Orthopaedics	Urology	Vascular Surgery	Well Baby	Total
DNA Rate	0.00%	0.00%	0.00%	6.06%	10.00%	5.04%	9.09%	3.70%	2.25%	4.00%	5.55%	4.94%	7.19%	10.81%	3.96%	6.53%	6.29%	0.39%	7.84%	4.14%	6.69%	1.18%	0.00%	3.57%	6.33%	3.58%	5.83%	1.69%	6.45%	6.20%	8.70%	5.91%	9.11%	5.58%	3.70%	6.43%	4.36%	8.57%	6.75%	5.11%

Executive Summary Our People

The Princess Alexandra Hospital NHS Trust

People Measures

• The overall trust vacancy rate now sits at 10.9%. The trust's largest vacancy rate was within the nursing staff group. This vacancy rate has improved considerably over this financial year, reducing from 40% to 20% as of October '19.

• The trust continues with its successful programme of overseas recruitment for both Nursing and Medical staff. Quarter 3 will see 8 medical staff and an additional 25 nurses commencing employment with the trust.

• The appraisal rate is sitting just below the trust KPI of 90%. Weekly meetings take place with the HCG to address non-compliance and agree a plan of action.

• Statutory and Mandatory compliance for the trust is 91%, 1% above the trust target. Monitored weekly at HCG meetings.

• Friends and Family test responses are above the trust KPI:

- Place to work 61% (KPI 65%)
- Care of treatment 78% (KPI 67%)

• Flu vaccination – Frontline staff 43%, all staff 42%.

• Improvements to temporary staffing spend, bi-weekly executive led meetings taking place to review governance and cost.

People Development

• Managers' induction launches in November, topics covered will include recruitment and selection, sickness absence, performance management.

• Unwrapping unconscious bias training session will continue until March 2020. 66% of managers have attended so far.

• PAHT will be leading on "Step into Work" programmes in conjunction with the STP.

• PAHT have exceeded the required 25%+ clinical placement capacity expansion target for new student nurses (adult and child) and midwives. We will be able to accept up to 60%+ additional numbers from October. A 1 year fixed term Practice Education Facilitator (HEE funded) will be recruited to support the additional intake.

• Preparations for the first cohort of the PAHT talent management programme in conjunction with Silvermaple have commenced.

Workforce Indicators Summary

Agency Spend 6.08%
Bank Spend 13.10%

Staff In Post
3192
WTE

Training
91%

Sickness
4.1%

11.0%

Medical 96%
Non-Medical 89%

Turnover
11%

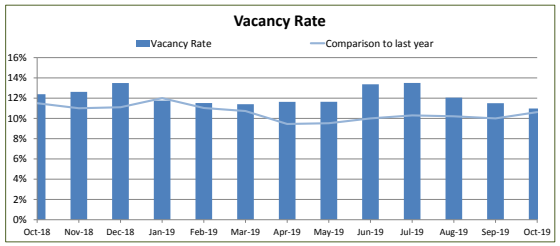
Scorecard

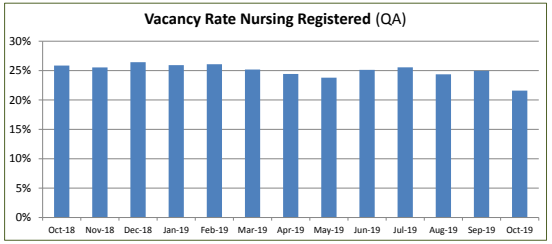
People Measures as at 31st October 2019	Trust Target	Trust	CCCS	FAWS	Medicine HCG	Surgery HCG	Estates & Facilities	Corporate	People	Finance
Funded Establishment- WTE		3613.62	882.05	459.25	891.93	762.83	277.18	129.75	54.68	155.95
Vacancy Rate	8.0%	11.10%	6.15%	9.90%	16.32%	16.69%	10.03%	0%↓	2.57%↓	8.83%↓
Agency % of paybill	7.0%	5.83%↑	2.93%↑	2.3%↓	10.8%↔	8.9%↑	0.0%	0.0%	0.0%	0.1%
Bank Usage - wte	n/a	270.06	29.95	28.27	124.93	59.41	9.78	6.62	3.29	7.81
Agency Usage -wte	n/a	102.22	11.40	4.46	48.92	33.80	0.00	3.64	0.00	0.00
September 2019 Sickness Absence	3.7%	4.6%↑	3.5%↓	4.6%↑	4.3%↑	3.5%↑	8.2%↑	3.2%↑	0.2%↓	1.5%↔
Long Term Sickness	1.85%	2.4%	2.2%	2.7%	2.1%	2.2%	6.0%	1.6%	0.0%	0.3%
Short Term Sickness	1.85%	1.7%	1.3%	2.0%	2.2%	1.4%	2.2%	1.5%	0.2%	1.1%
Rolling Turnover (voluntary)	12%	11.28%↔	10.6%↑	11.3%↓	11.9%↓	11.2%↔	10.6%↑	11.1%↔	17.0%↑	11.9↔
Statutory & Mandatory Training	90%	91%↓	96%↑	85%↑	89%↔	87%↓	94%↓	97%↓	97%↓	98%↔
Appraisal	90%	89%↑	92%↑	80%↑	88%↑	87%↑	92%↑	88%↑	92%↓	98%↑
FFT (care of treatment) Q2	67%	78%	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
FFT (place to work) Q2	61%	65%	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Flu Vaccination 19/20	100%	42%↑	47%↑	40%↑	39%↑	37%↑	38%↑	63%↑	50%↑	27.6%↑
% of Rosters Approve on Time	100%	96%↑	100%↑	75%↓	100%↑	100%↔				
Starters (wte)		63.77	9.11	3.80	9.12	17.00	2.15	13.00	3.60	6.00
Leavers (wte)		39.90	8.67	2.60	5.40	17.00	1.23	2.00	1.00	2.00
Time to hire (Advert to formal offer made)	31Days	56	53	21	71	64	71	46	n/a	n/a

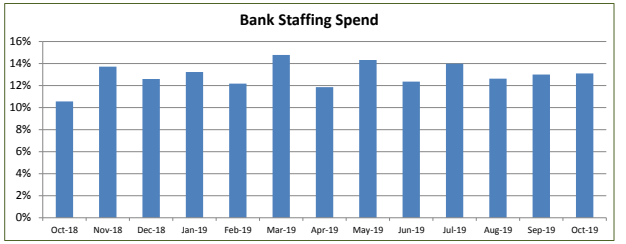
Above target	
Improvement from last month/above or below target	
Underachieving target	

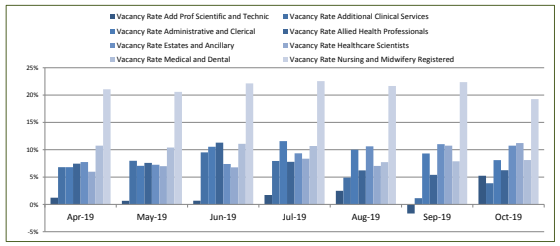
↔ ↓↑ Comparison from previous month

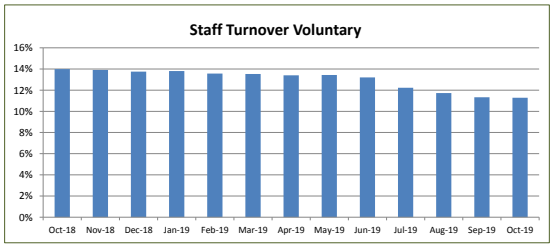
Workforce Indicators

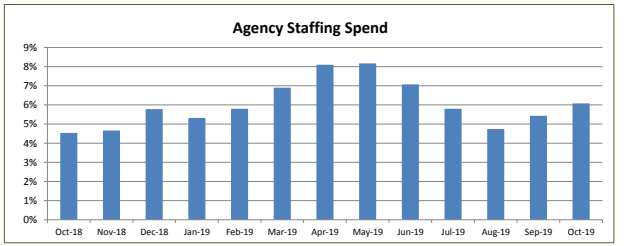


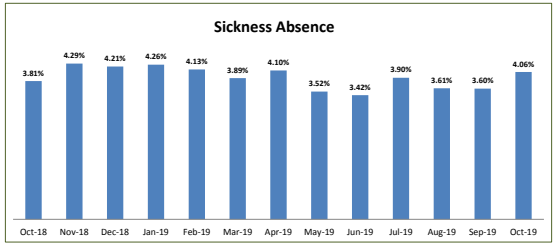


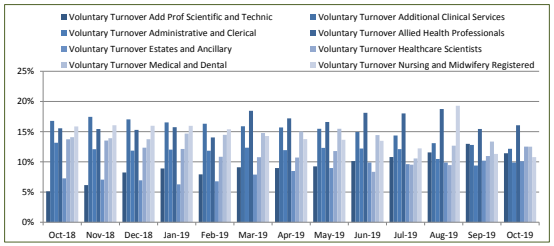


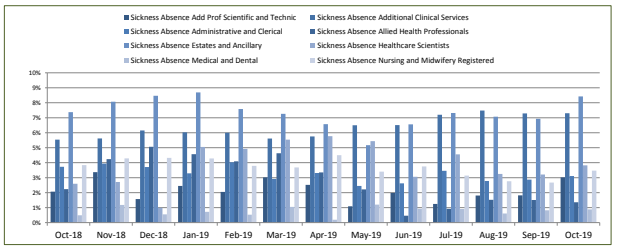


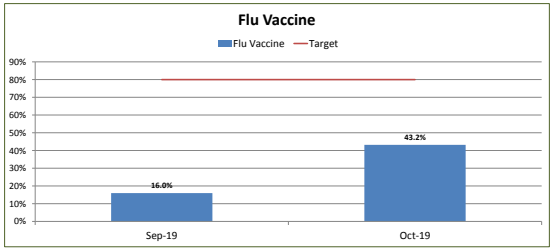




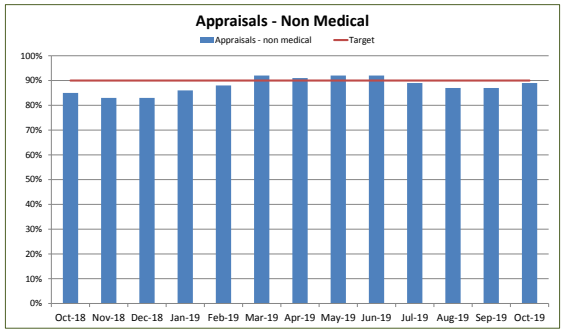


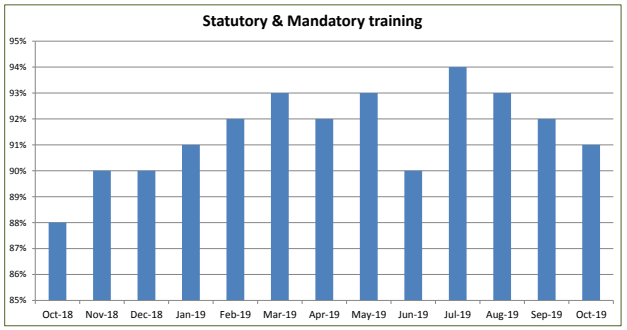


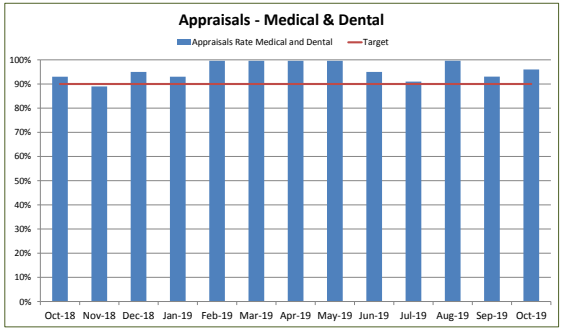


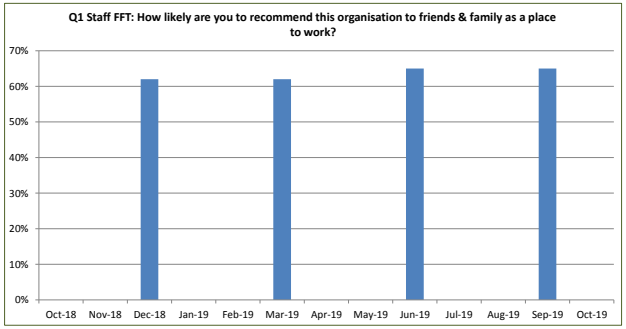


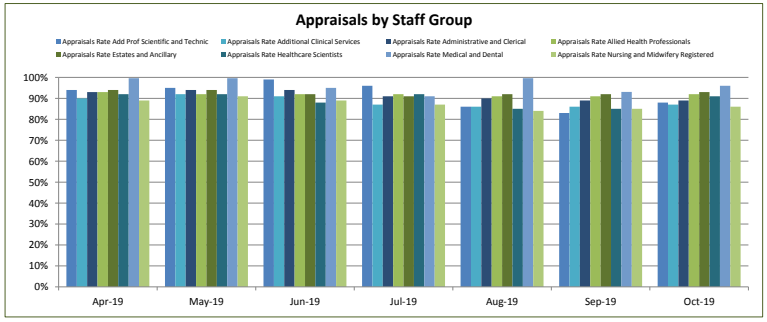
Workforce Indicators

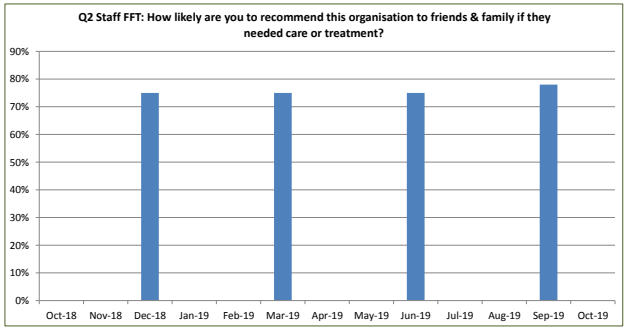












Annual Staff Survey 2019 & Workforce Race Equality Standard (WRES)

These measures are included as part of the NHS Oversight Metrics.

Measure	*Average rating of:*	*Percentage*
Support & Compassion	% experiencing harassment, bullying or abuse from staff in the last 12 months*	19.50%
	% not experiencing harassment, bullying or abuse at work from managers in the last 12 months	84.40%
Teamwork	% agreeing that their team has a set of shared objectives	73.50%
	% agreeing that their team often meets to discuss the team's effectiveness	58.70%
Inclusion (1)	% staff believing the trust provides equal opportunities for career progression or promotion	83.30%
	% experiencing discrimination from their manager/team leader or other colleagues in the last 12 months**	7.80%

*Note that this is a 'negative' experience question & does not exist within the structure of the NHS Staff Survey (all answers are scored positively); the survey asks about experience of harassment, bullying or abuse from 'managers' and 'other colleagues', but not 'staff'. Provided is the data for the responses for the 'other colleagues' question.

**Again, please note this is a 'negative' experience question & this specific data is not explicitly reported in the results – calculations are based on the raw data.

WRES Indicator No.	WRES Report March 2018	WRES Report March 2019	Direction
9. Percentage difference between PAH Board voting Membership and its overall workforce	White = 100% BME = 0%	White = 100% BME = 0%	⟺
Percentage difference between PAH Executive board membership and its overall workforce	White = 88.9% BME = -11.1%	White = 87.5% BME = -12.5%	

Executive Summary Our Places

The Princess Alexandra Hospital NHS Trust

Estates – The estates responses to the urgent jobs raised have dropped slightly due to the staff working on the backlog maintenance & dealing with emergency issues. Emergency issues are attended to immediately & urgent issues have a 1 day response time. Estates are currently working closely with the Capital team to address any emergency backlog maintenance issues, e.g. floors & roofs.

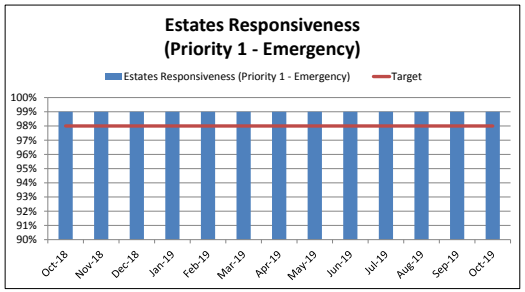
Domestic Services – There has been an increase in the scores for the very high risk areas due to these areas having their correct allocated cleaning hours. The high risk areas had their allocated cleaning hours reduced due to vacancies, annual leave & sickness within the department, we are working collaboratively with our human resources business partner to assess underlining causes & trends. The domestic transformation project is on-going with trials on wards of new working practices & equipment.

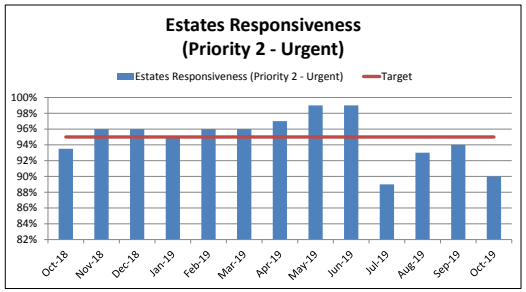
The PLACE audit took place at the end of September. The results have been entered onto the website & we are now waiting for the final results & report.

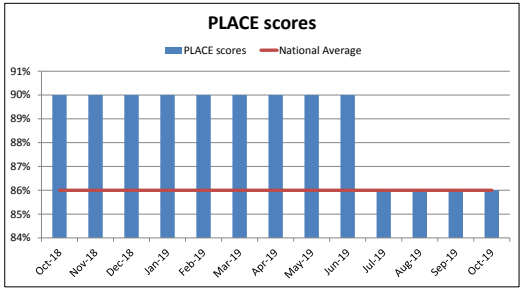
Catering Services – The number of meals & food waste has reduced again this month due to the introduction of the new ordering system & the training given to the staff on the ordering of meals for patients. The restaurant has started to make its own fresh baguettes at lunch service which are a sell out each day.

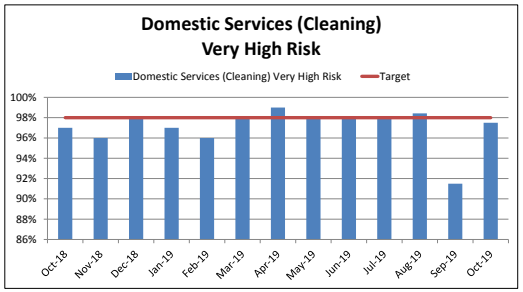
Capital Services - Currently there are 18 approved coded projects within the financial year with Capital funding of which 7 are in their contract defects period, 8 are onsite/planned to start in Q3 with completion through to March 2020 & the final 3 are in design/tendering stages for completion by end of March 2020. Executive management team have signed off the proposal for the minor works on Lister & Ray ward works to be carried out from early November to mid-December. Lister ward is on track for completion on 21st November & handover for operation use. Emergency capital funding has been applied for & in preparation for approval from the centre a robust resourcing plan using Government Framework options for both design team members & suppliers for the required works to meet the end of March 2020 timescale.

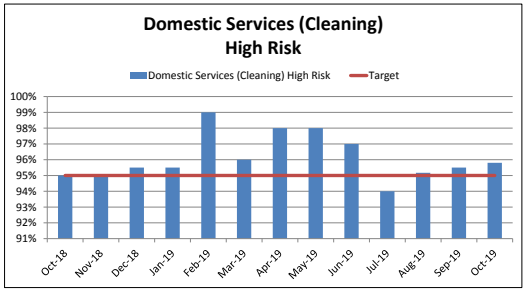
Mandatory Training & Appraisals – Appraisal compliance went up by 1% to 92%, however, mandatory training dropped slightly to 94% again this is due to information governance & fire training. All managers have been instructed to have these completed by end of November 2019, with targeted compliance levels of a minimum of 95%.

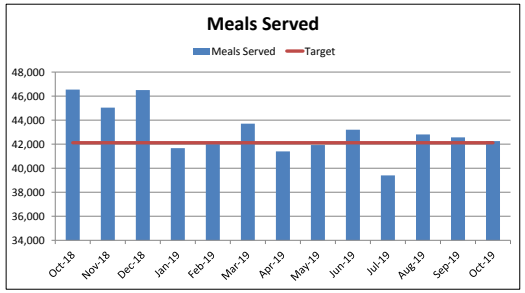

Estates Responsiveness (Priority 1 - Emergency)
Estates Responsiveness (Priority 1 - Emergency)
Target
100%
99%
98%
97%
96%
95%
94%
93%
92%
91%
90%
Oct-18
Nov-18
Dec-18
Jan-19
Feb-19
Mar-19
Apr-19
May-19
Jun-19
Jul-19
Aug-19
Sep-19
Oct-19

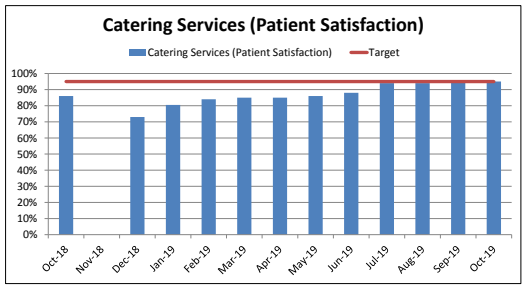

Estates Responsiveness (Priority 2 - Urgent)
Estates Responsiveness (Priority 2 - Urgent)
Target
100%
98%
96%
94%
92%
90%
88%
86%
84%
82%
Oct-18
Nov-18
Dec-18
Jan-19
Feb-19
Mar-19
Apr-19
May-19
Jun-19
Jul-19
Aug-19
Sep-19
Oct-19

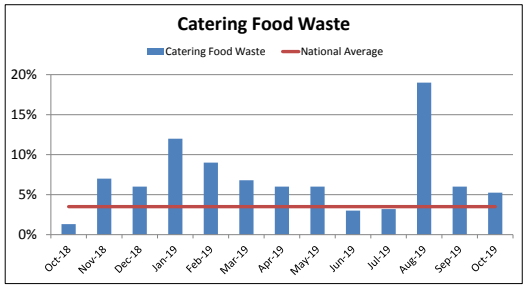

PLACE scores
PLACE scores
National Average
91%
90%
89%
88%
87%
86%
85%
84%
Oct-18
Nov-18
Dec-18
Jan-19
Feb-19
Mar-19
Apr-19
May-19
Jun-19
Jul-19
Aug-19
Sep-19
Oct-19


Domestic Services (Cleaning) Very High Risk
Domestic Services (Cleaning) Very High Risk
Target
100%
98%
96%
94%
92%
90%
88%
86%
Oct-18
Nov-18
Dec-18
Jan-19
Feb-19
Mar-19
Apr-19
May-19
Jun-19
Jul-19
Aug-19
Sep-19
Oct-19


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


Meals Served
Meals Served
Target
48,000
46,000
44,000
42,000
40,000
38,000
36,000
34,000
Oct-18
Nov-18
Dec-18
Jan-19
Feb-19
Mar-19
Apr-19
May-19
Jun-19
Jul-19
Aug-19
Sep-19
Oct-19


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


Catering Food Waste
Catering Food Waste
National Average
20%
15%
10%
5%
0%
Oct-18
Nov-18
Dec-18
Jan-19
Feb-19
Mar-19
Apr-19
May-19
Jun-19
Jul-19
Aug-19
Sep-19
Oct-19

Executive Summary Our Pounds

The Princess Alexandra Hospital NHS Trust

The in month deficit was £2.9m, £1.4m behind plan. Income performed to planned levels with adverse variances expenditure led. In particular, despite some improvements within Healthcaregroup to reduce temporary spend overall monthly spend was £2.9m, £0.8m above planned levels when compared to recovery trajectories. This was caused by unplanned sickness, activity increases and slower than expected intake of overseas nurses. The YTD deficit is £20.7m, £4.1m behind plan. As the Trust is behind plan it is not eligible to receive Provider Support or Financial Recovery Fund allocations YTD £9.1m.

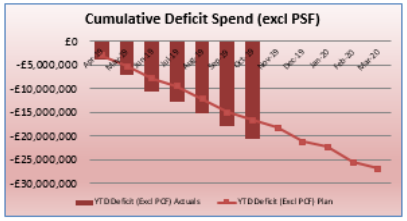
Pounds

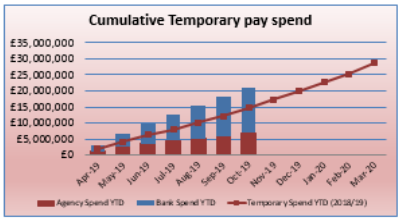
5 Our Pounds Summary

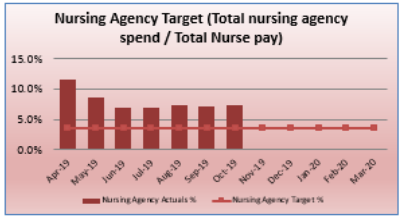
5.1 Overall financial position

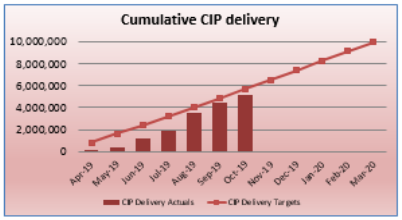
The Princess Alexandra Hospital NHS Trust

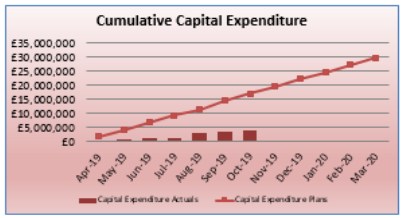
OUR POUNDS		
Metric	Annual Plan (Standard)	Latest Month
YTD Deficit (Excl. PSF)	-£26,942,000	-£20,658,692
Cumulative Agency Spend £s	-£10,292,000	-£6,948,559
Cumulative Bank Spend £s	N/A	-£14,091,341
Nursing Agency Target (Total nursing agency spend / Total Nurse pay)	3%	7%
Cumulative Capital Expenditure	-£29,714,000	-£3,973,000
BPPC Volume	95%	89%
BPPC - £s	95%	84%
Cash Balance	£1,000,000	£1,532,000

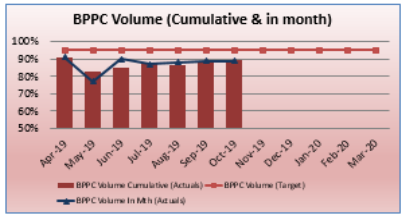


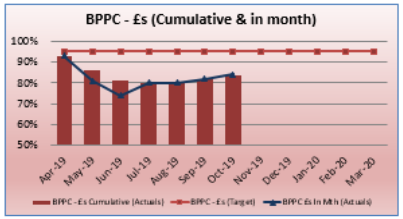


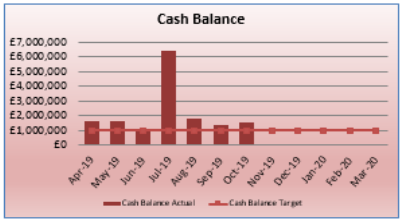












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CQC Rating

NHS
The Princess Alexandra Hospital
NHS Trust

CQC

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Requires improvement ↔ Jul 2019	Good ↔ Jul 2019	Good ↔ Jul 2019	Requires improvement ↔ Jul 2019	Good ↑ Jul 2019	Requires improvement ↔ Jul 2019
Medical care (including older people's care)	Requires improvement ↔ Jul 2019	Requires improvement ↓ Jul 2019	Good ↔ Jul 2019	Good ↑ Jul 2019	Requires improvement ↔ Jul 2019	Requires improvement ↔ Jul 2019
Surgery	Requires improvement ↔ Jul 2019	Good ↔ Jul 2019	Good ↔ Jul 2019	Good ↑ Jul 2019	Good ↔ Jul 2019	Good ↑ Jul 2019
Critical care	Good Mar 2018	Good Mar 2018	Good Mar 2018	Requires improvement Mar 2018	Good Mar 2018	Good Mar 2018
Maternity	Requires improvement Jul 2019	Requires improvement Jul 2019	Good Jul 2019	Good Jul 2019	Requires improvement Jul 2019	Requires improvement Jul 2019
Services for children and young people	Good ↑ Jul 2019	Good ↔ Jul 2019	Outstanding ↑ Jul 2019	Good ↑ Jul 2019	Good ↑ Jul 2019	Good ↑ Jul 2019
End of life care	Good ↔ Jul 2019	Good ↑ Jul 2019	Good ↔ Jul 2019	Good ↔ Jul 2019	Good ↔ Jul 2019	Good ↔ Jul 2019
Outpatients	Good Jun 2016	Not rated	Good Jun 2016	Requires improvement Jun 2016	Good Jun 2016	Good Jun 2016
Overall*	Requires improvement ↔ Jul 2019	Requires improvement ↓ Jul 2019	Good ↔ Jul 2019	Requires improvement ↔ Jul 2019	Requires improvement ↔ Jul 2019	Requires improvement ↔ Jul 2019

*Overall ratings for this hospital are from combining ratings for services. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

CQC Inpatient Survey (OS)
20 June 2019
This survey looked at the experience of 76,668 people who were discharged from an NHS acute hospital in July 2018. Between August 2018 & January 2019, a questionnaire was sent to 1,250 recent patients at each trust. Responses were received from 422 patients at The Princess Alexandra Hospital NHS Trust.

Patient survey	Patient response	Compared with other trusts
The Emergency / A&E department (answered by emergency patients only)	8.4/10	About the same
Waiting lists and planned admissions (answered by those referred to hospital)	8.7/10	About the same
Waiting to get to a bed on a ward	6.8/10	About the same
The hospital and ward	7.4/10	Worse
Doctors	8.3/10	About the same
Nurses	7.5/10	Worse
Care and treatment	7.6/10	About the same
Operations and procedures (answered by patients who had an operation or procedure)	8.0/10	About the same
Leaving hospital	6.6/10	About the same
Overall views of care and services	2.8/10	Worse
Overall experience	7.9/10	About the same

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Commissioning for Quality and Innovation

2019/20 CQUIN Forecast

	Scheme	Target	Current Trajectory					Max FY Value
			Q1 Act	Q2	Q3	Q4	FY	
CCG1a	Antimicrobial Resistance - Lower Urinary Tract Infections in Older People	90%	61%	70%	80%	90%	75%	244,128
CCG1b	Antimicrobial Resistance - Antibiotic Prophylaxis in Colorectal Surgery	90%	0%	0%	65%	90%	39%	244,128
CCG2	Staff Flu Vaccines	80%				80%	80%	488,257
CCG3a	Alcohol and Tobacco - Screening	80%	100%	90%	90%	90%	93%	162,752
CCG3b	Alcohol and Tobacco - Tobacco Brief Advice	90%	68%	85%	90%	90%	83%	162,752
CCG3c	Alcohol and Tobacco - Alcohol Brief Advice	90%	52%	65%	80%	90%	72%	162,752
CCG7	Three High Impact actions to Prevent Hospital Falls	80%	25%	26%	80%	80%	53%	488,257
CCG11a	SDEC - Pulmonary Embolus	75%	66%	75%	75%	75%	73%	162,752
CCG11b	SDEC - Tachycardia with Atrial Fibrillation	75%	80%	75%	75%	75%	76%	162,752
CCG11c	SDEC - Community Acquired Pneumonia	75%	93%	75%	75%	75%	80%	162,752
								2,441,283

Q1 CQUIN performance totalled c52% with good performance on the SEDC and Alcohol/Tobacco screen schemes. The work to date in implementing the schemes should result in improved performance from quarter 2, with most schemes delivering the target measures from Q3.
The current trajectory reaches a forecast of c70% for the full year. Focus is being put on The Anti-microbial Resistance and Falls schemes (CCG1, CCG7) to improve performance.

THE PRINCESS ALEXANDRA HOSPITAL NHS TRUST

ADoQ - Associate Director of Quality
ADoN&M - Associate Director of Nursing & Midwifery
ADOO - Associate Director of Operations FAWs
AMD - Associate Medical Director for Surgery
CMO - Chief Medical Officer
COO - Chief Operating Officer
DCMO - Deputy Chief Medical Officer
DoN - Director of Nursing
DDoN - Deputy Director of Nursing
DoP - Director of People
DoS&E - Director of Strategy & Estates
EoL - End of Life Group
HoCN - Head of Children's Nursing
HoM - Head of Midwifery
HoIPC - Head of Infection Prevention & Control
HS&GM - Health Safety & Governance Manager
MIB - Mortality Improvement Board
NUM - Neonatal Unit Manager
SHoPS&F - Strategic Head of Property Services & Development
UCB - Urgent Care Board

BRAG key:
Blue aims achieved and actins embedded in practice
Green actions achieved
Amber actions commenced
Red actions not started or breached delivery date

CQC INSPECTION March 2019: QUALITY IMPROVEMENT PLAN: September 2019 (Q.2)

MUST Recommendations

Theme	Must / Should No	KLOE	Trust wide	CQC Recommendation	Theme	Lead / Executive lead	Overarching Aim	Desired Outcome	Key Performance Indicators (KPI)	Milestones towards achievement	BRAG
Governance	S1	Safe	Trust wide	The Trust must ensure that structures & processes for governance are fully embedded at all levels throughout the Trust to enable timely response to risk & safety issues	Governance (structure)	ADoQ / DoN	1.Strengthen and embed a positive, open and supportive culture to deliver robust, standardised governance processes across the organisation and the wider health care system.	A Patient Safety & Quality team structure in place which is aligned to, and supports organisational governance. A standardised governance framework with groups, forums, committees that deliver a cross organisational approach to patient safety & quality. A strategy & process for sharing organisational learning which effects positive changes.	1. A fit for purpose governance resource in place to meet the needs of the organisation. 2. A standardised approach to all PS&Q meetings, including ToR, Agendas & minute taking. 3. Consistent reporting & processes for escalation embedded in practice. 4. Elimination of duplication in reporting & streamline processes for escalation & decision making. 5. Clearly identified & allocated responsibilities for the overseeing of identified risks in every ward & department. 6. Clearly identified & allocated responsibilities for overseeing compliance in every service. 7. Clearly identified & allocated responsibilities for overseeing clinical effectiveness in every service. 8. Clearly identified & allocated responsibilities for overseeing patient experience in every service. 9. All staff allocate with oversight responsibilities for risk, compliance, clinical effectiveness & patient experience will be trained & competent. 10. Key individuals (TBC) will complete QI training.	PDSA cycle 1 (by end of October 2019): Review current governance resource across the whole Trust. Benchmark current resource against other organisations to assess best approach. Review current structures and processes for governance; to facilitate achievement of agreed national & local standards. Completion of a mapping exercise for all patient safety & quality meetings & forums, reviewing ToR, Agendas, & mechanisms for reporting & escalation. Review content of current approaches to reporting, assessing content, analysis, presentation & impact. An analysis of all meetings associated with quality, safety & risk; aiming to achieve assurance that all opportunities to identify & escalate risks or concerns are in place. Identification of staff with allocated responsibilities for managing risk, compliance, clinical effectiveness & patient experience. Completed training needs analysis.	Amber
	M5	Safe	Medical care (including older people's care)	The service must ensure that systems & processes to identify risk at ward level are embedded.	Governance (structure)	ADoQ / DoN					
	M10	Responsive	Surgery	The service must ensure that actions to protect patient safety are put in place in a timely manner	Governance (structure)	ADoQ / DoN					
	M20	Safe	Maternity	The service must ensure all incidents are reviewed in a timely way to promote learning & service improvement	Governance (structure)	ADoQ / DoN					
	M21	Well Led	Maternity	The service must ensure risk registers accurately reflect the risks identified, are updated in a timely way & risks are closed appropriately once all actions are completed	Governance (risk management)	ADoQ / CMO					
	M13	Effective	Surgery	The service must ensure that policies are reviewed in a timely manner and that they are shared with staff	Governance (policies / clinical effectiveness)	ADoQ / CMO		A clear auditable process for alerting staff when policies are due for review, require updating due to changes in guidance & for sharing of new & updated policies across the whole organisation.			
	S4	Effective	Medical care (including older people's care	The service should monitor national audits and use the results to improve outcomes for patients	Governance (audits / Clinical effectiveness)	ADoQ / CMO		There is an agreed auditable methodology for using the results from all national audits, in conjunction with other information to underpin quality improvement work & improve patient outcomes.			
	S5	Effective	Surgery	The service should consider revising the consenting of patients on the day of surgery in line with best practice	Governance (Clinical effectiveness - Consent / audit)	ADoQ / CMO		Consent is undertaken in line with national best practice.			

	S13	Well led	Maternity	The trust should ensure managers use effective change management processes to facilitate required improvements in a timely way	Governance (structure / QI)	HoM / DoN (DoQI)		Managers to complete Leading Change & Leading Projects training. In order to facilitate timely improvements across the organisation			
	S14	Well led	Maternity	The trust should ensure detailed minutes of meetings are recorded to accurately reflect discussions, actions and responsibilities	Governance (structure)	HoM / DoN		A standardised approach to minute taking will be developed and cascaded across the organisation			
Documentation	M1	Safe	Urgent and emergency services	The service must ensure that staff keep detailed records of patient care & treatment.	Documentation	DDoN / DCMO / DoN	Review and improve current processes & practice in documentation of patient risk assessments, care and treatment to ensure it is in line with national best practice & professional & legal requirements.	Documentation will be completed in line with national best practice & provide an accurate comprehensive patient record which is evidenced by audit.	KPIs to be agreed in line with compliance & outcome measures.	1. Scope of QI project & form working group (end September) 2. Completion of driver diagram & fish bone diagram (end Oct 19) 3. Agree in scope documentation projects under three primary drivers: Ensure documentation templates are fit for purpose, drive compliance through behaviours & culture shift, monitor compliance.	Amber
	M6	Responsive	Medical care (including older people's care)	The service must ensure that staff keep detailed records in relation to risk assessments & care plans for patient falls & pressure ulcers.	Documentation	DDoN / DCMO / DoN					
	M14	Safe	Maternity	The service must ensure staff accurately complete women's care records with all necessary assessments required to safely monitor mothers & their babies.	Documentation	DDoN / DCMO / DoN					
	S17	Safe	Services for children and young people	The service should ensure discharge summaries are sent to GPs within 72 hours of discharge.	Documentation	DDoN / DCMO / CMO	Ensure all discharge summaries for all services are sent to GPs within 72 hours of discharge.	A reliable & consistent process that enables discharge summaries to be sent to GPs within 72 hours of discharge.			
										2	
raining	M2	Safe	Urgent and emergency services	The service must ensure that medical staff training meets the compliance target of 90%.	Mandatory training	AMD & ADOO / DoP	Ensure staff are compliant with the requirements for statutory mandatory training across all core services	90% of the workforce will be consistently compliant with statutory & mandatory training regardless of role or remit.	The Trust will achieve compliance of >80% by end Q2 >85% by end Q3 >90% by end Q4	Review existing policies & processes which inform training with staff groups, from key areas of sub optimal compliance to ensure the policy & processes drive & supports compliance with trust & national standards for stat & man training.	Amber
	M8	Safe	Medical care (including older people's care)	The service must ensure that medical staff training meets the trust compliance target of 90%.	Mandatory training	AMD & ADOO / DoP					Amber
	M18	Safe	Maternity	The service must ensure staff compliance with basic life support training meets the trust's compliance target of 90%.	Mandatory training	AMD & ADOO / DoP					Amber
	M22	Safe	Maternity	The service must ensure that staff complete mandatory training to meet the trust's compliance target	Mandatory training	AMD & ADOO / DoP					Amber
	S3	Safe	Medical care (including older people's care	The service should ensure all staff complete safeguarding training in line with national guidance	Mandatory training	AMD & ADOO / DoP					Amber
	S15	Safe	Services for children and young people	The service should continue to ensure staff complete safeguarding training, in line with national guidance	Mandatory training	AMD & ADOO / DoP					Amber
				The service should ensure there is a nurse trained in advanced paediatric life support (APLS) or European paediatric advanced life support (EPALS) on every shift, in line with guidelines from the Royal College of Nursing			All duty rosters to reflect Royal College of Nursing guidelines by identifying a minimum of one member of nursing staff on duty trained in APLs or EPALs	Ensure all paediatric nurses who take charge of paediatric areas hold a APLS or EPLS certificate	Duty rosters will have 100% day shifts compliant by end Q2	All ward managers, HDU facilitators & bleep holders meet the standard	Green

T	S16	Safe	Services for children and young people		Training	AND&M / DoP			100% day shifts & 50% night shifts will be compliant by end Q3 100% day shift & 75% night shift will be compliant by end Q4 By end Q1 (20/21) 100% day & night shifts will be compliant.	Emergency department rota meets the standard on all shifts day /night & are available to support all ward areas Paediatric Manager on call is available for escalation 24 hours a day/ 365 days a year Q4 Dolphin RNs will be completing EPAL 2 RNs completing High dependency course - will be completed in Q2 2020	Amber Amber Amber
Nurse Vacancy	M3	Safe	Urgent and emergency services	The service must ensure it has enough nursing staff with the right qualifications, skills, training & experience to keep patients safe from avoidable harm & to provide the right care & treatment	Nursing vacancy	DDoN / DoN	Recruit & retain nurses with the right skills & knowledge to ensure the skill-mix & staffing levels across the organisation are sufficient to deliver high quality, compassionate & safe care.	To achieve a < 10% nurse vacancy rate by end March 2020 & further reduce the vacancy rate over 2020/21	Start point RN vacancy rate 26.8% (April 19) End Q2 = < 20% End Q3 = < 15% End Q4 = < 10%	Develop & gain approval for the strategy to achieve <10% vacancy rate over current year	Blue
	M4	Safe	Medical care (including older people's care)	The service must ensure it has enough nursing staff with the right qualifications, skills, training & experience to keep patients safe from avoidable harm & to provide the right care & treatment	Nursing vacancy	DDoN / DoN				Refocus retention work plan to deliver a turnover rate of < national median of 15%	Amber
	M11	Safe	Surgery	The service must continue to monitor and actively recruit to ensure staffing with the appropriate skill mix is in line with national guidance	Nursing vacancy	DDoN / DoN				develop and gain approval for the next step in reduction of vacancy rate over 2020/21	Amber
Maternity Action Plan	M15	Safe	Maternity	The service must ensure staff complete foetal growth charts at each appointment	Maternity Action plan	HoM / DoN	Robust standardised governance processes embedded across the organisation and service lines. To monitor and oversee the impact of actions taken in the Maternity Improvement plan (2019)	Please see the Maternity Action Plan		Monitoring performance will be formally undertaken through monthly Executive led review meetings to ensure achievement of action plan milestones.	Amber
	M16	Safe	Maternity	The service must ensure staff complete & annotate cardiotocograph traces in line with national guidance	Maternity Action plan	HoM / DoN					
	M17	Effective	Maternity	The service must ensure policy & guidance documents are reviewed in a timely way & reflect current working practices to enable staff to be able to give women the most up to date information	Maternity Action plan	HoM / DoN					
	S10	Safe	Maternity	The trust should ensure senior midwives & consultants participate in skill simulation training.	Maternity Action plan	HoM / DoN					

Estates	**M7**	**Safe**	**Medical care (including older people's care)**	The service must ensure broken crockery and glass is safely disposed of on all wards.	Estates	SHoPS&F/DoS&E	To achieve assurance that new ways of working are fully embedded in practice	To comply with the requirements of the recent guidelines - Health Technical Memorandum – Safe Management of Healthcare Waste (HTML 07-01). It is the responsibility of all staff involved with the generation or handling of waste on Trust premises to be aware of the correct management and safety procedures associated with the waste produced.	Compliance with planned general inspections conducted by the Facilities Compliance Manager. Compliance with completion of Regulation 15 inspections of the clinical environment (to include compliance checks of safe management of waste). Compliance with agreed training requirements for the safe disposal of broken crockery in appropriate receptacles.	In-date waste management contract. Records of health care group waste management disposal certificates. Monitoring the results of inspections and following up on necessary actions.	
	S9	**Safe**	**Maternity**	The trust should ensure that electrical equipment is up-to-date with safety testing	Estates	SHoPS&F/DoS&E	To embed a resilient process for maintaining safety checks on electrical equipment.	To comply with the requirements of the recent guidelines Health Technical Memorandum – Safe Management of Healthcare Waste (HTML 07-01). It is the responsibility of all staff involved with the use of medical equipment to ensure they correctly comply with the required safety checks before use.	Compliance with planned general inspections (to be conducted by Facilities & Estates Compliance manager). Compliance with completion of Regulation 15 inspections by ward & department managers (to include checking compliance with portable appliance testing). All relevant staff (TBC) understand the necessity to carry out visual inspections of portable appliances before connecting to the mains supply. EBME equipment will include a reminder note on how to check portable appliance before plugging in. All new Trust staff will receive information about electrical appliance safety on Trust induction.	Evidence of an in-date contract. Documented records held centrally and accessible by the healthcare groups. Monitoring the results of inspections and following up on necessary actions. Monitoring of completed audits and relevant action plans.	

H&S	**M9**	**Safe**	**Medical care (including older people's care)**	The service must ensure that hazardous chemicals are kept in a locked cupboard.	H&S	HS&GM / COO	Confirm access to lockable cupboards to store medicines and hazardous substances and compliance with the standard across the Trust	All hazardous chemicals are stores in line with COSH requirements evidenced by monthly audits.	Compliance with quarterly audits of safe storage of substances hazardous to health carried out by the Health, Safety & Resilience team. Non-compliance recorded on the Datix system due to a breach of statutory duty & shared with ADON/ADOP & ward manager for all areas involved. Audit results are presented to the Health & Safety Committee & to the Performance & Finance Committee by exception. 100% compliance is required to achieve BRAG rating of blue (due to the inherent risks to safety, recent national incidents & regulatory compliance).	Review of compliance with evidence of improving trajectory *(percentage of COSHH cabinets/rooms unlocked: May 2018 - 60%, Aug 2019 - 43%. Percentage of hazardous substances stored incorrectly May 2018 - 26%, Aug 2019 17%)*	**Amber**
	M19	**Safe**	**Maternity**	The service must ensure medicines and hazardous substances are stored securely.	H&S	HS&GM / COO		All medicines are stored in line with national and local policy evidenced by monthly audits.	Compliance with quarterly audits of safe storage of substances hazardous to health carried out by the Health, Safety and Resilience team. Evidence of Non-compliance recorded on the Datix system due to a breach of statutory duty, and shared with ADON/ADOP and ward manager for all areas involved. Audit results are presented to the Health and Safety Committee and to the Performance and Finance Committee by exception. 100% compliance is required to achieve blue BRAG rating (due to the inherent risks to safety, recent national incidents and regulatory compliance).	Review of compliance with evidence of improving trajectory (percentage of COSHH cabinets/rooms unlocked: May 2018 - 60%, Aug 2019 - 43%. Percentage of hazardous substances stored incorrectly May 2018 - 26%, Aug 2019 17%)	**Amber**
MIB	**M12**	**Safe**	**Surgery**	The service must ensure that assessments are updated in patient records & that there is oversight of NEWS2 observation timeliness for deteriorating patients.	MIB	MIB	**Collaborate with Mortality Improvement Board to attain consistent compliance**				
Urgent Care	**S2**	**Responsive**	**Urgent and emergency services**	The trust should ensure that 95% of patients should be admitted, transferred or discharged within four hours of arrival in the emergency department	UCB	COO	**Collaborate with the Urgent Care Board to avoid duplication & strengthen the pursuit of national standards**				

Infection Control	**S6**	**Safe**	**Maternity**	The service should ensure there is an arrangement in place for a dirty utility in the antenatal clinic	Infection Control	ADoN&M / DoN	Review current arrangements and identify next steps from risk assessment	Appropriate management and disposal of dirty equipment and fluids embedded within the clinic	Action plan completion	Infection control team inclusion embedded & evidenced in the estates process to ensure proactive risk assessment to any estates works in clinical area. Management of dirty equipment & waste included in the operational policy for the antenatal clinic. Management of dirty equipment & waste for antenatal clinical is risk assessed & on the risk register	**Amber**
	S7	**Safe**	**Maternity**	The trust should ensure staff circulating in theatres wear personal protective equipment in line with national guidance to prevent health care associated infections	Infection Control	ADoN&M / DoN	Meet the expectations of national best practice guidance.	Theatre staff wear PPE in line with trust and national infection and prevention policy evidenced in IPC audits	Action plan completion	Review national best practice guidance (Standards and Recommendations for Safe Perioperative Practice, fourth addition, 2016) to identify PPE requirement. Implement any change to practice.	**Amber**
	S8	**Safe**	**Maternity**	The trust should ensure reusable equipment is cleaned appropriately after its use	Infection Control	ADoN&M / DoN	Embed best practice cleaning and decontamination processes for all reusable equipment	All reusable equipment is decontaminated in line with HSE and IPC regulations as evidenced by decontamination audit.	Action plan completion 100% compliance demonstrated through audit.	Scope current practice across theatres re: equipment cleaning assurance. Implement assurance process & reporting. Review cleaning policy & update with any changes to process.	**Amber**
Workforce	**S11**	**Effective**	**Maternity**	The trust should ensure maternity services have access to designated maternity physiotherapy practitioners	Workforce	HoM / DoP	Undertake a workforce and skill mix review to identify AHP requirements supported by a business case.	AHP's work as integral part of maternity team supporting outcomes.	The workforce reflects the needs of service users.	Benchmark of standards at other organisations re AHP access in maternity services. Create & introduce a pathway to access physiotherapy with supporting Standard Operating Procedure. Completion of a workforce review to meet service needs. Complete options appraisal to decide upon the need for a business case to introduce additional roles	**Red**
	S19	**Effective**	**Services for children and young people**	The service should improve access to allied health professionals, specifically in the Neonatal Intensive Care Unit	Workforce	NUM/DoP	To provide access to Allied Health Professionals within the Neonatal intensive care unit.	Neonatal services at the Trust will be compliant with agreed national standards and this will support achievement of BLISS accreditation	Workforce review Agree funding Access to physiotherapist Access to occupational therapist one day per week Compliance with provision of 2 year follow up clinics Access to clinical psychologist	Workforce review completed August 2019 Create job description for physiotherapy post Finalise funding between Health Care Groups Occupational therapist with special interest in neonatal neurology in post to deliver follow up clinics	**Amber**

Strategy	**S12**	**Well led**	**Maternity**	The trust should ensure improved sustainability and transformation partnership working in maternity services	Strategy	HoM/DoS	Strengthen current relationships across the STP to share output with the organisation	Engagement in STP transformation work streams for maternity	Attendance at Local Maternity Services (LMS) strategic meetings. Programme of transformation through agreed work streams & projects. Staff knowledge & awareness of strategic direction for services.	Monitoring achievement against agreed milestones will form part of the STP and LMS governance reporting framework. Outputs will be shared with Health Group teams work and Trust Board meetings.	**Amber**
CYP	**S18**	**Responsive**	**Services for children and young people**	The service should continue to improve transitional arrangements for young people moving to adult services	CYP	HoC / DoN	Improve transition arrangements for young people who are moving from children's services to adult services whether these are within PAH or other providers so that they are in line or exceed best practice guidance.	To have clear transition arrangements pathways that meet the individual young people's needs that support their safe transition from children's services to adult services.	Trust participating in cohort two of the national children's transitional collaborative. Creation of a delivery plan to meet the 150 days	Trust attending national launch meeting 25 September 2019. Establish Trust wide working group - October 2019 Formulate delivery plan to meet 150 days national deadline. Monitor delivery plan through working group meetings	**Amber**
EoL	**S20**	**Effective**	**End of life care**	The trust should continue to work towards providing a seven-day face to face service to support the care of patients at the end of life	EoL	EoL	Presentation of a comprehensive business case with agreed timeframes for the expansion of the service to facilitate 7 day face to face access for patients				

Grey background
indicates projects that will
be overseen through
another group
EOL Steering Group
MIB
PRMs

The Princess Alexandra Hospital NHS
NHS Trust

Trust Board - 5 December 2019

Agenda Item:	8.1
Presented by:	Steve Clarke - Trust Chairman
Prepared by:	Heather Schultz - Head of Corporate Affairs
Date prepared:	28 November 2019
Subject / Title:	NED Committee membership Changes

Purpose:	Approval	x	Decision		Information		Assurance	

Key Issues:	At the Board development sessions it was agreed to rotate the Chairs of the Board committees. Proposed changes are detailed in the paper and are to be effective from January 2020.
Recommendation:	The Board is asked to approve the membership changes.

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:	Well Led Framework
Appendices:	

8.1

respectful | caring | responsible | committed

Non-Executive Director Committee Membership Changes

At the Board development sessions it was agreed to rotate the Chairs of the Board committees. The principles driving the changes are:

- Subject matter experts not to chair their 'specialist' committee but to be a member of it
- Maximise the skills, knowledge and experience of all NEDs and ensure alignment with the most relevant committees
- All NEDs and all Execs to be on at least one of QSC and PAF
- All NEDs to have broadly the same time commitment to Board Committees as each other
- Andrew Holden's term ends at the end of March 2020 requiring a change of chairing arrangements for PAF

In line with the above, the following changes are proposed and will be effective from January 2020.

Committee	**Audit**	**QSC**	**PAF**	**Workforce**	**Strategy**	**CFC**
Chair	George	Helen Glenister	Pam	Andrew (until end March 2020)	John Hogan	John Keddie
Exec Lead	CFO	DoN&M	CFO	DoP	DoS	DoP
Frequency	4 per year	Monthly	Monthly	Bi-monthly	Bi-monthly	Quarterly

Steve Clarke	50%	50%	50%	50%	Y	50%
Andrew Holden	Y		Y	Y (Chair until end March 2020)		
John Hogan		Y			Y (Chair)	
Pam Court	Y		Y (Chair)		Y	
Helen Glenister		Y (Chair)			Y	Y
George Wood	Y (Chair)		Y	Y (from 20/21)		
Helen Howe	Y	Y		Y (Chair from 20/21)		
John Keddie			Y	Y		Y (Chair)

Recommendation:

- The Board is asked to discuss and agree the proposed changes.

8.1

The Princess Alexandra Hospital NHS
NHS Trust

BOARD OF DIRECTORS

MEETING DATE: 5 December 2019 **AGENDA ITEM NO: 8.2**

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

REPORT FROM: John Hogan

DATE OF COMMITTEE MEETING: 22 November 2019

SECTION 1 – MATTERS FOR THE BOARD'S ATTENTION
The following are highlighted for the Board to note or to take action:
Items for escalation to the Board: **Review Lists:** Due to capacity and demand imbalances, some 'review list' patients had not been seen within their target date leading to a backlog. The 2018 backlog (3786) would be cleared by 31.12.19 (to date no harm identified). For 2019 the backlog of circa 14,500 had a target for clearance and change in practice of 31.07.20. Review lists would cease to exist by 01.08.20 and would be replaced with an annual surveillance list as appropriate, based on changes to the Cosmic system and agreed with clinical teams as appropriate. **Chemotherapy Management System:** CCCS had raised concerns about the safety of the CMS system for the safe administration of chemotherapy drugs. This is on the risk register and is being overseen by the Chief Medical Officer (CMO). Whilst the recent upgrade to the system had fixed some issues, concerns still remain regarding the sustainability of the current mitigations. A decision would be taken in conjunction with the Chief Medical Officer early in the new year as to the continued use of the system. **Maternity Incident:** Members were updated on an incident in Maternity Theatres that week where a fire occurred. A full investigation would be taking place to identify causation. All similar equipment that was in use and adjacent to the fire would now be checked. The Health & Safety Executive had been informed and the incident would be RIDDOR (Reporting of Injuries, Diseases and Dangerous Occurrences Regulations) reportable. Duty of Candour has been undertaken with the patient.
SECTION 2 – ITEMS FOR THE BOARD'S INFORMATION AND ASSURANCE
Other items discussed: QSC also received the following reports: Cancer, Cardiology and Clinical Support Services Healthcare Group Quarterly Performance Report, M7 Integrated Performance Report, Referral to Treatment Recovery Plan and Actions, Patient Experience Update, Update from Patient Panel, Mortality Update, Anticoagulation Audit Update, Monthly Quality, Safety & Effectiveness Report, Monthly Report from Patient Safety & Quality Group, Annual Report on Clinical Ethics, Monthly Update on Nursing, Midwifery and Care Staff Levels, Sharing the Learning Update, Clinical Compliance Readiness 2019/20, Care Quality Commission Insight Report, Infection Control Update and Review of Board Assurance Framework Risks Allocated to QSC.
SECTION 3 – PROGRESS AGAINST THE COMMITTEE'S ANNUAL WORK PLAN
The Committee is making good progress against its work plan.

8.2

The Princess Alexandra Hospital NHS
NHS Trust

Trust Board – 05.12.19

Agenda item:	8.2
Presented by:	Safeguarding Leads: Sarah Cowley (Adult), Nicole Anderson (Children) and Christine Curtis (Maternity)
Prepared by:	Safeguarding Leads
Date prepared:	July 2019
Subject / title:	Safeguarding Adults and Children Annual Report 2018-19.

Purpose:	Approval	X	Decision		Information	X	Assurance	X

Key issues:	This report provides an overview of progress made in 2018/19 in relation to safeguarding Adults/CYP. The report identifies key achievements and challenges faced by the services. Detailed information on all aspects of adult and child safeguarding have been included. **Key Achievements for Children and Maternity Services** • Commissioned a safeguarding supervision course in January 2019 to additional staff members to support the facilitation of the supervision strategy • Updating and ratification of the Female Genital Mutilation Policy to include the national FGM-IS, (underpinned by FGM training to Midwives)
Recommendation:	The Board is asked to receive the Annual Report for Safeguarding Adults and Children and support the on-going work to safeguard adults and children, including the progress in achieving the PREVENT requirements

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

Previously considered by:	Safeguarding Steering Group August 2019 Trust Patient Safety and Quality Committee – August 2019 QSC.25.10.19
Risk / links with the	
Legislation, regulatory, equality, diversity and dignity implications:	• Mental Capacity Act (2005) • Deprivation of Liberty Safeguards (2005) • Care Act (2014) • Working Together to Safeguard Children (2018) • The Children Act (1989, 2004) Section 11 • The Health and Social Care Act 2017
Appendices:	Appendix 1: Adult Safeguarding Arrangements: National and Local Appendix 2: Child Safeguarding arrangements: National and Local Appendix 3: Training Compliance

The Princess Alexandra Hospital NHS
NHS Trust

Safeguarding Adults/Children Annual Report 2018/19

8.2

Sarah Cowley – Lead Nurse Safeguarding Adults
Nicole Anderson – Named Nurse Safeguarding Children
Christine Curtis – Named Midwife

Executive Summary

The role of the Safeguarding Adult/Children/Midwifery Team is to promote the welfare of Children/Young People/Unborn babies (CYP/UBB) and Vulnerable Adults and protect them from significant harm. Children/Young People/UBB (CYP/UBB) are defined as anyone up to their 18th birthday (The Children Act 1989). If a young person has 'special needs' the age extends to the young person's 19th birthday. The Director of Nursing is the executive lead for safeguarding adults/ children/young people.

The Safeguarding Team provides assurance to the Trust Board and Clinical Commission Group (CCG) through reporting to the Patient Safety and Quality Group and through the provision of a performance dashboard and audit

The Safeguarding Team operates Monday to Friday from 9am -5pm offering support and advice to all Trust employees. The Team provides safeguarding supervision, peer review and safeguarding training at all levels in line with the ***Safeguarding Children and Young People: Roles and Competences for Health Care Staff - Intercollegiate Document (2019) and RCN Adult Safeguarding Roles and Competencies for Health Care Staff (2018)***

This report provides an overview of progress made in 2018/19 in relation to safeguarding Adults/CYP. The report identifies key achievements and challenges faced by the services. Detailed information on all aspects of adult and child safeguarding have been included.

Key Achievements for Children and Maternity Services

- Commissioned a safeguarding supervision course in January 2019 to additional staff members to support the facilitation of the supervision strategy
- Updating and ratification of the Female Genital Mutilation Policy to include the national FGM-IS, (underpinned by FGM training to Midwives)
- On-going work to support the implementation of CP-IS – a national project ensuring all CYP/UBB presentations to unscheduled care at PAH are checked to ensure there is no CP plan or they are not 'Looked After'
- A further audit of the maternity information sharing process implemented in January 2016 ensuring HV, GP and MW's are informed, aware and involved in the care planning for vulnerable pregnant women
- An increase in safeguarding CYP training opportunities at levels 2/3 to drive the safeguarding agenda and to ensure compliance
- Delivery of bespoke training to the Surgeons during October 2018
- A CQC inspection in November 2018
- Significant increases in activity in all areas of safeguarding children/young people attending the PAH NHS Trust
- One SI in 2018/19
- Development of an e-learning for level 2 safeguarding CYP training that includes an assessment to measure and monitor staff knowledge
- The launch of the first multi-agency safeguarding conference for FII in December 2018 in Harlow
- Appointment of an additional safeguarding administrator in January 2019 to support the team and the safe electronic storage of historic records.
- The implementation of a new process for victims of Domestic Abuse across Essex

- **Key Achievements for Adults** Increase in Mental Capacity Assessments received in safeguarding team
- Consistency in Deprivation of Liberty applications.

- Continued partnership working with the supervisory body to ensure the quality of Deprivation of Liberty Safeguards (DoLs) applications
- Sustained domestic abuse training as part of the vulnerable patients study day
- Continued daily sit-rep for safeguarding cases including Deprivation of Liberty patients and 16/17 year olds on adult wards
- Implementation of separate MCA training for staff
- Review of safeguarding training in line with new guidance August 2018 – with planned implementation of Joint Level 3 training in September 2019
- Continued Partnership working with the Safer Harlow Partnership to promote the J9 initiative for Domestic abuse within the Trust
- Development of safeguarding practitioner who commenced post in April 2018
- Completion of monthly safeguarding audits across the Trust on staff knowledge and understanding of Safeguarding Adults
- Sustained evidence of consultation's within the team despite a decrease of 8%,- this being less than the previous financial year
- Extra supervisors within adult health care group to support the safeguarding supervision agenda as a result of a commissioned supervision course within the Trust
- Update and ratification of the Safeguarding Adults at Risk Policy

Key Challenges for Children and Maternity Services

- **Increasing and sustaining momentum for training compliance across the Trust so that a skilled and competent workforce can be demonstrated**
  Actions taken: PAH staff eligible for Level 3 safeguarding children training received training on an annual basis during 2018/19. The figures given in **Appendix 3** are based on an annual compliance rate. The Intercollegiate document (2014/19) recommends that staff working with children as part of their core work attend safeguarding training on a 3yearly basis. When re-evaluating our compliance level on this basis as we have in Q4~~,~~ k we have been close to meeting our KPI

  Level 1&2 training is delivered at induction and is thereafter available on-line on a three yearly basis

- **Lack of safeguarding CYP/UBB supervisee's to support the delivery of safeguarding supervision across the Trust**
  Actions taken: In January 2019 the Trust commissioned the services of an NSPCC safeguarding supervision trainer to deliver a supervision knowledge and skills course. Thirteen nominated midwives, adult and paediatrics nurses completed the course and are working towards supporting the safeguarding team to implement a 'Hub and Spoke' approach to safeguarding supervision.

- **Lack of administrative hours to support the increasing workload of the Named Midwife and CYP's/Adult safeguarding team**
  Actions taken: A temporary appointment from January 2019 was created for an additional administrator to support the safeguarding team with the increase in their workload

- **On-going difficulties regarding differing thresholds between the PAH NHS Trust and the Local Authority**
  Actions taken: An annual multi-agency safeguarding conference held in December 2018 was organised by the PAH Safeguarding Children Team, The West Essex CCG, Essex Children Services and Essex Police. This was a well-attended event across all agencies and is one of a number of ways for agencies to develop a better understanding of each service and their threshold for statutory intervention.

  A Partner Agency Review Group (PARG) is held on a quarterly basis for discussions about agency changes or of particular cases where there have been inter-agency challenges. In addition to this is a Multi-Agency Case Assessment (MACA) meetings where complex cases

can be put forward for further exploration. These are regularly attended by the PAH safeguarding children team so that learning can be filtered back to PAH staff via training/supervision.

Areas of historic difficulty have centred around subjects such as referral to the Sexual Assault Resource Centre, an updated procedure for this from the Essex Safeguarding Children Board (ESCB) has assisted in providing clarity for all services.

- **Lack of an integrated electronic records system for children in respect of their safeguarding information**
  Actions taken: The Safeguarding Team have worked closely with the IT service to improve safeguarding information recorded within the patient electronic record. It expected that these improvements will be implemented in 2019/20

- **Workplace becoming increasingly unsuitable for the safe storage of accumulating paper records**
  Actions taken
  The temporary appointment of an additional administrator within the team from January 2019 has focused on the reduction of existing paper records by storing the records electronically on a database. This will significantly reduce the concerns regarding information governance and safe storage of confidential records

- **Workplace unsuitable to engage staff with the supervision process, sharing information and discussions due to lack of space and privacy**
  Actions taken: The safeguarding team has made use of available rooms for supervision.

- **Changes within the Paediatric liaison service has created increased pressure on the safeguarding team to ensure all information is shared with out of West Essex and Hertfordshire school age children.**
  Actions taken: The safeguarding team receives a daily spreadsheet of all Paediatric Emergency Department attendances. We scrutinise all attendances to ensure out of area children, those who are 'Looked After' or where there are safeguarding concerns are liaised out to our community partners such as Health Visitors

- **The resignation of the senior safeguarding children nurse in December 2018**
  Actions taken: Preparations were made for the recruitment of a safeguarding children nurse. During the period the team were without a safeguarding children nurse, the Named Nurse was supported by the safeguarding midwives

Key Challenges for Adults

- **Safeguarding team receiving mental capacity assessments for quality checking.**
  Actions taken: Feedback to staff on assessments received , process for this is discussed in training to raise awareness .Forward plan is for health groups to review own capacity assessments to quality assure these with devised tool

- **Embedding the Mental Capacity Act and the assessment process in the Trust**
  Actions taken: Extra training in place both face to face and e learning**,** working in partnership with other specialist teams to raise this aspect as part of all areas of clinical work, and processes

- **Attendance on the PREVENT training**
  Actions taken: Extra sessions have been implemented which had led to a significant improvement in attendance, E - Learning has also been introduced

- **Lack of Best Interest Assessments of Deprivation of Liberty Safeguard (DoLs) applications by supervisory bodies**

Actions taken: This risk is on the Trust Risk register; all delays in assessments are reported via the datix system. The safeguarding team work closely with the supervisory bodies to prioritise cases and escalate concerns

- **Mandatory training levels for Safeguarding Children/Adults below requirement necessary to securely embed safeguarding practices**
  Actions taken: Review of the training on a monthly basis, the health groups have to give assurance on their training data as part of their performance review to the board. Level 2 training is available for relevant staff group to access. Joint level 3 training will be implemented from September 2019 with weekly sessions in order to achieve compliance over 12 months

- **Attendance on supplemented training sessions to enhance staff knowledge and skill**
  Actions taken: The team work closely with other organisations to provide other training in a variety of areas ,this is publicised via the safeguarding intranet page and also referenced in Mandatory training of these supplementary sessions .Target groups of staff are identified – i.e. matron's and Mangers to cascade this information

- **Timely investigation by health groups on safeguarding cases that are submitted to the Local Authority (LA)**
  Actions taken : A safeguarding scrutiny meeting is in place working in partnership with the Local Authority to review all cases raised against the Trust and give feedback on their presentation by the report author .Delays are escalated by the chair of the meeting to the relevant ADON. The LA are made aware of delays which may be the result of investigations going through the SI process

- **Timely feedback by LA on safeguarding cases raised by and against the Trust**
  Actions taken: As above, also have an agreed point of contact with the local authority hospital based team to review cases and obtain outcomes .This level of communication continues to improve

- **Lack of administrative hours to support the increasing workload of the Adult safeguarding team.**
  Actions taken: A number of options have been presented to the Health group, which have been refused to date, to recruit a permanent member of staff against cost pressure. Temporary plans are in place to cover of 0.75wte, however this is for a specific task related to below issue and not for day to day cover of admin tasks to support the safeguarding team .The current Admin cover is 0.8wte who cannot fully support the team in all required tasks and for this reason, this is on the Risk Register.

- **Difficulty of secure storage of records within workspace**
  Actions taken: Paper records are currently being scanned, saved and disposed of according to Trust Policy to reduce the amount of physically stored documents. Temporary admin support has been agreed by the health group to undertake this task as the current admin support of 0.8wte cannot complete this as part of their day to day work load. This is reviewed on a monthly basis in relation to the cost pressure by the Health Group.

- **Maintenance of the Health IDVA on site due to change in funding of this service provision across Essex**
  Actions taken: Current support for staff is via a telephone support line, relevant policies and procedures have been updated to reflect this. External funding is being explored with partner agencies via external charitable grants to have face to face support within the Trust as previously

- **Implementation of referral system for patients who disclose Domestic abuse as service provider change from April 2019**

Actions taken: Relevant policies have been updated with an agreed process for staff to follow for a support and guidance in Domestic abuse .The safeguarding team continue to support and signpost to relevant agencies as required

The Princess Alexandra Hospital NHS
NHS Trust

ANNUAL REPORT SAFEGUARDING ADULTS AND CHILDREN
April 2018 – March 2019

1. Introduction

1.1 This is the 5th Princess Alexandra Hospital NHS Trust's joint Safeguarding Adult/Children /Young People/Unborn Babies (Adult/CYP/UBB) Annual Report. It sets out the Trust's compliance with its legal duties for safeguarding children and adults and the work plan for the coming year 2019/2020

1.2 The purpose of this paper is to present to the Trust Board an annual report for safeguarding Adults/CYP/UBB in the period April 2018 – March 2019. The paper outlines our key joint achievements and challenges within the service with an overview of training for both specialties. The paper reports Adult, Child, Young People and Unborn Babies safeguarding progress and performance respectively.

1.3 Appendices 1&2 detail Adult/CYP/UBB safeguarding processes providing further detailed information for interest.

1.4 Safeguarding Adults/CYP/UBB is most effective when adhering to a partnership approach. The Trust's safeguarding team work collaboratively with Essex and Hertfordshire Children's Social Services, Essex and Hertfordshire Constabulary and a wide range of other agencies under the umbrella of Essex and Hertfordshire Safeguarding Children and Adult Boards/Partnerships (ESCB, HSCB/P & ESAB) to safeguard both.

1.5 Trust policies and procedures all adhere to the 'Working Together to Safeguard Children' document (2018) which is the pivotal national guidance for quality and standards for safeguarding CYP/UBB and the work plan reflects the Essex/Hertfordshire Safeguarding Children Board's (ESCB) business plan.

2.0 Trust Safeguarding Leads

Name	Role
Sharon McNally	Director of Nursing and Executive for Safeguarding Children/Adults
Dr Than Soe	Consultant Paediatrician and Named Dr – Safeguarding Children
Mrs Sarah Cowley	Safeguarding Adult Lead
Mrs Nicole Anderson	Named Nurse – Safeguarding Children/Young People
Mrs Christine Curtis	Named Midwife for Safeguarding

2.1 The Director of Nursing is the Executive Lead for Safeguarding Adults/CYP/UBB.

2.2 The Trust employs a Named Doctor, Named Nurse/Lead for Adult and Children and a Named Midwife. All work in partnership with the West Essex's and Hertfordshire Designated Doctor and Designated Nurses under the jurisdiction of the Essex/Hertfordshire Safeguarding Children and Adult Board/Partnership (ESCB, HSCB, ESAB).

2.3 The Lead Nurse for Safeguarding CYP, the Lead Nurse for Safeguarding Adults and the Named Midwife are co–located to support the Trust's commitment to a 'Think Family' approach to safeguarding vulnerable patients within the organisation; they are supported by a Senior Safeguarding CYP Nurse, a Safeguarding Midwife and an Adult Safeguarding Nurse.

3.0 Summary of Compliance

3.1 The PAH NHS Trust is compliant with Section 11 of The Children Act (2004) which places a duty on all NHS organisations to ensure that services are discharged having due regard to the need to safeguard and promote the welfare of Children, Young People and UBB (CYP/UBB).

3.2 Safeguarding children services seek to promote the welfare of CYP/UBB and prevent them from suffering or being at risk of suffering significant harm. CYP are defined as children from 0-17 years up to their 18th birthday.

3.3 Safeguarding is everybody's business and therefore all staff within the Trust have a responsibility to safeguard vulnerable adults and CYP/UBB wherever they work be it in a clinical or non-clinical setting.

3.4 There are seven main strands to the Princess Alexandra Hospital NHS Trust (PAH) safeguarding services.

- The undertaking of child protection (CP) medicals excluding sexual abuse medicals
- The provision of education for safeguarding vulnerable adults and CYP/UBB across the Trust
- The provision of supervision to Trust staff
- The provision of ad-hoc safeguarding advice as required by any Trust employee where it relates to patient care
- Supporting staff to make referrals to adult and CYP/UBB's social care and/or advice to social care relating to injury, abuse or neglect
- Deprivation of Liberty Safeguards
- Adherence to the Mental Capacity Act

3.5 In July 2018, the new 'Working Together to Safeguard Children' guidance was published. This document provides pivotal statutory guidance for all professionals working with CYP/UBB and their parents/carers. The new recommendations focus on children with disability, children in need of early intervention services and the management of allegations of abuse against staff working with children/UBB. The PAH NHS Trust has reflected these recommendations in the training, via supervision and will be included in the Trust policy to be updated in June 2019.

3.6 The Care Act (DH 2014) and associated statutory guidance was implemented on 1St April 2015. The introduction of the Care Act 2014 signals the largest change in legislation across the adult sector in over 60 years. It is clear within the Act that safeguarding must start and continue with the person at the centre of all action by seeking to fully involve and engage them in voicing the outcomes they wish to achieve to maintain or improve their feelings of safety and wellbeing. The Care Act dictates that people should not undergo a 'process' but lead the intervention and agree the direction towards resolution.

4.0 Risk and Quality Assurance

4.1 The Director of Nursing is responsible for safeguarding. She presents the Annual Adult and CYP/UBB Protection Report to the Trust Board and chairs the Trust Joint Safeguarding Steering Group.

4.2 Assurance is provided to the Trust Board throughout the year by the production of compliance reports to the Quality and Safety Committee each month. The compliance report includes information about performance, quality and exception reports. Assurance and strategy issues are overseen by the Director of Nursing via regular meetings with the Named Nurses.

4.3 The Family and Women Health Group have responsibility for the operational management of the Adult/CYP/UBB Safeguarding Service within the Trust. The Named/Lead Nurses/Midwife take the lead for the day-to-day management of the Adult/CYP/UBB Safeguarding Service and are supported by the Nursing Services Manager for Children's Service.

4.4 The Joint Adult/CYP/UBB Safeguarding Steering Group meets monthly. The aim is to promote shared learning between the Adult/CYP/UBB safeguarding teams and enable exploration of best practice in all the health groups in relation to the needs of C/YP/UBB's and adults with children where there are mental health, substance misuse and/or domestic abuse concerns.

4.5 The Executive Lead for Safeguarding Adults/CYP/UBB is notified immediately of any serious case reviews, untoward incidents and identified risk to the organisation.

5.0 Risk Register

5.1 There were seven risks relating to safeguarding Adults/CYP/UBB on the risk register for 2018/19

- **Percentage levels of safeguarding CYP training compliance at Level 3 – the Trust has consistently not met the compliance levels (90%) set by the CCG**

Risk score: 9
Plan: The safeguarding compliance level has been calculated on an annual basis as the training was delivered annually during 2018/19. The Intercollegiate Document (2014) states that staff who work with children as part of their core work require safeguarding training level 3 on a 3yearly basis. Shadow reporting of the training figures on this basis significantly altered our compliance in line with our KPI

- **The Deprivation of Liberty applications made to the supervisory body are not reviewed in the time frame by them**

Risk score: 6
Plan: All delays are reported by the datix system – discussions take place with the supervisory body to discuss prioritisation on cases .This risk is a nationally reported risk. The deprivation of Liberty safeguards as part of a review of the Mental Capacity Act (Amendment) Bill will be replaced with the Liberty Protection Safeguards in 2020.
A work plan will be devised to implement the guidance

- **An inability to meet the target levels for supervision due to the lack of appropriately trained supervisors across the Trust to support the supervision strategy**

Risk score: 9
Plan: The recruitment of 13 safeguarding supervisors to support the 'Spoke and Hub' approach to supervision within Family and Women's services

- **A lack of administrative support to the Team in response to the increasing safeguarding awareness within maternity services in particular, and across the Trust for Adults and CYP**

Risk score: 12
Plan: A number of options have been presented to the health group which to date have been refused due to cost pressure. Temporary admin support

has been agreed to support a specific task as the current admin 0.8wte cannot accommodate within her current workload .This is reviewed no monthly basis by the health group in relation to the cost pressure

- **Vacancy in the children safeguarding team due to resignation of the Senior safeguarding children nurse**

Risk Score:
Plan: Successful recruitment of a Safeguarding Children Nurse in February 2019, the Named Nurse – Safeguarding Children was supported by the safeguarding midwives.

- **MCA - to improve staff knowledge and application of The Mental Capacity Act and understanding of DoLS in relation to planning of care for Patients**

Risk score: 9
Plan: Extra training in place for staff to access both face to face and E-Learning, audits undertaken to review staff knowledge and training updated as a result of feedback Working with other specialist teams to incorporate mental capacity assessments as part of their assessment processes

- **Safeguarding children processes not consistently being followed correctly**

Risk score: 6
Plan: The concerns about the PAH processes not being consistently followed have reduced. There was one serious clinical incident during 2018/19 where safeguarding was a feature. This was quickly recognised as the incident unfolded and the appropriate safeguarding processes implemented avoiding a significant risk of harm. However, we have not been complacent; all lessons learned in practice, from our own serious, local and national incidents are included in our training and discussed during supervision.

6.0 Serious Case Reviews/Partnership Reviews

6.1 In accordance with national guidance, serious case reviews (SCR), partnership case reviews (PCR) and domestic homicide reviews (DHR) are requested by Local Safeguarding Children/Adult Boards when an Adult/CYP is seriously injured or an Adult/CYP dies in circumstances where there are safeguarding concerns and a whole system review is required. All children who are seriously injured or die as a result of injuries are reported as a serious incident to the LSCB and CCG regardless of any failing attributed to the Trust.

6.2 There were three SCR's in 2018/19 undertaken by the Hertfordshire and Essex local Safeguarding Children Boards where PAH were involved either directly or indirectly. PAH also provided information for a serious case review held in Haringey. Information was provided and participation by PAH staff in the discussions held during the course of the reviews. There was one Serious Incident in 2018/19, the findings from this are still under review. The safeguarding children team were called for four cases to be heard at the significant incident group.

6.3 The first SCR involved the suicide of a mother and possible homicide of her three month baby who both died in 2017. There had been historic involvement with the mother at PAH involving A&E, the medical health group, the alcohol liaison service and the maternity services prior to this baby. PAH were not involved in the care of mother during the pregnancy for this baby but had been during her previous two pregnancies. The findings from this SCR have yet to be published

6.4 The second SCR involved the death of a 5 month old baby from injuries that included a fractured skull. This case is on-going and is being investigated criminally. This child was born at PAH, spent some time in on Dolphin Ward and was known by the community nursing team. The findings from this SCR have yet to be published

6.5 This SCR was in respect of a sudden unexpected death in infancy (SUDI) for a child from Hertfordshire. The baby had a CP plan as an unborn due to concerns raised during the ante-natal period. The Named Midwife was actively involved in the review and we are awaiting publication by the Hertfordshire Safeguarding Children Board of the findings.

6.6 The final case involved a mother who had her first child at PAH who was left in the care of father due to the mother's mental health problems. The mother subsequently had a second baby elsewhere when concerns were raised about the ability of the mother to meet the child's basic care needs. The child suffered a fractured skull following discharge from NICU and died.

7.0 Complaints

7.1 The Trust received one safeguarding related complaint during the year 2018/19. The complaint was made by a parent who was unhappy that his allegation of fabricated illness had been inadvertently given to the mother of the child by this being recorded on the discharge summary.

8.0 Performance

8.1 In November 2018 The Care Quality Commission undertook a comprehensive inspection at the Princess Alexandra Hospital NHS Trust (PAH). The inspection was carried out to assess if improvements had been sustained in all core services with a focus on being 'Well-Led'. The publication of the inspection is due July 2019.

9.0 Training

9.1 Training compliance remains a key issue for the safeguarding team. The West Essex Clinical Commissioning Group (CCG) set a 95% compliance target for all levels of safeguarding children training. The Trust implemented annual level 3 training, widened the staff groups in receipt of the training and offered sufficient opportunities for all to attend. This was in response to the numerous safeguarding serious incidents during the course of 2016/17. At this time the training department calculated the compliance rate on an annual rather than a 3yearly basis as recommend in the Intercollegiate Document (2014). PAH struggled to meet the 95% KPI target set by the CCG. However, when the training rates were calculated over a 3yr period we were able to demonstrate a compliance rate of above 90% for the majority of Q4. Shadow reporting was implemented in Q4 2018/19 as seen in Appendix 3.

9.2 It can be observed that safeguarding CYP/UBB processes are better embedded within the organisation than has been seen in previous years and the safeguarding team is now considering news ways of delivering a safeguarding programme that encompasses the 'Think Family' approach that combines both adult and children safeguarding for 2019/20.

9.3 The compliance of all levels of safeguarding children/young people/adults training is monitored on a monthly basis and compliance reports are shared with health group leads, managers and matrons. The training reports are shared at the Patient, Safety and Quality group, the Safeguarding Steering group and Family and Women's divisional board.

9.4 The 'No Secrets' document (DoH, 2000) is clear that agencies should provide training for staff and volunteers on the safeguarding policy, procedures and professional practices that are in place locally, commensurate with their responsibilities in the adult protection process. Therefore all staff, encompassing both clinical and non-clinical, have basic awareness training (Level 1) for safeguarding. See **Appendix 3** for compliance

9.5 Since the introduction of the Care Act in April 2015 – the safeguarding adults training has incorporated the changes, including the definition of abuse and the categories.

9.6 Training has been introduced for all clinical staff on induction to the Trust and on the clinical refresher day held every 3 years. This training is for all clinical staff and is held on a 3 yearly cycle. At the end 2018/19, 91% of staff had attended this

9.7 The Adult safeguarding training has been reviewed in line with the RCN Adult Safeguarding Roles and Competencies for Health care Staff (August 2018) and the proposed The Safeguarding Team have updated the training needs analysis for staff groups and will be implementing a safeguarding day which will cover both adults and children level 3 – focusing on the "Think Family" tag line as from September 2019

10.0 SAFEGUARDING ADULTS PERFORMANCE 2018/19

10.1 Deprivation of Liberties Safeguards (DoLS)

10.2 The Trust continues to see a maintained approach in the DoLS applications (table 2), primarily due to increased awareness in this area, specifically since the Supreme Court ruling in March 2014. There has been an increase of 25% in this financial year in applications made

10.3 As a result of this increase nationally, this has elongated the time frame that the external supervisory body is taking to process the high number of applications. Although this is an issue external to the Trust, it has been placed on the risk register as DoLS timeframes are being exceeded. Assurance can be given that all applications have been approved or appropriately managed and each CQC notification is validated and approved by the Director of Nursing. The Trust has reflected this in our internal process to ensure compliance is met.

10.4 Over the last year, Parliament has been considering The Mental Capacity (Amendment) Bill which seeks to replace the current DoLS scheme with a new framework called the Liberty Protection Safeguards ("LPS"), as it is recognised that the current situation is presenting significant difficulties. Proposed changes will be implemented in 2020

10.5 The safeguarding adult's team record the data of themes from referrals made by the organisation in order to analyse recurrent safeguarding themes seen during presentations to the PAH NHS Trust and share this data as part of training. We have identified 22% of referrals are related to neglect, with 21% deemed to be physical injuries cases, this can include referrals for patients attending with pressure injuries from both their own home and from a care provider. Some categories overlap in both neglect, physical and psychological and we have to consider one category does not always fit all cases.

10.6 Some cases the referrer does not state the category and tick the box not determined. In relation to the self-neglect cases the outcome of these generally are case managed, and do not progress down the safeguarding route as the capacity and wishes of the patients are considered in actions taken by the Local Authority

Table 2: Safeguarding Adults Activity 2014-2019

Safeguarding Adults activity	2014/2015	2015/2016	2016/2017	2017/2018	2018/2019
Number of DOLS completed	197	160	196	213	273
Number of SetSaf completed by PAH	120	112	116	255	346
Number of SetSaf against PAH	32	36	58	49	38
Number of MCA's completed	159	183	228	269	230
Level 1 Training	93%	91%	71%	93%	97%
Level 2 training			65%	79%	91%
Consultations	204	329	572	465	427

Table 3: Safeguarding Adults Activity 2018/9

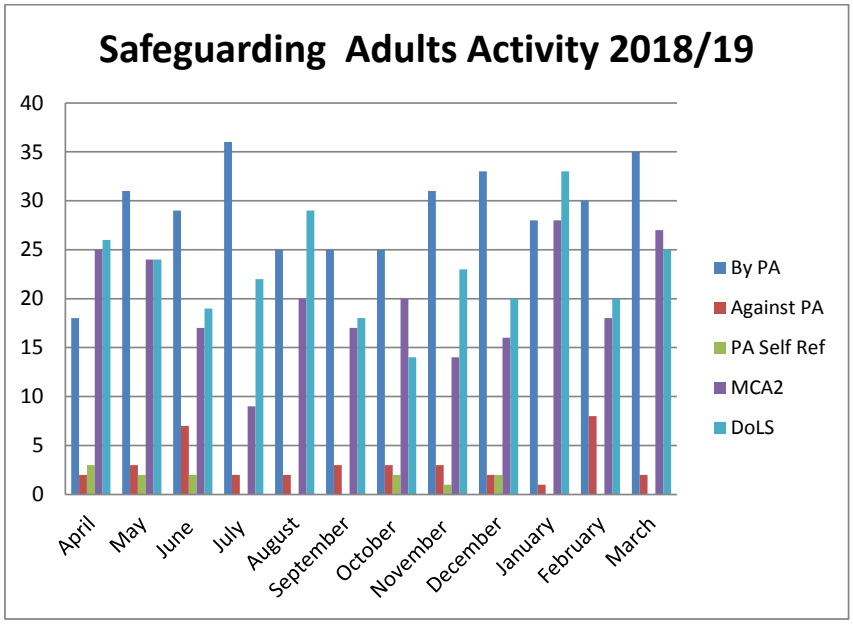
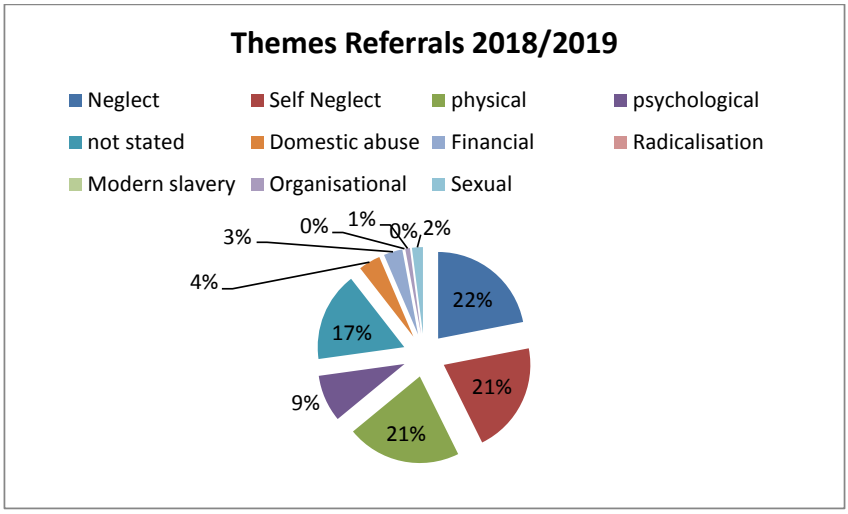


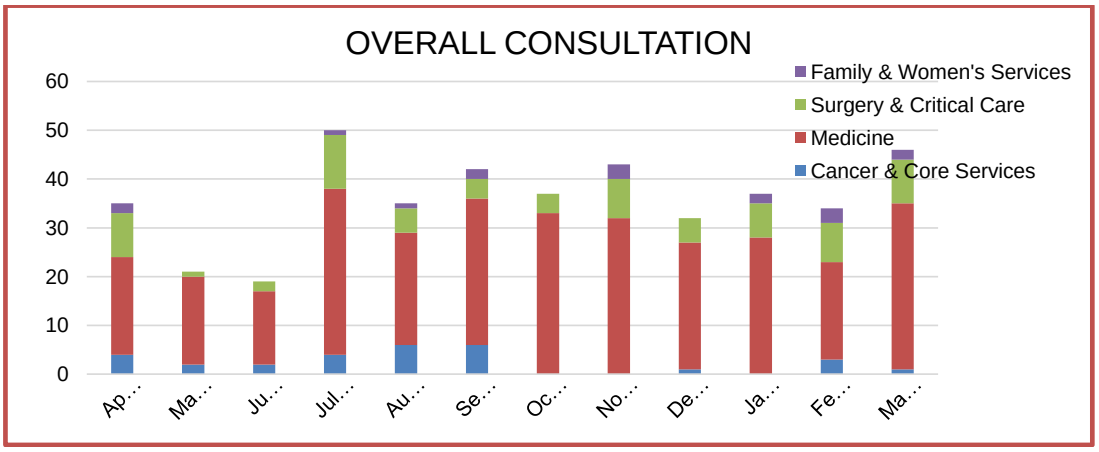
Table 4: Safeguarding Adults Themes 2018/19



11.0 Safeguarding Adult Consultations

11.1 During 2018/19 the Safeguarding Adults Team undertook a total of 427 consultations for safeguarding concerns compared to 465 in the period 2017/18, this demonstrates an 8.5% decrease in consultations compared to the same period in the previous year .These cover a wide range of areas including advice on potential safeguarding concerns to completion of mental capacity assessments and those patients who may meet the Deprivation of Liberty safeguards

Table 5



12.0 Safeguarding Adult Referrals (Table 2/3)

12.1 Predominantly safeguarding adult referrals raised by the Trust are in relation to neglect and cover concerns such as pressure injuries, lack of care from a care provider or carer. All referrals are flagged on COSMIC with information for staff reference where to access further information.

12.2 All cases are investigated by the Local Authority and the Trust works closely with partnership agencies, including the police and social services to ensure a safe discharge for these patients into the correct placement. There has been an increase of referrals made by the Trust of 30% compared to 2017/2018

12.3 In relation to safeguarding referrals raised against the organisation, the number has decreased in the last year by 25% compared to 2017/2018 This includes 12 self-raised against the Trust, which can be about staff related incidents, or where deemed avoidable harm to a patient has occurred whilst in the Trust.

- 38 have been raised by other agencies However in total; only 6 have been substantiated against the Trust. (See table below)
- Some have still not been finalised by the local authority and this is a constant, in chasing this up with the local authority and has been escalated to the Local Authority, Adult Head of Safeguarding in these delays

12.4 In July 2017 a safeguarding scrutiny panel was put in place to meet on a monthly basis chaired by the Deputy Chief Nurse, this also includes representation from both Herts and Essex social work teams.

12.5 The panel reviews all cases outstanding against the organisation with the Health Groups and their implementation plan/outcome for their investigations. The health groups will present their investigation to the panel and share the learning from this

12.6 One of the main objectives is to ensure investigations are completed in a timelier manner and following a robust process. The safeguarding Adults policy has been updated to reflect the investigation process which will follow the Incident reporting process in the Trust

12.7 This will also allow for reviewing themes of safeguarding cases and sharing the learning across the organisation and improve partnership working with the local authorities as there

- The 6 cases substantiated raised by other providers, were related to discharge of the patient's lack of communication on aspects of their care to the other provider, which includes medication and plan of care, and concerns related to lack of information on discharge relating to pressure injuries.
- The 5 cases substantiated against involved 3 cases of patients who left the hospital , who lacked capacity , and 2 involved staff related incidents of rough handling and restraint – both these cases were referred to the NMC
- Subsequently, directorate action plans and shared learning has been instigated from each incident. Key themes from these incidents have been verbal and written communication on discharge of patients

Table 6: Safeguarding Adult Referrals 2018/19

	Substantiated	Partially Substantiated	Unsubstantiated	On-going cases	Submitted LA - awaiting outcome
Self-Raised	5	1	4	0	2
Other provider	6	3	12	9	8

13.0 Mental Capacity Assessments (MCA) in Adults

13.1 A multi-agency MCA policy has been adopted across Essex and as part of the policy MCA forms are used to provide evidence and assurance regarding the implementation of the Mental Capacity Act. MCA forms are used by the Trust when health decisions need to be made regarding an individual's care.

13.2 There has been a decrease in MCA's of 15% over the last year received by the safeguarding team. This is highlighted on training for staff that forms should be sent for audit to the safeguarding team. The safeguarding team are aware that not all forms are received to quality check and review and this reiterated in staff training and at given opportunities within the clinical areas that forms should be sent to the team for this purpose

13.3 MCA forms which the team receives are reviewed by the safeguarding team – overall the quality of these continues to improve over the last year however the themes on the completion of the form are as stated

- lack of documentation of full patient details including address currently of patient
- evidence of the documentation of the best interest decision
- details of family /friends, time /date of assessments

13.4 Training is available for staff on Mental capacity and this is also covered currently a part of induction/level 2 and going forward will be part of the Level 3 training programme

14.0 Safeguarding Adult Audit

14.1 Safeguarding audits are undertaken as part of the Quality Assurance Trust work plan feedback is been given directly to the ward/clinical areas at the time. As a result of these audits, the training is reviewed and changed to cover aspects of learning identified by the audits

14.2 The safeguarding team are working with the Quality First /Information Team to adapt the audit so this can then be part of the Patient Safety and Quality Audit and the perfect ward audit to make this a more robust process giving clearer outcomes, with any action plans to be completed by the areas

15.0 Domestic Abuse

15.1 As a result of the Essex Domestic Homicide reviews, the Trust has worked in partnership with the 'Daisy Project and Safer places' which is a project supporting women suffering domestic abuse and working with them to plan a safer future. The project is to increase the opportunity for victims of domestic abuse to disclose within a health care setting and to educate the PAH staff around domestic abuse with a clear referral pathway integral to the continuing success and increase in referrals.

15.2 The Daisy Project had been focused primarily in maternity services, working with pregnant women and for victims disclosing domestic abuse within the emergency setting. This project works Trust wide in relation to disclosures of domestic abuse including those made by members of staff.

15.3 Health Independent Domestic Violence Advisors (IDVA) are based in the hospital and work alongside the safeguarding team. Due to the success of the project – Essex County Council has funded eight HIDVAs across three Essex hospitals from May 2017 to July 2018, from funding procured through the Transformation Challenge Award. These positions are being

managed by Safer Places and commissioned by the Castle Point and Rochford Clinical Commissioning Group (CCG).

15.4 The Health IDVAs will continue to provide one-to-one advocacy and support for victims of domestic abuse. Health IDVA's assist victims to access support for the full range of their physical, emotional, criminal justice and practical needs, with their focus on ensuring initial safety for the victim. The Health IDVA also plays a role for safeguarding children and adults by referring them to relevant safeguarding services, in line with the Southend, Essex and Thurrock (SET) Procedures and our own Trust safeguarding guidance.

15.5 Initial findings from a preliminary report in February 2018 was that victims referred to the Health IDVA's appeared to represent more vulnerable persons: from the data we have available, they are more likely to be pregnant, to have dependents, and to have accessed emergency services in the past. The service is also capturing a younger demographic, similar to other domestic abuse programmes, but older users are also captured: at least one of these older users had been in receipt of abuse for many years. More than half of users have dependents, with the possibility that the abuse they are experiencing is affecting other vulnerable people. Essex County Council stated that this would need to explore this aspect further: data has been collected on the support provided to the dependents of HIDVA service users.

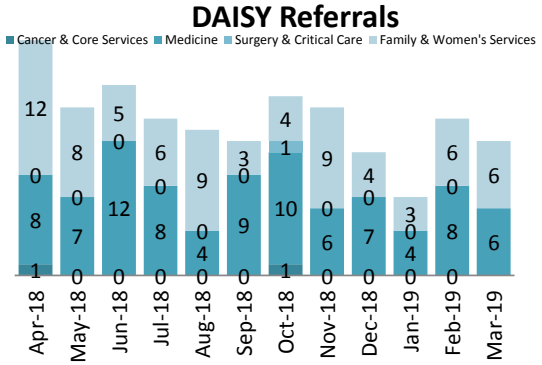
15.6 The project ended in July 2018, and until April 2019 this continued to be funded by Safer Places within the Trust, providing an onsite service for 3 days a week.

15.7 Domestic Abuse services across Essex and a single point of access has been implemented from April 2019- known as COMPASS. The Trust have reviewed this process as part of information sharing agreements and incorporate this into safeguarding pathways and training. Due to the change in commissioned service provision, the Trust will no longer have a Health IDVA on site and will look to work with the providers of the new service to see if funding options can be explored to provide this service.

8.2

15.8 The J9 Initiative was launched in 2016 across Harlow by the Safer Harlow Partnership and the Trust is actively engaged in promoting this. Training started initially with Domestic Abuse champions and the safeguarding team. The resource pack is promoted in the safeguarding/ domestic abuse training and all staff can access this for reference. Training is available for the Trust to access via this partnership working. This is also placed in the wider community to raise this awareness of having access to support services for those and their families suffering from Domestic Violence

Table 7: Daisy referrals by month and department 2018/2019



16.0 Adult Safeguarding Supervision

16.1 Safeguarding Supervision for adults was introduced in August 2016; this is currently in the format of group supervision for all clinical staff to access. The lead nurse for safeguarding adults is supported by one of the medical Matrons in provision of supervision to the staff. Over this period the take up for supervision has been poor, this continues to be promoted across the health groups and training to encourage staff to attend in monthly sessions are available for staff to book.

16.2 In January 2019 the commissioning of an NSPCC safeguarding supervisor trainer was arranged by the Safeguarding Children Team on behalf of the Trust. A three day safeguarding supervisor's course was facilitated comprising of six midwives, three paediatric nurses and four adult nurses increasing our supervisor list to .

16.3 The new supervisors will support a "Hub and Spoke" approach to safeguarding supervision across the health groups to support the supervisory requirements of the Trust. The safeguarding team will continue to offer safeguarding supervision on an Ad-Hoc, individual and group basis across the organisation and will support the new supervisors. This will allow staff to reflect on practice, develop the skills required to safeguard patients and can be used to support revalidation

16.4 The Trust is compliant with the KPI in that all named safeguarding professionals will receive quarterly 1:1 supervision; this is in the format of individual supervision.

17.0 Safeguarding Vulnerable People Who Use Services (including the PREVENT agenda)

17.1 The PREVENT Strategy is a cross-government policy that forms one of the four strands of CONTEST: The United Kingdom's Strategy for Counter Terrorism. It includes anti-radicalisation of vulnerable adults and children. The Trust delivers its PREVENT Training via a number of means to enable the Trust to meets its obligations for PREVENT Training.

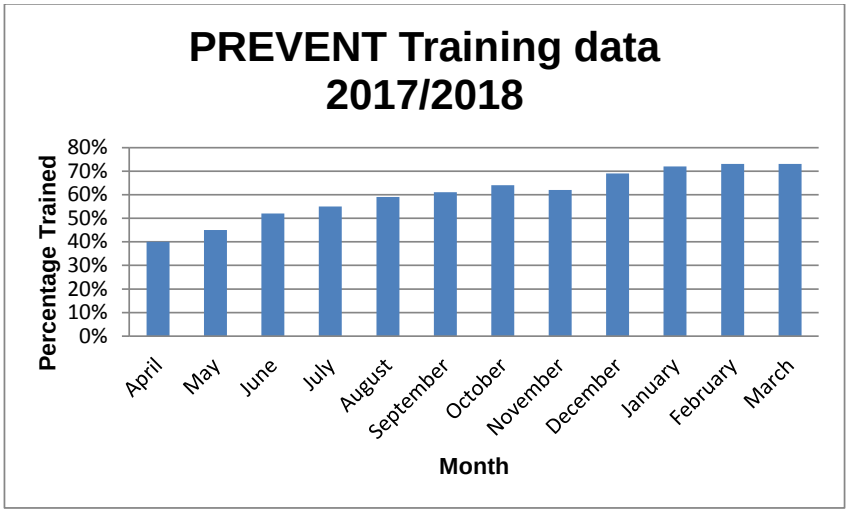
17.2 The NHS England – Prevent Training and Competencies Framework outlines the minimum requirements for training of staff in PREVENT. The training requirements fall in to 3 board categories

- Basic Prevent Awareness Training – Level 1 and 2
- PREVENT Awareness Training – Level 3, 4 & 5
- Competency Level for Organisational PREVENT Leads

17.3 The Trust has been delivering HealthWRAP training as required for Level 3, 4, & 5 staff as part of the Vulnerable Patient Study Day since June 2015. In addition to the Vulnerable Patient Study Day there are Drop In sessions held, advertised via InTouch and the Training Department, to enable staff to undertaken their HealthWRAP sessions outside of the planned Vulnerable Patient Study Days. Additionally, these sessions can be used for non-clinical staff, as the Trust recognises the importance of the training of all staff, and would like to work beyond the NHS England Framework and train all staff in HealthWRAP

17.4 The Prevent lead continues to work with health groups where compliance is low to target the training needs in these areas; this has included bespoke sessions at differing times to address this.

Table 8. Prevent HealthWRAP compliance figures



18.0 Serious Adult Reviews/Multi-Agency Serious Incident Reviews

18.1 Serious Adult reviews (SAR) occur when there are major concerns about adult protection working of system failures or where there is a death of a vulnerable adult. Any professional can request a serious case review by the Safeguarding Adults Board.

18.2 The purpose of the SAR is not to apportion blame as to who is responsible for the death or significant harm to the vulnerable adult or how the death or significant harm happened, that is for the criminal process or coroner's office.

18.3 The purpose of an SAR is to:

- Establish whether there are lessons to be learned from the case in which local professionals and agencies work together to safeguard vulnerable adults
- Identify what those lessons are, how they will be acted upon and what is expected to change as a result within a given timescale: and as a result to improve practice
- Inform and improve local inter agency working.
- Review the effectiveness of procedures (both multi-agency and those of individual organisations) and make recommendations for improvement.
- To prepare or commission an overview report which brings together and analyses the findings of the various reports from agencies in order to identify the learning points and make recommendations for future action.

18.4 The Trust has been actively involved in two SAR's in the period April 2018 to March 2019. This was commissioned by the Essex Safeguarding Adults Board.

- A Chronology was submitted for case 1 – this is still ongoing
- An IMR and chronology has been submitted for case 2 and this case is still ongoing – no areas of concern were identified.

18.5 Any Learning from SARS is published on the intranet and referenced in training to share the learning from this.

19.0 Domestic Homicide Reviews (DHR)

19.1 DHR's are when someone has been killed as a result of domestic violence and a review is carried out in line with Home Office guidance. Professionals need to understand what has happened in each homicide and to identify what needs to change to reduce the risk of future tragedies.

19.2 The Trust has been involved in 1 DHR's within the Hertfordshire Area and this is still ongoing.

- A chronology and IMR was submitted, however no areas of concern were identified

20.0 2019/20 Safeguarding Adults Work Plan

- Continuation of Mental Capacity Training for clinical staff
- Introduction of Safeguarding champions across the Trust encompassing the role of the supervisors
- Ratification of Trust Supervision policy to ensure Safeguarding Adults supervision is incorporated into this
- Continue to develop and support the supervisors trained ,within this financial year
- Explore the business case for increase admin support for safeguarding adults team in line with safeguarding children team.
- Continued development of Safeguarding nurse to meet the needs of the service and support the Lead nurse Safeguarding Adults
- Continue to work with ESAB and NHS England on projects and attend Safeguarding forums and subgroups
- Maintain the J9 Training to support the Domestic abuse agenda with support of Safer Places and the Safer Harlow partnership.
- Review and work with partner agencies in relation to provision of Health IDVA on site, scoping external funding opportunities
- Embedding of the Safeguarding Scrutiny panel across the health groups, to review all safeguarding cases raised against the Trust to ensure completed in a timely manner.
- Continue with the safeguarding staff knowledge audit as part of the audit plan
- Review and scope the process for Liberty Protection Safeguards in preparation for the implementation date
- Review the process for Managing allegations against staff – working alongside Workforce Dept. and the updating of this policy

21.0 Safeguarding Children Performance

21.1 The Safeguarding Children Team have experienced considerable increase in activity within the Paediatric and Adult Emergency services, Maternity Services and in fact across the Trust generally. It is considered that this increased activity has been attributable to the provision of mandatory safeguarding children training to a wider group of health professionals which has supported the embedding of the Trust's safeguarding processes. In addition the Level 3 which is delivered annually keeps the safeguarding agenda current. Alongside the training safeguarding supervision is offered to targeted groups and Ad-Hoc supervision is available to all.

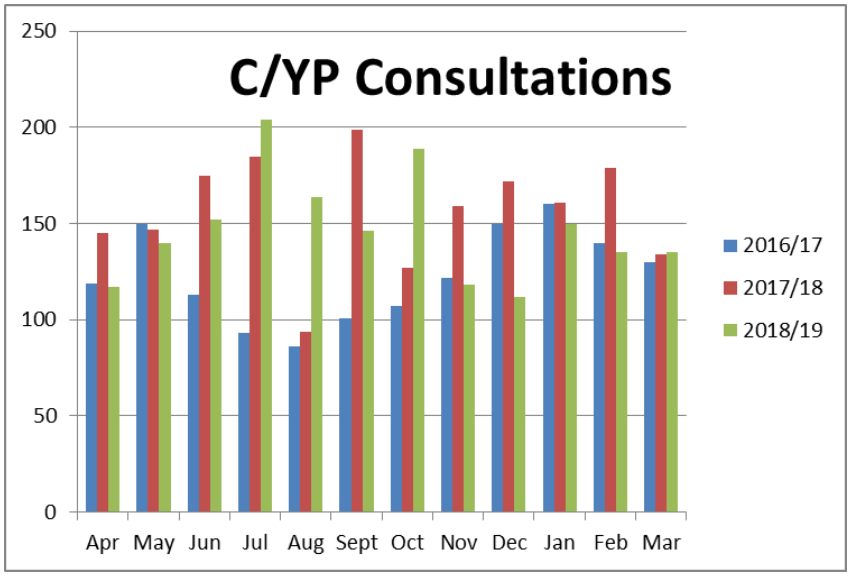
21.2 Trust Safeguarding Children performance is monitored through the use of a comprehensive dashboard that allows the team to monitor performance and quality measures. Updated monthly, the information is used to record safeguarding activity. The data illustrates

- The number of referrals made to children's social care
- The number of unborn babies/children and young people with a CP plan
- Figures for supervision and training
- CSE, FGM and LAC presentations to PAH NHS Trust
- 16/17 year olds that present to the Trust and admitted to adult wards
- Presentation of children and young people with MH problems
- Referrals to the Sexual Abuse Resource Centre (SARC)
- Child Deaths
- CP medicals
- Safeguarding Audits
- S17/47enquiries

22.0 Safeguarding Children Consultations

22.1 When a concern for a Child or Young Person (CYP) is identified a copy of the health record is stamped for the attention of the safeguarding children team. They are kept for collection by the Safeguarding Children Team (SCT) on a daily basis. Once collected the record is scrutinised by the SCT to ensure appropriate action has been taken, the data is stored for statistical evidence and outcomes for children completed. In addition to this the SCT receive numerous calls from staff and these consultations or Ad-Hoc supervision details are also recorded. During the course of 2018/19 a total of 1756 consultations were received and risk assessed by the SCT, showing a decrease of 155 **(**8%) from 2017/18. It is not of concern at this time that the consultations have reduced since the safeguarding referral rates have increased dramatically. This indicates that staff produce more appropriate and/or safeguarding related consultations than in previous years when safeguarding was the default position for any nature of concern.

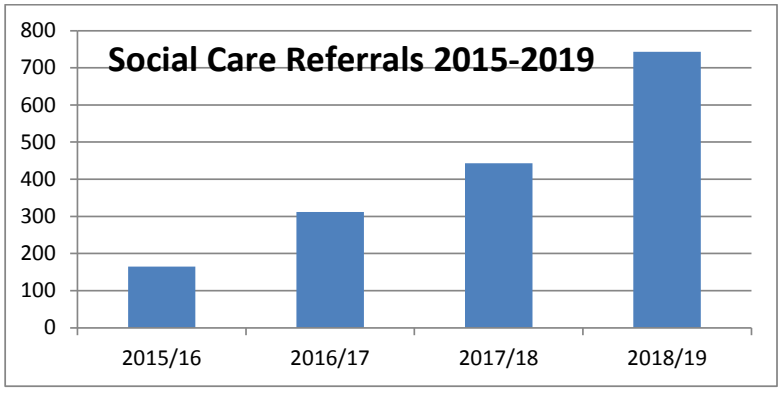
Table 5 Comparable Consultations by Month for 2016/17, 2017/18 and 2018/19



23.0 Safeguarding Children Referrals

23.1 Referrals are made to Children's Services when a professional considers a child or unborn baby to be at risk of significant harm. If a safeguarding referral is made a datix report is also completed. The number of safeguarding referrals made to social care from the Trust has increased by 59% from 443 referrals in 2017/18 to 743 referrals in 2018/19. This is a phenomenal increase in referrals from PAH staff and is partly attributed to the increasing referrals made in relation to parental behavior from both the Maternity and Adult Emergency Department. It also indicates that many more staff members are now more alert to the risks posed to CYP/UBB and respond more appropriately by initiating on-going services outside the Trust. The evidence suggests that staff taking responsibility for safeguarding CYP/UBB and vulnerable people is becoming more widely accepted as part of practice. The SCT have continued to extend the level 3 training to a wider audience on an annual basis through 2018/19 but consider that safeguarding processes are significantly better embedded than in past years. Due to this the safeguarding training process will be under review in 2019/20 so that a more time efficient training programme that incorporates the requirements of the adult safeguarding needs and our 'Think Family' approach.

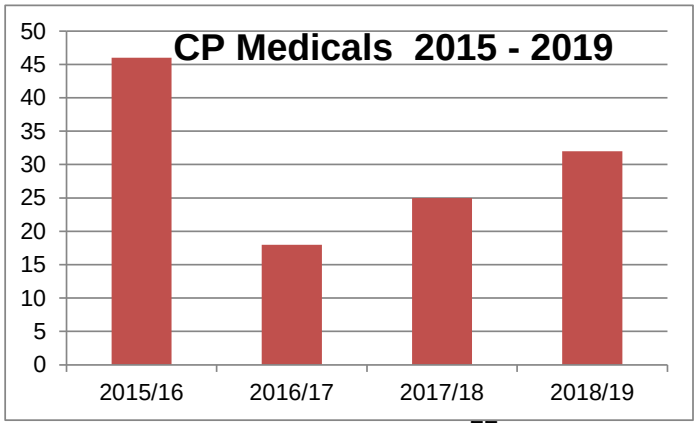
Table 6: Comparable Referrals by Year 2014-2018



24.0 Child Protection Medicals

24.1 Child Protection (CP) Medicals are completed adhering to the Royal College of Paediatrics and Child Health standards. 100% of all CP medicals are undertaken or overseen by a Consultant Paediatrician. The Trust work to a KPI that ensures CP medical reports are submitted to the Local Authority within 72hrs of the CP medical having taken place and we do achieve this target.

Table 7. Comparable Figures for CP Medical undertaken in 2015-2019



24.2 The safeguarding children team have previously raised concerns about the low number of requests for CP medicals from Social Services. Comparison with neighbouring Trusts shows large discrepancies between Local Authorities with some requesting as many as 200 CP medicals per year compared to others in Essex conducting only 9. The PAH NHS Trust have undertaken 32 CP Medicals in 2018/19 demonstrating a 28% increase in numbers (7) compared to 2017/18 when 25 CP Medicals were conducted. We have become less concerned about the numbers of requests for CP medicals than we were during 2016/17 as we have seen an increase but still consider the numbers to be lower than we would expect.

25.0 CP Plans

25.1 Essex has a population of 306,000 children/young people, the majority of whom lead healthy, safe lives. However a significantly small minority face challenges and family circumstances that put their safety and health at considerable risk. It is these children that the PAH NHS Trust must be equipped to identifiy and respond to appropriately ensuring they recieve the health and social support they require in order to be safeguarded.

25.2 The Safeguarding team continued to support the use of the national Child Protection – Information Sharing (CP-IS) project. This is an NHS project that assists health and children's social care staff to share information and better protect society's most vulnerable children. It works in unscheduled healthcare settings only and applies to the following unscheduled healthcare settings:

- emergency departments
- minor injury units
- walk-in centres
- GP out-of-hours services
- maternity units
- paediatric wards
- ambulance services

25.3 The information provided by CP-IS comes from local authorities that have a statutory responsibility for children's services only. Once a child is made subject to a child protection plan or becomes a Looked After Child, a child care alert is placed on the NHS spine by the responsible Local Authority. The NHS spine is checked against every CYP/UBB presenting to PAH for unscheduled services. This means the Adult and Paediatric Emergency Department, the Childrens ward and the Maternity Unit at PAH NHS Trust. A Standard Operating Procedure was devised to support the checking on CP-IS every CYP/UBB that presents to PAH. In line with the existing Trust safeguarding policy, health professionals are expected to inform the Local Authority of an attendance where CYP/UBB are known to them.

25.4 The PAH NHS Trust electronic records, at this time, do not allow mandatory recording of CP-IS to be able to audit and be assured the process is being followed in every case. The safeguarding team continue to pursue a solution to this with the COSMIC team but have started auditing CP-IS manually on a quarterly basis.

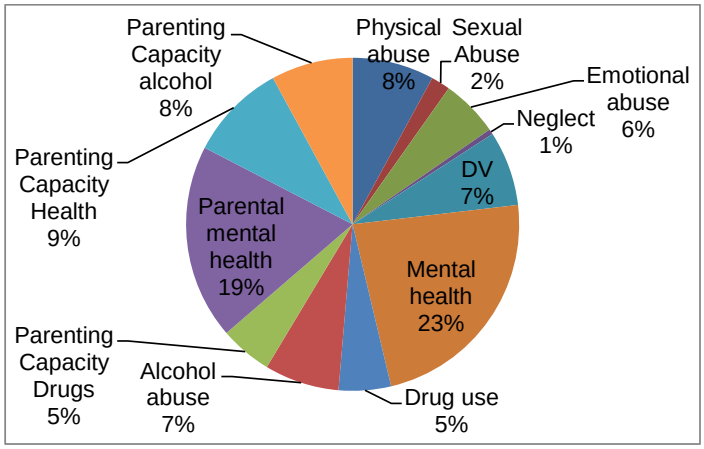
25.5 The Safeguarding Children team continued to be notified by Essex and Hertfordshire Social Care about children with a CP plan via a weekly list. The team administrator puts an alert on the child's electronic record for staff to see when a child presents to the Trust. It is recognised that this is not a failsafe way of working but prior to CP-IS was the only option. This had been raised as a concern to the risk register but since the introduction of CP-IS has reduced the risk.

25.5 Safeguarding Children Themes

25.6 The safeguarding children team have kept consultation data in order to anayse recurrent safeguarding themes seen during presentations to the PAH NHS Trust. The purpose of this is to consider if services available to meet these themes are timely, adequate and appropriate.

25.7 We have identified that 43% of the consultations recieved by the safeguarding team are made up of parent related issues that impact negatively on children. Drug and alcohol issues account for 25% of all consultations with parental mental health such as deliberate self-harm and overdose accounting for 19% of consultations. 23% of consultations are related to the emotional and mental well-being of CYP. Domestic Abuse accounts for 7% of the consultations which are often seen in association with issues such as drug, alcohol and mental health problems. 9% of parental problems are related to health issues and include cancer, sepsis, flu, diabetes and multiple sclerosis. Whilst some of the health issues are not the specific reason for safeguarding concerns it is the parents capacity to manage their children when they become ill that raises the concerns for the child. There are occassions when the illness leads to death and the bereavement needs of the child require exploration. Other difficulties experianced are that there is no extended family member who can look after children when a parent becomes unwell.

Table 8. Safeguarding Themes 2018/2019



25.7 From a child perspective our biggest concerns are regarding child and adolescent mental health with Q4 often peaking in presentations for this category. We believe that it is plausible that Q4 is linked to the pressures CYP endure during this time due to GCSE/A Levels. We now have a crisis team that respond to all CYP on a 24hr basis so that prompt support is initiated. Nationally there are difficulties finding appropriate mental health beds for CYP under these circumstances, we have experienced this locally with parents often managing extremely challenging situations and either refusing or reluctant to return home in such cases.

25.8 In respect of the four categories of abuse for children 2018/19 has seen 8% experiencing physical abuse, 2% sexual abuse, 6% emotional abuse and 1% for neglect. This is interesting since the majority of children with CP plans are related to Neglect, however this may not been easily recognised within an Acute Trust whose focus is arounfd the health needs. There is often an overlap in the differing categories of abuse and we consider that currently, we are not linking up the mental health, drug and alcohol issues with other aspects of abuse such as child sexual exploitation/sexual abuse.

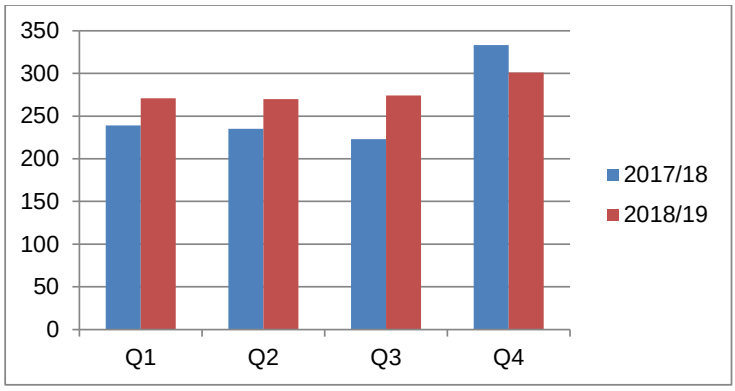
25.9 Child Sexual Exploitation (CSE) is an area that is fully covered in the level 3 training and discussed at levels 1 and 2. We have a CSE risk assessment tool and staff appear to have an understanding of the issues howver, this is not reflected in our data. We only actually recorded three cases of CSE in 2018/19 which seems a low figure considering what is known about CSE. We are concerned that CSE is hidden by the presenting concern and recognise further work in necessary to raise awareness in this area. CSE posters are displayed across the Trust and via our communications team on the electronic information screens that are also available to the public attending the organisation.

26.0 Maternity Safeguarding

26.1 The safeguarding team successfully recruited a safeguarding midwife to a newly formed development role in January 2018. The six-monthly development role was introduced initially to support the Named Midwife with the maternity safeguarding work and to upskill midwives by gaining experience in the field. Whilst the safeguarding midwife role has proved hugely successful in practice, the idea of this as a rotational opportunity is not manageable due to the additional pressures within the current team. The role has been extended for review in 2019.

26.2 From January 2016 information sharing was brought into the safeguarding team for dissemination out to our community health colleagues. A joint maternity, GP and HV audit to monitor the effectiveness of the new information sharing process between maternity, health visiting and GP services was conducted. The findings have been shared within maternity services, to the local GP's and health visitors. This has now been implemented for two years and a repeat audit report and action plan is currently ongoing due to be completed July 2019.

Table 8: Maternity Information Sharing Forms



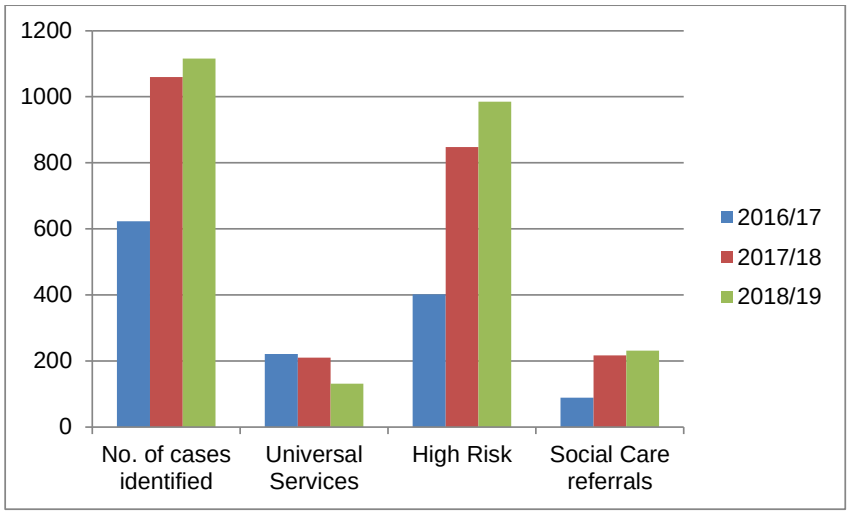
26.4 The maternity information sharing process has now been embedded for two years and is utilised well within the maternity safeguarding process. The information received is stored in individual files on a maternity database. Any additional information that is generated from strategy meetings, professionals meetings, child protection conference minutes, core group minutes and pre-birth plans are also stored in the individual file to be accessed by any midwife, at any time of the day in any area within the maternity service. The IT Team have arrangements in place to ensure midwives to have 'Read Only' access. This is to ensure that current information about vulnerable pregnant women and their unborn babies is accurate. Table 8 illustrates maternity activity in 2017/18 – 2018/19.

26.5 During 2018/19, 1116 pregnant women were identified as having a level of need that would indicate vulnerability compared to 1060 in 2017/18. This is an increase of 5% (56) of vulnerable cases compared to 2017/18 and equates to approximately 25% of all

pregnancies booked at PAH NHS Trust during the year 2018/19 which was approximately 4000. This is an increase of 42% from 2017/18, doubling the maternity safeguarding workload over the last two years. All the cases are risk assessed, and although now not classified into universal or high risk, 88% (985) required additional support and referrals such as mental health, domestic abuse and social care involvement requiring ongoing safeguarding monitoring. There is a continuing drop in ISF's being returned to universal services we believe this is related to the increase in ISF's being submitted where the midwives are better at recognising and escalating vulnerable pregnancies, rather than a lowered threshold for concern.

26.6 Maternity figures kept through 2018/19 show that 231 cases were referred to social services, an increase of 6% from 2017/18.The PAH maternity services supported the delivery of 4200 babies in 2017/18, 7.4% of those babies were referred to social services. Table 9 illustrates the maternity activity and comparable data during 2018/19. Although some months have seen a decrease, there has been an overall increase in child protection conferences, suggesting that referrals made are purposeful and more effective.

Table 9: Maternity Safeguarding Activity



27.6 During 2018/19, 40 Unborn Babies (UBB) had a Child Protection Plan implemented during pregnancy indicating an increase of 15% compared to 2017/18. This would indicate that the guidance from the Essex/Hertfordshire Pre-Birth Protocols is being reflected in practice and that early intervention to meet the needs of vulnerable pregnant women and their UBB's is effective. This in turn impacts on maternity safeguarding activity such as the provision of a child protection report, attendance at the the Child Protection Conference and Core Group meetings, working alongside our partner agencies to support families and to ensure an individual pre/post-birth plan is developed. Hospital midwives are responsible for organizing the discharge planning meeting supported by the safeguarding midwives, to include the social worker, health visitor, community midwife and parents so that an appropriate plan for monitoring and support is in place prior to discharge home.

27.7 When it is identified that UBBs are not safe to be discharged home with parents, Social Care plan the request of an Interim Care Order (ICO) from the Courts following the baby's birth. For 2018/19, six ICO were granted for newborns who were discharged into the care of extended family members or foster carers. This requires substantial input from the The maternity safeguarding team ensure plans are sensitively coordinated and that parents, as well as maternity staff and social workers are supported appropriately.

27.8 In 2018/19, the maternity safeguarding team assumed responsibility for completing "Obstetric and Neonatal Reports" for children who are to be placed for adoption. Forms have been completed for 29 children in 2018/19 with requests dating back to 2017. These forms are now competed in a timely manner, which has been complimented by both Essex and Hertfordshire Social Care. The obstetricians and paediatrician's receive payment for the forms to be completed and this will be explored further in 2019 since this work is being completed by the safeguarding midwifery team.

27.0 Female Genital Mutilation (FGM)

27.1 A joint approach to FGM training for midwives as part of the annual Skills & Drills' updates was implemented in January 2017. Collaboration with the National FGM Centre during the training has underpinned the Trust's FGM policy and encouraged the referral of women to the specialist family support workers from the National FGM Centre. The PAH NHS Trust identified 12 women who had FGM and all cases were detected via maternity services, this was an increase of 33%. This increase coincides with the publication of the new FGM policy in 2018. We have not seen any children identified who has experienced FGM.

27.2 FGM–IS is a national IT alert system that supports the early intervention and ongoing safeguarding of girls, under the age of 18, who are potentially at risk of FGM. FGM-IS enables healthcare professionals to apply an alert to the record of any female baby born to a mother who has had FGM or a child where the risk of FGM has been identified. This launched by the Department of Health (DH) and NHS England at the Girl Summit and was implemented at PAH NHS Trust in February 2018. All female babies born to mothers with FGM have an alert added to their record by the maternity safeguarding team.

28.0 Learning Disability

28.1 A learning disability pathway has been devised to support expectant parents with a learning disability and was launched in June 2018. This is a joint initiative between the community midwifery teams, the Named Midwife, the learning disability team and the designated obstetric consultant. The need for early assessment and possible intervention where significant concerns exist around parental capacity to self-care and/or to care for a child e.g. unsupported, young or learning disabled mother (SET Procedures Part B, chapter 41.3, Parents with Learning Difficulties) or a parent has mild, moderate or severe learning disabilities (HSCB Safeguarding Procedures, Chapter 6.9, Pre Birth Assessment and Guidance) cannot be emphasised enough. During 2018/19, 13 pregnant women were identified with a learning disability and were referred accordingly.

29.0 Perinatal Mental Health Service

29.1 The EPUT Perinatal Mental Health Service is an Essex-wide specialist service and was launched at PAH NHS Trust in October 2017. The service assesses and treats women with serious mental illness or complex disorders. The perinatal period starts at conception through to one year after birth and high risk groups such as patients with affective psychosis and severe depressive illness, drug misuse are indicators for those groups at risk of exacebating mental problems during the perinatal period. Suicide rates are highest during 6 weeks before birth and 12 weeks postnatally. New onset conditions arising after 28 weeks and before 6 weeks postpartum have the potential to be serious so urgent mental health assessments can be established within 2 days. (Perinatal Community Mental Health Standards CCQI 2016). Admission to a mother and baby unit will always be considered the mental health professionals to keep mother's and babies together

30.0 Supervision and Peer Review

30.1 The Working Together document (2018) acknowledges the importance of safeguarding supervision for staff who work directly with child and their parent/carers to enable reflection

and learning from case discussions and to obtain support for the emotional aspects associated with the safeguarding work. It is known that attendance at supervision increases staff knowledge, skills, and supports emotional consequences of face-to-face contact with child protection cases.

30.2 From April 2014, safeguarding supervision was included in the Trust's key performance indicators (KPI) with a target of 80%. The Trust continued to struggle to reach compliance with this requirement during 2018/19 due to a lack of individuals with the supervisory skill to provide safeguarding supervision. There were no more planned NHS England funded places for the NSPCC Safeguarding Supervision Knowledge and Skills course so the an independent safeguarding consultant was approached to provide an in-house 3day course for PAH staff. This was planned to take place in January 2019.

30.2 Thirteen staff members from across paediatric, maternity and adult services were recruited to undertake the course which went ahead in January 2019. This brings our total number of supervisors across Family and Women's Health Group to thirteen.

30.3 It is recommended that safeguarding supervision be delivered on a three monthly basis for all staff who work directly with CYP or their parents/carers. Work is underway for this to be implemented during 2019/20 The target areas are for all paediatric nursing staff, specialist community nurses (NICU), paediatricians, neo-natal staff, all midwives and obstetricians. This will be delivered as a combination of individual and group sessions as well as ad-hoc supervision on a needs basis. All supervision will continue to be recorded on our updated supervision database with support from the Information Team. This enables any themes to be considered, monitors supervisee discussions, solutions reached and can provide information if required for serious incidents.

30.4 Peer review for junior and senior medical staff is led by the Named Doctor – Safeguarding Children with support from the Named and Safeguarding Children Nurse on a monthly basis. Peer review is a training format using case discussions and is well attended by Consultant Paediatricians and their medical teams. Attendance and competencies achieved are mapped and recorded by the medical post-graduate team. The Named Doctor has completed the NSPCC Supervision Knowledge and Skills course during 2015/16 and offers six-monthly individual supervision to medical colleagues.

31.0 Looked After Children (LAC)

31.1 The national average for children who are 'Looked After' is 60 per 10,000 children, in West Essex, that figure is approximately 12/13 per 10000 children. Harlow has the highest number of children within West Essex who are 'Looked After' 45 per 10,000 children. This has a significant impact on our Trust as it is imperative that we identify 'Looked After' children to ensure the key worker from social services is made aware of any presentation to PAH NHS Trust.

31.2 Child Protection – Information Sharing (CP-IS) is a means for staff to check for CYP/UBB who are 'Looked After' and advise their allocated social worker of their attendance as they share parental responsibility for them with parents

31.3 PAH NHS Trust is not responsible for LAC Initial Health Assessments or Review Assessments however is responsible when children present to the organisation to ensure their key worker is informed. The safeguarding dashboard now monitors the number of 'Looked After' children presenting to the PAH NHS Trust and the safeguarding team ensure the key worker and the community LAC team is advised of their attendance

32.0 2019/20 Safeguarding CYP/UBB Work Plan

- To rollout safeguarding supervision to all staff who work directly with CYP/UBB or who have contact with their parents/carers (to include Dolphin ward, paediatric ED and maternity services.
- Safeguarding midwifery supervision figures to be recorded and reviewed monthly to ensure compliance and early escalation to midwifery managers if midwives do not attend
- To re-audit the maternity safeguarding information sharing process during 2019 against the action plan devised from the previous audit.
- To feedback the findings from the information sharing audit to HV's and GP's across West Essex
- To improve and forge good communication processes between community midwives and the GP's by attendance to the GP neighborhood meetings.
- To update the annual level 3 training programme to reflect the latest national guidance, local needs and ensure the new Intercollegiate Document (2019) core competencies continue to be met
- To continue the development of CSE Champions in all paediatric areas and in ED to raise the awareness of CSE, promote the use of the CSE toolkit to assist in identifying CSE and offering support to victims of CSE
- Continue to review and report monthly safeguarding children training figures, contacting staff and their managers who do not attend.
- Safeguarding Team to undertake and evaluate an audit of the quality of safeguarding supervision
- To review the CP medical arrangements and implement a dedicated contact number for referrers, to be negotiated via the CP Team in working hours and to monitor, record and report on categories for the medical
- Contribute to key projects and audits for the ESCB/CCG as required.
- To ensure the embedding of CP-IS by monitoring compliance with a quarterly audit
- To pursue an mandatory electronic means to record the checking of CP-IS on the PAH COSMIC system
- To maintain the current band 6 safeguarding midwifery post to a substantive WTE position within the team
- To take forward a collaborative initiative with the Police, Essex Social Care and the CCG for a multi-agency conference about Familial Sexual Abuse planned for December 2019.
- To report data for referrals to peri-natal mental health

33.0 Recommendations

The Trust Board is asked to receive the annual report for Safeguarding Adults and Children and support the on-going work to safeguard adults and children, including the PREVENT requirements.

Authors:
Sarah Kent Leybourn - Lead Nurse for Adult Safeguarding,
Nicole Anderson - Named Nurse for Child Safeguarding
Christine Curtis –Named Midwife

Appendix 1: Adult Safeguarding Arrangements: National and Local

In September 2012 the Department of Health published new guidance on funding of Deprivation of Liberty Safeguards. From April 2013 Local Authorities undertook the role of supervisory function for Deprivation of Liberty Safeguards in hospitals from Primary care

- As a result of this Local Authorities will be the only supervisory bodies authorising Deprivations of Liberty outside of the court of protection.

- In March 2014 the supreme court handed down its judgment in the case of" P v Cheshire West and Chester council and another" and P and Q v Surrey County Council .The judgement is important for deciding whether arrangements made for the care and treatment of an individual who might lack capacity to consent to those arrangements amount to a deprivation of liberty.

- A deprivation of liberty in such a situation must be authorised in accordance with one of the following regimes; deprivation of liberty authorisation or court of protection order under the Mental Capacity Act Deprivation of Liberty safeguards, or (if applicable) under the Mental Health Act 1983, or in some rare situations, under the inherent jurisdiction of the high court.

- The Care Act (DH 2014) and associated statutory guidance was implemented on 1st April 2015.

- The introduction of the Care Act 2014 signals the largest change in legislation across the adult sector in over 60 years. It is clear within the Act that safeguarding must start and continue with the person at the centre of all action by seeking to fully involve and engage them in voicing the outcomes they wish to achieve to maintain or improve their feelings of safety and wellbeing. The Care Act dictates that people should not undergo a 'process' but lead the intervention and agree the direction towards resolution.

Main Changes to Note

The Care Act does not give a definition of a "vulnerable adult" but instead states that safeguarding duties apply to an adult who has needs for care and support (whether or not the local authority is meeting any of those needs) and;

- is experiencing or is at risk of abuse or neglect; and

- as a result of those care and support needs is unable to protect themselves from either the risk of, or the experience of abuse or neglect.

Categories of Abuse

The Categories of abuse has extended from 7 to 10. The 3 new categories being domestic violence, modern slavery, self-neglect. Below is not an exhaustive list but an illustrative guide as to the sort of behaviour which could give rise to a safeguarding concern. The new SET guidance when published will give further guidance.

- **Physical Abuse** – including assault, hitting, slapping, pushing, and misuse of medication, restraint or inappropriate physical sanctions.

- **Domestic Violence** – including psychological, physical, sexual, financial, emotional abuse; so called 'honour' based violence.

- **Sexual Abuse** – including rape, indecent exposure, sexual harassment, inappropriate looking or touching, sexual teasing or innuendo, sexual photography, subjection to pornography or witnessing sexual acts, indecent exposure and sexual assault or sexual acts to which the adult has not consented or was pressured into consenting.

- **Psychological Abuse** – including emotional abuse, threats of harm or abandonment, deprivation of contact, humiliation, blaming, controlling, intimidation, coercion, harassment, verbal abuse, cyber bullying, isolation or unreasonable and unjustified withdrawal of services or supportive networks.

- **Financial or Material Abuse** – including theft, fraud, internet scamming, coercion in relation to an adult's financial affairs or arrangements, including in connection with wills, property, inheritance or financial transactions, or the misuse or misappropriation of property, possessions or benefits.

- **Modern Slavery** – encompasses slavery, human trafficking, forced labour and domestic servitude. Traffickers and slave masters use whatever means they have at their disposal to coerce, deceive and force individuals into a life of abuse, servitude and inhumane treatment.

- **Discriminatory Abuse** – including forms of harassment, slurs or similar treatment because of race, gender and gender identity, age, disability, sexual orientation or religion.

- **Organisational Abuse** – including neglect and poor care practice within an institution or specific care setting such as a hospital or care home, for example, or in relation to care provided in one's own home. This may range from one off incidents to on-going ill-treatment. It can be through neglect or poor professional practice as a result of the structure, policies, processes and practices within an organisation.

- **Neglect and Acts of Omission** – including ignoring medical, emotional or physical care needs, failure to provide access to appropriate health, care and support or educational services, the withholding of the necessities of life, such as medication, adequate nutrition and heating.

- **Self-Neglect** – this covers a wide range of behaviour neglecting to care for one's personal hygiene, health or surroundings and includes behaviour such as hoarding.

The Care Act also requires that each local authority must:

- Make enquiries, or cause others to do so, if it believes an adult is experiencing, or is at risk of, abuse or neglect. An enquiry should establish whether any action needs to be taken to prevent or stop abuse or neglect, and if so by whom

- Set up a Safeguarding Adults Board (SAB). As you are aware Essex already has an established Safeguarding Adults Board

- Arrange, where appropriate, for an independent advocate to represent and support an adult who is the subject of a safeguarding enquiry or Safeguarding Adult Review (SAR) where the adult has `substantial difficulty` in being involved in the process and where there is no other suitable person to represent and support them

- Co-operate with each of its statutory partners in order to protect the adult. In their turn each relevant partner must also co-operate with their local authority

Appendix 2: Child Safeguarding arrangements: National and Local

The new Working Together to Safeguard Children document came into effect in March 2015. The document streamlines previous guidance and clarifies the responsibilities of professionals towards safeguarding children and strengthens the focus away from processes and onto the needs of the child. It replaces Working Together to Safeguard Children (2013) which is Most of the responsibilities and procedures in the new 2013 Working together remain the same as the 2010 guidance, but the guidance is presented in a much more succinct and less detailed way.

The guidance seeks to emphasise that effective safeguarding systems are those where:

- the child's needs are paramount, and the needs and wishes of each child, should be put first, so that every child receives the support they need before a problem escalates;
- all professionals who come into contact with children and families are alert to their needs and any risks of harm that individual abusers, or potential abusers, may pose to children;
- all professionals share appropriate information in a timely way and can discuss any concerns about an individual child with colleagues and local authority children's social care;
- high quality professionals are able to use their expert judgment to put the child's needs at the heart of the safeguarding system so that the right solution can be found for each individual child;
- all professionals contribute to whatever actions are needed to safeguard and promote a child's welfare and take part in regularly reviewing the outcomes for the child against specific plans and outcomes;
- local areas innovate and changes are informed by evidence and examination of the data.

Effective safeguarding arrangements in every local area should be underpinned by two key principles

- safeguarding is everyone's responsibility: for services to be effective each professional and organisation should play their full part; and
- a child-centred approach: for services to be effective they should be based on a clear understanding of the needs and views of children

LSCBs are now required to publish a threshold document that includes: the process for the early help assessment and the type and level of early help services to be provided; and the criteria, including the level of need, for when a case should be referred to local authority children's social care for assessment and for statutory services under section 17 (child in need), section 47 (risk of significant harm), section 31 (care orders), section 20 (duty to accommodate) of the Children Act 1989. The Essex safeguarding children's board has published their threshold document and it is widely available to professionals. This in turn has helped professionals within the Trust to easily identify when they should refer to social care, and for what level of service.

Social care are now required to make a decision about the type of response a referral needs within one working day and acknowledge receipt of the referral. There is no longer a requirement to conduct separate initial and core assessments but the maximum timeframe for the assessment to conclude is within 45 working days from the point of referral.

Depending on the needs of the individual child, and the nature and level of any risk of harm faced by the child, the assessment may need to be concluded sooner

The Princess Alexandra Hospital NHS
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Appendix 3: Safeguarding Children's Training Report Month by Month 2018/19

% of staff compliant with safeguarding children's training

Meets CCG requirement of 95% staff trained

Between 85 -94% of staff meeting requirement

Less than 85% of staff meeting requirement

Competence Name	April	May	June	July	August	Sept	Oct	Nov	Dec		Jan		Feb		March	
Level 1	95%	93%	94%	94%	95%	95%	96%	96%	96%		96%		96%		97%	
Level 2	85%	87%	87%	90%	87%	86%	87%	96%	88%		89%		89%		91%	
Level 3	65%	70%	72%	79%	76%	79%	78%	81%	75%	96%	82%	89%	86%	90%	85%	91%

SGA Level 1	72%	71%	68%	75%	76%	82%	88%	93%	93%		93%		92%	93%
SGA Level 2	60%	69%	65%	68%	69%	72%	73%	77%	77%		77%		78%	79%

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The Princess Alexandra Hospital NHS
NHS Trust

8.2

The Princess Alexandra Hospital NHS Trust

BOARD OF DIRECTORS

MEETING DATE: 05/12/19 **AGENDA ITEM NO: 8.2**

REPORT TO THE BOARD FROM: Workforce Committee

REPORT FROM: Pam Court – Committee Chair

DATE OF COMMITTEE MEETING: 25/11/19

SECTION 1 – MATTERS FOR THE BOARD'S ATTENTION
The following are highlighted for the Board to note or to take action:
• BAF risks 2.1 and 2.3 were discussed and WFC considered a proposal to reduce the risk score for 2.1 Nurse Recruitment from 16 to 12. Although the committee noted the improvements in the nursing vacancy rate, it was agreed that the score would remain at 16 and would be reviewed again at the next WFC meeting in January 2020. Risk 2.3 Inability to recruit, retain and engage our people (12) was discussed and the score remains unchanged. • The Freedom to Speak Up Guardians report was discussed and the committee was concerned around the continued theme of bullying and harassment. • Time to hire in Medicine and Estates and Facilities was significantly behind target and WFC was informed that recruitment processes are under review. • The GMC survey results and action plans were discussed in detail; workload, supervision, induction and leadership issues were identified.
SECTION 2 – ITEMS FOR THE BOARD'S INFORMATION AND ASSURANCE
The following are highlighted for the Board's awareness and/or assurance:
The committee also received the following reports: Workforce Report (Targets and Performance), Temporary Staffing, Safer Staffing, Training and Education, Succession Planning and Talent Management, Voluntary Services, People Strategy metrics, STP update, Communications update and a report from the People Board.
SECTION 3 – PROGRESS AGAINST THE COMMITTEE'S ANNUAL WORK PLAN
The Committee's progress against its Annual Work Plan is set out below:
The Committee is making good progress against the work plan.

8.2

The Princess Alexandra Hospital NHS
NHS Trust

BOARD OF DIRECTORS

MEETING DATE: 5 December 2019 **AGENDA ITEM NO: 8.2**

REPORT TO THE BOARD FROM: Performance and Finance Committee (PAF)
REPORT FROM: Andrew Holden - PAF Chairman
DATE OF COMMITTEE MEETING: 28.11.19

SECTION 1 – MATTERS FOR THE BOARD'S ATTENTION
The following are highlighted for the Board to note or to take action:
• Overseas nurse recruitment numbers and costs were discussed. The recruitment campaign has been positive with improvement in local recruitment also noted. The 2020/21 nurse vacancy rate target is being considered and will be discussed at PAF in January 2020. • The nursing establishment review was discussed and it was agreed that costs associated with the recommended uplifts to establishments would be considered as part of the budget setting process which will be reported to PAF in January 2020. • Finance Month 7 - the in-month deficit was £2.9m, £1.4m behind plan. The YTD deficit was £20.7m, £4.1m behind plan. External support has been discussed and will be required to achieve the financial control total in view of the shortfall against recovery trajectories particularly on temporary staffing and stretch actions. In recognition of the current position, PAF recommended an increase in the risk rating for BAF risk 5.1 (Finance) from 15 to 20. The Trust must continue to significantly improve financial run rates going forward to minimise support requirements and ensure suitable run rates as it enters 2020/21. • Financial headlines for 2020/21 were discussed including required run rate, CIPs to be delivered and the scale of pressures and risks to be managed. This will be further detailed and worked on over the coming months. • Capital spend - the variance against plan is £3.9m and spend must be accelerated in order to meet plan. This includes proceeding on emergency capital projects. • The quarterly Estates and Facilities report provided assurance that robust water safety management processes are in place and that the birthing unit has re-opened. Assurance on delivery of CIPs was also provided.
SECTION 2 – ITEMS FOR THE BOARD'S INFORMATION AND ASSURANCE
In addition to the above, PAF received reports on the following agenda items: SLR, IPR and BAF risks 4.2, 3.1 and 1.2 were noted with no changes to the risk ratings.
SECTION 3 – PROGRESS AGAINST THE COMMITTEE'S ANNUAL WORK PLAN
The Committee continues to make good progress against the workplan.

The Princess Alexandra Hospital NHS
NHS Trust

BOARD OF DIRECTORS

MEETING DATE: 05.12.19 **AGENDA ITEM NO: 8.3**

REPORT TO THE BOARD FROM: Senior Management Team
REPORT FROM: Lance McCarthy - Chairman
DATES OF MEETINGS (Fortnightly): 5 and 19 November 2019

ITEMS FOR THE BOARD'S INFORMATION AND ASSURANCE

SMT meetings took place on 5th and 19th November 2019.

The following items were discussed at the meetings:

5 November 2019:

- ASI/Review List update
- Short notice clinic cancellations
- Deep dive in Cardiology
- Outpatient Modernisation Project (presentation)
- Review of management of generic email inboxes
- Ward refurbishment update
- Finance update

19 November 2019:

- Cyber Operational Resilience Feedback
- PATHWEB Decommissioning
- Winter Updates:
    - Winter Plan 2019/20
    - Nightingale - Model of Care Proposal
    - Opel Status Escalation Proposal
- Estates Updates:
    - Update on the new car parking systems and payments
    - Update on ward refurbishment project
- ASI/ Review List Update
- STP/ICP update
- Nursing establishment review
- Review of Matron role